Whittington Health
NHS Trust

# TRUST BOARD
# IN PUBLIC

**12:30pm – 3:00pm**
**Wednesday**
**29 January 2020**

**Whittington Education Centre**
**Room 7**

| | |
|---|---|
| **Meeting** | **Trust Board – Public meeting** |
| **Date & time** | **29 January 2020: 12.30pm – 3.00pm** |
| **Venue** | **Whittington Education Centre, Room 7** |

| **Non-Executive Director members:** | **Executive Director members:** |
|---|---|
| Anu Singh (Interim Chair)<br>Deborah Harris-Ugbomah<br>Professor Naomi Fulop<br>Tony Rice<br>Yua Haw Yoe | Siobhan Harrington, Chief Executive<br>Kevin Curnow, Acting Chief Finance Officer<br>Dr Clare Dollery, Medical Director<br>Carol Gillen, Chief Operating Officer<br>Michelle Johnson, Chief Nurse & Director of Allied Health Professionals |

**Attendees:**
Councillor Janet Burgess MBE, Islington Council
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Dr Sarah Humphery, Medical Director, Integrated Care
Swarnjit Singh, Trust Corporate Secretary

**Contact for this meeting:** jonathan.gardner@nhs.net

# AGENDA

| Item | Timing | Title and lead | Action |
|---|---|---|---|
| **Standing items** | | | |
| 1 | 12.30 | **Patient story**<br>*Michelle Johnson, Chief Nurse and Director of Allied Health Professionals* | Presentation |
| 2 | 12.50 | **Welcome & apologies**<br>*Anu Singh, Interim Chair* | Verbal |
| 3 | 12.51 | **Declaration of interests**<br>*Anu Singh, Interim Chair* | Verbal |
| 4 | 12.52 | **18 December 2019 public Board meeting draft minutes, action log, matters arising**<br>*Anu Singh, Interim Chair* | Approve |
| 5 | 12.55 | **Chair's report**<br>*Anu Singh, Interim Chair* | Note |
| 6 | 1.05 | **Chief Executive's report**<br>*Siobhan Harrington, Chief Executive* | Note |

| | | | |
|---|---|---|---|
| **Quality & patient safety** | | | |
| 7 | 1.15 | **Serious incidents**<br>*Dr Clare Dollery, Medical Director* | Review |
| 8 | 1.25 | **Quarterly learning from deaths report**<br>*Dr Clare Dollery, Medical Director* | Review |
| 9 | 1.35 | **Quality Improvement 2019 annual report**<br>*Dr Clare Dollery, Medical Director* | Review |
| **People** | | | |
| 10 | 1.45 | **Guardian of safe working hours**<br>*Dr Clare Dollery, Medical Director* | Review |
| **Performance** | | | |
| 11 | 1.55 | **Financial performance and capital update**<br>*Kevin Curnow, Acting Chief Finance Officer* | Review |
| 12 | 2.05 | **Integrated performance report**<br>*Carol Gillen, Chief Operating Officer* | Review |
| **Strategy** | | | |
| 13 | 2.15 | **Standing Orders, standing financial instructions and scheme of reservation and delegation of powers**<br>*Kevin Curnow, Acting Chief Finance Officer* | Approve |
| 14 | 2.20 | **Estate strategy**<br>Jonathan Gardner, Director of Strategy, Development & Corporate Affairs | Approve |
| 15 | 2.30 | **Quarter 3 delivery of 2019/20 strategic objectives**<br>Jonathan Gardner, Director of Strategy, Development & Corporate Affairs | Review |
| 16 | 2.40 | **Trust risk register**<br>*Michelle Johnson, Chief Nurse and Director of Allied Health Professionals* | Approve |
| 17 | 2.45 | **Committee Chairs' Assurance report template**<br>Jonathan Gardner, Director of Strategy, Development & Corporate Affairs | Approve |
| **Governance** | | | |
| 18 | 2.50 | **Charitable Funds Annual Report and Accounts**<br>*Kevin Curnow, Acting Chief Finance Officer* | Approve |
| 19 | 2.55 | **Audit & Risk Committee meeting held on 15 January 2020** | Note |

| | | | |
|---|---|---|---|
| | | *Deborah Harris-Ugbomah, Committee Chair* | |
| 20 | | **Minutes of the Workforce Assurance Committee meeting held on 11 December 2019**<br>*Yua Haw Yoe, Non-Executive Director* | Note |
| 21 | | **Minutes of the Quality Committee meeting held on 8 January 2020**<br>*Naomi Fulop, Committee Chair* | Note |
| 22 | | **Minutes of the Charitable Funds' Committee meeting held on 8 January 2020**<br>*Tony Rice, Committee Chair* | Note |
| 23 | 2.55 | **Questions to the Board on agenda items**<br>*Anu Singh, Interim Chair* | Verbal |
| 24 | 3.00 | **Any other business**<br>*Anu Singh, Interim Chair* | Verbal |

**Minutes of the meeting of the Trust Board of Whittington Health NHS Trust held in public on 18 December 2019 in the Whittington Education Centre**

**Present:**

| | |
|---|---|
| Anu Singh | Interim Chair |
| Kevin Curnow | Acting Chief Finance Officer |
| Clare Dollery | Medical Director |
| Norma French | Director of Workforce* |
| Naomi Fulop | Non-Executive Director |
| Jonathan Gardner | Director of Strategy* |
| Carol Gillen | Chief Operating Officer |
| Siobhan Harrington | Chief Executive |
| Deborah Harris-Ugbomah | Non-Executive Director |
| Sarah Humphery | Medical Director, Integrated Care* |
| Michelle Johnson | Chief Nurse & Director of Allied Health Professionals |
| Yua Haw Yoe | Non-Executive Director |

*non-voting member

**In attendance:**

| | |
|---|---|
| Councillor Janet Burgess | London Borough of Islington |
| James Connell | Patient Experience Manager (items 1 and 10) |
| Leon Douglas | Chief Information Officer |
| Casey Galloway | Patient Experience Officer (item 1) |
| Karen Johnston | Practice Development Nurse, Intensive Treatment Unit (item 1) |
| Sarah Nasaazi | Administrative Supervisor, Maternity Services (item 10) |
| Andrew Sharratt | Head of Communications & Engagement (from item 14) |
| Swarnjit Singh | Trust Corporate Secretary |

| | |
|---|---|
| **1.** | **Patient story** |
| 1.1 | Anu Singh and Michelle Johnson thanked the patient, Josien, for coming to the board meeting today to share her patient experience and any suggestions for areas for improvement. Yosien explained the following to Board members:<br><br>• 18 months ago, she was rushed to the emergency department (ED) by the London Ambulance Service, prior to being admitted to the Intensive Treatment Unit (ITU). She was severely unwell, diagnosed as having sepsis, pneumonia and flu<br>• Whittington Health worked closely with The Royal Brompton and Harefield NHS Foundation Trust to save Yosien's life with her being transferred to the Royal Brompton Hospital<br>• Once her condition stabilised, Yosien returned to the ITU at the Whittington Hospital. She was transferred to one of the inpatient wards before discharge to home |

| | |
|---|---|
| | • It had been a long journey of recovery; she was now recovered, was well and is now very engaged with patient involvement work. Last month, she attended a two day engagement course and is now part of the patent voice for the North East London Network<br>• In particular, Yosien wanted to thank Dr Andrew Badacsonyi, Consultant, Anaesthetics, for the excellent communication with her and her family members and cited the use of diaries by nurses as being really helpful for patients. She was also grateful for the ITU nurses coming to see her on the Cloudesley inpatient ward and to the physiotherapy team who arranged her home adaptations, prior to discharge<br>• Areas that Whittington Health could look at were staff handovers in the evening and increased awareness by all staff of the needs of patients with sepsis e.g. having lights turned off |
| 1.2 | During discussion, the following points were made:<br>• Learning which had been shared with staff included the aim for discharges to take place by 1700 hours and in 2020 there would be increased education for staff on the environmental needs of patients who transferred from ITUs to inpatient wards<br>• Yosien came and spoke to nurses on team development days about her experience and highlighted the importance of writing diary entries and including photographs as they were vital for patients with no memory of that time due to the treatment they received |
| 1.3 | **The Board thanked Yosien for her feedback on the importance of handovers and completing diaries and for her patient involvement work with Whittington Health.** |
| **2.** | **Welcome and apologies** |
| 2.1 | Anu Singh welcomed everyone to the meeting. |
| 2.2 | Apologies were noted from David Holt, Non-Executive Director and Tony Rice, Non-Executive Director. |
| **3.** | **Declaration of conflicts of interest** |
| 3.1 | There were none in addition to those already recorded. |
| **4.** | **Minutes, matters arising & action log** |
| 4.1 | Subject to the following amendments, the minutes of the Trust Board meeting held on 27 November 2019 were approved as a correct record:<br>• page 1, Michelle Johnson's title should read as Chief Nurse and Director of Allied Health Professionals;<br>• page 3, 'patients' be replaced by 'staff' in the second bullet point of section 5.3;<br>• page 12, include the following, additional bullet point in section 19.1:<br>o "Although there were two standing items carried forward, due to loss of quorum, these were not significant or cause for concern, and will be reviewed at the next committee meeting in January." |
| 4.2 | The updated action log was noted. Siobhan Harrington reported that the trust had |

| | |
|---|---|
| | carried out testing of the average call waiting times for non-emergency patent transport services (NEPTS) and, as of 17 December, they were at an average of 1.6 minutes against a target of 3 minutes. She provided assurance that the call times for the NEPTS service would continue to be monitored and reported that a monthly meeting of the Chief Executives of the provider trusts involved was in place to discuss the service. In addition, she reported that Whittington Health was working closely with DHL, the service provider, after issues had been identified in community services and this was be reported on a weekly basis to the executive team. |
| 4.3 | There were no matters arising. |
| **5.** | **Chair's report** |
| 5.1 | Anu Singh reported the following:<br>• On 17 December, she had with Siobhan Harrington attended a meeting of NHS Chairs and Chief Executives with Simon Stevens, Chief Executive, NHS England, and Amanda Pritchard, NHS England and NHS Improvement's Chief Operating Officer. A key message was the enormous thanks to all NHS staff for their hard work<br>• She had continued the initiative started by Steve Hitchins to hold a tea party with staff whose birthdays fell that month and highlighted the following:<br>o The availability of office space was a challenge in some areas<br>o There were good suggestions received on succession planning and on improved communication and engagement with community services staff which would be discussed by the Workforce Assurance Committee<br>o A query on recycling opportunities at the trust, especially at community sites |
| 5.2 | Non-Executive Directors reported the following from visits to services:<br>• Yua Haw Yoe had visited the Goodinge Health Centre and also received staff feedback on recycling and office space<br>• Naomi Fulop went to the Care of Older People Unit and thanked Kevin Gilbride, Matron, Acute Elderly Medicine, for his leadership in the service and drew attention to the following:<br>o She was struck by the level of patient acuity and complexity and by staff who were working really hard and well to deliver the best possible care<br>o There had been noticeable improvements in staff recruitment and retention and reductions in temporary staffing posts<br>o Improvements in enhanced care services were noticeable including the introduction a scheme for health care assistants to complete training on a patient-centred model which sought to facilitate patient mobility and safety<br>o She had discussed with Carol Gillen a delayed patient discharge which impacted on the admission to the ward of a patient from critical care. Carol Gillen reported that the learning demonstrated the importance of using the careflow system to flag delays in patient transport needed for discharges<br>o There was an excellent internship programme in place for people with autism or learning disabilities run by Project Search at Whittington |

| | |
|---|---|
| | Health and it would be helpful to review arrangements for reimbursing expenses for people on the programme<br>• Deborah Harris-Ugbomah reported that, on 10 December, she had delivered a presentation to eight allied health professional staff in Speech & Language Therapy services based on the google training – "I'm remarkable"<br>• Anu Singh reported on Tony Rice's email following his visit to diagnostic and imaging services in which he highlighted the investment in new equipment, a strengthened and collegiate management structure and the importance of benchmarking against model hospital data. Overall, he appreciated the capability shown for world class treatment and services |
| 5.3 | **The Board noted the :**<br>**i. verbal update from the Chair and other Non-Executive Directors; and**<br>**ii. that feedback from service visits would be communicated to respective integrated clinical service unit colleagues.** |
| **6.** | **Chief Executive's report** |
| 6.1 | Siobhan Harrington noted that this month's Board meeting was a week earlier than usual and that services were incredibly busy. She highlighted the following key points:<br>• Two of the main messages from the national NHS leadership meeting held on 17 December was the recognition that staff were working incredibly hard and that the focus should remain on ensuring patient safety and staff health and wellbeing<br>• 67% of staff had been vaccinated against winter flu and a major drive would take place to improve on this level and to exceed last year's outcome<br>• Communication was going out to all staff following the implementation of a local recycling policy whereby enhanced pay would be paid to impacted staff who have chosen or will choose to leave the NHS pension scheme in 2019/20<br>• Performance in November was challenged with 80.1% of patients being seen against the 95% four hour emergency department standard. There were eight mental health patients who waited more than 12 hours following a decision to admit them. She had chaired the local A&E Delivery Board meeting this morning and a system-wide approach was being taken with local authority partners to help better manage waits for mental health patients<br>• statutory and mandatory training and staff appraisals were below target and under review<br>• staff turnover and vacancy rates had improved throughout the year<br>• in terms of financial performance, there had been slower than anticipated progress on delivering recurrent cost improvement programme schemes and, while the trust was behind plan at the end of month eight, it was still forecasting achievement of its control total at year-end<br>• the Care Quality Commission (CQC) completed its inspection visit on 3-5 December, wrote to Whittington Health with its preliminary findings and asked for a draft action plan to be considered at the next meeting of the Board – this was appended. Michelle Johnson acknowledged the excellent |

| | |
|---|---|
| | response from integrated clinical service units (ICSUs) in responding to the CQC's preliminary findings with the initial draft action plan. She also confirmed that immediate actions were taken in response to the issues identified with medicines management in one site delivering children's and young people's services and the learning had been applied across all community services' sites<br>• a final response rate of 56.4% in the annual NHS staff survey represented an excellent proxy for staff engagement<br>• Whittington Health had been accepted on a national pilot on culture change linked to the workforce race equality standard (WRES). Norma French reported that the trust had improved outcomes on WRES indicators 2, 3 and 4 and was 9th out of 23 trusts in London for overall WRES outcomes. Siobhan Harrington advised that a more detailed report on the latest 2019 national WRES outcomes would be brought back to the Board in quarter four<br>• Lakshan Ariyawansa, Senior Radiographer, was awarded this month's staff award for consistently displaying the trust's excellence value<br>• Finally, she wished everyone a merry Christmas and a happy New Year, especially colleagues who would be working across hospital and community sites caring for patients through the holiday period |
| 6.2 | In discussion, Board members raised the following:<br>• Janet Burgess reported that she had spoken with her opposite number at the London Borough of Camden and there continued to be concerns with NEPTS in north central London. Siobhan Harrington provided assurance that the trust was keeping a tight grip on the NEPTS and, kept under review, performance on this contract by DHL<br>• Naomi Fulop welcomed the excellent staff survey response rate and reported that she was involved in research on NHS trusts in special measures and it was noticeable that those bodies had low staff survey response rates<br>• In reply to a question from Deborah Harris-Ugbomah on the WRES pilot, Siobhan Harrington said the pilot would help Whittington Health to achieve continuous improvement in developing an inclusive culture and also in its annual WRES outcomes' submission to NHS England<br>• Jonathan Gardner reported that members of the Finance and Business Development Committee had considered a paper setting out the joint bid proposal by Whittington Health and University College London Hospitals NHSFT (UCLH) to be an elective orthopaedic centre for NCL and were supportive. Pending approval at a joint commissioning meeting on 7 January 2020, public consultation on the proposals was due to begin on 13 January<br>• In reply to question from Kevin Curnow on the draft CQC action plan, Michelle Johnson advised that the plan was being reviewed by each ICSU Board and then delivery against it would be monitored by the Trust Management Group and reported to the Quality Committee. In addition, she reported that the quarterly Quality Assurance report considered by the Board would provide an update on the actions arising from the CQC's visit<br>• Carol Gillen confirmed that a whole system approach would be adopted for the emergency department to better manage patient inflow, throughflow |

| | |
|---|---|
| | and outflow and that greater capacity needed to be created within the sector with hospital and community services working with colleagues in primary and social care and mental health services. She provided assurance that there was weekly monitoring of emergency department performance by the executive team and reported that the A&E Delivery Board had, noted earlier that day, the reduced capacity within the private care home market in north central London. Siobhan Harrington commented that data released by NHS Improvement demonstrated that all NHS trusts in England were currently challenged in meeting the four hour standard for A&E waits and reported that there was a national review of access standards. She also gave assurance to Board members that the executive team would do everything possible to keep people safe and to strive to achieve the performance indicators |
| 6.3 | **The Board noted the report, in particular the draft CQC action plan and the work to take forward a joint bid between Whittington Health and UCLH for an elective orthopaedic hub in north central London.** |
| **7.** | **Serious Incidents (SIs)** |
| 7.1 | The report was taken as read. Clare Dollery highlighted the following:<br>• Due to a number of complaints about access to NEPTS, this had been declared as an SI<br>• It was disappointing to report the Never Event which took place when a wrong tooth extraction occurred. The dental practitioner had had their bag stolen on the way to work and was in a distressed state and did not follow the checklist available. The patient had received an apology, was obtaining appropriate dental advice on the next steps and was also aware of the investigation underway. Action had been taken to incorporate the Local Safety Standards for Invasive Procedures (LocSSIP) dental extraction checklist into the electronic patient record<br>• Learning from the Never Event which related to the unintentional connection of a patient intended to have oxygen to an air flowmeter had been implemented and included actions such as restricting medical air ports to areas where nebulised medications were frequently used; and, carrying out regular trustwide audits to ensure that air ports remained capped and that air flowmeter practice met national standards<br>• There was also learning shared following three investigations into the cases of patients who had gastroscopies following direct referral by a GP to a gastroscopy slot when a different process or procedure was intended by the GP. The three cases demonstrated issues with the referrals bookings, clinical triage and endoscopy procedures and emphasised the importance of listening to patients. A multi-disciplinary investigation panel including GPs, commissioners, the Trust's Medical Director for Integrated Care and the patient safety team had taken place and an integrated approach would be adopted to minimise the risk of recurrence |
| 7.2 | During discussion, the following points arose:<br>• In reply to a question from Anu Singh and the three gastroscopies, Clare Dollery explained that advice was taken from NHS Improvement's Patient Safety team and, because the patients' referrals were initially to a |

| | |
|---|---|
| | gastroscopy slot, this fulfilled a national exemption criteria for Never Events for these cases<br>• Sarah Humphery said that the GP Connect newsletter had reminded GPs of their responsibilities in this area and she had made personal contact with the practices<br>• Michelle Johnson reported that human factors' training would be provided to help staff. In reply to a question from Siobhan Harrington, she confirmed that the training would be jointly delivered, in partnership with Moorfields Eye Hospital NHSFT |
| 7.3 | **The Board noted the report and recognised the assurances within the paper demonstrated that the serious incident process was managed effectively and that lessons learnt as result of serious incident investigations were shared widely.** |
| **8.**<br>8.1 | **Six monthly safer staffing review of nursing and midwifery establishments**<br>Michelle Johnson explained that, in line with National Quality Board guidance, this report was brought to the trust Board on a six monthly basis. She advised that the next report would include caseloads for nursing and midwifery staff and drew the following areas to Board members' attention:<br>• There was a high level of patient acuity during the period covered by the report, occupancy on adult inpatient wards was near 100% and staff were working very hard<br>• A review of the establishments in the critical care unit had taken place and would daily staffing numbers and skill mix would be adjusted in line with patient acuity and dependency<br>• The review had shown that occupancy on the children's inpatient ward was low<br>• For Simmons House, it was recommended that one additional health care assistant post be established to help with the need for 1:1 observations and enhanced care<br>• There was good progress across all areas in reducing vacancy rates and staff turnover; 75% of new nursing graduates who joined Whittington Health 12 months ago had stayed and 100% of the international nurses recruited two years ago were still with the trust<br>• The financial implications of the recommendations to change staffing and skill mix on Nightingale ward and to increase health care assistant numbers on Victoria ward and in Simmons House would be met through changes to clinical areas where there was reduced occupancy |
| 8.2 | During discussion, the following points arose:<br>• Board members welcomed the detailed report from Maria Lygoura, Lead Nurse for Safer Staffing<br>• the analysis of care hours per patient day showed that the yearly trust average was consistently higher than the median of peer trusts. This was in part due to layout and the physicality of care needed<br>• Yua Haw Yoe welcomed the improvements in staffing stability and said this had been fed back to her by staff on visits to maternity services<br>• In answer to a question from Naomi Fulop on how the recommendations in the paper would be implemented, Michelle Johnson said that this would be |

| | |
|---|---|
| | reported in the next six monthly safe staffing review to the Quality Committee and Board<br>• Kevin Curnow reported that there was a potential £300k financial impact in real costs from the recommendations with, for instance, additional shifts in Simmons House. He also reported that the Trust Management Group had reviewed a business case for enhanced care recently which outlined proposals to use more health care assistants and suggested that the process for an implementation date and budgetary adjustments be discussed outside of the meeting |
| 8.3 | **The Board:**<br>**i. reviewed the report and agreed that the appropriate level of detail and assessment had been undertaken to provide assurance that the clinical areas reviewed were appropriately-staffed;**<br>**ii. noted the next six monthly safe staffing report would include details on caseloads and the implementation of the recommendations in this report;**<br>**iii. agreed the recommendation to approve the skills mix and registered nurse reduction as presented in appendix 2 of the report; and**<br>**iv. noted that, outside of the meeting, the Acting Chief Finance Officer would meet to work through the implementation date and budgetary adjustments needed.** |
| **9.** | **Emergency Planning Resilience Response – yearly report** |
| 9.1 | The report was taken as read. Carol Gillen explained that the report set out the work delivered during the year and welcomed the compliance achieved, including citation for good areas of practice by Whittington Health on business continuity planning and critical incident planning. She clarified that there only one amber-rated area of the report which dealt with impact on the environment and climate change which a number of trusts were discussing. |
| 9.2 | In discussion, Naomi Fulop welcomed the excellent report and Carol Gillen also highlighted work through the year on planning for an exit from the European Union, winter planning and a flu pandemic exercise. |
| 9.3 | **The Board approved the annual report on emergency planning resilience and response.** |
| **10.** | **Staff story** |
| 10.1 | Michelle Johnson introduced Sarah Nasaazi who shared the following:<br>• She currently worked as a Maternity Administration Supervisor within Women's Health. She had originally been seconded into this role until September this year, before having this opportunity extended into the early part of next year<br>• Sarah originally joined Whittington Health in 2013 as a volunteer, supporting with administration within Women's Health. She was then enrolled with the Bank staffing office to provide support as a rota-coordinator within Women's Health. From here she became substantively employed as an administrator with colposcopy services, prior to working as the gynaecology clinic co-ordinator. She had been in this position for three years, prior to being seconded into her current role |

| | |
|---|---|
| | • She had taken on additional responsibilities. These included volunteering as a freedom to speak up champion, taking the mental health first aider training course and mentoring Michelle Johnson as part of a reverse mentoring scheme<br>• She had found engaging with each of these projects positive experiences. from her staff journey so far, she suggested the following ideas for how these roles, could be improved: exploring ways to provide more organisational support for staff career development; allowing all frontline staff to complete mental health first aider training; and support from management structures to engage with freedom to speak up work<br><br>During discussion, the following points arose: |
| 10.2 | • Siobhan Harrington said it was really important feedback about how Whittington Health could enable people to attend training opportunities and to develop their careers and suggested that it would be helpful to carry out an audit<br>• Norma French commented that the development agenda was included under the culture work framework and additional resource was brought in to signpost staff to opportunities from the New Year<br>• In reply to a query from Deborah Harris-Ugbomah, Michelle Johnson said important learning from the reverse mentoring relationship included the need to have dedicated time in order to establish and build a relationship and the opportunities it provided to discuss issues openly |
| 10.3 | **The Board thanked Sarah Nasaazi for sharing her patient story and the passion she showed for taking on new opportunities during her career journey at Whittington Health.** |
| **11.** | **Financial performance and capital update** |
| 11.1 | Kevin Curnow presented the report and highlighted the following to Board members:<br>• At the end of month eight, the trust was £5.7m behind plan, which equated to an adverse variance of £3.1m after adjusting for provider sustainability funding<br>• There was positive performance on reducing temporary agency staffing expenditure which had been high in quarter one and now was c.£600k per month. Whittington Health was on trajectory to be below its agency spending cap at year-end<br>• £18m of capital expenditure was envisaged for the full year. At this stage, while the trust was £1.8m behind plan, there was assurance that the full year's plan would be achieved due to the modular build which would replace the Whittington Education Centre<br>• The prime driver behind the adverse variance was the inability to deliver cost improvement programme (CIP) schemes as planned with £5.1m achieved so far against a target of £8.1m at this stage of the year<br>• The trust was still forecasting achievement of the control total. There was a c.£6m risk to this worth c.£2m in each of the areas of commissioner income, integrated clinical service units' financial recovery plans and technical adjustments |

| | |
|---|---|
| 11.2 | Board members reviewed the report and, in discussion, raised the following:<br>• Siobhan Harrington reported that the Trust Management Group carried out a detailed discussion of financial performance at the end of month eight and agreed to review the existing support as it was important to deliver a higher level of recurrent CIP schemes this year<br>• Deborah Harris-Ugbomah said that, in January 2020, the Audit & Risk Committee would look at some of the proposed technical adjustments<br>• Kevin Curnow welcomed the impact made by the vacancy scrutiny panel in reviewing temporary staff bookings |
| 11.3 | **The Board noted:**<br>**i. the month eight finance report;**<br>**ii. the Trust was forecasting achievement of its control total; and**<br>**iii. the identified risks for which mitigating actions were being taken.** |
| **12.** | **Integrated performance report** |
| 12.1 | The report was taken as read. Carol Gillen drew attention to:<br>• Good performance on theatre utilisation which needed to be sustained<br>• A fall in the level of acute Did Not Attend percentage rate to near the target of 10%<br>• Compliance with referral to treatment time targets<br>• Compliance with the 62 days' cancer treatment target and a marginal miss against the two week cancer wait target<br>• A challenged emergency department due to a range of factors which saw 80% performance against a target of 90% and an average of 312 patients seen per day in November<br>• waits for autism services in Islington and Haringey. In the former, they had fallen from an average of 39 weeks to 23 weeks; in the latter, the service covered children up to the age of 12 years and following redesign akin to the Islington model, it was expected that average waits would fall to 12-18 weeks |
| 12.2 | In discussion, Board members highlighted the following:<br>• Sarah Humphery noted the challenges across the health and social care system and the increased patient acuity and said that the GP Connect newsletter would remind GPs to emphasise the importance of patients attending appointments. Carol Gillen reported that the trust was relaunching a campaign called *The Empty Chair* as part of the work of the Outpatient Transformation Programme<br>• Siobhan Harrington commented that waiting times for autism and learning disability services was a national issue and said that the integrated performance scorecard would be amended to include these indicators and performance reviewed in February 2020<br>• Michelle Johnson gave assurance that safe staffing numbers were reviewed on a daily basis and escalation plans put in place, where necessary<br>• In response to a question from Jonathan Gardner, Carol Gillen said that additional capacity had been created in gynaecological and dermatology services to help ensure that performance against the cancer two week wait target improved |

| | |
|---|---|
| | • Naomi Fulop commented that national data released the previous Friday showed the lowest performance against the four hour emergency department wait target since its introduction<br>• Clare Dollery reported that the summary hospital-level mortality indicator (SHMI) increased from 0.77 to 0.82 but remained lower than expected statistically. Review had suggested that no single category had seen an increase in deaths and that the number of expected deaths predicted in the SHMI methodology had fallen year-on-year (as had the actual deaths). The learning from deaths process and trustwide mortality review remained an important part of the Trust's quality of care processes |
| 12.3 | **The Board reviewed the integrated performance report and took assurance that Whittington Health was managing performance compliance and had remedial plans in place for areas off plan.** |
| **13.** | **Section 75 report with the London Borough of Islington** |
| 13.1 | Carol Gillen thanked the team for really good work throughout the year to help provide better co-ordinated services to vulnerable people. She drew attention to the following:<br>• Integrated teams reviewing patients with a lower risk level<br>• Significant work from integrated care networks (multi-agency teams wrapped around primary care) to support GP practices<br>• Good work from the Lead Nurse on the implementation of the NHS England, Enhanced Health in Care Home experience to help improve quality in care homes<br>• Improved harnessing of digital technology<br>• The key to continued improvement was embedding locality configurations<br>• Whittington Health was working with local authority and mental health partners to develop an Integrated Intermediate Care strategy |
| 13.2 | During discussion, the following issues were raised:<br>• Janet Burgess thanked the trust for an exceptional partnership in its work with the London Borough of Islington and cited the excellent joint locality work taking place. She also noted the fragile state of the social care market over recent years with only two care homes left in the borough<br>• Carol Gillen reported that Whittington Health also had a s75 agreement in place with the London Borough of Haringey only for people with a learning disability and its annual report would be brought to the February 2020 Board meeting<br>• In reply to a question from Naomi Fulop, Carol Gillen confirmed that, an access visit was carried out to care homes to verify the risks and adjustment needs for a patient, prior to their discharge to a care home |
| 13.3 | **The Board:**<br>**i. welcomed the 2018/19 s75 annual report on partnership working with the London Borough of Islington;**<br>**ii. agreed the direction of travel indicated by both organisations; and**<br>**iii. noted that a s75 annual report with the London Borough of Haringey would be considered at the February 2020 meeting.** |

| | |
|---|---|
| **14.** | **Whittington Pharmacy financial statements** |
| 14.1 | Kevin Curnow reported that the Whittington Pharmacy Board had reviewed and approved the financial statements which would be submitted to Companies House prior to the 31 December 2019 deadline. He explained that this was the second year in which Whittington Pharmacy had made a profit. He also highlighted the fact that the accounts had received a qualified opinion from external auditors which related to stock system, revenue raised and debts owed. He provided assurance that the stock system had been replaced and the issue of revenue and debts was more of a technical matter. |
| 14.2 | **The Board noted the 2018/19 Whittington Pharmacy financial statements.** |
| **15.** | **Questions to the Board on agenda items** |
| 15.1 | There were none. |
| **16.** | **Any other business** |
| 16.1 | There were no items reported. |

**Action log, 18 December 2019 Public Board meeting**

| Item | Action | Lead(s) | Progress |
|---|---|---|---|
| Chairs report | Communicate the feedback from Non-Executive Director service visits to respective integrated clinical service unit teams | Carol Gillen | Completed |
| Safer staffing | Include caseloads and details of progress with the implementation of agreed recommendations in the next six monthly report to the Board | Michelle Johnson | In hand for next six monthly report |
| | Meet with the Chief Nurse to work through the implementation date and budgetary adjustments needed. | Kevin Curnow | Completed |
| S75 report with the London Borough of Islington | Bring a s75 report on integrated work with the London Borough is Haringey to the February 2020 Board meeting | Carol Gillen | In hand for February 2020 meeting |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Chief Executive's report** | **Agenda Item: 6** |
| **Executive director lead** | Siobhan Harrington, Chief Executive | |
| **Report author** | Swarnjit Singh, Trust Corporate Secretary | |
| **Executive summary** | This report provides Board members with an update on recent national and local developments as well as highlighting and celebrating achievements by Trust staff. | |
| **Purpose:** | Review | |
| **Recommendation(s)** | Trust Board members are invited to review the report and its contents, in particular the feedback from the Care Quality Commission's team following the well led review on 14-15 January 2020. | |
| **Risk Register or Board Assurance Framework** | All Board Assurance Framework entries | |
| **Report history** | Report to each Board meeting | |
| **Appendices** | Appendix 1: Executive committees' governance structure | |

**Chief Executive's report**
As anticipated, January is already proving to be incredibly busy and everyone is working extremely hard to provide high quality and safe care for our patients.

This report provides Board directors with highlights of key developments within the health and social care sector at a national and local level.

## 1. National news

**Queen's speech**
The Queen's speech introduced three bills directly related to health and social care: the NHS Funding Bill, the Health Service Safety Investigations Bill and the Medicines and Medical Devices Bill. The Government has also signalled it will introduce legislation to implement the NHS Long Term Plan.

**Healthwatch**
On 14 January 2020, Sir Robert Francis QC, Chair of Healthwatch England wrote to all NHS provider Chief Executives highlighting their report "Shifting the Mindset – A closer look at NHS complaints"[1] which emphasised the importance of using complaints to learn from mistakes and to share learning to help improve care. These important recommendations will be taken forward by our Patient Advice & Liaison team.

## 2. Regional news

On 16 January, NHS England and NHS Improvement announced the non-Executive Director Chairs of the five London NHS sectors, as follows:

- North Central London: Mike Cooke, former Camden Council Chief Executive
- North East London: Marie Gabriel, Chair of East London and Norfolk and Suffolk Foundation trusts, and a long-term leader in education, health and voluntary sectors, and champion of race equality
- North West London: Penny Dash, Head of Healthcare for Europe at management McKinsey and Co, and formerly a head of strategy at the Department of Health
- South East London: Richard Douglas, former Director General for Finance at the Department of Health, and a Non-Executive Director of NHS Improvement nationally
- South West London: Millie Bannerjee, a long-time leader in the public sector in London, and currently Chair of NHS Blood and Transplant

## 3. Local news

**Quality and safety operational performance**
December 2019 was another challenging month for the local healthcare system with an A&E performance of 77.75%, below the 90% trajectory. It is worth noting that performance was challenged across the country; the national average in December was 77.9%, the London average was 80.4%

[1] https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20191126%20-%20Shifting%20the%20mindset%20-%20NHS%20complaints%20.pdf

and the North Central London average was 77.47%. The daily A&E four hour performance at Whittington Health during December was very volatile and similar to previous months, ranging between 66.8% and 87.6%. There were 9,768 A&E attendances in December, an increase of 5.8% when compared to the same period last year (the year-to-date increase is 2.8%). The daily attendances ranged between 174 on 25 December 2019 and 383 which a record breaking number of attendances for the Trust. On average, there were 315 attendances per day during December 2019.

There were six mental health patients who waited in excess of 12 hours following a decision to admit. There is a local improvement plan which operational leads are working closely on and are looking at ways to protect capacity to improve Urgent Treatment Care and Paediatrics performance. There is also some ongoing work with length or stay and delayed transfers of care to improve flow out of the department.

**Mental Health Place of Safety**

On 21 January, Camden and Islington NHS Foundation Trust opened a Mental Health Place of Safety at the Highgate Mental Health Centre site. Previously the Whittington Health Emergency Department was used as a health-based Place of Safety to support people detained under Section 136 of the Mental Health Act. Following a phone triage, the police can now bring people in mental health crisis directly to the Highgate Mental Health Place of Safety to access timely care and assessment in a new purpose-built environment.

During November 2019, the Trust recovered its cancer performance for the 14 day target for suspected cancer patients (96.6% against a 93% target) following three months of non-achievement. Work continues to progress in gynaecology to increase outpatient capacity in the rapid access clinic and hysteroscopy clinic.

In terms of workforce indicators, the mandatory training and appraisal rates continue to improve. Mandatory training has improved its performance from 82.1% in November 2019 to 83.3% in December 2019 against a target of 90%; staff appraisals in November 2019 were 77.5% against a target of 90% and the staff sickness absence rate in November was 3.83% against a target of 3.35%.

**Non-Emergency Patient Transport Services**

The Trust continues to work with partners to resolve issues with the new non-emergency transport contract which is a collaboration of North London Partners in Health and Care provider trusts supported by our commissioners.

The service provider, DHL, continues to demonstrate week-by-week improvement to both their telephone booking service and the actual service of transporting our patients. Their key performance indicators for Whittington show significant improvement, particularly towards the end of January.

The Whittington Health NHS Trust patient transport team are closely monitoring improvements. Importantly, they are carefully reviewing all occurrences where a patient does not meet the eligibility criteria for transport to ensure consistency and fairness. Also, where a decision is upheld, ensuring the patient is fully aware of the appeal process, transportation alternatives and also that the clinic that the patient is attending are notified.

The member trusts (Royal Free London NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust and North Middlesex University Hospital NHS Trust) with Whittington Health NHS Trust have agreed to convene a Clinical Oversight Group which will have senior clinical leadership representation from all constituent trusts. The first meeting will take place in February.

**Flu vaccination campaign**
As of 21 January, 75% of frontline staff have been vaccinated against winter flu. The Trust's Flu Champions are continuing to working to help meet the 80% target by 31 March 2020.

**Financial performance**
At end of December, the Trust delivered an actual deficit of £6.9m (excluding Provider Sustainability Funding and Financial Recovery Fund monies). This was £3.2m worse than plan. Key drivers for the year to date adverse variance are slippage in the delivery of cost improvement programme schemes and pay overspends relating to temporary staff usage and unfunded beds. Action is being taken by the executive team to support financial recovery and the Trust continues to forecast that it will achieve its control total at year end. As the Trust moves into the last quarter of this financial year, it has started planning for next year including developing robust plans to deliver its 2020/21 financial challenge.

**Care Quality Commission (CQC) well led review**
The CQC inspection team have sent written feedback to Whittington Health following their well led review carried out on 14-15 December 2019. The content of the letter supports the positive verbal feedback provided immediately after the well led review. Overall, the CQC team was impressed at the openness and welcome they received from staff. Below are a few highlights they included in the correspondence:

- **Leadership:** They felt the leadership of the Trust was visible, had the appropriate skills and knowledge and integrity, but that succession planning could be improved
- **Vision and strategy:** They felt a clear vision and strategy was in place which showed continuity, simplicity and consistency and good engagement and was solidly embedded. There were good links with primary and mental health and staff patients and carers could contribute
- **Culture:** the CQC team felt the Trust was courageous in taking forward its work to tackle organisational culture work and noted it seemed to be showing green shoots; excellence was noted around learning. There is further to go with the staffside and there was humility, openness and willingness to learn and no sense of being defensive

- **Governance:** the Board functioned effectively and there were effective structures and processes to deliver strategy; the Board Assurance Framework was fit for purpose. Non-Executive Directors were sighted on key issues and ward to board links were good
- **Management of risks:** learning from risks, serious incidents and complaints was working well and risks on register aligned with staff views
- **Engagement:** there was good engagement with staff and equality groups, but engagement with ancillary staff could be improved. Whittington Health was well engaged with the North Central London Sustainability and Transformation Partnership and also nationally
- **Learning, continuous improvement and innovation:** Quality improvement was fine, and learning from deaths was good; the Trust may wish to strengthen clinical research

There has also been feedback about where there could be more improvement and this will be incorporated into the Trust's ongoing BetterNeverStops initiative. The final CQC inspection report outcome will be available this Spring.

**#CaringForThoseWhoCare - inclusive culture activities**

**Reverse mentoring**
Training for the second Reverse mentoring cohort begins on 7 February 2020, with 20 members of staff expressing an interest in being a mentor. So far ten mentees have joined the cohort and their training starts on 10 February 2020. As well as Black and Minority Ethnic (BAME) mentors, there will also be representation from Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) staff and employees with disabilities.

**National Workforce Race Equality Standard (WRES) pilot**
Whittington Health is one of six Trusts across England participating in the new national WRES pilot and is the first London Trust involved. The first meeting took place on 22 January 2020. As part of the preparation, a more in-depth analysis has been started to align the development of the Trust's targets with the Model Employer and London WRES strategy so that as well as improving performance, improvements are measured against the targets and timescales of the London WRES strategy. For example, Whittington Health has increased BAME representation in total from Agenda for Change pay bands 8A to Very Senior Manager levels by 4% since last year. In tandem with the national pilot, the Trust will report internally on the WRES Improvement plan in terms of targets against each indicator.

**Staff networks**
The governance structure for the networks is being taken forward, and broadly agreed in principle with minor amendments to ensure oversight by the Workforce Assurance Committee, and includes participation from each Integrated Clinical Service Unit and directorates, and is being implemented. The BAME network has agreed its terms of reference and there is a schedule of dates planned for the rest of the year. 'Whittability', the Trust's network for disabled staff was launched in December 2019. Internal stakeholders are

being invited and include Staff-Side, the Freedom to Speak Up Guardian, Mental Health First Aiders, and Occupational Health. The LGBTQ+ network will be meeting to agree its terms of reference in February (LGBT History Month). Launch of the Women's network is planned for March as close as possible to National Women's Day on Sunday, 8 March 2020.

**Executive committee governance arrangements**
A review to strengthen governance arrangements across the Trust's committee structure had been undertaken and was agreed by the Trust Management Group. It will come into effect from 1 April 2020 (see appendix 1). The next steps will be to review all terms of reference to ensure they are fit for purpose and align with the changes in time for the new financial year.

**Estate strategy**
Whittington Health has developed a refreshed estate strategy following discussions with integrated clinical service units and planners. It is a separate agenda item at the January 2020 Board meeting and approval is sought prior to public engagement in February.

In addition, there are two information items to report in terms of current works: first, the Waterlow building has now been demolished; and secondly, the refurbishment of the post-natal ward will be completed at the end of March 2020.

**Staff excellence award winners**
This month there are two worthy Excellence Award winners:

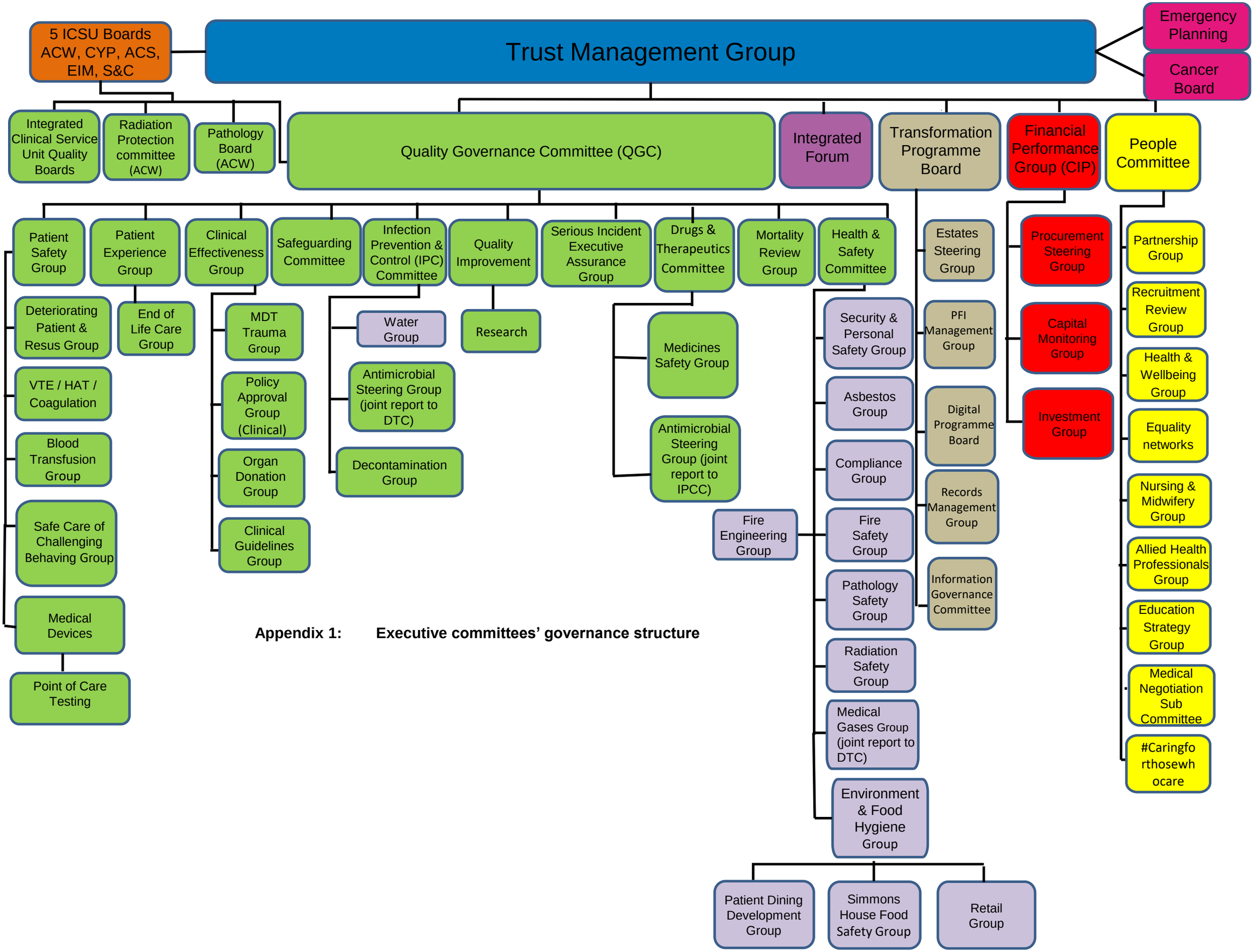
**Elyse Luxon, Speech and Language Therapy - Camden Learning Disability Service – Excellence and Innovation**
Elyse has been working with a young man with learning disabilities and autism who was excluded from his school and had come into adult service with no activities in place. Workers were scared of his behaviour, which also concerned staff and his family, and he often indicated that people should leave and rarely left his home. As a result of Elyse's input since the summer, he has started to go out with his support workers and colleagues are no longer scared of him and now enjoy his company.

She achieved this by responding to the patient's non-verbal requests and came up with the innovative solution of making an innovative secure digital record that includes videos, a communication passport, and a 'Now and Next' board that helps the patient with the structure of the session and allows him to choose activities and provides clear advice on how to work and talk with him. Elyse has even trained his support workers on how to use it and they say that this way of displaying information is so helpful.

Elyse has helped transform how services view her patient: from initially being very negative, it is now much more positive with people understanding his needs far better. She has also helped the Trust reflect on its practice and to consider innovative ways of working.

**Sarah Swann – Camden Community Paediatrics Speech Therapy - Compassion**

Sarah has unofficially taken on the role of social and wellbeing star by supporting the needs of people across two teams (approximately 30 staff) in response to staff reporting feeling over worked and stressed in the staff survey. She quietly goes about doing all the office jobs that make people's working environment better (e.g. descaling the kettle, putting up Christmas decorations, using positive comments on the whiteboard, etc.) and also arranges team lunches and after work social events for the teams that she works in, bringing staff together. Sarah will always offer to deal with the tricky issues that no one else wants to do. She has had great mediation with a patient who felt that no one was listening and has displayed examples of good leadership at all levels. Sarah thinks beyond her role and what is best for the team, and more importantly for the patients. She will offer her time and her positivity when others are stressed.




**Appendix 1: Executive committees' governance structure**

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | Date: 20.1.2020 |
| **Report title** | **Serious Incidents** | **Agenda item:** 7 |
| **Executive director lead** | Dr Clare Dollery, Medical Director | |
| **Report author** | Jayne Osborne, Quality Assurance Officer and Serious Incident (SI) Co-ordinator | |
| **Executive summary** | This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during December 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.<br><br>Three serious incidents were declared in December 2019. This report describes the Immediate actions and learning from these incidents.<br><br>Two Serious incident investigations have been completed. This report outlines the recommendations and lessons learned. | |
| **Purpose:** | Assurance | |
| **Recommendation(s)** | The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely. | |
| **Risk Register or Board Assurance Framework** | Corporate Risk 636. Create a robust SI learning process across the Trust. The Trust Intranet page has been updated with key learning points following recent SIs and root cause analysis investigations. | |
| **Report history** | Report presented at each Public Board meeting | |
| **Appendices** | Appendix 1: Spotlight on Safety | |

# Serious Incidents: December 2019

## 1. Introduction

1.1 This report provides an overview of serious incidents declared externally via Strategic Executive Information System (StEIS) and a summary of the key learning from serious incident reports completed in December 2019.

## 2. Background

2.1 The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director, Chief Nurse and Director of Allied Health Professionals, Chief Operating Officer, Head of Quality Governance and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold for a serious incident (as described within the NHS England Serious Incident Framework, March 2015).

## 3. Serious Incidents

3.1 The Trust is investigating three Serious Incidents declared in December this brings the total number of reportable serious incidents to 26 since 1 April 2019.

| SI Ref: | Integrated Clinical Service Unit (ICSU) | Description | Incident Date | Datix Date | Incident Datix Interval | StEIS Date | Datix-StEIS Interval |
|---|---|---|---|---|---|---|---|
| 26604 | Emergency & Integrated Medicine | *A patient deteriorated with acute kidney injury following a change to medication as an outpatient* | 25/11/19 | 01/12/19 | **5** | 06/12/19 | **4** |
| 27077 | Children & Young People Services | *Attempted self harm* | 10/12/19 | 11/12/19 | **1** | 13/12/19 | **2** |
| 27965 | Adult Community Services | *Delayed diagnosis. A delay in assessment of swallowing was followed by admission with pneumonia* | 26/11/19 | 27/11/19 | **1** | 24/12/19 | **19** |

*Table 1: All serious incidents declared to NHS England externally via the Strategic Executive Information System (StEIS) in December 2019.*

**4 Serious incidents declared and investigations completed in this financial year to date.**

Chart 1 below indicates the number of serious incidents declared by the Trust between 1 April 2019 and 31 December 2019 as well as the number of investigation reports which were submitted to the North East London Commissioning Support Unit (NELCSU).

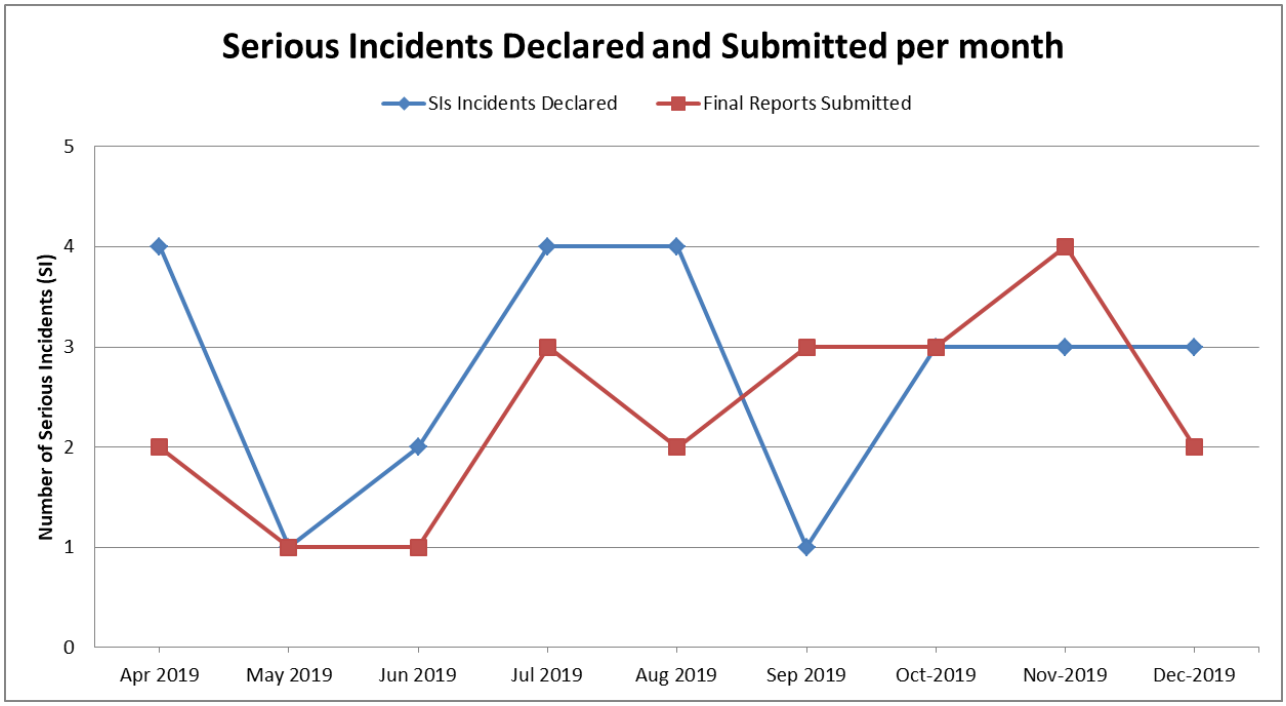



*Chart 1: Serious incidents declared and investigations completed*

4.1 The chart below shows the number of serious incidents declared by ICSU each month between 1st April 2019 and 31st December 2019.

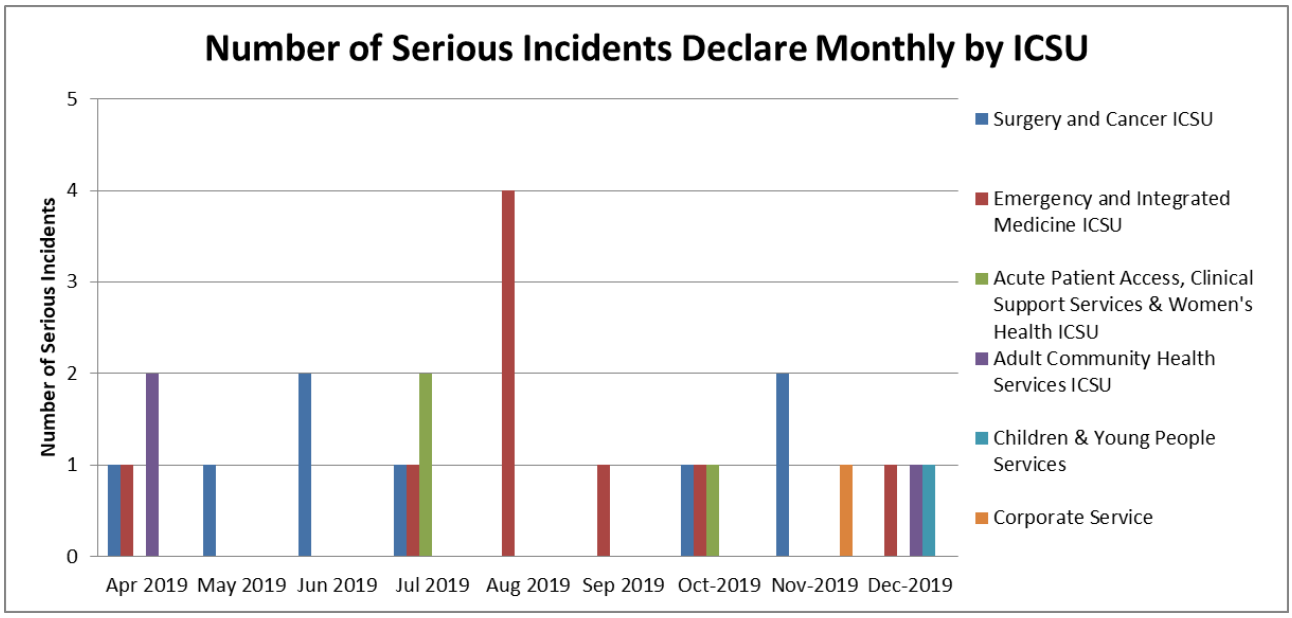



*Chart 2: Serious incidents declared by ICSU*

4.2 All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Executive Medical Director or Chief Nurse and Director of Allied Health Professionals). The Integrated Clinical Support Unit's (ICSU) Associate Directors of Nursing or representatives attend each meeting when an investigation from their services is being presented. The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm. On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

## 5. Duty of Candour

5.1 The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in December 2019.

## 6. Shared learning from reports submitted to NELCSU during December 2019.

6.1 Lessons learnt following the investigation are shared with all staff and departments involved in the patient's care through various means including the Trust wide Spotlight on Safety Newsletter *(see appendix 1),* 'Big 4' in theatres, 'message of the week' in Maternity and EIM, and '10@10' in the Emergency Department. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

6.2 Themes from serious incidents are captured in quarterly aggregated learning reports and an annual review, outlining areas of good practice and areas for improvement and Trust wide learning.

6.3 We are continuing to review and improve how we share our learning from all incidents, near misses and SIs to ensure we mitigate risks and fully embed actions and learning.

6.4 Open actions from serious incident investigations are monitored monthly at SIEAG and ICSUs have been asked to include a report on open actions as part of the Quarterly ICSU performance reviews. This is to help ensure the timely completion of actions which is necessary for improvement.

### 6.5 Learning from SI 2019.19256 - A non-standard technique was used for a chest drain insertion resulting in the retention of a small piece of equipment.

6.5.1 The following recommendations and actions have been made by the investigation panel:

- To ensure that all ED staff are aware of the trust guideline on management of spontaneous pneumothorax, and pleural procedures (chest drain insertion) guideline. For wider learning this is now included as part of various teaching sessions, the ED Newsletter and are available on the staff intranet site.
- ED to develop a system to ensure that all ED doctors are assessed as competent prior to performing invasive or high risk procedures.
- The ED senior clinician in charge should be informed prior to any procedure being performed in Resus, and should check that the performing clinician has been signed off as competent, or should directly observe the procedure being performed.

The following three key messages were also shared for wider learning.

- Be aware of the trust guideline on management of spontaneous pneumothorax, and pleural procedures (chest drain insertion).
- Inform your lead clinician prior to performing any procedure in Resus.
- Make sure you check you are signed off competent before you perform any procedure as per Trust new guidelines.

**6.6 Learning from SI 2019.18666 Delayed diagnosis of ovarian torsion, which may have contributed to need to remove one ovary.**

6.6.1 The following recommendations and actions have been made by the investigation panel:

- The gynaecology on-call Standard Operating Procedure (SOP) is being reviewed to ensure that all patients who have clear gynaecological pathology demonstrated on imaging are referred to the on-call gynaecology team for face to face review by the gynaecology registrar on-call.
- Joint training sessions have been arranged with ED and Gynaecology staff to ensure that if a serious complication is suspected, patients should be admitted until diagnosis can be ruled out by a senior specialist.
- A review of the Gynaecology administrative booking SOP is being undertaken to review and strengthen the booking and cancelation procedures to mitigate the risk of administrative human error.

The following three key messages were also shared for wider learning.

- Ovarian torsion is a gynaecological emergency requiring immediate surgery. Delays in diagnosis and treatment may lead to loss of the ovary.
- All patients with demonstrated pathology on imaging who have been referred to a specialty should only be discharged following senior specialist review of the patient.
- If a serious complication is suspected, patients should be admitted until diagnosis can be ruled out by a senior specialist.

**7. Spotlight on Safety** *(Appendix 1).*7.1 The Trust wide Patient Safety Newsletter is now printed as a hard copy document, as well as being made available on the intranet and circulated via the noticeboard.

7.2 The latest edition (for January/February 2020) contains learning from:

- Legal Claims – The cost of Cauda Equina Claims
- Near Miss: Incorrect device was nearly used to administer insulin
- Intravenous Infusion – Partial Extravasation incident
- Flu Vaccine – Whittington Health Flu Stats
- Carecentric –The shared care record facility linking Islington GP practices, Social Services and local community services.

7.3 **The Patient Safety Learning page**

7.3.1 The Patient Safety Learning page is available on the Trust Intranet and is linked to other available resources, such as: root cause analysis (RCA) tools page, spotlight on safety and patient safety case studies, as well as linking to the newly created Local Safety Standards for Invasive Procedures (LocSSIPs) page. The quarterly aggregated learning reports are now available to all staff on this page, as well as

SI reports, the annual never event gap analysis reports and learning from grand round sessions. Case studies on a number of areas are now available to staff also, linking through to the learning from clinical claims section.

## 8. Recommendation

8.1 The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.

**Appendix 1**

NHS
Whittington Health
NHS Trust

# SPOTLIGHT ON SAFETY

## YOUR PATIENT SAFETY UPDATE

Vol. 20 January/February 2020

## Spotlight on: legal claims -The cost of Cauda Equina claims

### The cost of Cauda Equina claims

### What is Cauda equina syndrome (CES)?

Cauda equina syndrome (CES) is a rare condition that occurs when the nerves at the base of the spinal cord are squeezed together. It can cause pain in the lower back and/or legs, numbness or weakness in one or both legs, in the buttocks or between the legs. CES is a medical emergency and a quick referral is needed to ensure investigation and treatment takes place to prevent permanent neurological damage occurring.

### Background to claims

The Medical Protection Society identified that failures or delays in diagnosing CES were one of the top five GP errors resulting in the most expensive clinical claims. Claims can be awarded if the claimant can show a breach of duty which caused loss or damage, such as:

- a failure to diagnose
- a failure to treat
- inadequate or negligent surgery; or
- a failure to recognise post-operative complications.

As a Trust we have received two CES claims in recent years, one of which was taken forward and cost the Trust close to £1 million.

### Key Learning - Top tips for clinicians

- Conduct a full exam to establish the likely cause of the back pain and make a record of this
- Consider if there are any red flags;
  - bilateral sciatica
  - severe or progressive bilateral neurological deficit of the legs, (e.g. major weakness with knee extensions, ankle eversion or foot dorsiflexion)
  - difficulty initiating micturition / impaired sensation of urinary flow, if untreated this may become irreversible
  - urinary retention with overflow urinary incontinence
  - loss of sensation of rectal fullness, if untreated this may become irreversible
  - faecal incontinence
  - perianal, perineal or genital sensory loss
  - laxity of the anal sphincter.
- If red flags are present, call an orthopaedic or neurosurgical specialist for immediate advice
- If no red flags make a record to demonstrate you have actively considered this option
- If, post-assessment, the patient is being managed as having simple mechanical back pain, make sure you give appropriate safety netting advice Including advice around the red flag symptoms and the importance of seeking medical advice if these appear. Record any discussions of advice in the patients notes.

**Source: Medical Defence Union Journal and NICE guidelines**

Please see the better never stops hub for SPOTLIGHT ON: Litigation and Learning from Legal Action, whcih includes a litigation learning checklist.

## Case 1: Near miss: incorrect device was nearly used to administer insulin

### What happened

A patient with type 1 diabetes mellitus (T1DM) was admitted to an in-patient ward following an episode of diabetic ketoacidosis (DKA). His usually injects insulin using a Flexpen at home to manage his diabetes. A nurse on the ward drew up his prescribed dose of NovoRapid insulin from an insulin pen refill (insulin cartridge). One of the diabetic specialist nurses was on the ward at the time and stopped the dose being administered.

