Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 26 September 2018

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public**
Date & time	**26 September 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 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
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: jonathan.gardner@nhs.net

Agenda Item		Paper	Action & Timing
Standing Items			
18/116	**Patient Story** *Michelle Johnson, Chief Nurse*	*Verbal*	1400hrs
18/117	**Declaration of Conflicts of Interest** *Steve Hitchins, Chair*	*Verbal*	*Review 1420hrs*
18/118	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Review 1425hrs*
18/119	**Draft Minutes, Action Log & Matters Arising 25 July 2018** *Steve Hitchins, Chair*	1	*Approve 1430hrs*
18/120	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Review 1435hrs*
18/121	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Review 1440hrs*
Patient Safety & Quality			
18/122	**Serious Incident Report Month 5** *Richard Jennings, Medical Director*	3	*Review 1450hrs*
18/123	**Learning from Mortality Quarter 4 Report** *Richard Jennings, Medical Director*	4	*Review 1500hrs*
18/124	**Medical Appraisal and Revalidation – Annual Board Report** *Richard Jennings, Medical Director*	5	*Review 1505hrs*

18/125	**End of Life Care (Opiate Prescribing report)** *Richard Jennings, Medical Director*	6	*Review 1515hrs*
18/126	**Annual Research Report** *Richard Jennings, Medical Director*	7	*Review 1520hrs*
Operational Performance and Planning			
18/127	**Financial Performance Month 5** *Stephen Bloomer, Chief Finance Officer*	8	*Review 1525hrs*
18/128	**Performance Report Month 5** *Carol Gillen, Chief Operating Officer*	9	*Review 1535hrs*
18/129	**Workforce Directorate Annual Report** *Norma French, Director of Workforce*	10	*Review 1540hrs*
18/130	**Nursing Establishment Review – 6 months** *Michelle Johnson, Chief Nurse and Director of Patient Experience*	11	*Review 1545hrs*
Strategy and Governance			
18/131	**National Staff Survey Action Plan** *Norma French, Director of Workforce*	12	*Approve 1600hrs*
18/132	**National Inpatient Survey Action Plan** *Michelle Johnson, Chief Nurse and Director of Patient Experience*	13	*Review 1610hrs*
18/133	**Annual Modern Slavery Act Declaration** *Jonathan Gardner, Director of Strategy, Development and Corporate Affairs*	14	*Approve 1615hrs*
18/134	**Standing Financial Instructions Integrated Governance** *Steve Bloomer, Chief Finance Officer*	15	*Approve 1620hrs*
18/135	**Risk Register Summary Report** *Michelle Johnson, Chief Nurse and Director of Patient Experience*	16	*Review 1630hrs*
18/136	**Strategic Business Continuity Plan** *Carol Gillen, Chief Operating Officer*	17	*Approve 1645hrs*
Committee Draft Minutes			
18/137	**Quality Committee (12 September)** *Anu Singh, Chair, Quality Committee*	18	*Approve 1655hrs*
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			
31 October 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 jonathan.gardner@nhs.net or www.whittingtonhealth@nhs.net

Whittington Health
NHS Trust

ITEM: 18/119
Doc: 01

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday 25th July 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
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
	Kate Green	Minute Taker
	Sarah Hayes	Deputy Chief Nurse
	Sarah Humphery	Medical Director, Integrated Care

18/100 Patient Story

100.01 Patient Experience Manager James Connell introduced patient Carol, present to recount her story to the Board. Carol was accompanied by Catherine, MSK physiotherapist, and Jo, psychological wellbeing practitioner.

100.02 Carol informed the Board that until August 2014 she had worked as a member of a community palliative care team. She had then suffered a very bad fall, and had attended hospital, where she was given a splint and told that she would be fine in about two weeks' time. Unfortunately this did not happen, and she experienced multiple waits for an orthopaedic appointment, physiotherapy etc.

100.03 Eleven months later, during which time she had been at home unable to cook, clean, wash etc, her workplace took action against her as she was no longer able to do her job. Although suffering from depression, she conducted extensive internet research into various treatments and also trying to find different ways of carrying out everyday tasks. Eventually it was discovered that she had suffered considerable nerve damage and she was referred for surgery.

100.04 It was only after Carol was referred to the pain service that her life began to turn around, and she had nothing but praise for the team treating her. The key message which she wished to relay to the Board was that if she had been referred there sooner she would not have suffered long months of pain and depression, the latter being so severe she had considered suicide. She now accepted it was likely she would always suffer from chronic pain, but the pain service had provided her with the tools she needed not only to manage her pain but also to function both at home and in a new job. Catherine and Jo echoed this view, saying that Carol's experience had provided them with important issues to raise at the pain MDT.

100.05 Siobhan Harrington spoke about the way the MSK service was developing across both Islington and Haringey, and hoped this would make a significant difference to the treatment of such patients. In answer to a question from Tony Rice about how referrals could be speeded up, Catherine replied that there was now a single point of access, where referrals once received are triaged so that patients can be quickly referred to the most appropriate service. There was also now an increasing number of physiotherapists attached to GP practices.

100.06 Richard Jennings asked Carol whether she might be willing to become a patient advocate in the event of such a system being introduced for the pain service, and she agreed to consider this. On behalf of the Board, Steve Hitchins thanked Carol, Catherine, Jo and James for attending the Board that day; Board members agreed the story had been a hugely important one from which many valuable lessons had already been learned.

18/101 Declaration of Conflicts of Interest

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

18.102 Welcome and apologies

102.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence had been received from Michelle Johnson, and Steve thanked Sarah Hayes, Deputy Chief Nurse, for attending on her behalf.

18/103 Minutes, Matters Arising & Action Log

103.01 The minutes of the Trust Board meeting held on 27th June were approved. There were no matters arising other than those already scheduled for discussion.

Action log

103.02 35.04: The report on nursing establishment had been deferred until the September meeting.

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

78.07: The community dashboard had been included in the monthly Performance Dashboard on which Carol Gillen would report.

90.03: A statement about the use of opiates had been included in the Chief Executive's report, and a more detailed paper would be brought to the September meeting.

95.05: The presentation on the bed modelling work would be brought to the September meeting.

97.08: The Board agreed that community metrics should also be discussed at a Board seminar in the autumn.

99.03: Steve Hitchins had written a letter of thanks to Susan Sorensen.

18/104 Chairman's Report

104.01 Steve Hitchins began his report by speaking about the recent NHS 70th Birthday celebrations. In addition to the extremely successful day held by the Trust on 5th July, he had also been invited by the London Mayor to attend an event at City Hall. The Trust had also held an event the previous Monday to celebrate the nomination of 70 Whittington 'heroes'. He thanked all involved in the organisation of these events.

104.02 It was noted that this was to be Graham Hart's last Board meeting at Whittington Health, and Steve thanked him for his immense contribution to the Board. He also updated the board on the process for appointing Graham's replacement as UCL representative on the Board. Interviews were planned for 17th September, and Steve, Siobhan and Jane Dacre would form the panel.

104.3 Since the previous Board meeting Steve had also attended the following events:

- the summer party at Lauderdale House, hosted by consultants to thank the junior doctors for all their work during the year
- Simmons House 50th birthday
- a visit to Finchley Memorial for the Dementia Club UK including a demonstration of Tovertafel
- Visits to community services at Tynemouth Road, St Anne's, The Laurels and the Holloway Health Centre
- With Siobhan, welcoming NHSE Director of Strategy Michael McDonnall to the Trust.

18/105 Chief Executive's Report

105.01 Siobhan Harrington began her report by drawing attention to two recent national announcements; Matt Hancock MP's setting out his future priorities, and Simon Stevens' ten year plan. The latter especially was an absolute fit for Whittington Health, focusing as it did on integrated care. Locally, the Haringey & Islington Wellbeing Partnership had had submitted a bid to become a pilot to provide place-based care, developing a prototype for an all-age community focused approach in partnership with local authorities.

105.02 Siobhan's report contained a section on the governance and assurance around opiate prescribing, and Siobhan commended the work of newly-appointed palliative care consultant Anna Gorringe and her team for their work in this area. A more detailed report would be brought to the September Board meeting.

105.03 Siobhan felt the Trust's 70th birthday celebrations to be an inspiring event, likewise the event on Monday for the 70 'Whittington heroes', for which 180 nominations had been received.

105.04 The new ICSUs had come into place at the beginning of the month, and appointments had been made to all 15 'triumvirate' positions. The most recent appointment had been to the position of Clinical Director for the Children & Young People's ICSU, and Siobhan was pleased to report that she had appointed consultant Claire Rohan and occupational therapist Lesley Platts as a job share for an initial period of one year following which arrangements would be reviewed. Siobhan also extended her congratulations to interim Director of Communications Juliette Marshall, who had been appointed substantively. The Trust had also appointed Swarnjit Singh as Head of Corporate Affairs. Siobhan also expressed her congratulations to Caroline Fertleman on her promotion to Professor at UCL. Graham Hart had presented this, and said it had been universally well

received. A joint Whittington Health/UCLH appointment had been made to a consultant post; this important appointment would lead the LUTS service.

105.05 Moving on to performance, Siobhan informed the Board that ED performance had reached 90.6% in June. This was an improvement, although it fell short of where the Trust had aspired to be. Performance on the 62 day cancer wait was also proving a challenge, and disappointingly, there had been a case of MRSA bacteraemia in June. In answer to a question from David Holt about whether the heatwave was having an adverse effect on ED performance, Carol Gillen replied that it had, and there was a 16% rise in attendances as compared to the position in June of last year. The previous Monday had seen a record number of attendances. Neighbouring organisations faced similar pressures. Deborah expressed concern for the staff working during the heatwave, administrative as well as clerical. Norma replied that this was being kept very much in mind; the uniform policy had been relaxed, and the executive team were carrying out visits across the organisation to see what might further be done to support staff. Sarah Hayes added that the Trust had a heatwave plan, and significant action was taken place within community services to support the vulnerable. The Trust's financial position was close to being on plan; Stephen Bloomer would expand on this as he delivered the financial report.

105.06 Concluding, Siobhan congratulated junior doctor Sam Barclay on achieving the monthly staff excellence award for his tireless work in developing the digital experience at the Trust. Sam had, she said, set a benchmark in clinical digital leadership in establishing the role of Chief Clinical Information Officer.

18/106 <u>Cultural Survey</u>

106.01 Introducing this item, Siobhan stated that Professor Lewis's report had been the hardest report she had read since becoming Chief Executive. She had felt it really important to bring the report to the Board quickly with the Trust's initial response, but stressed that there was a great deal of work to do before providing a more detailed response and action plan. There had been over 1,100 responses to the survey itself, which had been fairly lengthy, so this was a significant piece of work. The report had found that 72% of the workforce had not experienced bullying or harassment, but 25% had. Page 4 summarised the examples, which Siobhan had found quite difficult to read.

106.02 The Trust was accepting the recommendations in full, and work was already in hand to consider the next steps to be taken. Professor Lewis felt that the Trust had sufficient systems and processes in place to tackle the problems identified, but much of this was about culture, and all Trust leaders had a role to play in addressing this. On the whole, Siobhan felt that Whittington Health was a friendly organisation, but she recognised that some struggled with difficult conversations, and she was sure that this was not a problem which had developed overnight.

106.03 Siobhan highlighted some of the key themes from the report, including:

- behavioural standards
- people not being clear about their roles
- the need for leadership development (the OD team was beginning to do some great work)
- the need for leaders to understand how they are perceived.

106.04 Another strong theme was around the grievance culture and how issues are resolved, with a general view that the Trust ought to be able to resolve some matters more speedily. More generally, behaviours needed to be put in place to support cultural

change. The report had however concluded that the Trust did not have an endemic culture of bullying and harassment.

106.05 In answer to a question about how the Board would know that progress had been made, Siobhan spoke about the regular 'pulse survey' carried out in Salford, but added that it would be important to consider what information needed to be reported to the Board, and to the Workforce Assurance Committee. There was also a need to consider the WRES report and staff surveys and produce a triangulation piece.

106.06 Anu agreed that the report had made for hard reading, and enquired what the Trust was planning to do to help staff come to terms with it, particularly for those for whom the results might come as a shock. Norma replied that there would need to be some follow-up communications, and perhaps some drop-in sessions. Information would also be provided for team briefings and cascades. There might additionally be a role for the Speak Up Guardian, though it was noted that changes were to be made to this role so this might be considered in the longer term.

106.07 Siobhan said that from the outset efforts had been made to socialise the themes of the report, and discussions had been held at the Executive Team Meeting, Trust Management Group (TMG) and the previous evening's Medical Committee. ICSU leaders were to have development sessions with the OD team, and Siobhan was also discussing the themes of the report at her one to one sessions with clinical directors. A paper on e-mail etiquette had also been taken to the previous day's TMG, this would be sent out to staff within the next week or so. Anu felt that what was needed was some 'peer to peer space', and Steve Hitchins asked for further discussion at the Board seminar in September.

106.08 Steve Hitchins also stressed the importance of staff understanding reasons for change. Tony felt that the Board should recognise the Trust's status as an urban organisation, adding that it would be helpful to know what 'good' looked like. Deborah acknowledged that the report had made for difficult reading, although she was already familiar with some of the themes contained within it. She reminded the Board of the work being carried out in the area of grievances to introduce a fair treatment panel.

18/107 <u>Workforce Race Equality Standards Report (WRES)</u>

107.01 Norma informed the Board that the report demonstrated the Trust continued to make year on year improvement; she acknowledged that there was still work to be done, but felt that the Trust was moving in the right direction. She had taken on board comments made the previous year, and also looked at the WRES reports produced by other organisations to see where there were examples of good practice which might be usefully employed.

107.02 Norma then took the Board through the various sections of the report, describing the external work in which the Trust is involved, comparative data (rag rated), key indicators, local and national comparisons, and the action plan, which demonstrated achievements to date.

107.03 In answer to a question about whether the inclusion champions had role descriptions, Norma replied that they had, and that Dorian Cole as Speak Up Champion had been involved in the preparation of these. Norma added that the inclusion champions had seen an early draft of the report, which had been presented at TMG.

107.04 Siobhan had met with Yvonne Coghill, National Director for WRES implementation, who had held up NE London as an example of best practice; however she had added that it had taken then five years to reach that position. Yvonne had offered to act as mentor

for Siobhan and Anu. Siobhan added that one immediate action which could be taken was to ensure there was BME representation on all interview panels for grades 8A and above. Richard Jennings, whilst supporting this approach, said that there was already very good BME representation amongst the Trust's clinicians, and it was important that clinical expertise on selections panels was not compromised.

107.05 Norma reminded the Board that disability standards would also be monitored this year. In answer to a question from Deborah about whether the Trust's reports had been published, Norma assured her that they had – last year's annual report had been published in December 2017, and this year's would be published before the end of the calendar year.

107.06 Steve Hitchins commented that whilst he appreciated the benchmarking comparators in the report, it was important to reflect upon mirroring the Trust's local population. Norma reassured him that data demonstrated this had already been exceeded.

18/108 Serious Incident Report

108.01 Richard Jennings said that the report contained details of all serious incidents (SIs) reported during June, and details of the learning gleaned from completed Root Cause Analysis investigations. He briefly described the three SIs received in June as follows:

- an information governance breach involving the loss of hard copy patient information
- a (social services) care worker who had been assaulted at the home of a patient and subsequently and tragically died of her injuries (this was being investigated by the police)
- a medication incident which had caused temporary kidney and liver injury.

108.02 Turning to the section of the report which described the learning derived from completed investigations, Richard highlighted two cases. The first involved a patient who had fallen on the ward and sustained a fractured neck of femur, and Richard explained there were lessons to be learned around the recognition that the recognition of delirium could be an integral part of falls prevention. The second case involved the sub-optimal care of a district nursing patient, and Richard described the improvements which had already been made to the service as a direct result of that case.

108.03 Richard informed the Board that the facilitated work within surgery described at the previous Board meeting had now begun – preliminary interviews were being carried out, and the formal facilitated process with the whole team was to take place in September.

18/109 Quarterly Safety & Quality Report

109.01 Richard began his report by informing the Board that Whittington Health no longer had the lowest SHMI in the country rather the second lowewst, and it remained well below the national average. He expanded on the MRSA bacteraemia case mentioned in the Chief Executive's report, saying that the review had shown the case to be avoidable as it had been caused by a contaminated central venous line, and the infection prevention and control team was working with the imaging department to review practice in this area.

109.02 There had been a major increase in the incidence of patients presenting with measles, both in England and more widely in Europe. Richard assured the Board that Trust staff had been alerted to the risk, although it was noted that all Trust staff should be measles immune.

109.03 Siobhan enquired about progress on the Sign Up to Safety objectives as reflected in the Trust's Quality Account. Richard replied that he was confident that the Trust's performance on acute kidney injury was better than was indicated by the data, and he and colleagues were in discussion about how to address this. Work was proceeding on the stop falls initiative, and new training had been introduced in the workplace.

18/110 Integrated Safeguarding

110.01 Introducing this item, Sarah Hayes said that this was the first time that an integrated adult and children report had been brought to the Board. It had, she said, been taken to the safeguarding board. For children, there was a major focus on the OFSTED inspection which had taken place in April, from which the Trust had received positive feedback, there was also a section on the Haringey Joint Area Targeted Inspection, details of which had already been brought to the Board. Two Serious Case Reviews were also described, along with learning which had come about from issues raised.

110.02 It was noted that there had been a slight rise in the number of staff compliant with the correct level of mandatory training. Richard added that junior doctors' corporate induction had been changed to allow for the safeguarding module to be incorporated rather than having it separate.

110.03 Moving onto Adult Safeguarding, it was noted that there had been an increase in referrals of 27%, a figure with which the Trust was proud. Significant work had been undertaken on the prevention of pressure ulcers; also noteworthy was the requirement to increase prevention of terrorism training. Referring to paragraph 8.2 of the report, it was noted this needed to be updated to make it clear it related to inpatient services. Richard pointed out that those making decisions needed to be clear about their responsibilities. Anu enquired whether the team had considered the impact the DOLS judgment changes might have on staff, and Sarah replied that Theresa Renwick (adult safeguarding lead) was working on a plan to address this. Priorities for 2018/19 were set out at the end of the report.

110.04 Board members were pleased to receive this integrated report, particularly as they were familiar with cases where there had been difficulties with the transfer of vulnerable patients from children's to adult services. In answer to a question from David about how the service could be confident that enough concerns were being raised, Sarah acknowledged that this was a difficult area, compounded by the disparity between the two boroughs served. Janet Burgess enquired whether the Trust was represented on Islington's children's board, Sarah replied that it was.

110.05 Richard Jennings had noted good progress in this area, and commended both teams, particularly congratulating Theresa Renwick for her work on adult safeguarding. The report was formally approved by the Board.

18/111 Financial Report

111.01 Introducing the financial report covering Month 3, Stephen Bloomer was pleased to note that performance represented a break even position against plan in June, although for the year to date the position was £0.3m behind plan. The Trust had qualified in part for PSF income, but would not accrue funding for its A&E performance due to non-delivery of targets in that area. A chart on page 3 of the report showed the in-month and cumulative financial position, and it was noted that the latter part of the year was likely to prove more challenging as efforts were made to achieve a surplus in each month.

111.02 To date the Trust was achieving 61% of its CIP target, which meant that in terms of in-year performance the position was considerably improved from that of this time last year. There remained as yet however some unidentified schemes. The Trust was also behind on its capital programme, but work was continuing apace, noting that all schemes scheduled were rated red and therefore important to deliver during this financial year.

111.03 Stephen was confident that the Trust would meet its control total, however he informed the Board that the funding received by the Trust in order to deliver the national pay award was considerably less than the award would cost. He stressed that Whittington Health was by no means the only Trust in this position. He also mentioned the agency ceiling target, which the Trust would not meet if spending continued along the same lines as the first quarter. There was no financial penalty for this, but remaining below the ceiling was a metric for NHSI ratings around performance and governance.

111.04 Steve Hitchins enquired whether the ICSU reconfiguration might have an adverse effect on their CIP performance. Siobhan felt not, explaining that all had expressed confidence to deliver at the recent round of performance review meetings. Carol Gillen said that if there was an area of risk it was more around the larger transformational schemes; for the ICSUs the requirement to deliver 2% savings was almost 'business as usual'. David suggested that the executive team might also like to consider incentives for the ICSUs, such as additional capital funding which might become available.

18/112 <u>Performance Dashboard</u>

112.01 Carol Gillen introduced the performance dashboard covering the month of June. She had been pleased to see the progress made on complaints, but said that the Trust remained challenged on the 62 day cancer target, largely due to underperformance in urology and colorectal services.

112.02 The report contained a great deal of narrative on community services, and Carol explained that all community teams had been asked to focus on their individual targets.

112.03 Turning to the section of the report on safe staffing, Sarah Hayes informed the Board that there had been a reduction in red shifts, but CHPPD (care hours per patient day) had increased, due mainly to the need for one to one care for mental health patients. Theatre utilisation was likely to have another challenged month, but after this Carol expected to see some improvement.

112.04 During discussion the following points were noted:

- the significant improvement that had been made in the timing of health visitors seeing newborn babies
- a trajectory for appraisal and mandatory training was to be agreed for each of the ICSUs, this would be included in the following month's report
- it was extremely useful for the Board to have the detailed narrative on community services
- OT services, in particular for children, there was a marked difference between services in Islington and Haringey
- Nadine Jeal was commended for the improvements she had made within the podiatry service.

112.05 In answer to a question about mixed sex accommodation breaches, Sarah Hayes replied that this reflected a change in the way these were reported. Until now, there had been agreement with the commissioners that ITU breaches were exempt; however this was no longer the case. The report in no way signified any deterioration in performance.

112.06 In answer to a comment about the district nursing service (page 10) Carol explained that the problem described was attributable to having long term agency staff on the shift, and a solution needed to be found to this.

18/113 Results of the National Inpatient Survey 2017

113.01 Introducing this item, Sarah Hayes explained that the data referred to the survey which had been carried out during July 2017, at which time the Trust had had a particular issue around temporary staffing. Although this was an important survey, there was also a need to plan how other surveys were brought to the Board.

113.02 Sarah highlighted some key points from the survey. Responses showed that had been a deterioration in the quality of the food served at the hospital, and Sarah informed the Board that she was running a food focus group. She was also aware that the contract with Sodexo was being reviewed, and Adrien Cooper was working with Phillipa Alston and Cecil Douglas on this.

113.03 Another key finding was that some respondents felt they had not been treated with sufficient dignity and respect. Sarah felt this was likely to be attributable to having had a high proportion of agency staff at that time, but measures had been put in place the minimise the possibility of this happening again, and an action plan had been drawn up which was to go to the Nursing & Midwifery Executive Committee. David asked whether, in view of complaints, FFT etc. these findings had been expected. Sarah replied that they had, and discussions had been held at the Trust's Patient Experience Committee.

