Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 25th July 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**25 July 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yua Haw Yoe, Non-Executive Director	Siobhan Harrington, Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse & Director of Patient Experience

Attendees
Sarah Hayes, Deputy Chief Nurse for Michelle Johnson
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Sarah Humphery, Medical Director, Integrated Care

Secretariat
Kate Green, Minute Taker

Contact for this meeting: Fiona.Smith19@nhs.net

Agenda Item		Paper	Action & Timing
Standing Items			
18/100	**Patient Story** *Sarah Hayes, Deputy Chief Nurse*	*Verbal*	1400hrs
18/101	**Declaration of Conflicts of Interest** *Steve Hitchins, Chair*	*Verbal*	*Review 1420hrs*
18/102	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Review 1425hrs*
18/103	**Draft Minutes, Action Log & Matters Arising 27 June 2018** *Steve Hitchins, Chair*	1	*Approve 1430hrs*
18/104	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Review 1440hrs*
18/105	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Review 1450hrs*
Patient Safety & Quality			
18/106	**Serious Incident Report Month 3** *Richard Jennings, Medical Director*	3	*Review 1500hrs*
18/107	**Quarterly Safety and Quality Board Report** **Richard Jennings, Medical Director**	4	*Review 1510hrs*
18/108	**Integrated Safeguarding** *Sarah Hayes, Deputy Chief Nurse*	5	*Approve 1520hrs*

Operational Performance and Planning			
18/109	**Financial Performance Month 3** *Stephen Bloomer, Chief Finance Officer*	6	*Review 1530hrs*
18/110	**Performance Dashboard Month 3** *Carol Gillen, Chief Operating Officer*	7	*Review 1550hrs*
18/111	**Results for National Hospital Inpatients Survey** *Sarah Hayes, Deputy Chief Nurse*	8	*Review 1610hrs*
Strategy and Governance			
18/112	**Workforce Culture** *(to follow)* *Siobhan Harrington, Chief Executive*	9	*Review 1620hrs*
18/113	**Workforce Race Equality Standard Report** *Norma French, Director of Workforce*	10	*Approve 1630hrs*
18/114	**Nursing and Midwifery Revalidation** *Sarah Hayes, Deputy Chief Nurse*	11	*Approve 1640hrs*
18/115	**2018/19 Trust Objectives** *Jonathan Gardner, Director of Strategy, Development and Corporate Affairs*	12	*Approve 1650 hrs*
AOB			
	None notified to the Trust in advance		
Questions from the public on matters covered on the agenda			
	None notified to the Trust in advance		
Date of next Trust Board Public Meeting			
26 September 2018 -1400hrs-1700hrs -Whittington Education Centre, Magdala Avenue, N19 5NF			
Register of Conflicts of Interests: The Register of Members' Conflicts of Declarations of Interests is available for viewing during working hours from Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or Fiona.smith19@nhs.net or www.whittingtonhealth@nhs.net			

Whittington Health
NHS Trust

ITEM: 18/103
Doc: 1

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday 27th June 2018 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Chief Executive
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Michelle Johnson	Chief Nurse
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Janet Burgess	London Borough of Islington
	Adrien Cooper	Director of Environment (for item 18/94)
	Norma French	Director of Workforce
	Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
	Kate Green	Minute Taker
	Sarah Humphery	Medical Director, Integrated Care

Patient Story

The Board welcomed Farhiya, mother of a patient, accompanied by James Connell, Head of Patient Experience, Sita Chitambo, Head of Nursing for the Emergency & Urgent Care ICSU, and Joanne Flanagan, lead nurse for Paediatric ED. The main presentation took the form of a film. Farhiya has a three year old son, Taha, who suffers from autism, resulting in his having problems in communicating and challenging behaviour.

The film showed Farhiya giving an account of two occasions when Farhiya had had cause to visit the Emergency Department. The first was as a result of an accident at school, and the second when he had been ill with a temperature and infection. On the latter occasion she had initially called 111, but their advice had been to take Taha to hospital so she had done so.

On both occasions Farhiya had experienced a long wait at ED. She had not been kept informed of likely waiting times, nor had any support been offered to her as the mother of a child with special needs. There had been a great many people waiting, and the environment (noise, bright lights etc) had not been conducive to a three year old with challenging behaviour who had been very difficult to look after.

On being asked whether there was anything which could have been done to improve the family's visit to ED, Farhiya replied that the best option would have been for Taha, as a child with special needs, to have been seen straight away, or, failing that, to have been taken to a quiet room. Jo apologised for Farhiya's experience, saying that staff needed to learn from such accounts. David Holt expressed his sympathy and recounted a similar experience with his own family; this was therefore not an isolated incident. Jo reported that televisions had now been installed showing details of the nurses on duty; these were updated after every shift change.

She added that the department had been particularly busy, and acknowledged that when nurses were juggling several urgent priorities there was occasionally a failure to keep those waiting informed.

Michelle Johnson informed the Board that this was an important message for the Board to hear at this time, in particular because national learning disabilities week had recently taken place. Carol Gillen asked about the play specialist, and Jo said that she had had excellent results but the service was not one which could be offered 24 hours per day. Sita highlighted the importance of good communication, and it was noted that special needs children were flagged when the department had the necessary information. Some schools also offered support, including leaving files of information in the department. Information cards were also available. It was also noted that the Trust had recently signed up to 'Ambitious about Autism'.

In answer to a question from Michelle about what Farhiya felt was the single most important thing which could be done to improve her experience, Farhiya reiterated that it would have been for Taha to have been seen immediately, or to have been able to wait in a room with no noise. Richard Jennings pointed out that the Trust had made great progress in prioritising appointments for adults with learning difficulties so ought therefore to be able to replicate this for children.

Steve Hitchins thanked Farhiya and the staff for attending to recount their story.

18/85 Declaration of Conflicts of Interest

85.01 No member of the Board declared any interest in any of the business to be transacted that afternoon.

18.86 Welcome and apologies

86.01 Steve Hitchins welcomed everyone to the meeting, and especially Jonathan Gardner, attending his first Board meeting as newly-appointed Director of Strategy, Development & Corporate Affairs. No apologies for absence had been received.

18/87 Minutes, Matters Arising & Action Log

87.01 It was noted that Graham Hart had been present at the May Board meeting.

87.02 Two amendments to the minutes of the public Board meeting on 30th May were requested. The first was the insertion of the word 'parliamentary' to the third bullet point on minute 72.02. The second was to minute 76.02 (Quality Account), and Michelle Johnson would provide the exact wording for this amendment outside the meeting.

Action log

87.03 13.02: The assurance report on fire training was scheduled for discussion that afternoon.

35.04: The report on nursing establishment had been deferred until the July meeting.

40.05: The action plans from the staff survey remained on track to come to the Board in September.

73.05: The change in Responsible Officer would be implemented during July to allow Mr Sherwin to take over these responsibilities from the beginning of August.

78.07: The community dashboard containing an exception report on children's services would be brought to the Board in July.

18/88 Chairman's Report

88.01 Steve Hitchins noted the communication on the strategic estates partnership which had been issued by the Defend the Whittington Coalition; this had been circulated to all Board members as requested.

88.02 Steve drew attention to the following events and activities he had attended since the previous Board meeting as follows:

- the event to celebrate Comfort Offorjindu's Lifetime Achievement Award at the NHS Windrush Awards; Eddie Kent had also been shortlisted
- with Michelle Johnson and Sarah Hayes, the drawing up of a Visible Leadership programme which would ensure Board members had a higher profile in the Trust's community services
- also with Michelle, an event to mark Volunteers' week, where they had noted quite what amazing volunteers Whittington Health was fortunate to have
- the previous day's job fair at the Islington Assembly Hall
- the 500th anniversary of Richard Cloudesley's legacy in Islington
- the very impressive Quality Improvement Day.

88.03 Future events and plans included:

- the Open Day and NHS 70th celebrations on 5th July, for which he thanked Andrew and Juliette from the Communications team for the efforts they had put into arranging
- the awards ceremony on which all were welcome to attend
- the Trust's Eid celebrations, which would take place on 13th July.

18/89 Chief Executive's Report

89.01 Siobhan began her report by informing Board members that she had been present when the Prime Minister had delivered her speech on increased funding for the NHS. Although the announcement of an additional 3.4% finding had been a positive one, she regretted social care had not been included, and noted the need for further local work in this area. The Trust would be actively contributing to the 10 Year Plan to be drawn up in response to the announcement.

89.02 An interesting report on integrated care had also been published; this had been announced by Steve Powis, who had sought views from Richard Jennings prior to attending the Select Committee. Jonathan Gardner commented on the real opportunities this presented for Whittington Health as an integrated care organisation.

89.03 Siobhan had been present at the NHS Confederation conference, where she had taken the opportunity to tell Simon Stevens about the three national awards won by the Trust in the last few weeks. She had also met with HSJ Editor Alastair McClellan, who had been most impressed with her account of recent Trust achievements and plans. There had also been a great deal of positive coverage on social media.

89.04 Turning to quality and safety, Siobhan informed the Board that the Trust continued to struggle with the 4 hour ED target, coming in at 88.4% for May against a trajectory of 90%. A number of key actions had been agreed, primarily around workforce in ED. David Holt asked whether any factors beyond the Trust's control were contributing to the Trust's failure to achieve this target, since this could potentially jeopardise STF funding. Carol Gillen, said that the department had been challenged by being unable to discharge mental health patients due to a lack of beds; there were also some delayed transfers of care for patients with complex needs. The current heatwave might also affect services.

Siobhan commented that performance was volatile, with 94% achieved on some days and far less on others, this was in the main due to workforce issues which are being addressed.

89.05 Cancer targets also presented a challenge, in particular the 62 day target, and it was noted that the methodology was due to change imminently. Commenting on community services waiting times, Siobhan said there was a plan to move to Statistical Process Control (SPC) charts so the Board could view performance over time. On finance, the Trust had come in just under plan; Stephen would cover this in detail in his report.

89.06 The new ICSU structure would come into place from the following Monday. There were three vacancies, one Clinical Director post and two Directors of Operations. Reporting on the Clinical Director vacancy, Norma French informed the Board that ten expressions of interest had been received – from a wide range of disciplines – interviews would be conducted during July. For the two Directors of Operations, it was likely that one would be a secondment, and one an interim appointment. One of these two would also become Deputy Chief Operating Officer.

89.07 Concluding, Siobhan commended Anne-Marie Campbell, Discharge Flow Co-ordinator, on achieving this month's staff excellence award.

18/90 Serious Incident Report

90.01 Richard Jennings said that the report contained details of all serious incidents reported during May, and details of the learning gleaned from completed Root Cause Analysis investigations. The Board would see that in May there were four incidents related to surgery, and Richard reminded colleagues he had spoken about this at last month's meeting in terms of themes and work was planned to address this. There was to be an externally facilitated piece of work to look at the right model for surgery; this was scheduled to take place during the first week in September. On 28th June Richard and Siobhan would be interviewing for a physician with a surgical liaison role, such posts have been demonstrated to be extremely beneficial for quality and safety.

90.02 There was no common theme to the other four incidents reported in May. Reporting on lessons learned from completed investigations, Richard highlighted two. The first concerned the fire which had broken out in the hospital earlier in the year, and the Board would hear more about the learning from this in the fire safety report scheduled for discussion later on the agenda. The second concerned a patient who had removed their own endotracheal tube, and work was in hand to review best practice guidelines and to develop standard operating procedures in order to minimise the possibility of this happening in future.

90.03 In view of the recent publication of the enquiry into deaths at Gosport War Memorial Hospital, Steve Hitchins asked whether action had been taken to review the Trust's procedures for the prescription of opiates. Richard replied that all arrangements were being scrutinised, including for all patient pathways, palliative care and end of life care, and that palliative care consultant Anna Gorringe was working on this. A paper would be brought back to the Board.

90.04 Jonathan commended the website established to help staff learn from serious incidents. He suggested that a report be run every few months to show how many 'hits' the website had received. Steve Hitchins asked whether the Trust was moving sufficiently fast to resolve the issues in surgery. Richard replied that a balance had to be drawn between moving very quickly and taking sufficient time to ensure the exercise was conducted appropriately and with the right degree of thoroughness. He also pointed out that the external facilitation exercise was only one part of a wider piece of work.

18/91 Eliminating Mixed Gender Hospital Inpatient Accommodation

91.01 Introducing this item, Michelle Johnson explained that the statement of assurance presented here had been developed in conjunction with the Equality & Inclusion Team. The Trust is committed to ensuring that any patients requiring either in-patient or day-case care will be cared for in single gender accommodation. Once approved the statement will be available to the public via the internet. It has been recognised that the issue of gender has now become wider than single sex, and Michelle and colleagues are working with Charlotte Johnson and Harri Weeks to see how best to address this. She added the rider that no patient would be turned away from hospital in the event of the right bed not being available. Breaches had to be reported to the CCG, and a financial penalty was levied.

91.02 Difficulties could arise where a transgender patient was admitted who either lacked capacity or might be unconscious, and the meeting discussed the difficulties of capturing breaches in what was effectively a new area. Deborah Harris asked what advice had been made available by the CCGs or by the Centre, Michelle replied that none had been forthcoming to date. Until recently the Trust had had an agreement that breaches in ITU were exempt from penalty, however this no longer felt appropriate so these were also now reported externally.

91.03 Referring back to the patient story that had been related at the start of the meeting, Deborah pointed out that much of this was about estates. During discussion the following points arose:

- priorities for capital spending were becoming increasingly complex and required careful consideration
- there were financial implications to being honest, and no-one wished to see a return to a culture where dishonesty was the most convenient option
- there was a need to bear in mind people who may have changed their names and ensure records were appropriately updated
- there was an LGBTQ+ workshop the following day, everyone was welcome to attend

91.04 The Board formally approved this statement of assurance and agreed it could now be publicised.

18/92 Whittington Health – Next Steps to Outstanding

92.01 Michelle opened this item by saying that the paper covered both planning for the Trust's next CQC inspection and the ambition to move from its rating of good to outstanding. She was aware that this ambition was currently the subject of much discussion amongst Trust staff, and urged colleagues to encourage such discussion as they carried out their planned programme of visits. The plan included both key milestones and a communications strategy going forward.

92.02 Section 3 of the paper set out in detail what CQC was saying about future inspections. It was understood from this that those services rated good in 2015 were likely to be rigorously inspected during 2018/19 since there was a three year cycle for such inspections. There was of course also a need to focus on those areas rated as 'requiring improvement'. The Trust had a robust preparation plan in place, which included self-assessment tools and a peer review process. Michelle was confident that achieving a rating of outstanding was within the Trust's grasp, and she drew attention to Section 4 of the paper, which set out what needed to be done to move to that point.

92.03 Siobhan suggested there was a need for a discussion centred around how ambitious the Trust wished to be, and David echoed Michelle's earlier points about the importance of robust preparation. Anu commended the quality of the paper, but felt that mention should be made of WRES and bullying and harassment as well as social change and cultural issues. There was a general consensus that the strategy should be one of 'engagement' rather than communication, and that the missing element was that of mobilisation.

92.04 Carol Gillen reminded colleagues of the enthusiasm that had been generated at the time of the previous CQC inspection, saying that she felt this could and would be repeated, but needed to be better planned for. It was agreed that the achievement of outstanding should be an ambition that underpinned day to day provision of services, i.e. business as usual should be outstanding. It was also important that staff did not feel the Trust was measuring its worth against a standard over which it had little or no influence.

92.04 Steve Hitchins emphasised that all staff had a role to play, and it would be especially important on this occasion to increase the focus on corporate services. Michelle suggested there should be a performance review of corporate services, and was happy for her own directorate to be amongst the first to be chosen. Jonathan added that a refreshment of the Trust's corporate objectives might be timely.

92.05 The proposal in the paper was approved.

18/93 <u>CNST for Maternity</u>

93.01 Richard Jennings informed the Board that NHS Resolution was offering a scheme to Trusts whereby if progress could be demonstrated against a range of maternity safety actions they would receive a 10% rebate of their CNST insurance premium. Chandrima Biswas and Manjit Roseghini had carried out an assessment of the Trust's position, and subsequently met with Richard as the Board level champion for this area. He felt that this was an accurate picture of the Trust's position, and was therefore confident to recommend Board approval.

93.02 David enquired what, if any, was the penalty for Trusts should it be proven they had not carried out a sufficiently robust process. Richard admitted he did not know the answer to this but suggested that the act of self-certification in itself suggested a degree of Trust in the process. He added that if the Trust had had any major problems this would have become apparent during the process. David asked whether this report might be compared with information from the SI Panel, and Richard assured him this could be done, and a written report be produced which triangulated the information and learning from the SI Panel with the self-certification. The quality committee would also take this forward also. Steve Hitchins added that he felt that the recommendations could be strengthened. Michelle suggested, and there was general agreement, that the best way to address these points might be through the scheduling of a 'deep dive' at Quality Committee.

93.03 The self-certification was agreed by the Board and would be submitted the following day.

18/94 <u>Fire Safety Update</u>

94.01 In attendance for this item, Adrien Cooper explained that his paper gave a summary of action taken since his last paper to the Board in January, in three distinct parts. Following the fire which had taken place in the hospital on 17th January, a report had been sent to the Serious Incident Panel. An action plan had been drawn up and shared with the London Fire Brigade. Part two focused on operational compliance; new policies and procures had been drawn up, 456 fire wardens had been trained (the aim had been to train 300), and there was now a robust Fire Safety Group which met monthly.

94.02 The final section of the paper focused on capital investment, showing the traction achieved over the past six months and the commitment to future capital spending. Siobhan said that Adrien had done a great job over the last twelve months. The Trust was still not 100% compliant but great strides had been made and the Trust was now in a very different place to where it was six months ago. The Fire Brigade had also expressed confidence in what had been achieved.

94.03 In answer to a question from David Holt about whether the fire in January had triggered this action, Adrien strongly refuted this suggestion, saying that the need to properly address fire safety had been an immediate priority on his appointment. David also asked whether there were other areas Adrien was concerned about, and Adrien replied that there were areas around backlog maintenance, improving the level of estates governance, and issues around asbestos and water all of which were on the appropriate risk registers.

94.04 Richard commended Adrien and colleagues for the achievement of having more than one in ten of Trust staff as trained fire marshals. He added that fires were treated as SIs, meaning they were reviewed and scrutinised at the SI Panel. It was recognised that when fires occurred not everything went according to plan so there was no room for complacency. He also hoped that improvements had been made around the storage and handling of flammable gases. The importance of carrying out fire drills could not be emphasised enough. Steve Hitchins added his praise on the team's achievements.

18/95 <u>Financial Report</u>

95.01 Introducing the financial report for Month 2, Stephen Bloomer informed the Board that the Trust was reporting a £0.5m deficit against a planned deficit of £0.3m. The key factor here was income performance, mitigated in part by underspends in pay. There remained however concerns about agency spend, and given that the agency costs had been in excess of £2m to date, it seemed likely that the Trust would miss the agency cap of £8.8m for the year.

95.02 The CIP target for the year was £16.5m, and this had been divided into three distinct categories – the full year effect of schemes started during 2017/18, the 2% target for each ICSU during 2018/19, and the wider transformational schemes across the Trust. Some of the latter, for example the outpatient transformation project, were likely to have far more of an effect later in the year.

95.03 The Trust's balance sheet and cash position were broadly in line with plan. The capital spending plan had increased in the light of the STF funding, and the Trust had been challenged by NHSI, but had been able to respond robustly that all works carried out were targeted to reduce known risks. Delivery of the capital programme was hugely important in supporting service delivery moving forward.

95.04 In response to a question from Yua Haw about why the additional beds remained open, Carol Gillen replied that the service was working actively with clinical teams to reduce 'stranded patients' by improving flow. She was also leading a major piece of work on bed modelling as this was an area the Trust had been struggling with for the last three to four years. It had also been noted that the positive work carried out jointly with social services had brought down the length of stay. An audit was to be carried out at the end of July. Siobhan raised the issue of patient choice – what if patients were unwilling to leave hospital? Carol assured the Board there was a choice policy, but this was also about important conversations with families and carers.

95.05 It was agreed that a presentation would come back to the board in relation to the bed modelling transformation and the gap analysis from the NHSI good practice guides.

18/96 Performance Dashboard

96.01 Carol opened her report by saying that Siobhan had effectively covered the ED position in her Chief Executive's report. The team remained determined to achieve 90% in June, but pressures during the evenings continued to make this challenging. There had also been an increase in mental health patients, which impacted on time taken to treat; at some points in May there had been seven or eight mental health patients within the department. Moving on to cancer targets, Carol informed the Board that the Trust had failed to meet the 62 day target, primarily due to the urology and gynaecology specialties. It had however achieved both the two week and 31 day targets. There had been a slight dip in theatre utilisation.

96.02 Referring to page 24 of the report, which showed the safe staffing figures for the month, Michelle said the picture was a positive one, alerts (i.e. the number of red shifts) were down; this was mainly attributable to regular meetings and reviews. No clinical harm had been brought about because of red shifts. The position on complaints was disappointing, but the operations team was working closely with PALs to resolve this and improve response times.

96.03 Carol introduced the section of the report on community services, saying that the same information was also sent to the CCGs. A community service improvement group had now been established, and was already bringing about positive results. District nursing waits had improved, though other services were less good. The main reason for delays in the community rehabilitation service was the waiting time for speech & language therapy appointments. There were some issues around workforce, and some around productivity. Carol had high expectations of the new ICSU.

96.04 The team had been looking at reasons for the long waits within children's services. One was social care assessments in Islington, where Carol hoped real improvements would be seen by the next Board meeting. More generally, they were looking at demand and capacity. Workforce did appear to be an issue in some services, with vacancies in some areas difficult to recruit to. Commissioners were keen to look at school nursing and where there might be scope for improvement. Siobhan congratulated Carol on her report, saying that this was the first time the Board had received a report giving this level of detail for community services, and assured the Board that the focus is on improvent.

96.05 The Board discussed the CAMH service, and concern was expressed over waiting times, which stood at ten weeks when they should be a maximum of four. Carol was leading a piece of work to look at the clinical models. Jonathan enquired about the reporting line for the Clinical Services Improvement Group, and Carol replied that it reported into the Haringey & Islington Health & Wellbeing Partnership Group but that it should also report into Trust Management Group.

96.06 Steve Hitchins said that he would like to see more of a focus on outcomes – 'turnstiles' were important but did not give a sufficient account of the patient experience. Complaints were a good example of this, where for a long time there had been more of a focus on response times and less detail on the actual outcome. Referring back to CAMHS, the huge increase in referrals around examination times was noted, and Carol suggested more resources might usefully be directed towards schools. There was also a question about whether we track themes of complaints, with the response being that themes from all complaints go to the quality committee. When a number of complaints are received from any one area these are triangulated at service level as they might be an indicator of things going wrong. In answer to a question of how the Trust captures when we get things right, Carol said that the Children & Young People's ICSU had been piloting something called Greatex, and she was looking to expand this.

96.07 Concern was expressed about waiting times in the respiratory service, mainly in Haringey around spirometry, with GP referrals having increased. Group classes were now being created. More generally, Carol was expecting to receive, in the next couple of months, a trajectory with improvements from each of the ICSUs.

97.08 Jonathan Gardner suggested that one or two high level community metrics should be moved to the summary slide at the top of the pack to demonstrate the importance we place on this. This was agreed.

96.08 It was noted that there were a number of gaps within the May figures (pages 13 and 16 were specifically mentioned). Carol explained that this was due to the reporting and validation timelines. The Board thanked all involved in the production of the report, and in particular the community services improvement group.

18/97 Annual Report and Accounts

97.01 Stephen Bloomer assured the Board that the audited Annual Report and Accounts circulated as part of the suite of Board papers had been through all due process and had been approved by the Audit Committee. It was noted that in previous years the Board had received the Annual Report and Accounts at its AGM in September. The Board noted that the approval of the annual report and accounts had previously been delegated to the Audit Committee and so formal approval now was not necessary.

18/98 Cyber Security

98.01 Introducing this item, Leon Douglas reminded the Board that cyber security was an area the organisation could never be complacent about and drew attention to the milestones contained within the paper. The main ongoing risk was, he said, staff, as they were a constant target through hackers, false pleas for help, phishing etc. It was impossible to completely remove such risks, but one could to a degree mitigate against them. Almost all red risks had now been removed.

98.02 Appendix C set out the detail of the regulator return, and Leon felt that the Trust's position was a fairly favourable one and therefore recommended Board approval. Deborah Harris (as Non-Executive lead for this area) commended the robustness of the report, and pronounced herself happy to support it.

98.03 Steve Hitchins said that the report needed a front sheet flagging up the areas where there was still work to do. Stephen Bloomer felt the Trust was as well prepared as it could be; this was challenged by Siobhan in respect of take-up rates for IG training. Deborah said that cyber security would always be an area of risk, using the analogy of someone living with a chronic condition. Tony Rice commended Leon and his team for 'doing a great job'.

98.04 Richard Jennings said that an area which remained of concern for him was the risk for patients – and for clinical staff – if IT systems failed, and for this reason the Trust needed to take a really diligent approach and to ensure that the staff voice was heard clearly. Leon expressed his complete agreement with this, saying that one route for this was through close working with emergency planning colleagues such as Carol and Lee Smith on business continuity planning. The Board formally approved both report and submission.

18/99 Provider License Self-Certification and Board dates, Bi-annual Plan and Terms of Reference Annual Review

99.01 Jonathan Gardner introduced the paper which set out the Trust's compliance with the NHS Provider License FT4 relating to the organisation's governance arrangements. He invited the Board to sign off the Wording in Appendix 1 (which had already been reviewed by the Trust Management Team) in order that it could be placed on the website. He acknowledged that some Terms of Reference were outstanding or required updating, but assured the Board there were plans for sub-committees to address this at their next meetings.

99.02 Steve Hitchins said that he would like to see this report presented annually, ideally in March so that all documentation and governance assurances were updated in time for the start of the new financial year.

99.03 This report and the self-certification contained within were formally approved by the Board. Jonathan commended Susan Sorensen's contribution to its development, and either he or Steve would be writing to thank her on behalf of the Board.

Any other business

There being no other business, the meeting concluded at 5.10pm.

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Action Log

Minute	Action	Date	Lead
35.04	Nursing Establishment Review to be carried out in April with report to Board in July.	July 2018	MJ
40.05	Action plans arising from the Staff survey to be brought back to the Board following discussion at the W.A.C.Committee	Sept 2018	NF
78.07	Community dashboard to be produced with exception report on children's community services	July 2018	CG
90.03	Paper on the Trust's position on the prescription of opiates to be brought to the July Board	July 2018	RJ
95.05	Presentation to come to the Board on the bed modelling transformation work and NHSI good practice guides	Sept 2018	CG
97.08	Some high level community metrics should be moved to the summary slide at the top of the pack to highlight importance	July 2018	CG
99.03	Letter to be written to Susan Sorensen to thank her for all the work she had done for the Trust.	Complete	SH/JG

Trust Board

25 July 2018

Title:	Chief Executive Officer's Report for the Trust Board		
Agenda item:	**18/105**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To note the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	19 July 2018		

Author name and title:		**Fiona Smith Corporate Affairs**		**Director name and title:**		**Siobhan Harrington, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER REPORT

The purpose of this report is to highlight issues and key priorities to the Trust Board.

NEWS

Matt Hancock MP sets out early priorities

Matt Hancock MP, Health and Social Care Secretary has set out his early priorities as workforce, technology and prevention of illness.

He has also announced a new round of digital technology funding with £412m available to STPs to make regional bids for allocations from the autumn. Developments in technology are expected to help achieve improvements in workforce and prevention of illness.

The £412m will be made available to transform technology in hospitals, to improve care and give more patients access to health services at home. A further £75m will be available for trusts to replace paper-based systems with electronic systems.

Mr Hancock has also announced:

- A new consultation on "challenges" for the workforce, include bullying and harassment and how to establish better pathways for clinicians to move into leadership roles;
- more training for pharmacists based in GP surgeries;
- better support for nurses in acute hospitals to become advanced nurse practitioners;
- an apprenticeship scheme for health and social care;
- setting up a new panel of clinical and professional advisers for NHS and social care workforce issues

Simon Stevens sets out 10-year plan priorities

In an interview with the Health Service Journal, Simon Stevens has highlighted five long term priorities which will form a core part of the NHS 10-year plan. The priorities are:

- Mental health, especially services for children and young people
- Cancer screening services
- A new focus on cardiovascular disease and stroke and heart attacks in particular
- A renewed focus on children's services, and prevention and inequality
- New objectives for reducing health inequalities.

Mr Stevens said the 10-year plan would contain other priorities that will be developed with clinicians and leaders of NHS organisations, sustainability and transformation partnerships and integrated care systems.

Mr Stevens said the NHS change agenda set out in the *Five Year Forward View*, aimed at integrating services will not change and that he expects new milestones to be set out to accelerate its spread.

Haringey and Islington Wellbeing Partnership Integrated Care System Expression of Interest

Haringey and Islington Wellbeing Partnership is a well-established alliance between Haringey and Islington Councils, CCGs, Whittington Health, UCLH, North Middlesex Hospital, BEH Mental Health Trust, Camden and Islington Foundation Trust and the GP Federations.

Our joint working provides a strong foundation for integration and Partnership is now in a position to move to the next level of integrated working. The Partnership has submitted an expression of interest to the 'Healthy London Partnership' to provide place-based care, using two neighbourhoods, one in Haringey and one is Islington, to develop a prototype for an all-age, community-focused approach, maximising the opportunities presented by collaboration with the local authorities, beyond Adult Social Care.

This place-based approach and integration across care pathways require a very different way of managing resources. The partnership is aiming to be making investment decisions together within a place (borough) and across our system (Haringey and Islington), by 2019/20. Partners finances and estates will support the movement of resource towards prevention and community-based responses that will improve health outcomes.

Through this EOI the partnership would look to:

- Establish multi-agency and resident design-teams
- Develop system governance and regulation to support joint decision-making on resources and enable neighbourhood level influence.
- Develop a mechanism for shared investment decisions at borough level or for a particular set of services (e.g. integrated intermediate care).

Governance and assurance on opiate prescribing

In response to the recent review of the tragic deaths of many patients at Gosport War Memorial Hospital in the 1980s and 90s, following inappropriate opiate prescribing, in common with many other Trusts, this Trust is reviewing the governance and assurances around our own opiate prescribing, particularly for patients who are receiving or approaching end of life care. A report detailing these assurances will be brought to public Trust Board in September 2018. In the meantime, it should be noted that:

- A full Trust audit of opiate prescribing in 2015 provided robust assurance at that time.
- The Trust is participating in the National Audit of End of Life Care, which is carried out every 2 years, and which looks at the care of all eligible patients in the month of April of the audit year. In common with other Trusts, this Trust is adding additional local questions about opiate prescribing and dosing to the national audit questions.
- A multidisciplinary education event on opiate prescribing and End of Life Care (EoLC) will take place at the Grand Round in September, led by the Palliative Care team.
- A District Nursing education event on the same subject will take place in October led by the Trust Palliative Care Doctor Consultant.
- The Trust is applying for funding for two Band 7 MacMillan EoLC facilitators to further strengthen our education and capacity to provide appropriate opiate prescribing and EoLC.

NHS 70th Birthday celebrations

The Trust celebrated the NHS's 70th birthday with a Big7Tea party and open day at the Whittington Hospital site. Many local businesses, organisations and stakeholder partners contributed to making the day a huge success.

The event was opened by the Mayors of Islington and Haringey and Comfort Offorjindu, one of our longest serving members of staff. At the opening ceremony the Chairman unveiled a plaque commemorating Comfort's recent Lifetime Achievement award at the

NHS Windrush70 Awards which will act as a constant reminder of her hard work and service to the NHS over the past four decades.

