Whittington Health
NHS Trust

TRUST BOARD MEETING HELD IN PUBLIC

9:00am – 10:00am
Wednesday
29 July 2020

Meeting via Microsoft Teams

Meeting	**Trust Board – meeting held in public**
Date & time	**29 July 2020: 0900 to 1000**
Venue	**Whittington Education Centre, Room 7/ Microsoft Teams**

Non-Executive Director members:	**Executive Director members:**
Baroness Julia Neuberger, Chair Professor Naomi Fulop Amanda Gibbon Tony Rice Anu Singh Baroness Glenys Thornton Robert Vincent CBE	Siobhan Harrington, Chief Executive Kevin Curnow, Acting Chief Finance Officer Dr Clare Dollery, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse and Director of Allied Health Professionals

Attendees:
Junaid Bajwa, Associate Non-Executive Director
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Wanda Goldwag, Associate Non-Executive Director
Dr Sarah Humphery, Medical Director, Integrated Care
Rob Larkman, Director of Development
Swarnjit Singh, Trust Corporate Secretary

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

AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	*0900*	**Welcome and apologies** *Julia Neuberger, Chair*	Approve
2	*0901*	**Declaration of interests** *Julia Neuberger, Chair*	Verbal
3	*0902*	**Draft minutes of the meeting held on 24 June 2020** *Julia Neuberger, Chair*	Approve
4	*0905*	**Chair's report** *Julia Neuberger, Chair*	Note
4.1	*0910*	**BAME staff network update** *Anu Singh, Non-Executive Director*	Verbal
5	*0915*	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Note

Item	Timing	Title and lead	Action
Quality			
6	*0925*	**Serious Incidents (June)** *Clare Dollery, Medical Director*	Review
7	*0930*	**National patient experience survey report** *Michelle Johnson, Chief Nurse and Director of Allied Health Professionals*	Note
Performance			
8	*0935*	**Financial performance and capital update** *Kevin Curnow, Acting Chief Finance Officer*	Review
9	*0940*	**Integrated performance report** *Carol Gillen, Chief Operating Officer*	Review
People			
10	*0945*	**Workforce Race and Disability Equality Standard** *Kate Wilson, Deputy Director, Workforce*	Approve
Governance			
11	*0950*	**2020/21 Board Assurance Framework** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
12	*0955*	**Quality Assurance Committee Chair's report** *Naomi Fulop, Committee Chair*	Note
13	*1000*	**Any other business**	Verbal

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on Wednesday, 24 June 2020

Present:	
Baroness Julia Neuberger	Chair
Siobhan Harrington	Chief Executive
Kevin Curnow	Acting Chief Finance Officer
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Carol Gillen	Chief Operating Officer
Michelle Johnson	Chief Nurse & Director of Allied Health Professionals
Tony Rice	Non-Executive Director (items 1-15)
Anu Singh	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
In attendance:	
James Connell	Patient Experience Manager (item 1)
Norma French	Director of Workforce
Jonathan Gardner	Director of Strategy, Development & Corporate Affairs
Dr Sarah Humphery	Medical Director, Integrated Care
Rob Larkman	Director of Development
Andrew Sharratt	Head of Communications and Engagement
Swarnjit Singh	Trust Corporate Secretary
Observer:	
Councillor Janet Burgess MBE	Deputy Leader, the London Borough of Islington & Executive Member for Health & Adult Social Services

No.	**Item**
1. 1.1	**Patient story – Sing for your lungs** Board members watched a short video introduced by James Connell which highlighted "*Sing for your lungs"*, a free weekly singing group for people with long-term respiratory conditions such as chronic obstructive pulmonary disease, asthma, emphysema, chronic bronchitis and fibrosis. The video highlighted the following: • Research had shown that singing can help people with respiratory conditions in a number of ways including exercising the major muscle groups in the upper body, improving the efficiency of the cardiovascular system and improving oxygen intake leading to increased alertness • Through singing, vocal exercise and postural work led by experienced music therapists, those attending the group may see an improvement in their symptoms • During the pandemic, the group held sessions virtually each week to help ensure this very valuable activity continued to take place

	• The Whittington Hospital Charitable funds are currently investing in this initiative. However, the group is oversubscribed and it would benefit both from expansion and continued support from charitable funds and elsewhere, if possible.
1.2	In discussion, the following points were raised: • Anu Singh welcomed the video and wondered whether funding should be provided by commissioners through activities such as social prescribing at a system level • Amanda Gibbon said the video was wonderful and showed Whittington Health at its best. She also raised a concern that, connectivity, particularly the availability of Wi-Fi, was important for some patients • Sarah Humphery concurred and reported that virtual GP consultations were invaluable and would help support to vulnerable patients through plans for the winter and any possible second pandemic surge. She noted that some patients did not have access to smartphones or tablets and suggested that additional support might be provided to help them gain access • Tony Rice welcomed this initiative's ability to positively transform people's lives and said Whittington Health would continue to support the group. He also raised the role of local authorities in helping to ensure that broadband was available • Siobhan Harrington thanked the group for the positive impact of its activities with patients and sought assurance that membership of the group was diverse and inclusive. Michelle Johnson clarified that the majority of patients were invited to join the group regardless of their background and that referrals to the group were also made by GPs and the British Lung Foundation
1.3	The Board thanked James Connell for arranging the video of the Sing for your Lungs Group's support and help for patients.
2. 2.1	**Welcome and apologies** The Chair welcomed everyone to the meeting. There were no apologies.
3. 3.1	**Declarations of interest** There were no new declarations of interest reported.
4. 4.1	**Minutes of the meeting held on 29 April 2020** The minutes of the previous meeting were agreed as a correct record, subject to replacement of "administrative and respiratory teams" with "acute medicine and respiratory services" in the final bullet point of section 11.1. The updated action log was noted. There were no matters arising.
5. 5.1	**Chair's report** The Chair reported that, during this month, there had been a focus on the work of the North Central London (NCL) Provider Alliance, particularly collaborative work on the post-covid recovery phase as an integrated system. The Chair reiterated her thanks to all staff for their hard work over the past months.

5.2	**The report was noted and it was agreed that membership of Board Committees by Tony Rice and Rob Vincent be reviewed.**
6.	**Chief Executive's report**
6.1	Siobhan Harrington highlighted three areas of the paper: **Black lives matter (BLM)**
6.1.1	Racism was absolutely unacceptable and against the values and ethos of Whittington Health. The Trust was proud of its workforce, approximately half of which was from a black and minority ethnic (BAME) background. The Trust had taken a number of actions, including the following: • Webinars were held to listen to staff experiences and concerns • On 26 June, the first workforce race equality standard (WRES) pilot meeting would take place. Whittington Health was one of five NHS providers across England taking part in this excellent opportunity to help achieve a step change around inclusion • Participation in a King's Fund programme for London's NHS Chief Executives **Recovery plans**
6.1.2	There had been collaborative work and shared learning across the NCL system by all providers for paediatric services. It was important that proposals for child and adolescent mental health services (CAMHS) were taken forward through engagement with the local communities and clinicians. **2020/21 Eliminating mixed gender hospital inpatient accommodation**
6.1.3	The Trust would publish its annual statement of assurance and remained committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity. Breaches would be included in the integrated performance report.
6.2	Key points raised in discussion included the following: • Anu Singh welcomed the regular reporting back to Board members from engagement with the BAME staff network and drew attention to the valuable feedback received from staff • Norma French reported that risk assessments for all staff were being taken forward with a focus on BAME colleagues • Siobhan Harrington clarified to Naomi Fulop that details of re-opened services were provided on the Trust's website using a traffic light system. In addition, work was also taking place across the NCL system on clinical priorities for services restarting and their location • Rob Vincent asked about planning for a second COVID-19 wave and it was suggested that learning from the After Action Review conducted with NHS Elect would be shared to provide further details
6.3	**The Board:** **i. agreed that racism was absolutely unacceptable and against the values and ethos of Whittington Health;**

	ii. noted the Chief Executive's report and that learning from the After Action Review with NHS Elect on planning for a second COVID-19 wave would be shared with Board members; and **iii. agreed that the 2020/21 statement of assurance for eliminating mixed gender hospital inpatient accommodation be published on its webpages.**
7.	**National Guardian's Office case review**
7.1	Michelle Johnson referred to the review by the National Guardian's Office (NGO) of two cases which took place in 2015 and of current practice and procedures. She explained that the NGO identified evidence of good practice including an established Freedom to Speak Up Guardian role (FTSUG) with good supervision and support in place, and also the inclusion of human resources business partners as part of a strengthened process. Michelle Johnson provided assurance that areas identified for improvement were being addressed and would continue to be monitored.
7.2	Amanda Gibbon welcomed the report and the learning it promoted. She noted that both the work of the FTSUG and the WRES were fundamental to promoting a culture of openness. Sarah Humphery thanked the FTSUG for the significant progress achieved over the past year. The Chair reported that Rob Vincent had agreed to be the lead non-executive director with responsibility for freedom to speak up matters.
7.3	**The Board noted:** **i. the report and was assured on the monitoring of the actions taking place to implement the review's recommendations;** **ii. noted that Rob Vincent was the lead non-executive director for freedom to speak up matters; and** **iii. agreed that thanks on behalf of the Trust Board be sent to the Trust's Freedom to Speak Up Guardian for the progress achieved.**
8.	**Quality Assurance report**
8.1	Michelle Johnson reported that, following the publication in March 2020, of the Care Quality Commission's (CQC) inspection report, the Trust was rated as 'Good' overall, and as 'Outstanding' for community services and caring. She confirmed that the action plan responding to three regulatory actions identified had been shared with the CQC.
8.2	In reply to a question from Amanda Gibbon, Michelle Johnson provided assurance that each case of a patent receiving rapid tranquillisation was reported on the Datix system and the learning was shared and that the new adult mental health s.136 pathway had reduced the already low number of patients in the emergency department receiving rapid tranquillisation.
8.3	**The Board noted the actions taken and also planned in response to the regulatory requirements from the CQC inspection report and thanked Michelle Johnson and her team for the continued work taking place as part of the Better Never Stops programme.**

9.	**Serious Incidents**
9.1	Clare Dollery confirmed there were three reportable incidents declared between 1st April and 31st May 2020. They covered a Never Event involving the unintentional connection of a patient requiring oxygen to an air flowmeter, a maternal death, and an outbreak of Klebsiella aerogenes on the critical care unit (CCU). Clare Dollery also reported that the Emergency Department now had nine air compressors available, all with air outlets capped.
9.2	The Chair and Naomi Fulop welcomed the quality of the reports presented. In reply to a question from the latter, Clare Dollery reported that eight patients were affected in the CCU and required treatment with intravenous antibiotics; no patients were currently infected and a further update would be provided at the next meeting of the Quality Assurance Committee.
9.3	**The Board thanked Clare Dollery for the serious incident reports and noted they demonstrated the serious incident process was managed effectively, and that lessons learnt were shared widely. The Board noted that an update on the Klebsiella aerogenes outbreak would be provided to the Quality Assurance Committee.**
10.	**Financial performance and capital update**
10.1	Kevin Curnow presented the following headlines: • In line with the new financial guidance, the Trust reported a breakeven position at end of May. This included a retrospective top up payment of £2.2m related to additional costs incurred up to the end of May due to Covid-19 pandemic (£3.2m), which were partly offset by other underspends arising due to activity reductions (£1m) • Whittington Health had received approval for a £14.5m capital expenditure programme in 2020/21, a c. £4.5m reduction on the previous year. At the end of May, £1.1m of capital allocation had been used • The underlying deficit was c. £11m and cost improvement plans were being developed to help address this, particularly through non-recurrent savings. It was recognised that some schemes were reasonably delayed due to the impact of Covid-19
10.2	Board members raised the following during discussion: • It was important to continue to follow the approach adopted across the NCL system of maintaining control of expenditure, embedding transformational changes and delivering a better underlying position • The breakeven arrangements applied until the end of July 2020 in the first instance and were likely to be extended to the end of October 2020
10.3	**The Board noted the financial report and the outturn at end of May 2020.**
11.	**Integrated performance report**
11.1	Carol Gillen reported the following: • In May 2020, performance against the four hour access standard was

	90.6%, below the 92% trajectory • There was significant assurance that, throughout the Covid-19 period, bed occupancy, patent acuity & dependency of the patients across the hospital and staff capacity was discussed twice per day; high risk areas were identified and risk was mitigated with further re-deployments to help keep patients safe
11.2	Amanda Gibbon highlighted the increase in pressure ulcers and also the readmission rate. In response, Michelle Johnson reported that a new Lead Tissue Viability Nurse had been appointed and was working closely with the District Nursing team to review risk assessments for pressure ulcers. Carol Gillen explained that a senior clinician would be carrying out a deep dive to identify any particular themes and reasons for the readmission rate.
11.3	**The Board noted the integrated performance report and that an update on readmission rates would be provided at the September meeting following consideration by the Quality Assurance Committee.**
12.	**Quality Assurance Committee**
12.1	Board members noted the Committee Chair's assurance report for the meeting held on 13 May 2020 and also noted the 2019/20 quarter four Quality report.
13.	**Audit & Risk Committee**
13.1	Tony Rice reported that the Audit & Risk Committee had a good meeting which focussed on the 2019/20 end year accounts. He explained that a good outcome had been achieved as , both Grant Thornton and KPMG had provided largely clean opinions. Kevin Curnow outlined the discussions which had taken place regarding the impact on the valuation of assets by Covid-19 and explained that, following review, it was agreed that asset valuation was not a material issue. Kevin Curnow also reported that the Trust had challenged the reduction in the asset lives for certain buildings, however, this was reflected in an unadjusted error of £1.3m.
13.2	Jonathan Gardner reported that since the Audit & Risk Committee meeting was held, Grant Thornton had issued an assessment of *"Significant assurance and no improvements required"* following their internal audit review of Strategy and Planning arrangements.
13.3	**The Board noted the Committee Chair's assurance report for the meeting held on 20 May 2020.**
14.	**Charitable Funds Committee**
14.1	Tony Rice reported that charitable funds were currently just under £1m and highlighted the improved facilities for the hospital portering service as an example of the investment made He also reported the recruitment of a Fundraising Officer to help achieve ambitious targets within the strategy and plans to recruit a Head of the Charity and a Project Officer.
14.2	**The Board noted the Committee Chair's assurance report for the**

	meeting held on 10 June 2020.
15.	**Workforce Assurance Committee**
15.1	Anu Singh thanked Norma French and the workforce and organisational development team for providing excellent reports for discussion at the committee meeting. She highlighted the positive impact that diverse panels were having on the outcome of recruitment exercises at band 8A and above and reported that the workforce team was working on embedding this for all levels of recruitment. Anu Singh also reported on the procurement of an organisational and learning development system to help increase compliance with statutory and mandatory training requirements which had been agreed by the Trust Management Group. The Chair thanked Anu Singh for the report and the feedback provided to the Board from BAME staff webinars.
15.2	**The Board noted the Committee Chair's assurance report for the meeting held on 17 June.**
16.	**2019/20 Annual Report & Accounts**
16.1	Jonathan Gardner presented the draft annual report for approval. He thanked everyone who had contributed and noted the significant achievements included in the report. Siobhan Harrington thanked Swarnjit Singh for writing the annual report which reflected another busy year. In reply to a question from Norma French, Jonathan Gardner confirmed that a summary version would be prepared for the local community and the annual general meeting. He also confirmed to Glenys Thornton that the annual report was sent to local Members of Parliament.
16.2	Kevin Curnow apprised Board members of one minor amendment to the annual accounts. This related to an auditor request to move £1.5m relating to a pre-payment on a contract to a liability.
16.3	**Board members approved the 2019/20 annual report and noted the final accounts. They also agreed that the annual report be produced in a summary version highlighting achievements in time for the Annual General Meeting**
17.	**Annual provider licence self-certification**
17.1	Jonathan Gardner thanked Swarnjit Singh for the report and highlighted the evidence in the appendix which demonstrated compliance with licence conditions, NHS Acts, NHS Constitution and required governance arrangements.
17.2	**The Board approved the positive compliance statements for the annual self-certification against NHS provider licence conditions G6 and FT4.**
18.	**Post-covid-19 2020/21 corporate objectives**
18.1	Jonathan Gardner presented the paper which set out how the detail of Whittington Health's four strategic objectives had been flexed, where

	necessary, to maintain direction and consistency, while allowing for the emergent post-pandemic landscape. He explained that the appendices provided information on some detailed service changes along with longer term service considerations.
18.2	During discussion, the following points arose: • Jonathan Gardner explained that proposals to have more virtual appointments, where considered appropriate, were being considered and a bid was being prepared for community sites to make it possible for local people to have access to digital services • Naomi Fulop commented that for some patients who were visually-impaired, virtual consultations would be inappropriate • The Chair confirmed to Glenys Thornton that the Trust was contributing to planning in London for any second pandemic surge
18.3	**The Board agreed the draft corporate objectives for the remainder of 2019/20. The Board also took assurance that Whittington Health continued to play a strong and important role in the NCL sector and was framing its strategy and operational priorities in line with the principles set out by NHS England/Improvement (London).**
19.	**Trust risk register**
19.1	Michelle Johnson drew attention to the risks scored at 16 and above which were not included on the Board Assurance Framework (BAF) and proposed the alignment of the covid-19 specific BAF with the 2020/21 BAF.
19.2	**The Board noted the risk register and that the Covid-19 board assurance framework would be reviewed and aligned with the 2020/21 board assurance framework, for which revised corporate objectives had been agreed.**
20.	**Heatwave plan**
20.1	The report was taken as read. Carol Gillen updated Board members by explaining that a public health alert was received on 23 June which highlighted the greater risk of heat stress on person protective equipment (PPE).
20.2	In reply to a question from the Chair on the mitigating actions being taken in response to concerns about the impact on PPE, Carol Gillen explained that safety advice communicated to staff included the need to take regular breaks, to remain hydrated and as cool as possible, and to regularly change PPE. Michelle Johnson provided assurance that the senior team was very visible and was helping to ensure that there was a good availability of water and ventilation in Trust areas. In response to a query from Janet Burgess, Carol Gillen clarified that a level three alert would only be triggered once the threshold temperatures for London were 32 ºC (day time) and 18 ºC (night time) for a period of three or more continuous days.
20.3	**The Board approved the updated heatwave plan.**

21. 21.1	**Questions to the Board on agenda items** There were none received.
22. 22.1	**Any other urgent business** The Chair thanked the executive team for their huge efforts during this time.

Action log, 24 June 2020 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Chair's report	Review membership of Board Committees by Tony Rice, non-executive director, and Rob Vincent, non-executive director.	Julia Neuberger	Completed
Chief Executive's report	Publish the mixed gender declaration approved by the Board on the Trust's webpages	Michelle Johnson	Completed
	Share learning from the After Action Review with NHS Elect on planning for a second COVID-19 wave with Board members	Carol Gillen	The comprehensive action plan being developed by the Emergency Planning Lead captures this learning and will be circulated to Board members
National Guardian's Office review	Rob Vincent to be the non-executive director lead for speaking up issues	Rob Vincent	Completed
	Send thanks on behalf of the Trust Board to the Trust's Freedom to Speak Up Guardian for the work he has completed in the first year	Michelle Johnson	Completed
Serious Incidents	Provide an update on the outbreak of Klebsiella aerogenes to the July Quality Committee meeting	Clare Dollery	Completed
Integrated performance scorecard	Provide an update on the deep dive carried out into readmission rates at the September meeting, following consideration by the Quality Assurance Committee	Clare Dollery	Due at September's meeting
2019/20 Annual Report	Convert the annual report into a short version highlighting achievements in time for the Annual General Meeting (AGM)	Jonathan Gardner	In preparation for the AGM
Trust risk register	Review the Covid-19 board assurance framework and align it with the revised 2020/21 board assurance framework and strategic and corporate objectives agreed at the June Board meeting	Jonathan Gardner	Completed

Meeting title	**Trust Board – public meeting**	**Date: 29 July 2020**
Report title	**Chair's report**	**Agenda item: 4**
Director lead	Julia Neuberger, Chair	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	This report provides a summary of recent activity.	
Purpose:	Noting	
Recommendation(s)	Board members are asked to note the report, including the changes shown to Board meeting dates, and to agree the revised terms of reference for Board Committees.	
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	None	
Appendices	1: Board meeting dates 2: Board Committees' terms of reference	

Chair's report

Associate Non-Executive Directors
I am delighted to welcome Dr Junaid Bajwa and Wanda Goldwag as Associate Non-Executive Directors on the Board of Whittington Health. They respectively serve as Non-Executive Directors on the Boards of University College London Hospitals NHSFT and The Royal Free London NHSFT, two key partners in our integrated North Central London system. They took up their roles on 1 July and will serve for two year terms.

Covid-19
Along with all other Non-Executive Directors, I have been overwhelmed by the dedication and professionalism shown by our staff during these difficult four months responding to the pandemic. I encourage our staff to take some annual leave over the summer period to recuperate.

London NHS Chairs' meetings
On 25 June, I attended a meeting of London's NHS Providers' Chairs with Sir David Sloman, London Regional Director, NHS England and Improvement.

North Central London (NCL) Partnership Board
On 16 July, I attended a meeting of the NCL Partnership Board where system partners are continuing to work closely together on plans for recovery and preparations for a potential "second wave" of COVID-19.

Board Committee membership
Membership of some of the Board's Committees has been reviewed and updated as below:

Board Committee	Non-Executive Director members (C - Chair)
Audit & Risk	Amanda Gibbon, Glenys Thornton, Rob Vincent (C)
Finance & Business Development	Naomi Fulop, Amanda Gibbon, Tony Rice (C), Rob Vincent
Quality Assurance	Naomi Fulop (C), Amanda Gibbon, Glenys Thornton
Workforce Assurance	Anu Singh (C), Glenys Thornton, Rob Vincent
Charitable Funds	Julia Neuberger, Tony Rice (C)
Remuneration	Naomi Fulop, Amanda Gibbon, Julia Neuberger (C), Tony Rice, Anu Singh, Glenys Thornton, Rob Vincent

Lead Non-Executive Director roles
The following arrangements have been agreed for lead Non-Executive Director (NED) roles:

Trust role	NED
Chair	Julia Neuberger
Vice-Chair	Anu Singh
Senior Independent Director	Naomi Fulop
NED for Freedom to Speak Up	Rob Vincent
NED for Child health	Glenys Thornton
NED for End of life care group	Naomi Fulop
NED for Unexpected deaths	Naomi Fulop
NEDs for Maintaining Professional Standards	Naomi Fulop / Glenys Thornton
NED for Estate	Rob Vincent

Trust role	NED
NED for Inclusion, equality and diversity	Anu Singh
NED for Procurement	Tony Rice
NED for Cyber security	Tony Rice
NED for Emergency preparedness, resilience and response	Junaid Bajwa

Board meeting dates
Revised Board meeting dates are shown at appendix 1. The changes highlighted reflect the need to avoid clashes with Board meetings of other NCL providers with whom some Non-Executive Directors are shared.

Board Committees' terms of reference
In line with good governance practice, Board Committees have reviewed and updated their terms of reference which are shown at appendix 2.

Appendix 1: Board meeting dates, July 2020 to March 2021

The schedule of Board meeting dates is shown below. Changed dates are highlighted in red.

Month	Board meeting date and time
July 2020	29 July (930am – 1230pm)
August (no meetings)	
September	30 September (1230pm – 400pm)
October	**29 October** (930am – 1230pm)
November	26 November (1230pm – 400pm)
December	16 December (930am – 1230pm)
January 2021	27 January (1230pm – 400pm)
February	24 February (930am – 1230pm)
March	**25 March** (1230pm – 400pm)
April	*28 April* (1230pm – 400pm)
May	*26 May* (930am – 1230pm)
June	*30 June* (1230pm – 400pm)
July	*28 July* (930am – 1230pm)
August (no meetings)	
September	**30 September** (1230pm – 400pm)
October	*27 October* ((930am – 1230pm)
November	*24 November* (1230pm – 400pm)
December	*15 December* (930am – 1230pm)
January 2022	*26 January* (1230pm – 400pm)
February	*23 February* (930am – 1230pm)
March	***31 March*** (1230pm – 400pm)

Appendix 2: Board Committees' terms of reference

Audit & Risk Committee terms of reference	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee to attend, as and when required.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Audit & Risk Committee is to provide assurance to the Board of Directors through a means of independent and objective review of: • the arrangements in place for governance, risk management and internal control • the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accounting Officer's requirements
2.2	To support its role, the Audit & Risk Committee will have particular engagement with the work of internal and external audit and with financial reporting issues.
3.	**Membership**
3.1	The Audit & Risk Committee will be appointed by the Board of Directors. The Committee shall be made up of three, independent Non-Executive Directors of the Trust, one of whom will Chair the Committee.
3.2	The Chair of the Committee will normally also attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.
3.3	The Chair of the Trust must not be a member of the Committee.
3.4	Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.
3.5	At least one member of the Audit & Risk Committee should have recent and relevant financial experience.
4.	**Quorum and attendance**
4.1	The quorum necessary for the transaction of business shall be at least two members. A

	duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by it.
4.2	The Secretary of the Committee shall maintain a register of attendance.
4.3	The Chief Finance Officer will be the lead executive director for the committee.
4.4	The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
4.5	Other attendees include appropriate External and Internal Audit and LCFS representatives shall normally attend meetings. In addition, The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.
4.6	At least once a year, the external and internal auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
4.7	The lead executive director for the Committee will identify a Committee Secretary who will also be attendance, along with the Trust Board Secretary.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per financial year is suggested, with one meeting devoted to the draft annual accounts.
5.2	The external or internal auditor may request a meeting should they consider it necessary.
6.	**Agenda & papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee should carry out the following duties for the Trust:
	Governance, risk management and internal control
7.2	The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non- clinical), that support delivery of Trust's strategic objectives.

7.3	In particular, the Committee will review the adequacy of: i. all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's Judgement Framework), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors; ii. the Board Assurance Framework and underlying assurance processes that indicate the degree of the achievement of Trust's strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; iii. the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Board's Quality Committee; iv. the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority; v. the system of management for the development, approval and regular review of all trust policies, including those for ensuring compliance with relevant regulatory, legal and code of conduct requirements; vi. the financial systems; vii. the system of management of performance and finance across the whole of the organisation's activities (both clinical and non- clinical), that supports the achievement of the organisation's objectives; viii. the internal and external audit services, and counter fraud services; and ix. compliance with Trust's Standing Orders (SOs) and Standing Financial Instructions (SFIs).
7.4	The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following: i. the process for the completion and up-dating of the Assurance Framework; ii. the relevance and quality of the assurances received; iii. whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and iv. whether the Board Assurance Framework remains relevant and effective for the organisation.
7.5	The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
7.6	In relation to the management of risk, the Committee will: i. maintain an oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements; ii. review processes to ensure appropriate information flows to the Committee from executive management and other board committees in relation to the Trust's overall control and risk management position; iii. receive reports from other Committees highlighting control risks identified

	during the course of their work which require further review action and outlining the action to be taken; iv. review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions; and v. review the statements to be included in the Annual Report concerning risk management.
7.7	The Committee will, at least once a year, review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders, standing financial instructions and scheme of delegation.
7.8	The Committee will monitor the effectiveness of the processes and procedures used in undertaking due diligence.
7.9	In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit, the local counter fraud service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.
7.10	The Committee shall review at each meeting a schedule of debtors' balances, with material debtors more than six months requiring explanations/action plans.
7.11	The Committee shall review at each meeting a report of tender waivers since the previous meeting.
	Internal audit
7.12	The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by: i. consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal; ii. review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework; iii. consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources; iv. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; v. monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework; and vi. ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation.
	External audit
7.13	The Committee shall review the work and findings of the external auditor appointed by the Trust Board, and consider the implications and management's responses to their

work. This will be achieved by:

i. approval of the remuneration to be paid to the external auditor in respect of the audit services provided;
ii. consideration of recommendations to the Trust Board relating to the appointment and performance of the external auditor
iii. confirming the independence of the external auditor, including approval of any non-audit work and fees.
iv. discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
v. discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and
vi. review all external audit reports, including agreement of the annual audit letter before submission to the Board of Directors and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

Counter fraud

7.14 The Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters.

7.15 In particular the Committee will:

i. review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority;
ii. approve and monitor progress against the operational counter fraud plan;
iii. receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
iv. monitor progress on the implementation of recommendations in support of counter fraud; and
v. receive the annual report of the local counter fraud specialist.