113.04 It was noted that although the survey had been conducted last July the report had not been received by the Trust until April this year. The response rate was fairly low, and Sarah explained that whilst Trust staff did encourage its completion, this was largely out of our control.

113.05 Richard Jennings remarked that complaints were a very good source of information about dignity and respect issues, with patients often relating quite unexpected information about their treatment. Anu felt that there needed to be more narrative in the report, it felt rather data-focused, a view with which Sarah concurred. Graham informed the Board that the end of life care group also reviewed complaints and was therefore able to gauge the changes that had been put in place. Steve Hitchins felt there was insufficient information on menu cards for patients to make informed choices about what they eat, and Sarah assured him that work was in hand on this, with the aim of creating information in the form of a booklet.

18/114 Nursing and Midwifery Revalidation

114.01 Sarah Hayes reported that the final cohort of nurses and midwives to be revalidated (including herself and Siobhan) had now been completed, and she expressed confidence in the process. 302 staff had been revalidated this year, and the one who was unsuccessful was followed up very quickly. The Board formally accepted the report.

18/115 Trust Objectives for 2018/19

115.01 Jonathan Gardner had updated the objectives following the recent awayday, and informed the Board he would continue to work on their design. There was a need to set out the objectives the new ICSUs were to be measured against as well as the Board. The main six remained the same, but he had added three enablers on workforce, finance and estates and IT. The paper also set out the sub-priorities and gave some example of key metrics of success which could be highlighted going forward. TMG was happy with it, and the aim was now to share it with the ICSUs.

115.02 Anu stated that FFT was not a proxy for patients being active in their own care. Siobhan agreed, adding that she was not certain that the objectives had quite captured some of the cultural change requirements discussed earlier in the meeting. It was agreed that Anu, Siobhan and Jonathan would give this further consideration and suggest amendments, with Jonathan noting that even the nine objectives might change in light of changes to the strategy; this was only an interim set of objectives for this financial year. He added that his team had also come up with a business planning template, and both documents would come back to the challenge day in October.

18/116 Any other business

116.01 Richard Jennings announced the sad death of former staff member Michael Clift, who had been a practice development nurse at Whittington Health. He would chiefly be remembered for leading work on compassion, which he had presented to the Board. The board sent condolences to his family and friends.

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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.	Sept 2018	MJ
40.05	Action plans arising from the Staff survey to be brought back to the Board following discussion at the Workforce Assurance Committee	October 2018	NF
73.05	Implement change in Responsible Officer to take over case management	Sept 2018	RJ
78.07	Community dashboard to be produced with exception report on children's community services	Complete	CG
90.03	Paper on the Trust's position on the prescription of opiates to be brought to the Sept Board	Sept 2018	RJ
93.02	To look at CNST maternity submission alongside information from SI panels and present results to Quality Committee	Complete	RJ
95.05	Presentation to come to the Board on the bed modelling transformation work and NHSI good practice guides	Oct 2018	CG
97.08	Some high level community metrics should be moved to the summary slide at the top of the pack	Oct 2018	CG

Whittington Health
NHS Trust

Trust Board
26 September 2018

Title:	Chief Executive Officer's Report for the Trust Board		
Agenda item:	**18/121**	**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 Sept 2018		

Author name and title:		**Jonathan Gardner, Dir Strategy**		**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.

NATIONAL / POLICY NEWS

Update on 10-year plan

The government has now set the NHS five financial tests to show how the service will put the service onto a more sustainable footing. Those tests are:

1. “improving productivity and efficiency
2. eliminating provider deficits
3. reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live
4. getting much better at managing demand effectively
5. making better use of capital investment”

10 workstreams have been set up and I have been asked to join the workforce one.

- Prevention and Personal Responsibility
- Healthy Childhood and Maternal Health
- Integrated and Personalised Care for People with Long Term Conditions and the Frail Elderly (including Dementia)
- Cancer
- Cardiovascular and respiratory
- Learning Disability and Autism
- Mental Health
- Workforce, Training and Leadership
- Digital and Technology
- Primary Care
- Research and Innovation
- Clinical Review of Standards
- System Architecture
- Engagement

There will be engagement over September and October with a view to publication in November.

Report from the Care Quality Commission: Quality improvement in hospital trusts - Sharing learning from trusts on a journey of QI

The report is aimed at senior leaders in healthcare organisations, particularly trust boards, considering adopting organisation-wide structured quality improvement (QI) as a strategic priority. It focuses on leadership alongside the behavioural and cultural aspects of hospitals that have built and embedded a QI and aims to share learning to inspire and encourage wider improvement in the quality of care delivered. There are many good examples provided in the report of how trusts are using structured QI approaches, and we encourage the board to read the report in full. It is available here: https://www.cqc.org.uk/news/stories/how-hospital-trusts-are-embedding-quality-improvement-deliver-high-quality-sustainable

QUALITY AND SAFETY

Emergency Department (ED) four hours' wait:

Our performance against the 4 hour waiting target has remained challenging. Overall performance against the 95% target for July 2018 was 90.5% and for August was 90.0%. July was one of the busiest months ever and saw 9,287 attendances which was an 8.79% increase compared to July 2017. Nationally performance has been challenged over the last 3 months with increases in activity likely to have been caused in some part by the heatwave over the summer.

Complaints:

The Trust achieved the target of 80% answered in 25 days for 3rd consecutive month achieving 94% in July.

Cancer 62 days:

Our performance against the cancer 62 days target has underachieved at 82.9% against target of 85%. There is continued management focus on delivering our improvement plan in gynaecology in particular as outlined in the report.

Community waiting times

Our work on improving waiting times in community services continues. Our performance report on the services has now been split by borough which allows us to consider issues within each borough. Many of the metrics show improvement and a specific area of focus is on our children's services.

Diagnostic waits

The target has not been achieved for August which is due to a backlog in Endoscopy. Additional capacity has been put in place. The expectation is to be fully compliant in September and going forwards.

WORKFORCE

The Annual Workforce Directorate Report in this month's papers and highlights the progress the workforce directorate have made over the last year making improvements in the recruitment and retention of staff, progressing equality and inclusion initiatives, and innovating in OD and staff development and wellbeing.

We are continuing to work with staff to engage clinicians and managers in considering the Culture report and develop an engagement strategy that enables us to address the issues within the report. A number of actions have been put in place over the summer including agreement of an email etiquette; the instigation of a 'Fair treatment panel'; and 'staff focus September'. Through October we will be engaging and listening to staff to inform the full report on next steps and action plan that will come to the Board when complete.

FINANCIAL

Month 5 Financial Position

The Trust is reporting a £0.3m deficit for the month of August (month 5) against a planned deficit of £0.2m. The year to date position of a £1.1m deficit is £0.4m behind plan.

The main driver for the in month performance is the underperformance of clinical income The under achievement is attributed to maternity services and day cases procedures primarily within the Surgery ICSU. The Executive have performance reviews with the ICSUs in October and the detail of recovery plans will be discussed.

The Trust is reporting a positive variance in relation to non-pay in the year to date position. This trend has been further improved by a rebate of £0.5m from CNST premium due to achievement of the maternity standards. As with last month, the pay spend is in excess of budget, this is as a result of the agenda for change payment being made in month, back-dated for April, May and June.

ESTATES

Building a second obstetric theatre

Later this month, contractors will start work on building our new obstetric theatre, opposite the labour ward in the Kenwood Wing. This is great news. We will also be refurbishing Cellier ward. Eddington ward will be the ward that will be used for our postnatal care.

Activity has started following the announcement earlier this summer that we are going to develop plans for our whole estate in-house. We are now in the process of bringing in a specialist team to support us in developing a Master Plan for the estate, including architects, health planners and surveyors. We are aiming to have the team in place to start work in October. Part of the function of this team will be to engage with staff and stakeholders on how our estate can work in the best way for our staff and patients.

North London Health and Care Partners quarterly update

Appendix 02.1 has the quarterly update from the STP for the board's information.

Orthopaedic Review

North London Health and Care Partners are reviewing orthopaedic services in the sector and the 'case for change' sets out a vision for centres of orthopaedic excellence where orthopaedic elective work is centralised on 'cold' sites with ringfenced beds to improve outcomes and reduce costs. We would be very keen to house an orthopaedic centre on our site in a new build, but are also supportive of a hub and spoke model with partners in the sector.

Winter planning

The government have announced that, as expected, there is no substantial new money for winter this year (apart from some capital that has already been earmarked). One of the big drivers this year is for us all to have our flu jabs – something that WH has done very well in previous years. We will be presenting our winter bed plans next month.

Brexit

The board will be discussing the impact of Brexit and 'no deal' over the next couple of months. The key message we would like to give is one of assurance to our staff wherever they come from. They are valued and we want them to stay. The Home Office has published a new toolkit with practical advice for EU citizens on how to apply for settled status. The toolkit includes videos, how-to-guides, leaflets and posters. The settlement scheme will open in phases later this year and will be fully open by 30 March 2019. The deadline for applications will be 30 June 2021. The Home Office is piloting the digital process for applying for settled status with EU staff at 12 NHS trusts and students and staff at three universities in the North West.

Staff Awards

As I write this, we are preparing for our Annual Staff awards, the number and quality of the nominations this year was astounding and I look forward to an exciting evening.

Siobhan Harrington
Chief Executive

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

North London Partners in Health and Care
North Central London STP

Quarterly provider update

20 September 2018

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Ambitions of the STP

Improve the health and wellbeing of the local population

Ambition for the STP is built on existing CCGs, Local Authorities and Providers values and strategy

Maximise out of hospital care and build resilient well supported communities

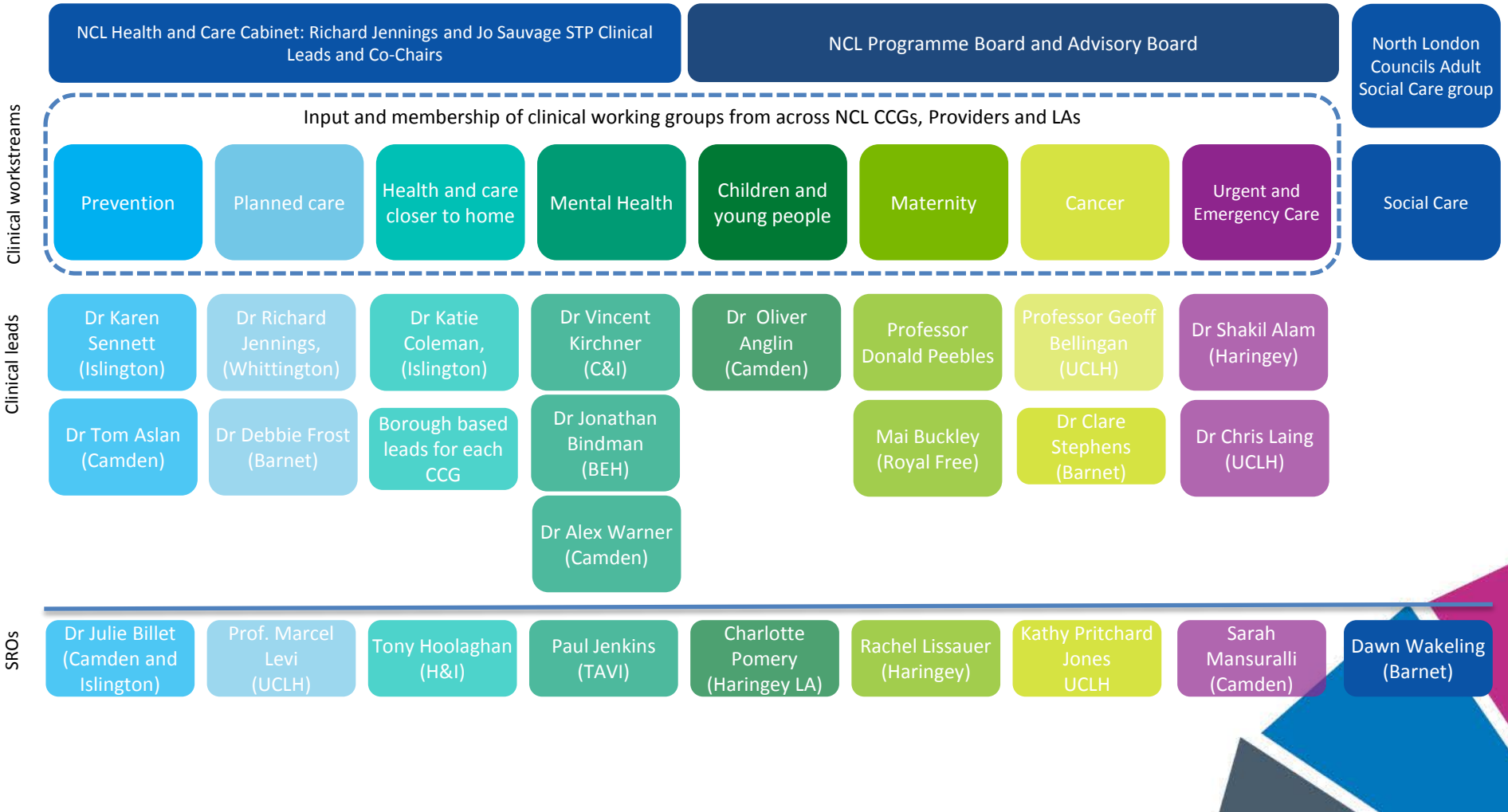
Reduce health inequalities

A partnership of the NHS and local authorities, working together with the public and patients where it's the most efficient and effective way to deliver improvements.

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Clinical and senior leadership in place across North London Partners



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NHS

Examples of progress so far

Case 1

New specialist perinatal mental health service for north central London

The service provides specialist treatment and support for pregnant and postnatal women with severe mental illness and offers consultation and training with staff in the wider system, supporting them to work more effectively with women with less complex problems. It is improving equity of access to specialist support for local women.

Case 2

Review of adult elective orthopaedic services across NCL

We have launched a review of adult elective orthopaedic services across NCL to explore how services might be improved.

A review group led by local clinicians, involving patients, commissioners and those who currently carry out these operations is coordinating the development of how this kind of care could be delivered in the future.

We are currently engaging with ourstakeholders on the draft case for change before considering next steps.

Case 3

Opening of two new maternity community hubs

Better Births

The Better Births report of 2016 has been a driving force at a national level to transform maternity care. Our work in north central London, as a Better Births early adopter, has been to work collaboratively across Barnet, Camden, Enfield, Haringey and Islington to:

- Improve continuity of care
- Improve choice and personalisation
- Ensuring maternity care remains safe and accessible for women

Earlier this year, the team opened a new maternity community hub at Harmood's Children's Centre in Kentish Town. – a major step towards improving maternity care for women in NW Camden postcodes who currently access services at the Royal Free and UCLH. A second centre is due to open at Park Lane Children's Centre in Haringey next month.

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NHS

Headlines from across the programme

UEC

- 'Star divert numbers' enable clinical staff to get through to a clinical expert for urgent advice and support by dialling the appropriate number. In the past year star line activity has increased 42%, from 751 calls to 1068 calls per month (1,929 calls in the past year)
- We have made it faster and safer for patients to get home from hospital by agreeing standard ways of working and working more effectively with social care. Use of the new discharge to assess pathways has increased by 50% over the past six months.

Planned Care

- Clinical advice and navigation now live across providers in NCL in 8 specialities with further specialties going live in November 2018.
- Review of adult elective orthopaedic care commenced in March 2018 . Our ambition is to create a comprehensive adult elective orthopaedic service for NCL, which will be seen as a centre for excellence with an international reputation for patient outcomes and experience, education and research.

Health and Care Close to Home

- Since April 2018 it has been possible for residents to access GP services 8am-8pm across the whole of NCL through extended access.
- Established the first NCL Care and Health Integrated Networks and Quality Improvement Support Teams, focusing on improving quality and reducing unnecessary variation.

Mental Health

- A new women's psychiatric intensive care unit at Camden and Islington NHS Foundation Trust service opened in November 2017. All women who require intensive care services can now be treated close to where they live. All women have been repatriated back from out of area placements (OAPs) and we currently have zero women in OAPs.

UEC SRO: Sarah Mansuralli

Overall workstream objective:

A consistent and reliable UEC service by 2021 that is accessible to the public, easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes. Work focuses on Admissions avoidance, ambulatory care, end of life and discharge to assess.

Notable progress made this reporting period (Q2 2018)

- Direct Booking from 111 into GP Federation Hubs (extended hours & weekends) is live across NCL;
- Mental Health Patients being warm transferred to MH teams via NHS 111
- Single Choice policy related to Discharge approved;

Notable progress planned for next reporting period (Q3 2018)

- Standardised specification for Rapid Response community services ready in October;
- System wide demand and capacity based 7 day community model to support more patients to return home through Discharge to Assess.
- Agreed NCL approach to Single Point of Access for out of hospital palliative care

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Integrated urgent care	£, Q, P, E, C	Digital	Acute, GPs, Pharmacies, NHS111	**Partners involved:** • Acute Trusts, Community services, MH providers GP Practices; Care Homes **Potential future commitments:** • Last phase of life single point of access model • Common provider choice policy for discharge • Stroke business case to increase community rehab
Admission avoidance	£, Q, P, E, C	Digital, Workforce	Acute, GPs / Community	
Simplified discharge	£, Q, P, E, C	Digital, Social Care	Acute, Care Homes, Community	
Last Phase of life	£, Q, P, E, C	Digital, Social Care	Care Homes, NHS111, Remote	

Planned Care SRO: Marcel Levi

Overall workstream objective

Deliver better value planned care through new models of care and reducing unwarranted variation across providers.

Notable progress made this reporting period (Q2 2018)

- Advice and guidance service live across primary care and acute trusts
- Public engagement on orthopaedic review case for change

Notable progress planned for next reporting period (Q3 2018)

- Teledermatology service to go live across NCL

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Using NHS money wisely	£, Q, C	-	GPs, Providers	**Partners involved:** • Acutes, CCGs, GPs **Potential future commitments:** • Common NCL PoLCE Policy • Teledermatology and Advice and Navigation services implemented across NCL • Involvement in orthopaedic review
Advice & Navigation	£, Q, P, E, C	Digital	GPs	
Dermatology	£, Q, C	Digital	GPs, Acute Providers	
Urology	£, Q, C	HCCH	Acute Providers	
Orthopaedic review	£, Q	-	Acute Providers	

Health and Care Closer to Home SRO: Tony Hoolaghan

Overall workstream objective

A 'place-based' population health system of care base around neighbourhoods of 50-80k which draws together social, community, primary and specialist services underpinned by a systematic focus on prevention and supported self-care.

Notable progress made this reporting period (Q2 2018)

- Launch of Quality Improvement network

Notable progress planned for next reporting period (Q3 2018)

- Full population coverage of neighbourhoods
- Commence procurement process for online consultations provider

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
CHIN/Neighbourhood	C	Workforce, Estates, Digital	GP practices, social care, community	**Partners involved:** • CCGs, GP, community pharm , Mental Health & Social Care **Potential future commitments:** • NCL-wide strategy for General Practice • NCL wide approach to Atrial Fibrillation improvement • NCL model for social prescribing • Enhanced services review • Contracting for Care & Health Integrated Networks
Quality Improvement	£, Q	Workforce	Virtual, GP practices	
P. Care Commissioning	£, Q, E		CCGs, GPs	
Social Prescribing	£, Q	Workforce	GP practices, social care, community	
Primary Care at Scale	£, Q, P, E		GP practices	

* £ = Savings, Q = Quality, P=Performance, E=Efficiency, C=Clinical Outcomes ** See appendix 2 for detail on interdependencies

Mental Health
SRO: Paul Jenkins

Overall workstream objective

- Working to address inequalities for those with SMI and provide consistent care.
- Deliver services closer to home, reducing demand on the acute sector and mitigating the need for additional MH inpatient beds.

Notable progress made this reporting period (Q2 2018)

- NCL STP met the CYP access standard for 2017/18
- Funding for Adult HBPoS, Dementia, W2 perinatal, & CAMHS Projects.
- Agreed common PROM/PREM for Primary Care MH Services across NCL.

Notable progress planned for next reporting period (Q3 2018)

- MH Liaison options developed for 2019/20.
- Initial evaluation of IAPT Long Term Conditions Pilot and lessons learnt available.
- Workforce development programme to improve CYP MH skills across settings

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Improve acute care	E	HCCH, Social Care, UEC	Acute, MH Trusts, Community	**Partners involved:** • CCGs, Acute, GPs/CHINs, MH Trusts, HEE **Potential future commitments:** • Development of frontline mental health services across settings • Agree single approach to Psych Liaison services in acute • Expand workforce to ensure capacity to meet national targets for improved access.
Improve CAMHS	Q	CYP	Schools, GPs, Community, MH Trusts	
MH Liaison services	Q, P, £	UEC	Acute, MH Trusts, Community	
Primary Care MH inc. IAPT	Q, P, £	HCCH, Digital, Estates (2)	GPs, Community	
MH Workforce	Q, P, £	Workforce (3), Digital	Acute, MH Trusts, Community, GPs	

Maternity
SRO: Rachel Lissauer

Overall workstream objective

Delivery of the National Maternity Transformation programme through improved continuity and safety of perinatal care for women, working across professional and organisational boundaries to drive better patient experience and integrated care.

Notable progress made this reporting period (Q2 2018)

- Earlier this year, the team opened a new maternity community hub at Harmood's Children's Centre in Kentish Town

Notable progress planned for next reporting period (Q3 2018)

- Second centre is due to open at Park Lane Children's Centre in Haringey next month

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Quality & Safety	Q	Digital	Acute, community	**Partners involved:** • Acute trusts **Potential future commitments:** Portability of staff across services Single point of booking across NCL
Personalisation & choice	Q	Digital	Acute, community	
Single point of access	£,Q	Digital , Workforce	Acute, community	
Community services dvt	Q	HCCH	Community settings	
NCL collaborative working	£, Q	Workforce	Acute, community	

Health and Prevention
SRO: Julie Billet

Overall workstream objective

Driving system-wide approach to prevention and population health working to enable success in the overall STP strategy for care

Notable progress made this reporting period (Q2 2018)

- Agree a consistent and coordinated approach to NCL wide MECC training
- Submitted bid to DWP funded Challenger Fund for improving workforce retention for people with mental health needs

Notable progress planned for next reporting period (Q3 2018)

- Working with Cancer workstream to support delivery of awareness and early diagnosis programme in NCL.

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Workforce for prevention	E, P	Workforce, Estates, Digital	Acute, MH Trusts, Community	**Partners involved:** • GP practices **Potential future commitments:** • Working to towards healthier workplaces • Alignment of organisational strategies • Commitment to prevention (primary and secondary)
Healthier environment	O	Workforce	Acute, MH Trusts, Community	
Healthier choices	C, Q	Workforce		

* £ = Savings, Q = Quality, P=Performance, E=Efficiency, C=Clinical Outcomes ** See appendix 2 for detail on interdependencies

Cancer
SRO: Kathy Pritchard-Jones

Overall workstream objective

Delivery of improved survival, patient experience, efficiency of service delivery including services closer to home; reduced costs £ financial sustainability; reduced variation.