I would like to pass on the thanks of the Trust Board to everyone who contributed, helped with the organisation on the day and in advance, hosted a stall, donated a raffle prize, helped with the logistics, attended, bought a raffle ticket or just came along to celebrate the NHS's many achievements over the past 70 years.

Culture survey

In the annual staff survey at Whittington Health (WH), staff have consistently reported their experiencing bullying and harassment (B&H) at work. In the 2017 staff survey, WH had a 7% higher score for B&H from other staff compared to the average for similar Trusts.

To understand staffs' experience of B&H more clearly, I commissioned Professor Duncan Lewis, from Plymouth University Business School, to undertake an independent review of the workplace culture at Whittington Health.

The findings indicate that bullying and harassment is not endemic in the organisation, but a significant number staff have a lived experienced of bullying and harassment.

Professor Lewis' report is presented under a separate paper to the Board where we will have an opportunity to discuss these findings and our response in more detail.

Management restructure

The new operational structure of five integrated clinical service units has now been implemented and nearly all the leadership roles have been filled, some with new leaders, and others with existing leaders whose remit is changing. This restructure will now be supported by working with the clinical leaders and managers to develop their skills, capabilities and effectiveness.

Professor Caroline Fertleman

Congratulations to Caroline Fertleman, Consultant Paediatrician at Whittington Health, who has been promoted to Professor at UCL. Caroline is one of the very few professors of medical education in the UK. I am pleased that Caroline has been recognised for her teaching and commitment to medical education, both undergraduate and postgraduate.

LUTS update

The Trust is continuing to implement the recommendations following the Royal College of Physicians invited review. Most recently the Trust has appointed to a joint WH/UCLH consultant post to substantively fill a post left vacant when Professor Malone Lee retired.

The Trust and CCG continues to meet with the LUTS Patients Group and provide updates to local stakeholders through the JHOSC.

QUALITY AND SAFETY

Emergency Pathway

Performance against the 95% target for June was 90.6%, improving for the 4th consecutive month.

In June we saw 8,700 attendances, a 5.6% increase on June 2017 when we saw 8,239 attendances. Ambulance activity was up by 1% compared to the same time last year: 1656 ambulance arrivals compared to 1628 in June 2017.

The Emergency Department have trialled a new streaming process and an enhanced Rapid Assessment and Treatment Model which proved successful in the ED "Super Week". Learning from this will be considered to determine what system and process changes should be implemented for sustained performance improvement.

Cancer 62 days

The Trust has achieved the cancer standard for 2 week waits and 31 day, however we are underachieving against the national 62-day standard of 85% with a performance of 72%. Details of the actions taken to improve performance can be found in the Performance Dashboard report (Agenda item 7)

MRSA

One MRSA bacteraemia was reported in June 18. This is the first MRSA bacteraemia at Whittington Health in 2018/19. The case has been determined as avoidable following a Post Infection Review. Further learning for clinical teams has been identified through the review.

FINANCIAL

June Financial Position

The Trust is reporting a £0.4m deficit for the month of June (month 3) against a planned £0.4m deficit. Actual performance therefore represents breakeven against plan. Year to date the Trust remains at £0.3m behind plan.

Though the overall in month position is breakeven, pay was £0.1m adverse, offset by a similar favourable variance in income. The key driver for the adverse pay variance is agency expenditure with escalation beds remaining open longer than planned continuing in June (24 down from 31 in May).

The Trust has assumed non-delivery of the A&E quarter one performance (achieving 88.4% against a target of 92.4% for the quarter) and therefore has not accrued any Provider Sustainability Fund (PSF) income related to this.

As reported last month, the Trust is currently awaiting confirmation of its capital allocation for 2018/19. The revised operating plan submission was submitted 20th June reiterating the £15.8m capital request.

EXCELLENCE AWARD

I have great pleasure in announcing that this month's staff excellence award goes to Dr Sam Barclay, Chief Clinical Information Officer.

Sam is a Consultant at Whittington Health. He has worked tirelessly to develop the digital experience at Whittington Health while balancing his demanding clinical responsibilities. He has set a benchmark in clinical digital leadership in establishing the role of Chief Clinical Information Officer.

Through his leadership and engagement, the Trust has a robust digital strategy and national investment through the Global Digital Exemplar (GDE) Fast Follower programme, which is a programme the Trust is part of and which is funding our digital development. The benefits of Sam's work are starting to pay dividends; we no longer use fax machines; pathology requests are electronic, and diagnostic images being centralised in the PACS VNA, which is the diagnostic image system we use within the trust, to name a few.

Thanks to Sam for his continued hard work and insightful leadership.

Siobhan Harrington
Chief Executive

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Trust Board

25 July 2018

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**18/106**	**Paper**	**3**
Action requested:	It is recommended that the Board recognises and discusses the assurances contained within this report that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via Strategic Executive Information System (StEIS) during June 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis. The Board is invited to consider focussing discussion on: • Steps being taken to improve the care of patients who lack mental capacity or who have acute delirium; • Further ways in which we might disseminate learning and be assured that we are learning.		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	17/07/2018		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Richard Jennings, Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incident Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during July 2018. This includes serious incident reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.

2. Background

The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director/Associate Medical Director, Chief Nurse and Director of Patient Experience, Chief Operating Officer, Head of Governance and Risk and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared three serious incidents during June 2018, bringing the total of reportable serious incidents to 17 since 1st April 2018.

All serious incidents are reported to North East London Commissioning Support Unit (NEL CSU) via StEIS and a lead investigator is assigned to each by the Clinical Director of the relevant Integrated Clinical Support Unit.

All serious incidents are uploaded to the National Reporting and Learning Service (NRLS) in line with national guidance and CQC statutory notification requirements.

3.2 The table below details the Serious Incidents currently under investigation

Category	Month Declared	Summary
Unexpected Admission to NICU Ref:8303	April 18	Term baby born in poor condition and admitted to NICU and subsequently transferred to a tertiary unit. Possible hypoxic injury, prognosis unknown at present.
Unexpected Admission to NICU Ref:8308	April 18	Full term baby born in very poor condition, admitted to NICU and subsequently died.
Treatment delay Ref:12146	May 18	Following elective laparoscopic cholecystectomy surgery a patient was returned to theatre due to a suspected injury to the common bile duct.
Treatment delay Ref:12153	May 18	A patient developed septic shock five days post-surgery and was returned to theatre requiring a laparotomy.
Diagnostic Incident including delay Ref:12155	May 18	Patient was returned to theatre following an appendectomy due to developing abdominal sepsis.

Category	Month Declared	Summary
Diagnostic Incident including delay Ref:12811	May 18	A delay in diagnosing a lung malignancy.
Unexpected Admission to NICU Ref: 13327	May 18	A baby was born in poor condition and transferred to Neonatal Intensive Care Unit (NICU). The baby is now on a palliative care pathway.
Return to theatre Ref:13332	May 18	A patient had surgery for a hiatus hernia, and there was an apparent delay in recognising that the patient needed to return to theatre for a complication.
Unexpected Neonatal Death Ref:13530	May18	Unexpected neonatal death following an emergency Caesarean section and prolonged neonatal resuscitation.
Unexpected death Ref:13561	May 18	A patient who was seen and discharged from the Emergency Department after being seen by the Mental Health Liaison Team was readmitted as an emergency and subsequently died.
Confidential information leak/loss/IG Breach Ref:13920	June 18	A staff member had her ruck sack stolen which contained a caseload list with patient confidential information.
Disruptive/aggressive/violent behaviour Ref:13923	June 18	A carer sustained a serious head injury while visiting an elderly community patient, and sadly subsequently died.
Medication Incident Ref:13925	June 18	A patient received incorrect doses of vancomycin and paracetamol, which caused temporary kidney and liver injury.

3.3 The table below detail serious incidents by category reported to the NEL CSU between April 2017 – March 2018.

STEIS 2017-18 Category	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Safeguarding	0	0	0	0	0	0	0	1	0	0	0	0	1
Attempted self-harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG Breach	0	0	1	1	0	1	0	0	0	0	0	0	3
Diagnostic Incident including delay	0	1	1	1	1	0	1	1	0	1	0	0	7
Disruptive/ aggressive/ violent behaviour	0	0	0	0	0	0	1	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	0	0	0	0	0	0	0	0	1	0	0	1
Failure to source a tier 4 bed for a child	0	0	0	0	0	0	0	0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI criteria	0	0	0	0	0	0	0	0	0	2	0	1	3
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	0	1	0	0	0	0	1	0	0	0	0	0	2
Maternity/Obstetric incident mother only	0	0	0	0	1	0	0	0	0	0	0	0	1
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0	0	0	1	0	0	0	0	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	0	1	0	0	2	0	1	0	0	1	0	1	6

Sub Optimal Care	0	0	1	0	0	0	0	0	0	0	1	0	2
Treatment Delay	1	1	0	0	0	1	0	0	0	1	0	0	4
Unexpected death	1	0	1	0	0	0	1	0	0	1	0	0	4
Retained foreign object	0	0	0	0	1	0	0	0	0	0	0	0	1
HCAI\Infection Control Incident	0	0	0	0	1	0	0	0	0	0	0	0	1
Total	**2**	**4**	**4**	**3**	**6**	**2**	**5**	**2**	**0**	**7**	**1**	**2**	**38**

3.4 The table below details serious incidents by category reported to the NEL CSU between April 2016 – April 2018

STEIS 2017-18 Category	2016/17 Total	2017/18 Total		Apr 18	May 18	June 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	0		0	0	0	0
Confidential information leak/Information governance breach	6	3		2	0	1	3
Diagnostic Incident including delay	8	7		0	2	0	2
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	1
Environment Incident meeting SI criteria	0	1		0	0	0	0
Failure to source a tier 4 bed for a child	1	0		0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0		0	0	0	0
HCAI/Infection control incident meeting SI criteria	0	3		0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	4
Maternity/Obstetric incident mother only	2	1		0	0	0	0
Medical equipment/devices/ disposables incident meeting SI criteria	1	0		0	0	0	0
Medication Incident	0	1		0	0	1	1
Nasogastric tube	1	0		0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	1
Sub Optimal Care	4	2		1	0	0	1
Surgical/invasive procedure incident meeting SI criteria	0	0		0	1	0	1
Treatment Delay	3	4		0	2	0	2
Unexpected death	10	4		0	1	0	1
Retained foreign object	1	1		0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**17**

4. Submission of SI reports

All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Executive Medical Director or Chief Nurse and Director of Patient Experience). The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken

and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in June 2018.

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

4.1 The Trust submitted two reports to NELCSU during June 2018.

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation reports submitted in June 2018. The Trust had four reports due for submission of which two were submitted. One extension was given by the CCG and there is one late submission. An additional report was submitted early.

Summary	Actions taken as result of lessons learnt include;
Ref:6532	A patient had a witnessed fall on the ward, resulting in a fractured neck of femur. Although the investigation into this incident did not identify any care and service delivery problems that contributed to the fall, this incident did however highlight the complex needs of patients with delirium. The recommendations included actions to improve awareness of delirium screening and management on the ward, as well as a trust-wide refocus on delirium to share the learning more widely, including relaunching the delirium guideline.
Ref:9647 submitted early	Sub optimal care of a deteriorating patient in the district nursing service. • The process for identifiying and monitoring new patients has been reviewed and strengthened to ensure that full assessments are completed appropriately in a timely way. All new patients requiring initial assessments are now included on a list which is discussed at the senior District Nursing (DN) teleconference each morning. Assessments should be carried out within 72 hrs and where this is not completed a Datix incident form (The Trust incident information system) is completed and delays escalated to the Lead DN. • The DN handover process has been strengthened to ensure it is robust making use of the SBAR (Situation, Background, Assessement, Recommendation) format and providing a clear process for following up outstanding assessments and concerns raised by carers and other stakeholders. DN team handover diaries have been introduced to capture key information and will be

Summary	Actions taken as result of lessons learnt include;
	audited to ensure good practice. • The DN messaging process has been reviewed to ensure there is a more robust process for documenting actions required (via the handover sheet) and escalating outstanding issues. The DN team manager will carry out regular audits to ensure compliance with the new process. • Band 3, 4 & pharmacy technicians will be competency assessed on completing SSKIN (Surface, Skin inspection, Keep patients moving, Incontinence, Nutrition/hydration) bundle template to manage and prevent pressure damage, Waterlow score and MUST (Malnutrition Universal Screening Tool) score.

5. Shared learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies. The Trust also runs a series of multi-disciplinary learning workshops throughout the year to share the learning from serious incidents and complaints, and learning is disseminated through 'Spotlight on Safety', the trust wide patient safety newsletter. Themes from serious incidents are captured in quarterly learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning.

6. Summary

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.

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25th July 2018

Title:	**Quarterly Safety and Quality Board Report** **Quarter 1 2018/19 (01 April 2018 – 30 June 2018)**		
Agenda item:	18/107	**Paper**	4
Action requested:	It is recommended that the assurances contained within this paper are recognised, and that the Board discusses any further actions that we may need to take to improve our performance against our Quality Account Priorities and to maintain antimicrobial and medicines safety.		
Executive Summary:	This is the regular quarterly paper for the Trust Board to provide an overview of safety and quality in the organisation. This report provides an update on mortality, and the Trust's HSMR and SHMI figures. On this occasion this report provides an overview of antimicrobial and medicines safety in the Trust.		
Fit with WH strategy:	To deliver consistent high quality, safe services.		
Reference to related / other documents:	Quality Account 2017-18 Clinical Strategy 2015-20 CQC standards 7 day services clinical standards		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Quality and safety category risks on risk register.		
Date paper completed:	16th July 2018		

Author name and title:	**Richard Jennings, Executive Medical Director**	**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Equality Impact Assessment complete?	**N/A**	**Quality Impact Assessment complete?**	**N/A**	**Financial Impact Assessment complete?**	**N/A**

1. Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.

This report provides an update on mortality and the Trust's HSMR and SHMI figures remain assuring. On this occasion this report provides an overview of antimicrobial and medicines safety in the Trust.

2. Contents

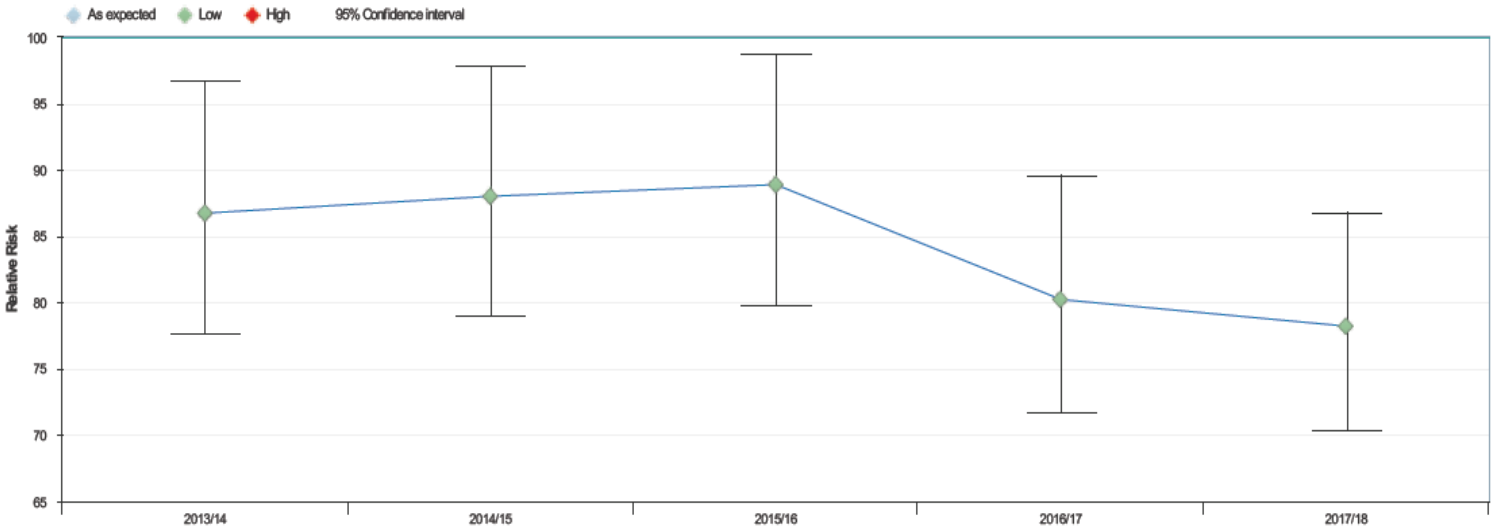
3. Mortality

This Trust's HSMR and SHMI have both been 'lower than expected' since 2005/06.

3.1 Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is a measure of the number of deaths in a hospital expressed as a number which is a ratio of the national average, which is set at 100. HSMR is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement. HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. A ratio less than 100 indicates that a hospital's mortality rate is lower than the average national rate of the baseline year.

Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2013 – March 2018)



The green diamonds on Chart 1, above, represents this Trust's HSMR, which is 'lower than expected'. The bars above and below the green diamonds represent the 95% confidence interval, which means that the actual HSMR has a 95% chance of falling between the higher and lower values of the bars. If the entire confidence interval range is *below* the standardised mean of 100, there have been fewer (with 95% certainty) deaths in the trust than expected, which is formally described as 'lower than expected'. The opposite would be true if the entire confidence interval was above the standardised mean.

3.2 Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator that may suggest the need for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.

In the data published for the period January 2017 – December 2017 Whittington Health does not have the lowest SHMI in the country. NHS Digital have noted that 'there is a shortfall in the number of records in the reporting period April 2016 - March 2017 for Guy's and St Thomas' NHS Foundation Trust meaning that values for this trust will be based on incomplete data and should therefore be interpreted with caution'[1]. We consider that Whittington Health's data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal.

[1] NHS Digital Indicator Portal, (July 2018, NHS Digital), available from https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current

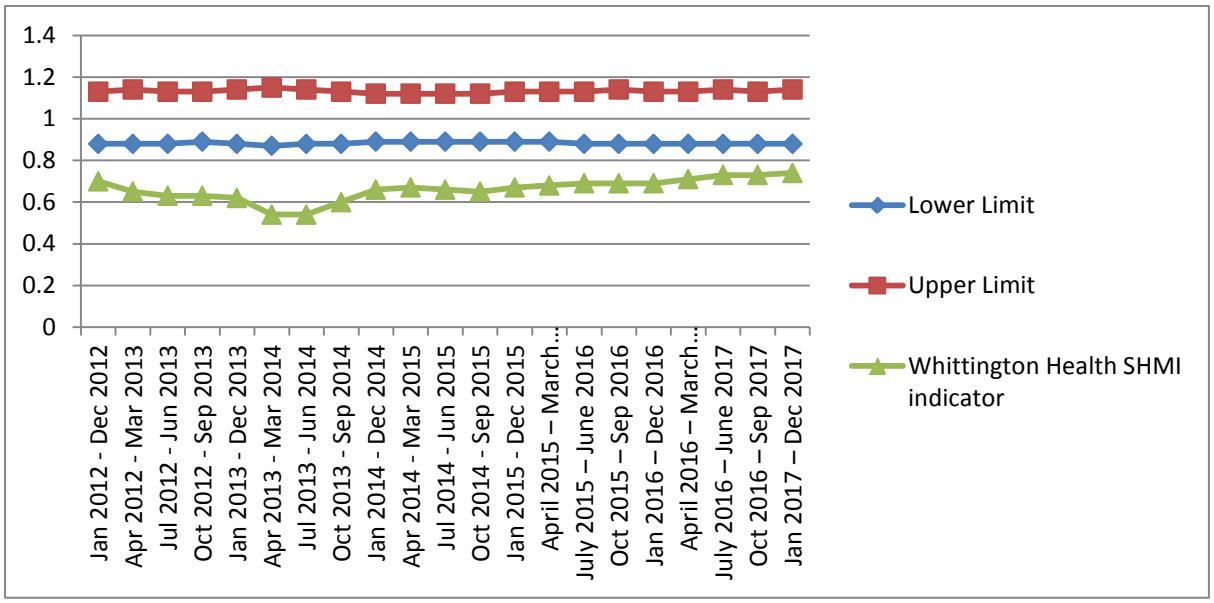
The most recent data available (released in July 2018) covers the period January 2017 – December 2017:

Whittington Health SHMI score	**0.74**
National standard	**1.00**
Lowest national score	**0.72 (Guy's and St Thomas' NHS Foundation Trust)**
Highest national score	**1.21**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – December 2017)

Data Period	Lower Limit	Upper Limit	Whittington Health SHMI indicator
Jan 2012 - Dec 2012	0.88	1.13	0.7
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.6
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67
April 2015 – March 2016	0.89	1.13	0.68
July 2015 – June 2016	0.88	1.13	0.69
Oct 2015 – Sep 2016	0.88	1.14	0.69
Jan 2016 – Dec 2016	0.88	1.13	0.69
April 2016 – March 2017	0.88	1.13	0.71
July 2016 – June 2017	0.88	1.14	0.73
Oct 2016 – Sep 2017	0.88	1.13	0.73
Jan 2017 – Dec 2017	0.88	1.14	0.74

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – December 2017)



In the above Chart 2 the lower limit (blue diamonds) represents the lower 95% confidence limit from the national expected value; the upper limit (red squares) represents the upper 95% confidence limit from the national expected value.

4. Infection control report

4.1 MRSA Related Issues

There has been one Trust-attributable MRSA bacteraemia since 1 April 2018. This was found in June 2018 on the Coronary Care Unit. The patient had been admitted at the end of March 2018 and was not found to be MRSA positive prior June 2018. A Post Infection Review has been completed, which determined that this bacteraemia was avoidable. It was noted that it appeared that a PICC line was contaminated, although it was not possible to determine whether it was contaminated at the time of insertion or during maintenance. The Infection Prevention & Control Nurses are liaising with the Imaging Department to review practices in the insertion of central lines.

Table 2: Whittington Health MRSA colonisation acquisition events April 2018 - January 2019

MRSA acquisition April 2018 - March 2019													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
ITU	0	0	0										0
NICU	0	0	0										0

SCBU	0	0	0										0
Meyrick	0	1	1										2
Cloudesley	0	1	2										3
Bridges rehab	0	0	0										0
Coyle #NOF	0	1	0										1
Cavell	0	0	1										1

4.2 *Clostridium difficile*- associated diarrhoea

Since April 2018 there have been three Trust-attributable *C. difficile* cases. Consultant-led Post-Infection Reviews have been held on all cases and the reports disseminated to relevant parties. All have been determined as not avoidable. The breakdown of cases by ward is shown in table 3. The tolerance for 2018/19 has been set as 16.

Although there have been two cases on Bridges Ward it has been confirmed that the two cases are not related.

Table 3: Whittington Health *Clostridium difficile*–associated diarrhoea cases by ward

Date	No. of Cases	Ward
April 2018	1	Bridges
May 2018	2	Bridges, Nightingale
June 2018	0	

4.3 MSSA / *E. coli* Bacteraemia Episodes

There have been one Trust-attributable MSSA bacteraemia for 2018/19. There are no set national or local thresholds for MSSA bacteraemia.

Table 4: Whittington Health MSSA Bacteraemia cases by ward

Date	No. of Cases	Ward
April 2018	1	Cloudesley
May 2018	0	

Date	No. of Cases	Ward
June 2018	0	

There have been three Trust-attributable *E.coli* bacteraemias for 2018/19 and short Post-Infection Reviews have been completed for each. We are attempting to reduce the number of *E.coli* bacteraemias by 20% this year to ensure that we can meet the national target to reduce the total number of Trust-attributable *E.coli* bacteraemias by 50% by 2021.

In 2016/17 there were 14 Trust-attributable *E.coli* bacteraemia episodes. This meant the trust's 2017/18 local tolerance for Trust-attributable *E.coli* bacteraemia episodes was 11, which we achieved with only nine episodes in 2017/18. In 2018/19 our local tolerance will be eight episodes.

The Trust has produced an updated *E. coli* improvement plan for 2018/19 and we are waiting for this to be agreed by the local Clinical Commissioning Group.

Table 5: Whittington Health *E. coli* Bacteraemia cases by ward

Date	No. of Cases	Ward
April 2018	1	Cloudesley
May 2018	1	Meyrick
June 2018	1	Cloudesley

4.4 Infection Prevention and Control Training

Infection Prevention and Control (IPC) mandatory clinical and non-clinical training is now provided predominately via E-learning. As of 30 June 2018, 82% of Whittington Health staff has received recent (within the last 2 years) IPC training.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the Trust by our IPC nursing staff. IPC Link Practitioner study days are held twice a year. The next study day is to be held in October 2018 and was well attended. Face to face IPC training is provided monthly for all staff.

4.5 Other Relevant Healthcare Associated Infection (HCAI) Issues

Carbapenemase Producing Enterobacteriaceae (CPE)

Since the beginning of April 2018 there have been no new CPE positive patients.

All patients admitted should be reviewed to determine if they are liable to be suspected cases and the reviewing questions are part of the paperwork for the pre-admission clinic as

well as the Emergency Department. The IPCT review the ongoing screening of patients through the surgical site infection surveillance scheme for orthopaedics. Each of the patients on the scheme has their paperwork reviewed to ensure the questions have been asked and specimens taken, if required. For most quarters, around 90% of patients have been asked the questions. Patients with fractured neck of femur are the patient group in which it is most difficult to achieve the CPE screening target. The screening questions asked to the patient cannot be answered by patients with acute confusion or delirium, and the rectal swabs that might be indicated by the answers to the questions cannot be taken from patients who cannot be turned because of their fracture. These limitations are recognised and accepted by the IPC team.

Measles

There has been an increase in the number of patients attending both paediatric and adult Emergency Department with measles. This reflects an increase in measles cases within the community nationally, which in turn reflects a sharp rise in measles cases in Europe. There have been minor issues with patients admitted with rashes being isolated immediately but the IPCT has discussed this with the ED staff.

5. Antimicrobial and medicines safety

Antimicrobial Resistance (AMR) CQUIN

The trust achieved all of the AMR CQUIN targets for 2017/18 (see table 6).

72-hour review of antimicrobials is continually promoted through the multidisciplinary sepsis team effort in raising the awareness of sepsis and the 'Sepsis 6' pathway. Pharmacy has implemented a 3-day maximum supply restriction for non-stock intravenous (IV) antimicrobials, which allows antimicrobial therapy to be initiated immediately and serves as a prompt for pharmacists, nurses and doctors to review the IV antimicrobials within 72 hours.

Table 6: AMR CQUIN results for 2017/18 (pending publication on PHE website):

CQUIN	Indicator	Target	Q1	Q2	Q3	Q4
2c	Clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	Q1 – 25% Q2 – 50% Q3 – 75% Q4 – 90%	**88%**	**88%**	**95%**	**96%**
2d	Reduction in antibiotic consumption (per 1,000 admissions):					
	Total antibiotic usage	1% reduction against 2016				**Achieved**
	Total use of carbapenem	1% reduction against 2016				**Achieved**
	Total use of piperacillin-tazobactam	1% reduction against 2016				**Achieved**

Reductions in antimicrobial usage was achieved through the joint Microbiology and Pharmacy Antimicrobial Stewardship round - working with clinicians to reduce unnecessary use of last-line antimicrobials and minimise duration of treatments, which encompasses 23% and 14% of antimicrobial stewardship review outcomes respectively (see table 7). Low antimicrobial usages are associated with lower antimicrobial resistance.

Table 7: Audit results of Antimicrobial Stewardship review outcomes (2016/17)

Outcomes	**Antimicrobial Stewardship reviews (n = 111)**
Discharged	1 (1%)
Stop	15 (14%)
Continue – with review date	39 (35%)
Continue – without review date	29 (26%)
Escalation to broader antimicrobials	1 (1%)
De-escalation to narrower antimicrobials	25 (23%)
Switch due to allergy / intolerance	0 (0%)
IV to oral switch – with review date	0 (0%)
IV to oral switch – without review date	0 (0%)
Outpatient Parenteral Antimicrobial Therapy (OPAT)	1 (1%)

Antimicrobial and Vaccine Shortages

There have been a high number of antimicrobial and vaccine shortages experienced throughout 2017/18, which remains a problem. Essential antimicrobials including piperacillin-tazobactam, gentamicin, meropenem, ceftriaxone, ceftazidime, ciprofloxacin, clindamycin, co-trimoxazole and chloramphenicol have been affected.

Pharmacy continues to work closely with the trust's microbiology consultants, local and national antimicrobial pharmacist networks, regional procurement consortiums and local STPs to develop local solutions to manage antimicrobial shortages.

Regular updates on shortages and alternative treatment options are provided to front-line staff through emails, memos, pharmacy electronic newsletter and screensavers, to minimise disruptions to services and to limit the impact on patient safety.

Medicines Safety

Medicines safety is overseen in the Trust by The Medicines Safety Group (MSG). This group meets every two months and reports into the Drug & Therapeutics Committee and Patient Safety Committee. The Group consists of representatives of different staff groups and services.

Medicines Safety Group meetings now have a particular theme. Themes covered in 2018 have been controlled drugs, never events and insulin – particularly the high strength insulins.

The next meeting will discuss palliative care and opiate prescribing, and this will be led by the Trust's Palliative Care Consultant, Dr Anna Gorringe.

All medication safety incidents are reviewed by the Trust Medication Safety Officer, and any trends in types of incident, and associated learning, are shared throughout the organisation via the Trust Medicines Safety Group.

Medicines incidents 2018/19

There have been 104 medication related incidents in the first two months of 2018/19, compared to 105 in the same period last year. Medication related incidents accounted for 8.7% of all trust reported patient safety incidents, which is marginally below the national average.

Learning from incidents

Learning from incidents occurs in the following ways:

1. Articles in 'Medicines Matter'. This is a quarterly Pharmacy publication that is sent to all staff and available on the intranet. Each edition has a medicines safety section. Areas covered recently have included
    - Alendronic acid and methotrexate weekly prescribing
    - Insulin safety bulletin
    - Multicompartment compliance aid issues
2. Articles in Spotlight on Safety. This is a bi-monthly publication produced by the Risk Department and available on the intranet. The latest edition – April 2018 featured an article on omitted drugs and doses that occurred when patients were transferred within the hospital.
3. Presentations to the monthly Patient Safety Forum (PSF). Medication related incidents are frequently used for teaching at the Patient Safety Forum led by the Associate Medical Director for Patient Safety. These are usually undertaken by junior medical staff who present and reflect on an incident they have been involved in. These have recently included:
    a. A review of how we as an organisation follow-up patients with Acute Kidney Injury after discharge with particular reference to re-starting medication. As a consequence, a working group is being set up to review the content of discharge summaries which a view to enhance the provision of this medication related information.
    b. Highlighting the importance of accurate medication histories specifically relating to high risk medicines, e.g. Methotrexate, and ensuring that these are accurately reported on admission and acted upon.
    c. This is coordinated by the Associate Medical Director for Patient Safety.
4. Feedback to individuals via Datix.
5. Feedback to ward staff via the ward pharmacy network.
6. Feedback to the local Medicines Safety Officer (MSO) & Medical Devices Safety Officer (MDSO) network – this includes community colleagues as well as other local hospitals.

Other recent changes in practice following learning from incidents:

1. Change of midazolam concentration used for palliative care patients. This was changed following a medication incident reported by the Palliative Care Team. The existing policy was reviewed and it was decided to switch to the higher concentration – with appropriate safeguards in place.
2. Review of vancomycin guideline following an erroneous dosing incident. The guideline was updated immediately with involvement of the multidisciplinary team.

Electronic Prescribing

All medication incidents related to prescribing are also considered by the e-prescribing team with a view to implementing changes within the prescribing system that would subsequently reduce risk of recurrence.

