GROUP TRUST BOARD MEETING IN PUBLIC

The next meeting of the group trust board will take place on Wednesday 27 June 2018 at 1.00pm in the boardroom, 2nd floor, Royal Free Hospital.

Dominic Dodd
Chairman

A G E N D A

<table>
<thead>
<tr>
<th>ITEM</th>
<th>LEAD</th>
<th>PAPER</th>
</tr>
</thead>
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<td><strong>ADMINISTRATIVE ITEMS</strong></td>
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<td>2018/74</td>
<td>Apologies for absence – E McManus, S Shaw</td>
<td>D Dodd</td>
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<td>2018/75</td>
<td>Declaration of interests</td>
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<td>Minutes of meeting held on 23 May 2018</td>
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<td>2018/78</td>
<td>Record of items discussed at the Part II board meeting on 23 May 2018</td>
<td>D Dodd</td>
</tr>
<tr>
<td><strong>QUALITY, PATIENT SAFETY AND EXPERIENCE</strong></td>
<td></td>
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<tr>
<td>2018/79</td>
<td>Royal Free Hospital emergency department – clinical practice group improvement project – focusing on patient streaming</td>
<td>C Streather</td>
</tr>
<tr>
<td></td>
<td>Dr Kerrie Whitwell, ED consultant and CPG pathway lead</td>
<td></td>
</tr>
<tr>
<td>2018/80</td>
<td>Annual safeguarding report 2017/18</td>
<td>D Sanders</td>
</tr>
<tr>
<td>2018/81</td>
<td>Patients’ voices</td>
<td>P Ridley</td>
</tr>
<tr>
<td>2018/82</td>
<td>Go see visits</td>
<td>Emma Kearney</td>
</tr>
<tr>
<td>2018/83</td>
<td>Progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions</td>
<td>D Sanders</td>
</tr>
<tr>
<td><strong>FINANCE AND PERFORMANCE</strong></td>
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<tr>
<td>2018/84</td>
<td>Financial performance report</td>
<td>C Clarke</td>
</tr>
<tr>
<td>2018/85</td>
<td>Operational performance report</td>
<td>P Ridley</td>
</tr>
<tr>
<td><strong>GOVERNANCE AND REGULATION: REPORTS FROM BOARD COMMITTEES – DISCUSSION BY EXCEPTION ONLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/86</td>
<td>Chair’s and chief executive’s report</td>
<td>D Dodd / D Sloman</td>
</tr>
<tr>
<td>2018/87</td>
<td>Quality improvement and leadership committee (21 May 2018)</td>
<td>J Owen</td>
</tr>
<tr>
<td>2018/88</td>
<td>Clinical standards and innovation committee (14 May 2018)</td>
<td>A Schapira</td>
</tr>
<tr>
<td>2018/89</td>
<td>Group services committee (14 June 2018)</td>
<td>W Goldwag</td>
</tr>
<tr>
<td>2018/90</td>
<td>Audit committee (11 and 18 May 2018)</td>
<td>M Basterfield</td>
</tr>
</tbody>
</table>

1 In accordance with the Health & Social Care Act 2012, all Trust Board meetings must be held in public. All decisions which require the board’s collective approval can only be made at a Trust Board (or a Part II meeting held in closed session to discuss confidential matters).
<table>
<thead>
<tr>
<th>OTHER BUSINESS</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>2018/91 Questions from the public</td>
<td></td>
<td>D Dodd</td>
</tr>
<tr>
<td>2018/92 Any other business</td>
<td></td>
<td>D Dodd</td>
</tr>
<tr>
<td>2018/93 Date of next meeting – 25 July 2018</td>
<td></td>
<td>D Dodd</td>
</tr>
</tbody>
</table>
REGISTER OF INTERESTS OF MEMBERS OF THE BOARD OF DIRECTORS

Executive summary

The trust constitution requires trust board members to declare interests which are relevant and material to the NHS board of which they are a member. The register of interests is presented at each board meeting.

There are no changes since the last meeting.

Action required

Board members are asked to provide an update if they have any changes in interests since the last meeting.

Board members are asked to declare any interests which are relevant to matters on the board agenda.

The board is asked to ratify the register, subject to any further changes made.

Public Patient and Carer involvement

The register will be made available to the public.

Report From
Dominic Dodd, chairman
Author(s)
Alison Macdonald, board secretary
Date
19 June 2018
### REGISTER OF THE INTERESTS OF MEMBERS OF THE TRUST BOARD

<table>
<thead>
<tr>
<th>Board Member and position</th>
<th>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</th>
<th>Ownership or part-ownership of private companies, business or consultancies likely or possibly seeking to do business with the NHS</th>
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<th>Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the Trust must be declared)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominic Dodd, Chair 8/4/16</td>
<td>Director of UCLPartners¹ Member of NHSI's Chairs' Advisory Group. Unpaid position.</td>
<td>Nil</td>
<td>Nil</td>
<td>Trustee, The King's Fund. Unpaid position</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Non-executive directors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Stephen Ainger Non-executive director 5/1/16</td>
<td>Chair Downshire Hill Residents' Association. Director of ATL trust fund.</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Mary Basterfield Non-executive director 8/3/18</td>
<td>Flatberg Ltd (property management) Chief finance officer, UKTV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

¹ The Company’s constitutional documents have been drafted in accordance with charity law and Charity Commission guidance, so that the Company can apply for charitable status in the future as and when its Board of Directors considers this appropriate.

Declaration of interests – board members are requested to highlight any changes to the register of interests at each board meeting held in public.
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Wanda Goldwag</td>
<td>Chair of the Office of Legal Complaints (OLC) Lay Member QC Appointments Panel Advisor Smedvig Venture Capital Director, Goldwag Consultancy Ltd</td>
<td>Nil</td>
<td>Nil</td>
<td>Adopted sister is chief pharmacist of Barnet Enfield and Haringey Mental Health Trust</td>
<td>Nil</td>
<td>I have a shareholding via Smedvig Capital in Antidote Technologies Ltd the clinical trial matching platform</td>
<td></td>
</tr>
<tr>
<td>Non-executive director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/4/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jenny Owen,</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Board member of Housing and Care 21 Vice chair of Alzheimer’s Society Member of General Advisory Council King’s Fund</td>
<td>Housing 21 and Care 21 Alzheimer’s Society</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Non-executive director</td>
<td>6/4/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Akta Raja</td>
<td>Enhabit Ltd Geneff Ltd Thornriver Management Ltd Riverside Homes Ltd Ansor Ltd (not currently trading)</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Non-executive director</td>
<td>1/1/17</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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<th>Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the Trust must be declared)</th>
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</thead>
<tbody>
<tr>
<td><strong>Professor Anthony Schapira</strong>&lt;br&gt;Non-executive director 13/5/16</td>
<td>Upper Hampstead Walk Residents' Association. AHV Schapira Ltd&lt;br&gt;Non-executive director, Ministry of Justice</td>
<td>Nil</td>
<td>Nil</td>
<td>Parkinson’s Disease Society Research Strategy Group</td>
<td>Nil</td>
<td>Medical Research Council, Wellcome Trust, Parkinson’s Disease Society and other charitable sources of research funding</td>
<td>Nil</td>
</tr>
<tr>
<td><strong>James Tugendhat</strong>&lt;br&gt;Non-executive director</td>
<td>Director of BHFS One Ltd and BHFS Two Ltd</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

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## Executive directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<th>Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the Trust must be declared)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline Clarke</td>
<td>Deputy group chief executive &amp; chief finance officer</td>
<td>Director RFL Property Services Company</td>
<td>Nil</td>
<td>Nil</td>
<td>Director Royal Free Charity (1/4/16)</td>
<td>Trustee, Overcoming MS</td>
<td>Trustee, Healthcare Finance Managers Association</td>
<td>Nil</td>
</tr>
<tr>
<td>Deborah Sanders</td>
<td>Group chief nurse</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Board member, The Royal Free Hospital Nurses’ Home of Rest Trust Trustee, Royal Hospital for Neuro-disability</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Kate Slemeck, RFH chief executive</td>
<td>7/4/16</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Chair of NHS Elect Advisory Committee Chair of NHS Providers COO Network</td>
<td>Husband works for Canon who provide the trust’s managed print service.</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Chris Streather</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Unpaid advice to ZPB on e-rostering which will contribute to a report commissioned from them by Allocate. It involved two meetings and reviewing a document and Health Education England (HEE) also were involved. The trust has a contract with Allocate, but not ZPB, for whom this work was done.</td>
<td>Nil</td>
<td>Nil</td>
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<tr>
<td>--------------------------------</td>
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<th>Research funding/grants that may be received by an individual or their department</th>
<th>Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the Trust must be declared)</th>
<th>State when interest acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Sloman</td>
<td>Director, UCLPartners2 Accountable Officer for North Middlesex University Hospital NHS Trust (September 2017)</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>State when interest acquired</td>
</tr>
<tr>
<td>Group chief executive</td>
<td>15/11/16</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>State when interest acquired</td>
<td></td>
</tr>
</tbody>
</table>

2 The Company’s constitutional documents have been drafted in accordance with charity law and Charity Commission guidance, so that the Company can apply for charitable status in the future as and when its Board of Directors considers this appropriate. Declaration of interests – board members are requested to highlight any changes to the register of interests at each board meeting held in public.
### Non-voting directors

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</thead>
<tbody>
<tr>
<td>David Grantham</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Board Member and Treasurer London Healthcare People Management Academy – March 2013 Chair of NHS Employers Medical Workforce Forum – August 2010</td>
<td>Board Member Health Education North and East London (HENCEL) – July 2014 Board Member and Treasurer London Streamlining Programme(s) – March 2014</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Group director of Workforce and OD 7/4/16</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Emma Kearney</td>
<td>Director, EK Consulting Ltd</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Group director of corporate affairs and communications</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Andrew Panniker</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Director, Royal Free Charity Development Co</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Group director of capital and estates</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>Peter Ridley</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Group director of Planning</td>
<td></td>
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</tr>
<tr>
<td>Steve Shaw</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Chief executive BH</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Glenn Winteringham</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Chief information officer</td>
<td>3/5/17</td>
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MINUTES OF THE TRUST BOARD
HELD ON 23 MAY 2018

Present

Mr D Dodd  Chairman
Mr S Ainger  Non-executive director
Ms M Basterfield  Non-executive director
Ms C Clarke  Group chief finance officer and deputy group chief executive
Ms W Goldwag  Non-executive director
Ms J Owen  Non-executive director
Prof A Schapira  Non-executive director
Ms D Sanders  Group chief nurse
Ms K Slemeck  Chief executive – Royal Free Hospital
Sir David Sloman  Group chief executive
Dr Chris Streather  Group chief medical officer
Mr J Tugendhat  Non-executive director

Invited to attend

Mr D Grantham  Group director of workforce and organisational development
Ms E Kearney  Group director of corporate affairs and communications
Ms E McManus  Group chief transformation officer
Mr A Panniker  Group director of capital and estates
Mr P Ridley  Group director of planning
Dr S Shaw  Chief executive – Barnet Hospital
Mrs J Dewinter  Lead governor
Ms A Macdonald  Board secretary (minutes)

Others in attendance

Dr J Mountford  Director of quality (for item 2018/59)
Dr A McGlennan  Medical director (for item 2018/59)
Ms Amy Wood  Quality governance manager, Chase Farm Hospital (for item 2018/59)

<table>
<thead>
<tr>
<th>2018/54</th>
<th>APOLOGIES FOR ABSENCE AND WELCOME</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms A Raja  Non-executive director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr G Winteringham  Group chief information officer</td>
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<tr>
<td>The chairman welcomed those present to the meeting.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/55</th>
<th>DECLARATION OF INTERESTS</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>There were no further changes advised and the report on the register of interests was noted.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2018/56</th>
<th>MINUTES OF MEETING HELD ON 25 APRIL 2018</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The minutes were accepted as an accurate record of the meeting.</td>
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</table>
The matters arising report was noted.

It was noted that the third bullet point should have read “proposed sale of Queen Mary’s House”.

Subject to this amendment, the report was noted.

Dr Alan McGlennan, Chase Farm Hospital medical director, and Ms Amy Wood, quality governance manager, Chase Farm Hospital, were in attendance for this item.

Dr McGlennan described how the governance processes at CFH had been redesigned, building on the previous divisional structures and also being the subject of a workshop event. He referred to the CFH ‘governance universe’ in which the weekly serious incident review panels (SIRPs) played a key role. The aim was to identify immediate actions to be taken, areas for improvement, learning to be shared and any incidents that needed to be reported externally. He commented on how important it was to ensure that the patient’s story was heard.

Ms Wood then described the introduction of internal patient safety alerts and safety lessons of the week. There was always a danger that nothing would happen other than pinning them to the notice boards, but they were reinforced by being discussed at staff meetings and safety huddles. Dr McGlennan then referred to the importance of supporting staff who had been involved in an incident. This was a new process which was being trialled in theatres.

Dr McGlennan informed the board of the way central alerting system (CAS) alerts were handled at CFH. The system made sure that their receipt was recorded, the required action was taken and the alert was then closed.

Ms Wood advised the board that the governance team were undertaking ‘governance safaris’ to raise their visibility and approachability for staff, also to pick up issues that had not been raised as incidents but which might need further action. They also talked to patients and relatives to gain their perspectives.

The chairman asked whether this approach was replicable across the group. Dr McGlennan responded that some of the systems were very new so needed to be assessed. The RFH chief executive commented that much of what had been described did feel generalisable.

The chairman thanked Dr McGlennan and Ms Wood for attending the board meeting and providing an insight into CFH’s safety governance processes.
### 2018/60 GO SEE VISITS

Ms Basterfield, non-executive director, reported back on her visit to the intensive therapy unit (ITU) at the Royal Free Hospital (RFH) focusing on a project to improve nurse staff retention.

She had met with the matron and colleagues who had talked at length about the work that was being done to prevent nurses leaving including development and education, flexible working and better rostering. Being flexible with staff had proved particularly effective. Ms Owen, non-executive director, commented that a presentation had been given at the recent quality improvement and leadership meeting and this was an impressive project which was eminently transferable to other areas.

The group chief information officer commented that 12 staff had been present at his go see visit which was to endoscopy at RFH and there was discussion about whether this was to be encouraged and go see visits should be more ‘low key’. However it was noted that many staff were proud of what they did and wanted the opportunity to share this with the trust’s leadership. Ms Goldwag, non-executive director, suggested a longer interval between visits.

The group chief executive then reported on his visit to the ITU at Barnet Hospital (BH) during which he had been shown the upgraded staff room where the biggest single change had been to place a table in the middle of the room rather than at the edge, thereby encouraging staff to communicate with each other. The BH team were also working with the RFH matron on retention.

The board noted the report.

### 2018/61 PATIENTS’ VOICES

Ms Basterfield, non-executive director, read out a complaint from a patient in the Royal Free maternity unit who met a different midwife every time she attended the hospital and experienced no continuity of care, nor did anyone follow her up to check all was well with her pregnancy. She felt she was not meeting human beings, but robots. The complaint was investigated and the outcome was that regrettably due to an oversight, the patient had not been allocated a named midwife/buddy, which had caused her initial care to be fragmented and not personalised to her needs. The consultant midwife met with the patient and her husband to apologise and explain the above, and agreed a plan of care to include on-going continuity of care from a named midwife.

The compliment was from the husband of a patient giving birth at Barnet Hospital. His wife had serious anxiety issues about invasive procedures or examinations but the two student midwives looking after her were sensitive and understanding and gave her the individual and personalised care and support she really needed. Similarly she encountered a senior midwife at the maternity day unit who performed examinations with understanding and patience.

The group director of planning would present the patients’ stories item next time.

### 2018/62 FINANCIAL PERFORMANCE REPORT

The group chief finance officer presented this report, noting that the trust had submitted a deficit plan of £65.8m for the 2018/19 financial year.
In April the trust delivered an actual deficit of £12.3m. This was £0.6m worse than plan. Clinical income performance for April was currently assumed to be on plan. There was a risk that actual performance could be lower.

The financial plan for 2018/18 included delivery of £45.4m financial improvement programme (FIP) savings. At the end of April, the trust had delivered £1.1m of FIP.

The cash balance on 30 April was £41.9m. This continued to be high due to the Parcel B land sale receipts being ring fenced for the Chase Farm capital redevelopment. The trust anticipated that it would need to access working capital loans from September onwards. Focus continued on reducing debt with clinical commissioning groups (CCGs) and NHS England (NHSE) who accounted for the majority of the aged debt in order to minimise loan drawdown and therefore interest charges.

The board noted the current financial position of the trust.

2018/63 OPERATIONAL PERFORMANCE REPORT

The group director of planning presented this report. He noted that cancer performance for March 2018 was reported at 83.3% and for April at 89.7%. The month to date figure was 89.7%, so the trend was in the right direction. The main concern remained the backlog which had increased to 141 against a target of 48. The cancer target and backlog was being closely managed.

Regarding referral to treatment time (RTT) the March position was 83.1%. The trust would continue to experience ‘pop-ons’ (long waiters being identified late on the pathway making it difficult to treat them within the 18 week and 52 week targets) until patient tracking list construction problems were fully resolved. There were currently 35 patients (compared with 32 in February) who had waited more than 52 weeks and every effort was being made to bring their treatment forward.

The board noted the current operational performance of the trust.

2018/64 CHAIR’S AND CHIEF EXECUTIVE’S REPORT

The group chief executive highlighted that the handover date of 12 July 2018 for Chase Farm Hospital (CFH) had been agreed. He also highlighted the opening of the new 30 bedded unit in the Royal Free Hospital emergency department to which nine clinical decision unit (CDU) beds had opened. The RFH chief executive advised that it was too early to assess the impact of this, but 4 hour performance had been better since the unit opened with good flow and engagement with specialties.

The board noted the report.

2018/65 QUALITY IMPROVEMENT AND LEADERSHIP COMMITTEE

Ms Owen, chair of the committee, highlighted the committee’s discussion of the signature initiative for 2018/19 which would be joy in work and had requested a paper on this. The group chief medical officer commented that there were a
A number of initiatives were relevant to this, including the estates and facilities project that the board had heard about a few months ago. The group chief nurse suggested that it was important to first find out from staff "what matters to you" before designing a joy in work programme.

The board noted the report from the committee.

<table>
<thead>
<tr>
<th>2018/66</th>
<th>CLINICAL STANDARDS AND INNOVATION</th>
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<tbody>
<tr>
<td>Prof Schapira, chair of the committee noted that mortality statistics remained better than average/expected. Delays in completing serious incident investigations were increasing and the committee was keeping a close eye on this.</td>
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<tr>
<td>Mr Ainger, non-executive director, was concerned at the number of never events being reported, with one each month for the last six months. The group chief executive commented that it was important to have transparency and that the approach described for Chase Farm Hospital earlier in the meeting was exemplary.</td>
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<tr>
<td>The board noted the report from the committee.</td>
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<thead>
<tr>
<th>2018/67</th>
<th>GROUP SERVICES COMMITTEE</th>
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<tr>
<td>The board noted the report from the committee.</td>
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<tr>
<th>2018/68</th>
<th>POPULATION HEALTH AND PATHWAYS COMMITTEE</th>
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<tr>
<td>The board noted the report from the committee.</td>
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<thead>
<tr>
<th>2018/69</th>
<th>AUDIT COMMITTEE</th>
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<tbody>
<tr>
<td>Ms Basterfield noted that the audit committee workshop and formal meeting had taken place recently to review the trust’s annual report, accounts and quality report. The head of internal audit opinion had been significant assurance with minor improvements needed. The external auditor’s statement had referred to the deficit and going concern issue but had acknowledged that the trust was in year two of a four year improvement journey and had low reference costs.</td>
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<tr>
<td>The board noted the report from the committee.</td>
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<tr>
<th>2018/70</th>
<th>Board code of conduct</th>
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<tr>
<td>The group director of corporate affairs and communications noted that the code of conduct had been updated to refer to the General Data Protection Regulation (GDPR). Reference had also been added to hospital leadership teams and wholly owned subsidiaries.</td>
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<tr>
<td>The board approved the code of conduct and board members confirmed their continued commitment to compliance with it.</td>
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<thead>
<tr>
<th>2018/71</th>
<th>QUESTIONS FROM THE PUBLIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were no questions.</td>
<td></td>
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<tr>
<td>2018/72</td>
<td>ANY OTHER BUSINESS</td>
</tr>
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<td>---------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>There was no other business.</td>
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<tr>
<th>2018/73</th>
<th>DATE OF NEXT MEETING</th>
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<tr>
<td></td>
<td>The next trust board meeting would be on 27 June 2018 at 1300 in the boardroom, 2nd floor, Royal Free Hospital.</td>
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Agreed as a correct record

Signature ..................................date 27 June 2018.................................