### How did this happen

A multidose vial (MDV) of NovoRapid insulin was not available on the ward at the time. But pen refills of NovoRapid were in the ward fridge.

**An overdose of insulin due to abbreviations or incorrect device use is a Never Event.**
If a healthcare professional withdrew insulin from an insulin pen or pen refill and administered this using a syringe and needle there is the potential that this could cause an overdose.

### What did we learn

- That some wards do not have access to appropriate formulations of insulin

Follow-up actions taken
1. The insulin preparations stocked by all wards were reviewed
2. It was agreed that four insulins – all available as MDVs - would be stocked on all general adult wards.

These are:
- Actrapid (insulin soluble – short acting)
- NovoRapid (insulin aspart - short acting)
- Insulatard (insulin isophane - intermediate acting)
- Lantus (insulin glargine – long acting)
- All doses of insulins administered by nursing staff should be withdrawn from a MDV using an insulin syringe
- Insulin flexpens will only be dispensed by pharmacy for individual patients and will be labelled with their name and date of dispensing.
- Insulin pen refills will only be dispensed by pharmacy for patients using their own reusable insulin pen devices
- If a patient is admitted on an insulin not available as a MDV - such as Tresiba (insulin degludec) or NovoMix 30 – pharmacy will dispense a flexpen for use for that patient only
- All patients using insulin on admission will be assessed for self-administration
- Insulin should always be stored in a locked ward fridge or for patients self-administering in a locked bedside drug locker
- A 10 point insulin safety session is planned for all clinical staff – including agency staff
- The diabetic specialist nurses gave a teaching session to pharmacy
- Insulin administration training for ward staff will be made available on ESR as mandatory training
- JAC training for new doctors will include examples of the different insulin preparations available and how to prescribe accurately
- The pharmacy top-up service will remove from wards all insulin preparations that are not routinely stocked and those for patients who have been discharged
- All patient discharged on insulin into the care of a District Nurse should be prescribed and dispensed a flexpen on their TTA and discharge summary

To access further learning from incidents please see the patient safety learning page on our intranet, which links through to the patient safety case studies page.

# Hot topic: Flu

Flu/influenza is a virus that can cause a respiratory infection. Flu is very infectious and is easily spread to others.

Symptoms appear suddenly and can include:

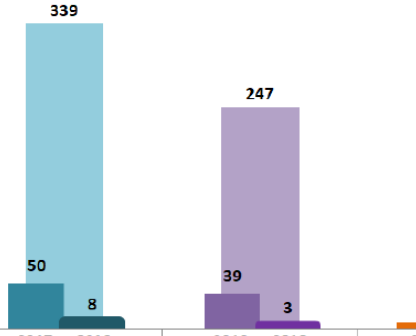
- a high temperature
- feeling shivery
- headache
- aching body
- extreme tiredness
- sore throat
- cough
- diarrhoea and vomiting

Most people recover within a week or two. Though for some, flu can be much more severe and can be fatal.

**Flu Fact:**
On average 8,000 people in the UK die from flu every year

**Flu Fact:**
In 2018/19 3,157 people were admitted to an ITU or HDU due to flu in the UK

**Whittington Health Flu Stats (2017 to Present)**



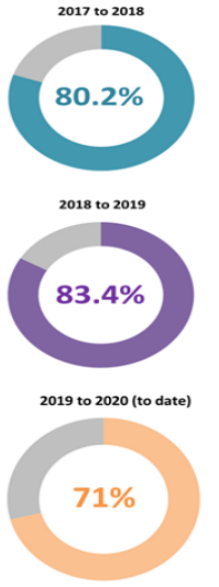

| | 2017 to 2018 | 2018 to 2019 | 2019 to date |
|---|---|---|---|
| Total no. of flu cases | 339 | 247 | 92 |
| Acquired flu cases* | 50 | 39 | 3 |
| Deaths | 8 | 3 | 0 |

NHS workers are more at risk of being exposed to flu and can spread the virus via their hands or equipment that has not been decontaminated.

Flu virus can live on hands and surfaces for 24 hrs, to reduce risk of spreading flu:




**Flu jab - staff uptake**




Get your flu jab - see intranet for flu clinic locations to obtain your free vaccine.


- Gov.uk *Flu vaccination: The main things to know about the 2019 programme.* Available: https://publichealthmatters.blog.gov.uk/2019/10/04/flu-vaccination-the-main-things-to-know-about-the-2019-programme/. Last accessed 09th Dec 2019.
- https://www.nhs.uk/conditions/flu/

# Do you know how to use Carecentric?

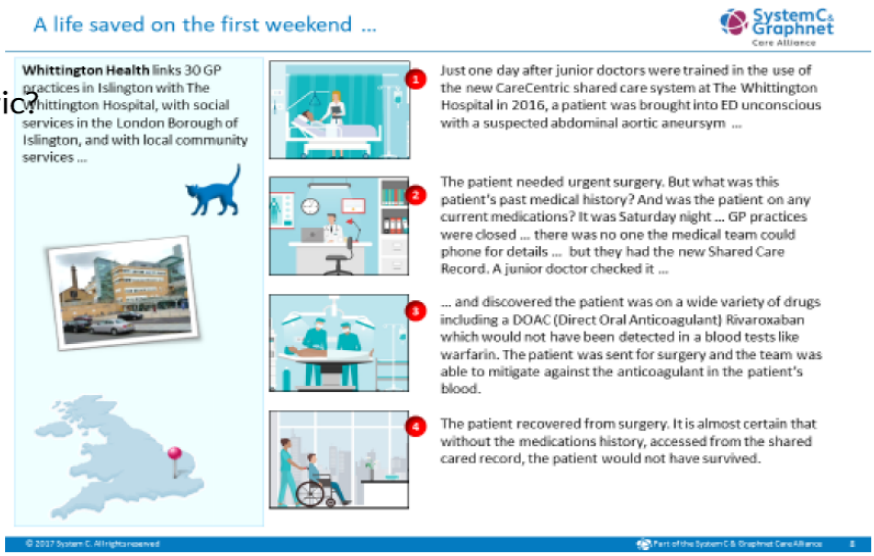
Carecentric has been in operation at Whittington Health since December 2016, however it is not always used appropriately which has been highlighted as a contributing factor in adverse incidents.

## What is Carecentric?

**Carecentric is a shared care record which allows staff to:**

- To be able to see clinical dictated specialty outpatient letters, ED and inpatient discharge letters and operation notes.
- View outpatient referrals and any appointments the patient may have/had.
- GP information including medications, problems and investigations.
- Information regarding community referrals & appointments.
- Social care information for adults in Islington.

## Why should I use Carecentric?




Feedback from a SHO in Acute Medicine:

*"I just wanted to let you know that I have been finding the new patient information on Medway very useful. We had an elderly woman on our ward who had dementia so we only had the limited information that her son had given us on admission. We were investigating her for myeloma. I thought I'd check the medway system to see if it had more information and from it found that she infact already had a myeloma diagnosis on her GP records. It has become a routine part of my routine when I see a patient, on take and now also on the ward."*

Check out the user guide on the intranet for further information:
https://whittnet.whittington.nhs.uk/default.asp?c=28469&q=

## EVENTS AND TRAINING

Patient Safety Forum - 30th January, 12:30-2pm, WEC
- 27th February, 12:30-2pm, WEC

Grand Round - every Wednesday, 1-2pm, WEC

Do you have items for the newsletter?
Contact: claire.challinor@nhs.net

## Datix training for 2020

The risk management team run monthly datix training sessions through the year to run through incident reporting, management and how to search for incidents and run reports. Please find details of each session below:

13th January, 09:30, WEC Room 8
4th February, 10:00, WEC Room 13
3rd March, 10:00, WEC Room 5
6th April, 09:30, WEC Room 8
5th May, 11:00, WEC Room 5
2nd June, 11:00, WEC Room 5
7th July, 10:00, WEC Room 5
4th August, 09:30, WEC Room 5
8th September, 14:00, WEC Room 8
6th October, 10:00, WEC Room 8
10th November, 10:00, WEC Room 8
2nd December, 14:00, WEC Room 8

To book onto a training session please email: datixadministrator.whitthealth@nhs.net.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Quarterly "Learning from Deaths" report - Quarter 1, 2019/20 (1 April 2019 to 30 June 2019)** | **Agenda item: 8** |
| **Executive director lead** | Dr Clare Dollery, Executive Medical Director | |
| **Report author** | Dr Julie Andrews, Associate Medical Director, learning from deaths clinical lead | |
| **Executive summary** | This "learning from deaths" report covers quarter one of 2019/2020 (1 April 2019 to 30 June 2019).<br><br>The report describes:<br>a) how Whittington Health performs against our local and national expectations in reviewing the care of patients who have died whilst at the acute site of Whittington Health (inpatient and emergency department (ED) deaths); and<br>b) the learning and actions being taking from the themes that emerge from these reviews to improve the care and experience of our patients and their families/carers.<br><br>In Quarter 1 of 2019/20, 1st April 2019 to 30th June 2019, there were 125 inpatient/ED deaths. In Quarter 1, 98% of all "category A" deaths (34 out of 35) were reviewed using a structured judgement review (SJR) (or equivalent review process) as compared with 96% in Quarter 4 2019/20. Each SJR or equivalent review was presented at a departmental mortality meeting or if relevant shared across mortality meetings. In addition each SJR or review had a final assessment by the learning from deaths clinical lead to ensure all possible learning had been captured and shared.<br><br>54% (49 out of 90) of category B deaths were reviewed in Q1 (compared to 49% in Q4) using a mortality review form (or equivalent) with an avoidability of death judgement score plus presentation at a departmental mortality meeting.<br><br>None of the 83 reviews carried out were assessed as representing potentially avoidable deaths. Four reviews were assessed as a score of 4 meaning there was a possibility of avoidability (but less than 50%). Three of these were patients managed in Critical care and one involved an inter-uterine death at 37 weeks gestation.<br><br>There was a death in a patient with known learning disabilities who | |

| | |
|---|---|
| | had been known to Whittington Health for many years. His death was assessed as unavoidable but this is also subject to review under the learning from deaths of patients with learning disabilities) (LeDeR) national framework. The LeDeR review for this patient (to be carried out by Islington adult safeguarding team) has not yet been completed.<br><br>An overarching mortality review group was held in November 2019. This reviewed overarching themes of learning, reviewed 3 structured judgement mortality reviews, and considered the mortality process as a whole with a view to continuous improvement. There were further discussions about the role of the medical examiner and how to ensure maximum embedding of learning from mortality reviews.<br><br>This paper gives assurance that this process to strengthen governance, learning and transparency around inpatient death is now developed and relatively robustly embedded, and that progress continues to be made in developing ways to disseminate the learning and continue to improve the quality of our care.<br><br>The Medical Examiner process will become statutory by 1 April 2020. Medical Examiners and Medical Examiner Officer(s) will act independently from the Trust to ensure that all deaths not referred to the coroners service have as accurate death certificate as possible and that the family/carers are kept fully informed of the processes around the death of their relatives. A business case for investment is being developed. |
| **Purpose:** | Review |
| **Recommendation(s)** | Board members are invited to:<br><br>i. 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; and<br>ii. 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** | Included on the Trust Quality and Safety Risk Register |
| **Report history** | This quarter's report not previously presented. Previous quarters from April 2017 onwards have been presented to Trust Board |
| **Appendices** | Appendix 1: NHS England Trust mortality dashboard |

**Quarterly "Learning from deaths" report Quarter 1 2020/21 (covering 1st April 2019 to 30th June 2019)**

## 1. Introduction

This report reflects quarter 1 of 2019/20 to Trust Board on learning from deaths. These reports describe:

a) performance against local and national expectations in reviewing the care of patients who have died whilst in this hospital (inpatient and emergency department deaths),
b) the learning taken from the themes that emerge from these reviews,
c) actions being taken to both to improve our care of patients and to improve the learning from deaths process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with General Medical Council *Good Medical Practice*, for many years. Following the launch of the NHS Quality Board "*National guidance on learning from deaths*[1]" (March 2017) we introduced a more systematised approach to reviewing the care of patients who have died in hospital from category A deaths.

Category A deaths are:

- deaths where families, carers or staff have raised concerns about the quality of care provision;
- all inpatient deaths of patients with learning disabilities;
- all inpatient deaths of patients with a severe mental illness (SMI) diagnosis;
- 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;
- all inpatient paediatric, neonatal and maternal deaths;
- deaths that are referred to HM Coroner's Office without a proposed MCCD.

Category B deaths are:

- all deaths of inpatients that do not meet any of the criteria of Category A deaths.

**Table 1** - Reasons for deaths being assigned as category A in Quarter 1 2019/2020

| | Number of deaths in Q1 | Comments |
|---|---|---|
| Staff raised concerns about care | 3 | |
| Death of a patient with Learning disabilities | 1 | Investigated as a SJR and referred to the LeDeR framework |
| Death of a patient with Serious mental illness | 0 | |
| Death in surgical patients | 2 | |
| Paediatric/maternal/neonatal/intra-uterine deaths | 5 | Investigated as a Serious incident, internal RCA investigations, CDOP or perinatal mortality reviews |

[1] "*National guidance on learning from deaths*" (NHS Quality Board, March 2017) available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

| | Number of deaths in Q1 | Comments |
|---|---|---|
| Deaths referred to coroner's office | 16 | Excludes deaths in other categories |
| Deaths related to specific patient safety or QI work e.g. sepsis | 8 | All were sepsis deaths, these are additionally investigated by the sepsis team<br>1 was not completed as notes were incomplete |
| Total | 35 | |

Category A deaths are reviewed by an individual independent clinician using a structured judgement mortality review form (or equivalent tool) then this is reviewed and agreed on in departmental mortality meetings.

The aims of this review process are 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 patients' 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.

The Trust has set an internal target that 90% of all category A deaths and 25% of all category B deaths should be reviewed.

**2. NHS Mortality Dashboard**

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. This dashboard shows data from 1 April 2018 onwards.

There were 125 deaths recorded in Quarter 1. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation.

The dashboard (appendix 1) shows that in Quarter 1, 83 of the 125 patient deaths were systematically reviewed. 98% of the category A deaths were reviewed using structured mortality judgement methodology or equivalent and 54% of category B deaths were reviewed using either similar methodology or a comprehensive case note review with an assigned avoidability of death score. The majority of reviews occurred within 12 weeks following the death of the patient apart from seven late reviews, the delays mainly due to limited administrative support or difficulties getting hold of notes or trained reviewers.

42 patient deaths out of 125 in Q1 (34%) were not reviewed in a mortality process but the majority of these (41 out of 42) were category B deaths. One category A patient death was not reviewed by SJR or equivalent process; this was a patient under the care of the ITU team who death was referred to the coroner's office. Despite extensive searches a comprehensive set of notes could not be found to perform a SJR. This situation was escalated early and reported through the incident reporting system Datix. Departments and teams are reminded when category A reviews are outstanding but further work is needed and is ongoing to embed the support structures,

including project management support to ensure that the risk of category A reviews being overlooked is minimalised and reviews are carried out within expected timeframes. There are discussions with the corporate governance team that SJR allocation is taken into the workload of the ICSU risk management teams with monitoring by the corporate governance team.

The dashboard outlines the avoidability of death judgement scores for inpatient deaths in Quarter 1, 2019/2020 and this is summarised below, in table 2. None of the 83 reviews carried out were assessed as representing potentially avoidable deaths. Four reviews were assessed as a score of 4 meaning there was a possibility of avoidability (but less than 50%). Three of these were patients managed in Critical care and one involved an inter-uterine death at 37 weeks gestation.

There was a death in a patient with known learning disabilities who had been known to Whittington Health for many years. His death was assessed as unavoidable but this is also subject to review under the LeDeR(learning from deaths of patients with learning disabilities) national framework. The LeDeR review for this patient (to be carried out by Islington adult safeguarding team) has not yet been completed.

An overarching mortality review group was held in November 2019. This reviewed overarching themes of learning, reviewed 3 structured judgement mortality reviews, and considered the mortality process as a whole with a view to continuous improvement. There were further discussions about the role of the medical examiner and how to ensure maximum embedding of learning from mortality reviews.

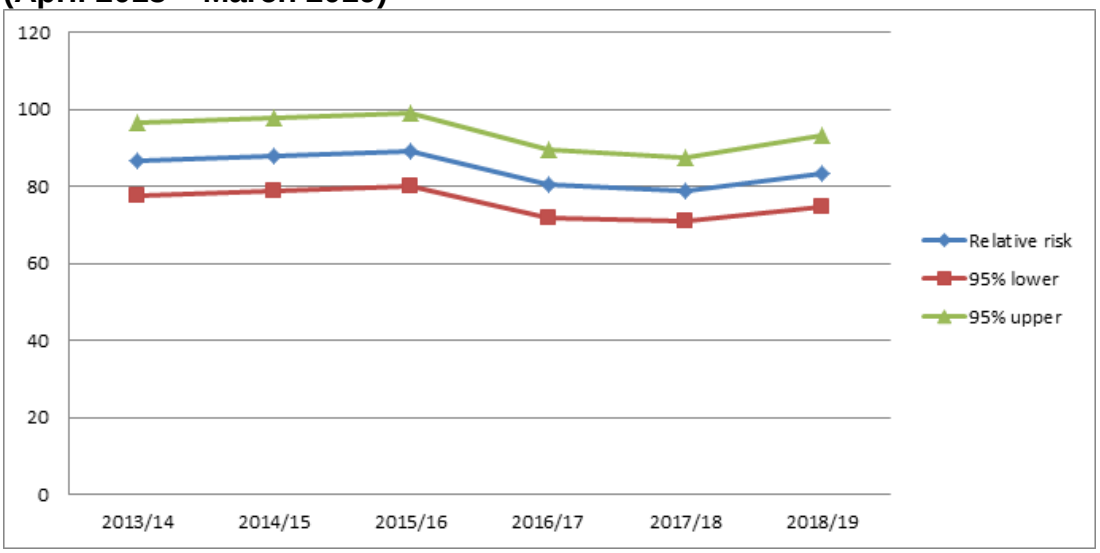
**Table 2 – Avoidability of death judgement scores for Q4: 2018/19**

| Avoidability of death judgement scores (of deaths reviewed) | Number of patients with each avoidability score |
|---|---|
| 1 - Definitely avoidable | 0 |
| 2 - Strong evidence of avoidability | 0 |
| 3 - Probably avoidable, more than 50/50 | 0 |
| 4 - Possibly avoidable but less than 50/50 | 4 |
| 5 - Slight evidence of avoidability | 4 |
| 6 - Definitely not avoidable | 75 |

### 3. Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. A ratio less than 100 indicates that a hospital's mortality rate is lower than the average national rate of the baseline year.

**Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2013 – March 2019)**




The blue diamonds on Chart 1, above, represent this Trust's HSMR, which is 'lower than expected'. The green triangles above and the red squares below represent the 95% confidence interval, which means that the actual HSMR has a 95% chance of falling between the higher and lower values. The Trust HSMR is 'lower than expected'.

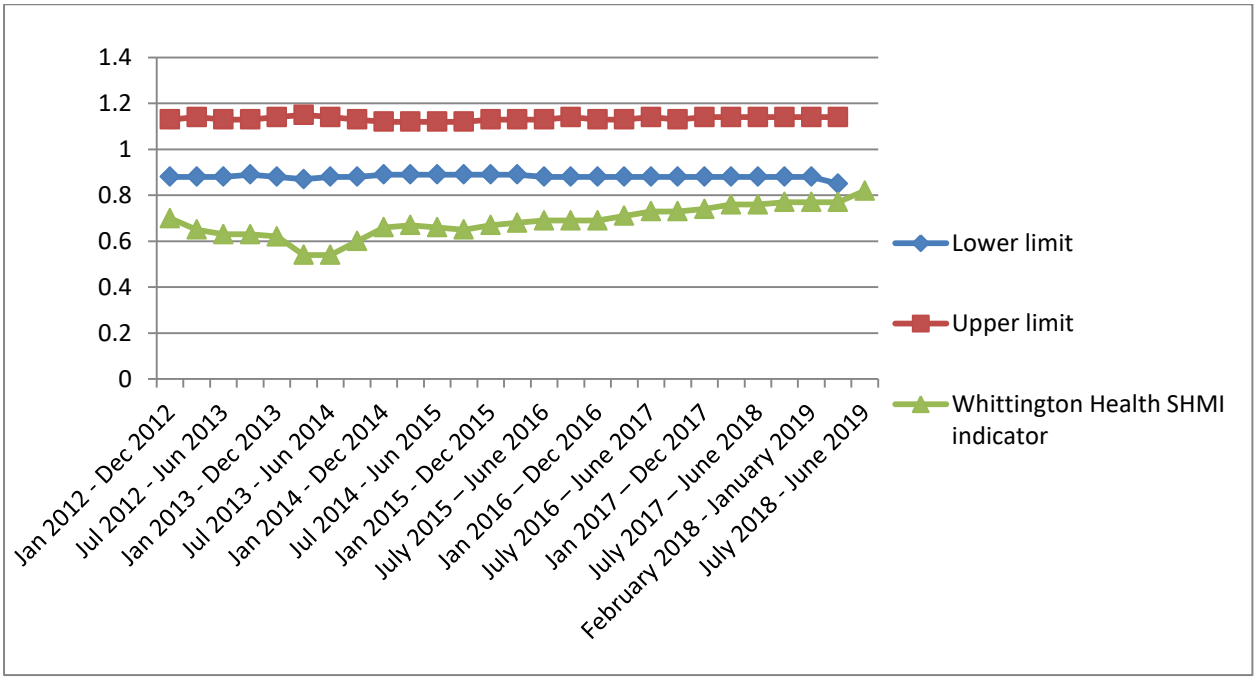
## 4. Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations. National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator that may suggest the need for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths. The most recent data available (released in November 2019) covers the period July 2018 to June 2019- the Trust's SHMI is lower than expected.

| | |
|---|---|
| **Whittington Health SHMI score** | **0.82** |
| **National standard** | **1.00** |
| **Lowest national score** | **0.7052 (Guy's and St Thomas')** |
| **Highest national score** | **1.2073** |

**Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – June 2019)**




## 5. Examples of key points of learning and actions from Mortality Reviews

### a) New/revised protocols, pathways and checklists

A mortality review carried out in Critical care highlighted there were differing opinions into the use of albumin for deteriorating patients amongst the Critical care consultants and gastroenterology team. This has led to a review of current literature and a development of a albumin protocol for use in ITU.

There have been recent revisions to the sepsis pathway in ED for adult patients to take into account the revised National early warning scores (NEWS2).

There was a minor modification to the gentamicin guideline but more importantly revised education programme on gentamicin therapeutic drug monitoring following a review which demonstrated that human error had led to a patient being prescribed ongoing gentamicin in the context of already raised levels.

There have been minor changes to the silver trauma pathway to take into account spinal injuries in line with the national guidelines.

There were modifications made to the foetal growth assessment and late booking pathways based on learning from the serious investigation report on the intra-uterine death of a 37 week foetus.

**b) Quality improvement work**

There is ongoing QI work on ensuring completion of treatment escalation plans at the time of admission and there a weekly opportunities as part of the weekend handover documentation. Performance in this area has greatly improved but mortality reviews did show that treatment escalation plans are not always completed in surgical patients, this has been escalated to relevant staff.

3 mortality reviews this quarter have discussed the need to involve the hospital based palliative care teams earlier in patient's care and 1 review discussed concerns about limited handover and equipment available for a patient under the community palliative care team. These reviews are all shared with the lead for end of life care and are reviewed as part of a wider QI project.

There has been a refresh of all fall QI work based on feedback from mortality reviews, patient safety reviews and feedback from staff and families. This work is ongoing to attempt to make our falls plans more bespoke for individual patients and ensure the patient and families are more involved in care plans.

There is ongoing QI work about the timings and reviewing of CT scans in the acute /deteriorating surgical patient.

**c) Training and education**

There has been refinement of the skills and drills education programme for maternity staff to ensure there is a focus on use of refined protocol for foetal ultrasound scans including how to manage women that book late.

Two of the SJR's comment on slightly different information being relayed to patient/family by surgical team and Critical care teams. This has been reflected on in both teams mortality meetings and will be subject to ongoing review in the light of the impact differing information can have on grieving families.

There has been another recent refresh to the ED patient safety focused "10 @10" education sessions covering Datix reporting, patient safety investigations, medicine safety incidents and silver trauma pathway. The quality of learning from incidents in ED was highlighted by the recent CQC visit.

There have been education events to cover the need remember to consider toxicology testing for patients that have deteriorated especially in the context of dual diagnoses, to remember to use scrotal support for patients with scrotal oedema to encourage mobilisation and to think about earlier referrals to cardiothoracic centres such as Barts' Health.

There was a SJR that discussed delays in contacting the organ donation team which has been discussed with the teams involved.

There was a grand round completed on "dying matters" by the palliative care team recently which covered many aspect of excellent care including focus on co-ordinate my care, desired place of death, appropriate times to stop investigations and maximising quality of death for patient and carers.

Two completed medical cause of death certificates (MCCD) did not correctly reflect the precise hierarchical cause of death according to the mortality reviewers. The introduction of the medical examiners in April will improve the quality of completed MCCD's.

There was really clear and regular liaison with the Learning disability nurse and the LD hospital passport in the SJR completed on the patient with LD which is reassuring to see as this is an extremely important to ensure care is bespoke for our most vulnerable patients.

## 6. Conclusion and recommendations

The board is asked to recognise the significant work from frontline teams to learn from deaths in order to improve care and note the contents of the report.

**Appendix 1: NHS England Trust Mortality Dashboard**

# Whittington Health: Learning from Deaths Dashboard - June 2019-20

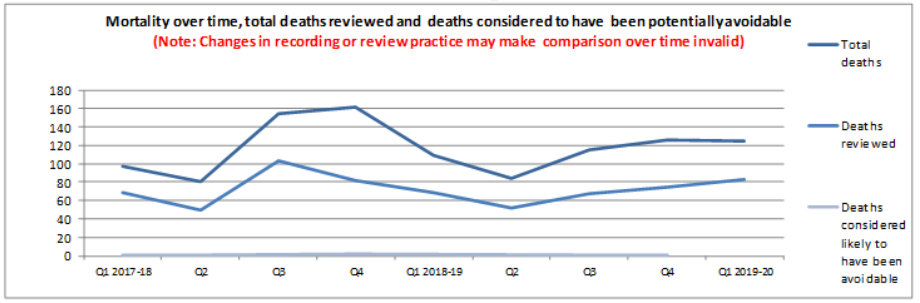
**Description:**
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

## 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 |
| 42 | 39 | 28 | 29 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 125 | 126 | 83 | 74 | 0 | 1 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 125 | 434 | 83 | 262 | 0 | 2 |

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1




### Total Deaths Reviewed by RCP Methodology Score

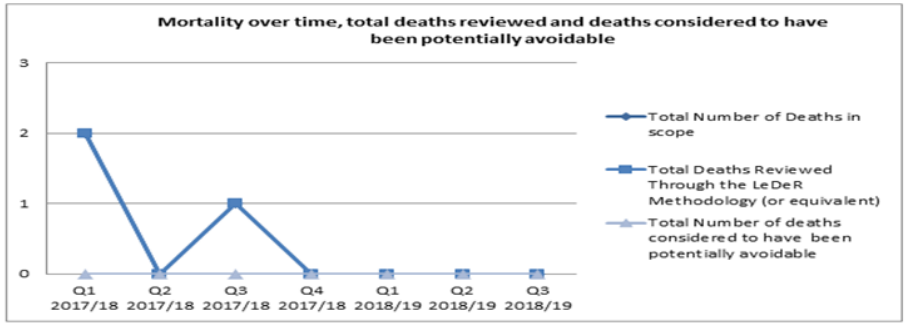
| Score 1 Definitely avoidable | | | Score 2 Strong evidence of avoidability | | | Score 3 Probably avoidable (more than 50:50) | | | Score 4 Probably avoidable but not very likely | | | Score 5 Slight evidence of avoidability | | | Score 6 Definitely not avoidable | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 2 | 7.1% | This Month | 26 | 92.9% |
| This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 4 | 4.8% | This Quarter (QTD) | 4 | 4.8% | This Quarter (QTD | 75 | 90.4% |
| This Year (YTD) | 0 | 0.0% | This Year (YTD) | 0 | 0.0% | This Year (YTD) | 0 | 0.0% | This Year (YTD) | 4 | 4.8% | This Year (YTD) | 4 | 4.8% | This Year (YTD) | 75 | 90.4% |

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

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

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

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1



| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Quality Improvement 2019 Annual Report** | **Agenda item: 9** |
| **Executive director lead** | Clare Dollery, Medical Director | |
| **Report author** | Paula Ryeland, Quality Improvement Lead | |
| **Executive summary** | 2019 saw Quality Improvement (QI) become further embedded into all areas at Whittington Health. Examples of success were:<br>• A QI Lead being able to deliver training in house with 200 staff having now attended<br>• All registered projects are mapped to the Trust's strategic objectives and the clinical governance headings<br>• Projects are identified by both a top-down and bottom-up approach<br>• The second annual QI celebration afternoon in June 2019 was attended by over 85 people and generated a real excitement around the achievements shared<br>• We have been sharing learning through presenting at the North Central London (NCL) QI events, publishing articles and submitting projects to conferences. | |
| **Purpose:** | Review | |
| **Recommendation(s)** | The Board is asked to review this report. | |
| **Risk Register or Board Assurance Framework** | BAF entry Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation. | |
| **Report history** | Quality Committee, 11 January 2020 | |
| **Appendices** | 1: 2019 Quality Improvement Annual Report | |

**Appendix 1: Quality Improvement 2019 Annual Report**

## 1. Introduction

1.1 This is the first annual Quality Improvement report and it provides an overview of the Quality Improvement taking place at Whittington Health, highlighting the key successes and challenges in 2019, as well as identifying the next steps for 2020.

1.2 Driven by our vision 'Helping local people live longer, healthier lives', Whittinhgton health is committed to continually improving the care that Whittington Health provides for patients,in line with our. Better Never Stops initiative and this attitude is embedded in our Quality Improvement approach.

1.3 This report is divided into three key sections;

- Overview of Quality Improvement at Whittington Health
- An update on 2019 - Training and QI projects
- Next steps for 2020

## 2. Overview of Quality Improvement

2.1 The board lead for Quality Improvement is the Medical Director and a 2 Programmed Activity (0.2 WTE) Associate Medical Director (AMD) for Quality Improvement is funded. This post has been vacant since June 2019 and is currently out to internal recruitment.

2.2 In October 2019, the newly convened Quality Improvement Steering Group met for the first time including the QI lead, Medical Director, Chief Nurse and Chief Operating Officer. It is envisaged that this group will be important in developing a renewed QI strategy for the Trust.

2.3 In January 2019, the Trust appointed a Quality Improvement Lead; this was a newly created role and signalled the Trust's move to a more structured approach to QI with in-house training and a recognised methodology e.g. Plan, Do, Study, Act (PDSA) cycles. In identifying areas for quality improvement the Trust has adopted a two-way approach:first, bottom up by encouraging grass roots development; and secondly, top down byusing performance and outcome data to drive improvement.

### Identifying areas for QI

2.4 One of the successes of the Whittington Health QI journey so far has been the enthusiasm of individuals to lead a project to improve an area in their work that they are passionate about. There have been some clear successes with the bottom-up approach and the Trust wants to continue empowering staff to have the freedom and confidence to improve aspects which they feel are necessary and are important.

2.5 Projects and areas to improve are also identified from a top-down approach based on information collated through the Quality Account, Getting It Right

First Time visits, national or local audits, untoward incidents, complaints, legal claims, peer reviews and both patient and staff feedback.

2.6 All registered Quality Improvement projects can be mapped under the three underpinning aspects of quality (patient safety, patient experience and clinical effectiveness), and are also aligned to the four Trust strategic objectives:

- Deliver outstanding safe, compassionate care
- Empower, support and develop engaged staff
- Integrate care with partners and promote health and wellbeing
- Transform and deliver innovative, financially sustainable services

Table 1: Projects aligned against the four Trust strategic objectives (note: projects can be aligned to two objectives so each project could be counted here twice)

| Deliver outstanding safe, compassionate care | Empower, support and develop engaged staff | Integrate care with partners and promote health and wellbeing | Transform and deliver innovative, financially sustainable services |
|---|---|---|---|
| 86 | 31 | 25 | 53 |

Table 2: Projects aligned under Quality Priority categories (note: projects can be aligned to two objectives so each project could be counted here twice)

| Patient Experience | Patient Safety | Clinical Effectiveness |
|---|---|---|
| 58 | 57 | 81 |

**Prioritising QI projects**

2.7 All projects are registered centrally and are available online so that teams can contact other project leads to share learning or ask questions. In order to ensure adequate resource is provided, projects are then prioritised both centrally and within Integrated Clinical Service Units (ICSUs). The Quality Improvement Lead manages the trustwide QI priority list, while each ICSU or clinical area manages their own list of priorities based on the specific needs of services and the management of risks.

2.8 A quarterly themed meeting has been relaunched and is attended by leads for patient safety, patient experience, complaints and PALS, compliance, clinical audit, legal services and learning from deaths, supports discussions around prioritisation, and progress and highlights any areas for improvement work.

**Support available for QI projects**

2.9 Whittington Health aims to empower staff to deliver QI themselves through providing training and making resources available on the intranet, as well as having mentors who can offer advice and coaching. In this way, QI becomes embedded in everyday practice.

2.10 However when a project is identified as a priority area for the whole Trust, additional resources can be provided to support with project planning and delivery. All trustwide priority projects are monitored centrally by the QI lead, and resources allocated as required in the form of project leadership or management support from the QI lead or QI coaches (see description below), or support with data collection, analysis or report writing from the Quality Governance team.

2.11 In addition to the QI Lead, there is a cohort of QI coaches who completed the Quality, Service Improvement and Redesign (QSIR) course in 2018 or the University College London (UCL) Partners' Improvement Fellowship programme. These individuals can act as mentors providing advice and support for staff on QI projects, and may join QI teams as members or lead individual projects.

2.12 QI mentorship usually involves meeting with the project lead beforehand and at key milestones throughout to provide advice. This does not include collecting data, providing analysis, or writing reports.

2.13 A number of staff have since left the Trust so the current pool of QI coaches is 7 staff including the QI lead. In 2019, there was no formal programme or guidance for QI coaches on the expectations or requirements of the role, and the majority of project support has therefore fallen to the QI Lead. This is an area for development in 2020.

## 3. Trustwide QI Projects 2019

3.1 For 2019, the priority projects for the Trust have been identified below. In 2020/21, we will identify up to 10 priority projects which will be monitored centrally and provided additional resource.

Table 3: 2019 QI priorities

| **Trustwide QI priorities 2019** | | |
|---|---|---|
| **Project** | **How it has been identified as a priority area** | **Support provided** |
| Frailty | Quality Account | QI Lead working in project team and Information analyst has built reports for the data. |
| Falls | Quality Account | Quality Governance team support with the monthly falls' audit, with data collection, analysis and reporting the data. |
| Discharge Summaries | The project was started by a medical consultant. However, had been highlighted as a concern from local GP feedback and Healthwatch and communication | QI Lead working on project team |

| | | |
|---|---|---|
| | breakdowns at discharge has been a contributing factor in incidents and complaints. | |
| 'Hello my name is' | Project initially inspired from a foundation year 2 doctor. Prioritised as critical area for Trust due to evidence based of national campaign on links to patient safety, patient experience and team morale. | QI lead has led the implementation of badges across trust |

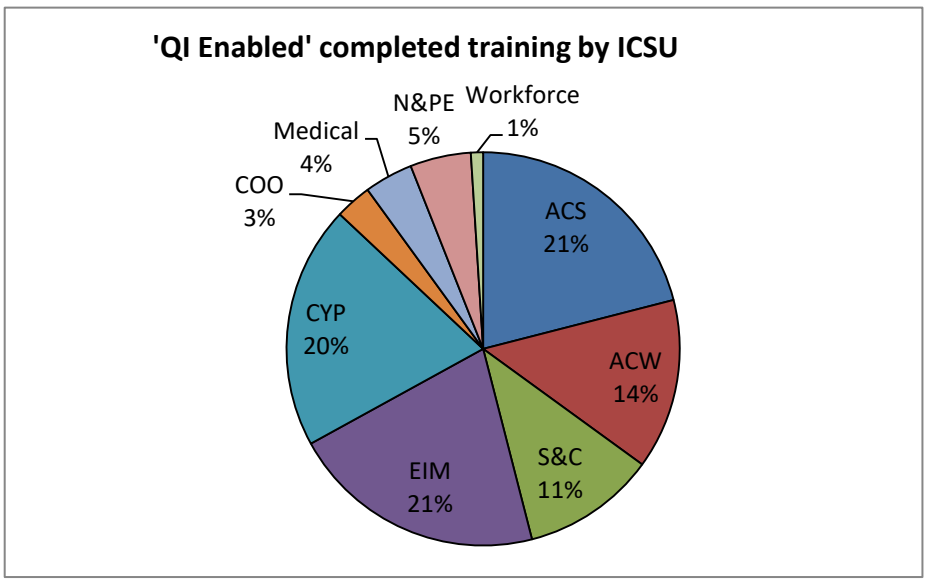
## 4. Training

4.1 The Trust offers a two-tiered training programme to empower staff to design and lead QI projects. We have an e-learning module on the Electronic Staff Record which acts as an Introduction to Quality Improvement (previously known as Bronze training) and then we offer a more advanced training session entitled "QI Enabled" (previously known as Silver training) which teaches the Institute for Healthcare Improvement (IHI) Model for Improvement method. This half day course aims to equip and empower staff with the skills and knowledge to design, lead and complete a QI project.

4.2 The feedback from face to face training sessions is very positive - with 100% of staff recommending it to colleagues and all staff rating the standard as good or excellent; 92% of staff rated the trainer as excellent.

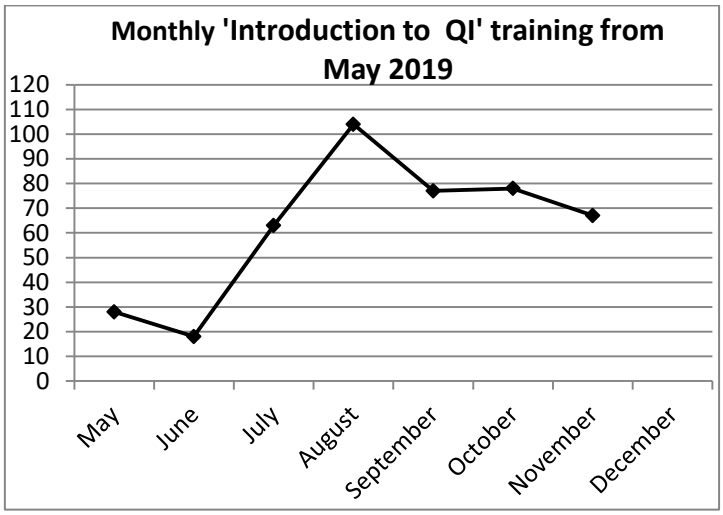
4.3 Since January 2019, in addition to providing QI training, the QI Lead has delivered training at junior doctor induction days, nurse preceptorship courses, various ICSU quality meetings, team meetings and multiple staff development courses including three different ICARE courses and a junior doctor development course (LEAD).

4.4 In total, 208 staff at Whittington Health have been on the face-to-face QI Enabled training. 120 of these have been trained since January 2019. It has been possible to break down these staff by ICSU and also by staff group:



4.5 Although medical staff are the smallest percentage in the trained group of QI leads, they are the staff group delivering the majority of QI projects. This could possibly be attributed to the requirement for junior doctors to complete a QI project as part of their training.

4.6 Since the summer of 2019, Whittington Health has been able to measure the number of staff completing the “Introduction to QI” training. This is predominantly online but is sometimes delivered in person in a half an hour session. The spikes in July - October can be attributed to the QI Lead delivering the 30 minute introduction session at the junior doctor induction sessions. There have been difficulties with individuals being able to access the online QI training on Electronic Staff Record, however, the Learning and Development team will rectify this if the individual contacts them directly.




4.7 In January 2019, a QI intranet page was developed and this has resources and external links to provide staff with assistance. On this page is a list of active and completed QI projects as well as the project posters which are completed at the end of a project.

**QI projects and improvements delivered for the Trust, its patients and staff**

5.1 There are currently 148 registered QI projects although some projects are not completed.

Table 4: QI project status

| Number of QI projects currently registered | Number of completed QI projects | Number of projects stopped/ paused |
|---|---|---|
| 148 | 32 | 22 |

5.2 All completed projects submit a poster, using a template designed to emphasise the key learning. Selections of these write-ups are shared on the intranet and presented at the Annual QI Celebration Event.

***"Hello My Name Is"***

5.3 To further our compassionate and patient-centred care, Whittington Health introduced 'Hello my name is' badges, following the National initiative started by the late Dr Kate Granger. Over 100 patients were consulted to hear their experiences with introductions and knowing staff names. The results were variable - some sites reported 100% of clinicians introduced themselves but other areas were as low as 20%.Between September and December 2019, staff were reminded of the importance of introductions, and screensavers, staff emails and the emailed staff noticeboard bulletin used to raise awareness. A successful bid for charitable funds, allowed the ordering a clear and visible badge that displays their first name for all substantive staff. When these were distributed, staff photos with messages were used to state why they would be wearing their badge. The next cycle of the project is working on speaking to patients again to identify any potential improvement in staff introducing themselves.

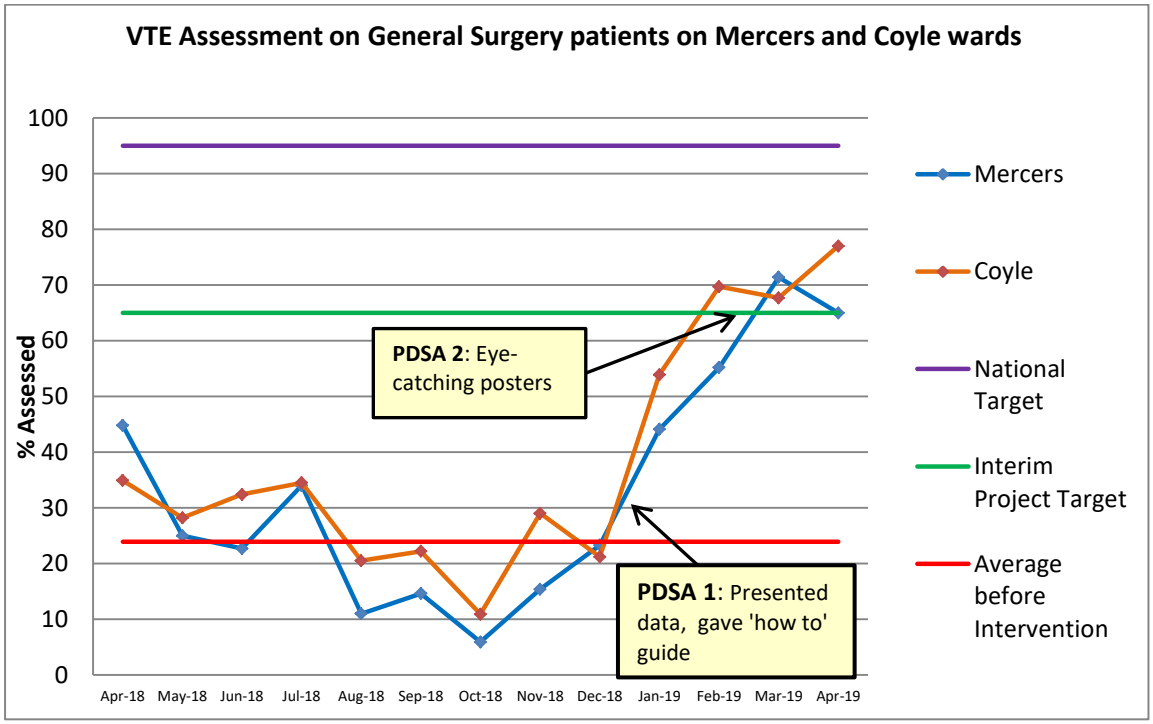

**Enhanced Care**

5.4 Following a successful bid for funding from UCL Partners, the CNS for Older People and a small team are training Health Care Assistants (HCAs) to provide patient-centred enhanced care for patients on the Older Peoples wards. The team have successfully provided high quality training days for a group of HCAs and are now monitoring the success and gathering data. It is hoped that providing this training will reduce agency staff usage and instead provide a group of enabled staff who can create an engaged relationship between staff, patients and families.

**Venous thromboembolism (VTE) Assessment in General Surgery**

5.5 This project commenced following concerns raised at the Patient Safety Committee over the low VTE assessment rate in surgery. A surgical registrar and the QI Lead worked to improve this and aimed to improve the assessment rate for General Surgery patients on Mercers and Coyle wards to

65% by April 2019. This was achieved and the results made a significant difference to the Trust's overall VTE assessment rates. It has recently been reported that an increased rate has been maintained even after the surgical registrar involved left the Trust.

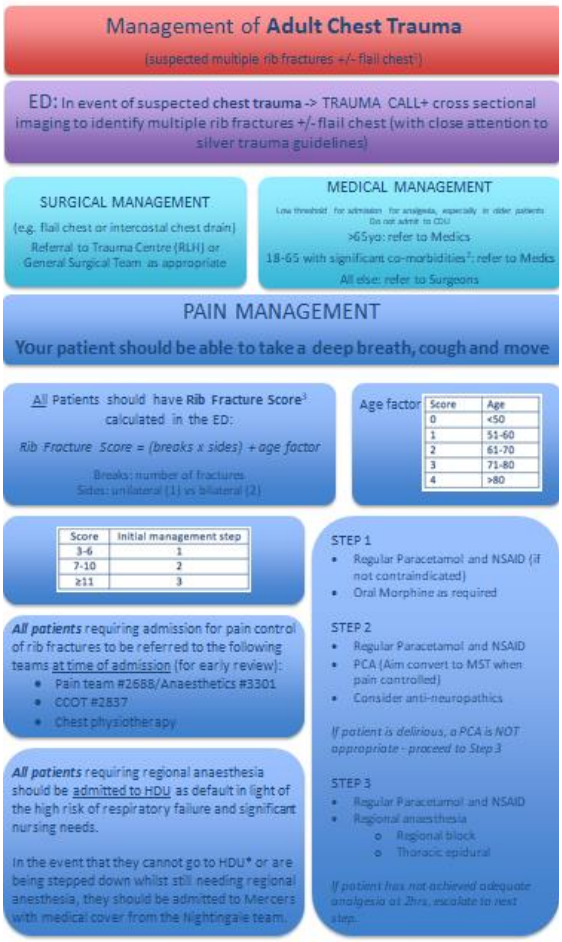



**Improving discharge summaries**

5.6 The Acute Medicine Consultant, and the QI Lead, are taking this project forward to improve inpatient discharge summaries to provide a safe handover of care; give patients information about their admission, diagnoses and next steps in simple language and to improve the recording of co-morbidities. There had previously been some negative feedback from GPs and patients around these documents. After a number of multidisciplinary stakeholder meetings, the electronic template was redesigned. To measure the success of the project, the team identified a number of quality indicators and carried out quarterly checks. The results showed improvement and the identified next steps are to increase the education and to provide more guidance around the content of the patient information.

| Quality Indicators | Mar-19 | Jun-19 | Oct-19 |
|---|---|---|---|
| Co-Morbidities | 86% | 96% | 94% |
| Investigations | 46% | 79% | 60% |
| Patient Info | 32% | 64% | 58% |
| GP Actions | 82% | 85% | 85% |
| Medications | 82% | 94% | 93% |
| Named Consultant | 73% | 77% | 75% |
| **Average** | **67%** | **83%** | **78%** |

## 5.7 Development of a chest trauma pathway




This project was developed after a series of rib fracture cases were presented at the Acute Medicine Morbidity and Mortality meetings. It became apparent that there was a need to have in place management or best practice care plans for these serious traumas. A multi-disciplinary team was created to develop a pathway. The pathway clarified early identification and assessment, effective analgesia, placement on appropriate wards with experienced medical and nursing staff. As with most successful projects, part of the success of this can be attributed to the passion of the staff involved to improve this area.

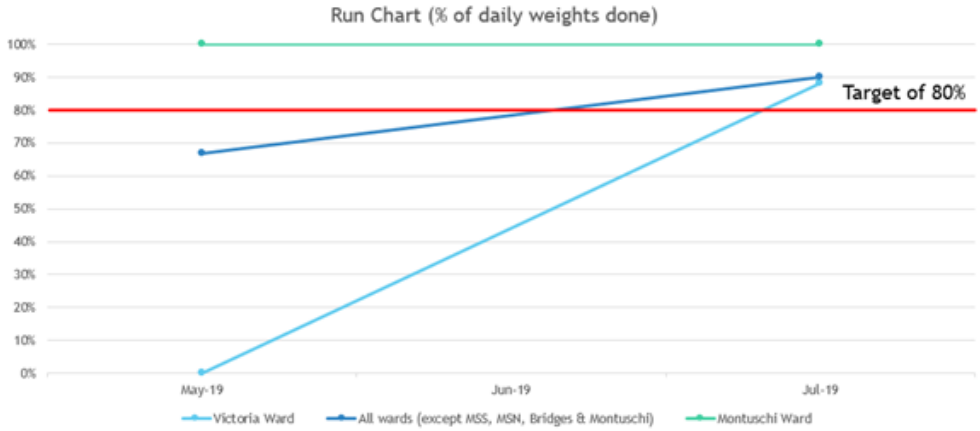
### Frailty pathway

5.8 The frailty pathway was designed to improve the journey of frail older people moving through the Emergency Department (ED); decrease the number of unplanned admissions; increase appropriate community support; and, increase access to Comprehensive Geriatric assessment in ED. The frailty pathway began in April 2018 and in April 2019, an extrapolated audit suggested that almost 200 potential hospital admissions were avoided, and in turn this saved an estimated £750,000 (based on the average length of stay of 15 days on a Care Of Older Patients' ward). A new frailty consultant has recently joined the Trust and the team are refocussing on increasing the proportion of patients given a frailty score in ED.

### Others

5.9 A small project to reduce the amount of time it took speech and language therapy (SLT) Early Years staff to complete group session notes showed times reduced by 50% and the team found staff morale increased as a result.Another project increased the recording of inpatient daily weights.

| Summary of Results | Learning |
|---|---|
| • 33.3% of doctors strongly agreed and 41.7% agreed with the statement "when I required daily weights, I also prescribed them on JAC".<br>• 75% strongly agreed and 25% agreed that the daily weights feature on JAC was useful.<br>• Victoria ward went from 0% weights done/ attempted in April to 88% in July. All medical wards (excluding MSN, MSS, Montuschi and Bridges) went from 66.7% in April to 90.1% in July. Montuschi ward consistently measured/attempted 100% of required weights. | Overall, in this first PDSA cycle we achieved our initial aims. However, Montuschi ward displays that attempting 100% of weight recordings is possible, therefore for future cycles the aim should potentially be changed to achieving 100% of daily weights.<br><br>Future plans include additional change such as allowing the new EPMA to allow noting of the weight when administering a daily weight to make the results easier to view for clinicians and allow remote viewing of weights as opposed to by the bed. |




## 6 Celebrating and reporting QI

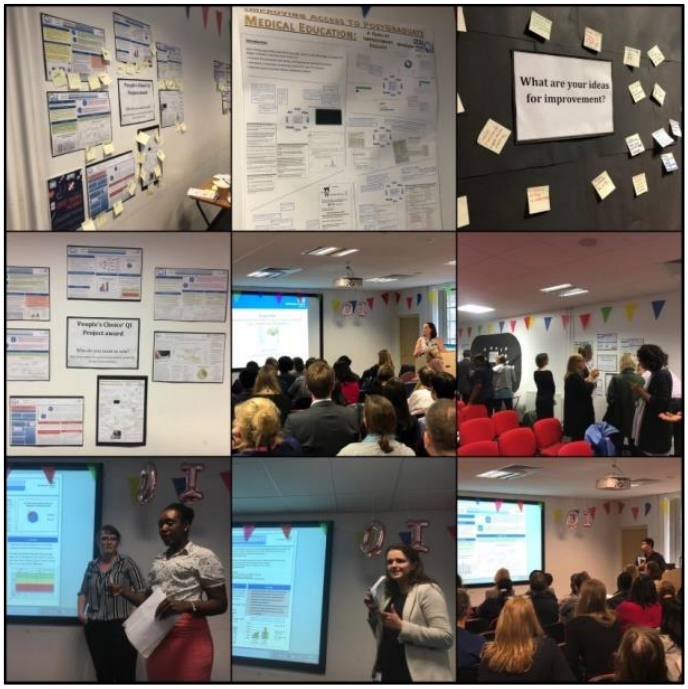
6.1 Whittington Health aims to be an organisation continually seeking to improve and therefore be synonymous with QI. The aim is for QIto be regularly discussed at team meetings and for staff to be confident using QI language. Through equipping and empowering staff, the Trust wants to see continual growth in projects that produce sustainable change and to be in a position to share good practice with other trusts, through conferences, awards and learning events. A number of trusts have already contacted Whittington Health to share the learning from our successful Frailty and Discharge Summary QI projects.

6.2 Quality Improvement reports to Quality Committee and there is a verbal presentation from staff on a QI project at every meeting.

6.3 As previously reported to the Quality Committee in June 2019 the Trust held its second annual QI celebration afternoon. Building on the success of the 2018 event, there were 13 presentations representing all ICSUs and staff groups. In 2019, teams who were interested in presenting had to apply and this resulted in a higher standard with 23 projects submitted. Moreover, where possible, project posters were displayed. Two prizes were awarded - 'Best Project' (Development of a Chest Trauma pathway) and 'The People's Choice' (Improving Access to Medical Education). Over 85 people came to the event generated further suggested areas for quality improvement.

Table 5: Projects presented at QI Celebration event

| **Established QI projects** | **Beginning projects with clear next steps** |
|---|---|
| Mindful Eating Group sessions (Adult Community Servicess ICSU - Dieticians) | Reducing same day theatre cancellations (Surgery & Cancer ICSU  Junior doctor) |
| VTE Assessments in General Surgery (Surgery & Cancer ICSU Junior doctor) | Management of Neonatal Jaundice (Children & Yound People's Services ICSU Junior doctor) |
| Development of a Chest Trauma pathway (Emergency & Integrated Medicine  Junior doctor) | Continuity of Carer within Midwifery (Community Midwives) |
| Critical Care Unit Delayed discharges (Surgery & Cancer ICSU Matron) | 'What matters to me' (Emergency & Integrated Medicine Junior doctors) |
| Improving Access to Medical Education (Junior doctors) | Discharge Summaries (Emergency & Integrated Medicine Consultant) |
| 48 hour review for wheeze (Children & Young People's Services ICSU Nurse and administrator) | Induction of Labour (Junior doctor) |
| Frailty pathway (Emergency & Integrated Medicine Consultant) | |




6.4 In addition to Whittington Health's Quality Improvement celebrations, staff were encouraged to submit their work and present widely at conferences. This year, members of staff have presented successful projects at North Central London QI events.

6.5 Junior doctors have submitted projects for poster presentation at specialty conferences and we also had a poster on the Discharge Summary work accepted to a Patient Safety conference. For the second year running, the

Trust has had a publication in the British Medical Journal Open Quality- this time about the Frailty Pathway.

## 7 Next steps

7.1 Once the new Associate Medical Director for QI is appointed the AMD and QI lead will work with the executive triumvirate and stakeholders to renew the Quality Improvement strategy for the Trust.

7.2 Training has been a success this year but in order to support teams in identifying and running improvement projects, it would be beneficial for managers at band 7 and above to attend the face to face training. This will also help ICSUs to manage their QI programmes and assign projects if necessary.

7.3 Although registering projects is done centrally, each ICSU has ownership over the projects running in the area. In 2020, we will work with the ICSUs to manage these projects. Quality Improvement is now a standard agenda item for ICSU Quality and Safety meetings which it is hoped will help the ICSUs in prioritising resources and identifying where projects are no longer active.

7.4 Although learning is being shared, there is more that could be done to embed QI projects after adverse incidents. In 2020, Whittington Health will strengthen the Serious Incident action planning process to include clearer links to Quality Improvement.

7.5 In 2020, Whittington Health will develop a robust QI mentorship programme and increase the involvement of the existing QI Coaches in projects. This will enable the Trust to prioritise more projects through providing additional resources and support.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Guardian of Safe Working Hours (GoSWH) report Q3 2019-20** | **Agenda item: 10** |
| **Executive director lead** | Dr Clare Dollery, Medical Director | |
| **Report author** | Dr Rebecca Sullivan, Guardian of Safe Working Hours | |
| **Executive summary** | Nationally, there is a steady increase in exception reporting. During this quarter Whittington Health has had a slight increase when compared to the last quarter. This quarter contains a number of bank holidays however which is often associated with more exception reports. When compared to the same quarter in 2018/19 there are considerably fewer reports. The reasons for this are discussed.<br><br>Most exception reports continue to occur within the Emergency and Integrated Medicine Integrated Clinical Service Unit (ICSU). This is as expected as it has the highest number of trainees and the largest proportion of inpatient work.<br><br>Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against.<br><br>The GoSWH is continuing to work with the postgraduate department and the JDF to review the perception of high workload amongst the foundation trainees which may be contributing to exception reporting. Progress has been made in ensuring fines are paid into the junior doctors fund and that the GSWH can access the funds to spend as identified by the junior doctors group | |
| **Purpose:** | To provide assurance to the board that junior doctors are working safe hours in accordance with the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training. | |
| **Recommendation(s)** | The Board is asked to review this report | |
| **Risk Register or Board Assurance Framework** | Cross reference to the relevant BAF or corporate risk register entry | |
| **Report history** | None | |
| **Appendices** | None | |

## Guardian of Safe Working Hours report Q3 2019-20

### 1 Introduction

This report is presented to the Board with the aim of providing context and assurance around safe working hours for Whittington Health Junior Doctors.

In August 2016 the new Terms & Conditions (TCS) were introduced for doctors in training. There are clear guidelines of safe working hours and adequate supervision. Trainees submit 'exception report' if these conditions are breached. The 2016 TCS has more recently been amended in 2019 and we are in the progress of implementing the new changes.

Exception reports (ER) are raised by junior doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through the Allocate's E-Rota system. The educational/clinical Supervisor for the individual doctor and the Guardian of Safe Working Hours (GoSWH) receive an alert which prompts a review the ER and requires the supervisor to meet with the trainee to discuss the events leading to the ER and to take appropriate action to rectify. Such action may include time off in lieu or payment for additional hours worked. They are also asked to review the likelihood of a further exception recurring and address this with the trainee also. Where issues are not resolved or a significant concern is raised the guardian may request a review of the doctors work schedule. The GoSWH in conjunction with the Medical Workforce team reviews all exception reports to identify whether a breach has occurred which incurs a financial penalty. The GoSWH will levy a fine to the department employing the doctor for those additional hours worked.

In line with the 2016 Terms and Conditions of Service (TCS), a Junior Doctors' Forum was jointly established with the GoSWH and the Director of Medical Education. It is chaired by the Guardian for Safe Working. The forum meets on an alternate monthly basis. We continue to have good attendance and engagement well above other local trusts.