Examples of such intervention include:

1. Warning placed on clarithromycin re drug interaction with warfarin – following an incident where a patient's anticoagulation was destabilised.
2. Warning for paracetamol dosing in patients < 50kg – following an incident where a patient developed a temporary liver injury after a high IV paracetamol dose.
3. Increased warnings on methotrexate and alendronic acid re weekly administration.
4. Changes to the way insulins are prescribed – brand name is now selected by the prescriber to reduce the risk of confusion and mis-selection.
5. Time bands added to JAC to facilitate the safer prescribing of insulin and medication for Parkinson's Disease that reflect individual patient routines more accurately.
6. Analgesia protocols reviewed and updated following incidents where the incorrect protocol had been selected - Acute Pain Team input.

6. Update on progress against Quality Account priorities

Table 8: Update on progress against Whittington Health Quality Account priorities

Quality Account priority	Progress in Quarter 1 (April – June) of 2018/19
We will equal or reduce the number of avoidable falls in the hospital resulting in serious harm to patients compared to 2017/18	2016/17: 6 2017/18: 4 Q1 2018/19: 0
We will increase compliance with our STOPfalls bundle to **85%** in our acute assessment units and care of older people wards	**Q1 2018/19:** Cavell – 96% Cloudsley – 80% Meyrick – 70%
We will develop a mandatory training package for falls prevention	**Progress:** 1. Falls Lead invited to Manual Training Leads Group 2. Fall training now to become mandatory

The Critical Care Outreach Team will review 90% of patients with a grade 3 AKI within 24 hours of detection	Data being reviewed – not yet available.
We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2019	**Q1 2018/19:** April – 87% May – 60%
We will reduce the number of avoidable grade 4 pressure ulcers from 5 in the community and continue to maintain 0 within the hospital	**Q1 2018/19:** April – Community = 1, Hospital = 0 May – Community = 1, Hospital = 0
We will promote *John's Campaign – 'for the right to stay with people with dementia'* – whilst patients with dementia are in our care	**Progress:** 1. Falls Lead is working with the Head of Patient Experience and Dementia Lead 2. *John's Campaign* has been incorporated into falls training and falls monthly multidisciplinary meeting 3. There is a planned visit to the Homerton University Hospital NHS Foundation Trust to see *John's Campaign* in practice
We will develop a frailty pathway that will prioritise the care of patients over 75 who have been diagnosed with frailty	**Progress:** 1. Frailty pathway was relaunched on 23rd April 2018. 2. Patients aged 75 and above are screened in ED and are assessed using the Rockwood Frailty score. 3. Patients who score 5 and above and who have the possibility of being discharged that day are referred to the 'Ambulatory Frailty Pathway' for a comprehensive geriatric assessment and supported discharge. 4. The Frailty Group meets weekly to review project progress. 5. Data is collected for the % of patients scoring 5 or more by the ED
Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours	**Q1 2018/19:** April – 71% May – 64%
We will increase the number of people with learning disabilities involved in trust activities e.g. volunteering, hospital guides	**Progress:** 1. Work undertaken with interim LD lead to provide LD people with taster volunteering sessions 2. LD stall in atrium advertising for volunteers 3. Volunteers with LD to support and recruit new volunteers during LD week

7. New initiatives to disseminate learning from serious incidents, near misses, inquests, complaints and claims

Y-MCA (Why Mental Capacity Act) inter-professional simulation (SIM) training

Understanding and awareness of the principles of The Mental Capacity Act is an essential requirement for all staff involved in the care, treatment and support of people over the age of 16 years who may lack the capacity to make decisions for themselves.

Learning outcomes of this SIM training

- An increased understanding of the Mental Capacity Act
- A better understanding of the effective ways to communicate with patients and those important to them
- Increased confidence in caring for those vulnerable patients in the application of assessments to determine mental capacity in relation to specific decision making
- Increased understanding of the system wide approach

Target audience

- General Practice Staff
- Secondary Care Staff
- Community Pharmacists
- Community Services Staff
- Social Care including Care Homes
- Mental Health Services

Two pilot sessions were run on 25th June and 6th July 2018 and trained 37 professionals from the following staff groups: Care home team leaders, Care navigators, Health visitors, GPs, Nurses and Social workers. Organisations involved: Whittington (lead organisation), Age UK, Camden and Islington Foundation Trust, Care homes, Haringey CCG and Islington Council.

The findings have been presented to the UCLPartners Simulation Network Event on 12th July.

The feedback received was excellent, which along with the high demand suggests that we will need to deliver more sessions in the future.

First Aid Mental Health training

There is a plan to deliver more **First Aid Mental Health training** for WH staff as part of Trust's commitment to support health and wellbeing and increase awareness of mental health. Sessions will take place between October 2018 and January 2019 and will be advertised soon.

Reading Well - Collaboration with Islington public libraries

The Whittington Health Librarian and Library Manager has agreed to collaborate with Islington Public Libraries for the 'Reading Well' campaign. Reading Well is a national campaign developed to help members of the public understand and manage their health and wellbeing through recommendations of helpful reading. There will be public events held in October to provide public and patient information around health and wellbeing.

8. References

1. NHS Digital Indicator Portal, (July 2018, NHS Digital), available from https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current
2. Further information about *John's campaign* is available from https://johnscampaign.org.uk/#/about
3. Further information about the 'Reading Well' campaign is available from https://reading-well.org.uk/about

Whittington Health NHS

Trust Board
25th July 2018

Title:	Yearly update to Safeguarding Adults and Children Annual Report (April 2017 – March 2018)		
Agenda item:	**18/108**	**Paper**	**5**
Action requested:	The Trust Board is asked to review and approve the report following recommendation from Quality Committee		
Executive Summary:	**Executive summary** This report provides a summary of the work undertaken across adult and child safeguarding and covers the period between March 2017 and April 2018 and includes the work plans for adult and child safeguarding for 2018/19. The Trust's safeguarding teams continues to provide a range of services to support key areas of safeguarding work, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective and meet satutory and regulatory obligations. ***Adult*** Over the reporting period safeguarding adult referrals have increased by 27%, with virtually every month showing an increase on the previous year's number. Neglect and acts of omission continue to be the most used category of abuse, with more women than men identified as experiencing abuse. 48% of all safeguarding adult concerns raised were for adults over the age of 75. The overwhelming ethnic group having a safeguarding adult concern raised for them were white British. This data is in keeping with the most recent data looking at national data for safeguarding adults. The number of assessments of capacity following the tenants of Section 3 of Mental Capacity Act 2005 recorded is low. Following changes to eligibility for Deprivation of Liberty Safeguards (DoLS) following *Ferreria v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31, numbers of urgent authorisations have reduced this year in comparison to last year. Training compliance for level 1 safeguarding adults has stood at 90% or above throughout this period of reporting. Level 2 has seen a drop following a sustained 85% compliance rate for the first five months of this reporting period, though finished the year on 72%. In line with requirements to reduce the risk of radicalisation as outlined in Counter-Terrorism and Security Act 2015, extensive training of staff with patient contact has taken place over the past year, with the compliance rate increasing from 20% in quarter 2 to 74% by the end of quarter 4. Over twenty staff have received training to become Home office registered WRAP (Workshop for Raising Awareness of Prevent)		

	3 trainers. Whittington Health was involved in one Serious Adult Review and had input into a Significant Learning Event Process (SILP). In addition, the Trust has undertaken one review under the Learning Disability Mortality Review (LeDeR) framework, and hosted a successful and very well received learning event. ***Safeguarding Children*** In December 2017 Haringey borough was subjected to a Joint Area Targeted Inspection (JTAI) with a specific focus on school age children and neglect. The outcome of this inspection highlighted some significant gaps within the school nursing service (gaps related to clinical as well as safeguarding practice i.e. health assessment protocol, use of RIO, record keeping). A multi-agency action plan has been developed to address recommendations made. The JTAI inspection also identified gaps, which had been previously recognised in previous inspections and reviews inspections, of the ability of staff to capture the voice of the child and have awareness of the child's journey. A focus of all safeguarding training and supervision has a focus on 'Think Family'. Compliance with statutory training continues to be a focus for the Trust and was achieved across the Trust for the periods August and November 2017. Compliance remains in level 1, but for level 2 and 3 compliance levels have dipped slightly to 75% and 84% respectively. This is on account of training compliance recording for trainee doctors on rotation. A new system of recording and capturing junior doctor compliance with safeguarding training is being identified.
Recommendations:	To continue to develop the integrated reporting to the Board and Quality Committee with a yearly update on the work of the safeguarding teams. To continue to provide assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care. To ensure partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.
Fit with WH strategy:	We will maintain a focus on delivering high quality, safe and compassionate care for our patients We will meet all national minimum standards and regulatory requirements, delivering consistent and standardised clinical practice.
Reference to related / other	• Children Act 1989 and 2004. Mental Capacity Act 2005; Care Act

documents:	2014 • Standards for Safeguarding Adults and Safeguarding Vulnerable People in the Reformed NHS • Accountability and Assurance Framework 2015. Children and Social Care Act 2017 • Pan-London Policies and Procedures for Child and Adult Safeguarding
Reference to areas of risk and corporate risks on the Board Assurance Framework:	This report provides assurance that work is being undertaken to ensure the Trust is meeting statutory requirements to protect adults and children at risk of abuse and neglect. A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety
Date paper completed:	02 June 2018

Author name and title:		Head of Safeguarding (Children) Karen Miller Head of Safeguarding (Adults) Theresa Renwick		**Director name and title:**		**Michelle Johnson, Chief Nurse**	
Date paper seen by EC	**Yes**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

ANNUAL REPORT TO THE TRUST BOARD
(APRIL 2017-MARCH 2018) SAFEGUARDING ADULTS AND CHILDREN

1. INTRODUCTION

1.1 This yearly report for safeguarding children and adults informs the Quality Committee and Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for adults and children across Whittington Health NHS Trust. It builds on the bi-annual (6 monthly) report submitted in November 2017, covering the period to end April 2017. The report provides assurance around the following:

- Adoption of national policy changes
- Responding to and learning from safeguarding concerns raised from internal incidents and serious incidents; Serious Case Reviews, Safeguarding Adult and Domestic Homicide Reviews and regulatory inspections
- Work plan and objectives for the coming year

2. SAFEGUARDING CHILDREN

2.1 The Trust is working closely with their respective Local Safeguarding Children Boards (LSCBs) and CCGs. Post the Wood Independent Review of LSCBs and the new Children and Social Care Act 2017 there are expected changes expected in how Boards operate and possible a change in title from LSCB to Safeguarding Partnerships.

2.2. Child sexual exploitation is high within both the national and local priorities for safeguarding children. Since the Trust received notice of the Independent Inquiry Child Sexual Abuse **(https://www.iicsa.org.uk)** there has been a collaborated approach to records management and retention requirements between CSS ICSU and safeguarding team. To date the Trust has not received notification from the Inquiry in relation to any potential disclosures that involve the Trust. However, the full terms of reference for the inquiry have not been finalised.

2.3. In April 2017 the London Borough of Islington was subjected to an OfSTED Inspection. Positive comments were received in respect of partnership working, and health workers within Looked After Children team and CAMHS were described as highly motivated. Their approach to children was deemed to be child-centred and comprehensive in respect of their health needs with effective information sharing. Ofsted were particularly impressed with the pathway used by Islington social care to include health within strategy meetings for high level safeguarding referrals. Building this pathway is also being utilised for our MASH health professional role in Hackney and also within Haringey MASH.

2.4. In November 2017 CPIS (Child Protection Information System) went live across the hospital site. This system allows staff in unscheduled care settings (ED) to access a national database to identify children subject to a Child Protection Plan and Looked After. The system is also utilised in maternity triage.

2.5. In December 2017 Haringey borough was subjected to a Joint Area Targeted Inspection (JTAI) with a specific focus on school age children and neglect. The outcome of this inspection highlighted some severe gaps in safeguarding provision within the school nursing provision. A subsequent action plan has been developed across the agencies to address these deficits, namely capacity of school nursing team, record keeping, training, cross-agency working and the ability to safely assess and provide holistic care and safeguarding support to the vulnerable school age population. The JTAI Action Plan is monitored through the Whittington Health Safeguarding Committee and the Haringey LSCB.

2.6. Within this reporting period there have been two Serious Case Reviews (SCR's). A number of Serious Incident Investigations (SI) was undertaken during this period which highlighted gaps in provision for children's care pathways when transitioning to adulthood. This was particularly relevant for adolescents presenting with acute onset mental illness. We have employed a specialist mental health nurse within the children's ward, designated an area of Ifor ward as specifically for adolescents as well as developing a pathway for use in the Emergency Department to ensure a smooth and safe transitions across the Trust in treatment pathways

2.7. There is mandatory reporting of FGM, with FGM incorporated into safeguarding training for staff. We have not identified any cases of FGM requiring escalation to social care based on risk assessments carried out in accordance with WH FGM Policy.

2.8. The Haringey Multi Agency Safeguarding Hub (MASH) was successful in achieving additional funding from the CCG to support a dedicated post holder. This has strengthened our position within the multi- agency framework for collaborative working.

MASH SCENARIO

A 14 year old girl telephoned Child Line indicating she felt suicidal and had tried to cut her wrists. She was struggling at school and felt that the teachers disliked and bullied her. In accordance with ChildLine protocol a referral to social care was agreed with the child as it was felt she was at imminent risk. Historical Information gathering through the MASH identified that her older sister had alleged high level physical abuse against her and her siblings perpetrated by the father and brother. This was investigated three years ago but the case was closed due to lack of evidence and corroboration from the family. Following the MASH referral a decision was made by social care that it did not meet threshold for further intervention from social care and the case was passed to school nurses and the G.P. for follow up. The school nurse made contact with the young person and met with her three times to offer support whilst also liaising with the G.P. and the family to refer the young person to CAMHS. On the fourth consultation with the school nurse the child disclosed that she was suffering extreme physical abuse from her father and brother and was fearful for her safety in the home. She was contemplating suicide. This was referred back to social care who immediately commenced an investigation. The child was eventually moved to live with an older sibling and her mental health has improved as has her confidence at school.

This case shows the value of health contributions to the multi-agency partnership approach to safeguarding.

2.9. Supervision continues to be delivered one to one to all school nurses, health visitors, Safe Talk nurses and Family Nurses. Other community health practitioners access group supervision. The Emergency Department continues to hold a weekly

Multidisciplinary Team meeting (MDT). This offers the opportunity to reflect on previous weeks admissions where safeguarding issues were identified and ensure that robust actions have been carried out.

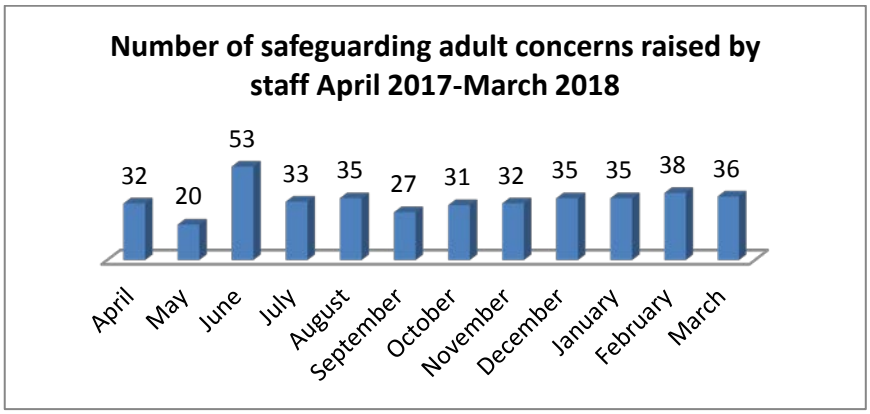
2.10. Haringey Safeguarding team contributes to partnership working with good attendance at multi-agency LSCB meetings in particular working jointly to safeguard children and young people at risk of CSE.

3. SAFEGUARDING ADULTS

3.1. The CQC inspection in October 2017 found that staff had a good knowledge about both identifying vulnerable adults, and what to do.

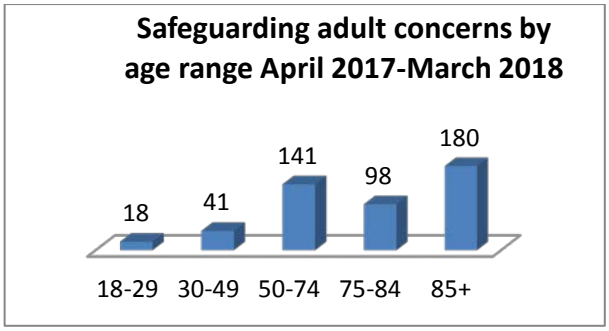
3.2. The '*Safeguarding Adults Collection (SAC), Annual Report, England 2016-2017*' [1] was published in November 2017, and found adults over the age of 65 were most likely to experience abuse. This finding is replicated by data of patients identified by Whittington Health staff as being abused, and is shown in graphs 1 and 2 below.

3.3. Graph 1 shows there have been a 27% increase in numbers of safeguarding adult concerns raised by Trust staff across this past year. Such an increase demonstrates the understanding staff has of their responsibilities in relation to safeguarding adults. The CQC inspection in October 2017 found that staff had a good knowledge about both identifying vulnerable adults, and what to do. Numbers of safeguarding adult concerns raised by Trust staff continue the trend seen last year of increasing. We can see the last six months have shown more concerns being raised by staff.



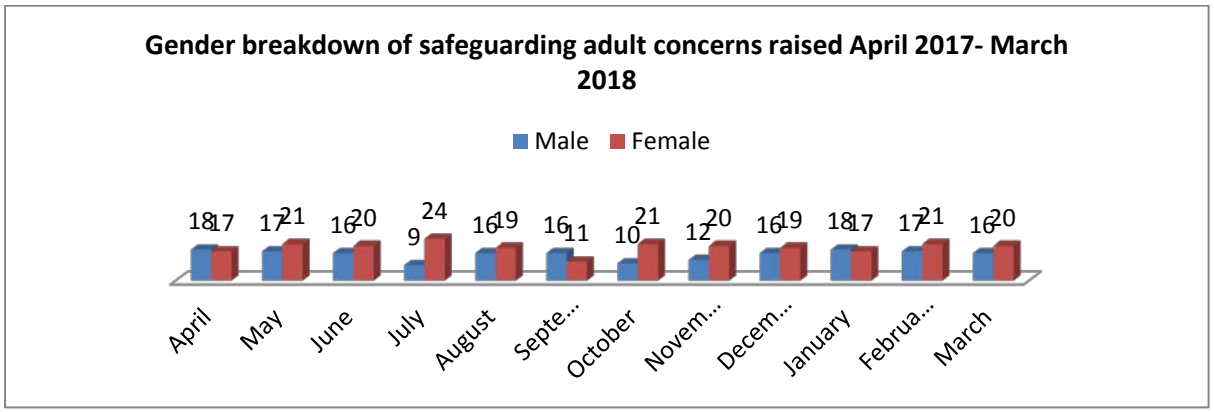
Graph 1

[1] Safeguarding Adults Collection (SAC), Annual Report, England 2016-17 Experimental Digital https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557866/SAC__1516_report.pdf



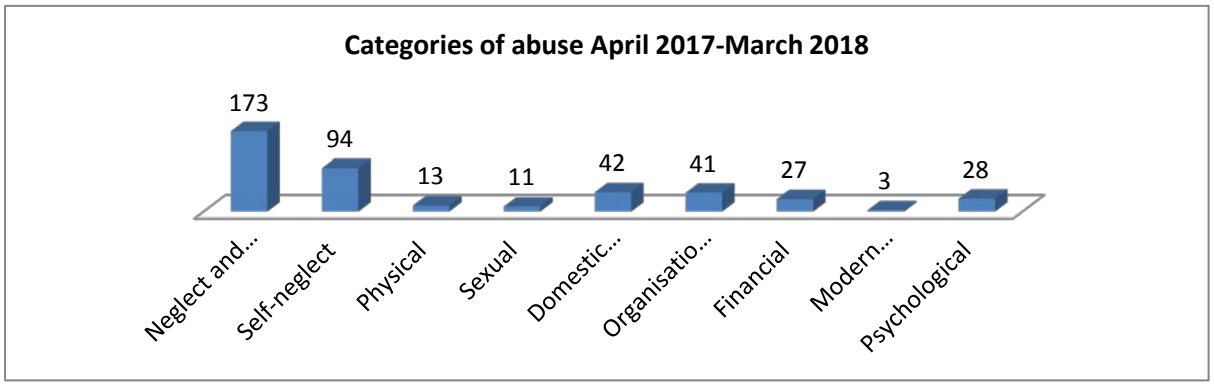
Graph 2

3.4. Graph 3 follows the findings of national data from 2016-2017, in that women were more likely than men to be identified as being abused.



Graph 3

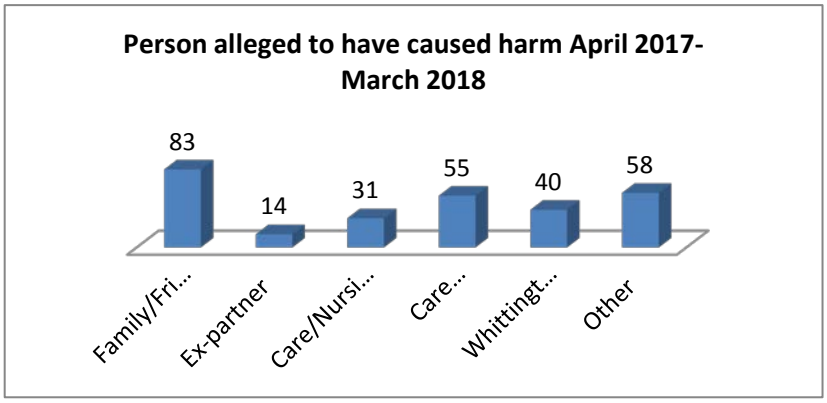
3.5. Since collection of data in relation to the ten categories of abuse (graph 4) stipulated in the Care Act 2014, neglect and acts of omission has been the category most often identified. Whittington Health data reflects this.



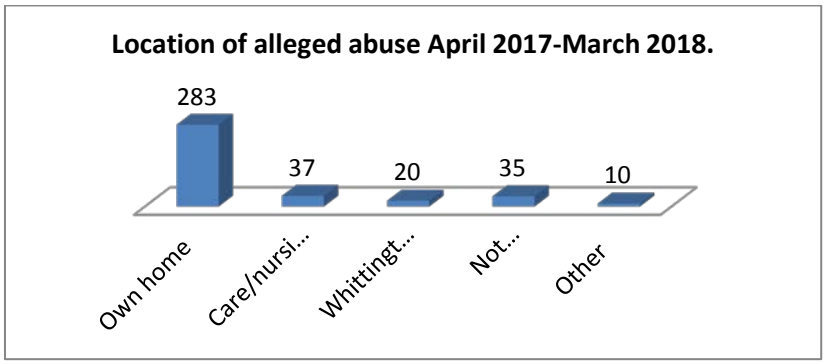
Graph 4

3.6. Discriminatory abuse was not identified as a category of abuse by Whittington Health staff, and has a comparatively low representation in national data too.

3.7 Graphs 5 and 6 reflect that the person alleged to have caused harm is very likely to know the vulnerable adult. Where Whittington Health staff have been identified as the person alleged to have caused harm, this is in relation to the development of pressure ulcers either in hospital or the community, and/or unsafe discharges. The overwhelming location of alleged abuse was found to be in the persons' own home alongside that of someone the person knows. Significant work is underway around 'Stop the Pressure' and 'React to Red' Campaigns alongside the SSKIN bundle. The Trust also worked with CCG director of quality to undertake an assurance visit to one of the hospital wards reviewing pressure ulcer prevention and management. In the community there have been specific caseload reviews for patients with pressure ulcers including reviewing documentation of pressure ulcers upon admission to caseload. There is also increased visibility of TVN service and the head of adult safeguarding now attends the DN/TVN caseload review in district nursing teams. The head of safeguarding has also attended a number of MDTs across the hospital wards to assist with discharge planning issues, and support staff within WH with this.

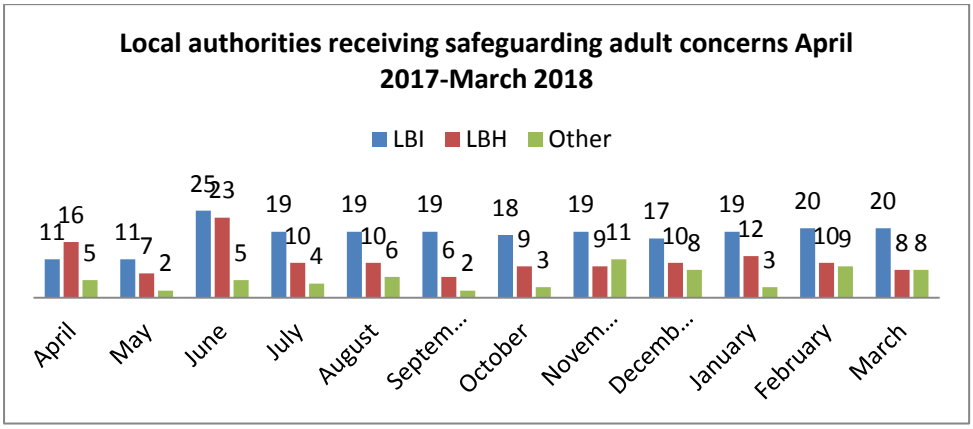


Graph 5



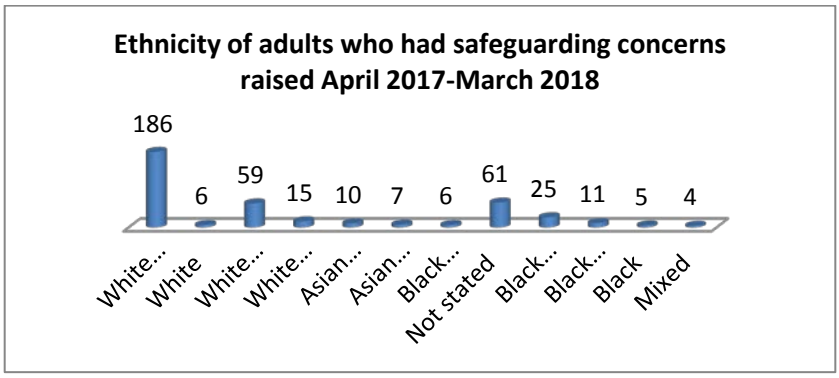
Graph 6

3.8 Given the location of the Whittington, and that community services are provided predominantly in the London Boroughs of Islington and Haringey, the distribution of safeguarding adult referrals geographically is as expected in graph 7.



Graph 7

3.9 Graph 8 shows the ethnic makeup of safeguarding adult referrals. It is not possible to compare this with more up to date data than the 2011 census for both Islington and Haringey; however, both Islington and Haringey Safeguarding Adult Boards are looking at the ethnicity of adults referred for safeguarding, to ensure there is appropriate representation. Haringey and Islington CCG receive quarterly activity reports and are aware of the breakdown. As part of the QAA sub group for SABs, ethnicity breakdown and how this needs to responded too as a partnership is being considered.



Graph 8

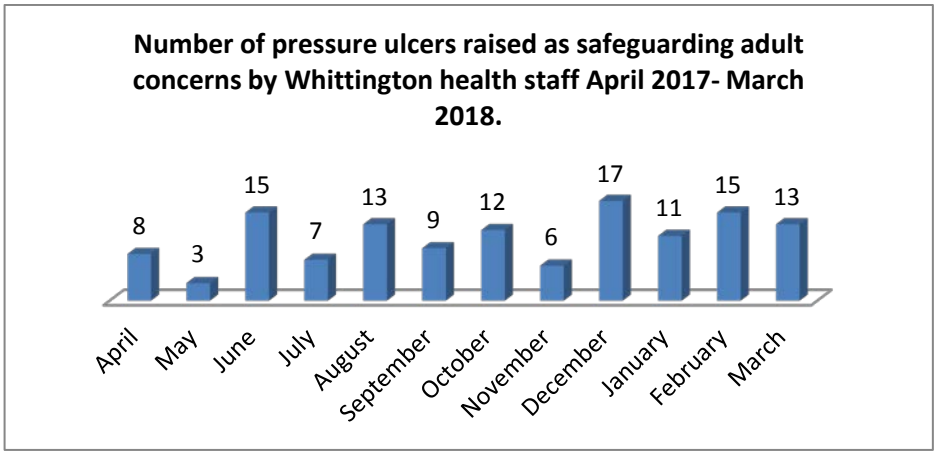
EXAMPLE 1

John is in his 70s, has poor mobility, refuses assistance with personal care and to declutter his flat, and lives in supported accommodation. Concern has been expressed about his ability to attend to his personal care needs and to take action to reduce the fire risk from his flat as a result of his smoking, placing an electric fan heater in a pool of water in his kitchen and refusing to remove it, and his refusal to remove flammable materials. A discussion at the Integrated Network of Care ensured all agencies were aware, specialist assessments took place, and the risks were managed.

EXAMPLE 2

Mary was in her 50s when she was brought to hospital having collapsed due to a brain tumour. Mary had a 17 year old son who had severe learning disabilities and autism. He was admitted and the multiagency teleconference resource used to ensure upon discharge all appropriate services were available for the family.

3.10 In line with the *London Multi-Agency Adult Safeguarding Policy and Procedures,*[2] and *'Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry,' Department of Health January 2018,* pressure ulcers are only reported as safeguarding concerns if they are felt to have been avoidable, and the result of abuse and/or neglect. Whittington Health continues to play a key role in distributing information to the local community to raise awareness about prevention of pressure ulcers (Graph 9).



Graph 9

4. ALLEGATIONS MADE AGAINST STAFF

4.1 In this reporting period there have been two cases of staff employed by the Trust referred to the LADO (Local Authority Designated Officer). The cases have all been in relation to aspects of their personal life that could have an impact on their ability to respond appropriately to potential safeguarding children situations or place a child at risk due to their behaviour. In both cases on further investigation, it was found that a formal investigation was not required.

4.2 The number of cases referred to the LADO from health settings is low, but this is in line with other health partners and is linked to the nature and time health workers spend with children comparative to colleagues in education and social care settings.

5. TRAINING

Children

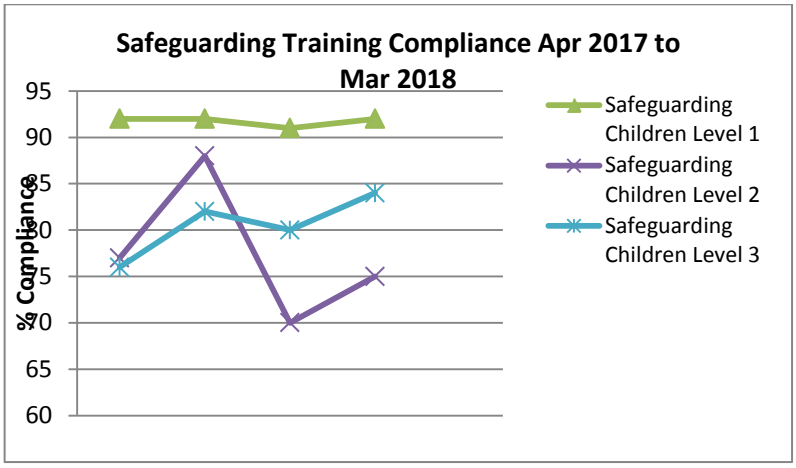
5.1 Compliance with statutory training continues on an improvement trajectory (Graph 10).

5.2 Whittington Health secured funds to purchase the 'Rosie' Simulation training

[2] https://www.safeguardingadultsyork.org.uk/media/1070/pan-london-safeguarding-adults-procedures.pdf

package. The utilisation of safeguarding scenarios have been piloted and received postitive feedback from participants and peer evaluation from the faculty.