Dominic Dodd, chairman
## Trust Board
### Matters arising report as at 27 June 2018

<table>
<thead>
<tr>
<th>Minute No</th>
<th>Action</th>
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<tr>
<td><strong>FROM TRUST BOARD HELD ON 25 APRIL 2018</strong></td>
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</table>
| 2018/61   | Patients' voices  
           | Learning from deaths review |
| 2018/62   | Presentation on end of life care – to be presented alongside next learning from deaths review  
           | The group chief medical officer undertook to include the actual learning from deaths in future reports, which would be derived from the serious incidents investigation reports. He would also ensure that the time taken to conclude investigations was kept under review. |
|           | Lead: Group chief medical officer  
           | Complete:  
           | Board date/ agenda item:  
           | Outstanding: Next report scheduled for July 2018 board meeting. |
| **FROM TRUST BOARD HELD ON 21 MARCH 2018** |
| 2018/43   | Gender pay gap |
|           | Ms Owen, non-executive director, said that she would like to see a very focused plan of three items with clear outcomes defined. The group chief executive commented that it was necessary to fully understand the data in order to arrive at an action plan, but an action plan would be brought back to the board in due course. |
|           | Lead: Group director of workforce and OD  
           | Complete:  
           | Board date/ agenda item: To be scheduled for the July 2018 board meeting. |
ITEMS DISCUSSED AT THE CONFIDENTIAL BOARD MEETING HELD ON 23 MAY 2018

Executive summary

Decisions taken at a confidential trust board are reported where appropriate at the next trust board held in public. Those issues of note and decisions taken at the trust board’s confidential meeting held on 23 May 2018 are outlined below. The board discussed the trust’s financial position and performance report, although a detailed discussion also took place within the public part of the meeting. The following matters were also discussed at the meeting:

- Governance of the development of the Institute of Immunity and Transplantation (Pears Building) – this is summarised in the chairman and chief executive’s report.
- Group goals – the board agreed to a change of a goal linked to the quality improvement and leadership committee
- Establishment of the Royal Free property services company – the board received an update and delegated the detailed discussion and final decision to the group services and investment committee.
- Information governance update - the board was provided with assurance that the trust would be compliant with two new regulatory information governance requirements: the NHS Data Security and Protection requirements and the General Data Protection Regulation (GDPR). The trust had also completed the undertakings required by the Information Commissioner’s Office (ICO)
- The board debated changes to its committee structure and agreed in principle to the disestablishment of the quality improvement and leadership committee and the redistribution of its responsibilities to the clinical standards and innovation committee and population health and pathways committee.
- The board approved the self-certifications required by NHS Improvement
- The board approved the annual report, annual accounts and quality account 2017/18 which will be presented at the annual members’ meeting on 18 July 2018.

Action required

For the board to note.

D Dodd, chairman

Report From
Author(s)       A Macdonald, board secretary
Date           1 June 2018
Executive summary
This is the annual report of the Integrated Safeguarding Committee. The purpose of the report is to provide assurance that the trust is fulfilling its responsibilities to promote the welfare and safety of people who use services across the trust.

The report will also be shared with Barnet, Camden and Enfield Clinical Commissioning groups

Key points to note:

- We continue to have a strong team with no vacancies that fulfils the statutory requirements
- Robust governance and reporting structure
- Strong partnership working
- Positive CQC Children Looked After and Safeguarding review at Barnet hospital
- Consistency across most of the safeguarding referral activity
- Better identification of people with a learning disability
- Increase in the number of statutory case reviews the team are required to contribute
- Introduction of the better birth and case loading model for the specialist midwives for vulnerable women and families with some very positive outcomes and recognition from the CQC
- Recognition by NHSE & the Enfield LeDeR steering group of best practice making reasonable adjustments for learning disability
- Early Help partnership pilot with Camden local authority based at Royal free hospital
- Review of the Domestic Abuse service against the NICE guidelines
- New three year work plan that will further develop the think family approach and put the patient at the centre of the safeguarding process
- Consistency of quality and uptake of safeguarding training

Action required/recommendation
The board is requested to consider if the report provides sufficient assurance that the trust is meeting its responsibilities in ensuring appropriate safeguarding arrangements are in place.

Relevant group goals
- Top 10% for education, training and workforce development
### CQC Regulations supported by this paper

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Description</th>
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<tbody>
<tr>
<td>9</td>
<td>Person-centred care</td>
</tr>
<tr>
<td>10</td>
<td>Dignity and respect</td>
</tr>
<tr>
<td>11</td>
<td>Need for consent</td>
</tr>
<tr>
<td>12</td>
<td>Safe care and treatment</td>
</tr>
<tr>
<td>13</td>
<td>Safeguarding service users from abuse and improper treatment</td>
</tr>
<tr>
<td>14</td>
<td>Meeting nutritional and hydration needs</td>
</tr>
<tr>
<td>16</td>
<td>Receiving and acting on complaints</td>
</tr>
<tr>
<td>20</td>
<td>Duty of candour</td>
</tr>
<tr>
<td>20A</td>
<td>Requirement as to display of performance assessments</td>
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</tbody>
</table>

### Care Quality Commission (Registration) Regulations 2009 (Part 4)

### Risks attached to this project/initiative and how these will be managed (assurance)

None

### Equality analysis

- No identified negative impact on equality and diversity

### Report from

Deborah Sanders, group chief nurse

### Author(s)

Helen Swarbrick, head of safeguarding

### Date

20 June 2018
Annual Safeguarding Report 2017/ 2018

1. Introduction

This is the annual report of the Integrated Safeguarding Committee. The purpose of the report is to provide assurance that the trust is fulfilling its responsibilities to promote the welfare and safety of people who use services across the trust. In addition this report will set out how the trust intends to move forward with the safeguarding agenda in the form of an integrated approach for 2018- 2019.

Safeguarding remains one of the fundamental components of all care provided by the trust. As a healthcare provider the trust is required to demonstrate that it has strong safeguarding leadership and a commitment to safeguarding at all levels of the organisation.

The trust provides evidence to assure its regulators, clinical commissioning groups and local safeguarding boards that as an organisation we are responding to both national and local practice and training guidance.

All members of the integrated safeguarding team work in partnership with the multi-agency network from the frontline to strategic planning.

2. Core functions

2.1 Integrated Safeguarding team

The safeguarding team comprises of a range of professionals with expertise in safeguarding adults at risk, safeguarding children, safeguarding in maternity services, supporting people with learning disabilities, a lead for learning and development, administrative support and independent advisors supporting victims of domestic abuse. The establishment of the team ensures that the trust complies with its responsibility to have named professionals in statutory posts. There are no current vacancies and recruitment to posts when they were vacant has been successful with a strong pool of applicants.

The team are able to access safeguarding training at the appropriate level and there is a model of supervision in place. Training and supervision rates are monitored by the ISC and the CCG’s.

The head of safeguarding is supported by the group chief nurse.

The commitment to a joined up approach to safeguarding is now embedded through the integrated safeguarding committee (ISC) and is evident in the ongoing work plan.

The ISC meets every quarter and is chaired by the group chief nurse. The membership is made up of senior staff from each hospital site including the directors of nursing. The work of the committee is shaped by the safeguarding strategy and associated work plan. The aim of the committee is to monitor safeguarding activity across the trust and to ensure that the safeguarding team deliver against the work plan and any actions required from case review, audit or national and local directives. The work of the ISC is supported by the hospital site specific safeguarding operational groups. The ISC has membership from Barnet, Camden & Enfield CCG.
2.2 ISC reporting and monitoring

All safeguarding activity is monitored each quarter. Key performance indicators are:

- Referrals data for unborn babies, children and adults broken down by type to allow analysis of themes and trends
- Referral data and activity relating to people with learning disabilities
- Risk and governance related to safeguarding - including serious case reviews, serious adult reviews, serious incidents, domestic homicide reviews, Learning disabilities mortality review, complaints, allegations of abuse against staff, attendance at child protection case conferences
- Audits – including section 11 Children Act, safeguarding adult self-assessment framework, commissioned audits and other audit activity identified in the annual audit plan or requested by the safeguarding boards
- Safeguarding supervision compliance
- Safeguarding training compliance
- Domestic violence referral data
- Female genital mutilation identification and reporting data
- Preparation for and outcome of external inspection and review
- Quarterly prevent training figures to NHSE and Home office
- Quarterly Deprivation of Liberty applications to Care Quality Commission (CQC)

In addition to the above the CCG’s are provided with quarterly reports for both safeguarding adults and safeguarding children in the form of an audit/dashboard.

Following the agreed trust governance and reporting structure the clinical performance and patient safety committee will receive the ISC reporting data for children and adults bi-annually.

This report will be received by the Clinical Standards and Innovations committee prior to coming to the full trust Board.

2.3 Safeguarding strategy and policy development

The safeguarding strategy and associated work plan (2018 -2021) has been built on the strong achievements made in safeguarding across the trust over previous years. The aim of the strategy is to ensure there is a shared vision that safeguarding all our patients is everyone's business; that we foster a think family approach, that we listen to what matters to our patients and that safeguarding is central to core business across the trust. The full safeguarding team came together in November to develop the five key strategic aims. These have been agreed by the ISC and these form the basis of the safeguarding work plan. The strategy has been developed with full regard to the trust world class values and these are seen as central to delivering a culture of compassionate care that values patients, the public and staff. The ISC ratifies and monitors policy development.

The safeguarding children and safeguarding adult policy have been reviewed and amalgamated to form a single integrated document that better reflects a think family approach to safeguarding.
2.4 Partnership working

Good partnership working is recognised as the corner stone of effective safeguarding. As such the safeguarding team work hard to build and maintain good relationships with partner agencies from the frontline to strategic leadership and development.

There is trust representation at all six safeguarding boards and/ or their associated sub groups.

Following the Wood review in 2016 into the role and functions of the Local Safeguarding Children Boards’ (LSCB) will change and the boards are currently reviewing their structures and as partner agencies we are being consulted and welcome the opportunity to influence change. It is hoped that some boards will share or amalgamate some responsibilities, such as child death overview panel, which would reduce the number of sub-groups

The lead safeguarding professionals from Barnet, Camden and Enfield CCG’s are also core members of the ISC.

RFLNHSFT staff benefit from access to multi-agency training which enables them to learn alongside colleagues from other agencies from all three local authorities.

The trust is working with Barnet Safeguarding Children Board and Barnet CCG on the improvement plan following the Ofsted inspection in 2017.

Members of the safeguarding team are involved in multi-agency case review, audit and policy development.

We have worked with the local authorities to implement the Child Protection information sharing system in our unscheduled care settings.

We work with the commissioned domestic abuse services to host domestic abuse advisors.

We are working with Camden to raise awareness of Early Help and have a worker located at the Royal Free Hospital.

3. Safeguarding regulation and Inspection

Safeguarding is a key priority for the CQC. The CQC will focus on ensuring the trust has adequate systems in place to safeguard all patients, whatever their age and circumstance, and that those systems are followed in practice.

The trust must ensure it is compliant with regulation 13. The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment.

To meet regulation 13 providers must have a zero tolerance of abuse, unlawful discrimination and restraint. This includes:

- Neglect
- Subjecting people to degrading treatment
- Unnecessary or disproportionate restraint
- Deprivation of liberty
Safeguarding is a key line of enquiry in the CQC core inspection framework for NHS acute hospitals. All CQC inspectors will ask about safeguarding in whatever area they inspect.

3.1 Review of health services for Children Looked After and Safeguarding (CLAS)

In February the CQC undertook a CLAS review in Barnet. The inspectors visited Barnet hospital to review the emergency department, the maternity services and the paediatric ward. They spoke to staff, children and young people, parents, mothers to be and new mothers. They also reviewed case files.

The findings of the review were published on 7th June 2018.

The general feedback was very positive and several areas of good practice were highlighted. Some recommendations were made about how we could make better use of specific risk assessment tools in unscheduled care settings and how we could further expand our model of safeguarding supervision. The action plan resulting from the recommendations will be progressed by the safeguarding operational groups and monitored by the ISC.

CQC Children looked after and safeguarding review.pdf

3.2 Section 11 Children Act 2004

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The requirements of section 11 include:

- clear lines of accountability
- senior board leadership
- clear whistle blowing procedures
- information sharing procedures
- named professionals
- safe recruitment practices
- supervision
- training
- policies for dealing with allegations against staff who work with children

It is a function of the LSCB’s to ensure that the trust complies with its duty under section 11. Each LSCB will ask for evidence to be submitted in the form of a self-assessment and then request a representative of the trust to attend a challenge event. The most recent section 11 audit was submitted to Enfield safeguarding children board in March 2017. The areas identified for further development were:

- Working with the communications team to raise the profile of safeguarding
- Child friendly complaints leaflet
- Review supervision policy
- Identifying young carers
- Implement CP-IS

These elements are in the work plan and monitored by the ISC and several have been achieved.

The next section 11 audit is due to be completed and submitted to BSCB by 31st May 2018.
3.3 Safeguarding Adult Assessment Framework (SAAF)

The safeguarding adults at risk audit tool has been developed by the London chairs of safeguarding adults boards (SABs) network and NHS England (London). It reflects statutory guidance and best practice.

The aim of this audit tool is to provide all organisations with a consistent framework to assess, monitor and/or improve their safeguarding adults arrangements. In turn this will support the safeguarding adult boards’ (SAB) in ensuring effective safeguarding practice.

The audit tool is a two-part process:
- Completion of a self-assessment audit
- A safeguarding adult board challenge and support event.

The purpose of the tool is to provide the SAB with an overview of the safeguarding adult arrangements that are in place identifying:
- Strengths, in order for good practice can be shared
- Common areas for improvement where organisations can work together with support from the SAB
- Single agency issues that need to be addressed
- Partnership issues that may need to be addressed by the SAB

The lead for safeguarding adults along with the head of safeguarding completed the assessment and attended the challenge event. Out of 33 elements there was 1 area where improvement was required and was RAG rated amber.

The area identified for improvement was:
- PREVENT training- amber

Actions in place to address these areas are monitored by the ISC

Three sections were rated as good;
1) Full quota of hospital based IDSVA’s who had seen increased numbers of patients across all our sites.
2) Our Integrated approach to safeguarding with adults and children leading on our ‘Think Family’ approach.
3) Reasonable adjustments made for patients with a learning disability in the phlebotomy service.

4. Safeguarding activity

4.1 Safeguarding adults- Referrals to safeguarding team

Between April 2017 and March 2018, there were 905 cases referred to the adult safeguarding team which were shared with the local authorities and a further 68 were screened as a concern that did not meet the threshold for safeguarding. The referral rates have decreased by 5% this year compared to last year.
Safeguarding concerns from the Royal Free Hospital
Safeguarding concerns from Barnet Hospital and Chase Farm Hospital

In the year 2017-2018 the adult safeguarding team supported patients from 30 different Boroughs or Local Authorities

Our data shows that neglect (48%) continues to be the main reason for a safeguarding concern being raised by trust staff.

4.2 Safeguarding children and unborn- referrals to social services and Early Help

Between April 2017 and March 2018 there were 399 referrals made to social services or early help services. Of those 66 were for the unborn. There is considerable liaison activity between the safeguarding team and other professionals for children, young people and families who are already known to services that is not reflected in the referral rates. The most common reason for referral for children, young people and the unborn is concerns about parental mental ill health.

4.3 Referrals to the learning disability nurses

The rate of referrals to the acute liaison nurses (ALN’s) has increased over the last year. There were 258 referrals at the Royal Free hospital which is a 12% increase, and 345 referrals at Barnet hospital and Chase Farm hospital which is an 18% increase. Approximately half of the referrals are from within the trust, a quarter are from the local community learning disability teams and the others come from G.P’s, family and carers or self-referrals. In addition, there has been a 34.5% increase in the number of people with a learning disability flagged on the patient administration system from 2017-18.

4.4 Case reviews

Safeguarding Adult Review (SAR), Domestic Homicide Review (DHR), Serious Case Review (SCR children), LeDeR (Mortality review of people with a learning disability)

Safeguarding adult reviews and serious case reviews are commissioned by the local authority when someone dies or suffers significant harm and abuse or neglect are known or suspected and there are lessons to be learnt about the way all local professionals and agencies worked together.

A DHR, led by the community safety partnership, is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship or, a member of the same household

Each review will produce recommendations for single agency and multi-agency learning.

The extent to which the safeguarding team will be involved with a review will depend on the relationship between the trust and the patient at the centre of the review and the scope and timescale of the review. Some reviews will require a significant input and may have several recommendations for the trust and others less so.

Following the implementation of the Care Act and the statutory requirement to hold SAR’s and the implementation of the mortality review for people with a learning disability the number of case reviews that the trust are required to contribute to has increased.
During the period of this report the trust has contributed to six SARs, one for Camden, two for Enfield, two for Barnet and one for Islington, three DHR’s, one each for Enfield, Barnet and Hertfordshire, three SCR’s and two LeDeR reviews.

The reports are not yet all final but there is already some identified learning for the trust and there will be further multi-agency recommendations to follow.

All recommendations for RFLNHSFT following a case review and the disseminated learning is monitored by the Integrated Safeguarding Committee.

There was significant learning implemented following the Camden SAR which was:

- Improved our safeguarding referral system to make it much easier
- Improved information sharing about the pressure ulcers
- Improved awareness of eating disorder specialist support and advice
- Attendance at multi-agency high risk panel
- Better clarity of discharge planning to ensure continuity of care.

The safeguarding adult lead and the lead consultant in the case gave a presentation at the safeguarding conference hosted by Camden SAB which aimed to share learning from the findings.

4.5 Attendance at Child protection case conferences

From April 2017 – March 2018 staff were invited to 116 child protection case conferences 58% of which were for the midwives from the specialist midwifery teams Unity and Acacia. Where staff cannot attend a case conference a report must be provided for the conference. Attendance at conference is monitored by the ISC and the CCG’s.

4.6 Audit

The safeguarding team has an annual audit programme that has been agreed by and monitored by the ISC and the CCG’s quarterly. The audit programme is directed by recommendations from case reviews, internal incidents and service development.

4.7 Allegations of abuse against staff working with adults or children

10 allegations of abuse against staff were raised during the period of this report; a decrease from 19 allegations last year. Details of all allegations are taken to the serious incident panel and the number and type of allegation are monitored by the Integrated Safeguarding committee. All allegations of abuse are reported to the local authority and or the police where appropriate or according to the individual’s wishes.

Three of these allegations are still open and under multi-agency investigation. To date one of the allegations has been substantiated and that member of staff has been dismissed.

There is a policy in place to help staff understand their responsibility to raise concerns.

Where allegations are substantiated and the member of staff is a regulated professional the professional body will be notified as well as the DBS.
The management of staff who are alleged to have commit abuse in their personal life are also managed under this policy.

5 Domestic abuse and violence against women and girls

The domestic violence and violence against women and girls (DV &VAWG) steering group is a subgroup of the ISC and is led by public health and safeguarding teams. It is responsible for coordinating all aspects of work aimed at improving the trusts response to domestic and sexual violence for patients and staff. The ISC monitors the activity and referral data of both domestic abuse and FGM on a quarterly basis.

This year we undertook a review of our domestic abuse programme focusing on how we benchmark ourselves against national good practice. Underlying this was a desire by the steering group to ensure the trust was at the forefront of responding effectively to domestic abuse and improving its trust wide programme. The key findings from the review are:

1. The trust meets 10 of the 12 recommendations relevant to an acute trust in the NICE guidance on Domestic violence and abuse (PH50). Recommendation 5: ‘create an environment for disclosing domestic violence and abuse’ and Recommendation 9: ‘help people who find it difficult to access services’ are not fully met across all sites of the trust.

2. The trust works in partnership with organisations that are commissioned to provide specialist DA services to the local authorities; a hospital based Independent Domestic and Sexual Violence Advisor (IDSVA) model is employed to provide support for patients and staff who are experiencing or have experienced DA. A recent gap in recruitment for the position of an emergency department based IDSVA at Barnet hospital resulted in a complete cessation in referrals from this department until the position was re-filled.

3. The hospital IDSVAs are employed by external organisations and work at the trust under co-location agreements; all the contracts are short term, mostly annual contracts, and are dependent on continuation of external funding which in most instances is reviewed on an annual basis. The trust is therefore vulnerable to changing priorities of partner organisations and cuts to funding.

4. The trust has a responsibility to ensure staff have the opportunity to address issues relating to DA. Advice for managers on staff disclosure is included in the trust’s DA policy, however there is no training provided to support managers to fulfil this duty. The information about DA displayed at the trust is targeted towards patients and is not provided in areas designated for staff, such as occupational health.

The referral data from the last 3 years has demonstrated the need and the value of a hospital based IDSVA.
The overall number of referrals has increased in the last year showing that recognition and use of the service has been steadily growing over time. The Barnet service is now well established with 55% of referrals coming from Barnet ED or maternity based IDSVAs. Interestingly 28% of all referrals are from maternity – highlighting the importance of focussing work in this area. However, attention should be paid to the dip in referrals in quarter 1 of 2017 where there was no IDSVA based at Barnet A&E department. This links to a review finding around the importance of having IDSVAs based within the Trust.

**Referrals to hospital based IDSVAs from 2015- January 2018.**

76% of referrals come from the trust's main catchment areas: Barnet, Camden, Enfield and Hertfordshire.

The A&E IDSVAs position was filled in Q2 2017/18 and referrals increased immediately during this period.

These findings suggest that referral is dependent on there being an IDSVAs located on site at the hospital. Overall there are approximately double the numbers of referrals made at Barnet hospital compared to the Royal Free, this indicates that the number of referrals is proportionate to the amount of time there is an IDSVA located on site and the number of patients in unscheduled care and maternity.

Figure 2 below shows referrals broken down by age group. 14% of referrals have no age information provided. Of those referrals received by the IDSVAs service for whose age is known, 21% are in the 30-34 year age group, more than half (56%) of referrals are between 16 and 34 years age and 10% are aged 65 or over.
Number of referrals by age group

![Proportion of DV referrals by 5-year age group (where age is known): Q2 2015/16 to Q3 2017/18]

Outcome of referrals

Data collection for the outcome of hospital referrals is grouped into four main categories: risk evaluation and safety planning, onward referrals, provision of information and negative outcomes. As shown in the chart below, 48% of referrals were provided with information, with local services and safety information being the most common outcome for these clients. 46% of clients had an outcome of onward referrals, of which 23% were referred to local DV organisations or services, and 34% of referrals received risk evaluation and safety planning. 32% of referrals had a negative outcomes; the client declined the service in 15% of these cases.