### 2 High level data

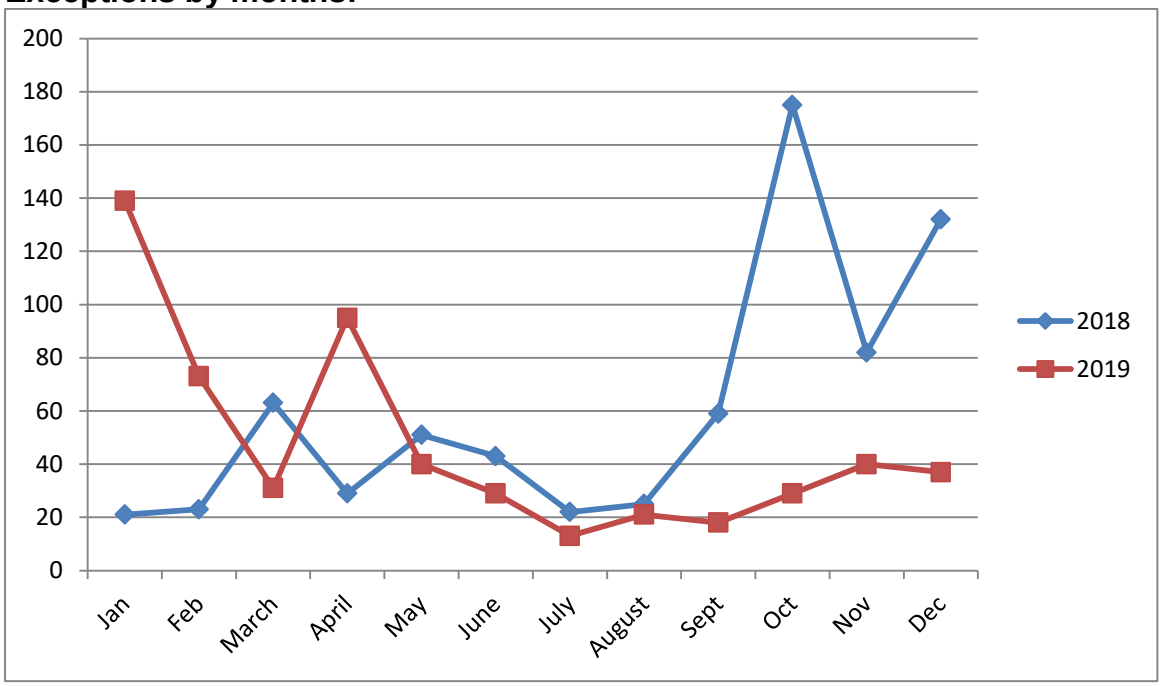
| | |
|---|---|
| Number of doctors / dentists in training (total): | 218 |
| Number of doctors / dentists in training on 2016 TCS (total): | 218 |
| Job planned time for guardian: | 1 PA |
| Admin support provided to the guardian (if any): | as required from MD office |
| Amount of job-planned time for educational supervision | 0.25 PAs per trainee |

### 3 Exception reports (with regard to working hours)

Between 1 October 2019 and 31 December 2019 a total of 108 exception reports were raised. The tables below give detail on where exceptions were raised and the response times to deal with the issue raised.

| | | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|
| Reports | Grand Total | 29 | 40 | 37 | 106 |
| | Closed | 29 | 40 | 15 | 84 |
| | Open | 0 | 0 | 22 | 22 |
| Individual doctors / specialties reporting | Doctors | 12 | 20 | 14 | - |
| | Specialties | 2 | 2 | 2 | - |
| Immediate concern | | 0 | 0 | 0 | 0 |
| Nature of exception | Hours & Rest | 29 | 38 | 37 | 104 |
| | Education/Training | 0 | 2 | 0 | 2 |
| Additional hours | Total hours | 44.5 | 59.5 | 45 | 149.5 |
| Response | Agreed | 28 | 38 | 24 | 90 |
| | Not Agreed/Not yet actioned | 1 | 2 | 13 | 16 |
| Agreed Action *('No action required' is the only response available for 'education' exception reports)* | Time off in lieu | 6 | 6 | 4 | 16 |
| | Payment for additional hours | 20 | 30 | 20 | 70 |
| | No action required | 1 | 4 | 0 | 5 |
| | Other/Pending | 2 | 0 | 13 | 15 |
| Grade | Foundation year 1 (FY1) | 23 | 27 | 28 | 78 |
| | Foundation year 2 (FY2) | 2 | 0 | 3 | 5 |
| | Core Medical Trainee/Specialty Trainee 1 or Specialty Trainee 2 | 4 | 12 | 6 | 22 |
| | GP Specialty Registrar | 0 | 0 | 0 | 0 |
| | Specialty Registrar | 0 | 1 | 0 | 1 |
| Exception type *(more than one type of exception can be submitted per exception report)* | Work Load | 12 | 13 | 16 | 41 |
| | Patient/Dr ratio too high | 12 | 15 | 12 | 39 |
| | Rota gaps | 0 | 1 | 1 | 2 |
| | Late running ward round | 3 | 0 | 3 | 6 |
| | Deteriorating patient | 1 | 5 | 4 | 10 |
| | Educational | 0 | 2 | 0 | 2 |
| Specialty | General Medicine | 26 | 36 | 35 | 97 |
| | General Surgery | 0 | 0 | 2 | 2 |
| | Trauma and orthopaedics | 2 | 0 | 0 | 2 |
| | Paediatrics | 0 | 4 | 0 | 4 |
| | Anaesthetics/Intensive Treatment Unit | 0 | 0 | 0 | 0 |
| | Radiology | 0 | 0 | 0 | 0 |
| | Psychiatry | 1 | 0 | 0 | 1 |
| | Obstetrics and gynaecology | 0 | 0 | 0 | 0 |
| | Accident and emergency | 0 | 0 | 0 | 0 |
| | Histopathology and micro | 0 | 0 | 0 | 0 |
| | Ophthalmology | 0 | 0 | 0 | 0 |

**Exceptions by months:**




The number of exception reports submitted per month is very variable throughout the year and year on year. As might be expected there are more reports in the winter months and less in the summer months when the wards are slightly less busy. When reviewed year on year it is possible to see that in 2018 there were a number of months with exceptionally high numbers of exception reports and the reasons for this have been reviewed in previous quarterly reports. In brief, the primary reason for the high levels of reporting in October - December 2018 was due to the issues that were arising on Victoria ward at that time leading to the junior doctors staying late on a daily basis. There was also retrospective reporting occurring at that time due to a number of issues. The practice of batch retrospective reporting has now substantially reduced as the exceptions are reviewed on a more regular basis and issues are addressed in a more timely fashion. The exception reports from colleagues working on Victoria and escalation by the clinical and management teams resulted in a planned reduction in the number of beds on Victoria ward to match the work force.

This in keeping with an increasingly supportive culture with regards to exception reporting alongside the ongoing work of the GoSWH and Educational Supervisors in trying to encourage trainee doctors to handover work at the end of the shift and to work to their scheduled hours there has been a steady fall in ERs during 2019. It appears we have now reached more of a plateau in reporting levels which is reassuring.

Given that the vast majority of exception reporting is still undertaken by FY1s, Quarter 3 represents the new cohort of junior doctors. We would therefore expect that reporting in these first few months might be higher than at other times of the year as they settle into the job and also as this is a busy time of the year.

**Immediate safety concerns**
There have been no “immediate safety concerns” relating to his working hours raised this quarter.

**Work Schedule reviews**
No formal work schedule reviews have taken place during this quarter. The previous issues relating to the working hours of the psychiatry juniors who work one day a week to cover the medical admissions units has now been resolved following review of working hours. Due to variation between the working hours of the psychiatry FY and the other FY1s on the medical admissions unit it frequently led to the psychiatry junior staying late. This has now been reviewed and hours adjusted to ensure the juniors feel more comfortable to leave at the same time as the rest of the team.

## 4 Establishment and vacancy data:

### I. Bank and Agency usage

The table below shows the agency usage across specialities for the period of October to December 2019.

| Speciality | Current Agency use – shifts put out to locum agency October to December 2019 |
|---|---|
| General Medicine | 108 shifts put out to agency<br>• 100% covered by internal bank<br>• 0 % covered by external bank |
| General Surgery | General Surgery<br>72 shifts put out to agency<br>• 74% covered by internal bank<br>• 26% covered by external agency<br><br>Trauma and orthopaedics (T&O)<br>110 shifts put out to agency<br>• 88% covered by internal bank<br>• 12% covered by external agency<br><br>Urology<br>82 shifts put out to agency<br>• 99% covered by internal bank<br>• 1% covered by external agency |
| Obstetrics and Gynaecology | 93 shifts put out to agency<br>• 63% covered by internal bank<br>• 37% covered by external agency |
| Paediatrics (including NICU) | 23 shifts put out to agency<br>• 100% covered by internal bank<br>• 0% covered by external agency |

### II. Locum work carried out by trainees

The table below shows the additional work carried out by our own trainees across specialists for the period of October to December 2019.

| Speciality | Additional shifts worked by trainees |
|---|---|
| General Medicine | 108 additional shifts; 1005.25 additional hours worked |
| General Surgery | General Surgery: 72 additional shifts; 742 additional hours worked<br><br>T&O:110 additional shifts; 1158.5 additional hours worked<br><br>Urology: 82 additional shifts; 1044.25 additional hours worked |
| Obstetrics and Gynaecology | 93 additional shifts; 1033.5 additional hours worked |
| Paediatrics in NICU | 23 additional shifts; 261 additional hours worked |

### III. Vacancies

The table below shows the current vacancy rates across specialists for the period of October to December 2019.

| Speciality | Current vacancies |
|---|---|
| General Medicine | Senior House Officer (SHO)<br>1 whole time equivalent (WTE) vacant October - December<br>1 WTE vacant November - December |
| General Surgery | SHO<br>1 WTE vacant Urology<br>Registrar<br>2 WTE vacant<br>On-going gaps in the T&O and Urology on-call rota gaps |
| Obstetrics and Gynaecology | SHO<br>1 WTE vacant<br>1 Less than full-time (LTFT) trainee leading to 30 % vacancy (plus 70% on-calls)<br><br>Registrar<br>4 LTFT trainees leading to 1.2% WTE vacancies |
| Paediatrics (inc NICU) | Registrar<br>I LTFT trainee 0.6 – 0.4 vacancy |

### 5 Fines and payment

For this quarter a total of 144.5 hours are to be re-paid either in time off in lieu (TOIL) or if this is not possible as pay for additional hours worked. It would not be appropriate for TOIL accrued in one specialty to be rolled over to another specialty.

Currently, these hours equate to a total of approximately £1,367.85 of which £771.48 has so far been paid to the junior doctors directly. £1,464.88 has been issued in fines to the Trust in accordance with the terms and conditions laid out in the contract. This is to be added to pre-existing fines that have been accrued and is to be kept in a spate fund for the junior doctors. Prior issues with ensuring that these

fines have been paid and the money is ring-fenced for the junior doctors' fund have now been resolved.

**Breakdown of fines by ICSU**

| ICSU | Amount of fine to Doctor | Amount of fine to Guardian |
|---|---|---|
| Emergency & Integrated Medicine | £670.24 | £794.64 |
| Surgery & Cancer | Nil | Nil |
| Children & Young People | Nil | Nil |

Fines to the Guardian go into the junior doctor's fund.

## 6 Next steps

- GoSW to continue to ensure all unclosed exception reports (ERs) are signed off in a timely fashion. Changes made to the contract in 2019 enables the GoSW to action outstanding ERs at 30 days.
- GoSW and HR to work with finance team to ensure junior doctors' forum fund is active and ring-fenced as per the TCS. The Medical Director and the GoSW continue to work together to ensure this is resolved as soon as possible.
- Continue to work with ICSU leadership teams, rota coordinators and the bank office to try to reduce the need for exception reporting by working to fill rota gaps whenever possible. The GoSW is confident that all possible options are currently being explored.

## 5 Conclusions / recommendations

- Levels of reporting need to continue to be reviewed regularly to ensure the Trust does not become an outlier. The majority of exception reporting continues to be done by the more junior trainees e.g. FY1 and 2. Ongoing effort is required to promote engagement from more senior trainees.
- Most exception reports are occurring within the Emergency and integrated Medicine ICSU. This is as expected as it has the highest number of trainees and the largest proportion of inpatient work.
- Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against but the post graduate team, along with the GoSWH are looking into this in more detail and hope to be able to give more insight into this in the next report.
- Concerns relating to training issues which have been highlighted via the ER mechanism continue to be addressed by the DME.
- There are still very low levels of reporting in certain specialities, e.g. anaesthetics, radiology etc. and at higher grades. Attempts are being made to increase engagement. This is a well-recognised issue nationally; the GoSWH continues to promote ER in these areas.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **January (Month 9) 2019/20 – Financial Performance** | **Agenda item: 11** |
| **Executive director lead** | Kevin Curnow, Chief Finance Officer (Acting) | |
| **Report author** | Finance Team | |
| **Executive summary** | The Trust is reporting a year to date actual deficit of £6.9m which is £3.2m behind plan (excluding PSF and FRF). As the Trust has not achieved the year to date financial target it has not assumed any PSF, therefore resulting in a negative variance of £6.2m from plan. Should the Trust achieve the Control Total for the year, then PSF can be recovered by March 2020.<br><br>The adverse variance is still mainly driven by the failure to achieve the Cost Improvement Programme (CIP), however £1.0m was delivered this month. CIP achievement year to date is £5.7m with an adverse variance of £5.1 against a £9.2m target. Forecast CIP delivery is £7.7m against £12.3m annual target.<br><br>The year to date pay costs are in excess of budget by £3.8m. Agency spend at £0.8m this month is a slight increase from the previous month, though is still beneath the agency cap which was expected to be higher over December. However year to date agency spend is £0.4m above the ceiling. Combined temporary spend is £2.5m down on the previous year to date average of £2.9m.<br><br>Non-pay expenditure is £0.3m underspent in month and £2.0m year to date overspent. The variances predominately driven by underachieved CIP.<br><br>Failure to deliver recurrent savings is adversely impacting the underlying financial position of the Trust.<br><br>The Trust has spent £7.0m on capital expenditure at month 7. The planned spend is £8.4m. | |
| **Purpose:** | To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends | |
| **Recommendation(s)** | To note the financial results relating to performance during December 2019, recognising the need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans | |
| **Risk Register or Board Assurance Framework** | BAF entry - Sustainability 1 | |
| **Report history** | | |
| **Appendices** | None | |

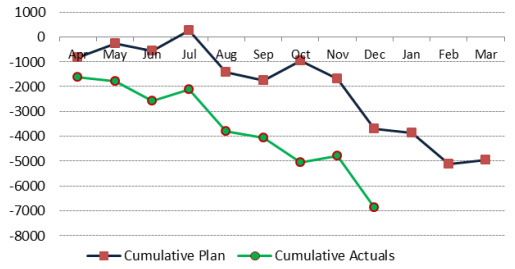
# Finance Report

**Month 9 2019-20**

# YTD Performance at M9

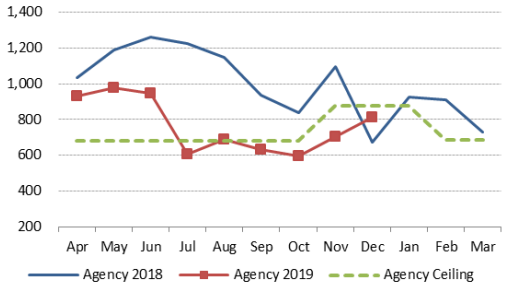


### Performance against Plan




*YTD adverse variance of £3.2m before PSF. Adverse variance driven by slippage against CIP target and expenditure overspends.*

### Agency Spend Vs. Last year




*Agency spend below ceiling for December and has been so for the last four months. Year to date agency spend £0.4m above ceiling at end of December.*

### Key indicators

| Measure | Target | Actual | Previous month | RAG |
|---|---|---|---|---|
| Funded Beds | 197 | 208 | 207 | |
| CIP Forecast | £12.3m | £7.7m | £8.0m | |
| CIP YTD delivery | £9.2m | £5.8m | £5.1m | |
| Emergency Length of stay | TBC | 4.9 | 3.9 | |
| EL Activity planned delivered | 100% | 94% | 95% | |
| Agency spend | £0.9m | £0.8m | £0.7m | |

### YTD CIP Performance

| | Full Year | | | |
|---|---|---|---|---|
| ICSU | Target | Forecast | Variance | YTD Actuals |
| ACS | 582 | 576 | (6) | 422 |
| ACW | 2,220 | 1,182 | (1,038) | 974 |
| CYPS | 1,246 | 1,265 | 19 | 928 |
| EIM | 2,757 | 681 | (2,076) | 484 |
| S&C | 2,112 | 1,378 | (734) | 960 |
| Corporate | 3,385 | 2,624 | (761) | 1,987 |
| | **12,302** | **7,706** | **(4,596)** | **5,754** |

### Variance from plan by ICSUs and Corporate

| 3CCN - Level 3 Cost Centre N | In Month variance | YTD Variance |
|---|---|---|
| Adult Community | 44 | 158 |
| Children & Young People | (79) | (307) |
| Emergency & Integrated Medicin | (562) | (6,908) |
| Surgery & Cancer | (328) | (3,604) |
| ACW | (292) | (1,769) |
| Corporate Services | (397) | (395) |
| Corporate Central | 1,539 | 9,637 |
| **Grand Total** | **(76)** | **(3,189)** |

# CFO Message



**Trust delivered an actual deficit of £6.9m - £3.2m adverse to plan at end of December**

1 The trust delivered an actual deficit of £6.9m (excluding PSF and FRF) at end of December. This was £3.2m worse than plan. Key drivers for the year to date adverse variance are

- Adverse variance due to slippage in CIP delivery – Year to date CIP slippage of £3.5m
- Pay overspend relating to bank and agency usage within both medical and nursing pay group
- Non-pay overspends within estates
- Adverse variance partly offset by over performance in income and other non-recurrent benefits

**YTD CIP performance at M9 - £3.5m adverse to target**

2 CIP target to end of December was £9.2m. The trust delivered £4m of recurrent CIP and £1.7m of non-recurrent savings at end of December. The Trust is currently forecasting recurrent in year CIP delivery of £5.6m and non-recurrent CIPs of £2.1m for 2019-20.

**FY20 underlying – worsening due to non-delivery of recurrent CIP**

3 The trust was expected to deliver £12.3m of recurrent savings in 2019-20. Based on December forecast the level of recurrent CIP for the year is £5.6m. This slippage in CIP delivery and expenditure overspends is adversely impacting the underlying position of the trust. This will impact the level of CIP required for 2020-21 to meet the financial improvement trajectory. The forecast underlying position for 2019-20 is likely to be £10m deficit - £5m worse than the planned underlying position for 2019-20. Teams are continuing to review and validate the underlying assumptions.

**Cash at end of M9 is £29.9m**

4 Cash at end of December was £29.9m. This is £2.0m ahead of plan, and reflects the completion of the land sale transaction to Camden and Islington NHS FT in March 2019 and the receipt of £22m in Provider Sustainability Funding (PSF) from NHS England in July. The Trust will not require any cash support during 2019/20.

**Forecast outturn and emerging risks**

5 The planned deficit for the Trust for 2019-20 is £4.9m deficit. Delivering the plan is contingent on ICSUs delivering the required run rate improvement identified at M7 and agreeing an outturn value with commissioners for clinical income. Any adverse outcome will impact on the Trust's ability to deliver its plan for 2019-20.

Though the trust is actively managing its ongoing legal challenges, any adverse outcome will impact the financial performance of the Trust

Though there is a risk for potential overspend within the estates capital budget, the trust is actively managing this risk through the capital monitoring group to ensure that the overall capital forecast remains within this funding envelope.

# YTD Performance at M9

| | In Month | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Annual Budget |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Income** | | | | | | | |
| Nhs Clinical Income | 21,555 | 22,625 | 1,071 | 204,948 | 210,704 | 5,755 | 273,494 |
| High Cost Drugs - Income | 684 | 844 | 160 | 6,155 | 6,347 | 192 | 8,207 |
| Non-Nhs Clinical Income | 1,225 | 1,002 | (223) | 11,770 | 9,902 | (1,868) | 16,036 |
| Other Non-Patient Income | 2,085 | 2,086 | 1 | 18,684 | 18,792 | 108 | 24,846 |
| Income Cips | 67 | 0 | (67) | 602 | 0 | (602) | 802 |
| | **25,615** | **26,557** | **942** | **242,160** | **245,744** | **3,584** | **323,384** |
| **Pay** | | | | | | | |
| Agency | (30) | (813) | (783) | (304) | (6,898) | (6,593) | (394) |
| Bank | (94) | (1,810) | (1,716) | (839) | (16,936) | (16,097) | (1,096) |
| Substantive | (19,483) | (17,498) | 1,985 | (172,611) | (153,721) | 18,891 | (230,716) |
| | **(19,607)** | **(20,121)** | **(514)** | **(173,755)** | **(177,555)** | **(3,800)** | **(232,206)** |
| **Non Pay** | | | | | | | |
| Non-Pay | (6,034) | (6,454) | (420) | (54,307) | (57,361) | (3,053) | (72,408) |
| High Cost Drugs - Exp | (668) | (796) | (129) | (6,008) | (6,233) | (225) | (8,011) |
| | **(6,701)** | **(7,250)** | **(549)** | **(60,316)** | **(63,594)** | **(3,278)** | **(80,420)** |
| **EBITDA** | **(693)** | **(814)** | **(121)** | **8,090** | **4,596** | **(3,494)** | **10,759** |
| **Post EBITDA** | | | | | | | |
| Depreciation | (621) | (593) | 28 | (5,570) | (5,278) | 292 | (7,436) |
| Interest Payable | (270) | (249) | 21 | (2,430) | (2,475) | (45) | (3,238) |
| Interest Receivable | 15 | 11 | (4) | 111 | 170 | 59 | 156 |
| Dividends Payable | (432) | (432) | 0 | (3,888) | (3,888) | 0 | (5,187) |
| | **(1,308)** | **(1,263)** | **45** | **(11,777)** | **(11,471)** | **306** | **(15,705)** |
| **Reported Surplus/(deficit) before PSF** | **(2,001)** | **(2,077)** | **(76)** | **(3,687)** | **(6,876)** | **(3,188)** | **(4,946)** |
| PSF | 490 | 30 | (460) | 3,251 | 273 | (2,978) | 4,946 |
| **Reported surplus/(deficit) before PSF** | **(1,511)** | **(2,047)** | **(536)** | **(436)** | **(6,603)** | **(6,166)** | **0** |

At end of Month 9 the Trust is reporting an actual deficit of £6.9m – this is £3.2m worse than plan.

Key drivers for the adverse variance from plan are

- Under delivery of YTD CIP of £3.5m
- Medical pay overspend of £2.4m predominantly within EIM and Surgery and Cancer ICSUs
- Nursing over spend of £1.3m within EIM
- Non-pay overspends within estates relating to legal fees, consultancy and utilities
- Expenditure overspends partly offset by central reserves

M9 actuals was £0.4m worse than what was forecast for the month. This was driven by non-recurrent costs in non-pay and increased pay costs for December

I·C A R E

# CIP Performance

| | Full year target | YTD Target | YTD Delivery: Recurrent | YTD Delivery: Non-recurrent | YTD Delivery: Total | YTD Variance | Full year delivery: Recurrent | Full year delivery: Non-recurrent | Full year delivery: Full year forecast | Full year delivery: Forecast variance | % of target delivered recurrently |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACS** | 582 | 437 | 347 | 75 | 422 | (15) | 476 | 100 | 576 | (6) | 82% |
| **ACW** | 2,220 | 1,669 | 310 | 664 | 974 | (695) | 473 | 708 | 1,182 | (1,038) | 21% |
| **CYPS** | 1,246 | 937 | 590 | 338 | 928 | (9) | 816 | 449 | 1,265 | 19 | 66% |
| **EIM** | 2,757 | 2,072 | 484 | 0 | 484 | (1,589) | 681 | 0 | 681 | (2,076) | 25% |
| **S&C** | 2,112 | 1,588 | 509 | 451 | 960 | (628) | 792 | 583 | 1,378 | (734) | 37% |
| **Corporate** | 3,385 | 2,545 | 1,771 | 216 | 1,987 | (558) | 2,334 | 290 | 2,624 | (761) | 69% |
| | **12,302** | **9,248** | **4,010** | **1,744** | **5,754** | **(3,494)** | **5,573** | **2,130** | **7,706** | **(4,596)** | |

- Year to date CIP delivery of £5.7m. This is £3.5m below plan. Trust continues to rely on non-recurrent measures to deliver its CIP.
- Full year forecast CIP delivery for the year is £7.7m; this is £4.6m adverse to plan
- The trust is currently forecasting to deliver £5.6m of its 2019-20 target recurrently
- Reliance on non-recurrent measures to deliver the 2019-20 target is adversely affecting the Trust underlying position and increasing the level of CIPs required for 2020-21.
- The PMO team is currently focussing on reviewing all non-recurrent CIP schemes and convert them to recurrent schemes for next year.

# Income

| Category | In Month Income Plan £000's | In Month Income Actual £000's | In Month Variance £000's | YTD Income Plan £000's | YTD Income Actual £000's | YTD Variance £000's |
|---|---|---|---|---|---|---|
| Elective and Day Case | 1,559 | 1,790 | 231 | 16,284 | 17,662 | 1,378 |
| Non Elective 0 LOS | 1,057 | 1,015 | (42) | 9,377 | 9,450 | 73 |
| Non Elective LOS I Day or Greater | 3,723 | 3,576 | (147) | 33,019 | 33,278 | 259 |
| OP Attendances - 1st | 854 | 941 | 87 | 8,924 | 8,837 | (87) |
| OP Attendances - follow up | 770 | 723 | (47) | 8,039 | 7,412 | (627) |
| A&E Attendances | 1,433 | 1,485 | 52 | 12,713 | 12,699 | (14) |
| High Cost Drugs (excludes CDF) | 650 | 810 | 160 | 5,850 | 6,063 | 213 |
| Community | 6,160 | 6,098 | (62) | 55,440 | 55,363 | (77) |
| Other Clinical income NHS | 4,440 | 5,182 | 742 | 46,373 | 48,726 | 2,353 |
| Other Clinical Income Non NHS | 2,893 | 2,851 | (42) | 27,457 | 27,462 | 5 |
| **Total Income From Patient Care Activities** | **23,539** | **24,471** | **932** | **223,476** | **226,952** | **3,476** |
| **Other Operating Income Excluding PSF** | **2,076** | **2,086** | **10** | **18,684** | **18,792** | **108** |
| **Total** | **25,615** | **26,557** | **942** | **242,160** | **245,744** | **3,584** |
| PSF/FRF/MRET | 490 | 30 | (460) | 3,251 | 273 | (2,978) |
| **Revised Total** | **26,105** | **26,587** | **482** | **245,411** | **246,017** | **606** |

Month nine performance was slightly higher than planned, with an in month over-performance of £0.5m, 1.8%.

At end of December, the Trust is over performing (before the application of PSF) by £3.6m.

The main areas of material activity variance are within controllable planned care. Elective admissions and day cases are £1.4m (8.5%) favourable year to date (YTD), – a small increase. There continues to be under performance in Outpatients, with £0.7m (4.2%) YTD adverse to plan.

The Trust has not assumed any income relating to the Provider Sustainability/Financial Recovery Fund as the Trust is not currently meeting its planned financial position.

**Income Risks**

The trust is yet to agree an year end position with NCL commissioners. Any outcome lower than our current income assumption in our forecast will have an adverse impact in delivering our plan for 2019-20

# Pay

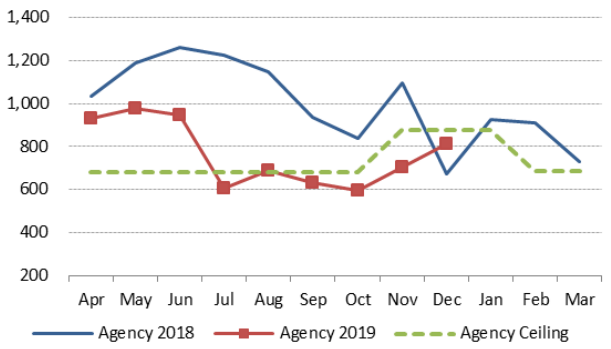
| | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Forecast | Forecast | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ICSU** | **M01** | **MO2** | **M03** | **M04** | **M05** | **M06** | **M07** | **M08** | **M09** | **M10** | **M11** | **M12** |
| Substantive | £17,167 | £16,732 | £16,823 | £16,906 | £16,817 | £16,994 | £17,319 | £17,465 | £17,498 | £17,117 | £17,129 | £17,229 |
| Bank | £1,843 | £1,847 | £1,897 | £2,024 | £1,981 | £1,751 | £1,902 | £1,881 | £1,810 | £1,795 | £1,798 | £1,798 |
| Agency | £932 | £979 | £944 | £606 | £689 | £634 | £594 | £706 | £813 | £839 | £804 | £781 |
| **Grand Total** | **£19,942** | **£19,559** | **£19,665** | **£19,536** | **£19,487** | **£19,379** | **£19,816** | **£20,051** | **£20,121** | **£19,751** | **£19,731** | **£19,809** |

- Total pay expenditure for December was £20.1m, £0.5m adverse to in-month budget and £3.8m adverse YTD.
- Pay pressures continue within Emergency Integrated Medicine and Surgery ICSUs. In December pay was overspent by £0.6m in EIM and £0.3m in Surgery.
- Within total pay spend for December, agency costs were £0.8m and bank costs were £1.8m .
- Enhanced care continues to be a pressure on pay spend. The trust is addressing this through enhanced care business case
- Agency spend was below the ceiling for December

## Enhanced Care WTE

| ICSU | Request Reason | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|
| EIM | 1-1 RMN | 0.14 | 0.21 | 1.68 | 1.06 | | | |
| | Enhanced Care | 41.79 | 40.44 | 41.42 | 32.92 | 52.04 | 51.25 | 49.26 |
| | Extra dependency/acuity | 10.1 | 11.98 | 8.49 | 6.82 | 3.78 | 4.64 | 2.19 |
| **EIM Total** | | **52.03** | **52.63** | **51.59** | **40.8** | **55.82** | **55.89** | **51.45** |
| Surgery | 1-1 RMN | - | 0.35 | | | | | |
| | Enhanced Care | 1.46 | 0.84 | 3.58 | 1.9 | 1.41 | 1.76 | 1.89 |
| | Extra dependency/acuity | 0.3 | 0.37 | 2.48 | 1.66 | 2.82 | 1.96 | 4.72 |
| **Surgery Total** | | **1.76** | **1.56** | **6.06** | **3.56** | **4.23** | **3.72** | **6.61** |
| **Grand Total** | | **53.79** | **54.18** | **57.65** | **44.36** | **60.06** | **59.61** | **58.05** |

### Agency Trend



# Non Pay

| | Year To Date | | | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Actual | Forecast | Forecast | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICSU | YTD Budget '£000 | YTD Actual '£000 | YTD Variance '£000 | M01 | MO2 | M03 | M04 | M05 | M06 | M07 | M08 | M09 | M10 | M11 | M12 |
| Establishment | £2,513 | £2,296 | £217 | £170 | £224 | £219 | £295 | £199 | £312 | £276 | £371 | £230 | £267 | £268 | £267 |
| Ext Cont Staffing & Cons | £1,462 | £1,681 | (£219) | £265 | £180 | £199 | £174 | £77 | (£17) | £225 | £220 | £358 | £346 | £238 | £188 |
| Healthcare From Non Nhs | £515 | £529 | (£14) | £62 | £60 | £62 | £62 | £17 | £91 | £68 | £48 | £59 | £56 | £56 | £56 |
| Miscellaneous | £14,032 | £14,019 | £13 | £2,001 | £1,341 | £1,283 | £1,162 | £1,929 | £1,657 | £1,558 | £1,660 | £1,429 | £1,694 | £1,707 | £1,807 |
| Non-Pay Reserve | (£59) | £0 | (£59) | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| Premises & Fixed Plant | £14,986 | £15,240 | (£254) | £1,640 | £1,738 | £1,827 | £1,649 | £1,702 | £1,766 | £1,530 | £1,642 | £1,746 | £1,721 | £1,716 | £1,716 |
| Supplies & Servs - Clin | £25,430 | £28,041 | (£2,611) | £3,133 | £3,366 | £3,049 | £3,503 | £3,041 | £3,038 | £2,636 | £3,095 | £3,180 | £2,906 | £3,092 | £3,020 |
| Supplies & Servs - Gen | £1,437 | £1,788 | (£351) | £153 | £173 | £168 | £182 | £163 | £180 | £221 | £298 | £249 | £174 | £174 | £174 |
| **Grand Total** | **£60,316** | **£63,594** | **(£3,278)** | **£7,424** | **£7,082** | **£6,808** | **£7,028** | **£7,129** | **£7,027** | **£6,514** | **£7,333** | **£7,250** | **£7,164** | **£7,251** | **£7,227** |

- Non-pay expenditure for November was £7.3 for December
- The non-pay variance in month 9 is a adverse variance of £0.4m and this brings the year to date overspend to £3m.
- Overspends on non-pay are due to clinical supplies for theatres, endoscopy insourcing, utilities and non-delivery of CIP programme schemes

# Statement of Financial Position

## THE WHITTINGTON HEALTH NHS TRUST

### Statement of Financial Position

| | Year to Date | | |
|---|---|---|---|
| | As at 31 Dec 2019 £000 | Plan 31 Dec 2019 £000 | Plan variance 31 Dec 2019 £000 |
| Property, plant and equipment and intangibles | 221,258 | 228,212 | (6,954) |
| Trade and other receivables | 1,075 | 1,400 | (325) |
| **Total Non Current Assets** | **222,333** | **229,612** | **(7,279)** |
| Inventories | 2,123 | 1,355 | 768 |
| Trade and other receivables | 34,174 | 24,191 | 9,983 |
| Cash and cash equivalents | 29,913 | 27,958 | 1,955 |
| **Total Current Assets** | **66,210** | **53,504** | **12,706** |
| **Total Assets** | **288,543** | **283,116** | **5,427** |
| Trade and other payables | 51,150 | 41,995 | 9,155 |
| Borrowings | 27,075 | 29,012 | (1,937) |
| Provisions | 912 | 1,391 | (479) |
| **Total Current Liabilities** | **79,137** | **72,398** | **6,739** |
| **Net Current Assets (Liabilities)** | **(12,927)** | **(18,894)** | **5,967** |
| **Total Assets less Current Liabilities** | **209,406** | **210,718** | **(1,312)** |
| Borrowings | 28,748 | 30,936 | (2,188) |
| Provisions | 839 | 842 | (3) |
| **Total Non Current Liabilities** | **29,587** | **31,778** | **(2,191)** |
| **Total Assets Employed** | **179,819** | **178,940** | **879** |
| Public dividend capital | 66,691 | 69,191 | (2,500) |
| Retained earnings | 18,473 | 5,178 | 13,295 |
| Revaluation reserve | 94,655 | 104,571 | (9,916) |
| **Total Taxpayers' Equity** | **179,819** | **178,940** | **879** |

There are some significant variances in the balance sheet against plan. Overall, the value of the balance sheet is £879,000 higher than plan. In the taxpayers' equity section (bottom of the balance sheet), the main reason behind this is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF). This has been partially offset by decreases in the revaluation reserve following the valuation of the Trust's land and buildings portfolio (information available after the submission of the 2019-20 operating plan), which indicated an average decrease of approximately 2%.

Property, Plant & Equipment (PPE) and intangible assets are £7.0m lower than plan. This variance against plan largely arises from the revaluation decreases mentioned above. The gap between capital plans and actual capital spend is £2.2m at the end of month 9. The Trust remains confident that it will be able to spend capital allocations in year, and has plans in place to do so.

Cash and cash flow: the Trust has £29.9m in cash at the end of December 2019. This is £2.0m ahead of plan, and reflects the completion of the land sale transaction to Camden and Islington NHS FT in March 2019 and the receipt of £22m in Provider Sustainability Funding (PSF) from NHS England in July. The Trust will not require any cash support during 2019/20.

Receivables (Debtors) are at £34.2m at the end of December 2019. This is £10m greater than plan. The most significant outstanding items in the balance relate to NHS organisations, notably unpaid SLA instalments from Haringey CCG; which we are escalating at CFO level. In addition, £4.2m of the outstanding relates to the quarter 4 income to Health Education England. This debtor has already been settled at the time of writing.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Integrated performance report** | **Agenda Item: 12** |
| **Executive director lead** | Carol Gillen, Chief Operating Officer | |
| **Report author** | Paul Attwal, Head of Performance, Operations | |
| **Executive summary** | **Areas to draw to Board members' attention are:**<br><br>**Emergency Department (ED) four hours' wait:**<br>December was another challenging month with an A&E performance of 77.75%, below the 90% trajectory. This has been the most challenged month in relation to A&E performance since the recording began. It is worth noting that performance was challenged across the country; the national average in December was 77.9%, the London average was 80.4% and the NCL average was 77.47%. There were six mental health patients who waited in excess of 12 hours following a decision to admit. The focus of the ED delivery team is to improve Urgent Treatment Care and Paediatrics performance as both areas are key to delivering overall target.<br><br>**Cancer 14 days to be seen:**<br>During November, the trust recovered its cancer performance for the 14 day target for suspected cancer patients (96.6% against a 93% target) following 3 months of non-achievement.<br><br>**Appraisals and Mandatory Training rates:**<br>Mandatory training and appraisal rates continue to improve. Mandatory training has improved its performance from in November 2019 of 82.1% to 83.3% in December 2019 against a target of 90%; staff appraisals in November were 77.5% against a target of 90% and the staff sickness absence rate in November was 3.83% against a target of 3.35%.<br><br>**Child and Adolescent Mental Health Services (CAMHS)**<br>CAMHS data for Q3 and December continues to demonstrate improving figures. Average waits time in December were now below 8 weeks, with 69% of patients being seen within 8 weeks. | |
| **Purpose:** | Review and assurance of Trust performance compliance | |
| **Recommendation(s)** | That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan | |

| | |
|---|---|
| **Risk Register or Board Assurance Framework** | The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2. |
| **Report history** | Trust Management Group |
| **Appendices** | Integrated performance report |


**Performance report**
**January 2019**

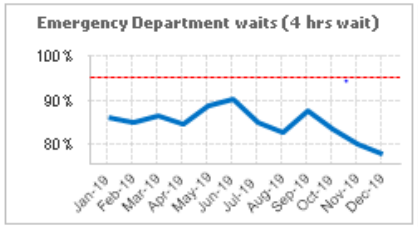
**Month 9 (2019 – 2020)**

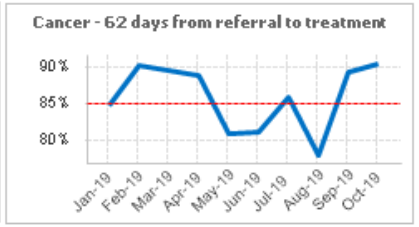


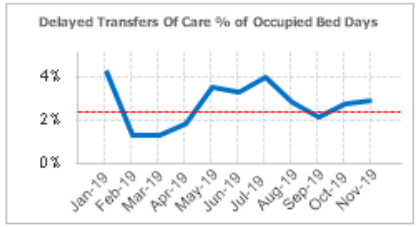
Date & time of production: 16/01/2020 14:15:00

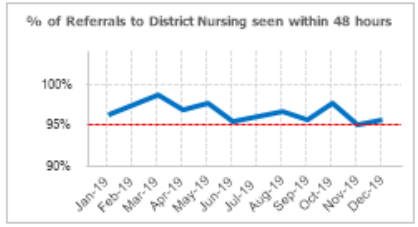
# Summary

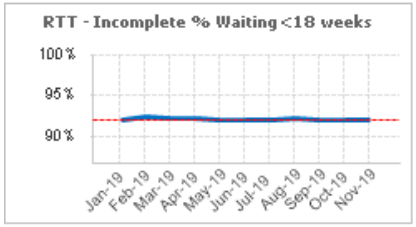
| Category | Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | Emergency Department waits (4 hrs wait) | >95% | 86.0% | 85.1% | 86.6% | 84.6% | 88.6% | 90.1% | 84.8% | 82.8% | 87.7% | 83.6% | 80.1% | 77.8% | 84.4% | ! |
| Cancer | Cancer - 14 days to first seen | >93% | 95.9% | 94.8% | 96.2% | 95.0% | 97.7% | 97.0% | 94.4% | 92.0% | 89.8% | 91.3% | 96.6% | | 94.2% | |
| Cancer | Cancer - 62 days from referral to treatment | >85% | 84.9% | 90.2% | 89.6% | 88.9% | 81.0% | 81.3% | 85.9% | 78.2% | 89.4% | 90.3% | | | 85.3% | |
| Admitted | Non Elective Re-admissions within 30 days | <5.5% | 5.48% | 5.92% | 6.38% | 6.34% | 5.24% | 4.23% | 5.06% | 5.72% | 5.63% | 5.45% | 4.94% | 5.44% | 5.33% | |
| Admitted | Delayed Transfers Of Care % of Occupied Bed Days | <2.4% | 4.3% | 1.3% | 1.3% | 1.8% | 3.6% | 3.3% | 4.0% | 2.8% | 2.2% | 2.8% | 2.9% | | 2.9% | |
| Access | RTT - Incomplete % Waiting <18 weeks | >92% | 92.1% | 92.3% | 92.2% | 92.1% | 92.1% | 92.0% | 92.0% | 92.2% | 92.1% | 92.0% | 92.1% | | 92.1% | |
| Outpatients | Outpatients - FFT % Positive | >90% | 93.4% | 93.3% | 91.9% | 90.5% | 91.4% | 92.1% | 93.8% | 94.3% | 96.9% | 94.2% | 95.3% | 96.7% | 94.4% | |
| Community | Community - FFT % Positive | >90% | 96.7% | 97.7% | 97.6% | 96.8% | 97.7% | 98.0% | 92.7% | 95.0% | 94.6% | 95.9% | 97.0% | 94.4% | 95.8% | |
| Staff | Staff - FFT % Recommend Care | >70% | | | 74.0% | | | 75.9% | | | 77.1% | | | | 76.4% | |
| Community | % seen <=2 hours of Referral to District Nursing Night Service | >80% | 84.1% | 89.7% | 90.3% | 94.1% | 100.0% | 96.0% | 100.0% | 92.5% | 100.0% | 95.8% | 92.3% | 85.3% | 94.8% | |
| Community | % seen <=48 hours of Referral to District Nursing Service | >95% | 96.4% | 97.4% | 98.7% | 96.8% | 97.7% | 95.5% | 96.2% | 96.6% | 95.7% | 97.8% | 95.1% | 95.6% | 96.3% | |
| Community | Haringey New Birth Visits - % seen within 2 weeks | >95% | 92.4% | 95.5% | 94.9% | 94.1% | 91.7% | 93.0% | 91.2% | 95.1% | 89.8% | 90.7% | 89.7% | | 91.9% | ! |
| Community | Islington New Birth Visits - % seen within 2 weeks | >95% | 95.4% | 92.2% | 95.4% | 97.0% | 90.4% | 94.3% | 93.3% | 96.2% | 92.9% | 96.1% | 94.9% | | 94.4% | |

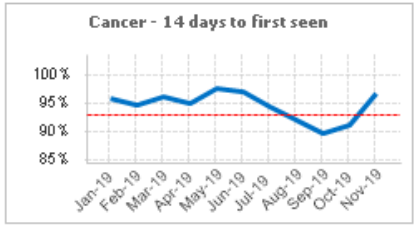


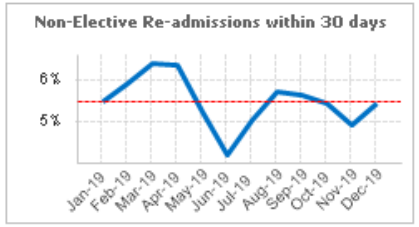



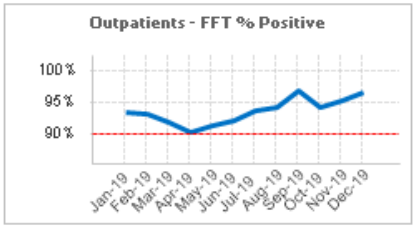






Date & time of production: 16/01/2020 14:15:00

**Safe** | Caring | Effective | Responsive | Well Led

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions to Adult Facilities of pts under 16 yrs of age | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| HCAI C Difficile | <16 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 4 | | |
| Actual Falls | 400 | 44 | 43 | 34 | 42 | 38 | 35 | 32 | 38 | 32 | 25 | 39 | 36 | 317 | | |
| Category 3 or 4 Pressure Ulcers | 0 | | | | 5 | 13 | 3 | 8 | 4 | 2 | 10 | 14 | 10 | 69 | | ! |
| Harm Free Care % | >95% | 90.54% | 91.22% | 94.21% | 93.55% | 89.58% | 94.96% | 90.70% | 93.04% | 93.64% | 94.34% | 91.73% | 93.79% | 92.71% | | ! |
| Non Elective C-Section % Rate | <19% | 20.1% | 22.3% | 24.7% | 24.0% | 22.5% | 19.2% | 21.1% | 22.8% | 23.4% | 16.3% | 23.9% | 22.9% | 21.8% | | |
| Medication Errors causing serious harm | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | |
| MRSA Bacteraemia Incidences | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Never Events | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | 1 | 1 | 0 | 6 | | |
| Proportion of reported Patient Safety Incidents Causing Harm | N/A | 20.9% | 18.4% | 22.4% | 18.8% | 26.0% | 21.4% | 21.4% | 20.1% | 21.7% | 24.7% | 22.6% | | 22.1% | | |
| Serious Incidents | 0 | 1 | 1 | 1 | 4 | 1 | 2 | 4 | 4 | 1 | 3 | 4 | 3 | 26 | | ! |
| VTE Risk Assessment % | >95% | 95.3% | 95.2% | 95.9% | 95.3% | 95.2% | 96.4% | 95.4% | 95.3% | 95.6% | 95.1% | 95.3% | | 95.5% | | |
| Mixed Sex Accomodation Breaches | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 8 | 1 | 5 | 5 | 2 | 21 | | ! |
| Hospital Standardised Mortality Ratio (HSMR) | 100 | 84.9 | 80.3 | 100.7 | 90.8 | 103.5 | 93.3 | 82.8 | 91.2 | 76.4 | | | | 89.5 | | |
| Summary Hospital Level Mortality Indicator (SHMI) | 1.14 | | | 0.77 | | | 0.82 | | | | | | | 0.82 | | |

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

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **Category 3 or 4 Pressure Ulcers, Unstageable, Deep Tissue Injury and Devise Related Pressure Ulcers reported in December 2019**<br><br>**Standard:**<br>10% reduction in the total number of attributable PUs during 2019/20 compared to 2018/19 including a breakdown of Pressure Ulcers by category | **Variance against plan**<br>Total numbers recorded = 25<br>Category 3 = 6 ( 5 attributed to Whittington Health)<br>Category 4 = 4 ( 0 attributed to Whittington Health)<br>Unstageable = 9<br>Deep Tissue Injury = 2<br>Devise related – 4 - Category 2 pressure ulcers attributed to Whittington Health<br><br>**Action to recover:**<br>The Trust has an overall reduction in the number of pressure ulcers reported this month. We continue to see a high number of unstageable pressure ulcers reported in the community. The District Nursing (DN) team have introduced a monthly Pressure Ulcer monitoring group to review process and help with raising awareness and improve management. The DN teams have improved their documentation and care planning in relation to pressure ulcer care. On-going training and surveillance continues.<br><br>The Critical Care Team is involved in the NHS Improvement programme focusing on the reduction of devise related pressure ulcers. This has improved awareness across the team. | **Named person:**<br>Tissue Viability Service<br><br>**Timescale to recover performance:**<br><br>Ongoing monitoring |
| **Harm Free Care %:** Percentage of patients with no harm on the Safety Thermometer (includes old and new harm)<br><br>**Standard: 95%** | **Variance against plan: 93.85% - 1.25% off target**<br><br>**Safety thermometer** shows an improvement in the number of pressure ulcers from 51 to 30 (5 new), a reduction of falls from 10 to 4 with harm (2 Emergency & Integrated Medicine (EIM), 1 Intensive Treatment Unit and 1 Community).<br><br>**Action to recover:**<br>Ongoing training “What will prevent your patient from Falling today” programme continues, discussion at ward board rounds and handovers to help continue to raise awareness is in place. Bay watch and the enhanced care programme continue to help prevent high risk patients from falling. The monthly fall audits in place. Plans to explore the development of a quality improvement project within the community to identify and mitigate High Risk patients in the New Year. The Enhanced Care programme which includes specialist training in identifying and managing High Risk patients on the wards also in place.<br><br>The ongoing NHS Improvement programme in relation to management of pressure ulcers will be evaluated to determine key learning objectives. Monthly community pressure ulcer group has been set up to review and address incidence | **Named person:**<br>Lead Nurse for Safer Staffing<br><br>**Timescale to recover performance:**<br><br>July 2020 |

| | | |
|---|---|---|
| | and management plans. | |
| **Mixed sex accommodation breaches:**<br><br>**Standard: 0** | **Variance against plan: 2 breaches – all breaches are in ICU**<br><br>**Action to recover:**<br>Breaches in December were as a result of patients that could not be stepped down from ICU as a result of delayed onward bed capacity. The recovery plan is to mitigate breaches, where possible, including robust escalation whilst not compromising patient safety. Overall length of stay programme will support the ongoing flow management for the Trust. | **Named person:**<br>Matron, Intensive Care Unit (ICU)<br><br>**Timescale to recover performance:**<br>Ongoing monitoring |
| **Serious Incidents (SIs):** | There were three Incidents declared as SIs in December 2019.<br><br>**December 2019**<br>1. 2019.26604 - [EIM] Sub-optimal care of the deteriorating patient meeting SI criteria<br>2. 2019.27077 - [Children & Young People] Apparent/actual/suspected self-inflicted harm meeting SI criteria<br>3. 2019.27965 - [Adult Community Health Services] Diagnostic incident including delay meeting SI criteria | **Named person:**<br>Quality Assurance & Serious Incident Officer |

Safe | **Caring** | Effective | Responsive | Well Led

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED - FFT % Positive | >90% | 82.8% | 78.3% | 75.6% | 78.6% | 78.6% | 81.9% | 78.4% | 81.7% | 84.9% | 82.2% | 81.5% | 79.7% | 80.9% | |
| ED - FFT Response Rate | >15% | 13.2% | 11.9% | 11.7% | 10.3% | 12.6% | 13.0% | 13.3% | 15.1% | 15.3% | 10.9% | 12.7% | 13.0% | 12.9% | |
| Inpatients - FFT % Positive | >90% | 95.5% | 96.3% | 98.4% | 96.6% | 97.4% | 98.2% | 97.6% | 98.0% | 96.7% | 98.3% | 97.5% | 97.8% | 97.6% | |
| Inpatients - FFT Response Rate | >25% | 14.1% | 21.7% | 23.5% | 15.1% | 23.3% | 21.0% | 19.9% | 26.4% | 18.1% | 27.0% | 28.9% | 25.2% | 22.7% | |
| Maternity - FFT % Positive | >90% | 95.6% | 96.5% | 94.0% | 95.1% | 93.9% | 94.1% | 93.8% | 94.0% | 92.8% | 97.4% | 94.1% | 91.3% | 94.2% | |
| Maternity - FFT Response Rate | >15% | 53.1% | 50.7% | 52.4% | 31.1% | 41.3% | 52.2% | 34.1% | 48.1% | 45.8% | 50.9% | 45.4% | 29.8% | 42.0% | |
| Outpatients - FFT % Positive | >90% | 93.4% | 93.3% | 91.9% | 90.5% | 91.4% | 92.1% | 93.8% | 94.3% | 96.9% | 94.2% | 95.3% | 96.7% | 94.4% | |
| Outpatients - FFT Responses | 400 | 423 | 389 | 421 | 419 | 233 | 126 | 273 | 690 | 586 | 514 | 380 | 516 | 3737 | |
| Community - FFT % Positive | >90% | 96.7% | 97.7% | 97.6% | 96.8% | 97.7% | 98.0% | 92.7% | 95.0% | 94.6% | 95.9% | 97.0% | 94.4% | 95.8% | |
| Community - FFT Responses | 1500 | 1014 | 1028 | 953 | 842 | 909 | 799 | 832 | 762 | 792 | 991 | 670 | 657 | 7254 | |
| Staff - FFT % Recommend Care | >70% | | | 74.0% | | | 75.9% | | | 77.1% | | | | 76.4% | |
| Complaints responded to within 25 or 40 working days | >80% | | | | 75.0% | 92.9% | 84.2% | 88.9% | 82.1% | 81.8% | 70.4% | 83.8% | 66.7% | 81.0% | |
| Complaints (including complaints against Corporate division) | N/A | 0 | 0 | 0 | 20 | 28 | 19 | 27 | 28 | 22 | 27 | 37 | 24 | 232 | |

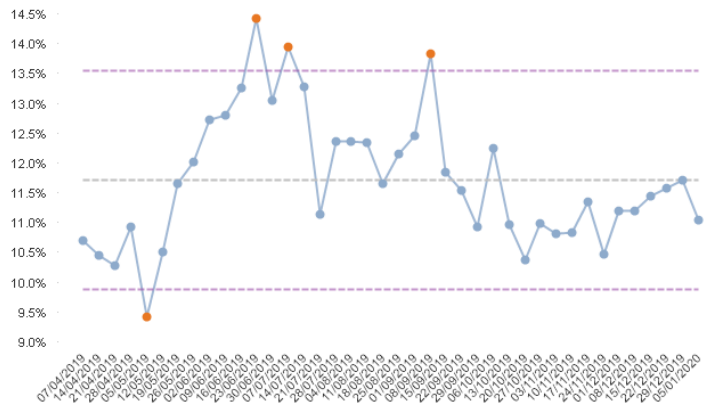
**Target has not been achieved for the past three months

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **ED - FFT % Positive Response and Response Rate :** December Positive responses, 80%; December Response rate, 13%. | **Variance against plan:** In December 2019, the Emergency Department (ED) missed their key performance indicator (KPI) targets for positive recommend rates (80%) and for response rates (13%). The KPI for positive recommend rates is 90% and for response rates is 15%.<br><br>**Action to recover:** As has been noted previously, a monthly patient experience group is in progress. Additional multi-disciplinary team (MDT) support has been recruited in order to share actions for improvement across staff disciplines.<br>A new process for the SMS Friends & Family Test (FFT) messages has been agreed for implementation in late-Jan/early-Feb. These text messages will now contain a URL link for FFT completion, as opposed to follow-up texts containing the additional FFT questions. It is forecast that this will improve responses due to only one text being required for providing full feedback. | **Named person:** Patient Experience Manager<br><br>**Timescale to recover performance:** March 2020, as this is a Quality Account Priority for 2019/20 |
| **Inpatients FFT Response Rate:** December Positive responses, 98%; December Response rate, 25%. | **Variance against plan:** No variance – Inpatient areas met both KPI targets for the third month in succession. This is a notable success, as Q3 of 2019/20 is the first recorded quarter that both KPI targets have been met for Inpatient FFT. 4 of the 5 instances of this occurring have taken place since August 2019.<br><br>**Action to recover:** Not applicable | **Named person:** Patient Experience Manager<br><br>**Timescale to recover performance:** Not applicable |
| **Community FFT Responses:** December Positive responses, 94%; December Responses, 657 | **Variance against plan:** December's response total of 657 is under the KPI target of 1,500.<br><br>**Action to recover:** The patient experience team have recommended an amended response total for the KPI moving into 2020/21. The patient experience team are arranging training for the new dashboard used to report on FFT – Meridian is being upgraded. This will not impact on individual logins and reporting access, but will feature a new, enhanced interface. This is expected to be launched in February. The training to use this new interface will include a spotlight on training community staff, with sessions being planned for February and March. These sessions will include webinar and remote sessions. | **Named person:** Patient Experience Manager<br><br>**Timescale to recover performance:** March 2020 |

Safe | Caring | **Effective** | Responsive | Well Led

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Cancelled Operations | 0 | 5 | 14 | 7 | 10 | 3 | 10 | 18 | 4 | 4 | 9 | 8 | 2 | 68 |  | ! |
| Cancelled ops not rebooked < 28 days | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  | |
| Urgent Procedures Cancelled > once | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  | |
| Theatre Utilisation | >85% | 80.14% | 78.49% | 77.53% | 81.47% | 84.89% | 84.45% | 84.97% | 85.71% | 85.11% | 84.89% | 88.96% | 85.49% | 85.07% |  | |
| Breastfeeding Initiated | >90% | 91.3% | 92.4% | 93.9% | 91.7% | 89.9% | 89.9% | 91.9% | 91.1% | 88.8% | 87.7% | 90.6% | 89.6% | 90.1% |  | |
| Mortality rate per 1000 admissions in-months | 14.4 | 7.7 | 6.0 | 9.2 | 8.1 | 7.3 | 7.3 | 7.4 | 7.1 | 6.9 | 6.3 | 8.0 | 8.4 | 7.4 |  | |
| Community DNA % Rate | <10% | 7.5% | 7.4% | 6.7% | 7.6% | 7.0% | 7.1% | 7.8% | 8.1% | 7.1% | 7.3% | 7.4% | 8.1% | 7.5% |  | |
| Community Services - Provider Cancellations | <8% | 6.3% | 6.0% | 6.3% | 6.3% | 6.3% | 5.9% | 6.4% | 6.9% | 6.6% | 6.5% | 7.3% | 6.9% | 6.6% |  | |
| Acute DNA % Rate | <10% | 10.0% | 10.6% | 9.7% | 10.5% | 11.5% | 13.3% | 12.6% | 12.2% | 12.0% | 11.0% | 10.9% | 11.3% | 11.7% |  | ! |
| % of GP Referrals that were completed via ERS | | 87.6% | 87.5% | 88.2% | 88.3% | 88.1% | 88.9% | 88.6% | 86.7% | 87.9% | 87.6% | 86.7% | 86.9% | 87.8% |  | |
| Outpatients New:FUp Ratio | 2.3 | 1.96 | 1.86 | 1.92 | 1.94 | 1.92 | 1.87 | 1.83 | 1.84 | 1.84 | 1.75 | 1.77 | 1.70 | 1.83 |  | |
| Delayed Transfers Of Care % of Occupied Bed Days | <2.4% | 4.3% | 1.3% | 1.3% | 1.8% | 3.6% | 3.3% | 4.0% | 2.8% | 2.2% | 2.8% | 2.9% | | 2.9% |  | |
| Non Elective Re-admissions within 30 days | <5.5% | 5.48% | 5.92% | 6.38% | 6.34% | 5.24% | 4.23% | 5.06% | 5.72% | 5.63% | 5.45% | 4.94% | 5.44% | 5.33% |  | |
| Rapid Response - % of referrals with an improvement in care | | 84.1% | 90.2% | 84.9% | 89.7% | 81.0% | 78.7% | 81.8% | 90.3% | 82.7% | 86.2% | 81.4% | 80.4% | 83.6% |  | |

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

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **Hospital Cancelled Operations: 2** | **Variance against plan:** 2 x Gynaecology.<br>One case cancelled due to previous list overrunning. New date was offered within 28 days, however patient declined and accepted booking for 7th January. Procedure completed.<br><br>Second cancellation due to equipment not available on the day. The case was rebooked and completed within 28 days. This is not a reoccurring issue and was equipment specific to the case. No additional recovery action required.<br><br>**Action to recover:**<br>Theatre overruns are reviewed on a daily basis. The Theatre improvement programme priority was to reduce theatre list overruns to only 1 per month, this has been achieved in December 2019. | **Named person:** General Manager, Theatres<br><br>**Timescale to recover performance:**<br>Ongoing monitoring |
| **Acute DNA % rate:** percentage of patients who did not attend their outpatient appointments<br><br>**Standard** : <10%<br>  <br> | **Variance against plan:** 1.7% Adverse.<br><br>The Trust Outpatient Transformation Programme 2019/20 continues to focus its attention on did not attend (DNA) rate reductions strategy. As a result the DNA rate has improvement from 13.3% to 11.7% YTD. December saw a DNA rate of 11.4% which was 0.4%> than November, a likely result of the festive season which increased DNA rate from 9.5% in week 1 to 11% in week 3.<br><br>Work is in progress to enable the Trust to pilot Electronic consultations as a forward leader in the NCL patch and a Business case has been written to support the investment requirements.<br><br>**Action to recover:** Since 26 November, the trust has adopted a 10 day and 3 day text message reminder system**,** the next phase is to roll out Email reminders and Electronic Calendar appointment reminders in late February (pending capital investment approval). | **Named person:** Head of Programme Management Office<br><br>**Timescale to recover performance:**<br>March 2020 |

Safe | Caring | Effective | **Responsive** | Well Led

| Indicator | Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Department waits (4 hrs wait) | >95% | 86.0% | 85.1% | 86.6% | 84.6% | 88.6% | 90.1% | 84.8% | 82.8% | 87.7% | 83.6% | 80.1% | 77.8% | 84.4% | |
| ED Indicator - median wait for treatment (minutes) | <60 mins | 85 | 92 | 97 | 91 | 76 | 67 | 84 | 72 | 65 | 69 | 92 | 98 | 79 | |
| Ambulance handovers waiting more than 30 mins | 0 | 18 | 53 | 28 | 56 | 35 | 28 | 30 | 41 | 19 | 60 | 37 | 86 | 392 | |
| Ambulance handovers waiting more than 60 mins | 0 | 2 | 14 | 7 | 5 | 4 | 1 | 3 | 5 | 0 | 0 | 1 | 15 | 34 | |
| 12 hour trolley waits in A&E - Non Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 12 hour trolley waits in A&E - Mental Health | 0 | 0 | 1 | 0 | 1 | 0 | 7 | 12 | 10 | 8 | 10 | 8 | 6 | 62 | |
| Cancer - 14 days to first seen | >93% | 95.9% | 94.8% | 96.2% | 95.0% | 97.7% | 97.0% | 94.4% | 92.0% | 89.8% | 91.3% | 96.6% | | 94.2% | |
| Cancer - 14 days to first seen - breast symptomatic | >93% | 100.0% | 100.0% | 100.0% | 98.0% | 97.4% | 97.7% | 95.5% | 100.0% | 100.0% | 98.1% | 96.2% | | 97.5% | |
| Cancer - 62 days from referral to treatment | >85% | 84.9% | 90.2% | 89.6% | 88.9% | 81.0% | 81.3% | 85.9% | 78.2% | 89.4% | 90.3% | | | 85.3% | |
| Cancer ITT - Reallocated Breach Performance for 62 Day Pathways | >85% | 83.0% | 90.0% | 89.6% | 88.2% | 76.7% | 82.6% | 80.6% | 78.2% | 87.9% | 86.2% | 76.0% | | 82.2% | |
| Cancer ITT - % of Pathways sent before 38 Days | >85% | 100.0% | 40.0% | 75.0% | 62.5% | 25.0% | 100.0% | 33.3% | 45.5% | 37.5% | 25.0% | 33.3% | | 40.3% | |
| Cancer - % Pathways received a Diagnosis within 28 Days of Refer... | | 88.3% | 88.2% | 83.3% | 89.9% | 94.9% | 96.4% | 94.5% | 92.8% | 91.2% | 92.9% | 89.4% | | 92.7% | |
| Cancer - 31 days to first treatment | >96% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.6% | 97.8% | | | 99.2% | |
| Cancer - 31 days to subsequent treatment - surgery | >94% | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 20.0% | | | 69.2% | |
| Cancer - 62 Day Screening | >90% | | | | 100.0% | 100.0% | 100.0% | 0.0% | 0.0% | 100.0% | 75.0% | | | 79.2% | |
| DM01 - Diagnostic Waits (<6 weeks) | >99% | 99.0% | 99.0% | 99.0% | 99.2% | 99.2% | 99.1% | 99.4% | 99.3% | 99.5% | 99.0% | 99.0% | 99.2% | 99.2% | |
| RTT - Incomplete % Waiting <18 weeks | >92% | 92.1% | 92.3% | 92.2% | 92.1% | 92.1% | 92.0% | 92.0% | 92.2% | 92.1% | 92.0% | 92.1% | 92.0% | 92.1% | |
| Referral to Treatment 18 weeks - 52 Week Waits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| % seen <=2 hours of Referral to District Nursing Night Service | >80% | 84.1% | 89.7% | 90.3% | 94.1% | 100.0% | 96.0% | 100.0% | 92.5% | 100.0% | 95.8% | 92.3% | 85.3% | 94.8% | |
| % seen <=48 hours of Referral to District Nursing Service | >95% | 96.4% | 97.4% | 98.7% | 96.8% | 97.7% | 95.5% | 96.2% | 96.6% | 95.7% | 97.8% | 95.1% | 95.6% | 96.3% | |
| Haringey New Birth Visits - % seen within 2 weeks | >95% | 92.4% | 95.5% | 94.9% | 94.1% | 91.7% | 93.0% | 91.2% | 95.1% | 89.8% | 90.7% | 89.7% | | 91.9% | |
| Islington New Birth Visits - % seen within 2 weeks | >95% | 95.4% | 92.2% | 95.4% | 97.0% | 90.4% | 94.3% | 93.3% | 96.2% | 92.9% | 96.1% | 94.9% | | 94.4% | |