5.3 Level 2 compliance is heavily impacted upon by trainee doctor rotations and issues with training history capture on commencement of service within Whittington. Trust Induction is being revised to accommodate level 2 training.

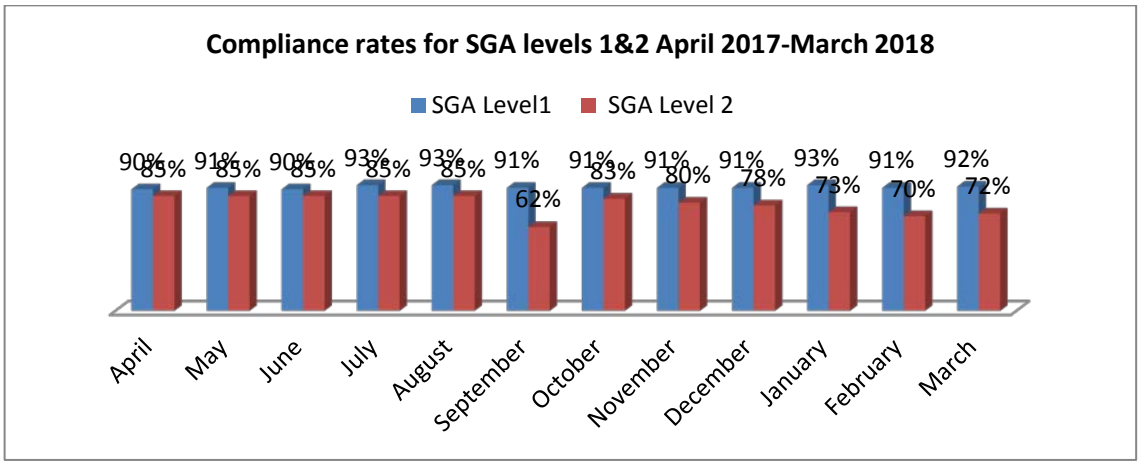


Graph 10

Adults

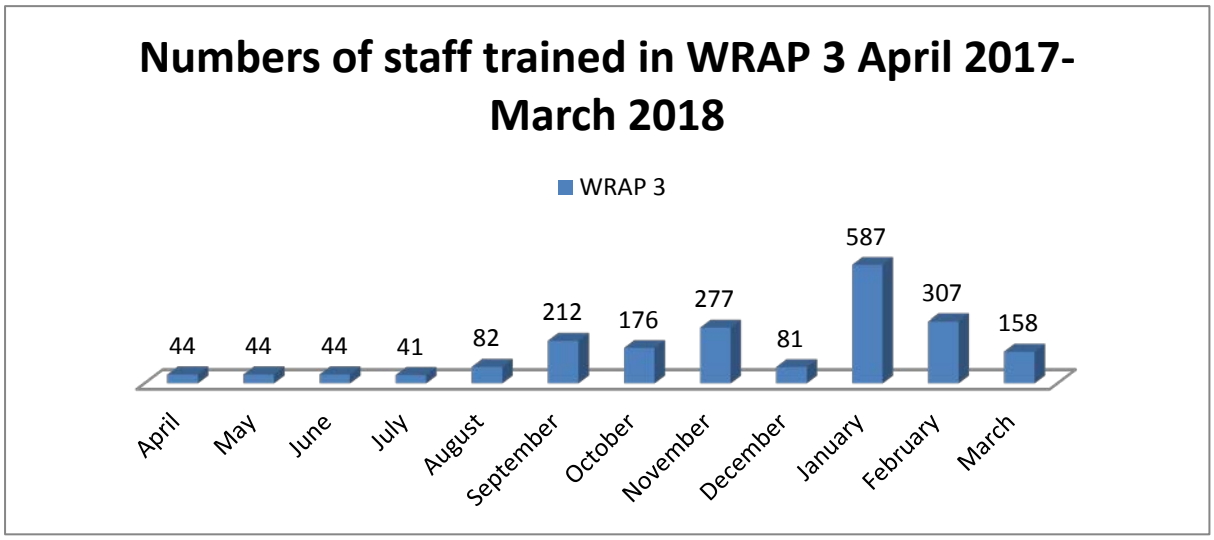
5.1 It is encouraging to see compliance of safeguarding adults remain at 90% or above throughout the whole year.

5.2 The drop in compliance rates for level 2 safeguarding adults is attributed to large numbers of staff losing compliance in the latter part of this reporting year. To address this, from January 2018, the number of refresher sessions was increased from one monthly session to on average three sessions a month. This is in addition to the induction training. Graph 11 below shows the compliance rate as of March 2018.



Graph 11

5.3 In order to work towards the required 85% compliance rate of applicable staff receiving face to face WRAP training by the end of March 2018, weekly drop in sessions were provided from January 2018. These were in addition to sessions already scheduled within the maternity department. The introduction of an e-learning module in February 2018 means weekly drop in sessions are no longer necessary to ensure compliance.



Graph 11

6. LEARNING FROM SERIOUS INCIDENTS (SI), SERIOUS CASE REVIEWS (SCR CHILD), SAFEGUARDING ADULT (SAR) AND DOMESTIC HOMICIDE REVIEWS (DHR)

Learning and action plans from the SCRs and relevant SI's are presented to the internal Safeguarding Committees (adults at risk and safeguarding children) and through sub groups of the relevant LSCB and SAPB.

6.1 Safeguarding Children

During the reporting period there were two active SCRs where the Trust was involved. There was also an SI that involved safeguarding children.
The summary of learning themes:

- Responding to gang activity through unscheduled care
- Engaging with children missing education
- Pathways for escalation for repeat A&E attendances
- The impact of domestic abuse on children when perpetrated by mother
- Supervision and record keeping
- Ongoing support for vulnerable teenage mothers who disengage from services
- Liaison between midwifery and health visitors

6.2 *Safeguarding Adults*

Section 44 of the Care Act 2014 stipulates a Safeguarding Adult Review (SAR) is to be undertaken by the SAB when there are concerns about how partner agencies worked together, and the SAB suspects an adult has experienced significant harm, or has died as a result of abuse and/or neglect. [3]The aim of undertaking such a comprehensive review is to look at what can be learned and how practice can be influenced and developed.

Follows a summary of activity and learning themes

- London Borough of Camden request Whittington Health to assist with looking into SAR. Whittington Health fully participated in the investigation and final report, which is available via the London Borough of Camden website[4]. There were no specific areas of learning for Whittington Health; however, general learning included use of the Mental Capacity Act 2005 when working with vulnerable adults.
- London Borough of Barnet - request information in order to assist with a SILP (Serious Incident Learning Process). Finished report is not yet available, however, involvement from Whittington Health had been some years prior to the incident being discussed.
- There is an increasing awareness of the need to look in detail at unexpected deaths within the NHS following the publication of reports such as the Mazars Report 2015[5].Whittington Health is part of the partnerships in both Islington and Haringey which look into the deaths of people with a learning disability, under the framework devised by the Learning Disability Death Mortality Review (LeDeR).[6]
- A review of the care and treatment of a patient with learning disabilities was undertaken in August 2017, with the learning shared at a multi-agency learning event in October 2017. Main themes of learning was around the use of hospital passport and make reasonable adjustments, and to use the tenants of the MCA, to carry out assessments of capacity, follow the five principles of the Act, and understand the roles of lasting power of attorney and power of attorney.

6. DEPRIVATIONS OF LIBERTY SAFEGUARDS

7.1 Graphs 12 and 13 below show the numbers of Deprivation of Liberty urgent authorisations which was applied for within Whittington Health. This data is further broken down into gender, ethnicity and age range, before looking at the distribution of urgent applications to local authorities, and the originating ward of the hospital. This

[3] http://www.legislation.gov.uk/ukpga/2014/23/section/44

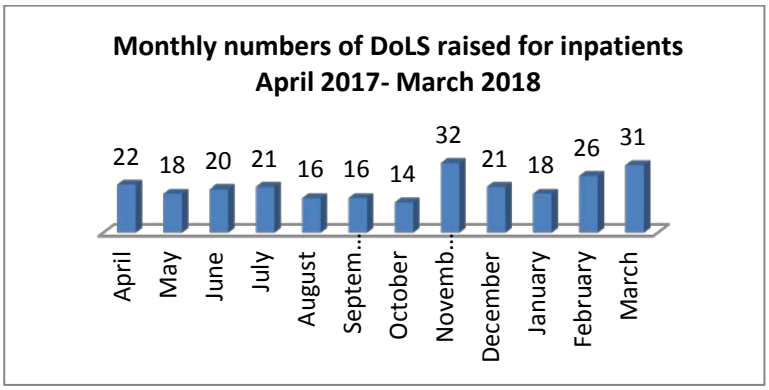
[4] http://camden.gov.uk/ccm/cms-service/stream/asset/;jsessionid=8AEE3213BCD2C0BAE448CA1FF19D91B7?asset_id=3650812

[5] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

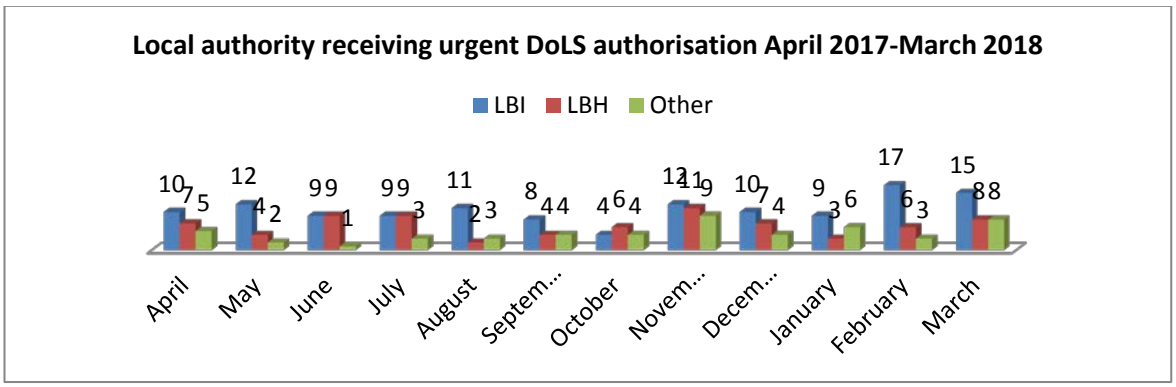
[6] http://www.bristol.ac.uk/sps/leder/

data is in keeping with the CQC findings highlighted in their annual report '*State of Care 2016/2017*'[7].

7.2. The number of assessments of capacity following the tenants of Section 3 of Mental Capacity Act 2005 recorded is low – reasons for this are discussed further below. As anticipated, following changes to eligibility for Deprivation of Liberty Safeguards (DoLS) following *Ferreria v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31[8], numbers of urgent authorisations have reduced this year in comparison to last year.



Graph 12



Graph 13

8.0 MENTAL CAPACITY ACT (MCA)

8.1 The Mental Capacity Act 2005 is applicable for people aged 16 and above, and who have "an impairment of, or disturbance in the functioning of, the mind or brain."[9] As

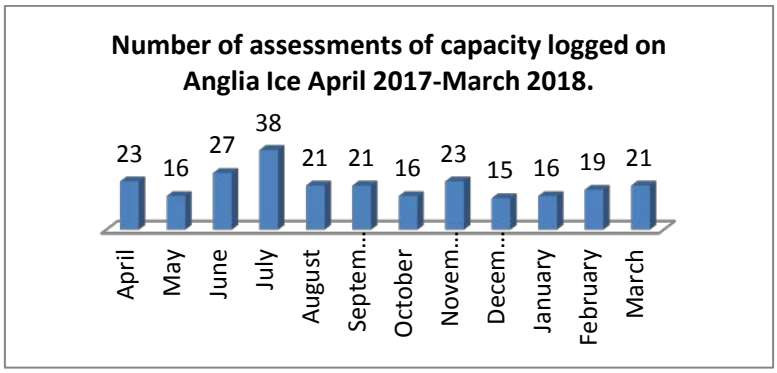
[7] https://www.cqc.org.uk/publications/major-report/state-care

[8] http://www.bailii.org/ew/cases/EWCA/Civ/2017/31.html

[9] Mental Capacity Act 2005, Section 2(1).

Graph 14 below shows, numbers of capacity assessments logged on Anglia Ice were fairly consistent throughout the year. Whilst these figures show an increase of almost 30% in numbers of assessments logged on Anglia Ice in comparison to 2016-2017, they are not a true representation of the amount of assessments of capacity undertaken within Whittington Health.

8.2 Assessments of capacity are often handwritten in the notes, so there is no way to reliably collect this data other than to look at each paper file. A case note audit is planned to look at assessments of capacity to assist with this.



Graph 14

8.3 An increase in assessments in those over the age of 75 is in keeping with the data in relation to the age of those subject to DoLS within Whittington Health, and perhaps also this has relevance to the increased likelihood safeguarding adult concerns will be raised for those aged 65 and above.

8.4 There does not appear to be any national data on age and gender so it is not possible to know if this data is in keeping with other agencies.

9. PRIORITIES 2018/19

Children

- To continue to provide high level safeguarding training packages whilst aiming to achieve compliance across all three levels
- To work with Learning & Development and the Medical directorate to improve trainee doctor training compliance recording
- To deliver on the safeguarding actions and recommendations emerging from the JTAI
- To embed the safeguarding agenda fully across the Integrated Care Organisation by moving safeguarding team from under the Children's ICSU to sit under corporate structure
- To contribute and develop practice across the organisation with regards to emerging themes around contextual safeguarding e.g. Think Family and voice of the child

- Develop health strategies in relation to gangs, adolescent mental health and child sexual exploitation
- To further develop partnership working between midwifery and health visiting services
- To continue to develop pathways within MASH teams that support the transmission of proportionate health data across the partnership to help protect children and young people effectively

Adults

- Achieve compliance rates for both WRAP 3 and safeguarding adults level 2
- Roll out across the Trust advanced training in use of the Mental Capacity Act 2005
- Prepare for planned changes to the DoLS legal framework, which will have significant implications for Whittington Health
- Incorporate learning disabilities data and concerns within the safeguarding adults governance structure
- Maintain community safeguarding adult forums

10. CONCLUSION

- Annual report of safeguarding adult and child across Whittington Health
- Trust Board to approve the Report

NHS
Whittington Health
NHS Trust

Trust Board
25 July 2018

Title:	June (Month 3) 2018/19 – Financial Performance		
Agenda item:	**18/109**	**Paper**	**6**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust is reporting a £0.4m deficit for the month of June (month 3) against a planned £0.4m deficit. Actual performance therefore represents breakeven against plan. Year to date the Trust remains at £0.3m behind plan. Though the overall in month position is breakeven, pay was £0.1m adverse, offset by a similar favourable variance in income, even after adjusting for the Provider Sustainability Fund (PSF) variance. The Trust has assumed non delivery of the A&E quarter one performance (achieving 88.4% against a target of 92.4% for the quarter) and therefore has not accrued any PSF income related to this. The key driver for the adverse pay variance is agency expenditure with escalation beds remaining open longer than planned continuing in June (24 down from 31 in May). The agency costs are now in excess of £3.4m at the end of June against an annual spend ceiling of £8.8m. As reported last month, the Trust is currently awaiting confirmation of its capital allocation for 2018/19. The revised operating plan submission was submitted 20th June reiterating the £15.8m capital request.		
Summary of recommendations:	To note the financial results relating to performance during June 2018		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	19 July 2018		

Author name and title:	**Anis Choudhury Head of Financial Planning and Analysis**			**Director name and title:**		**Stephen Bloomer Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Financial Overview

The Trust is reporting a £0.4m deficit for the month of June (month 3) against a planned deficit of £0.4m. Actual performance therefore represents a breakeven position against plan. The year to date position remains £0.3m behind plan at a deficit of £0.9m.

The main reason for the Trust's year to date adverse position (£0.3m) is the underperformance of income (£0.4m) against plan. In total, including Provider Sustainability Funding (PSF), the income performance is £0.8m behind plan. The PSF underperformance contributes £0.4m of this variance, which is a result of the Trust not achieving its improvement trajectory target for A&E performance. The Trust achieved 88.4% against a target of 92.4% for the quarter. The remaining under achievement can be attributed to clinical activities including maternity services and day cases procedures.

The Trust is reporting a positive variance in relation to both pay and non-pay in the year to date position.

The average pay bill over the first quarter is £18.6m. This month has seen an increase mainly as a result of increased agency costs. The agency bill has increased from £1.0m in month 1 to £1.3m in month 3 The main increases in agency spend are as a result of vacancies across a number of specialities, but largely as a result of escalation beds.

Non pay expenditure was on budget in month falling slightly in month 3 to £7.0m from £7.3m in month 2. The reduction was mainly on Clinical Supplies and Services across a number of ICSUs and Premises costs (utilities).

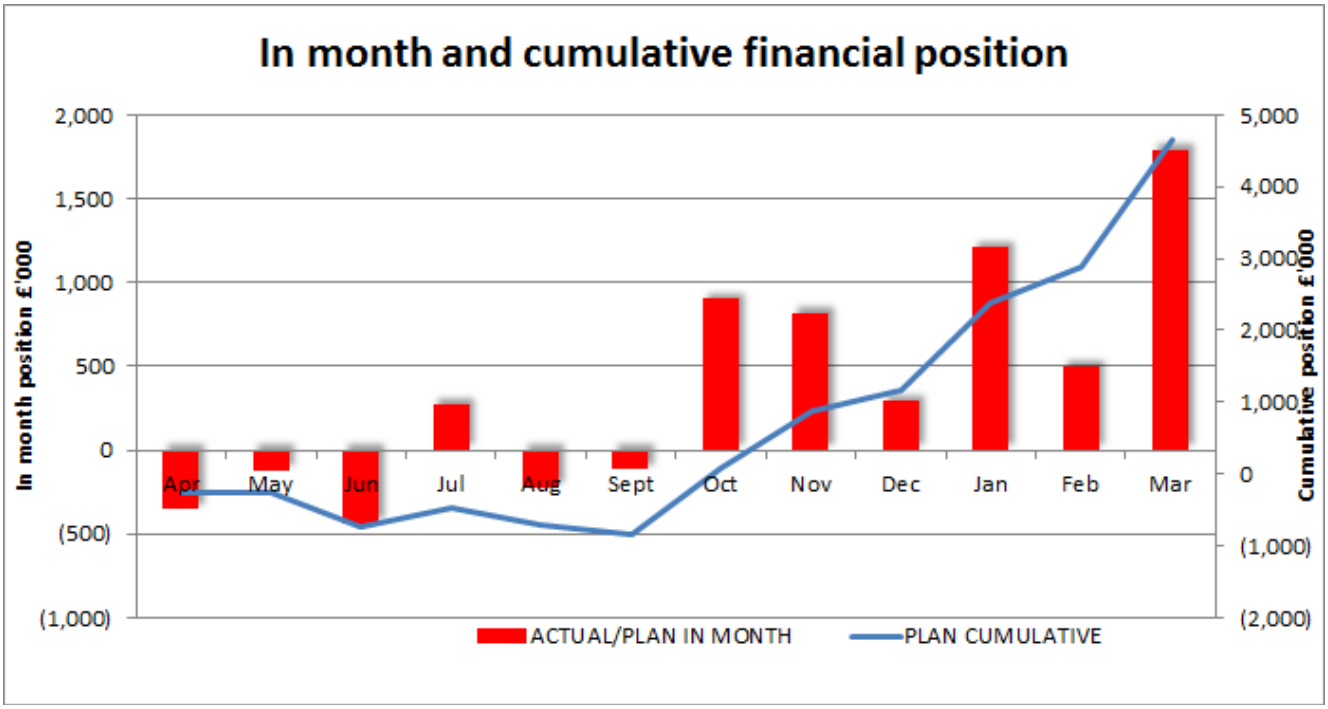
The table below shows the summary position for the month and year to date.

2018/19, Month 03 (June 2018)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	Variance (£000s)	FULL YEAR BUDGET (£000s)
NHS Clinical Income	22,532	23,105	574	68,763	69,704	941	266,700
Non-NHS Clinical Income	1,713	1,000	(713)	4,869	3,207	(1,662)	22,933
Other Non-Patient Income	1,732	2,106	374	4,988	5,355	367	26,156
Total Income	**25,977**	**26,211**	**234**	**78,619**	**78,266**	**(353)**	**315,789**
Pay	(18,648)	(18,735)	(87)	(55,940)	(55,709)	231	(222,445)
Non-Pay	(7,006)	(7,011)	(5)	(21,068)	(20,717)	351	(95,904)
Total Operating Expenditure	**(25,654)**	**(25,746)**	**(92)**	**(77,008)**	**(76,426)**	**582**	**(318,349)**
EBITDA	**323**	**465**	**142**	**1,611**	**1,840**	**229**	**(2,560)**
Depreciation	(541)	(542)	(1)	(1,623)	(1,673)	(50)	(6,500)
Dividends Payable	(430)	(430)	0	(1,291)	(1,267)	24	(5,198)
Interest Payable	(278)	(275)	3	(833)	(846)	(13)	(3,341)
Interest Receivable	1	5	4	3	15	12	12
P/L on Disposal of Assets	0	0	0	0	0	0	13,730
Total	**(1,248)**	**(1,242)**	**6**	**(3,744)**	**(3,771)**	**(27)**	**(1,297)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(925)**	**(777)**	**148**	**(2,133)**	**(1,932)**	**201**	**(3,857)**
Provider Sustainability Fund (PSF)	469	328	(141)	1,407	985	*(422)*	*9,380*
Net Surplus / (Deficit) - before IFRIC 12	**(456)**	**(448)**	**8**	**(726)**	**(947)**	**(221)**	**5,523**
Add back							
Impairments	0	0	0	0	0	0	(51)
IFRS & Donate	29	(6)	36	17	(19)	37	899
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(485)**	**(442)**	**(28)**	**(743)**	**(928)**	**(258)**	**4,675**

The graph below shows the actual and planned in month performance of the adjusted net surplus (the bottom line financial target which the Trust is measured on by NHSI) by month and the cumulative Trust position over the financial year.

Though the Trust is ahead of plan cumulatively in months 1 to 3, the graph shows that in month 4 and from month 6 onwards the plan is to achieve a surplus in each month culminating in the £4.7m surplus for the year.



Income & Activity

Overall the Trust is £0.8m behind plan on Income, which includes £0.4m for Provider Sustainability Fund. This is an improvement in month of £0.1m (PSF having an adverse impact of £0.1m)

Outpatients: Outpatients continue to perform well overall, with the under-performance in follow ups more than offset by over performance in first attendances and procedures giving a YTD favourable variance of £0.2m. Within this there are areas of under-performance, particularly on Children's follow up attendances.

Day Cases & Elective: In month Day cases and Electives continue to under-perform, with an in month adverse variance of £0.2m and first quarter adverse variance of £0.6m. The main driver of this is pre-assessment in Surgery, which impacts on the number of Elective admissions. Endoscopy is also behind plan, but there is a positive upward trend seen in month 3 which is closer to plan than in previous months. Month 3 was also a quieter month for Bariatrics, which has an impact on the case mix, as Bariatrics generate more income than an average Elective spell.

Emergency: A&E, UCC and ambulatory care are all performing at or above plan level, and the Trust has continued to over-perform against Non-electives, with the YTD over-performance of £0.6m.

Clinical Support Services: All clinical support services are performing well against plan YTD, with Diagnostic Imaging showing over-performance of £0.1m YTD.

Maternity: Both Maternity Pathways and deliveries under-performed in month with an adverse variance of £0.3m, and a YTD adverse variance of £0.5m.

Provider Sustainability Fund: For Q1 the Trust will not receive £0.4m of its allocated PSF, as this is the 30% that was contingent on the A&E 4 hour wait performance.

The table below provides the split of income and activity by category.

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,150	1,157	7	3,488	3,521	34	8,489	8,700	211	25,749	26,571	822
Ambulatory Care	357	379	22	1,055	1,139	84	1,544	1,507	(37)	4,564	4,569	5
Adult Critical Care	619	728	109	1,878	1,682	(196)	1,463	1,302	(161)	4,439	4,073	(366)
Community Block	5,708	5,708	0	17,575	17,575	0	0	0	0	0	0	0
Day Cases	1,190	1,015	(175)	3,516	3,153	(363)	1,559	1,495	(64)	4,605	4,584	(21)
Diagnostics	260	320	60	768	870	102	2,636	3,127	491	7,787	8,659	872
Direct Access	1,020	1,231	211	3,014	3,182	168	100,066	96,263	(3,803)	295,651	289,753	(5,898)
Elective	818	755	(63)	2,418	2,217	(201)	209	236	27	617	601	(16)
High Cost Drugs	656	608	(48)	1,968	1,913	(54)	0	0	0	0	0	0
Maternity - Deliveries	1,152	974	(177)	3,493	3,179	(314)	315	281	(34)	956	896	(60)
Maternity - Pathways	770	615	(155)	2,276	2,065	(210)	727	611	(116)	2,148	1,987	(161)
Non-Elective	3,301	3,350	49	10,013	10,510	497	1,566	1,681	115	4,751	4,922	171
OP Attendances - 1st	922	983	61	2,724	2,946	222	5,111	5,044	(67)	15,102	15,906	804
OP Attendances - follow up	823	823	0	2,430	2,324	(107)	13,253	11,908	(1,345)	39,156	36,721	(2,435)
OP Procedures	396	489	94	1,169	1,277	108	2,282	2,892	610	6,743	7,960	1,217
Other Acute Income	1,143	1,226	82	3,999	3,951	(49)	7,175	7,195	(185)	12,490	11,877	(613)
CQUIN	484	455	(29)	1,450	1,386	(63)	0	0	0	0	0	0
Total SLA	**20,769**	**20,815**	**47**	**63,234**	**62,891**	**(343)**	**146,396**	**142,242**	**(4,359)**	**424,758**	**419,079**	**(5,679)**
Marginal Rate	0	0	0	0	0	0						
	20,769	**20,815**	**47**	**63,234**	**62,891**	**(343)**						
Other Clinical Income	2,832	2,962	130	8,533	9,032	499						
Other Non Clinical Income	2,376	2,434	58	6,852	6,343	(509)						
Total Other	**5,208**	**5,396**	**188**	**15,385**	**15,375**	**(10)**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**25,977**	**26,211**	**234**	**78,619**	**78,266**	**(353)**	**146,396**	**142,242**	**(4,359)**	**424,758**	**419,079**	**(5,679)**
PSF	469	328	(141)	1407	985	(422)						
Revised Total	**26,446**	**26,540**	**94**	**80,026**	**79,251**	**(775)**						

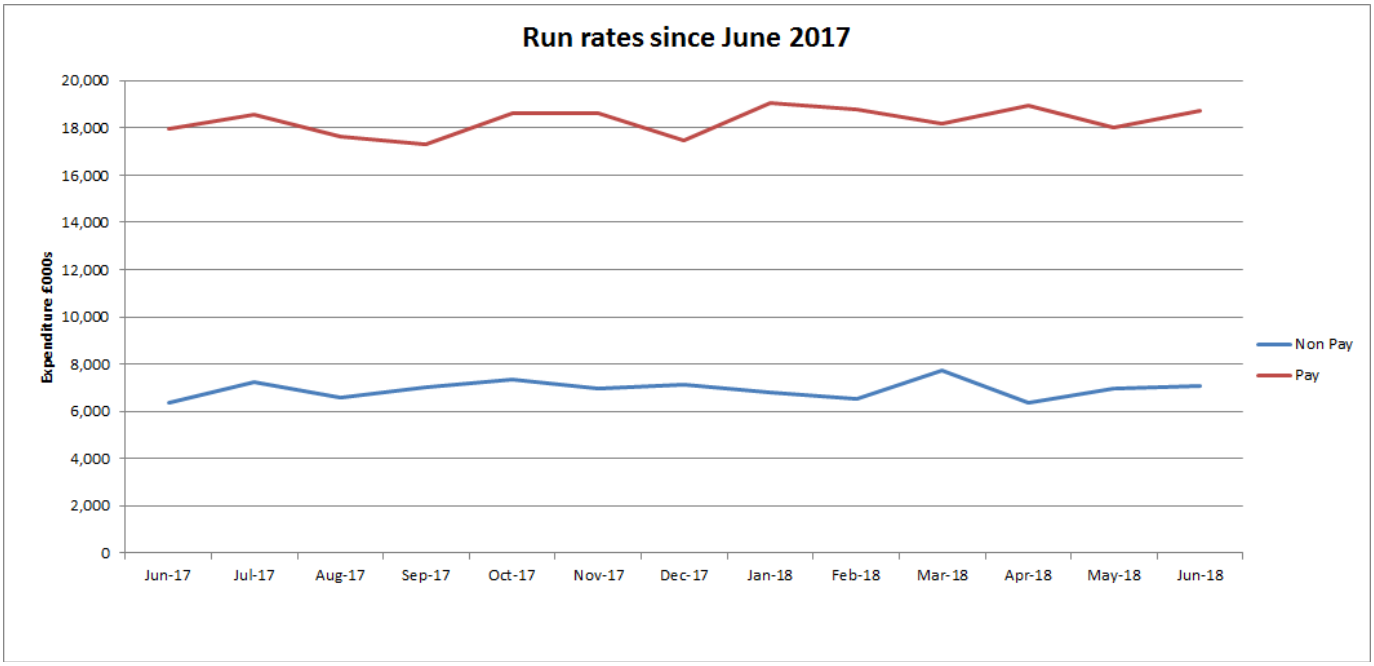
Monthly Run Rates – Expenditure

The year to date combined expenditure position is £0.6m favourable. Key points of note include:

- **Pay**
  - Total pay expenditure for June was £18.7m, which is £0.5m higher than the twelve month rolling average.
  - During June the Trust continued to operate with additional escalation bed capacity. The cost of this was £0.2m.
  - Within total pay expenditure, agency costs were £1.3m. This is 6.7% of the total pay costs for the month, up from 6.6% in month 2 and higher than the 4.3% average for 2017/18. In financial terms agency costs were £0.1m higher than month 2.
  - The agency ceiling target for 2018/19 is £8.8m (£9.5m 17/18). Total agency costs at month 3 are c. £3.5m. Therefore 40% of the annual ceiling has been expended within the first quarter of the financial year. If the Trust does not improve the agency run-rate it will breach the agency ceiling.

- **Non Pay**
  - Non pay expenditure for June was £7.0m, which is £0.1m more than the 12 month rolling average but £0.3m lower than month 2
  - The reduction in expenditure is related to Supplies and Services across a number of ICSUs and Premises costs.

The graph below provides the pay and non-pay expenditure run rates over a 13 month period from June 2017 to June 2018.



Cost Improvement Programme

As part of plans to achieve its control total for 2018/19 the Trust has set a CIP target of £16.5m. The target has been split into three categories:

1. Flow through – the full year effect of schemes that commenced during the last financial year
2. 2% target for cost improvements within each ICSU
3. Transformational schemes that span across the organisation, the scope of which has been derived from analysing model hospital/carter metrics and other benchmarking data

To date £14.5m of plans have been identified across the categories:

- Flow through - £2.7m
- ICSU 2% target - £5.1m
- Transformational schemes - £6.7m

In addition to the £14.5m of plans that have been identified a further £0.9m has been scoped for the transformational schemes, which is being validated to confirm the actual level of delivery possible in 2018/19. Depending upon the level of delivery possible, the current unidentified gap against the full target is in the range of £1.0m to £1.9m.

The PMO continues to work with the ICSUs and Corporate functions to identify and develop plans to ensure delivery of the Trust's CIP requirement and has appropriate governance arrangements in place including the Trust Management Group, overseeing progress and being responsible for ensuring corrective actions are undertaken.