The focus for 2018 will be on addressing the recommendations from the Domestic Abuse review.

6 Early Help Pilot

Families who need social care support often also face multiple and complex health problems. Research undertaken with families eligible for the national Complex Families programme, for example, found that 71% of families reported poor health, including 46% with a mental health problem and 32% a long standing illness or disability. Drug and alcohol dependency among both parents and children and domestic violence were also very common.

These health problems will often have gone undiagnosed, untreated and/or poorly managed for many years. In part this reflects poor health and social care access among these families, although secondary care (particularly emergency services) use is often more frequent than by other members of the community. This results in high costs to both the NHS and the local authority, with limited or late engagement resulting in poorer health and care outcomes.

The Royal Free is working with Camden council to try innovative ways to be able to identify families in need of support and provide help sooner. A pilot project for a year has a member of the council’s Early help team co-located at the trust to raise awareness and train staff on
referring to early help and to also identify families in need and support them to access help sooner. The aim of the project is to

1. Explore how vulnerable families are using hospital services
2. Establish whether hospitals make an acceptable and effective setting to identify individuals and families with complex social needs, and link them to early help services
3. Assess the cost benefits and long-term impacts of this approach, including whether engagement with early help and whole family approaches reduces unscheduled care and use of hospital services.
4. To evaluate this approach and share the learning and outcomes with partner agencies across health and social care.

This project has been accepted as a Quality Improvement project.

7 Deprivation of Liberty Safeguards

The deprivation of liberty safeguards (DoLS) are a set of protections for adults who lack the mental capacity to consent to being accommodated in a hospital or care home for care or treatment. The DoLS are in place to deliver safeguards to the person and provide a means to challenge any such deprivation.

In 2014 a Supreme Court decision, the Cheshire West decision, significantly widened the numbers of those vulnerable people considered to be deprived of their liberty.

As a result, health and social care services have been unable to cope with the resulting increase in cases and the added administrative burden.

In March 2017 the Law Commission recommended a new system, the Liberty Protection Safeguards. These safeguards would give more rights to the person and increase the range and care setting that the safeguards apply to as well as removing some of the administrative requirements.

The government is still to put the law commissions report into practice.

In the interim we continue to abide with the law as it stands and our applications increase year on year.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2017-18 DoLS applications</th>
<th>2016-17 DoLS applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>101</td>
<td>51</td>
</tr>
<tr>
<td>2</td>
<td>68</td>
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<td>4</td>
<td>90</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>265</td>
</tr>
</tbody>
</table>

*This amounts to an increase of 23%*
8 Prevent Radicalisation and counter terrorism

Prevent is an element of the government’s anti-terror strategy and a key safeguarding priority for NHSE. 18 priority areas are located in London, including Camden. The named nurse for safeguarding adults is the Prevent lead for the trust and attends the north London multi-agency sub-group as well as the NHS London Prevent meetings. Monthly returns relating to training figures and referrals are quarterly reported to NHS England, the Home Office as well as to the ISC.

The main concern on a national level are teenagers, young women and mothers with children and 34% of referrals to Channel were made by mental health services. An overview of Prevent training is covered in the training section.

The trust made 3 referrals to Prevent over the last year

9 Patients with learning disabilities

Learning Disability Mortality review (LeDeR)

It is a national requirement that a case review of the death is carried out for all deaths of people with learning disabilities. The acute liaison nurses (ALN) within the trust undertake an initial review of the death in conjunction with a senior clinical member of staff. The review is presented to the serious incident review panel. As trained LeDeR reviewers the two ALN’s have assisted external reviewers by providing information to complete LeDeR reviews. Two reviews have been completed during 2017/2018. In one of these reviews NHS England highlighted care provided by staff on Walnut ward at Barnet hospital as an example of best practice. The staff had implemented reasonable adjustments for a patient with a learning disability who was receiving palliative care. The Enfield LeDeR steering group are supporting the family member to feedback her experience as learning for other cases.

Phlebotomy Quality Checkers

The action plan from the Quality Checkers (users who assess how well services support people with learning disabilities and other disabled people) that came to Barnet Hospital has progressed. Easy read information for patients who need a blood test has been created and is in the process of being finalised. Once complete this will be shared with our community and primary care colleagues as well as being available within our phlebotomy sites and on the Trust internet pages. Friends and family tests are available and work is underway with the patient experience team to develop easy read Friends and Family Tests to improve ways for patients to be able to feedback their experience.

Ophthalmology learning disability clinic

The ophthalmology department are setting up a learning disability clinic in St Pancras every month. This is being run as a QI project. It will give people with learning disabilities and their carers more time, and in an environment that is calmer and more relaxed. It is targeted at Camden and Islington residents with a learning disability. This is a fantastic example of reasonable adjustments been made to support people with learning disabilities to access healthcare more easily.
**Hospital Champions**

The role of the Learning Disability Champion has been introduced on two wards at Barnet Hospital before being rolled out across the trust. The aim is this new role will have benefits for both patients and staff, as it will mean that a named member of staff will have increased knowledge of learning disabilities on each ward, to ensure key aspects of care are being put in place as soon as a patient arrives on a ward, rather than waiting for ALN's to attend. There has been interest in the role from a variety of professionals from therapies, nurses and health care assistants.

**Mental Capacity Process**

Learning from incidents it was noted that in some areas there was a lack of understanding about undertaking capacity assessments for patients with a learning disability prior to treatment. On occasion it has led to surgery or intervention being cancelled at short notice. The ALN's are doing training needs analysis, undertaking an audit and working closely with the implementation team at Chase Farm Hospital to build the Mental Capacity Assessment into the pre assessment process.

**10 Safeguarding in maternity services**

**Supporting Women with Mental Health Needs**

The newly commissioned perinatal service for NCL commenced in November 2017. The service is for women who fulfil the criteria of moderate to severe mental health illness. The team is made up of a perinatal psychiatrist, as well as community based support from a specialist team. Weekly multi-disciplinary referral meetings take place to discuss all new referrals and the named midwife for safeguarding and/or the vulnerable women’s team attend, ensuring an integrated approach to providing care. There is already anecdotal evidence that safeguarding issues have been identified ensuring early intervention and an integrated approach to providing care is achieved.

Improving access to psychological therapies (I.A.P.T.) services in a few of the boroughs now have a specialist perinatal service to support women who have mild to moderate mental health needs.

This fulfils the recommendation from The National Maternity Review (NHS England, 2016) that there should be mental health support for all and that the NHS needs to consider the mental wellbeing of women and their families in an integrated way.

**Additional Support**

An integrated perinatal mental health pathway has been developed by key stakeholders in Barnet to ensure that all mothers are offered the opportunity to be identified for mental health support. The pathway focuses on mild to moderate perinatal mental health presentations and will act as a step up/ step down service to the NCL perinatal mental health service.

The women's health counselling (WHC) service continues to offer support to all women who access maternity or gynaecology services at the RFH site. The WHC work very closely with
the specialist team for vulnerable women at the Royal Free (Unity team) and the perinatal mental health team to support women with a variety of concerns in the mild to moderate range. There is not a comparable service for women at Barnet hospital.

**London Perinatal Mental Health Champions Training**

The London perinatal mental health network has secured funding from Health Education England (London region) to train an additional 80 Perinatal Mental Health Champions.

There are currently two mental health champions already in place at Barnet hospital and one at the Royal Free hospital and two places have been offered to the trust for the forthcoming training.

**Redesign of community midwifery**

Current maternity policy provides a clear direction for the provision of maternity service with an emphasis on safety, evidenced based practice, improved postnatal care, choice and personalisation and continuity of carer.

On 1st April 2017, the trust introduced a modified case loading model for vulnerable women. All vulnerable women are assessed and risk rated accordingly. Women assessed as red and amber are offered care provided by midwives from the specialist team for vulnerable women; Unity team on the Royal Free Site and Acacia team on the Barnet Site.

Women who are considered high risk/ high need receive enhanced continuity of carer in the antenatal, intra-partum and postnatal period and women rated as high amber receive continuity of carer in the antenatal and postnatal period.

This model aligns to the national drive in “Better Births” in improving the outcomes for mothers and babies in these high risk groups. Women assessed as vulnerable but at low risk will continue to receive care from the community midwifery teams who are supported by a specialist midwife from the vulnerable team. Staff report greater job satisfaction, there is an increase in recruitment and retention rates and a reduction in burn out.

**11 Safeguarding Training April 2017 – March 2018**

During the last year the safeguarding team has worked hard to deliver the Prevent training. A new calculation to accurately reflect the Level 3 training compliance was introduced in September and compliance in all other safeguarding subjects maintained above the general MAST compliance rate. Preparations for the introduction of safeguarding adults level 3 training have been made.

The CQC CLAS review in February noted that “Staff at Barnet hospital emergency department, including healthcare assistants, are offered training to level 3 safeguarding on an annual basis which exceeds the minimum intercollegiate requirements. Staff spoke highly of the Level 3 training and subject specific sessions”.

The training strategy was reviewed and updated
11.1 Prevent Training
As part of the trusts Prevent duty all staff are required to receive training that will enable them to recognise when a vulnerable person is at risk of radicalisation and to know how to respond. The trust delivers two levels of Prevent training. Basic Awareness of Prevent (BAP) is for all staff and at the end of March 2018 the target of 85% compliance was achieved.

The extended level of training, Workshop to Raise Awareness of Prevent (WRAP) is mandatory for clinical staff in ED, maternity and paediatrics as well as the chaplains. At the end of March the compliance was 76%. NHSE had set us a target of 85%.

11.2 Safeguarding Children and Adults Level 1 and Level 2, Mental Capacity Act Training
All new starters complete level 1 safeguarding children and adults training as part of their corporate induction. Clinical staff will also complete Level 2 including mental capacity act training. While Level 1 training for both safeguarding adult and children maintained compliance above the target of 85% throughout the first half on the year in autumn 2017 compliance declined in line with the decrease of the general MAST compliance. However all safeguarding level 1 and level 2 modules continue to consistently exceed the average MAST compliance.
11.3 Safeguarding Children Training Level 3

Level 3 training is mandatory for clinical staff in the emergency department, maternity and paediatrics. All new starters attend a full Level 3 training day then an annual update. Level 3 updates are delivered in the form of seminars addressing specific aspects of safeguarding children in greater detail. Most updates are co-delivered with our partners from statutory and third sector agencies. The lead for safeguarding learning and development has worked with the named midwife to develop a programme of training specific to midwives. The ALN's are supporting the midwives to better understand the needs of pregnant women who have a learning disability. This was noted by the CQC in the CLAS review as demonstrating positive outcomes.

Between April 2017 and March 2018 L3 updates covered the following topics:

- deliberate self-harm (with the Barnet and Enfield Mental Health Trust and CAMHS)
- fabricated and induced illness (with the Designated Doctor and Nurse in Barnet)
- safeguarding children living with alcohol and substance misuse (with WDP and FWD)
- female genital mutilation (with the Designated Doctor for Camden)
- trafficking children / modern slavery including county lines (with the Metropolitan police and the NSPCC’s Child Trafficking Advice Centre)
- risk of harm online
- domestic violence (with the hospital based IDSVA’s)
- neglect

11.4 Safeguarding adult level 3 training

Several drafts of the Intercollegiate Guidance for Adult Safeguarding outlining content and staff criteria have been out for consultation in the last year. The publication of the final document is expected in the near future and the safeguarding team has been preparing for the inclusion of adult safeguarding level 3 training to the MAST programme. Training will follow a modular model such as the Level 3 update seminars for safeguarding children and initially focus very strongly on MCA/DoLS but also include seminars on domestic abuse, trafficking/modern slavery, substance misuse, homelessness, and other vulnerability factors.

Where possible the children safeguarding and adult safeguarding level 3 training will be combined and delivered together in a session promoting a think family approach.

12 Key aims of the safeguarding strategy

The key aims listed here have been agreed by the ISC and form the structure of the overall safeguarding work plan 2018 -2021. They have been chosen to build upon the strong pathways and processes already in place and to further develop staff in their awareness and response to safeguarding. They reflect national and local policy and priorities and reflect the teams aim to do what really matters for each and every patient that requires safeguarding and support.

1. To ensure that staff adopt a think family approach to safeguarding
2. That the principles of making safeguarding personal (MSP) and the voice of the child (VOC) are central to all policy, process and service development.
3. To develop systems that allows better data analysis and assurance and support information sharing.

4. To ensure that prevention and early intervention/ early help are at the forefront of our safeguarding

5. To develop safeguarding processes that actively supports staff in their professional and personal lives.

In conclusion it can be seen that the trust continues to work in a proactive way to drive the increasingly complex safeguarding agenda forward.
Appendix 1
Safeguarding Governance Structure

Group Trust Board

Clinical standards & Innovations committee

Integrated Safeguarding Committee (ISC)
Chair: Group Chief Nurse
Executive board lead for safeguarding
Deputy Chair – Head of Safeguarding
Frequency: Quarterly
Provides annual report to Group Trust Board & CSIC
biannual report to Clinical performance & patient safety committee on each hospital site

Local Safeguarding Children Boards
Barnet | Camden | Enfield

Local Safeguarding Adults Boards
Barnet | Camden | Enfield

CCGs
(Barnet, Enfield, Camden)

Safeguarding Operational Group BH & CFH
Chair: Safeguarding lead (children/maternity/adults)
Frequency: Every 12 weeks
Progress the workplan
Reports to ISC

Safeguarding Operational Group BH & CFH
Chair: Safeguarding lead (children/maternity/adults)
Frequency: Every 12 weeks
Progress the workplan
Reports to ISC
Royal Free London NHS Foundation Trust
Safeguarding Strategy 2018 -2021
**Foreword**

Our safeguarding strategy aims to achieve excellence in safeguarding and this updated version builds on achievements we have made and recognises that we must strive for continuous improvement. This strategy sets out how we plan to drive forward our safeguarding activities and reputation over the next three years. Our vision is to meet the highest standards of safeguarding practice achievable.

The trust aims to ensure commitment to quality & safety in everything we do for children, young people and adults at risk across all services we provide.

Our Safeguarding Strategy acknowledges the requirements of the Royal Free London NHS Foundation Trust Board to ensure there is a board level focus on the needs of patient safety and that safeguarding is an integral part of the governance system. It should be seen as part of a dynamic approach to ensuring that the Trust meets its duties to people who use our services, supports and guides our staff and assures others that we do subscribe to the belief that safeguarding is *everybody's business*.

The strategy is our shared vision for the future and our intention to strive to make services at Royal Free London NHSFT, as safe as they can be and we are doing this from a position which focuses upon continued learning from within and from outside the organisation. It is an inspired piece of work that sets out how we will be transforming our safeguarding practice; and ensures that the Trust Board fulfils its corporate responsibility and continues to provide direction in relation to safeguarding of all vulnerable patients, whatever their age, within Royal Free London NHS Foundation Trust.

**Deborah Sanders – Group Chief Nurse, Executive lead for safeguarding**
Introduction

The Royal Free London NHS Foundation Trust is committed to safeguarding all vulnerable patients who access services across the Trust.

We recognise that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. In order to do this we will work closely with others to ensure that all of the services we provide have regard to our duty to protect individual human rights, treat individuals with dignity and respect and safeguard against abuse, neglect, discrimination, embarrassment or poor treatment. We acknowledge the balance between an individual’s rights and choices and the need to protect those at risk.

Our commitment to safeguarding is reflected in this strategic approach with overarching aims that serve to steer and inform an on-going programme of work. This will strengthen arrangements for safeguarding adults and children across the trust, working collaboratively with partner agencies, ensure that there is a person centred and think family approach.

Within this document the term ‘safeguarding’ describes the range of care interventions which enable a child, young person or adult at risk to live a life that is free from abuse and neglect. Safeguarding also recognises the need to prevent abuse and neglect occurring and intervene and offer support early on.

The strategy acknowledges the principles and multi-agency working explicit within the Local Safeguarding Children Boards Business Plans and the Local Safeguarding Adults Business Plans. In addition the strategy is supported throughout with an adherence to safeguarding principles and commitments which are set within statutory and policy framework.

As a health care provider we are required to demonstrate that we have strong safeguarding leadership and a commitment to safeguarding at all levels of the organisation. This includes safe recruitment, effective safeguarding training of all staff,
effective supervision arrangements and the identification of Named safeguarding professionals. Most importantly we must ensure a culture exists where safeguarding is everybody’s business and poor practice is identified, tackled and eliminated. In order to ensure safeguarding is central to our core business we have developed an Integrated Safeguarding Committee. This is a tangible demonstration of our commitment to protect all vulnerable patients whatever their age, who access services across the organisation; and to integrate safeguarding across all services.

**Strategy development**

The Royal Free London NHS Foundation trust holds the value that living a life that is free from harm and abuse is a fundamental right of every person whatever their age. It acknowledges its statutory responsibility to promote the welfare of children and young people and to protect adults from abuse and risk of harm.

This strategy has been written with full regard to the Trust Values and these are seen as central to delivering a culture of compassionate care that values patients, the public and staff. In addition it is supported by local and national policies and procedures

**World Class Values**

**Welcoming, respectful, communicating & reassuring;** these are the four words which describe how we interact with each other and our patients.

At the Royal Free, our ambition is simple: to offer our staff and patients world class care and expertise. In April 2012 the trust launched its values, devised by our patients and staff to ensure that we deliver world class care to every patient, every colleague, every day.

The values are: to be **positively welcoming; actively respectful; clearly communicating** and **visibly reassuring.**
We will continue to work in the context of national legislation, policy guidance and within the local commissioning frameworks.

**Care Quality Commission (CQC)**

We are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are appropriately skilled and supported.

The CQC has an operating framework which focusses on five key questions of services provided. Safeguarding can be seen to cut across all five key questions:

<table>
<thead>
<tr>
<th>Are they safe</th>
<th>This means people are protected from abuse and avoidable harm</th>
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<tbody>
<tr>
<td>Are they effective</td>
<td>This means peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence</td>
</tr>
<tr>
<td>Are they caring</td>
<td>This means staff involve and treat people with compassion, kindness, dignity and respect</td>
</tr>
<tr>
<td>Are they responsive</td>
<td>This means services are organised so that they meet peoples needs</td>
</tr>
<tr>
<td>Are they well led</td>
<td>This means leadership and governance of the organisation assures delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture</td>
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Safeguarding priorities are central to ensuring high quality and safe care. NHS England NHS, Outcomes Framework 2014/15, particularly:

- Domain 3: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Our strategy incorporates the 6C’s, **Care, Compassion, Competence, Communication, Courage and Commitment** which also aim to drive up the standards of care across the NHS. We believe the 6C’s can be seen as the very foundation of what effective safeguarding is about.
We have taken into account the recommendations of the Francis Report:

“Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture and protected from avoidable harm and any deprivation of their basic rights”

Francis Report 2013

The term safeguarding is intended to be used in its widest sense, to both encompass prevention and protection activity. The strategy is supported throughout with adherence to safeguarding principles, priorities and commitments which are set out within this strategy and associated safeguarding policies.

The Care Act April 2015 places adult safeguarding on a legal footing.

**Governance**

The Integrated safeguarding committee (ISC) has been established because we have recognised the need to integrate safeguarding across children and adult services. The ISC meets every quarter and is chaired by the Group Chief Nurse. The ISC is responsible for monitoring all safeguarding activity. Hospital site specific Safeguarding operational groups are responsible for ensuring that the associated three year workplan is delivered and they report directly to the ISC. The ISC provides biannual report to the Clinical performance & patient safety committee on each hospital site and an annual report to the Clinical Standards and innovation committee and the full Trust board.

**Key strategic aims**

The key aims as listed below will form the structure of the overall work plan. They have been chosen to build upon the strong pathways and processes already in place and to further develop staff in their awareness and response to safeguarding. They reflect national and local policy and priorities and reflect the teams aim to do what really matters for each and every patient that requires safeguarding and support:
1. To ensure that staff adopt a think family approach to safeguarding

2. That the principles of making safeguarding personal (MSP) and the voice of the child (VOC) are central to all policy, process and service development.

3. To develop systems that allows better data analysis and assurance and support information sharing.

4. To ensure that prevention and early intervention/ early help are at the forefront of our safeguarding.

5. To develop safeguarding processes that actively supports staff in their professional and personal lives

From strategy to reality

Making this strategy a reality requires a robust infrastructure.

This includes:

- Continued clear lines of accountability, well defined structures and clarity about roles and responsibilities

- Recognition by the organisation as a whole that safeguarding all our patients is everybody's business

- A sustained profile, ensuring that safeguarding our patients, whatever their age is viewed as an individual responsibility as well as an organisational priority

- A dynamic work plan to support the realisation of this strategy which is monitored through the strong governance arrangements.
Executive summary

The board agreed to a new approach to go see visits at its December 2017 meeting, building on the previous programme of go see visits designed to increase visibility and engagement between trust leaders and governors with staff.

Go see visits are open to all group directors, including site chief executives, non-executive directors and governors. They will take place monthly and ‘visit’ all areas of the trust, including corporate support services. Prior to the visits, a fact sheet will be provided giving some key information about the areas. This will include information on staffing and where appropriate, patient or client feedback. The current sheet is in the process of being reviewed. Visits are not designed to be inspections, but opportunities to listen to staff and where appropriate, meet patients.

While non-executives will continue to be paired with governors, executive directors will visit a separate set of areas.

Three key questions will be asked:

1. What is working?
2. What is not working?
3. What would you like to change?

This information will be fed back verbally at the following trust board meeting. Logistically this will mean there is feedback from more than one area. This will be dealt with by a list of areas visited being circulated in the papers and the chairman asking for any specific areas to be highlighted.