Raising concerns (whistleblowing) policy

7.16 The Committee will review, at least annually, the effectiveness of the Trust's raising concerns policy including any matters concerning patient care and safety.

7.17 The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

Other assurance functions

7.18 The Committee will also provide assurance to the Board of Directors in the following areas:

i. it shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust;
ii. These will include, but will not be limited to, any reviews by NHS Improvement, Department of Health & Social Care, Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Resolution.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal

Colleges, accreditation bodies, etc.);

iii. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed;

iv. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function at least annually;

v. The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Data Security and Protection Toolkit and the production of annual Quality Accounts to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced;

vi. The Audit & Risk Committee will also receive performance and assurance reports on information governance matters.

Management

7.19 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

7.20 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial reporting

7.21 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. In particular, it will review:

i. the Annual Report and Financial Statements, together with the external auditor's report to those charged with governance (ISA260), and recommend the accounts to the Trust Board of Directors, for formal approval and adoption, focusing particularly on the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

ii. changes in, and compliance with, accounting policies and practices;

iii. unadjusted mis-statements in the financial statements;

iv. major judgemental areas; and

v. significant adjustments resulting from the audit.

7.22 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

Appointment, reappointment, and removal of external auditors

7.23 The Committee shall appoint the Auditor Panel to make recommendations to the Board of Directors on its behalf, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors.

7.24 The Committee shall approve the terms of reference of the Auditor Panel, and review the function and membership of the Auditor Panel annually.

8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
8.2	Members and those present should state any conflicts of interest and the Committee Secretary will minute them accordingly.
8.3	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
8.4	The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.
8.5	The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's Judgement Framework.
8.6	The Committee will make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.
8.7	The Committee will produce an annual report to the Board of Directors reviewing its effectiveness and performance and to make any recommendations for change that it considers necessary to the Board of Directors for approval.
8.8	The Committee will receive and consider minutes from other Board Committees when requested. The Committee will also receive and consider other sources of information from the Chief Finance Officer.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan. The Committee should consider holding a discussion at the end of its meetings with regards to its effectiveness, in relation to its terms of reference.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's Chair's assurance reports and any such verbal reports that the Chair of the Committee might provide.
9.3	The Committee Secretary will assess agenda items to ensure they comply with its responsibilities.
9.4	These terms of reference were approved by the Board of Directors in July 2020 and will be reviewed, at least annually.

Charitable Funds' Committee terms of reference	
1.	**Authority**
1.1	Whittington Health NHS Trust, as an NHS body, holds the charitable funds in the capacity of a corporate trustee. The trustee is accountable to the Charity Commission for the proper use of the charitable funds and to the public as a beneficiary of those funds.
1.2	The Board of Directors hereby resolve to establish a Committee to be known as the Charitable Funds' Committee (the Committee) and delegate to it the powers and functions of the corporate trustee and to oversee funds for charitable purposes within the organisation.
1.3	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee.
1.4	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Charitable Funds' Committee is to oversee and provide assurance to the Board of Directors on the governance of the charitable funds and discharge the delegated responsibilities from the Board.
2.2	The Committee is established to represent the interests of the Trust, as the Corporate Trustee of Whittington Hospital Charitable Funds. It will specifically: i. oversee the operation of the Charity investments owned by the Charity; ii. seek assurance that the Charity is operating in accordance with relevant legislation and with the regulations associated with its registration with the Charities Commission; and iii. raise funds for the Charity and ensure its successful contribution to the efforts of the Whittington Health Trust.
3.	**Membership**
3.1	The Charitable Funds' Committee will be appointed by the Board of Directors. The Committee shall be made up of: • Three, independent non-executive directors of the trust, one of whom will chair the committee • Chief finance officer (lead executive director for the committee) • Chief executive officer • Director of nursing • One medical staff representative • One non-medical clinical staff representative
3.2	Members are expected to attend at least 75% of meetings. The Secretary of the Committee will keep a register of attendance for inclusion in the Trust's Annual Report.

4.	**Quorum and attendance**
4.1	A quorum of the committee will consist of a minimum of three members, as follows: • a Non-Executive Board Member or Trust Chairman, • the Chief Finance Officer or nominated deputy • the Chief Executive Officer or nominated deputy
4.2	All members are required to nominate a deputy to attend meetings if they cannot be present themselves. Committee membership will be reviewed by the Board as part of the annual review cycle.
4.3	The Director of Communications, Engagement & Fundraising and Head of Financial Services will also regularly attend the Committee.
4.4	The lead executive director for the Committee will arrange for a Secretary to support the Committee's administration.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. That said, there will be not less four meetings (one each quarter) and the Committee Chair has the option to call other meetings, if required, to deal with a high volume of bids.
6.	**Duties**
6.1	The duties delegated to the Committee are as follows: i. To set the strategic framework for investments; ii. To monitor investment performance; iii. To govern, manage, regulate and plan the finances, accounts, investments, assets, business and all affairs of the charity; iv. To advise the Trustee (the Whittington Health NHS Trust Board) of their legal obligations under Charity Law; v. To seek advice from the Charity Commission and professional financial/investment advisors, where appropriate, on the investment of funds and formulate a reserves and investment policy; vi. To disseminate information and guidance to fund holders to ensure their compliance with Charity Law; vii. To monitor quarterly financial and fund activity; viii. Decide whether donations given with restrictions applied should be accepted by the Charity; ix. Approve the request to open a new fund; x. To consider recommendations for new major appeal to be taken to the Trust Board; xi. To review year end accounts of the Charitable Funds as at 31st March and the annual report to the Charity Commission; xii. To regularly review the expenditure of funds, the level of fund balances and advise the Trustee on investment strategies; xiii. Review the spending plans and balances held within individual Charitable Funds; xiv. To ensure that systems are in place to provide appropriate and effective financial controls and procedures in order that the funds are operated correctly, that money is used for the appropriate purpose and the funds are not overspent; xv. To encourage the use of the funds for the benefit of patient and staff welfare, including professional development and training; xvi. To review changes in legislation and approve plans for their implementation;

xvii. To consider and/or develop projects and campaigns which warrant funding, by promoting the benefits of the fund to CPFT staff members and identifying funding needs;

xviii. To determine and disseminate best practice guidelines for fundraising and fund expenditure;

xix. In conjunction with the investment managers/advice, agree an investment policy which lays down guidelines in respect of:

a. The balance required between income and capital growth
b. The balance of risk within the portfolio
c. Any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds
d. Determine a policy for the distribution, or otherwise, of realised and unrealised gains on losses on investments

xx. To raise or receive funds from community, corporate and individual donors; and

xxi. To act in accordance with the delegated powers for individual transactions as follows:

Value	Delegated powers
Up to £5,000	Fund Holder and Chief Finance Officer
£5,000 - £500,000	Charitable Funds' Committee
Above £500,000	Trust Board

7. Reporting

7.1 It shall be the responsibility of the Chair to arrange for the following:

- The publication of an annual list with the dates, time and venue of each meeting.
- The agenda and relevant papers to be distributed to the Committee, at least one week prior to the meeting.
- A record of any action points to be made and for this to be distributed to the Committee, no later than 14 days following the meeting.
- Action points carried forward to a future meeting to be followed up.
- Provide an exception commentary to the Board (as Trustee) as and when required.
- Distribute minutes to the Chair of the Audit Committee for assurance purposes.
- Liaison with Chairs of other Board Committees, raising matters of significance which need to be brought to the attention of those Committees, ensuring that the Chair and Chief Executive are aware at all times.
- Timely production of a Chair's assurance report (in partnership with the lead executive director for the Committee and the Trust Corporate Secretary).

7.2 The Committee will receive the following reports:

Quarterly Reports

- Finance Report
- Transactions under £5,000 approved after the previous meeting
- Quarterly investment valuation and review
- Details of the Charity's operational plan cash requirements
- Fund balances
- Details of all non-pay transactions itemising those over £25,000 in value
- Details of funds highlighting those with balances in excess of £100,000
- Fundraising update

	• Fundraising events performance against targets
8.	**Monitoring and review**
8.1	The Committee will produce an annual work plan which will be a standing information item at meetings. In line with good corporate governance practice, the Committee will carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
8.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee Chair's assurance reports and such verbal reports that the Chair of the Committee might provide. In addition, the Committee will produce an annual report of delivery of its annual work plan and terms of reference.
8.3	These terms of reference were approved by the Board of Directors in July 2020 and will be reviewed, at least annually.

Finance & Business Development Committee terms of reference	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Finance & Business Development Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.
1.3	The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.
1.4	The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.
2.	**Role**
2.1	The role of the Committee is to provide assurance to the Board of Directors through review of the financial performance, business planning, business development and investment decisions of the Trust.
2.2	The Committee will focus on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee will seek assurances, mitigations and recovery action plans where appropriate. The Board Assurance Framework and risk register will be standing agenda items at each meeting.
2.3	The Committee will work with the Chief Executive and executive management to ensure the organisation has the structure, resources and capacity for business development that will enhance core operations.
2.4	The Board may request that the Committee reviews specific aspects of finance and/or business development matters where the Board requires additional scrutiny and assurance.
3.	**Membership**
3.1	The Committee shall be appointed by the Trust Board and be composed of: i. Three Non-Executive Directors appointed by the Board ii. Non-Executive Director Lead for estate matters iii. Chief Executive Officer (ex-officio) iv. Chief Finance Officer (lead executive director for the Committee) v. Chief Operating Officer vi. Medical Director vii. Director of Strategy, Business Development & Corporate Affairs
3.2	One Non Executive member of the Board will be appointed as the Chair of the Committee by the Trust Board.

4.	**Quorum and attendance**
4.1	A quorum shall be three members, at least two of whom should be Non-Executive members of the Trust Board.
4.2	The Secretary of the Committee shall maintain a register of attendance.
4.3	The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.
4.4	The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.
4.5	The following members of staff will be in attendance for committee meetings: • Operational Director of Finance • Director of Contracting & Business Development • Trust Corporate Secretary
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
5.2	There will be six meetings per year. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five working days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: **1. Finance:** i. Review the Trust's annual financial plans: revenue (operating expenditure), capital (capital expenditure), working capital, investments, borrowing and key performance targets; ensuring these are consistent with operational plans and risk assessed. Financial Plans should also be assessed against regulatory requirements and demonstrate appropriate consultation with key stakeholders, as appropriate; ii. Gain assurance that an appropriate performance management process is in place to allow the executive to identify the need for corrective action and identify emerging risks;

iii. Oversee and evaluate the development of the Trust's financial strategy to deliver its annual business plan, incorporating a review of the risks and opportunities;

iv. Review and maintain an overview of the Trust's contract and service delivery agreements (>£5m pa) and material supplier agreements (>£1m pa) and ensure an adequate assessment of delivery risk. The Committee may wish to conduct a review of any new and innovative contract structures below the figures above;

v. Review the Trust's Information Management & Technology strategy and progress against the Fast Follower Programme;

vi. Review major investment plans (business cases) as defined by:

- Capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years
- All proposed asset disposals where the value of the asset exceeds £1 million.

vii. Review Trust performance against in-year delivery of the financial plan (income, expenditure, capital, cash, working capital and regulatory requirements), including delivery of the Trust's cost improvement programme supporting the financial plan; while recognising that the primary ownership and accountability for the Trust's financial performance rests with the full Trust Board;

viii. Request, review and monitor any corrective action against financial plans;

ix. Oversee the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting;

x. To oversee the development and application of Service Line Reporting and Reference Costs to support operational improvement and strategic decision making;

xi. Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately;

xii. Request and receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources; and

xiii. Address any specific requests by the Trust Board in relation to finance matters.

2. Business Development:

i. Oversee and evaluate the development of the Trust's Business Development strategy, incorporating a review of consistency with the 2019/24 Trust strategy, risks (business, delivery and reputational) and market conditions;

ii. Approve the resource structure, operating policies and procedures for the preparation of business development bids;

iii. Receive, review and recommend to the Board proposals for new business development and existing major contracts due for renewal: market development, acquisitions, potential investments and disinvestments in order to recommend options to the Board;

iv. Review the case for, and make recommendation to the Trust Board for, the establishment of any subsidiary bodies, joint ventures, strategic partnerships or other commercial partnerships (within the Trust's delegated authority under the Health and Social Care Act 2012) having regard to the risk profile and adequacy of investment requirements;

v. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of start-

	up companies; vi. Monitor the outcomes of business development initiatives. Receive regular reports and updates from management regarding progress in the achievement of the business development elements of the Strategic Plan; and vii. Examine any matter referred to the Committee by the Trust Board.
8.	**Reporting**
8.1	The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance. The minutes of all meetings shall be formally approved at the subsequent meeting.
8.2	A Committee Chair's assurance report produced by the Trust Secretary in partnership with the Committee Chair and lead executive director will be presented to the subsequent Board meeting, thus enabling the Trust Board to oversee and monitor the functioning and effectiveness of the Committee.
8.3	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.4	In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan which will be a standing information item at meetings. In line with good corporate governance practice, the Committee will carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee Chair's assurance reports and such verbal reports that the Chair of the Committee might provide. In addition, the Committee will produce an annual report of delivery of its annual work plan and terms of reference.
9.3	These terms of reference were approved by the Board of Directors in July 2020 and will be reviewed, at least annually.

Quality Assurance Committee terms of reference	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee known as the Quality Assurance Committee (the Committee). The Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality for all services provided by the Trust. The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the integrated care organisation and to escalate findings as necessary to the Trust Board.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Quality Assurance Committee is to provide assurance to the Board of Directors on: i. the quality of services and improvement through the following key areas: ▪ Patient safety and clinical risk ▪ Clinical audit and effectiveness ▪ Patient experience ▪ Health and safety and ▪ Quality improvement ii. the establishment and maintenance of effective risk management and quality governance systems within the organisation so that the Trust Board can be assured that the Trust: ▪ has adequate systems and processes in place to ensure and continuously improve patient and staff safety, quality, clinical effectiveness, and risk management ▪ has effective structures in place to measure and continuously strive to improve the effectiveness of care ▪ is responding to patients' feedback about their experiences and taking action appropriately ▪ Is promoting a culture of openness and transparency across the Trust which values innovation and improvement. ▪ has mechanisms in place to share learning and good practice in order to share learning and to raise standards ▪ effectively implements and delivers its key quality strategies
2.2	The Board Assurance Framework and risk register will be standing agenda items at each meeting.
3.	**Membership**
3.1	The Quality Assurance Committee will be appointed by the Board of Directors. The Committee shall be made up of the following: • Non-Executive Director (Chair)

	• Non-Executive Director (Deputy Committee Chair) • Non-Executive Director • Medical Director • Chief Nurse & Director of Allied Health Professionals • Chief Operating Officer
3.2	The Committee will be able to co-opt patient representatives as members. The Secretary of the Committee will keep a register of attendance.
4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by any two Non-Executive Directors (NEDs) of the Trust (to include the Chair or designated alternate) and two executives. All NEDs can act as substitutes on all Board Committees.
4.2	In the event that an executive director member of the committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead.
4.3	The following members of staff will be in attendance (or send a representative) at relevant committee meetings: • Deputy Chief Nurse • Associate Medical Directors • Head of Quality Governance • Integrated Clinical Service Units (ICSUs) Clinical Directors or Associate Directors of Nursing – to attend on rotation, when their ICSU presenting 'Better Never Stops' • Director of Environment (by request) • Chief Pharmacist (by request) • Trust Secretary • Lay members
4.4	The committee is empowered to request any other office employed by the Trust to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee.
4.5	The Secretary of the Committee will be the Executive Assistant to the Chief Nurse Director of Allied Health Professionals and they will keep a register of attendance for inclusion in the Trust's Annual Report.
4.6	The Quality and Compliance Manager will ensure the effective and efficient management of the Committee under the leadership of the Committee Chair and Chief Nurse.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.
5.2	Committee meetings will be held every two months, with a minimum of six per year. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

6. Agenda and papers

6.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

6.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, one full week before the meeting. Supporting papers will also be sent out at this time.

7. Duties

7.1 The Committee will carry out the following duties for the Trust Board:

i. monitor, review and implement quality assurance and risk management strategies and action plans, including quality assessments for all cost improvement plans;

ii. fulfil the following obligations for risk management:
- review the Trust Risk Register entries (defined as risks of >15, as per the Risk Management Strategy)
- seek assurance that risks to staff and patients are minimised through the application of a comprehensive risk management system
- contribute to the annual review of the Trust's Risk Management Strategy

iii. receive presentations from each ICSU once per year, on 'Better Never Stops', highlighting key learning and developments.

iv. Review recommend to the Trust Board for approval and monitor implementation of the Trust's Quality Strategic priorities;

v. review and recommend to the Trust Board, the organisation's annual Quality Account publication;

vi. monitoring organisational compliance against the Care Quality Commission's Essential Standards of Quality and Safety, and providing assurance to the Trust Board that effective systems are in place to monitor compliance (i.e. internal peer review programme);

vii. seek assurance from the Quality Governance Committee and reporting Committees on the following areas:
- patient safety issues through regular reporting, including the National Safety Thermometer, learning from serious incidents, learning from death reviews, infection control, and clinical incidents
- that there are robust arrangements in place for the management of safeguarding adults and children and a system in place for managing patients who are Deprived of their Liberties at Whittington Health through the Safeguarding Committee
- clinical audit and effectiveness through regular reporting, including national audits,
  NICE guidelines, and recommendations from relevant external reports
- patient experience through regular reporting, including the friends and family test, complaints, Patient Advice & Liaison Services, and equality and diversity
- that appropriate action is taken in response to adverse clinical incidents, complaints and litigation
- the research programme and associated governance frameworks is implemented and appropriately monitored
- health and safety through regular reporting from the Health and Safety Committee, including fire safety, health and safety assessments, medical equipment and estates

	o delivery of the trust's quality improvement and patient experience strategies o medicines management through the Drugs and Therapeutic Committee viii. seek assurance that the Trust maintains oversight of all relevant national and external reports; and ix. seek assurance that there is an annual review of performance against the patient/carer domains of the NHS Equality Delivery System.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and presented at the next meeting for approval.
8.3	A Committee Chair's assurance report produced by the Trust Secretary in partnership with the Committee Chair and lead executive director will be presented to the subsequent Board
8.4	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.5	The following groups will report regularly to the Quality Assurance Committee: • Quality Governance Committee • Health and Safety Committee
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee Chair's assurance reports and any such verbal reports the Committee Chair may wish to provide. In addition, the Committee will produce an annual report of delivery of its annual work plan and terms of reference.
9.3	These terms of reference were approved by the Trust Board in July 2020 and will be reviewed, at least annually.

Workforce Assurance Committee terms of reference	
1.	**Authority**
1.1	The Board of Directors hereby resolves to establish a Committee to be known as the Workforce Assurance Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.
1.2	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires for any employee, and all employees are directed to co-operate with any request made by the Committee.
1.3	The Committee is also authorised by the Board to obtain outside legal or other professional Advice, if it considers this necessary, via the Trust Secretary.
2.	**Role**
2.1	The role of the Committee is to provide assurance to the Trust Board that: • there is an effective structure, process and system of control for the governance of workfoce matters and the management of risks related to them; • human resources services are provided in line with national and local standards and policy guidance and in line with the Trust's corporate objectives; • the Trust's Workforce Strategy is being sucessfully implemented; and • the Trust complies with its obligations under equality, diversity and human rights legislation.
3.	**Membership**
3.1	The membership of the Committee shall comprise: • At least two Non-Executive Directors (one of whom shall Chair this Committee); • Director of Workforce (lead executive director for the committee); • Chief Nurse and Director of Allied Health Professionals; • Medical Director • Chief Operating Officer; • Chief Finance Officer; • Director of Integrated Care Education representative.
4.	**Quorum and attendance**
4.1	The Committee shall be deemed to be quorate if attended by any two Non-Executive Directors (NEDs) of the Trust (to include the Chair or designated alternate) and two executive directors. All NEDs can act as substitutes on all Board Committees.
4.2	In the event that an executive director member of the committee is unable to attend a meeting, they are required to send a deputy director from their directorate in their stead.
4.3	The following members of staff will be in attendance at committee meetings: • Integrated Clinical Service Units' Directors of Operations (will be invited) • Assistant Director of Learning & Organisational Development • Deputy Director of Workforce • Trust Corporate Secretary

4.4	The Secretary of the Committee will be the Personal Assistant to the Director of Workforce and they will keep a register of attendance for inclusion in the Trust's Annual Report.
5.	**Frequency of meetings**
5.1	The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Committee shall meet at least four times a year. The Committee Chair is able to call special meetings, if required.
6.	**Agenda and papers**
6.1	Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
6.2	Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least one full week before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.
7.	**Duties**
7.1	The Committee will carry out the following duties for the Trust Board: i. Keep under review the development and delivery of the Trust's Workforce Strategy in reponse to the natinal People Plan to ensure performance management is aligned to strategy implementation. The Committee will ensure that the workforce is agile and adaptable so that the Trust can respond swiftly to changes in the external environment; ii. Receive details of workforce planning priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues; iii. Ensure that effective workforce enablers are put in place to drive high performance and quality improvement; iv. Review performance scorecard indicators for workforce–related matters; v. Monitor and evaluate Trust compliance with its startutory duty to produce an annual public sector equality duty report; vi. Review annual performance against the national workforce equality standards for race and disability and any other workforce standards established; vii. Review annual performance against the workforce domains of the NHS Equality Delivery System viii. Monitor delivery of the workforce culture improvement plan; ix. Advise the Board on key strategic risks relating to workforce and employment practice and review their effective mitigation; x. Receive and review regular reports on human capital management including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing; and xi. Receive and review reports on the staff survey and ensure that action plans support improvement in staff experience and services to patients.
7.2	Non-Executive Director Committee members are asked to: i. Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and

	provision; ii. Review data on workforce on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients; iii. Ensure that decisions taken at a Board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcome measures; and iv. Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation.
8.	**Reporting**
8.1	Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.
8.2	The draft minutes of Committee meetings shall be formally recorded and presented at the next meeting of the Trust Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or executive action.
8.3	The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.
8.4	The Committee shall receive reports from the following Trust fora: • People Committee (new executive committee w.e.f April 2020) • Partnership Group • MDT Recruitment & Retention Group • Health & Wellbeing Group • Junior doctor forum • Education Committee • Staff equality networks • Medical Staff Negotiating Committee (MNSC) • #Caringforthosewhocare programme
9.	**Monitoring and review**
9.1	The Committee will produce an annual work plan and, in line with good corporate governance practice, carry out an annual review of effectiveness against its terms of reference and delivery of its annual work plan.
9.2	The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
9.3	These terms of reference were approved by the Board of Directors in July 2020 and will be reviewed, at least annually.

Meeting title	**Trust Board – public meeting**	**Date: 29 July 2020**
Report title	**Chief Executive's report**	**Agenda item: 5**
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 important national and local developments since the last Board meeting as well as highlighting and celebrating achievements by Trust staff. The report also includes for approval an appendix which details the outcome of the 2018/19 annual clinical excellence awards.	
Purpose:	Approval	
Recommendation(s)	Trust Board members are invited to: i. discuss the report and note its contents; and ii. receive the 2018/19 outcome from local clinical excellence awards, prior to their publication on our webpages.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Monthly report to each Board meeting	
Appendices	1: 2018/2019 Local Clinical Excellence Awards Annual Report	

Chief Executive's report
This paper provides an overview of matters to bring to the Board's attention within the health and social care sector at a national and local level.

1. National and regional news

NHS birthday
The National Health Service celebrated its 72nd birthday on 5 July. I strongly echo the comments made on this anniversary by Chris Hopson, the Chief Executive of NHS providers, who said: "The achievements of the NHS this year have been nothing short of remarkable. It has been an extraordinary year in the NHS' history. The entire workforce, be they doctors, nurses, paramedic or porters – whatever their role – have gone above and beyond to keep people safe, treating COVID-19 and other urgent health conditions". At Whittington Health, I was tremendously proud of everybody who contributed to a poignant and powerful recording of the poem, "These are the hands" by local poet, Michael Rosen.

National Guardian's Office
On 9 July, the latest Freedom to Speak Up (FTSU) Index[1] was published. This is a key metric for NHS organisations to monitor their speaking up culture. Whittington Health's index outcome was 78.9%, up from 76% in 2019. Fostering a positive speaking up culture is a key leadership responsibility and it is clear that organisations with higher FTSU Index scores tend to be rated as Outstanding or Good by the Care Quality Commission and this is an area where the Trust is proud of the progress it has made in the last year, in particular, it is in the top ten of NHS providers in England with the greatest overall increase in their FTSU Index score.

2. Local news

Covid-19 and recovery plans
At the time of writing this report, it is 120 days since the full lockdown was declared in England. I want to repeat the acknowledgement of the skill and dedication of all of our colleagues during what has been a tremendously challenging time to help keep people as safe as possible. The common propose, focus and determination of all staff during this unprecedented time has been excellent, especially as we re-start services.

Keeping everyone safe
The safety of our patients and our people is our top priority and drives every decision that we make. With that in mind, in line with new Government advice and learning from other NHS organisations who have had to close services due to outbreaks amongst staff who were not wearing personal protective equipment (PPE) or staying 2m apart as directed, Whittington Health introduced a series of new requirements which apply to all staff at all times to

[1] https://www.nationalguardian.org.uk/news/latest-freedom-to-speak-up-index-published/

help embed the new requirements as business as usual. It is vital that all staff follow these guidelines carefully and the leadership team have been visible across the organisation in helping to ensure the guidelines are followed.

Invitation to be part of COVID-19 antibody research
Whittington Health is one of several sites around the UK taking part in the SIREN study to help find out if having COVID-19 antibodies makes someone immune to the virus. Since the Trust began offering the COVID-19 antibody test, 3,263 colleagues have received one with 932 of our people (28.56%) showing that they do have antibodies.

Welcoming back shielding colleagues
The Government issued guidance this month which stated that, from 1 August 2020, those colleagues who have been shielding from home can begin to return to work. This has been a worrying and uncertain time for many shielding colleagues and I thank them for their ongoing commitment whilst being kept at home. Whittington Health understands that the prospect of returning to work will cause a range of reactions amongst those returning and has provided ongoing support via webinars from the WhitAbility Network (staff disability network) and also have prepared a range of resources to support the transition for staff and line managers.

COVID-19 staff risk assessments
There has been a significant national focus on the impact of the pandemic on people on at risk groups, particularly the review of disparities in risk and outcomes published by Public Health England2. Whittington Health has been carrying risk assessments for staff and, at the time of writing, 70% of staff have been either risk assessed or confirmed that they have declined an assessment.

Quality and safety operational performance

Emergency Department (ED) four hours' wait
In June 2020, performance against the four hour access standard was 90.7%, below the 92% trajectory. The national average in June was 92.8%, the London average was 93.3% and the NCL average was 92.9%. Attendances at the ED are now rising as we continue to encourage people to use NHS services responsibly and to assure them that they are safe to see us when they need us. However, they remain well below the corresponding period last year with- ED attendances in June 2020 28% down on the figure for June 2019.

Outpatients
Outpatient face to face appointments have been undertaken at the Trust for emergencies, cancers and other clinical urgent requirements throughout the COVID-19 period. June continued to see an increase in the numbers of

2
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

patients seen in an outpatients setting and seeing 69% of our previous activity. There has been a 900% increase in non-face-to-face appointments during the COVID-19 period. Did Not Attend rates continue to be lower than our target of 10% and were 8.2% for new appointments and 6.2% for follow up appointments in June 2020.