In-year delivery – Month 3

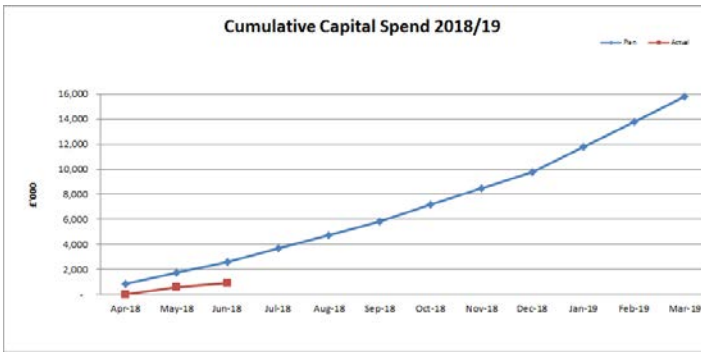
The Trust's CIP programme for 2018/19 has been profiled across the year based on the proposed implementation dates for individual schemes. Based on this profile expected delivery, as at Month 3 was £2.2m, with actual delivery recorded as £1.4m. There is a further £0.3m anticipated under the Outpatients Transformation scheme.

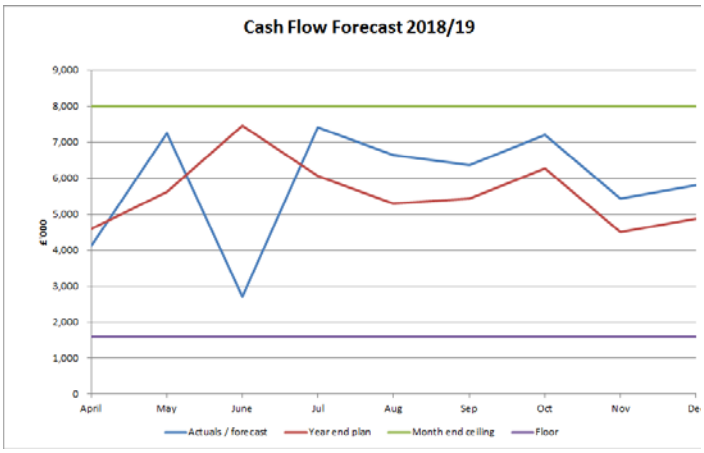
CIPs as at Month 3

Integrated Clinical Service Unit	NHSI Annual Plan £'000	Updated Plan £'000	M3 YTD Target £'000	M3 YTD Actual £'000	M3 YTD Variance £'000	M3 YTD % achieved
Children's services	555	772	307	126	(180)	41.2%
Clinical Support Services	641	529	114	100	(15)	87.1%
Emergency & Urgent Care	440	440	47	49	2	104.8%
Integrated Medicine	658	658	160	79	(81)	49.4%
PPP	207	379	28	32	5	116.5%
Surgery	967	762	25	58	33	234.7%
Women's services	397	397	72	58	(14)	81.0%
Estates & Facilities	728	728	96	54	(41)	56.7%
Corporate	500	519	81	78	(3)	96.5%
Flow through	2,673	2,673	658	592	(66)	90.0%
Transformation	6,698	6,680	655	144	(511)	22.0%
Unidentified	2,039	1,964				
Total	**16,500**	**16,500**	**2,241**	**1,371**	**(870)**	**61.2%**

Given the increase required in the latter months and that there are unidentified schemes it is becoming more difficult for the Trust to achieve its target.

Statement of Financial Position





Statement of Financial Position

	As at 30 June 2018 £000	Plan 30 June 2018 £000	Year to Date Plan variance 30 June 2018 £000
Property, plant and equipment	214,399	217,224	(2,825)
Intangible assets	4,721	4,386	335
Trade and other receivables	833	656	177
Total Non Current Assets	**219,953**	**222,266**	**(2,313)**
Inventories	1,406	1,355	51
Trade and other receivables	34,637	27,371	7,266
Cash and cash equivalents	2,732	7,463	(4,731)
Total Current Assets	**38,775**	**36,189**	**2,586**
Total Assets	**258,728**	**258,455**	**273**
Trade and other payables	41,523	37,748	3,775
Borrowings	19,908	19,882	26
Provisions	1,129	1,391	(262)
Total Current Liabilities	**62,560**	**59,021**	**3,539**
Net Current Assets (Liabilities)	**(23,785)**	**(22,832)**	**(953)**
Total Assets less Current Liabilities	**196,168**	**199,434**	**(3,266)**
Borrowings	38,151	41,161	(3,010)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**42,003**	**(3,013)**
Total Assets Employed	**157,178**	**157,431**	**(253)**
Public dividend capital	64,679	64,679	0
Retained earnings	(5,994)	(5,821)	(173)
Revaluation reserve	98,493	98,573	(80)
Total Taxpayers' Equity	**157,178**	**157,431**	**(253)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Overall, the value of the balance sheet is £0.3m away from plan. Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £2.5m lower than plan for two principal reasons: (1) expenditure in 2018-19 is £1.0m less than plan (month 3 £0.2m behind plan); (2) the opening balance was £1.1m below originally expected levels due to a change in planning assumptions. 2018-19 spend is currently behind plan on most projects. While the Trust expects IM&T and medical equipment to be able to spend their allocations, Estates has a challenge to complete projects such as maternity, NICU and Cellier ward in year.

- **Receivables (Debtors)** are £7.4m more than plan. The Trust had assumed that outstanding 2017-18 STF (£6.3m) would be paid by the end of month 3, but this did not happen until 6 July.

- **Cash and cash flow:** the Trust is holding £2.7m in cash as at the end of June 2018. This is £4.7m lower than plan due to the later than planned payment of STF funds and slower receipt of NHSE contract funding.

The Trust has modelled its cash flow for the whole of 2018-19 to assess whether/when cash support will be required. The chart above shows the results of the current modelling and reflects the assumptions used in the revised 2018-19 planning submission to NHSI in June 2018, and concludes that no cash support should be required during 2018/19.

NHS
Whittington Health
NHS Trust

Trust Board
25 July 2018

Title:	Trust Performance report July 2018 (June 2018 data)		
Agenda item:	**18/110**	**Paper**	**7**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Performance against the 95% target for June was 90.6%, improving for the 4th consecutive month. In June we saw 8,700 attendances which was a 5.6% increase on June 2017 where we saw 8,239 attendances. Ambulance activity was up by 1% compared to the same time last year; 1656 ambulance arrivals compared to 1628 in June 2017. The Emergency Department have trialled a new streaming process and an enhanced Rapid Assessment and Treatment Model which proved successful in the ED Super week. **Complaints:** Achieved after two months of underachieving. **Cancer 62 days:** Underachieving. Capacity created in Urology and Colorectal. Continued management to focus on improvement plan. **Community waiting times** Most narrative now included. **Safer Staffing** Number of RED shifts has gradually reduced over the last months and work has been completed to assure accurate recording. Overall Care hours are now included. An increase in CHPPD has been recorded due to increased need to provide enhanced one to one care to patients on wards, particularly Mary Seacole North and South.		
Summary of recommendations:	That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	N/A		
Reference to risk and corporate risks on the BAF:	N/A		
Date paper completed:	17th July 2018		

Author name and title:		**Hester de Graag, Risk and Quality Manager**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Integrated Performance Report

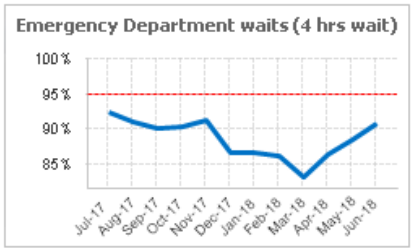
July 2018

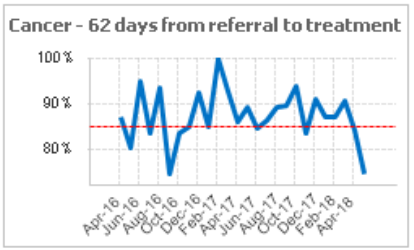
Month 3 (2018 – 2019)

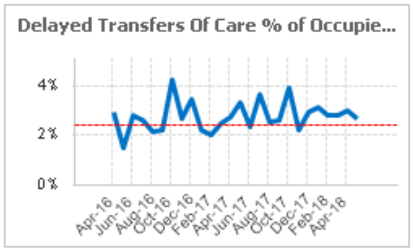
Date & time of production: 20/07/2018 13:41

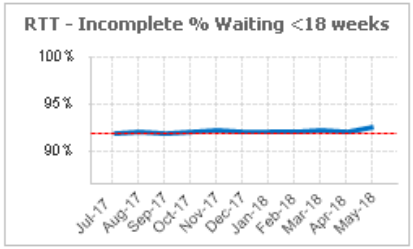
Summary Page - Indicators

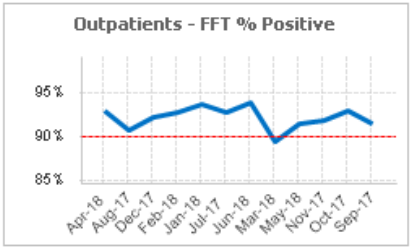
Category	Indicator	17_18 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	88.4%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	59	64	72	82	82	81	75	77	95	91	87	79	85
Cancer	Cancer - 14 days to first seen	**>93%**	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.3%	97.5%		96.1%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.1%	74.5%		78.9%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.1%	6.3%	6.1%	6.7%	6.4%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	3.7%	2.6%	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%		2.9%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%
Outpatients	Outpatients - FFT % Positive	**>90%**	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	92.7%
Community	Community - FFT % Positive	**>90%**	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.2%
Staff	Staff - FFT % Recommend Care	**>70%**			69.4%			70.6%			75.0%			77.3%	77.3%

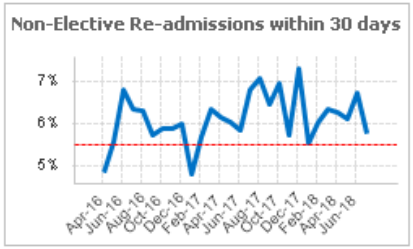












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	1	0	1	3	0	0	0	1	0	1	2	0	3	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	34	31	27	34	28	35	38	27	43	37	52	33	122	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	2	2	3	3	3	3	9	3	3	2	4	2	8	
All Areas	Harm Free Care %	>95%	93.5%	93.9%	95.1%	94.1%	93.5%	94.2%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.4%	
Maternity	Non Elective C-Section % Rate	<15%	22.5%	18.8%	19.8%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	18.4%	
All Areas	Medication Errors causing serious harm	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	0	0	0	0	1	0	1	0	0	0	0	1	1	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	17.3%	21.7%	17.1%	16.5%	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	18.2%	
All Areas	Serious Incidents	0	3	6	2	5	2	0	7	1	2	6	8	3	17	
Admitted	VTE Risk Assessment %	>95%	95.3%	96.7%	96.0%	95.3%	96.0%	95.2%	95.1%	95.2%	96.2%	95.9%	95.1%		95.5%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	0	0	0	0	0	0	5	7	0	12	

Date & time of production: 20/07/2018 13:41

Safe Services - Commentary

Pressure Ulcers
The number of avoidable grade three or four pressure ulcers has halved this month. Both cases were in district nursing and both did not have a holistic assessment completed and therefore a prevention plan could not be discussed with the patient and carers. Over the past year there has been a downward step change in the number of pressure ulcers and the Trust is now closer to the national average.

Non elective C-section
The indicator improved slightly by 1.8%. This indicator is based on non–elective singleton cephalic. Whittington Health has high risk pregnancies (twins). This is difficult to benchmark as it depends on caseload including in utero transfers from other units. Saving Babies lives' Bundle work group now set up, which includes:
1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour.

MRSA
There was one MRSA bacteraemia reported in June 18. This is the first MRSA for Whittington Health in 2018/19. It was found in the Integrated Medicine ICSU and has been determined as avoidable following a Post Infection Review.
Lessons learned: although policy was followed, it was found that recording and labelling was unclear and incomplete both related to inserting the PICC line and taking of the blood culture. The patient had a long admission and routine MRSA swabs as well as blood cultures taken from other sites did not have MRSA. All staff involved have been debriefed.

Serious Incidents
1. 2018.13920 – [CYP Services] Confidential information leak/loss/IG Breach
2. 2018.13923 – [EUC] Disruptive/aggressive/violent behaviour
3. 2018.13925 – [EUC] Medication Incident

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	85.5%	83.0%	80.4%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	80.3%	
ED	ED - FFT Response Rate	>15%	13.1%	13.7%	12.6%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	14.5%	
Admitted	Inpatients - FFT % Positive	>90%	95.8%	95.2%	97.7%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	
Admitted	Inpatients - FFT Response Rate	>25%	20.9%	14.9%	16.0%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.8%	
Maternity	Maternity - FFT % Positive	>90%	92.7%	89.4%	92.4%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	94.0%	
Maternity	Maternity - FFT Response Rate	>15%	23.5%	30.1%	18.5%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	51.0%	
Outpatients	Outpatients - FFT % Positive	>90%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	92.7%	
Outpatients	Outpatients - FFT Responses	400	485	338	433	569	593	336	420	461	249	327	445	348	1120	
Community	Community - FFT % Positive	>90%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.2%	
Community	Community - FFT Responses	1500	1224	858	940	731	638	605	875	1157	779	1206	1181	1148	3535	
Staff	Staff - FFT % Recommend Care	>70%			69.4%			70.6%			75.0%			77.3%	77.3%	
All Areas	Complaints responded to within 25 working day	>80%	76.0%	81.0%	72.2%	72.7%	68.8%	88.2%	76.9%	87.5%	92.0%	71.4%	78.3%	92.6%	80.8%	
All Areas	Complaints (including complaints against Corporate division)	N/A	32	24	25	26	24	18	30	21	33	33	30	38	101	

**Staff FFT % Recommended Care for Dec-17 is based on the Staff Survey results (not the Staff FFT).

Date & time of production: 20/07/2018 13:41

Caring Services - Commentary

FFT

The Trust KPI for the Friends and Family Test is for each area to record 90% in positive responses, and to record the following for response rates:

- ED (including CDU): 15%
- Inpatients (including day-case): 25%
- Maternity: 15%
- Outpatients: 400 responses
- Community: 1,500 responses

For June, the Emergency Department recorded 14.1% for response rate. This is below the 15% KPI target, but does record continued improvement from the area. June is the fifth consecutive month where ED has recorded over 14% for response rate. June also saw ED's highest positive recommend rate (82%) since February 2018. In support of continuing to improve the response rate in ED, the patient experience team are working with the paediatric ED team to create a child friendly FFT survey. This will be completed in September 2018.

Inpatients saw a decreased response rate from May to June (18% in June in comparison to 22% in May) and an increased recommend rate (98% in June from 96% in May). Ongoing efforts to improve response rates include working the with Day Treatment team to increase responses from this area. The response rate from Day Treatment patients' remains low (4%). The patient experience team are working with Day Treatment to utilise iPads for FFT collection.

Outpatients saw a decrease in FFT responses, with 348 In June being below the Trust set KPI. June 2018 did mark the joint highest recommend rate (94%) for Outpatients since April 2017. The patient experience team will work with the Outpatient matron to structure collection of FFT cards and inputting support from the volunteer team.

The ongoing work to improve the Community responses has fostered a sustained improvement in the number of responses. June's total (1,148) is the fourth instance over the past five months where the community teams have recorded over a thousand responses. The work has continued in the targeted areas of MSK Physiotherapy, District Nursing and Podiatry to record higher numbers of FFT. This focus will expand as of July to cover the community CYP team also.

The Trust's Maternity services continue to exceed both response rate and positive recommend rates (93.2% recommend rate for June; 45.2% response rate). This sustained record of exceeding Trust set KPIs is due to the diligence and commitment from the local areas towards collecting FFT responses from patients.

Caring Services - Commentary

Complaints

During June 2018 the Trust closed 39 complaints; 27 complaints required a response with 25 working days and 12 were allocated 40 working days for investigation due to their complexity.

In regard to the 25 working day target of 80%, the Trust achieved a performance of 92%.

- Of the 12 complaints allocated 40 working days, 33% hit their target (4).
- In addition, four of these complaints remain outstanding and overdue, i.e. EUC (1) and IM (3).

The majority of complaints were allocated to EUC 31% (12), IM 20% (8), S&C 13% (5) and PPP 13% (5).

Severity of complaints: 49% (19) were designated 'low' risk, 49% (19) were designated 'moderate' and 2% (1) were designated 'high'.

- As in June the complaint designated high risk related to 'nursing care' (i.e. inadequate monitoring provided).

A review of the complaints for June shows that 'medical care' 33% (13) and 'attitude 18% (7) were the main issue for patients. In June this was followed by 'nursing care' 13% (5) and 'delay' 13% (5)

- In regard to 'medical care,' 46% of patients (6) felt that 'inadequate treatment' had been provided.
- In regard to 'attitude', 43% % of patients (3) stated that staff had displayed 'inappropriate behaviour'.
- In regard to 'nursing care', 60% of patients (3) indicated that a poor standard of care had been provided.
- In regard to 'delay', issues were evenly spread across delays in 'being seen for an appointment (x2)'; 'delay in operation taking place' and delays in test results and treatment (x2).

Of the 35 complaints that have closed, (including those allocated 40 working days), 43% (15) were 'upheld', and 31% (11) were 'partially upheld' meaning that, currently, 74% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	94.5%	92.3%	93.2%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	95.8%	93.4%	91.7%	93.6%	
Maternity	Smoking at Delivery	<6%	7.5%	4.8%	7.1%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	6.7%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.7%	6.4%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	70.0	77.7	45.8	91.8	97.0	75.5	75.5	72.2	93.0					
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	72.5	92.4	39.5	105.2	104.3	38.7	86.8	73.7	94.3					
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.73			0.74								
Admitted	Mortality rate per 1000 admissions in-months	14.4	6.4	7.2	2.6	8.6	8.5	12.0	9.4	9.9	10.3	7.3	7.5	6.4	7.1	
Community	IAPT Moving to Recovery	>50%	52.3%	56.5%	55.1%	50.8%	53.0%	50.9%	47.5%	51.4%	59.4%	56.3%	53.4%		55.0%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%			84.2%	93.5%	86.7%	78.7%	96.1%	87.0%	92.5%	86.7%	86.1%		86.4%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%			29.0%	52.6%	75.0%	86.1%	91.7%	91.4%	86.7%	83.2%	91.1%	82.7%	85.9%	

Date & time of production: 20/07/2018 13:41

Effective Services - Commentary

Smoking at delivery

Whittington Health is following NICE guidance in offering CO screening to pregnant women. Training for staff is ongoing with support from the smoking cessation team.

Coding on Medway for CO screening continues to be incorrect. One code is still used for two different outcomes: i.e. declining the screening as well as not offered screening. There is no immediate solution.

Whittington Health have met with smoking cessation providers to strengthen our referral pathways and reporting mechanisms.

The London Maternity Services with Public Health Islington looking with NCL for a whole systems approach such as 'Baby Clear' to support smoking cessation support for pregnant women. Current provision is seen as too fragmented across NCL with different smoking cessation providers.

Non-elective re-admission

Increase in re-admissions of 0.6%.

Whittington Health discharge to assess pathway 1, Haringey and Islington: As more data is available the initial trend suggests the first week of discharge is resulting in low re-admission rates. The 30 day readmission rate is 17% and 90 day readmission rate is 38%. The 30 day readmission rate in this cohort of patients who require additional support on discharge compares favourably with the 22% 30-day readmission rate for all Islington adult (> 55yrs) with admissions Oct 2017 – February 2018 (emergency admission with discharge 30 days prior).

Ongoing monitoring of readmission rates to collect 6 month data and then a decision on appropriate frequency of ongoing monitoring will be made.

Speech and Language Therapy in hospital: Re-admission rate is monitored closely and is going up: March: 2.9% and April: 3%, May 5.4%, June 9.1% - this has continued to rise since the rapid response SLT service stopped at the end of winter 2017/18. ICSU reviews SLT provision and audits on re-attendance and re-admission will be repeated.

District Nursing

Seen within 2 hrs: Underachieving at 78%. Data not entered in real time due to agency staff not being able to access the electronic system, this is a particular issue during nightshift. Assurance is given by the service that all patients are seen within 2 hours.

Seen within 48 hrs: Under achieving due to capacity issues in Priority 1 assessments and DNA at first visit (which had been booked at 48hrs).

Action: Processes in place reinforced. Improvement to be seen next month.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	88.4%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	59	64	72	82	82	81	75	77	95	91	87	79	85	
ED	Ambulance handovers waiting more than 30 mins	0	27	23	35	38	15	34	34	37	69	22			22	
ED	Ambulance handovers waiting more than 60 mins	0	4	2	1	0	3	11	12	3	18	8			8	
ED	12 hour trolley waits in A&E	0	2	4	3	0	0	0	0	0	0	0	0	0	0	
Cancer	Cancer - 14 days to first seen	>93%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.3%	97.5%		96.1%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	95.9%	98.1%	98.9%	100.0%	100.0%	97.9%	95.0%	97.0%	97.7%	95.7%		97.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.1%	74.5%		78.9%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Cancer	Cancer - 62 Day Screening	>90%		100.0%												
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.0%	99.0%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	3	1	1	0	0	0	0	0	0	0	0	0	0	

Date & time of production: 20/07/2018 13:41

Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

Indicator	17_18 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
Breast	>85%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>85%	50.0%	66.7%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	33.3%			33.3%	
Haematological (Excluding Acute Leukaemia)	>85%				100.0%					100.0%		50.0%		50.0%	
Lower Gastrointestinal	>85%	87.5%	50.0%	100.0%	71.4%	76.9%	85.7%	75.0%	66.7%	100.0%	72.7%	66.7%		70.6%	
Lung	>85%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	50.0%		100.0%	50.0%		71.4%	
Other	>85%									100.0%					
Skin	>85%	100.0%	100.0%	100.0%	94.7%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Testicular	>85%		100.0%									100.0%		100.0%	
Upper Gastrointestinal	>85%	100.0%	100.0%	100.0%	100.0%	0.0%	66.7%	0.0%	50.0%		66.7%			66.7%	
Urological (Excluding Testicular)	>85%	57.1%	50.0%	57.1%	94.1%	100.0%	83.3%	100.0%	100.0%	66.7%	90.0%	58.8%		70.4%	
Sarcoma	>85%					0.0%				50.0%					

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2017-2018	Performance
Breast	>93%	99.2%	93.9%	98.3%	98.7%	97.3%	99.0%	98.8%	95.1%	95.4%	97.8%	98.7%		97.2%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	
Gynaecological	>93%	96.2%	100.0%	100.0%	96.5%	100.0%	100.0%	96.2%	98.5%	94.4%	90.0%	97.7%		97.9%	
Haematological	>93%	100.0%	100.0%	85.7%	100.0%	88.9%	100.0%	100.0%	50.0%	83.3%	100.0%	70.0%		90.9%	
Lower Gastrointestinal	>93%	89.3%	88.0%	89.7%	79.7%	93.9%	90.6%	87.2%	90.7%	91.8%	92.5%	96.6%		89.1%	
Lung	>93%	100.0%	100.0%	90.5%	100.0%	84.2%	100.0%	96.2%	95.2%	94.1%	100.0%	100.0%		95.2%	
Other	>93%														
Skin	>93%	99.4%	99.4%	98.7%	97.1%	100.0%	100.0%	98.0%	98.6%	99.3%	97.4%	97.9%		98.9%	
Upper Gastrointestinal	>93%	83.8%	79.5%	57.7%	77.8%	78.8%	60.0%	73.5%	80.8%	98.3%	82.4%	97.6%		79.8%	
Urological	>93%	98.2%	100.0%	95.9%	100.0%	98.5%	100.0%	98.9%	97.3%	95.5%	93.6%	98.0%		98.2%	

Community Average Waits

Community Average Waits from Referral Received Date to Date First Seen

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Apr-18	May-18	Jun-18	Avg Wait (Jun)	No. of Pts Seen	% Threshold	Target Weeks	Apr-18	May-18	Jun-18	Avg Wait (Jun)	No. of Pts Seen
CAMHS	>95%	8	66.2%	67.3%	60.9%	7.8	133	>95%	2	100.0%			-	0
Child Development Services	>95%	8	43.4%	62.3%	56.5%	1.2	46	>95%	-				-	0
Community Children's Nursing	>95%	2	83.3%	85.2%	82.7%	10.3	75	>95%	1	100.0%	100.0%	100.0%	0.2	7
Community Paediatrics Services	>95%	12	59.1%	86.5%	83.3%	6.5	48	>95%	1	36.4%	43.1%	32.5%	6.5	40
Haematology Service	>95%	12	100.0%	100.0%	100.0%	0.9	10	>95%	-				-	0
Looked After Children	>95%	4	80.0%	79.2%	88.9%	6.5	18	>95%	-				-	0
Occupational Therapy	>95%	8	19.2%	30.4%	28.6%	17.4	21	>95%	-				-	0
Physiotherapy	>95%	8	55.7%	47.8%	53.8%	8.0	91	>95%	-				-	0
PIPS	>95%	12	100.0%	100.0%	66.7%	8.5	9	>95%	-				-	0
School Nursing	>95%	12	90.8%	88.1%	78.9%	6.8	90	>95%	-				-	0
Speech and Language Therapy	>95%	6	35.9%	34.6%	42.8%	8.7	187	>95%	2		0.0%	33.3%	5.0	3
Bladder and Bowel - Children	>95%	12	28.6%	37.5%	26.7%	11.5	15	>95%	-				-	0
Community Matron	>95%	6	100.0%	95.7%	100.0%	0.7	43	>95%	-				-	0
Adult Wheelchair Service	>95%	8	87.1%	97.8%	85.7%	4.1	28	>95%	2				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	1.9	33	>95%	2	0.0%	100.0%	81.8%	1.4	11
Community Rehabilitation (CRT)	>95%	12	97.7%	95.5%	92.5%	4.7	134	>95%	2	62.9%	56.5%	68.8%	2.1	32
Community Rehabilitation (ICTT)	>95%	12	78.1%	84.8%	89.2%	5.0	296	>95%	2	29.3%	37.9%	43.4%	3.0	99
Diabetes Service	>95%	6	65.7%	72.2%	67.1%	5.5	143	>95%	2	100.0%	100.0%	50.0%	6.0	2
Intermediate Care (REACH)	>95%	6	86.3%	80.6%	73.2%	6.7	164	>95%	2	60.7%	41.4%	45.8%	3.3	24
Paediatric Wheelchair Service	>95%	8	80.0%	100.0%	66.7%	6.6	3	>95%	-				-	0
Respiratory Service	>95%	6	53.2%	36.4%	63.6%	4.9	110	>95%	2	6.5%	0.0%	100.0%	1.4	3
Bladder and Bowel - Adult	>95%	12	44.3%	50.4%	61.0%	12.0	467	>95%	2	0.0%			-	0
Musculoskeletal Service - CATS	>95%	6	81.6%	76.0%	89.5%	3.8	141	>95%	2	0.0%	75.0%	100.0%	1.3	1
Musculoskeletal Service - Routine	>95%	6	89.5%	92.1%	92.6%	3.8	1463	>95%	2				2.7	7
Nutrition and Dietetics	>95%	6	74.6%	83.9%	89.6%	3.6	183	>95%	2				-	0
Podiatry (Foot Health)	>95%	6	38.2%	59.7%	72.7%	4.9	587	>95%	2	38.2%	59.7%	72.7%	3.6	3
Lymphodema Care	>95%	6	73.3%	95.2%	95.0%	2.9	20	>95%	-				-	0
Tissue Viability	>95%	6	96.2%	93.9%	98.9%	1.5	95	>95%	2			100.0%	0.4	1

Date & time of production: 20/07/2018 13:41

Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time

Performance against the 95% target for June 18 was 90.6% against a Trajectory of 92.4%. Quarter one finished on 88.4% for 2018 / 2019. This was unfortunately lower than June 2017 which was at 92.4%. In June we saw 8,700 attendances which was a 5.6% increase on June 2017 where we saw 8,239 attendances.

Ambulance activity has also increased by 1% in comparison to last year. In June 2018 we saw 1656 ambulance arrivals compared to 1628 in June 2017. In June 2018 – we had 1x 60 minute LAS handover time breach and 14x 30 minute breaches. There is ongoing work to reduce these numbers in terms of enhancing the RAT (Rapid Assessment and Treatment) model that we currently offer.

Actions:

The trust has embedded bi-weekly MADE (Multiple Discharge Events), attended by all wards and senior representatives from both Haringey and Islington.

There is a continued focus on reducing stranded (over 7 days) and super stranded (over 21 days) there has been good progress in reducing the latter from 18% to 14% bed base. The expectation is for the trust is to reduce long stay patients by a further 25% by December 2018, this equates to 12 beds (ref letter NHSE – reducing long stays in hospital – to reduce patient harm and bed Occupancy).

The Emergency Department have trialled a new streaming process and an enhanced Rapid Assessment and Treatment Model which proved successful in the ED Super week. The leadership team are now working on embedding these processes to work towards meeting our KPIs (key performance indicators) and 95% target.

Responsive Services - Commentary

Cancer
The Trust has achieved the cancer standard for 2ww and 31 day, however underachieving at 72% against the national target of 85% for 62 day standard.

2ww report: 97.8% overall
Haematology: 70%, 3 breaches out of 10

62day report: 74.5% overall
Colorectal: 66%: 1 breach out of 3, delayed with diagnostic test & patient cancellation.
Haematology: 50%, 1 breach out of 2, delayed with biopsy test at UCLH.
Lung: 33%, 1 breach out of 1.5, complex case. Patient was unwell to attend multiple diagnostic tests.
Urology: 58%, 3.5 breach out of 8.5, delay with template biopsy, 0.5 incidental finding from Colorectal.

Actions:
Urology: increase capacity in one stop clinic from 6 to 7 new patients' slots, to prioritise template biopsy onto consultant lists, clinicians to contact GP to discuss possible downgrading i.e. whenever a patient decide to delay diagnostic tests.
Colorectal: Capacity issue in Endoscopy. To increase target lists from 10 to 12 on a weekly basis. Work in progress to improve 'straight to test' in colonoscopy, to meet the 28 day referral-to-diagnosis target. UCLH have presented their model of working, which includes a Band 4 Lower IG MDT Assistant. Whittington Health is working with NCL to mirror this process. Next meeting will be at the end of July 18.
Haematology: Plan in place to cover cancer lead during absence.

Responsive Services - Commentary

Community Waiting Times

Service	Why below target	What in place to improve	Expected date for target to be achieved
CAMHS (Islington)	Historical backlog despite CCG investment. Increase in referrals during May and June is compounding the issue of clinical capacity – annual pattern of increase due to exam pressures and external teams referring to ensure support is in place for the summer holidays. Team structures not necessarily allocated for maximum effectiveness.	Changes to the intake process to reduce screening time; Intake Meeting twice-weekly with screening for risk on the day of referral. Allocation of clinical time to provide additional Choice appointments (an additional 30 per month June – Sept). Expectation of reduction of service demand over the summer holidays enables the service to process some of the backlog.	Opt-in to first appointment - Projections indicate wait times will plateau at 7 weeks against a target of 4 weeks by the end of September 18. Proposed new team structure will support the achievement of 4/4 in the longer term. Choice to treatment. Projections indicate wait times will continue to increase if we continue with the current model of low-intensity interventions. Data will be reviewed when proposed new team structure is agreed.
Child Development Services	Haringey: Achieved target Islington: Underachieving. Social Communication Team waiting times are over 30 weeks due to clinical capacity.	Islington: Additional investment received from CCG to reduce waiting times.	Islington: Target to reach 18 weeks waiting time by September 18 agreed with commissioners.
Community Children's nursing (Islington)	Administrative issues around inputting contacts correctly.	The team are working towards correcting errors on the current records and will ensure that the contacts are recorded correctly going forward.	31st July 2018
Community Paediatrics Service	Haringey: ASD current wait 52 weeks; urgent waits due limited clinical capacity. Service for children Under 5 / Over 5. Islington: Average time for ASD is 52 weeks. Service is for Over 5 only.	Haringey: Process and pathway changes, as recommended by UCLP have been made to alleviate pressures. Business case has been submitted to CCG for additional investment. Islington: recruitment in process.	Haringey: No target agreed, pending outcome of meeting with CCG regarding business case. Service continues to make changes to processes and pathways to reduce backlog within existing capacity. Islington: Target agreed with CCG to reach 18 weeks by March 19.