Since the last meeting the following visits have taken place. Work has now commenced on organising the next set of visits.

<table>
<thead>
<tr>
<th>Area</th>
<th>Director</th>
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<tr>
<td>Endoscopy (RFH)</td>
<td>Glenn Winteringham</td>
</tr>
<tr>
<td>Surgery – reduction of never events</td>
<td>Glenn Winteringham</td>
</tr>
<tr>
<td>Therapies</td>
<td>Stephen Ainger and Vineeta Manchanda</td>
</tr>
<tr>
<td>Neonatal care standards (BH)</td>
<td>Mary Basterfield and Frances Blunden</td>
</tr>
<tr>
<td>Pharmacy (BH)</td>
<td>David Grantham</td>
</tr>
<tr>
<td>RF Charity hub for people with long term conditions</td>
<td>Deborah Sanders</td>
</tr>
</tbody>
</table>
Action required

The board is asked to note the report.

Report From  Emma Kearney, director of corporate affairs and communications
Author(s)    Alison Macdonald, board secretary
Date         18 June 2018
Board report on Royal Free London NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Executive summary
The 2018 /2019 CNST has been developed to support the delivery of the Department Of Health and Social Care’s maternity safety strategy. The maternity element of the trust CNST contributions for 2018/2019 has been increased by 10% to create a maternity incentive fund. The scheme requires the Trust to self-certify (with board sign off) their progress against 10 actions and discuss this with their commissioners before submitting a template board report to NHS Resolution by Friday 29th June 2018.

The chief nurse has reviewed the evidence on behalf of the board which shows compliance with the 10 standards and the evidence will be available to view at the board meeting.

Action required/recommendation
The Board is required to confirm that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.

- The content of this report has been shared with the commissioner(s) of the Trust’s maternity services

- If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B

<table>
<thead>
<tr>
<th>Trust strategic priorities and business planning objectives supported by this paper</th>
<th>Board assurance risk number(s)</th>
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<td>5. A strong organisation for the future – to strengthen the</td>
<td></td>
</tr>
</tbody>
</table>
CQC Regulations supported by this paper

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>Dignity and respect</td>
</tr>
<tr>
<td>11</td>
<td>Need for consent</td>
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</tr>
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<td>18</td>
<td>Staffing</td>
</tr>
</tbody>
</table>

Risks attached to this project/initiative and how these will be managed (assurance)

Equality analysis

- No identified negative impact on equality and diversity

Report from  Deborah Sanders, group chief nurse
Author(s) Mai Buckley, group director of midwifery, Carla Long, head of quality governance
Date 18 June 2018
Board report on Royal Free London NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Background

The 2018/2019 CNST has been developed to support the delivery of the Department Of Health And Social Care’s maternity safety strategy. The maternity element of the trust CNST contributions for 2018/2019 has been increased by 10% to create a maternity incentive fund. The scheme requires the Trust to self-certify our progress against the 10 actions and discuss this with our commissioners before submitting a template board report to NHS Resolution by Friday 29th June 2108. Maternity services have completed the benchmark against the 10 criteria as of the 31st of April 2018 and believe they are compliant against each of the standards (see attached).

The Board is required to confirm that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.

- The content of this report has been shared with the commissioner(s) of the Trust’s maternity services

- If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B
SECTION A: Evidence of Trust’s progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site’s performance against the required standard.

<table>
<thead>
<tr>
<th>Safety action – please see the guidance for the detail required for each action</th>
<th>Evidence of Trust’s progress</th>
<th>Action met? (Y/N)</th>
</tr>
</thead>
</table>
| 1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths? | **Status**  
The NPRMT was launched on 5th February 2018. The aim of the tool is to support standardised perinatal mortality reviews across NHS maternity services in the UK. The tool provides a structure that actively involves parents and identifies learning for organisations. Data submitted provides a national report identifying national themes and trends.  
All stillbirths and neonatal deaths at the Trust on the Royal Free Hospital and Barnet Hospitals' from 1st January 2018 have been reported on to the PMRT and have been reviewed and evaluated by a multidisciplinary team. | Yes |
| 2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | **Status**  
The Information team has undertaken significant developmental work on the Maternity Services Dataset (MSDS) submission process and the Trust is in compliance with the standard and is able to meet 10 out of 10 of the MSDS criteria. | Yes |
| 3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the | **Status**  
Transitional care is provided at Barnet and Royal Free Hospitals' in the postnatal wards for babies meeting the British Association of Perinatal Medicine (BAPM) criteria for transitional care | Yes |
### Implementation of the Avoiding Term Admissions into Neonatal units (ATAIN) Programme?

Including those receiving intravenous antibiotics and late preterm infants.

The Maternity services across both Royal Free Hospital and Barnet Hospital sites have implemented ATAIN and ongoing work is in progress as part of the Keeping Mothers and Babies Together CPG pathway and is currently digitalised and embedded.

### 4). Can you demonstrate an effective system of medical workforce planning?

**Status**
The Clinical Directors of Obstetrics and Gynaecology for Royal Free and Barnet hospitals’ have completed the self-assessment against a consecutive 4 week period using the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool and the criteria has been met.

Yes

### 5). Can you demonstrate an effective system of midwifery workforce planning?

**Status**
Midwifery workforce planning is conducted using the north central London workforce planning tool. The trust also has a maternity escalation policy which supports the delivery of patient care and the management of staff in the event of increased clinical activity. Midwifery staffing is reviewed every 6 months by Heads of midwifery. A Project Initiation Document to seek additional staffing is in the final stages of being prepared for submission to reduce the midwife to birth ratio to 1:28 across RFL site in accordance with national guidance.

Birth rate plus methodology for staffing and acuity was commenced across RFL sites in June 2018.

Yes

### 6). Can you demonstrate compliance with all 4 elements of the Saving Babies’ Lives (SBL) care bundle?

**Status**
1. Reducing smoking in pregnancy – Fully compliant.
2. Risk assessment and surveillance for fetal growth restriction – fully compliant. GAP/GROW protocol was implemented across the service in 2015.

Yes
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Raising awareness of reduced fetal movement - Fully compliant. The national leaflet on fetal movements is in place across the services.</td>
</tr>
<tr>
<td>4.</td>
<td>Effective fetal monitoring during labour – fully compliant in progress. Quality improvement work in progress on fetal monitoring as part of the NHS Improvement wave 1 National Maternal and Neonatal Health Safety Collaborative is in progress.</td>
</tr>
<tr>
<td>7).</td>
<td>Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback? <strong>Status</strong> The purpose of the Royal Free London NHS Foundation Trust (RFL) Maternity Voices Partnership (MVP) is to provide a forum for co-production of the planning, design, implementation and evaluation of maternity services. The MVP involves commissioners, providers and users of maternity services working together as equal partners. The meetings are held in community centres. Information on the MVP is available on the Trust website and flyers are circulated to community hubs. A Better births study day is in place for all staff to support the woman choice agenda. There are quarterly inpatient surveys on the wards and Friends and Family test is ongoing and reported on a monthly basis in order to capture women’s voices. <strong>Yes</strong></td>
</tr>
<tr>
<td>8).</td>
<td>Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? <strong>Status</strong> Compliance for all staff groups of midwifery, obstetric and anaesthetic staff meets the 90% standard. <strong>Yes</strong></td>
</tr>
<tr>
<td>9).</td>
<td>Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to <strong>Status</strong> Obstetrician - clinical directors for obstetrics and gynaecology – Barnet and Royal Free Hospitals’ Midwife – divisional director of midwifery/nursing Board level champions – group chief nurse <strong>Yes</strong></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>escalate locally identified issues?</td>
<td>Maternity safety action plan has been developed and has been signed off by the Divisional leads</td>
</tr>
<tr>
<td>10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?</td>
<td><strong>Status</strong>&lt;br&gt;100% of qualifying 2017/18 incidents have been reported. This is validated with the legal team on an on-going basis.</td>
</tr>
</tbody>
</table>
SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

There are no further actions required to achieve compliance with the 10 criteria.
SECTION C: Sign-off

For and on behalf of the Board of Royal Free London NHS Foundation Trust confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.
- The content of this report has been shared with the commissioner(s) of the Trust’s maternity services
- If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B

Position:  ............................
Date:  ............................

We expect trust Boards to self-certify the Trust’s declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm’s length body/NHS System leader.

..........................................................................................................................
SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Evidence embedded above
Finance report for Month 2 – May 2018

Executive summary
The trust reported an actual deficit of £2.3m in month which is an adverse variance of £0.2m, and year to date (YTD) an actual deficit of £14.7m which is an adverse variance of £0.9m. The YTD adverse variance was driven by the Royal Free site (£1.2m) and Barnet site (£1.5m).

Key drivers are clinical income underperformance, residual winter pressure costs and lower than planned private practice unit (PPU) contribution.

The 2018/19 financial plan includes delivery of £45.4m financial improvement programme (FIP) savings. The trust delivered £4.0m of FIP YTD compared to a plan of £3.4m. The trust has identified £40.9m of plans to deliver the £45.4m FIP target.

The cash balance on the 31st of May was £39.5m. This continues to be high due to the Parcel B land sale receipts being ring fenced for the new Chase Farm Hospital. The trust anticipates that it will need to access working capital loans from September onwards. Focus continues on reducing debt with CCGs and NHSE who account for the majority of the aged debt in order to minimise loan drawdown and therefore interest charges.

The trust is resubmitting its 2018/19 operating plan on 20 June. The reported deficit plan will remain the same with a few updates including phasing and FIP.

Action required
For information

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### CQC Regulations supported by this paper

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<tr>
<td>Regulation 4</td>
<td>Requirements where the service provider is an individual or partnership</td>
</tr>
<tr>
<td>Regulation 5</td>
<td>Fit and proper persons: directors</td>
</tr>
<tr>
<td>Regulation 6</td>
<td>Requirement where the service provider is a body other than a partnership</td>
</tr>
<tr>
<td>Regulation 7</td>
<td>Requirements relating to registered managers</td>
</tr>
<tr>
<td>Regulation 8</td>
<td>General</td>
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<td>Regulation 9</td>
<td>Person-centred care</td>
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<td>Regulation 15</td>
<td>Premises and equipment</td>
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<td>Receiving and acting on complaints</td>
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<tr>
<td>Regulation 18</td>
<td>Staffing</td>
</tr>
<tr>
<td>Regulation 19</td>
<td>Fit and proper persons employed</td>
</tr>
<tr>
<td>Regulation 20</td>
<td>Duty of candour</td>
</tr>
<tr>
<td>Regulation 20A</td>
<td>Requirement as to display of performance assessments</td>
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### Care Quality Commission (Registration) Regulations 2009 (Part 4)

<table>
<thead>
<tr>
<th>Regulation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 12</td>
<td>Statement of purpose</td>
</tr>
<tr>
<td>Regulation 13</td>
<td>Financial position</td>
</tr>
<tr>
<td>Regulation 14</td>
<td>Notice of absence</td>
</tr>
<tr>
<td>Regulation 15</td>
<td>Notice of changes</td>
</tr>
<tr>
<td>Regulation 16</td>
<td>Notification of death of a service user</td>
</tr>
<tr>
<td>Regulation 17</td>
<td>Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983</td>
</tr>
<tr>
<td>Regulation 18</td>
<td>Notification of other incidents</td>
</tr>
<tr>
<td>Regulation 19</td>
<td>Fees</td>
</tr>
<tr>
<td>Regulation 20</td>
<td>Requirements relating to termination of pregnancies</td>
</tr>
<tr>
<td>Regulation 22A</td>
<td>Form of notifications to the Commission</td>
</tr>
</tbody>
</table>

### Risks attached to this project/initiative and how these will be managed (assurance)

### Equality analysis
- No identified negative impact on equality and diversity

### Report from:
Caroline Clarke, group chief finance officer  
Author(s): Senior Finance Team  
Date: 18th June 2018
Contents

- In Year Performance Slides 3 to 5
YTD Performance M2 – Key Headlines

Performance against Plan

• YTD performance against plan - £0.9m adverse

Agency Spend Vs. Last year

Agency spend for the month was £1.9m. Agency spend is £0.4m above target at end of May

FIP Performance

• YTD FIP delivery of £4m - £1.3m above

Better Payment Performance Code

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Value £'m</th>
<th>%</th>
<th>%</th>
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<tbody>
<tr>
<td>Total</td>
<td>34,490</td>
<td>125.69</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td>NHS</td>
<td>810</td>
<td>14.76</td>
<td>25%</td>
<td>58%</td>
</tr>
<tr>
<td>Non NHS</td>
<td>33,680</td>
<td>110.93</td>
<td>77%</td>
<td>75%</td>
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Cash Flow forecast

Capital Expenditure

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<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
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<tbody>
<tr>
<td>YTD</td>
<td>21.1</td>
<td>16.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Forecast</td>
<td>72.4</td>
<td>72.4</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Delivered an actual deficit of £2.3m for May; £0.2m worse than plan

In May the Trust delivered an actual deficit of £2.3m. This was £0.2m worse than plan. The year to date adverse variance at end of May was £0.9m. Key drivers for the YTD adverse are

- Underperformance in clinical income of £1.8m
- Residual winter pressure costs
- Earlier than planned delivery of FIP partly offsetting the clinical income underperformance
- Lower than planned contribution from PPU

Delivered £2.9m of FIP in M2

FIP target for M2 was £1.4m and the actual delivery was £2.9m for May. The Trust has currently identified £40.9m of plan and imminent schemes to deliver the £45.4m FIP target for the year.

Cash position – £39.5m at end of May

The cash balance on the 31\(^{st}\) of May was £39.5m.

This continues to be high due to the Parcel B land sale receipts being ring fenced for Chase Farm capital redevelopment. The Trust anticipates that it will need to access working capital loans from September onwards. Focus continues on reducing debt with CCGs and NHSE who account for the majority of the aged debt in order to minimize loan drawdown and therefore interest charges.

The Trust is continuing to manage its cash position in the best interests of both patients and creditors.

FY19 plan resubmission

Following feedback from NHSI, the Trust is resubmitting its FY19 operating plan on the 20\(^{th}\) of June. The resubmission will focus on the issue highlighted such as phasing, updating the efficiency programme, update RTT metrics etc.
## M02 Overview

### M02 (May) Performance FY19

<table>
<thead>
<tr>
<th></th>
<th>In Month</th>
<th>YTD</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £ '000s</td>
<td>Actual £ '000s</td>
<td>Variance £ '000s</td>
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<tr>
<td>NHS Clinical Income</td>
<td>62,371</td>
<td>60,491</td>
<td>(1,880)</td>
</tr>
<tr>
<td>TEDD Income</td>
<td>16,670</td>
<td>14,321</td>
<td>(2,349)</td>
</tr>
<tr>
<td>Non NHS Clinical Income</td>
<td>2,322</td>
<td>2,253</td>
<td>(69)</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>8,021</td>
<td>9,518</td>
<td>1,497</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>89,384</td>
<td>86,583</td>
<td>(2,801)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In Month</th>
<th>YTD</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>(44,876)</td>
<td>(44,613)</td>
<td>264</td>
</tr>
<tr>
<td>Other Pay (Apprentice Levy)</td>
<td>(192)</td>
<td>(192)</td>
<td>0</td>
</tr>
<tr>
<td>Non-Pay Expenditure (Excl. TEDD)</td>
<td>(25,171)</td>
<td>(25,175)</td>
<td>(4)</td>
</tr>
<tr>
<td>TEDD Expenditure</td>
<td>(16,160)</td>
<td>(13,914)</td>
<td>2,246</td>
</tr>
<tr>
<td><strong>Total Operating Expenditure</strong></td>
<td>(86,399)</td>
<td>(83,894)</td>
<td>2,505</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In Month</th>
<th>YTD</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLR</td>
<td>0</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>Interest, Dividends &amp; Depreciation</td>
<td>(5,093)</td>
<td>(5,026)</td>
<td>67</td>
</tr>
<tr>
<td>P/L Disposal of Fixed Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment In Joint Ventures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surplus/Deficit</strong></td>
<td>(2,108)</td>
<td>(2,337)</td>
<td>(229)</td>
</tr>
</tbody>
</table>
**Operational performance report**

**Action required/recommendation**
The board is asked to review the current performance of RFL against the key cancer, A&E and RTT operational performance standards.

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</tr>
</tbody>
</table>

**CQC Regulations supported by this paper**

<table>
<thead>
<tr>
<th>Regulation</th>
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</tr>
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<tbody>
<tr>
<td>Regulation 8*</td>
<td>General</td>
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<tr>
<td>Regulation 9</td>
<td>Person-centred care</td>
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<td>Regulation 10</td>
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<td>Requirement as to display of performance assessments</td>
</tr>
</tbody>
</table>

**Risks attached to this project/initiative and how these will be managed (assurance)**

Failure to achieve and maintain compliance against Monitor risk assessment framework standards and targets.

**Equality analysis**

- No identified negative impact on equality and diversity

**Report from** Peter Ridley
  Director of planning

**Authors** Sally Dootson, chief executive (Barnet), Sarah Dobbing, chief executive (RFH) Amy Caldwell-Nichols, head of group performance

**Date** 17 June 2018
## Operational performance summary report

<table>
<thead>
<tr>
<th>Where we are</th>
<th>Predictions</th>
<th>Key Risks</th>
</tr>
</thead>
</table>
| **Cancer – Apr 2018** | • Performance in April was reported at 85.8%  
• The majority of breaches were in the Breast, HPB and Upper GI | • Un-validated May performance is 83.6%  
• The backlog has increased again since April, now at 149 patients with 61 diagnosed over 62 days. This is driving continued high risk of non-compliance. | • We have seen high referrals in:  
• Breast  
• Bladder  
• Prostate  
• These have driven the trust PTL and backlog above target  
• Lower GI backlog has persisted and requires further pathway work to address |
| **RTT – May 2018** | • Performance in April 2018 was 82.6%, slight decrease on March and April  
• 23 over 52 week waiters, compared to 35 in March and 41 in April | • Expect persistence of >52 week waiters due to ‘pop-ons’ until Patient Tracking List construction problems are fully resolved | • The quality and availability of our data in this area is a priority for improvement, external support is being procured |
| **A&E – May 2018** | • Overall performance in May 89.8%  
• Both sites similar to performance last year | • Further improvements at RFH via opening of new AAU in mid-May 2018  
• AAU proposal in development at BH | • Performance problems at other trusts, leading to redirections of ambulance and walk-in activity  
• Volatility in attendances and admissions |
62 Day Cancer – Performance Summary

Current Period April: stable, below year, above trajectory and standard at Trust level

% cancer patients waiting < 62 days from GP referral to first treatment

Relative position Apr 2018: 3rd quartile in London

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon Health</td>
<td>93.1%</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>92.9%</td>
</tr>
<tr>
<td>St George's</td>
<td>92.3%</td>
</tr>
<tr>
<td>Kingston</td>
<td>91.4%</td>
</tr>
<tr>
<td>Epsom &amp; St Helier</td>
<td>87.8%</td>
</tr>
<tr>
<td>Barts Health</td>
<td>87.4%</td>
</tr>
<tr>
<td>Barnet &amp; Chase Farm</td>
<td>87.4%</td>
</tr>
<tr>
<td>Kings College</td>
<td>86.9%</td>
</tr>
<tr>
<td>BHR</td>
<td>86.8%</td>
</tr>
<tr>
<td>Imperial</td>
<td>86.7%</td>
</tr>
<tr>
<td>London North West</td>
<td>85.9%</td>
</tr>
<tr>
<td>Royal Free London</td>
<td>85.8%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>85.4%</td>
</tr>
<tr>
<td>Homerton</td>
<td>85.2%</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>84.8%</td>
</tr>
<tr>
<td>Whittington</td>
<td>84.1%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>81.7%</td>
</tr>
<tr>
<td>North Middlesex</td>
<td>79.7%</td>
</tr>
<tr>
<td>UCLH</td>
<td>76.9%</td>
</tr>
<tr>
<td>Guys &amp; St Thomas¹</td>
<td>72.7%</td>
</tr>
<tr>
<td>Peer Average</td>
<td>87.1%</td>
</tr>
</tbody>
</table>

Source: NHS England, June 2018
In April, 4 out of 17 tumour sites accounted for 39% of the trust’s total breaches:

- Upper GI – 2.5 breaches (performance 28.6%)
- HPB – 2.5 breaches (performance 37.5%)
- ENT – 1.5 breaches (performance 0%)
- Unspecified cancer – 1 breach (performance 0%)

Note: the national data submission process has changed and this month the site detail is unavailable. This will be resolved for next month.
## 62 Day Cancer – Diagnosis and Actions

<table>
<thead>
<tr>
<th>What is our diagnosis of what is driving current performance and future risks?</th>
<th>What are our action priorities and what is our status on them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Backlog in breast pathway – may be a result of increased referrals following Public Health England breast cancer awareness campaign</td>
<td>1. Re-plan breast capacity based on recent levels of demand, put in place temporary capacity at Finchley Memorial Hospital</td>
</tr>
<tr>
<td>2. Increase in backlog for Lower GI at Barnet Hospital and recent increases in referrals on this pathway</td>
<td>2. Re-place capacity based on more recent demand data. Further iterations for new straight-to-test element of pathway.</td>
</tr>
<tr>
<td>3. Increase in referrals to prostate and bladder pathways. Public Health England haematuria campaign running over July-August.</td>
<td>3. Re-plan prostate and bladder capacity based on current levels of demand with uplift in capacity for July/August.</td>
</tr>
<tr>
<td>4. Below standard performance on 2 week wait standard in April, leading to risk of increased &gt;62 day backlog in June and July.</td>
<td>4. Re-plan capacity based on more recent estimates of demand.</td>
</tr>
</tbody>
</table>
RTT – Performance Summary