Notable progress made this reporting period (Q2 2018)

- Findings from annual review – 1-year survival rate better than England average
- % people in NCL diagnosed at early stage good relative to England average

Notable progress planned for next reporting period (Q3 2018)

- Workforce modelling re: radiology gaps in employment
- System work on 62 day target

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Cancer waits	Q, P	Diagnostics capacity	Acute, Primary Care , community	**Partners involved:** • Acute providers, GPs **Potential future commitments:** • TBC
Early diagnosis	Q, P	HCCH, Prevention	Acute, Primary Care , community	
Living w & beyond cancer	Q	HCCH, Planned	Acute, Primary Care , community	

Children and Young People
SRO: Charlotte Pommery

Overall workstream objective

'Right care, right place, right time'. Transformed health & social care services: equitable, accessible, efficient & deliver improved outcomes. Enabling high quality, responsive services for children, young people & families, delivered locally where possible, with shared focus on promoting wellbeing, reducing health inequalities & improving health & social outcomes.

Notable progress made this reporting period (Q2 2018)

- Admissions Avoidance baseline report complete
- Agreed priorities/initiatives for Complex Needs project
- #AAA Asthma NCL communications campaign

Notable progress planned for next reporting period (Q3 2018)

- Asthma logic model workshop with agreed NCL outcomes, objectives and measures
- CYP Surgery case for change report
- Complex Needs enhanced data review

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Paediatric surgery	Q	Workforce, digital	Acute trusts (GDH & Tertiary)	**Partners involved:** Acute Trusts, Primary Care, Commissioners, Pharmacy, Public Health, Local Authority **Potential future commitments:** System approach to managing & preventing asthma in C&YP • Developing surgical network across NCL • Preventative approach to care & support for CYP & families
Asthma	Q	Prev, HCCH, workforce, digital	Acute, Primary Care , community	
Complex Needs	£, Q	UEC, HCCH, Mental Health	Acute Trusts, LA Placements	
Paed. admissions avoid.	£, P, Q	UEC, Prev, HCCH, workforce, digital	Acute, Primary Care , community	

Social Care
SRO: Dawn Wakeling

Overall workstream objective

Working to address care inequalities in provision and improving longer term strategic approach to workforce and care market.

Notable progress made this reporting period (Q2 2018)

- Detailed analysis of all boroughs purchasing of care homes informing a joint commissioning strategy; councils and CCGs collaborating with LPH around exploring sustainable price bandings for nursing care.

Notable progress planned for next reporting period (Q3 2018)

- Develop proposals for an NCL Care Academy
- First draft of Care Analytics report on sustainable care prices for residential and nursing care

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Ind. Care Sector Workforce	£, E, Q	HCCH, UEC, Workforce	Home Care, Care Homes	**Partners involved:** Local authorities, CCGs, care providers **Potential future commitments:** Joint commissioning strategy
Social Care Markets	Q, £, E	HCCH, UEC, MH, Workforce	Home Care, Care Homes	

Digital
SRO: David Sloman

Notable progress made this reporting period (Q2 2018)

- Submission of provider digitisation funding bid

Notable progress planned for next reporting period (Q3 2018)

- Begin work on technical delivery across partner organisations

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Health Information Exch	Q, £	Clinical Workstreams	All	**Partners involved:** • Acute Trusts, Primary Care, Commissioners, Pharmacy, Public Health, Local Authority **Potential future commitments:** Ongoing partnership working to delivery Health Information exchange
Pop Health Management	Q, £	Clinical Workstreams	All	

* £ = Savings, Q = Quality, P=Performance, E=Efficiency, C=Clinical Outcomes

Workforce
SRO: Siobhan Harrington

Overall workstream objective
To attract people to live and work in NCL so we have the best possible workforce to deliver high quality services to our community

Notable progress made this reporting period (Q2 2018)
- Detailed work on financial benefit of Collaborative bank
- Funded priority areas through securing of £500k HEE money

Notable progress planned for next reporting period (Q3 2018)
- ACP begin placements (18 funded)
- Physician associates begin placements (up to 43)
- Training of care home staff and AHP in new ways of working

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
UEC prep. winter 2019	P, Q	UEC	Acute, Community, Primary care	**Partners involved:** • All **Potential future commitments:** • Standardisation of mandatory training to aid portability • Standardisation of employment contracts to aid portability
Portability (including passports, MAST)	P, Q, £	Prevention, HCCH	Acute, Community, Primary care	
Temporary Staffing	£, Q, C	-	Acute and Community trusts	
Social & Primary C /Community/Place based	£, P, Q	UEC	Community, Primary care	
Analytics (WF planning)	£		All	

Estates
SRO: Simon Goodwin

Overall workstream objective
To provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population.

Notable progress made this reporting period (Q2 2018)
- Estates strategy drafted and submitted to NHSE&I.

Notable progress planned for next reporting period (Q3 2018)
- Production of the NCL STP Delivery Plan to take forward key priorities in the NCL Estates Strategy
- Workshop on NCL STP principles of placed based care community – 8 Nov 18.
- Locality planning – phase 1 to be completed by end of financial year to be ready for wave 5 and London Estates board capital pipeline.

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
NCL estates strategy	£, Q	All	All STP partners	**Partners involved:** • CCGs and Trusts **Potential future commitments:** Partnership working on NCL estates strategy iteration
St Pancras devt. – C&I	£, Q	Mental Health	C&I hospital site	
St Ann's devt.– BEH	£, Q	All	BEH hospital site	
Project Oriel	Q	-	Moorfields, C&I hospital sites	
Reducing void spaces	£, Q	All	All STP partners	

Provider Productivity
SRO: Tim Jaggard

Overall workstream objective
To scope and take forward areas of savings requiring collaboration across providers

Notable progress made this reporting period (Q2 2018)
- Scoping of 5 areas of opportunity including detailed work on financial benefit of Collaborative bank

Notable progress planned for next reporting period (Q3 2018)
- Presentation to Provider Chief executives of scoped opportunity for decisions on programme of work

Priority project	Impact*	Major Independencies	Key Care Settings	Partner involvement
Workforce	£	Workforce	NHS Trusts	**Partners involved:** • Providers **Potential future commitments:** • Consideration of collaborative bank option • Ongoing engagement in modelling, scoping and emerging programme of work
Procurement	£	-	NHS Trusts	
Facilities management	£	-	NHS Trusts	
Diagnostics	£, Q	Planned Care	NHS Trusts	

* £ = Savings, Q = Quality, P=Performance, E=Efficiency, C=Clinical Outcomes ** See appendix 2 for detail on interdependencies

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

NHS

Appendix 1: Capacity to delivery change

Dedicated capacity now in place across majority of workstreams to facilitate working across partner organisations to deliver agreed STP initiatives.

Workstream	Programme lead	Email Address
Adult Social Care	Richard Elphick	Richard.Elphick@camden.gov.uk
Cancer	Nasar Turabi	n.turabi@nhs.net
Children and Young People	Sam Rostom	sam.rostom@nhs.net
Digital	Martyn Smith	martyn@brightive.net
Estates	Dianne MacDonald	diane.macdonald3@nhs.net
Health and Care Closer to Home	Sarah McIlwaine	sarah.mcilwaine@nhs.net
Maternity	Kaye Wilson	TBC
Mental Health	Chris Dzikiti	Christopher.Dzikiti@nhs.net
Planned Care	Donal Markey	donal.markey@nhs.net
Prevention	Mubasshir Ajaz	mubasshir.ajaz@islington.gov.uk
Productivity	Shahbaz Bhutta	shahbaz.bhutta@nhs.net
Orthopaedic review	Anna Stewart	anna.stewart3@nhs.net
Urgent and Emergency Care	Alex Faulkes	alex.faulkes1@nhs.net
Workforce	Sarah Young	Sarah.young11@nhs.net

Whittington Health NHS Trust

Trust Board

26th September 2018

Title:	**Serious Incidents – Months 4 and 5**		
Agenda item:	**18/122**	**Paper**	**3**
Action requested:	It is recommended that the Board recognises and discusses the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during July and August 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 reduce the risk of information governance breaches in the community; • Steps being taken to reduce the risks of medication errors.		
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:	12/09/2018		

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 and August 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

The Trust declared two serious incidents during July and August 2018, bringing the total of reportable serious incidents to 19 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 Service Unit (ICSU).

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

3.1 The table below details the Serious Incidents currently under investigation

Category	Month Declared	Summary
Return to theatre Ref:13332	May 18	A patient with complex co-morbidities 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.
Diagnostic Incident including delay Ref:18774	July 18	A patient presented to the Emergency Department acutely unwell with small bowel obstruction. The patient was initially admitted to ITU for conservative management, but it subsequently became apparent, when the patient deteriorated, that an urgent laparotomy was required. There may have been inappropriate delay in making this decision.
Diagnostic Incident including delay/Unexpected Death Ref:20462	Aug 18	A patient was referred by the GP for a targeted CT scan, which unexpectedly showed a subacute bowel obstruction. The patient was then seen again by their GP and referred to ED where the patient was admitted for urgent laparoscopic surgery. The patient subsequently died. There is a concern that

Category	Month Declared	Summary
		the response to the initial CT scan may have been delayed.

3.2 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**

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

STEIS 2017-18 Category	2016/ 17 Total	2017/ 18 Total		Apr 18	May 18	June 18	Jul 18	Aug 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	0		0	0	0	0	0	0
Confidential information leak/Information governance breach	6	3		2	0	1	0	0	3
Diagnostic Incident including delay	8	7		0	2	0	1	1	4
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	1
Environment Incident meeting SI criteria	0	1		0	0	0	0	0	0
Failure to source a tier 4 bed for a child	1	0		0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0		0	0	0	0	0	0
HCAI/Infection control incident meeting SI criteria	0	3		0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	0	0	4
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0

Medical equipment/devices/ disposables incident meeting SI criteria	1	0		0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	1
Sub Optimal Care	4	2		1	0	0	0	0	1
Surgical/invasive procedure incident meeting SI criteria	0	0		0	1	0	0	0	1
Treatment Delay	3	4		0	2	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	1
Retained foreign object	1	1		0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**19**

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 July and August 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 thirteen reports to NELCSU during July/August 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 July/August 2018. The Trust had sixteen reports due for submission of which thirteen were submitted. One extension was given by the CCG and there is one SI which is overdue. One report was de-escalated after submission as there were no care & service delivery problems identified which caused or contributed to the outcome of the incident.

The Trust was asked by NHSE to downgrade one incident on StEIS (ref:13923). Although a joint investigation is taking place with Whittington Health, another Trust is leading on this due to the patient being under their care at the time of the incident.

Summary	Actions taken as result of lessons learnt include;
Treatment delay Ref:12146	Following elective laparoscopic cholecystectomy surgery a patient was returned to theatre due to a suspected injury to the common bile duct. • The pathway for management of acute gallstone disease is being reviewed to include a strategy for managing a 'complex' gallbladder with appropriate imaging and MDT discussion where necessary. This will be shared with relevant staff via team meetings and surgical forum. • An audit of acute gallbladder disease is being undertaken to identify any common problems and themes and will be presented at the surgical forum and reflections from this SI shared in the Patient Safety Committee (PSC) meeting for discussion.
Treatment delay Ref:12153	A patient developed septic shock five days post-surgery and was returned to theatre requiring a laparotomy. • In response to the learning from this serious incident, a Quality Improvement initiative to revise the consent forms will be undertaken with the aim of improving their usage and effectiveness. This will involve: (i) Standardising practice in relation to all appropriate surgical procedures using patient specific and procedure specific consent forms. (ii) Increase the number of procedure specific consent forms available for different surgeries. (iii) Develop and put in place ways of recording individual morbidity and mortality risk scores on the consent form.
Confidential Information Breach Ref:10532	Unable to locate patient records recalled from the Trust archive system. • Due to the lack of a local process to proactively monitor and manage retrieved records, a new administrative system has been set up to record requests for archived record retrieval. This system will be audited to ensure this process is being followed appropriately. • The replacement of paper records with an electronic system RiO) is already in place and the requirement to access archive information will diminish over time as records are destroyed in line with record retention guidance.
Unexpected Neonatal Death Ref:13530	Unexpected neonatal death following an emergency Caesarean section and prolonged neonatal resuscitation. • The guidelines for the management of hypertension in pregnancy must be available and used in all areas of maternity where women attend in the antenatal period. • The system for review and follow up of key blood tests

Summary	Actions taken as result of lessons learnt include;
	and investigations carried out in the Maternity Assessment Unit must be robust in order to ensure abnormal results are noted and acted upon to enable intervention and treatment when required.
Confidential information leak/loss/IG Breach Ref:13925	A staff member had their ruck sack stolen, which contained a hardcopy caseload list with patient confidential information. • To facilitate the secure electronic storage of patient information, a capital business case for new equipment across the Children and Young People community teams is currently being written and is being presented to the Investment Committee. • All Community therapy staff who work off site have been sent a copy the leaflet '*Confidentiality Guidelines for Working Off-Site and From Home'* with a covering letter on information regarding what patient information may be carried on paper out of the Trust. • All new staff are given a copy of the staff leaflet '*Confidentiality Guidelines for Working Off-Site and From Home*' as part of their induction. • The '*Confidentiality SOP for Working Off-site and from Home*' has been updated to include information about the anonymisation and pseudoanonymisation of data.
Medication Incident Ref:13920	A patient received incorrect doses of vancomycin and paracetamol, which caused temporary kidney and liver injury. • All patients should be weighed within 48 hours of admission and their weight should be recorded on JAC (the trust electronic prescribing system). This is now included as part of the JAC handover and will be audited to ensure patients weight is documented. This will also be flagged by pharmacy so that the patients' weights are reviewed at the time of medication review. • The Trust '*Vancomycin and Teicoplanin in Adults*' guideline has been updated and includes guidance on dosing in underweight patients and a high risk alert added to JAC for prescribers to contact out-of-hours (OOH) support before prescribing in patients who fall outside of 'normal adult' dosing. • A high risk alert for IV paracetamol has been added to JAC to remind prescribers when prescribing IV paracetamol that the dose should be reduced for patients who weigh less than 50kgs. This will also function as an educational tool for prescribers and staff who administer paracetamol.

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.

Whittington Health

Trust Board

26th September 2018

Title:	Learning from death – Quarter 4 2017/18 (1 January – 31 March 2018)		
Agenda item:	18/123	**Paper**	4
Action requested:	It is recommended that the assurances contained within this paper are recognised and that the Board discusses potential opportunities for further improvement. The Board may wish to consider focussing its discussion on: • The potential benefit of setting up a defined bereavement service for adult patients' carers and families; • Further ways in which learning from this process might be disseminated and further embedded.		
Executive Summary:	This is the fourth quarterly report to Trust Board on learning from death. The previous reports came to the Trust Board October 2017 (covering Quarter 1 2017/18), January 2018 (covering Quarter 2 2017/18) and May 2018 (covering Quarter 3 2017/18). These reports describe: a) How we are performing against our local targets, and national expectations, in reviewing the care of patients who have died whilst in this hospital (inpatient and ED deaths); b) What learning we are taking from the themes that emerge from these reviews; and c) What actions we are taking both to improve our care of patients, and to improve the learning from deaths process. In Quarter 4 of 2017/18 (Q4), 1 January – 31 March 2018, there were 162 patient deaths. This includes all inpatient deaths and all deaths in the emergency department. In Q4, 50.6% of all inpatient deaths were reviewed using a Structured Mortality Review process and then a departmental mortality review meeting, as compared with 67% in Quarter 3 2017/18. In Q4 of 2017/18: • 83.4% of all category A deaths were reviewed (desired performance 90%) • 42.3% of all category B deaths were reviewed (desired performance 25%) There is no benchmarking of data with other trusts, as trusts are encouraged to track their own performance as it changes over time rather than comparing their performance to that of other trusts. This paper gives assurance that this important process to strengthen governance, learning and transparency around inpatient death is now well-		

	developed and relatively robustly embedded, and that progress continues to be made in developing ways to disseminate the learning and continue to improve the quality of our care. There is some further work to do to secure both the clinical and the administrative capacity required to robustly meet the on-going demands of this learning from death process.				
Fit with WH strategy:	Working together with families and carers				
Reference to related / other documents:	• "*National guidance on learning from deaths*" (NHS Quality Board, March 2017) available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf • '*Learning, candour and accountability*', Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf • 'Good Medical Practice' (General Medical Council, 2013), available from https://www.gmc-uk.org/-/media/documents/Good_medical_practice___English_1215.pdf_51527435.pdf • 'Learning from deaths – guidance for NHS Trusts on working with bereaved families and carers'. National Quality Board July 2018 https://www.england.nhs.uk/wp-content/uploads/2018/07/learning-from-deaths-working-with-families.pdf				
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on the Trust Quality and Safety Risk Register				
Date paper completed:	17th August 2018				
Author name and title:	**Julie Andrews, Associate 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. Introduction

This is the fourth quarterly report to Trust Board on learning from death. The previous reports came to Trust Board in October 2017, January 2018 and May 2018. These reports describe:

a) How we are performing against our local targets, and national expectations, in reviewing the care of patients who have died whilst in this hospital (inpatient deaths),
b) What learning we are taking from the themes that emerge from these reviews,
c) What actions we are taking both to improve our care of patients and to improve the learning from deaths process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with domain 2 of GMC *Good Medical Practice*, for many years. Following the launch of the NHS Quality Board "*National guidance on learning from deaths*[1]" (March 2017) we introduced a systematised approach to reviewing the care of patients who have died in hospital (individual review then departmental agreement using structured judgement review process). This process formally commenced on 1 April 2017, when Dr Julie Andrews, Associate Medical Director for Patient Safety & Quality Improvement, was appointed as Trust Mortality Lead.

The aims of this process are to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify, and learn from, episodes relating to problems in care;
- Identify, and learn from, notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patients' and carer's wishes were identified and met;
- Enable informed and transparent reporting to the Public Trust Board, with a clear methodology;
- Identify potentially avoidable deaths and ensure these are fully investigated through the serious incident (SI) process, and are clearly and transparently recorded and reported.

2. Potential Avoidability of Death – Judgement Scoring System

The "*National guidance on learning from deaths*[2]" was published in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS services through the review of deaths. A retrospective study across 34 English acute hospital trusts conducted in 2015 estimated that 3% of all deaths in hospital were potentially avoidable[3].

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

[3] Hogan H, Hutchings, A, Black, N et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study, BMJ 2015;351:h3239

The Avoidability of Death Judgement Scoring System (Table 1) was developed by the Royal College of Physicians (RCP) and it is this scoring system that has been adopted by the Trust to conduct Structured Judgement Mortality Reviews by individuals and then reviewed in departments.

Table 1 – Avoidability of Death Judgement Scoring System

Score	Description
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable, more than 50/50
4	Possibly avoidable but not very likely, less than 50/50
5	Slight evidence of avoidability
6	Definitely not avoidable

3. Our performance against our local targets for the proportion of deaths that should be reviewed

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

The Trust has also set an internal target that 90% of all discharge summaries for patients who die in hospital should be completed.

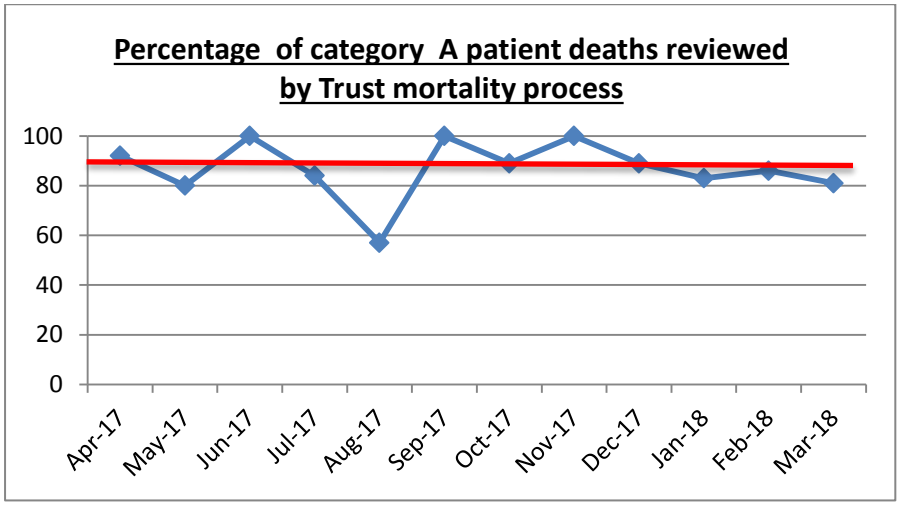
Category A deaths are:

- Deaths where families, carers or staff have raised concerns about the quality of care provision;
- All inpatient deaths of patients with learning disabilities;
- All inpatient deaths of patients with a mental health diagnosis;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall;
- All inpatient paediatric, neonatal and maternal deaths;
- Deaths that are referred to HM Coroner's Office.

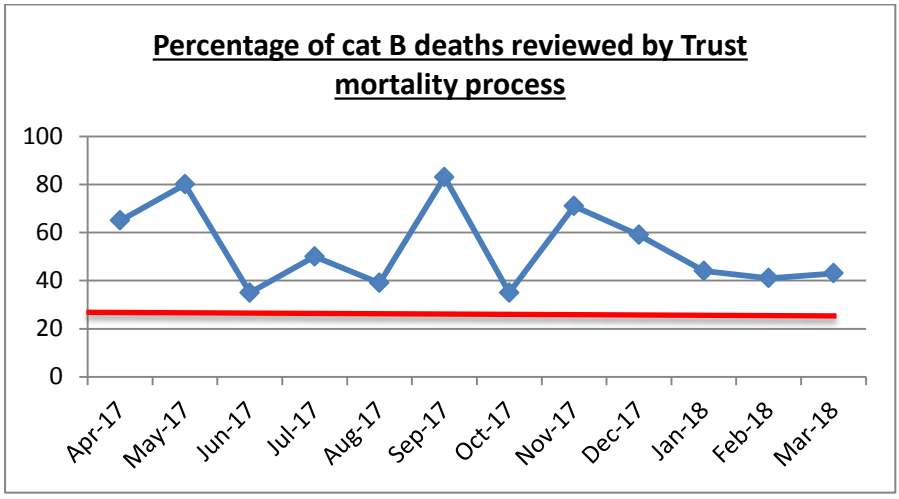
Category B deaths are:

- All deaths of inpatients that do not meet any of the criteria of category A deaths.