Service	Why below target	What in place to improve	Expected date for target to be achieved
Haematology Service	Achieved target		
Looked After Children	Haringey: All data validated and now 100% for June and July 18. Islington: Improved from 50 to 88.9%. Issues with initial health reviews outsourced to LAC team in the area which the child is placed.	Haringey: Compliance will show in next month's dashboard. Islington: Exploring solution to exception report where target is outside influence of the local LAC team with Rio Team.	Haringey: Completed Islington : October 18
Occupational Therapy/ Physiotherapy (Haringey)	Historical issues around understaffing, maternity leave, and difficult to recruit posts.	Therapy review about to commence Team now fully staffed	Following therapy review commissioners will agree on the priorities and agree waiting times and staffing levels.
Occupational Therapy/ Physiotherapy (Islington)	OT: Performance for OT significantly improved from 50% to 83.3% PT: Physio performance has improved from 45% to 68%	OT: Two initiatives; monthly parent workshops and fortnightly drop in clinics. PT: Group sessions and a locum youth gym have been set up and this increased capacity significantly	OT: October 2018 PT: October 2018
PIPS	Capacity issues due to vacancies and trainee now off for maternity leave.	Recruitment in process and new trainee starting in October 18 to support the service.	December 18
School Nursing (Haringey)	Understaffed in school Nursing, and increase of referrals particularly with Safeguarding. Recruitment partly successful.	Recruitment planned for band 5. New Band 6 and Band 7's nurses are permanent in the team. Recent successful workshop with School Nurses with performance improvement plans included. Part of the caseload covered with agency staff. ED and MASH referrals under review by safeguarding team.	Aim to have full establishments for new school year in September 18; however, there are SNs leaving at end of this term for career progression.

Service	Why below target	What in place to improve	Expected date for target to be achieved
School Nursing (Islington)	Staffing capacity. A&E notifications are populated on the MTP often arriving in bundles (100plus) creating a resource demand which can't be met consistently. Most need processing and will not require direct contact.	Rota in place to ensure all staff members engaged in managing the MTP and PTL on a weekly basis. Strategic conversations with safeguarding leads re value and effectiveness of current process. Recruitment of Band 5/6/7 in place.	Likely to be worse over the summer holidays as only one nurse working in summer break. Anticipated change in process Autumn 2018.
Speech and Language Therapy (Haringey)	Increase in referrals due to introduction of healthy child programme.	Increase in staffing agreed to reduce waits. This is now impacting on waits for therapy. Therapy review ongoing with commissioners.	Following therapy review commissioners will agree on the priorities and agree waiting times and staffing levels.
Speech and Language Therapy (Islington)	Longer waits in school team due to timing of referrals in school holidays.	Initial assessment process have been reviewed and new process will be in place in September 18	December 18
Bladder and Bowel – Children and Adults	Part of CSIG and performance improvement. Capacity - Vacancies have been long standing unable to recruit.	Recruitment, interviews endo of July 18 Old referrals re-contacted. Performance improvement plans include class based first point of access, senior team organisational development work and a focus on operational efficiencies.	6 months (February 2019)
Community Matron	Achieved target		
Adult and Paeds Wheelchair Services	Capacity and demand, 1 vacancy (service exists of two posts only).	Recruitment in progress. Extra clinics being ran by existing member of staff.	Improvement expected in September 18, but relying of filling the post.
Cardiology Service	Achieved target		
Community Rehabilitation (CRT) and (ICTT)	The main issue for both boroughs is SALT, insufficient capacity. Minor gap in physio recruitment.	Physio recruitment Review of SLT capacity	3 - 4 months (November 18)
Diabetes Service	Urgent only 2 patients, 1 was unable to contact. Routine – Capacity issues, high DNA rates.	'Cuby' (Contact us by) letters reintroduced. Reviewing clinic templates to reduce appointment length. Close review of PTL.	3 months (November 18)

Service	Why below target	What in place to improve	Expected date for target to be achieved
Intermediate Care (REACH)	Long-term sickness and Annual Leave affecting waiting times. Issues with booking appointments via Central Booking.	Locums now in started, screening meetings now in place picking up urgent referrals and breaches. CBS service manager invited to business meeting to discuss improvement booking system in the REACH Team.	September 2018 (if staffing level continues to improve)
Respiratory Service	Spirometry for Haringey needs to be removed. Need another PR class in Islington to cope with backlog of referrals.	Looking for venue for PR in Islington. Group assessments.	3 months (November 18) if PR venue found
Musculoskeletal Service CATS and Routine	The pilot Single Point Of Access has been redirecting more referrals from hospital MSK services into the community than anticipated which has had an impact on access times. CATS referrals have doubled compared to last year.	Plans are in place to expand community capacity further.	September 18
Nutrition and Dietetics	Part of CSIG and performance improvement.	Performance improvement plans include class based first point of access, senior team organisational development work and a focus on operational efficiencies.	December 18
Podiatry (foot health)	Part of CSIG and performance improvement.	Performance improvement plans include class based first point of access, senior team organisational development work and a focus on operational efficiencies.	December 18
Lymphodema	Achieved target		
Tissue Viability	Achieved target		

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	2	6	8	15	9	10	8	2	8	3	5		8	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	5	1	1	0	0	0	0		0	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	334	250	247	398	211	282	334	269	312	292	281		573	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	3.7%	2.6%	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%		2.9%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	58.0%	61.4%	59.0%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	61.6%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.7%	97.3%	98.8%	95.0%	97.5%	94.5%	95.0%	93.6%	94.5%	93.9%	92.7%		93.4%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	88.7%	89.3%	89.4%	91.6%	88.6%	86.1%	91.7%	93.4%	90.5%	89.7%	92.7%		91.4%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	91.7%	94.6%	94.8%	92.1%	96.6%	95.8%	96.2%	95.2%	96.4%	94.4%	93.0%		93.7%	
Community	Haringey - HR1 % carried out before child aged 15 months		45.3%	39.6%	33.1%	68.7%	61.6%	60.5%	66.8%	67.1%	64.5%	65.3%	74.2%		69.0%	
Community	Haringey - HR2 % carried out before child aged 30 months		48.9%	36.2%	51.0%	44.9%	44.1%	38.1%	60.6%	68.5%	60.5%	56.9%	63.6%		60.3%	
Community	Islington - HR1 % carried out before child aged 15 mths		61.0%	68.8%	73.0%	66.7%	68.3%	67.9%	71.2%	78.9%	81.5%	69.8%	80.0%		74.3%	
Community	Islington - HR2 % carried out before child aged 30 mths		79.8%	72.1%	72.0%	63.7%	75.3%	70.6%	71.3%	70.5%	76.5%	77.8%	76.3%		77.1%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		41.9%	31.4%	35.6%	31.6%	32.9%	33.0%	26.6%	27.7%	40.1%	38.0%	48.5%		43.8%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		48.1%	48.2%	41.6%	55.7%	60.6%	60.3%	56.0%	71.1%	66.1%	68.4%	73.9%		71.3%	

Date & time of production: 20/07/2018 13:41

Responsive Services - Commentary

Cancelled Operations

There were 5 patients cancelled in May none were urgent
2 patients cancelled in General Surgery; theatre list overran.
2 patients Urology; 2 theatre list overran both on the same day due to an earlier complex case.
1 patient T&O; theatre list overran.

All patients have been booked within 28 days of their cancellation date
Although we have been checking lists carefully, to make sure they are booked correctly, list overruns do occur due to unexpected circumstances.

Delayed transfer of Care (DToC)

This indicator has changed as the denominator was being calculated wrongly, as patients with more than one episode in their spell were not included. After re-running the data correctly the new internal target was set as below 2.4%, as this was the overall performance for last year. For June the indicator improved to 2.7%, and although still above trust internal target of 2.4%, achieved for the National Targets which is below 3%. DToCs issues are now predominantly relating to external bed availability, waiting for intermediate or care home beds. The bi-weekly MADE events continue to support management of DToC.

New Birth Visit

Islington: 93.0% Very slight fall again - just below target of 95%. Strong correlation between performance and vacancies; band 6 Health Visitors recruited to start in September 18
Haringey: 92.7% Continuing on upward trajectory; 3x HVs in recruitment process. On track to meet 95% target as per Improvement Plan.

Responsive Services - Commentary

Mandated HCP: Health Reviews at 8 weeks, 1 and 2-2 1/2 years

1 year review at 15 months:

Islington: 80.1% significant recovery from last month's fall in performance.
Haringey: 74.2% continued improvement on month and on track to achieve trajectory of 80% by Q2.

2 - 2 1/2 review at 30 months:

Islington: 76.3% steady progress by Islington and remain on track in spite of slight fall in performance.
Haringey: 63.6% continued improvement on month and on track to achieve agreed trajectory of 80% by Q2.

6-8 week review:

Islington: 73.9% continued upward trajectory.
Haringey: 48.5% continued significant improvement (10% increase on previous month) and have achieved 40% target set for Q2.

Haringey is working to improve all aspects of the mandated HCP with a robust service improvement plan to achieve trajectories agreed below:

- NBV - 95%
- 6-8 weeks - 50% (40% by Q2)
- 1 yr. review at 15 months - 80% by Q2
- 2 yr. review at 30 months - 80% by Q2
- Integrated 2 yr. review at 30 months - 65% (30% by Q2)

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	78%	78%	75%	71%	69%	71%	71%	72%	69%	70%	71%	71%		
HR	Mandatory Training % Rate	>90%	82%	82%	79%	80%	80%	81%	81%	81%	83%	83%	83%	83%		
HR	Permanent Staffing WTEs Utilised	>90%	86.1%	87.4%	87.3%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.2%	86.2%	86.9%	
HR	Staff FFT % recommended work	>50%			53.3%			59.5%			58.6%			60.8%	60.8%	
HR	Staff FFT response rate	>20%			21.5%			39.1%			17.8%			16.6%	16.6%	
HR	Staff sickness absence %	<3.5%	3.22%	3.40%	3.30%	3.61%	3.57%	3.65%	4.01%	3.73%	3.02%	3.27%	3.47%		3.37%	
HR	Staff turnover %	<10%	14.7%	15.0%	14.4%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%		14.0%	14.0%	
HR	Vacancy % Rate against Establishment	<10%	13.9%	12.6%	12.7%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.8%	13.8%	13.1%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		87.3%	85.9%	79.6%	85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	85.3%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		114.3%	110.7%	122.8%	133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	143.5%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		92.3%	92.8%	102.8%	96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	91.3%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		128.2%	113.8%	136.7%	146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	141.7%	
HR	Safe Staffing Alerts - Number of Red Shifts		0	121	55	32	16	33	31	12	19	18	8	0	26	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.8	9.1	8.3	7.4	8.6	8.4	8.2	8.4	8.6	8.7	9.3	9.4	9.1	

**Staff FFT % Recommended Work and Staff FFT Response Rate for Dec-17 is based on the Staff Survey results (not the Staff FFT).

Date & time of production: 20/07/2018 13:41

Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Trend
Medical	Average staff cost per patient		96	97	97	95	94	93	98	104	96	101	88	
Nursing	Average staff cost per patient		171	171	164	165	167	198	167	182	181	182	172	
Other	Average staff cost per patient		209	205	209	196	193	214	191	195	166	203	179	

Well Led Services - Commentary

Human Resources

There has been a reported increase of 1% in vacancies, with the new establishments reset as part of the budgets for the new financial year. The Trust Management Group recently approved a combined nurse recruitment plan targeting planned UK, overseas and (limited) EU recruitment going forward, to continue to maintain our recruitment pipeline for band 5 nursing staff; most notably as well there is a planned cohort (c. 50) newly qualified UK band 5 nurses due to commence in post in September, along with the new starters from both India and the Philippines.

Turnover has slightly increased and remains above target; a relaunched approach to both issuing exit questionnaires and to exit interviewing which is commencing now will provide improved real time information on the reasons staff leave, enabling this to be fed back to ICSUs leadership to address the underlying causes in hotspot areas.

Both appraisal and sickness remain unchanged and below target. Ensuring the new ICSU leaders develop trajectories to bring compliance levels to within target will be a priority for the current round of ICSU quarterly performance reviews. Reporting on statutory and mandatory training via the new ESR portal has been improved in last few months which will facilitate staff and managers to view their compliance in real time and ensure this is improved.

Well Led Services - Commentary

% day fill rate-nurses

All wards received adequate nurse staffing levels during June18. Staff are moved between wards to ensure sufficient and safe cover. Some of these moves are not being adequately recorded on the safe care and health roster systems and the Deputy Chief Nurse, Associate Directors of Nursing and matrons for medicine and surgery are working to rectify this. This also continues to be impacted by the use of Band 4 Assistant Practitioners in place of Band 5 nurses (see below).

% day and night fill rate-HCAs

There have been a number of patients with high risk needs across the wards and Emergency Department needing enhanced one to one care. This includes patients at risk of falls and those with mental health needs. Appropriate decision making process is being followed and enhanced care shifts are scrutinised and authorised by the Associate Directors of Nursing. This was in place for all ICSUs with the exception of CYP ICSU but there is now an Associate Director of Nursing in place who is applying the same level of scrutiny.

Band 4 assistant practitioners are now working across all hospital departments replacing band 5 posts. There is not yet a national agreement about where the band 4 assistant practitioner's data for the shifts should be registered; therefore they are included in the HCA data at Whittington Health.

Red shifts

There has been a gradual reduction in the number of red shifts recorded month on month. The Deputy Chief Nurse is clear that the monitoring process has been followed and that there have not been shifts left at red staffing level and that recording errors are cleared. The use of the safe care module is now embedded in practice, including the use of the professional judgement application and it is anticipated that next month the recording will be completely accurate.

Overall Care hours

This indicator has been newly added to the Performance report this month. Care Hours per Patient Day is the number of nursing hours that are available to each patient. It is an NHSI requirement to publish CHPPD on My NHS and NHS Choices by September 2018. There has been an increase in CHPPD this month. This is due to an increased need to provide enhanced one to one care to patients on wards, particularly Mary Seacole North and South.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Activity
ED	ED Attendances	**8285**	8537	7853	8051	8816	8549	8579	8897	8082	9217	8645	9226	8699	
ED	ED Admission Rate %		15.1%	15.8%	16.5%	17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	
Community	Community DNA Rate %	**<10%**	7.3%	7.8%	7.7%	8.1%	8.0%	6.8%	7.6%	7.5%	7.7%	7.8%	8.0%	7.9%	
Community	Community Face to Face Contacts		59825	51885	57507	57634	60673	50476	60013	54210	60269	55669	63545	61760	
Admissions	Elective and Daycase		1904	1830	1828	1907	2004	1587	1944	1735	1878	1718	1827	1869	
Admissions	Emergency Inpatients		2163	2128	2238	2455	2368	2180	2216	1908	2248	2181	2337	2254	
Referrals	GP Referrals to an Acute Service		6976	7255	6909	7602	7639	5927	7872	7364	7893	7188	7716	7585	
Referrals	% of GP Referrals that were completed via ERS		22.5%	28.4%	30.3%	32.7%	34.5%	37.2%	46.0%	44.0%	47.0%	58.0%	73.5%	79.8%	
Referrals	% e-Referral Service (e-RS) Slot Issues	**<4%**	35.7%	25.0%	22.4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	18.2%	12.2%	10.1%	
Maternity	Maternity Births	**333**	314	319	344	347	337	332	321	253	315	291	323	282	
Maternity	Maternity Bookings	**377**	380	378	338	420	385	302	405	375	370	400	369	317	
Outpatients	Outpatient DNA Rate % - New	**<10%**	11.8%	12.6%	11.4%	11.0%	10.3%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	10.0%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	11.7%	12.0%	11.1%	10.2%	10.2%	10.7%	12.1%	9.9%	10.9%	10.1%	12.1%	10.4%	
Outpatients	Outpatient New Attendances		8636	8755	8884	9776	10118	8008	10496	9209	9593	9305	10233	9593	
Outpatients	Outpatient FUp Attendances		17780	17369	17418	19454	19251	15885	18881	16555	17758	17391	18616	17761	
Outpatients	Outpatient Procedures		5747	5786	6470	7097	7451	5837	7410	6817	7070	6782	7396	7126	
Theatres	Theatre Utilisation	**>85%**	83.4%	80.8%	81.2%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	

Date & time of production: 20/07/2018 13:41

Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Trend
Average Tariff	Daycases		699	704	693	687	717	710	697	684	614	740	686	
Average Tariff	Elective		4014	3535	4042	3959	3525	3526	3403	3550	3710	4033	3831	
Average Tariff	Non-Elective		2199	2335	1693	2188	2180	2561	2670	2362	2194	2484	2511	

Activity - Commentary

Maternity bookings and births

• Bookings: showing as low for June 2018 compared to June 17. Attrition from referrals to booking was high at 24% (June 2017 was 11.1%) average for the year to date 14.4%

• Births: were lower than expected, however attrition bookings to births was 11% (lower than May 2018)

DNA

Extensive work around which teams manage which clinic codes is almost complete. Working with the access centre and the individual specialties we are identifying the contact numbers, for each clinic code, a patient needs to call in order to reschedule or cancel appointments. Roll out for the simple text reminder is on track. Remaining specialties will be moving over to DrDoctor from Remind+ in the next few weeks. Once this has been completed we can fully track any impact on DNAs. Work is underway to pull actual data from Netcall to see what impact DrDoctor has had in Imaging since go live date last year. Direct feedback from the booking reduction of time they are spent on telephone calls from patients.

e-RS

Weekly PTL meeting and e-RS Implementation Groups meeting bi-weekly and a continuous improvement is seen in ASI list to 10.1% in June 18. New Implementation Group Lead to be identified due to current Lead going on maternity leave.

Theatre Utilisation

Theatre utilisation was maintained just below 84% for June 2018. An Improvement project is currently being undertaken in order to ensure we can deliver the agreed activity for the remaining of the year.

Whittington Health NHS Trust

Trust Board
25 July 2018

Title:	**Results of the National Inpatient Survey 2017**		
Agenda item:	**18/111**	Paper	**8**
Action requested:	To discuss the results and provide assurance on the actions that will be undertaken by the Trust		
Executive Summary:	• The 2017 National Inpatient Survey results have now been received by the Trust • Full publication of survey results available https://www.cqc.org.uk/provider/RKE/surveys • Picker (who undertakes the survey on our behalf) provided a presentation of the results to ICSU leads and facilitated an action planning workshop on 4th June 2018 • This report provides a summary of the results of the feedback received from a sample of patients • A total of 1248 patients from the Trust were sent the questionnaire. 297 patients returned a completed questionnaire, giving a response rate of 23.8%. The average response rate for the 81 Picker surveyed Trusts was 38.3%. • Results are in comparison across the 81 Trusts • There are 56 questions which were the same as the 2016 survey and only 2 questions showed any deterioration and the rest remained the same • The CQC recently published the full national results. In comparison with all NHS acute hospitals the Trust scored 'about the same' on all but 2 questions. The Trust scored: o significantly worse with regards to the quality of food o significantly better with regards to patients being told how to take medication in a way that could be understood		
Summary of recommendations:	• An action planning workshop was facilitated by Picker and included representatives from the inpatient wards, nutrition and dietetics, patient experience and estates and facilities • The actions from the survey are monitored at ICSU and Estates and Facilities Directorate and reported to Patient Experience Group and then to Quality Committee • Work to improve the food available for patients is being implemented		
Fit with WH strategy:	Patient experience relates to all areas of the WH strategy		
Reference to related / other documents:	Patient Experience Strategy 2014 (currently in the process of being updated)		
Date paper completed:	12 July 2018		

Author name and title:		James Connell, Patient Experience Manager Phillipa Alston, Head of Patient Experience		**Director name and title:**		Michelle Johnson, Chief Nurse and Director of Patient Experience	
Date paper seen by EC	**N/A**	**Equality Impact Assessment completed?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

RESULTS OF THE NATIONAL INPATIENT SURVEY 2017

1. INTRODUCTION

1.1 The 2017 National Inpatient Survey results have now been received. Picker (who undertakes the survey on our behalf) will be providing a presentation of the results and facilitating an action planning workshop on 4th June 2018. The full survey results can be accessed on the CQC website Full publication of survey results available https://www.cqc.org.uk/provider/RKE/surveys

1.2 This report provides a summary of the results of the feedback received from a sample of patients for the survey attended as inpatient or day cases during July 2017. A total of 1248 patients from the Trust were sent the questionnaire. 297 patients returned a completed questionnaire, giving a response rate of 23.8%. The average response rate for the 81 Picker surveyed Trusts was 38.3%. Picker presents their results across two different reporting methodologies: Whittington Health's results historically against our previous surveys; Whittington Health's results in comparison to the other 81 trusts. A breakdown of the Trust's results across these methodologies can be seen below:

Picker

Significant differences

In comparison to other Picker trusts:

Of the 62 problem scored questions, your Trust is:

- Significantly BETTER on 6 question(s)
- Significantly WORSE on 8 question(s)
- The scores show no significant difference on 48 question(s)

Historically:

Of the 56 questions that were used in both the 2016 and 2017 surveys, your Trust is:

- Significantly BETTER on 2 question(s)
- Significantly WORSE on 0 question(s)
- The scores show no significant difference on 54 question(s)

For further information on how your results are reported, please see *Understanding this report* within the *Final Report*.

1.3 In comparison to other Picker trusts, Whittington Health performed significantly better for the following questions:

Lower scores are better

	Trust	Average
8. Planned admission: specialist not given all the necessary information	0 %	2 %
15. Hospital: bothered by noise at night from staff	15 %	19 %
57+. Discharge: not fully told purpose of medications	19 %	25 %
58+. Discharge: not fully told side-effects of medications	52 %	61 %
59+. Discharge: not told how to take medication in an understandable way	15 %	24 %
69. Overall: not asked to give views on quality of care	61 %	69 %

1.4 In comparison to other Picker trusts, Whittington Health performed significantly worse for the following questions:

	Lower scores are better	
	Trust	**Average**
19+. Hospital: food was fair or poor	56 %	39 %
20. Hospital: not always offered a choice of food	26 %	20 %
26+. Nurses: did not always get clear answers to questions	36 %	29 %
27. Nurses: did not always have confidence and trust	27 %	20 %
37+. Care: could not always find staff member to discuss concerns with	68 %	61 %
62+. Discharge: family or home situation not considered	44 %	37 %
67. Overall: not always treated with respect or dignity	21 %	16 %
68. Overall: rated as less than 7/10	19 %	14 %

1.5 In comparison with our 2016 Picker Inpatient Survey, the Trust has improved significantly on the following questions:

	Lower scores are better	
	2016	**2017**
14. Hospital: bothered by noise at night from other patients	48 %	34 %
64. Discharge: not told who to contact if worried	23 %	17 %

1.6 In comparison with our 2016 Picker Inpatient Survey, the Trust has not worsened significantly on any questions.

2. NEXT STEPS

2.1 An action planning workshop was facilitated by Picker and included representatives from the inpatient wards, nutrition and dietetics, patient experience and estates and facilities.

2.2 The group agreed that the focus should be on improving respect and dignity as this would naturally support improvement in some of the other areas that were of concern. Actions are currently being agreed through the inpatient wards managers meeting and senior nurses meeting and progress will be monitored at the Patient Experience Committee.

2.3 Another key area that requires focus is the quality of the food for inpatients. A working group with representation from clinical areas, catering and nutrition and dietetics is in progress. Some actions have already been implemented:

- Plated food trials on three wards.
- Volunteers have received training to support patient mealtimes
- Menu cards have been improved to ensure patients are aware that different portion sizes are available
- Ensuring that menu booklets with the full range of choice are easily accessible to patients and visitors
- The clinical lead dietician has delivered informative and interactive training to staff to support delivery of mealtimes
- The clinical lead dietician has developed a nutrition newsletter for staff

3.0 RECOMMENDATIONS

- An action planning workshop was facilitated by Picker and included representatives from the inpatient wards, nutrition and dietetics, patient experience and estates and facilities. It would be useful for the Trust Board to review the actions detailed in next steps and provide comment and feedback

- The actions from the survey are monitored at ICSU and Estates and Facilities Directorate and reported to Patient Experience Group and then to Quality Committee

- Work to improve the food available for patients is being implemented and actions captured in 2.3 Board is asked to comment on appropriateness and stretch of the actions

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Whittington Health Trust Board

25th July 2018

Title:	**Culture Survey**		
Agenda item:	**18/112**	**Doc**	**9**
Action requested:	The Board to discuss the findings of the report and the proposed response		
Executive Summary:	In the annual staff survey at Whittington Health (WH), staff have consistently reported they are experiencing bullying and harassment at work for a number of years. The Trust has put in place action plans to address bullying and harassment, however the year on year figures in the staff survey suggest limited progress has been achieved. In the 2017 staff survey, WH had a 7% higher score for bullying and harassment from other staff compared to the average for similar Trusts. To understand staffs' experience of bullying and harassment more clearly, and with a commitment to publish the findings in full in order to co-create with staff a cultural change movement, Professor Duncan Lewis, from Plymouth University Business School, was commissioned to undertake an independent review of the workplace culture at Whittington Health. This report details the key findings, and suggests a response to the findings that, although do not offer a quick fix, provide the organisation with a suggested approach to reset its leadership and organisational culture towards more compassionate collective leadership.		
Summary of recommendations:	The Board is asked to: • Accept the findings of the review • Endorse the approach recommended by this paper • Endorse the development of a co-ordinated response to each recommendation in the review • Agree to the implementation of pulse check • Agree to the Workforce Assurance Committee providing assurance to the Board on the implementation of the response actions, including reviewing the information that is scrutinised		
Reference to related / other documents:	Workplace Culture at Whittington Health NHS Trust: Key Findings and Recommendations, Professor Duncan Lewis July 2018		

Reference to areas of risk and corporate risks on the Board Assurance Framework:							
Date paper completed:		18 July 2018					
Author name and title:		**Fiona Smith Corporate Affairs**		**Director name and title:**		**Siobhan Harrington, CEO**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1.0 Introduction

In the annual staff survey at Whittington Health (WH) staff have consistently reported they are experiencing bullying and harassment at work, for a number of years. The Trust has put in place action plans to address bullying and harassment, however the year on year figures in the staff survey suggest limited progress has been achieved. In the 2017 staff survey, WH had a 7% higher score for bullying and harassment from other staff compared to the average for similar Trusts.

There is evidence that when people are under stress at work error rates can increase, quality of care can be negatively impacted and staffs' ability to be compassionate reduces. There is also evidence that compassionate leadership engenders psychological safety, where staff feel safe to raise concerns about errors, near misses and problems that they perceive in the workplace. When they are empowered to develop and implement ideas for new and improved ways of doing things, there is more collaborative and cooperative work in climates characterised by cohesion, optimism and a sense of efficacy. (1) The people that work at Whittington Health are our greatest asset and the heart and soul of our organisation - the way we support our staff is therefore one the biggest determinants of our collective future success.

To understand staffs' experience of bullying and harassment more clearly, and with a commitment to publish the findings in full in order to co-create with staff a cultural change movement, I commissioned Professor Duncan Lewis, from Plymouth University Business School, to undertake an independent review of the workplace culture at Whittington Health.

As a Board we have approached patient safety in an open and transparent way with an emphasis on learning and continuous improvement. As a result, patient safety and quality of care has improved. I recommend that we take the same approach to addressing the findings of this review.

In the interests of openness, honesty and transparency Professor Lewis' full report is available here and an executive summary is presented as an appendix to this paper. It is presented to bring awareness to us all of the experience of some of our colleagues; as a step in further developing trust and co-operation between people who work at Whittington Health; to help all staff to understand what part they play in developing the culture of the organisation, and with a commitment to ensure leaders throughout the organisation develop and improve their leadership skills, capability and effectiveness.

This report details the key findings, and suggests a response to the findings that, although do not offer a quick fix, provide the organisation with a suggested approach to reset its leadership and organisational culture towards more compassionate collective leadership.

2.0 Key findings

Whittington Health employs circa 4,400 staff. In his study Professor Lewis reviewed 1172 usable survey responses, 120 hours of 1:1 telephone interviews and 20 hrs of face to face interviews.

Key findings from the review are as follows:

- 25% of respondents experiencing reported bullying/harassment; 72% did not.
- 35% of respondents reported observing bullying and harassment

(1) https://www.kingsfund.org.uk/audio-video/michael-west-collaborative-compassionate-leadership

- Staff reported that most bullying and harassment emanates from managers and colleagues
- Staff reported inappropriate manager behaviours and a perceived unwillingness by the Trust to do anything when issues were raised
- Evidence of Laissez-Faire leadership behaviour which leads to destructive leadership through inaction, unresponsiveness and an inability/unwillingness to support junior colleagues undertake key tasks and responsibilities.
- Bullying and harassment directly negatively affecting line manager relationships and a perceived lack of senior manager commitment to safe psychological working which ultimately impacts on organisational effectiveness as well as job satisfaction.
- Staff reported a perceived collusiveness between senior leaders that underpins an unwillingness to challenge inappropriate behaviours and provide effective leadership role models
- Evidence of apparent discrimination behind alleged bullying/harassment as well as discriminatory practices between ethnic groups. Several accounts of purported age discrimination by managers. Also, limited evidence of the effectiveness of the existing anti-bullying and harassment scheme and for using the Freedom to Speak Up Guardian as a conduit for bullying and harassment.
- Bullying and harassment directly impacting upon communications and willingness to speak up which has implications for the effectiveness of the Freedom to Speak Up Guardian role.
- Staff reported excessive work demands, poor clarity around role and fit to strategic goals and objectives, poor change management processes/engagement with change
- Bullying and harassment negatively impacting organisational citizenship behaviours but not adversely affecting collegiate citizenship.
- Staff reported that amongst the medical body and senior staff there are inappropriate behaviours
- Evidence of staff bypassing formal communication channels to go directly to the Chief Executive or Trust Chair when concerns are raised
- A grievance culture that shows poor process and entrenched behaviours that is costing the Trust diminished employee commitment, early retirement and a defensive and fractious culture.

3.0 Response

We accept the findings of the review. Professor Lewis' Workforce Culture review shows that bullying and harassment is not endemic in the organisation, nevertheless we must accept, and regret, that a significant number staff have a lived experienced of bullying and harassment.

If we are to develop an organisation where staff work co-operatively together, as individuals, groups and across groups, we must create a sense of mutual trust. An important aspect of compassionate leadership is not about being in charge but about taking care of those in our charge. This results in accepting that bullying and ill-treatment can be an organisational problem requiring an organisational response, rather than a conflict between individuals.

We must also recognise that staff of all grades and in all roles can sometimes be caught between poor systems, stressed colleagues, organisational pressure and the behaviours of others. For this reason, it is important that when reading the report, we do not adopt an attitude of blame, or scapegoat individuals or groups. It is clear that every interaction by every individual every day, shapes or nurtures the culture of the organisation and in response to the findings we should instead reflect on what we do next.

The review evidences that our organisational climate is strongly influenced by the behaviours and values of managers and clinical leaders, and their commitment to supporting the wellbeing of staff. We must be mindful of this in our subsequent actions. An organisation-wide commitment, from the Trust Board through to the frontline, to align behaviours with our values, that are centred on respect and well-being, is required.