Current Period April 2018: stable and below standard and trajectory

% patients waiting < 18 weeks from referral to treatment

<table>
<thead>
<tr>
<th>Trust name</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homerton</td>
<td>96.0%</td>
</tr>
<tr>
<td>Kingston</td>
<td>94.0%</td>
</tr>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>93.2%</td>
</tr>
<tr>
<td>Croydon Health</td>
<td>92.8%</td>
</tr>
<tr>
<td>North Middlesex</td>
<td>92.1%</td>
</tr>
<tr>
<td>Whittington</td>
<td>92.1%</td>
</tr>
<tr>
<td>UCLH</td>
<td>91.1%</td>
</tr>
<tr>
<td>Guys &amp; St Thomas'</td>
<td>89.1%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>88.8%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>88.2%</td>
</tr>
<tr>
<td>BHR</td>
<td>87.1%</td>
</tr>
<tr>
<td>Epsom &amp; St Helier</td>
<td>86.7%</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>86.1%</td>
</tr>
<tr>
<td>Imperial</td>
<td>84.2%</td>
</tr>
<tr>
<td>Barts Health</td>
<td>84.2%</td>
</tr>
<tr>
<td><strong>Royal Free London</strong></td>
<td>83.2%</td>
</tr>
<tr>
<td>London North West</td>
<td>81.4%</td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>81.2%</td>
</tr>
<tr>
<td>Kings College</td>
<td>80.6%</td>
</tr>
<tr>
<td>St George's</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Peer Average 88.4%

Source: NHS England, June 2018

Relative position Apr 2018: 4th quartile in London

![Graph showing % patients waiting < 18 weeks from referral to treatment, with April 2018 data Highlighted.](image-url)
RTT – Sources of Current Performance

Current Period Performance by Specialty/Hospital Combination

**Barnet Hospital**

- Current Period Performance by Specialty/Hospital Combination
- *Actual breaches minus breaches if achieving 85% standard*

**Royal Free Hospital**

- Current Period Performance by Specialty/Hospital Combination

Current Period > 52 week waiters

- Introduction of new patient tracking list August 2017
- Apr-18 = 41

* Actual breaches minus breaches if achieving 85% standard
## RTT – Diagnosis and Actions

<table>
<thead>
<tr>
<th>What is our diagnosis of what is driving current performance?</th>
<th>What are our action priorities and what is our status on them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Patient Tracking List (the waiting list) continues to suffer from unexpected ‘pop-on’ long-waiting patients.</td>
<td>1. Revise the construction of the RTT Patient Tracking List with support from the Intensive Support Team and external experts</td>
</tr>
<tr>
<td>2. The full suite of waiting list and performance reports is not yet available to operational and clinical teams to enable them to monitor their performance and act on early warnings.</td>
<td>2. These reports will rely on construction of accurate waiting lists. While the RTT list is being reviewed, we are prioritising development of the inpatient and outpatient waiting lists.</td>
</tr>
<tr>
<td>3. Need for productivity improvements in outpatients and theatres.</td>
<td>3. The outpatients productivity programme work has started and we are refreshing our theatres productivity programme. This will include a re-designed theatres productivity dashboard.</td>
</tr>
<tr>
<td>4. Need for close oversight of new &gt;52 week waiters.</td>
<td>4. Weekly PTL reviews of &gt;40 week waiters and regular escalation meetings for specialties of concern.</td>
</tr>
</tbody>
</table>
A&E – Performance Summary

Current Period May 2018: stable and similar to last year, on trajectory but below standard

% patients waiting < 4 hours in A&E

Relative position May 2018: 2nd quartile in London

<table>
<thead>
<tr>
<th>Trust name</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea &amp; Westminster</td>
<td>95.7%</td>
</tr>
<tr>
<td>Homerton</td>
<td>94.6%</td>
</tr>
<tr>
<td>Epsom &amp; St Helier</td>
<td>93.5%</td>
</tr>
<tr>
<td>St George's</td>
<td>93.3%</td>
</tr>
<tr>
<td>Kingston</td>
<td>91.9%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>90.1%</td>
</tr>
<tr>
<td>Royal Free London</td>
<td>89.6%</td>
</tr>
<tr>
<td>Barnet Hospital</td>
<td>88.9%</td>
</tr>
<tr>
<td>Whittington</td>
<td>88.4%</td>
</tr>
<tr>
<td>Croydon Health</td>
<td>88.2%</td>
</tr>
<tr>
<td>London North West</td>
<td>87.6%</td>
</tr>
<tr>
<td>Barts Health</td>
<td>87.6%</td>
</tr>
<tr>
<td>Imperial</td>
<td>86.9%</td>
</tr>
<tr>
<td>Royal Free Hospital</td>
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<tr>
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<tr>
<td>Guys &amp; St Thomas'</td>
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<tr>
<td>North Middlesex</td>
<td>85.2%</td>
</tr>
<tr>
<td>BHR</td>
<td>84.1%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>80.5%</td>
</tr>
<tr>
<td>Kings College</td>
<td>79.8%</td>
</tr>
</tbody>
</table>

Peer Average: 88.2%

Source: NHS England, June 2018
A&E – Barnet Sources of Current Performance

**Current Period Performance**

Performance against 4 hour standard

Performance is above trajectory and continues to improve
The improvement plans continue to embed changes:
- Ambulance handover
- Ambulatory majors
- ED workforce
- Flow / length of stay

**DTOC and MOs**

Total DTOC and MO bed days

DTOC by borough – May 2018

<table>
<thead>
<tr>
<th></th>
<th>Herts</th>
<th>Barnet</th>
<th>Enfield</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care</td>
<td>29</td>
<td>13</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>NHS</td>
<td>195</td>
<td>96</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>224</td>
<td>109</td>
<td>56</td>
<td>23</td>
</tr>
</tbody>
</table>
# A&E – Barnet Diagnosis and Actions

<table>
<thead>
<tr>
<th>What is our diagnosis of what is driving current performance?</th>
<th>What are our action priorities and what is our status on them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Flow has improved bed occupancy has reduced</td>
<td>1. Focus on early discharge, continues. Bed closure programme to allow deep cleaning is taking place</td>
</tr>
<tr>
<td>2. We currently have decreased DTOC &amp; stranded patent numbers</td>
<td>2. Daily &amp; weekly reviews</td>
</tr>
<tr>
<td>3. ED workforce vacancies cause inconsistent staffing levels &amp; skill mix</td>
<td>3. Workforce plan in place &amp; reviewed weekly but the divisional team.</td>
</tr>
</tbody>
</table>
A&E – Royal Free Sources of Current Performance

Current Period Performance

Performance against 4 hour standard

Similar to performance last year; below standard

Current actions
- Improved flow through the hospital (high number of discharges), has reduced delays for beds
- Improved streaming and ambulance handover times
- AAU opened 17th May

DTOC and MOs

Total DTOC and MO bed days

DTOC by borough – May 2018
# A&E – Royal Free Diagnosis and Actions

<table>
<thead>
<tr>
<th>What is our diagnosis of what is driving current performance?</th>
<th>What are our action priorities and what is our status on them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ED process delays. Breach reports suggest that 40%-50% of current breaches are attributed to ED processes.</td>
<td>1. CPG work now focusing on improvement in: Streaming, the SitRep process and AAU. Streaming is improving with 73% of patients last week seen within 15 minutes.</td>
</tr>
<tr>
<td>2. ED workforce capacity. We need to complete our middle grade and consultant establishments.</td>
<td>2. Revised ED workforce plan has been developed, with support from ECIP.</td>
</tr>
<tr>
<td>3. In-hospital flow. Current average length of stay for patients who stay at least 1 day is 7.3 days.</td>
<td>3. The new Adult Assessment Unit (AAU) will open in May, and focus is on delivering a new models of care for this</td>
</tr>
<tr>
<td>4. Out of hospital capacity. DTOCs have increased as we have improved our process for capturing information. The % of stranded patients has declined as we have focused on MDT reviews of these patients.</td>
<td>4. Improved focus on DTOCs and additional resource within the discharge team has led us to identify more patients who are delayed, and therefore an increase in DTOCs. Each division has a weekly stranded patient review.</td>
</tr>
</tbody>
</table>
CHAIRMAN’S AND CHIEF EXECUTIVE’S REPORT

Executive summary
This is a combined chairman’s and chief executive’s report containing items of interest / relevance to the board.

Action required
The board is asked to note the report.

Report From D Dodd, group chairman and D Sloman, group chief executive
Author(s) Alison Macdonald, board secretary
Date 18 June 2018
CHAIRMAN’S AND CHIEF EXECUTIVE’S REPORT

A TRUST DEVELOPMENTS

CHASE FARM HOSPITAL REDEVELOPMENT UPDATE

The redevelopment of Chase Farm Hospital remains on budget and the handover of the new hospital is scheduled for 12 July 2018. This is dependent on the building passing mechanical and electrical (M&E) safety tests in advance of this date.

It is planned that the first patients will be seen in the new hospital on 30 July 2018, in outpatients. A detailed timetable of sequential moves has been agreed, whereby all other services will move during July, August and September. The communications team are implementing a plan to communicate key dates to stakeholder groups. Letters are being sent to patients whose next appointment will be in the new hospital. Works to roads and landscaping will be completed in 2019, after which an official opening ceremony will take place.

The trust project team continues to support staff in preparing to move into the new hospital. Designated move managers have been identified in each department, and teams have been provided with move checklists and plans setting out when they will receive training for new information management and technology (IM&T) systems. Significant clinical engagement is underway to sign off the new IM&T systems and oversee the transition to a digital paperless hospital at Chase Farm. This work will realise efficiencies, making a major contribution to the trust’s financial strategy. Staff consultations are underway to agree shift patterns in the new hospital, and effect the changes required to move into the new hospital.

ROYAL FREE HOSPITAL EMERGENCY DEPARTMENT REDEVELOPMENT UPDATE

The Royal Free Emergency Department redevelopment was undertaken under two contracts. The first has provided a new dedicated paediatric emergency department and waiting area, new staff facilities and office accommodation and a new ambulatory care unit.

Contract 2 started on 26 September 2016 and comprised three main phases. The first phase of the construction works delivered Part 1 of majors, a new reception desk, and the rapid assessment and treatment area including new London Ambulance Service handover facilities. Phase 2 which provides a new imaging facility (including two x-ray rooms and one CT suite) and a six bedded resuscitation unit was completed in November 2017. Works are now completed on the largest phase which completes the majors’ facility and delivers a new 30 bedded adult assessment unit (AAU). These facilities went live on 17 May 2018 as planned. The remaining works are underway and allow for some minor changes to allow temporary rooms to convert into their final usage. The project has made good progress and the clinical and project teams are working closely to maintain clinical operations at all times.

THE PEARS BUILDING

The demolition of the car park is now complete and work is starting on the piling for the Pears Building, which will house the UCL Institute of Immunity and Transplantation. During the demolition work there were some concerns about dust voiced by local residents and the neighbouring school, despite measures being taken to minimise this. It is expected that any dust issues will now recede.
Discussions are underway with design companies and local schools as part of a project to provide some informative and attractive artwork on the extensive area of hoardings. It is hoped to have these in place in the autumn.

The construction working group, which includes local residents, representatives of the school and St Stephen's Church, Camden councillors and officers, held a meeting on 26 June. The terms of reference have been broadened and processes changed to allow community input into the meeting agendas. On 28 June there will be a "drop-in" in the Peter Samuel Hall, open to all, which will provide information about the building and the research programme, as well as an opportunity to ask questions.

**B REGULATION**

**INFORMATION COMMISSIONER’S OFFICE (ICO) UNDERTAKINGS**

The trust continues has now met all the requirements of the undertakings agreed with the Information Commissioner. The final stage of this was the publication of the report of the audit carried out by Linklaters LLP into the use of the Streams app (designed to deliver improved care to patients with acute kidney injury (AKI)), which took place on 12 June 2018.

The audit concluded that RFL’s use of Streams is lawful and complies with data protection laws. While the audit identified areas in which further improvement could be made, it contains the following important conclusions:

- DeepMind only uses patient information for the purpose of providing Streams. It does so under the direction of RFL and in strictly controlled conditions. DeepMind is not permitted to use patient information for any other purpose.

- Streams does not use artificial intelligence. Instead, it implements a simple decision tree used across the whole of the NHS.

- The audit revealed nothing that casts doubt on the safety and security of the patient information used in Streams. The audit confirmed appropriate systems and controls are in place to protect patient information.

Streams is a secure instant alert app which delivers improved care for patients by getting the right data to the right clinician at the right time. Similar to a breaking news alert on a mobile phone, the technology notifies nurses and doctors immediately when test results show a patient is at risk of becoming seriously ill, and provides all the clinical information they need to take action.

Each year, many thousands of people in UK hospitals die from preventable conditions like AKI, because the warning signs are not picked up and acted on in time. AKI is estimated to cause 40,000 deaths and cost the NHS over £1 billion every year.

Streams integrates different types of data and test results from a range of existing IT systems used by the Royal Free Hospital. Because patient information is displayed in one place – on a mobile application – it reduces the administrative burden on staff and means they can dedicate more time to delivering direct patient care.
The Streams app was built in close collaboration between experts at DeepMind and clinicians at the Royal Free London. It was introduced in January 2017 and is already helping to provide better, safer and faster care to our patients. Nurses report it is saving them around two hours each day – time which would previously have been spent looking through paper patient notes.

C  BOARD AND COUNCIL MATTERS

ANNUAL MEMBERS’ MEETING

The annual members’ meeting takes place on 18 July in the Sir William Wells atrium at the Royal Free Hospital.

This is an opportunity for patient, public and staff members to hear about the trust’s achievements over the last year, some of the latest developments and our plans for the year ahead. There will also be the opportunity to put questions to members of the council of governors, who have been elected to represent members’ interests, and the trust board.

Doors will open at 5pm when there will be a range of display stands showcasing the trust’s achievements and plans for the future. Light refreshments will also be available.

D  LOCAL NEWS AND DEVELOPMENTS

PRIME MINISTER’S VISIT TO THE ROYAL FREE HOSPITAL

The prime minister announced the government’s vision for the future of the NHS at a visit to the Royal Free Hospital on 18 June. She was joined by health secretary Jeremy Hunt, chancellor Philip Hammond and the chief executive of the NHS Simon Stevens, and the speech was attended by some of the most senior leaders in the NHS, and staff from across the Royal Free London. The prime minister chose the Royal Free London to speak about how the government intended to “secure the future of the NHS: now and for generations to come”.

Ahead of her speech to a packed auditorium, the prime minister visited the Royal Free Hospital’s children’s ward to speak to staff, patients and parents. She also heard about the progress of the Royal Free London group which was established in July 2017.

COMMUNICATIONS BOARD REPORT: MAY 2018

Media coverage

The trust was mentioned in 236 stories. In addition, we were featured in BBC News coverage about a kidney transplant at the Royal Free Hospital. This had nine million viewers.

Main positive story: BBC News at 6 and 10 on 29 May, showed kidney donor Prafula Shah’s operation taking place at the Royal Free Hospital, conducted by Mr Colin Forman. Meanwhile her niece, Shakti, who has chronic kidney disease, was in a nearby theatre at the
hospital, receiving another person’s kidney (part of the ‘paired donation’ sharing scheme). Prafula's experience was part of a wider story about the shortage of BME donors.

The table below shows the sentiment of press mentions in May:

<table>
<thead>
<tr>
<th>May</th>
<th>Royal Free Hospital</th>
<th>Barnet Hospital</th>
<th>Chase Farm Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>48</td>
<td>2</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Neutral</td>
<td>101</td>
<td>43</td>
<td>2</td>
<td>146</td>
</tr>
<tr>
<td>Negative</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>45</td>
<td>2</td>
<td>236</td>
</tr>
</tbody>
</table>

Digital Communications

Total number of Facebook followers: 5646 (+ 97) Number of Posts: 37, reaching 82k people
Total number of Twitter followers: 15,522 (+151) Number of Tweets: 97, reaching 207k people.

Our top tweet was a social share of the No Hospital is an Island video on YouTube which showcases our clinical practice groups. The film can be seen here https://www.youtube.com/watch?v=VlyamewFGY.

Internal communications

Digital transformation: as part of our activity to engage staff with the roll out of the new electronic patient record (EPR), we were delighted that the special week-long future state validation event saw 400 attendees, with 80% saying that they were confident with the new system. Future comms includes a suite of ‘The face of EPR’ posters and banners, a new Freenet hub and a newsletter.

Dementia Action Week: we celebrated Dementia Action Week by asking staff to take action to make positive changes for people affected by dementia. As part of this, we promoted the launch of the pioneering radio session, the ‘Sundown Sessions’ – developed by Royal Free Radio and Danielle Wilde, trust dementia lead. The show is ground-breaking in its use of hospital radio and volunteers as a clinical intervention.

GDPR: we helped raised staff awareness around the changes to the General Data Protection Regulation by creating Freenet, screensaver and chief executive’s briefings content. We also supported the update of our public-facing information, including the website and the messaging around each hospital, updating and distributing the trust’s ‘How we use and share information’ leaflet.

**E NATIONAL NEWS AND DEVELOPMENTS**

**FIVE YEAR FUNDING SETTLEMENT FOR THE NHS**

During her visit to the Royal Free Hospital, the prime minister announced a new five year funding settlement for the NHS, giving real terms growth of more than 3% for the next five years. She has also tasked the NHS with producing a 10-year plan to improve performance, specifically on cancer and mental health care, and unpick barriers to progress. The main points are summarised below.
Government reveals more money for the NHS

- The government has announced a major new package of funding for the NHS covering the five financial years from 2019-20.
- The average annual uplift is 3.4 per cent per year above inflation – based on Office for Budget Responsibility projections.
- The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.
- This will equate to £20.5bn more revenue in real terms compared with 2018-19.
- A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.
- The funding is for the NHS England commissioning budget only. This means it does not include capital funding, public health, health education, or social care.
- In an appearance in front of the Public Accounts Committee, the NHS chief executive said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.
- The NHS chief executive also told the Public Accounts Committee that the extra money does include funding for an increase in Agenda for Change salaries from next year.

A 10 year plan

- In return for the increase in funding, the NHS has been tasked to develop a 10-year plan, via an “assembly” convened by national leaders. The prime minister has emphasised that this should have strong clinical input.
- The 10-year plan, which will likely be delivered by the autumn budget, should set out how the service intends to deliver major improvements in mental health and cancer care.
- Ministers may be considering legislative reform: the prime minister described the number of contracts held between NHS organisations as a “problem”, and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.
- The prime minister set out five priorities for the NHS: Putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention; and “true parity of care” between mental and physical health.
- The prime minister said she would like to see the 10-year plan set out ambitious “clinically defined access standards” for mental health.
- Finally, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that ministers may be willing to reconsider key performance standards.
Report from the quality improvement and leadership committee (QILC) meeting held 21 May 2018

Executive summary

To follow is a report outlining the key items discussed and actions taken at the QILC meeting on 21 May 2018.

QILC aligned goals and Board Assurance Framework (BAF) risks

The committee received the standard report in respect of its goals and BAF risks. It was noted that the group director of planning was working with the individual hospitals on developing a set of goals and priorities at site level. This work was ongoing at the time of the meeting but it was hoped that an update on the agreed hospital strategies would be available by the July QILC.

Quality Improvement (QI)

- ICU nurse retention – Joy at Work

The committee received a presentation on the ICU retention project, the aim of which was to reduce qualified nursing turnover in ICU at Barnet Hospital (BH) and Royal Free Hospital (RFH) to 25% by December 2018 by improving Joy in Work. It heard of the work undertaken and planned to prevent nurses leaving the trust, including around education and training, flexible working and improved rostering. The committee was pleased to see that staff were happier as a result of choosing when they wanted to be on shift thus improving their work / life balance, and there had been a number of added benefits in that there was now greater staff retention, less sickness absence and improved recruitment. A particular success of the project was the fact that the target of reducing qualified nursing turnover in the units by 25% had been achieved within the first 6 months of the project.

- General QI update

The committee’s view was sought on key three areas of QI, namely the capability of staff and the organisation, building a strong infrastructure and the proposed ‘signature initiative’ – Joy in Work. It noted that discussions had been had with the local executive committees (LECs) on how to align the demand for QI work with the individual site’s priorities. In addition, it endorsed the request by the QI team to propose new board metrics and to implement appropriate learning system solutions, and also endorsed the ‘signature initiative’ – Joy in Work. A request was made for a paper to be taken to the June QILC on how the signature initiative, staff engagement and leadership would come together.

Trust CQC self-assessment – Q3 2017-18

This was the first iteration of the report completed under the new group operating structure with management and coordination of the self-assessments having been devolved to the divisions and under new teams. The committee noted that there were a number of factors that were influencing performance, e.g. greater staff reflection on Never Events, and which
meant it was a challenge to self-assess. This was compounded by the fact that self-assessing a service as ‘good’ or ‘outstanding’ was equally challenging.

**Patient involvement update**
The committee approved the four tier approach (by the nature of activity required) to patient involvement but suggested that this work be rolled out in stages, e.g. Tier 1 (the most high level) undertaken first. It was noted that a paper on the financial ask was due to go to the Royal Free Charity (RFC) board meeting in June and would outline those board committees that would be affected by Tier 1. It was noted that the RFC and the Point of Care Foundation were willing to support the patient involvement initiative but they would want to see that this was meaningful and not simply a tick-box exercise. It was agreed that the group chief nurse would take a paper on patient involvement to the next group executive committee.