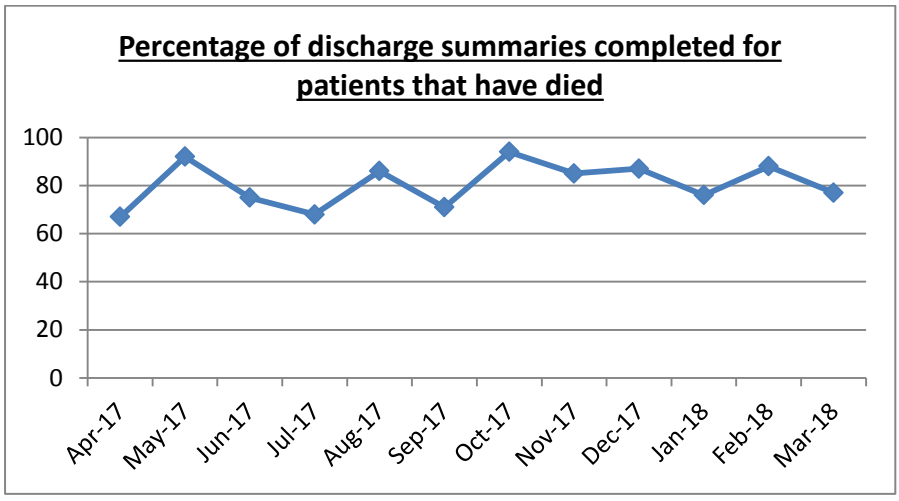
Graph 1: Percentage of 'category A' patient deaths reviewed by Whittington Health (April 2017 – March 2018) (Local Trust target 90%)



Graph 2: Percentage of 'category B' patient deaths reviewed by Whittington Health (April 2017 – March 2018) (Local Trust target 25%)



Graph 3: Percentage of death discharge summaries completed (April 2017 – March 2018) (Local Trust target 90%)



4. NHS Mortality Dashboard

The *National Guidance on Learning from Deaths* gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1. This dashboard shows data from 1 April 2017 until 31 March 2018. The 'last quarter' referred to is Q4 (1 January – 31 March 2018), the 'last month' referred to is February 2018, and 'this month' referred to is March 2018.

There were 162 deaths recorded in Quarter 4. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation. There were 2 potentially avoidable patient deaths recorded in Quarter 4 2017/18 (where potentially avoidable is taken to mean patient deaths with avoidability scores of between 1-3). Both deaths were in general surgical patients and these were investigated as SIs, and the learning from these investigations was shared widely. There was one potentially avoidable death in Quarter 1, one potentially avoidable death in Quarter 2 and none in Quarter 3. In total for 2017/2018 there were four potentially avoidable deaths.

The dashboard shows that in Quarter 4 83 of the 162 patient deaths were reviewed, and this was done using the methodology that has already been described in the April 2017 Trust Board paper "*National Guidance on Learning from Deaths*".

80 patient deaths out of 162 deaths in Quarter 4 (49%) were not systemically reviewed, but the majority of those (73 out of 80) involved category B deaths. Seven category A patient deaths were not reviewed; these were deaths in patients under the following teams; care of the older person (COOP) (3), general surgery (2), gastro (1) and urology (1). Departments are reminded when category A reviews are outstanding but further work is needed and is ongoing to embed the support structures, including administrative support, to ensure that the risk of Quarter 4 category A reviews being overlooked is minimalised.

The dashboard outlines the avoidability of death judgement scores for inpatient deaths and deaths within the Emergency Department in Quarter 4 and this is summarised below, in table 2. There was 1 death in a patient with learning disabilities this quarter which was definitely not avoidable (6). The patient's death has been referred to the LeDer process (national review panel looking at deaths in patients with learning difficulties).

Table 2 – Avoidability of death judgement scores for Quarter 4: 2017/18

Avoidability of death judgement scores (of deaths reviewed)	**Number of patients with each avoidability score**
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable, more than 50/50	2
4 - Possibly avoidable but not very likely, less than 50/50	5
5 - Slight evidence of avoidability	9
6 - Definitely not avoidable	66

5. Themes from Mortality Reviews

i) Key areas for improvement

a) In some clinical areas and teams, improvements are still required in the standard of documentation in the notes to record the degree to which patients have been kept

informed, engaged in shared decision making and given the opportunity to express their wishes.

b) A number of mortality reviews found evidence of medicine safety incidents which had not been reported – two such incidents were found in the reviews of deaths that occurred in Quarter 4, and the level of harm in those two incidents was either low or none.
c) There were five instances when a palliative care referral was not sent early enough in patient care. These have been shared with the EoL Group and on Grand Round focussed events.
d) The mortality review process found 12 instances in which the reviewers felt that there had been delays in investigating the patient, escalating a change in the patient's condition, or making an appropriate referral to another team. In each case the concerns of the reviewers were shared with the relevant clinical departments so that the learning could be appropriately disseminated and discussed.
e) The mortality review process found clear evidence that we are not yet meeting the Trust's internal target that an electronic discharge summary should be completed for at least 90% of inpatients deaths. This is very important to ensure that we meet the needs of the bereaved family and communicate the death appropriately to the General Practitioner and to other relevant involved clinicians. A specific discharge summary group is being set up to address this issue, and other issues relating to discharge summaries.
f) Other similar sized trusts have a defined bereavement service (including a clinical bereavement specialist post, designated medical examiner post and resource for the bereavement office (separating it from mortuary service) for adult patients' carers and families, that provide support and information. Whittington Health does have defined services in Maternity and Community Children (Life Force) that are highly regarded. In the opinion of the EoL Group and the Mortality Leads, the lack of a defined bereavement service for the hospital is a gap within our services at Whittington Health.
g) Now that the mortality review departmental process is fully established, it is clear that there is a need to recognise within Mortality Lead job plans the time needed to act as a lead, as well as ensuring that other reviewers, including trainee doctors and other clinicians, have time for this important work. There is also a need to identify appropriate administrative capacity and time to support both the departmental and Trust mortality review process.

ii) Notable practice

a) As the mortality review process has grown, most teams have developed a focus on using the reviews through existing or new education structures to share learning. This education and learning is generally highly multi-disciplinary, and gives prominence to trainees in leading on the dissemination of learning.
b) Trainee doctors and senior nurses are now being recruited as reviewers – they are bringing very valuable skills and insight to this role, while at the same time being trained in safety and governance processes.
c) There is good evidence of documented patient, family and carer involvement in EoL decision-making by most teams.
d) The reviews have highlighted themes around EoLC that have directly led to a quality improvement project that involves collecting the views of bereaved families. This initiative was launched on 1 July 2018.
e) The trust has improved in linking the learning from mortality reviews to discussions at Grand Rounds and other educational events in order to share learning. An example is the Grand Round of Wednesday 23rd May 2018, at which two trainee doctors

presented the learning from two mortality reviews in which they had played a role as one of the reviewers.

f) We are starting to network with other NHS trusts in sharing learning from the Trust's mortality review processes.
g) Dr Julie Andrews has been asked, in her role as Trust Mortality Lead, to represent London at the NHS Improvement Collaborative.
h) The Trust's mortality review process has led to an improved sharing of expertise between teams. Examples of this are discussion about local improvements in venous thromboembolism (VTE) prevention, earlier planning around patient treatment escalation and earlier referrals to appropriate specialist clinical teams.
i) The Trust's mortality review process is now being formally linked in with other quality and safety governance processes. Examples of this include amendments to refine and improve clinical guidelines (for instance on VTE prevention and palliative care), feeding back to trainee doctors and other staff at the Patient Safety Forum and triangulating with the Complaints/Patient Advice and Liaison (PALs) team and legal team to improve learning and feedback to families.

6. Potentially Avoidable Deaths

In 2016/17 there were probably 7 potentially avoidable deaths; we did not score deaths using a structured judgement scoring system so cannot directly compare data. In 2017/18 we have had 4 potentially avoidable deaths.

7. Summary

This paper provides assurance that we now have a robust mortality review process, and that we meet our local targets in terms of the proportion of inpatient deaths that are being reviewed.

Recent verbal feedback from NHSI (London) suggests acute trusts in the region are managing to review between 10% and 70% of inpatient deaths, so we appear to be clearly at the higher end of this performance range.

This process has highlighted the need to improve our bereavement support to families, and our need to find out more about family and carer experience of EoL care and this has led to the planned quality improvement initiatives that have been described.

Because this has now become a recurrent and permanent process, with a significant workload associated with it, we now need to develop and embed sustainable support for its continuation, both in terms of recognising this work in job plans, and in providing the administrative capacity to support it.

This paper provides the evidence that this process is now established and making a positive and significant contribution to the patient safety culture of this trust.

Appendix 1: NHS England Trust Mortality Dashboard

Whittington Health: Learning from Deaths Dashboard - March 2017-18

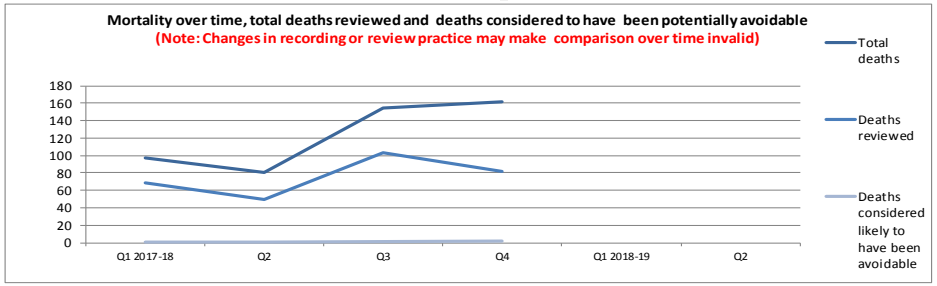
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
60	49	28	26	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
162	155	82	103	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
494	0	304	0	4	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

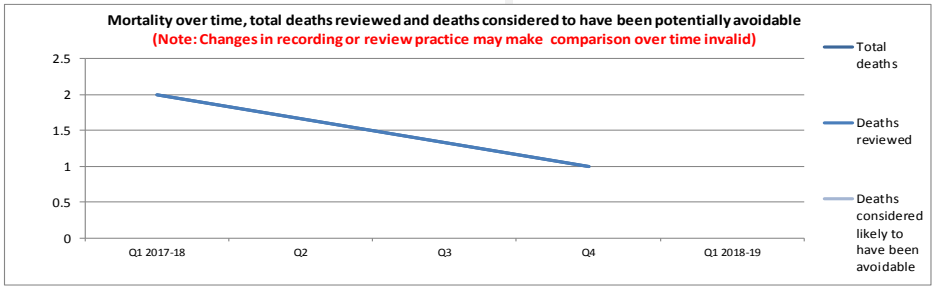
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	7.1%	This Month	2	7.1%	This Month	24	85.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	2.4%	This Quarter (QTD)	5	6.1%	This Quarter (QTD)	10	12.2%	This Quarter (QTD	65	79.3%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	4	1.3%	This Year (YTD)	21	6.9%	This Year (YTD)	31	10.2%	This Year (YTD)	248	81.6%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	1	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	0	3	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Whittington Health
NHS Trust

Trust Board

26th September 2018

Title:	Medical Appraisal and Revalidation: Annual Board Report		
Agenda item:	**18/124**	Paper	**5**
Action requested:	The Board is asked to accept the report. The CEO is asked to approve the 'statement of compliance' (Appendix E) confirming that the organisation, as a designated body, is in compliance with the regulations.		
Executive Summary:	This is the annual Medical Appraisal Board Report in the format suggested by NHS England as part of the quality assurance process for medical appraisal and revalidation. Medical revalidation was introduced in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical system. This report reviews appraisals completed and revalidation recommendations submitted in the financial year 2017/18.		
Summary of recommendations:	The Board is asked to accept the report, which will be shared (along with the Annual Organisational Audit or AOA) with the higher level Responsible Officer for NHS England, London Region. The Board is invited to focus discussion on how we may further strengthen the appraisal process for doctors, and the confidence of our stakeholders and public in this process. The CEO is asked to approve the 'statement of compliance' (Appendix E) confirming that the organisation, as a designated body, is in compliance with the regulations.		
Fit with WH strategy:	This report is a requirement under NHS England Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). It is designed to provide the Board with oversight and assurance of its local medical appraisal and revalidation processes.		
Reference to related / other documents:	Medical Appraisal and Medical Revalidation Policy Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff		

		Maintaining High Professional Standards in the Modern NHS Responsible Officer Regulations					
Date paper completed:		12/09/2018					
Author name and title:		**Ashleigh Soan Medical Director Portfolio Manager** **Rob Sherwin, Associate Medical Director for Revalidation**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

Medical Appraisal and Revalidation: Annual Board Report

September 2018

1. Background

Medical revalidation was introduced in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but was designed as a way to ensure that doctors stay up to date and fit to practice.

All provider organisations known as Designated Bodies have a statutory obligation to support their Responsible Officer in fulfilling his or her duties under the Responsible Officer Regulations[1]. For this reason, this report has been designed to ensure that the Board has oversight of the following areas:

- monitoring the frequency and quality of medical appraisals within the Trust;
- checking there are effective systems in place for monitoring the conduct and performance of the Trust's doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for the Trust's doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work that they perform.

Dr Richard Jennings, the Trust's Executive Medical Director, was appointed to the role of Responsible Officer and has been in post since June 2014.

Mr Robert Sherwin, the Trust's Associate Medical Director for Revalidation, has been in post since 1st February 2016.

2. Terminology

'Revalidation': the process whereby the General Medical Council (GMC) renews a doctor's license to practise every five years, based on a recommendation from the doctor's Responsible Officer.

'Designated body': an organisation recognised by the GMC as responsible for submitting revalidation recommendations. Every designated body must have a Responsible Officer.

'Responsible Officer' (RO): a senior doctor, usually the Medical Director, who is responsible for medical appraisal and revalidation within the organisation and who makes recommendations to the GMC about doctors' fitness to practise. The revalidation recommendations submitted by the RO are considered by the GMC when they make the final decision with regards to a doctor's revalidation. The RO's responsibilities are laid out in the Responsible Officer Regulations, and in additional documents provided by the GMC such as the Responsible Officer Framework.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

'Prescribed Connection': the term used to indicate the link with a doctor and their designated body. The prescribed connection is determined by law in the Responsible Officer Regulations and cannot be chosen, though it can be altered in exceptional circumstances. For doctors in a formal training programme, their prescribed connection is with the relevant region for Health Education England (HEE) that administrates their course. All GPs on performers' lists have a prescribed connection to their Area Team for NHS England. Doctors who only work privately have a prescribed connection to the private organisation for which they do most work, and doctors employed only by an agency will usually have a prescribed connection to that agency. For all other doctors, including those with honorary contracts or on the bank, their prescribed connection is to the organisation for which they do most work, or, in the case of doctors who do an equal amount of work at two different NHS Trusts, to the organisation which is closest to their GMC registered address.

'Medical Appraisal': the evidence to inform revalidation recommendations is based on annual medical appraisals. Medical appraisals are performed by trained appraisers, and include a process whereby the doctor must provide a portfolio of evidence regarding their practice, including six kinds of information which are considered mandatory by the GMC. These should relate to:

1. Continuing Professional Development
2. Quality improvement activity
3. Significant events (including but not limited to Serious Incidents)
4. Colleague feedback (Completed through a formal 360)
5. Patient feedback (Completed through a formal 360)
6. Review of complaints and compliments

Revalidation recommendations

Responsible Officers are only able to submit one of three revalidation recommendations about a doctor to the GMC[2]:

1. ***'Positive recommendation':*** a recommendation from the Responsible Officer to the GMC that in his/her opinion a doctor is up to date, fit to practice, and without unaddressed concerns.

2. ***'Deferral request':*** a request from the Responsible Officer to the GMC to delay a doctor's revalidation submission date to allow for additional information to be considered (for example, if the doctor has not completed a 360 Multi-Source Feedback exercise, or if they are in a local HR process that has not yet come to a conclusion). Deferral of revalidation is neutral and has no impact on a doctor's practice; however, more than one request for deferral of revalidation date for an individual will lead to the GMC requesting further information as to the reasons for the deferral.

3. ***'Recommendation of non-engagement'***: a recommendation of non-engagement is made by the Responsible Officer to the GMC where a doctor is failing to engage with the processes that support revalidation (for example, where a doctor has repeatedly failed to complete an appraisal). A recommendation of non-engagement can be made at any point in the revalidation cycle.

[2] Revalidation Statements, accessible at http://www.gmc-uk.org/doctors/revalidation/12394.asp

3. Prescribed connection and appraisal completion rate

It should be noted that due to the nature of the prescribed connection, which includes doctors on honorary contracts, as well as doctors on short term contracts, these figures fluctuate. For this reason it is expected that the appraisal completion rate will fall short of 100%. At 31st March 2018, there were 262 doctors with a prescribed connection to Whittington Health.

Between 1st April 2017 and 31st March 2018 177 medical appraisals (68%) were completed, between 1st April 2018 and 31st May 2018 a further 27 doctors (10%) completed a late 2017/18 medical appraisal. 47 doctors (18%) had an agreed postponement of appraisal with the RO. 11 doctors are now significantly past their appraisal due dates and the Associate Medical Director for Revalidation is in contact with these doctors to support them to meet their appraisal obligations.

4. Governance Arrangements and Responsibilities

The Responsible Officer is supported by the Associate Medical Director for Revalidation, Medical Director Portfolio Manager and the Project Support Officer. The responsibilities of the Medical Director Portfolio Manager and Project Support Officer include:

- Maintaining the Trust's prescribed connection list on GMC Connect;
- Monitoring revalidation submission dates;
- Responding to revalidation information requests from other organisations on behalf of the Responsible Officer;
- Storing information relating to revalidation recommendations;
- Maintaining and monitoring the annual appraisal list, including providing reminders to doctors that their appraisals are due and escalating missed appraisals appropriately to Clinical Directors and the Responsible Officer;
- Supporting the Clinical Directors in allocating appraisers to the Trust's doctors, and keeping records of appraisal pairings in order to ensure that these are in line with the policy;
- Monitoring the Trust's online Revalidation Management System and liaising with the provider (Equiniti360Clinical) on improvements and development;
- Providing training for doctors with regard to using the online system, as well as more generally about the requirements of appraisal and revalidation;
- Providing refresher training to appraisers;
- Ensuring that Trust-held data on complaints, incidents and registered audit is entered onto the Revalidation Management System;
- Assisting the Director of Postgraduate Medical Education with the completion of the Trainee Revalidation Portal, as required;
- Monitoring new advice from the GMC and NHS England and providing advice on process to individual doctors and to the Responsible Officer as necessary;
- Reviewing and updating the Medical Appraisal Policy in line with new guidance;
- Managing appraisal reporting, including locally to the Responsible Officer, and the completion of quarterly reports to NHS England;
- Completing the Annual Organisational Audit;
- Completing first stage quality assurance audit of annual appraisals.

The responsibilities of the Associate Medical Director for Revalidation include:

- To oversee the medical appraisal process to help ensure that all non-training grade doctors employed by the trust have an annual appraisal.
- With the day to day support of the Medical Director Portfolio Manager and Project Support Officer, to agree a strategy to ensure improvements in the medical appraisal and medical revalidation processes.
- To develop reviews of medical appraisal outputs to ensure the inclusion of all required documentation and to use regular reviews to set a standard for medical appraisals in the trust.
- To offer bespoke advice and support to colleagues who have complex issues around evidencing performance and quality.
- To support the Responsible Officer in ensuring the evidencing of recommendations made to the GMC about the fitness to practice of doctors employed by the trust.
- To oversee the continuous quality review and improvement of training and guidance for trust medical appraisers.
- To assist the Medical Director in overseeing the trust's process for responding to correspondence from the GMC.
- To refer concerns about a doctor to the Responsible Officer (Medical Director) for further investigation and support the Responsible Officer in ensuring that appropriate timely action is taken, in accordance with trust procedures, when a concern is raised about a doctor's performance or conduct.
- To oversee existing processes to ensure that the trust complies with the external reporting related to medical revalidation and medical appraisals.
- To chair appropriate meetings relating to the role.

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports and updates provided by the recruitment team.

5. Medical Appraisal

a) Appraisal and Revalidation Performance Data

As at 31st March 2018 177 appraisals had been completed and a further 27 appraisals were completed late between 1st April 2018 – 31st May 2018. The audit of missed or incomplete appraisals (Appendix A) provides detail on the reasons for those appraisals not completed in the window within which they were due.

Agreed and acceptable reasons for not completing an appraisal may include:

- Maternity leave
- Long-term sickness absence
- Having joined the trust within the previous 6 months
- Absence on agreed sabbaticals or career breaks
- The doctor no longer clinically active and in the process of voluntary self-erasure from the GMC register

Completion of medical appraisals in 2017/18 by grade of doctor (n = 262)

Consultants (n = 186)

- 147 (79%) completed appraisals in line with policy
- 19 (10%) completed appraisals, but were late in doing so
- 14 (8%) did not complete appraisals, but had previously agreed and acceptable reasons for not completing
- 6 (3%) did not complete appraisals and did not have previously agreed or acceptable reason for not completing

Specialty Doctors/Associate Specialists (SASG)/Doctors on Performers Lists (n = 14)

- 12 (86%) completed appraisals in line with policy
- 1 (7%) completed appraisals, but were late in doing so
- 0 did not complete appraisals, but had previously agreed and acceptable reasons for not completing
- 1 (7%) with no previously agreed or acceptable reason for not completing

Trust grade doctors or doctors on short term contracts (including non-training grade junior doctors) (n= 62)

- 18 (29%) completed appraisals in line with policy
- 7 (11%) completed appraisals, but were late in doing so
- 33 (53%) did not complete appraisals, but had previously agreed and acceptable reasons for not completing
- 4 (6%) with no previously agreed or acceptable reason for not completing

Table 1: Appraisals in-line with policy in 2015/16, 2016/17 and 2017/18 by grade of doctor

Appraisals in-line with policy (%)	Consultants	SASG doctors	Trust grade doctors
2015/16	77	77	25
2016/17	90	88	45
2017/18	79	86	29

b) Appraisers

The Trust had 61 active appraisers for the 2017/18 appraisal period (an active appraiser is defined as having performed at least one appraisal in the year). This represents approximately one third of the total number of consultants with a prescribed connection. All appraisers have received revalidation-ready training from approved external providers.

Appraiser feedback 2017/18

Following each completed appraisal doctors are invited to complete a short survey to give feedback to their appraiser. All appraisers are provided with an anonymised copy of their feedback at the end of each appraisal year to include in their own appraisals. Table 2 below shows the feedback received for all of our appraisers for the period 10th May 2017 to 10th July 2018:

Table 2: Appraiser feedback 2017/18

Area	Unable to comment	Poor	Borderline	Satisfactory	Good	Very Good
Establishing rapport	0	0	0	1	30	193
Demonstrating thorough preparation for your appraisal	0	0	0	4	25	189
Listening to you and giving you time to talk	0	0	0	0	28	187
Giving constructive and helpful feedback	0	0	0	2	44	173
Supporting you	0	0	0	1	38	189
Challenging you	0	1	1	4	65	149
Helping you to review your practice	0	0	0	5	45	170
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	0	0	0	5	44	168
Helping you to review your progress against your Personal Development Plan (PDP)	0	0	0	3	39	189
Helping you to produce a new PDP that reflects your development needs	0	0	0	1	33	184

The written feedback received about medical appraisals has been exceedingly positive. This list provides examples of anonymous written feedback received for medical appraisers in 2017/18

"*I really enjoy my yearly appraisals. It really helps to discuss, get advice and reassurance for my plans for the year. Very motivating and useful. Thank you*"

"*Thank you for a useful, detailed yet efficient appraisal process*."