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **ED - Performance:**<br>**4 hour target** | **Overall performance**<br>December was another challenging month for Trust with an A&E performance of 77.75%, below the 90% trajectory. This has been the most challenged month in relation to A&E performance since the recording began.<br><br>It is worth noting that performance was challenged across the country; the national average in December was 77.9%, the London average was 80.4% and the North Central London (NCL) average was 77.47%.<br><br>The daily A&E 4 hour performance at Whittington Health during December was very volatile and similar to previous months, ranging between 66.8% and 87.6%.<br><br>There were 9768 A&E attendances in December, an increase of 5.8% when compared to the same period last year (year to date is 2.8%). The total number of attendances was 1.2% more than what the Trust projected for the month (9644).<br><br>The daily attendances ranged between 174 on Christmas Day and 383 which a record breaking number of attendances for the Trust. On average there were 315 attendances per day for the month.<br><br>**Ambulance conveyances**<br>Eighteen percent (18%) of all attendances in December were ambulance conveyances (1800 patients) of which 37.2% required a ward admission. Both the number of conveyances and admission rates were lower when compared to the same period last year.<br><br>**London Ambulance Service (LAS) handover**<br>LAS handover times remain a challenge across NCL hospitals. Whittington Health was the highest performing Trust across NCL in relation to the % of Ambulance handover in 15 minutes (44.95 %) and 30 minutes (93.04%).<br><br>There were 86 thirty minute breaches reported in December, an increase when compared to the previous month (16). There were 15 incidents reported of a 60 minute breach.<br><br>**Acuity**<br>In the month of December 48% of patients were seen in Majors and 52% in Minors. The number of paediatric attendances saw an increase of 231 additional attendances when compared to the previous month and 339 additional | **Named person:**<br>General Manager, ED Department |

| | | |
|---|---|---|
| | attendances when compared with the same period last year. The majority (221) of the additional attendances in December were treated in Majors. The number of older people attendances saw a very minimal decrease of 1% when compared to the same period last year. The Mental Health related attendances saw a reduction in December (193) compared to the previous month (228) and the same period last year (230). Although there is no data available for the low acuity attendances the projections are showing a downward trajectory in line with previous months.<br><br>**Patient flow**<br>Seventy-eight percent (69.7%) of patients were assessed within 15 minutes, 31% were seen for treatment within 60 minutes and 23% were discharged within 2 hours. Fifty-two (52%) were streamed to Urgent Treatment Centre (UTC) of which 13% were seen by primary care. Only a small percentage (3.6%) was streamed to Ambulatory Care.<br><br>Out of 9768 patients attending A&E in December only 13% required admission. Forty-two percent (42%) of patients that required admission were admitted within 4 hours, a reduction of 11% when compared to the previous month. The remaining 58% of patients with a decision to admit (DTA) waited on average 6.4 hours.<br><br>**Mental health breaches**<br>There were 6 MH 12 hour trolley breaches reported for the month, 5 x Adults and 1 x CAMHS all waiting for a mental health bed to become available. | |
| **ED – Performance – recovery plan** | **Action to recover overall performance:**<br><br>Key focus to maintain UTC and Paediatrics over 98% performance<br><br>The ED team have started to use a 6 x chair to fit to sit room in UTC. The aim is to create capacity and turnover UTC spaces maximise flow in UTC.<br><br>The ED team have secured a temporary bank GP for 5 days per week including weekends to work 1800-0000 for patients presenting with primary care and minor illness. This aim to increase streamed patients to primary care, reduce overall waiting times for those type patients and increase flow within UTC in the late evening.<br><br>The ED team have established a specific UTC flow registrar shift from 1700-0300 to support flow in UTC in the late evening, provide senior leadership in UTC and overnight to reduce long waits in the morning. | **Named person:**<br>General Manager, ED Department<br><br>**Timescale to recover performance:**<br><br>UTF fit 2 sit – work started 13th January 2020 to end February 2020<br><br>GP bank started 17th January 2020 for three months<br><br>UTC extra flow registrar from January to March 2020 |

| | | |
|---|---|---|
| | The Emergency Nurse Practitioner (ENP) roster has been revised to introduce a night ENP shift (2000-0800) with the aim to have a senior nurse (Band 7) seeing and treating minor injuries and illness in UTC and overall reduce long waits in UTC overnight into the morning. Shifts have been allocated from the February 2020 roster and the matron and general manager will review the effectiveness of this change.<br><br>**Mental Health 12 hour breaches** – Camden and Islington NHSFT to ensure that 90% of patients in ED are referred to mental health trusts are assessed within 60 minutes of arrival. Timely escalation of all mental health patients with DTA in ED to be followed and ensure adherence to agreed escalation processes<br><br>**Ambulance breaches** - New LAS handover model to be implemented in January 2020, this includes streaming, redirection, triage & Rapid assessment Triage (RAT). Local ED team have been working with local LAS rep to ensure revised pathways work smoothly. | ENP nights from February 2020 roster and ongoing<br><br>January 2020<br><br>Ongoing work with the front of house model to include the LAS handover nurse with the focus on 10 to 15 minutes handover of all LAS activity. New model to be embedded in January 2020 |
| **Cancer – ITT - % of Pathways sent before 38 days** | **Variance against plan:**<br>33% against the national standard of 85%. 6 out of 9 patients transferred late<br><br>Gynaecology: 2 late inter-Trust referrals (ITRs), delays due to access to pre assessment and hysteroscopy biopsy clinic. 1st patient was transferred to University London College Hospital day 56 and the second one day 39.<br>Urology: patient was referred to Guys & St Thomas Hospital day 51 on the pathway. This was due to multiple tests and delay with the biopsy clinic.<br>Lung: Late ITR due to delay with CT reporting time.<br>Upper Gastro Intestinal (GI): This is a complex pathway. Diagnostic tests were performed within 14 days but patient had multiple tests MRCP, CT liver and CT CAP therefore causing a delay to complete final diagnosis.<br><br>**Action to recover:**<br>There has been some improvement regarding the waiting time for biopsy clinic for both Gynaecology and Urology by increasing capacity. Imaging has implemented a plan to improve reporting turnaround times; this will be reflected in Quarter 4 performance. | **Named person:**<br>General Manager, Cancer Services<br><br>**Timescale to recover performance:**<br>Quarter 4 2019/20 |
| **New birth visits seen within 2 weeks:** 95 % of New Birth Visits should be carried out within 14 days of birth.<br><br>**Target:** 95% | **Variance against plan:**<br>306 New birth visits - 274 completed in timeframe. 89.7% against target of 95%<br><br>**Action to recover:**<br>Health visiting teams continue to work to achieve the 95% target and provide | **Named person:**<br>Head of Haringey Children and Young People's Services |

| | | |
|---|---|---|
| | exception reports to account for those visits completed after 14 days. Principal reason for delays is babies that are still in hospital. Updated new birth protocol states new birth contact should be made with family in hospital where appropriate. Parental choice is also having an impact where appointments are booked outside of the 14 day target– work has been done with teams to address this with a change in the administrative processes to ensure families are contacted earlier to avoid breach with implementation from February 2020 into March 2020. | **Timescale to recover performance:**<br>March 2020 |

Safe | Caring | Effective | Responsive | **Well Led**

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Appraisals % Rate | >90% | 72.7% | 72.4% | 72.6% | 71.3% | 69.8% | 71.4% | 72.4% | 74.2% | 75.5% | 75.8% | 76.4% | 77.5% | 73.9% | |
| Mandatory Training % Rate | >90% | 80.8% | 80.8% | 80.8% | 80.2% | 80.1% | 79.9% | 82.2% | 80.8% | 81.1% | 81.0% | 82.1% | 83.3% | 81.2% | |
| Permanent Staffing WTEs Utilised | >90% | 88.1% | 88.0% | 88.0% | 87.3% | 86.9% | 87.2% | 88.9% | 86.8% | 87.9% | 88.5% | 88.9% | | 87.8% | |
| Staff FFT % recommended work | >50% | | | 61.8% | | | 59.9% | | | 59.6% | | | | 59.8% | |
| Staff FFT response rate | >20% | | | 16.2% | | | 22.3% | | | 16.3% | | | | 19.3% | |
| Staff sickness absence % | <3.5% | 3.71% | 3.69% | 3.49% | 3.27% | 3.13% | 3.62% | 3.57% | 3.19% | 2.99% | 3.93% | 3.83% | | 3.44% | |
| Staff turnover % | <10% | 11.7% | 11.4% | 10.8% | 10.6% | 10.9% | 10.9% | 10.8% | 10.7% | 10.6% | 10.6% | 10.5% | 10.7% | 10.7% | |
| Vacancy % Rate against Establishment | <10% | 11.9% | 12.0% | 12.0% | 12.7% | 13.1% | 12.8% | 11.1% | 13.2% | 12.1% | 11.5% | 11.1% | | 12.2% | |
| Average Time to Hire (Days) | <61 Days | | | 63 | 65 | 69 | 60 | 61 | 62 | 59 | 63 | 63 | 61 | 63 | |
| Nursing Staff Average % Day Fill Rate - Nurses | | 89.3% | 87.4% | 86.1% | 86.7% | 86.2% | 89.8% | 93.2% | 87.4% | 89.3% | 92.6% | 96.3% | 94.6% | 90.6% | |
| Nursing Staff Average % Day Fill Rate - HCAs | | 112.6% | 117.1% | 112.6% | 109.1% | 115.0% | 113.8% | 115.6% | 127.8% | 125.9% | 126.2% | 126.8% | 125.1% | 120.4% | |
| Nursing Staff Average % Night Fill Rate - Nurses | | 92.2% | 90.8% | 88.6% | 88.4% | 87.2% | 92.1% | 92.9% | 91.8% | 90.4% | 92.4% | 94.8% | 92.9% | 91.4% | |
| Nursing Staff Average % Night Fill Rate - HCAs | | 134.5% | 124.4% | 115.7% | 109.3% | 114.6% | 113.2% | 131.1% | 126.2% | 134.7% | 144.0% | 135.9% | 136.9% | 126.5% | |
| Safe Staffing Alerts - Number of Red Shifts | | 0 | 2 | 1 | 0 | 0 | 3 | 2 | 3 | 5 | 6 | 10 | 5 | 34 | |
| Safe Staffing - Overall Care Hours Per Patient Day (CHPPD) | | 9.0 | 9.0 | 9.1 | 9.0 | 9.1 | 9.7 | 9.3 | 9.2 | 8.8 | 9.3 | 9.2 | 9.4 | 9.2 | |

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

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **Appraisals % Rate : 78%**<br><br>Target/Standard = 90% | **Variance against plan: - 12% (2% increase** on last month)<br><br>**Action to recover:**<br>Whilst Workforce maintain statistics and provide documents and process, appraisals take place between managers and their staff. Workforce teams have improved the quality and accessibility of appraisal documentation, guidance and instructions on loading dates into the Electronic Staff Record (ESR). If there is any other support that can be offered, managers' comments and requests are welcome. Direct support for those struggling to input the date of completed appraisals into ESR is available on Tuesday, Wednesday and Friday mornings at the hospital (Social Club Computer Suite) and throughout the week (am and pm) at the Crouch End Computer Suite. | **Named person:**<br>Assistant Director Learning & Organisational Development<br><br>**Timescale to recover performance:**<br>12% of staff is approximately 500 employees. Appraising them depends on the availability to release them from duties for both the member of staff and manager to complete the appraisal. |
| **Mandatory Training % Rate : 83%**<br><br>Target/Standard = 90% | **Variance against plan: -7% (1% increase** on last month)<br><br>**Action to recover:**<br>Audit recommendations being implemented and actions undertaken<br>Intra-authority transfers (IAT) to transfer compliance data now routine processes in both Recruitment and Learning & Development (L&D).<br>Supported e-learning sessions at Hospital site since 13 August 2019<br>Improving communications and 'how to' guides for staff<br>L&D team supporting staff to input workbook updates on ESR<br>Involving ESR account manager in complex queries<br>'Deep Dive' QI project into one ICSU to investigate issues and gather learning that can be applied to other areas<br>Improving reporting by consulting with users and report writers<br>Restructure resulting in new larger L&D team being recruited to. | **Named person:**<br>Assistant Director Learning & Organisational Development<br><br>**Timescale to recover performance:**<br>Milestones: QI project results and actions expected shortly. Rollout of deep-dive (checking competency structure and staff profiles, ICSU by ICSU) by the end of Aug-20. (With 2nd to 5th ICSUs completed end Feb-20, Apr-20, Jun-20, Aug-20) |
| **Permanent Staffing WTEs Utilised: 88.68%**<br><br>**Standard:** 90% | **Variance against plan:** 1.14%<br><br>**Action to recover:** WTEs utilised has remained steady from November. While they are currently under target, there is extensive work across the trust on recruitment drives for hard to fill areas, and converting bank post to permanent posts. This continues to be reviewed in line with vacancy rate reviews, staff turnover and recruitment and retention planning. | **Named person:** Deputy Director of Workforce<br><br>**Timescale to recover Performance:** March 2020 |

| | | |
|---|---|---|
| **Staff Turnover Rates: 10.69%**<br><br>The Trust should have less than 10% of staff who have left the Trust within the last 12 months<br><br>**Standard:** 10% | **Variance against plan:** 0.69%<br><br>**Action to Recover:** Turnover rates have remained steady from November, and only 0.69% variable, with an in year improvement overall. Work continues to improve retention rates in hard to fill areas. | **Named person:** Deputy Director of Workforce<br><br>**Timescale to recover performance:** March 2020 |
| **Vacancy Rates: 11.32%**<br><br>The Trust should have less than 10% unfilled posts<br><br>**Standard:** 10% | **Variance against plan:** 1.32%<br><br>**Action to recover:** Vacancy rates have remained steady from November. The recruitment dashboard continues to be shared with the ICSUs identifying blockers within the process. Recruitment and selection training including system training is on-going with Managers. | **Named person:** Deputy Director of Workforce<br><br>**Timescale to recover performance:** March 2020 |
| **Time to hire: 61 days**<br>Time taken from resignation/creation of new post to confirmed start date<br><br>**Standard:** 61 days | **Variance against plan:** 0 days<br><br>**Action to recover:** The time to hire was within target for December. Work is ongoing to retain target, particularly with busy recruitment months of January and February. | **Named person:** Kate Wilson, Deputy Director of Workforce<br><br>**Timescale to recover performance: March 2020** |
| **Safer Staffing**<br><br>**Aim for:**<br>Zero Red shifts<br>Trust CHPPD 8.5 (national average 8.6) | **Variance against plan**: 5 shifts were reported as Red, all within Emergency and Integrated Medicine ICSU. The shifts were due to staff shortages (unfilled vacant shifts, and unfilled shifts for enhanced care). No reported clinical incidents or complaints lodged to date.<br><br>**Action to recover:**<br>• The red shifts were due to unfilled shifts to cover vacancy, absence and enhanced care of registered and un-registered staff and increased activity. This is a reduction in comparison to the previous month. Ongoing monitoring by Senior staff continues. Staffing Escalation policy followed accordingly. A more in-depth analysis of the impact of the red shifts will be undertaking in the New Year.<br>• For safer staffing this month, the percentage day and night fill rate for registered nurses was 94.6%. Escalation beds (14) are open. Approximately 10% of nursing staff are working as Band 4's who are currently recognised as non-registered on our rostering system.<br>• Care Hours per Patient Day (CHPPD) in December was 9.4 which is above the national average. Data shows that the CHPPD across the wards averages at 7.8%. The trust average is driven above the national average is related to CHPPD in Midwifery services.<br>• The percentage Day fill rate for Health Care Assistants (HCAs) was 125% day fill rate and 136% night fill rate, this activity was related to Enhanced Care for patients under Deprivation of Liberty Standards (DOLs) and patients under Mental Health in additional to 14 escalation beds within | **Named person:** Lead Nurse for Safer Staffing<br><br>**Timescale to recover performance:**<br><br>April 2020 |

| | | |
|---|---|---|
| | acute medicine. The appropriate decision making process (including assessment, and evaluation of care) is being followed and enhanced care shifts are scrutinised and authorised by the Associate Directors of Nursing. The operational team is making every effort to close escalation beds.<br>• Safety was maintained through senior nurse oversight at all times. New training for Health Care assistants on Enhanced Care is ongoing as part of the Enhanced Care programme. The business case to support this model has been approved and recruitment for this team is ongoing. | |

# Appendix 1. Community Performance Dashboard

| Indicator and Definition | Commentary and Action Plan | Named Person & Date Performance will Recover |
|---|---|---|
| **Children's community waiting times**<br>Services under Children, Young People (CYP) have CCG specific waiting time target, and performance is monitored through contract monitoring arrangements with CCG and Public health commissioners in both boroughs. | **Overall summary and actions to recover:**<br>Islington Community CAMHS service continues to improve performance and monitored separately and is on track with Referral To Treatment (RTT) performance plan. Average waiting time in December below 8 weeks. Average wait from referral to 1st appointment into CAMHS in December = 7.8 weeks. Average wait from 1st to 2nd appointment in December 2019 = 2.4 weeks. Referral to Treatment data showing improvement to 69% patients being seen within target RTT.<br><br>**Haringey Occupational Therapy**<br>Service making steady improvement in performance as staff vacancies within the service are being filled. The lead for the service is recruiting to vacancies and expects continued improvement over the coming months.<br><br>**Haringey Autism**<br>Operational and clinical leads reviewing data from pilot and will update trajectory for performance and delivery of improvements.<br><br>**Islington Autism Service (ASC) and Social Communication Team (SCT)**<br>Waiting times and increase in demand for ASC services seen increase in waiting times for Social Communication Team. Current review joint with commissioners and the local authority to look at demand and utilising multi-agency capacity and training<br><br>**Islington Children Looked After (CLA) services**<br>Increasing in waiting time for initial health assessments in CLA team, due to increase in complexity and rise in number of unaccompanied asylum seekers, a rise in DNA and rebooking clinics for vulnerable young persons. Demand and capacity review is being carried out, including review of young persons' universal services.<br><br>The service is recruiting an additional Specialist Registrar (SPR) to support increase in demand in the team June 2020<br><br>**Islington Paediatrics Nutrition and Dietetics**<br>Nutrition and Dietetics have seen increase in demand for service due the end of CCG contract with Oviva to manage all cows' milk allergy. This is monitored by the provider and CCG regarding the follow on service | **Named person:** Director of Operation CYP<br>**Timescale to recover performance:**<br><br>February 2020<br><br>February 2020<br><br>October 2020<br><br>January 2020<br><br>June 2020<br><br>Ongoing monitoring |

| | | |
|---|---|---|
| **Adults community waiting times**<br>Adults community waiting times Adult Community Services (ACS) operate on different waiting time targets, performance is monitored monthly at ACS ICSU Board and in the ACS PTL meeting. | **Overall summary:**<br>Performance is showing an upward trend with notable sustained improvements in the past quarter in Community Rehabilitation Team (CRT), REACH Intermediate Care and Bladder & Bowel.<br><br>**Community Rehabilitation CRT (93.6%)**<br>On trajectory to meet target in Jan 2020. Reduction in vacancies has increased service capacity and resulted in improved performance.<br><br>**Integrated Community Therapy Team (ICTT) (90.1%)**<br>The service continues to review service provision to meet the required waiting times by January 2020.<br><br>**ICTT Stroke & Neuro (61.55%)**<br>Marginal improvement from 59.1% in previous month. Speech and Language Therapy (SLT) waits are a particular concern and additional agency support is being sourced. The service has undertaken a demand and capacity analysis indicating that further capacity is required to meet targets and minimise clinical risk. As of January 2020 to support this, the service has sourced SLT staff from other areas of the Trust to manage urgent referrals.<br><br>**REACH Intermediate Care (94.6%)**<br>Improved position and ahead of recovery trajectory.<br><br>**Bladder & Bowel (86.7%)**<br>A significant improvement from 56.3% in October with further pathway transformation planned to streamline referral pathways.<br><br>**Muscoloskeletal (MSK) CATS (63.5%) & MSK Routine (84.7%)**<br>Shift in activity from secondary care has been higher than expected (36% as compared to 22%).<br><br>**Action to recover:**<br>• Recruitment ongoing to ensure capacity in place to meet targets – impact of reductions have already demonstrated improvements in CRT and REACH<br>• Additional agency support to SLT to reduce waiting times<br>• Musculoskeletal services continue to experience referrals above expected levels following roll-out of the Single Point of Access. Demand and capacity analysis undertaken to inform further investment in the service. | **Named person:** Director of Operations ACS<br><br>**Timescale to recover:**<br><br>Jan 2020<br><br>Jan 2020<br><br>April 2020 (previously Jan 2020)<br><br>Feb 2020<br><br>May 2020<br><br>May 2020 |

# Appendix 1. Community Performance Dashboard

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IAPT Moving to Recovery | >50% | 62.3% | 65.1% | 59.1% | 62.2% | 54.2% | 60.8% | 60.5% | 56.6% | 55.5% | 55.2% | 54.5% | | 57.6% |  |
| IAPT Waiting Times for Treatment (% < 6 wks) | >75% | 95.6% | 95.4% | 94.3% | 96.9% | 95.0% | 97.4% | 97.8% | 94.0% | 95.8% | 91.5% | 96.2% | | 95.7% |  |
| Haringey - 8wk Review % carried out before child aged 8 weeks | N/A | 83.5% | 91.8% | 88.1% | 90.5% | 89.4% | 87.2% | 91.1% | 87.9% | 88.7% | 87.4% | 90.8% | | 89.1% |  |
| Haringey - HR1 % carried out before child aged 15 months | N/A | 77.0% | 77.3% | 79.0% | 80.9% | 80.1% | 79.5% | 87.3% | 80.1% | 83.9% | 80.5% | 83.5% | | 82.0% |  |
| Haringey - HR2 % carried out before child aged 30 months | N/A | 67.6% | 69.7% | 71.1% | 70.2% | 71.9% | 69.4% | 74.0% | 75.5% | 82.9% | 89.4% | 96.0% | | 78.3% |  |
| Islington - 8wk Review % carried out before child aged 8 weeks | N/A | 86.5% | 90.3% | 91.7% | 92.4% | 95.4% | 90.8% | 90.6% | 93.4% | 93.4% | 95.1% | 94.7% | | 93.2% |  |
| Islington - HR1 % carried out before child aged 15 mths | N/A | 74.1% | 73.6% | 82.9% | 80.2% | 79.5% | 82.6% | 86.1% | 78.4% | 79.2% | 83.6% | 81.5% | | 81.5% |  |
| Islington - HR2 % carried out before child aged 30 mths | N/A | 77.1% | 75.2% | 72.6% | 77.7% | 76.5% | 79.1% | 82.6% | 80.7% | 85.8% | 77.8% | 78.8% | | 79.9% |  |
| % of MSK pts with a significant improvement in function (PSFS) | >75% | 85.1% | 92.9% | 92.9% | 89.3% | 95.3% | 95.5% | 92.1% | 94.3% | 90.8% | 92.5% | 91.5% | 95.7% | 92.8% |  |
| % of Podiatry pts with a significant improvement in pain (VAS) | >75% | 89.7% | 90.0% | 86.2% | 78.8% | 87.1% | 96.2% | 95.8% | 84.6% | 86.2% | 88.1% | 83.3% | 79.2% | 87.2% |  |
| ICTT - % Patients with self-directed goals set at Discharge | >70% | 73.8% | 71.9% | 78.5% | 80.6% | 74.3% | 84.8% | 88.1% | 70.2% | 71.2% | 87.1% | 76.3% | 73.6% | 78.5% |  |
| ICTT - % GAS Scores improved or remained the same at Discharge | >70% | 93.3% | 95.7% | 93.5% | 98.7% | 96.2% | 91.0% | 87.6% | 96.6% | 95.7% | 95.1% | 93.1% | 96.6% | 94.2% |  |
| 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% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |  |
| Nutrition and Dietetics - % Weight Loss Achieved at Discharge | >65% | 42.9% | 78.6% | 100.0% | 81.8% | 75.0% | 71.4% | 60.0% | 75.0% | 40.0% | 90.0% | 50.0% | | 70.9% |  |
| Nutrition and Dietetics - % Weight Maintained or Gained at Discharge | >70% | 77.8% | 100.0% | 90.0% | 100.0% | 100.0% | 85.7% | 88.9% | 93.3% | 88.9% | 100.0% | 83.3% | | 91.5% |  |
| Hackney Smoking Cessation: % who set quit date & stopped after 4 we... | >45% | | | 42.3% | | | 59.8% | | | 53.9% | | | | 56.8% |  |
| Islington Self-Management - Average Increase in PAM Score | >=9 | | | 18 | | | 8 | | | 13 | | | | 21 |  |
| Haringey Self-Management - Average Increase in PAM Score | >=9 | | | 15 | | | 9 | | | 12 | | | | 21 |  |

# Appendix 2. Community Waiting Times Dashboard

| | ROUTINE REFERRALS | | | | | | | URGENT REFERRALS | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SERVICE | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen |
| Bladder and Bowel - Children | >95% | 12 | 100.0% | | | - | 0 | >95% | - | | | | - | 0 |
| Community Matron | >95% | 6 | 100.0% | 100.0% | 100.0% | 0.7 | 26 | >95% | 2 | 100.0% | | | - | 0 |
| Adult Wheelchair Service | >95% | 8 | 92.5% | 100.0% | 100.0% | 1.2 | 23 | >95% | 2 | 100.0% | 100.0% | 0.0% | 3.0 | 1 |
| Community Rehabilitation (CRT) | >95% | 12 | 89.7% | 93.0% | 93.6% | 4.5 | 110 | >95% | 2 | 54.3% | 80.6% | 73.0% | 1.5 | 37 |
| ICTT - Other | >95% | 12 | 98.4% | 92.6% | 90.1% | 4.0 | 243 | >95% | 2 | 69.1% | 65.6% | 60.9% | 2.5 | 110 |
| ICTT - Stroke and Neuro | >95% | 12 | 79.1% | 59.1% | 61.5% | 9.1 | 26 | >95% | 2 | 64.8% | 32.0% | 35.1% | 4.4 | 37 |
| Intermediate Care (REACH) | >95% | 6 | 82.5% | 86.6% | 94.6% | 2.3 | 112 | >95% | 2 | 83.3% | 88.5% | 89.3% | 0.9 | 56 |
| Paediatric Wheelchair Service | >95% | 8 | 100.0% | 100.0% | 100.0% | 1.2 | 3 | >95% | 2 | | | | - | 0 |
| Bladder and Bowel - Adult | >95% | 12 | 56.3% | 72.5% | 86.7% | 8.6 | 83 | >95% | 2 | | 0.0% | | - | 0 |
| Musculoskeletal Service - CATS | >95% | 6 | 78.7% | 75.6% | 63.5% | 5.5 | 537 | >95% | 2 | 41.2% | 71.4% | 42.9% | 2.9 | 7 |
| Musculoskeletal Service - Routine | >95% | 6 | 87.7% | 87.2% | 84.7% | 4.2 | 1385 | >95% | 2 | 66.7% | 66.7% | 100.0% | 1.7 | 1 |
| Nutrition and Dietetics | >95% | 6 | 100.0% | 98.9% | 96.6% | 2.8 | 178 | >95% | 2 | 100.0% | 100.0% | | - | 0 |
| Podiatry (Foot Health) | >95% | 6 | 95.7% | 94.5% | 90.3% | 4.0 | 547 | >95% | 2 | | | | - | 0 |
| Lymphodema Care | >95% | 6 | 100.0% | 100.0% | 100.0% | 2.0 | 7 | >95% | 2 | | | | - | 0 |
| Tissue Viability | >95% | 6 | 97.4% | 100.0% | 100.0% | 1.5 | 6 | >95% | 2 | | | | - | 0 |
| Cardiology Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 2.7 | 27 | >95% | 2 | 100.0% | 100.0% | 100.0% | 0.6 | 2 |
| Diabetes Service | >95% | 6 | 100.0% | 100.0% | 93.3% | 3.1 | 45 | >95% | 2 | | | | - | 0 |
| Respiratory Service | >95% | 6 | 94.8% | 97.3% | 97.1% | 2.5 | 68 | >95% | 2 | 100.0% | | 100.0% | 0.2 | 6 |
| Spirometry Service | >95% | 6 | 98.4% | 100.0% | 100.0% | 2.4 | 26 | >95% | 2 | | | | - | 0 |



Date & time of production: 16/01/2020 14:15:00

# Appendix 2. Community Waiting Times Dashboard

## Haringey

### ROUTINE REFERRALS

| SERVICE | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen |
|---|---|---|---|---|---|---|---|
| Bladder and Bowel - Children | >95% | - | | | | - | 0 |
| Community Matron | >95% | 6 | 100.0% | 100.0% | 100.0% | 0.3 | 8 |
| Adult Wheelchair Service | >95% | 8 | 100.0% | 100.0% | 100.0% | 1.2 | 21 |
| Community Rehabilitation (CRT) | >95% | 12 | 100.0% | 100.0% | 100.0% | 4.7 | 1 |
| ICTT - Other | >95% | 12 | 98.3% | 92.1% | 90.0% | 4.0 | 231 |
| ICTT - Stroke and Neuro | >95% | 12 | 76.9% | 57.1% | 60.0% | 9.3 | 25 |
| Intermediate Care (REACH) | >95% | 6 | 100.0% | 100.0% | 100.0% | 1.2 | 3 |
| Paediatric Wheelchair Service | >95% | 8 | 100.0% | 100.0% | 100.0% | 1.2 | 3 |
| Bladder and Bowel - Adult | >95% | 12 | 51.4% | 70.1% | 86.8% | 7.3 | 53 |
| Musculoskeletal Service - CATS | >95% | 6 | 79.8% | 78.8% | 64.9% | 5.4 | 279 |
| Musculoskeletal Service - Routine | >95% | 6 | 86.8% | 84.1% | 81.1% | 4.3 | 735 |
| Nutrition and Dietetics | >95% | 6 | 100.0% | 98.0% | 96.2% | 3.1 | 105 |
| Podiatry (Foot Health) | >95% | 6 | 96.3% | 94.0% | 88.1% | 4.2 | 260 |
| Lymphodema Care | >95% | 6 | 100.0% | 100.0% | 100.0% | 0.6 | 1 |
| Tissue Viability | >95% | 6 | 100.0% | 100.0% | 100.0% | 1.2 | 4 |
| Cardiology Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 3.0 | 13 |
| Diabetes Service | >95% | 6 | 100.0% | 100.0% | 93.3% | 3.4 | 30 |
| Respiratory Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 3.1 | 26 |
| Spirometry Service | >95% | 6 | 98.4% | 100.0% | 100.0% | 2.4 | 26 |

### URGENT REFERRALS

| % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen |
|---|---|---|---|---|---|---|
| >95% | - | | | | - | 0 |
| >95% | - | | | | - | 0 |
| >95% | 2 | 100.0% | 100.0% | 0.0% | 3.0 | 1 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | 68.4% | 64.8% | 60.4% | 2.6 | 101 |
| >95% | 2 | 64.0% | 29.2% | 35.1% | 4.4 | 37 |
| >95% | 2 | | 0.0% | 100.0% | 1.4 | 2 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | 28.6% | 80.0% | 33.3% | 3.3 | 6 |
| >95% | 2 | 60.0% | 33.3% | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | | - | 0 |
| >95% | 2 | | | 100.0% | 0.0 | 1 |
| >95% | 2 | | | | - | 0 |

# Appendix 2. Community Waiting Times Dashboard

## Islington

| SERVICE | ROUTINE REFERRALS | | | | | | | URGENT REFERRALS | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen |
| Bladder and Bowel - Children | >95% | 12 | 100.0% | | | - | 0 | >95% | - | | | | - | 0 |
| Community Matron | >95% | 6 | 100.0% | 100.0% | 100.0% | 0.9 | 16 | >95% | 2 | 100.0% | | | - | 0 |
| Adult Wheelchair Service | >95% | 8 | 100.0% | | | - | 0 | >95% | - | | | | - | 0 |
| Community Rehabilitation (CRT) | >95% | 12 | 88.9% | 92.4% | 93.5% | 4.5 | 107 | >95% | 2 | 58.1% | 80.0% | 73.0% | 1.5 | 37 |
| ICTT - Other | >95% | 12 | 100.0% | 100.0% | 87.5% | 5.1 | 8 | >95% | 2 | | | | - | 0 |
| ICTT - Stroke and Neuro | >95% | 12 | | | | - | 0 | >95% | 2 | | | | - | 0 |
| Intermediate Care (REACH) | >95% | 6 | 82.7% | 86.5% | 94.4% | 2.3 | 108 | >95% | 2 | 83.8% | 89.5% | 90.0% | 0.9 | 50 |
| Paediatric Wheelchair Service | >95% | - | | | | - | 0 | >95% | - | | | | - | 0 |
| Bladder and Bowel - Adult | >95% | 12 | 61.8% | 74.0% | 88.5% | 6.5 | 26 | >95% | 2 | | | | - | 0 |
| Musculoskeletal Service - CATS | >95% | 6 | 77.9% | 70.9% | 61.5% | 5.6 | 252 | >95% | 2 | 50.0% | 50.0% | 100.0% | 1.0 | 1 |
| Musculoskeletal Service - Routine | >95% | 6 | 90.1% | 92.5% | 90.8% | 4.1 | 513 | >95% | 2 | | 100.0% | 100.0% | 1.7 | 1 |
| Nutrition and Dietetics | >95% | 6 | 100.0% | 100.0% | 97.3% | 2.3 | 73 | >95% | 2 | 100.0% | 100.0% | | - | 0 |
| Podiatry (Foot Health) | >95% | 6 | 95.1% | 95.0% | 92.1% | 3.8 | 279 | >95% | 2 | | | | - | 0 |
| Lymphodema Care | >95% | 6 | 100.0% | 100.0% | 100.0% | 2.3 | 6 | >95% | 2 | | | | - | 0 |
| Tissue Viability | >95% | 6 | 93.8% | 100.0% | 100.0% | 2.0 | 2 | >95% | 2 | | | | - | 0 |
| Cardiology Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 2.4 | 13 | >95% | 2 | 100.0% | 100.0% | 100.0% | 0.6 | 2 |
| Diabetes Service | >95% | 6 | 100.0% | 100.0% | 93.3% | 2.5 | 15 | >95% | 2 | | | | - | 0 |
| Respiratory Service | >95% | 6 | 90.9% | 95.1% | 95.1% | 2.1 | 41 | >95% | 2 | 100.0% | | 100.0% | 0.2 | 5 |
| Spirometry Service | >95% | - | | | | - | 0 | >95% | 2 | | | | - | 0 |

# Children's Community Waits Performance

| SERVICE | ROUTINE REFERRALS | | | | | | | URGENT REFERRALS | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen | % Threshold | Target Weeks | Oct-19 | Nov-19 | Dec-19 | Avg Wait (Dec) | No. of Pts Seen |
| CAMHS | >95% | 8 | 69.3% | 63.4% | 70.1% | 8.5 | 87 | >95% | 2 | 100.0% | 71.4% | 100.0% | 0.8 | 8 |
| Community Children's Nursing - Haringey | >95% | 2 | 100.0% | 50.0% | 50.0% | 2.5 | 2 | >95% | 1 | | | | - | 0 |
| Community Children's Nursing - Islington | >95% | 2 | 86.0% | 93.7% | 95.0% | 0.6 | 60 | >95% | 1 | 94.4% | 100.0% | 100.0% | 0.0 | 33 |
| Community Paediatrics - Haringey (SCC) | >95% | 18 | 40.9% | 23.5% | 33.3% | 33.6 | 18 | >95% | 1 | 0.0% | 0.0% | 0.0% | 55.7 | 1 |
| Community Paediatrics - Haringey (NDC) | >95% | 18 | 96.0% | 100.0% | 100.0% | 10.1 | 20 | >95% | 1 | | | | - | 0 |
| Community Paediatrics - Haringey (Child Protection) | >95% | 18 | 100.0% | 100.0% | 100.0% | 0.1 | 17 | >95% | 1 | | | | - | 0 |
| Community Paediatrics - Haringey (Other) | >95% | 18 | 100.0% | 100.0% | 100.0% | 1.1 | 3 | >95% | 1 | | | | - | 0 |
| Community Paediatrics - Islington | >95% | 18 | 92.9% | 92.9% | 90.5% | 5.6 | 21 | >95% | 1 | | | | - | 0 |
| Family Nurse Partnership - Haringey | >95% | 12 | 92.3% | 100.0% | 100.0% | 1.7 | 8 | >95% | - | | | | - | 0 |
| Family Nurse Partnership - Islington | >95% | 12 | | 100.0% | 100.0% | 3.4 | 2 | >95% | - | | | | - | 0 |
| Haematology Service - Islington | >95% | 12 | 100.0% | 92.3% | 100.0% | 0.5 | 13 | >95% | - | | | | - | 0 |
| IANDS | >95% | 18 | 90.3% | 88.9% | 100.0% | 1.3 | 7 | >95% | 2 | | 100.0% | 100.0% | 0.9 | 2 |
| IANDS - SCT | >95% | 20 | 0.0% | 11.1% | 8.3% | 37.8 | 12 | >95% | 2 | | | | - | 0 |
| Looked After Children - Haringey | >95% | 4 | 85.7% | 72.7% | 66.7% | 3.2 | 6 | >95% | 2 | | | | - | 0 |
| Looked After Children - Islington | >95% | 4 | 70.0% | 42.9% | 62.5% | 4.1 | 16 | >95% | 2 | | | | - | 0 |
| Occupational Therapy - Haringey | >95% | 18 | 65.6% | 70.0% | 75.0% | 6.8 | 8 | >95% | 2 | | | | - | 0 |
| Occupational Therapy - Islington | >95% | 18 | 73.7% | 88.5% | 100.0% | 7.5 | 7 | >95% | 2 | | | | - | 0 |
| Paediatrics Nutrition and Dietetics - Haringey | >95% | 12 | 87.5% | 100.0% | 100.0% | 1.0 | 6 | >95% | - | | | | - | 0 |
| Paediatrics Nutrition and Dietetics - Islington | >95% | 12 | 100.0% | 100.0% | 92.9% | 4.4 | 14 | >95% | - | | | | - | 0 |
| Physiotherapy - Haringey | >95% | 18 | 80.0% | 92.8% | 97.2% | 6.4 | 72 | >95% | 2 | | | | - | 0 |
| Physiotherapy - Islington | >95% | 18 | 100.0% | 98.3% | 96.9% | 4.8 | 32 | >95% | 2 | | | | - | 0 |
| PIPS | >95% | 12 | 90.9% | 100.0% | 100.0% | 2.3 | 2 | >95% | - | | | | - | 0 |
| SALT - Haringey | >95% | 15 | 47.9% | 75.0% | 79.5% | 9.2 | 39 | >95% | 2 | 0.0% | 0.0% | 0.0% | 6.4 | 2 |
| SALT - Islington | >95% | 15 | 89.7% | 93.3% | 97.1% | 5.9 | 34 | >95% | 2 | | | | - | 0 |
| SALT - MPC | >95% | 18 | 98.9% | 100.0% | 100.0% | 3.8 | 32 | >95% | 2 | | | 100.0% | 0.4 | 1 |
| School Nursing - Haringey | >95% | 12 | 86.7% | 88.1% | 96.7% | 2.1 | 61 | >95% | - | | | | - | 0 |
| School Nursing - Islington | >95% | 12 | 98.0% | 96.2% | 96.0% | 2.1 | 50 | >95% | - | | | | - | 0 |

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

## Cancer - 62D Performance by Tumour Group

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breast | >85% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 84.6% | 100.0% | 83.3% | 75.0% | 100.0% | | | | |
| Gynaecological | >85% | 66.7% | 0.0% | 100.0% | 50.0% | 50.0% | | 0.0% | 44.4% | 33.3% | 33.3% | | | | |
| Haematological (Excluding Acute Leukaemia) | >85% | | 100.0% | 0.0% | 100.0% | 100.0% | | | 100.0% | 100.0% | 100.0% | | | | |
| Lower Gastrointestinal | >85% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 83.3% | 100.0% | 88.9% | | | | |
| Lung | >85% | 100.0% | 85.7% | 100.0% | 100.0% | 50.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | | | |
| Other | >85% | 100.0% | | 100.0% | 100.0% | | | | | 0.0% | | | | | |
| Skin | >85% | 85.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% | 100.0% | 100.0% | | | | |
| Testicular | >85% | | 100.0% | | 100.0% | | 0.0% | | 100.0% | 100.0% | 100.0% | | | | |
| Upper Gastrointestinal | >85% | 100.0% | | 100.0% | 50.0% | 100.0% | 66.7% | 0.0% | | 100.0% | 100.0% | | | | |
| Urological (Excluding Testicular) | >85% | 64.7% | 80.0% | 76.9% | 88.9% | 70.6% | 71.4% | 62.5% | 80.0% | 88.9% | 85.7% | | | | |

## Cancer - 2WW Performance by Tumour Group

| Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | 2019-2020 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breast | >93% | 98.5% | 93.7% | 96.0% | 93.9% | 99.0% | 96.8% | 98.0% | 95.5% | 96.9% | 98.5% | 95.7% | | 96.8% | |
| Childrens | >93% | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | 100.0% | | 100.0% | |
| Gynaecological | >93% | 97.1% | 91.8% | 96.6% | 94.5% | 96.0% | 96.1% | 96.4% | 94.3% | 51.8% | 48.1% | 92.4% | | 83.1% | |
| Haematological | >93% | 100.0% | 91.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | |
| Lower Gastrointestinal | >93% | 92.8% | 94.2% | 95.8% | 91.2% | 96.7% | 96.2% | 92.8% | 95.5% | 93.4% | 98.6% | 95.3% | | 95.1% | |
| Lung | >93% | 100.0% | 100.0% | 100.0% | 100.0% | 80.0% | 83.3% | 83.3% | 100.0% | 85.7% | 92.9% | 100.0% | | 90.0% | |
| Skin | >93% | 97.6% | 99.3% | 96.2% | 98.0% | 98.8% | 97.5% | 91.1% | 82.3% | 90.1% | 98.3% | 100.0% | | 94.4% | |
| Upper Gastrointestinal | >93% | 87.2% | 98.2% | 98.9% | 91.4% | 96.6% | 98.5% | 97.9% | 97.1% | 92.9% | 97.7% | 98.1% | | 96.1% | |
| Urological | >93% | 91.8% | 92.4% | 92.1% | 98.8% | 98.4% | 98.8% | 93.8% | 95.0% | 98.0% | 97.8% | 98.9% | | 97.2% | |

# Appendix 4. Trust Level Activity

| Category | Indicator | 19_20 Target | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Activity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | ED Attendances | 8285 | 9595 | 8868 | 9720 | 9077 | 9281 | 8921 | 9458 | 8778 | 8658 | 9428 | 9371 | 9768 |  |
| ED | ED Admission Rate % | | 14.9% | 14.3% | 15.1% | 15.0% | 14.2% | 14.8% | 13.4% | 13.5% | 13.8% | 14.4% | 14.9% | 13.1% |  |
| Community | Community Face to Face Contacts | | 62556 | 56392 | 60522 | 55983 | 60051 | 59796 | 61879 | 52278 | 59344 | 63272 | 60124 | 49241 |  |
| Admissions | Elective and Daycase | | 2149 | 1989 | 2133 | 2130 | 2083 | 2159 | 2244 | 1976 | 1896 | 2171 | 2081 | 1779 |  |
| Admissions | Emergency Inpatients | | 2268 | 2036 | 2297 | 2224 | 2217 | 2096 | 2101 | 2042 | 2087 | 2140 | 2182 | 2097 |  |
| Referrals | GP Referrals to an Acute Service | | 8146 | 7909 | 8632 | 8452 | 8915 | 8195 | 7919 | 6593 | 7009 | 8046 | 7213 | 6426 |  |
| Referrals | % of GP Referrals that were completed via ERS | | 87.6% | 87.5% | 88.2% | 88.3% | 88.1% | 88.9% | 88.6% | 86.7% | 87.9% | 87.6% | 86.7% | 86.9% |  |
| Referrals | % e-Referral Service (e-RS) Slot Issues | <4% | 7.6% | 7.1% | 10.3% | 12.7% | 12.0% | 11.5% | 13.4% | 14.3% | 11.0% | 15.7% | 18.3% | 18.7% |  |
| Maternity | Maternity Births | 320 | 295 | 246 | 300 | 306 | 312 | 283 | 315 | 307 | 310 | 304 | 317 | 292 |  |
| Maternity | Maternity Bookings | 377 | 420 | 379 | 419 | 367 | 390 | 342 | 408 | 357 | 314 | 357 | 344 | 353 |  |
| Outpatients | Outpatient DNA Rate % - New | <10% | 10.5% | 10.5% | 9.8% | 10.7% | 11.4% | 12.9% | 12.9% | 12.9% | 12.5% | 11.2% | 11.2% | 11.7% |  |
| Outpatients | Outpatient DNA Rate % - FUp | <10% | 9.7% | 10.7% | 9.7% | 10.3% | 11.5% | 13.6% | 12.4% | 11.6% | 11.5% | 10.8% | 10.6% | 11.1% |  |
| Outpatients | Outpatient New Attendances | | 10201 | 9405 | 9413 | 9481 | 9684 | 9193 | 10371 | 9093 | 9444 | 10755 | 9851 | 9113 |  |
| Outpatients | Outpatient FUp Attendances | | 20030 | 17465 | 18049 | 18382 | 18595 | 17162 | 18957 | 16755 | 17335 | 18867 | 17389 | 15486 |  |
| Outpatients | Outpatient Procedures | | 8410 | 7549 | 7983 | 7494 | 7558 | 7535 | 8299 | 7222 | 7708 | 8330 | 7837 | 7405 |  |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Standing orders, standing financial instructions and scheme of delegation and reservation of powers** | **Agenda item: 13** |
| **Executive director leads** | Jonathan Gardner (standing orders) and Kevin Curnow, Acting Chief Finance Officer (standing financial instructions) | |
| **Report author** | Jonathan Ware, Head of Financial Services | |
| **Executive summary** | The Audit & Risk Committee annually reviews the Trust's integrated governance document (comprising standing orders, the scheme of delegation and standing financial instructions).<br><br>The document was reviewed in Finance and by the Trust Corporate Secretary. On 15 January, the Committee approved the following principal changes to the document:<br><br>• the inclusion of a standing order in section 2.2 which highlights the fact that one of our Non-Executive Directors is co-opted from University College London;<br>• the removal of section 7.3.1iv)c) to align with the Managing Conflicts of interest in the NHS policy and the Nolan Principles of Public Life;<br>• inclusion of Nolan Principles in full in section 7.4.1(2);<br>• updates to the scheme of delegation to include the approval routes for contracts for the Trust's services (for example, with NHS CCGs and NHS England); and<br>• wording changes, particularly in relation to updated terminology.<br><br>No changes were approved to the standing financial instructions' section of this document. | |
| **Purpose:** | Approval | |
| **Recommendation(s)** | Following approval of the revised document at Audit & Risk Committee, the Trust Board is asked to ratify the document. | |
| **Risk Register or Board Assurance Framework** | Quality 1 – Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation. | |
| **Report history** | Audit and Risk Committee 30 October 2019; Audit and Risk Committee 15 January 2020 | |
| **Appendices** | Integrated Governance document, January 2020 | |

Whittington Health NHS

# Standing Orders Reservation and Delegation of Powers Standing Financial Instructions

| | |
|---|---|
| Ratified by: | Trust Board |
| Ratification date: | |
| Approval Committee: | Audit and Risk Committee |
| Date Approved: | 15 January 2020 |
| Executive Owner: | Kevin Curnow, Acting CFO |
| Name of Author and Job Title: | Jonathan Ware, Head of Financial Services |
| Target Audience: | All staff |
| Review Date: | 15 January 2021 |

UCL MEDICAL SCHOOL

*Helping local people live longer healthier lives*

**CONTENTS** Page

**CONTENTS** Page

**CONTENTS** Page

**CONTENTS** Page

**CONTENTS** Page

**CONTENTS** Page

**CONTENTS** Page



**Note: Throughout this document, references to male gender should be interpreted as referring to both genders.**

## SECTION A

## 1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the NHS Act 2006, the Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means Whittington Health.

1.2.3 **"Board"** means the Chair, executive and non-executive members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chair of the Board (or Trust)"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the chief officer of the Trust.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.9 **"Committee"** means a committee or sub-committee created and appointed by the Trust.

1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12 **"Chief Finance Officer"** means the Chief Financial Officer of the Trust.

1.2.13 **“Funds held on trust”** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.2.14 **"Member"** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chair.

1.2.15 **“Associate Member”** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.16 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

1.2.17 **"Nominated executive"** means an executive charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.18 **"Non-executive member"** means a member of the Trust who is not an executive of the Trust and is not to be treated as an executive by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

1.2.19 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.20 **"Officer member**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member).

1.2.21 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust’s compliance with the law, Standing Orders, and Department of Health & Social Care guidance.

1.2.22 **"SFIs"** means Standing Financial Instructions.

1.2.23 **"SOs"** means Standing Orders.

1.2.24 **"Deputy Chair"** means the non-executive member appointed by the Board to take on the Chair’s duties if the Chair is absent for any reason.

## SECTION B – STANDING ORDERS

## 1. INTRODUCTION

### 1.1 Statutory Framework

The Whittington Hospital NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The Whittington Hospital NHS Trust (Establishment) Order 1992 No 2510 (the Establishment Order). In 2017, the Trust's name became Whittington Health.

(1) The principal place of business of the Trust is Magdala Avenue, London N19 5NF.

(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 the, Health Act 1999 and consolidated in the National Health Service Act 2006 and the NHS (Consequential Provision) Act 2006.

(3) The functions of the Trust and all its subsidiaries, including Whittington Pharmacy, are conferred by this legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. as well as to the Secretary of State for Health for any other funds held on trust.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

### 1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health & Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. From 1 January 2005, this was superseded by the Freedom of Information Act 2000.

### 1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders (SO) set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of SO 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct".

Reservation of Powers are covered in Section C. These documents have the effect as if incorporated into the Standing Orders.

### 1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health & Social Care on the move toward and implementation of integrated governance has been issued and will be incorporated in the Trust's Governance Strategy. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

## 2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

### 2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust;

(2) Up to 6 non-executive members;

(3) Up to 5 executive members (but not exceeding the number of non-executive members) including:

- the Chief Executive;
- the Chief Finance Officer;
- a Medical Practitioner;
- a Registered Nurse or Midwife;

The Trust shall have not more than 12 and not less than 8 voting members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

### 2.2 Appointment of Chair and Members of the Trust

(1) Appointment of the Chair and Members of the Trust - Paragraph 4 of Schedule 5A o the 1977 Act, as inserted by the Health Act 1999, provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the

Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

(2) One of the Trust's Non-Executive Directors will be appointed from University College London.

**2.3 Terms of Office of the Chair and Members**

(1) The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

**2.4 Appointment and Powers of Vice Chair**

(1) Subject to SO 2.4 (2) below, the Chair and members of the Trust may appoint one of their number, who is not also an executive member, to be Vice Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice Chair in accordance with the provisions of SO 2.4 (1).

(3) Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice Chair.

**2.5 Role of Members**

The Board will function as a corporate decision-making body, Executive and Non-executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Director**

Executive Directors are normally employees of the Trust. However, a person holding a post in a university or a person seconded to work for the Trust may be appointed as an Executive director. Executive directors (apart from the Chief Executive and the Chief Financial Officer) may be removed from the Trust Board if, in the view of the appointing committee, it is not in the interest of the Trust for them to continue as a Director. If any Executive director is suspended from his post with the Trust, he will also be suspended from being a director for the period of his suspension. Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. She is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial

Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) **Chief Finance Officer**

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with NHS Improvement over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

**2.6 Corporate role of the Board**

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in SO No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

**2.7 Schedule of Matters reserved to the Board and Scheme of Delegation**

(1) The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to executives and other bodies are contained in the Scheme of Delegation. Both are set out in section C.

**2.8 Lead Roles for Board Members**

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health & Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services).

## 3. MEETINGS OF THE TRUST

### 3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chair of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

### 3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chair or by an executive authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under SO 3.6.

(4) A member desiring a matter to be included on an agenda shall make his request in writing to the Chair at least 15 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chair.

(5) Trust Board papers must be written in the required Trust Board format and be submitted to the Trust Office at least 7 days before the date of the Trust Board meeting to facilitate timely distribution of the papers. Additional papers are at the Chair's discretion.

(6) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices and on the Trust's website at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

### 3.3 Agenda and Supporting Papers

The Agenda will be sent to members on the Friday of the week before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will

certainly be despatched no later than two clear days before the meeting, save in emergency.

### 3.4 Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

### 3.5 Notice of Motion

(1) Subject to the provision of SOs 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 15 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

### 3.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of SO 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

### 3.7 Motions: Procedure at and during a meeting

#### i) Who may propose

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

#### ii) Contents of motions

The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

#### iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see SO 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

**3.8 Motion to Rescind a Resolution**

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

**3.9 Chair of meeting**

(1) At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair (if the Board has appointed one), if present, shall preside.

(2) If the Chair and Vice Chair are both absent, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair. An Executive director cannot take the chair.

**3.10 Chair's ruling**

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

**3.11 Quorum**

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least two Executive directors and two Non-Executive directors) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

**3.12 Voting**

(i) Save as provided in SOs 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote.

(ii) At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

(v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

(viii) For the voting rules relating to joint members see SO 2.5.

**3.13 Suspension of Standing Orders**

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Members of the Board are present (including at least one Member who is an Executive Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) The Audit and Risk Committee shall review every decision to suspend Standing Orders.

**3.14 Variation and amendment of Standing Orders**

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under SO 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

**3.15 Reporting of Waivers of Standing Orders and Standing Financial Instructions**

(1) All waivers of Standing Orders should be reported to the Audit and Risk Committee after approval has been granted. The Audit and Risk Committee should ensure that waivers have only been granted in compliance with the regulations and where necessary. However, these provisions do not apply where the competitive tendering process is to be omitted or modified. Approval should then be sought as detailed in the relevant section of the Standing Financial Instructions. All such waivers will be reported retrospectively to the Trust's Audit and Risk Committee.

### 3.16 Record of Attendance

The names of the Chair and Directors/Members present at the meeting shall be recorded in the minutes.

### 3.17 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

### 3.18 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

- Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the Members of the Board.

Members and executives or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

### 3.19 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

## 4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

### 4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider the minutes and reports of such committees.

### 4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other Trusts or health bodies consisting of, wholly or partly of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

### 4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the

context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

**4.4 Terms of Reference**

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

**4.5 Delegation of powers by Committees to Sub-Committees**

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

**4.6 Approval of Appointments to Committees**

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance. The appointment of directors to committees and sub-committees of the Trust comes to an end on the termination of their terms of office as directors.

**4.7 Appointments for Statutory functions**

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

**4.8 Committees established by the Trust Board**

The committees, sub-committees, and joint-committees established by the Board are:

4.8.1 **Audit and Risk Committee**

In line with the requirement of the NHS Audit and Risk Committee Handbook, NHS Codes of Conduct and Accountability and more recently the Higgs report, an Audit and Risk Committee will be established and constituted to provide the Trust Board with an independent and objective review on *inter alia* its financial systems, financial information, risk management systems, clinical governance, health and safety, and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Higgs report recommends a minimum of three non-executive members be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience. No executive directors will be members of the Audit and Risk Committee.

4.8.2 **Remuneration and Terms of Service Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Terms of Service and Remuneration Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

The purpose of the Committee will be to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms.

4.8.3 **Trust and Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board may establish a Trust and Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission.

The provisions of this Standing Order must be read in conjunction with SO 2.7 and Standing Financial Instructions 29.

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

4.9 **Confidential Proceedings**

A director or officer of the Trust shall not disclose a matter considered by the Trust Board or a Committee in confidence without its permission until the Board or Committee has considered the matter in public or has resolved to make the matter public.

## 5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

### 5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of SO 4, or by an executive of the Trust, or by another body as defined in SO 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Trusts

(Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, NHSI/E London office or Clinical Commissioning Groups (CCGs);

(iii) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with the NHSI/E London office, NHS Trusts or CCG.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

**5.2 Emergency Powers and urgent decisions**

The powers which the Board has reserved to itself within these Standing Orders (see SO 2.8) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive members. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

**5.3 Delegation to Committees**

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

**5.4 Delegation to Officers**

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Finance Officer to provide information and

advise the Board in accordance with statutory or Department of Health & Social Care requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

**5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers**

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

**5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions**

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## 6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS, PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

**6.1 Policy statements: general principles**

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Whittington Health. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

**6.2 Specific Policy statements**

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and the "managing conflicts of interest in the NHS policy" for Trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.
- the Trust's Procurement Policy and Procedures

**6.3 Standing Financial Instructions**

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

**6.4 Specific guidance**

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

# 7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS, DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

## 7.1 Declaration of Interests

### 7.1.1 Requirements for Declaring Interests and applicability to Board Members

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Members should declare such interests. Any Board members appointed subsequently should do so on appointment.

### 7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of Authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department

g) Interests in pooled funds that are under separate management

h) Any other interest in relation to an issue to be considered by the Trust Board.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable (and in any event within 28 days).

### 7.1.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust's Corporate Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of Interests in Trust Board minutes**

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

**7.2 Register of Interests**

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

**7.3 Exclusion of Chair and Members in proceedings on account of pecuniary interest**

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he, or a nominee of his, is a Member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he or any person connected with him has any beneficial interest in the securities of a company of which he or such person appears as a member, or

b) any interest that he or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract.

7.3.2 **Exclusion in proceedings of the Trust Board**

(i) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Trust Board may exclude the Chair or a Member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a Member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chair" is –

(a) at a meeting of the Trust, the Chair of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chair of that Committee, the Chair of the Trust;

(ii) in the case of any other member, the Chair of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of Whittington Health ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

**7.4 Standards of Business Conduct**

7.4.1 **Trust Policy and National Guidance**

All Trust staff and Members of must comply with :

1. The Trust's Standards of Business Conduct, the "managing conflicts of interest in the NHS policy" for Trust staff, and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

2. The Seven Principles of Public Life as set out by the Nolan Committee and which apply to everyone who works in public services. These are as follows:

| Nolan Principle | Board members' requirement |
|---|---|
| **Selflessness** | Holders of public office should act solely in terms of the public interest. They should not do so in order to |

| | |
|---|---|
| | gain financial or other benefits for themselves, their family or their friends. |
| **Integrity** | Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties. |
| **Objectivity** | In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit. |
| **Accountability** | Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office. |
| **Openness** | Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands. |
| **Honesty** | Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest. |
| **Leadership** | Holders of public office should promote and support these principles by leadership and example. |

7.4.2 **Interest of Executives in Contracts**

i) Any officers or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the executive shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable.

ii) An executive should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates. This provision does not prevent candidates from arranging to meet non-executive and executive members as part of their preparation for competition and interview.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 **Relatives of Members or Officers**

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

7.5 **Acceptance of Gifts and Donations**

(1) Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined regardless of value. Low cost branded promotional aids to the value of £6 may be accepted.

(2) Gifts up to the value of £50 from other sources, such as patients, patients' relatives or carers can be accepted, but their senior officer must be informed and a record made. The Trust's Standards of Business Conduct Policy sets out the rules in relation to gifts and donations and should be read as if incorporated into Standing Orders.

(3) Any donated sums of money, cheques or gift vouchers given to a member of staff must be passed to the relevant charitable fund. A receipt should be issued and letter of thanks sent.

(4) Where the donor specifies how the money is to be spent, his/her wishes must be followed.