**Leadership development**
The committee received two members of staff who had attended the meeting to talk on their experience of having participated in the Step up to Lead programme and the Licence to Lead programme. Both experiences had been positive and particular note was made to working with and learning from others, coaching and how that had provided a greater understanding of how to assess and develop managers and junior staff in the right way, and collaboration and seeing the person behind the role. The committee considered the feedback to have been insightful and that it was helpful to hear of the participant’s experience first-hand.

**Equality**
- **Workforce race equality standards (WRES)**
The committee received an update on progress against the WRES. It noted that 1% of staff had not registered their ethnicity but the trust now had a more complete level of ethnicity data from which to work from; that work was continuing on ensuring all recruiting managers at all levels sitting on trust interview panels had undertaken unconscious bias training; and a new model of staff listening events was being developed and dates agreed. The committee discussed how the trust could recognise if there was an issue with unconscious bias and if so, how would it monitor the solution, and also how could recruitment managers be supported on overcoming any unconscious bias they may hold.

- **Workforce disability equality standards (WDES)**
The committee agreed that those staff that had disclosed a disability on ESR should have the final say on which logo they considered best represented the trust’s staff disability forum. The committee noted that efforts were being made on raising awareness around disability and asking staff to declare a disability as the numbers declared on ESR were at odds with those that had made a declaration in the recent staff survey. The QILC appreciated that without this information and an improved data set it would be difficult for the trust to identify where improvement action around disability was required.

- **Equality Delivery System 2 (EDS2) progress update**
The committee agreed not to endorse the new approach to the ED2 grading event.

**Staff satisfaction and staff engagement**
The committee noted the large amount of work underway in respect of staff satisfaction and engagement. It was noted that feedback from the trust-wide Friends and Family Test was being analysed with the LECs undertaking thematic reviews.

**Quality Account (QA) 2017-18**
The committee was assured that QILC’s request to change the reference to ‘stakeholders’ in priority 1.3 to ‘patients and carers’ had been undertaken and was reflected in the version of the QA being presented to the trust board on 23 May 2018.
Local patient and staff experience and workforce committees (PSE&WC)
Due to apologies having been received, the committee only received an update from the patient experience element of the RFH’s PSE&WC which had reviewed compliance issues, quarterly PALS and complaints reports, specifically the timeliness in managing and responding to those, and dementia work.

The committee was asked to note that the trust would be implementing Sundown radio sessions for its inpatients; these would provide music and memories from years gone by every evening to help staff manage ‘sundowning’ in patients. ‘Sundowning’ was the clinical term used to describe the changes in behaviour that occur with people with dementia in the evenings. The committee noted that this was the first time that this would have been used in a clinical setting and would be of benefit to staff.

Action required
The trust board is asked to note the report.

Trust strategic priorities and business planning objectives supported by this paper

| 2. | Excellent user experience – to be in the top 10% of relevant peers on patient, GP and staff experience |
| 4. | Excellent compliance with our external duties – to meet our external obligations effectively and efficiently |

CQC Regulations supported by this paper

| Regulation 9 | Person-centred care |
| Regulation 13 | Safeguarding service users from abuse and improper treatment |
| Regulation 16 | Receiving and acting on complaints |
| Regulation 18 | Staffing |

Risks attached to this project/initiative and how these will be managed (assurance)
Any risks would be outlined in the report.

Equality analysis
No identified negative impact on equality and diversity

Report from Jenny Owen, non-executive director and chair of the QILC
Author(s) Veronica Jackson, committee secretary
Date 31 May 2018
**Executive summary**

The CSIC met on 14 May 2018. The key issues discussed and actions agreed are outlined below.

**CSIC aligned goals and Board Assurance Framework (BAF) risks**

The committee discussed its ‘Top 3 for citation’ goal, namely how to ensure both NHS (consultant) and clinical academic research was captured within that, and ensuring the trust RFL library had the right infrastructure to maintain a correct record of all the documentation required.

A discussion was also had in respect of ‘zero avoidable infection’; the committee considered the goal needed to cover a broader level of harm (e.g. falls, serious incidents (SIs) etc.), noting that zero avoidable harm had been a focus of the now disbanded patient safety committee and that it would be preferable to maintain this wider focus. There was general agreement for the goal to be modified, especially as this would offer a level of assurance to the group board. This would be discussed further at the CSIC in June.

**Clinical Pathway Groups (CPGs)**

- **CPG pathway – haematuria**
  The committee received a presentation on the CPG pathway – haematuria, the aim of which had been to implement a clinical effective pathway with quick access to tests to tell patients if they had cancer and offer a personalised plan of care. The committee heard of the successes seen; the 31 day target for first treatment (haematuria) had been positive, as had the 62 day target for definitive treatment following urgent GP referral (haematuria) which, on occasion, had achieved 100%. The committee was pleased to note that there had been patient involvement in the pathway, with patient feedback having been sought through the standardised surveys. In terms of future plans, efforts would focus on digitisation of the pathway to improve data capture and accessibility for review; reviewing the pathway from patients’ perspective; further patient co-design; and cost benefit analysis.

- **CPG general update**
  The committee noted the development of cost benefit analysis methodology to support the CPG pathway teams to identify potential benefits to be realised through the reduction of unwarranted variation. Initially, the cost of variation would be a theoretical exercise to model the costs against the benchmarks in the measurement plan. Subsequent more bespoke costing work would be required to identify the main cost effects of the actual pathway change with a timeline for implementation and mechanisms for monitoring, including the digitisation of outcomes. It was noted that work was also underway in respect of patient co-design to ensure the experience and views of the patient were taken on board.
Consultant level outcomes 2017-18
The committed noted that of the 15 specialist areas published on NHS Choices, five were relevant to the trust’s services. No individual surgeon’s outcome was identified as a cause for concern and the committee noted that the aim was to use this data in clinician appraisals. The chair considered that this data would sit better with the local clinical performance and patient safety committees (CPPSCs) with the site medical directors flagging any issues / areas of concern to CSIC as required. However, it was agreed that the principles around this work would continue to come to CSIC.

Review of mortality statistics
The trust continued to have a lower than expected mortality on both SHMI (Summary Hospital-level mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio). Barnet Hospital had a higher mortality than the trust’s other hospital sites though mortality rates from all sites fell within or better than ‘expected’ levels. In addition, there were no diagnosis groups with negative outlier SHMI values.

Serious incidents (SIs) performance report
The CISC was maintaining a watching brief on the number of overdue SIs to ensure they did not increase significantly but appreciated that this would be a challenge due to the lack of staff resource within the SI team currently. The chair considered it was important to invest the necessary resource to ensure there was no continuing increase in the number of overdue SIs and asked that efforts be maintained to ensure the numbers were down by the September CSIC.

Never Event (NE) action implementation plan
The committee considered that the patient safety programme (PSP) CPG was a good starting point for improving and achieving sustained traction on safer surgery, with efforts made in ensuring the relevant guidelines on counting in theatres were rolled out and implemented across the trust. The committee discussed what could be done to highlight surgical NEs in theatres, plus better communication around NEs more widely. It was noted that there were a number of events on NEs taking place across the trust but there was a question as to whether the right people were attending those events. Furthermore, the committee considered the culture of the organisation in the context of NEs, specifically that good surgical performance should be regarded alongside financial improvement, patient safety etc. as a trust priority.

Annual safeguarding report
The committee received its first annual report from the integrated safeguarding committee. It noted the detail within which highlighted the large amount of work undertaken and progress made throughout the year and which offered assurance that the trust was fulfilling its responsibilities to promote the welfare and safety of people who used its services.

NIHR portfolio clinical research studies
The committee noted that the recruitment achieved in 2018-19 was 6% lower than the previous year due to the loss of a number of observational studies and that the trust had failed to meet its aspirational strategic target but did meet the Clinical Research Network target.

Education
  • Undergraduate medical student feedback
The committee noted that there had been further improvement in the feedback received compared to the previous year. CSIC’s views would be sought at its next meeting on whether it would wish to receive additional feedback on faculty teaching and Chase Farm Hospital teaching in future reports.
• Report from the education workforce and development committee
The committed noted that the next round of the General Medical Council survey was underway and the data arising from that would be reported back to CSIC in due course. The committee was pleased to see that 84 apprentices had started the trust in FY18; this was well above the numbers recruited previously and efforts were underway to meet the national target of 220 annually by 2020.

Reports from the local clinical performance and patient safety committees (CPPSCs)
The committee agreed that there should be consistency across the local CPPSC agendas, namely a portion of their agendas should be the same across all three committees, with the remainder focussing on local issues specific to that site. The CSIC would receive an executive summary, in addition to the CPPSC minutes, highlighting two key areas of focus that the local committees considered were important for the CSIC to be aware of. This would help to identify whether triangulation of any matter / trend was required.

**Action required**
The board is asked to note the report.

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<tr>
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<td>Meeting nutritional and hydration needs</td>
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<td>Good governance</td>
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<td>Staffing</td>
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<td>Regulation 19</td>
<td>Fit and proper persons employed</td>
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<td>Regulation 20</td>
<td>Duty of candour</td>
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**Risks attached to this project/initiative and how these will be managed (assurance)**

N/A

**Equality analysis**

• No identified negative impact on equality and diversity

**Report from** Prof Anthony Schapira, non-executive director and chair of CSIC
**Author(s)** Veronica Jackson, committee secretary
**Date** 5 June 2018
Executive summary
The group services and investment committee (GSIC) held on 14 June 2018. The key agenda items are outlined below.

Governance of subsidiary undertakings
The committee was asked to consider and approve the governance framework and board composition of the Royal Free London Property Services Limited board.

RFL Property Services Company Limited
The committee received a paper setting out the ‘red lines’ that the trust must seek shareholder approval for, and the delegated authorities it will be subject to in its day to day governance. A separate update was provided in respect of novating the building services contract from the original procuring entity to the new RFL Property Services Company Limited.

Radiology – dialogue 2
The committee received a report on starting the process of procuring the urgent replacement of priority radiology equipment. Funding sources for this equipment would be reviewed through the committee at a later stage and any funding would need to fit into the long term strategic direction for radiology equipment investment.

Catering services
The committee received an update report on the future provision of catering services (patient feeding and staff and visitor restaurant) on the Royal Free Hospital site.

Queen Marys House (QMH)
The committee received a paper setting out the options for any potential development/disposal of QMH.

GSIC goals and Board Assurance Framework risks
The committee undertook regular review of its group goals;

- efficiency leader on corporate services
- CFH deficit eliminated
- double contribution of private patients
- being a digital exemplar
- efficiency leader on middle office operations
- proceeds from QMH (>£75m)
- £5m benefit from improved asset financing
The committee also reviewed its forward planner.

**Action required**

The board is asked to note the report.

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| CQC Regulations supported by this paper |
|---|---|
| Regulation 15 Premises and equipment |
| Regulation 17 Good governance |
| Regulation 13 Financial position |

**Risks attached to this project/initiative and how these will be managed (assurance)**

N/A

**Equality analysis**

No identified negative impact on equality and diversity

**Report from** Wanda Goldwag, non-executive director  
**Author(s)** Duncan Gordon-Smith, trust secretary  
**Date** 19 June 2018
Executive summary

To follow is a report highlighting the key discussion items and agreed actions at the audit committee workshop held 11 May and the audit committee meeting held 18 May 2018.

Action required

The board is asked to note the report.

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<td>Regulation 13</td>
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Risks attached to this project/initiative and how these will be managed (assurance)

Nil.

Equality analysis

- No identified negative impact on equality and diversity

Report from Mary Basterfield, non-executive director and chair of the audit committee

Author(s) Veronica Jackson, committee administrator

Date 20 June 2018
**AUDIT COMMITTEE WORKSHOP**
On 11 May 2018, the audit committee held its workshop with key members and financial colleagues present to review the trust’s 2017-18 annual accounts and the working drafts of the annual report, including the audit committee’s annual report, and quality report in advance of the formal audit committee later that month. Following discussion, a number of requests for additional information were made in respect of the trust’s asset valuation calculations and the annual accounts, and amendments to the annual report and quality report were suggested, in particular around strengthening the narrative around the RFL group. Members agreed to defer review of the draft audit committee’s annual report to the formal audit committee on 18 May 2018 as that would enable the report to be updated with the outstanding detail arising from the end of year external and internal audit reports.

**AUDIT COMMITTEE MEETING**
The committee held its regular meeting on 18 May 2018. The key matters discussed and action taken are outlined below.

**ASSURANCE ITEM**
- **Speaking up**
The trust’s speaking up guardian and chair of staff side had attended the meeting to provide separate assurance to the audit committee on the trust’s speaking up processes. Discussions centred on the number of open and closed speaking up cases; how the speaking up champions were faring in their roles, noting that feedback had been positive thus far; and creating a culture in which staff felt confident in raising speaking up incidents and taking their concerns to the next level. In closing, the committee noted the report and trend data within, and thanked the speaking up guardian for their helpful insight into how speaking up processes were being embedded and received across the trust.

**RFL NHS FT ANNUAL REPORT 2017-18**
- **Annual accounts**
The committee noted that there had been a minor amendment to the accounts following the workshop the previous week. It also received a follow up report clarifying the Building Cost Information Service (BCIS) process and calculations on the trust’s asset valuation 2017-18; the chair considered the report to be clear and confirmed that it addressed the committee’s queries. The trust’s external auditors noted that they had considered the valuation and impairment of the trust’s land and buildings as part of their audit of the trust’s accounts and confirmed that there was no issue to report.

The committee accepted the change to the accounts, and the external auditor’s confirmation that the approach taken in respect of asset valuation was correct. It approved the end of year accounts and recommended they be submitted to the trust board for their sign off at the board meeting on 23 May 2018.

- **Going Concern**
The committee received a report on Going Concern and post-balance sheet events assessment for the 2017/18 accounts which was supported by the cash mitigation plan 2018-19. The report confirmed that the directors had a reasonable expectation that the trust had, or had access to adequate resources (including PDC borrowing) and was performing in line with its four year recovery plan, and therefore they continued to adopt the going concern basis in preparing the accounts.

The committee approved the Going Concern report and the chair requested an update on the cash position, cash management approach and controls at its September meeting.

- **Annual report**
The committee noted that the comments on the report arising from the workshop had been addressed and there had been a number of additional edits made to some sections of the
report which the committee accepted. It considered that the revised report read much better and was clearer. A further change was made in respect of highlighting within the report the trust’s performance on its capital spending, e.g. ward refurbishment.

Subject to the further change above, the committee approved the annual report and recommended it be submitted to the trust board for their sign off at the board meeting on 23 May 2018.

- **Audit committee annual report**
  Each year the committee administrator drafts an annual report to provide the trust board with an overview of the work undertaken by the committee during the year and to identify how it has fulfilled the duties required by the trust board. Subject to a minor edit in respect of NHS Protect having been renamed the NHS Counter Fraud Authority, the committee approved the audit committee annual report for inclusion in the RFL NHS FT annual report and accounts 2017-18.

For ease of reference, a copy of the audit committee annual report 2017-18 is attached at Annex A.

- **Quality account**
  The committee received the next iteration of the quality report. It suggested that the report could benefit from greater detail in respect of the RFL group as this would help improve the flow of the document particularly in terms of explaining the variation across the different pathways and workstreams. The committee appreciated that the narrative in the quality account 2018-19 would be very different from that currently as it would be more reflective of the RFL group’s clinical successes, e.g. pulling out the work of the clinical practice groups.

**EXTERNAL AUDIT**
- **Report to those charged with governance (ISA260)**
  The committee received the external auditor's report in respect of their audit of the trust for the year ended 31 March 2018. It was pleased to hear that the year-end audit had gone well in terms of process and the external auditors offered their thanks to the trust’s finance colleagues for their assistance.

  The external auditors confirmed that they foresaw no issue that would hold up their approval of the trust’s accounts. They highlighted that they had considered clinical income to be a significant risk within their audit plan given a prior year adjustment having been recorded by the trust in 2015-16, and challenges identified with the financial health of local commissioners and their ability to pay contract values billed by the trust, and that this area had been given considerable focus during their work.

  The committee noted that the external auditors were expecting to issue a modified conclusion on Value for Money in 2017/18. However, there was recognition of the trust’s efforts in reducing its underlying deficit and improving its underlying financial position, and having achieved £44m in savings over the year. It was suggested that these positives be brought upfront in the report. This would ensure the report felt more balanced in terms of showing what had gone well and what outstanding financial matters still needed to be resolved.

  In closing, the committee noted the draft ISA20 report, and the external auditors agreed to strengthen the comments in relation to financial improvement plan delivery within the report and recirculate to members for information.

- **Limited assurance report on the quality accounts and mandated indicators**
  The committee noted that the external auditors were expected to issue a qualified assurance report. They had identified a number of data quality issues in respect of the
mandated indicators, i.e. percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge. The committee had discussed data quality on a number of occasions, but considered it needed to follow up on these issues specifically. It was agreed that the group director of planning would provide a report on RTT reporting and data quality at the committee’s next meeting.

The external auditors confirmed that no issue had been identified in respect of local indicator chosen by the council of governors, i.e. maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers. They would ensure a segment on that indicator was included in the final version of their ISA20 report.

In closing, the committee noted the draft ISA20 report in respect of the comments on the quality accounts and mandated indicators.

- **Management letter of representation**
The trust's external auditors had no issue and confirmed that the letter, with the changes accepted, should be submitted to the trust board for signing at its meeting on Wednesday 23 May 2018.

The committee noted the management letter of representation and approved its submission to the group trust board.

**INTERNAL AUDIT**

- **Progress report and technical update**
The committee noted internal audit's progress report. Due to unavoidable delays, it had not been possible to present the internal audit review of the trust's digital strategy 2018/19 at the meeting. It was agreed that this be circulated to members as soon as it was finalised for comments / questions.

- **Follow up recommendations**
The committee noted that there had been a concerted effort to follow up on outstanding recommendations. There were currently 18 overdue; there was no medium priority recommendation that was overdue by more than six months.

It was noted that the data quality recommendations had been subject to revised implementation dates and as such were extremely overdue. A request was made for these to be finalised by September and if that was not the case, then the committee would need to look at raising their priority rating. It was agreed that the committee would receive a report outlining the overdue data quality recommendations alongside their original and revised implementation dates, plus a response from the relevant executive lead, at its September meeting.

- **Annual report 2017/18 and Head of Internal Audit Opinion (HoIA) 2017/18**
The committee was pleased to see the overall rating of 'significant assurance with minor improvements required' in the HoIA opinion. This confirmed that there was generally a sound system of internal control which was designed to meet the trust’s objectives and that controls in place were being consistently applied in all key areas reviewed.

- **Final internal audit plan 2018/19**
The committee received internal audit’s final audit plan. In terms of the group governance structure, the committee noted that the bulk of the internal audit work would largely remain with the audit committee as the primary reporting mechanism. However, internal audit would also be attending individual hospital boards and liaising with a greater number of hospital leads on the internal audit reviews in future. The chair was conscious that the hospital unit
leads may have had limited interaction with internal audit, an issue that the committee would need to be mindful of. It was suggested that it would helpful going forward for the committee to have a table highlighting what reviews had been reviewed elsewhere and by whom. In addition, it was agreed that the group chief finance officer would undertake a piece of work on raising internal audit’s profile across the organisation.

The committee approved the revised internal audit plan 2018/19.

LOCAL COUNTER FRAUD SPECIALIST (LCFS)
- **LCFS annual report 2017/18 including outcome of the self-review tool**
The committee noted that the trust had received an amber rating overall in respect of the Self-Review Tool. It considered it would be helpful to see benchmarking of the trust’s compliance against other NHS foundation trusts and the trust’s counter fraud providers agreed to undertake this.

GOVERNANCE
- **Board assurance framework (BAF)**
The committee noted the current status of the BAF and the process around which the BAF was created and managed.

  - **Well led**
The committee received an update on the trust’s well-led assessment which would dovetail with the Care Quality Commission’s (CQC) regulatory assessment of well-led including key lines of enquiry which formed part of the CQC’s inspection process. Discussions were had on ensuring the trust’s governance processes were robust; ensuring there was consistency at a group and hospital level; the timeframe for the well-led assessment and inspection in respect of preparations and what needed to be achieved and by when; and identifying areas that were working well and those areas that still required improvement action. In light of the comments, the committee considered the trust board needed greater assurance around well-led and suggested it receive an assurance report before September.

FINANCIAL
- **Standing financial instructions and scheme of delegation**
The committee approved the standing financial instructions and scheme of delegation subject to a request for the trust’s internal auditors to look them over and agree the limits, plus some minor edits suggested by local counter fraud colleagues.

  - **Tender waivers**
The committee noted that there was a greater of number of tender waivers this time around which reflected the digital CFH work underway.

  - **Losses and special payments**
The committee noted that efforts were underway in assisting recovery of overseas patient debt.

MINUTES
- **Attached are the minutes, redacted as appropriate, from the audit committee meeting held 8 March 2018.**

End
Annex A

Audit committee annual report 2017/18

1. Purpose of the report

1.1 The annual report has been prepared for the attention of the group trust board and reviews the work and performance of the audit committee during 2017/18 in satisfying its terms of reference. The production of the audit committee report represents good governance practice and ensures compliance with the NHS Audit Committee Handbook, the principles of integrated governance and NHS Improvement’s Single Oversight Framework.

2. Overview

2.1 The audit committee is the senior independent non-executive committee of the group trust board. Through the audit committee, the group trust board ensures that robust internal control arrangements are in place and regularly monitored. The audit committee regularly reviews the group board assurance framework (BAF) and is therefore able to focus on risk, control and related assurances that underpin the delivery of the group’s strategic priorities.