"*Good feedback given. Helpful information provided regarding further professional development*."

"*The level of professionalism displayed and the support given by my appraiser I found to be exemplary*."

"*This has been the most valuable appraisal I have had so far. I was challenged, listened to, encouraged to improve on what I have already achieved and I am grateful to my appraiser for taking the time to do this.*"

"*A very fair appraiser who has encouraged me to improve myself in several appropriate areas. Many thanks*."

"*I was very lucky to have such an excellent and helpful appraiser*"

"*My appraiser was well - prepared for the appraisal and was very familiar with my supporting documentation, despite being from a different specialty. He was a good listener and was supportive and empathic to my personal work situation.*"

"She was really supportive, caring and professional. She helped me to show the things I have done in a clear way and she high lightened the areas that need improvement so that I can complete them in the next year, like attending some useful courses."

"*He had read my documentation thoroughly which meant that the appraisal was personal and individualised….He manages to take a good overall view and pinpointed the main areas for progress. I found this a stimulating and motivating appraisal."*

"…approachable, always supportive and I just want to thank her for going through my appraisal with me."

"*Really made me think about my work and provided useful advice which I shall be taking forward."*

Table 3: Appraiser feedback received in 2015/16, 2016/17 and 2017/18

Area	2015/16 (%)			2016/17 (%)			2017/18 (%)		
	Satisfactory	Good	Very Good	Satisfactory	Good	Very Good	Satisfactory	Good	Very Good
Establishing rapport	2	19	79	1	17	82	0	13	86
Demonstrating through preparation for your appraisal	2	23	74	3	13	84	2	11	87
Listening to you and giving you time to talk	2	18	80	3	17	80	0	13	87
Giving constructive and helpful feedback	3	22	74	2	19	79	1	20	79
Supporting you	3	21	74	2	17	80	0	18	82
Challenging you	4	31	64	4	28	68	2	30	68
Helping you to review your practice	3	28	68	2	27	71	2	20	77
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	4	30	64	3	25	71	23	20	77
Helping you to review your progress against your PDP	3	28	68	2	18	80	1	17	82
Helping you to produce a new PDP that reflects your development needs	2	26	71	2	22	75	0	15	84

c) Quality Assurance

Quality assurance of appraisals

Individual appraisal portfolios and output documents are reviewed at two stages.

Firstly, an audit is conducted by the RO's team of completed appraisals following the completion of the appraisal cycle. For the most recent appraisal cycle (2017/18), the audit was conducted through a peer review with two neighbouring trusts: Homerton University Hospital NHS Foundation Trust (HUH) and North Middlesex Hospital NHS Trust (NMUH). This is the first peer review that we have conducted around medical appraisals.

This peer review was conducted using an adapted version of the NHS England Appraisal Summary and PDP Audit Tool Template (ASPAT) (Appendix C) that the three trusts agreed. We redacted 24 appraisal summaries and PDPs of appraisals conducted by 24 different appraisers in 2017/18 appraisal year; 12 were given to HUH to score and 12 to NMUH to score. When the initial scores had been compiled the representatives for each trust met to review the scores, ensure that the same reasoning had been used in the scoring process, and to discuss learning and feedback.

The summary results of this peer review audit are encouraging (table 4), but there are specific areas where the trust will need to develop, including:

- the inclusion of mandatory training in medical appraisal;
- the inclusion of objective prose statements by the appraiser in the appraisal summary about the quality of the supporting information;
- the inclusion of a statement by the appraiser in the appraisal summary to describe the doctor's progress towards being prepared for revalidation;
- the inclusion within the appraisal summary of reasons for not completing any agree Personal Development Plan (PDP) actions.

The full results of this audit are included in Appendix B.

Table 4: Average scores received for the Peer Review Audit for appraisals completed in 2017/18

Trust	Average score for section 1: Setting the scene (out of 16)	Average score for section 2: reflection and effective learning (out of 6)	Average score for section 3: The PDP and developmental progress (out of 16)	Average score for section 4: General standards and revalidation readiness (out of 8)	Overall score (out of 46)
WH	10	5	12	7	34
NMUH	7	3	11	6	28
HUH	11	4	12	6	33

An individual doctor's appraisal output documents and some key pieces of evidence from the appraisal portfolio are always reviewed by the Responsible Officer and a member of his team prior to a revalidation recommendation being made.

Quality assurance for appraisers

All Trust appraisers have undertaken revalidation-ready training in order to provide a level of assurance that they have the skills and knowledge appropriate for the role. In addition, the Trust collects anonymous feedback on individual appraisers via the online Revalidation Management System; this feedback is collated by the RO's team and provided to individual appraisers so that they can reflect on it at their own appraisal. In cases where an appraiser consistently scores very low in a number of areas, where multiple doctors have requested not to be appraised by one individual, or where audits have identified substandard appraisals conducted by one appraiser, the RO's team will escalate this to the Responsible Officer and this appraiser may be asked to undertake further training. The Trust also keeps records of appraiser attendance at refresher training events which can be used in the appraiser's portfolio as evidence of ongoing professional development.

Higher Level Responsible Officer visit

On the 13th December 2017 the Trust was visited by a team who were acting on behalf of the Higher Level Responsible Officer (HLRO) Dr Vin Diwakar, to provide him with assurance that the RO and designated body has appraisal and revalidation systems and processes in place in keeping with '*The Medical Profession (Responsible Officers) Regulations 2010, Amendments 2013'*. The visit was also to highlight good practice, to identify areas for development and to provide the RO with support and advice on any revalidation issues.

Examples of good practice

- "*The responsible officer Dr Jennings had developed the appraisal and revalidation systems and processes since his appointment as responsible officer in 2014. He has a firm understanding of appraisal and revalidation and provides good leadership to their doctors. The RO was also the Medical Director and provided the Trust Management Board with regular updates and an Annual Medical Revalidation Report. He was well supported by experienced administrative staff who managed the appraisal and revalidation processes*."

- "*The revalidation team had a good working relationship with the HR Manager & Medical HR Specialists, who advised on HR matters, practice, checks on new doctors, bank and agency staff and any fitness to practice concerns*."

- "*The organisation reported an improved system of uploading complaints and SIs into doctors' portfolios from PALS, Datix and quality records*."

- "*The Revalidation Group met regularly, had Terms of Reference and records were kept of RO decisions*."

- "*The Medical Directorate Portfolio Manager and Lead Appraiser will work with North Middlesex Hospital, Homerton to peer review 10% of their appraisals using the ASPAT tool*."

Suggested areas for development

- "*NHS England London recommends that the RO consider the membership of the Revalidation Decision Making Group to potentially include lay representation and/or non-executive members to provide an external oversight and an audit trail of governance and decisions*."

- "*NHS England London recommends that the RO review the appraisal and revalidation information held and collected by the organisation for: all doctors who work at the Trust, locums, hold honorary contracts with the Trust and those who work at the Trust but are connected to another designated body/RO*."

- "*NHS England London recommends the RO sets out a plan to increase the overall appraisal rate for doctors from its current rate (31/3/2017) of 85% to the same sector national average in England of 90% or above*."

- "*NHS England London recommends the RO reduce the number of incomplete/missed appraisals of temporary or short-term doctors*."

- "*NHS England London recommends the Revalidation Medical Appraisal and Revalidation Decision Making Group consider the process for using GMC REV 6 forms as appropriate."*

- "*NHS England London recommends the RO and Lead Appraiser establish an Appraiser Forum to facilitate the sharing of good appraisal practice, to calibrate decision and to keep appraisers up-to-date with policies and procedures. The Appraiser Forum to meet regularly, e.g. twice yearly*."

- "*NHS England London recommends the organisation review the feedback it provides to locum agencies regarding the locum doctors' placement.*"

- "*NHS England London recommends that the RO review with the Serious Incident Executive Approval Group (SIEAG) that all clinicians named in SI reports have the SI and Datix number linked and cross referenced."*

- "*NHS England London recommends the RO consider how positive stories of appraisal that have improved patient care can be shared*."

d) Access, security and confidentiality

In line with the GMC requirement that all medical appraisals be performed electronically, the Trust uses the Revalidation Management System (RMS) provided by software company Equiniti. The system is part of the G-cloud programme, which provides a very high level of data security and assurance. A doctor's appraiser only has access to the appraiser's portfolio once it has been submitted to them, and loses access once the appraisal is signed off. The Responsible Officer has access to a doctor's information in order to be able to make revalidation recommendations, and the RO's team have administrative access in order to be able to provide IT and technical support, as well as conducting audits.

e) Clinical Governance Data

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and compliments;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

This data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

This year we have also been able to provide surgical activity for all operating clinicians.

6. Revalidation Recommendations

The audit of revalidation recommendations (Appendix D) details recommendations made for the year 1st April 2017 to 31st March 2018. Since revalidation was introduced in November 2012 to 7th September 2018, the Trust has made 386 recommendations for doctors with a prescribed connection to the Whittington, of which 247 were positive recommendations, and 139 were requests for deferrals. So far there have not been any recommendations of non-engagement.

Between the 1st April 2017 and 31st March 2018 the Trust has made 15 positive recommendations, and 11 doctors had their revalidation dates deferred pending further information, for 4 of these doctors this was due to their being in a formal MHPS process.

In this time period no recommendations were submitted later than the requested submission dates; this is an improvement on 2016/17 where 4 recommendations were submitted later than the requested dates. This improvement has been largely due to the implementation of the Medical Appraisal and Revalidation Decision Group who review revalidation recommendations up to 4 months in advance.

7. Recruitment and engagement background checks

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- Criminal records checks and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK, where this is necessary
- Verification of license to practice and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

With regard to doctors working at the Trust via an agency, the Trust has framework agency agreements which are used to secure the majority of agency bookings for medical staff. However, when the trust uses non-framework agencies, where there is no such agreement, there is no assurance that the agency is following NHS mandated recruitment standards.

8. Responding to Concerns and Remediation

The Trust has a local policy for '*Conduct, Performance and Ill-Health Procedures for Medical and Dental staff*'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the

national framework 'Maintaining High Professional Standards in the Modern NHS'[3] and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

11. Action Planning and Next Steps

Table 5: Agreed actions for 2017/18

Action	Progress
Work with educational supervisors to offer appraisal for all newly-appointed trust grade doctors; thereby reducing the number of late appraisals due to 'new starter more than 3 months from appraisal due date (within 6 months)' (see appendix A).	All trust grade doctors are assigned an appraiser at the start of the appraisal season. We are arranging meetings with trust grade doctors individually to go through the appraisal and revalidation process.
We will focus on the incorporation of surgical volume data for operating clinicians and anaesthetists. This will allow appraisal discussions regarding outcomes and complications. We will endeavour to work with colleagues in Theatres and other service areas to provide this information for Consultants and other grades.	This has been completed for 2018/19 and surgical volume data was added to appraisal portfolios.
Work with Clinical Directors to implement formal recognition of medical appraiser roles in individual doctor's job plans. We will also work with Clinical Directors to develop a selection process for medical appraisers.	The medical appraiser role has been included in the trust's Job Planning Toolkit. However, work around departmental planning and ensuring that this is included within individual job plans is on-going.
Complete a benchmarking exercise with two other local trusts to identify areas for further development.	This has been completed.

For 2018/19 we are focussing on the areas for review identified by the Higher Level Responsible Officer

- "*Ensure that we have a lay or public representation on the Medical Appraisal and Revalidation Decision Making Group.*" This has been acted upon and Non-Executive Director Yua Haw Yoe is now a member of the Medical Appraisal and Revalidation Decision Making Group.

[3] Department of Health, *Maintaining High Professional Standards in the Modern NHS*, accessible at http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

- "*Hold twice yearly Appraiser Forum for our medical appraisers*." This has been acted upon and the first of these forums will be held on the 12th October 2018.

- "*Increase appraisal rates for Trust Grade Doctors*". The Medical Directorate Portfolio Manager is holding meetings with Trust Grade Doctors to assist them in preparing for appraisal and revalidation.

- "*Publicise Appraisal and Revalidation on the trust's extranet to increase public awareness of the processes*." We are in the process of discussing the best approach to this with our Communications Department.

- "*Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation*." We are considering approaches to this issue.

11. Recommendations

The Board is asked to accept the report, which will be shared (along with the Annual Organisational Audit or AOA) with the higher level Responsible Officer for NHS England, London Region.

The CEO is asked to approve the 'statement of compliance' (Appendix E) confirming that the organisation, as a designated body, is in compliance with the regulations.

Medical Appraisal Annual Board Report Appendix A - Audit of all missed or incomplete appraisals audit

Please note that this relates only to doctors due for an appraisal within the year 1st April 2017 – 31st March 2018

Acceptable or not acceptable	**Doctor factors (total)**	
Acceptable	Maternity leave during the majority of the 'appraisal due window'	6
Acceptable	Career break during the majority of the 'appraisal due window'	2
Acceptable	Sickness absence during the majority of the 'appraisal due window'	0
Acceptable	Prolonged leave during the majority of the 'appraisal due window'	0
Acceptable	Exclusion during the majority of the 'appraisal due window'	0
Acceptable	New starter within 3 month of appraisal due date	20
Acceptable	New starter more than 3 months from appraisal due date (within 6 months)	13
Acceptable	Other doctor factors: Doctor was no longer practicing and was in the process of applying for voluntary removal from the GMC register	1
Unacceptable	Postponed due to incomplete portfolio/insufficient supporting information	1
Unacceptable	Appraisal outputs not signed off by doctor within 28 days	0
Unacceptable	Doctor cited insufficient time and capacity	1
Unacceptable	Lack of engagement of doctor*	9
	Appraiser factors (total)	
	Unplanned absence of appraiser	0
	Appraisal outputs not signed off by appraiser within 28 days	0
	Lack of time of appraiser	0
	Other appraiser factors (describe): Organising a joint NHS and academic appraisal	1
	Organisational factors (total)	
	Administration or management factors – Requirement to change appraiser	0
	Failure of electronic information systems	0
	Insufficient numbers of trained appraisers	0
	Other organisational factors (describe)	0

Medical Appraisal Annual Board Report Appendix B – External peer review audit conducted with North Middlesex Hospital NHS Trust and Homerton University Hospital NHS Foundation Trust

Scale: 0 = No evidence, 1 = Limited evidence / does not meet requirements, 2= Good evidence / Meets requirements

Reference number for the appraiser who conducted the appraisal reviewed	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**Average**
Section 1																									
1.1 There is a **summary** of the doctor's scope of work	1	0	0	2	0	1	0	2	0	0	2	1	2	2	1	2	2	1	2	2	2	2	2	2	1.29
1.2 There is documentation of whether or not the supporting information covers the **whole scope of work**	1	0	0	2	0	1	0	1	0	0	2	1	2	2	1	2	2	1	2	2	2	2	2	2	1.25
1.3 Specific supporting information is summarised with a description of what it demonstrates	1	0	2	2	2	1	2	2	0	0	2	2	2	2	1	2	2	1	2	2	2	2	2	2	1.58
1.4 The appraiser's summary includes **objective statements** about the **quality** of the supporting information provided	0	0	0	0	0	0	0	1	0	0	0	0	2	2	0	2	2	1	2	2	2	2	2	2	0.91
1.5 **All** statements made by the appraiser are supported by evidence	2	1	1	2	2	1	2	2	1	0	2	1	2	2	1	2	2	1	2	2	2	2	2	2	1.63
1.6 There is **reference to the four GMC domains** as set out in the GMC guidance *Good Medical Practice Framework for Appraisal and Revalidation*	2	2	2	2	2	2	2	2	1	0	2	2	2	2	1	2	2	1	2	2	2	2	2	2	1.80
1.7 There is reference to **specialty specific guidance** for appraisal (e.g. college recommendations for CPD)	0	0	0	1	1	0	2	2	0	0	2	1	2	2	2	2	2	1	2	1	2	2	2	2	1.30
1.8 There is reference to the doctor's **mandatory training status**	0	0	0	0	0	0	0	2	0	0	0	2	0	0	0	2	0	0	2	0	2	0	2	2	0.58
Section 2																									
2.9 There is evidence that **reflection on learning** has taken place, or that the appraiser has discussed how the doctor should document their reflection	2	0	0	2	0	2	0	2	1	0	2	0	2	2	2	2	2	2	2	2	2	2	2	2	1.45

2.10 There is evidence that **learning has been shared with colleagues** or that the appraiser has discussed with the doctor that learning should be shared with colleagues	1	0	2	2	0	0	2	2	1	0	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1.58
2.11 There is evidence of the doctor having put measures in place to **improve patient care or of him/her changing his/her clinical practice** to improve patient care, or that the appraiser has discussed this with the doctor	2	1	2	2	2	1	2	2	2	0	2	2	2	2	2	2	2	2	2	1	2	2	2	2	1.79
Section 3																									
3.12 There is a **summary** of the doctor's achievements over the last year	2	1	1	0	0	2	2	2	2	0	2	2	2	2	2	2	2	1	2	2	2	2	2	2	1.62
3.13 There is evidence of **appropriate challenge** from the appraiser in the discussion and formation of the new PDP	0	0	2	0	2	2	2	2	1	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	1.67
3.14 The progress against last year's PDP is **recorded**	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	1.96
3.15 **Reasons for incompletion** are recorded for any PDP points that were not completed	2	2	2	2	2	2	2	0	2	2	2	2	0	0	0	0	0	0	0	0	0	2	0	0	1.00
3.16 There are **clear links** between the summary of discussion and the doctor's new PDP	2	2	1	0	2	2	2	2	0	0	2	2	2	2	2	2	2	1	2	2	1	2	2	2	1.63
3.17 The PDP has **SMART** objectives	2	1	2	1	2	2	2	2	2	2	2	2	0	2	2	2	2	0	2	2	1	2	1	1	1.63
3.18 The **PDP** covers the doctor's **whole scope of work**	2	0	0	2	0	1	0	2	0	0	2	1	2	2	2	2	2	0	2	2	1	2	1	1	1.21
3.19 The **PDP** contains between **3-6 items**	2	2	2	0	1	2	2	2	2	2	2	2	2	2	2	2	2	0	2	0	0	2	2	2	1.63
Section 4																									
4.20 The documentation is typed in **clear and fluent English** and is electronically and retrievably stored	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.00
4.21 There is evidence regarding the doctor's **progress towards**	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	2	2	0	2	2	2	0	0	2	0.63

revalidation and outstanding supporting information or requirements have been discussed with the doctor																										
4.22 The appraiser has made **appraisal statement** (including about fitness to practice)	2	2	2	2	2	2	2	2	2	2	2	2	0	2	2	2	2	1	2	2	2	2	2	2	1.88
4.23 The appraiser and doctor have both reviewed and agreed to the appraisal summary	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.00
Total	**32**	**20**	**27**	**30**	**26**	**30**	**33**	**40**	**23**	**16**	**40**	**35**	**36**	**42**	**33**	**44**	**42**	**22**	**44**	**38**	**39**	**42**	**40**	**42**	**34**

Amended ASPAT tool for Homerton, North Mid and Whittington medical appraisal peer review 2018

Appraiser's name	
Date of appraisal	
Organisation	
Auditor	
Auditor's organisation	
Date of audit	

Scale:

0 – No evidence

1 – Limited evidence / Doesn't meet requirements

2 – Good evidence / Meets requirements

Section 1: Setting the scene		**Score (out of 2)**
1.	There is a **summary** of the doctor's scope of work	
2.	There is documentation of whether or not the supporting information covers the **whole scope of work**	
3.	Specific supporting information is summarised with a description of what it demonstrates	
4.	The appraiser's summary includes **objective statements** about the **quality** of the supporting information provided	
5.	**All** statements made by the appraiser are supported by evidence	
6.	There is **reference to the four GMC domains** as set out in the GMC guidance *Good Medical Practice Framework for Appraisal and Revalidation*	
7.	There is reference to **specialty specific guidance** for appraisal (e.g. college recommendations for CPD).	
8.	There is reference to the doctor's **mandatory training status**	

Section 2: Reflection and effective learning		**Score (out of 2)**
9.	There is evidence that **reflection on learning** has taken place, or that the appraiser has discussed how the doctor should document their reflection	
10.	There is evidence that **learning has been shared with colleagues** or that the appraiser has discussed with the doctor that learning should be shared with colleagues	
11.	There is evidence of the doctor having put measures in place to **improve patient care or of him/her changing his/her clinical practice** to improve patient care, or that the appraiser has discussed this with the doctor	

Section 3: The PDP and developmental progress		Score (out of 2)
12.	There is a **summary** of the doctor's achievements over the last year	
13.	There is evidence of **appropriate challenge** from the appraiser in the discussion and formation of the new PDP	
14.	The progress against last year's PDP is **recorded**	
15.	**Reasons for incompletion** are recorded for any PDP points that were not completed	
16.	There are **clear links** between the summary of discussion and the doctor's new PDP	
17.	The PDP has **SMART** objectives	
18.	The **PDP** covers the doctor's **whole scope of work**	
19.	The **PDP** contains between **3-6 items**	

Section 4: General standards and revalidation readiness		
20.	The documentation is typed in **clear and fluent English** and is electronically and retrievably stored	
21.	There is evidence regarding the doctor's **progress towards revalidation** and outstanding supporting information or requirements have been discussed with the doctor	
22.	The appraiser has made **appraisal statement** (including about fitness to practice)	
23.	The appraiser and doctor have both reviewed and agreed to the appraisal summary	

Score out of 46	

Medical Appraisal Annual Board Report Appendix D - Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	26
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**26**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	**26**

Employment relation cases concerning the Trust's medical & dental staff for the period 1st April 2015 – 31st March 2018

The purpose of this paper is to provide a numerical breakdown of the employment relations casework relating to the Trust's Medical & Dental staff. This is in accordance with the requirement under the NHS England Annual Organisational Audit and the Trust Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff, to provide this information to the Trust Board. Please note this information is based on all cases notified and managed by Medical HR.

1. Number of formal cases by grade

	2015/16	2016/17	2017/18
Consultant	10 cases involving 7 consultants	5	5
SASG*	1	0	0
GPs	0	0	0
Dentists	0	1	1
Trainee Doctors	1	1	0
Total	9	7	6

2. Number of informal cases by grade

	2015/16	2016/17	2017/18
Consultant	3	1	1 case involving 2 consultants
SASG*	0	0	0
GPs	0	0	0
Dentists	1	0	0
Trainee Doctors	0	0	0
Total	4	1	0

3. Number of medical & dental staff excluded by grade

	2015/16	2016/17	2017/18
Consultant	0	0	0
SASG*	0	0	0
GPs	0	0	0
Dentists	0	0	0
Trainee Doctors	1	1	0
Total	1	1	0

4. Number of medical & dental staff restricted from clinical practice or with restrictions on their clinical practice but not excluded from work.