Elective and day case surgery has been undertaken at both the Trust as emergencies and in the Independent sector which are 'clean' non-COVID surgical sites throughout the pandemic. A number of elective and day case services started on 17 June 2020 at the Trust and other elective work in a number of independent organisations across London from 22 June 2020. Endoscopy services have been running since 29 April 2020 with additional capacity made available from Highgate Hospital from the 4 June 2020.

Community Services

COVID-19 continues to have an impact on delivering a number of community services such as the Musculoskeletal Clinical Assessment and Treatment Service (MSK CATS). MSK waiting times were significantly impacted by the redeployment of staff to support acute services with activity limited to patients that were triaged and assessed as high risk. The service has resumed with a focus medium and high risk patients, with delivery predominately through virtual consultations. The service has improved performance as compared to the previous month increasing from 3.6% to 16.8% in the CATS and from 22.1% to 25% MSK.

A Community Services recovery plan has been developed in collaboration with other North Central London (NCL) community providers. There are agreed principles regarding the prioritisation and feasibility of service restoration that have been signed off at NCL Clinical Advisory Group. The focus on high and medium risk patients has meant that some routine patients are waiting in excess of the six week standard. Digital options are being piloted to support new ways of working including virtual consultations and remote monitoring. Options for group consultations are being explored to support the restart of these activities.

Workforce

At the end of June, mandatory training compliance was 81% - 1% higher than last month but still 9% lower than target. Similarly, appraisal rates were 62% against a 90% target. This is understandable given the pandemic period, however, as we begin to find our new normal, this needs to increase.

Financial performance

Whittington Health is continuing to operate on a financial framework of block payment and top up model. In line with this new reporting guidance, the Trust is reporting a breakeven position at end of June. Up to the end of June, the Trust has incurred £4.65m of additional costs relating to the covid pandemic. These additional costs have been fully funded after netting off any expenditure underspends arising due to non-delivery of activity.

During these unprecedented times it is essential that Whittington continues to take its responsibilities in relation to managing public money seriously. The Trust is logging all COVID-19-related spend and ensuring that significant commitments are reviewed and are clinically justified. The trust is also continuing to develop its cost improvement programme so that upon returning to a more normal financial regime we are in a financial sustainable position.

#CaringForThoseWhoCare - inclusive culture activities

Steering Group
The first Culture, Health and Wellbeing Steering Group (the amalgamation of the Culture Steering Group the Health and Wellbeing Steering Group) and took place on DATE since the start of the pandemic. This group considers a wide range of factors relevant to culture and wellbeing, including the annual flu inoculation campaign, leadership and culture, staff wellbeing and access to psychological support during the pandemic, and planning for support needs afterwards.

Workforce Equality Standard submissions
As a separate agenda item at this meeting, the Board is asked to approve the submissions for the outcomes of the Workforce Race Equality Standard (WRES) and also the Workforce Disability Equality Standard (WDES). The Trust's WRES results this year show continuing and some significant improvements in scores, and closing of the gap between black and minority ethnic (BAME) and white staff experiences.

Cellier ward
On 20 July, along with the Trust Chair, I was very happy to attend the opening of Cellier, our post-natal ward, following a complete refurbishment which was produced in collaboration with parents who have had their baby with us and staff who work on the wards to create a better birth experience on the newly refurbished and refreshed environment. The opening of the refurbished Cellier is the latest in a series of improvements to our maternity service completed over recent months. In February we opened our new dedicated obstetric operating theatre whilst our labour ward and maternity triage units received new doors and a fresh coat of paint over recent weeks.

Workforce Education Centre (WEC)
From October 2020 Camden and Islington Foundation Trust will be taking occupation of the WEC and surrounding area to start building their new mental health unit on that site. Whittington Health's new WEC will be provided in March 2021 due to delays as a result of requirements on Highgate Hill. As a result, the Trust has worked with University College London (UCL) and the users of the WEC to temporarily re-provide that space in the Jenner building, UCL rooms, and other meeting rooms around the organisation.

Clinical Excellence Awards (CEA)
Board members are presented with the 2018/19 annual CEA report for approval at appendix 1.

Staff excellence award
This month the award goes to the whole multi-disciplinary team who continued to provide new mothers and babies with exceptional care despite the challenges of doing so on Eddington Ward whilst Cellier was being refurbished.

Eddington Ward was a significantly smaller space than Cellier and this presented issues around privacy and dignity as well as intense heat. However, the team worked hard for two years to ensure that we continued to provide a tranquil environment and the very best and safe postnatal care even during the COVID pandemic. This is evidenced by positive patient experience scores being received.

Meeting title	**Trust Board – public meeting**	**Date: 29.7.2020**
Report title	**2018 / 2019 Local Clinical Excellence Awards - Annual Report**	Agenda item: 5 Appendix to Chief Executive's report
Executive director lead	Dr Clare Dollery – Medical Director	
Report author	Emily Clayton – Business Manager to the Medical Director	

The Board is asked to receive the Trust's Local Clinical Excellence Awards (LCEAs) Annual report for the 2018/19 round.

This report is for the LCEAs round that was opened in January 2020 (this round was for 2018/19). The number of eligible consultants for consideration for the 2018/19 round was 158.

The number of awards allocated in the round was 19 - all applicants received an award. The amount awarded in this round was £146,560.80 as per NHS Employers' guidance. The table below shows protected characteristics of eligible applicants and those awarded.

	Eligible applicants		*Applicants meeting eligibility criteria* *Note - All successful*	
Total consultants	158		19	
Female consultants eligible for consideration	89 (56%)		12 (63%)	
Consultants from a BAME background eligible for consideration	57 (36%)		8 (42%)	
The age ranges of consultants eligible for consideration	>70 60-70 50-60 40-50 30-40	4 8 57 71 18	>70 60-70 50-60 40-50 30-40	0 1 2 13 3
Full-time consultants	90 (57%)		13 (68)	
Part-time consultants	68 (43%)		5 (32%)	

Purpose:	The report is provided in line with the; Local Clinical Excellence Awards Guidance 2018-21 (England) which states that the information in this report should be made available on the trust website, after it has been considered by the Board.
Recommendation(s)	The Board is asked to receive the attached report for Information and approval before it is placed on the Trust's website.
Report history	An extended version of this report was presented at the Medical Negotiating Sub Committee (MNSC) on Friday 19th June 2020

Meeting title	**Trust Board – public meeting**	**Date: 29.7.2020**
Report title	**Serious Incidents Update – June 2020**	**Agenda item: 6**
Executive director lead	Dr Clare Dollery, Executive 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) declared externally via the Strategic Executive Information System (StEIS) during June 2020. • No Serious Incidents were declared in June 2020. • No new completed investigation reports have been received in June 2020. Due to Covid-19 pandemic, the 60 day deadline for Investigations has been temporarily suspended.	
Purpose	Assurance	
Recommendation(s)	The Trust 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 SI's and root cause analysis investigations.	
Report history	Report presented at each Public Board meeting	
Appendices	None	

Serious Incidents Update: June 2020 Board report.

1. Introduction

1.1 This report provides an overview of Serious Incidents (SI) declared externally via Strategic Executive Information System (StEIS) and a summary of the key learning from Serious Incident reports completed in June 2020

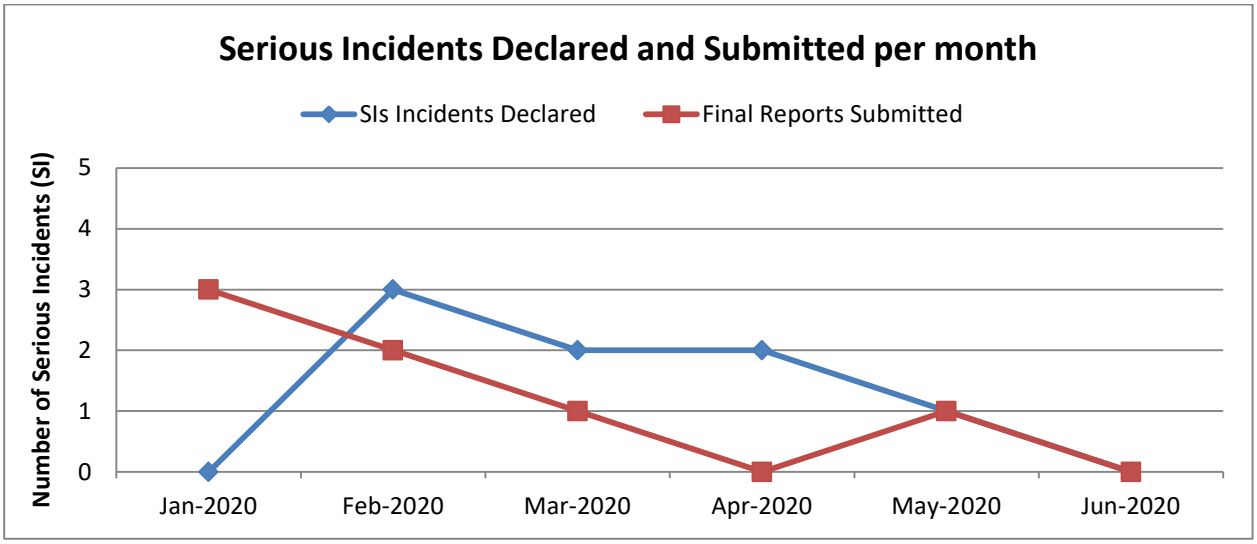
2. Serious Incidents

2.1 The Trust did not declare any Serious Incidents in June 2020. The total number of reportable incidents declared by the Trust between 1st April 2020 and 30th June 2020 is three.

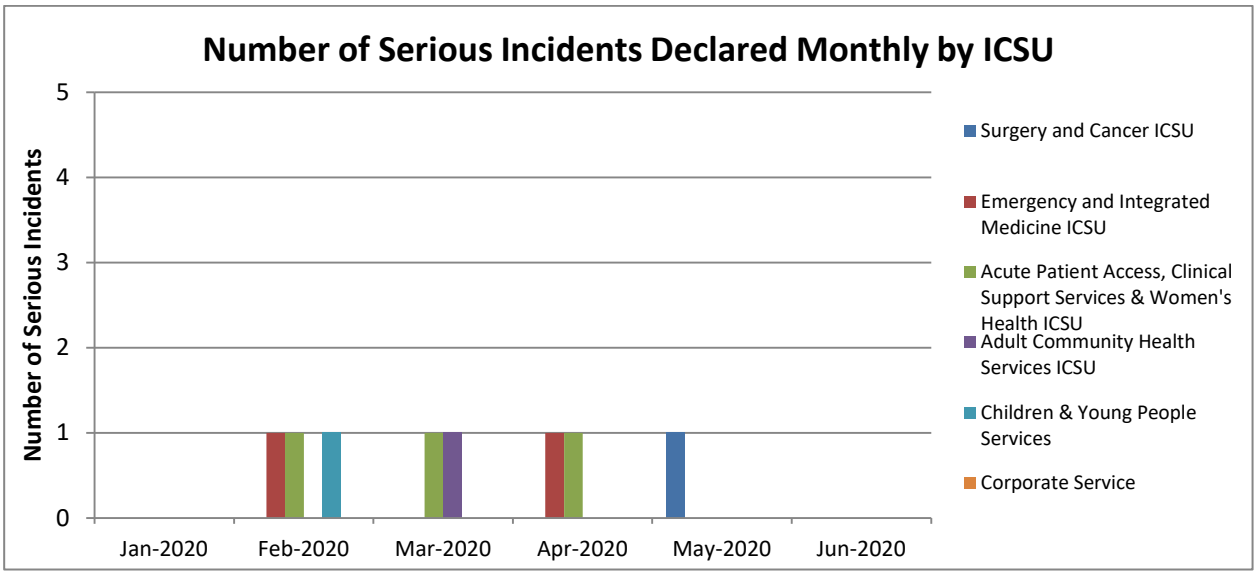
3. Serious Incidents declared and investigations completed in the last six months

3.1 Chart 1 below indicates the number of Serious Incidents declared by the Trust in the last six months as well as the number of investigation reports which were submitted to the North East London Commissioning Support Unit (NELCSU).

3.2 **Chart 1:** (Below): Serious Incidents declared and investigations completed in the last 6 months.



3.3 **Chart 2** (*overleaf):* Shows the number of Serious Incidents declared by Integrated Clinical Service Unit (ICSU) in last 6 months (between January 2020 and June 2020)



4. Duty of Candour

4.1 The Trust has executed its duties under the Duty of Candour Process in June 2020.

5. Recommendation

5.1 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.

Meeting title	**Trust Board – public meeting**	**Date: 29 July 2020**
Report title	**Patient Experience: Update on National Patient Experience Surveys, July 2020**	**Agenda item: 7**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Allied Health Professionals	
Report author	James Connell, Patient Experience Manager	
Executive summary	This report provides an update to the Board on: • The report findings from the most recent national patient experience surveys • Work ongoing from previous national patient experience surveys	
Purpose:	Review	
Recommendation(s)	The Trust Board is asked to discuss and gain assurance from the results and actions in response to National Patient experience surveys.	
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	Sections from this report had been included in the quarter 1 (2020/21) update for patient experience, at the Patient Experience Group and the Quality Governance Committee.	
Appendices	Appendix 1: Executive summary for the National Inpatient Patient Experience Survey 2019	

1. Introduction

This report provides an update for the Trust Board on the Trust's activity towards fulfilling our commitment to the national patient experience survey schedule; this report includes updates on:

- The report findings from the most recent national patient experience surveys
- Work ongoing from previous national patient experience surveys
- Appendix 1: Executive summary for the National Inpatient Patient Experience Survey 2019

2. Report findings from the most recent National Patient Experience Surveys

Included below is a summary on the findings and actions taken in response to each of the published national patient experience surveys. The surveys included in this section are the:

- National Inpatient Patient Experience Survey 2019
- National Cancer Patient Experience Survey 2019
- Previously reported National Patient Experience Surveys (National Maternity Patient Experience Survey 2019; National CYP Inpatient Survey 2019)

2.1 National Inpatient Patient Experience Survey 2019

On July 2nd 2020, the Trust's results for the National Inpatient Patient Experience Survey 2019 were published by the Care Quality Commission (CQC). A summary of the report's findings are summarised in appendix one. The patient experience team are working with the Picker Institute's in hosting a virtual action planning session to support the relevant ICSU leads and Trust colleagues in making improvements based on the findings from the report. This report provides a summary of progress made following the 2018 survey results which demonstrates some areas of improvement to the 2019 results but there are still areas where improvement in results is not evidenced.

2.2 Key successes

As compared with previous surveys, the Trust has significantly improved in in the question asking how patients found written/printed discharge communication (Trust scored 8% higher than in 2018). The Trust scored significantly higher than the average score achieved by the 74 other trusts surveyed by Picker for this question.

	Historical				
	2015	2016	2017	2018	2019
Discharge: patients given written/printed information about what they should or should not do after leaving hospital	67%	65%	66%	63%	**71%**

Table 1: Trust significantly better than historical performance

Overall, the Trust performed significantly better across five questions:

		Organisation type	
		Average	Organisation
Q46	Procedure: told how to expect to feel after operation or procedure	86%	87%
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	63%	71%
Q57+	Discharge: told purpose of medications	91%	96%
Q58+	Discharge: told side-effects of medications	57%	65%
Q70+	Overall: asked to give views on quality of care	14%	20%

Table 2: Trust significantly better than 'Picker average' score

It is worthwhile noting here that a Quality Improvement project to improve discharge communication among the inpatient wards was launched during the spring of 2019. It is suggested that the work on this project likely had a positive impact on patient experience with discharge communication, as this can be tracked through the improved scoring on questions relating to discharge communication from the inpatient areas. The fieldwork for this survey was conducted through June and July 2019.

2.3 Areas for improvement

There were three questions where the Trust's performance has significantly worsened in comparison to scoring from the 2018 survey:

		Historical				
		2015	2016	2017	2018	2019
Q9	Admission: did not have to wait long time to get to bed on ward	62%	58%	64%	61%	54%
Q24	Doctors: had confidence and trust	97%	97%	97%	99%	96%
Q62+	Discharge: family, friends or carers given enough information to help care	67%	74%	74%	82%	73%

Table 3: Trust significantly worse than historical performance

In addition to these 3 questions, there were 9 questions where the Trust's performance is significantly worse in comparison with the average score across all 74 Trusts. These areas are the focus for improvement work this year.

		Organisation type	
		Average	Organisation
Q9	Admission: did not have to wait long time to get to bed on ward	62%	54%
Q16	Hospital: room or ward very or fairly clean	97%	95%
Q19+	Hospital: food was very good or good	59%	44%
Q20	Hospital: offered a choice of food	94%	91%
Q28	Nurses: not talked in front of patients as if they weren't there	83%	77%
Q30	Nurses: knew which nurse was in charge of care	80%	75%
Q31+	Other clinical staff: had confidence and trust	96%	92%
Q32+	Care: staff worked well together	96%	94%
Q61+	Discharge: family or home situation considered	82%	77%

Table 4: Trust significantly worse than the 'Picker average'

2.4 Next steps for the National Inpatient Patient Experience Survey 2019

Following the virtual presentation on the survey's findings and action plan which will be monitored at the patient experience group and then to the trust Quality Assurance Committee.

3. National Cancer Patient Experience Survey 2019

The report for the National Cancer Patient Experience Survey (NCPES) 2019 was published late June 2020. Included below is a summary of the key findings from the report. This is a very positive report and has been very well received by the clinical service.

The Trust had a response rate of 47%, with 56 of 119 people responding:

	Sample Size	Adjusted Sample	Completed	Response Rate
Trust	127	119	56	47%
National	119,855	111,366	67,858	61%

Table 5: Trust response rate for National Cancer Survey 2019

Patients primarily completed the question through the 'paper' postage method, with 50 respondents here against 6 respondents completing the questionnaire online. The majority of people who responded were female (41 against 15 male) and the primary type of cancer among respondents had been breast cancer:

	Age 16-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+	Total
Male	1	0	1	1	2	2	8	0	15
Female	0	0	4	12	10	10	4	1	41
Total	1	0	5	13	12	12	12	1	56

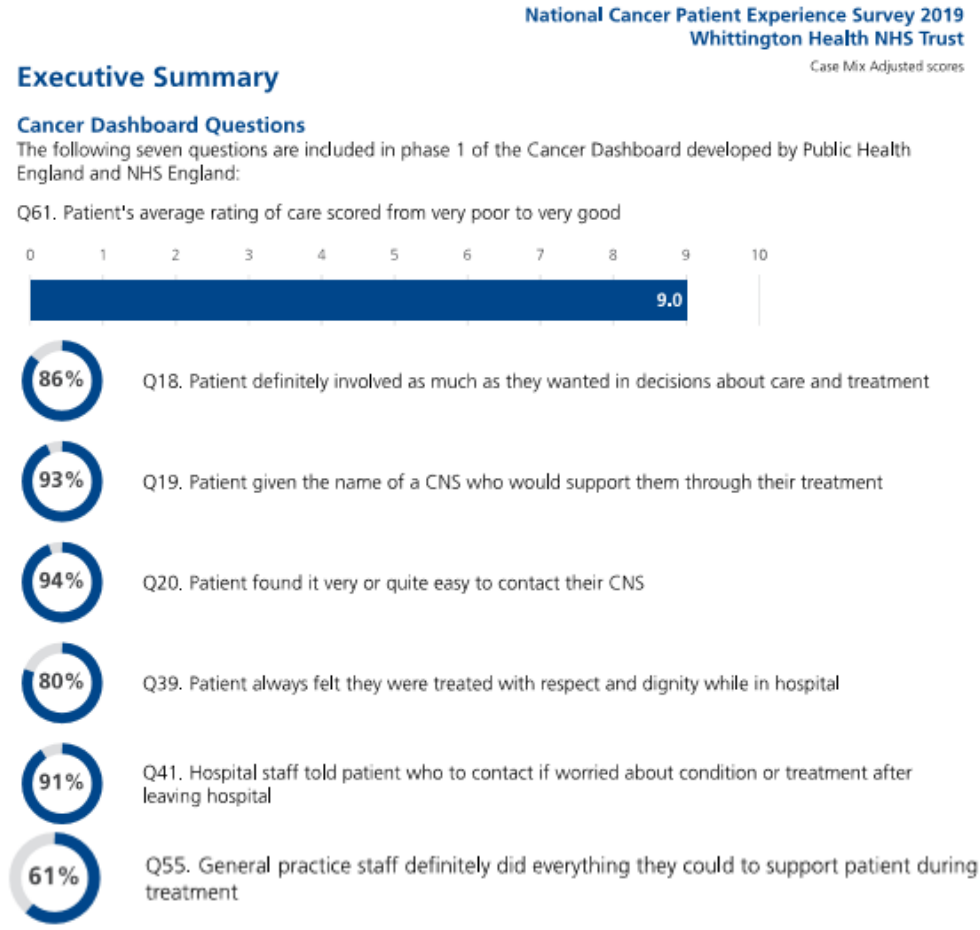
Table 6: Number of responses by gender

3.2 Notable findings from the NCPES 2019

Key findings are summarised in the infographic in table 7, demonstrating the Trust has performed above the national average; as well as two questions where we have performed above the expected range for responses (among the highest across all trusts for question

25), and among the lower expected range for responses (among the lowest for question 30). The Trust scored second highest in London for question 61.

Where patients score their average rating for care received: the Trust scored an impressive 9 which was second only to The Royal Marsden NHS Foundation Trust.



Questions Outside Expected Range

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q23. Hospital staff discussed or gave information about the impact cancer could have on day to day activities	**95%**	73%	95%	**84%**

	Case Mix Adjusted Scores			National Score
	2019 Score	Lower Expected Range	Upper Expected Range	
Q30. Hospital staff didn't talk in front of patient as if patient wasn't there	**67%**	69%	98%	**84%**

Table 7: Executive summary for phase 1 questions of the NCPES 2019

3.3 Next steps for the National Cancer Patient Experience Survey 2019

The summary of the report findings were included in the Surgery and Cancer integrated clinical service unit report to the Patient Experience Group. The clinical leads are reviewing with patient groups on further developments for 2020/21.

4. Work ongoing from previous National Patient Experience Surveys

4.1 Included below is a summary on the findings and actions taken in response to the learning from previous national patient experience surveys. The surveys included in this section are the:

- National Maternity Patient Experience Survey 2019
- National Children and Young People Inpatient Survey 2018

4.2 Across the third and fourth quarter of 2019/20, the 2019 National Maternity Patient Experience Survey and the 2018 National CYP Inpatient Patient Experience Survey were both published by the CQC.There has been action planning sessions in response to each report's findings.

4.3 The Maternity team presented an update to the Trust Management Group (TMG) in January 2020 on the survey's findings and on the actions to be taken in response to this survey. The actions have been included below:

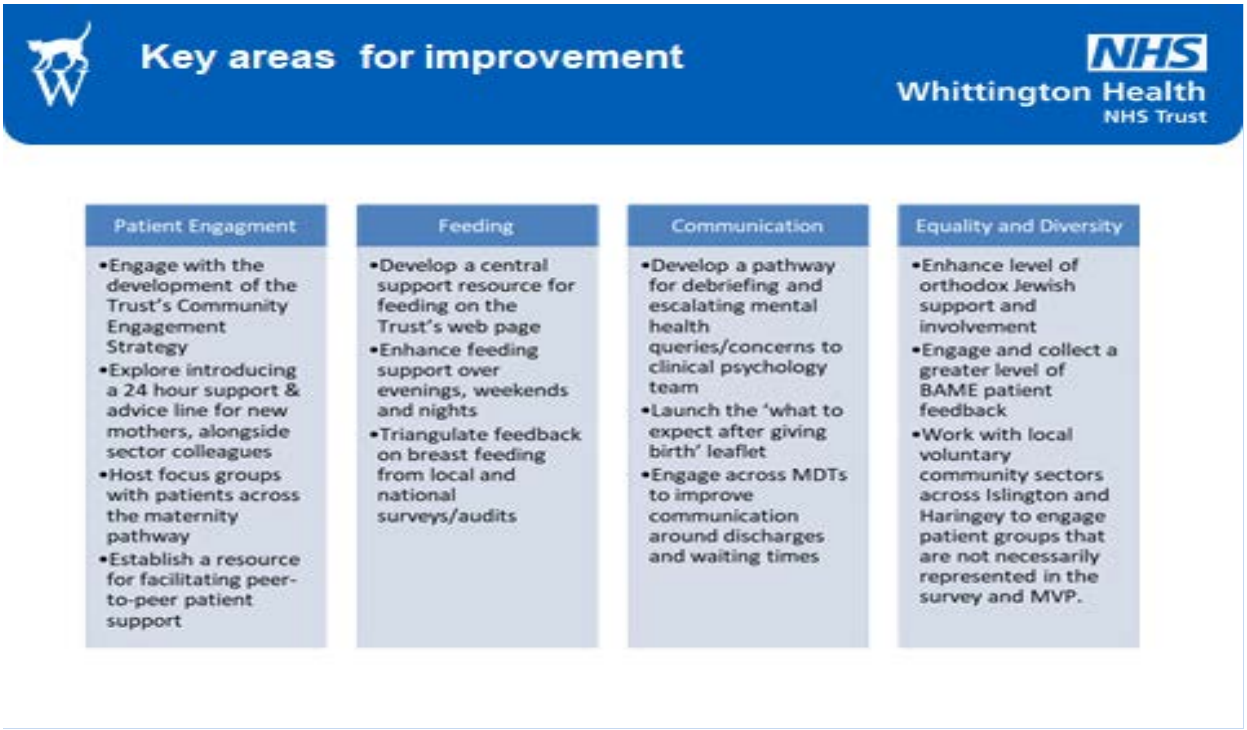


Table 8: Key areas for improvement identified from the Maternity Patient Experience Survey 2019

4.4 Key improvements for the CYP 2018 survey, from the 2016 survey, included:

- Parents were happy with the level of written information they received about their child's condition or treatment
- That staff explained to parent how the operation or procedure had gone
- That staff were available when child needed attention
- That staff caring for child worked well together

Suggested issues from the CYP 2018 survey for the team to address in their action plans in response to the survey, included:

- Children felt that there were not enough things to do in hospital
- Children did not feel they were sufficiently told what would happen next with their care
- Children given advice on how to look after themselves when they went home
- Parents did not feel they were able to prepare food in the hospital (should they want to)
- Children did not like the hospital food

4.5 The COVID-19 pandemic has affected all aspects of the Trust's work and continued progress with these developments has stalled. Both the Maternity team and the CYP team are scheduled to present their patient experience update for quarter 2 of 2020/21 at the next Patient Experience Group meeting. The patient experience team will support both ICSUs in developing and advancing their action plans in advance of their presentation at this meeting.

5. Recommendation

The Trust Board is asked to discuss and gain assurance from the results and actions in response to National Patient experience surveys.

Appendix 1 – National Inpatient Patient Experience Survey Results – Whittington Health 2019

1. Executive summary (2 posters)

Executive summary (part 1 of 2)

This document summarises the findings from the NHS Inpatient Survey 2019, carried out by Picker, on behalf of Whittington Health NHS Trust. Picker was commissioned by 74 acute trusts. This report presents your organisation's results in comparison to the average for these trusts.

A total of 62 questions were asked in the 2018 and 2019 surveys, which have been used for historical and overall comparisons. Your results include every question where your organisation had the minimum required 30 respondents.