## 8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, as required by law or requested by any other party, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

## 9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

## SECTION C - SCHEME OF RESERVATION AND DELEGATION

| REF | THE BOARD | DECISIONS RESERVED TO THE BOARD |
|---|---|---|
| NA | THE BOARD | **General Enabling Provision**<br><br>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. |
| NA | THE BOARD | ***Regulations and Control***<br><br>1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.<br>2. Suspend Standing Orders.<br>3. Vary or amend the SOs.<br>4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2<br>5. Approve a scheme of delegation of powers from the Board to committees**.**<br>6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.<br>7. Require and receive the declaration of officers' interests that may conflict with those of the Trust.<br>8. Approve arrangements for dealing with complaints.<br>9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.<br>10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.<br>11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.<br>12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.<br>13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.<br>14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.<br>15. Ratify or otherwise instances of failure to comply with SOs brought to the Chief Executive's attention in accordance with SO 5.6.<br>16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. |

| REF | THE BOARD | DECISIONS RESERVED TO THE BOARD |
|---|---|---|
| NA | THE BOARD | **Appointments/ Dismissal**<br><br>1. Appoint the Vice Chair of the Board.<br>2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.<br>3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2).<br>4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.<br>5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under SOs).<br>6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee. |
| NA | THE BOARD | ***Strategy, Plans and Budgets***<br><br>1. Define the strategic aims and objectives of the Trust.<br>2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.<br>3. Approve the Trust's policies and procedures for the management of risk.<br>4. Approve Outline and Final Business Cases for Capital Investment in excess of £1.5m<br>5. Approve budgets.<br>6. Approve annually Trust's proposed organisational development proposals.<br>7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.<br>8. Approve PFI proposals.<br>9. Approve the opening of bank accounts.<br>10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1.5m over a 3 year period or the period of the contract if longer.<br>11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.<br>12. Approve individual compensation payments.<br>13. Approve proposals for action on litigation against or on behalf of the Trust.<br>14. Review use of NHSLA risk pooling schemes |
| | THE BOARD | **Policy Determination**<br>1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.<br><br>Policies so adopted shall be listed and appended to this document by the Secretary. |

| REF | THE BOARD | DECISIONS RESERVED TO THE BOARD |
|---|---|---|
| | THE BOARD | **Audit**<br>1. Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Committee.<br>2. Receipt of an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit and Risk Committee. |
| NA | THE BOARD | **Annual Reports and Accounts**<br>1. Receipt and approval of the Trust's Annual Report and Annual Accounts.<br>2. Receipt and approval of the Annual Report and Accounts for funds held on trust. |
| NA | THE BOARD | **Monitoring**<br>1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated.<br>2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health & Social Care and the Charity Commission shall be reported, at least in summary, to the Board.<br>3. Receive reports from CFO on financial performance against budget. |

**DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES**

| REF | COMMITTEE | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES |
|---|---|---|
| SFI 11.1.1 | AUDIT AND RISK COMMITTEE | The Committee will:<br><br>1. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;<br>2. Act as guardian of the Assurance Framework and Health Commission Annual Core Standards Healthcheck, responsible for updating and monitoring action plans<br>3. Ensure policies and procedures in respect of governance are in line with NHS guidelines<br>4. Report to the Board on risk management, controls, and assurance issues<br>5. Agree reporting formats and frequency of reports<br>6. Agree and monitor the Clinical Governance Development Plan and the Annual Clinical Governance Report<br>7. Consider action in response to Health Commission and NICE recommendations<br>8. Support a culture of learning<br>9. Advise the Board on internal and external audit services;<br>10. Monitor compliance with SOs and Standing Financial Instructions;<br>11. Review schedules of losses and compensations and making recommendations to the Board.<br>12. Review schedules of debtor/creditor balances >£5k, >6 months<br>13. Review the annual financial statements prior to submission to the Board.<br>14. Review tender waivers and write off of debts |
| SFI 20.1.2 | REMUNERATION AND TERMS OF SERVICE COMMITTEE | The Committee will advise and report to the Board on<br><br>1. Appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including:<br>2. All aspects of salary (including any performance-related elements/bonuses).<br>3. Provisions for other benefits, including pensions and cars<br>4. Arrangements for termination of employment and other contractual terms.<br>5. Recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff.<br>6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff.<br>7. The Committee shall report in writing to the Board the basis for its recommendations. |

| REF | COMMITTEE | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES |
|---|---|---|
| | OTHER COMMITTEES | PFI Decision-making Sub-Committee has delegated authority to take urgent decisions relating to the PFI contract subject to advice from the DoH PFU |

**SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM**

| REF | DELEGATED TO | DUTIES DELEGATED |
|---|---|---|
| 7 | CHIEF EXECUTIVE (CE) | Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources |
| 9 | CE AND CHIEF FINANCE OFFICER (CFO) | Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.<br>Sign the accounts on behalf of the Board. |
| 10 | CHIEF EXECUTIVE | Sign a statement in the accounts outlining responsibilities as the Accountable Officer.<br>Sign a statement in the accounts outlining responsibilities in respect of Internal Control. |
| 12 & 13 | CHIEF EXECUTIVE | *Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers:*<br>□ "have a clear view of their objectives and the means to assess achievements in relation to those objectives<br>□ be assigned well defined responsibilities for making best use of resources<br>□ have the information, training and access to the expert advice they need to exercise their responsibilities effectively." |
| 12 | CHAIR | Implement requirements of corporate governance. |
| 13 | CHIEF EXECUTIVE | Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities.<br>Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO). |
| 15 | CHIEF FINANCE OFFICER | Operational responsibility for effective and sound financial management and information. |

| REF | DELEGATED TO | DUTIES DELEGATED |
|---|---|---|
| 15 | CHIEF EXECUTIVE | Primary duty to see that CFO discharges this function. |
| 16 | CHIEF EXECUTIVE | Ensuring that expenditure by the Trust complies with Parliamentary requirements. |
| 18 | CE and CFO | Chief Executive, supported by Chief Finance Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness. |
| 19 | CHIEF EXECUTIVE | If CE considers the Board or Chair is doing something that might infringe probity or regularity, he should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit and Risk Committee to inquire and if necessary the SHA and Department of Health & Social Care. |
| 21 | CHIEF EXECUTIVE | If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that the CE is overruled it is normally sufficient to ensure that the CE's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the NHSI/E London office and the DHSC. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting. |

**SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY**

| REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 1.3.1.7 | BOARD | Approve procedure for declaration of hospitality and sponsorship. |
| 1.3.1.8 | BOARD | Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns. |
| 1.31.9 & 1.3.2.2 | ALL BOARD MEMBERS | Subscribe to Code of Conduct. |
| 1.3.2.4 | BOARD | Board members share corporate responsibility for all decisions of the Board. |

| REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 1.3.2.4 | CHAIR AND NON EXECUTIVE/OFFICER MEMBERS | Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities. |
| 1.3.2.4 | BOARD | The Board has six key functions for which it is held accountable by the Department of Health & Social Care on behalf of the Secretary of State:<br><br>1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;<br>2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;<br>3. to appoint, appraise and remunerate senior executives;<br>4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them;<br>5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;<br>6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs. |
| 1.3.24 | BOARD | It is the Board's duty to:<br><br>1. act within statutory financial and other constraints;<br>2. be clear what decisions and information are appropriate to the Board and draw up SOs, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these,<br>3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;<br>4. establish performance and quality measures that maintain the effective use of resources and provide value for money;<br>5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;<br>6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board. |

| REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 1.3.2.5 | CHAIR | It is the Chair's role to:<br><br>1. provide leadership to the Board;<br>2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;<br>3. ensure that key and appropriate issues are discussed by the Board in a timely manner,<br>4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;<br>5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members;<br>6. advise the Secretary of State on the performance of Non-Executive Board members. |
| 1.3.2.5 | CHIEF EXECUTIVE | The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship.<br>The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.<br>The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum. |
| 1.3.2.6 | NON EXECUTIVE DIRECTORS | Non-Executive Directors are appointed by Appointments Commission to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health & Social Care to Ministers and to the local community. |
| 1.3.2.8 | CHAIR AND DIRECTORS | Declaration of conflict of interests. |
| 1.3.2.9 | BOARD | NHS Boards must comply with legislation and guidance issued by the Department of Health & Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. |

**SCHEME OF DELEGATION FROM MODEL STANDING ORDERS**

| SO REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 1.1 | CHAIR | Final authority in interpretation of Standing Orders (SOs). |

| SO REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 2.4 | BOARD | Appointment of Vice Chair |
| 3.1 | CHAIR | Call meetings. |
| 3.9 | CHAIR | Chair all Board meetings and associated responsibilities. |
| 3.10 | CHAIR | Give final ruling in questions of order, relevancy and regularity of meetings. |
| 3.12 | CHAIR | Having a second or casting vote |
| 3.13 | BOARD | Suspension of SOs |
| 3.13 | AUDIT AND RISK COMMITTEE | Audit and Risk Committee to review every decision to suspend SOs (power to suspend SOs is reserved to the Board) |
| 3.14 | BOARD | *Variation or amendment of SOs* |
| 4.1 | BOARD | Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.) |
| 5.2 | CHAIR & CHIEF EXECUTIVE | The powers which the Board has retained to itself within these SOs may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members. |
| 5.4 | CHIEF EXECUTIVE | The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. |
| 5.6 | ALL | Disclosure of non-compliance with SOs to the Chief Executive as soon as possible. |
| 7.1 | THE BOARD | Declare relevant and material interests. |
| 7.2 | CHIEF EXECUTIVE | Maintain Register(s) of Interests. |
| 7.4. | ALL STAFF | Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and the Seven Principles of Public Life as set out by the Nolan Committee |
| 7.4 | ALL | Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.) |

| SO REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 8.1/8.3 | CHIEF EXECUTIVE | Keep seal in safe place and maintain a register of sealing. |
| 8.4 | CHIEF EXECUTIVE/EXECUTIVE DIRECTOR | Approve and sign all documents which will be necessary in legal proceedings. |

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

**SCHEME OF DELEGATION FROM MODEL STANDING FINANCIAL INSTRUCTIONS**

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 10.1.3 | CHIEF FINANCE OFFICER | Approval of all financial procedures. |
| 10.1.4 | CHIEF FINANCE OFFICER | Advice on interpretation or application of SFIs. |
| 10.1.6 | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Performance and Finance as soon as possible. |
| 10.2.4 | CHIEF EXECUTIVE | Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control. |
| 10.2.4 | CHIEF EXECUTIVE & CHIEF FINANCE OFFICER | Accountable for financial control but will, as far as possible, delegate their detailed responsibilities. |
| 10.2.5 | CHIEF EXECUTIVE | To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 10.2.6 | CHIEF FINANCE OFFICER | Responsible for:<br>1. Implementing the Trust's financial policies and co-ordinating corrective action;<br>2. Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented;<br>3. Ensuring that sufficient records are maintained to explain Trust's transactions and financial position;<br>4. Providing financial advice to members of Board and staff;<br>5. Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties. |
| 10.2.7 | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, Financial Instructions and financial procedures. |
| 10.2.8 | CHIEF EXECUTIVE | Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply. |
| 11.1.1 | AUDIT AND RISK COMMITTEE | Provide independent and objective view on internal control and probity. |
| 11.1.2 | CHAIR | Raise the matter at the Board meeting where Audit and Risk Committee considers there is evidence of ultra vires transactions or improper acts. |
| 11.1.3 & 11.2.1 | CHIEF FINANCE OFFICER | Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit and Risk Committee in the selection process when/if an internal audit service provider is changed.) |
| 11.2.1 | CHIEF FINANCE OFFICER | Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption. |
| 11.3 | HEAD OF INTERNAL AUDIT | Review, appraise and report in accordance with NHS Internal Audit Manual and best practice. |
| 11.4 | AUDIT AND RISK COMMITTEE | Ensure cost-effective External Audit. |
| 11.5 | CHIEF EXECUTIVE & CHIEF FINANCE OFFICER | Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist. |
| 11.6 | CHIEF EXECUTIVE | Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 13.1.2 & 13.1.3 | CHIEF FINANCE OFFICER | Submit budgets to the Board for approval.<br>Monitor performance against budget; submit to the Board financial estimates and forecasts. |
| 13.1.6 | CHIEF FINANCE OFFICER | Ensure adequate training is delivered on an on going basis to budget holders. |
| 13.3.1 | CHIEF EXECUTIVE | Delegate budget to budget holders. |
| 13.3.2 | CHIEF EXECUTIVE & BUDGET HOLDERS | Must not exceed the budgetary total or virement limits set by the Board. |
| 13.4.1 | CHIEF FINANCE OFFICER | Devise and maintain systems of budgetary control. |
| 13.4.2 | BUDGET HOLDERS | Ensure that<br>*a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;*<br>b) approved budget is not used for any other than specified purpose subject to rules of virement;<br>c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment. |
| 13.4.3 | CHIEF EXECUTIVE | Identify and implement cost improvements and income generation activities in line with the LDP. |
| 13.6.1 | CHIEF EXECUTIVE | Submit monitoring returns |
| 14.1 | CHIEF FINANCE OFFICER | Preparation of annual accounts and reports. |
| 15.1 | CHIEF FINANCE OFFICER | Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.<br>(Board approves arrangements.) |
| 16. | CHIEF FINANCE OFFICER | Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash. |
| 16.2.3 | ALL EMPLOYEES | Duty to inform CFO of money due from transactions which they initiate/deal with. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 17. | CHIEF EXECUTIVE | Tendering and contract procedure. |
| 17.5.3 | CHIEF EXECUTIVE/CHIEF FINANCE OFFICER | Waive formal tendering procedures. |
| 17.5.3 | CHIEF FINANCE OFFICER | Report waivers of tendering procedures to the Audit and Risk Committee |
| 17.5.5 | CHIEF FINANCE OFFICER | Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE. |
| 17.6.2 | CHIEF EXECUTIVE | Responsible for the receipt, endorsement and safe custody of tenders received. |
| 17.6.3 | CHIEF EXECUTIVE | Shall maintain a register to show each set of competitive tender invitations despatched. |
| 17.6.4 | CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER | Where one tender is received will assess for value for money and fair price. |
| 17.6.6 | CHIEF EXECUTIVE | No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. |
| 17.6.8 | CHIEF EXECUTIVE | Will appoint a manager to maintain a list of approved firms. |
| 17.6.9 | CHIEF EXECUTIVE | Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote. |
| 17.7.2 | CHIEF EXECUTIVE | The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. |
| 17.7.4 | CHIEF EXECUTIVE or CHIEF FINANCE OFFICER | No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. |
| 17.10 | CHIEF EXECUTIVE | The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. |
| 17.10 | BOARD | All PFI proposals must be agreed by the Board. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 17.11 | CHIEF EXECUTIVE | The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust. |
| 17.12 | CHIEF EXECUTIVE | The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. |
| 17.15 | CHIEF EXECUTIVE | The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. |
| 17.15.5 | CHIEF EXECUTIVE | The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust. |
| 18.1.1 | CHIEF EXECUTIVE | Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services |
| 18.3 | CHIEF EXECUTIVE | As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA |
| 20.1.1 | BOARD | Establish a Remuneration & Terms of Service Committee |
| 20.1.2 | REMUNERATION COMMITTEE | *Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements;*<br>*Monitor and evaluate the performance of individual senior employees;*<br>Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments. |
| 20.1.3 | REMUNERATION COMMITTEE | Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees. |
| 20.1.4 | BOARD | Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee. |
| 20.2.2 | CHIEF EXECUTIVE | Approval of variation to funded establishment of any department. |
| 20.3 | CHIEF EXECUTIVE | Staff, including agency staff, appointments and re-grading. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 20.4.1 and 20.4.2 | CHIEF FINANCE OFFICER | Payroll:<br>a) specifying timetables for submission of properly authorised time records and other notifications;<br>b) final determination of pay and allowances;<br>c) making payments on agreed dates;<br>d) agreeing method of payment;<br>e) issuing instructions (as listed in SFI 10.4.2). |
| 20.4.3 | NOMINATED MANAGERS* | Submit time records in line with timetable.<br>**Complete time records and other notifications in required form.**<br>Submitting termination forms in prescribed form and on time. |
| 20.4.4 | CHIEF FINANCE OFFICER | *Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.* |
| 20.5 | NOMINATED MANAGER* | Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and<br>Deal with variations to, or termination of, contracts of employment. |
| 21.1 | CHIEF EXECUTIVE | Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.<br>It is good practice to append such lists to the Scheme of Delegation document. |
| 21.1.3 | CHIEF EXECUTIVE | Set out procedures on the seeking of professional advice regarding the supply of goods and services. |
| 21.2.1 | REQUISITIONER* | In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. |
| 21.2.2 | CHIEF FINANCE OFFICER | Shall be responsible for the prompt payment of accounts and claims. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 21.2.3 | CHIEF FINANCE OFFICER | a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and regularly reviewed;<br>b) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;<br>c) Be responsible for the prompt payment of all properly authorised accounts and claims;<br>d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;<br>e) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;<br>f) Instructions to employees regarding the handling and payment of accounts within the Finance Department;<br>g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received |
| 21.2.4 | APPROPRIATE EXECUTIVE DIRECTOR | Make a written case to support the need for a prepayment. |
| 21.2.4 | CHIEF FINANCE OFFICER | Approve proposed prepayment arrangements. |
| 21.2.4 | BUDGET HOLDER | Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered). |
| 21.2.5 | CHIEF EXECUTIVE | Authorise who may use and be issued with official orders. |
| 21.2.6 | MANAGERS AND OFFICERS | Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer. |
| 21.2.7 | CHIEF EXECUTIVE CHIEF FINANCE OFFICER | Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director. |
| 21.3 | CHIEF FINANCE OFFICER | Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act. |
| 22.1.1 | CHIEF FINANCE OFFICER | The CFO will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 22.1.2 | BOARD | Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and CFO.) |
| 22.1.3 | CHIEF FINANCE OFFICER | Prepare detailed procedural instructions concerning applications for loans and overdrafts. |
| 22.1.4 | CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER | Be on an authorising panel comprising one other member for short term borrowing approval. |
| 22.2.2 | CHIEF FINANCE OFFICER | Will advise the Board on investments and report, periodically, on performance of same. |
| 22.2.3 | CHIEF FINANCE OFFICER | Prepare detailed procedural instructions on the operation of investments held. |
| 23 | CHIEF FINANCE OFFICER | Ensure that Board members are aware of the Financial Framework and ensure compliance |
| 24.1.1 & 2 | CHIEF EXECUTIVE | Capital investment programme:<br>a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans<br>b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost;<br>c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;<br>d) ensure that a business case is produced for each proposal. |
| 24.1.2 | CHIEF FINANCE OFFICER | Certify professionally the costs and revenue consequences detailed in the business case for capital investment. |
| 24.1.3 | CHIEF EXECUTIVE | Issue procedures for management of contracts involving stage payments. |
| 24.1.4 | CHIEF FINANCE OFFICER | Assess the requirement for the operation of the construction industry taxation deduction scheme. |
| 24.1.5 | CHIEF FINANCE OFFICER | Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure. |
| 24.1.6 | CHIEF EXECUTIVE | Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.<br>Issue a scheme of delegation for capital investment management. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 24.1.7 | CHIEF FINANCE OFFICER | Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes. |
| 24.2.1 | CHIEF FINANCE OFFICER | Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector. |
| 24.2.1 | BOARD | Proposal to use PFI must be specifically agreed by the Board. |
| 24.3.1 | CHIEF EXECUTIVE | Maintenance of asset registers (on advice from CFO). |
| 24.3.5 | CHIEF FINANCE OFFICER | Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers. |
| 24.3.8 | CHIEF FINANCE OFFICER | Calculate and pay capital charges in accordance with Department of Health & Social Care requirements. |
| 24.4.1 | CHIEF EXECUTIVE | Overall responsibility for fixed assets. |
| 24.4.2 | CHIEF FINANCE OFFICER | Approval of fixed asset control procedures. |
| 24.4.4 | BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF | Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure. |
| 25.2 | CHIEF EXECUTIVE | Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.) |
| 25.2 | CHIEF FINANCE OFFICER | Responsible for systems of control over stores and receipt of goods. |
| 25.2 | DESIGNATED PHARMACEUTICAL OFFICER | Responsible for controls of pharmaceutical stocks |
| 25.2 | DESIGNATED ESTATES OFFICER | Responsible for control of stocks of fuel oil and coal. |
| 25.2 | NOMINATED OFFICERS* | *Security arrangements and custody of keys* |
| 25.2 | CHIEF FINANCE | Set out procedures and systems to regulate the stores. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| | OFFICER | |
| 25.2 | CHIEF FINANCE OFFICER | Agree stocktaking arrangements. |
| 25.2 | CHIEF FINANCE OFFICER | Approve alternative arrangements where a complete system of stores control is not justified. |
| 25.2 | CHIEF FINANCE OFFICER | Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items. |
| 25.2 | NOMINATED OFFICERS* | Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking. |
| 25.3.1 | CHIEF EXECUTIVE | Identify persons authorised to requisition and accept goods from NHS Supplies stores. |
| 26.1.1 | CHIEF FINANCE OFFICER | Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers. |
| 26.2.1 | CHIEF FINANCE OFFICER | Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft. |
| 26.2.2 | ALL STAFF | Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and CFO. |
| 26.2.2 | CHIEF FINANCE OFFICER | Where a criminal offence is suspected, CFO must inform the police if theft or arson is involved. In cases of fraud and corruption CFO must inform the relevant LCFS and NHS CFA Regional Team in line with SoS directions. |
| 26.2.2 | CHIEF FINANCE OFFICER | Notify NHS CFA and External Audit of all frauds. |
| 26.2.3 | CHIEF FINANCE OFFICER | Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial). |
| 26.2.4 | AUDIT AND RISK COMMITTEE | Approve write off of losses (within limits delegated by DHSC). |
| 26.2.6 | CHIEF FINANCE OFFICER | Consider whether any insurance claim can be made. |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| 26.2.7 | CHIEF FINANCE OFFICER | Maintain losses and special payments register. |
| 27.1 | CHIEF FINANCE OFFICER | Responsible for accuracy and security of computerised financial data. |
| 27.1 | CHIEF FINANCE OFFICER | Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation. |
| 27.1.3 | CHIEF OPERATING OFFICER | Shall publish and maintain a Freedom of Information Scheme. |
| 27.2.1 | RELEVANT OFFICERS | Send proposals for general computer systems to CFO. |
| 27.3 | CHIEF FINANCE OFFICER | *Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.*<br><br>Seek periodic assurances from the provider that adequate controls are in operation. |
| 27.4 | CHIEF FINANCE OFFICER | *Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.* |
| 27.5 | CHIEF FINANCE OFFICER | Where computer systems have an impact on corporate financial systems satisfy himself that:<br>a) systems acquisition, development and maintenance are in line with corporate policies;<br>b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists;<br>c) CFO and staff have access to such data;<br>Such computer audit reviews are being carried out as are considered necessary. |
| 28.2 | CHIEF EXECUTIVE | Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission. |
| 28.3 | CHIEF FINANCE OFFICER | Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff |

| SFI REF | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
|---|---|---|
| | | whose duty is to administer, in any way, the property of. |
| 28.6 | DEPARTMENTAL MANAGERS | Inform staff of their responsibilities and duties for the administration of the property of patients. |
| 29.1 | CHIEF FINANCE OFFICER | Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately. |
| 30 | CHIEF FINANCE OFFICER | Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff |
| 32 | CHIEF EXECUTIVE | Retention of document procedures in accordance with HSC 1999/053. |
| 33.1 | CHIEF EXECUTIVE | Risk management programme. |
| 33.1 | BOARD | Approve and monitor risk management programme. |
| 33.2 | BOARD | Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually. |
| 33.4 | CHIEF FINANCE OFFICER | Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.<br><br>Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed. |
| 33.4 | CHIEF FINANCE OFFICER | Ensure documented procedures cover management of claims and payments below the deductible. |

Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

| DELEGATED MATTER | AUTHORITY RELATED TO |
|---|---|
| Requisitioning, Ordering and Paying for Revenue Goods and Services | |
| Non Pay Expenditure which has been budgeted | |
| All invoices /requisitions up to £5,000 | Service Manager/Budget Holder |
| All invoices /requisitions up to £10,000 | Head of Services |
| All invoices /requisitions up to £20,000 | Director of Operations |
| All invoices /requisitions up to£100,000 | Director |

Note that the Chief Executive and the Chief Finance Officer can sign off requisitions up to the value of £1.5m. Board is required by this Scheme of Delegation to approve all proposals for contracts with value in excess of £1.5m, so for that purpose the limits have been harmonised and documented here.

We also document in this scheme of delegation approval limits for contracts and responsibility for signing contracts between the Trust and other contracting bodies in different circumstances. In doing so, we have ensured consistency with the Healthcare Service Contracts Management Policy, which is in place across the NHS.

| CONTRACT TYPE AND VALUE | CONTRACT SIGNED BY |
|---|---|
| Annual contracting round (NHS CCGs / NHS England) | Chief Executive, or delegated to Chief Finance Officer (CFO) |
| New contracts and in year changes (NHS CCG/NHSE/Local Authority): | |
| Contracts up to £100,000 or where changes have no financial impact | Director of Contracts and Business Development |
| Contracts above £100,000 in value | Chief Finance Officer (CFO) |
| Ad hoc contracts | |
| Contracts up to £20,000 | ICSU Clinical Director / Director of Operations and Assistant Director of Financial Management |
| Contracts up to £100,000 | Director of Contracts and Business Development |
| Contracts over £100,000 | Chief Finance Officer (CFO) |

## SECTION D - STANDING FINANCIAL INSTRUCTIONS

## 10. INTRODUCTION

## 10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

### 10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) and defining and approving essential features in respect of important procedures financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust has established.

10.2.4 **The Chief Executive and Chief Finance Officer**

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.5 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.6 **The Chief Finance Officer**

The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.7 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.8 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

## 11. AUDIT

### 11.1 Audit and Risk Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the current NHS Audit and Risk Committee Handbook, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans;

(g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health & Social Care. (To the Chief Finance Officer in the first instance.)

11.1.3 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit and Risk Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

**11.2 Chief Finance Officer**

11.2.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee (and the Board). The report should cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health & Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

**11.3 Role of Internal Audit**

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health & Social Care.

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

11.3.3 The Chief Internal Auditor will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

11.3.4 The Chief Internal Auditor shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit and Risk Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

**11.4 External Audit**

11.4.1 From December 2016, the Trust Board, on recommendation of the Auditor Panel, will appoint the external auditor, external audit fees shall be paid for by the Trust. The Audit and Risk Committee must ensure a cost efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the National Audit Office if the issue cannot be resolved.

**11.5 Fraud and Corruption**

11.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health & Social Care Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Chief Finance Officer and shall work with staff in the NHS Counter Fraud Authority (CFA) in accordance with the Department of Health & Social Care Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

### 11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the CFO, the NHS CFA and local counter fraud specialist.

## 12. RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

## 13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

### 13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

13.1.2 As soon as possible at the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit a corporate budget for approval by the Board. As soon as practicable at the beginning of the financial year detailed budgets will be agreed with directors and submitted for to the Board for approval. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Local Delivery Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.1.3 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

13.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

13.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

13.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

**13.2 Budgetary Delegation**

13.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

13.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. In circumstances where revenue expenditure proposals cannot be contained within existing budgetary provision and insufficient virements are available, the investment template requires completion and submitted to the Executive Committee for scrutiny. Any decision to incur unfunded pressures may only be taken by the Chief Executive with reporting to the Trust Board for information, as part of the Finance Report.

13.2.3 Any budgeted funds not required for their designated purpose(s) may revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

13.2.4. Non-recurring budgets should not be used to finance recurring expenditure without the agreement of the agreement of the Chief Executive as advised by the Chief Finance Officer.

13.2.5 Investment/cost pressure requests, other than for replacement capital expenditure schemes e.g. backlog maintenance require completion of the investment template prior to submission to the Divisional Management Teams or Corporate Department and subsequently to the Operations Senior Management Team in the case of Operational Divisions Templates require validation by the relevant Finance Manager before submission. Schemes that are anticipated to be self-financing through either income or savings are still required to submit cases. The Divisional Team and Senior Management Team may support the submission and can agree self-financing proposals. Proposals which generate a cost pressure will require the additional approval of the Executive Committee and Chief Executive before there is authority to proceed.

13.2.6 Capital schemes which are developments will also require the approval of the Capital Monitoring group, prior to obtaining authorisation from the Executive Committee. The revenue consequences of these schemes must also follow the process outlined in 13.2.5.

**13.3 Budgetary Control and Reporting**

13.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of theChief Executive and that the template process for submission to Executive Committee is followed;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

13.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operating Framework and a balanced budget.

**13.4 Capital Expenditure**

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

### 13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

## 14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health & Social Care and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the Department of Health & Social Care certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health & Social Care for each financial year in accordance with the timetable prescribed by the Department of Health & Social Care.

14.2 The Trust's annual accounts must be audited by an auditor within the Public Sector Audit Appointments (PSAA) regime. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health & Social Care's Manual for Accounts.

## 15. COMMERCIAL AND GBS BANK ACCOUNTS

### 15.1 General

15.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Department of Health & Social Care. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

### 15.2 Commercial and GBS Accounts

15.2.1 The Chief Finance Officer is responsible for:

(a) Lloyds accounts and Government Banking Services (GBS) accounts, the latter comprising Citibank and NatWest/Royal Bank of Scotland (RBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring that payments made from Lloyds, Citibank or NatWest/RBS accounts do not exceed the amount credited to the accounts except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DHSC guidance on the level of cleared funds.

**15.3 Banking Procedures**

15.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of Lloyds and GBS accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

15.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

**15.4 Tendering and Review**

15.4.1 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

## 16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

**16.1 Income Systems**

16.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

16.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

**16.2 Fees and Charges**

16.2.1 The Trust shall follow the Department of Health & Social Care's advice in the "Costing" Manual in setting prices for NHS service level agreements.

16.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health & Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health & Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

16.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

### 16.3 Debt Recovery

16.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

16.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

### 16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

## 17. TENDERING AND CONTRACTING PROCEDURE

### 17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

### 17.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health & Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

### 17.3 Reverse eAuctions

Prior to running Reverse eAuctions the Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. A decision to run reverse eAuctions will lie with the procurement department and is covered within the trust Contracts and Purchasing Procedures Document.

### 17.4 Capital Investment Manual and other Department of Health & Social Care Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health & Social Care "Capital Investment Manual" in respect of capital investment and estate and property transactions.

### 17.5 Formal Competitive Tendering

#### 17.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms service contracts and management consultancy services temporary staffing whether through a temporary staff agency or directly contracted and management consultancy services (other than specialised services sought from or provided by the DHSC);
- For the design, construction and maintenance of building and engineering
- works (including construction and maintenance of grounds and gardens); for disposals.

| **THRESHOLDS** | |
|---|---|
| **Supplies & Services** | |
| 1 quote | 1 quote minimum up to £10,000 |
| 3 quotes | 3 quotes minimum £10,001 to £50,000 |
| **Tender process**<br>£ or More Written Tenders | From £50,001 to OJEU Limit |
| **Works** | |
| 1 quote | **1 quote minimum up to £10,000** |
| 3 quotes | **3 quotes minimum £10,001 to £50,000** |
| **Tender Process**<br>4 Tenders | **Minimum 4 tenders** received for works/estates £50,001 to £500,409 |
| **Tender Process**<br>5 Tenders | **Minimum 5 tenders** received for works/estates £500,410 to OJEU Limit |
| **Tender process**<br>>OJEU Limit | Tender Process<br>European procurement requirements adhered to. ie advert in OJEU and formal tender. |

17.5.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.5.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£50,000**;

(b) where the supply of goods and services/works is proposed under framework agreements to which the Trust has access, the requirement to tender is not applied provided that either a mini competition of prices is permissable or that a direct award would, following proof, deliver value for money. In the event that neither of these options is available then a framework agreement should not be used. The framework agreements include but not limited to, those negotiated by the Government Procurement Service, NHS Supply Chain, London Procurement Partnership (LPP), Health Trust Europe, Shared Business Services and Eastern Shires Purchasing Organisation.

These frameworks include the following options:

I. award direct;
II. undertake a mini competition.

The Trust policy is to maximise the use of framework agreements where they directly correspond with the Trust's requirements. It is also Trust policy to undertake a further mini competition, where this option is available from a framework agreement, to ensure that value for money is obtained. If however, there is compelling financial and technical evidence that awarding direct to a contractor chosen would provide value for money without undertaking further competition, then a direct award is permissible by Trust persons with the appropriate financial delegation covering the total value of the contract for the full contract term.

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

17.5.4 **Formal tendering procedures may be waived in the following circumstances:**

(a) where the Chief Executive or Chief Finance Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(b) where framework agreements are in place (see (b) above;

(c) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(d) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(e) where specialist expertise is required and is available from only one source;

(f) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(h) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee at each meeting.

. An Application to waive Standing Financial Instructions must be completed in all instances.

17.5.5 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

17.5.6 **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. The list of suppliers established on the Electronic Requisitioning and Ordering System (EROS) shall constitute the approved list. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

17.5.7 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Department of Health & Social Care approval.

17.5.8 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

**17.6 Contracting/Tendering Procedure**

17.6.1 **Invitation to tender**

(i) All tenders shall be run through the Trust's electronic tendering system operated by the Procurement Department in accordance with the guidance set out in section 2.9 and section 4 of the Trust Purchasing and Contracts Procedures. The Trust's system provides an electronic governance framework that ensures a record is kept of tender issue and return date, opening procedures and executives involved in opening, all documents, forms and terms and conditions used in the tender, a record of all written queries and trust responses, and notification to successful and unsuccessful tenderers.

(ii) Every tender for goods, materials, services, contracts or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works except those let under P21 or PFI governance shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health & Social Care guidance and, in minor respects, to cover special features of individual projects.

17.6.2 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two executive directors designated by the Chief Executive.

(ii) Two members of the trust executive committee will be required to open all tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(iii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

17.6.3 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.6.4 **Late tenders**

(i) The eTendering system prevents the submission of late tenders and there are no circumstances in which the controls can be over ridden.

(ii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.6.5 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

17.6.6 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

17.6.7 **List of approved firms (see SFI No. 17.5.5)**

(a) **Responsibility for maintaining list**

Only companies set up on eProcurement can be used by the trust. Companies not on eProc may be added after due diligence has established their technical and financial competence. Technical competence shall be assessed by the Procurement Department in association with nominated trust officers. A finance officer nominated by the Chief Finance Officer shall assess financial competence. The status of all suppliers will be reviewed regularly and those who fail the re-assessment or who have not been used in the relevant period for the type of procurement will be removed from the database.

All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers..

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.6.8 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist

services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

**17.7 Quotations: Competitive and non-competitive**

**17.7.1 General Position on quotations**

One quotation is required for the initial purchase of items expected to cost up to £10,000. Competitive quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £50,000.

17.7.2 **Competitive Quotations**

(i) Quotations shall be sought in accordance with the Request for Quotation Procedure set out in the Purchasing and Contracts Procedures and should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

v) In the event that the Trust introduces a formal quotation tool then this method will be the authorised channel for obtaining quotations.

17.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations. This assessment should be supported by an opinion obtained from the Procurement Department

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

(v) Business Planning Group to recommend to Chief Executive/Chief Finance Officer whether or not to accept a non-competitive quote.

17.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

**17.8 Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided according to the scheme of delegation which may be varied or changed by the Trust Board. Current levels of authorisation are set out in the Contracts and Purchasing Procedures document which is an appendix to this document.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in the minutes.

**17.9 Private Finance for capital procurement (see overlap with SFI No. 24)**

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health & Social Care for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

**17.10 Compliance requirements for all contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the capital investment guidelines

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

**17.11 Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

The Director of Human Resources is responsible for ensuring the trust has robust procedures covering engagement of agency staff and for entering into appropriate and robust agreements with agencies through national framework agreements or exception circumstances directly. In all cases the rules of competition as set out by this instruction (SFI 17) must be adhered to.

**17.12 Healthcare Services Agreements (see overlap with SFI No. 18)**

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

**17.13 Disposals (See overlap with SFI No. 26)**

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £30k, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

**17.14 In-house Services**

17.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative. For services having a likely annual expenditure exceeding a sum to be determined in each case, a non-officer member should be a member of the evaluation team.

17.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.14.4 The evaluation team shall make recommendations to the Board.

17.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

**17.15 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)**

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

## 18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

**18.1 Service Level Agreements (SLAs)**

1. The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Local Delivery Plan (LDP) and wherever possible, be based upon integrated care

pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected
- the relevant national service framework (if any)
- the provision of reliable information on cost and volume of services
- the NHS National Performance Assessment Framework
- that SLAs build where appropriate on existing Joint Investment Plans
- that SLAs are based on integrated care pathways
- Acceptable levels of risk and performance metrics/non-mandatory penalties
- The need to maintain adequate cash flow arrangements for the Trust
- that SLAs reflect the advent of the patient–led NHS and practice-based commissioning

**18.2 Reports to Board on SLAs**

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs. Any increase in the use of block or fixed SLAs should be risk assessed and reported to the Trust Board.

## 19. COMMISSIONING

In circumstances when the Trust may become involved in the commissioning of services, it will refer to the model SFIs on commissioning provided for CCGs and/or the relevant paragraph in the host commissioner's SFIs.

## 20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

### 20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 **Funded Establishment**

20.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

**20.3 Staff Appointments**

20.3.1 No executive or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

## 20.4 Processing Payroll

20.4.1 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) 79the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

**20.5 Contracts of Employment**

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

## 21. NON-PAY EXPENDITURE

**21.1 Delegation of Authority**

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

21.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

21.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

**21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)**

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought. Where this advice is not followed, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

**2.** 21.2.2**System of Payment and Payment Verification**

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

**5.** 21.2.5 **Requisitions and Official orders**

Official Orders must placed on EROS in the form of a requisition which, will remain as a requisition until properly authorised and released to the supplier in the form of an order. Orders will:

(a) be consecutively numbered;

(b) be issued in the standard EROS format;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance contained in the Purchasing and Contracts Procedures and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health & Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

**(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff");**

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered through EROS including works and services executed in accordance with a contract or tender but excluding purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". Staff who request goods or services verbally without appropriate authority will be held personally responsible for any expenditure incurred.

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

21.2.7 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and the Capital Investment Manual . The technical audit of these contracts shall be the responsibility of the relevant Director.

**21.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with SO 9.1)**

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts. (See overlap with SO 9.1)

## 22. EXTERNAL BORROWING

22.1.1 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health & Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short-term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

22.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health & Social Care.

22.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Finance Officer. The Board must be made aware of all short-term borrowings at the next Board meeting.

22.1.6 All long-term borrowing must be consistent with the plans outlined in the current LDP and be approved by the Trust Board.

### 22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

22.2.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

22.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

## 23. FINANCIAL FRAMEWORK

23.3.1 The Chief Finance Officer should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to NHSI regarding resource and capital allocation and funding to Trusts. The Chief Finance Officer should also ensure that the direction and guidance in the framework is followed by the Trust.

## 24. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

### 24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

24.1.2 For every capital expenditure that is an investment proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

24.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management.

24.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

24.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

24.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall delegate to the director responsible for the overall programme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender ( see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

24.1.7 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

**24.2 Private Finance (see overlap with SFI No. 17.10)**

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health & Social Care or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

**24.3 Asset Registers**

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 Each Trust shall maintain an asset register recording fixed assets

24.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

24.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

24.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health & Social Care, or an alternative approach that has been approved by the Audit and Risk Committee in accordance with the latest valuation policies that can be followed

24.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health & Social Care, or in accordance with the latest policies specifed by the Department of Health & Social Care.

24.3.8 The Chief Finance Officer of the Trust shall calculate and pay capital charges as specified in the *Capital Accounting Manual* issued by the Department of Health & Social Care.

**24.4 Security of Assets**

24.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

24.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

24.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

24.4.6 Where practical, assets should be marked as Trust property.

## 25. STORES AND RECEIPT OF GOODS

### 25.1 General position

25.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

### 25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation

being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

25.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

### 25.3 Goods supplied by NHS Supply Chain

25.3.1 For goods supplied via the NHS Supply Chain , the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

## 26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

### 26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Procurement Department working in collaboration with the relevant Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

**26.2 Losses and Special Payments**

26.2.1 **Procedures**

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the Local Security Management Specialist (LSMS) if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant LCFS and NHS Counter Fraud Authority (CFA) regional team in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer must notify the CFA and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

26.2.4 Within limits delegated to it by the Department of Health & Social Care, the Board shall approve the writing-off of losses.

26.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

26.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

25.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health & Social Care.

26.2.9 All losses and special payments must be reported to the Audit and Risk Committee at every meeting.

## 27. INFORMATION TECHNOLOGY

**27.1 Responsibilities and duties of the Chief Finance Officer**

27.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

**27.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application**

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in a particular locality wish to sponsor jointly) all responsible directors and employees will send to the Head of Information Technology

(a) details of the outline design of the system;

(c) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.2.2 The officer within the Corporate Secretariat responsible for implementing the requirements of the Freedom of Information Act (FOI) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority.

**27.3 Contracts for Computer Services with other health bodies or outside agencies**

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

**27.4 Risk Assessment**

The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

**27.5 Requirements for Computer Systems which have an impact on corporate financial systems**

Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

## 28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

28.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

28.4 Where Department of Health & Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

## 29. FUNDS HELD ON TRUST

### 29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

### 29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for any other funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

### 29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

## 30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health & Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

## 31. AUTHORISATION AND CONTRACTING FOR MANAGEMENT CONSULTANTS AND INTERIM MANAGERS

31.1 The Trust on occasions may require to contract for the services of management consultants and interim management to fulfil specific project work; that is a piece of work that has a defined timescale and deliverables in return for payment.

31.2 Prior to considering the contracting of management consultants and/or interim managers, financial authorisation to proceed should be sought from Chief Finance Officer with an indication from the Trust sponsor of purpose, term and cost. The Trust sponsor is required to be at executive director level. Once authorisation is secured to proceed, then the Trust sponsor is authorised to source the requirement via tendering or single-sourcing routes in accordance with current procurement procedures. Once the sourcing of managing consultants or interim managers has been completed the sign-off of contract for such services rests solely with either CEO or Chief Finance Officer. Under no circumstances should verbal contracts be established.

31.3 The engagement of all management consultants and interim staff is required to be covered by a formal contract of services. In the majority of cases, NHS Terms and Conditions for management consultancy services should be applied and form part of any contract. In all cases, a schedule of project work should be drawn-up, that includes the project deliverables, the term, payment, performance management and review and termination clauses. The contract should also make clear that the person and or persons do not constitute a contract of employment. The formal contract reference is required to be quoted on all invoices, and if absent, then payment should be withheld. In the event that consultants and interim staff are already employed by the Trust then retrospective contracts need to be established by the lead directorate executive director at the earliest opportunity.

31.4 Any contract term extension is required to be authorised by the CE or Chief Finance Officer. Changes to the contract schedule may be amended by an executive director provided the financial liability to the Trust is not increased over and above the original contract value. Any changes to the value of the contract, incurring additional financial liability within the term of contract is required to be authorised by the Chief Finance Officer.

31.5 As part of the decision to employ management consultants and interim managers through a limited company or partnership, Trust sponsors are to check to establish

whether IR35 rules will apply to the contract as this will change the tax and NI that the contractor will have to pay as part of the contract. If the consultant and/or interim can answer 'yes' to the following questions, then this individual would probably be classed as an employee of the Trust and IR35 rules apply:

- Do you work set hours, or a given number of hours a week or a month?
- Do you have to do the work yourself rather than hire someone else to do the work?
- Can someone tell you at any time what to do, when to do it and how to do it?
- Are you paid by the hour, week or month?
- Do you work at the premises of the person you work for, or at a place or places that they decide?
- Do you generally work for one client at a time, rather than having a number of contracts?

31.6 If the management consultant or interim manager can answer 'yes' to many of the following questions, they would probably **not** be classified as an employee of the Trust and are therefore outside of the IR 35 rules.

- Are they hired to undertake a specific project for a finite duration?
- Do they decide how, when and where to carry out your services?
- Can they make a loss on the contract?
- Do they provide the main items of equipment they need to do the job for the Trust?
- Are they free to hire other people on there own terms to do the project work that they have taken on? Do they pay them out of their own pocket?
- Do they have to correct unsatisfactory work in their own time and their own expense?
- Do you have a number of customers at the same time?

31.7 As part of the formal sign-off by the CE and or Chief Finance Officer, the Trust sponsor is required to declare the IR 35 status of the management consultant and/or interim manager to be contracted for based on the above tests.

## 32. RETENTION OF RECORDS

32.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health & Social Care guidelines.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with latest Department of Health & Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

## 33. RISK MANAGEMENT AND INSURANCE

### 33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health & Social Care

assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health & Social Care guidance.

**33.2 Insurance: Risk Pooling Schemes administered by NHSLA**

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

**33.3 Insurance arrangements with commercial insurers**

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health & Social Care.

**33.4 Arrangements to be followed by the Board in agreeing Insurance cover**

(1) Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Draft Estate Strategy** | **Agenda item: 14** |
| **Executive director lead** | Jonathan Gardner, Director of Strategy | |
| **Report authors** | Sophie Harrison, Adrien Cooper, Jonathan Gardner | |
| **Executive summary** | The attached paper is the draft estate strategy. This is the culmination of all the extensive work with Integrated Clinical Service Units (ICSUs) and planners throughout 2019 which had been put on hold due to other pressures.<br><br>The strategy forms the basis, and the first few chapters, of any future Strategic Outline Cases that Whittington Health will develop take to progress individual pieces of work.<br><br>The aim is "To provide high quality, patient and staff focussed environments that support our vision to help local people live longer healthier lives". The strategy outlines principles, and transformation opportunities and sets out three phases of work.<br><br>**Phase one:**<br>○ New Maternity & neonatal unit and infrastructure<br>○ Locality based integrated community hubs<br>○ Office and Education facilities<br><br>**Phase two:**<br>○ Children's services delivered from 'fit for purpose' accommodation<br>○ Primary and urgent care on the Archway campus<br>○ Make the most of the value of our estate through working with the Greater London Authority and councils to support wider public sector requirements such as housing, and/or care home beds, and generate needed investment capital<br>○ Improved access to low cost, high quality staff accommodation<br><br>**Phase three:**<br>○ Phase three could include work to improve the theatre complex and the ward configuration<br><br>It should be noted that:<br>• engagement with staff and stakeholders in the creation of this has been extensive. In addition, the public has been involved through Bridge Renewal Trust and Healthwatch commissioned | |

| | |
|---|---|
| | work last year. In February 2020, there are further engagement events planned to take the public through more of the details and to receive their feedback; and<br>• to be a full and compliant NHS Improvement Estate strategy the paper needs more details on the 6 facet survey and a detailed update on the impact and therefore real costs of backlog maintenance. These things will be completed over the next months but should not delay or change the key messages outlined in the strategy. |
| **Purpose:** | To ask the Board for approval of the estate strategy to enable it to be taken to external public engagement in February. |
| **Recommendation(s)** | That the Board approve this document |
| **Risk Register or Board Assurance Framework (BAF)** | BAF sustainability and estate risks |
| **Report history** | Executive Team, Transformation Programme Board, Trust Management Group |
| **Appendices** | Draft Estate Strategy |

NHS
Whittington Health
NHS Trust

# WHITTINGTON HEALTH

# DRAFT Estate Strategy

# 2020

(A refresh of the 2016 Estate Strategy)


| Version | Date |
|---|---|
| Draft v6 | 6.1.20 |
| AC comments | 7.1.20 |
| SH Comments | 8.1.20 |
| Exec comments | 10.1.20 |

# Contents

# 1. Trust profile

Whittington Health NHS Trust is an integrated care organisation providing hospital and community care services to a population of approximately 500,000 people living in the London Boroughs of Islington, and Haringey, as well as other London Boroughs including Barnet, Enfield, Hillingdon, Camden and Hackney. We have an annual income of c. £320 million and employ over 4,400 staff. Hospital services are provided mainly from our Whittington hospital site (Fig 2.1), and from over 40 locations across the community (Fig 2.2).

The most recent CQC report for the Trust was published on 28 February 2018. The Trust retained its overall rating of 'Good' from its previous inspection and the hospital site improved from 'Requires Improvement' to 'Good'.

The Trust was rated 'Outstanding' in the Caring domain and 'Good' in the Well Led domain. A number of areas in the hospital outpatient department improved from 'Requires Improvement to 'Good', and improvements in the hospital's Critical Care unit resulted in the Safe domain rating being raised to 'Good'.

# 2. Islington and Haringey strategic drivers

**Population** is projected to increase particularly those over 65 across both boroughs.

**Age profiles** in Islington and Haringey show similarities and have higher proportions of younger people than other London boroughs. There are strong parallels in terms of age demographic. This has implications on the type and volume of services we provide and those provided by other health and social care partners.

**Life expectancy** has marked inequalities: the poorest in Islington will live for 6.3 (men) and 8.3 (women) fewer years than the richest.

**Ethnicity** is diverse across both boroughs, with more than 100 languages spoken in Haringey.

**Health and wellbeing issues** show poor performance in areas relating to smoking-related conditions and deaths, substance misuse and mental health issues in young people.

**North Central London Integrated Care System and Clinical Commissioning Groups:** The priorities for the system include increasing prevention programmes; providing care closer to home so people only go to hospital when it is clinically necessary and to attract people to live and to work in North London (Appendix 1)

# 3. Our estate strategy

We have a clear strategy for our estate

"To provide high quality, patient and staff focussed environments that support our vision to help local people live longer healthier lives"

Our estate will help us deliver our four strategic objectives:

- Deliver outstanding safe compassionate care
- Empower, support and develop engaged staff
- Integrate care with partners and promote health and well-being
- Transform and deliver innovative, financially sustainable services

Our estate strategy sets out our plan to make sure we have the right facilities to deliver our services, both now, and in the future, and provides a framework, for future investment and decision making on the development and management of the Trust's estate for the period 2020 to 2030.

The strategy provides a review of the Trust's current estate, analysis of how our estate needs to develop to support the delivery of our Trust strategy, and sets out what is required and how this could be delivered.

This document refreshes our previous estate strategy, approved by the Trust Board in 2016.

# 4. Where are we now – the challenge?

We need a modern estate that is designed to deliver our clinical services and enables us to provide care, where and when people need it. We are committed to providing our patients, staff and communities, with care in buildings that are fit for the provision of modern healthcare services.

Our analysis shows that our estate provides a good foundation for meeting our patient's future needs and provides a number of opportunities to further transform the way in which our facilities can support excellent patient care.

## 4.1 Archway hospital site

Our hospital site, located in Archway, is the currently the main site for delivery of our acute clinical services. The site is bisected by an access road. It has good transport links with a number of buses and an underground station nearby.

The hospital site has a number of clear investment needs, including backlog costs to bring the estate up to national condition B standard of c. £15m. However, the hospital estate has significant functional layout deficiencies and constraints which do not allow for reconfiguration to meet 21st century standards and expectations.

These backlog and functional layout deficiencies constraints are clearly evident in the facilities within which we deliver our maternity and neonatal services. These services are located within the third of the hospital building which was built in the late 19th century.

These Victorian era buildings with long and narrow Nightingale ward layouts are configured over four levels; the departments as a whole are disjointed resulting in inefficient staffing as well as being confusing in terms of wayfinding. The maternity labour ward provides poor accommodation for women and families, with no en-suite facilities to the delivery rooms and poor provision for storage both within the rooms and for equipment not in immediate use. Staff facilities are limited, with poor changing facilities, rest facilities and office accommodation. The facilities are not compliant with Health Building Note (HBN) space standards.

Neonatal services are also delivered within the same buildings, hence constrained by the same challenges as the maternity functions. This creates an increased pressure on the management of infection control and does not provided a parent friendly environment.

These concerns are currently being mitigated by excellent staff and processes.

Our emergency department service is delivered from facilities built in 1977 in space designed for 50,000 attendances, but which currently manages 108,000 attendances each year, with predictions of growth year on year. The building which houses these facilities also carries significant backlog.

**Office and staff accommodation**

A considerable portion of our office accommodation is in the 1848 Grade II listed Jenner building which has many small rooms or offices which are not conducive for the delivery of effective modern agile working.

During 2020 our core education and training facilities will be re-located to a temporary building in the NE area of the hospital site to facilitate the re-location of the Camden and Islington Foundation Trust mental health in-patient beds. A permanent long-term solution for the training and education facilities will be required.

**Site Infrastructure**

The current electrical power infrastructure supplying the existing buildings does not have the capacity to support the re-development of the acute site and also carries significant backlog risk. The provision of thermal energy for heating and hot water serving the existing Victorian estate including the Jenner Building will need to be moved as part of the re-development of the site.

Both these major infrastructure constraints provide a positive opportunity to determine a low carbon and cost efficient solution that will demonstrate Whittington Health's long term commitment to a sustainable and environmentally credible future.

Therefore as part of the vision set out in this document, significant investment in infrastructure will be required to support the creation of new buildings.

**PFI (Private Finance Initiative) Buildings (A & L Block)**

The large proportion of Whittington Health's core beds are exclusively located within the PFI buildings. The buildings are maintained in condition B for the duration of the PFI. However, there is no inclusive provision or liability to alter the current configurations without an 'instruction to alter' which carries relevant financial liabilities.

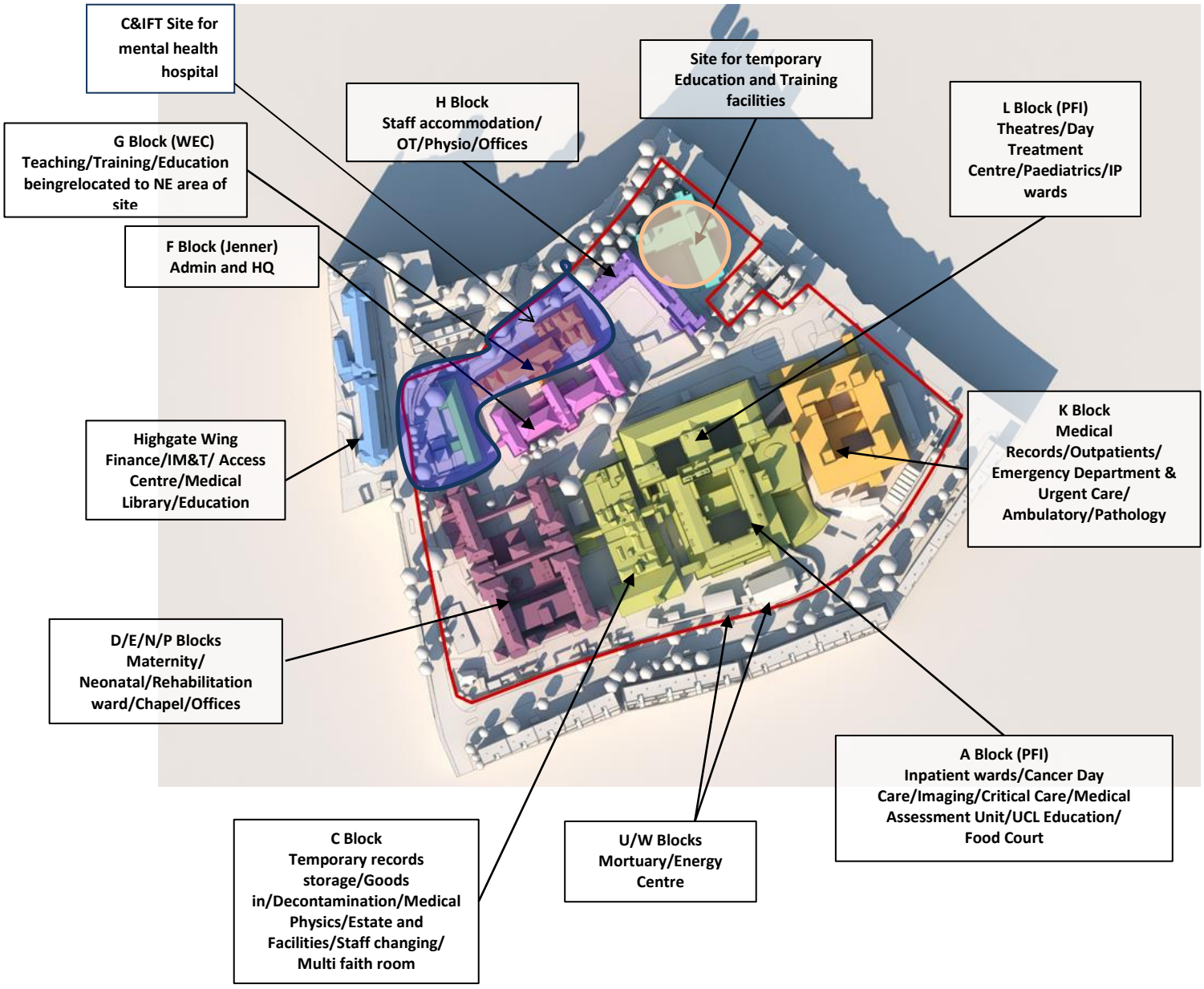
Block A and L also require improvements which have been identified following a fire in January 2018. A full remediation plan is currently in planning. This project is likely to take in excess of five years, and is reliant on a decant strategy that will involve additional bed capacity being created either on or off site. The risks are currently being mitigated through staffing and management solutions.

Within the PFI building is our theatre complex which is situated over two floors. Ideally, with appropriate adjacencies we co-locate theatres on one floor to enable the most efficient use of space and effective flow of patients. In doing this we would also solve the issues around capacity of endoscopy and the need for more flexibly designed treatment rooms. In addition the layout and size of the wards is not ideal for efficient staffing models.

**Staff accommodation**

We currently provide around 80 units of staff accommodation housed within an 1890Victorian building. These facilities do not have en-suite bathroom facilities or common rooms and the self-catering food preparation areas facilities are cramped. We would like to be able to provide modern and welcoming accommodation for our staff. We would also like to provide access to significantly more accommodation units.

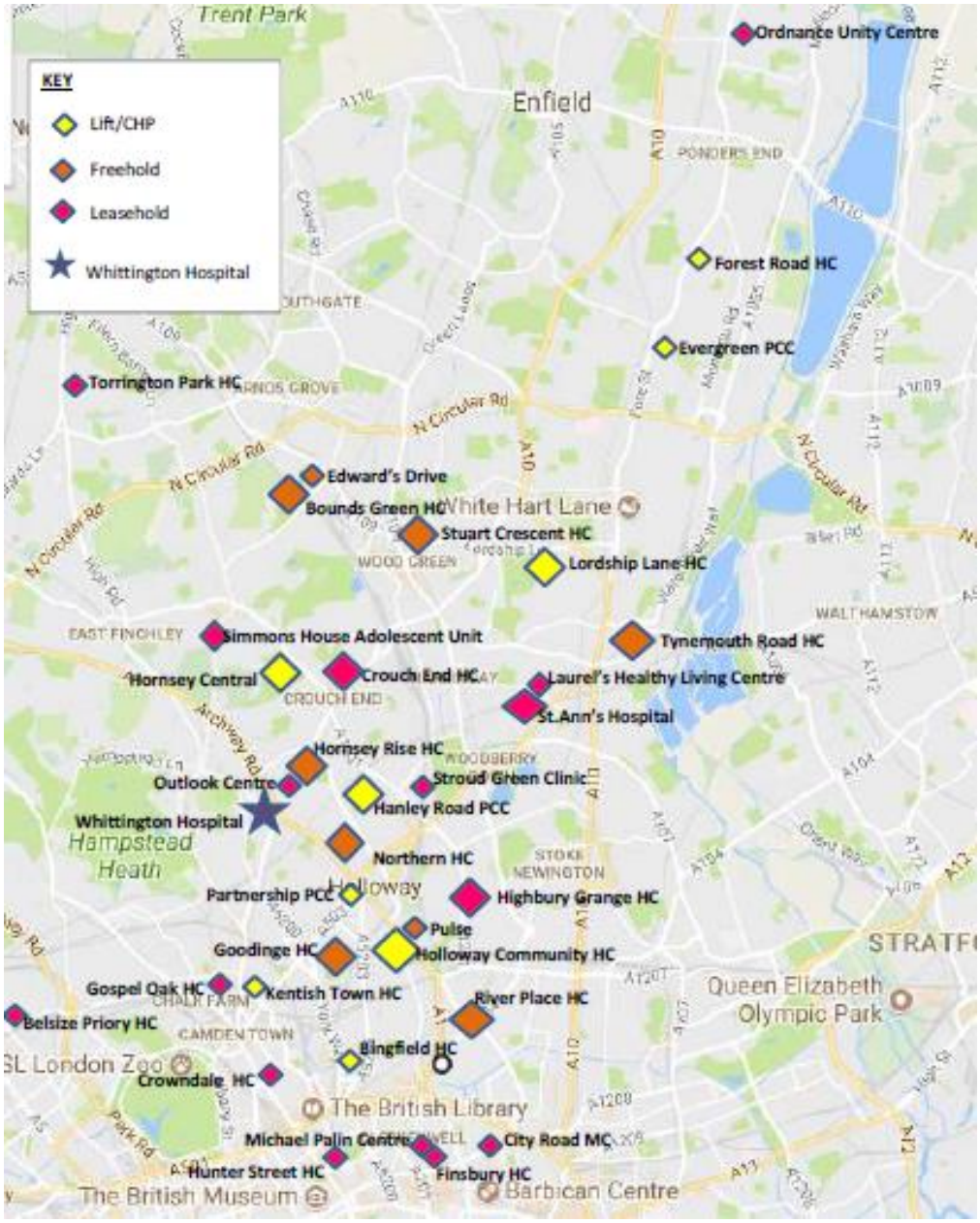
Figure 1.1: Whittington hospital site – key buildings



## 4.2 Community estate

The Trust is occupying space, in addition to the Archway hospital site, in more than 39 community premises, 9 of which are freehold and 8 are Local Improvement Finance Trust (LIFT) premises. Our community estate is mainly spread throughout Haringey and Islington and requires an investment of c.£5m to bring it up to national condition B standard. The locations of our sites are not always optimal for travel, nor are the buildings large enough or purpose built to allow effective use of space; or integrated working with other service providers; or expected growth as a result of 'care closer to home'. This issue is particularly acute for our community children's services in the Northern Health Centre, where the building is not optimal for these services.

Figure 1.2: The community estate in local boroughs



# 5. Our clinical vision for our services in the future

Our vision for services in the future in relation to estate can be summarised as follows:

Specifically we will transform our services so that:

- Everything residents need for general care is provided by us in a seamless way with partners in the community
- More care is provided in the community
- More treatment is ambulatory care and day case work
- More outpatients are delivered virtually and through greater use of technology

This will be enabled by

- Digitally enabled staff that can work flexibly from any site
- Roles that are constantly evolving to provide development and the right skills
- An estate that is up-to-date and situated in the right place, accessibly by public transport, to allow co-location of community services where that makes sense
- IT capabilities that join up services and patients seamlessly and enable staff to work differently

Our estate strategy will ensure that the development of our estate is patient centred and builds on digital innovation; enables services to be delivered in the right location; is guided by a set of agreed principles; and supports the Trust in delivering its vision and strategic directives.