	2015/16	2016/17	2017/18
Consultant	1	3	2
SASG*	0	0	0
GPs	0	0	0
Dentists	0	0	0
Trainee Doctors	0	1	0
Total	1	4	2

*SASG: Includes all doctors in the following grades: Associate Specialist, Specialty Doctor, Staff Grade & Trust Grade

Designated Body Statement of Compliance

The board/executive management team of Whittington Health has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[4] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: Yes

[4]Doctors with a prescribed connection to the designated body on the date of reporting.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[5] have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: Signed: _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date:

[5]Doctors with a prescribed connection to the designated body on the date of reporting.

Medical Appraisal Annual Board Report Appendix G – Appraisal Summary and PDP Audit Tool Template (ASPAT)

NHS England

Appraisal Summary and PDP Audit Tool Template

Appraiser identifier	Click here to enter text.
Doctor identifier	Click here to enter text.
Date of appraisal	Click here to enter a date.
Organisation	Click here to enter text.
Auditor (usually the senior appraiser)	Click here to enter text.

Scale:
0 Unsatisfactory
1 Needs improvement
2 Good

Score each item out of two

1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	Choose an item.
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	Choose an item.
c) There is documentation of whether the supporting information covers the whole scope of work	Choose an item.
d) Specific evidence is summarised with a description of what it demonstrates	Choose an item.
e) Objective statements about the quality of the evidence are documented	Choose an item.
f) All statements made by the appraiser are supported by evidence	Choose an item.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance *Good medical practice framework for appraisal and revalidation*	Choose an item.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	Choose an item.
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/)

Comments: Click here to enter text.

1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the doctor should document their reflection	Choose an item.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	Choose an item.
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	Choose an item.
Comments: Click here to enter text.	

1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	Choose an item.
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	Choose an item.
c) The completion (or not) of last year's PDP is recorded	Choose an item.
d) Reasons why any PDP learning needs that were not followed through are stated *(if the PDP was completed then score 2)*	Choose an item.
e) There are clear links between the summary of discussion and the agreed PDP	Choose an item.
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	Choose an item.
g) The PDP covers the doctor's whole scope of work and personal learning needs and goals	Choose an item.

h) The PDP contains between 3-6 items	Choose an item.
Comments: Click here to enter text.	

1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	Choose an item.
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	Choose an item.
c) The stage of the revalidation cycle is commented on	Choose an item.
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	Choose an item.
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given *(if signed off score 2)*	Choose an item.
Comments: Click here to enter text.	

TOTAL SCORE (OUT OF 50)	Click here to enter text.

General comments from the senior appraiser:

Click here to enter text.

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

The Medical Appraisal and Revalidation Decision Group

Terms of Reference

Version 0.3 10.05.2018

1. Authority and Scope

1.1 The Medical Appraisal and Revalidation Decision Group has been established by the executive authority of the Executive Medical Director.
1.2 The Medical Appraisal and Revalidation Decision Group shall meet no fewer than 10 times per year.
1.3 The Group is authorised by the Executive Medical Director to act within its terms of reference and to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation by the General Medical Council (GMC).
1.4 The revalidation recommendation is made by the Trust's Responsible Officer and the Responsible Officer is not obliged to take the advice of the Medical Appraisal and Revalidation Decision Group.
1.5 The Group is authorised by the Executive Medical Director to obtain such internal information as is necessary to exercise its functions and discharge its duties.

2. Membership

2.1 The Group will be chaired by the trust's Associate Medical Director for Revalidation and administered by the Medical Director Portfolio Manager or appropriate nominated officer.
2.2 The Group will comprise of the Medical Staffing Manager, Head of Integrated Risk Management, Responsible Officer, Executive Medical Director, Medical Director Project Officer, Associate Medical Director for Patient Safety, and Non-Executive Director as a lay member.
2.3 If the Medical Staffing Manager and Head of Integrated Risk Management are not able to attend meetings then a summary document detailing the relevant information for each individual doctor may be sent to the Chair in advance of the meeting.
2.4 The Responsible Officer, Executive Medical Director, and Medical Director Project Officer are members of the Group, but attendance by these members or their nominated officers is not required for the Group to be quorate.

3. Purpose and role

3.1 The purpose of the Group is to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation to the GMC.
3.2 The Group will provide scrutiny of the medical appraisal documentation and information from Trust governance and risk systems to inform the recommendations made to the Responsible Officer.

3.3 The Group will make one of three recommendations to the Responsible Officer for each individual doctor linked to the Trust for the purposes of revalidation. The three recommendations the Group can make are: revalidate, defer, or non-engagement.

3.4 A recommendation by the Group that a doctor should be positively recommended for revalidation will act to provide the Responsible Officer with assurance that all information required by the GMC has been appropriately considered and is deemed by the Group to be sufficient for a positive revalidation recommendation to be made by the Responsible Officer.

4. Duties

4.1 Ahead of the meeting a list of all medical doctors to be considered will be circulated to members. Members of the Group are required to review and interrogate all relevant information in their area of expertise for all doctors to be considered at the meeting. Members are required to bring summary information for each doctor to the meetings.

4.2 The Head of Integrated Risk Management is required to review information from the Trust's risk management systems and information highlighted to them through patient safety.

4.3 The Medical Staffing Manager is required to review information all employee relation and human resourcing matters.

4.4 The Associate Medical Director for Patient Safety will bring to the attention of the group patient safety concerns relating to the practice of doctors considered.

4.5 The Associate Medical Director for Revalidation is required to review appraisal output documentation, colleague and patient feedback and external information received or sent by the trust relating to the doctor (e.g. correspondence with other employers, correspondence from the GMC).

4.6 The Group will decide on the recommendation to make to the Responsible Officer for each doctor considered by the Group. If a consensus between members cannot be reached then the Chair will decide on the recommendation.

4.7 The Group will ensure a completed summary form (Appendix A) is made available to the Responsible Officer in good time to ensure that revalidation recommendations can be submitted to the GMC.

5. Review

5.1 The terms of reference of the Group will be reviewed annually by the Trust's Executive Medical Director.

Whittington Health Trust Board

26th September 2018

Whittington Health NHS Trust

Title:	**End of Life Care (Opiate Prescribing report)**		
Agenda item:	**18/125**	**Paper**	**6**
Action requested:	The Board is asked to decide whether it agrees that sufficient assurances are currently in place, and to discuss and suggest anyways of strengthening the improvement initiative actions.		
Executive Summary:	The Report of the Gosport Independent Panel, chaired by The Right Reverend James Jones KBE, into events at Gosport War Memorial Hospital was published in June 2018[i]. It highlights the failings of the NHS and other organisations resulting in the hastened deaths of at least 456 patients while in the hospital over a ten-year period from 1991. These events have had the potential to understandably damage public confidence in the quality of end of life care nationally. This trust has responded by reviewing the assurances currently in place that can assure the board, our stakeholders, and our patients and families about the quality of end of life care, and in particular of opioid prescribing and use, within the trust. This paper sets out the background to this issue, those assurances, and the improvement initiatives that we are currently taking to further strengthen the quality and safety of our end of life care.		
Summary of recommendations:	In addition to the action requested above, the Board is invited to discuss ways in which we might further strengthen the confidence of all our staff, patients and relatives to speak up if they have questions or concerns about any aspect of end of life care in general or in any particular instance. The recommended actions listed at the end of this paper will be monitored through the trust's End of Life Care Board and the trust's Medicines Safety Group which report into the Quality Committee via the Patient Experience and Patient Safety Committees respectively.		
Fit with WH strategy:			
Reference to related / other documents:	Gosport Independent Panel Report, available from https://www.gosportpanel.independent.gov.uk/panel-report/		
Date paper completed:	18.09.2018		

Author name and title:	**Anna Gorringe, Consultant Physician Palliative Medicine Richard Jennings, Executive Medical Director**			**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

End of life care at Whittington Health; quality assurances and improvement initiatives

Background; the report of the Gosport Independent Panel

The Report of the Gosport Independent Panel, chaired by The Right Reverend James Jones KBE, into events at Gosport War Memorial Hospital was published in June 2018[ii]. It highlights the failings of the NHS and other organisations resulting in the hastened deaths of at least 456 patients while in the hospital over a ten-year period from 1991. The report describes a period of time at the hospital where there was a disregard for human life and a culture of shortening the lives of a large number of patients by prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified. In particular, inappropriate doses of opioids were prescribed. Concerns raised by nursing staff and patient's relatives were repeatedly and brusquely dismissed. Organisations including the NHS, the police, civil service, General Medical Council, Crown Prosecution Service, Nursing and Midwifery Council and the local MP failed to recognise or prevent these events. The panel report suggests each organisation acted in its own interests and those of its leaders, motivated by reputation management, career self-preservation and taking the path of least resistance.

Implications for providers currently providing end of life care, in relation to assurance and public confidence

Events in Gosport understandably have the potential to shake public confidence in the quality of treatment, and end of life care in particular, provided by the NHS. The report of the Gosport Independent Panel follows high-profile confidence-damaging issues including the Harold Shipman Inquiry and the withdrawal of the Liverpool Care Pathway. The events at Gosport therefore have the potential to have a significant impact on the public confidence in end of life care as it is currently delivered throughout the NHS.

This trust has chosen to respond by reviewing the assurances currently in place that can assure the board, our stakeholders, and our patients and families about the quality of end of life care, and in particular of opioid prescribing and use, within the trust.

The key messages that all providers of end of life care should put to their stakeholders and their public in order to maintain public confidence are that the events at Gosport clearly do not represent good practice, but that appropriate use of opioids and syringe drivers at the end of life are an essential part of good symptom control and do not hasten death. Correct opioid use, at the end of life, does not shorten life. This is confirmed by the Association for Palliative Medicine Position Statement on the use of opioids[iii].

Assurances currently in place at Whittington Health regarding the safety and quality of end of life care

The Gosport Review has prompted Whittington Health to carry out a review of our symptom control and end of life care practice at Whittington Health. Whittington Health has been represented at PallE8, the network of palliative care specialists for North East and North Central London. The list of assurances and actions in this board paper are in line with discussion at this forum. This section lists the various means through which we can be assured that our end of life care practice is safe and that patients and families are receiving appropriate, compassionate care.

<u>Actions undertaken/in progress:</u>

- In July 2018, NHS England requested assurance that Graseby syringe drivers, which were associated with drug errors, were no longer in use. We withdrew Graseby pumps following National Patient Safety Agency (NPSA) safety alert (reference

NPSA/2010/RRR019) issued on 16th December 2010 and we now use CME T34 syringe drivers.

- There has been a subsequent joint alert from the Medicines and Healthcare products Regulatory Agency (MHRA) and Association for Palliative Medicine recommending a particular battery for use in T34 syringe drivers[iv]. The trust has restricted selection of the appropriate battery via its procurement service and communicated the requirements of the alert with all users of such devices. There have been no incidents related to the issue raised in this alert at this trust, but the Medical Physics team will remain vigilant to this concern.
- The National Audit for Care at the End of Life (NACEL) is underway, reviewing all expected adult hospital deaths in April 2018. Data collection will be complete by the end of October 2018 with full results likely in Spring 2019. The National Audit no longer collects information on whether prescribing of opioids and symptom control medication is within guidelines, as they have been reassured by good practice observed nationally in multiple previous audits. This has provided significant assurance nationally that the issues in Gosport were particular to that place and time. However, as further assurance and in line with other local trusts, we have collected additional data on prescribing for April 2018 acute hospital deaths, while concurrently completing the national audit. Initial review of this trust data from April 2018 shows safe practice in opioid and other symptom control prescribing. Notably of the 22 sets of appropriate and available patient notes, only 3 patients had a syringe driver prescribed. For most patients in this data set, appropriate symptom control was achieved without the need for syringe drivers, using palliative medication prescribed on our JAC electronic prescribing system, in accordance with our clinical guidelines, to be given as required.
- An audit of opioid prescribing at the end of life in the acute trust in 2015 also indicated safe practice. The results confirmed that clinicians are accurately identifying patients at the end of life and that both prescription and administration of symptom control medication were within guidelines[v].
- The trust's Learning from Deaths Policy (POL/0406) ensures that a proportion of all hospital deaths are regularly reviewed. Themes are discussed via the Mortality Group and departmental Mortality and Morbidity meetings, as well as fed back to the End of Life Care Board.
- The trust has recently launched a bereavement survey, given to relatives of all patients who die in the acute trust. We do not yet have a full quarter of data to report, but initial responses are positive about care received
- Updates to Whittington syringe driver policy and palliative care prescribing guidelines are in progress. Existing guidelines are fit for purpose in the interim (see action plan below)
- The trust End of Life Care Board is attended by the trust Patient Advice and Liaison Service (PALS) team and regularly reviews all concerns and complaints regarding end of life care, in both the community and acute trust
- The District Nursing teams provide a significant amount of end of life care in the community, and they are well-supported and have access to 24hr specialist palliative care telephone advice from the North London Hospice in Haringey and the CNWL ELiPSe team in Islington
- Further assurance regarding the oversight of the quality and safety of our end of life care is provided by the systems in place to document and escalate individual concerns through Datix (risk management system) and the Serious Incident Executive Group (SIEAG) and the existing arrangements to triangulate this information with information coming from complaints, inquests and claims. The Associate Medical Director for Patient Safety, who is also the lead for mortality reviews, is included in correspondence that triangulates these sources of information.

- The quality and safety of end of life care is overseen at the monthly End of Life Care Board, Chair (up to September 2018) Graham Hart, Non-Executive Director, Clinical Lead Dr Anna Gorringe, Consultant Physician in Palliative Care. The issues raised by the Gosport Inquiry have been discussed at this Board, which continues to review the above points and ensure learning is disseminated.
- The End of Life Care Board reports into the Quality Committee via the Patient Experience Committee.

Action Plan

1. To permanently strengthen the education and training of staff in end of life care, Whittington Health has submitted a bid to Macmillan for funding for two full time Band 7 End of Life Care Facilitators, whose remit will include staff education on End of Life care in both the community and the hospital.
2. The Palliative Care Physician, Dr Anna Gorringe, will give a palliative care presentation, with the relevant learning, at the Grand Round on 19th September 2018 and at the District Nursing Forum on 25th September 2018
3. Further on-going education is needed to ensure that all clinical staff document the rationale for symptom control and route administration. The nurses should document why they are choosing to give a PRN (as required) medication, and the doctors should record the reason for prescribing it. This education and training will be provided on an on-going basis by the Palliative Care Team.
4. The recording of the indication for palliative medication on the trust's electronic prescribing and medicines administration (ePMA) system JAC is under review and will be discussed, and and a future approach agreed, at the Medicines Safety Group in November 2018.
5. The trust's Clinical Guidelines and Syringe Driver Policy will be revised and updated by the end of 2018. We will adopt the Palliative Adult Network Guidelines (PANG) as endorsed by PallE8, the network of palliative care specialists across North Central and North East London. Dr Anna Gorringe will lead on this with the support of the Palliative Care Team and Pharmacy. This will include clear examples of how to prescribe Syringe Drivers on the trust's approved prescription chart.
6. The results of The National Audit for Care at the End of Life (NACEL) will be available in Spring 2019 and these will be discussed at the following End of Life Care Board, and any relevant improvements or learning will be acted on or disseminated as required.
7. The MHRA and Associate for Palliative Medicine issued an alert recommending a particular battery for use in T34 syringe drivers[vi]. The trust is acting on this alert.
8. At present, the trust's ePMA system, JAC does not allow for prescribing of syringe driver medications and so these are prescribed on a separate paper chart, as are other infusions. This increases the risk that there will be an error in the prescribing of a syringe driver and its contents.. The Palliative Care Team is liaising with pharmacy colleagues to mitigate this risk and will be reporting to the Medicines Safety Group in November 2018 on the recommended approach.
9. The trust will review existing systems to monitor the overall usage of opiates across the organisation on a frequent basis, allowing for significant deviation and unwarranted variation to be reviewed and challenged where appropriate. An update on this will be provided to the Medicines Safety Group in November 2018.
10. We plan to add additional questions to the Structured Judgement Reviews to guide reviewers in assessing whether it was appropriately recognised that the patient was dying; whether there was compassionate communication by a senior clinician with the patient and family that s/he was deteriorating and likely to be in the last days of life; whether compassionate care was delivered, including appropriate prescription of symptom control medication and assessment of hydration and nutrition; and whether

appropriate documentation was used to guide care, including a Treatment Escalation Plan, DNACPR ('Do not attempt cardio-pulmonary resuscitation') documentation in the hard-copy notes and electronically, and the End of Life Care Plan Aid.

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[i] https://www.gosportpanel.independent.gov.uk/panel-report/
[ii] https://www.gosportpanel.independent.gov.uk/panel-report/
[iii] https://apmonline.org/news-events/apm-position-statements/
[iv] https://apmonline.org/wp-content/uploads/2018/09/joint-apm-mhra-t34-statement.pdf
[v] See attached audit poster
[vi] https://apmonline.org/wp-content/uploads/2018/09/joint-apm-mhra-t34-statement.pdf

Whittington Health
NHS Trust

Trust Board

26th September 2018

Title:	**Research and Development Annual Report 2017-18**		
Agenda item:	**18/126**	Paper	**7**
Action requested:	The Board is invited to focus its discussion on ways in which the trust's performance may be further strengthened in this regard, and in particular how the trust may strengthen its performance and reputation in research into innovative integrated care.		
Executive Summary:	This annual report describes the trust's achievements and progress against its targets and strategy with regard to research.		
Summary of recommendations:	That the board receives this report and supports the writing of a business case for more resources.		
Fit with WH strategy:	Whittington Health Research Strategy		
Reference to related / other documents:	Whittington Health Research Strategy		
Date paper completed:	17th September 2018		

Author name and title:		**Kathryn Simpson, Research Portfolio Manager** **Rob Sherwin, Director of Research and Innovate**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

Research and Development Annual Report 2017-18

Introduction

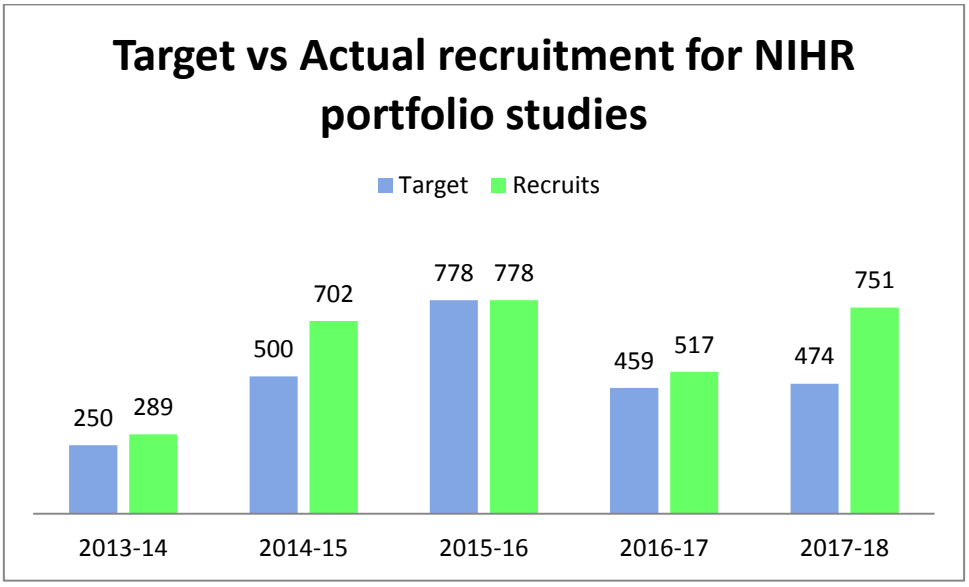
Whittington Health is a research active organisation and is committed to research as we believe it improves the care of our patients[1]. Our research strategy[2] outlines our research objectives as:

a) Increasing research in clinical areas where we have a research track record.
b) Developing research in integrated clinical care.
c) Increasing income from commercial research studies.
d) Increasing the culture of research within Whittington Health.

Review of recruitment into NIHR studies 2017-18

We have continued to successfully recruit patients into National Institute of Health Research (NIHR) portfolio studies. These are studies that are recognised as nationally important by the NIHR, where the funding for the studies has been awarded in open competition eg from the Medical Research Council (MRC) or charitable funding eg Wellcome Trust. In 2017-18 we exceeded the recruitment target, which was set by the North Thames Clinical Research Network (CRN); see graph 1 below. The recruitment target is agreed annually between the Trust and the North Thames CRN. The target was derived by a different formula this year, taking the previous three years recruitment into account, removing large sample size studies (that are often impossible to replicate) and setting the target as the average from the previous three years. The recruitment target does not reflect the complexity of studies e.g. simple observational studies compared to complex interventional drug trials. Whittington Health has a track record of recruiting patients into complex interventional studies, which was again the case this year.

Graph 1: Whittington Health recruitment into NIHR portfolio studies 2013 to 2018



Maintaining a similar target from 2016-17 to 2017-18 reflected the reduction in the portfolio of simple observational studies that had boosted recruitment in 2015-16. However, carefully selected additions to the portfolio ensured that the target was met within the first half of the year and we then continued to recruit well in the second half. The highest recruiting studies for the year are shown in table 1. The clinical areas in which these patients were recruited from were not solely from those areas that have historically been areas of research strength at Whittington Health, the addition of high recruiting reproductive health and neonatal studies being a welcome development within the portfolio. Thus we have again been successful in our research strategy of building on research in clinical areas where we have a research track record as well as expanding research capability within women's health and paediatric services as evidenced by recruitment to studies.

Table 1 Top 5 recruiting adopted studies during 2017-18 (6 due to joint placement)

Study Title	Local Investigator	ICSU	Recruitment
ASCOT: Lifestyle study for cancer survivors	Kayleigh Gilbert	*Surgery & Cancer*	201
DRN082 (DARE)	Maria Barnard	*Medicine, Frailty and Network Services*	55
High Intensity Specialist-Led Acute Care (HiSLAC) project	Clarissa Murdoch	*Emergency and Urgent Care*	52
ANODE Trial	Meg Wilson	*Women's Health*	48
Optimising neonatal services provision for preterm babies (27-31 weeks)	Wynne Leith	*Children's Services*	36
MUCS 4535 (Degenerative Disease of the Hip)	William Bartlett	*Surgery and Cancer*	36

The total number of patients recruited into NIHR portfolio studies per ICSU is shown below in table 2. Again these recruitment numbers show our on-going development of recruitment into areas of research strength.