1250	1200	33%	44%	33%
Invited to complete the survey	Eligible at the end of the survey	Completed the survey (400)	Average response rate for similar trusts	Your previous response rate

82%	Q68+. Overall: rated experience as 7/10 or more
98%	Q67. Overall: treated with respect or dignity
96%	Q24. Doctors: had confidence and trust

Historical comparison*

Comparison with average*

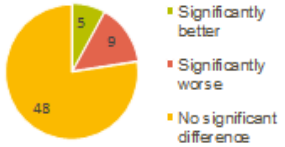


*Chart shows the number of questions that are better, worse, or show no significant difference

Picker

Executive summary (part 2 of 2)

	Top 5 scores (compared to average)
65%	Q58+. Discharge: told side-effects of medications
71%	Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
20%	Q70+. Overall: asked to give views on quality of care
96%	Q57+. Discharge: told purpose of medications
93%	Q46. Procedure: told how to expect to feel after operation or procedure

	Bottom 5 scores (compared to average)
44%	Q19+. Hospital: food was very good or good
54%	Q9. Admission: did not have to wait long time to get to bed on ward
77%	Q28. Nurses: not talked in front of patients as if they weren't there
77%	Q61+. Discharge: family or home situation considered
67%	Q37+. Care: found staff member to discuss concerns with

	Most improved from last survey
71%	Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
81%	Q7. Planned admission: admission date not changed by hospital
68%	Q33. Care: staff did not contradict each other
93%	Q46. Procedure: told how to expect to feel after operation or procedure
78%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation

	Least improved from last survey
73%	Q62+. Discharge: family, friends or carers given enough information to help care
54%	Q9. Admission: did not have to wait long time to get to bed on ward
44%	Q19+. Hospital: food was very good or good
81%	Q38+. Care: enough emotional support from hospital staff
77%	Q65+. Discharge: staff discussed need for further health or social care services

Picker

2. Trust poster of results

NHS Inpatient Survey 2019 Results

Thank you everyone who took part in the survey. Here are our top line results.

NHS
Whittington Health
NHS Trust

Key Improvements since 2018

- Discharge: patients given written/printed information about what they should or should not do after leaving hospital
- Planned admission: admission date not changed by hospital
- Care: staff did not contradict each other
- Procedure: told how to expect to feel after operation or procedure
- Discharge: staff discussed need for additional equipment or home adaptation

Our core strengths

- Discharge: told side-effects of medications
- Discharge: patients given written/printed information about what they should or should not do after leaving hospital
- Overall: asked to give views on quality of care
- Discharge: told purpose of medications
- Procedure: told how to expect to feel after operation or procedure

Our views

82% Q68+. Overall: rated experience as 7/10 or more

98% Q67. Overall: treated with respect or dignity

96% Q24. Doctors: had confidence and trust

Issues to address

- Hospital: food was very good or good
- Admission: did not have to wait long time to get to bed on ward
- Nurses: not talked in front of patients as if they weren't there
- Discharge: family or home situation considered
- Care: found staff member to discuss concerns with

To find out more about the survey and our results please contact: James Connell, Patient Experience Manager – james.connell@nhs.net

Picker

Meeting title	**Trust Board – Public meeting**	**Date: 29 July 2020**
Report title	Financial Performance - June (Month 3) 2020/21	**Agenda item: 8**
Executive Director Lead	Kevin Curnow, Chief Finance Officer (Acting)	
Report Author	Finance Team	
Executive Summary	The Trust is reporting a breakeven position at the end of June in line with the new financial reporting guidance. This includes a retrospective top up payment to the trust of £3.2m which relates to additional Covid-19 related costs of £4.5m, partly offset by other underspends as a result of activity reductions of £1.3m. The trust is continuing to monitor its costs base to ensure where possible expenditure incurred is aligned with activity and costs committed to Covid-19 are non-recurrent in nature. Cash at end of June 2020 was £63.6m. The Trust has spent £2.8m of its capital allocation to end of June. The Trust continues to develop its cost improvement programme (CIP) for 2020-21 to deliver its CIP target of £15m.	
Purpose:	To discuss the month 3 performance and agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends	
Recommendation(s)	The Board is asked to note the financial results relating to performance during June 2020, recognising the need to improve income delivery, reduce temporary spend and improve the delivery of cost improvement plans.	
Risk Register or Board Assurance Framework	Sustainability entries	
Report history	Monthly report to Trust Management Group and Board	
Appendices	None	

Trust reporting breakeven position at end of June

In line with the new financial reporting guidance, the Trust is reporting a breakeven position at end of June. The breakeven position includes a retrospective top up payment of £3.2m. The retrospective top up is required to offset the additional costs incurred due to Covid-19 pandemic. At end of June, the Trust incurred £4.5m of additional costs relating to the pandemic. This additional cost is partly offset by other underspends arising due to activity reductions (£1.3m).

Cash of £63.6m at end of June

Cash at end of June was £63.6m. The higher cash value is due receipt of May and June block and top-up payments. The Trust is not anticipating any cash support for 2020/21.The Trust is unable to place funds with the National Loan fund as they are not accepting deposits due to Covid-19.

Capital plan for 2020-21 is £15.3m. Spend at end of June was £2.8m

The Trust has a capital plan of £15.3m. This plan is in line with North Central London STP allocation. The Trust has spent £2.8m of its allocation at end of month 3 which is 0.8m ahead of the YTD plan.

Funding arrangements from August to March

The funding arrangement for the first four months was based on the run-rate in months 8 to 10 of 2019/20 and allowing for a 'retrospective top-up' for any shortfalls to enable Trusts to breakeven. Guidance on funding beyond this period is expected imminently. It is expected that the current regime will be extended at least into August and possibly into September to allow more time for the national team to determine a suitable funding regime beyond this period.

The Trust is continuing to monitor its costs base to ensure where possible expenditure incurred is aligned with activity and costs committed to Covid-19 are non-recurrent in nature. The Trust continues to develop its cost improvement programme (CIP) for 2020-21 to deliver its CIP target of £15m.

1.0 Summary of I&E Position – Month 3

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
NHS Clinical Income	22,983	23,657	674	71,567	71,130	(438)
High Cost Drugs - Income	700	745	45	2,101	2,087	(14)
Non-NHS Clinical Income	1,993	972	(1,021)	3,360	3,254	(106)
Other Non-Patient Income	2,949	4,005	1,056	8,835	12,221	3,386
Income Cips	0	0	0	0	0	0
	28,625	**29,379**	**754**	**85,863**	**88,692**	**2,829**
Pay						
Agency	(27)	(452)	(426)	(80)	(1,754)	(1,674)
Bank	(143)	(1,674)	(1,530)	(438)	(5,487)	(5,049)
Substantive	(20,067)	(18,505)	1,563	(60,193)	(55,199)	4,994
	(20,237)	**(20,630)**	**(393)**	**(60,711)**	**(62,440)**	**(1,729)**
Non Pay						
Non-Pay	(6,514)	(6,069)	445	(19,546)	(19,352)	194
High Cost Drugs - Exp	(686)	(744)	(59)	(2,066)	(2,044)	22
	(7,199)	**(6,813)**	**386**	**(21,612)**	**(21,396)**	**216**
EBITDA	**1,189**	**1,935**	**746**	**3,540**	**4,856**	**1,316**
Post EBITDA						
Depreciation	(592)	(980)	(388)	(1,776)	(2,362)	(586)
Interest Payable	(244)	(458)	(214)	(732)	(995)	(263)
Interest Receivable	19	0	(19)	57	6	(51)
Dividends Payable	(512)	(496)	16	(1,536)	(1,505)	31
	(1,329)	**(1,935)**	**(606)**	**(3,987)**	**(4,856)**	**(869)**
Reported Surplus/(deficit) before PSF	**(140)**	**0**	**140**	**(447)**	**0**	**448**
PSF	154	0	(154)	462	0	(462)
Reported surplus/(deficit) after PSF	**14**	**0**	**(14)**	**15**	**0**	**(15)**

- Trust is reporting a year to date breakeven position for M3. This in line with reporting guidance from NHSI/E
- Breakeven position was achieved by including an additional top up of £3.2m. This additional top up was required to offset the incremental cost impact of Covid-19
- Costs incurred due to Covid-19 for June was 1.2m (reduced from 1.6m in May and £1.7m in April)

	£'m
Block Income	73.06
NHSI notified top-up	2.72
Retrospective top up to breakeven (covid offset)	3.16
Total	78.94

2.0 Income and activity

2.1 Income

Due to the COVID-19 pandemic the usual PBR national tariff payment architecture and associated administrative/transactional processes have been suspended and the Trust is being funded through a combination of block payments and retrospective top up year to date. These funding streams are enabling the Trust to deliver a break-even position.

The comments and tables below refer to the Trust's performance against the Trust's original operating plan adjusted for the NHSE/I expected income requirement. Month three year to date position was £2.6m favourable to plan.

Income	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Variance £000's
A&E	1,424	1,063	(361)	4,309	2,850	(1,460)
Elective	2,179	638	(1,541)	6,052	1,152	(4,900)
Non-Elective	4,798	3,693	(1,105)	14,554	10,421	(4,133)
Critical care	579	639	60	1,756	2,509	753
Outpatients	3,149	974	(2,176)	8,773	2,307	(6,466)
Outpatients (Non Face to Face)	31	252	221	87	715	628
Direct Access	1,093	286	(807)	3,041	636	(2,406)
Community	6,113	6,113	0	18,340	18,340	0
Other Clinical income NHS	4,316	10,744	6,427	16,756	34,288	17,532
NHS Clinical Income	**23,683**	**24,402**	**719**	**73,668**	**73,216**	**(452)**
Non NHS Clinical Income	1,993	1,184	(809)	3,360	3,466	106
Total Income From Patient Care Activities	**25,676**	**25,586**	**(90)**	**77,028**	**76,682**	**(346)**
Other Operating Income Excluding Top Up	**3,103**	**2,105**	**(998)**	**6,576**	**6,339**	**(237)**
Operating Plan Total	**28,779**	**27,691**	**(1,088)**	**83,604**	**83,021**	**(583)**
Block payment (Top up)	0	907	907	2,721	2,721	0
Retrospective Top Up	0	993	993	0	3,161	3,161
Revised Total	**28,779**	**29,591**	**812**	**86,325**	**88,904**	**2,579**

2.2 Activity

There was an increase in all activity compared to month 2. The most significant increases were in elective activity (111%) and Outpatients (39%). There were also continued increases in critical care (22%), A&E attendances (12%) and non-elective (12%). There is continued year to date significant underperformance across all activities, except for critical care and outpatients non face to face.

Activity	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	Activity Diff
A&E	6,070	4,512	(1,558)	18,411	11,589	(6,822)
Elective	2,253	1,209	(1,044)	6,250	2,382	(3,868)
Non-Elective	1,846	1,412	(434)	5,599	3,893	(1,706)
Critical care	452	693	241	1,371	1,761	390
Outpatients	29,305	11,691	(17,614)	81,606	30,278	(51,328)
Outpatients (Non Face to Face)	1,019	8,949	7,930	2,835	25,305	22,470
Direct Access	101,712	28,154	(73,558)	283,025	67,065	(215,960)
Other Clinical income	9,114	6,410	(2,704)	26,423	17,750	(8,673)

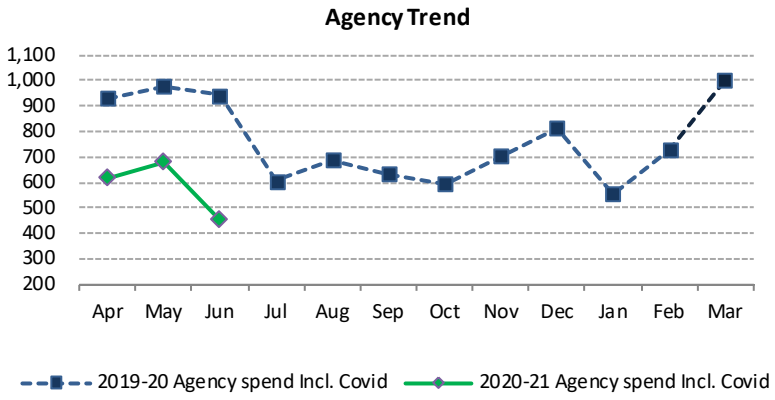
3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Pay spend for June was £20.6m including £0.7m of costs relating to Covid-19.

	2019-20					2020-21			
	Nov	Dec	Jan	Average	Average Uplifted	April	May	June	Movement
Agency	706	813	554	691	691	479	510	296	(214)
Bank	1,881	1,810	1,969	1,887	1,887	1,588	1,145	1,280	134
Substantive	17,465	17,498	17,521	17,495	17,926	17,998	18,129	18,372	243
Total	**20,051**	**20,121**	**20,044**	**20,072**	**20,503**	**20,065**	**19,785**	**19,948**	**163**
Covid costs						785	1,174	682	(492)
Total pay costs						**20,850**	**20,959**	**20,630**	**(328)**

Agency spend for June was £0.5m. This included £0.2m incurred due to Covid-19 pandemic and £0.3m of agency costs relating to non-covid expenditure.



- Agency spend for June was £0.5m. This included £0.2m incurred due to Covid-19 pandemic and £0.3m of agency costs relating to non-covid expenditure.
- Year to date spend excluding covid is £0.8m lower than year to date plan of £2.1m (which is based on 2019-20 agency run rate from October to December)

3.2 Non-pay Expenditure

Non-pay expenditure in June was £6.1m and included £0.6m of costs relating to treatment of Covid-19 pandemic.

	2019-20				2020-21			
	Nov	Dec	Jan	Average	April	May	June	Movement
Supplies & Servs - Clin	2,407	2,384	2,671	2,487	1,985	1,439	1,452	13
Supplies & Servs - Gen	298	249	281	276	204	381	32	(349)
Establishment	371	230	628	410	307	265	67	(198)
Healthcare From Non Nhs	48	59	59	55	54	52	52	
Premises & Fixed Plant	1,642	1,746	1,946	1,778	1,893	1,647	1,601	(46)
Ext Cont Staffing & Cons	220	358	317	298	303	132	366	234
Miscellaneous	1,660	1,429	1,954	1,681	1,821	1,535	1,948	413
Non-Pay Reserve								
Grand Total	**6,645**	**6,454**	**7,856**	**6,985**	**6,567**	**5,450**	**5,517**	**67**
Covid Costs					854	412	552	140
Total non-pay costs					**7,422**	**5,862**	**6,069**	**207**

Excludes high cost drug expenditure

4. Integrated Clinical Service Units' (ICSUs) / Corporate Divisions in month and YTD variance from plan

	Trust Total		Adult Community		Children & Young People		Emergency & Integrated Medicine		Surgery & Cancer		Acw		Corporate Services		Corporate Central	
	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000	In Month variance £'000	YTD variance £'000
Income																
Nhs Clinical Income	674	(438)	(211)	(747)	(327)	(1,458)	(1,185)	(5,689)	(2,494)	(7,368)	(1,206)	(4,313)	(0)	(15)	6,097	19,152
High Cost Drugs - Income	45	(14)									45	(14)				
Non-Nhs Clinical Income	(1,021)	(106)	2	6	125	324	5	8	(11)	(33)	5	22	30	20	(1,177)	(451)
Other Non-Patient Income	1,056	3,386			(73)	(180)	(4)	(8)	53	(40)	5	(42)	(13)	(75)	1,088	3,733
Income Cips																
	754	**2,829**	**(209)**	**(742)**	**(275)**	**(1,315)**	**(1,184)**	**(5,689)**	**(2,452)**	**(7,442)**	**(1,151)**	**(4,348)**	**17**	**(69)**	**6,007**	**22,434**
Pay																
Agency	(426)	(1,674)	(33)	(280)	(28)	(166)	(35)	(211)	(32)	(97)	(112)	(353)	(36)	(106)	(149)	(462)
Bank	(1,530)	(5,049)	(102)	(306)	(116)	(320)	(289)	(897)	(121)	(362)	(189)	(484)	(166)	(641)	(548)	(2,039)
Substantive	1,563	4,994	231	823	180	560	348	1,011	53	379	286	965	246	590	219	666
	(393)	**(1,729)**	**95**	**238**	**36**	**73**	**24**	**(96)**	**(99)**	**(80)**	**(15)**	**128**	**44**	**(156)**	**(478)**	**(1,835)**
Non Pay																
Non-Pay	445	194	(53)	(144)	(160)	(268)	(120)	(261)	380	1,121	237	455	(105)	(321)	266	(389)
High Cost Drugs - Exp	(59)	22									(59)	22				
	386	**216**	**(53)**	**(144)**	**(160)**	**(268)**	**(120)**	**(261)**	**380**	**1,121**	**178**	**478**	**(105)**	**(321)**	**266**	**(389)**
EBITDA	**746**	**1,316**	**(166)**	**(648)**	**(399)**	**(1,509)**	**(1,280)**	**(6,046)**	**(2,172)**	**(6,402)**	**(988)**	**(3,742)**	**(44)**	**(547)**	**5,795**	**20,210**
Post EBITDA																
Depreciation	(388)	(586)													(388)	(586)
Interest Payable	(214)	(263)													(214)	(263)
Interest Receivable	(19)	(51)													(19)	(51)
Dividends Payable	16	31													16	31
	(606)	**(869)**													**(606)**	**(869)**
Reported Surplus/(deficit) before PSF	**140**	**448**	**(166)**	**(648)**	**(399)**	**(1,509)**	**(1,280)**	**(6,046)**	**(2,172)**	**(6,402)**	**(988)**	**(3,742)**	**(44)**	**(547)**	**5,189**	**19,342**
PSF	(154)	(462)													(154)	(462)
Reported surplus/(deficit) before PSF	**(14)**	**(15)**	**(166)**	**(648)**	**(399)**	**(1,509)**	**(1,280)**	**(6,046)**	**(2,172)**	**(6,402)**	**(988)**	**(3,742)**	**(44)**	**(547)**	**5,035**	**18,879**

Note: Corporate central above includes Covid cost centre

5. Statement of Financial Position

Overall, the value of the balance sheet is £195.7m, £21.2m lower than plan. The plan is based on the March submission that included impact of IFRS16. In the taxpayers' equity section (bottom of the balance sheet), the postponement of IFRS16 adoption (due to Covid-19) until 21/22 means the Trust would defer moving all leases onto the balance sheet which would have an impact on tax payers equity.

Property, Plant & Equipment (PPE) and intangible assets are £34.1m lower than plan also largely due to the IFRS16 delayed implemention to transfer all our leases onto the balance sheet. The year end valuation was favourable and increased our assets by £3.1m.

Cash and cash flow: Cash at the end of June 2020 was £63.6m. This is £33.4m higher than plan due advance payments received relating to block contract. The trust is not anticipating any cash support for 2020/21. The Trust is unable to place funds with the National Loan fund as they are not accepting deposits due to Covid-19.

Receivables (Debtors) are at £30m at the end of June 2020. This is £6m lower than plan. Credit control team is actively managing the outsatnding receivables.

Statement of Financial Position

			Year to Date
	Actual	Plan	Plan variance
	30 June 2020	30 June 2020	30 June 2020
	£000	£000	£000
Property, plant and equipment and intangibles	233,400	267,500	(34,100)
Trade and other receivables	721	700	21
Total Non Current Assets	**234,121**	**268,200**	**(34,079)**
Inventories	2,454	2,000	454
Trade and other receivables	29,957	36,000	(6,043)
Cash and cash equivalents	63,575	30,175	33,400
Total Current Assets	**95,987**	**68,175**	**27,812**
Total Assets	**330,108**	**336,375**	**(6,267)**
Trade and other payables	78,299	89,038	(10,739)
Borrowings	25,864	1,694	24,170
Provisions	1,026	900	126
Total Current Liabilities	**105,189**	**91,632**	**13,557**
Net Current Assets (Liabilities)	**(9,202)**	**(23,457)**	**14,255**
Total Assets less Current Liabilities	**224,919**	**244,743**	**(19,824)**
Borrowings	28,674	27,056	1,618
Provisions	555	803	(248)
Total Non Current Liabilities	**29,229**	**27,859**	**1,370**
Total Assets Employed	**195,690**	**216,884**	**(21,194)**
Public dividend capital	72,358	99,584	(27,226)
Retained earnings	24,514	23,300	1,214
Revaluation reserve	98,819	94,000	4,819
Total Taxpayers' Equity	**195,690**	**216,884**	**(21,194)**

6.0 Capital Expenditure

The capital programme is ahead of the revised plan by £785k at M3, mainly due to estates spend on the WEC provision, NICU and completion of obstetrics theatre and backlog projects which include 2019/20 rollover. The Trust is currently forecasting to spend its allocated capital budget by the end of the financial year.

Capital Expenditure	2020/21 Plan	YTD Plan	YTD Actual	YTD Variance	Forecast Outturn
	£'000	£'000	£'000	£'000	£'000
Estates					
WEC provision - centrally funded	1,500	90	90	0	1,500
WEC provision - Trust funded	4,915	90	303	(213)	4,915
Car parking	120	0	0	0	120
Emergency department capacity	120	0	0	0	120
Estates team costs	500	90	161	(71)	500
NICU and completion of obstetrics theatre	722	108	514	(406)	722
Backlog projects including 2019/20 rollover	752	150	612	(462)	752
Simmons House	216	0	0	0	216
Estates strategy development costs	150	30	6	24	150
Estates Total	**8,995**	**558**	**1,686**	**(1,128)**	**8,995**
Medical Euipment					
Managed Equipment Service capital investment	293	72	72	0	293
Replacement of end of life equipment	900	75	113	(38)	900
Medical Equipment	**1,193**	**147**	**185**	**(38)**	**1,193**
IT					
GDE Fast Follower commitments	1,424	150	195	(45)	1,424
Infrastructure upgrade	600	90	208	(118)	600
Rolling IT refresh	500	60	3	57	500
IT Total	**2,524**	**300**	**406**	**(106)**	**2,524**
Other					
Contingencies and business cases	750	0	18	(18)	750
PFI lifecycle costs	778	193	258	(65)	778
PMO	250	39	7	32	250
Other Total	**1,778**	**232**	**283**	**(51)**	**1,778**
Covid 19					
Covid 19 - Estates - Buildings	88	88	125	(37)	125
Covid 19 - Medical Equipment	694	694	119	575	657
Covid 19 Total	**782**	**782**	**244**	**538**	**782**
Grand Total	**15,272**	**2,019**	**2,804**	**(785)**	**15,272**

Meeting title	**Trust Board – public meeting**	**Date: 29 July 2020**
Report title	**Integrated performance report**	**Agenda Item: 9**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Paul Attwal, Head of Performance	
Executive summary	**Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait:** During June 2020 performance against the 4 hour access standard was 90.7% below the 92% trajectory. The national average in June was 92.8%, the London average was 93.3% and the NCL average was 92.9%. Attendance numbers continue to be lower than previous years June 2020 saw 6399 attendances compared to 8921 during June 2019. **Delayed Transfer of Care (DTOCs)** The percentage of DTOCs during May 2020 continues to remain low at 0.1%. **Non-Elective readmission Rates** Following a period of 3 months of seeing an increase in non-elective readmission rates, June 2020 has seen the rate achieving the target. 5.49% against target of 5.5%. **Cancer** Performance against the national cancer standards for April 2020 has not been achieved. This is due to significant reduction in the number of referrals due to Covid-19 and also the subsequent significant reduction in capacity to treat cancer patients. In June 2020 referrals have started to increase and the continuous monitoring of patients on the tracking list continues. **Workforce** KPIs have now been reinstated; however performance has been affected by the pandemic. Appraisal rates for June 2020 are at 62.3% against a target of 90%. The compliance against Mandatory Training has remained consistent at 80.5% in June 2020 against a target of 90%. Staff absence continues to be monitored on a daily basis. Turnover is lower than usual due to pauses in recruitment and start dates across London. **Community services** A Community Services Recovery Plan has been developed in	

	collaboration with other NCL community providers. There are agreed principles regarding the prioritisation and feasibility of service restoration that have been signed off at NCL Clinical Advisory Group (CAG). The focus on high and medium risk patients has meant that some routine patients are waiting in excess of the 6 week standard.
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 and People
Report history	Trust Management Group, 28 July 2020
Appendices	None

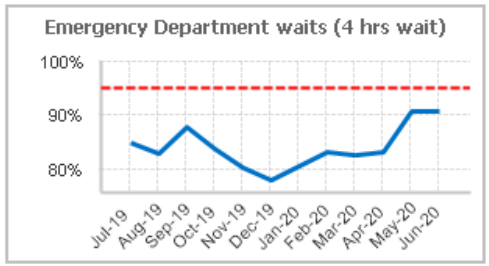
Performance Report
July 2020

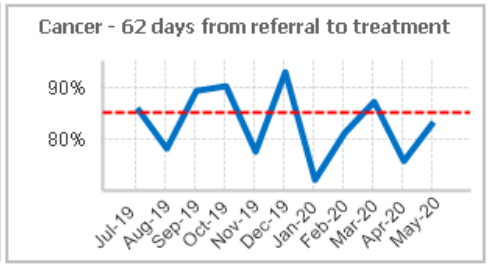
Month 3 (2020 – 2021)

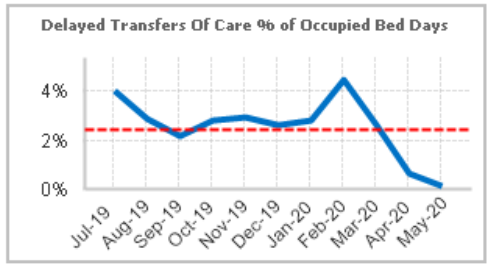
Date & time of production: 21/07/2020 13:00

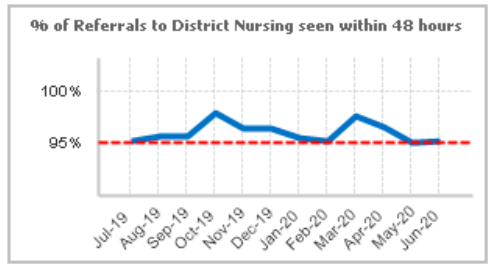
Summary

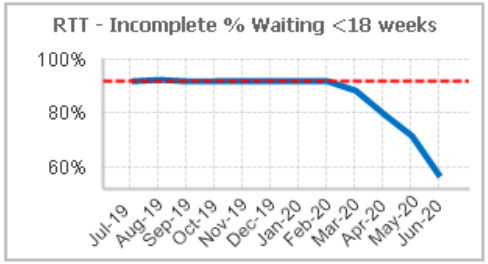
Category	Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	
ED	Emergency Department waits (4 hrs wait)	>95%	84.8%	82.8%	87.7%	83.6%	80.1%	77.8%	80.5%	83.2%	82.5%	83.2%	90.6%	90.7%	88.8%	!
Cancer	Cancer - 14 days to first seen	>93%	94.4%	92.0%	89.8%	91.3%	96.6%	97.3%	95.5%	96.8%	95.5%	85.5%	89.5%		87.9%	
Cancer	Cancer - 62 days from referral to treatment	>85%	85.9%	78.2%	89.4%	90.3%	77.6%	93.0%	72.1%	81.1%	87.1%	75.9%	83.3%		79.7%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.06%	5.72%	5.65%	5.48%	4.94%	5.43%	4.91%	4.85%	5.97%	8.10%	7.05%	5.41%	6.56%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	4.0%	2.8%	2.2%	2.8%	2.9%	2.6%	2.8%	4.5%	2.6%	0.6%	0.1%		0.4%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.2%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	88.3%	79.9%	71.6%	56.1%	69.7%	!
Outpatients	Outpatients - FFT % Positive	>90%	93.8%	94.3%	96.9%	94.2%	95.3%	96.7%	94.4%	94.5%						
Community	Community - FFT % Positive	>90%	92.7%	95.0%	94.6%	95.9%	97.0%	94.4%	94.3%	95.8%						
Staff	Staff - FFT % Recommend Care	>70%			77.1%			62.2%								
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	100.0%	92.5%	100.0%	96.0%	93.8%	85.7%	97.5%	97.6%	86.4%	94.6%	96.3%	91.4%	94.2%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	95.2%	95.7%	95.7%	97.8%	96.4%	96.5%	95.5%	95.2%	97.6%	96.6%	95.1%	95.2%	95.5%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.2%	95.1%	89.8%	91.0%	90.3%	91.5%	92.4%	93.3%	93.8%	96.0%	93.6%		94.9%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	93.3%	96.2%	92.8%	96.1%	95.4%	93.8%	97.1%	95.1%	96.1%	95.4%	95.9%		95.6%	