## ▪ Principles to guide the development of the estate

Fig. 1.3: Estate Strategy Principles

| Estate Strategy Principles |
|---|
| **Patient centred**<br>Improve the estate to be patient/client centred with ease of access to care both physical access and transportation access; supporting the co-location of services to enable integrated care through the development of networks/hubs. |
| **Quality**<br>Improve the quality of the estate to meet patient and staff expectations |
| **Effective use of assets**<br>Maximise the effective use of the estate to support clinical service delivery. |
| **Design and IT**<br>Ensure that our estate has flexible and modern space in all our buildings that is digitally enabled and future proof for new innovation and technologies in care provision |
| **Capacity**<br>Ensure that the Trust's estate has the capacity to meet demand for healthcare in the right places |
| **Statutory and non-statutory compliance**<br>Continue to manages estate risks and meet all necessary standards |
| **Environmental and financial sustainability**<br>Ensure that the delivery of the Estate strategy supports the future sustainability of the organisation in terms of quality, financially (reduced expenditure and contributing to a |

| |
|---|
| reduction in debt), effective working and environmental sustainability. We want to create a low carbon campus. |
| **Partnerships and engagement**<br>Maximise the opportunity of partnerships and engagement with our local community and ensure Trust plans align with wider health economy plans. Also to work with the GLA and local authorities to get the best value from our estate for the wider public sector priorities such as housing. |

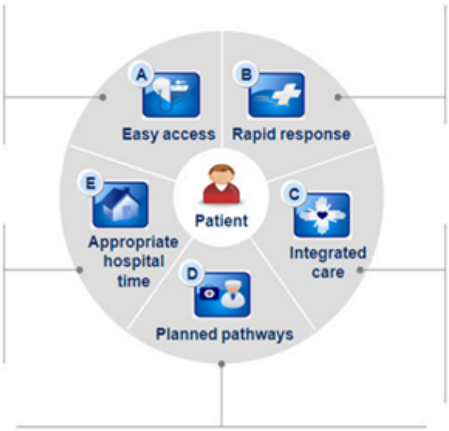
# 6. Transformation opportunities

## ▪ Patient centred

Fig. 1.1: Patient-centred development

The estate will be in areas of health need serviced well by public transport. It will support mobile working, e-conferencing and initial access will be through patient portals and on-line communities

The estate and technology will support prevention and early discharge to the community where wearable technology will help monitor patient progress mobile working will increase the ability for healthcare close to home and virtual consultation will reduce travel



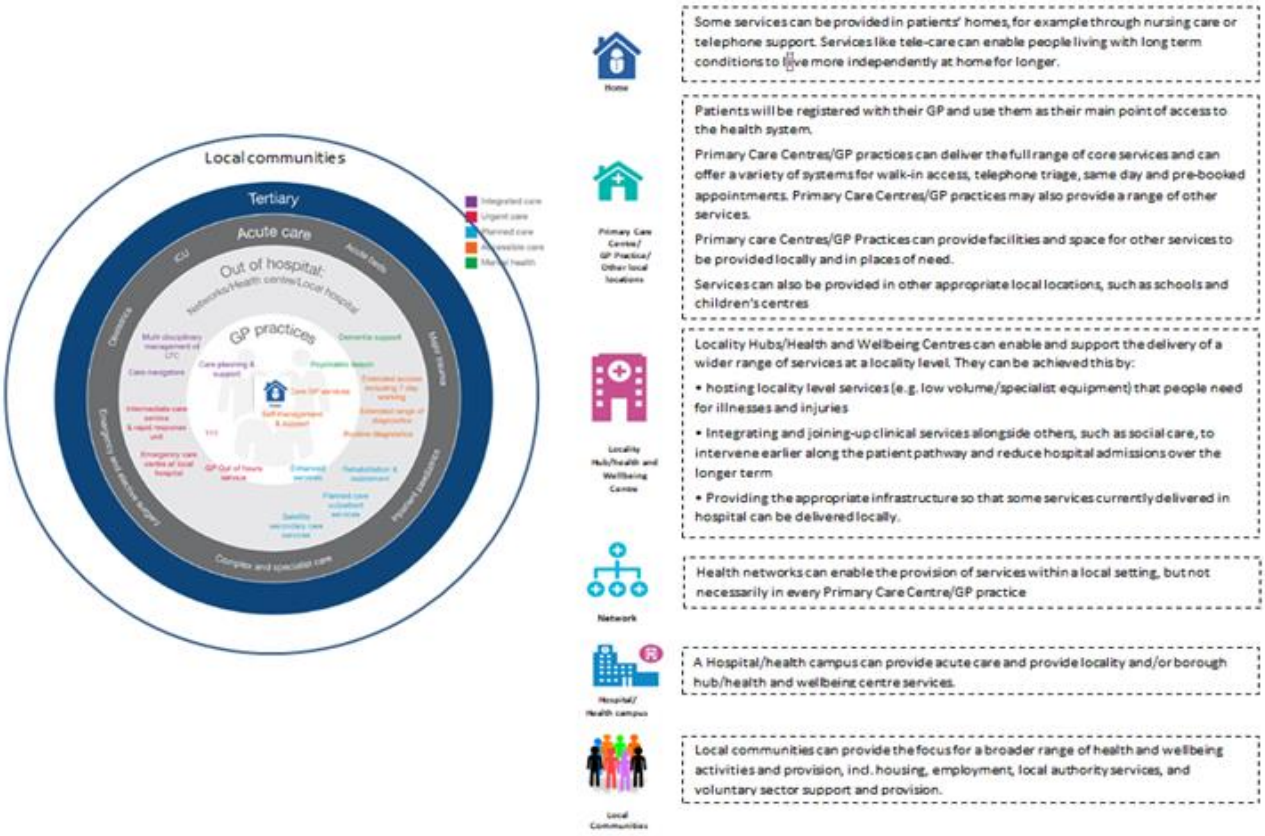

Whole system working on the health campus and community hubs including mental health, primary care and social care services will increase multi-disciplinary team working and faster response supported by shared patient records and remote monitoring

The estate will bring services together which will make the service user and patient journey easier to navigate and enhance the ability for staff and teams to work together

Integrated Care through the health campus and community hub approach will enable the development of simplified planned care pathways

- **Care delivered in the most appropriate location**

Fig. 1.2: Service delivery locations




- **Reducing acute burden through early diagnosis treatment, and preventative locality working**

We want to create a step forward in how well we prevent health issues arising and treat them early, through more integrated public services and more resilient local communities.

This means:

- A simpler, more joined up local system that offers the right support at the right time, that manages the growth in demand and reduces duplication in the system
- Integrated, multi-disciplinary teams from across the public sector, working together on the same geography and tackling issues holistically, focused on relationship-building and addressing the root causes
- A workforce who feel connected to each other and able to work flexibly, better able to meet people's needs
- A new system partnership with the voluntary sector to co-ordinate local activity, networks and opportunities – so that we make the best use of the strengths and assets of our communities

This will mean fewer GP attendances and fewer ED attendances, and shorter lengths of stay and our vision for community hubs set out below will deliver the spaces for these things to happen.

We have started doing this in the Lordship Lane health centre as the council run "connected communities" service which includes housing, debt advice, voluntary sector, etc. from this building, but this is just the start.

- **Improving utilisation and realising value from the estate to reduce cost**

We are working closely with commissioners and partner organisations in the development of our community estate to ensure the estate is used effectively for the delivery of health and care services and promotes the health and wellbeing of our communities.

We want to work collaboratively to achieve:

- More effective use of our existing estate to meet health and social care needs, including primary and community based care improvements
- Reduced running costs
- A reconfigured estate to better meet service delivery needs
- Agreements to share property (particularly between health and social care and wider public sector)
- Realise value from the estate to generate capital for reinvestment or a revenue stream
- Effective future investment

- **Optimising outpatient space and time requirements through digital transformation**

We will progress virtual outpatient models including:

- Video conference calls where appropriate
- Video advice and guidance to patients and staff within community hubs
- Telephone appointments
- Patient portals to allow access to results before appointments
- Diagnostics completed before appointments reducing wasted time

This will mean that we free up space in the acute hospital site for other needs such as reconfiguration of the Emergency Department and same day emergency care space.

- **Reducing office requirements through flexible mobile working enabling improved education space**

We will progress our plans for staff to be able to work remotely and from any setting through mobile devices and hot-desking docking stations. We will also look to use council and other sites for offices including expanding programmes such as the colocation of District Nursing office space with the Social Workers' office space in Newington Barrow Way. Some of our non-clinical support staff will also be able to be based in buildings away from the Archway site. All this will mean that we can free up critical space in the hospital and community for clinical space and/or education space. For example we plan to free up space within the Jenner Building (currently an office building) to house the new education centre.

- **Integrating emergency and primary care with acute services through co-located primary care**

  Our transformation vision for emergency demand is to bring primary care onto the Archway site. The reconfiguration plans for the site will create opportunities to locate a community and primary care centre on the Archway site. This will be close to, but not in the same building as, the Emergency Department, allowing us to create three distinct streams a) an urgent care and redirecting service run by primary care b) a normal emergency department c) an ambulatory care unit. This means we will be able to manage the ever increasing demand on ED without having to continually increase the size of the department

- **Enabling wider system transformation through expansion of step down beds/care home beds**

  As an integrated care organisation we are uniquely placed to support the wider North Central London system to solve the problem of insufficient care home, or step down capacity in the system. The reconfigured estate will generate opportunities for other uses, including step down beds, nursing homes, or care homes. Depending on future business cases these may or may not be run by ourselves.

- **Enabling delivery of wider system priorities such as staff accommodation and housing needs**

  The reconfigured hospital and community estate will also generate opportunities for more innovative future use such as health services and community hubs on the ground floors and key-worker, social and private housing on other floors. Our close working with the councils and our memorandum of understanding with the Greater London Authority will hopefully make this an exciting opportunity for all parties and enable us through partnerships to deliver greater access to affordable staff accommodation.

# 7. Priorities and proposals for change

Our analyses of the condition of the estate and appropriateness of that estate for modern health care, in line with the principles above, lead us to the following priorities. The phases are indicative only:

**PHASE ONE**

- **New Maternity & neonatal unit**: we will build a new maternity, and neonatal unit and supporting site wide infrastructure that will be large enough for any demand and state of the art to be more efficient. Using the height of the site, we will be able to put more space on a smaller footprint. This frees up space of the current maternity unit for the purposes in phase two.
- **Locality based integrated community hubs**: we plan to reduce the number of our sites, whilst investing in better located buildings to enable the clinical vision of integrated,

efficient community services as above. This may also release some value or different use of existing land as per phase two.

- **Office and Education facilities**: we will work to provide innovative, agile and fit for purpose office and education facilities that empower our staff to deliver exemplary **healthcare services**

**PHASE TWO**

- **Children's services delivered from 'fit for purpose' accommodation:** we will explore options to rehouse community children's services in single borough locations, one of which may be on the Archway site and the other potentially a refurbishment of Tynemouth road.
- **Primary and urgent care on the Archway campus:** as above and with outpatient transformation this will enable fit for purpose environments for outpatients and ED
- **Make the most of the value of our estate through working with the GLA and councils to support wider public sector requirements such as housing, and/or care home beds, and generate needed investment capital**
- **Improved access to low cost, high quality staff accommodation**: we will work with partners to improve the numbers and quality of our staff accommodation either on site or elsewhere

**PHASE THREE**

- Phase three could include work to improve the theatre complex including the endoscopy unit and the ward configuration to improve flexibility, enable efficient staffing models, improve use of space depending on further work regarding the requirements in the local health system.

However, it is important to note how all the transformation plans above come together to create a coherent whole, where they all fit together, and it would be hard to deliver one without the other.

# 8. What will this look like?

- **The Archway campus**


A number of fixed points on the site have been identified:

- Block A is a fixed point to remain, ideally with minimal intervention due to PFI contract term remaining.
- Block L, originally built in 1992, since being refurbished under phase two of the PFI contract in the last 10 years, is intrinsically linked to the main clinical core of Block A and hosts a significant area of clinical activity.
- Block F, Jenner building to remain due to Grade II listing – future function to be explored
- The disposal of site occupied by Blocks G and S to Camden & Islington FT requires a vehicle access route from Highgate Hill through the site needs to be retained.

The principal options explored, revolved around the potential enhancement and rationalisation of the remaining estate, including physical functions and built forms, that should be considered for Blocks C, D & E, H, J and K. All potential areas for refurbishment, relocation of displaced services and/or disposal in varying degrees formed part of the options for the site.

Testing of the options against Critical Success factors identified a preferred way forward for the future development of the Archway Campus.

Fig 4.2: Preferred way forward for the Archway Campus (hospital site)


- **Community sites**

Our development control plan (DCP) sought to investigate the opportunities within the physical estate which would bring forward options to ultimately deliver the community services from fewer sites, whilst retaining a presence at a very local, locality hub, and borough hub levels.

The DCP work concentrated on providing viable options for the hub locations, based on a cohort of three adult hubs per borough across Islington and Haringey and a children's hub in each. Whilst very local and locality services can still be provided with services delivered from rooms in other local health provider accommodation. Focusing on six potential adult hub, and two children's hub, locations for the Trust offers the opportunity to:

- Enable modern fit for purpose hubs which can support integrated working
- Develop clinical treatment spaces as identical pods with standard consult/exam rooms, treatment and interview rooms.
- Operate from fewer sites which would reduce revenue expenditure. The current leased community estate has a lease burden of circa £8m per annum. The current freehold estate carries £5m of backlog, is energy inefficient and generally does meet the functional suitability criteria.
- Ensure that the facilities can be used in an adaptable and flexible manner.

Fig 4.3: London Borough of Islington

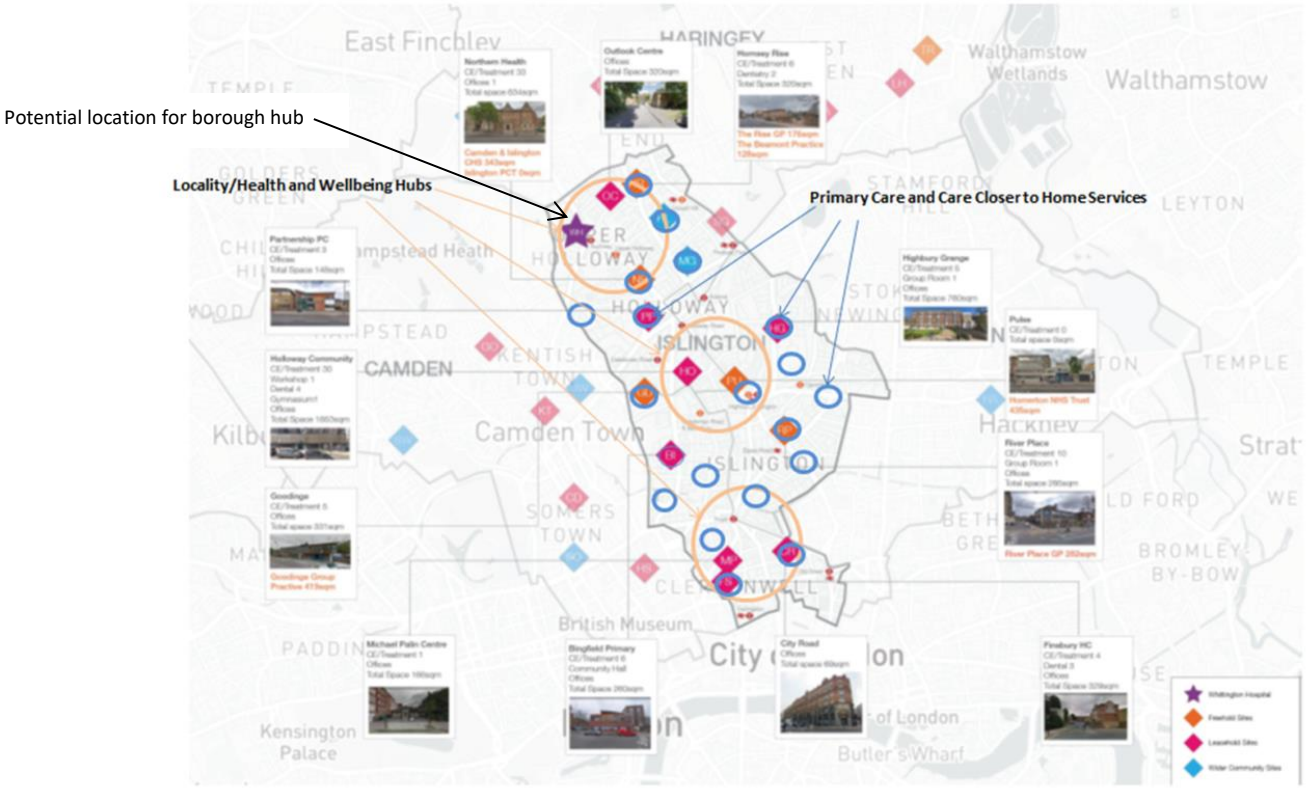
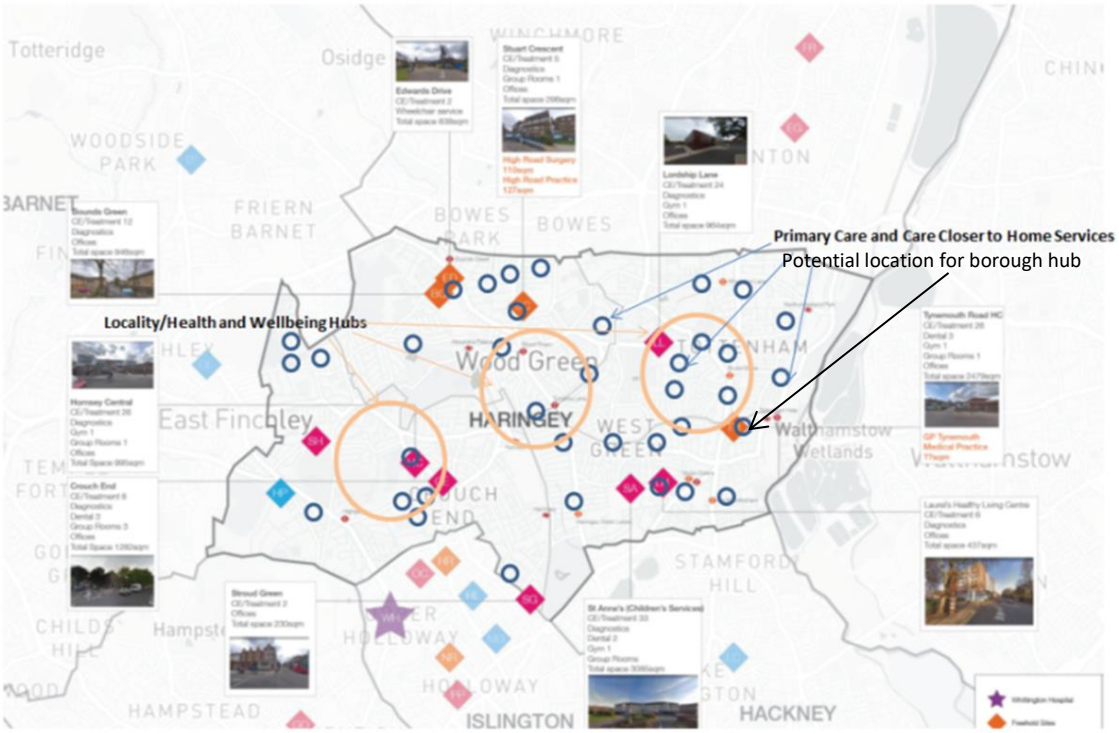



Fig 4.4: London Borough of Haringey



# 9. Opportunities to realise value and create recurrent savings or revenue opportunities

The Trust believes there are significant opportunities for delivering value from the hospital and freehold community sites, to support the required investment.

The Trust's is working with the GLA and councils to consider the options to realise the land value of some of our sites through a mixture of affordable/private housing. In addition, opportunities may arise for step down / care home beds and alternative models to address the demand for emergency care services through investment in primary and urgent care.

The GLA has been involved in the preparation of the Trust's estate development control plan and has indicated an interest in working with the Trust to secure the delivery of land for housing, possible through the use of the Land Assembly Fund (currently being committed to a number of London projects by GLA).

- Reducing the number of community sites we work out of will
  - reduce the backlog maintenance costs,
  - reduce recurrent revenue costs of managing the buildings
- Reconfiguring the way we work clinically and non-clinically will
  - reduce the amount of office space needed so reducing recurrent and capital costs
  - reduce the clinical space required to allow us to free up some buildings or land for other use
- Reducing our overall foot print will
  - Allow us to realise the value of that land giving us capital and revenue income to help fund the investment in maternity and neonatal services
  - Allow us to work with other partners to develop parts of our site for multi use so the council and the GLA or others can develop sites the buildings of which we can then use (e.g. development of primary care on the Archway Campus could be made possible through GLA development of the site)

# 10. What is required?

From the analysis of where we are and where we want to be to deliver the best service to patients, there are a number of key deliverables required:

i) **Targeted capital investment** is required for a new maternity and neonatal unit with supporting site infrastructure to ensure the estate supports the delivery of high quality clinical services and generates opportunities for more efficient and flexible use of the site, including provision of staff accommodation. Some of this investment will be enabled by points ii and iii below.

ii) **Reconfiguration of the community estate portfolio** is required to support the development of locality hubs and provision of care closer to home; provision of high quality clinical and patient care environments; and more efficient service delivery; and crucially the realisation of value to support investment elsewhere.

iii) **A change in working practices** as per the transformation opportunities above is required to enable the estate to be reconfigured so that it can be used more efficiently and the value of some sites can be better realised to help fund the needed investment.

## 11. What about the short term?

In the short term we have plans to continue to deliver improvements to our estate including:

- Finish the temporary WEC on the Waterlow site
- Improve integrity and safety within PFI buildings
- Continue refurbishment and back log maintenance plans
- Reconfigure D&E block to create a better maternity and neonatal space for the interim
- Refurbish and improve the emergency department environment
- Working with Camden and Islington Mental Health Trust to deliver a new Mental Health Hospital on the Archway Campus .

## 12. The next steps

The Trust will progress the delivery of this strategy through a number of strands of work:

i) **Preparation of a Strategic Outline Case for investment on the health campus site to deliver facilities for maternity and neonatal services;** create flexible space for further health development; and generate opportunities for more efficient, and flexible use of the site.

ii) **Continue engagement with commissioners and a range of partners to develop a community estate delivery plan** that will enable the Trust to progress the development of integrated locality hub sites and delivery of services at a local level where appropriate, realising value from the estate as per above opportunities.

iii) **Investing in staff**: we will produce further business cases to enable work to provide expanded staff accommodation and innovative, agile and fit for purpose office and education facilities that empower our staff to deliver exemplary healthcare services

iv) **Investment to deliver the digital strategy as a key enabler** to changing working practices to deliver efficiencies in estate usage.

v) **Further development of future service models and change management** to ensure any investment in the estate is targeted at the most efficient and effective use; and that staff are supported to make changes to working practices e.g. to reduce the need for office space through peripatetic working and premises sharing, and for clinical space through MDT working and in-home services.

vi) **Continued communication and engagement** with internal and external stakeholders.

**vii) Renewing the Energy and Engineering Strategy.**

# 13. Conclusion

This strategy confirms that there are a number of opportunities open to the Trust that will allow us to create the high quality, patient focussed environments we need for delivery of excellent services. Our strategy provides direction for future estate development, allowing flexibility to accommodate evolving service delivery plans.

There is a need to transform and invest in our estate to support the clinical strategy, reduce the cost of occupation and release capital for re-investment.

We have a clear vision for our estate and have prepared a development control plan which will enable us to transform the way our estate supports the delivery of excellent care to our patients – ensuring it is well used to deliver a consistent and excellent environment in a way that we can afford.

This strategy provides high level direction for estate development, allowing flexibility to accommodate evolving service delivery plans.

The Trust has a well-developed service-led estate development control plan which will enable a planned approach to investment in the estate over the next 5-15 years, delivering the following:

- Improving quality of care
- Reducing backlog maintenance and revenue costs
- Delivering the community locality vision
- Significant contribution to sector targets for releasing value from land to enable investment
- Significant contribution to delivery of London housing targets and possibly key worker housing

# Appendix 1: Strategic drivers

This section of the document outlines the factors that will drive changes to our estate in the future, as a result of enabling the delivery of our Trust strategy; building on digital innovation, listening and working with our stakeholders; addressing issues with the existing estate; and responding to developments in the healthcare environment.

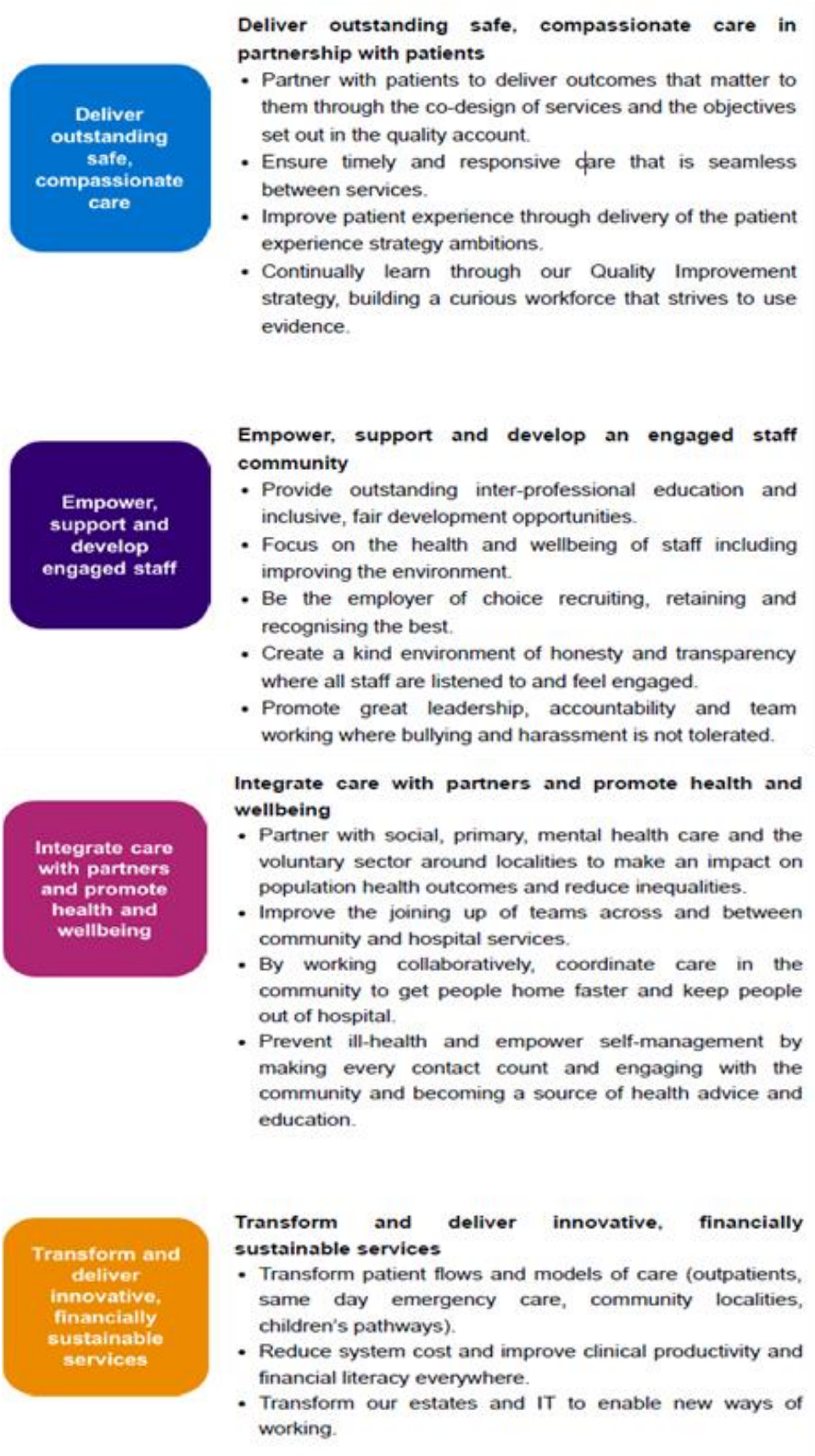
## 1. WH Strategy

- **Our vision**

> ***'' Helping local people live longer, healthier lives''***

- **Our values**

- **Our Objectives 2019-2024**




**Deliver outstanding safe, compassionate care in partnership with patients**

- Partner with patients to deliver outcomes that matter to them through the co-design of services and the objectives set out in the quality account.
- Ensure timely and responsive care that is seamless between services.
- Improve patient experience through delivery of the patient experience strategy ambitions.
- Continually learn through our Quality Improvement strategy, building a curious workforce that strives to use evidence.

**Empower, support and develop an engaged staff community**

- Provide outstanding inter-professional education and inclusive, fair development opportunities.
- Focus on the health and wellbeing of staff including improving the environment.
- Be the employer of choice recruiting, retaining and recognising the best.
- Create a kind environment of honesty and transparency where all staff are listened to and feel engaged.
- Promote great leadership, accountability and team working where bullying and harassment is not tolerated.

**Integrate care with partners and promote health and wellbeing**

- Partner with social, primary, mental health care and the voluntary sector around localities to make an impact on population health outcomes and reduce inequalities.
- Improve the joining up of teams across and between community and hospital services.
- By working collaboratively, coordinate care in the community to get people home faster and keep people out of hospital.
- Prevent ill-health and empower self-management by making every contact count and engaging with the community and becoming a source of health advice and education.

**Transform and deliver innovative, financially sustainable services**

- Transform patient flows and models of care (outpatients, same day emergency care, community localities, children's pathways).
- Reduce system cost and improve clinical productivity and financial literacy everywhere.
- Transform our estates and IT to enable new ways of working.

## 2. Whittington Health Digital Strategy (Appendix B)

Advances in digital technology are having a fundamental impact on the delivery of health and care services and the future shape of the estate. Whittington Health approved a digital strategy in 2017 with the following vision and mission:

- **Vision:**

To become the most digitally integrated care organisation in the NHS, which will enable the delivery of patient centred, high quality, safe and sustainable care, to our community.

- **Mission:**

To empower patients and staff to securely access information anytime, anyplace, on any device.

The vison is underpinned by four key digital themes

Digitally Connected Patients - empower patients to actively manage their health and care

Digitally Enabled Workforce – enable staff to access shared health and care records

Business Intelligence and Analytics – insight driven culture to improve quality, outcome & research

Digital Infrastructure – provide secure access and interoperability

Recent progress (2018/2019) with implementation of the digital strategy has included:

- The introduction of Care Flow Vitals: an electronic observation and decision support system designed to improve patient safety and outcomes. It monitors and analyses patient vital signs to identify deteriorating conditions and provide risk scores to trigger escalation pathways
- The introduction of Care Flow Connect: a secure and mobile clinical communication platform designed to facilitate faster/safer care co-ordination

Delivery of the Digital Strategy is essential for transforming the future shape of the estate.

## 3. National and local drivers for change

The NHS is undergoing further change. In developing a strategy, it is important to be aware of the direction of national policy and the key national drivers of change.

Although there is increasing demand for healthcare fuelled by a rising population and long-term and complex health conditions, alongside an increasing focus on quality and standards, there is no real growth in funding. Transformation programmes are expected to change "how and where" NHS Trusts deliver their services. This is coupled with significant financial and performance challenges posed by existing needs to produce efficiency savings.

- **National Strategy**

On 7th January 2019, NHS England published the NHS Long Term Plan, setting out its priorities for healthcare over the next ten years. In summary, the plan sets out the following:

The NHS will increasingly be:

- more joined-up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals.

Five significant changes to the NHS service model to bring this about over the next five years:

- Boost 'out-of-hospital' care, and dissolve the primary and community health services divide, through NHS organisations working with their local partners as integrated care systems
- Redesign and reduce pressure on emergency hospital services
- People will have more control over their own health, and more personalised
- care
- Digitally-enabled primary and outpatient care will go mainstream across the
- NHS
- Local NHS organisations will increasingly focus on population health through
- preventing illness and tackling health inequalities

The delivery of the long term plan will be through the Sustainability and Transformation Partnerships (STPs) and developing Integrated Care Systems (ICSs), who are required to develop and implement their own strategies to set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of their communities

- **London**

A number of key London themes are described in the NCL Estate Strategy as follows:

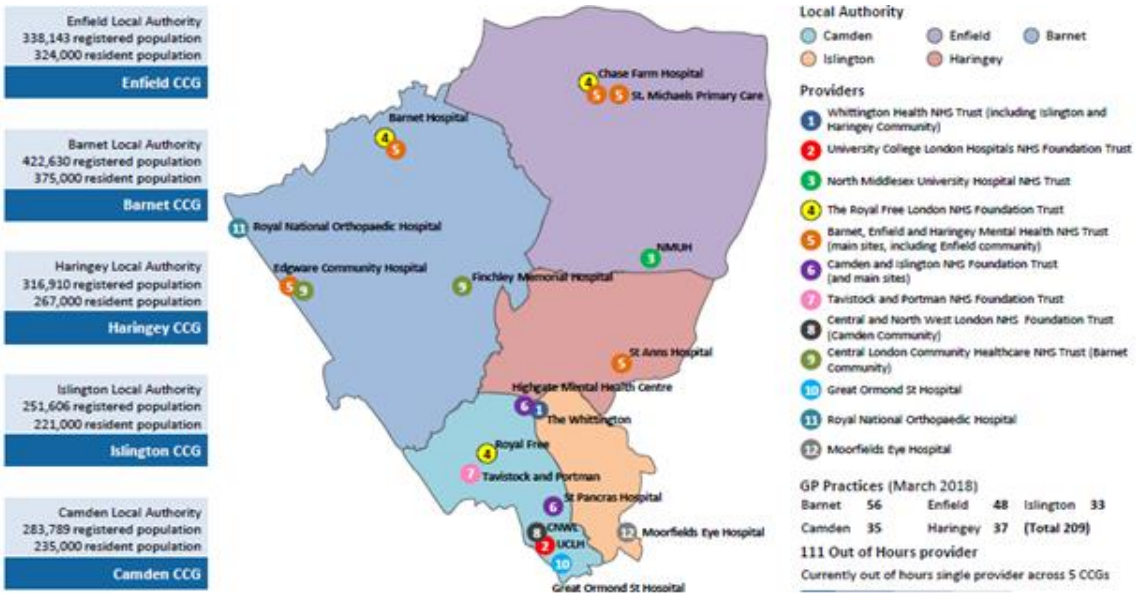
- London Health and Social Care Devolution: Memorandum of Understanding signed November 2017.
- Strategic framework to redress the under-funding in primary care and improve issues with workforce, workload, infrastructure, care design and sustainability in general practice.
- Framework to redress the lack of house building in London, where the annual supply is far outstripped by need and demand resulting in an affordability crisis.
- Targets have been set for each borough, including the redevelopment of surplus or under-utilised public sector owned sites.
- 50% of all homes should be affordable.
- In 2015, all London CCGs came together as London Partners to work together on initiatives such as 'devolution pilots' of which Estate in North Central London is one.

- **North London Partners in Health and Care (NCL STP) Integrated Care System**

Whittington Health is one of the NHS provider organisations working in partnership with the five councils of Barnet, Camden, Enfield, Haringey and Islington as North London Partners in Health and Care. (North Central London's sustainability and transformation partnership - NCL STP.)

NCL is a diverse area covering five local authorities and Clinical Commissioning Groups, 12 Trusts and 209 GP practices, as described in fig 3.1.

Fig. 3.1: Map of NCL STP coverage




The stated aims of the partnership are as follows:

- To increase prevention programmes with the aim of supporting people to stay well and when people become unwell, to recover quickly
- To partner with people and organisations to help residents to remain independent for as long as possible as they age, and to have more control over their own health and wellbeing
- To give children and their mothers, families and their care givers the right support so they can have the best possible start in life
- To provide care closer to home so people only go to hospital when it is clinically necessary
- To give mental health services equal priority to physical health services
- To improve cancer services
- To provide a consistent standard of care available to everyone and reduce variation
- To attract people to live and to work in North London to have the best possible workforce to deliver high quality services to our community.

## NCL Drivers and opportunities for change

*In addressing health & wellbeing, care & quality, and financial sustainability, NCL faces both significant challenges and opportunities around its estate. These are summarised below and described in more detail on later pages. Our approach to addressing these recognises the interdependencies between them, eg taking a place based approach to support delivery of care closer to home can optimise use of assets, reduce running costs and release surplus space for development.*

### Population & Demand

- ***Growing population*** with an increase of 6% expected between 2018 to 2028 from 1.5m to 1.6m [1] including through regeneration and development of new communities.
- ***Diverse population*** across NCL, with areas of affluence and deprivation, leading to inequalities in life expectancy and morbidity (page 23).
- NCL has a unique mix of providers ***serving local, national and international population*** due to recognised specialist centres of expertise and links to academic research (e.g. UCLH , Royal Free, Moorfields, Tavistock and Portman, GOSH and RNOH) and require a fit for purpose estate to retain their 'world class' status.

### Vision for care

- Future vision for care is focused on both radical service transformation and incremental improvements to address demand changes.
- Move towards a 'population health' approach to deliver services differently with a greater focus on prevention, moving care closer to home (Place Based Care) and reducing demand in hospitals.
- Aim to reduce variation, improve quality of care and drive productivity across the STP.
- ***Future care model and vision (described in section 5) outlines the opportunity for delivery of 'holistic' health and social care services utilising the estate in different ways.***

### Estate

- General condition of the primary and provider estate is mixed in terms of age, quality and fitness for purpose with rising backlog maintenance impacting on running costs and patient experience. [2]
- Whilst central capital funding is focussed on transformational projects, improving the overall condition of the estate remains a key priority and enabler for wider transformational objectives.
- Better utilisation of the estate (including through wider local government and public sector collaboration) is needed.
- ***Plans to modernise and utilise the estate are being explored to drive service improvement, reduce voids and improve productivity (in line with national guidance e.g. Carter). See section 6&7.***

### Financial

- Estates running costs (£501m)[3] impact overall affordability and financial sustainability. It is noted that PFI contracts can impact flexibility over running cost management.
- The underlying deficit at the end of 2017/18 was £203m. Substantial efficiencies will need to made over the next five years to both remove the underlying deficit and manage future pressures.
- ***Potential for capital receipts to support estates transformation. However in some cases, release of land is reliant on investment in other areas.***

### Enablers

- Ageing workforce (more than half the GP workforce is aged over 50) along with limited recruitment and retention of staff, will impact future service sustainability. Access to affordable homes and improved condition of workplace environments is a contributing factor for future recruitment challenges. [2]
- ***Digital interventions*** and associated security measures to support service ambitions and delivery (e.g. self care, staff ability to work in an agile and integrated way) are currently hindered by poor existing infrastructure. ***Opportunities to address this alongside estate changes are being explored.***

### Housing

- ***Partners' land disposal pipelines create a significant opportunity for development of new housing including social and affordable housing.***
- Shortage of ***key worker accommodation*** needs to be addressed within NCL to support recruitment and retention with opportunities to address this being pursued (see section 6), through site disposals and ***Homes for NHS Staff*** pilot.
- More widely ***housing and the environment are key drivers of health*** and addressing those wider environmental factors is critical to the prevention of ill health.

## NCL Estate Strategy

The NCL Estate strategy states:

'Our vision for care services looks to improve the health and wellbeing of our population through reduced health inequalities, addressing the wider determinants of health and supporting care closer to home through a neighbourhood based approach to services, all whilst ensuring that when hospital care is needed, it takes place in high quality buildings in the right configuration.

'The Estate is a core enabler to the delivery of this vision. We want to work towards a high quality, flexible and accessible estate, which is appropriately utilised. We know that if we get this right, the estate can have a truly positive impact on the physical and mental health and wellbeing of our communities and staff.'

The STP estate priorities are described as follows:

- To develop a place based approach to support service delivery and optimise use of assets, drawing on the principles of One Public Estate;
- To respond to care requirements and changes in demand by putting in place a quality estate, further enabling us to tackle health inequalities and wider determinants of health in the STP;
- To increase the operational efficiency of the estate –improving utilisation; tackling backlog maintenance; and optimising running costs;
- To enhance delivery capability –supporting wider changes in health care delivery, alongside workforce and digital enablers, including supporting opportunities to create Homes for NHS staff;
- To enable the delivery of a portfolio of estate transformation projects which support the implementation of vision for care and further development of social and affordable housing in the STP.

- **Clinical Commissioning Groups (CCGs)**

**Strategic priorities**

The strategic drivers for Islington CCG and Haringey CCG are described below.

- Offer person-centred care through improved integration of services across health & social care, across physical health & mental health, across adults & children's
- Transform inpatient care for residents experience mental illness; deliver parity of esteem
- Transform urgent and emergency care across acute & community pathways
- Transform primary care through common standards and reduced variation; ensure accessible, coordinated, proactive care
- Ensure services are high quality, cost effective, clinically safe delivering a positive experience of care
- Improve use and impact of public estate supported by devolution pilot
- Connect health and care providers and patients by developing an integrated digital care record and person held record
- Improve capacity and capability of health and care workforce

**CCG led estate planning - Local Strategic Estate Plans**

Since June 2015, Clinical Commissioning Groups have led the development of Local Strategic Estate Plans through Local Estate Groups/Forums.

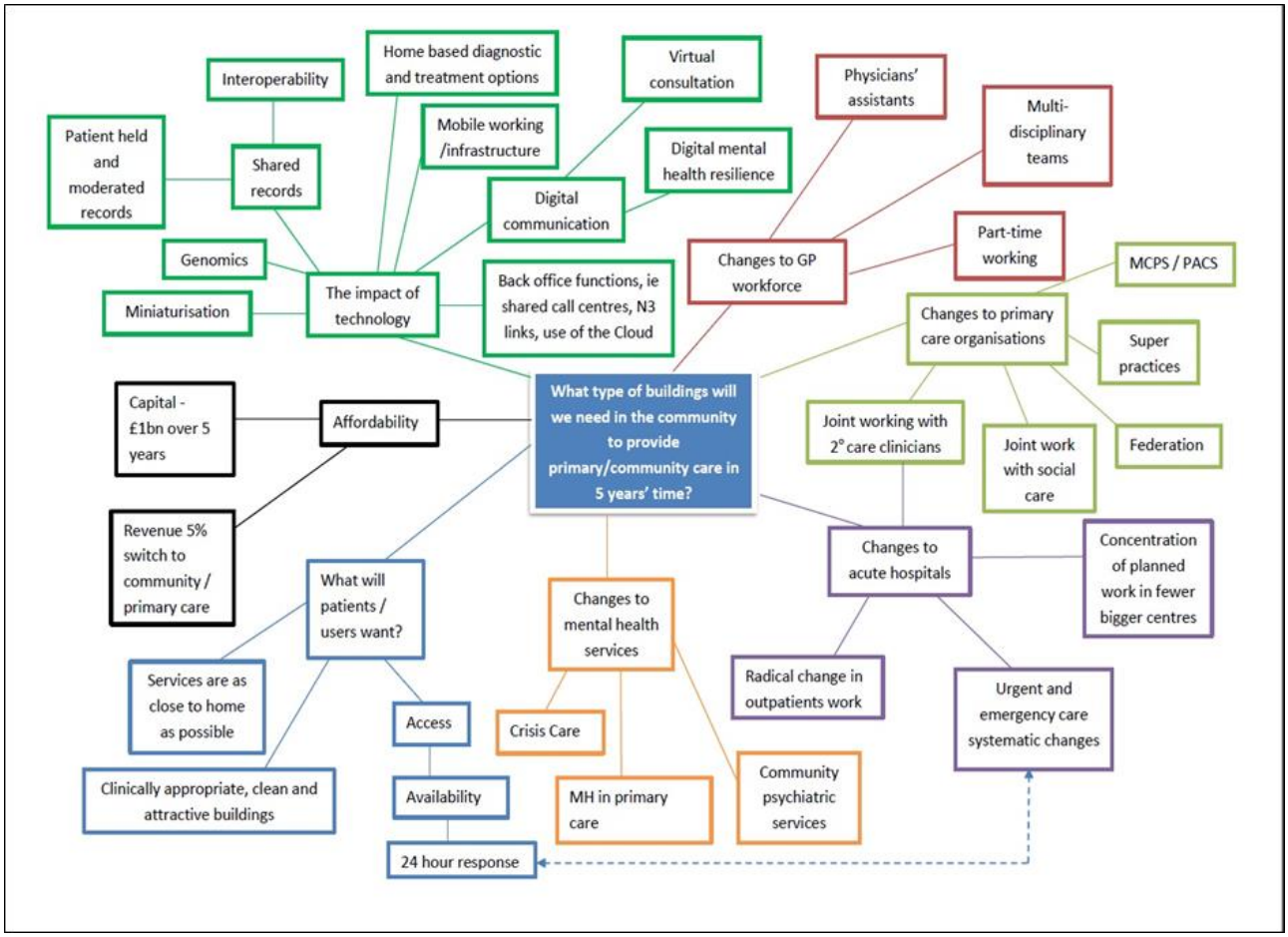
The Local Strategic Estate Plan is intended to support the health economy to create a fit for purpose estate at less cost, specifically addressing:

- changes in demography and population demand;
- changes in the way that health care services are provided – specifically reflecting plans for integrated health and social care, greater levels of care within communities and new commissioning models;
- challenges in funding and affordability.

Representatives from CCGS, local authorities and local provider trusts have been meeting as the Haringey and Islington Estate Group (and now Borough-based Estate Forums) to develop strategic estate plans.

Some of the complexities of the issues that have been identified through this work are described in the following figure. These issues are not specific to Haringey and Islington, but provide an overview of some of the issues the strategies need to address.

Fig 3.2 CCG Estate Strategy Development – complexities map




## 4. Stakeholder engagement – internal and external to the Trust

We understand the importance of both working with our stakeholders and keeping them informed. We have been talking to many of our stakeholders during the refresh of the estate strategy in order to inform the shape our future direction. This engagement will continue as we shape and progress the detail of our delivery plans.

Partnerships exist in many forms, through the more formal, membership of established partnerships, through to the day to day relationships that clinicians form with patients, carers and service users.

Whittington Health has many partnerships and relationships in place including the following:

- **Islington and Haringey CCGs, London Borough of Islington, London Borough of Haringey and NHSE**

Whittington Health has on-going close contractual arrangements with a number of commissioners of which the most significant are Islington CCG, Haringey CCG London Borough of Islington, London Borough of Haringey and NHSE.

In addition Whittington Health works closely with Islington Social Services through a long established Section 75 partnership, focused on the provision of integrated services for adults and older people.

- **Haringey and Islington Borough Partnerships**

Whittington Health is a member of the Haringey and Islington Borough Partnerships, which bring together Local Authorities, commissioners and providers to work together to deliver a better and more integrated services for the residents of Haringey and Islington. A number of specific areas have been progressed, in particular: frailty, diabetes, respiratory and intermediate care. We are now working on innovative ways we can organise ourselves around smaller localities (around three per borough).

- **Haringey and Islington GP Federations**

The Trust has signed a memorandum of understanding with the two local GP Federations to work together for the benefit of our populations. The Trust has been working closely with GPs and commissioners in Haringey and Islington to develop new ways of working as they begin to work more at scale through primary care networks. Examples of this have been the new integrated diabetes team that supports and trains GPs to keep patients' diabetes managed in the community, and the Trust team working with Age UK and the GPs to use an e-frailty index to find and support patients before they deteriorate.

- **North London Partners in health and care (NCL STP)**

Whittington Health is one of the NHS provider organisations working in partnership with the five councils of Barnet, Camden, Enfield, Haringey and Islington as North London Partners in Health and Care (North Central London's sustainability and transformation partnership (NCL STP).)

- **GLA**

Whittington Health has a Memorandum of Understanding in place, from December 2018, with the Greater London Authority which establishes a working relationship between the two organisations to support improvements to the health and wellbeing of residents in Islington and Haringey through: the transformation of the Trust estate and improved clinical services; and by considering possible opportunities to deliver housing.

- **University College London Hospitals NHS Foundation Trust**

The Trust collaborates with UCLH in a number of clinical areas, including breast services, maternity, and general surgery. One particular success has been that patients with abscesses now come to Whittington Health for their day surgery instead of being admitted to a bed at UCLH.

- **North Middlesex University Hospital NHS Trust**

The Trust has signed an MOU with NMUH with the view to collaborating on clinical pathways and other areas where the organisations can improve quality and efficiency better together.

- **University College London Medical School**

Whittington Health is one of the three main teaching sites of UCL Medical School. A teaching hospital for several decades, it has always been highly regarded for the educational experience it offers students in their clinical years.

- **Camden & Islington NHS Foundation Trust**

The plans to build a new mental health hospital alongside the Whittington Health hospital based services, is providing WH and Camden and Islington FT with an important opportunity to work more closely together for the benefit of staff and patients. Co-locating physical and mental

health services can break down barriers to provide better co-ordinated care for people with physical and mental health conditions and increase opportunities for staff to learn and share skills with each other.

- **Patients and Carers**

In February 2019, Whittington Health agreed a new patient experience strategy

to strengthen and expand on the Trust's previous 2014 strategy. Three ambitions have been established to enable staff and services to truly work in partnership with patients and carers.

- 'We will improve the information we provide to patients and carers to enhance two-way communication
- We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement
- Improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care.'

The ambitions were developed through discussions with patients about what is important to them and analysis of existing information and feedback regarding patient experience.

These ambitions will drive and shape the Trust's engagement with patients and carer's as we develop our plans to transform our estate.

- **Local Communities**

The importance of engaging with the local community is recognised by Whittington Health. The Trust has set out the purpose and objectives for the engagement:

- to have greater input from our community to inform our decisions
- to encourage our community to work collaboratively with us on future decisions and/or changes
- to inform our local community about what Whittington Health is doing and encourage them to join in celebrating our successes
- to play a more visible role in the community
- to promote public health messages and help people live healthier lives.

A number of key audiences in our local communities have been identified:

- Local residents
- Community Groups and Charities
- Healthwatch
- Local representatives – including MPs and councillors
- People in key council positions – Chief Executive, Leader and Health representative
- Local voluntary sector organisations
- Local campaign groups
- Schools

The Trust is committed to engaging through different channels:

- Face-to-face communication
- Existing networks and events
- Website
- Social media and networks
- Written digital communication
- Local media

Recent communications and engagement activity to inform the development of the refreshed Trust strategy, estate strategy and this Strategic Outline Case has included:

- Meetings with the London Boroughs of Islington and Haringey
- Regular meetings with the healthwatches and with Bridge Renewal Trust
- Regular meetings with the Defend the Whittington community group
- Presentation to CCG Council of Governors on a couple of occasions
- Presentation to Joint Health and Care Committee
- Involvement in partnership working to develop more integrated public services
- Local Community Focus Groups arranged by Bridge Renewal Trust and Healthwatch Islington

Going forward we are working with Bridge Renewal Trust and Manor Gardens and The Peel to create workshops with residents focussed on this strategy and the potential implications.

- **Internal partners – the staff community**

Whittington Health believes that the people that work at Whittington Health are the Trust's greatest asset and the heart and soul of the organisation.

This is recognised in the recently refreshed Trust strategy objectives which state the need to empower, support and develop an engaged staff community.

Engagement with staff has and continues to take place in many forms:

- Chief Executive Blog
- Chief Executive-led monthly staff briefing – meeting and electronic
- Attendance at Trust Partnership Group
- Weekly staff newsletter
- Intranet
- Whole staff surveys
- Open meetings
- Targeted work groups.

The Trust encourages two-way communication and is committed to responding and acting in an open and transparent way, with an emphasis on learning and continuous improvement and collective well-being and compassionate leadership.

The findings from the engagement opportunities to date demonstrate a wide spectrum of views on the future of our estate. There is recognition of the need for investment and change, supported by innovative and creative thinking.

Figure 3.6 summarises and links the strategic service drivers with the estate principles and Trust objectives, to describe appropriate estate responses and indicators of success.

Figure 3.6 Where do we want to be?

| Service Drivers | | Estate Principles | The Vision: Where do we want to be? | Measures of success and priorities |
|---|---|---|---|---|
| **Quality**<br>▪ Expectations from patients and regulators of a high quality service<br>▪ Competition for patients based upon patient choice<br>▪ The need to provide care close to home<br>▪ Continued access to high quality emergency and urgent care<br>▪ The availability of new investigations and treatments | | Patient centred<br><br>Quality<br><br>Capacity | **Objective 1: Deliver outstanding safe, compassionate care**<br>We will provide clinical services in high quality accommodation that supports the provision of outstanding safe, personal, coordinated care for the community we serve. | ▪ Maternity & neonatal unit redeveloped<br>▪ Locality based integrated networks/hubs in place for service delivery across Islington & Haringey<br>▪ Children's services delivered from 'fit for purpose' accommodation<br>▪ Fit for purpose environments for: theatres; wards; outpatients and ED |
| **Staff**<br>▪ The need to attract and retain high quality staff<br>▪ The need for high quality facilities to train and develop staff | | Design | **Objective 2: Empower, support and develop engaged staff**<br>We will have an estate that supports the recruitment, development and retention of our employees and enables them to work effectively in teams. | ▪ Access to low cost, high quality staff accommodation |
| **Financial**<br>▪ The need to achieve financial balance<br>▪ Limited access to capital to support investment<br>▪ Population growth not matched by similar increases in funding<br>▪ The need to obtain value for money through smart procurement | | Effective use of assets<br><br>Statutory and non- statutory compliance<br><br>Future sustainability | **Objective 3: Transform and deliver innovative, financially sustainable services**<br>We will have generated additional (capital and revenue) income and minimised our costs through the effective and efficient use of our estate assets supported by digital innovation, in order to make our healthcare services financially sustainable. | ▪ Non-clinical support space utilisation -reduce footprint<br>▪ Comply with all legal and regulatory requirements<br>▪ Capital investment programme in place and funded to enable refurbishment and redevelopment<br>▪ Carbon reduction |
| **Meeting local health needs**<br>▪ Rising activity levels<br>▪ The prevalence of health inequalities<br>▪ A relatively young population<br>▪ An ethnically diverse population<br>▪ The need to support prevention of ill health | | Partnerships and engagement | **Objective 4:**<br>**Integrate care with partners and promote health and wellbeing**<br>We will have continued to develop partnerships with other organisations in the local healthcare community in order to provide a wide range of | ▪ Partnerships in place<br><br>▪ WH estate as local community asset and making the most of the value that asset to support housing priorities and investment |

| | | | | | |
|---|---|---|---|---|---|
| **Structural**<br>▪ The need to continue to integrate services across the acute and community estate<br>▪ Working in partnership with other members of the local health and social care economy to support wider public sector needs such as housing | | | | effective services to our patients and users. | requirements |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Quarter three delivery of 2019/20 strategic objectives** | **Agenda Item: 15** |
| **Executive director lead** | Jonathan Gardner, Director of Strategy | |
| **Report author** | Jonathan Gardner, Director of Strategy, Development & Corporate Affairs | |
| **Executive summary** | Board members are presented with a review of quarter three delivery of the Trust's 2019/20 strategic objectives. The purpose of this report is to give the board an overview of progress against our strategic objectives at a high level. A few proxy measures have been highlighted against each of the four objectives to give a sense of progress and achievement.<br><br>This overview does not replace the detailed monthly performance report. The Board are asked to comment on where they feel more focus should be brought to bear, and to continue to confirm or comment on our priority actions. | |
| **Purpose:** | Review and comment on progress. | |
| **Recommendation(s)** | Board members are invited to review delivery against the performance metrics outlined for respective strategic objectives. | |
| **Risk Register or Board Assurance Framework** | All Board Assurance Framework entries | |
| **Report history** | Trust Management Group, January 2020 | |
| **Appendices** | None | |

# Quarterly progress report on the strategic objectives

## QUARTER 3

## January 2020

# Deliver outstanding safe and compassionate care in partnership with patients

Exec: Chief Nurse / MD

Committee: Quality

worse

better

Same

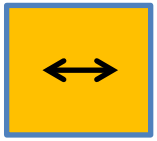
| Key metrics | Target | Score | RAG |
|---|---|---|---|
| SHMI score | | 0.82 | |
| Readmission rate | 5.5% | 5.37% | |
| Pressure ulcers grd. 4 and 3 | Reduce 10% | 34 (Oct/Nov/Dec) cf 14 prev. qu. | |
| FFT % satisfaction | 90% | IP: 97.8 OP: 96.7 | |

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| RTT | 92% | 92.1% | |
| ED 4hr | 95% | 77.8% | |
| Adult community metrics green | ↑ | 9 was 12 | |
| Child community | ↑ | 16 | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| PALS response time | 80% | 58.3% | |
| No. volunteers | 300 by 2021 | 225 | |

| Descriptor | Deliverables | Progress last quarter | Actions next quarter |
|---|---|---|---|
| Partner with those who use our services to deliver outcomes that matter to them through experience led design and delivery of services and the objectives set out in the quality account | • To move from Good to 'Outstanding' in our CQC rating including moving community children's services from 'Requires Improvement' to Good<br>• Improve feedback numbers and experience of people attending the Emergency department<br>• Improve our clinical effectiveness priorities as outlined in the quality account<br>• Work with patients and people who use our services to develop meaningful clinical outcomes, hear patient stories at Trust Board and embedded at Trust and ICSU committees | • The patient experience team have been working with clinical teams to catalogue current patient/service user groups.<br>• A patient representative has been identified to support at the Trust's Adult Community Services Board meeting<br>• Second rotation of CYP Youth Ambassadors recruited<br>• Action plan developed from initial feedback from CQC inspection. | • Finalise the development of a central framework for the creation and facilitation of patient/service user groups, including for patient representatives<br>• The introduction of two service user involvement groups for Rheumatology and Diabetes<br>• Implementation of text messages for collecting FFT across day case patients. |
| Ensure timely and responsive care that is seamless between services | • Meet constitutional standards<br>• Improve treatment and waiting time standards for our mental health patients within emergency department<br>• Continue to achieve cancer and referral to treatment national standards<br>• Improve the waiting times for people who need community health services<br>• Deliver the better births action plan | • Successful roll out of careflow handover<br>• Professional Behaviours and Patient Safety (GMC) seminars with 50 surgical and anaesthetic consultants<br>• 14 Day cancer target not met in October 2019 (91.3%)<br>• 23 mental health 12hr breeches in ED in Q3<br>• 2hr and 48hr district nursing targets with exception of December 48hr target<br>• New birth visit targets in Haringey not met. Islington achieved the target for October (96.1%) | • Actions through the A&E delivery board<br>• Actions through the community services improvement group |
| Improve patient experience through delivery of the patient experience strategy ambitions | • We will improve the information we provide to patients and carers to enhance two-way communication<br>• We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement<br>• We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care | • Volunteer Strategy for 2019-2021 launched in December 2019<br>• Peer reviewed walk-around of the Outpatient department undertaken, alongside a patient representative, utilising appointment letters to guide review.<br>• Quality governance notice boards rolled out to Trust and community sites to standardise the information. | • Collect feedback on outpatient appointment booking and communication, using new patient experience questionnaire<br>• Introduce translated FFT postcards Volunteer Rapid Response project to be implemented as part of NHSE winter pressure support programme |
| Continually learn through our Quality Improvement (QI)strategy building a curious workforce that strives to use evidence | • Embed a QI culture throughout the organisation from Board to ward/team<br>• Offer training to all staff<br>• Increase the number of QI initiatives across the Trust | • 153 active projects, 32 completed (wide range of projects)<br>• 'Hello my name is' widely adopted and substantive staff are now wearing yellow badges<br>• Project posters are displayed in key rooms in the WEC to share learning | • Recruit to AMD QI role and then work to write a new strategy<br>• Look at other ways we can share learning internally |

# Empower support and develop engaged staff



Exec: Workforce Director / COO

Committee: WAC

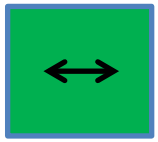
| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| Turnover rate | 10% | 10.7% | |
| Vacancy rate | 10% | 11.1% | |
| Appraisal rate | 90% | 77.5% | |
| Mandatory training | 90% | 83.3% | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| # teams doing 'team journey' | Tbc | 20 | |
| Likelihood BAME candidate being appointed | | 1.65 | |
| Staff FFT/Pulse response rate | | | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| Relative likelihood of disciplinary for BAME | | 1.4 | |
| % staff recommending WH as place to work | 65% | | |

| Descriptor | Deliverables | Progress last quarter | Actions next quarter |
|---|---|---|---|
| **Provide outstanding inter-professional education and inclusive, fair development opportunities** | • Roll out diverse interview panels for senior staff roles, consultants and bands 8A and above<br>• Continue to host CEPN and develop educational opportunities<br>• Complete the WRES Improvement Plan (which includes reduction targets)<br>• Where a panel does not appoint a BAME shortlisted candidate for an 8A and above role the Chair writes an explanation to the Director of Workforce | • Fully Implemented<br>• Fully Implemented<br>• WRES action plan developed<br>• Inclusion Lead Appointed<br>• Inclusion events commenced<br>• Social media presence improved | • Review the impact in line with WRES action plan<br>• Continue to raise profile of all inclusion events<br>• Continue with WRES actions<br>• Roll out range of Inclusion Networks<br>• Create new Inclusion Board |
| **Focus on the health and wellbeing of staff including improving the environment** | • Increase our offer of health and wellbeing to staff and promote well-being<br>• Enhanced staff access to smoking cessation<br>• Create the events calendar to promote to staff on intranet by June 2019<br>• Develop a staff engagement and wellbeing social media platform | • Health and Well being plan in place<br>• Implemented<br>• Implemented<br>• In progress<br>• Flu vaccination programme launched | • Continue with plan<br>• Engagement project in place for 6 months<br>• Review Health and Wellbeing agenda and strategy in line with #CaringForThoseWhoCare programme |
| **Be the employer of choice recruiting and retaining and recognising the best** | • Continue work with capital nurse<br>• Implementation of the NHSI Retention Plan including Implement Managers Breakfast and 'itchy feet' retention events<br>• Recruitment service Recovery Plan | • Working with Capital Nurse<br>• NHSI retention plan in place<br>• STP Lead on RTP<br>• Improved retention and vacancy rates<br>• In place | • Working with capital Nurse<br>• Continue with plan and reviews<br>• Continue with plan |
| **Create a kind environment of honesty and transparency where all staff are listened to and feel engaged** | • Take forward staff survey action plans locally and corporately<br>• Implement the Cultural survey action plan focussing on engagement and bullying and harassment<br>• Audit the Fair Treatment panels for reduction in BME disciplinary cases | • Currently being taken forwards<br>• Cultural Survey plan in place<br>• #CaringForThoseWhoCare Initiative Launched<br>• Programme Lead in Place<br>• Staff Survey 2019 results received | • Assurance through WAC<br>• Assurance through WAC<br>• Commenced<br>• Design brief to be commissioned. Intranet updates. #CFTWH Intranet Hub to be created;<br>• Culture Board established<br>• 2018 Staff survey results to be circulated and action plans developed |
| **Promote compassionate leadership, accountability and team working where bullying and harassment is not tolerated** | • Implement the Cultural survey action plan<br>• Promote the Leadership Development programmes<br>• Development of Managers 'passport' | • Action plan in place<br>• Current promotions in place<br>• Timeline of Inclusion events<br>• Resources identified, positions offered<br>• 600 managers identified to go through Challenging Behaviours Training | • Assurance through WAC<br>• Further developing leadership and focusing on middle managers; 500+ managers through programme<br>• Plans to secure resources to roll out to ALL staff.<br>• Plans to secure funds to develop "Outward Mind-set" training |