Although formal procedures still need to be in place for situations where resolution does not work, our aim must be to nurture a culture where staff can deliver compassionate care and service to our patients, and each other, supported by compassionate leaders.

4.0 What next?

Professor Lewis has described that "WH already has sufficient systems and processes in place to adequately tackle bullying". He has made several transactional recommendations that relate to policy review, the application of policies and procedures, role review, and performance review. We will develop a direct response to every recommendation, and progress will be reviewed through the Workforce Assurance Committee and reported to the Trust Board.

Professor Lewis also says that "bullying and harassment is fundamentally about inappropriate behaviour" and "This report will require a mature response that moves from actively seeking criticism to one of learning and sensitive emotional intelligence". The remainder of Professor Lewis' recommendations and reflections require a transformational response that change the way we behave with each other to ultimately shift our culture towards a compassionate collective where everyone feels they have leadership responsibility, and where leaders work interdependently prioritising staff satisfaction and high-quality patient care, across perceived boundaries, whether these are between individuals, groups and teams or across organisations.

The following outlines the key aspects of development required for the organisation with a suggested approach to reset our leadership and organisational culture towards more compassionate collective leadership. We will develop these into a co-ordinated plan once we have engaged with the Integrated Clinical Service Units (ICSUs) and more widely.

4.1 Behavioural standards

Professor Lewis says some staff describe Whittington Health as traditionally seen as a "*friendly workplace*" with a "*family-friendly feel*" but that this was changing. From the Trust Board, Executive, Consultant body and through all other staff groups we must match behaviours to our ICARE values.

Low level negative behaviours such as rudeness, disregard for others, or treating others with disrespect often overlap with bullying and, where left unchecked and unmanaged, contribute to the creation of cultures that tacitly accept bullying

Behavioural standards will be developed in collaboration with employees, and role-modelled by senior managers and senior clinicians. These will address what is and is not acceptable, from individuals, in teams, and the organisation as a whole.

People should feel empowered to talk more openly with each other about the line between acceptable and unacceptable behaviour. Employees at all levels should feel able to 'challenge' unwanted behaviours that they receive or witness. We will explore with staff the introduction of standard informal terminology that can make it easier for employees and managers to flag potential bullying in its earliest stages so the potential for early resolution is maximised and progress to grievance minimised.

4.2 Clarity of role

The report clearly indicates that some staff are uncertain about what is expected of them at work and that their role requires more clarity. There appears to be a link between this lack of clarity of role and sense of bullying and harassment due to perceived unfairness.

This has been acknowledged by the executive team and Trust Board and work is already underway to provide clarity of objectives. Once the objectives are approved by the Trust Board, the Executive Team will work with the ICSUs and wider organisation to ensure staff understand what this means for them in their roles and this will be incorporated into revised appraisal procedures.

Managers and staff will have an opportunity, through the revised appraisal process, to align their efforts within their roles and responsibilities to delivering the Trust's vision and objectives. This will contribute to staff feeling greater clarity of role, ability to describe their purpose and demonstrate their value and success in their role.

4.3 Leadership development

The findings of Professor Lewis' review indicate that, while policies and training are essential components for addressing bullying, our traditional approaches to handling bullying and harassment, such as anti-bullying policies, training managers in their application and upskilling supervisors and managers to apply policies and better handle workplace conflicts, has not led to an overall reduction in bullying at Whittington Health.

Staff describe their experience of a laissez faire or passive leadership, that they view as a destructive management style, where managers avoid or delay dealing with conflict which compounds the feelings of being bullied. Staff describe unpredictability caused by arbitrary and inconsistent behaviours and application of rules by managers, which is also being experienced as bullying.

Clinical leaders and managers must be aware of how easily management action can cross over into, or be perceived as, bullying. The recent ICSU restructure provides an opportunity to work with clinical leaders and managers and develop our leaders to deliver enlightened people management which is positive, supportive, open, honest, appreciative and authentic.

All Executives and ICSU leaders are agreeing their personal objectives and through this process will reflect on the implications of this review for their personal development as leaders.

The work of the organisational development team has been gathering momentum, as is acknowledged by Professor Lewis in his report. How we continue our approach to organisational and leadership development is critical to creating change in the culture of the organisation.

Mentoring, coaching and more specific leadership development programmes for the Executives and ICSU leadership teams are in progress. We will further support clinical leaders and managers with training and mentoring in every team to change the perception of what good management is. They will be supported to listen deeply to staff, find shared understanding, develop empathy, know how to take intelligent action and respond acknowledging both the concerns and the suggestions of colleagues.

A manager network, where managers support and learn from each other how to create conditions where staff can continually improve, will be established and include mentoring and coaching. A "passport to management" will be developed that includes training on key policies, developing skills that enable proactive difficult conversations, and build confidence and skills to recognise the causes and signs of ill-treatment, in order to engage effectively in early, informal and formal resolution, and to sensitively manage change.

4.4 New approaches to resolution

To address the grievance culture highlighted by Professor Lewis, informal resolution will be encouraged wherever appropriate. This will include encouraging open conversations in teams and between individuals and ensuring that line managers are equipped to be proactive and responsive.

Support structures to provide assistance to those experiencing bullying will be reviewed. This will be communicated to staff to access as an informal channel for reporting bullying. Our response will include also include reviewing our approach to the Freedom to Speak up Guardian and the development of a new Recognition Agreement and partnership model.

5.0 How will we know things are different?

Practical measures for the early identification of bullying behaviours are critical. The Trust already collates information from the annual staff survey and the staff Friends and Family Test, as well as confidential 'consequence free' exit interviews, and information on diversity and inclusion.

5.1 Pulse checks

Annual staff surveys and the staff friends and family test do not offer the organisation a real time mechanism for knowing whether the culture of the organisation is changing. Other NHS organisations have started to undertake quarterly "pulse checks" (through, for example, Survey Monkey) to explore staff satisfaction at work. Whittington Health will adopt this approach to know how staff view the culture of the organisation.

The following are suggested monthly pulse check statements that act both as a "behavioural nudge", to remind staff of the valued thinking and feeling behaviours and actions associated with compassionate leadership, and as a "culture temperature check". Although responses are anonymous, staff will state their staff group and ICSU. Staff will score the responses to enable analysis of results and focus. We will test these statements with staff before adopting them in our monthly pulse checks.

Example pulse check statements:

- I know what is expected from me in my job
- I can recite our organisation's values
- I use these three words to describe our culture (free text responses)
- I feel we authentically deliver our organisational values
- I feel co-workers treat each other with compassion and fairness

- When we finish our work we collectively reflect on what went well and what could be improved on next time
- If given the chance I would reapply to my current job
- I give feedback to my manager what I am thinking or feeling or notice
- I believe the leadership team takes my feedback seriously
- I frequently receive recognition from my manager
- I give my team and members of my team/ my manager frequent recognition

5.2 Executive Oversight

The Executive will, through their performance review process, scrutinise data to identify patterns and enable targeted action on contributory factors, such as management practices, workloads or organisational change.

5.3 Workforce Assurance Committee

The Trust has a Workforce Assurance Committee which is a subcommittee of the Trust Board. Workforce reports to the committee will be reviewed to provide further assurance on delivery of the actions outlined in section 4 and 5 of this report, and progress with the detailed co-ordinated direct response to every recommendation within Professor Lewis' report.

6.0 Conclusion

Professor Duncan Lewis was commissioned to undertake a Workforce Culture review to understand more deeply the causes of bullying and harassment reported by some colleagues at WH.

Professor Lewis' Workforce Culture review shows that bullying and harassment is not endemic in the organisation, nevertheless we must accept, and regret, that a significant number staff have a lived experienced of bullying and harassment.

Creating and maintaining a positive work climate requires more than reacting to individual instances of workplace conflict when those are brought to management attention. We must view bullying and ill-treatment as an organisational problem requiring an organisational response, rather than a conflict between individuals.

I have no doubt that having brought the experience of some of our colleagues to our collective awareness, and by continuing to respond and act in an open and transparent way with an emphasis on learning and continuous improvement by us all, we will succeed in shifting the culture of our organisation towards a commitment to collective well-being through compassionate leadership.

7.0 Recommendations:

The Board is asked to:

- Accept the findings of the review
- Endorse the approach recommended by this paper
- Endorse the development of a co-ordinated response to each recommendation in the review
- Agree to the implementation of pulse check
- Agree to the Workforce Assurance Committee providing assurance to the Board on the implementation of the response actions, including reviewing the information that is scrutinised

Workplace Culture at Whittington Health NHS Trust: Key Findings & Recommendations from a Report Commissioned by

Whittington Health NHS Trust

July 2018

Professor Duncan Lewis

Plymouth University Business School

&

Longbow Associates Ltd

Longbow
Associates Ltd.

Background

This mini report is based on a six-month study into workplace culture at Whittington Health NHS Trust (WH). The study is made up of a survey and over 120 hours of interviews with WH staff. No one has been identified as a result of speaking to the researchers and all information is held solely by them. Confidentiality was guaranteed. The study also examined policies and procedures that might relate to the issues being examined. The main report (68 pages) is available to any member of staff who wishes to read it. The main and mini reports have been written by Professor Duncan Lewis of Longbow Associates Ltd and Plymouth University. Duncan is an expert in bullying and harassment research and has undertaken significant work on bullying and harassment for the NHS.

Key Findings

- The Trust has begun to put in place a strategy to properly tackle alleged bullying and harassment (B&H).
- WH has appropriate systems and processes to tackle B&H but requires a more joined up approach to unite these to make clearer pathways to deal with it.
- 72% of staff who responded to the survey did not report any B&H but 25.5% did. A further 35% reported observing bullying and harassment.
- Staff who answered the survey reported most B&H came from managers and colleagues, but most interviewees reported bullying by managers/leaders.
- WH staff observe the behaviours of some leaders and are frustrated at what they see/hear. The most common 'unreasonable management' behaviours reported were; 'Having your views and opinions ignored'; 'Being given unmanageable workloads or impossible deadlines'; and 'Pressure from someone else to do work below your level of competence'.
- Behaviours associated with general incivility were less of a problem, but two behaviours stood out; 'Being humiliated or ridiculed in connection with your work'; and 'People excluding you from their group'. These behaviours come from managers and co-workers.
- The demands of the job, a lack of clarity about their role, and the management of change at work, were the major sources of stress for WH staff who responded to the survey. Two of these (role clarity and management of change) are relatively easy to address by the WH leadership.
- Overall, the staff who replied to the survey reported good support from their peers and managers, but this was reduced when staff reported being bullied or harassed. Most staff felt in control over the work that they did.
- Some staff feel the Trust is not doing enough to tackle bullying when they raise issues of concern. This mainly showed itself as an unwillingness by senior staff to take concerns seriously.
- Many staff who responded to the survey reported a lack of clarity about their role and how they could/should contribute to the effectiveness of WH.
- The Freedom to Speak Up Guardian and the Inclusion Champions/Advocates are important roles going forwards and these are not being as effective as they should in tackling B&H.
- Those affected by B&H feel more detached from their WH citizenship. Bullying also negatively impacts on relationships between some staff and their managers and

those reporting B&H have reduced job satisfaction which results in diminished WH effectiveness.

- The Chief Executive is generally viewed positively and is seen as supportive. However, many staff take issues directly to the CEO and this is inappropriate. The same is true of the Chair. Both the CEO and Chair have important roles leading the organisation.
- Some WH staff believe several of the senior leaders of the Trust, including senior medical staff, are not providing effective leadership role models. This shows itself in a number of ways, but is best summed up as:
    - Hands-off, inaction, slow to respond when asked for help by junior staff
    - Failing to prepare less experienced staff to undertake management tasks
    - Supporting a grievance/blame culture
- Some WH staff feel discriminated against, either because of their age or their ethnic background. There is a need for a co-ordinated effort by the Trust leadership and all staff to tackle discrimination.
- Allied Health Professionals feel they lack a voice and representation within WH.

Key Recommendations

The following are some of the key recommendations taken from the main report.

1. All leaders of WH, including senior medical staff, must demonstrate appropriate leadership styles and behaviours. Responding in a timely fashion and supporting junior colleagues who ask for help to undertake tasks/roles must be forthcoming.
2. Role modelling behaviours is important. If senior staff shout and swear this sets a poor example to other staff.
3. Staff raising concerns about others behaviour must be taken seriously. It is not acceptable to say, 'that is just how she is' or, 'he is like that with everyone'. Inappropriate behaviours must be raised and tackled, and every employee has a responsibility to raise issues of concern.
4. Senior medical staff have a role to play in ensuring organisational effectiveness. They too are role models and their behaviours inform others of how senior employees should behave.
5. There is a need for staff to understand what is entailed in taking out a grievance against another staff member. Grievances are costly, time consuming and often inappropriately used. It is important that any staff member can take out a grievance, but that they understand how grievances work and what is allowed and not allowed.
6. When grievances are raised, they must be tackled more speedily and with greater purpose. Grievance processes must be fair and clear.
7. WH needs to make better use of existing data by creating an action group, including the Freedom to Speak Up Guardian, Inclusion champion/advocates and trade unions. A new partnership model is needed to drive change. This must be driven by a member of the Executive and a Non-Executive Director.
8. A manager network to be created, dedicated to support managers lacking in experience of managing conflicts. Managers will need mentors and be appraised in their managerial performance and supported through material best practice.
9. Clarity around roles and contribution is needed. Similarly, the processes and management of change requires real engagement with WH staff. All of this has to

take place within the performance appraisal process. Staff must understand their roles and their contribution to organisational mission, goals and objectives.

10. Diversity and inclusion must be directly discussed in team meetings, individual appraisals and in other discussions. This is a strategic priority to be driven directly by the leadership of the trust and reported in quarterly Executive agendas.

Concluding Remarks

Tackling bullying and harassment requires leadership commitment. This commitment must feed down from the Executive through the heads of ICSUs down to all manager grades. Bullying and harassment can only be reduced when there are appropriate channels for employees to be able to speak up. This is obligatory for all WH staff. Staying silent is not an option in the same that suffering in silence is not an option. Similarly, inappropriate behaviours affect all levels of every organisation and WH is no different in this regard. Every employee is a role model for every other employee, but particularly when in a senior medical or leadership role. The old maxim of 'treat others as you would wish to be treated' is very appropriate, particularly in an organisation where health and care are fundamental to its purpose.

Whittington Health NHS

Trust Board

25 July 2018

Title:	**Workforce race equality standard report**		
Agenda item:	**18/113**	**Paper**	**10**
Action requested:	For agreement		
Executive Summary:	The report outlines the Whittington Health staff demographic profile and the Workforce Race Equality Standard (WRES) metrics for 2017-18, and compares the data with 2016-17 results. This report summarises progress with the 2017 action plan and provides an action plan for the forthcoming year, which includes ongoing workstreams from 2017 as well as new projects for 2018-19 which drive the Equality, Diversity and Inclusion (EDI) agenda forward. The Trust is required to publish the WRES data for 2017/18 by the end of July 2018. The report, with the accompanying action plan for 2018/19, meets the Trust's commitment to making improvements directly relating to equalities relating to race, as one of the protected characteristics under the Equality Act 2010.		
Summary of recommendations:	The Trust Board is asked to approve the action plan		
Fit with WH strategy:	This report is in line with the workforce Strategy and meets the Trust's statutory objectives under the WRES Metrics		
Reference to related / other documents:	Workforce Race Equality Standard (WRES) metrics		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	July 2018		

Author name and title:	**Helen Kent, Assistant Director of OD Charlotte Johnson, Head of Development and Inclusion**	**Director name and title:**	**Norma French Director of Workforce**

Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

EQUALITY AND INCLUSION REPORT AND ACTION PLAN

1.0 Introduction

1.1 This report outlines the Whittington Health staff demographic profile and the Workforce Race Equality Standard (WRES) metrics for 2017-18, and compares the data with 2016-17 results. The Inclusion Team at Whittington Health has committed to submitting these reports to the Workforce Assurance Committee (WAC) every 6 months.

1.2 This report summarises progress with the 2017 action plan and provides an action plan for the forthcoming year, which includes ongoing workstreams from 2017 as well as new projects for 2018-19 which drive the Equality, Diversity and Inclusion (EDI) agenda forward.

1.3 The publication of the annual WRES data return is an important commitment for the Trust as indicated in Appendix A, showing an infographic of the Trust's WRES data for 2016-17.

1.4 The Trust will be required to publish the WRES data for 2017/18 by the end of July 2018. This report, with the accompanying action plan for 2018/19, meets the Trust's commitment to making improvements directly relating to equalities relating to race, as one of the protected characteristics under the Equality Act 2010.

2.0 Participation in External Programmes

2.1 Whittington Health is part of a collaborative project between London Equality & Diversity Network, London HR Directors Network and the national WRES Team to focus on issues that require most attention.

2.1.1 As part of this network, the Trust is participating in the 'WRES 3 Project', focussing on WRES indicator 3 (the relative likelihood of staff entering a formal disciplinary process). This project includes:

- Agreeing standardised audit and review measures
- Implementing and monitoring impact of models of better practice and toolkits
- Identifying and addressing root causes
- Commissioning of an academic partner to conduct an evaluation, learning and share good practice

2.1.2 The project will report its progress throughout 2018-19 and this will be reported to the WAC through the six monthly reports.

2.1.3 In support of improving results for indicator 3, the Trust aims to introduce a "Fair Treatment Panel" which has been designed to provide a two-stage triage model incorporating the 'decision tree'[1] approach. It provides a sense check, by a senior manager (Director or Deputy Director), prior to any formal action being taken, to establish whether events merit formal disciplinary investigation, and to explore alternatives. Implementation is scheduled for September 2018.

[1] National Patient Safety Agency (NPSA) is a well-established checklist tool designed to assist with incident decision-making. The tool comprises an algorithm with accompanying guidelines which enables a series of structured questions to be asked to support the act of deciding if formal action is essential or if alternative options are feasible.

2.2 **London Leadership Academy Inclusion Labs Pilot**

2.2.1 Together with other London based NHS organisations, Whittington Health is participating in the Inclusion Labs pilot, based on the WRES 2017 data results. Equalities and Inclusion expert Mitzi Wyman has been assigned to support the Trust in the design and delivery of a range of interventions to build on the work already taking place to improve Equalities and Inclusion across the Trust.

2.3 **Diversity and Inclusion Partners Programme 2018-19**

2.3.1 Whittington Health is one of 40 organisations chosen, following an application process, to take part in the Diversity & Inclusion Partner Programme hosted by NHS Employers during 2018-19. The programme will provide a platform for Whittington Health to further progress and develop our equality performance, and to better build capacity in the area of Equalities, Diversity and Inclusion (EDI), which should consolidate initiatives beyond work related to the WRES. The ambition of the Trust is to embed EDI throughout all areas of its operation, to become a "Beacon Trust", a role model employer and healthcare provider.

2.3.2 The programme will be delivered in four modules, standards, capacity, delivery and evaluation which will enable the access strategic policy support. The appointment of an executive sponsor/lead to champion the EDI agenda will be critical. A working group will be established to drive the work of EDI throughout 2018/19.

3.0 **2016-17 and 2017-18 WRES Comparisons**

3.1 The table below provides a summary of the Trust's performance on the nine WRES indicators. The movement of scores since last year are colour-coded (red is 'worse', amber is 'no change' and green is 'better'). Some commentary on the direction of movement on the gap between White and BME experience is also colour coded (red shows a widening gap, amber shows the same gap and green shows a reduction in the gap unless this is an insignificant movement or there remains too great a gap in which case it is shown in amber). The table is followed by a discussion of the themes which arise from this data.

3.1.1 Table to Summarise WRES Data for 2017-18 and Compare with 2016-17 Data

Data Heading	WRES REPORT 2017	**WRES REPORT 2018**	**Change in White Scores**	**Change in BME Scores**	**Change in W/BME Gap (Direction)**	**Commentary**
Total number of staff employed in the organisation	4284	**4255**	NA	NA	NA	↓ fall of 29 total staff
Proportion of BME staff employed within the organisation	45%	**43%**	Increase of 2% ↑ RED	Decrease of 2% ↓ RED	2% increase in gap ↑ RED	
Proportion of total staff who have self-reported their ethnicity	93%	**90%**	↓ fall of 3% Overall RED			It is necessary for staff to engage in the collection of demographic data to enable us to progress the inclusion agenda.
Indicator 1 Percentage of BME staff by band separated by clinical and non-clinical staff	See Workforce Profile table (appendix B)	**See Workforce Profile table (appendix B)**				See Workforce Profile table (appendix A)
Indicator 2 Relative likelihood of staff being appointed from shortlisting	White staff are 2.17 times more likely to be appointed from shortlisting than BME staff across all posts	**White staff are 2.13 times more likely to be appointed from shortlisting than BME staff across all posts**	A slight reduction of 0.04 score is the right direction GREEN	There remains a significant gap in likelihood for White and BME staff being appointed RED	↓ There is a small but insufficient reduction in the score of 0.04 AMBER	Whilst the indicator has moved slightly in the right direction, there is still a significant gap in likelihood of White and BME staff being appointed from shortlisting
Indicator 3 Relative likelihood of staff entering the formal disciplinary process	BME staff are 2.41 times more likely to enter a formal disciplinary process than White staff	**BME staff are 0.75times less likely to enter a formal disciplinary process than White staff**	White staff are more likely to enter into a disciplinary process than BME staff RED	BME staff are 0.75 times less likely to enter into a formal disciplinary process than White staff GREEN	We cannot make assumptions about the change in data (please see the commentary)	There appears to be a significant change, however, the data is not directly comparable. In 2016-17 all formal cases were included (grievance, disciplinary, probation, performance), while the data for 2017-18 includes disciplinary only. The 2017-18 data shows BME staff are 0.75 times **less likely** to enter formal disciplinary processes than White staff.

Data Heading	WRES REPORT 2017	WRES REPORT 2018	Change in White Scores	Change in BME Scores	Change in W/BME Gap (Direction)	Commentary
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD	The recording processes for reporting non-mandatory training and CPD related development opportunities is not consistently used. Therefore there is no data for this period.	**A review to improve collection of data commenced in April 2018 by working with Clinical Education to identify gaps.**	Not known	Not known	Not known	There is currently no data to report.
Indicator 5 Percentage of staff experiencing bullying, harassment or abuse from patients, relatives or the public in the last year	White: 30% BME : 29%	**White: 28%** **BME : 29%**	White ↓ 2% fall (GREEN)	BME → no change (AMBER)	No change in size of gap 1% to 1% → (AMBER)	The concern is less about the gap, which is small, but more about the continued high level of staff reporting experiences of bullying.
Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last year	White: 25% BME: 32%	**White: 27%** **BME: 33%**	White ↑ 2% rise (RED)	BME ↑ 1% rise (RED)	↓ Fall of 1% from 7% to 6% (AMBER)	Whilst the gap is reducing a small amount, it is the result of an increase in experience of bullying from staff for both White and BME staff.
Indicator 7 Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	White: 87% BME 70%	**White: 85%** **BME 61%**	White ↓ 2% fall (RED)	BME ↓ 9% fall (RED)	↑ Rise of 7% to 24% (RED)	Not only is there a fall for both White and BME staff in believing that there are career opportunities, there is a widening gap between White and BME staff.
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following – manger, team leader, or colleagues?	White: 7% BME: 17%	**White: 8%** **BME: 17%**	↑ 1% rise (RED)	→ no change (AMBER)	↓ fall by 1% to 9% (AMBER)	Whilst the closing gap is movement in the right direction, the gap remains large and the experience of discrimination too high for both White and especially BME staff.

Indicator 9 Percentage difference between the Trust's Board membership and its overall workforce (which, for 2017-18 is: 43% BME; 47% White; and 10% undisclosed) Disaggregated by: • Voting membership of the Board • Executive membership of the Board	Voting: White: 52% BME: -45% Executive: White: 52% BME: -45%	**Voting:** **White: 47%** **BME: - 18%** **Executive:** **White: 47%** **BME: - 43%**	The requirement for reporting has changed in 2017/18 and therefore the change in scores cannot be attributed wholly to better WRES performance. We cannot make assumptions about the change in data.
			The Trust Board is made up of fifteen members, of which the board voting membership is twelve. The voting members of this Trust Board consists executive and non-executive members. Indicator 9 identifies the percentage difference between the Whittington Health board membership and its overall workforce disaggregated as follows:- • By the voting membership of the board: the data shows that 25% of the Trust board voting members are BME compared to 43% BME workforce. The percentage difference is therefore -18% (i.e. 25% - 43%) • By executive membership of the board: the data shows that there are no BME Executive members and the percentage difference is - 43% (i.e.0% - 43%= - 43%)

3.1 This report shows that there has been a fall in the proportion of BME staff, a reduction of 2%, in the past 12 months. It is also noted that there is a drop of 3% in staff who self-report their ethnicity, since reporting in 2016/17.

3.2 The Workforce Profile table (Appendix B) shows that the areas with the most significant drops in proportion of BME staff has been non-clinical as follows:

- Band 3 (4.8%)
- Band 7 (8.5%)
- Band 8B (4.1%)
- Band 8C (3.9%)

For clinical staff the most significant changes are:

- Bands 5 (5.6%)
- Band 8B (6.6%)
- VSM (19%)
- Doctors in training (7%)
- Career grade doctors (6.2%).

The most significant rises in proportions of non-clinical staff not reporting their ethnicity have been:

- Bands 2 (5%)
- Band 3 (2.9%)
- Band 5 (4.4%)
- Band 6 (2.9%)

For clinical staff the most significant non reporters have come from:

- Band 4 (4.2%)
- Band 5 (5.5%)
- Doctors in Training (5.1%)
- Career grade doctors (11%).

3.3 Indicator 2 shows a reduction in the ratio of White staff being appointed from shortlisting in comparison to their BME counterparts across all posts by 0.04. Whilst this is a move in the right direction, the gap is not closed and White staff are still 2.13 times more likely to be appointed from shortlisting than BME staff.

3.4 Indicator 3 appears to shows a significant improvement in the likelihood that BME staff will enter the formal disciplinary process in comparison to their White colleagues. However, the data included in each set is not directly comparable. The data for 2016-17 included all formal cases (grievance, disciplinary, probation, performance etc.), while the data for 2017-18 includes only disciplinary cases as indicated in the WRES technical guidance 2017[2]. What is positive is that data for 2017-18 shows that BME staff are 0.75 times *less likely* to enter a formal disciplinary process than White staff.

[2] Technical Guidance for the NHS Workforce Race Equality Standard (WRES) March 2017: page 32.

3.5 While Indicator 5 shows that there has been a very small reduction (2%) in the percentage of White staff experiencing bullying, harassment or abuse from patients, relatives or the public in the last year, there has not been a reduction for BME staff, which is of concern. The gap between the experience of White and BME staff has remained the same at 1%, and the focus for the Trust is about the level of bullying and less about the gap.

3.6 Indicator 6, however, shows an increase in the percentage of staff experiencing harassment, bullying or abuse from staff in the last year by 2% for White staff and 1% for BME staff. This is of considerable concern, and whilst there has been a minor close in gap of 1%, there remains a gap of 6% in the experiences of White and BME staff.

3.7 There has been a significant (9%) reduction in the proportion of BME staff who believes that the Trust provides equal opportunities for career progression or promotion (Indicator 7) and a smaller (2%) reduction for White staff.

3.8 Indicator 8 shows that there has been a small increase (1%) in White staff having experienced discrimination at work from colleagues (not reflected in the scores for BME staff).

3.9 It will be useful to consider the outcomes of the Bullying and Harassment research being conducted by Professor Duncan Lewis, in relation to the willingness to report, and whether this may have affected numbers. The 2017 Staff Survey, shows that the percentage of employees willing to report their most recent experience of harassment bullying or abuse are in our top five ranking scores. The Trust's score is 49% in comparison to the national average for combined acute and community trusts at 47%, a difference of 2%[3].

3.10 The requirements for calculating Indicator 9 has been amended. It is therefore not possible to comment on what appears to be an improvement in scores.

4.0 **Local and National comparisons**

4.1 The table below shows the national NHS workforce has a BME population of 16.3%, which is low compared to Whittington Health's 43%. Data suggests that the local population is 36% BME. Within London, the NHS workforce is 43.2% BME.

4.2 For NHS trusts nationally, across the non-medical workforce (clinical and non-clinical), the proportion of BME staff in the senior Bands 8A - 9 and VSM was 10.4%, and for Whittington Health, this is 21.5%.

4.3 Nationally, for clinical non-medical staff, the proportion of BME staff in Bands 8 to 9 and VSM was 10.8% compared with 17.6% in the workforce as a whole. The equivalent proportions for Whittington Health are 23.7% and 42.4%.

[3] 2017 National NHS staff survey: results from Whittington Health NHS Trust (full report), page 6.

4.4 For non-clinical staff, the proportion nationally of BME staff in Bands 8 - 9 and VSM was 9.7% compared with 13.2% in the workforce as a whole? For Whittington Health the figures are 15.5% compared with 50%.

4.5 The proportion of clinical staff in bands 8A - 9 and VSM for whom there is no ethnicity data (2.7%) is in line with national data (2.9%), however, for non-clinical staff in bands 8A - 9 and VSM, the national proportion for whom no ethnicity data is held is 4.2%, compared to Whittington Health's 11.8%.

4.6 The national picture shows that, with the exception of AfC Band 9, the proportion of BME staff increased from 2016 to 2017 across all other AfC bands. This was not the case at Whittington Health, where some bands showed marked increases and decreases and others remained stable – see Appendix B.

	NATIONAL NHS WORKFORCE	LONDON NHS WORKFORCE	WHITTINGTON HEALTH	LOCAL POPULATION
TOTAL BME POPULATION (%)	16.3%	43.2%	43.0%	36%
BME NON MEDICAL Clinical and non-clinical) Band 8A - 9 and VSM (%)	10.4%		21.5%	
BME NON MEDICAL Clinical) Band 8A - 9 and VSM (%)	10.8%		23.7%	
BME NON MEDICAL Non-Clinical Band 8A - 9 and VSM (%)	9.7%		15.50%	

4.7 The relative likelihood of white staff being appointed from shortlisting compared to BME staff, across all posts in the NHS, was 1.60 times greater than for BME staff. Whittington health is one of 27 trusts (11.6%) in which it was more than twice as likely (2.13) that white staff would be appointed from shortlisting compared to BME staff. This is a slight decrease from 38 (17%) trusts in 2016.

4.8 If the data held for Indicator 3 is accurate and comparable to local and national results, Whittington Health is to be commended, as the national picture is that BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to White staff.

4.9 A total of 205 (87%) trusts provided data for Indicator 4 of a quality which enabled it to be analysed. Data quality for this indicator has improved this year, with only 23 NHS trusts failing to provide any data, compared to 48 trusts last year. Whittington Health is one of these trusts. A further seven trusts provided data of a quality that had low confidence levels, compared to 26 in the 2016 collection. In April 2018 work has been started with Clinical Education to identify the gaps in order to improve data quality.

4.10 The WRES Data Report 2017[4] reports that "practice of recording non mandatory and CPD training differs between organisations. The current definition does not explicitly include access to acting up, shadowing, leading projects, secondments, coaching and so on, which may be the most important aspects of staff development". When progressing our improvement to the collection and monitoring of this information, these categories of training should be considered.

4.11 Our data on percentage of staff experiencing bullying, harassment or abuse from patients, relatives or the public (Indicator 5) in the last year is now in line with the national picture. However, our percentage of staff experiencing harassment, bullying or abuse from staff in the last year (Indicator 6) (White 27%, BME 33%) differs significantly from the national picture (White 23%, BME 26%), particularly in relation to BME staff. In the London region, the proportion of BME staff is on average 29%, and across the NHS, for Acute trusts, the proportion of BME staff is on average 27.1%, while for Community it is 22.5%. As a Trust, we are not alone in our proportion of staff who, in the last 12 months have personally experienced discrimination at work from colleagues (Indicator 8) having increased – there has been an overall increase from 11% to 13% of all staff. National proportions for White staff (6%) and BME staff (14%) remain lower than for Whittington Health (White – 8%, BME 17%).