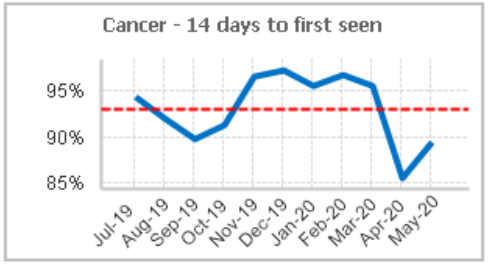


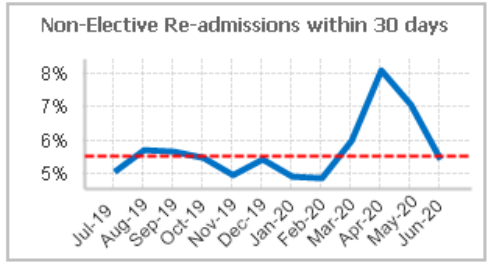


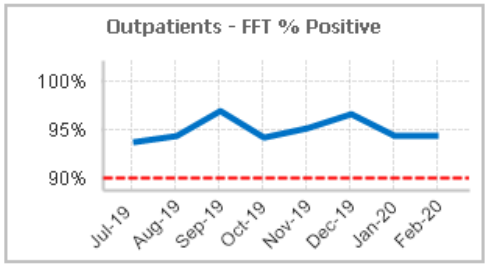












Date & time of production: 21/07/2020 13:00

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Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	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	2	1	1	0	0	0	0	2	0	0	0	3	3	
Actual Falls	400	29	35	30	25	38	34	40	32	36	30	35	21	86	
Category 3 or 4 Pressure Ulcers	0	8	4	2	10	14	10	21	17	7	21	12	6	39	
Harm Free Care %	>95%	90.70%	93.04%	93.64%	94.34%	91.73%	93.79%	92.24%	94.04%	92.89%					
Non Elective C-Section % Rate	<19%	21.1%	22.8%	23.4%	16.3%	23.9%	22.9%	20.6%	20.3%	23.9%	23.0%	21.3%	23.5%	22.6%	
Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
MRSA Bacteraemia Incidences	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Never Events	0	0	1	0	1	1	0	0	0	0	1	0	0	1	
Proportion of reported Patient Safety Incidents Causing Harm	N/A	21.4%	20.1%	21.7%	24.7%	22.6%	19.2%	21.0%	20.1%	21.1%	29.9%	30.4%	30.1%	30.1%	
Serious Incidents	N/A	4	4	1	3	4	3	0	3	2	2	1	0	4	
VTE Risk Assessment %	>95%	95.4%	95.3%	95.6%	95.1%	95.3%	95.1%	105.2%	95.4%	96.2%	95.0%			95.0%	
Mixed Sex Accomodation Breaches	0	0	8	1	5	5	2	9	0	0	0	0	0	0	
Hospital Standardised Mortality Ratio (HSMR)	100	88.3	97.5	79.9	91.5	90.5	82.5	60.1	95.6	109.0					
Summary Hospital Level Mortality Indicator (SHMI)	1.14			0.87			0.89								

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

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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 June 2020 **Pan Trust Standard:** 10% reduction in the total number of attributable PUs during 2020/21 compared to 2019/20 including a breakdown of Pressure Ulcers by category **Community Standards** Appropriate Risk assessment completed Individualised care plan completed **Care plan to include:** Appropriate Management of wounds if present Appropriate Information provided about repositioning Appropriate Information provided about diet and fluids Reassessments completed in line with assessment recommendations	**Variance against plan** **Breakdown** : Total numbers of Category 3 or 4 Pressure Ulcers: No reported Pressures ulcers on the Acute Wards Category 3 – 4 in the Community Category 4 – 2 in the Community Unstageable, Deep Tissue Injury and Devise Related Pressure Ulcers recorded: 4 – Deep Tissue Injury - Community 12 – Unstageable – Community No Device Related Pressure Ulcers – Pan Trust **Action to recover:** During June 2020 the Trust has seen a decrease in the number of pressure ulcers reported this month. The number of category 3 and category 4s in the community has halved, however there has been an increase in the number of unstageable pressure ulcers in the community. There are no reported device related pressure ulcers. The Lead Tissue Viability nurse continues to work closely with the District Nursing (DN) team to review risk assessments and care plans. The service has identified a number of new Key Performance Indicators to help ensure appropriate management and assessment and will be reviewed at the bimonthly Pan Trust Pressure Ulcer Group; the group also shares the learning from 72 hour reports. The Lead Tissue Viability Nurse is reviewing the current training programmes with the aim to improve pressure ulcer awareness training across the acute and community areas.	**Named person:** Tissue Viability Service **Timescale to recover performance:** Ongoing monitoring
Non Elective C-Section Rates: <19%	**Variance against Plan:** 4.5% from standard for June 2020. **Action to Recover:** Twice weekly Multi-Disciplinary C Section Review Meeting continues to keep	**Named Person:** Consultant in Obstetrics and Fetal Medicine

	track of activity and review performance. A full review was carried out previously and the findings will be presented at the audit meeting on Thursday 23/07/2020. As a result of the review show that the Caesarean section rate target is realistic and safe. The service has asked for the target to be reviewed with a view for it to be modified or removed.	**Time Scale to Recover Performance:** Review of target – August 2020

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Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
ED - FFT % Positive	>90%	78.4%	81.7%	84.9%	82.2%	81.5%	79.7%	81.1%	79.8%						
ED - FFT Response Rate	>15%	13.3%	15.1%	15.3%	10.9%	12.7%	13.0%	10.3%	10.4%						
Inpatients - FFT % Positive	>90%	97.6%	98.0%	96.7%	98.3%	97.5%	97.8%	95.6%	97.6%						
Inpatients - FFT Response Rate	>25%	19.9%	26.4%	18.1%	27.0%	28.9%	25.2%	16.5%	20.2%						
Maternity - FFT % Positive	>90%	93.8%	94.0%	92.8%	97.4%	94.1%	91.3%	98.7%	95.9%						
Maternity - FFT Response Rate	>15%	34.1%	48.1%	45.8%	50.9%	45.4%	29.8%	34.4%	46.2%						
Outpatients - FFT % Positive	>90%	93.8%	94.3%	96.9%	94.2%	95.3%	96.7%	94.4%	94.5%						
Outpatients - FFT Responses	400	273	690	586	514	380	516	409	308						
Community - FFT % Positive	>90%	92.7%	95.0%	94.6%	95.9%	97.0%	94.4%	94.3%	95.8%						
Community - FFT Responses	1500	832	762	792	991	670	657	619	525						
Staff - FFT % Recommend Care	>70%			77.1%			62.2%								
Complaints responded to within 25 or 40 working days	>80%	88.9%	82.1%	81.8%	70.4%	83.8%	66.7%	87.0%	85.7%	88.5%	100.0%	100.0%	75.9%	77.4%	
Complaints (including complaints against Corporate division)	N/A	27	28	22	27	37	24	23	28	26	1	1	29	31	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
All Friends and Family Tests Indicators	Most recent update from NHS England regarding FFT is that the collection (and reporting) of FFT remains suspended until further notice and advice is to not use methods of feedback collection that may pose an increased risk of infection. NHSE are currently exploring when will be the optimum time to restart data collection.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance: TBC**

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

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Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
Hospital Cancelled Operations	0	18	4	4	9	8	2	7	5						
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0						
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0						
Theatre Utilisation	>85%	84.97%	85.71%	85.26%	84.94%	88.45%	84.19%	87.37%	86.88%	78.12%					
Breastfeeding Initiated	>90%	91.6%	92.7%	92.4%	93.0%	92.9%	94.4%	93.1%	89.1%	90.3%	91.4%	91.5%	93.1%	92.0%	
Mortality rate per 1000 admissions in-months	14.4	7.4	7.1	6.9	6.3	8.0	8.4	7.2	8.3	16.5	42.1	14.8	5.8	18.9	
Community DNA % Rate	<10%	7.8%	8.1%	7.1%	7.2%	7.4%	8.0%	7.5%	7.6%	8.3%	8.9%	8.7%	9.0%	8.8%	
Community Services - Provider Cancellations	<8%	6.3%	6.8%	6.6%	6.5%	7.3%	7.0%	6.7%	6.7%	14.1%	22.1%	8.8%	7.5%	12.7%	
Acute DNA % Rate	<10%	12.6%	12.2%	11.9%	10.9%	10.8%	11.1%	9.7%	9.6%	11.8%	8.7%	6.8%	7.0%	7.4%	
% of GP Referrals that were completed via ERS		88.6%	86.6%	88.0%	87.7%	87.1%	87.3%	86.6%	86.9%	83.9%	53.3%	66.4%	80.4%	72.5%	
Outpatients New:FUp Ratio	2.3	1.83	1.85	1.84	1.75	1.79	1.76	1.85	1.87	2.00	2.28	2.26	2.30	2.28	
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	4.0%	2.8%	2.2%	2.8%	2.9%	2.6%	2.8%	4.5%	2.6%	0.6%	0.1%		0.4%	
Non Elective Re-admissions within 30 days	<5.5%	5.06%	5.72%	5.65%	5.48%	4.94%	5.43%	4.91%	4.85%	5.97%	8.10%	7.05%	5.49%	6.61%	
Rapid Response - % of referrals with an improvement in care		81.8%	90.3%	82.7%	86.2%	81.4%	80.4%	82.4%	85.7%	87.0%	65.4%	56.7%	67.2%	63.5%	

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

Date & time of production: 21/07/2020 13:00

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatres: Theatre utilisation and cancelled operations	**Variance against Plan:** This measure has not been recorded while the Trust has been managing COVID 19 as this measures elective theatre activity utilisation. As the Trust has not carried out any elective theatre work this has not been collected. **Action to Recover:** Elective surgery restarted on Wednesday 17th June 2020 at Whittington Health and other elective work in a number of independent organisations across London from Monday 22nd June 2020. The recording of theatre utilisation and cancelled operations will restart from July 2020.	**Named Person:** Director of Operations, Surgery **Time Scale to Recover Performance:** Ongoing

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Indicator	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
Emergency Department waits (4 hrs wait)	>95%	84.8%	82.8%	87.7%	83.6%	80.1%	77.8%	80.5%	83.2%	82.5%	83.2%	90.6%	90.7%	88.8%	
ED Indicator - median wait for treatment (minutes)	<60 mins	84	72	65	69	92	98	91	88	56	25	36	43	35	
Ambulance handovers waiting more than 30 mins	0	30	41	19	60	37	86	100	37	32	8	7	13	28	
Ambulance handovers waiting more than 60 mins	0	3	5	0	0	1	15	10	1	5	0	0	0	0	
12 hour trolley waits in A&E - Non Mental Health	0	0	0	0	0	0	0	0	0	1	0	1	0	1	
12 hour trolley waits in A&E - Mental Health	0	12	10	8	10	8	6	10	11	6	0	0	0	0	
Cancer - 14 days to first seen	>93%	94.4%	92.0%	89.8%	91.3%	96.6%	97.3%	95.5%	96.8%	95.5%	85.5%	89.5%		87.9%	
Cancer - 14 days to first seen - breast symptomatic	>93%	95.5%	100.0%	100.0%	98.1%	96.2%	97.8%	95.2%	98.4%	89.5%	71.4%	85.2%		82.4%	
Cancer - 62 days from referral to treatment	>85%	85.9%	78.2%	89.4%	90.3%	77.6%	93.0%	72.1%	81.1%	87.1%	75.9%	83.3%		79.7%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	80.6%	78.2%	87.9%	86.2%	76.0%	92.7%	70.5%	75.9%	88.5%	73.3%	80.0%		76.7%	
Cancer ITT - % of Pathways sent before 38 Days	>85%	33.3%	45.5%	37.5%	25.0%	33.3%	71.4%	40.0%	11.1%	25.0%	60.0%	33.3%		45.5%	
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		94.5%	92.8%	91.2%	92.9%	89.4%	89.8%	84.9%	87.3%	85.3%	75.6%	70.2%		72.3%	
Cancer - 31 days to first treatment	>96%	100.0%	100.0%	97.6%	97.8%	97.5%	97.4%	97.2%	100.0%	100.0%	95.2%	95.8%		95.6%	
Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	20.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Cancer - 62 Day Screening	>90%	0.0%	0.0%	100.0%	75.0%		100.0%	72.7%	60.0%	70.0%	100.0%			100.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.4%	99.3%	99.5%	99.0%	99.0%	99.2%	99.3%	99.6%	90.1%	33.2%	34.3%	49.9%	38.7%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.2%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	88.3%	79.9%	71.6%	56.1%	69.7%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	1	0	0	6				
% seen <=2 hours of Referral to District Nursing Night Service	>80%	100.0%	92.5%	100.0%	96.0%	93.8%	85.7%	97.5%	97.6%	86.4%	94.6%	96.3%	91.4%	94.2%	
% seen <=48 hours of Referral to District Nursing Service	>95%	95.2%	95.7%	95.7%	97.8%	96.4%	96.5%	95.5%	95.2%	97.6%	96.6%	95.1%	95.2%	95.5%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	91.2%	95.1%	89.8%	91.0%	90.3%	91.5%	92.4%	93.3%	93.8%	96.0%	93.6%		94.9%	
Islington New Birth Visits - % seen within 2 weeks	>95%	93.3%	96.2%	92.8%	96.1%	95.4%	93.8%	97.1%	95.1%	96.1%	95.4%	95.9%		95.6%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - Performance: **4 hour target**	**Overall performance:** The overall Performance for June was 90.7%. The national average in June was 92.8%, the London average was 93.3% and the NCL average was 92.9%. Performance was volatile throughout June with daily performance ranging between 82.96% and 98.43%. There were 597 breaches reported for the period, with 24% due to "Delay in completion of treatment, 23% due to Delay in assessment and 20% due to flow and awaiting test results. The majority of the patients (86.6%) were assessed within 15 minutes with an average time to treat in less than 50 minutes. The department had an 11% increase in attendances from previous month, however, the time to assessment remained static due to the revision of the Rapid Assessment Treatment (RAT) and Streaming model. Sixty-six percent (68%) of the patients with DTA were admitted to ward within 4 hours of arrival. A 2% improvement when compared to May. The focus of the ED delivery team has been to Urgent Treatment Care (UTC) and Paediatrics performance, both of which have been a contributing factor in the improvement in performance in June with UTC achieving 97.6% and Paediatrics achieving 94.6%. The focus for July is to embed and refined the medical assessment pathways to increase the % of patients admitted with 4 hours. **London Ambulance Service (LAS) handover:** There were 13 x 30 minute breaches reported in June, an increase of 6 when compared to the previous month. There was 0 x 60 minute breach in June. **Mental health breaches:** The Trust reported zero acute 12 hour trolley breaches in June. Mental Health attendances have seen a reduction of 55% when compared to the same period last year; however the proportion of 4 hour MH breaches remains the same (50% average). The Trust is working with its partners to carry out a deepdive into Mental Health 4 hour breaches with findings to be reported back at the A&E Delivery Board in August 2020.	**Named person:** General Manager, Emergency Department **Timescale to recover performance:** Ongoing
ED – Performance – recovery plan	**Action to recover overall performance:** Key focus is to continue with maintaining UTC and Paediatrics to achieve 98% performance. Continue to review the productivity of the front door streaming model with plans to extend. This will support with flow into ED but also for appropriate "zoning" of patients into red and green areas.	**Named person:** General Manager, Emergency Department **Timescale to recover**

	There are 5 main focus points the team are working: 1. Rapid Assessment and Treatment – Think 60! 2. Streaming and Redirection – embedding Senior clinicians in our FOH to make timely decisions 3. Increased usage of the CDU 4. Escalation processes: embedding effective and early escalation processes for clinical and operational concerns to allow for the best possible patient outcomes. Encouraging an environment for zero tolerance to unnecessary delays 5. Specialty referral, maintaining Hospital flow and patient flow awareness July focus is to promote an environment for early bed allocation and reducing the length of stay admitted patients spend in the Emergency Department. The assessment units began to take referrals direct from ED and the assessment and clerking processes happening outside of ED. Encouraging, maintaining and driving early assessment of admitted patients by the accepting specialty; developing communications and removing barriers between the MDTs. This will include raising awareness of ED standards through educational material and documents such as internal professional standards. The department continues to review processes for smoother referrals from FOH; working closely with AEC to embed an SDEC model of care using both ED and Acute Medicine streams and to become better at identify patients at the point of arrival rather than toward end of their journey to ensure Majors space is used for its sicker patients. Ongoing monthly ED Improvement project “A Journey to 95%” is now in place with a view to drive PDSA processes as outlined.  ED improvement poster.pdf Ambulance breaches The Emergency Department continue to work with the front of house LAS handover nurse with the focus on 10 to 15 minutes handover of all LAS activity. The ED team are working with the LAS crews to ensure the revised pathways are adhered to and operating smoothly.	**performance:** Ongoing.

Cancer performance	**Update:** Compliance against the national cancer standards since April 2020 has not been achieved. This is due to significant reduction in the number of referrals due to COVID 19 and also significant reduction in capacity to treat cancer patients. All cancer patients on the tracking list have been reviewed and the cases which meet the NCL guidance to treat been actioned. Others are being continuously monitored and action taken as necessary Treatments and diagnostics are being undertaken at both the Trust as emergencies and in the Independent sector which are 'clean' non COVID 19 surgical sites. In June 2020 referrals have started to increase and the continuous monitoring of patients on the tracking list continues. Risk assessments (clinical harm) are being carried out on all patients who are at >104 days in the cancer pathway and these have been reported at the Trust Patient Safety Committee.	**Named person:** General Manager, Cancer Services **Timescale to recover performance:** Ongoing
DM01 Diagnostics Waits	**Update:** Performance against the national diagnostic waiting target June 2020 have not been achieved, however there has been an improvement compared to May 2020 This is due to significant reduction in the number of referrals due to COVID 19 and also the subsequent significant reduction in capacity to carry out diagnostics. Diagnostics are being undertaken at the Trust for emergencies, cancers and other clinical urgent requirements. Additional activity has also taken place in the Independent sector at 'clean' i.e. non COVID 19 sites. With further internal capacity switched on performance against the diagnostics standard is expected to improve in July 2020.	**Named person:** Head of Performance **Timescale to recover performance:** Ongoing
Referral to Treatment: **Incomplete % waiting < 18 weeks** **52 + week waits**	**Update:** Performance against the national standards for referral to treatment incomplete pathways below 18 weeks has not been achieved. This is due to a significant decline in the number of referrals due to COVID 19 and the subsequent reduction in capacity in outpatients, diagnostics services and elective surgery. Capacity is beginning to increase again since June 2020 and some elective surgery as the number of referrals is also increasing. There has also been a significant increase in the number of patients waiting more	**Named person:** Head of Performance **Timescale to recover performance:** Ongoing

	than 52 weeks for their treatment, also due to the above. Risk assessments (clinical harm) are being carried out on all patients who are at >52 weeks on the referral to treatment pathway and these were reported at the Trust Patient Safety Committee.	

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Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
Appraisals % Rate	>90%	72.4%	74.2%	75.5%	75.8%	76.4%	77.5%	76.0%	76.1%	70.1%	65.9%	65.8%	62.3%	64.7%	
Mandatory Training % Rate	>90%	82.2%	80.8%	81.1%	81.0%	82.1%	83.3%	83.0%	83.3%	82.1%	80.4%	79.9%	80.5%	80.3%	
Permanent Staffing WTEs Utilised	>90%	88.9%	86.8%	87.9%	88.5%	88.9%	88.7%	89.0%	89.6%	92.8%	88.5%	88.4%	88.9%	88.6%	
Staff FFT % recommended work	>50%			59.6%			69.2%								
Staff FFT response rate	>20%			16.3%			55.6%								
Staff sickness absence %	<3.5%	3.57%	3.19%	2.99%	3.93%	3.83%	3.86%	3.90%	3.45%	5.00%	6.66%	5.00%		5.82%	
Staff turnover %	<13%	10.8%	10.7%	10.6%	10.6%	10.5%	10.7%	10.7%	10.5%	9.9%	9.7%	9.2%	9.1%	9.3%	
Vacancy % Rate against Establishment	<10%	11.1%	13.2%	12.1%	11.5%	11.1%	11.3%	11.0%	10.4%	7.2%	11.5%	11.6%	11.1%	11.4%	
Average Time to Hire (Days)	<63 Days	61	62	59	63	63	61	83	76	72	73	73	76	74	
Nursing Staff Average % Day Fill Rate - Nurses		93.2%	87.4%	89.3%	92.6%	96.3%	94.6%	95.2%	97.8%				100.2%	100.2%	
Nursing Staff Average % Day Fill Rate - HCAs		115.6%	127.8%	125.9%	126.2%	126.8%	125.1%	119.8%	125.7%				132.5%	132.5%	
Nursing Staff Average % Night Fill Rate - Nurses		92.9%	91.8%	90.4%	92.4%	94.8%	92.9%	94.3%	95.5%				93.1%	93.1%	
Nursing Staff Average % Night Fill Rate - HCAs		131.1%	126.2%	134.7%	144.0%	135.9%	136.9%	135.6%	152.4%				154.0%	154.0%	
Safe Staffing Alerts - Number of Red Shifts		2	3	5	6	10	5	3	7	0	0	0	2	2	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		9.3	9.2	8.8	9.3	9.2	9.4	9.3	9.3				10.0	10.0	

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

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Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate : 62.3% **Target = 90%**	**Variance from target of – minus 27.7%** This equates to approximately 200 appraisals required to be completed per month over 6 months **Action to Recover:** The L&D Team remain supportive to help load completed appraisals onto ESR whilst managers continue to focus on bringing their clinical and operational services back to business as usual. The introduction of the Totara system, currently being purchased, will enable managers to upload appraisal data more easily, and may reduce the estimated turnaround time.	**Named Person:** Assistant Director Learning & Organisational Development **Time Scale to Recover Performance:** Six months assuming there is no second Covid-19 peak and unless Totara is introduced earlier.
Mandatory Training % Rate : 80.5% **Target = 90%**	**Variance from target – minus 9.5%** **Action to Recover:** The compliance against this KPI has remained consistent. As well as returning to business as usual, compliance is dependent on developing a culture of personal responsibility which the L&D team are ready to support given the challenges of the current ESR system for online learning. There were a number of revisions to the type of learning that would be acceptable to enable maximum flexibility to learning during the pandemic. The L&D Team have been consistently supporting remote working for the duration as well as exploring further new approaches. These variances can continue to allow staff to access training in the easiest way for them. A new system is now being purchased that enables reporting from ESR but enables learners to undertake training in a user-friendly environment using any preferred device. Progress on whether this can be implemented will be provided in future reports.	**Named Person:** Assistant Director Learning & Organisational Development **Time Scale to Recover Performance:** Estimate six months given a new improved user-friendly system Estimate a year without, providing compliance leadership is apparent unless Totara implemented within this period in which case earlier
Permanent Staffing WTEs Utilised: 88.9% **Target: 90%**	**Variance against Plan: 1.1%** **Action to Recover:** This has fallen slightly in the past three months, and this is attributable to lower recruitment and redeployment during COVID.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** September 2020

Staff Turnover Rates: 9.1% **Target: 10%**	**Variance against Plan: N/A** **Action to Recover:** Turnover is lower than usual due to pauses in recruitment and start dates across London.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** N/A
Vacancy Rates: 11.1% **Target: 10%**	**Variance against plan: 1.1%** **Action to recover:** The Vacancy rate had increased through April and May and is attributable to COVID 19. This is starting to stabilise and there has been a slight increase from June 2020.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** September 2020
Time to hire: 76 days Time taken from resignation/creation of new post to confirmed start date **Standard:** 63 days	**Variance against plan:** 13 **Action to recover:** The primary reason for an extension to TTH is delays in recruitment due to COVID 19. This also includes redeploying staff as some staff were temporarily redeployed meaning substantive recruitment was delayed, and start dates remain an issue.	**Named person:** Deputy Director of Workforce **Timescale to recover performance:** September 2020
Safer Staffing **Aim for:** Zero Red shifts Trust CHPPD 8.5 hours (national average 8.6)	**Variance against Plan for June 2020** 2 shifts were reported as Red in June 20, all within Emergency and Integrated Medicine ICSU. The shifts were red as a result of staff shortfall to meet the increased acuity on the ward. No reported clinical incidents or complaints lodged to date Care Hours per Patient Day (CHPPD) in June 20 was 10. All the adult wards reported above 100% fill rate for HCAs in response to enhanced care requirement. **Action to Recover:** The number of red shifts is showing improvement in comparison to the previous months. Ongoing monitoring by senior staff continues using the Staffing Escalation policy. The Acuity and Dependency (A&D) level of the patients is returning to the trust baseline following the peak that was experienced during March and April. Enhanced Care requirement remains high driving the CHPPD above the national average. Recruitment efforts and training of the enhanced care team is being reinstated.	**Named Person:** Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** Ongoing

Appendix 1. Community Performance Dashboard

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children's community waiting times 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:** **Islington IANDS (59.2%)** Islington SCT has seen a continued rise in referrals, primarily due to non-face to face contact for ADOS diagnostic assessment. The service is trialling the first online diagnosis using the Vanderbilt and it is hoped that this will help see a reduction in waiting times. The service is also providing advice guidance and support for families with CYP who are on the waiting list and who need help around managing their CYP behaviour and communication **Islington Occupational Therapy (50%)** There is a significant rise in waiting time for occupational therapy (19.3 weeks) due to mainstream occupational therapists being redeployed to ITU/ community rehab, plus unable to run drop in clinics and sensory workshops which were being used to manage waiting times this will be addressed in phase 2 or restoration plan **Haringey Occupational Therapy (29.2%)** A combination of factors impacted on the teams capacity to offer initial appointments. This included vacancies, the move to provide essential services only, staff redeployment and sickness in the team. The return of staff and re-opening of services from June accounts for the improvement in month. **Haringey Physiotherapy (88.5%)** The physio team were able to maintain shorter waiting times because the therapists responsible for the majority of first appointments work in early years and were not redeployed or off sick during quarter 1. **Haringey SLT (51.9%)** The performance in May and June was a result of redeployment, sickness and a focus on offering appointments for children waiting for therapy as well as first appointments. There are some discrepancies in first appointment numbers included in the report that we are looking into. **Haringey community paediatrics SCC (0.0%)** The team continues to develop new assessment pathways in response to covid-19. A proposal outlining the resource required to reduce waits that increased March to June 2020 has been shared with the CCG. **Haringey community paediatrics NDC (27.3%)**	**Named person:** Director of Operation CYP August 2020

	The service has increased the number of new patient appointments per clinic and face to face appointments are restarting in July for children where a physical assessment is essential. The service has increased the number of clinics by running telephone slots for review patients in a separate clinic. It is planned that trainees, previously redeployed, will return to the community in September which will further increase appointments offered. In June, 45 new patients were seen by the service. **Haringey school nursing (75.9%)** The long waits shown are for the Enuresis service. This is an ongoing issue and commissioners are working to support a service change to improve the service for CYP and families. In the meantime during the covid response the team have developed a different system for managing referrals to try to reduce waits for families.	
Adults community waiting times 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 and actions to recover:** Community Services Recovery Plan has been developed in collaboration with other NCL community providers. There are agreed principles regarding the prioritisation and feasibility of service restoration that have been signed off at NCL Clinical Advisory Group (CAG). The focus on high and medium risk patients has meant that some routine patients are waiting in excess of the 6 week standard. Specific actions and areas of focus are outlined below: **Community Rehabilitation CRT (70.4%) & REACH Intermediate Care (67.4%)** Group therapy and exercise classes remain paused and this is impacting on waiting times. High and medium risk patients are being prioritised resulting in higher waiting times for routine physiotherapy and OT referrals. Urgent and high risk patients continue to be prioritised in line with national guidance resulting in higher waiting times for routine patients. **Bladder & Bowel services (28.0%)** The majority of staff in the Bladder & Bowel team was redeployed to District Nursing in April. Routine activity was paused in line with guidance and face to face activity was minimised for urgent patients. The service has a recovery plan in place to reduce waiting times. **MSK CATS (11.6%) & MSK Routine (24%)** MSK waiting times were significantly impacted by the redeployment of staff to support acute services with activity limited to patients that were triaged and assessed as high risk. The service has resumed with a focus medium and high risk patients, with delivery predominately through virtual consultations. The service has improved performance as compared to the previous month increasing from 3.3% to 11.6% in CATS and from 16.99% to 24% MSK routine. **Diabetes (92.7%)** The service has reduced waiting times for patients with 92.7% of patients being seen within the 6 week waiting time. This is a significant improvement on the previous month (69.4%) **Podiatry (26.1%)**	**Named person:** Director of Operations ACS

	The service continues to support high risk patients during the COVID period with telephone appointments and face to face activity as required. Moderate risk patients are being assessed virtually to address any rising risk. The service has developed plans to address waiting times over future months including virtual consultations using Attend Anywhere. **Spirometry** Community spirometry activity remains paused in line with guidance. **Action to recover:** • Community reset principles and priorities agreed with NCL non-acute Gold and community providers • Digital options being piloted to support new ways of working including virtual consultations and remote monitoring. Options for group consultations are being explored to support the restart of these activities.	