# Integrate care with partners and promote health and well-being



Exec: Director of Strategy / COO

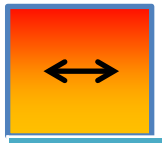
Committee: Board

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| DTOC rate | 2.5% | 2.9% | |
| Careflow project status | Green | Amber/Green | |
| NMUH project status | Green | Red | |
| UCLH project status | Green | Amber | |
| Locality project status | Green | Green | |

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| Intermediate care project | Green | Amber | |
| No. staff completed MECC | All DN by Dec (revising this) | 10+ | |
| Website project status | Green | Amber | |

| Descriptor | Deliverables | Progress last quarter | Actions next quarter |
|---|---|---|---|
| **Partner with social, primary, mental health care, and the voluntary sector around localities to make an impact on population health outcomes and reduce inequalities** | • Develop and begin to implement a new model of care around localities<br>• Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP<br>• Collaborate with other NHS providers to improve efficiency and resilience) | • "connected communities" now present in Lordship Lane<br>• Leadership team for North Islington now meeting<br>• Meetings held to discuss joint venture with PCNs and GP Feds<br>• Borough partnership boards have met<br>• WH / UCLH ortho hub consultation launched & implementation board started<br>• NMUH progress has been slow<br>• Ran workshops about community estate options | • Workshop for South and Central Islington to create similar teams<br>• Engage with community on estate options<br>• Continue to refine borough partnership boards<br>• Continue implementation of ortho hub<br>• Contract offer for MSK first contact practitioners stalled due to insufficient central funding so looking at other options<br>• Progress NMUH collaboration further |
| **Improve the joining up of teams across and between community and hospital services** | • Progress work of the 'integrated forum'<br>• Support roll out of 'careflow connect' | • Integrated forum continues to meet now with direct report to TMG<br>• Good discussion around the role of the specialty services in localities<br>• Review of community teams usage of careflow ( other than DNs ) in context of using own devices | • Roll out careflow as per plans |
| **By working collaboratively, coordinate care in the community to get people home safely faster and keep people out of hospital where appropriate** | • Design and implement new intermediate care pathway<br>• Consider business case for delivering new model at Osborne Grove | • the emphasis has been on refocusing the vision and objectives at borough-level<br>• Osborne Grove no update | • Plan is to prioritise work related to the respective borough Ageing Well strategies.<br>• Senior representative group has been set up to over see the operation delivering of the IC strategy.<br>• A diagnostic review of intermediate care is being commissioned as part of MTFS plan. |
| **Prevent ill-health and empower self-management by making every contact count and engaging with the community and becoming a source of health advice and education** | • Continue to grow the self-management service<br>• Restart 'make every contact count' MECC model<br>• Begin new approach to community engagement and advice and guidance | • Self-management team have been attending community events and signing people up<br>• No longer rolling out MECC to all as we are revising what the 'routes into services' are.<br>• Updated all the "about us" pages on the website<br>• Sending out estates newsletter week of board | • Define 'routes into services' and begin to communicate<br>• Set up next community event (delayed)<br>• Send out next community newsletter (delayed)<br>• Describe better the engagement already going on<br>• Performance continues to be monitored through the Outpatient programme Board and ensuring that there is alignment between and secondary care A&G objectives<br>• ICSUs to consider the impact of A&G within the context of job planning. |

# Transform and develop financially sustainable innovative services



Exec: Finance Director / COO

Committee: TMG

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| % CIP delivery against target | 100% (£9.2m) | £5.8m (YTD target £9.2m) | |
| Average beds used | 197 | 208 was 203 | |
| Financial position | On plan | M9 £3.2m worse than plan | |
| Capital spend against plan | On plan | £2.2m gap | |
| % D2A | TBC | | |
| Average LOS Non-elective | 4 | 4.9 | |

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| % stranded pts | 35% | 41.8% | |
| Elective activity | 100% on plan | 94% | |
| Theatre utilisation | >85% | 70.69% | |
| Estates strategy project status | Green | Green | |
| Fast follower project status | Green | Green | |
| Financial training sessions delivered | >12 per year | 4 | |
| WEC project status | Green | Red/delay | |

| Descriptor | Deliverables | Progress last quarter | Actions next quarter |
|---|---|---|---|
| **Transform patient flows and models of care (outpatients, same day emergency care, community localities, children's pathways)** | • Operate within funded bed base by optimising discharge to assess and reducing length of stay<br>• Develop locality working and create locality leadership team<br>• Improve outpatient productivity, develop new virtual clinic models and increase advice and guidance<br>• Improve emergency care and ambulatory care (adult and children) | • The revised bed place model n place – and achieving LLOS reduction ( NHSE target )<br>• Locality working is progressing at pace<br>• AVLOS has remained broadly similar<br>• Outpatient workstream is progressing with CCG / STP input but has not found the realisable saving required from Trust perspective | • Focus on optimising bed through continued LOS improvement programme.<br>• Achieve LLOS trajectory<br>• Outpatient programme – implement E-consultation and group consultation pilots<br>• Progress roll out of kiosks and set centralised reception as part of extending working.<br>• Achieve DNA trajectory<br>• Achieve A&G trajectory |
| **Reduce system cost and improve clinical productivity and financial literacy everywhere** | • Deliver £12m savings through CIPs and deliver to budgets to deliver the 19/20 control total<br>• Identify alternative pathways to outpatients with primary care<br>• Roll out programme of financial awareness to key staff<br>• Implement new intermediate care pathway<br>• Restructure therapy and autism pathways for children | • £5.8m of year CIP target achieved (66% of quarter 3 target)<br>• Recovery meetings instigated. CT achievement still forecast<br>• Budget Holder meetings held to discuss finances and raise financial awareness | • Continue recovery plan and improved delivery on CIP<br>• Ongoing Surgeries to be offered in all ICSUs<br>• By end of January agree Gastro funding mechanism<br>• MSK impact to be reviewed by the end of the quarter.<br>• 2020/21 budget setting<br>• 2020/21 Operational Planning |
| **Transform our estates and IT to enable new ways of working** | • Create the case and plans for a transformed estate and produce various legal documentation<br>• Deliver estates improvement programme<br>• Deliver the fast-follower programme | • Further mtgs held with STP estates leads<br>• Waterlow demolition underway but programme delayed<br>• Fast Follower remains on track | • Launch the estates strategy<br>• Launch first SOC<br>• Continue Waterlow / WEC project<br>• Consider D&E block reconfiguration<br>• As per plans |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Trust risk register summary report** | **Agenda item: 16** |
| **Executive director lead** | Michelle Johnson, Chief Nurse & Director of Allied Health Professionals | |
| **Report author** | Gillian Lewis, Head of Quality Governance | |
| **Executive summary** | This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥16) currently on the Risk Register in January 2020.<br><br>The report demonstrates that the top three risks to the organisation are aligned with the principle Board Assurance Framework (BAF) risks. They are **failure to deliver savings plan**, **failure to modernise the Trust's estate** and **lack of improvement in the culture of the organisation**. The Executive Team have undertaken a review of the culture risk against the Trust risk assessment matrix as agreed following the previous report to Board (30.10.19). This is now risk assessed as 16 on the BAF, Risk ID People 2.<br><br>The Trust has set a threshold for risks reviewed at Board Committee level (≥15) to ensure Non-Executive Director oversight. The Non-Executive Director who chairs the committee will escalate any ≥15 risks to the Trust Board as required.<br><br>All risks <15 are managed at an Integrated Clinical Service Unit (ICSU) or corporate directorate level and escalated to the relevant Trust Board Committee if necessary.<br><br>This report outlines the key changes to the Quality and Safety Risk Register since November 2019.<br><br>In response to comments from the Trust Board (30.10.19) the report includes more information on mitigating actions and their timescales.<br><br>**There have been the following changes:**<br><br>**1. Risk closures**<br>91 Labour ward obstetric theatre: Second labour theatre now in operation. Risk closed.<br>1017 Existing VRA systems in Paediatric Audiology not compatible with Windows 10 PCs: VRA equipment in situ and working at both sites - St Ann's Hospital and Northern Health Centre. Electrically safety tested. Risk closed. | |

| | |
|---|---|
| | **2. Downgraded risks (now below 16)**<br>750 Mental Health Patient Secure Vehicle unreliable<br>Update: Van expected to be delivered in February 2020; risk reduced to 12 and will be closed upon arrival of van.<br><br>1014: Failure of Everlight (Outsource radiology reporting provider) to maintain reporting services within KPIs<br>Update: Contract performance notice issued 21/10/19, Two locum consultants hired to reduce backlog and keep KPIs within target. Risk rating reduced and contract continues to be monitored closely.<br><br>**3. Risk increases**<br>• 683 – Overcrowding in the Emergency Department: risk increased following review at ICSU quality meeting<br>• 970 – Central booking team staffing provision inadequate: risk that correct booking processes will not be followed leading to errors affecting income activity.<br><br>**4. New Risks**<br>• 1035 Ligature and anchor point estate works Simmons House (16): If identified work from the November 2018 Simmons House ligature assessment are not completed, then there is a risk that young people in our care might cause serious harm to themselves through use of known environmental risks<br>• 1036 Secure garden fencing at Simmons House requires upgrading (16): If the garden fencing at Simmons House is not replaced with a higher and more secure fence, then there is a significant risk that young people in our care who are detained under the Mental Health Act will continue to be able to jump over the fence and inflict serious harm to themselves |
| **Purpose** | Review and approval |
| **Recommendation(s)** | The Trust Board is asked to:<br><br>(i) review the risk register and approve the removal of closed risk entries;<br>(ii) review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks; and<br>(iii) consider if any ≥16 risks not currently on the Board Assurance Framework (BAF) should be considered for entry by the Trust Board. |
| **Risk Register or Board Assurance Framework (BAF)** | All BAF entries and linked entries on the corporate risk register |
| **Report history** | The information in this report is presented at the relevant Committee of the Board (Quality, Workforce Assurance, Finance & Business, Audit & Risk) |
| **Appendices** | None |

## 1. Introduction

1.1 Risk is an inherent part of the delivery of healthcare. Whittington Health is therefore committed to ensuring that there is a robust organisational governance structure, with clear lines of reporting and accountability for risks. This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥15) of quality and safety currently on the Trust Risk Register in December 2019. It also provides information of the mitigating actions and timescales to address the identified risk.

1.2 The report demonstrates that the top risks to the organisation, as reflected in the Risk Register, are aligned with the principle board assurance framework (BAF) risks. Which are failure to deliver savings plan, and failure to modernise the trust's estate. In addition the executive team have undertaken a review of the culture risk against the Trust risk assessment matrix due to lack of improvement in the culture of the organisation. As agreed following the previous report to Board (30.10.19) BAF Risk People 2 in relation to culture of the organisation is now rated as 16.

## 2. Risk management overview

2.1 The Trust maintains a central database for all risks on DATIX, an electronic incident and risk management system. In order to maintain consistency across the trust all risks are collated by Integrated Clinical Service Unit (ICSU), Corporate Directorates (Information Management &Technology (IMT); Facilities and Estates; Finance, Human Resources and Workforce) or as an organisation wide risk.

2.2 All risks are categorised under key headings and given a risk rating. This process ensures that risks can be automatically collated and filtered through DATIX to ensure they are reviewed by the appropriate leads. All ICSUs/Directorates/Board Committees are responsible for ensuring there are clear risk management structures and processes in their areas.

## 3. ≥ 16 Risk register

3.1 The Trust has set a threshold of ≥16 risk grading for review at Board Committees. This is to ensure that there is Non-Executive oversight of these risks and a clear escalation process to Board.

3.2 To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Committees with responsibility for risk. These include:

- Audit and Risk Committee
- Quality Committee
- Finance and Business Committee
- Workforce Assurance Committee

3.3 All have a critical role in monitoring risk and providing assurance to the Trust Board that there are systems in place to effectively identify, manage and escalate risks across the Trust. Each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information flows quickly to the Board as

required. In this way the Trust can identify patterns and promote best practice throughout the organisation.

## 4. Relationship between the risk register and the Board Assurance Framework

4.1 The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

4.2 While the risk register may help to inform the BAF, they are two distinct risk tools with different purposes. The fundamental difference between the Risk Register and the BAF is that the Risk Register is an operational and dynamic tool focused on the day to day management of the organisation. The BAF focuses on the strategic, long-term priorities of the Trust. At times the operational risks affecting the day to day management of the Trust will have implications for the delivery of the Trust's strategic objectives. These risks are escalated for inclusion on the BAF via the Board Committees and the Trust Management Group. All the key risks that are identified in achieving the Trust's strategic goals or corporate annual objectives will be recorded on the BAF and reported to the Board.

## 5. Risk register update: January 2020

5.1 As at 13 January 2020, the Trust has two risks graded as graded as ≥20, fourteen risks graded as 16. There are twelve risks graded as 15 which are monitored at Board Committee level. There are two key themes from the current high level risks on the risk register.

- Facilities and estates
- Financial

5.2 These risks have all been escalated for inclusion on the BAF due to the strategic implications and are monitored by the Trust Board through this assurance mechanism. A brief summary of the risks and key mitigating actions are outlined below.

### Facilities and Estates

| Datix ID | ICSU/ Directorate | Category | Title | Current risk grade | Mitigations and controls |
|---|---|---|---|---|---|
| 697 | Acute Patient Access Clinical Support Services and Women's Health | Patient Safety and Quality | Maternity and neonatal redevelopment. – Poor patient experience if redevelopment and modernisation delayed | 20 | Update: Second labour theatre now in operation. Further redevelopment to follow as part of Estates development strategy. |
| 858 | Children and Young People Services | Patient Safety and Quality | Neonatal Unit environment - including lack of space between cots Linked to risk 697 | 16 | Update: Risk ongoing and regularly reviewed against national recommendations. Infection control team carried out review of cots allocated to isolation space. |
| 890 | Facilities and Estates | Health and Safety | PFI Fire Building Strategy | 16 | Controls: PFI has introduced Fire Warden |

| Datix ID | ICSU/ Directorate | Category | Title | Current risk grade | Mitigations and controls |
|---|---|---|---|---|---|
| | | | Deficiencies (in relation to building passive and active ventilation system and smoke fire dampers to deal with a fire and smoke) | | system 24 hours on the site; Staff are trained to shut down ventilation system manually on their own initiative or instruction of the Fire Service; weekly meetings with PFI to review assurances. Risk reviewed at Fire Safety Group. |
| 907 | Trustwide | Estates or Infrastructure | High ambient temperatures of ward treatment rooms affecting quality of medicines. | 16 | Update: Calibrated thermometers and new SOP for the monitoring of room temperature now fully implemented across Trust. Updated SOP approved and implemented for the management of medicines within environments where temperatures are higher than recommended. Medicines being reviewed and discarded in accordance with SOP where required. Stock lists reviewed and reduced where possible. Business case in progress for Temperature Controlled Cabinets (TCC). On-going updates provided to the Drugs & Therapeutics Group and Nursing & Midwifery Executive Committee. |
| 1035 | Children & Young People Services | Estates or Infrastructure | Ligature and anchor point estate works Simmons House (CAMHS). Risk of serious harm if identified work from November 2018 Simmons House ligature risk assessment audit not completed. | 16 | Controls: All patients have a comprehensive risk assessment and risk plan. Any areas with known environmental risks are currently mapped by the ward on a ligature heat map, and additional risk management plans put into place where necessary. Update: Building maintained by Camden and Islington NHS Foundation Trust on behalf of Whittington Health. Actions |

| Datix ID | ICSU/ Directorate | Category | Title | Current risk grade | Mitigations and controls |
|---|---|---|---|---|---|
| | | | | | still outstanding in November 2019, so decision for WH estates team to complete works directly. Review of work required undertaken and plan for work agreed. |
| 1036 | Children & Young People Services | Estates or Infrastructure | Secure garden fencing at Simmons House requires upgrading (CAMHS inpatient unit) - the current fence is not secure and is too low. Patients have been able to jump over the fence and leave the premises, putting themselves at risk. | 16 | Controls: Individual care plans and risk assessments are being used to plan and mitigate against this, and the unit is being kept locked to stop young people from going outside into the unit garden without supervision<br><br>Update: Simmons House falls within a conservation area so planning permission required to increase height of fence. Planning process and costing in progress. |

5.3 The Executive Team have reviewed the estates and facilities risks and have consequently made the decision to increase the related BAF risk rating [*BAF Risk Sustainable 2: Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience*] to 16 to reflect the impact against the trust's strategic objectives.

5.4 There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our corporate objective to 'deliver quality, patient safety and experience'. The Trust Board monitors actions against this risk through the BAF process, including implementation of the estates strategy.

**5.5 Financial**

| DATIX | ICSU/Directorate | Category | Title | Current risk grading | Mitigations and controls |
|---|---|---|---|---|---|
| 723 | Emergency Integrated Medicine | Financial | Finance deficit in EIM ICSU | 16 | Regular finance meetings to review budgets and CIPs. Risks reviewed at Quarterly ICSU |
| 772 | Surgery and Cancer | Financial | Not meeting CIP target and financial balance for 2018/19. | 20 | |
| 780 | Finance | Financial | Budget Control | 16 | |

| DATIX | ICSU/Directorate | Category | Title | Current risk grading | Mitigations and controls |
|---|---|---|---|---|---|
| | | | | | Performance meetings and Finance and Business Development Committee. |

## 6. Other ≥16 risks reflected on BAF

**Workforce and recruitment**

6.1 The executive team have undertaken a review of the culture risk against the trust risk assessment matrix as agreed following the previous report to board (30.10.19) and it is now rated as 16 on the BAF The operational risks on the risk register have not highlighted any themes in relation to workforce, recruitment or culture of the organisation.

6.2 <15 risks continue to be monitored at ICSU level and the trust wide controls and actions are reflected in the *BAF Risk People 1: Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. nursing, junior doctors, medical posts).*

| DATIX | ICSU/Directorate | Category | Title | Current risk grading | Mitigations and controls |
|---|---|---|---|---|---|
| 970 | Surgery and Cancer | HR and Workforce | Central Book team staffing provision inadequate which risks processes not being followed and booking errors occurring. | 16 | Update: Band 3 posts recruited to; awaiting recruitment to Band 4. |
| 1002 | Surgery and Cancer | HR and Workforce | Inadequate establishment of anaesthetic staff | 16 | Controls: All rotas are examined in advance and populated so that activity is covered Update: Business case in progress for 1.5 WTE consultant anaesthetist |

## 7. ≥16 Risks not currently on the BAF

| DATIX | ICSU/ Directorate | Category | Title | Current risk grading | Comments and key mitigations and controls |
|---|---|---|---|---|---|
| 683 | Emergency & Integrated Medicine | Patient Safety & Quality | Overcrowding in ED | 16 | Update: Risk increased to 16 following review at EIM Quality meeting. Ongoing work in ED to manage demand, influence GP referral processes and increase referrals to Ambulatory Care. New 136 suite provision at Highgate to open end January 2020, review impact of this in March 2020. |
| 760 | Acute Inpatient Access, Clinical Support Services, Women's Health | Patient Safety & Quality | Radiology systems interface | 16 | Radiology works across several systems for which there is a parallel paper system; if paper system does not change unlikely to meet cancer targets without significant costs incurred. Update: Business case agreed at Capital Monitoring Group in December 2019. |
| 901 | Trust wide | Patient Safety and Quality | Lack of equipment for flat-lifting patients (post-falls) | 16 | When a patient has fallen and if they cannot get up with minimal assistance, current practice is to hoist. This carries a risk to the patient and to staff. Update: Business case approved at Capital Monitoring Group December 2019. Risk to be removed when equipment purchased and staff training completed. |

## 8. Recommendations To The Trust Board

8.1 The Trust Board is asked to:

i. review the risk register and approve the removal of closed risk entries;
ii. review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks; and
iii. consider if any ≥16 risks not currently on the Board Assurance Framework (BAF) should be considered for entry.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Committee Chairs' Assurance report template** | **Agenda item: 17** |
| **Executive lead** | Jonathan Gardner, Director of Strategy, Development & Corporate Affairs | |
| **Report authors** | Swarnjit Singh, Trust Corporate Secretary | |
| **Executive summary** | As part of work to enhance corporate governance arrangements at Whittington Health, it is proposed that Board Committee Chairs will present assurance reports from their meetings to the Board.<br><br>The aim of the Chair's assurance report is to succinctly apprise the Trust's Board on the items covered at the Board Committee meeting and to report back items where significant, moderate or only limited assurance could be taken and to escalate any areas of concern.<br><br>A draft template is attached at appendix 1. It is proposed that the Chairs' assurance reports will replace the draft Board Committee meeting minutes being presented at the Board as they will highlight areas of success, challenge and concern more easily to Board members.<br><br>The Committee Chair's assurance template will also be used for executive forums reporting to the Trust Management Group from 1 April 2020. | |
| **Purpose:** | Approval | |
| **Recommendation(s)** | Board members are asked to:<br>i. support proposals to strengthen corporate governance arrangements at Whittington Health;<br>ii. review and approve the draft Committee Chairs' assurance report template at appendix 1;<br>iii. note the guidance on assurance definitions at appendix 2;<br>iv. note that the template will be used for reports Board Committees reporting to the February 2020 Board meeting onwards; and<br>v. note that the template will be implemented from 1 April 2020 for the new executive committees structure agreed by the Trust Management Group in December 2019. | |
| **Risk Register or Board Assurance Framework** | All BAF entries | |
| **Report history** | Executive Team, 6 January 2020 | |
| **Appendices** | Appendix 1: Committee Chairs' Assurance report template<br>Appendix 2: Assurance definitions | |

**Appendix 1: Committee Chairs' Assurance report template**

| | |
|---|---|
| **Committee name** | |
| **Date of meeting** | |
| **Summary of assurance:** | |
| **1.** | **The committee can report significant assurance to the trust Board in the following areas:** |
| **2.** | **The Committee is reporting moderate assurance to the Board on the following matters:** |
| **3.** | **The Committee took limited assurance on these items for which remedial actions are in place:** |
| **4.** | **Attendance:** |

**Appendix 2: Assurance definitions**

**What is "Assurance"?**
Assurance is "confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved." Source: Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health.

**Who is required to seek assurance?**
The simple answer is everyone. The Board and its committees are not involved in operational management and delivery, but exercise oversight of the management of the organisation. The Board and its committees require assurance from management (and other sources) in order to carry out their role in corporate governance. Managers are responsible for managing risk and developing and implementing the detailed systems of internal control in their areas of responsibility. This effort should be aimed at delivering the Board's strategic objectives and improvement. Consequently, management need to assured themselves that those systems of internal control and risk management are operating as intended. If they successfully do so, they can efficiently provide assurance to a committee and the Board, as and when required.

**The following definitions are proposed for Committee Chairs' assurance report template:**

| **Assurance definitions** | |
|---|---|
| **Significant assurance:** | • The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that it is designed to deliver.<br>• Examples of when significant assurance can be taken are:<br>○ The purpose is quite narrowly defined, and it is relatively easy to be comprehensively assured.<br>○ There is little evidence of system failure and the system appears to be robust and sustainable.<br>○ The committee is provided with evidence from several different sources to support its conclusion. |
| **Moderate assurance:** | • The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains some areas of residual risk which are being managed<br>• Moderate assurance can be taken where:<br>○ In most respects the "purpose" is being achieved<br>○ There are some areas where further action is required<br>○ The report includes a proposed remedial action plan, the Committee considers it to be credible and acceptable |
| **Limited assurance:** | • The Board can take some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk which requires action to be taken e.g. non-achievement of the annual cost improvement programme target<br>• Examples of when limited assurance can be taken are:<br>○ There are known material weaknesses in key areas.<br>○ It is known that there will have to be changes to the system (e.g. due to a change in the law) and the impact has not been assessed and planned for.<br>○ The report has provided incomplete information, and not covered the whole purpose of the report.<br>○ The proposed action plan to address areas of identified residual risk is not comprehensive or credible or deliverable. |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Charitable Funds Annual Report and Accounts 2018-19** | **Agenda item: 18** |
| **Executive director lead** | Kevin Curnow, Acting Chief Finance Officer | |
| **Report author** | Jonathan War, Head of Financial Services | |
| **Executive summary** | This paper accompanies the 2018-19 Annual Accounts and Annual Report, which were presented to the Charitable Funds Committee on 8 January 2020. The key headlines are:<br>· The accounts have been subject to independent examination. An opinion stating that the accounts of the charity are 'true and fair' has been awarded.<br>· The total value of the Charity's funds as at 31 March 2019 is £2.7m. This represents a reduction in funds in the year of £950k, reflecting the Charity's £1m commitment to part fund the Trust's development of a second obstetrics theatre.<br>· Income for the year is £291k, an increase of £84k from 2017-18. This reflects the early part of the fundraising drive for the Ifor Ward play terrace, as well as stronger fundraising generally around large events.<br>· Expenditure for the year is £1,278k. As stated above, this is significantly higher than in 2017-18, and reflects the Charity's contribution to the Trust's second obstetrics theatre. Besides this, spend was 29% lower than the previous year, reflecting the lower number of high value bids approved during the year.<br>· No significant adjustments were made to the 2018-19 financial statements or annual report as a result of the independent examination.<br><br>The accounts and annual report are due to be submitted to the Charity Commission by 31 January. | |
| **Purpose:** | This paper summarises the outcome of the annual report and accounts of the Trust's Charitable Funds; and the independent examination undertaken on them. | |
| **Recommendation(s)** | Following review of the annual report and accounts by the Charitable Funds Committee, the Trust Board is asked to approve the accounts and annual report prior to submission to the Charity Commission. | |
| **Report History** | Charitable Funds Committee | |
| **Appendices** | Appendix 1: 2018-19 accounts<br>Appendix 2: 2018-19 annual report | |

Whittington Health NHS

# Whittington Hospital NHS Trust Charitable Funds

# Annual Accounts for the year ending 31 March 2019

Registered charity number: 1056452

The Whittington Hospital NHS Trust Charitable Funds
Magdala Avenue
London N19 5NF

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Schedule of Contents

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Statement of Trustee's responsibilities in respect of the Trustee's annual report and accounts

Under charity law, the Trustee is responsible for preparing the Trustee's Annual Report and accounts for each financial year which show true and fair view of the state of affairs of the charity and of the excess of expenditure over expenditure for that period.

- In preparing these financial statements, generally accepted accounting practice entails that the Trustee:
- Selects suitable accounting policies and then applies them consistently;
- Makes judgements and estimates that are reasonable and prudent;
- States whether the recommendations of the Statement of Recommended practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- States whether the financial statements comply with the Trust deed, subject to any material departures disclosed and explained in the financial statements;
- Prepares the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustees are required to act in accordance with the trust deed and the rules of the charity, within the framework of trust law. The trustees are responsible for keeping proper accounting records, sufficient to disclose at any time with reasonable accuracy, the financial position of the charity at that time, and enable the trustees to ensure that, where any statements of accounts are prepared by the trustees under section 132(1) of Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The trustees have general responsibility for taking such steps as are reasonably open to the trustees to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the Trustees:

Siobhan Harrington, Chief Executive Officer

8th January 2020

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Independent Examiners Report to the Trustees of the Whittington Hospital NHS Trust Charitable Funds

I report to the charity trustees on my examination of the accounts of the charity for the year ended 31 March 2019, which are set out on pages 6 to 17.

This report is made solely to the charity's Trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. My work has been undertaken so that I might state to the charity's Trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's Trustees, as a body, for my work or for this report.

### Responsibilities and basis of report

As the charity's trustees you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the charity's accounts carried out under section 145 of the Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

### Independent examiner's statement

Your attention is drawn to the fact that the charity has prepared the accounts in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to Accounting and Reporting by Charities: Statement of Recommended Practice issued in 1 April 2005 which is referred to in the extant regulations but has since been withdrawn.

I understand that this has been done in order for the accounts to provide a true and fair view in accordance with the Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

- accounting records were not kept in respect of the charity as required by section 130 of the Act; or
- the accounts do not accord with those records; or
- the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view' which is not a matter considered as part of an independent examination.

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Independent Examiners Report to the Trustees of the Whittington Hospital NHS Trust Charitable Funds continued

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Robert Smith

Griffin Stone Moscrop & Co
21-27 Lamb's Conduit Street
London
WC1N 3GS

Dated: 8th January 2020

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Statement of Financial Activities for the year ended 31 March 2019

| | Note | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2018/19 Total (£000) | 2017/18 Total (£000) |
|---|---|---|---|---|---|---|
| **Income and endowments from -** | | | | | | |
| Donations | 4 | 70 | 63 | 0 | 133 | 52 |
| Legacies | 4 | 0 | 38 | 0 | 38 | 32 |
| Other trading activities | 5 | 33 | 44 | 0 | 77 | 77 |
| Investments | 7 | 14 | 28 | 1 | 43 | 46 |
| **Total Income** | | **117** | **173** | **1** | **291** | **207** |
| **Expenditure on -** | | | | | | |
| Raising funds | 8 | (17) | (55) | (1) | (73) | (117) |
| Charitable activities | 9 | (1,141) | (27) | 0 | (1,168) | (244) |
| Governance costs | 9 | (18) | (19) | 0 | (37) | (30) |
| **Total expenditure** | | **(1,176)** | **(101)** | **(1)** | **(1,278)** | **(391)** |
| **Net Income / (Expenditure)** | | **(1,059)** | **72** | **0** | **(987)** | **(184)** |
| Gains / (Losses) | | 0 | 37 | 0 | 37 | (19) |
| **Net movement in funds** | | **(1,059)** | **109** | **0** | **(950)** | **(203)** |
| **Reconciliation of Funds** | | | | | | |
| Funds brought forward | 21 | 1,739 | 1,926 | 24 | 3,689 | 3,892 |
| **Total funds carried forward** | | **680** | **2,035** | **24** | **2,739** | **3,689** |

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Balance Sheet at 31 March 2019

| | Note | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2018/19 Total (£000) | Restated 2017/18 Total (£000) |
|---|---|---|---|---|---|---|
| **Fixed Assets** | | | | | | |
| Investments | 16 | 268 | 802 | 9 | 1,079 | 2,292 |
| **Total fixed assets** | | **268** | **802** | **9** | **1,079** | **2,292** |
| **Current Accounts** | | | | | | |
| Debtors | 17 | 6 | 14 | 0 | 20 | 39 |
| Cash | 18 | 1,434 | 1,248 | 15 | 2,697 | 1,636 |
| Stock | | 4 | 5 | 0 | 9 | 9 |
| **Total current assets** | | **1,444** | **1,267** | **15** | **2,726** | **1,684** |
| **Liabilities** | | | | | | |
| Creditors due within one year | 19 | (1,032) | (34) | 0 | (1,066) | (287) |
| **Net current assets / liabilities** | | **412** | **1,233** | **15** | **1,660** | **1,397** |
| **Total assets less current liabilities** | | **680** | **2,035** | **24** | **2,739** | **3,689** |
| **The funds of the Charity** | | | | | | |
| Endowment funds | 21 | 0 | 0 | 24 | 24 | 24 |
| Restricted income funds | 21 | 0 | 2,035 | 0 | 2,035 | 1,926 |
| Unrestricted income funds | 21 | 680 | 0 | 0 | 680 | 1,739 |
| **Total funds carried forward** | | **680** | **2,035** | **24** | **2,739** | **3,689** |

On behalf of the Whittington Hospital NHS Trust Charitable Funds

Kevin Curnow
Chief Finance Officer (Acting)

8th January 2020

# The Whittington Hospital NHS Trust Charitable Funds
# Registered Charity 1056452

## Notes to the accounts for the year ended 31 March 2019

### 1. Accounting Policies

**Basis of preparation**
The financial statements have been prepared under the historic cost convention, with the exception of investments, which are included at market value. Furthermore, the financial statements have been rounded to the nearest (£000) and the presentation currency is GBP.

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16th July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts have been prepared to give 'true and fair view and have departed from the Charities Regulations 2008 only to the extent required to provide a 'true and fair view'.

The trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks.

The Charity meets the definition of a public benefit entity under FRS 102.

**Funds structure**
Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as an endowment fund, where the donor has expressly provided that only the income of the fund may be expended, or as a restricted income fund where the donor has provided for the donation to be spent in furtherance of a specified charitable fund.

The Trust has one endowment fund, where the capital is held to generate income for charitable purposes.

Unrestricted income funds which are sub analysed between designated funds where the trustees have set aside amount to be used for specific purposes, often reflecting the non-binding wishes of the donors and unrestricted funds which are applicable for any purpose of the charity.

**Incoming resources**
All incoming resources are recognised once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms and conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point.

**Incoming resources from legacies**
Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain: this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions have been fulfilled and it is virtually certain that the amount of incoming resources is known.

**Incoming resources from endowment funds**
The incoming resources received from the invested endowment fund are wholly restricted.

**Resources expended and irrecoverable VAT**
All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities.

Expenditure is recognised when the following criteria are met:

a. There is a present legal or constructive obligation resulting from a past event
b. It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
c. The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Grants are only made to related or third party NHS bodies and non NHS bodies in furtherance of the charitable objects of the funds. A liability of such grants is recognised when approval has been given by the trustee.

**Allocation of overhead and support costs**
Overhead and support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 12. Where costs are shared by two or more charitable activities, support costs have been apportioned between categories, for example, financial administration costs, on the basis of fund value.

**Expenditure on raising funds**
The expenditure on raising funds are those costs attributable to generating incoming resources for the charity including fundraising and investment management costs.

**Expenditure on charitable activities**
Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objectives of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure therefore include support costs and an apportionment of overheads, as shown in note 9.

**Governance Costs**
Governance costs comprise all costs attributable to ensuring the public accountability of the charity and its compliance with regulation and good practice. These costs include those related to statutory audit and are included in expenditure on 'charitable activities'.

**Fixed asset investments**
Investments are stated at market value as at the balance sheet date. The statement of financial activities includes the net gains and losses arising on revaluation and disposal throughout the year.

Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividend.

**Realised gains and losses**
All gains and losses are taken to the statement of financial activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the carrying value at the year end and opening market value.

**Accounting for trade receivables and trade payables**
Current assets and current liabilities arising from contractual rights or obligations (for example trade debtors or trade liabilities) are carried in the balance sheet at the cash amount or other consideration expected to be received or paid in their settlement.

**Pensions**
All staff members recharged to charitable funds are on the payroll of the Whittington Hospital NHS Trust, which deducts any pension contributions due. The gross cost including pension contributions is charged to charitable funds.

**Risk**
Acceptable risk - A “medium risk” approach is to be adopted in the management of the charity's investment assets. This is noted on the Trust Risk Register.

**Investment strategy**
The aim of the portfolio structure is to provide both long term growth in capital values and income to maintain those values in real terms. This is achieved through a balance between fixed assets securities, UK equities and collective funds such as unit trust and investment trusts. As there have been significant draw-downs over the years, it’s been necessary to take a gradually lower risk profile with the remaining assets.

The Trustee has made the following ethical provisions within their instructions to the investment managers such as no investment in tobacco (nor vaping) companies, no investment in businesses whose primary role is the manufacture of armaments and investments in alcohol producers and related companies should be kept in moderation. The trustee aims to maintain sufficient liquid cash resources available to meet six months’ estimated payment commitments.

**Consolidation of Charity accounts with linked NHS body**
As charitable income during the year is less than 1% of the Trust's revenue (£291k compared to £348,646k), the funds are not considered sufficiently material for consolidated accounts to be prepared. The position will be reviewed annually to confirm whether or not the charity's funds are material enough for consolidation to be appropriate.

**Financial instruments**
The Charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value.

## 2. Prior year comparatives by type of fund

Paragraph 4.2 of the SORP states that FRS102 requires that comparative information must be provided for all amounts in the Statement of Financial Activities (SoFA). The SORP requires that comparative information for the total funds of a charity must be provided on the face of the SoFA and comparative information for each class of funds can be provided either on the face of the SoFA or in a note to the accounts.

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the SoFA and the Balance Sheet for each of the three types of funds that Whittington Charity manages.

The prior year comparatives have been restated to reflect the transfer of two former restricted funds to the unrestricted funds category, on review of their purposes. This has not impacted the overall value of funds, but how they are categorised on the balance sheet.

| | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2017/18 Total (£000) | 2016/17 Total (£000) |
|---|---|---|---|---|---|
| **Income and endowments from -** | | | | | |
| Donations | 51 | 1 | 0 | 52 | 43 |
| Legacies | 32 | 0 | 0 | 32 | 4 |
| Other trading activities | 66 | 11 | 0 | 77 | 55 |
| Investments | 19 | 27 | 0 | 46 | 43 |
| **Total Income** | **168** | **39** | **0** | **207** | **145** |
| **Expenditure on -** | | | | | |
| Raising funds | (43) | (72) | (2) | (117) | (105) |
| Charitable activities | (78) | (166) | 0 | (244) | (305) |
| Governance costs | (11) | (19) | 0 | (30) | (42) |
| **Total expenditure** | **(132)** | **(257)** | **(2)** | **(391)** | **(452)** |
| **Net Income / (Expenditure)** | **36** | **(218)** | **(2)** | **(184)** | **(307)** |
| Gains / (Losses) | 1 | (20) | 0 | (19) | 125 |
| **Net movement in funds** | **37** | **(238)** | **(2)** | **(203)** | **(182)** |
| **Reconciliation of Funds** | | | | | |
| Funds brought forward | 1,511 | 2,355 | 26 | 3,892 | ,4,074 |
| Transfer of Funds | 191 | (191) | 0 | 0 | 0 |
| **Total funds carried forward** | **1,739** | **1,926** | **24** | **3,689** | **3,892** |

## 3. Related party transactions

The corporate Trustee consisted of either employees of the Whittington Hospital NHS Trust or non-executive directors of Whittington Health NHS Trust.

During the year none of the employees or non-executive directors acting as Corporate Trustees or members of the key management staff or parties related to them has undertaken and transactions with Whittington Hospital NHS Trust Charitable Funds.

## 4. Income from donations and legacies

Donations from individuals are gifts from members of the public, relatives of patients and staff.

| | Unrestricted Funds (£000) | Restricted Funds (£000) | Total 2019 (£000) | Total 2018 (£000) |
|---|---|---|---|---|
| Corporate & personal donations | 70 | 63 | 133 | 52 |
| Legacies | 0 | 38 | 38 | 32 |
| Grants | 0 | 0 | 0 | 0 |
| **Total** | **70** | **101** | **171** | **84** |

## 5. Analysis of income from other trading activities

Paragraph 4.42 of the SORP requires that the notes to the accounts provide an analysis of the material components of income included within each analysis heading of the Statement of Financial Activities (SoFA).

| | Unrestricted Funds (£000) | Restricted Funds (£000) | Total 2019 (£000) | Total 2018 (£000) |
|---|---|---|---|---|
| Merchandising | 1 | 19 | 20 | 10 |
| Events organised by volunteers | 32 | 25 | 57 | 67 |
| **Total** | **33** | **44** | **77** | **77** |

## 6. Role of volunteers

Like all charities, Whittington Charity is reliant on a team of volunteers for our smooth running. Our volunteers provide two key roles, Fund advisors and Fund Raisers.

## 7. Gross investment income

| | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2018/19 Total (£000) | 2017/18 Total (£000) |
|---|---|---|---|---|---|
| Fixed Asset Equity | 13 | 27 | 0 | 40 | 33 |
| Cash Deposit | 1 | 1 | 1 | 3 | 13 |
| **Total** | **14** | **28** | **1** | **43** | **46** |

## 8. Analysis of expenditure on raising funds

| | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| Fundraising office | 66 | 105 |
| Fundraising events | 7 | 12 |
| Investment management | 0 | 0 |
| Support Costs | 0 | 0 |
| **Total** | **73** | **117** |

## 9. Analysis of charitable and governance expenditure

The charity did not undertake any direct charitable activities on its own account during the year. All of the charitable expenditure was in the form of grant funding. The expenditure below includes governance costs in the 2018-19 year of £37k; these costs were £30k in 2017-18.

Spend in 2018-19 was significantly higher than in 2017-18, due to the agreement by the Charity to fund £1m of the redevelopment of the Trust's second obstetrics theatre. This spend has been accrued at year end, and was transacted in April 2019.

| | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| Patients | 1,039 | 30 |
| Equipment | 57 | 204 |
| Staff (training, research and other) | 58 | 10 |
| Support staff costs | 35 | 28 |
| Statutory independent examination fees | 2 | 2 |
| Legacy Income Not Recovered | 14 | 0 |
| **Total** | **1,205** | **274** |

## 10. Analysis of grants

The Charity did not make any grants to individuals for 2018/19 or 2017/18.

## 11. Movement in funding commitments

As at 31 March 2019, there were no funding commitments (2017/18: Nil)

## 12. Allocation of support costs and overheads

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs that relate to the strategic and day to day management of a charity.

| | Unrestricted Funds (£000) | Restricted Funds (£000) | Total 2019 (£000) | Total 2018 (£000) |
|---|---|---|---|---|
| Raising funds | 14 | 52 | 66 | 105 |
| Governance Costs | 16 | 19 | 35 | 28 |
| **Total** | **30** | **71** | **101** | **133** |

## 13. Trustees' remuneration, benefits and expenses

The charity's trustees give their time freely and receive no remuneration for the work that they undertake as trustees. However, they can claim expenses to reimburse them for costs that they incur in fulfilling their duties.

Please note that none of the trustees are employed full time by the Whittington Charity.

Trustees expenses were incurred, as detailed below and these were wholly in fulfilment of charity business.

| | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| **Travel and subsistence** | 0 | 0 |
| **Total number of trustees paid** | 0 | 0 |

## 14. Analysis of staff costs and remuneration of key management personnel

The Whittington Charity does not employ anyone full time. Some Whittington Health NHS Trust staff are trustees and are paid by Whittington Health NHS Trust.

## 15. Independent examiners fees

The independent examiners fee of £2k (2017/18: £2k) related solely to the review with no additional work being undertaken.

## 16. Fixed asset investments

All investments are carried at fair value. The significance of financial instruments to the ongoing financial sustainability of Whittington Charity is considered in the risk analysis section of the trustees' annual report.

| Fixed asset investments | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| UK equities | 491 | 467 |
| Overseas equities | 241 | 242 |
| Bonds and fixed interest | 228 | 182 |
| Property | 55 | 51 |
| Other (including cash held by managers) | 65 | 101 |
| **Total Listed investments** | **1,079** | **1,043** |
| Cash on interest bearing deposit | 0 | 1,250 |
| **Total** | **1,079** | **2,293** |

| Reconciliation of fixed asset investments | Bfwd Balance at 01/04/2018 | Purchases | Disposals | Net Gains / (Losses) | Cfwd Balance at 31/03/2019 |
|---|---|---|---|---|---|
| UK Equities | 467 | 39 | (33) | 19 | 491 |
| Overseas Equities | 242 | | (20) | 19 | 241 |
| Bonds and fixed interest | 182 | 80 | (35) | 1 | 228 |
| Property | 51 | 4 | (1) | 1 | 55 |
| Other (incl cash) | 101 | 7 | (37) | (6) | 65 |
| **Listed investments** | **1,043** | **129** | **(126)** | **34** | **1,079** |
| Cash on interest bearing deposit | 1,250 | 0 | (1,250) | 0 | 0 |
| **Total** | **2,293** | **129** | **(1,376)** | **34** | **1,079** |

The main risk from financial instruments lies in the combination of uncertain investment markets and volatility in yield. Due to “quantitative easing” and the market favouring lower risk investments, the yield on bonds has been low giving rise to a significant downside risk of a fall in capital values when interest rates return to “normal” levels.

Whittington Charity manages these investment risks by retaining expert advisors and operating an investment policy that provides for a high degree of diversification within investment asset classes.

## 17. Analysis of current debtors

| Debtors under 1 year | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| Trade debtors | 20 | 39 |
| **Total** | **20** | **39** |

## 18. Analysis of cash and cash equivalents

| | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| Cash in hand | 2,697 | 1,636 |
| **Total cash and cash equivalents** | **2,697** | **1,636** |

The notice deposits are sums held on interest bearing deposit with any bank and represent restricted appeals to fund specific equipment or funds to facilitate cash-flow. The funds are held on a 90 day notice account and therefore classified as liquid and therefore cash and cash equivalent.

No cash or cash equivalent were held in non-cash investments or outside of the UK.

All of the amounts held on interest bearing deposit are available to spend on charitable activities.

## 19. Analysis of liabilities

| **Creditors under 1 year** | 2018/19 (£000) | 2017/18 (£000) |
|---|---|---|
| Charitable activities | 1,000 | 39 |
| Recharges for staff salaries | 66 | 247 |
| **Total** | **1,066** | **286** |

Whittington Charity does not have any creditors greater than 1 year (2017/18: Nil)

## 20. Transfer between funds

There has been no transfer between funds during 2018/19; (2017/18: £191k)

## 21. Analysis of charitable funds

### (a) Analysis of fund movements for 2018/19

| | Bfwd (£000) | Income (£000) | Expenditure (£000) | Transfer (£000) | Gain / (Loss) (£000) | C/fwd (£000) |
|---|---|---|---|---|---|---|
| ***Fund type*** | | | | | | |
| Restricted | 1,926 | 173 | (101) | 0 | 37 | 2,035 |
| Unrestricted | 1,739 | 117 | (1,176) | 0 | 0 | 680 |
| Endowment | 24 | 1 | (1) | 0 | 0 | 24 |
| **Total** | **3,689** | **291** | **(1,278)** | **0** | **37** | **2,739** |

**(b) Analysis of fund movements for 2017/18**

| | Bfwd (£000) | Income (£000) | Expenditure (£000) | Transfer (£000) | Gain / (Loss) (£000) | Restated C/fwd (£000) |
|---|---|---|---|---|---|---|
| ***Fund type*** | | | | | | |
| Restricted | 2,355 | 39 | (257) | (191) | (20) | 1,926 |
| Unrestricted | 1,511 | 168 | (132) | 191 | 1 | 1,739 |
| Endowment | 26 | 0 | (2) | 0 | 0 | 24 |
| **Total** | **3,892** | **207** | **(391)** | **0** | **(19)** | **3,689** |

The trustees set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated (earmarked) funds. In the interest of accountability and transparency a complete breakdown of all such funds is available upon written request.

Analysis of material funds is included in the following table.

| Material Fund Name | Balance at 31/03/2019 (£000) | Purpose |
|---|---|---|
| The Kanitz Bequest | 767 | Earmarked for Trusts ITU unit. |
| Andre Kanitz Bequest | 129 | Earmarked for cancer research. |
| General Restricted Fund | 117 | These funds are ring-fenced and ear marked for allocation across Restricted funds. |
| Montuschi | 111 | For use of Montuschi ward to improve medical and clinical services as well as staff welfare. |
| Beatrice Kanitz Bequest | 107 | Earmarked for use on Nightingale ward, to support Asthma sufferers. |

## 22. Total return on investments

The total return on investments for 2018/19 was a £37k gain, (2017/18: £19k loss)

Whittington Health NHS

# Whittington Hospital NHS Trust Charitable Funds

# Annual Report for the year ending 31 March 2019

Registered charity number: 1056452

Whittington Health NHS Trust
Magdala Avenue
London N19 5NF

## Statement and welcome from the Chair

This year was a special one for our trust and our charity: it was the 70th anniversary of the NHS and we witnessed celebrations taking place right across the country. Whittington Health was no exception – our charity both supported and raised funds at our celebration.

This was also the year when we bolstered the fundraising efforts for our Children's Ward Play Terrace appeal, a project which had not managed to get off the ground in previous years. We invested in dedicated support for the project and I am delighted to say that that investment and focused activity bore fruit and, at the time of writing, the fundraising target has been successfully reached.

Our charity is extremely proud to support not just the care and treatment that our staff provide, but in some cases our staff themselves. Every bid that we receive looks at the benefit to the care, treatment or service we provide, whether that is specific – such as the improved safety and environment that our new obstetric theatre will provide – or general – such as showing our staff how much we care by contributing to staff recognition schemes.

I would like to thank everybody – be they staff, patients or their families or even local residents – for all the support you have shown us this year. Every donation makes a difference, whether you leave a legacy in your will or drop a coin in a bucket, whether you train for months to run for miles to make your sponsors proud or host a coffee morning to encourage local friends to donate or get involved – thank you to every single one of you.

**Tony Rice**
Chair
Charitable Funds Committee

## Objectives and activities

The purpose of the Whittington Hospital NHS Trust Charitable Fund (registered charity 1056452) ('the Charity') is to accept, hold and administer any property on trust for all or any purposes relating to Whittington Health services. This includes better patient experience, education and research, or to any other part of the health service associated with the Trust.

The Charity is dedicated to raising money for patients, services and staff at Whittington Health. As a registered charity we manage and distribute funds to offer support to patients and improve the environment for service users, patients and staff.

The Charity includes the Whittington Hospital Medical Education Charitable Fund (transferred in 2001) and Haringey and Islington Primary Care Trust's Charitable Funds (transferred from North Central London (Camden PCT) in 2011).

In planning our activities for the year we kept in mind the Charity Commission's guidance on public benefit at Charitable Fund Committee meetings. This included decisions made on whether to approve expenditure items in excess of £5,000 in line with the governance arrangements of the Charity.

In the achievement and performance, and fundraising sections below, we set out the principal activities undertaken during the year to further the Trust's work for the public benefit in the community.

## Whittington Health

Whittington Health occupies a unique place in North London – as an integrated care organisation providing hospital and community services, we have a clear vision to help local people live longer, healthier lives.

We serve the communities of Islington and Haringey as well as Camden, Hackney, Enfield, Barnet and other parts of North West London.  This might be through patients coming to our hospital for planned or emergency care, patients coming to appointments at one of our community centres or by our staff, such as health visitors, district nurses or community pharmacists, coming into their homes.  Providing such a range of care is what makes us a truly integrated care organisation.

Despite demand rising, our staff always aim to provide high quality, timely care to our patients and our charity exists to support that – either by supporting care and treatment directly or by supporting our staff to provide that care and treatment.

## Achievements and performance

### Financial review of 2018/19

The charity generated income of £291,000 in the year, which was £84,000 (41%) higher than in 2017-18. The increase primarily resulted from the Trust's fund raising drive around the Ifor Ward play terrace, which is due for construction in 2019-20. In addition, fundraising around significant events such as the London Marathon remains strong. Other income in 2018-19 largely consisted of donations and income from trading.

The charity's main item of expenditure in the 2018-19 financial year was to make a £1m donation to the construction of the Trust's second obstetrics theatre, which is due for completion in 2019-20.

The charity also purchased a range of equipment for different services that directly supported patients and staff within the hospital and community to provide better services.

### Our second obstetric theatre

Our maternity services are there from the very start of a woman's pregnancy through to the birth of their baby and beyond. The charity will be supporting this by putting considerable funds towards a new obstetric theatre located close to our labour ward and existing theatre.

This will mean that women in labour do not need to be moved to our main operating theatres, which are located in a different part of the hospital. It also gives us the opportunity to include a new recovery area for our obstetric patients.

The work began at the end of the reporting year – however, by the time of publication of this report, the new theatre will have seen its first birth.

### Ifor Ward Play Terrace

It has been a long-held ambition of our hospital paediatric staff to expand and improve the Play Terrace located just outside our children's ward. Due to the nature of the building, this was not a straightforward project and anticipated costs reached £250,000. However, thanks to the tenacity of our staff, a fundraising partnership with Bright Horizons nurseries and some resources dedicated to making this a reality, fundraising for this projected was reinvigorated in January.

With a more focused resource, the charity was able to explore a range of income opportunities, including applications to grant-making organisations, corporate partnerships, a greater focus on engaging with local supporters and providing more support for staff-led fundraising.

Special thanks must go to Paediatric Consultant Kerry Robinson and parent Lucy Searle, who undertook a sponsored bike ride through Kerala and raised an amazing £24,851. They went beyond this activity to be ambassadors for the project and their work and dedication was key to refreshing this project. We also have to thank Lara Chinn, whose support and involvement was fundamental to our successful fundraising.

This strengthened approach to the project, which began in January, took hold as we moved into the next reporting year. However, we are delighted to report that the project was successful, with building work commencing the following summer – we will bring you more detail on this in next year's annual report.

## Fundraising news

This year also marked a very exciting one for the NHS – its 70$^{th}$ birthday. Whittington Health, supported by the charity, celebrated in style, culminating in an open day for local people at the hospital. The event showcased our staff and our services, as well as helping us to develop new relationships with local organisations. As part of this, our charity signed up the "The Big 7Tea", the nationally-coordinated fundraising for NHS charities.

Our relationships with local supporters is something we value very highly. From the annual quiz night hosted by Whittington Health and run by the Islington, Highgate and Muswell Hill Rotary Club to the parents whose children received our care and who decided to get involved in fundraising for the Play Terrace, we know that we would not exist without their contributions.

We are also extremely grateful for the support of our volunteers who staff our charity stall in the hospital as well as help us at local community events. Our attendance at these events has begun to increase and in future years we will be looking at how this can go even further.

We continue to get good interest from staff in taking part in challenge events – most notably the London Marathon in the spring and the London 10k held in the summer. However, we would like to explore in future years how we can provide more regular opportunities for people to fundraise in this way.

During the year, following a vacancy opening up in the Fundraising team, the charity decided to take some time to assess how to move forward. We engaged the help of external experts to advise our committee on how we can meet our ambitions for our charity in the future. While this work took place, we outsourced our fundraising function on an interim basis. The project to review the charity completed at the end of the reporting year and how we deliver our plans is a matter for the next reporting year.

Our fundraising supplier was primarily focused on fundraising for our children's ward play terrace. As well as ensuring the delivery of the project, this also served to positively engage our staff in fundraising, demonstrating the value of the fundraising function and setting clear expectations for future projects. Our supplier also made some positive progress on exploring new ways for people to donate – however, most of the work fell into the following reporting year so we will provide a more detailed update on this in our next annual report.

To find out how you can get involved please visit our section of the Trust website www.whittington.nhs.uk, email us at fundraising.whitthealth@nhs.net or call us on 020 7288 3402.

To make a donation online please visit www.justgiving.com/whittington or send a cheque payable to 'Whittington Hospital Charitable Funds' with a short note explaining which part of the Trust you would like to benefit to:

Whittington Hospital Charitable Funds
Whittington Health NHS Trust
Communications Office
Jenner Building
Magdala Avenue
London
N19 5NF

## Corporate Trustee

The Board of Whittington Health NHS Trust acts as corporate trustee of the charitable funds and is accountable to the Charity Commission. Following the transfer of services from the Royal Northern Hospital, the main consolidated hospital funds were formally established by model declaration of trust in 1996, for any charitable purposes relating to the Trust. In 2001, The Whittington Hospital Medical Education Charitable Fund, which had been a separate entity, was brought under the same corporate trustee as the main funds. In July 2011 Statutory Instrument SI 2011 no.1552 transferred the former Haringey and Islington PCT funds held on trust from Camden PCT to the Whittington Hospital NHS Trust.

## Delegation to fund-holders

The Corporate Trustee delegates day-to-day administration of funds to relevant senior Whittington Health employees or people with joint contracts of employment with the health organisation and the university. These fund holders work within a framework of rules and policies set down by the Corporate Trustee. Fund holders are responsible for ensuring that the funds are used in accordance with the donors' wishes and the objectives of the charity.

## Board Members acting during 2018-19

| | |
|---|---|
| Steve Hitchins | Chairman |
| Siobhan Harrington | Chief Executive |
| Dr Richard Jennings | Medical Director (to November 2018) |
| Dr Julie Andrews | Acting Medical Director (from November 2018) |
| Michelle Johnson | Chief Nurse and Executive Director of Patient Experience |
| Stephen Bloomer | Chief Finance Officer |
| Carol Gillen | Chief Operating Officer |
| Jonathan Gardner | Director of Strategy and Corporate Affairs (from May 2018) |
| David Holt | Non-Executive Director |
| Tony Rice | Non-Executive Director |
| Anu Singh | Non-Executive Director |
| Prof. Graham Hart | Non-Executive Director |
| Yua Haw Yoe | Non-Executive Director |
| Deborah Harris-Ugbomah | Non-Executive Director |
| Prof. Naomi Fulop | Non-Executive Director |

**The Chair of Corporate Trustee for 2018-19:** Steve Hitchins

**The Chair of Charitable Funds Committee for 2018-19:** Tony Rice

**Charity's principal address:** Whittington Health NHS Trust, Magdala Avenue, London N19 5NF.

**Bankers:** Lloyds TSB **(**City Office Gillingham), PO Box 72, Bailey Drive, Gillingham, Kent, ME8 0LS

**Investment Managers:**

- Investec Wealth & Investment Limited - 2 Gresham Street, London, EC2V 7QN;
- CCLA Investment Management – 2 Fore Street, London, EC2Y 5AQ
- Lloyds TSB **(**City Office Gillingham), PO Box 72 Bailey Drive, Gillingham, Kent, ME8 0LS

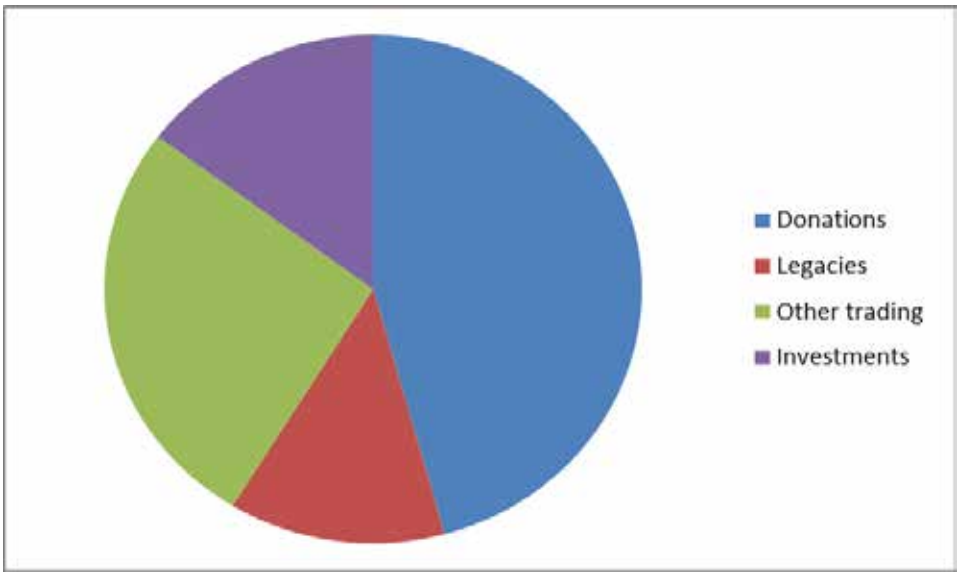
**Independent Examiner:** Griffin Stone Moscrop & Co, 21-27 Lamb's Conduit Street, London WC1N 3GS.

## Income and Expenditure: Overview of the 2018-19 year

### Income

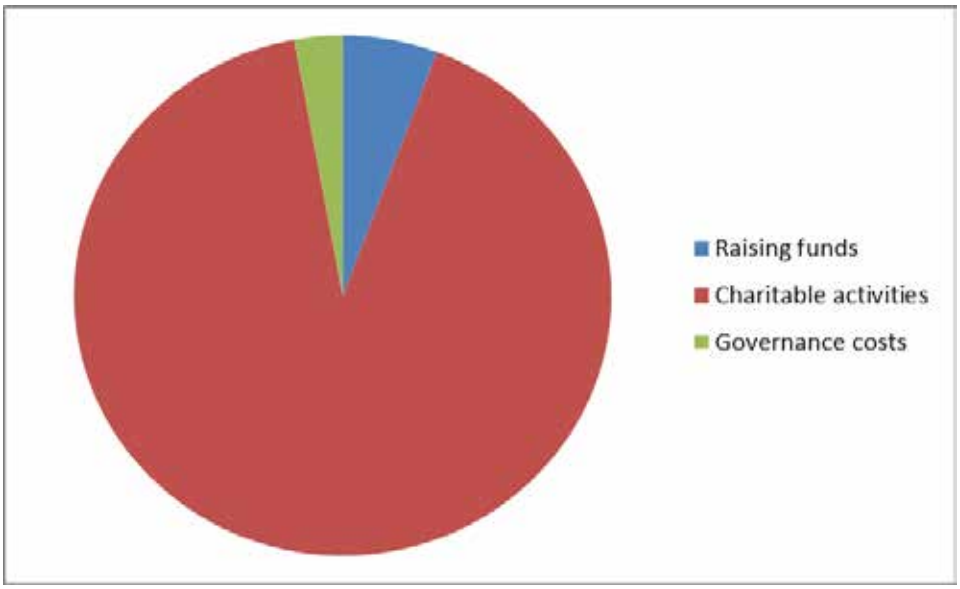
The charity raised incoming resources of £291k in 2018-19. Out of these donations was £133k (2017-18: £52k). Legacies received for the year were £38k (2017-18: £32k). Other trading activities income was £77k (2017-18: £77k); and income from investments for the year was £43k (2017-18: £46k). Increased donations were driven by the Charity's fundraising initiative for the Ifor Ward play terrace.

2018-19 income by different categories is shown in the pie chart below.




### Expenditure

Total expenditure for the year was £1,278k (2017-18: £391k). £1,168k was spent on various charitable activities, £73k on cost relating to income-generating activities (2017-18: £244k and £117k respectively). £37k was spent on governance costs (£30k in 2017-18). The large increase in spend was driven by the Charity's contribution to the construction of a second obstetrics theatre at Whittington Health. 2018-19 expenditure by different categories is shown in the pie chart below.



The Charity does not hold reserves specifically; although it does have funds of approximately £2.7m as at 31 March 2019. Funds are able to support the Charity's operations for the foreseeable future, and there are no going concern uncertainties in relation to the Charity. There are no individual funds in deficit.