2.2 The audit committee is responsible for monitoring the externally reported performance of the trust and providing independent and objective assurance on the effectiveness of the organisation’s governance, risk management and internal control; the integrity of the trust’s financial statements, in particular the trust’s annual report and accounts; and the work of internal and external audit and local counter fraud providers and any actions arising from that work.

3. Compliance with terms of reference

3.1 During the reporting period, the audit committee has been chaired by two non-executive directors; Deborah Oakley until May 2017 and Mary Basterfield since then. The committee is attended by the other non-executive directors listed in the table below. The internal and external auditors and providers of local counter fraud services attend all meetings of the committee in addition to the group chief finance officer, although they are not members of the committee. The group chief executive and other members of the senior executive team attend meetings by invitation. The broad coverage of knowledge and skills of the members and attendees ensures that the audit committee is effective. The trust is satisfied that the audit committee is sufficiently independent.

3.2 After every audit committee meeting members have the opportunity to meet in private with the internal and / or external auditors and providers of local counter fraud services so that any issues of concern can be raised in confidence.

4. Membership and attendance

4.1 The audit committee met five times during the year. Following the formal audit committee meeting in May 2017, a further exceptional meeting was held for audit committee members and other members of the group trust board and group executive directors to resolve an outstanding accounting issue in the 2016/17 accounts before undertaking final approval of the annual report and accounts. This exceptional meeting is not captured in the table below.
Non-executive directors (members)  Attendance at meetings (actual / possible)

Deborah Oakley (previous chair)*  1 / 1
Mary Basterfield (current chair)**  5 / 5
Jenny Owen***  1 / 1
Stephen Ainger  5 / 5
Akta Raja****  2 / 3
Wanda Goldwag*****  2 / 2

*Deborah Oakley ceased to be the chair of the audit committee from May 2017.
**Mary Basterfield was a member of the audit committee and became the chair of the audit committee following Deborah Oakley’s departure, chairing her first meeting in September 2017.
*** Jenny Owen ceased to be a member of the audit committee in May 2017.
**** Akta Raja became a member of the audit committee in November 2017.
***** Wanda Goldwag became a member of the audit committee in January 2018.

5. Work and performance of the audit committee during 2017/18
5.1 The audit committee has largely adhered to its work programme. The majority of reports scheduled for each audit committee meeting have been received on time.

5.2 During 2017/18, the audit committee has remained observant of the key financial, operational and strategic risks facing the trust through regular review of the group BAF and through internal sources of assurance and validation by way of triangulation with the following group level committees: patient safety committee (now disbanded), quality improvement and leadership committee and clinical standards and innovation committee. The audit committee has reviewed progress reports and evaluated the major findings of internal and external audit work.

5.3 The audit committee has also sought greater assurance in a number of areas as outlined below.

<table>
<thead>
<tr>
<th>Group BAF</th>
<th>Data quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>The committee has undertaken regular scrutiny of the group BAF, i.e. whether the detail within adequately reflected the strategic risks to the trust and that these were scored appropriately. The audit committee has also recommended to the group trust board a number of amendments to existing risks. One around the trust’s transition to a group model to include focus on ensuring that there was effective operational governance in place; the second to clearly defining the separate elements to IT risks - data quality, future changes planned, cybersecurity and current infrastructure stability.</td>
<td>The audit committee has received regular updates in respect of the trust’s data quality processes. Improving data quality has been identified as one of the trust’s key goals, the aim of which was to have high quality data available to confirm income claimed, inform business decisions and ensure that patient safety was not compromised. The audit committee wished to be assured on the short, medium and long term priorities for data quality improvement, order of those priorities and timeframes so that it could assure itself that the data quality issues identified the previous year in respect of income and billing would not be repeated. The audit committee requested a report outlining target dates and a high level timeline for implementation of data quality matters so that it could understand progress / identify slippage, etc.</td>
</tr>
</tbody>
</table>

Cybersecurity  Financial year 2016/17 learning  

FINAL
The audit committee requested a high level discussion on the trust’s cybersecurity control framework, recognising that cybersecurity was currently a high profile issue. It was pleased to note that a digital strategy and cybersecurity roadmap was in place, plus the executive leadership alongside that. The audit committee discussed the key areas of vulnerability to the trust, the trust’s preparedness, and investment both in terms of cyber security and the trust’s current IT infrastructure more generally.

The audit committee undertook a review of the trust’s 2016-17 year-end accounts process, included what had gone well and identifying lessons for the future. The audit committee recognised that improvement was needed in respect of the communication and timeliness around the accounting treatment. It agreed that the trust’s proposed structure of significant financial transactions would be completed earlier in the year to allow for detailed debate and assurance (in written form) to be taken on the accounting treatment, thus providing assurance for the group trust board during the decision making process, and ensuring there was better lines of communication between the audit partner, group chief finance officer and committee members.

In light of the prior period adjustment made to the previous year’s accounts in respect of the 2015-16 income loss, the audit committee had kept a watching brief on the trust’s current income position. The audit committee requested an update on progress against the recommendations arising from internal audit’s review of the effectiveness of the trust’s processes for recording clinical activity and was encouraged to see that was all on track. In terms of the 2017-18 accounts, the audit committee was assured that this were being managed at a more granular level with management being better sighted on provisions etc. earlier in the year.

<table>
<thead>
<tr>
<th>Group governance and evolution</th>
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<tbody>
<tr>
<td>The audit committee has discussed the trust’s new group model governance structure and benefits realisation monitoring arrangements that were being embedded across the group. The audit committee recognised that the group structure was new and had few precedents so the focus had been on a process of review and learning as the group progressed. However, the audit committee wished to see clarity of accountability between group and hospitals, and the appropriate flow of information from group to hospital units and between hospital units. The committee was therefore pleased that this would be a focus of the trust’s upcoming externally facilitated well led review. The audit committee also wished to see some assurance milestones at this stage of the group’s evolution.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Register of interests, gifts, gratuities, benefit hospitality and sponsorship</th>
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</thead>
<tbody>
<tr>
<td>The committee approved a new conflicts of interest policy. A key area of concern for the audit committee was whether staff who were required under the policy to make declarations were in fact doing so. The audit committee noted the effort made in trying to achieve an increased compliance rate and discussed simplifying the declaration process so that staff had to sign a positive statement that they were complying with the policy and the lack of sanctions for non-responders, two issues that it would follow up on later in 2018.</td>
</tr>
</tbody>
</table>
development and, on the back of this, it was now receiving a formal report from the Well Led steering group at each meeting, alongside the project milestone plan.

Local security management service (LSMS)
The audit committee receives an annual report on the provision of the trust’s LSMS which undertakes the delivery of a full range of security management work across the trust’s three main hospital sites. It was assured that the trust’s security management compliance was good and met the standards set by the NHS Counter Fraud Authority and that a programme of work was underway to improve this further, including investing in improved technology for new lone worker devices. The audit committee was pleased to see that the trust was continuing to report on assaults on staff both clinical and non-clinical, and that clarity had been provided on Datix, the trust’s incident reporting system, to clearly differentiate between clinical and other types of assaults on staff. The audit committee was also assured of the trust’s counter-terrorism processes in terms of resilience, policies and procedures, and planning.

5.4 The audit committee has received regular reports on counter fraud activity at the trust, ensuring appropriate action in matters of potential fraudulent activity and financial irregularity. Upon completion of a counter fraud investigation, the audit committee receives a closure report setting out the findings and confirming whether or not a fraud has been committed.

5.5 The audit committee also receives a log of whistleblowing (‘speaking up’) incidents. This captures whistleblowing incidents logged by the trust’s workforce and organisational development department and those logged via other routes, thus ensuring all incidents are captured and tracked so that the audit committee can fulfil its role set out in its terms of reference.

5.5.1 The committee approved the speaking up policy and procedure at its meeting in January 2018 and was assured on the associated processes; speaking up incidents were being investigated and closed, the speaking up champions were promoting their work across the trust which had been well received, and it was clear that the messages behind this were being embedded across the trust’s three main hospital sites. The audit committee had requested that its regular report include trend data and this was now presented in graphical form. At its meeting in May 2018, the audit committee received a presentation from one of the trust’s speaking up champions on their view of how the whistleblowing procedures and processes were faring across the organisation. The audit committee would seek further assurance around ensuring there was sufficient staff resource to assist with carrying out future speaking up investigations.

5.6 The audit committee has also fulfilled its oversight responsibilities with regard to monitoring the integrity of financial statements and the annual accounts, including the annual governance statement before submission to the board.

5.7 The audit committee has considered the following significant issues in relation to the financial statements:
• **Management override of controls** – The audit committee is aware of the main areas of judgement within the financial statements and the approach taken by management. The audit committee holds an annual workshop to scrutinise the accounts and receives an analysis of the key movements within the financial statements and the main areas of judgement. The audit committee also approves, where necessary, any changes to accounting policies.

• **Risk of fraud in revenue and expenditure recognition** – Where significant financial variances are identified, is it normal practice for the audit committee to receive an exception report. It would also be briefed on any instances where significant risk, such as significant sums of money or reputational risk facing the trust as a result of suspected fraud etc., had been identified.

5.8 The audit committee also relies on the work of the trust’s internal and external auditors to check that key controls are operating effectively.

6. **Review of effectiveness of the audit committee**

6.1 Members and attendees of the audit committee undertake an annual assessment of the audit committee’s effectiveness in discharging its duties. Audit committee members, local counter fraud services, internal audit and external audit colleagues plus colleagues from the finance department are asked to respond to a series of questions related to behaviours and processes, with each rated from one (hardly ever/poor) through to five (all of the time/fully satisfactory).

6.1.1 All the respondents’ ratings were reviewed to provide a median average score in order to highlight any potential areas for improvement. Out of 32 statements, the median score for almost all the statements was 4 and above. There were six statements which received a median score of 5, namely:

- quality of chairmanship;
- frank, open working relationship with executive directors;
- open channels of communication;
- sufficient number and timings of meetings;
- private meetings with internal and external auditors; and
- role in relation to whistleblowing

6.1.2 Non-audit committee group board members are also asked to undertake a short assessment of the audit committee and the assurance it provides to the board, with each question rated ‘strong’, ‘adequate’ and ‘needs improvement’. Overall, the group board members rated the committee’s performance as ‘strong’ on all questions, with the exception of one where a comment under ‘needs improvement’ was raised in respect of **oversight of the audit processes**.

6.1.3 The audit committee ensures that any action that could be taken to help improve the committee’s performance in relation to the feedback raised is agreed and acted upon. Those themes raised for forward action were:

- **oversight of the audit processes**;
- quality of interaction with external auditors; and
- understanding of key financial matters

As reported above, the audit committee has taken to steps to address these issues, particularly in the context of the audit of the trust’s 2017-18 accounts.

7. **External audit**
7.1 Appointment of the trust’s external auditors

7.1.1 The trust’s external audit services have been provided by PricewaterhouseCoopers (PwC). The council of governors appointed PwC in September 2012 for a period of three years following a full procurement exercise with the potential to extend the contract for a further two years. In March 2015 the council of governors agreed to re-appoint PwC for a further year following completion of the 2015/16 statutory audit. The council of governors was asked to consider whether to extend the contract for a further year, or to start the process for tendering the Royal Free London 2016/17 audit provision from May 2016. The council of governors took the decision to reappoint PwC until June 2017 after which time a full tender exercise would be undertaken.

7.1.2 Following a robust and competitive tender exercise, the trust appointed PwC for a further three years in October 2017 with the option to extend the contract for two additional years. The council of governors debated the appointment of PwC as the external auditor at an extraordinary meeting on 13 October 2017. Particular note was made of the importance of the trust’s external auditor having a higher profile with the council and that an invitation should be extended for the external auditor to present to the council. The council also agreed that it should seek to shape its relationship with the external auditor more actively in future given that all bidders had indicated they would be flexible as to the support they could offer the council.

7.2 The audit committee approved the external audit plan 2017-2018 which outlined how PwC planned to discharge its audit duties for the financial year. The audit committee also agreed the planned audit fee which was lower than the previous year. The audit committee considered the risks which were thought to be either significant or elevated in relation to PwC’s audit for the year ended 31 March 2018:

- Fraud in revenue recognition
- Fraud in expenditure recognition
- Management override of controls
- Valuation of trust’s land and buildings
- Significant asset disposals
- Going concern and financial stability
- Allowance for doubtful debts

7.3 Throughout the year, the audit committee has received and reviewed progress reports from PwC in delivering its responsibilities as the trust’s external auditor, together with other matters of interest such as key technical areas and sector updates. Furthermore, the audit committee had specifically received an update on PwC’s accounting matters and / or judgements expected to impact on the 2017/18 year end and their audit work. This item was requested in order to draw members’ attention to those areas where either heightened audit focus or material changes to the way items were accounted for were needed. In addition, the trust worked closely with the audit partner to schedule any work arising from this in good time.

7.4 PwC had arranged and held regular meetings with the trust’s finance team to discuss technical matters ahead of year end and their accounts and audit process.

7.5 The audit committee has confirmed throughout the year that the risks identified in the external audit plan have remained valid.

8. Review of effectiveness of the trust’s external auditors

8.1 The audit committee reviews the effectiveness of the trust’s external auditors each year. This is particularly important in a foundation trust because the council of governors appoint the external auditor and the audit committee and finance staff conduct the evaluation on their behalf. Audit
committee members and senior finance managers were asked to rate 19 statements related to behaviours and processes in the following areas: quality control; audit team; audit scope; audit fee; audit communications; quality account; and audit governance. An additional rating was also sought from the trust’s medical director specifically on the quality account statement.

8.1.1 As with previous years, responses to the survey were generally positive, with the majority of responses rated as “strongly agree” or “agree” with the statements made. Two statements in particular were rated very strongly by the majority of respondents, with the first having been rated as such by all six respondents:

- the external audit team has an effective working relationship with internal audit; and
- the quality report is completed in a timely fashion and recommendations are made to help the trust improve.

8.1.2 For the purposes of reflection and continuous improvement, details on those areas where less favourable ratings were received, albeit by a limited number of respondents, and included:

- the external auditor discusses the critical accounting policies and passes judgement on whether the accounting treatment is conservative or aggressive and the external audit firm resolves accounting issues in a timely manner - as reported above, the audit committee has taken to steps to address these issues, particularly in the context of the audit of the trust’s 2017-18 accounts.

- the audit team spend time engaging with governors and assisting their development – in March 2018, the external auditors provided a seminar for governors. The chair of the audit committee and the group chief finance officer also attended. During the session, the external auditors went through the draft audit strategy with the governors and reviewed the last annual report and accounts in the context of the trust’s development as a hospital group. The format of the session allowed governors to ask questions of the auditors as well as the group chief finance officer and the chair of the audit committee. The intention was that this session would be the start of a closer working relationship between the council of governors and external audit. Feedback from governors about the session was positive.

8.2 Independence of external auditor

8.2.1 As external auditors of the trust, PwC is required to be independent of the trust in accordance with the ethical standards established by the UK Auditing Practices Board. PwC have confirmed that there is no matter which they perceive has impacted on their independence or the objectivity of the audit team, nor have they provided any services to the trust.

9. Internal audit

9.1 During the reporting period, the trust’s internal audit services have been provided by KPMG. KPMG were appointed in November 2016 for a period of three years following a full and competitive procurement exercise in September 2016.

9.2 The audit committee received and approved the draft internal audit strategic and operational plan for 2017/18 at its meeting in March 2017. Sufficient work was undertaken to provide evidence to support the head of internal audit opinion (HoIA opinion), which in turn contributes to the assurances available to the trust board in its completion of its annual governance statement. The HoIA Opinion 2017/18 was presented to the audit committee in May 2018 and for the period 1 April 2017 to 31 March 2018 an overall rating of ‘significant assurance with minor improvements required’ was given on the overall adequacy and effectiveness of the trust’s framework of governance, risk management and control.
9.3 The audit committee has been pleased to note that the majority of internal audits for the year have resulted in positive ratings of ‘significant assurance’ and ‘significant assurance with minor improvement potential’. There was only one internal audit where limited assurance had been given (cybersecurity) and one review (medical illustrations) had been deferred to 2018/19.

9.4 The audit committee noted the conclusions in and accepted the recommendations arising from the internal audit reviews. It has continued to receive status reports on implementing the recommendations at each meeting. Over the course of the reporting period, internal audit have raised 57 recommendations in the course of their reviews. No high risk recommendation has been raised in that period. Internal audit has also followed up outstanding recommendations both this year and the previous year. There is no high priority recommendation outstanding.

9.5 The audit committee approved the internal audit strategic and operational plan 2018/19 at its meeting in March 2018.

9.2 Review of effectiveness of the trust’s internal auditors
9.1 The audit committee undertakes an annual review of effectiveness of the internal audit provision. This consisted of six participants comprising committee members and senior finance managers who were asked to rate 14 statements related to behaviours and processes in the following areas: mandate and strategy; organisation and structure; stakeholders; audit fee; leadership; risk assessment and planning; execution; reporting; and overall. One statement was for management response only. Respondents were asked to provide any additional comments by exception only.

9.1.1 Overall, responses to the survey were very positive with the majority of statements having been rated as either “strongly agreeing” or “agreeing”. Two statements in particular were rated highly, namely internal audit regularly attend audit committee meetings to present audit findings, trends and current views (of the control environment) and through its activities the internal audit is able to articulate to senior management the risks of their actions in a structured and balanced manner, and provide credible recommendations to mitigate risks.

9.1.2 In terms of forward action, it was suggested that consideration needed to be given on how to involve internal audit in group business / governance in the future.

9.1.3 Limited assurances and significant issues considered
The audit committee focussed on the audit report which had received limited assurance and where the risk profile represented significant issues for the trust as noted above. The chair requested the presence of key individuals at that meeting so the audit committee could discuss the current position, take assurance or note action plans where necessary.

10. Financial matters
10.1 Tender waivers - the audit committee receives reports of all single tender actions at each meeting and requests additional information where it is not satisfied with the explanation provided. During the reporting period, the committee agreed that the contract limit should be reduced from £90k to £30k. Specific assurance has been sought in respect of the tender waiver process, including the timeline for extending contracts, and achieving value for money. The audit committee has received trend data within the report but agreed that this could be improved upon in order to provide a more meaningful data set, e.g. average value, distribution, frequency etc.

10.1.2 Losses and special payments - a report on losses and special payments is also presented to each meeting.
10.2 The audit committee has also taken action over the course of the year in respect of the following financial issues:

- reviewed private patient outstanding debt;
- approved the implementation of the inventory management system, Genesis, having discussed the risks and how these would be mitigated; and
- approved a revision to the trust’s scheme of delegation within the standing financial instructions.

11. Anti-fraud
11.1 During the reporting period, the trust’s local counter fraud services have been provided by RSM. RSM were appointed in November 2016 for a period of three years following a full and competitive procurement exercise in September 2016.

11.2 The audit committee approves an annual counter fraud work plan. It also receives a report at each meeting detailing cases of possible fraud and the outcome of any investigations. Progress in respect of proactive work and themed reviews is also reported and has included a focus on fraud and bribery risks within the trust’s IT department and a comprehensive review of the trust’s expenses policy from a counter fraud perspective. The audit committee monitors the implementation of any recommendations made by RSM by way of a management action tracker. The tracker also monitors those cases that have been referred back to the trust’s employee relations team for follow up and would remain on the tracker until RSM was confident that these could be closed off. The audit committee receives an annual fraud report and benchmarking report, as well as a self-assessment against NHS Counter Fraud Authority standards.

11.3 As part of the audit committee’s approval of the external audit plan 2017/18, it was asked to provide its views on fraud. The audit committee’s responses, taking into account the role of the local counter fraud specialist and the monitoring role played by the audit committee, were accepted by PwC.

11.4 Review of effectiveness of the counter fraud provision
11.4.1 It is good practice for the audit committee to review the effectiveness of the trust’s local counter fraud services (LCFS) on at least an annual basis and the NHS Audit Committee Handbook supports this position.

11.4.2 Respondents were asked to complete a checklist comprising 14 statements related to behaviours and processes in the following areas: quality control processes; LCFS team; liaison with management; LCFS fee; audit communications; and governance. Five of those statements were expected to be rated by management only. Ratings were: strongly agree; agree; neither agree or disagree; disagree; and strongly disagree. Respondents were asked to provide any additional comments by exception only. Other board members (i.e. those that do not attend the audit committee) were asked to also complete the assessment but all felt they were unable to respond as they had very little, if any, interaction with counter fraud colleagues.

11.4.3 Overall, no negative responses were given. Responses were 100% positive for three of the statements in particular:

- There is a regular trust liaison with suitable qualifications and access to suitably qualified staff (investigatory officers and specialist fraud staff)
- The LCF has an effective working relationship with management
- The LCF team consider the wider control environment when conducting reviews and investigations, and make recommendations to improve controls
11.4.4 There were a number of statements where half the respondents had provided a ‘neither agree nor disagree’ rating but there was no comment to elucidate why this was so. The audit committee requested that the group chief finance officer address those comments outside of the audit committee.

11.4.5. In terms of future actions, the audit committee has agreed that it would be helpful to get a broader view of counter fraud effectiveness. A review of the questionnaire would be addressed in advance of the next survey and colleagues working in key areas, such as finance, HR and so on, will be also be asked for their views.

12. Accounting policies
12.1 The audit committee has not been required to consider and approve any such policies within the year.

13. Audit committee report to trust board
13.1 Throughout the year, the audit committee has submitted a regular report to the trust board. The report has covered the key items discussed at the meetings, provided assurance to the board on the assurance items chosen by the audit committee, and highlighted any risks to the trust. The confirmed minutes of each meeting, redacted where deemed necessary, are also presented to the trust board and, once a year, the audit committee submits it annual workplan to the trust board for noting.