Appendix 1. Community Performance Dashboard

Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
IAPT Moving to Recovery	>50%	60.5%	56.6%	55.5%	55.2%	54.5%	59.9%	58.7%	43.1%	56.4%	39.2%	52.3%		44.7%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	97.8%	94.0%	95.8%	91.5%	96.2%	94.4%	94.6%	91.8%	94.6%	93.6%	93.8%		93.7%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	91.1%	87.7%	88.4%	86.6%	88.7%	85.2%	82.5%	85.3%	90.2%	87.8%	86.4%		87.0%	
Haringey - HR1 % carried out before child aged 15 months	N/A	87.3%	79.7%	82.5%	79.7%	81.7%	82.8%	85.6%	80.3%	77.7%	77.4%	78.8%		78.0%	
Haringey - HR2 % carried out before child aged 30 months	N/A	71.7%	73.3%	73.4%	75.9%	75.4%	76.8%	78.8%	79.5%	68.8%	73.8%	73.3%		73.6%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	90.6%	93.4%	93.4%	93.1%	94.2%	94.5%	95.1%	94.1%	93.8%	95.4%	93.4%		94.4%	
Islington - HR1 % carried out before child aged 15 mths	N/A	85.7%	77.1%	79.2%	84.6%	82.6%	81.1%	82.9%	84.5%	83.5%	74.6%	82.1%		78.4%	
Islington - HR2 % carried out before child aged 30 mths	N/A	81.7%	77.2%	84.3%	77.6%	78.3%	79.4%	82.6%	82.3%	82.9%	81.0%	81.4%		81.2%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	92.1%	94.3%	90.8%	92.5%	91.5%	95.7%	92.5%	90.0%	95.7%		100.0%	60.0%	81.8%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	95.8%	84.6%	86.2%	88.1%	83.3%	79.2%	87.8%	86.5%	96.0%	100.0%		100.0%	100.0%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	88.1%	70.2%	71.2%	87.1%	76.3%	73.6%	75.7%	83.9%	80.1%	75.7%	71.3%	70.8%	73.2%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	87.6%	96.6%	95.7%	95.1%	93.1%	96.6%	95.4%	95.7%	94.2%	96.4%	97.4%	94.1%	96.3%	
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%	80.0%	87.5%	83.3%	100.0%	100.0%	90.0%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	60.0%	75.0%	40.0%	90.0%	50.0%									
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	88.9%	93.3%	88.9%	100.0%	83.3%									
Hackney Smoking Cessation: % who set quit date & stopped after...	>45%			53.9%			59.5%			43.2%					
Islington Self-Management - Average Increase in PAM Score	>=9			13			12			13					
Haringey Self-Management - Average Increase in PAM Score	>=9			12			17			14					

Appendix 2. Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	59.6%	48.1%	59.1%	14.5	44	>95%	2	100.0%	100.0%		-	0
Child Development Services	>95%	12	100.0%	83.3%	100.0%	0.9	9	>95%	2			100.0%	0.4	1
IANDS	>95%	18	84.5%	78.4%	59.2%	17.6	120	>95%	2	100.0%	100.0%	100.0%	0.0	1
Community Children's Nursing	>95%	2	93.9%	82.1%	97.4%	0.3	78	>95%	1	100.0%	100.0%	97.2%	0.1	36
Community Paediatrics Services	>95%	18	63.9%	76.4%	51.2%	18.7	80	>95%	1	0.0%	0.0%	0.0%	18.7	1
Family Nurse Partnership	>95%	12	75.0%	100.0%	75.0%	11.4	4	>95%	-			-	-	0
Haematology Service	>95%	12	100.0%	100.0%	100.0%	0.0	16	>95%	-				-	0
Looked After Children	>95%	4	47.8%	60.0%	88.9%	2.0	9	>95%	2				-	0
Occupational Therapy	>95%	18	21.4%	21.1%	29.6%	17.0	27	>95%	2				-	0
Physiotherapy	>95%	18	98.6%	84.6%	88.5%	5.9	26	>95%	2				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	2.7	27	>95%	-				-	0
School Nursing	>95%	12	81.3%	80.6%	83.0%	4.6	53	>95%	-				-	0
Speech and Language Therapy	>95%	8	93.6%	73.5%	60.4%	11.2	96	>95%	2	0.0%	100.0%	0.0%	5.4	1
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6			100.0%	0.2	9	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	1.9	29	>95%	2	100.0%	75.0%	100.0%	0.9	2
Community Rehabilitation (CRT)	>95%	12	93.5%	91.3%	70.4%	8.3	54	>95%	2	69.2%	80.0%	93.8%	1.1	16
ICTT - Other	>95%	12	92.4%	98.5%	98.8%	1.4	169	>95%	2	88.1%	88.8%	87.5%	1.0	88
ICTT - Stroke and Neuro	>95%	12	73.5%	100.0%	100.0%	2.6	33	>95%	2	73.0%	81.3%	67.5%	1.8	40
Intermediate Care (REACH)	>95%	6	84.2%	73.8%	67.4%	5.5	89	>95%	2	93.5%	94.2%	85.5%	1.2	76
Paediatric Wheelchair Service	>95%	8	100.0%		100.0%	2.3	4	>95%	2			0.0%	2.5	2
Bladder and Bowel - Adult	>95%	12	92.3%	81.8%	28.0%	15.3	82	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	50.0%	3.3%	11.6%	15.0	545	>95%	2		0.0%	50.0%	6.1	6
Musculoskeletal Service - Routine	>95%	6	34.6%	16.9%	24.0%	11.6	990	>95%	2		83.3%	61.5%	2.1	26
Nutrition and Dietetics	>95%	6	96.4%	81.4%	64.4%	6.1	118	>95%	2	100.0%			-	0
Podiatry (Foot Health)	>95%	6	81.6%	87.1%	26.1%	11.4	291	>95%	2		100.0%		-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	1.7	17	>95%	2				-	0
Tissue Viability	>95%	6	100.0%	97.0%	94.8%	1.7	58	>95%	2				-	0
Cardiology Service	>95%	6	93.3%	100.0%	100.0%	1.4	15	>95%	2	0.0%		100.0%	1.1	5
Diabetes Service	>95%	6	53.1%	69.4%	92.7%	2.5	55	>95%	2				-	0
Respiratory Service	>95%	6	95.2%	100.0%	100.0%	0.5	54	>95%	2	100.0%			-	0
Spirometry Service	>95%	6		0.0%		-	0	>95%	2				-	0

Appendix 2. Community Waiting Times Dashboard

Haringey

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	0.0%			-	0	>95%	-				-	0
Child Development Services	>95%	12	100.0%	83.3%	100.0%	0.9	9	>95%	-				-	0
IANDS	>95%	18	71.4%		100.0%	0.1	1	>95%	-				-	0
Community Children's Nursing	>95%	2	100.0%	100.0%	90.0%	0.8	10	>95%	1	100.0%	100.0%	100.0%	0.1	7
Community Paediatrics Services	>95%	18	36.8%	70.0%	40.3%	22.2	62	>95%	1	0.0%	0.0%	0.0%	22.2	1
Family Nurse Partnership	>95%	12		100.0%		-	0	>95%	-				-	0
Haematology Service	>95%	12	100.0%	100.0%	100.0%	0.0	3	>95%	-				-	0
Looked After Children	>95%	4	20.0%	66.7%	100.0%	1.5	2	>95%	-				-	0
Occupational Therapy	>95%	18	23.1%	23.5%	29.2%	17.1	24	>95%	-				-	0
Physiotherapy	>95%	18	98.5%	84.0%	88.5%	5.9	26	>95%	2				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	2.6	23	>95%	-				-	0
School Nursing	>95%	12	72.7%	76.0%	75.9%	6.5	29	>95%	-				-	0
Speech and Language Therapy	>95%	8	75.0%	65.4%	51.9%	12.5	77	>95%	2	0.0%	100.0%	0.0%	5.4	1
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6				-	0	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	1.9	29	>95%	2	100.0%	75.0%	100.0%	0.9	2
Community Rehabilitation (CRT)	>95%	12				-	0	>95%	2				-	0
ICTT - Other	>95%	12	92.7%	99.2%	98.8%	1.3	162	>95%	2	89.5%	88.1%	86.4%	1.0	81
ICTT - Stroke and Neuro	>95%	12	75.4%	100.0%	100.0%	2.7	31	>95%	2	72.2%	80.6%	69.2%	1.7	39
Intermediate Care (REACH)	>95%	6		66.7%		-	0	>95%	2		100.0%		-	0
Paediatric Wheelchair Service	>95%	8	100.0%		100.0%	2.3	4	>95%	2			0.0%	2.5	2
Bladder and Bowel - Adult	>95%	12	87.5%	100.0%	32.4%	13.9	34	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	60.0%	3.4%	10.6%	15.1	284	>95%	2		0.0%	50.0%	8.8	2
Musculoskeletal Service - Routine	>95%	6	38.1%	14.1%	21.8%	11.9	499	>95%	2		100.0%	75.0%	2.1	8
Nutrition and Dietetics	>95%	6	98.1%	90.6%	63.1%	6.7	65	>95%	2	100.0%			-	0
Podiatry (Foot Health)	>95%	6	75.0%	88.2%	25.2%	11.8	155	>95%	2		100.0%		-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	1.8	8	>95%	2				-	0
Tissue Viability	>95%	6	100.0%	100.0%	89.3%	2.4	28	>95%	2				-	0
Cardiology Service	>95%	6	75.0%	100.0%	100.0%	1.0	7	>95%	2	0.0%		100.0%	0.6	1
Diabetes Service	>95%	6	29.4%	66.7%	93.9%	1.5	33	>95%	2				-	0
Respiratory Service	>95%	6	100.0%	100.0%	100.0%	0.5	28	>95%	2				-	0
Spirometry Service	>95%	6		0.0%		-	0	>95%	2				-	0

Appendix 2. Community Waiting Times Dashboard

Islington

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	56.5%	50.0%	59.1%	14.5	44	>95%	2	100.0%	100.0%		-	0
Child Development Services	>95%	12	100.0%			-	0	>95%	-				-	0
IANDS	>95%	18	84.7%	77.3%	58.1%	17.9	117	>95%	2	100.0%	100.0%		-	0
Community Children's Nursing	>95%	2	89.7%	80.0%	98.4%	0.2	61	>95%	1	100.0%	100.0%	96.4%	0.1	28
Community Paediatrics Services	>95%	18	100.0%	92.9%	88.2%	6.8	17	>95%	1				6.8	0
Family Nurse Partnership	>95%	12	75.0%	100.0%	75.0%	11.4	4	>95%	-				-	0
Haematology Service	>95%	12	100.0%	100.0%	100.0%	0.0	11	>95%	-				-	0
Looked After Children	>95%	4	66.7%	100.0%	100.0%	1.5	4	>95%	2				-	0
Occupational Therapy	>95%	18		0.0%	50.0%	12.2	2	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	100.0%		-	0	>95%	-				-	0
PIPS	>95%	12				-	0	>95%	-				-	0
School Nursing	>95%	12	100.0%	90.9%	90.0%	2.5	20	>95%	-				-	0
Speech and Language Therapy	>95%	8	100.0%	100.0%	100.0%	5.6	8	>95%	2				-	0
Bladder and Bowel - Children	>95%	12				-	0	>95%	-				-	0
Community Matron	>95%	6			100.0%	0.2	9	>95%	2				-	0
Adult Wheelchair Service	>95%	-				-	0	>95%	-				-	0
Community Rehabilitation (CRT)	>95%	12	93.5%	90.9%	68.6%	8.6	51	>95%	2	75.0%	80.0%	93.8%	1.1	16
ICTT - Other	>95%	12	80.0%	100.0%	100.0%	3.5	3	>95%	2		100.0%	100.0%	0.5	3
ICTT - Stroke and Neuro	>95%	12	0.0%			-	0	>95%	2		-	0.0%	2.7	1
Intermediate Care (REACH)	>95%	6	85.7%	75.7%	68.2%	5.5	88	>95%	2	93.0%	94.0%	85.3%	1.2	75
Paediatric Wheelchair Service	>95%	-				-	0	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	100.0%	55.6%	25.5%	16.1	47	>95%	2				-	0
Musculoskeletal Service - CATS	>95%	6	40.0%	2.1%	12.3%	15.1	253	>95%	2			50.0%	4.8	4
Musculoskeletal Service - Routine	>95%	6	29.6%	24.0%	29.4%	11.1	411	>95%	2		75.0%	55.6%	2.1	18
Nutrition and Dietetics	>95%	6	92.6%	75.0%	66.0%	5.4	50	>95%	-				-	0
Podiatry (Foot Health)	>95%	6	88.2%	85.7%	26.2%	11.2	126	>95%	2				-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	1.6	9	>95%	2				-	0
Tissue Viability	>95%	6	100.0%	96.2%	100.0%	1.0	27	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	1.7	8	>95%	2			100.0%	1.3	4
Diabetes Service	>95%	6	88.5%	85.7%	90.9%	4.1	22	>95%	2				-	0
Respiratory Service	>95%	6	94.7%	100.0%	100.0%	0.4	24	>95%	2	100.0%			-	0
Spirometry Service	>95%	-				-	0	>95%	-				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-20	May-20	Jun-20	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	59.6%	48.1%	59.1%	14.5	44	>95%	2	100.0%	100.0%		-	0
Community Children's Nursing - Haringey	>95%	2	100.0%		50.0%	2.2	2	>95%	1				-	0
Community Children's Nursing - Islington	>95%	2	93.8%	82.1%	98.7%	0.3	76	>95%	1	100.0%	100.0%	97.2%	0.1	36
Community Paediatrics - Haringey (SCC)	>95%	18	9.1%	0.0%	0.0%	49.3	12	>95%	1	0.0%	0.0%	0.0%	85.3	1
Community Paediatrics - Haringey (NDC)	>95%	18	50.0%	85.7%	27.3%	19.9	33	>95%	1				-	0
Community Paediatrics - Haringey (Child Protection)	>95%	18	100.0%	100.0%	100.0%	0.8	14	>95%	1				-	0
Community Paediatrics - Haringey (Other)	>95%	18				-	0	>95%	1				-	0
Community Paediatrics - Islington	>95%	18	100.0%	100.0%	88.2%	6.1	17	>95%	1				-	0
Family Nurse Partnership - Haringey	>95%	12		100.0%		-	0	>95%	-				-	0
Family Nurse Partnership - Islington	>95%	12	75.0%	100.0%	75.0%	11.4	4	>95%	-				-	0
Haematology Service - Islington	>95%	12	100.0%	100.0%	100.0%	0.0	16	>95%	-				-	0
IANDS	>95%	18	87.5%	100.0%	100.0%	1.8	4	>95%	2		100.0%		-	0
IANDS - SCT	>95%	20	15.4%	0.0%	4.5%	47.6	22	>95%	2				-	0
Looked After Children - Haringey	>95%	4	33.3%	50.0%	100.0%	1.7	4	>95%	2				-	0
Looked After Children - Islington	>95%	4	57.1%	66.7%	80.0%	2.2	5	>95%	2				-	0
Occupational Therapy - Haringey	>95%	18	15.4%	21.1%	26.9%	17.7	26	>95%	2				-	0
Occupational Therapy - Islington	>95%	18	100.0%	54.5%	11.1%	21.3	27	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.0%	75.0%	100.0%	1.1	7	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	100.0%	100.0%	100.0%	1.4	10	>95%	2				-	0
Physiotherapy - Haringey	>95%	18	98.6%	84.6%	88.5%	5.9	26	>95%	2				-	0
Physiotherapy - Islington	>95%	18	100.0%	100.0%	94.4%	2.9	18	>95%	2	100.0%			-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	2.7	27	>95%	-				-	0
SALT - Haringey	>95%	15	87.5%	50.0%	46.7%	12.7	45	>95%	2	0.0%	100.0%		-	0
SALT - Islington	>95%	15	78.0%	84.2%	92.3%	10.5	39	>95%	2			100.0%	0.0	1
SALT - MPC	>95%	18	100.0%	100.0%	100.0%	5.5	20	>95%	2				-	0
School Nursing - Haringey	>95%	12	75.0%	76.0%	75.0%	6.7	28	>95%	-				-	0
School Nursing - Islington	>95%	12	100.0%	90.9%	92.0%	2.3	25	>95%	-				-	0

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

Cancer - 62D Performance by Tumour Group

Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
Breast	>85%	100.0%	83.3%	75.0%	100.0%	100.0%	100.0%	66.7%	80.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>85%	0.0%	44.4%	33.3%	33.3%	0.0%	100.0%	0.0%	0.0%		0.0%	0.0%		0.0%	
Haematological (Excluding Acute Leukaemia)	>85%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%			100.0%	
Lower Gastrointestinal	>85%	100.0%	83.3%	100.0%	88.9%	40.0%	100.0%	100.0%	100.0%	66.7%	0.0%	0.0%		0.0%	
Lung	>85%	100.0%	100.0%	100.0%		0.0%	50.0%	50.0%	66.7%	80.0%	50.0%	100.0%		75.0%	
Other	>85%			0.0%		100.0%			100.0%						
Skin	>85%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Testicular	>85%		100.0%	100.0%	100.0%					100.0%		100.0%		100.0%	
Upper Gastrointestinal	>85%	0.0%		100.0%	100.0%	0.0%	0.0%		0.0%	0.0%		100.0%		100.0%	
Urological (Excluding Testicular)	>85%	62.5%	80.0%	88.9%	85.7%	76.9%	95.7%	66.7%	76.5%	66.7%	50.0%	100.0%		66.7%	

Cancer - 2WW Performance by Tumour Group

Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	2020-2021	Performance
Breast	>93%	98.0%	95.5%	96.9%	98.5%	95.7%	97.9%	96.4%	98.9%	92.0%	82.4%	96.8%		90.8%	
Childrens	>93%	100.0%	100.0%			100.0%						50.0%		50.0%	
Gynaecological	>93%	96.4%	94.3%	51.8%	48.1%	92.4%	95.9%	91.5%	92.9%	93.3%	87.7%	98.3%		93.1%	
Haematological	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>93%	92.8%	95.5%	93.4%	98.6%	95.3%	98.2%	93.0%	97.9%	93.8%	75.8%	72.9%		74.4%	
Lung	>93%	83.3%	100.0%	85.7%	92.9%	100.0%	71.4%	88.9%	100.0%	100.0%	100.0%	100.0%		100.0%	
Skin	>93%	91.1%	82.3%	90.1%	98.3%	100.0%	97.5%	98.6%	96.2%	98.8%	100.0%	99.2%		99.4%	
Upper Gastrointestinal	>93%	97.9%	97.1%	92.9%	97.7%	98.1%	100.0%	100.0%	90.9%	90.9%	50.0%	61.4%		57.4%	
Urological	>93%	93.8%	95.0%	98.0%	97.8%	98.9%	95.6%	96.3%	96.9%	100.0%	100.0%	81.6%		91.4%	

Appendix 4. Trust Level Activity

Category	Indicator	20_21 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Activity
ED	ED Attendances	8285	9458	8778	8658	9428	9371	9768	9561	8732	6565	4028	5703	6399	
ED	ED Admission Rate %		13.4%	13.5%	13.8%	14.4%	14.9%	13.1%	12.0%	12.7%	15.3%	16.6%	16.0%	16.2%	
Community	Community Face to Face Contacts		61971	52361	59513	64426	60854	50546	60164	53716	41347	19432	20930	23550	
Admissions	Elective and Daycase		2244	1977	1898	2171	2084	1791	2116	2085	1450	390	569	1142	
Admissions	Emergency Inpatients		2101	2043	2087	2140	2182	2110	1959	1853	1758	1338	1522	1653	
Referrals	GP Referrals to an Acute Service		7921	6595	6998	8019	7184	6404	7289	6690	4841	1711	3021	6358	
Referrals	% of GP Referrals that were completed via ERS		88.6%	86.6%	88.0%	87.7%	87.1%	87.3%	86.6%	86.9%	83.8%	53.3%	66.4%	80.6%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	13.4%	14.3%	11.0%	15.7%	18.3%	18.7%	13.9%	14.3%	19.3%	72.1%	77.9%	49.7%	
Maternity	Maternity Births	320	315	307	310	304	317	292	283	269	300	253	236	252	
Maternity	Maternity Bookings	377	408	357	314	357	344	353	437	368	338	399	413	392	
Outpatients	Outpatient DNA Rate % - New	<10%	12.9%	13.0%	12.5%	11.2%	11.2%	11.6%	9.7%	9.7%	13.0%	11.2%	8.2%	8.2%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	12.4%	11.6%	11.5%	10.8%	10.5%	10.7%	9.7%	9.5%	10.9%	7.2%	5.9%	6.2%	
Outpatients	Outpatient New Attendances		10381	9108	9475	10795	9885	9214	10574	9518	8131	5788	5810	6748	
Outpatients	Outpatient FUp Attendances		18970	16827	17385	18941	17697	16188	19514	17828	16252	13208	13122	15483	
Outpatients	Outpatient Procedures		8299	7222	7707	8333	7838	7421	8698	7916	5680	2897	3289	4423	

Meeting title	**Trust Board – public meeting**	**Date: 29.7.2020**
Report title	**Workforce Race and Disability Equality Standard 2020 submissions**	**Agenda item: 10**
Executive director	Norma French, Director of Workforce	
Report author	Helen Kent, Assistant Director, Organisational Development	
Executive summary	An important and integral feature of a healthy organisational culture is the diversity and inclusion evident in processes and outcomes. To support performance and improvement in equality, diversity and inclusion, Whittington Health and other NHS organisations have been required to report on the nine indicators of the Workforce Race Equality Standard (WRES) since 2016. Reporting on the ten indicators of the Workforce Disability Equality Standard (WDES) has been required since 2019. This report provides this year's WRES and WDES results. The WRES and WDES data must be published publically, and are provided to the Trust Management Group and Trust Board in advance of publication. The Trust's WRES results this year show continuing and some significant improvements in scores, and closing of the gap between BAME and White staff experience. The most notable gap is seen in indicator 7 for career development, and the recruitment targets should help to close this gap. The 2020 WDES results show that there continues to be a very low level of disclosure of disabilities in our electronic staff record (ESR) system. What results we have over the ten indicators show that staff with a disability fare less well in comparison with staff with none, although there has been some improvements in many of the scores and closing of some gaps.	
Purpose	Approval	
Recommendation	The Board is asked to approve the submission of the WRES and WDES data to NHS England.	
Risk Register or Board Assurance Framework	BAF entries related to the delivery of the People strategic objective	
Report history	A revised WRES Improvement Plan which includes Whittington Health senior level recruitment targets was provided to the Workforce Assurance Committee on 17 June 2020.	
Appendices	None	

Workforce Race and Disability Equality Standard 2020 submissions

1. Workforce Race Equality Standard (WRES)

1.1 The purpose of collecting data on diversity and inclusion is to enable organisations to focus on specific areas for improvement in order to create and sustain a more inclusive culture. The Trust has now accumulated five years of reported data. Some of the parameters and reporting requirements have changed over that period (for example for indicator nine), however, seeing the data together provides an overview of progress.

1.2 The WRES is based on data held in the Trust's Electronic Staff Record (ESR) and other systems for indicators 1, 2, 3, 4 and 9 for the financial year 2019-20; and data for indicators 5, 6, 7 and 8 are taken from the 2019 Annual NHS Staff Survey, undertaken in the Autumn in 2019 with results published in March 2020.

1.3 Table 1 below summarises the Trust's WRES results since the start of reporting.

Table 1: Summary of WRES Indicators for 2020 and previous years

WRES Indicator	2016		2017		2018		2019		2020	
	White	BME	White	BME	White	BME	White	BME	White	BME
1. Ethnic Profile	67.1%	32.9%		45.0%		43.0%	42.6%	41.6%	37.8%	40.2%
2. Likelihood of being appointed	2.28		2.17		2.14		1.65		1.55	
3. Likelihood of entering process for disciplinary	2.67		2.41		1.18		1.44		0.85	
4. Take-up of non-mandatory training	-		-		-		0.94		0.91	
5. Experience of bullying from public	28.8%	28.5%	30.3%	28.6%	28.0%	29.0%	31.0%	36.0%	31%	33%
6. Experience of bullying from colleagues	27.0%	27.3%	24.6%	31.9%	27.0%	33.0%	31.0%	36.0%	30%	32%
7. Career development	87.3%	67.3%	86.6%	70.0%	85.0%	61.0%	83.0%	58.0%	87%	65%
8. Experience of discrimination	7.4%	14.5%	6.6%	16.6%	8.0%	17.0%	9.0%	20.0%	8%	16%
9. Board / Trust comparative representation	76.9%	23.1%	-45.0%		-23.0%		-21.8%		-28.5%	

1.4 Commentary on the results and trends follows separately for each of the nine WRES indicators, and brief reference is made throughout to the work being done to improve the Trust WRES performance. The Trust's progress with the previous improvement plan, and the new improvement plan (which includes recruitment targets for senior roles), was reported to the Workforce Assurance Committee on 17 June 2020.

1.5 **Indicator 1** (Trust Profile: White and BAME staff at different pay-bands). In many NHS trusts, including Whittington Health, there is a typical *X* - shape with White staff increasing with the

band, and BME staff decreasing with the bands. This is the reason for setting targets for appointing at senior levels to bring results to equity by 2028.

1.6 **Indicator 2** (Relative likelihood of being appointed). This shows a slow improvement year on year overall. The Trust's performance in meeting recruitment targets shows that progress with targets for Bands 8B, 8D, 9 and very senior manager (VSM) is being maintained; the target for Band 8C is slightly ahead, and the target on Band 8A is behind.

1.6 **Indicator 3** (Relative likelihood of entering into a formal disciplinary process). Evaluation of the impact of the 'Fair Treatment Panel' provided insight into unnecessary early escalation of cases, which has been the focus for reducing the number of formal stage disciplinaries. This work has been successful and the number of cases being brought to the formal process has reduced considerably. With very low numbers, one more person in either the White or BAME group has a greater impact on the ratio between them than with high numbers, and the score suggests BAME staff are less likely to enter into formal process. The work recently undertaken to improve the 'not disclosed' category has also improved this score.

1.7 **Indicator 4** (Relative take-up of non-mandatory training). There is relatively equal access to non-mandatory training with BAME staff slightly ahead. Competition to enrol on programmes is monitored and managed to ensure equal participation, and appears to be working well.

1.8 **Indicator 5** (Relative likelihood of experiencing harassment and bullying form the public). The 2020 results showing staff experience of bullying from the public, show an improvement of 3% for BAME staff currently at 33 per cent, and no change for White staff at 31 per cent. The gap in experience between BAME and White staff has reduced from 5 percent to 3 per cent.

1.9 **Indicator 6** (Relative likelihood of experiencing harassment and bullying from colleagues). The results show a 4 per cent reduction in BAME staff experience of bullying from colleagues at 32 per cent, and one per cent reduction for White staff at30 per cent. The gap between BAME and White staff experience has reduced by 3 per cent from 5 to 2 per cent. The anti-bullying training undertaken in 2019 by 502 managers is being rolled out to all staff in 2020. During the pandemic, online, a live and interactive session was piloted and found to be as effective as the face-to-face training, and less expensive to run. Therefore sessions have been booked for this highly regarded training from July 2020 for the rest of the year.