### Fund Balances

The Charity holds the following fund balances as at 31 March 2019, divided in the following service areas:

| Division | Total funds (£k) |
|---|---|
| Children's | 275 |
| Community | 39 |
| Corporate | 847 |
| Medicine | 358 |
| Postgraduate | 65 |
| Surgery | 1,002 |
| Women's and ACW | 153 |
| **TOTAL** | **2,739** |

## Investment Review

The combined value of the investment portfolio as at 31 March 2019 was £1,079k. This balance consisted mostly of a combination of stocks and high interest deposits. Over the course of the year, no cash withdrawal was made from the investment portfolio, but some high interest deposits expired and were reinvested.

### Investec Portfolio

This portfolio is made up of an acute fund and a community fund. The total combined value of the portfolio was £1,076k, of which 89% was held in equities and fixed interest; in addition the portfolio included a cash balance of £62k.

Of this combined portfolio value, £413k relates to community funds and £663k relates to the acute funds.

### Investments – Acute

The value of the investment portfolio as at end of March 2019 is £663k (2017-18: £641k) of which 6.2% of the portfolio was held as cash.

- Total investment gain for the financial year 2018-19 was £22k. In 2017-18, there was an investment loss of £15k on the acute portfolio.
- Portfolio Review: The portfolio investment performed strongly in 2018/19 and outperformed the benchmark by 1%. This was despite global economic and geopolitical challenges in the USA and Europe. Investment asset allocations were largely in line with benchmark; the fund manager overinvested slightly in overseas equities and infrastructure; but these had performed strongly compared to UK-based investments in the financial year.

| ACUTE | Fund growth % | Benchmark growth % | Variance |
|---|---|---|---|
| Last quarter (31/12/18 - 31/3/19) | 6.1 | 7.4 | -1.3 |
| Financial year 1/4/18 - 31/3/19 | 7.7 | 6.6 | 1.1 |

**Asset allocation by category**

| | Actual % | Benchmark % | Variance |
|---|---|---|---|
| UK fixed interest | 25.8 | 25 | 0.8 |
| UK equities | 46.6 | 50 | -3.4 |
| Overseas equities | 21.3 | 20 | 1.3 |
| Infrastructure | 2.7 | 0 | 2.7 |
| Cash | 3.6 | 5 | -1.5 |
| | 100 | 100 | |

## Investments – Community

The value of the investment portfolio as at 31 March 2019 is £413k (2017-18: £398k) of which 4.8% of the portfolio was held as cash.

- Total investment gain for the financial year 2018-19 was £15k. In 2017-18, there was an investment loss of £6k on the community portfolio.
- Portfolio Review: Commentary on the community investments is similar to that for acute. As with acute, the fund grew strongly in quarter 4 and outperformed the benchmark generally across the year by approximately 1%.

| COMMUNITY | Fund growth % | Benchmark growth % | Variance |
|---|---|---|---|
| Last quarter (31/12/18 - 31/3/19) | 6.5 | 6.8 | -0.3 |
| Financial year 1/4/18 - 31/3/19 | 8.0 | 6.8 | 1.2 |

**Asset allocation by category**

| | Actual % | Benchmark % | Variance |
|---|---|---|---|
| UK fixed interest | 13.7 | 16 | -2.3 |
| UK equities | 44.1 | 45 | -0.9 |
| Overseas equities | 24.1 | 21 | 3.1 |
| Property | 13.2 | 13 | 0.2 |
| Infrastructure | 2.9 | 0 | 2.9 |
| Cash | 2.0 | 5 | -3.0 |
| | 100 | 100 | |

## Investec's Investment Outlook

Investec's outlook to success remains promising despite global economic and geopolitical challenges. They promise a focused and determined yet cautious approach to investment and would be looking to commit funds to the most favoured opportunities in the coming year, bearing the uncertainties around interest rate risks etc.

***CCLA:*** This is a low value portfolio; value as at end of March 2019 in the COIF Charity Funds was £3k and at the end of March 2018 was also £3k.

## Risk Management

The financial controls of the Trust also apply to the Charity; the only major area of financial risks for charitable funds is the performance of the investments.

The aim of the investment portfolio structure is to provide both long term growth in capital values and income to maintain those values in real terms. This is achieved through a balance between fixed assets securities, UK equities and collective funds such as unit trust, investment trusts and high interest deposits. Based on financial market history where significant drawbacks have happened in the last few years , it's been necessary to take a gradually lower risk profile with our assets, to mitigate such risks of investment performance the trustees have adopted a medium risk policy to the management of the charity's assets. The current account balance is also being monitored as part of achieving the overall strategy.

The objects of the charity portfolio are to be met by way of a prudent investment strategy based on a diversified range of bonds and equities which are quoted on a recognised investment exchange, and unit trusts which are authorised under the Financial Services and Markets Act 2000. The type of each investment and the individual investments themselves is suitable to meet the charity's purposes.

Principal financial statements (Statement of Financial Activities and Balance Sheet) for the Charity are included below.

## Statement of Financial Activities

| | Note | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2018/19 Total (£000) | 2017/18 Total (£000) |
|---|---|---|---|---|---|---|
| **Income and endowments from -** | | | | | | |
| Donations | 4 | 70 | 63 | 0 | 133 | 52 |
| Legacies | 4 | 0 | 38 | 0 | 38 | 32 |
| Other trading activities | 5 | 33 | 44 | 0 | 77 | 77 |
| Investments | 7 | 14 | 28 | 1 | 43 | 46 |
| **Total Income** | | **117** | **173** | **1** | **291** | **207** |
| **Expenditure on -** | | | | | | |
| Raising funds | 8 | (17) | (55) | (1) | (73) | (117) |
| Charitable activities | 9 | (1,143) | (27) | 0 | (1,170) | (244) |
| Governance costs | 9 | (16) | (19) | 0 | (35) | (30) |
| **Total expenditure** | | **(1,176)** | **(101)** | **(1)** | **(1,278)** | **(391)** |
| **Net Income / (Expenditure)** | | **(1,059)** | **72** | **0** | **(987)** | **(184)** |
| Gains / (Losses) | | 0 | 37 | 0 | 37 | (19) |
| **Net movement in funds** | | **(1,059)** | **109** | **0** | **(950)** | **(203)** |
| **Reconciliation of Funds** | | | | | | |
| Funds brought forward | 21 | 1,739 | 1,926 | 24 | 3,689 | 3,892 |
| **Total funds carried forward** | | **680** | **2,035** | **24** | **2,739** | **3,689** |

## Balance Sheet

| | Note | Unrestricted Funds (£000) | Restricted (£000) | Endowment (£000) | 2018/19 Total (£000) | Restated 2017/18 Total (£000) |
|---|---|---|---|---|---|---|
| **Fixed Assets** | | | | | | |
| Investments | 16 | 268 | 802 | 9 | 1,079 | 2,292 |
| **Total fixed assets** | | **268** | **802** | **9** | **1,079** | **2,292** |
| **Current Accounts** | | | | | | |
| Debtors | 17 | 6 | 14 | 0 | 20 | 39 |
| Cash | 18 | 1,434 | 1,248 | 15 | 2,697 | 1,636 |
| Stock | | 4 | 5 | 0 | 9 | 9 |
| **Total current assets** | | **1,444** | **1,267** | **15** | **2,726** | **1,684** |
| **Liabilities** | | | | | | |
| Creditors due within one year | 19 | (1,032) | (34) | 0 | (1,066) | (287) |
| **Net current assets / liabilities** | | **412** | **1,233** | **15** | **1,660** | **1,397** |
| **Total assets less current liabilities** | | **680** | **2,035** | **24** | **2,739** | **3,689** |
| **The funds of the Charity** | | | | | | |
| Endowment funds | 21 | 0 | 0 | 24 | 24 | 24 |
| Restricted income funds | 21 | 0 | 2,035 | 0 | 2,035 | 1,926 |
| Unrestricted income funds | 21 | 680 | 0 | 0 | 680 | 1,739 |
| **Total funds carried forward** | | **680** | **2,035** | **24** | **2,739** | **3,689** |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 29.1.2020** |
| **Report title** | **Audit & Risk Committee update** | **Agenda item: 19** |
| **Executive director lead** | Kevin Curnow, Acting Chief Finance Officer | |
| **Report author** | Deborah Harris-Ugbomah, Non-Executive Director and Chair of the Audit & Risk Committee | |
| **Executive summary** | Board members are provided with an update from the 15 January 2020 meeting of the Audit & Risk Committee. | |
| **Purpose:** | Noting | |
| **Recommendation(s)** | Board members are asked to note the Chair's update from the Audit & Risk Committee meeting held on 15 January 2020. | |
| **Risk Register or Board Assurance Framework** | All BAF entries | |
| **Report history** | None | |
| **Appendices** | None | |

**Audit & Risk Committee Chair's Update**

*Our activity reflects consideration of key risks to the corporate strategy, with detailed review of specific risks for which this committee has board-delegated responsibility (e.g. Financial Reporting, Counterfraud, Financial Management).*

**1. Governance**

**1.1 Items carried forward from October 2019 meeting**

These were considered at the January 2020 meeting.

**Recommendation: None**

Assurances received for this period covered the following risks themes:

- Board Assurance Framework and governance considerations
- Corporate Risks
- Assurances on process to consider the 2019/20 Quality Report
- Counterfraud
- Internal Audit progress
- Preparations for audit of the Financial statements
- Year End reporting and audit planning
- Financial Reporting, Financial Management Risks, Losses and Special Payments

**1.2 Committee membership**

The committee noted the trust is currently recruiting for additional Non Executive Director role (NED) which may help address the membership needs of the Audit Committee in due course.

**1.3 Review of governance documents**

The independent NED definition was to be clarified for board understanding and discussion.

**Recommendations:**

**The Board is asked to accept all changes to the governance documents.**

**The Board to confirm dependent and independent NED authority is appropriately addressed.**

**1.4 Board Assurance Framework (BAF)**

The BAF was presented with a recommendation to increase the risk score for the entry Sustainability 2, following review by the Trust Management Group.

**Recommendation: Board to agree an increased risk score from 12 to 16 for BAF entry Sustainability 2.**

**1.5 Standing Financial Instructions (SFIs), Standing Orders (SOs), Scheme of Reservation and Delegation of Powers**

The review of standing orders (SO), standing financial instructions (SFI), and scheme of reservation and delegation of powers was considered. These changes had been considered since November and were supported.

**Recommendation: That the Board approve the revised SOs, SFIs and Scheme of Reservation and Delegation of Powers.**

**2. Risks & assurances: systems and controls around Quality**

*Note: In line with Good to Great initiatives, this committee considers Quality risks and assurances for **D**elivery, **O**utcomes, **S**afety and **E**xperience ('DOSE').*

As well as the minutes from the Quality Committee, the committee was given assurances that executive leads would share highlights of the 2019/20 Quality report prior to its finalisation at the next Committee meeting in March, in line with previous years.

**3. Risks & assurances: Financial management**

**3.1. SFI waivers, losses and special payments**

The log of SFI Waivers, Losses and Special Payments was noted. No untoward items were highlighted or noted. An action to take additional action to address frequent waivers was noted.

**3.2. Accounts receivable**

The members reviewed the current position and following a discussion on the cost benefits to the NHS, agreed the proposed position for bad debt write offs

**4. Risks & assurances: Year-end financial reporting**

The members noted the plan for year end reporting and the external audit schedule. The Committee Chair will meet with Acting Head of Finance prior to the start of the external audit work.

**5. Risk & assurances - Counter fraud**

The Committee received an update on progress of Local Counter Fraud Service (LCFS) cases reported and status to date. Members received summary assurances on the working between LCFS.

**6. Risk & assurances: Progress of internal audit reviews**

Committee members noted the rescheduled timetable for internal audit reviews which caused some concern. Capacity and timely communication from both management and internal auditors had contributed to this current position. A schedule of work has been agreed to bring all reviews to completion prior to the year-end meeting. An additional meeting and a further conference call will be available to ensure the members can review and discuss all assurances in advance of the Committee meeting in May. A formal letter confirming this position will be provided for internal auditor consideration.

**Recommendation: The Board may wish to seek assurances from the Audit Committee Chair on the status of progress of this work prior to the May Board meeting.**

| | |
|---|---|
| | **Workforce Assurance Committee – Draft minutes of the meeting held on Wednesday 11th December 2019** |

**Present:**

| | |
|---|---|
| Kevin Curnow | Acting Chief Finance Officer (via telephone link) |
| Clare Dollery | Medical Director |
| Norma French | Director of Workforce |
| Carol Gillen | Chief Operating Officer |
| Michelle Johnson | Chief Nurse & Director of Allied Health Professionals |
| Helen Kent | Assistant Director of Learning & OD |
| Tony Rice | Non-Executive Director |
| Kate Wilson | Deputy Director of Workforce |
| Yua Haw Yoe | Non-Executive Director (in the Chair) |

**In attendance:**

| | |
|---|---|
| Kate Green | PA to Director of Workforce (Minutes) |
| Gordon Houliston | Director of Operations, Children & Young People |
| Beverleigh Senior | Director of Operations, ACW |
| Swarnjit Singh | Trust Corporate Secretary |

**Apologies:**

| | |
|---|---|
| Anu Singh | Non-Executive Director |

19/34 Welcome and Introductions

34.01 Yua Haw Yoe welcomed everyone to the meeting, explaining that she was standing in as Chair for Anu Singh who was unable to be present. She was particularly pleased to welcome the two ICSU Directors of Operations present, and it was noted that ICSU representatives would from henceforth try to be present by rote.

19/35 Minutes of the last meeting

35.01 The minutes of the WAC held on 20th September were approved. It was noted that due to that meeting having been inquorate, there was a need for this meeting to formally approve the minutes of the meeting held on 24th April. Copies of these minutes were distributed and it was agreed to take this item towards the end of the meeting in order to give committee members opportunity to review them.

35.02 It was noted there had been some Board-level discussion about the nomenclature of 'Board sub-committees'. Asked for his advice, Swarnjit Singh said that the most important thing was to ensure consistency. It was agreed that 'Board Committee' would be used in future.

Board Assurance Framework (BAF)

35.03 Introducing this item, Swarnjit reminded committee members that the BAF had been taken to the previous Trust Board meeting. The committee should focus on whether any additional action needed to be taken to ensure risks were being effectively mitigated.

35.04 Yua Haw invited the committee to consider 'People 1', i.e. failure to recruit and retain high quality substantive staff. Norma French said that there were several measures in place to mitigate against this risk, including the weekly Vacancy Scrutiny Panel and monthly multi-disciplinary Recruitment & Retention Group. The latter had been temporarily paused for the winter but would reconvene in the New Year. Michelle suggested that the Recruitment & Retention Group should in future focus more on retention, beginning with looking at an analysis of generation data; there was also scope for increased usage of exit interviews.

35.05 Tony Rice had visited the imaging service, and had been struck by how the introduction of new technology had appeared to contribute to increased retention of staff. Michelle said that succession planning was a concern in interventional radiology. Clare asked whether the national situation around pensions might be having a negative effect, and Norma agreed this was a good point though should only be affecting the current year as was a short-term measure put in place whilst the outcome of the public consultation was formulated. . Swarnjit asked about the sector's approach to bank rates, but Norma felt this was not an issue as it did not impact on substantive staff and at present there are only high level discussions at a sector level. Kate Wilson said that the team would be introducing the 'first hundred days' survey in the New Year and this should generate increased useful date.

35.06 Moving to 'People 2', i.e. organisational culture, Michelle wondered whether the risk rating was sufficiently high, however there was general agreement that it was quite difficult to carry out a risk rating on culture, with Tony making the point that one could feel it, but not measure it. It was noted however that the CQC had commented favourably on the Trust's culture during their recent visit. Also of relevance were staff survey results and numbers of referrals to the Freedom to Speak up Guardian.

35.07 Kevin Curnow pointed out that there were no Tier 3 assurances (external checks and challenges) on either of the risks. It was agreed that the staff survey, Freedom to Speak Up Guardian and CQC all potentially fell into this category and could be shown as such on the BAF.

**The committee formally approved the BAF subject to the inclusion of Tier 3 assurances as described above.**

19/37 Quarter 2 Workforce Report

37.01 Kate Wilson introduced the workforce report for Q2 of 2019/20. She highlighted the following:

- The overall sickness rate stood at 3.3%, virtually no change from the previous report, although rates had dropped in all ICSUs bar S&C. Sickness rates in Facilities remained high in although there had been some reduction since Q1.

- The overall turnover rate for the Trust in Q2 was 10.6%, with all areas below the 13% target other than CYP.

- There had been a decrease in the overall vacancy rate since Q1, although there had been a very minor increase in nursing. It was confirmed that AHP data was also included within the report.

- Kate was pleased to report that temporary staffing usage continued to reduce. In answer to a question from Clare about the movement of staff from agency to bank, Norma replied that the team would try to illustrate this in a future report. Michelle asked whether the Trust's data aligned to that of the Model Hospital, and Norma replied that it did and the Trust was below the indicator for both sickness absence and vacancy, as had been demonstrated during the use of resources inspection.

- Compliance with mandatory training reached 81% for Quarter 2, a slight increase from the previous quarter, with five areas having reached the 90% target. Appraisal rates had also improved, rising from 72% in Quarter 1 to 74% in Quarter 2. Kate informed the committee that a working group had been established to help support increased compliance with both appraisal and mandatory training.

37.02 Pointing out that Whittington Health's performance against targets was higher in some areas than that of other organisations within the sector, Michelle suggested there was a case for reviewing targets, with a view to introducing new measures at the start of 2020/21. This would in no way justify any reduction in performance. Within mandatory training, Carol pointed out that some of the specific modules (e.g. information governance) might require different treatment.

37.08 It was noted that some trusts' targets are lower (at 80%) that that of Whittington Health (at 90%). Helen Kent said that the 90% compliance rate was agreed across the STP, however, lowering the target did not create an obstacle for the portability of staff and their learning records, and so the wish to remain in alignment with NCL STP would not be affected by the lowering of the Trust's internal compliance rate.

37.09 Norma asked about the most appropriate vehicle to take forward a review of targets, and Swarnjit Singh suggested this could be done via the committee chair's assurance report to the Board then actioned during Q4 when the 2020/21 integrated performance scorecard would be finalised. It was noted CQC inspectors had appeared satisfied with the Trust's performance in this area.

**The committee noted the report and agreed to recommend a review of targets via the chair's assurance report to the Board.**

19/38 <u>Employee Relations Activity</u>

38.01 Kate Wilson informed the committee that there were now twenty-one ongoing cases, with fourteen having now been closed. Five members of staff were currently suspended, an increase of three since the previous report. Referring to the 90-day completion standard, Kate said that there had been a slight decline from the previous quarter, however four had been resolved during October, leaving only one outstanding, and there were very specific reasons for the delay in resolving this particular case.

38.02 This quarter the team had been looking at Dido Harding's recent report and putting together options in response to the recommendations contained within the review into the Mr Abdullah case at Imperial NHS Trust. One of the first to be tested was the allocation of a 'buddy' to be the point of contact for staff who had been dismissed, especially those going through the appeal process. These buddies were from a different department than the one the member of staff they were supporting worked, and were senior staff recommended by the Employee Relations team. Fortnightly case reviews continued, and the team was also reviewing the impact of the Fair Treatment Panels.

38.03 Kate informed the committee that she was formulating a restructure of the team. There had recently been two resignations, and a high turnover in the employee relations manager post, and Kate was considering the introduction of a designated investigation support team.

38.04 Michelle asked whether there were any formal grievances to report, and Kate replied that there had been none during that quarter. It was agreed that this demonstrated a sea change in culture from the time when Professor Duncan Lewis had carried out his survey, at which time Whittington Health had been perceived as having a grievance culture. Beverley asked whether it was possible to report on dismissals, and it was agreed that this would only be possible to report at a Trust level in order to guard against the possible identification of any individual. Yua Haw was interested in seeing whether any dismissals had occurred for capability, rather than disciplinary reasons.

38.05 Michelle suggested that from Quarter 1 of next year the report should also include a section on Fair Treatment Panels, and Carol agreed, saying there had been several instances where the panels had made recommendations not to proceed.

**The committee noted the report, and agreed to implement the changes recommended from the start of the next financial year.**

19/39 <u>Time to Hire Report</u>

39.01 Introducing this report, Kate Wilson informed the committee that this report followed a new improved format, and clearly demonstrated progress made over the past few months. The reasons for delays in recruitment had not changed, the chief delay being the length of time between the resignation of a staff member and a form being taken to VSP. Time to hire is now down to eight weeks. The team has been developing pages on social media (LinkedIn, Twitter etc.) which were generating considerable interest.

39.02 Kate added that a new team was now in place and she had seen real improvement; Norma echoed this, saying that it was worthy of note that there had been no complaints for some two months now. Yua Haw asked about the delay between resignation and advertisement of the post, and Gordon explained there were often valid reasons for this, such as a decision to restructure (unlikely to take place during a CQC inspection). Carol added that in some cases delays could be caused by a simple lack of capacity within a service; just having the time to get things done. This was particularly the case where the recruiting manager was a clinical one.

39.03 The committee discussed the function of VSPs, with Clare citing an example of where they had proved effective and asking whether relevant key performance

indicators (KPIs) might be applied. Carol replied that the Trust's VSP did ask questions, and although it seldom withheld approval, there was robust scrutiny of posts brought to it. Beverleigh added that within her ICSU (ACW) posts were scrutinised thoroughly before being brought to VSP.

39.04 Tony Rice pointed out that there was really only opportunity to improve timings in the first two KPIs set out in the chart – the remainder did not allow for much 'wriggle room'. Kate replied that the latter ones were the responsibility of recruitment, although some, such as the receipt of references, were outside the team's control. Michelle mentioned that she was aware of a recent post where the recruitment manager had had to shortlist from 179 applicants. Kate said that it was possible to apply filters but not everyone would be familiar with the methodology for doing this.

39.05 Gordon had found this report interesting and useful and said that it would be useful to have this level of detail for ICSU Boards. Kate would follow this up with the team. She added that the team had been working closely with finance colleagues to refine forms and processes.

39.06 The report on nursing recruitment and retention is produced monthly for the executive team, and had been included with these papers for information only. Michelle asked for thanks to be passed on to the recruitment team for all the hard work they had undertaken.

**The report was formally received by the committee.**

19/40 Caring for those who care

Mandatory Training, Audit & Governance

40.01 Introducing this item, Helen Kent informed the committee there had been an audit of mandatory training for which the recommendations were accepted. It noted that whilst the Trust had signed up to the national Core Skills Training Framework, there were one or two areas which are not aligned including the following subjects:

- Infection Control; for which the subject matter expert (SME) was in agreement with aligning with delivery frequency. Whilst this will initially reduce compliance the SME is working hard to raise compliance levels
- Resuscitation; which is delivered every two years instead of annually. Michelle felt strongly that it should be aligned although this would be impacted by capacity. Clare Dollery recommended action taken by Oxford Trust which enabled delivery to larger cohorts. It was agreed to ask the team to undertake an options appraisal and if necessary build a business case for consideration.
- Fire Awareness; although e-learning is available it is not used in the Trust. It was noted that this is under discussion with the SME and other stakeholders.

40.02 Referring to paragraph 3 of the executive summary of the paper (governance), Swarnjit Singh advised the committee that the most appropriate body to provide a governance structure for mandatory training was the Trust Management Group. There were no objections to this.

Staff Survey

40.03 Numbers are being validated by Picker. The final result is not yet known but should be received by the end of the week. The response rate to the survey currently stands at 53%, however, the central coordination centre is removing data (e.g. duplicates and people who have left), and the final figure will be available next week. (Update since the meeting: the rate has been finalised at 55.6%).

Michelle asked whether the Trust would receive 'spider charts' as these were very useful, and Norma replied that these had been built into the specification and paid for so should be forthcoming.

WRES Improvement Plan Update

40.04 Work on this was proceeding to plan.

Caring for those who care

40.05 Helen reported that the team had been successful in securing finance to support the appointment of a project manager, Kallon Basham. Kallon's brief was to work on pulling together all strands of the caring for those who care programme under a single umbrella, this covered communications including the intranet.

40.06 Reporting on the training that had taken place, Helen said that over 500 staff had attended the Nelson training on anti-bullying and harassment (their being specialists in this area) and this had been extremely well received, with only one negative feedback response. The team was now bidding for funding to extend the training to all staff. In addition, a bid was being made for 'Outward Mindset' training.

Equality, Diversity & Inclusion Timeline

40.07 Introducing the timeline produced by Charles Rukwengye, Helen was pleased to report that Charles had been invited to join the WRES expert programme. He was also currently working on the development of an organisational approach to enable Trust staff to deal with racist patients. Tony Rice highlighted the importance of work on dealing with difficult conversations. Clare Dollery asked how many WRES experts were employed by the Trust; Helen replied that there were four.

40.08 Swarnjit drew attention to the chart at the top of page 3 of the paper, and explained that the governance structure should show the equality groups reporting to the Workforce Assurance Committee – this was consistent with its terms of reference.
**Reports and updates were received by the committee.**

19/41 Any other business: minutes of April WAC meeting

41.01 Although the September meeting had been inquorate those who had been present at it had agreed that the minutes of the April meeting were an accurate record of proceedings. The minutes of the April Workforce Assurance were therefore approved by the committee.

The minutes of the April 2019 WAC were formally approved.

**Workforce Assurance Committee 11th December 2019: Action Log**

| Item | Action | Lead | Progress/Date |
|---|---|---|---|
| 35.03 | Tier 3 Assurances to be included in future versions of the BAF(People 1 and People 2) | SS | March WAC |
| 37.01 | A summary of AHP data to be included in the front sheet of the quarterly workforce report | KW | March WAC |
| 37.09 | Review of targets to be included within the Chair's assurance report to the Board | SS | January 2020 |
| 38.04 | Information on dismissals to be included in quarterly ER reports | KW | March WAC |
| 38.05 | Report on Fair Treatment Panels to be added from the start of the next financial year | KW | June WAC |
| 39.05 | To ensure that the detailed Time to Hire report is received by all ICSUs | KW | January 2020 |

**Minutes**
**Quality Committee, Whittington Health**

| | |
|---|---|
| **Date & time:** | Wednesday 8th January 2020 |
| **Venue:** | Room 6 Whittington Education Centre, Whittington Hospital |
| **Chair:** | Naomi Fulop (NF), Non-Executive Director |
| **Members Present:** | Tony Rice (TR) Non-Executive Director<br>Clare Dollery (CD) Medical Director<br>Carol Gillen (CG) Chief Operating Officer<br>Michelle Johnson (MJ) Chief Nurse & Director AHPs |
| **In attendance:** | Sita Chitambo (SC) Associate Director of Nursing EIM<br>Deborah Clatworthy (DC) Associate Director of Nursing Surgery & Cancer<br>Sarah Crook (SCr) Head of Clinical Audit & Effectiveness<br>Rose Hensman (RH) Senior Nurse CYP<br>Lorna Jeng (LJ)Consultant Radiologist<br>Alison Kett (AK) Associate Director ACS<br>Gillian Lewis (GL) Head of Quality Governance<br>Karen Miller (KM) Head of Children's Safeguarding<br>Kat Nolan-Cullen (KNC) Compliance and QI Manager<br>Theresa Renwick (TRe) Adult Safeguarding Lead<br>Paula Ryeland (PR) – QI Lead<br>Swarnjit Singh (SS) Trust Corporate Secretary<br>Shahida Trayling (ST) Associate Director of Nursing ACW<br>Carolyn Stewart (CS) Minute taker |

## Agenda items

| 1.1 | **Welcome & Apologies** | **Chair** |
|---|---|---|
| | NF welcomed everyone to the meeting and wished everyone a Happy New Year.<br><br>Apologies were received and recorded from:<br>Deborah Harris-Ugbomah (DHU) Non-Executive Director<br>Jeanette Barnes (JB) Associate Director of Nursing CYP<br>Fiona Isacsson (FI) Director of Operations –S&C<br>Nick Harper (NH) Clinical Director S&C<br>Stuart Richardson (SR) Chief Pharmacist<br>Leanne Rivers (LR) Patient Representative<br>Helen Taylor (HT) Clinical Director ACW | |

| 1.2 | **Declarations of Conflicts of Interests** | **Chair** |
|---|---|---|
| | No conflicts of interest were noted. | |

| 1.3 | Minutes of the previous meeting | Chair |
|---|---|---|
| | 1.1 No amendments were requested to be made to the minutes of the previous meeting held on 13th November 2019. The minutes were approved. | |

| Action Log – open items | Deadline | Owner |
|---|---|---|
| See action tracker | | |

| 1.4 | Matters Arising | Chair |
|---|---|---|
| | There were no matters arising that were not on the agenda | |

| 2.1 | Nursing & Midwifery Strategic Priorities – Bi-annual Review |
|---|---|
| 2.1.1 | MJ referred to the presentation that had been submitted and advised the committee that in relation to Allied Health Professionals (AHPs), most of these priorities are aligned with Nursing and Midwifery. She added that the last 2 slides cover the progress made this year and suggested that the ADONs use them to consider their priorities in each ICSU and to celebrate success. |
| 2.1.2 | With regard to progress and achievements, MJ praised the leadership of the ADONs and the AHP leadership group. She highlighted that Two Nursing Times awards had been won. Staff are attending leadership programmes, including Florence Nightingale, QNI and Aspirant Director of Nursing. Preparing AHP job plans by 2021 is in progress to cover the 800+ employed in the Trust. |
| 2.1.3 | With regard to education, MJ advised that we are moving into a new phase of preceptorship which is in its 2nd year. 55 new graduates started last year, 85% of them are still working at WH. MJ was pleased to report that as a result of focus on recruiting District Nurses, the vacancy rate had decreased from 46% to 10% (over the last 2 years). |
| 2.1.4 | NF requested detail regarding assurance be included. MJ replied that it is not currently detailed in this report but would take the report to the AHP and Nursing & Midwifery Executive Committees to articulate. |

| Actions | Deadline | Owner |
|---|---|---|
| Assurance discussion at AHP & NMEC committees for inclusion in strategic priorities work plan | 15/2/20 | MJ |

| 2.2 | Board Assurance Framework (BAF) – Quality Entries |
|---|---|
| 2.2.1 | MJ advised that updates confirming assurances in relation to Quality have been entered on the BAF quality risk. There has been a review of the risk in relation to the culture of the organisation which will be reported to the Trust Board. |
| 2.2.2 | CD advised that the CQC prep meetings were a time limited group and would no longer be required to provide assurance for the Quality Committee. Starting in January 2020 a new Better never Stops Group has been established and this will be reported in the quality entry of the BAF. Additional assurance to the risk has been confirmed through the establishment of the Clinical Effectiveness Committee. |
| 2.2.3 | CD referred to the BAF entry in regard to integrated care and wellbeing. This related to vacancies in the Breast Services and Bariatrics, and recommended that as a result of an oncology consultant leaving the Trust, medical oncology staffing should be added as a risk. She added that UCLH are providing support to our existing services and that there |

| | |
|---|---|
| | are regular meetings with UCLH to consider this further. |
| 2.2.4 | SS advised that the BAF would be presented to the Audit & Risk Committee and it was requested that it should be approved at TMG. |

| Actions | Deadline | Owner |
|---|---|---|
| 2.2.3 Medical Oncology/Bariatrics staffing risk should be added as a risk to BAF<br>2.2.4 BAF to be approved at TMG | 31/1/20<br>14th Jan 2020 | SS<br>SS |

| 2.3 | Corporate Risk Register |
|---|---|
| 2.2.1 | GL advised that this was a more detailed report, as requested by the Committee. She updated that the mental health vehicle risk has been downgraded. A new risk had been added that related to garden fencing at Simmons House. She confirmed that the video laryngoscope is in the process of being quoted and purchased. |
| 2.2.2 | Deb C pointed out that the bleep coverage in obstetrics risk should be included after a risk assessment concluded that the risk was at >16-20. GL reported that the report had been run prior to this risk being finalised. |
| 2.2.3 | NF queried that with regard to risk 1035 (CYP ICSU Simmons House ligature and anchor point estates work) whether the Nov 19 audit had been completed. MJ queried whether this version matches the Board report that goes with >16 above risks. GL confirmed that it is the same report but that only >16 risks are included in the Board report. |
| 2.2.4 | GL confirmed that the register has been reviewed but has not been updated yet. The divisional performance board reports will focus on this and GL will speak to ICSU managers to ask them to update all their outstanding risks.<br><br>The risk register was approved to go to the Board once it has been updated and the obstetric bleep risk added. |

| Actions | Deadline | Owner |
|---|---|---|
| 1. Bleep coverage in obstetrics to be included on the Risk Register related to bleep coverage in Theatres.<br>2. ICSU managers to update all outstanding risks.<br>3 To confirm risk 1035 re-audit completed | 31/1/20<br>29/2/20<br>31/1/20 | GL<br>ICSUs<br>GL |

| 3.1 | ICSU Update – Adult Community Services (ACS) |
|---|---|
| 3.1.1 | AK advised the committee that this was a 6 monthly report from June to November 2019. There were 79 incidents during the period, of which 63 were pressure ulcers. The Duty of Candour (DoC) figures also relate to pressure ulcers. In moderate or above pressure ulcers, a 72 hour report is produced and uploaded on Datix. This identifies whether the pressure ulcer is attributable to the DN service. If this is the case then a further report is produced within 3 weeks. DoC does not happen until the grade of pressure ulcer has been identified. CD stated that DoC has to be with10 days. It was recommended that an initial DoC letter should be sent giving brief details and advising that it will be investigated with an update to follow. NF asked for the DoC to be reviewed and an update to be reported back to Quality Committee. MJ recommended that it should be reviewed at the pressure ulcer steering group. GL advised that guidance had been requested from |

| | |
|---|---|
| | NHSE/I as there was a national issue on how pressure ulcers with Duty of Candour should be reported. |
| 3.1.2 | CD referred to the 11 incidents that require DoC compliance and requested that an addendum is added to the report to reflect that incidents that are recorded as moderate are non-compliant for DoC. |
| 3.1.3 | In response to SS seeking clarification on assurances the committee is asked to recognise, AK referred to the patient safety appendix, and advised that one Serious Incident (SI) had been declared during the period which is currently being investigated. Pressure ulcers are being closely monitored with the reporting having significantly improved since the previous year. The ICSU had achieved 100% response rate to complaints, most of which related to issues with communication. |
| 3.1.4 | A Quality Improvement (QI) report is presented to the monthly ICSU meeting. There are 32 QI projects for this year. A District Nursing continuity audit was presented. It identified that of 23 patients who required Health Care Assistant (HCA) or above staff, 12 of them had been visited by more than 20 different staff. For patients who require a registered member of staff there were 5 different patients, 1 of which had been visited by 20 different staff. AK stressed that with registered nurses and above there were 6 patients with more complex needs and this was challenging. This should be addressed in the imminent District Nursing restructure. The previous 4 teams in Islington and Haringey have been changed to 3 localities. The number of deputy team managers will be increased in a bid to achieve smaller caseloads. Using an updated version of E-community as well as the Twilight changes will also improve the situation. MJ congratulated AK and her team for an excellent piece of work. AK advised that the team had started looking at activity within the new localities and GPs and a further audit will be carried out. CD added that this was a good example of a Quality Improvement and that the guidance was really impressive and it should be circulated to the committee attendees. |
| 3.1.5 | CG had envisaged that with the reduction in DN vacancies an improvement in continuity of care would be evident. NF asked if evidence for continuity had been researched nationally. AK replied that the new E-community case load management should improve continuity with clinicians.<br>NF was pleased with the new template, but suggested that highlights from appendices could be replaced with bullet points in the executive summary specifically for submission to the Quality Committee. |

| **Actions** | **Deadline** | **Owner** |
|---|---|---|
| 3.1.1 Results of review of DoC to go to next Quality Committee. | 31/1/20 | AK |
| 3.1.2 Add addendum to the report that incidents recorded as moderate are non-compliant for DoC. | 31/1/20 | AK |
| 3.1.4 QI report on DN continuity of care should be circulated to committee attendees | 11/3/20 | AK |
| 3.1.5 Future reports to include more information on the executive summary. | | |

| 3.2 | **ICSU Update – Children & Young People (CYP)** |
|---|---|
| 3.2.1 | RH highlighted key points regarding patient safety:<br>Over 574 incidents reported in CYP ICSU, 169 of which relate to Simmons House, with 104 relating to staffing levels at Simmons House.<br>40 medication errors were reported. No themes have been identified but further investigation will take place. There is now a plan to move forward with the electronic prescribing and administrative system with the Neonatal Unit. MJ asked for an update on the timeline for the JAC system. |
| 3.2.2 | There was 1 Serious Incident in December on IFOR ward which is being investigated via |

| | |
|---|---|
| | an external review. MJ highlighted the deadline for this.<br>An RCA relating to a missed newborn hearing screen, discussed at the SI Panel, has been completed. |
| 3.2.3 | One previous incident with open actions in regard to a disabled child who developed pressure ulcers with no relieving equipment being provided, 21 of the 22 actions have now been completed (95.5%). |
| 3.2.4 | With regard to the unexpected child death, an RCA investigation found no evidence indicating any care or service delivery problems which caused or contributed to this. All unexpected deaths are logged on Datix and Legal services are involved in all cases. |
| 3.2.5 | RH reported that there are 4 open risks at >16 on the Corporate risk register:<br>• Lack of space in NICU environment causing infection control issue with positioning of sinks, which is currently being reviewed.<br>• Shortage of PMHT Consultants. 2 vacancies are currently being advertised.<br>• Compatibility issues with Audiology equipment. Upgrades to the system being investigated.<br>• Some progress made regarding secure garden fencing requirements at Simmons House. |
| 3.2.6 | Reporting in October achieved 96% on Venous Thrombolytic Embolism (VTE) assessments but there were problems reporting on Datix. There are 3 open complaints; PHSO Ombudsman case which should be updated by the end of this week. MJ stated that the transition policy should have been sent to all the ICSUs for comment. There had been1 complaint re continuity care which involved the transfer of a patient from Tower Hamlets to WH. RH is leading this investigation. |
| 3.2.7 | It was noted that there have been some changes regarding the process across CAMHS to help improve the way children are managed in the CAMHS Out of Hours Service. NF queried if this would affect ED mental health patients. It was reported this work included emergency care.<br>MJ advised SS that all Ombudsmen reports are included in the complaints report. |
| 3.2.8 | CD asked how the medicine management actions from the CQC visit are progressing. RH updated that with regard to the CQC, all of the issues that they raised were remedied within 24 hours. The return of out of date medicines process was strengthened and the Pharmacy team will be visiting the Health Centre on a regular basis.<br>TR suggested using technology bar coding to avoid medication errors and support pharmacy to reach all parts of the community as well as the hospital. |
| 3.2.9 | CD requested that the number of open and completed actions from Serious Incidents to be included in the ICSU report.<br><br>NF thanked RH for presenting and standing in for Jeanette Barnes. |

| **Actions:** | **Deadline** | **Owner** |
|---|---|---|
| 1. Update on timeline for implementation of JAC system | 31/1/20 | RH/JB |
| 2. Transition policy completion – PHSO Actions | 31/1/20 | ICSUs |
| 3. Open and completed serious incident actions to be included in quarterly ICSU reports. | 31/3/20 | ICSUs |
| 4. Investigate using technology bar coding to reduce medication errors | 31/1/20 | Stuart Richardson |

| 4.1 | Central Alert System (CAS) Yearly Update Report |
|---|---|
| 4.1.1 | GL advised the committee that the CAS alert process has been improved to include 6 monthly meetings to review progress. The process structure has been updated so that the alerts will go to the ICSU leads. |
| 4.1.2 | MJ queried the overdue patient safety alert and GL replied that this related to unidentified patients coming to the emergency department. A working group has been established to rectify the issue and the IT team is also working on a system to improve effectiveness. CG requested that GL discuss this with her outside of the meeting and to liaise with Lee Smith in relation to emergency planning.<br><br>NF stated that the committee was assured that processes are in place and thanked Claire Challinor for producing the report and GL for presenting. |

| Actions | Deadline | Lead |
|---|---|---|
| 4.1.2 Unidentified patients presenting to Emergency Department procedure to be discussed. | 31/1/20 | CG/GL/LS |

| 4.2 | Quality Assurance Report |
|---|---|
| 4.2.1 | MJ advised the Committee that the CQC focus groups had been held the previous day. There were 3 focus groups with a larger number of staff attending than expected. Staff networks and Staff Side also met with the CQC. Core services were inspected at the beginning of December. There had been no subsequent unannounced visits, although there is a 2 week window after the announced period. The Well Led phase of the inspection commences on 14/15 January. The lead CQC Governance Inspector is joining this visit and may walk around the Trust. (Preliminary feedback core Inspection 3-5 December 2019). |
| 4.2.2 | KNC referred to the 2 appendices that included the CQC improvement plan and the Quality Account priorities for 2020. The “Good to Outstanding” and Better Never Stops” campaigns are continuing, providing a good resource for staff. There are 4 actions from the previous inspection (2017) that are being monitored. |
| 4.2.3 | Service self- assessment and peer reviews will continue to be held to improve our quality. 39 Quality Account actions are being monitored and 24 have been achieved. All concerns are included in the appendices/report.<br>There was positive feedback on the Haringey Children’s Social Care Ofsted inspection of the Multi Agency Safeguarding Hub (MASH). |
| 4.2.4 | The Committee recommended that this report is submitted to the Trust Board. CD suggested strengthening a Quality Account action tracker to include a rag rated forecast of progress. |
| 4.2.5 | MJ confirmed that the draft CQC action plan had been discussed at the ICSU boards and it could be shared with relevant staff. |

| Actions | Deadline | Owner |
|---|---|---|
| 4.2.4 Amend Quality Account action tracker detailing RAG rated forecast of progress | 31/1/20 | KNC/GL |

| 4.3 | Serious Incident Report |
|---|---|
| 4.3.1 | CD advised the Committee that this report had been noted at the public Trust Board in December. The never events related to a wrong tooth extraction and oxygen/airflow meters. There had also been serious incidents reported of unnecessary endoscopy procedures due to patients being booked in to the wrong clinics. A process has been put in place to prevent recurrence. CD added that it would be helpful to have a discussion about how the Serious Incidents reports should be presented to the Quality Committee and suggested that a quarterly learning report is produced to also include assurance that patients cannot be identified in the reports. |

| Actions | Deadline | Owner |
|---|---|---|
| Discuss developing a quarterly learning report from serious incidents. | 31/1/20 | CD/MJ/GL |

| 4.4 | Bi-annual Adults and Children's Safeguarding report |
|---|---|
| 4.4.1 | It was noted that this report will go to the integrated Safeguarding Committee and Trust Board in February. MJ queried why adult safeguarding reporting was on a downward trajectory and TR replied that it had increased by 40% from October to December. With regard to Deprivation of Liberty Safeguarding (DoLS) for 2019 there had been 523 formal applications. TR added that every DoLS application is submitted to the CQC. The Increased DoLS reporting is mainly due to increased awareness and TR had no concerns regarding DoLS reporting. |
| 4.4.2 | MJ asked KM what progress had been made with the Children's Safeguarding training staff numbers and recording on ESR. KM replied that there are 3 levels of Safeguarding Children training and that some of the requirement levels recorded on ESR were incorrect. MJ advised KM to take this up with Helen Kent to rectify. |
| 4.4.3 | DC stated that the dates for training need to be set 10–12 weeks in advance to factor in releasing staff to attend training courses. KM replied that Children's Safeguarding Training sessions have been booked for the year (2020) and her team would be happy to provide bespoke training if requested.<br><br>NF thanked TR and KM for the excellent report and the Committee approved the report which will be submitted to the Trust Board. |

| Actions | Deadline | Owner |
|---|---|---|
| 4.4.2 Children's Safeguarding Training recording on ESR to be discussed | 31/1/20 | KM/Helen Kent |
| Report to be presented to Trust Board | 29/1/20 | MJ |

| 4.5 | Bi-annual Nursing Establishment Review |
|---|---|
| 4.5.1 | MJ advised that this report has already been to the Trust Board, the Trust Management Group (TMG) as well as the Nursing & Midwifery Executive Committee (NMEC). She added that there were a few workforce challenges regarding the role of Assistant Practitioners as there has been a shift to Nurse Associates. All Associate Directors of Nursing (ADONs) are involved in ongoing discussions. |

| | |
|---|---|
| | |

| Actions | Deadline | Owner |
|---|---|---|
| None | | |

| 4.6 | Getting it right first time (GIRFT) |
|---|---|
| 4.6.1 | CD advised the committee that the reports had been presented to the ICSU Boards and TMG. This had been a huge piece of work that included the learning from the last 5 years' claims. CD thanked the governance teams of all ICSUS for their input which has helped to increase learning when things have gone wrong to prevent further incidents. |
| 4.6.2 | CD thanked all involved and NF acknowledged the importance of linking up processes with relevant teams across the Trust. |

| Actions | Deadline | Owner |
|---|---|---|
| None | | |

| 4.7 | Quality Improvement (QI) Annual Report |
|---|---|
| 4.7.1 | PR informed the Committee that this was the first annual report for Quality Improvement. She has been working with the Comms team on rebranding "Better Never Stops" quality improvement. |
| 4.7.2 | All projects are aligned with the Trust Strategic objectives. PR recommended that the ICSUs and clinical leads are recognised as the owners of the QI projects. |
| 4.7.3 | PR reported an increase in QI training, with over 200 staff completing the face to face training. Positive feedback had been received. Bookings for this year are in progress. There were a few issues with online training and access to the system but this is being addressed. Staff are being encouraged to apply to present at UCLP conferences, applying for awards and exhibiting the work that we are proud of.<br>The 2020 annual QI celebration event has been booked. |
| 4.7.4 | PR is working with the Programme Management Office (PMO) team on the Quality Improvement Strategy and with linking up Quality Improvement with Serious Incidents. Also looking to develop QI coaches and setting up a coaching network. |
| 4.7.5 | CG stated that this was a very good paper and it was encouraging to see the progress made. She mentioned that ITU had completed a good QI around length of stay and added that ICSUs should be made aware of the key quality improvements required and then given the required support. DC flagged that some staff register their own QI projects without having the initial conversations with the leadership triumvirate directors, where duplication of the QI projects can be prevented. |
| 4.7.6 | MJ mentioned the speech and language QI project which resulted in the time taken to complete group session notes had reduced by 50% and has subsequently increased staff morale. She asked how this is being scaled up and the learning shared. PR replied that this will be built into the QI Strategy as work to do to achieve this. |

| Actions | Deadline | Owner |
|---|---|---|
| 4.7.5 Awareness and support of QI projects to be provided for ICSUs | 29/2/20 | PR |
| 4.7.6 Successful QI project scaling up and sharing learning to be incorporated into the QI Strategy | 31/3/20 | PR/GL |

| 4.8 | Quality Improvement update |
|---|---|

| | |
|---|---|
| 4.8.1 | LJ advised the committee that a QI project had been carried out for Muscular Skeletal (MSK) Imaging. This was as a result of considerable ultrasound GP referrals, some of which were inappropriate and unnecessary and this resulted in patients waiting longer for appointments.<br>The demand for ultrasound appointments exceeded the slots available within Radiology. There was also a backlog of requests. The project introduced vetting referrals.<br>Baseline identified that 65% of MSK requests came from GPs. 21% were inappropriate in that no x-ray had been carried out. Sometimes MRI scans or physiotherapy would be more appropriate than an ultrasound. |
| 4.8.2 | It was identified during the first audit that there was ultrasound demand of 91requests with a capacity of only 71 slots per week.<br>12 months later this was reviewed and triaging and reviewing criteria was introduced for GP referrals and published in GP bulletins with a pathway created with the admin and clinical team for vetting requests. 2 MSK stenographers as well as breast radiologist were recruited.<br>As a result of reducing inappropriate GP referrals, the demand for imaging has reduced to 73 per week with the backlog down by 85% to 15%.<br>7% of requests are referred back to GPs providing information as to why the request was declined and signposting and suggesting alternative therapies/routes. |
| 4.8.3 | The referral slots have reduced from 91 to 69 and capacity has increased. There has been a reduction of 20% in requests. The number of declined is reducing and the demand is now in line with capacity. GP requests are the only referrals being triaged.<br>LJ advised that there was insufficient information on GP referrals for them to be compared with NICE guidelines. A question was asked on NICE Guidelines for MSK referrals but it was not possible to determine from the GP referral alone if this is compliant.<br><br>The committee congratulated LJ on the presentation and report. |

| **Actions** | **Deadline** | **Owner** |
|---|---|---|
| None | | |

| **4.9** | **Quality Impact Assessment Pathology Network update** |
|---|---|
| 4.9.1 | The Committee noted the papers submitted for the QI assessment Pathology network update. The reports were not presented in detail as there was no-one available to present. |

| **Actions** | **Deadline** | **Owner** |
|---|---|---|
| None | | |

| **4.10** | **Clinical Audit and Effectiveness 6 monthly update** |
|---|---|
| 4.10.1 | SCr assured the Committee that the Clinical Audit team is on track to meet all targets and will provide evidence of how clinical audit is utilised to enable QI initiatives. |
| 4.10.2 | The team is building on the learning from outcomes of QI initiatives, an example of which is the project on Chronic Obstructive Pulmonary Disease (COPD) and applying this to other long term conditions. SCr advised that support will be required within the ICSUs. She added that audit afternoons are held to share learning and that a new working audit group will be set up to focus on learning. MJ suggested that “Better Never Stops” is included in the title as this is linked with the work and includes learning on striving to improve. |
| 4.10.3 | SCr advised that the audit half days, within the hospital group, are bi–monthly and are |

| | |
|---|---|
| | working well, particularly in surgery with good attendance from surgeons. Medical attendance is variable but is improving. |
| 4.10.4 | The Trust has a good track record of data collection for National audit. The data is also submitted to teams to identify quality improvement and compare internally.<br>SCr added that the guidelines page on the intranet received 615,000 hits. MJ suggested that the methodology of reviewing hits on the intranet and social media is included in the Spotlight on safety paper. |
| 4.10.5 | Implementation of NICE guidance is circulated to ICSU boards and requires a formal response. When asked how this is tested, SCr replied that an average of 50 guidelines form part of the quarterly patient safety report are included with a list of audits and those that have been implemented. She added that there are no guidelines that have not been reported as implemented. |
| 4.10.6 | The Committee noted the report and the assurance it provided on compliance with audit work and agreed that the implementation of NICE guidelines be included in quarterly quality and patient safety reports. It was also agreed that further assurance and evidence be provided to demonstrate that NICE guidelines were being implemented in practice. |

| **Actions** | **Deadline** | **Owner** |
|---|---|---|
| 4.10.6 NICE guidelines to be included in quarterly quality and patient safety reports | 15/2/20 | SCr |
| 4.10.6 Assurance and evidence required to demonstrate NICE guidelines are being implemented in practice. | 11/3/20 | SCr |

| **5** | **Minutes from reporting groups – for information only** |
|---|---|
| 5.1 | The ICSU Quality & Safety minutes were taken as read and noted. |
| 5.2 | The minutes from the Patient Safety Committee (November) were taken as read and noted. |
| 5.3 | The minutes from the Patient Experience Committee (November) were taken as read and noted. |

| **Actions** | **Deadline** | **Owner** |
|---|---|---|
| None | | |

| **6** | **Any Other Business** |
|---|---|
| 6.1 | MJ updated the committee that the issues related to the new non-emergency patients is being investigated as a serious incident. |

The meeting closed at 4.30pm
The next Quality Committee is scheduled for **Wednesday 11th March 2020**

Future dates: 2pm – 4.30pm – WEC 6

- 13th May 2020
- 8th July 2020
- 9th September 2020
- 11th November 2020

| Item 22 | Draft minutes of The Whittington Health Charitable Trust Committee meeting held on 8th January 2020 |
|---|---|

| Present | Name | Initials | Title |
|---|---|---|---|
| | Tony Rice | TR | Non-Executive Director (Committee Chair) |
| | Anu Singh | AS | Interim Chair |
| | Kevin Curnow | KC | Chief Finance Officer (Acting) |
| | Jon Ware | JW | Head of Financial Services |
| | Jonathan Gardner | JG | Director of Strategy, Development & Corporate Affairs |
| | Siobhan Harrington | SMH | Chief Executive Officer |
| | Michelle Johnson | MJ | Chief Nurse & Executive Director of Allied Health Professionals |
| | Juliette Marshall | JM | Director of Communications |
| | Eddie Mitchell | EM | Fundraising Officer |
| | Rob Smith | RS | Griffin Stone Moscrop & Co. *for item 20/003 & 4* |
| | Vivien Bucke | VB | Business Support Manager, Finance |

| Item | Discussion |
|---|---|
| | |
| **20/001** | **Welcome, Apologies for Absence & Declarations of Interest** |
| 1.1 | No apologies or declarations of interest were received. |
| | |
| **20/002** | **Approval of Minutes of the meeting held on 26th June & Action Notes** |
| 2.1 | The minutes were agreed as an accurate record. |
| | |
| 2.2 | 1. It was suggested an experienced fundraiser or patient to be invited to join the committee EM and the Patient Experience Manager would work together on this item and the committee agreed this would be looked at when the new Whittington Chair arrives.<br>2. Costed Website Proposal This is part of the rebrand of the Charity and is being worked on currently. Action closed.<br>3. Patient Area Screens and Leaflets MJ confirmed to the committee that the department lead was looking at condition specific leaflets. The TV screens were to be added to the Patient Services Agenda and MJ would pick up outside of the meeting. The Action was closed.<br>4. Kanitz Fund administrative support JG and MJ had met with the teams and JG had been told admin support was not required. MJ said that staff still held the perception that it is difficult to get funds from the Charity. **Action agreed that JM/MJ/JW to meet and look at the fund holders list and KC to look at the process and feedback to fund holders and to pick up the issue and ensure money spent.**<br>5. Meeting with major fundraiser EM/JM confirmed the fundraiser had been nominated for the volunteer of the year award and she would be attending the opening of the Play Terrace on the 30th January at 4.30 p.m.<br>6. EM reported that the most successful contactless giving terminal was in the atrium and in less than one month had raised £150 - £200. MJ suggested the |

| | |
|---|---|
| | Northern Health Centre to be added and EM confirmed the cost of each terminal was £33 per month and while the Charity had not rolled out all 5 terminals as yet they were still making a profit. The Committee members agreed they were keen to experiment with sites and find the most effective ones to then roll out more terminals. **Action : EM**<br>7. <u>Review of other charities using the hospital entrance</u> JM confirmed the LAS were expanding their footprint and there was a need to develop a policy on letting out the Atrium space, to include fundraising at Trust events. **Action: JM to take policy to TMG then back to the Charitable Funds Committee.** |
| | |
| **20/003** | **Annual Report and Accounts** |
| 3.1 | JW stated the Annual Accounts were presented for approval and would then go the Charity Commission by the 31st January deadline. The report was in line with papers brought throughout the year and therefore there were no major differences. **Action: JW** |
| | |
| 3.2 | Income for the year was £291k an increase of £84k from 2017-18. Expenditure was £1,278k significantly higher than 2017-18 due to the £1m spend on maternity. Besides this item underlying expenditure was £278k for the year, 29% lower than the previous year. |
| | |
| 3.3 | JW highlighted there were no significant amendments from the independent examination and it was noted the Charity was compliant with FRS102. |
| | |
| 3.4 | **Action: JM to check with TR that correct version of foreword had been included in the Annual Report.** |
| | |
| 3.5 | EM & MJ asked when the Annual report was uploaded to the Charity Commission will the Trustees names be updated (including addition of Clare Dollery). JG believed the voting Board Members were Trustees of the Charitable Funds committee. **Action: JG and SS to confirm governance on the committee and Trustees and whether final accounts should go to the January Trust Board.** *(it had been confirmed that the Trust Board would approve the accounts on the 29th January 2020).* |
| | |
| **20/004** | **Independent Report and Accounts for 201819** |
| 4.1 | RS stated the Accounts fell under the remit of an independent examination rather than an audit, however with income at current levels, if the balance sheet grew beyond £3.25m, then an audit would be required. RS confirmed his job was to review the accounts and ensure compliance. The prior year examination had highlighted some recommendations and they have been carried out which he felt was good to see. The Charity is compliant and he said communication had been good with Finance staff steadfastly answering any questions. |
| | |
| 4.2 | JG queried if the Board were the Trustees then would they need to approve these accounts at the January Trust Board. This was agreed and the letter of representation and accounts could be signed together on the 29th January. (KC raised an amendment to the letterhead which should state Interim Chair Anu Singh) **Action completed.** |
| | |
| **20/005** | **Financial Report Month 8 2019/20 including Fund Balances** |
| 5.1 | JW outlined the headlines : |

| | |
|---|---|
| | - Income in the first eight months of 2019-20 is significantly higher than for the same period in 2018-19, and is approaching the number reported for the whole of 2018-19. £249k has been raised in eight months (approximately £30k per month) compared to £277k for the whole of 2018-19. JW stated if the charity continues on track for fundraising there will be £350-£400k by the end of the year.<br>- Spend in 2019-20 is on par with 2018-19 (as a monthly equivalent); £179k has been spent in eight months. There were a number of significant bids presented to the Committee and therefore spend is likely to grow in the remainder of 2019/20. |
| | |
| 5.2 | SMH stressed the need to grow the unrestricted funds. It was noted that unrestricted specific use funds are the Charity noting if someone has a preference but are still unrestricted technically. JM confirmed the Compton report recommendation was that the Charity has too many funds and needed to get to perhaps only the separate ICSU funds while JM recognised on the opposite side it was good for people to see where the funds they had raised were going to. |
| 5.3 | TR stated that gains on investment should go to unrestricted and JW agreed to undertake some work on whether can move this to the general funds. **Action: JW** |
| | |
| 5.4 | EM asked if there had been any movement on getting the charity VAT registered and JW confirmed that because of the size of the Charity there had been no previous need for this but the Ifor ward project had meant it was better to be VAT registered. **The Committee approved being VAT registered and** JW would send an email to committee once this had been confirmed. |
| | |
| **20/006** | **Applications for Funding** |
| 6.1 | HK outlined two additional bids from Organisational Development, Workforce Directorate. Following a very successful first tranche of training the first case for was additional 3 hour sessions challenging bullying & harassment for 4000 staff. This was at a cost of £84,825 excluding VAT. However, MJ confirmed the £18k element on venue hire would not be required. The second was for Outward Mindset training which HK felt would underpin all Trust work on culture and behaviours at a cost of £41K for 700 staff. MJ was concerned at releasing staff for a 3 day training course. JG felt the Trust had seen the impact of the bullying and harassment training and was supportive but hesitated with regard to the outward mindset and asked how did this fit in with the strategic approach to a suite of programmes. Committee members did not approve Outward Mindset.<br>**The Committee approved the bullying and harassment training in principle but there was a need to look at all cases before making a final decision on spends from the £190k**. **Action HK to circulate copies of both cases.** |
| | |
| 6.2 | 1. Funding to support 5 members of staff to undertake Registered Nurse Degree Apprenticeships for 2 years: MJ stated nursing apprenticeships are not being funded by the levy. Both MJ and SMH totally supported the case but following committee discussion felt this should be from the core NHS funding. The bid was not approved.<br>2. Messi Doppler machines x 10 – **Committee agreed to purchase 5.** ***(to be agreed how to be funded)***<br>3. Reconfigure Bay 5 in Coyle Ward – Committee agreed.<br>4. Classical Music Programme – Committee agreed |

| | |
|---|---|
| | 5. Alphascopes in Gynae Department - Committee agreed<br>6. Psychological support for Cancer patients via 'C Factor' group sessions Committee agreed.<br>7. Funding for awards ceremony/Christmas party for the district nursing team. Bid withdrawn. |
| | |
| **20/007** | **General Fundraising** |
| 7.1 | JM stated the Play Terrace fundraising had been hugely successful and believed that was reflected in the volumes of the bids received this month. |
| | |
| **20/008** | **Fundraising Strategic Review** |
| 8.1 | JG stated he felt it was important to take a paper to TMG on targeted fund raising and there was a need to get started on this asap while the Fundraising resource was in place. **Action JG/EM.** |
| | |
| **20/009** | **AOB** |
| | None. |
| | |

**Action Notes updated 8th January 2020**

| | | | | |
|---|---|---|---|---|
| 1. | TOR update:-Medical Representative<br><br>NED Representative | It was suggested an experienced fundraiser or patient to be invited to join the committee | EM | April 2020 |
| 2. | Kanitz Fund administrative support | JM/MJ/JW to meet and update the fund holders list. KC to look at the process and feedback to fund holders and to pick up the issue and ensure money spent**.** | JM<br>KC | ASAP |
| 3. | Contactless Giving Terminals | The Committee members agreed they were keen to experiment with sites and find the most effective ones to then roll out more terminals. | EM | ASAP |
| 4. | Review of other charities using the hospital entrance | JM to take policy to TMG then back to the Charitable Funds Committee. | JG | September |
| 5. | Annual Accounts | Annual Accounts to the Charity Commission by the 31st January deadline | JW | By 31/1/2020 |
| | | | | |
| 6. | Annual Report and Accounts | JM to check with TR that correct version of foreword had been included in the Annual Report. | JM | ASAP |
| 7. | Annual Report and Accounts | JG and SS to confirm governance on the Charitable Funds Committee and Trustees and whether final accounts should go to the January Trust Board. | JG | Trust Board to approve the accounts on 29/1/2020 |
| 8. | Independent Report and Accounts for 201819 | Amendment to letterhead to state 'Interim Chair Anu Singh' & Letter of representation to be signed on 29/1/2020 | JW | By 29/1/2020 |
| 9. | Financial Report Month 8 2019/20 including Fund Balances | Gains on investments to go to unrestricted funds; JW agreed to undertake work on whether these could be moved to the general funds. | JW | March |
| 10. | Charity becoming VAT registered | JW would send an email to the committee once this had been confirmed. | JW | ASAP |
| 11. | Applications for Funding | HK to circulate copies of both tabled cases. JW to confirm funding for approved cases. | HK<br>JW | **Completed.**<br>ASAP |
| 12. | Fundraising Strategic Review | A paper to go to TMG on targeted fund raising | JG/EM | ASAP |

**Next Meeting:** 4th March 202013.30 – 15.30 CEO Office