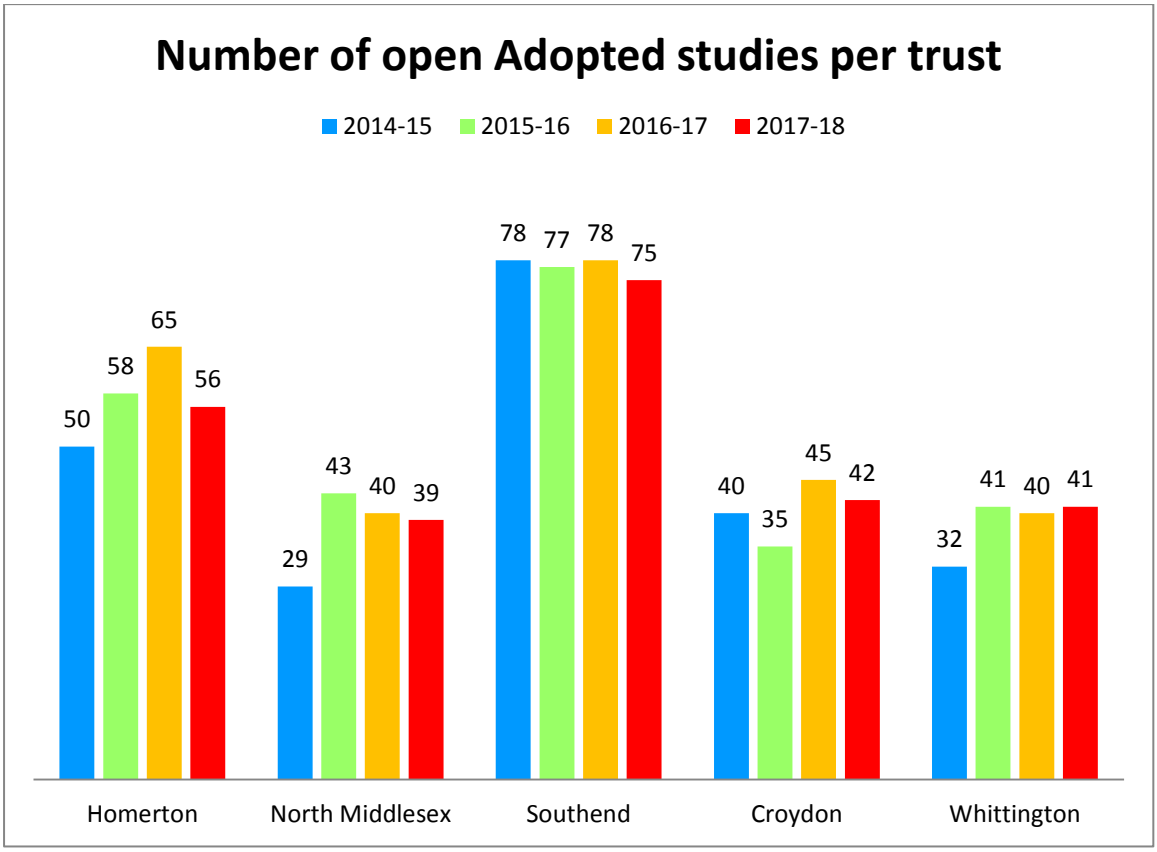
Table 2 Adopted study recruitment in 2017-18 per ICSU.

ICSU	Recruitment during 2017-18	Number of studies
Children's Services	135	6
Emergency and Urgent Care	61	3
Medicine, Frailty and Network Services	102	7
Outpatient, Prevention & Long Term Conditions	12	3
Surgery and Cancer	334	15
Women's Health	107	7

Benchmarking of recruitment into NIHR portfolio studies

When compared to other similar size acute trusts, the number of studies that are open and recruiting at Whittington Health is similar to the North Middlesex Hospital and Croydon*, but significantly less than the Homerton and Southend Hospitals; see graph 2.

Graph 2: Number of NIHR portfolio studies open in benchmarked acute trusts within the North Thames CRN (2014 to 2018).

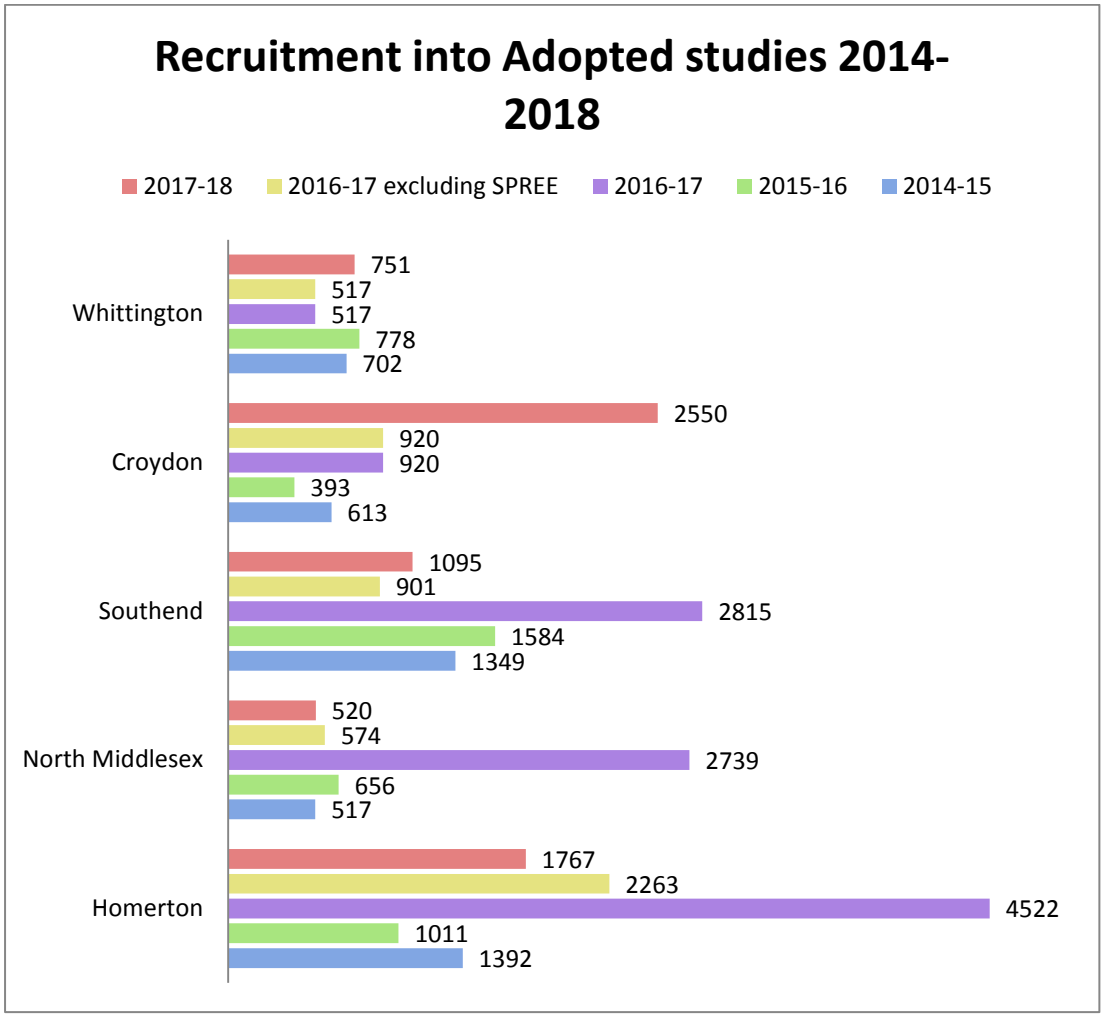


*Croydon has been added as a comparator, whilst within the South Thames Local Clinical Research Network (LCRN) and an outer London Trust similarities in terms of size, population and services have been noted (whilst not labelled as an Integrated Care Organisation (ICO), the fact that there is delivery of community services alongside acute care make Croydon University Hospital a relevant comparator).

In 2016-17 the Homerton, North Middlesex and Southend Hospitals all opened and recruited into the SPREE (Screening programme for pre-eclampsia) study, which resulted in 2259, 2165 and 1914 patients respectively being recruited in to this study at the various sites. This study was never made available to Whittington Health to open. With this in mind, the recruitment numbers for the last five years for these trusts, Croydon and Whittington Health are shown below.

Whittington Health was the only trust to increase the number of studies from 2016-17. All of the other trusts shown had less studies in 2017/18 compared to 16/17, the increase was small but reflective of continuing development of the portfolio here.

Graph 3 Recruitment of patients into NIHR portfolio studies in benchmarked trusts within the North Thames CRN (2013-18)



Whittington Health did recruit fewer patients into NIHR portfolio studies in in 2017-18 than some but not all comparator trusts. During 2017-18 Croydon had *Optimal: Effectiveness of discharge advocate to reduce readmission* which accounted for 1324 of the 2550 total recruits for that year, and it is worth remembering that a single study can have this effect on the fluctuation of recruitment from year to year.

Financial Support to R&D from the North Thames CRN in 2017/18

When compared to other similar size trusts in the North Thames Clinical Research Network (CRN), the allocated financial support to Whittington Health from the North Thames CRN in 2017/18 is significantly less. This is then reflected in the number of research nurses and support workers that are employed within Whittington Health compared to other trusts. The income received from the CRN is pre-allocated for specific research delivery posts or for recharge to clinical support services.

Table 3. – CRN funding provided for employment of research delivery staff & clinical support services

	2017/18 CRN Total Support	2018/19 CRN Total Support *indicative figure	2018/19 Clinical Services Support	2018/19 Research Delivery staff
Homerton	£614,060.09	£561,060	£57,979	£561,060
North Middlesex	£362,415.25	£305,267	£47,671	£305,267
Southend	£1,031,748.67	£820,487	£88,293	£820,487
Whittington	£323,626.23	£383,232	£30,044	£383, 232

Due to a cut in funding from the NIHR to CRN North Thames of 5.5% to reflect performance in terms of overall participant recruitment figures for the region and recruitment to time and target for commercial and non-commercial studies (NIHR HLO 2A & 2B) for 2018/19, it was decided that this should be reflected in trust allocations. It should be noted that whilst the Homerton, North Middlesex and Southend Hospital trusts each faced a reduction in funding, due to careful negotiations and successful business case submissions Whittington Health were able to secure an increase in funding. Only 4 of 23 trusts saw an increase in allocation.

Table 4. – CRN VFM - value for money analysis Q4 2017-18

Trust name	No. of recruits	IV/Obs/LSS %*	Weighted recruitment (11:3.5:1)	Spend	VFM – cost per recruitment unit	Previous year VFM	Previous 3-Year VFM average
Homerton	1,547	46/21/34	9,397	£580,296	£62	£37	£75
North Middlesex	493	18/32/51	1,753	£352,276	£201	£89	£119
Southend	984	18/49/33	3,972	£1,014,896	£256	£186	£125
Whittington	707	55/19/26	4,920	£313,816	£64	£155	£72

*IV – Interventional studies, Obs – Observational studies, LSS – Large Sample Size studies (those that have a UK target of 10,000 or more).

Whittington Health has the highest percentage of interventional (and therefore more complex) studies than any other comparator trust by almost 10% the smallest percentage of observational and LSS studies. The team's impressive VFM analysis of the average cost per recruitment unit of £64 for the year is certainly aided by this study mix and is not far behind the 'best value recruitment acute trust' within the CRN NT, Mid Essex with a cost of £58, and ahead of the 'best value large academic trust' within the same CRN geography, Moorfields, with a cost of £76 per recruitment unit. This has had a positive influence on additional business case submissions to the CRN and shows our commitment to improving research performance within the trust.

Grant applications submitted within 2017-18

A number of grant applications for large sums of money have been made over the year by some key researchers associated with the Trust (Table 4).

Table 5. – Grant applications submitted during 2017/18

Applicant	Study Title	Funding Competition	Costing Status	Grant Outcome
Professor Ibrahim Abubakar	Research to Improve the Detection and treatment of latent tuberculosis infection (RID-TB)	NIHR (PGfAR) Competition 23 Stage 2 - Full Grant	Submitted	Successful
Dr Sharon Millard	Feasibility study to explore the effectiveness of a therapy programme for children who stammer aged 8-14.	NIHR (RfPB) Competition 34 Stage 1 - Outline	Submitted	Progressed to the next stage
Dr Sharon Millard	Evaluating Palin Stammering Therapy for Children: a feasibility study	NIHR (RfPB) Competition 34 Stage 2 - Full Grant	In progress	Awaiting decision

Research Infrastructure in 2017-18

Following on from the expansion of the R&D department's infrastructure in 2016/17 the team has continues to thrive and grow. Collaboration with the North Thames CRN has been successful and has led to additional funding being secured to establish new posts. The work supporting the ICSUs to engage in research has been underpinned in the last year and many specialties (anaesthesia, surgery and orthopaedics, for example) have engaged with

the research team and developed a keen interest in research, and expansion in the portfolio is following. Increased capacity and clinical engagement has enabled the trust to participate in more complex studies and to support an increased number of commercial trials, as well as to expand the number of specialities engaging in research.

Commercial research

Progress continues to be made with commercial studies. The success of the dermatology, gynaecology and orthopaedic commercial research has been positive, with each delivering studies to the NIHR recruitment to time and target metrics. Each of these specialities has delivered studies to a high standard and each has seen sponsors and CROs return to the trust to discuss future studies. Success with the ASTEROID 5 trial (gynaecology) has been such that we increased our recruitment target, and Whittington Health staff will be travelling to support other sites with recruitment into the trial.

Table 5, below shows all of the commercial studies which closed during 2017/18. As can be seen, many were closed early from the sponsor, this can be for many reasons but is generally due to overall study recruitment targets being met prior to the planned end date.

Table 5. Commercial studies which closed during 2017/18

Title	Date closed	Recruitment target	Actual recruitment	Reasons for closure
A Phase 3, double-blind, randomized, placebo-controlled, multicentre study to determine the efficacy and safety of luspatercept (ACE-536) plus best supportive care versus best supportive care in adults who require regular red blood cell transfusions	10/06/2017	3	2	Withdrawn by sponsor
Acceptability and Effectiveness of an Internet Delivered Intervention for Psychological Distress in Patients with Type 2 Diabetes.	01/12/2017	17	3	Withdrawn by sponsor
Tailored internet-delivered cognitive behavioural therapy for depression and anxiety in patients with a long-term condition (Chronic Pain, COPD and Diabetes)	01/12/2017	35	4	Withdrawn by sponsor

Tralokinumab monotherapy for moderate-to-severe atopic dermatitis ECZTRA 2 (ECZema TRAlokinumab trial no. 2)	23/03/2018	4	5	Recruitment finished

Raising the Profile of Research

An annual event for the team that improves the visibility of research within the Trust is International Clinical Trials Day, held in May each year. This again proved a good forum to engage both staff and patients and to inform them of the research activity ongoing within the trust and also with the NIHR '*I am Research*' campaign. The research delivery team in 2017 ran the lemonade trial: a mock research study that explains the process of consent and randomisation in clinical trials. In 2017-18 the research delivery team also began planning the I CARE for Research campaign, which is having a phased launch during 2018-19.

Summary and Conclusion

In 2017-18, the R&D team, along with the Principal Investigators within Whittington Health, continued to recruit patients into NIHR portfolio studies. The recruitment number was in excess of the target set by the NIHR. In addition, a number of grant applications have been submitted by researchers at Whittington Health; the results of these are awaited. Furthermore, we have expanded the number of commercial studies that are open at the trust and have been rewarded for our successful recruitment by pharmaceutical companies approaching us for follow-up studies.

There is, however, still scope for further development. Our ambition of creating a commercial income stream to support a clinical researcher who specialises in studies of integrated clinical care has not yet been realised. We need to consider whether as a trust we have an appetite to fund a part time research appointment that will be the focus of our research into integrated care. Such a post may not be focussed solely on research of integrated care but in the range of specialties where we are leaders in the field. To achieve the capability to employ a researcher to support and lead other research projects, we will have to continue to build our links with industry, the North Thames CRN, and other links to commercial research studies and support grant bids that attract RCF (Research Capability Funding), to enable us to realise this aim.

References

1. Boaz A, Hanney S, Jones T, et al. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015; 5
2. Whittington Health Research Strategy

Whittington Health NHS

Trust Board Report August 2018

Title:	August (Month 5) 2018/19 – Financial Performance		
Agenda item:	**18/127**	**Paper**	**8**
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 loss of £0.3m for the month of August (month 5) against a planned £0.2m loss, a variance of £0.1m. Year to date the Trust is £0.4m behind the NHS Improvement adjusted plan, with a deficit of £1.1m. The in month position has benefitted from a CNST rebate of £0.5m and £0.2m of old agency accruals being released. PSF income related to months 4 and 5 has been accrued due to the satisfactory Delivery Board performance, even though the Trust performance is below target. Income performance excluding PSF income and agenda for change funding is £1.3m off plan. A deterioration in month of £0.8m. The pay variance in month is predominately but not exclusively, the result of the agenda for change back pay for April, May and June. The Trust is reporting to NHSI a funding gap of £0.9m between the cost and funded position. The agency costs to the end of month 5 are £5.9m. The Trust has revised its CIP forecast in month from £16.5m to £12.4m to reflect the current assessment of delivery. The predicted forecast out-turn remains the achievement of the control total subject to the pay funding being resolved. The Trust has reduced the planned capital expenditure by £1m to £14.8m.		
Summary of recommendations:	To note the financial results relating to performance during August 2018 recognising the income delivery being below plan and the reduction in CIP with the need to agree a recovery trajectory.		
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:	17 September 2018		

Author name and title:		**Kevin Curnow** **Operational Director of Finance**		**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 £0.3m deficit for the month of August (month 5) against a planned deficit of £0.2m. Actual performance therefore represents a negative variance against plan. The year to date position of a £1.1m deficit is £0.4m behind plan.

The main driver for the poor in month performance is the underperformance of clinical income (page 2). Clinical income was £4m behind the average income for the previous four months and £0.7m behind the plan which was reduced to reflect annual leave in August. This is offset by central pay award funding of £1m. The under achievement is attributed to maternity services and day cases procedures primarily within the Surgery ICSU.

The Trust is reporting a positive variance in relation to non-pay in the year to date position. This trend has been further improved by a rebate of £0.5m from CNST premium due to achievement of the maternity standards. As with last month, the pay spend is in excess of budget, this is as a result of the agenda for change payment being made in month, back-dated for April, May and June. In addition, in month, £0.2m of unbilled and unfilled shifts within the agency accrual relating to 2017/18 have been released.

The cumulative agency spend is £5.9m

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

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)
Clinical Income	21,126	20,404	(722)	120,359	117,735	(2,624)	0	280,253
Other Non-Patient Income	4,829	4,761	(68)	10,685	11,974	1,289		35,536
Pay Award Funding	0	1,056	1,056	0	1,320	1,320		
Total Income	**25,955**	**26,221**	**266**	**131,044**	**131,030**	**(14)**		**315,789**
Pay	(18,633)	(19,619)	(986)	(93,207)	(94,319)	(1,112)		(222,445)
Non-Pay	(6,935)	(6,272)	663	(34,953)	(33,868)	1,085		(95,904)
Total Operating Expenditure	**(25,568)**	**(25,891)**	**(323)**	**(128,160)**	**(128,188)**	**(28)**		**(318,349)**
	387	**330**	**(57)**	**2,884**	**2,842**	**(42)**		**(2,560)**
Depreciation	(542)	(527)	15	(2,706)	(2,743)	(37)		(6,500)
Dividends Payable	(430)	(430)	0	(2,152)	(2,128)	24		(5,198)
Interest Payable	(277)	(296)	(19)	(1,389)	(1,344)	45		(3,341)
Interest Receivable	1	7	6	5	26	21		12
P/L on Disposal of Assets	0	0	0	0	0	0		13,730
Total	**(1,248)**	**(1,247)**	**1**	**(6,242)**	**(6,188)**	**54**		**(1,297)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(861)**	**(917)**	**(56)**	**(3,358)**	**(3,346)**	**12**		**(3,857)**
Provider Sustainability Fund (PSF)	625	625	0	2,657	2,235	*(422)*		*9,380*
Net Surplus / (Deficit) - before IFRIC 12	**(236)**	**(292)**	**(56)**	**(701)**	**(1,111)**	**(410)**		**5,523**
Add back								
Impairments	0	0	0	0	0	*0*		51
IFRS & Donate	(2)	1	3	6	27	*21*		(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(238)**	**(291)**	**(53)**	**(695)**	**(1,084)**	**(389)**		**4,675**

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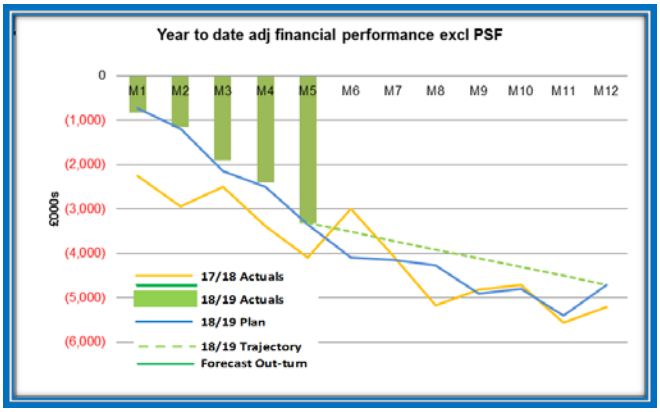
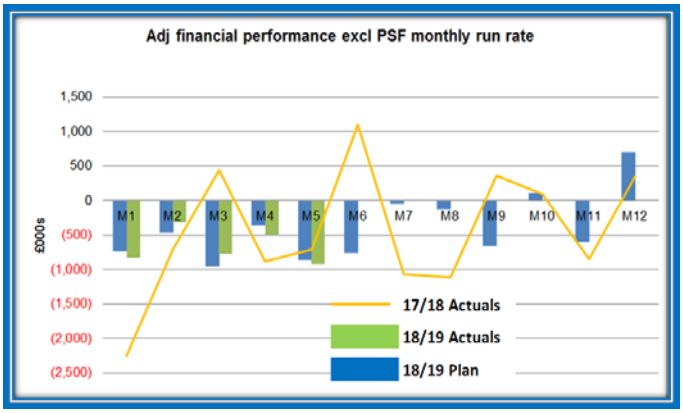




Income & Activity

The Trusts reported income position excluding Agenda for Change funding and Provider Sustainability Funding is a year to date adverse variance of £1.3m.

In month 5, the activity for all planned care was reduced to allow for increased levels of annual leave and initiatives were put in place to improve planning. Despite this, Day Case and Elective activity continue to under-perform, with an in month adverse variance of £0.2m and year to date adverse variance of £1m with Trauma & Orthopaedics significantly behind plan, Urology and General Surgery are also behind plan. Endoscopies performed to planned levels in month, but remain behind plan year-to-date.