4.12 The national percentage of staff believing that their trust provides equal opportunities for career progression or promotion has dropped slightly from 86% to 85%, in line with the experience of Whittington Health's White staff. However, for White staff nationally the proportion is 88%, and for BME staff, this proportion has increased from 74% to 76% national, in comparison with our significant reduction from 70% to 61%. In London, the BME percentage is 70%, in Acute trusts nationally it is 75% for BME staff, and in Community trusts nationally, 80% of BME staff believe that their trust provides equal opportunities for career progression or promotion.

4.13 Overall, the proportion of Board members in NHS trusts is comprised of 88% white, 7% BME, and 5% Null/Unknown. This is not reflective of the workforce as a whole where 17.7% of staff is from a BME background. Whittington Health data shows that 25% (3 non-executive members) of the voting members are from a BME background. At a national level, there is a steady increase in the number of trusts that have more two or more BME board members. There are now a total of 25 NHS trusts with three or more BME members of the board, compared to the 16 trusts reported in 2016. The WRES Data Report 2017 reports that "This welcomed increase between 2016 and 2017 has come during a period of intense WRES implementation support given to the boards of NHS trusts across the country. Further WRES support is planned during 2018 which will engage senior leaders, at local and national level, with the goal of positively influencing organisational succession planning so that boards are truly reflective of the workforce and population that they serve."

[4] NHS Workforce Race Equality Standard 2017 Data Analysis Report for NHS Trusts, First published: Dec-17, Prepared by: Dr Habib Naqvi, Saba Razaq and Reg Wilhelm on behalf of the WRES Implementation team. Publication Gateway Reference Number: 07477 Access online: https://www.england.nhs.uk/wp-content/uploads/2017/12/workforce-race-equality-standard-wres-data-report-2017-v2.pdf

5.0 Action Plan 2017/18

The actions below were reported to the Workforce Assurance Committee in November 2017. The action plan provides an update and progress of activities listed below.

	Activity	Start Date	End Date	Outcome with comments
1	Develop Equalities Research Bulletin	Nov-17	Dec-17	Achieved: staff on distribution list receive bulletin on a regular basis.
2	Send out survey on EDI & Networks	16-Nov-17	16-Nov-17	Achieved: Information informed the development of E & I Network.
3	Assess data from surveys on EDI & Networks	10-Jan-18	18-Jan-18	Achieved: see above.
4	Create Follow-up Video	26-Oct-17	04-Dec-17	Achieved: Video located on Intranet page; http://whittnet.whittington.nhs.uk/default.asp?c=30143
5	Disseminate Follow-up video and accompanying information	04-Dec-17	22-Dec-17	Achieved.
6	Meet to discuss EDI issues arising and begin planning work areas	04-Oct-17	04-Oct-17	Achieved.
7	Convene Data Improvement stakeholder team and work on identifying issues and opportunities with regards to equality and demographic data collection.	Expressions of interest received	Jan-18	In progress – will be continued in action plan for 2018/19.
8	Presentation of data to WAC	14-Feb-18	14-Feb-18	Achieved.
9	Liaison with PAG leads to agree ways of working for updating of policies	Dec-17	Jan-18	Subject to review.
10	Review of existing policies	Jan-18	Dec-18	In progress – see above.
11	Develop Inclusion Champions Programme	Sep-17	May 2018	Achieved: Nine Speak Up Inclusion Champions (SUIC) trained in May 2018.
12	Publicise and recruit to Inclusion Champions Scheme	Sep-17	Feb-18	Achieved.
13	Assess interest in Networks via surveys and feedback from Video-led discussions	26-Sep-17	Dec-17	Achieved.
14	Liaise with OD: overlap between networks and developing other support systems	21-Nov-17	On-going	In progress
15	Approach potential speakers for interim events	27-Oct-17	On-going	In progress
16	Develop format, and begin to approach stakeholders, for May 2018 event.	04-Oct-17	On-going	Achieved: Delivered a range of events during Equality & Diversity Week – 14 to 20 May.
17	Arrange to meet relevant staff to discuss EDI content within Nurses Conference.	17-Oct-17	On-going	Achieved: Equalities Lead attended 2018 Conference.
18	Attend Schwartz Rounds and arrange meeting with leads.	19-Oct-17	On-going	Achieved.
19	Publish WRES Data publically.	08-Nov-17	Dec-17	Achieved.
20	Gather and report on WRES Data for 2017/18.	Feb-18	July 2018	Achieved.
21	Work with Data team (above) to prepare to collect WDES and (EDS2 data).	Jan-18	April 2018	In progress – will be continued in action plan for 2018/19.

22	Annual Equality and Inclusion Report to Board.	May-18	Sep-18	In progress.
23	Meeting between masterclass leads + external training provider to develop content.	14-Dec-17	14-Dec-17	Achieved.
24	Masterclasses held.	Mar-18	July 2018	Achieved.
25	Task & Finish Groups convened & working on issues identified.	Apr-18	March 2019	In progress – will be continued in plan for 2018/19 – see A3 and A4.
26	ICSU/Directorate Action Plans updated.	Mar-18	June 2018	In progress.
27	Liaise with OD team to discuss ways in which their agenda can support the Anti-Bullying and Harassment agenda.	09-Nov-17	On-going	In progress.
28	Publicise and recruit to Anti-Bullying and Harassment Advisors Scheme.	26-Sep-17	Feb-18	In progress: recruitment of additional Anti-Bullying and Harassment Advisors have been postponed until further notice – awaiting the findings of the research conducted by Professor Duncan Lewis, Plymouth Business School.
29	Meet with senior leaders to gather intelligence on EDI at WH and raise its profile.	01-Aug-17	On-going	On-going
30	Engagement with Inclusion Labs Programme.	09-Feb-18	May 2019	In progress – will be continued in plan for 2018/19.
31	Join & engage with the London Leadership Academy's Communities of Practice.	25-Oct-17	On-going	No longer being progressed.

6.0 **Proposed Action Plan 2018/19**

This action plan outlines the work which will be led by the Workforce Directorate which will depend on a whole organisation engagement as the EDI agenda is the "golden thread" flowing through all of the Trust's operational activities. Working in collaboration with the Board, senior management and Workforce to develop a corporate action plan will provide direction for what the rest of the organisation will be required to do during 2018/19 and beyond. New activities required to progress the EDI agenda for providing excellent patient/service user care, and to better enable our local populations to live longer healthier lives, are reflected in the action plan below.

The action plan includes a number of activities which can be found in the 2017/18 that requires continuation.

Aims		Activities	Measures / Targets	Lead / Participants	Start date	Completion	Comments
A1	Improve the quality of data held on our workforce to enable analysis and targeted support for the improvement of WRES performance and the successful implementation of WDES	• Improve recording demographics relating to ethnicity, disability, sexual orientation and religion/belief for all staff • Conduct a communications campaign for staff to update ESR information • Work with Workforce Information, Clinical Education and Recruitment to develop better systems for reporting WRES and WDES	• No WRES indicators unreportable July 2019 • Successful and timely implementation of WDES	Head of Inclusion and Development and Equalities Lead Workforce Information Potentially IM&T	With immediate effect Anticipated Autumn 2018 (WDES) As required	End Mar-19 Anticipated Autumn 2019 (WDES)	Linked to items 7, 20 and 22 in previous action plan.
A2	Complete an in-depth analysis of existing data including the staff survey, WRES indicators, anonymised referrals to mediation, anti-bullying scheme, grievances, disciplinary investigations and Professor Duncan Lewis' Culture Report	• Anonymise data for sharing with leads for the task • Identify the different leads for the different sources of information • Identify key themes in results for each source of data • Compare the themes across the data • Identify the priorities and hotspots • Generate appropriate interventions designed to improve performance in those hotspots or within the themes	• Improved WRES scores for 2019 • Improved staff survey scores for 2019	Head of Inclusion and Development and Equalities Lead HRBPs and ER Task & Finish Groups Workforce Information IM&T	With immediate effect	The WRES data must be uploaded by end Jul-19 Staff Survey is conducted Oct/Nov-18 result out Feb/Mar-19	Better scores may be small because it takes time to change culture
A3	Using the in-depth analysis of data, review and update overarching equality and diversity objectives and set new objectives for the period 2018 to 2021.	• Set up working group and complete review • Draft objectives for approval from the Board • Use new objectives to revise the action plan and inform the development of an anti-discrimination strategy	• New (and confirmed previous objectives) approved	Head of Development and Inclusion / Inclusion Lead Stakeholders across the Trust	Start as the in-depth analysis is shared	31-Mar-19	New activity

Aims		Activities	Measures / Targets	Lead / Participants	Start date	Completion	Comments
A4	Develop an Anti-Discrimination Strategy	• Collaboratively develop the content for the strategy with stakeholders across the Trust • Draft the strategy demonstrating that the approach is built on the evidence from the data (A2/A3) and the strategy collaboration work • Seek Board approval for the strategy	• Anti-discrimination strategy agreed • Strategy is on the agenda and discussed in ICSU / Department team meetings	Head of Inclusion and Development, and the Equalities Lead Stakeholders across the Trust Task and Finish Groups	Begin as the in-depth data analysis is shared	Strategy drafted by Mar-19	New Activity building on the revision of objectives in A3
A5	Explore opportunities of partnership working in undertaking the EDS2 grading exercise with internal and external stakeholders where feasible.	• Learn from Trusts who have implemented EDS2 • Collaborate with key stakeholders in Patient Experience and Workforce to undertake grading exercise and prepare evidence. • Finalise arising action plan to maximise partnership working	• EDS2 implemented	Head of Development & Inclusion in collaboration with colleagues in the Trust	With immediate effect Action Plan Aug-18	Sep-18 Mar-19	New activity
A6	Review and update recruitment process to further eliminate any discrimination or bias occurring	• Update recruitment process, including unconscious bias training; better understanding of Trust's policies and practices, and better quality questions • Review to identify areas of poor practice and take appropriate action in identified "hot spots" • Ensure all staff at all stages in the recruitment process, attends recruitment training to better understand their role in promoting equity, fairness, rights and responsibility • Potential to use 'reverse mentoring'	• Better WRES Indicator 2 scores	Head of Development & Inclusion / representatives from ICSUs/directorates Task and Finish Group for Recruitment, Selection and Appointment Recruitment Manager and HRBPs In consultation with Partnership Group and Trust Stakeholders	With immediate effect	End Jul-19	Linked to item 25 in previous action plan.

Aims		Activities	Measures / Targets	Lead / Participants	Start date	Completion	Comments
A7	Review the effectiveness of the Speak Up Inclusion Champions (SUIC) so far, and potentially, recruit and train the second cohort	• Conduct a short online survey and focus groups to understand its profile • Address the gaps to improve effectiveness and raise its profile • Recruit and train a new cohort (preferably a minimum of one SUIC in every ICSU/directorate) • Assimilate the new SUICs with the existing cohort	• The existence of an effective SUIC resource • Profile and effectiveness measured through responses in surveys, focus groups and other feedback	Head of Development and Inclusion Equalities Lead Stakeholders from ICSUs and directorates	Aug-18	December 2018	Linked to item 11 on previous action plan
A8	Participate in the 'Diversity and Inclusion Partner Programme' 2018/19 Embed equalities as a 'golden thread' throughout the organisation to become a 'Beacon Trust'	• Attend all programmed events as a Diversity & Inclusion Partner. • Engage ICSUs and Departments to embed work locally and Trust-wide delivered through the programme • Develop and establish case studies and lessons learnt for sharing with wider NHS system. • Participate in continuous improvement initiatives led by NHS Employers	• Measured progress in the journey towards becoming a 'Beacon Trust'	Head of Development and Inclusion Equalities Lead Stakeholders from ICSUs and directorates	The programme has just started	Jul-18 Sep-18 Mar-19 Apr-19	New activity
A9	Continue to participate in the NHS London Leadership Academy pilot 'Inclusion Lab'	• Agree and implement interventions to underpin NHS Healthcare leadership model competencies selected for leadership programmes which supports the development of leaders' inclusive behaviours during 2018/19 • Seek opportunities to further embed LLA offering in events and other training opportunities, e.g. Equalities Showcase for Sep/Oct-18	• Improved WRES scores for 2019 • Improved staff survey scores for 2019	Head of Development and Inclusion Equalities Lead Stakeholders from ICSUs and directorates	The programme has started	Jul-19 Oct-18	Linked to item 30 in previous action plan

7.0 **Conclusions**

7.1 The Trust Board has made a commitment to gain a better understanding of what the Trust's data against the WRES indicators is revealing and to take appropriate action to make improvements to the lives of those staff that are impacted. The appointment of an executive sponsor to take a strategic lead will have an impact on this area of work.

7.2 The actions outlined in the WRES action plan for 2018/19 are designed to complement further actions on Equality, Diversity and Inclusion (EDI) which will be outlined in the Equality and Inclusion Annual Report. They also accompany other areas of work and initiatives implemented, such as the Staff Survey "We Said, We Did, What Next?" events which took place during May 2018. The purpose of which staff engagement events was to share the findings from the most recent staff survey; and, to ascertain views and offer possible solutions. The ultimate goal of the Trust Board in partnership with managers and staff is to greatly reduce the level of discrimination and bias experienced throughout the Trust.

8.0 **Recommendation**

8.1 The Trust Board is asked to approve this action plan.

Appendix A

Whittington Health NHS

2016/17

Whittington Health – WRES report highlights

The WRES provides data to facilitate the Trust's ability to make informed decisions and take action to actively promote equality of opportunity, as well as to reduce discrimination which may exist, to improve the working lives and wellbeing of staff, patients and service users.

Improvements made

Indicator 2:

There has been a slight increase in the likelihood of BME (Black and Minority Ethnic) staff being appointed compared to White staff, with the ratio of white to BME staff decreasing from 2.28:1 in 2015/16 to 2.17:1 in 2016/17.

Indicator 3:

There has been a reduction in the percentage of BME staff facing formal disciplinary from 1.83% in 2015/16 to 1.65% in 2016/17, (while the percentage of White staff has remained stable at 0.68%).

Indicator 5:

There has been a small decrease in the percentage of BME staff reporting experiencing harassment, bullying or abuse from patients, relatives or the public; from 30% in 2014/15 to 28.57% in 2015/16.

Indicator 6:

There has been decrease for all staff in the percentages reporting experiencing harassment, bullying or abuse from other staff. This improvement is by 1.12% for BME staff, and 0.41% for White staff.

Indicator 7:

The percentage of BME staff who believe that the Trust provides equal opportunities for career progression or promotion has improved by 8% since 2014/15 (and just under 3% since 2015/16), compared to the views of White staff, which have remained relatively stable (dropping by 0.4% since 2014/15).

Indicator 8:

The percentage of staff who report having experienced discrimination at work from management has fallen significantly for all staff, and the gap between the experiences of BME and White staff has also reduced slightly, from 11% to 9.95%.

Areas for improvement

Indicator 1:

There is a decrease in the percentage of BME staff between Bands 1-4 and Bands 5-7 of 17.56% (BME staff make up 63.86% of all B1-4 staff, and 46.3% of all B5-7 staff). Between Bands 5-7, and Bands 8, 9 & VSM there is a decrease of 23.47% (46.3% at B5-7, compared to 22.83% at Band 8, 9 & VSM).

Indicator 2:

While there has been some improvement, Whittington Health has a significantly higher ratio of White staff to BME staff being appointed from shortlisting than the national picture, at 2.17:1, compared to 1.57:1.

Indicator 4:

We do not have recording and reporting processes which are sufficiently robust to measure access to non-mandatory training and CPD (Continued Professional Development) by BME vs White staff. It is one of our key targets for the coming year to improve our data collection to enable this reporting.

Indicator 5:

Whilst some improvements have been made, more analysis is needed. There was a decrease in BME staff reporting harassment, bullying or abuse from patients, relatives or the public (30% in 2014/15, to 28.57% in 2016/17), but an increase in White staff reporting the same experiences over the same period (27% in 2014/15 to 30.33% 2016/17). We need to explore the reasons for this, for example, White staff may feel more confident in reporting, while BME staff might not feel this way.

Indicator 9:

There has been an increase in the size of the Board, but no increase in BME members, resulting in a decrease in the proportion of the board who are BME – dropping from 23% in 2015/16 to 20% in 2016/17. The BME proportion of the overall workforce in 2016/17 was 46%.

What we are doing to improve

- Improving our data capture.
- Working with colleagues across the trust to work on identified issues around equality in Recruitment and Retention and in Disciplinary and Grievance.
- Providing Unconscious Bias training to all new and existing managers.
- Running events and supporting in-team discussions about the importance of Equality, Diversity and Inclusion.
- Recruiting more Anti-Bullying and Harassment Advisors, and working with Organisational Development to further develop Equality, Diversity and Inclusion in leadership and management.
- Launching a new programme of Inclusion Champions to provide systems leadership on Equality, Diversity and Inclusion

Appendix B

WORKFORCE PROFILE TABLE

NON-CLINICAL STAFF

	Mar-17	White		BME		Unknown ethnicity		Total	Mar-18	White		BME		Unknown ethnicity		Total
Band 1		40	25.3%	109	68.9%	9	5.7%	158		35	23.2%	107	70.8%	9	5.9%	152
Band 2		44	34.1%	72	55.7%	13	10.0%	129		40	31.7%	67	53.0%	19	15.0%	127
Band 3		64	32.2%	114	57.2%	21	10.5%	199		68	34.0%	105	52.4%	27	13.4%	201
Band 4		72	34.1%	115	54.4%	24	11.3%	211		59	30.6%	110	56.9%	24	12.4%	194
Band 5		64	49.6%	54	41.7%	11	8.5%	129		46	40.0%	54	46.8%	15	12.9%	116
Band 6		45	46.4%	45	46.2%	7	7.1%	97		39	43.8%	41	45.8%	9	10.0%	90
Band 7		24	50.0%	19	39.2%	5	10.2%	49		27	60.0%	14	30.7%	4	8.7%	46
Band 8A		34	70.8%	9	18.5%	5	10.2%	49		35	72.9%	9	18.5%	4	8.2%	49
Band 8B		10	66.7%	4	25.5%	1	6.3%	16		13	72.2%	4	21.4%	1	5.3%	19
Band 8C		20	90.9%	2	8.7%	0	0.0%	23		18	90.0%	1	4.8%	1	4.8%	21
Band 8D		5	55.6%	2	20.9%	2	20.5%	10		5	55.6%	2	20.9%	2	20.5%	10
Band 9		4	80.0%	1	17.2%	0	0.0%	6		3	75.0%	1	21.1%	0	0.0%	5
VSM		8	50.0%	3	18.2%	5	30.0%	17		6	54.5%	0	0.0%	5	43.3%	12

Shaded red cells show decreases (in BME staff proportions) or increases (in unknown ethnicity staff proportions) of more than 2.9%. Shaded green cells show increases (in BME staff proportions) of more than 3.9% (next highest increase 2.5%)

CLINICAL STAFF

Clinical Agenda for Change (Afc) Staff excluding medical and dental staff

	Mar-17	White		BME		Unknown ethnicity		Total	Mar-18	White		BME		Unknown ethnicity		Total
Band 1		0	0.0%	0	0.0%	1	100.0%	1		0	0.0%	0	0.0%	1	100.0%	1
Band 2		33	22.3%	109	73.6%	6	4.0%	148		23	17.4%	103	77.9%	6	4.5%	132
Band 3		86	31.6%	145	53.3%	41	15.0%	272		83	34.0%	124	50.7%	37	15.1%	244
Band 4		79	48.8%	72	44.4%	11	6.8%	162		88	44.2%	89	44.6%	22	11.0%	199
Band 5		208	39.1%	285	53.6%	39	7.3%	532		204	39.1%	251	48.0%	67	12.8%	522
Band 6		351	49.5%	311	43.9%	47	6.6%	709		324	47.8%	301	44.4%	53	7.8%	678
Band 7		340	59.9%	186	32.7%	42	7.4%	568		358	59.4%	197	32.6%	48	7.9%	603
Band 8A		151	74.4%	49	24.1%	3	1.5%	203		148	73.3%	49	24.2%	5	2.5%	202
Band 8B		43	67.2%	20	31.3%	1	1.5%	64		46	71.9%	16	24.7%	2	3.1%	64
Band 8C		15	93.8%	1	6.3%	0	0.0%	16		14	82.4%	2	11.2%	1	5.6%	17
Band 8D		3	100.0%	0	0.0%	0	0.0%	3		3	100.0%	0	0.0%	0	0.0%	3
Band 9		0	0.0%	0	0.0%	0	0.0%	0		0	0.0%	0	0.0%	0	0.0%	0
VSM		2	33.3%	3	50.0%	1	14.6%	6		6	66.7%	3	31.0%	0	0.0%	9

Shaded red cells show decreases (in BME staff proportions) or increases (in unknown ethnicity staff proportions) of more than 5.5% (only other BME decreases 2.6% and 0.1%). Shaded green cells show increases (in BME staff proportions) of more than 4.3% (next highest increase 0.5%)

Medical and dental staff

	Mar-17	White		BME		Unknown ethnicity		Total	Mar-18	White		BME		Unknown ethnicity		Total
Doctors in training		139	57.4%	91	37.5%	12	4.9%	242		142	59.4%	73	30.5%	24	10.0%	239
Career grade		26	40.0%	38	58.1%	1	1.5%	65		25	35.2%	37	51.9%	9	12.5%	71
Consultants		118	60.8%	68	34.9%	8	4.1%	194		129	61.4%	73	34.7%	8	3.8%	210

Whittington Health NHS

Trust Board

25 July 2018

Title:	Nursing & Midwifery Revalidation Annual Report 2017/18		
Agenda item:	**18/114**	**Paper**	**11**
Action requested:	The board is asked to approve this report.		
Executive Summary:	This is the annual update report on the revalidation of nurses and midwives in the organisation. A new process for nursing and midwifery revalidation was introduced by the Nursing and Midwifery Council in April 2016 requiring registrants to revalidate every 3 years in order to practice. This report reviews revalidations undertaken in 2017/18. It then outlines the revalidation process as well as the ongoing monitoring process of revalidation that is now in place.		
Fit with WH strategy:	SG1- Deliver consistent high quality safe services. Clinicians will strive to deliver safe high quality care 'right first time, every time' and exceed patient expectations		
Reference to related / other documents:	Aligns with Clinical Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	None		
Date paper completed:	13th July 2018		

Author name and title:		**Sarah Hayes Deputy Chief Nurse**		**Director name and title:**		**Michelle Johnson Chief Nurse and Director of Patient Experience**	
Date paper seen by EC	**3 May**	**Equality Impact Assessment completed?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Nursing and Midwifery Revalidation
Annual Board Report June 2018

1. INTRODUCTION AND EXECUTIVE SUMMARY

1.1 A new process for nursing and midwifery revalidation was introduced by the Nursing and Midwifery Council in April 2016 requiring registrants to revalidate every 3 years in order to practice. By April 2019 all nurses and midwives will reached a revalidation date under the new process.

1.2 This paper provides an brief overview of the current process required by the Nursing & Midwifery Council (NMC) that nurses and midwives must renew their professional registration every three years and describes the Trust's system in place to support and monitor revalidation. Revalidations undertaken in 2017/18 are also described.

2. NMC REVALIDATION PROCESS

2.1 **Background** - The revalidation process was introduced by the NMC in April 2016 and is the process by which registered nurses and midwives demonstrate to the NMC that they continue to be fit to practice. Revalidation takes place every three years and replaced the post registration education and practice (PREP) standards, improving on it by setting new requirements for registered nurses and midwives. The revalidation process requires registered nurses and midwives to declare that they have;

- Met the requirements for practice hours (practice of at least 450 hours during the previous 3 years or 900 hours if holder of two professional qualifications)
- Met the requirements for continuing professional development (undertaken at least 35 hours of continuing professional development relevant to the registrants scope of practice as a nurse with a minimum of 20 hours being participatory learning)
- Reflected on their practice based on the requirements of the NMC Code (2015), using feedback from service users, patients relatives colleagues and others.
- Provided a health and character declaration and declare any conviction for criminal offence or the issuing of a formal caution
- Professional indemnity arrangements – confirmation of having or will have when practicing, appropriate cover under an indemnity scheme
- Received confirmation from a third party (referred to as a confirmer) that their declaration is reliable in accordance with the NMC Code (2015)

2.2 Revalidation aims to protect the public, increase public confidence in nurses and help those on the NMC register to meet the standards required of them.

2.3 Revalidation for nurses and midwives by the NMC is not the same as medical revalidation undertaken by the General Medical Council (GMC). The NMC register is larger and professionals on it practice in more diverse health care settings. The NMC operates under different legislation from the GMC and as such, NMC legislation around revalidation does not allow for the introduction of responsible officers.

2.4 **Responsibility** - Nurses and Midwives are responsible and held accountable for their own revalidation process. Every three years at the point of renewal of registration, they are required to demonstrate the requirements of revalidation and their fitness to practice in order to remain on the NMC register. The NMC has published detailed guidance for nurses and midwives to follow.

2.5 From April 2016, all nurses due to re-register commenced revalidation. By April 2019 everyone on the NMC register will be expected to have undergone revalidation.

3. COLLECTION OF EVIDENCE

3.1 Nurses and Midwives are required to collect evidence demonstrating compliance with the NMC requirements. The NMC have strongly recommended that evidence should be collected in a portfolio demonstrating compliance with the revalidation process.

4. WHITTINGTON HEALTH METHODOLOGY

4.1 **Trust Support** - The Trust has a nursing and midwifery revalidation policy in place. The majority of nurses and midwives working in Whittington Health are line managed by NMC registrants who are therefore best placed to hold the detailed professional discussion surrounding the requirements for revalidation.

4.2 Where a registrant's line manager is not another registrant, the revalidation part of the appraisal is undertaken by a senior nurse in that ICSU or the person who is identified as having professional accountability within the posts holders' job description.

4.3 The confirmer does not need to be a registrant and therefore is sometimes the non-registrant line manager if meeting criteria issued by the NMC.

4.4 **Active Professional Support -** The Deputy Chief Nurse, Assistant Chief Nurse, Associate Directors of Nursing/Midwifery and senior nurses provide support and advise appraisers in the ICSUs to ensure the necessary skills to assess revalidation requirements of each registrant. This is linked to the appraisal system already in operation within the organisation.

4.4 **Trust monitoring of Revalidation** - The Deputy Chief Nurse, Associate Directors of Nursing/Midwifery receive a list from the Human Resources Team each month of nurses and midwives due to revalidate in each ICSU. This list is provided three months in advance of the revalidation date to ensure sufficient time to support the individual nurse or midwife.

4.5 The revalidation process is undertaken via the appraisal system and the nurse/midwife confirms this using the appropriate NMC Online process.

4.6 Where concerns exist about a registrant's ability to revalidate because of lack of information or failure to comply with all the NMC requirements; the confirmer (senior nurse) provides information regarding the actual requirements not achieved to the registrant. The confirmer then supports the registrant to achieve the required missing elements. This is managed using existing Human Resources policy.

4.7 Following support, if the registrant does not comply with NMC requirements the Associate Director of Nursing informs the Deputy Chief Nurse and informs the Registrant that they may lose their licence to practice and as such will be unable to comply with their contract of employment.

4.8 Should a nurse/midwife not revalidate the Associate Director of Nursing manages the process using the Trust existing Human Resource policy – Registration of Professional Staff - POL/COR/0217 pg. 10 -13.

5.0 REVALIDATION DATA

5.1 Registrants revalidated in 2017/18.

Month	Number of Nurses and Midwives revalidating
Apr-17	21
May-17	14
Jun-17	17
Jul-17	15
Aug-17	21
Sep-17	45
Oct-17	41
Nov-17	29
Dec-17	17
Jan-18	14
Feb-18	15
Mar-18	53
TOTAL	302

5.2 There has been one case of a registrant within the Trust being unsuccessful in revalidating in 2017/18 due to not meeting NMC requirements which is being managed through appropriate procedures.

6. RECOMMENDATIONS

The Board is asked to accept the report.

Whittington Health Public Trust Board
25th July 2018

Title:	2018/19 Trust Objectives		
Agenda item:	**18/115**	**Paper**	**12**
Action requested:	The Trust Board is asked to approve the proposed Trust Objectives as previously discussed in the board seminar and commented on by TMG		
Executive Summary:	We are proposing 9 objectives. The 6 clinical strategy objectives remain and there are three enablers of workforce, support services, and finances.		
Recommendations:	To approve the wording to then be included in the ICSU objectives and translated into personal objectives.		
Fit with WH strategy:	These objectives come straight from the current strategy		
Reference to related / other documents:	Clinical strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	None		
Date paper completed:	17 July 2018		

Author name and title:		Jonathan Gardner, Dir Strategy		**Director name and title:**		**Jonathan Gardner, Dir. Strategy and Corp Affairs**	
Date paper seen by EC	**July**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

Whittington Health NHS

Our Mission: **Helping local people live longer, healthier lives**

Our Vision: **Providing safe, personal, coordinated care for the community we serve**

Our Values:

Our objectives:

To deliver consistent, high quality, safe services

To secure the best possible health and wellbeing for all our community

To support our patients and users in being active partners in their care

To integrate and coordinate care in person-centred teams

To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research

To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population -

Enabled by:

To recruit and retain high quality engaged staff

To deliver efficient and financially sustainable services

To deliver innovative estate, IT and other support services that enable the clinical objectives

10 Whittington Health Objectives	Sub priorities	Key metrics of success
1. To secure the best possible health and wellbeing for all our community	• Improve our clinical effectiveness as outlined in the quality account. • Deliver the better births action plan • Move community children's services from 'Requires Improvement' to Good	• See quality account
2. To integrate and coordinate care in person-centred teams	• Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP • Develop our community teams around the emerging neighbourhoods and CHIN networks • Collaborate with UCLH and other NHS providers to improve efficiency and resilience • Maintain treatment and waiting time standards for our Mental health patients	• New models of care in place • Mental health patient waiting times
3. To deliver consistent, high quality, safe services	• To move from Good to 'Outstanding' in our CQC rating. • Improve patient safety through achieving the priorities of the quality account. • Deliver actions to meet CQC areas for improvement • Improve community services • Deliver quality improvement plans to support achievement of four-hour target • Achieve cancer and referral to treatment national standards	• Community service contract metrics • National targets
4. To support our patients and users in being active partners in their care	• Improve FFT response and use to improve patient experience • Become a recognised expert provider of prevention services in adults and children	• FFT
5. To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research	• Continue to host the Haringey and Islington CEPN. • Develop the multi-professional integrated education work for WH and others • Continue to be recognised as an excellent education provider	
6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	• Expand Quality Improvement training • Develop the generic worker roles with the local authorities • Begin to integrate physical and mental health roles and services	• Take up of QI training
7. To recruit and retain high quality engaged staff	• Recruit and maintain sustainable workforce • Reduce turnover and maintain at lower levels • Reduce sickness and absence rates • Improve quality of appraisals	• Turnover rate • Sickness rate • Appraisal rate and quality in staff survey
8. To deliver efficient and financially sustainable services	• Deliver £16.5m savings through CIPs to deliver 2018/19 control total • Reduce agency / bank spend • Use Carter measures to improve productivity, including e-rostering and back office • Use GIRFT and Model Hospital to identify improvement priorities	• Financial targets • Agency spend • Productivity metrics
9. To deliver innovative estate, IT and other support services that enable the clinical objectives	• Deliver strategic estates plan and link to NCL STP • Progress digital fast follower projects	