1.10 **Indicator 7** (Relative opportunities for career development). Both White and BAME staff groups on average report more satisfaction with the career development opportunities. BAME staff report 17 per cent more satisfaction than in 2019 at 65 per cent reporting being satisfied. Four per cent more White staff report being satisfied at 87 per cent. This reduces the gap in satisfaction between BAME and White staff by 3 per cent to 22 per cent, which is high and of concern. The BAME staff network has grown significantly in recent months and it is hoped that this will support career development activity with the support of speakers and workshops.

1.11 **Indicator 8** (Relative experience of discrimination). The results for both White and BAME staff experience of discrimination has improved with one per cent decrease for White staff and 4 per cent decrease for BAME staff, reducing the gap by 3 per cent from 11 to 8 per cent.

1.12 **Indicator 9** (Relative level of Board representation). The minus percentage of 28.5 shows an under-representation on the Board in comparison to the organisational profile as a whole. This is an increase in under-representation in comparison to the 2019 results.

2. Workforce Disability Equality Standard (WDES) Performance

2.1 The first report was submitted at the end of July 2019 and based on the data from the 2018-19 financial year. The 2020 submission provides the data for 2019-20.

2.2 The ten indicators for WDES are taken from ESR and other systems for indicators 1, 2, 3 and 10; and from the annual staff survey for indicators 4, 5, 6, 7, 8 and 9.

2.3 As with the 2019 report, there is a limit to how meaningful and transferable the outcomes of the WDES data can be when the NHS National Staff Survey indicates that there are at least 5 per cent of staff who have a disability, and ESR indicates that only 2 per cent of staff have disclosed their disability. A concerted effort has been made to request disclosure at staff network events and through emails since the 2019 results were known and this will continue. The low disclosure rates means that there is limited meaning to the following analysis.

2.6 Table 2 below, shows the 2020 results for each of the ten WDES indicators.

Table 2: Summary of Performance on each Indicator

	WDES Indicator	2019 Results	2020 Results
1	Profile – disability at different bands	With only 2% of staff disclosing a disability on ESR, and 12% of respondents to the annual NHS staff survey declaring a disability, the following data has limited meaning.	ESR shows 2% of staff disclosed having a disability; just under 50% having no disability; and almost 50% did not disclose. In the annual staff survey approximately 5% of staff disclosed having a disability.
2	Likelihood of being appointed	Non-disabled staff are 1.24 times more likely to be appointed than staff with a disability	0.96
3	Likelihood of entering formal capability process	Staff with a disability are 1.74 times more likely to enter into a formal disciplinary process than non-disabled staff	Zero: (no staff with disclosed disabilities have entered into formal capability)
4	Percentage of staff experiencing harassment and bullying from - Patients & public - Managers - Colleagues	Staff with / Staff Disability / without Patients and Public 40.3% / 32% Managers 27.3% / 19.3% Colleagues 27.5% / 24.5%	Staff with / Staff Disability / without Patients and Public 33.4% / 31.3% Managers 24.1% / 16.3% Colleagues 32.9% / 23.5%
5	Percentage of staff believing there are equal opportunities for career development	Staff with Disability 63.3% Staff without Disability 74.1%	Staff with Disability 72.1% Staff without Disability 78.3%
6	Experience of feeling pressure from manager to work when not well	Staff with Disability 32% Staff without Disability 23.7%	Staff with Disability 33.5% Staff without Disability 22.0%
7	Percentage saying they are satisfied with how the extent to which the Trust values their work	Staff with Disability 36.8% Staff without Disability 48.4%	Staff with Disability 39.3% Staff without Disability 51.6%
8	Percentage saying employer made reasonable adjustments	62.5%	68.1%
9	(9a) Relative engagement scores	Staff with Disability 6.6 Staff without Disability 7.1	Staff with Disability 6.7 Staff without Disability 7.2
	(9b) At the time the results were collated, the response to the question 'has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?' was 'No'. Since this, a member of staff has expressed interest in creating a network for disabled staff.		There is now a 'Whittability' Network which has 'met' online several times during the pandemic in support of shielders and redeployed staff.

WDES Indicator		2019 Results	2020 Results
10	Relative level of board representation	11% over-representation of non-disabled; -2% under-representation of disabled. Given the level of disclosure across the Trust, this data has limited meaning.)	There is -2% under-representation of people with disclosed disabilities and an over-representation of 38% for non-disabled members.

2.8 **Indicator 1** (Trust profile for staff with and without disabilities at different bands) With only two per cent of staff represented in ESR, and 5 per cent of the staff who responded to the staff survey, the following analysis can only apply to those specific respondents. It is therefore a key priority that we engage staff in the benefits of uploading demographic data into ESR to enable the Trust to target resources and activity in support of those with disabilities. This has been promoted in all training including leadership, equalities, and appraisal training we well as the various staff networks, including BAME, 'LGBTQ+' and 'Whittability'.

2.9 **Indicator 2** (Relative likelihood of being appointed). The recruitment data suggests that there has been an improvement in the rate at which people with disabilities are recruited in comparison with non-disabled people. Whereas last year non-disabled applicants were 1.24 times more likely to be recruited, in 2020 the figure appears to be closer to equal.

2.10 **Indicator 3** (Relative likelihood of entering formal capability process). The 2019 results showed that staff with disabilities were 1.74 times more likely to enter into a capability process than non-disabled staff. There is an improvement in the 2020 results because only non-disabled staff (and those who have not specified) have entered into the process.

2.11 **Indicator 4** (Relative percentage of staff experiencing bullying from patients, managers and colleagues). There is a significant reduction of 6.9 per cent in staff with disabilities facing bullying from patients, their relatives and the public, now at 33.4 per cent. The reduction in non-disabled staff experience is less at 0.7 per cent now at 31.3 percent. This reduces the gap in experience from 8.3 per cent to 2.1 per cent.

2.12 There is a smaller reduction of 3.2 per cent of staff with disabilities experiencing bullying from managers, now at 24.1 per cent. The figure for non-disabled staff is 16.3 per cent which is a reduction of 3 per cent from 2019. This has reduced the gap in experience by 0.2 per cent.

2.13 There is a concerning increase of 5.4 per cent of staff with disabilities experiencing bullying form colleagues, now at 32.9 per cent. There is a small reduction of one per cent in non-disabled staff experiencing bullying from colleagues, now at 23.5 per cent. This increases the gap in relative experience of staff with and without disabilities experiencing bullying from colleagues from 3.5 per cent to 9.4 per cent.

2.14 **Indicator 5** (Relative percentage of staff believing there are equal opportunities for career development). In 2020, 72.1 per cent of staff with disabilities report that they believe there are equal opportunities for career development, which is an 8.8 per cent increase from 2019. There is a smaller increase for non-disabled staff of 4.2 percent, bringing the 2020 score to 78.3 per cent, reducing the gap from 10.8 per cent to 6.2 per cent.

2.15 **Indicator 6** (Relative experience of feeling pressure from manager to work when not well). In 2020, 1.5 per cent more staff with disabilities felt pressure from their managers to attend work when unwell than in 2019. This brought the level of pressure felt to 33.5 per cent for staff with disabilities in comparison to 22 per cent (1.7 per cent less than 2019) for non-disabled staff.

2.16 **Indicator 7** (Relative percentage saying they are satisfied with how the extent to which the Trust values their work). In 2020, 39.3 per cent of staff with disabilities report being satisfied – an increase of 2.5 per cent – in comparison with 51.6 per cent of non-disabled staff which is a higher increase on 2019 of 3.2 percent.

2.17 **Indicator 8** (Percentage saying employer made reasonable adjustments). There is an increase of 5.6 per cent of staff with disabilities reporting that the Trust has made reasonable adjustments. This brings the score to 68.1 per cent for 2020.

2.18 **Indicator 9** (Relative engagement scores). The 2020 staff engagement scores have increased by 0.1 (this is a score, and not a percentage) for both disabled and non-disabled staff. The gap in engagement remains the same, therefore, at 0.5.

2.19 **Indicator 10** (Relative level of board representation). This metric relates to the representation of Board members in comparison to the Trust staff overall. Given the level of staff disclosure throughout the Trust, the results have limited meaning. The 2020 results show that there is a -2 per cent under-representation of people with disclosed disabilities, and conversely, an over-representation of 38% for non-disabled members.

3. Priorities for 2020-2021

3.1 There are regionally set targets for WRES improvement specifically relating to recruitment of BAME staff at higher bands (bands 8A to VSM).

3.2 The revised WRES improvement plan was considered at the Workforce Assurance Committee on 17 June 2020 and specific amendments required from that Committee were the inclusion of risk assessments, use of personal protective equipment and interview panel training for lower banded BAME representatives. This has been re-circulated with amendments.

3.3 The BAME Staff Network has engaged with the discussion on the improvement plan through the online webinar sessions which take place fortnightly

3.4 The most important priority for WDES improvement continues to be the disclosure rate. This is being encouraged through the Whittability Staff Network, and all equality and inclusion modules of leadership, appraisal and other training programmes.

3.5 The adoption of a ‘Just and Learning Culture’ is being advanced through collaborative exploration of relevant processes and procedures throughout the Trust and is at the early stages of development. This is a key priority bringing together different aspects of the culture improvement work including the reduction of bullying, increasing inclusion and staff engagement.

3.6 The improvement of evaluation and the establishment of cause-and-effect activities will also be a focus in 2020-21.

4. Recommendation

4.1 The Board is requested to approve the submission of the WRES and WDES data for 2020 to NHS England.

Meeting title	**Trust Board – public meeting**	**Date: 29 July 2020**
Report title	**2020/21 Board Assurance Framework (BAF)**	**Agenda item: 11**
Report authors	Jonathan Gardner, Swarnjit Singh and respective executive risk leads and Gillian Lewis (risk register appendix)	
Executive summary	This paper sets out the updated, high level draft BAF (see appendix 1) following the Board's approval of the updated objectives at its 24 June 2020 meeting. The BAF has been reviewed and updated by risk leads and was also considered at the 8 July meeting of the Quality Assurance Committee. **BAF review** Grant Thornton UK LLP have finalised their review of Whittington health's Board assurance arrangements. The review concluded that there was *significant assurance with some improvement required*. This is a good outcome and the full internal audit report will be considered at the Audit & Risk Committee meeting on 30 July. The improvement recommendations will be taken forward in partnership with executive risk leads during quarter two with the aim of bringing an updated BAF to the Public Board meeting in September. The trust risk register is also shown in the appendices.	
Purpose	Review	
Recommendation(s)	The Board is asked to: i. review and provide feedback on the updated 2020/21 BAF; ii. note the successful outcome of the internal audit review and that work will take place with executive risk leads to implement the improvement recommendations in time for the September Board meeting; and iii. note the changes approved by the Quality Assurance Committee; and iv. consider if any Trust risk register entries scored at 16 and above should be considered for inclusion on the BAF.	
Risk Register or BAF	All BAF entries	
Report history	Executive Team and Trust Management Group	
Appendices	1: 2020/21 BAF summary 2: 2019/20 BAF detail for entries 3: Trust Risk Register summary report	

Appendix 1: 2020/21 Board Assurance Framework summary

As agreed at the June 2020 Board meeting, each of our four new strategic objectives has been summarised as:

Strategic objective	Summary
Deliver outstanding safe, compassionate care in partnership with patients	**Quality**
Empower, support and develop an engaged staff community	**People**
Integrate care with partners and promote health and wellbeing	**Integration**
Transform and deliver innovative, financially sustainable services	**Sustainability**

Risk Ref	Risk description	Current score			Target score	Date risk added	Lead director(s)
		I	L	R			
Quality 1	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation	4	3	12	4	April 2019	Chief Nurse / Medical Director
Quality 2	Lack of capacity, due to second wave of Covid-19, or winter pressures results in long delays in the Emergency Department, inability to place patients who require high dependency and intensive care, and patients not receiving the care they need across hospital and community health services	4	4	16	4	April 2020	Chief Nurse / Medical Director

Risk Ref	Risk description	Current score			Target score	Date risk added	Lead director(s)
		I	L	R			
Quality 3	Patients on a diagnostic and/or treatment pathway (elective and community) at risk of deterioration due to insufficient capacity to restart enough elective surgery and other services (as a result of Covid-19 Infection Prevention & Control (IPC) guidance), resulting in further illness, death or the need for greater intervention at a later stage	3	5	15	4	April 2020	Chief Nurse / Medical Director
Quality 4	Lack of attention to other key clinical performance targets, due to other Covid-19 priorities, or reduced capability, leads to deterioration of service quality and patient care	2	4	8	4	April 2020	Chief Nurse / Medical Director
People 1	Lack of sufficient staff, due to second Covid-19 results in increased infection rates and increased staff absence, or the impacts of Brexit lead to increased pressure on staff, a reduction in quality of care and insufficient capacity to deal with demand	4	3	12	9	June 2020	Workforce
People 2	Psychological and physical pressures of work due to Covid-19 impact and lower resilience in staff, resulting in a deterioration in behaviours, culture, morale and the psychological wellbeing of staff and impacts adversely on staff absence and the recruitment and retention of staff	3	3	9	4	June 2200	Workforce
People 3	Being unable to empower, support and develop staff, due to poor management practices, lack of dealing with bullying and harassment, poor communication and engagement, poor delivery on equality, diversity and inclusion, or insufficient resources, leads to disengaged staff and higher turnover	4	3	12	9	June 2020	Workforce

Risk Ref	Risk description	Current score			Target score	Date risk added	Lead director(s)
		I	L	R			
Integration 1	The reconfiguration of pathways or services, due to Covid-19 restart pressures, political pressures, or provider competition, results in some Whittington Health services becoming fragile or unsustainable, or decommissioned and therefore threatens the strategic viability of the Trust. (e.g. paediatrics inpatients, trauma, maternity)	**4**	**3**	**12**	6	June 2020	Strategy
Integration 2	Failure to effectively maximise the opportunity through system working, due to focus on near term issues, results in not solving the challenges of fragile services and sub-optimal clinical pathways	**2**	**4**	**8**	6	June 2020	Strategy
Integration 3	The progress made on integration with partners is put back, due Covid-19 pressures, and a system focus on acute pathways, resulting in benefits previously gained being lost.	**2**	**4**	**8**	6	June 2020	Strategy
Integration 4	The health and wellbeing of the population is made worse, due to the lack of available investment or focus on ongoing care and prevention work, resulting in demand after the Covid-19 outbreak being considerably higher than pre-Covid-19.	**4**	**3**	**12**	8	June 2020	Strategy
Sustainable 1	Covid-19 cost pressures are not collected properly and or not funded properly, due to poor internal systems, lack of funding or prioritisation of other trusts' need, and as a result our underlying deficit worsens	**3**	**3**	**9**	8	June 2020	Chief Finance Officer
Sustainable 2	Failure of key infrastructure, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm or reduced capacity in the hospital	**4**	**3**	**12**	8	June 2020	Environment
Sustainable 3	Unequal investment in services, due to lack of clarity over the NHS funding regime and other trusts taking opportunities, or rushed decisions, leads to a mismatch of quality of provision for our	**3**	**3**	**9**	6	June 2020	Chief Finance Officer / Chief

Risk Ref	Risk description	Current score			Target score	Date risk added	Lead director(s)
		I	L	R			
	population and delay, reduction, or cancelling of key investment projects for the Trust						Operating Officer
Sustainable 4	Failure to transform services to deliver savings plan, due to poor control or insufficient flexibility under a block contract, results in adverse underlying financial position, and failure to hit control total, that puts pressure on future years investment programmes and reputational risk	**3**	**4**	**12**	8	June 2020	Chief Finance Officer / Chief Operating Officer
Sustainable 5	The stopping or delay of existing transformation projects (e.g. orthopaedics / pathology / localities / maternity / estates), due to the focus on immediate issues around the Covid-19 restart, results in savings and improvements to patient care, not being realised	**3**	**4**	**12**	8	June 2020	Chief Operating Officer

Appendix 2: 2019/20 Board Assurance Framework detail for BAF risk entries

Risk IDs:	**Quality 1 – 4**
Risks: **1**	**Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients and families, due to errors, or lack of care or lack of resources, results in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation**
2	**Lack of capacity, due to second wave of Covid-19, or winter pressures results in long delays in the Emergency Department, inability to place patients who require high dependency and intensive care, and patients not receiving the care they need across hospital and community health services.**
3	**Patients on a diagnostic and/or treatment pathway (elective and community) at risk of deteriorating, due to insufficient capacity to restart enough elective surgery and other services (as a result of Covid-19 Infection Prevention & Control guidance), resulting in further illness, death or the need for greater intervention at a later stage**
4	**Lack of attention to other key clinical performance targets, due to other Covid-19 priorities, or reduced capability, leads to deterioration of service quality and patient care**

CQC Domain	Safe; Caring, Effective; Responsive; Well-led
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	Deliver outstanding, safe, compassionate care
Board Leads	Chief Nurse & Director of Allied Health Professionals & Medical Director
Committee	Quality Committee
Risk register codes	None

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Continue to partner with those who use services to deliver our quality, safety and patient experience priorities, with a focus on protecting people from infection and actions from the recent CQC inspection report • Maintain expanded rapid response services across adult and CYP and re-start other community services in a safe way, prioritising the vulnerable • Re-start planned care in a 'Covid-19-protected' safe way, prioritising with the system those most urgently in need • Maintain flexible capacity by continuing to promote working in new domains • Create flexible capacity by training people quickly in new domains • Maintain as much business as usual as possible to prevent escalation of other illnesses • Regular review of ward and ITU capacity and regular change of models of care to meet the demand • Incidents, risks and complaints, management system on DATIX • Serious incident (SI) reporting and action plans monitored to ensure learning • Mortality review panel learning from deaths process and reporting • Zoned areas in the hospital for IPC • Working on extra waiting area space for ED • Continued use of the full performance report to monitor all areas of quality and activity • Project Phoenix QI drive now on	• 1st tier – Weekly TMG Covid-19 meetings • 1st tier - Incident and SI reporting policies • 1st tier - Weekly incident review meeting with ICSU risk managers • 1st tier Quality Governance quarterly meetings (revised Terms of Reference starting April 2020) • 1st tier - 'Better Never Stops' Steering Group • 2nd tier - Clinical and national audit findings, GiRFT and NICE compliance) reported to Quality Assurance Committee on a quarterly period. • 2nd tier - Trust Risk Register reviewed by Quality Assurance Committee, Audit & Risk Committee and Board • 2nd tier - Policy status report to Quality Assurance Committee • 3rd tier – Peer review visits include NHSI and CCG leads • 3rd tier – Voluntary service steering group

Gaps in controls & assurances: (What additional controls and assurances should we seek?)
• Lower reporting volumes on DATIX

Risk IDs:	**People 1 – 3**
Risks: **1**	**Lack of sufficient staff, due to second Covid-19 wave, increased absence, or Brexit, leads to reduced increased pressure on staff, reduction in quality of care and insufficient capacity to deal with the demand**
2	**Psychological and physical pressures of work, due to Covid-19 impact and lower resilience in staff, results in deterioration in behaviours, culture, morale and psychological wellbeing of staff.**
3	**Being unable to empower, support and develop staff, due to poor management practices, lack of dealing with bullying and harassment, poor communication and engagement, poor delivery on equality, diversity and inclusion, or insufficient resources, leads to disengaged staff and higher turnover**

CQC Domain	Well-led
CQC Outcomes	Requirements relating to workers; staffing; supporting workers
Corporate Objective	Empower, support and develop engaged staff
Board Lead	Director of Workforce
Committee	Workforce Assurance Committee
Risk register codes	693, 859, 797, 868

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Protect our staff by following PHE infection control and prevention guidance and using the right PPE with special focus on supporting vulnerable staff • Continually improve our culture by compassionately helping and caring for each other, both with work and with wellbeing • Work flexibly but in a coordinated way recognising we will be required to work in this manner for some time • Support roll-out of agile working and ensuring that we support working safely in homes,	• Weekly report to ETM on staffing issues • Weekly report to TMG on staffing levels and issues • Monthly Partnership Group and MNSC with trade union representatives

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
offices and clinical environments • Promote inclusive, compassionate leadership, accountability and team working where bullying and harassment is not tolerated • Staff support group arrangements in place, including regular communication to all staff • Continued support for the "caring for those that care" initiative • Particular emphasis on black, Asian and minority ethnic (BAME) colleagues and other vulnerable groups in risk assessments and ongoing support • Continued work with our OH and IAPT teams and CIFT to provide psychological support for staff • Recruitment and retention strategy and updated action plan in place • Safe staffing reports (nursing staff) and exception reports (junior doctors) • Dedicated nurse, midwife and HCA recruitment team in place • Continued training and support for all managers and leaders • Regular email to all staff promoting wellbeing activities • Keep in touch scheme for staff on maternity leave, shielding and working from home • Quarterly pulse surveys and family and friends test **Action plans:** • WRES Improvement plan • Staff Survey action plan • Talent Management and Succession Planning Improvement • Health and Wellbeing action plan • Caring for those who care action plan	• 1st Tier Daily review of gifts and support and staffing gaps via TMG • 1st tier – ICSU boards consider quarterly pulse surveys, annual staff survey results and create local action plans • 2nd tier – Trust Management Group • 2nd tier - Workforce Assurance Committee • 3rd tier – National Guardian's Office's case review

Risk ID:	**Integration 1 – 4**
Risks: **1**	**The reconfiguration of pathways or services, due to Covid-19 restart pressures, political pressures, or provider competition, results in some Trust services becoming fragile or unsustainable, or decommissioned and threaten the strategic viability of the Trust (e.g. paediatrics inpatients, trauma, maternity)**
2	**Failure to effectively maximise the opportunity through system working, due to focus on near term issues, results in not solving the challenges of fragile services and sub-optimal clinical pathways**
3	**The progress made on integration with partners is put back, due Covid-19 pressures, and a system focus on acute pathways, resulting in benefits previously gained being lost.**
4	**The health and wellbeing of the population is made worse, due to the lack of available investment or focus on ongoing care and prevention work, resulting in demand after the Covid-19 outbreak being considerably higher than pre-Covid-19.**

CQC Domain	Effective; Responsive; Safe
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	Integrate care with partners and promote health & wellbeing
Board Lead	Director of Strategy, Development & Corporate Affairs
Committee	Quality Committee
Risk register codes	w32973 Steis 2015 33773 Surgery ICSU

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Work with our partners in localities to proactively care for vulnerable people in the community • Prevent ill-health and empower self-management by making every contact count and	• 1st tier - Weekly Trust Management Group • 1st Tier – Monthly Investment Group

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
engaging with the community and becoming a source of health advice and education • Help reduce exposure of our vulnerable patients in the community to Covid-19 and encourage people to use services appropriately and confidently • Create virtual connections with our community and mental health patients as much as possible • Provide for the population who need Covid-19 protected care needs through collaboration with NCL partners using each other's capacity and expertise • Maintain services for as long as possible to prevent illness escalation while training to cover other roles • Proactive planning of service implications and proposals by ICSUs and board on the back of strategy paper considering changes considered at TMG and Board • Considering better analysis of local data to proactively help people • Close liaison with the councils and driving integrated care ourselves through locality working will help increase our influence and reduce the risk • Participation in NCL governance meetings by Executives, regular communication with executive counterparts at other organisations, good liaison through the NEDs to other Trusts • Participation and influence in clinical networks by senior clinicians • Use of Transformation Programme Board and Investment Group to drive projects that might otherwise get left behind **Action plans**: • Transformation programme board plan • Borough partnership plans • Recovery plan • Community estates plan	• 1st Tier – Monthly review at the Transformation programme board • 1st Tier – Monthly Integrated Forum • 1st Tier – Community Estates Programme group • 2nd tier - Trust Board • 2nd tier - UCLH and WH Clinical Collaboration Board • 2nd tier – monthly meeting with GP Federations • 2nd tier – Locality leadership teams • 3rd tier – Borough Partnership Boards • 3rd tier – NHS Improvement oversight meetings • 3rd tier – Joint Overview and Scrutiny Committees

Risk ID:	**Sustainable 1 – 5**
Risks:	
1	**Covid-19 cost pressures are not collected properly and or not funded properly, due to poor internal systems, lack of funding or prioritisation of other trusts' need, and as a result our underlying deficit worsens**
2	**Failure of key infrastructure, due to insufficient modernisation of the estate or insufficient mitigation, results in patient harm or reduced capacity in the hospital**
3	**Unequal investment in services, due to lack of clarity over the NHS funding regime and other trusts taking opportunities, or rushed decisions, leads to a mismatch of quality of provision for our population and delay, reduction, or cancelling of key investment projects for the Trust**
4	**Failure to transform services to deliver savings plan, due to poor control or insufficient flexibility under a block contract, results in adverse underlying financial position, and failure to hit control total, that puts pressure on future years investment programmes and reputational risk**
5	**The stopping or delay of existing transformation projects (e.g. orthopaedics / pathology / localities / maternity / estates), due to the focus on immediate issues around Covid-19 restart, results in savings and improvements to patient care, not being realised**

CQC Domain	Well-led
CQC Outcomes	Financial position
Corporate Objective	Transform & deliver innovative, financially sustainable services
Board Leads	Chief Finance Officer / Chief Operating Officer / Director of Environment
Committee	Finance and Business Development Committee
Risk register codes	784,780,880,723,772, 91, 697, 817, 680, 820, 807, 750, 746

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Create replicable better more efficient and effective pathways for the long term including 'virtual by default' where possible and promoting self-management • Explore expansion of multidisciplinary research and education opportunities in the community • Think to the future and keep learning through QI, continue to reduce system cost and improve clinical productivity and financial literacy everywhere • Manage our expenditure to lower than last year's run-rate to enable investment in other services • Progress adapted estates and IT plans at pace • Use of Transformation Programme Board and Investment Group to drive projects that might otherwise get left behind • Maintain financial governance controls • Use of strategy, business plans and various committees to recommend areas of investment • Quarterly performance reviews continued and targeted support when necessary (as per Accountability Framework) • Monthly Cost Improvement Programme (CIP) delivery board continued • Joint Programme Management Office (PMO)/Finance CIP tracker • ICSU deep dives at Finance & Business Development Committee • Quality Impact Assessment process in place • Limits on the number of beds with CPAP that can be opened on any one ward and total • Capital programme addresses all red risks. • PFI monitoring group • Development of an estates plan • Annual health and safety report • Datix monitoring • Strong monitoring of fire safety procedures and fire warden training with a	• 1st tier – monthly reports to Trust Management Group • 1st Tier – Community Estates Programme group • 1st Tier Daily monitoring at TMG • 1st tier – Estates management group • 1st tier – Capital monitoring group • 1st Tier – Investment Group • 1st Tier – Transformation Programme Board • 1st tier – TMG • 1st tier – health and safety committee • 1st Tier – Estates Steering Group • 1st Tier – PFI monitoring group • 1st Tier – quarterly performance reivews • 1st Tier – Better Never Stops – Improving Value • 2nd tier – Finance & Business Development Committee • 2nd tier – Trust Board • 3rd tier - Internal audit reports and recommendations

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
comprehensive fire safety dashboard reported monthly to TMG	

Appendix 3: Risk register summary report

1. Risk register update: July 2020

1.1 As at 30 June 2020, the Trust has two risks graded as ≥20, seventeen risks graded as 16. There are thirteen risks graded as 15 which are monitored at Board Committee level. There are three key themes from the current high level risks on the risk register, are reflected under the BAF headings

- Sustainability; Estates and Finance
- People
- Quality

1.2 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.

2. Sustainability – Estates and IM&T infrastructure

There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our strategic objective to '**Transform and deliver innovative, financially sustainable services.** The Trust Board monitors actions against this risk through the BAF process, including implementation of the estates strategy.