14. Priorities for 2018/19
14.1 The audit committee will continue to carry out its current functions, modified to accommodate the new group model structures and requirements, and will give particular focus to data quality and assurance, the process for compliance with top level regulators, the process/inspections from second tier regulators, clinical audit, quality of care and other assurance items, declarations on the trust’s register of interests, speaking up investigations resource, and monitoring audit recommendations and reviewing all audits with a limited assurance rating.

15. Conclusions
15.1 The audit committee has been proactive in requesting reports in areas of concern in both financial and non-financial areas. The audit committee will continue its increased focus during 2017/18 on following up internal and external reports where limited assurance has been given, and ensuring that gaps in controls are identified and monitored as the trust’s group model structure evolves.

15.2 The audit committee has met its terms of reference as detailed throughout the report.

End
Minutes of the Audit Committee  
8 March 2018

Present:
Ms Mary Basterfield  Non-executive director (committee chair)
Mr Stephen Ainger  Non-executive director
Ms Akta Raja  Non-executive director
Ms Wanda Goldwag  Non-executive director

In attendance:
Ms Caroline Clarke  Group chief finance officer
Ms Lubna Dharssi  Assistant director of finance – financial control
Mr Mike Dinan  Director of financial operations
Mr Neil Thomas  Head of internal audit – KPMG
Ms Lynn Pamment  Engagement leader – PricewaterhouseCoopers
Mr Kevin Lowe  Senior manager – PricewaterhouseCoopers
Ms Gemma Higginson  Management consultant – RSM
Mr Duncan Gordon-Smith  Trust secretary
Mr Mark Redhead  Head of group planning (for item 07-18/19 only)
Mr Glenn Winteringham  Group chief information officer (for item 08/18-19 only)
Ms Laura Bell  Head of IM&T (for item 08/18-19 only)
Mr David Grantham  Group director of workforce and OD (for item 09/19-18 only)
Ms Veronica Jackson  Committee administrator (minutes)

<table>
<thead>
<tr>
<th>ACTION</th>
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<tbody>
<tr>
<td>01/18-19  APOLOGIES FOR ABSENCE</td>
</tr>
<tr>
<td>Apologies were received from the following:</td>
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<tr>
<td><strong>Members:</strong></td>
</tr>
<tr>
<td>There was no apology</td>
</tr>
<tr>
<td><strong>Attendees:</strong></td>
</tr>
<tr>
<td>Ms Charlotte Goodrich - Senior manager – KPMG</td>
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<tr>
<td>Ms Sarah McKean - Senior manager – KPMG</td>
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<tr>
<td>Mr Peter Ridley – Group director of planning (for group board assurance framework only)</td>
</tr>
<tr>
<td>02/18-19  DECLARATIONS OF INTEREST</td>
</tr>
<tr>
<td>The chief finance officer reported that her entry required updating. The register of audit committee members' interests was lifted from the version presented to the trust board and therefore the board secretary would be asked to ensure all entries were current.</td>
</tr>
<tr>
<td>AM</td>
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<tr>
<td>03/18-19  MINUTES OF THE AUDIT COMMITTEE MEETING HELD 11 JANUARY 2018</td>
</tr>
<tr>
<td>The minutes of the meeting held 11 January 2018 were agreed as true record of the meeting subject to a minor edit on page 10.</td>
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<tr>
<td>04/18-19  Review open actions log (for noting)</td>
</tr>
<tr>
<td>The action log was noted.</td>
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<tr>
<td>05/18-19  Matters arising</td>
</tr>
<tr>
<td>There was no matter arising.</td>
</tr>
<tr>
<td>06/18-19  Notice of discussion items marked for information</td>
</tr>
<tr>
<td>Members and attendees would decide which items they would like to discuss as the chair progressed through the agenda.</td>
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<tr>
<td>Date</td>
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<tr>
<td>07/18-19</td>
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<tr>
<td>08/18-19</td>
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<td>09/18-19</td>
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</table>
survey findings, there had been some modest improvements in some particular questions that may point to initiatives on ‘speaking up’ having started to make an impact. He confirmed that the survey had included a question on whether staff knew how to raise a whistleblowing incident.

It was noted that the current speaking up champions were trying to create a group of sub-champions.

Overall, the group director of workforce and OD assured the committee that the position in respect of the trust’s whistleblowing processes was positive and it was clear that the messages behind this were being embedded across all three hospital sites. He added that a list was being drawn up of those whistleblowing champions that would be attending the audit committee to give their view on how the whistleblowing procedures and processes were faring across the organisation.

The chair was pleased to see the trend data in the report. She asked about staff member’s capacity to undertake whistleblowing duties and investigations. The group director of workforce and OD responded that the team were starting to get a better grip on this with weekly progress meetings being held with the speaking up guardian, Jim Mansfield. The aim was to reinforce the message that one did not need to be a senior manager in order to undertake a whistleblowing investigation.

The committee noted the report.

**INTERNAL AUDIT**

**10/18-19  Progress report and technical update**

The committee received the regular internal audit progress report. It was pleased to see the high number of amber-green (significant assurance with minor improvement opportunities) ratings that had been given over the course of the year.

The committee noted the report.

**11/18-19  Follow up recommendations**

There had been a slight reduction in the number of outstanding internal audit recommendations that had been closed and this was continuing steadily. The internal auditors were content with the pace at which these were being closed off.

The chair asked how the audit committee could ensure that the overdue ones were completed; the chief finance officer and head of internal audit agreed to discuss this outside the meeting.

It was noted that there was one medium (amber) priority recommendation that was more than six months overdue in respect of gateway reviews. Mr Ainger, non-executive director asked whether in light of this being so overdue that the amber rating was still appropriate. The head of internal audit explained that this would have been rated as such in the context of when the internal audit assurance review was undertaken but appreciated that the definition of the amber rating would no longer be entirely accurate when applied to the current moment in time. Ms Goldwag, non-executive director added that the risk may have become more of a priority due to the passage of time and therefore if it was not closed then its urgency would be heightened. The head of internal audit noted that he was aware of one trust that would automatically change any recommendation overdue by six months to high priority (red –rated). The group chief information officer would be asked to confirm that

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**NT, CC**
Final

the revised deadline of 31 March 2018 would be met.

The committee noted the review.

12/18-19  *Internal audit review – Learning from deaths (data quality)*

KPMG had reviewed the processes in place at the trust for data quality and governance (learning from deaths) and had carried out sample testing to ensure compliance with the guidance published by the National Quality Board. An overall assessment of ‘significant assurance with minor improvement opportunities’ (amber-green) had been given.

KPMG noted that they had been particularly impressed with the trust’s learning from deaths policy which they considered gave a very ambitious view of how the trust wanted to manage this work and went above and beyond that stipulated in the national requirements. However, to enable this aspiration it would be necessary to ensure that a greater number of people were trained on the policy and procedure including for the trust to set out clearer expectations for the timeliness of reviews that it can hold itself to in the future.

The committee noted the report and the amber-green assurance rating.

13/18-19  *Internal audit review – Information governance (IG) toolkit 2017-18*

KPMG had assessed the overall design and operation of key information governance controls at the trust as having ‘significant assurance with minor improvement opportunities’ (amber-green). This was better than the trust’s forecasted assurance rating and was based on a number of additional pieces of evidence having been available to support the audit, namely the key actions which were required to meet the trust’s target self-assessments score for the IG Toolkit return by the deadline of March 2018.

It was noted that building up the evidence needed for the internal audit assessment was challenging. This lack of evidence had led to the IG team having overstated a number of assessment scores for a number of requirements due to a lack of supporting documentation submitted for the final March 2017 IG Toolkit submission to validate the IG work conducted at the trust. In light of this, KPMG had raised a recommendation that refreshed and updated documentation be available to support the IG Toolkit submission.

In terms of IG training, the trust’s compliance rate was below that required by the Toolkit (70% against the 95% target). A recommendation was made for the trust to conduct an exercise to scope whether or not achieving the 95% compliance level by 31 March 2018 was feasible. The trust would then need to focus on the subsequent year to develop monitoring and tracking procedures in order to take induction training into account.

The committee noted the report and the amber-green assurance rating.

14/18-19  *Internal audit review – Financial improvement plans 2017-18*

KPMG had reviewed the trust’s processes in place for financial improvement plans (FIPs) and had provided an overall assurance rating of ‘significant assurance with minor improvement opportunities’ (amber-green) which was consistent with management’s expectations. The head of internal audit advised that there had been a large amount of work undertaken behind this review so the committee could be very assured by the rating. He added that KPMG had deferred submission of the review to the audit committee in January as the team had wanted to undertake some further work on it. Three areas for improvement were recommended; ensuring clinical sign off of all divisional clinical project initiation documents (PIDs), the classification of FIPs, and strengthening the message around ensuring the full completion of PIDs.

The group chief finance officer updated the committee on the ‘FIP week’ that had taken place the previous week and which had asked staff to focus on how they could help reduce waste and improve efficiency and to start the new financial year in a positive position. The director of financial operations noted that staff had appreciated the push but there was still a
lot of work to do particularly in terms of FIP related paperwork such as PIDs.

Mr Ainger, non-executive director, noted the link between the FIP and staffing adding that he had received feedback from medical staff that they felt under pressure. The director of financial operations noted that admin and clerical and nursing staff were most affected by the FIP and that medical rosters needed to be completed and aligned at a local level, rather than coming from the centre.

It was noted that the clinical practice groups (CPGs) were enablers to the FIP but there was no explicit financial CPG. The CPG approach was to focus on the pathway first and foremost, and then the financial implications behind that.

The committee noted the report and the amber-green assurance rating.

<table>
<thead>
<tr>
<th>15/18-19</th>
<th>Internal audit review – Group governance and benefits realisation phase II</th>
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<tbody>
<tr>
<td>KPMG had reviewed the design of the governance structures in place at the trust and had provided an assessment of ‘significant assurance with minor improvement opportunities’ (amber-green) which was in line with management’s expectations.</td>
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<td>The review had focussed on the link between the group executive committee (GEC) and local executive committees (LECs). Broadly the review had identified that the GEC was undertaking a larger volume of work; clarification was needed on how assurance flowed from a local level to the group audit committee; and solid data points were needed for establishing the benefits realisation.</td>
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<td>In response to a question, the head of internal audit considered the amber-green rating to be sufficient in the context of that review.</td>
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<td>The chair considered it was clear that the sources of assurance were not joined up and asked how concerned the audit committee should be about that. The head of internal audit responded that they had devised a number of scenarios that might occur at all levels of the group, and determined how these would escalate or de-escalate through the governance structure to reach the most appropriate decision makers. He was confident that the relevant risks and issues would make its way through the current governance structure.</td>
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<tr>
<th>16/18-19</th>
<th>Internal audit review – Drug manufacture and wholesale</th>
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<tr>
<td>KPMG had reviewed the governance arrangements and performance reporting process of the trust’s pharmacy manufacturing unit. They had obtained an understanding of the risk management arrangements in place to ensure compliance with the Medicines and Healthcare Products Regulatory Agency standards. Based on their review, KPMG had provided an assessment of ‘significant assurance with minor improvement opportunities’</td>
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(amber-green) which was in line with management’s expectations.

The committee noted the report.

### 17/18-19 Internal audit review – Financial controls

KPMG had reviewed the policies and procedures in place at trust relating to financial controls. Their review specifically focussed on the areas of accounts payable; treasury management and stock management for pharmacy and theatres, including implementation of the new Genesis stock system in theatres. KPMG provided an assessment of ‘significant assurance with minor improvement opportunities’ (amber-green) which was in line with management’s expectations.

Mr Ainger, non-executive director, noted the reference to 4.4% of appropriate purchase orders that were raised after the invoice and asked if this was normal practice at the trust. The assistant director of finance – financial control explained that delayed implementation of the genesis stock management system in 2017 had led to a backlog in invoices, adding that the team were going to use KPMG’s findings to identify themes by department. The group chief finance officer noted that complaints from aggrieved suppliers and managers unable to fill their stocks had declined which was positive.

The chair was surprised to see the reference to new supplier set up for remediation by May 2018. The assistant director of finance – financial control clarified that action on this would be brought forward to year end and she would liaise with her procurement colleagues on ensuring that happened.

The committee noted the report.

### 18/18-19 Draft internal audit plan 2018/19

The head of internal audit started by noting that the plan was work in progress as interviews on the scope of a number of audit reviews were still ongoing. He added that a number of similar themes appeared to be consolidated across various reviews and this would need to be addressed. The relevant areas of focus were deemed to be: governance risk, IT / digital, and incidents and complaints. Staff retention was also an issue, particularly as the trust faced pressure in staff availability and turnover and therefore an adequate retention strategy would be needed for the enlarged group. The head of internal audit considered the plan as it stood was appropriate.

Reference was made to the fact that there was no further group governance internal review. The head of internal audit highlighted that phase I and II reviews had been undertaken in this respect already and there would be the recommendations follow up work arising from that throughout the year. He added that focus on complaints and serious incidents and performance management would also provide an eye into group governance.

The group chief finance officer noted that she had spoken with internal audit on this draft plan. She considered there were a number of issues that still required consideration in regards to the sub-GEC reporting structure, Capex and financing.

The chair asked whether establishment of the trust’s property services company could be incorporated into the plan; the head of internal audit confirmed that this was possible.

A revised, further populated plan would be provided at the May audit committee and KPMG would soon begin their fieldwork in respect of the reviews on data protection (GDPR) and IT / digital.

The committee approved the draft plan subject to the amendments noted.
### 19/18-19  
**Draft internal audit annual report and head of internal audit opinion 2017-18**

Particular reference had been made to the trust’s cybersecurity risks earlier in the year and the committee's (including in the presence of a new audit committee chair) re-focus on data quality and the associated outstanding recommendations.

At its meeting in January, the committee had received internal audit’s review of consultant job planning where an assessment of ‘significant assurance with minor improvement opportunities’ (amber-green) had been given. The committee had considered whether the assurance rating might be more appropriate graded as amber-red as that was more reflective of the current position and would help improve the messaging behind the enforcement of consultant job planning. The head of internal audit had reviewed this and confirmed that KPMG had agreed to maintain the amber-green rating. He would, however, discuss this further with Ms Goodrich, senior manager – KPMG and report back in May.

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### EXTERNAL AUDIT

#### 20/18-19  
**Progress report**

The engagement leader – PwC asked the committee to let them know whether they considered an external audit view on any other significant transaction was needed.

Ms Goldwag, non-executive director, made reference to the section on group hospital remuneration disclosures in the report where it stated that such disclosures would only be included in the annual report and remuneration report for those voting members of the group board and not other hospital site finance directors or chief executives. The engagement leader – PwC noted that this was in line with the accounting standards and went by job description but appreciated the need for disclosure from an audit committee’s perspective, adding that they would report on more if that was deemed necessary. Ms Goldwag considered a further conversation on this was needed. The group chief finance officer agreed to take this issue away and report back, adding that there was a broader question around how the group structure was best presented in the formal annual report 2017-18 bearing in mind it was still only year 1 of operation.

The reference to ‘PropCo’ would be amended to ‘property services company’. The committee noted that the company would not be trading in 2017-18 but it was necessary to note its existence. It appreciated, however, that the company’s establishment would not necessarily be deemed a ‘major’ transaction.

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### LOCAL COUNTER FRAUD SPECIALIST (LCFS)

#### 21/18-19  
**Progress report including follow up recommendations**

The latest NHS Standards For Providers 2018-19 had been released on 14 February 2018 and the Self-Review Tool submission needed to be completed by end of March 2018. The submission would be approved by the group chief finance officer in advance of its circulation to the audit committee.

The management consultant – RSM considered the number of fraud referrals across the trust was appropriate.

In response to a question, the management consultant – RSM clarified that a number of cases were referred back to employee relations because the trust was not the intended victim of the fraudulent activity but there was, however, a conduct issue. She confirmed, however, that RSM would continue to track these cases and not close-off the incident in their progress report until employee relations had undertaken their own investigation and reported back.
### Draft LCFS workplan 2018/19

The committee noted that it had been some time since an LCFS fraud and bribery risk-assessment had been undertaken at the trust and due to the control environment having changed significantly following the group model, an assessment would be done in 2018-19.

A question was asked on what RSM considered the top three areas for focus were; these were considered to be:

- Delivering a risk focussed plan
- Compliance with the standards (as far as possible given that the standards do not necessarily align to local risk or focus areas)
- Output from investigations (i.e. ensuring the deterrent message was being fed through the organisation)

The committee approved the workplan subject to the inclusion of reference to the three points highlighted above.

### Outcome of the review of effectiveness – LCFS

The group chief finance officer and director of financial operations would undertake some follow up in respect of the four statements where 50% of respondents had provided a ‘neither agree nor disagree’ rating and report back at the next audit committee meeting in May.

### Group governance - assurance and evolution

The committee welcome the group trust secretary to the meeting.

The new group structure was still being stood up with the first meeting of the population health and pathways committee taking place the following week. The board had always been mindful that it was not working to an existing operating model so the focus had instead been on a process of review and learning as the group progressed.

It was noted that NHS Improvement (NHSI) had, for some time, encouraged providers to undertake regular self-assessment of governance and leadership. The board had agreed that it would not undertake an externally facilitated well-led review until the group was stood up and it was felt that now was the right time to undertake that. The well-led steering group had met twice to undertake a self-assessment exercise and identify programs of work for 2018 related to aspects of well led and identify areas of specific focus for the externally facilitated well-led review. In light of the earlier discussion on KPMG’s phase II review of the group governance, the trust secretary highlighted that one area of focus agreed for the well-led review would be group and hospital governance, especially clarity of accountability between group and hospitals, and the appropriate flow of information from group to hospital units and between hospital units.

This work would dovetail with the Care Quality Commission’s (CQC) regulatory assessment of well-led including key lines of enquiry which formed part of the CQC’s inspection process. Although there were a number of ‘group’ led hospital organisations currently in operation, the trust was liaising with the CQC on ensuring that a one-size fits all approach to its inspection regime was not taken.

It was noted that a number of workstreams identified by the trust’s well led self-assessment exercise would take place in the first half of 2018 and the externally facilitated well-led review would take place in the second half of 2018, while UCL’s formative evaluation of the Royal Free London group’s progress as a vanguard took place over two years.
Mr Ainger noted, as an example, that the local level clinical performance and patient safety committees were not formally reporting into the group level clinical standards and innovation committee and asked at what point, therefore, could the chair take assurance that the basic reporting structure was in place and operating effectively. He appreciated that the trajectory for the UCL’s evaluation work was two years but felt that it was necessary to identify assurance milestones at this stage. The chair appreciated the evolution of the group was an important factor but concurred with Mr Ainger that the committee needed to see a series of assurance milestones now.

The trust secretary noted that the project group for the well-led review was up and running and he would assure that they had a milestone plan in place. The chair considered that the audit committee should receive a formal report from the well-led steering group. All agreed that this was an acceptable way forward particularly as the audit committee was responsible for the assurance around processes and policies.

Ms Raja, non-executive director considered that one issue that required clarification was the line of sight on the Health Services Laboratory, both from the customer and investor perspective. She asked if could be included in the follow up work arising from the governance phase II report.

The chair advised that she had spoken with the director of procurement outside of the meeting in regards to the committee’s concerns around tender waivers and the format of the tender waivers report. She was pleased to see the inclusion of some trend data as requested by the committee but noted that this could be improved upon in order to provide a more meaningful data set, e.g. average value, distribution, frequency etc. The head of procurement had advised that the challenge in providing the data was due to the information being collated on different spreadsheets and which were not joined up.

Ms Goldwag, non-executive director wanted to get a sense of the current position in terms of whether it was good or bad and asked if the trust knew how it compared to other London NHS trusts. She also asked whether other trust’s audit committees received such benchmarking data. The head of internal audit noted that each organisation set its own tender waiver limit so it was difficult to get one perspective but the trust’s position did not appear out of step with that seen at other organisations.

Mr Ainger, non-executive director, stated that he would like to see that when a contract was renewed that it was done over a longer period of time, e.g. 3 years, and that the best deal was achieved alongside that. In light of that, he asked whether the report could show data by 1 year versus 3 years.

The head of internal audit considered that a key data set missing from the report was on the number of waivers that had been rejected.

The committee noted the report. The chair asked that the committee’s comments in respect of the trend data set, including its thanks for the initial efforts in trying to establish a useful data set, be fed back to the director of procurement.

The committee considered it would also be helpful to see benchmarking data in respect of losses and special payments but noted that the current trend was not concerning.

The committee noted the report.
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<tr>
<th>Date</th>
<th>Item</th>
<th>Details</th>
<th>Signatures</th>
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<tbody>
<tr>
<td>27/18-19</td>
<td>Change to the trust’s scheme of delegation</td>
<td>The committee noted that the current scheme of delegation (SoD) was prohibitive and that an alternative was being worked up. This new SoD would be taken to the audit committee in May for discussion and approval.</td>
<td>CC, LD</td>
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<tr>
<td>28/18-19</td>
<td>ANY OTHER BUSINESS</td>
<td>There was no item of any other business.</td>
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<tr>
<td>29/18-19</td>
<td>REFLECTIONS AND IMPROVEMENTS FOR NEXT TIME</td>
<td>No reflection or improvement was raised.</td>
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<tr>
<td>30/18-19</td>
<td>PRIVATE MEETING BETWEEN AUDIT COMMITTEE MEMBERS AND AUDITORS AND COUNTER FRAUD OFFICERS</td>
<td>No meeting was held on this occasion.</td>
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</table>

**Date of next meeting:** 18 May 2018, 1100 – 1330, group HQ boardroom, first floor, Anne Bryans House, 77 Fleet Road, NW3 1QH