Datix ID	ICSU/ Directorate	Category	Title	Current risk grade	Mitigations and controls
858	Children and Young People Services	Patient Safety and Quality	Neonatal Unit environment - including lack of space between cots Linked to risk 697	16	Risk ongoing and regularly reviewed against national recommendations. Infection control team carried out review of cots allocated to isolation space. Current work is in progress to create additional cot space and carry out a deep clean, NICU and SCBU decanted to Eddington ward over July to facilitate this.
890	Facilities and Estates	Health and Safety	Private Finance Initiative (PFI) fire building strategy	16	Controls: PFI has introduced Fire Warden 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

Datix ID	ICSU/ Directorate	Category	Title	Current risk grade	Mitigations and controls
					reviewed at Fire Safety Group.
907	Trust wide	Estates or Infrastructure	High ambient temperatures of ward treatment rooms affecting quality of medicines.	16	Controls: Calibrated thermometers and new Standard Operating Procedure 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 for Temperature Controlled Cabinets (TCC) presented to Capital Monitoring Group. On-going updates provided to the Drugs & Therapeutics Group and Nursing & Midwifery Executive Committee.
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 Update: Estates reviewed in May and proposal agreed. Awaiting installation date confirmation from Estates.
1088	Adult Community	Estates or Infrastructure	Insufficient supply of	16	Controls for 1088 and 1096 Trialling Attend Anywhere

Datix ID	ICSU/ Directorate	Category	Title	Current risk grade	Mitigations and controls
	Services		appropriate IT and peripherals to deliver new service models		in MSK and IAPT Using telephone clinics as a second best. Use of personal protective equipment (PPE)for face to face essential appointments Advice, support and guidelines for patients *Actions:* Joint business case for funding for laptops and work phones discussed at Capital Monitoring Group. Trust wide review of Estates and Infrastructure priorities
1096	Children's and Young People	Estates or Infrastructure	CYP ICSU Covid recovery and NHS agile working transformation plans are hindered by lack of appropriate IT equipment	16	

3. Sustainability – Finance

DATIX	ICSU/Directorate	Category	Title	Current risk grade	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 Performance meetings and Finance and Business Development Committee.
772	Surgery and Cancer	Financial	Not meeting CIP target and financial balance for 2018/19.	20	
780	Finance	Financial	Budget Control	16	

4. People

There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our strategic objective to '**Empower, support and develop an engaged staff community.** The Trust Board monitors actions against this risk through the BAF process, including implementation of the estates strategy.

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Mitigations and controls
777	ACW	Workforce	Interventional Radiology (IR) – insufficient provision	16	Requirement to set up a hub and spoke model with a larger site to ensure patients have adequate IR provision. Options being reviewed with

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Mitigations and controls
					UCLH : 1) Treat and transfer (i.e. o a centre e.g. UCLH or RFL) 2) Increase service and resourcing to ensure resilience 3) Networked approach i.e. shared posts/services with RFH or UCLH to allow 24/7 cover on the WH site Covid update; Risk increased due to staff shortages during Covid; this was mitigated with temporary staffing from UCLH. All IR nurses now back at work.
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 Appointment of additional half WTE Anaesthetist pre-Covid. Risk to be reviewed in light of changes in demand.
1055	Surgery and Cancer	HR and Workforce	Risk of non continuity of care for some oncology patients	16	Locum Oncologist now on site to provide continuity. Strict guidelines associated with the management of patients during Covid-19 and there is a business case in preparation of the local cancer centre managing services at the Whittington.
1058	ACW	HR and Workforce	National Shortage of Sonographers and therefore limited allocation to Gynaecology Rapid Access Cancer Clinics.	16	Service manager is pursing external income generation initiatives in order to fund competitive market rates for sonographers in line with other NCL Services. The department has trained two sonographers this year that will be ready to practice autonomously in September. Posts advertised but little interest. .

5. Quality (including equipment)

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: Currently ED attendance still below pre-Covid levels, but risk continues to be monitored closely. Ongoing work in ED to manage demand, influence GP referral processes and increase referrals to Ambulatory Care. New 136 suite provision at Highgate open and revised pathways during Covid directing mental health patients to St Pancras hospital worked effectively.
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: Currently in the recruitment phase of the project with interviews happening shortly, the risk is unlikely to change until mid-2021 as the project will not complete until then
1065	ACW	Patient Safety & Quality	Women's Health compliance with national Cancer Waiting Times	16	Utilising independent sector to clear backlog, however, challenging due to late cancellations and variable access. Working with S&C ICSU to repatriate elective work. Truclear (hysteroscopic tissue removal system) Business case agreed at TMG June - supports activity in outpatients freeing up slots in surgery.
1070	Emergency & Integrated Medicine	Patient Safety & Quality	Risk of Oxygen/ Air error in Emergency Department	20	Risk assessment in ED undertaken and after trial period, agreement to move to nebuliser machines and block off air ports to remove

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and key mitigations and controls
					risk. *Note: The actions for this risk have now been completed and at the time of writing the Serious Incident report action plan was being signed off by SIEAG before risk closed.*
1090	Surgery and Cancer	Patient Safety & Quality	Lack of equipment for managing prone patients in ITU	16	Throughout Covid ITU used pillows to prone patients which worked well in some instances, but couldn't be consistently applied. Also problems with facial pressure sores. Action: Proning kits have already been sources and are being trialled on ITU.
1091	Surgery and Cancer	Patient Safety & Quality	Lack of depth monitoring in anaesthesia in ITU	16	In COVID crisis poor drug availability, compounded with very sick patients meant more use of NM blockers. ITU monitored patients using depth of anaesthesia monitors borrowed from theatre (reduced theatre lists). Action: Purchase depth monitoring equipment for ITU.

Meeting title	**Trust Board – Public meeting**	**Date: 29 July 2020**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 12**
Executive director leads	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals and Dr Clare Dollery, Medical Director	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	In line with governance arrangements, this Committee Chair's report covers items considered at the 8 July May Quality Assurance Committee meeting. The Committee is able to report to the Board that it took significant assurance from the following agenda items: • Infection Prevention and Control (Covid-19) board assurance self-assessment • Board Assurance Framework – quality risk entries • A presentation from the Adult Community Services Integrated Clinical Service Unit on the experience of using Attend Anywhere for outpatient appointments • The quarterly learning from deaths' report (see appendix 1) The Committee also took moderate assurance from the risk register report. Limited assurance was taken from the review of the six-monthly health and safety report where remedial actions were agreed around security audits and fire safety mandatory training levels. In addition, the Committee noted its revised terms of reference and agreed those for the Quality Governance Committee, the key executive forum which reports to it.	
Purpose	Noting	
Recommendations	Board members are invited to note: i. the report and the areas of significant and moderate assurance identified by Committee members; and ii. that limited assurance was taken from the six-monthly health and safety report for which remedial actions are being taken.	
Risk Register or Board Assurance Framework	All BAF entries	
Report history	Report to the Public Board following each Committee meeting	
Appendices	1: Quarterly Learning from deaths report	

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	8 July 2020
Summary of assurance:	

1. The Committee is reporting significant assurance to the Trust Board in the following areas:

Infection Prevention and Control (Covid-19) board assurance self-assessment

The Committee considered a detailed self-assessment against the infection prevention and control requirements set out in Public Health England's framework. It took significant assurance from the evidence-based assessment. The Committee was also able to take assurance from the Care Quality Commission's review on 25 June of Whittington Health's self-assessment which found that *"the Trust has effective infection prevention and control measures in place."*

During discussion, Committee members were also able to take assurance from updates on COVID-19 pathology services and on personal protective equipment (PPE). The Committee was informed that pathology services now had an improved amber rating in the self-assessment and that a point of care testing machine which provided COVID-19 swab results within one hour would be received as part of their national roll out. The Chief Nurse provided assurance that there was a sufficient stock of PPE available and that effective stock control measures were in place. She explained that Whittington Health was not complacent in ensuring adequate PPE stocks and that the current focus was to ensure that staff in health centre and office locations who were unable to socially distance in line with guidance were provided with PPE.

Board assurance Framework (BAF)

Committee members discussed the risks to the delivery of Whittington Health's quality strategic objective BAF following the Board's agreement of the revised, underpinning corporate objectives at its June meeting.

Assurance was provided on the mitigating actions being taken to reduce the risk that patients on a diagnostic and/or treatment pathway may deteriorate due to insufficient capacity to restart enough elective surgery and other services. The Medical Director explained that the area of most concern was the backlog in endoscopy services, with some patients presenting with later stage tumours and a shortfall in endoscopy capacity across London. The Chief Operating Officer emphasised that this was an area of considerable focus in the North Central London NHS sector and that providers were required to submit plans to the Integrated Care System (ICS) next week. The plans looked at estate and staffing availability. Committee members took assurance that Whittington Health was opening an additional procedure room to help tackle the backlog and that capital funding for decontamination would be provided by the ICS.

Committee members also discussed the BAF entries relating to the delivery of the Trust's People strategic objective. They took assurance from progress with

risks assessments being completed for all staff – 52% of staff had either had a completed risk assessment or had declined the offer of an assessment – the aim was for Whittington Health to send a 100% return for staff risk assessments to NHS London by the end of July 2020. In terms of addressing staff health and wellbeing, the Committee was assured by the results of a survey of redeployed staff where 80% of respondents confirmed they would be happy to be redeployed again to confront any second wave of Covid-19 infections, should the need arise. Committee members also took assurance from the range of help and assistance provided to assist the health and wellbeing of all staff and noted in particular, work undertaken by the Improving Access to Psychological Therapies team, Whittington Health's psychologists and by the Project Wingman initiative.

The Committee was able to take further assurance from the Trust Secretary's report that a review of Whittington Health's BAF arrangements had just been finalised by Grant Thornton UK LLP (internal auditors). The review's conclusion that there was significant assurance with some improvement recommendations was an important source of additional and independent assurance.

Adult Community Services Integrated Clinical Service Unit presentation
Committee members welcomed a presentation on the musculoskeletal physiotherapy department where the following issues were highlighted:

- Due to the pandemic, the service ran essential services as outlined by NHS England/Improvement but was unable to see the majority of its patients with the exception of district nursing which continued. With the restart of services, the backlog would be addressed by holding appointments either over the phone or virtually using the Attend Anywhere initiative. Pre-pandemic, approximately 5% of outpatient appointments were conducted virtually; currently, 65% of outpatient appointments in the service took place this way representing a huge shift in practice
- A user group established in adult community services which shared learning and advice on clinical queries. Furthermore, Meridian surveys were carried out to gather additional; feedback from patients on the new arrangements
- One finding was that it was more efficient to use virtual appointment arrangements, where possible, as they reduced the travel time between visits
- In response to concerns raised about the inability of some older and more frail patients to equally access the new modus operandi, assurance was provided that adjustments were offered to patients who did not have access to a smartphone or tablet such as having a family member present or directing patients to the Wavelength (an initiative to support local people with access to Wi-Fi and technology). The service was also looking to introduce safe face-to-face meetings for high risk patients who were not improving through virtual consultations
- A quality impact assessment of arrangements would be completed and would also review of letters sent to such patients. The Committee agreed to look at an update on this service in six months' time to gauge developments

Quarterly learning from deaths' report
The Committee considered an excellent report for quarter three in 2019/20 and

	took assurance from the fact that there were no potentially avoidable deaths of inpatients or those who presented at the emergency department and that structured judgement reviews were completed for 77% of category A deaths in this period. Important learning and actions taken included the earlier involvement of hospital-based palliative care teams in patient care; holding a virtual seminar in quarter four which covered guidance on treatment escalation planning for consultants; regular reviews of the adequacy of pain relief; and, a review of guidelines for the management of hyperkalaemia and the use of venous blood gases to monitor deterioration. While seven deaths were caused by sepsis during this period, no failure to follow guidance was identified and quality improvement work was taking place in this area. Assurance was also provided by the Medical Director that, despite the small increase in the summary hospital-level mortality indicator (SHMI), Whittington Health had a low SHMI rate which is now just within the expected range. Furthermore, the Committee noted that further quality improvement work was taking place on the accuracy of the medical cause of death certificate through the introduction of a medical examiner program and the appointment of a Lead Medical Examiner for Whittington Health.
2.	**The Committee is reporting moderate assurance to the Trust Board in the following areas:** **Quality & safety risk register** The Committee discussed the updated risk register since its last meeting and took assurance that adequate mitigating actions were in place for risk entries. It also sought further assurance by way of an indication of the timescales for actions for some risk entries and that some longstanding risk entries were being adequately addressed and updated on Datix. The Committee agreed that no risk register entries be escalated from the risk register to the BAF.
3.	**The Committee is reporting limited assurance to the Trust Board in the following areas:** Committee members reviewed the six monthly health and safety report. They noted that 44 incidents out of a total of 578 during the period covered were not reported within seven days. This was a good improvement. Concerns were discussed regarding compliance with fire training targets and also the number of security inspections carried out. The Committee noted that work was taking place to develop a fire safety training package which could be completed online and agreed this and the need for more security inspections of the site would be drawn to the Trust Board's attention.
4.	**Other key issues covered:** The Committee also noted its updated terms of reference and agreed the terms

	of reference for the Quality Governance Committee. In addition, the Committee also welcomed and noted a review of the themes identified from serious incidents during 2018/2020, particularly the alignment of actions with 2020/21 Quality Account priorities. It agreed that further data and graphs be provided on pressure ulcers at a future meeting.
5.	**Attendance:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Dr Clare Dollery, Medical Director Amanda Gibbon, Non-Executive Director Carol Gillen, Chief Operating Officer Emma James, Rotational Physiotherapist Nadine Jeal, Clinical Director, Adult Community Services Michelle Johnson, Chief Nurse & Director of Allied Health Professionals Gillian Lewis, Head of Quality Governance Breeda McManus, Deputy Chief Nurse Swarnjit Singh, Trust Corporate Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse Glenys Thornton, Non-Executive Director Aisling Thompson, Deputy Chief Operating Officer James Ward, Health & Safety Officer **Observer:** Ihuoma Wamuo, Associate Medical Director, Patient Safety and Learning from deaths

Meeting title	**Trust Board – public meeting**	**Date: 29.7.2020**
Report title	**Quarterly Learning from Deaths Report** *Quarter 3 – 1 October 2019 to 30 December 2019*	**Agenda item: 12** Appendix to Quality Committee Chair's report
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report authors	Dr Clare Dollery, Executive Medical Director and Vicki Pantelli, EA to Medical Director and Project Lead for Patient Safety and Mortality	
Executive summary	This Learning from deaths report covers Quarter 3 of 2019/2020 (1 October to 30 December 2019). The report describes: a) How Whittington Health is performing 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); b) What learning and actions are being taken from the themes that emerge from these reviews to improve the care and experience of our patients and their families/carers. In Q3 there were 131 inpatient/ED deaths; 77% of all "category A" deaths (24 out of 31) were reviewed using a structured judgement review (SJR) (or equivalent review process). 40% (40 out of 100) of category B deaths were reviewed in Q3 (compared to 54% in Q1 and 46% in Q2) using a mortality review form (or equivalent) with an avoidability of death judgement score plus presentation at a departmental mortality meeting. The Medical Examiner process became statutory on 1 April 2020 and a Lead Medical Examiner has been appointed. The regional Medical Examiner and Senior Coroner for North London were involved in the recruitment process. During the Covid 19 pandemic a modified medical examiner process has been in operation.	
Purpose	Review	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care	

	around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	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 3 - 2019/20: 1 October to 31 December 2019

1. Introduction

1.1. This report reflects Quarter 3 of 2019/20 on learning from deaths. These reports describe:

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

1.2. 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 deaths1" (March 2017) we introduced a more systematised approach to reviewing the care of patients who have died in hospital from category A deaths.

2. Review process

2.1 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 Medical Certificates of Cause of Death (MCCD).

2.2 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 3 2019/2020

Category	Number of deaths in Q3	Comments
Staff raised concerns about care	1	
Death of a patient with Learning disabilities	4	2 of these LD deaths were also referred to the Coroner but not included in "Deaths referred to Coroner's Office" row below.
Death of a patient with Serious mental illness	0	
Death in surgical patients	1	
Paediatric/maternal/neonatal/intra-uterine deaths	2	Investigated as a Serious incident, internal RCA investigations, CDOP or perinatal mortality reviews
Deaths referred to Coroner's office	18	Excludes deaths in other categories
Deaths related to specific patient safety or QI work e.g. sepsis	5	All were sepsis deaths, these are additionally investigated by the sepsis team
Total	31	

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

2.3 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. 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.

2.4 The aim of this review process is to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify, and learn from, episodes relating to problems in care;
- Identify, and learn from, notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether 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.

3. NHS Mortality dashboard

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

3.2 There were 131 deaths recorded in Quarter 3. This includes all inpatient deaths, all deaths in the Emergency Department, all neonatal deaths and all intrauterine deaths above 24 weeks gestation.

3.3 The dashboard (appendix 1) shows that in Quarter 3, 64 of the 131 patient deaths were systematically reviewed. 77% of the category A deaths were reviewed using structured mortality judgement methodology or equivalent and 40% 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, any delays were mainly due to limited administrative support or difficulties getting hold of notes or trained reviewers.

3.4 In Quarter 3, there were 131 inpatient/ED deaths. In Q3, 77% of all "category A" deaths (24 out of 31) were reviewed using a structured judgement review (SJR) (or equivalent review process). 40% (40 out of 100) of category B deaths were reviewed in Q3 (compared to 54% in Q1 and 46% in Q2) using a mortality review form (or equivalent) with an avoidability of death judgement score plus presentation at a departmental mortality meeting.

3.5 67 patient deaths out of 131 in Q3 (51%) were not reviewed in a mortality process but the majority of these were category B deaths. The dashboard outlines the avoidability of death judgement scores for inpatient deaths in Quarter 3, 2019/2020 and this is summarised below, in table 2. There were no potentially avoidable deaths this quarter.

3.6 A Trustwide Mortality Review Group was held in May 2020. This reviewed overarching themes of learning, reviewed three structured judgement mortality reviews and one serious incident (SI) report, and considered the mortality process as a whole with a view to continuous improvement. This group were assured that the reviews examined met the expected quality standards.

Table 2: Avoidability of death judgement scores for Q3: 2019/20

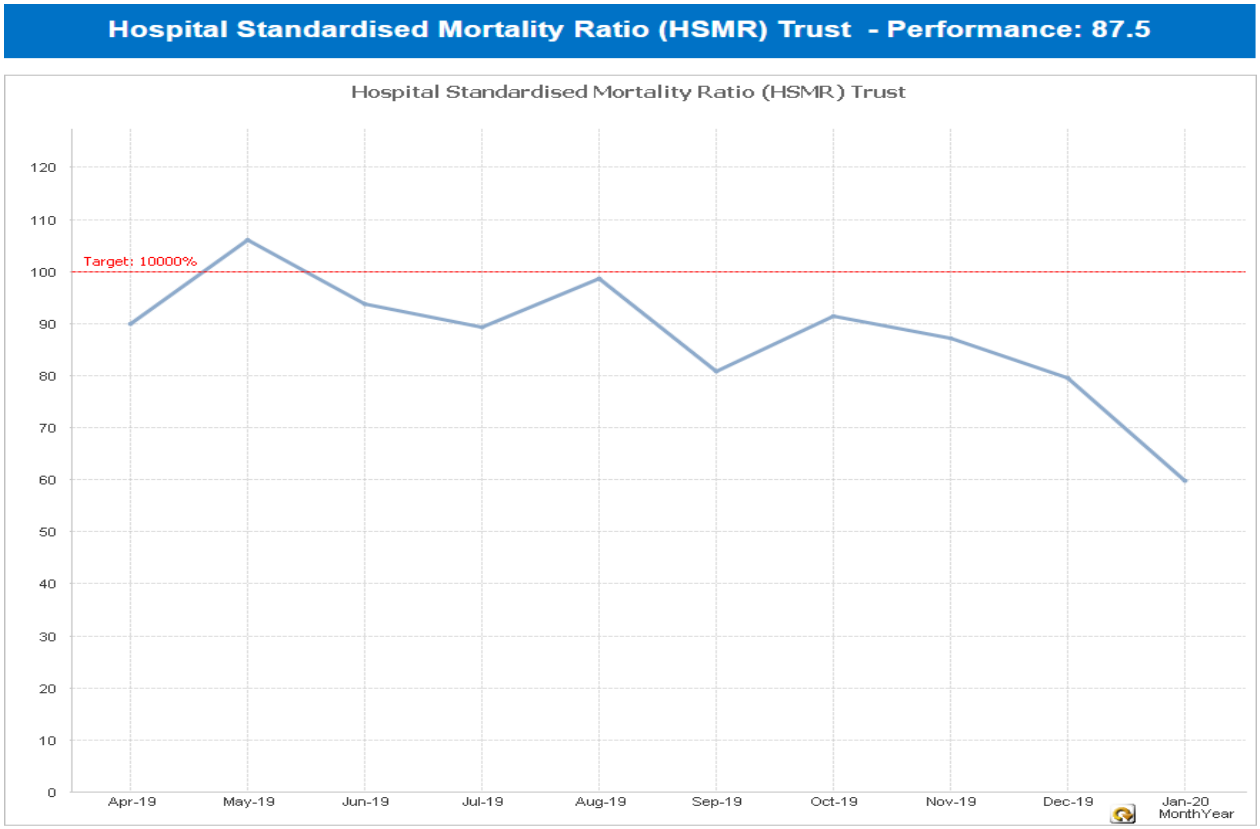
Avoidability of death judgement scores (of deaths reviewed)	Number of patients with each avoidability score
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable, more than 50/50	0
4 - Possibly avoidable but less than 50/50	0

Avoidability of death judgement scores (of deaths reviewed)	Number of patients with each avoidability score
5 - Slight evidence of avoidability	8
6 - Definitely not avoidable	56

4. Hospital Standardised Mortality Ratio (HSMR)

4.1 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. There is no significant difference between the weekday and weekend HSMR for non-elective admissions; both are within the expected range.

Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by month/year (April 2019 – Jan 2020*)*



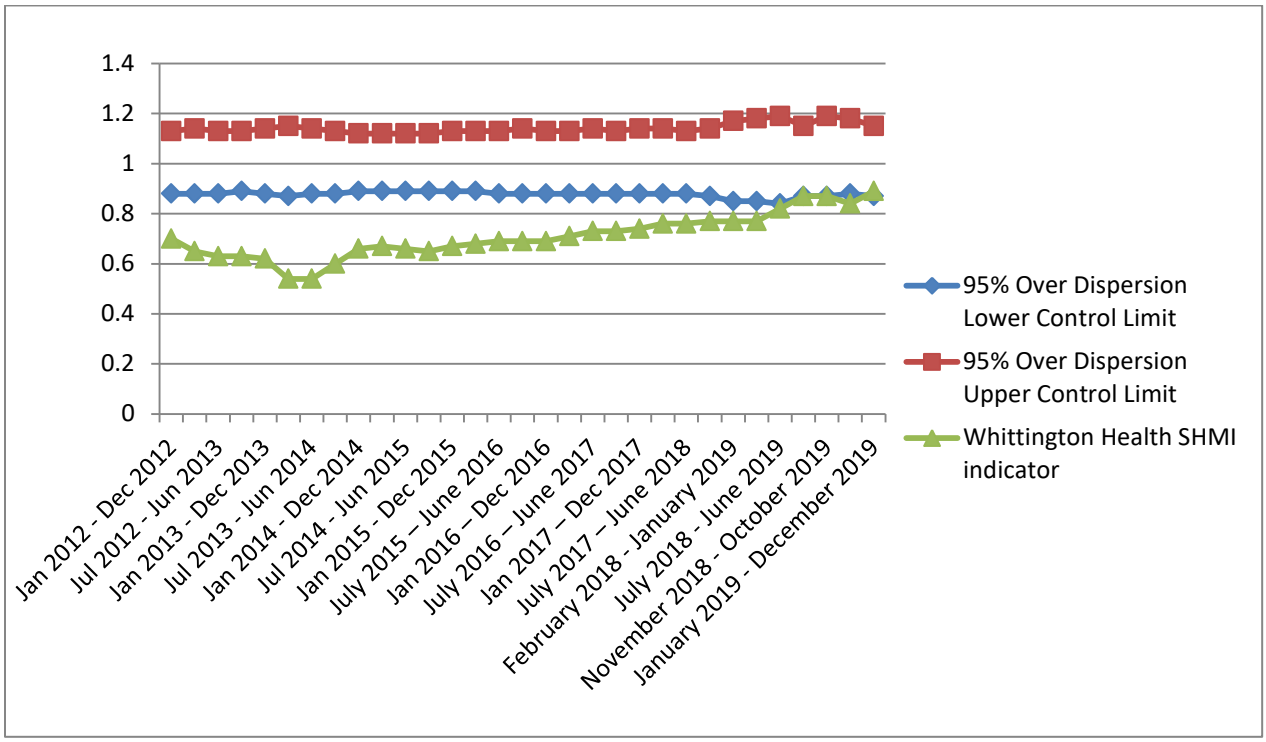
5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 SHMI is used 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.

5.2 The 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 (Table 3) (released

in May 2020) covers the period January 2019 to December 2019; the Trust's SHMI score for this period was 0.89.

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



6. Examples of key points of learning and actions from Mortality Reviews

Deaths in the emergency department

6.1 12 of the 31 deaths in this period occurred on presentation in extremis or in cardiac arrest in the emergency department. Reviews suggest that resuscitation occurred in line with national guidance but survival after out of hospital arrests is known to be low particularly where there is downtime prior to initiation of cardiopulmonary resuscitation outside hospital. There is an opportunity to liaise more directly with the coroner to ensure that causes of death where no inquest is held but there is a post-mortem come back to clinical teams for learning.

Quality Improvement

6.2 Two mortality reviews in the prior Quarter discussed the need to involve the hospital based Palliative Care teams earlier in patient's care. This was not a feature of the reviews in Q3 and a number of reviews highlighted the prompt involvement of palliative care. It is notable that treatment escalation planning has been a focus across the Trust and during the Covid Pandemic in Q4 the palliative care lead held a virtual seminar including guidance on the ethics of treatment escalation planning for consultants with high numbers of attendees.

6.3 Seven deaths were caused by sepsis but no lost opportunities to follow guidance have been identified. Sepsis QI work is ongoing.

6.4 There is ongoing QI work in Q1 2020-21 about the accuracy of the medical cause of death certificate through the introduction of the medical examiner program. Dr Ilana Samson has been appointed Lead Medical Examiner. This was supported by a group of local GPs during the height of the Covid-19 surge. These doctors phoned the relatives of all patients who died in March and April 2020 to explain their cause of death.

7. Training and education

7.1 Examples of good practice which were highlighted through reviews include:

- The use of comfort observations to replace vital signs observations in palliative patients so that regular reviews of adequacy of pain relief and use of anticipatory medicines could occur. Also instructions for 'no more needles' in these circumstances were used.
- Early and regular senior review with early communication with families of the probably severity of a patients illness.

7.2 Areas for learning included

- Awareness of the management of hyperkalaemia and the use of venous blood gases to monitor deterioration.

8. Conclusion and recommendations

8.1 Board members are 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 - December 2019-20

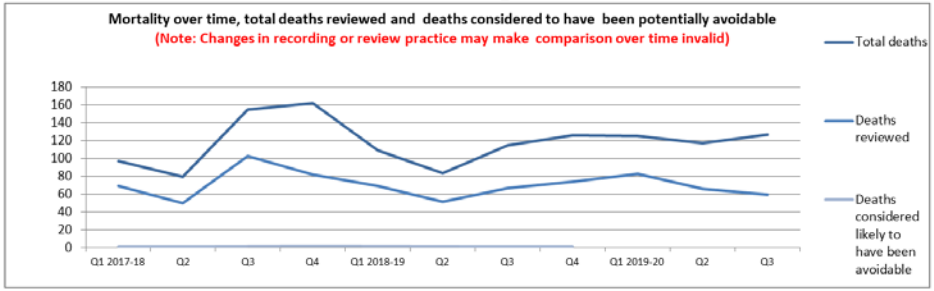
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
43	46	14	25	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
127	117	60	66	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
369	434	209	262	0	2

Time Series: Start date 2017-18 Q1 End date 2019-20 Q3



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	0	0.0%	This Month	14	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	8	13.3%	This Quarter (QTD	52	86.7%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	7	3.3%	This Year (YTD)	16	7.7%	This Year (YTD)	186	89.0%

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

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

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

Time Series: Start date 2017-18 Q1 End date 2019-20 Q3