The Maternity service deliveries were on plan for activity in August but the YTD variance is still £0.4m adverse. However, Maternity Pathways continued to under-perform in month, giving an adverse YTD variance of £0.3m.

Outpatients continue to perform well overall, and are ahead of plan in month by £0.1m, with the under-performance in follow ups still offset by over performance in first attendances and procedures. There is still considerable under-performance in follow ups across all ICSUs, and the high in month performance is partly attributable to an agreed lower plan in August to allow for the impacts of the holiday period.

Unplanned care has been over performing in the first four months of the year but this trend ceased with A&E, Urgent Care and non-elective all being behind plan in month. A&E activity dropped materially in month against the run-rate although attendances were higher than August 2017. Ambulatory Care remained above planned levels.

Although the Trust did not meet the required target for A&E in August, at the delivery board level the Trust did achieve the target and therefore the position includes the full PSF funding for July and August.

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 Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,188	1,126	(62)	5,864	5,881	17	8,777	8,164	(613)	43,315	44,022	707
Ambulatory Care	308	400	91	1,721	1,967	246	1,260	1,590	330	7,026	7,883	857
Adult Critical Care	640	373	(267)	3,157	2,706	(451)	1,512	955	(557)	7,463	6,437	(1,026)
Community Block	5,857	5,857	0	29,285	29,285	0	0	0	0	0	0	0
Day Cases	1,028	1,067	39	5,734	5,341	(393)	1,325	1,424	99	7,384	7,676	292
Diagnostics	225	316	91	1,253	1,502	249	2,277	3,238	961	12,698	14,903	2,205
Direct Access	881	1,197	316	4,916	5,282	367	85,870	93,181	7,311	479,347	475,994	(3,353)
Elective	707	484	(223)	3,943	3,351	(592)	181	176	(5)	1,001	883	(118)
High Cost Drugs	656	592	(64)	3,280	3,115	(165)	0	0	0	0	0	0
Maternity - Deliveries	1,170	1,118	(52)	4,604	4,237	(367)	321	319	(2)	1,583	1,513	(70)
Maternity - Pathways	665	609	(56)	3,711	3,419	(292)	628	645	17	3,503	3,322	(181)
Non-Elective	3,431	3,153	(279)	18,104	18,206	102	1,606	1,571	(35)	7,930	8,120	190
OP Attendances - 1st	796	811	15	4,442	4,810	368	4,273	4,749	476	23,923	26,117	2,194
OP Attendances - follow up	710	773	63	3,963	3,842	(121)	11,327	11,565	238	63,262	61,257	(2,005)
OP Procedures	342	391	50	1,906	2,134	228	1,950	2,417	467	10,892	13,250	2,358
Other Acute Income	1,153	1,303	150	6,347	6,378	31	6,297	5,901	(396)	34,881	32,778	(2,103)
CQUIN	463	435	(28)	2,398	2,275	(123)	0	0	0	0	0	0
Total SLA	**20,220**	**20,005**	**(215)**	**104,627**	**103,732**	**(896)**	**127,603**	**135,895**	**8,292**	**704,208**	**704,155**	**(53)**
Marginal Rate	0	0	0	0	0	0						
	20,220	**20,005**	**(215)**	**104,627**	**103,732**	**(896)**						
Other Clinical Income	3,564	3,065	(499)	15,732	15,323	(408)						
Other Non Clinical Income	2,172	3,151	979	10,685	11,975	1,290						
Total Other	**5,735**	**6,216**	**481**	**26,417**	**27,299**	**882**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**25,955**	**26,221**	**266**	**131,044**	**131,030**	**(14)**	**127,603**	**135,895**	**8,292**	**704,208**	**704,155**	**(53)**
PSF	625	625	0	2657	2234	(423)						
Revised Total	**26,580**	**26,846**	**266**	**133,701**	**133,264**	**(437)**						

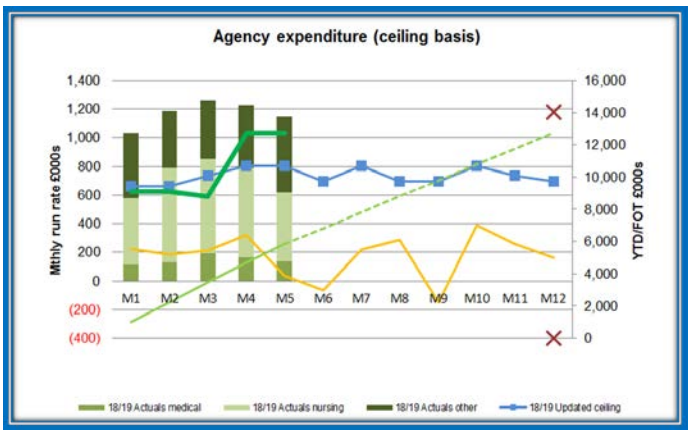
Further detail is provided in Annex 1.

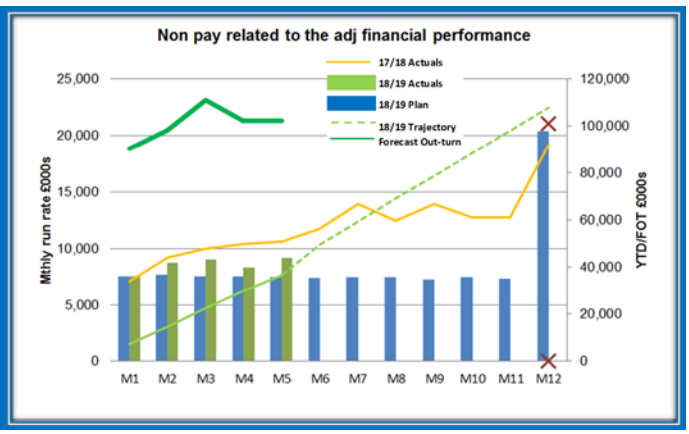
Monthly Run Rates – Expenditure

The year to date combined expenditure position is broadly on plan. Key points of note include:

- **Pay**
  - Total pay expenditure for August was £19.6m, with the back pay for the new Agenda for Change pay rates being made for April, May and June as well as the new levels for August. The funding for the pay award is reported within the income position, creating a positive variance. The Trust is reporting a cost pressure of £0.9m generated by the underfunded pay award. If this is not corrected it will impact on the Trusts ability to achieve the agreed control total as all forecasts are based on full funding.
  - Within total pay expenditure, agency costs were £1.1m. The total agency spend is £5.9m, reinforcing the decision to revise the agency forecast from £8.8m to £12.8m. The Trust is looking at the electronic rota system to ensure all rotas reflect the establishment and actual staffing levels match the plan
  - During the month a £0.2m benefit has been included in the pay position as a result of the release of agency accruals relating to 2017/18

- **Non Pay**
  - Non pay expenditure for July was £6.3m, which is £0.6m less than the average
  - The reduction in month is predominately as a result of a CNST rebate of £0.5m after successfully achieving the required maternity standards





ICSU Position

The table below provides an analysis of the monthly expenditure run rates as if the new ICSUs commenced from 1 April 2018

		In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)	Full Year Budget (£000s)
Adult Community	Income	(502)	(503)	1	(2,361)	(2,374)	13	(5,982)
	Pay	2,067	2,143	(76)	10,219	10,152	67	24,329
	Non-Pay	346	323	23	1,530	1,437	93	3,939
Adult Community Total		**1,911**	**1,963**	**(52)**	**9,388**	**9,215**	**173**	**22,287**
Children & Young People	Income	(2,114)	(1,883)	(230)	(10,727)	(10,245)	(482)	(25,249)
	Pay	3,992	3,791	200	20,012	19,582	430	47,302
	Non-Pay	190	225	(35)	951	1,080	(129)	2,268
Children & Young People Total		**2,068**	**2,132**	**(65)**	**10,236**	**10,416**	**(180)**	**24,321**
Emergency & Integrated Medicine	Income	(5,543)	(5,310)	(233)	(28,305)	(28,065)	(240)	(67,427)
	Pay	3,643	4,056	(413)	18,383	20,503	(2,120)	43,714
	Non-Pay	428	521	(93)	2,050	2,222	(171)	5,032
Emergency & Integrated Medicin Total		**(1,473)**	**(733)**	**(739)**	**(7,871)**	**(5,340)**	**(2,531)**	**(18,680)**
Surgery & Cancer	Income	(4,436)	(3,788)	(648)	(23,330)	(21,599)	(1,731)	(55,584)
	Pay	2,674	3,005	(331)	14,827	15,357	(530)	35,285
	Non-Pay	799	747	52	4,109	4,331	(222)	9,820
Surgery & Cancer Total		**(963)**	**(36)**	**(927)**	**(4,394)**	**(1,912)**	**(2,482)**	**(10,479)**
Women'S Health Diag & Outp	Income	(4,221)	(4,345)	124	(22,230)	(21,322)	(908)	(52,913)
	Pay	3,134	3,071	63	15,660	15,317	343	37,330
	Non-Pay	1,566	1,670	(104)	7,795	8,301	(506)	18,603
Women'S Health Diag & Outp Total		**479**	**397**	**82**	**1,224**	**2,296**	**(1,072)**	**3,019**
Corporate Services	Income	(727)	(676)	(51)	(3,633)	(3,549)	(84)	(8,720)
	Pay	2,742	2,644	97	13,730	13,200	529	32,722
	Non-Pay	3,192	2,526	666	16,008	14,930	1,078	38,248
Corporate Services Total		**5,207**	**4,494**	**713**	**26,105**	**24,581**	**1,523**	**62,250**
Other Total		**(6,993)**	**(7,925)**	**932**	**(33,988)**	**(38,146)**	**4,158**	**(88,240)**
Grand Total		**236**	**292**	**(56)**	**701**	**1,111**	**(410)**	**(5,523)**

The three ICSUs of concern are Medicine, Surgery and WHDO. The primary drivers for their material variance to plan are:

- Resilience beds remaining open all year to cope with the length of stay, delayed transfers of care and co-morbidity of patients
- Surgery have treated less planned care patients than the agreed plan
- Materially reduced levels of births and maternity pathway activity within Women's which is partly offset by improved income in clinical support areas.

As part of the month 6 review the Executive Team will agree an improvement trajectory with the ICSU leadership teams.

Cost Improvement Programme

Against the original programme, plans have been identified, which if able to be delivered in full, would cover the £16.5m requirement. The split by programme area being:

- Flow Through – £2.7m
- ICSU 2% targets – £5.5m
- Transformation Schemes – £8.3m

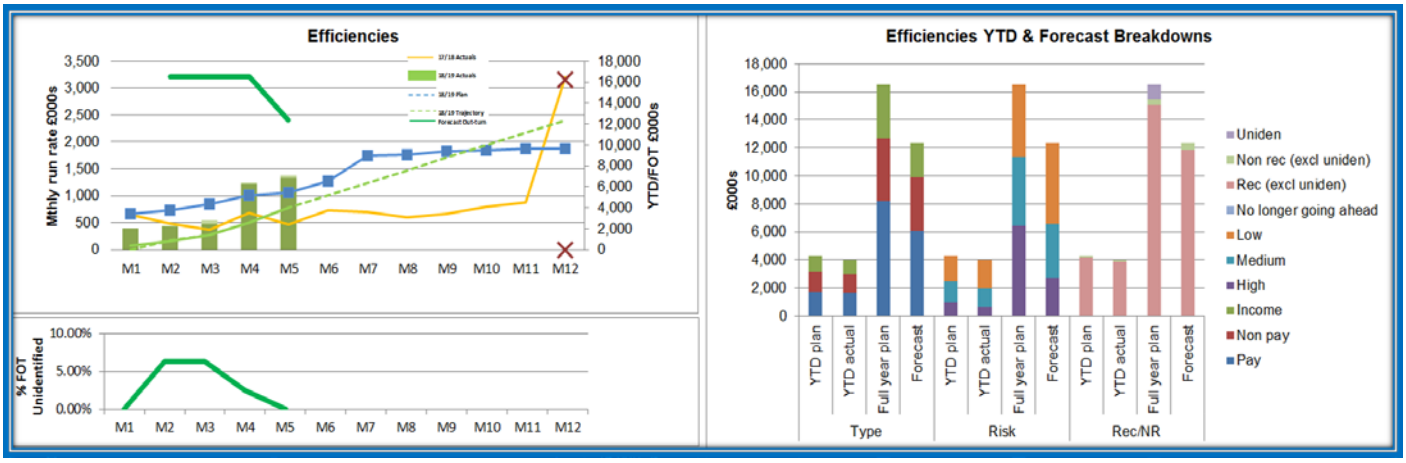
In-year delivery – Month 5

At the end of month 5 the Trust's planned delivery was £4.3m of CIP, against which £4.0m has been delivered, equating to c. 93%. Analysed by programme area:

- Flow Through – £1.1m (100%)
- ICSU 2% targets – £1.5m (88%)
- Transformation Schemes – £1.4m (93%)

Plan requirement & Forecast Delivery

As can be seen from the graphs below the required rate of delivery for CIP increases from Month 6, so whilst year to date performance is close to plan, acceleration in delivery is now required through to the end of the financial year.



From the Month 5 update of the CIP tracker, the current forecast delivery of planned schemes is £12.4m, representing a £4.1m shortfall against the full target.

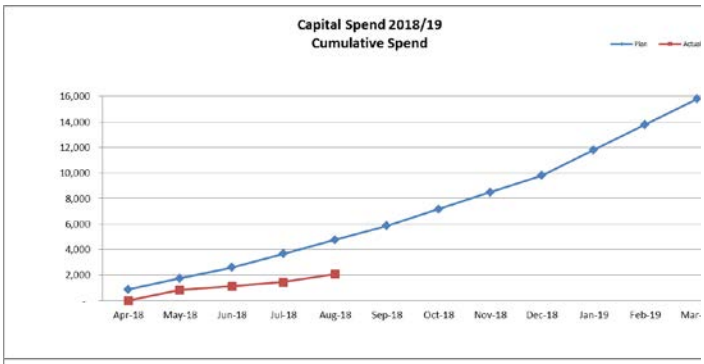
Forecast by programme area:

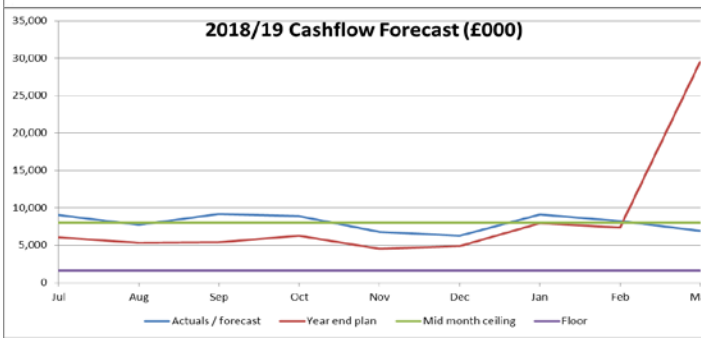
- Flow through – £2.7m (100%)
- ICSU 2% targets – £4.8m (87%)
- Transformation Schemes – £4.9m (59%)

Through working with ICSUs and directly on the Transformation Schemes, the PMO is supporting the identification of additional opportunities/mitigations to address the shortfall against the full year target.

Within the ICSUs, the key areas of focus will be for Surgery & Cancer, Children & Young People and Adult Community as the furthest away from plan in terms of forecast delivery, and within the Transformation Schemes, looking at those in relation to Outpatients, Community and Improving Medical Value.

Statement of Financial Position





THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 August 2018 £000	Plan 31 August 2018 £000	Year to Date Plan variance 31 August 2018 £000
Property, plant and equipment	214,252	218,137	(3,885)
Intangible assets	4,402	4,527	(125)
Trade and other receivables	1,121	656	465
Total Non Current Assets	**219,775**	**223,320**	**(3,545)**
Inventories	1,529	1,355	174
Trade and other receivables	23,954	28,877	(4,923)
Cash and cash equivalents	7,730	5,304	2,426
Total Current Assets	**33,213**	**35,536**	**(2,323)**
Total Assets	**252,988**	**258,856**	**(5,868)**
Trade and other payables	36,310	37,434	(1,124)
Borrowings	19,568	19,572	(4)
Provisions	1,105	1,391	(286)
Total Current Liabilities	**56,983**	**58,397**	**(1,414)**
Net Current Assets (Liabilities)	**(23,770)**	**(22,861)**	**(909)**
Total Assets less Current Liabilities	**196,005**	**200,459**	**(4,454)**
Borrowings	38,151	41,161	(3,010)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**42,003**	**(3,013)**
Total Assets Employed	**157,015**	**158,456**	**(1,441)**
Public dividend capital	64,679	65,679	(1,000)
Retained earnings	(6,082)	(5,798)	(268)
Revaluation reserve	98,398	98,573	(175)
Total Taxpayers' Equity	**157,015**	**158,456**	**(1,441)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

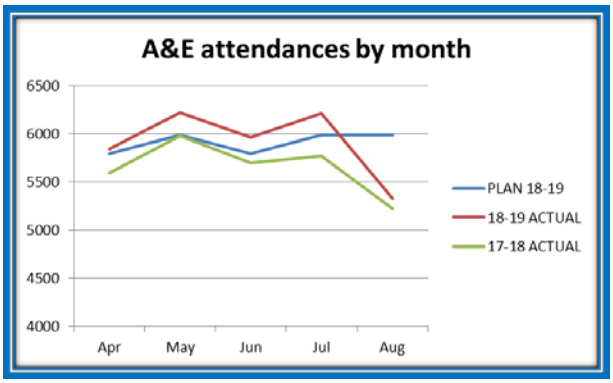
Overall, the value of the balance sheet is £1.4m away from plan.

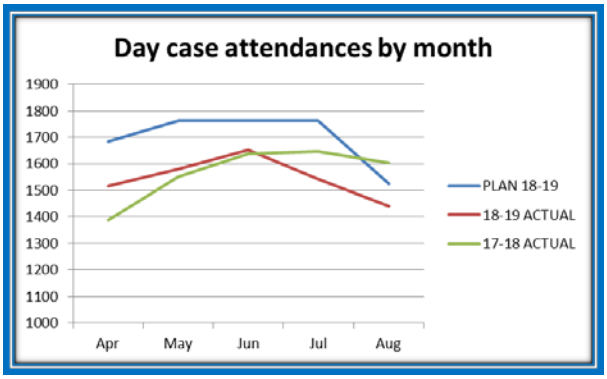
- **Capital Expenditure** spend in 2018-19 is £1.5m behind plan. The 2018-19 spend on most projects is not keeping pace with plan. Whilst the Trust expects IM&T and medical equipment to be able to spend allocations, Estates needs to accelerate spend to complete projects such as maternity, NICU and Cellier ward in year. Following the Capital Monitoring Group meeting in early September, the Trust have informed NHSI that it is likely to undershoot the capital limit by £1.0m.

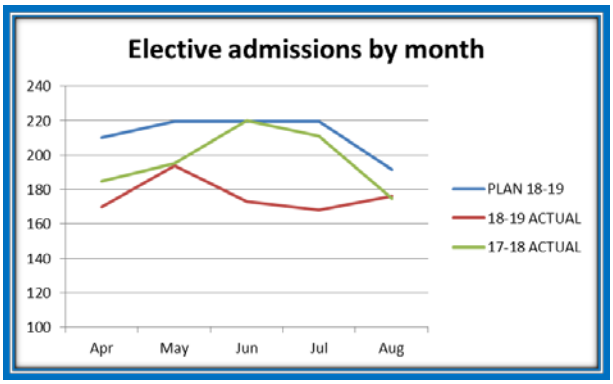
- **Cash and cash flow:** the Trust is holding £7.7m in cash as at the end of August 2018. This is £2.4m higher than plan due to the following reasons:
  - As stated above, we received £6.3m 2017-18 Sustainability and Transformation Funding in July, this is understandably still inflating the cash balance; and
  - SLA payments received in August from main commissioners contained catch up payments for months 1-4 as well as month 5. This yielded an additional £3.5m in cash.

  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.

Annex 1


A&E attendances by month
6500
6000
5500
5000
4500
4000
Apr
May
Jun
Jul
Aug
PLAN 18-19
18-19 ACTUAL
17-18 ACTUAL


Day case attendances by month
1900
1800
1700
1600
1500
1400
1300
1200
1100
1000
Apr
May
Jun
Jul
Aug
PLAN 18-19
18-19 ACTUAL
17-18 ACTUAL


Elective admissions by month
240
220
200
180
160
140
120
100
Apr
May
Jun
Jul
Aug
PLAN 18-19
18-19 ACTUAL
17-18 ACTUAL

Whittington Health NHS Trust

Trust Board
26th September 2018

Title:	Trust Performance report September 2018 (Jul/Aug 2018 data)		
Agenda item:	**18/128**	**Paper**	**9**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Overall performance against the 95% target for July 2018 was 90.5% and for August was 90.0%. July was one of the busiest months ever and saw 9,287 attendances which was an 8.79% increase compared to July 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 and are part of the 'First 60 minutes' project. **Complaints:** Achieved for 3rd consecutive month. **Cancer 62 days:** Underachieving. Continued management to focus on improvement plan in gynaecology. **Community waiting times** Performance has now been split by borough **Diagnostic waits** Target has not been achieved for August which is due to a backlog in Endoscopy. As of the 15/9/18 additional capacity has been put in place. Expectation to be fully compliant in September and going forwards. **Safer Staffing** Number of RED shift has gradually reduced over the last months and work has been completed to assure accurate recording.		
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:	18th September 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

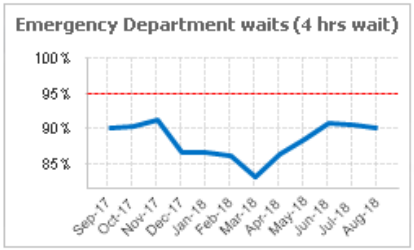
September 2018

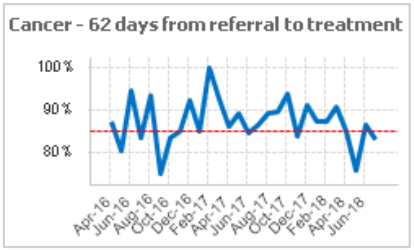
Month 4 and 5 (2018 – 2019)

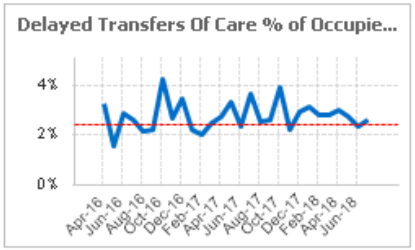
Date & time of production: 02/10/2018 12:19

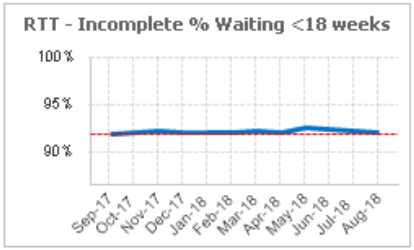
Summary Page - Indicators

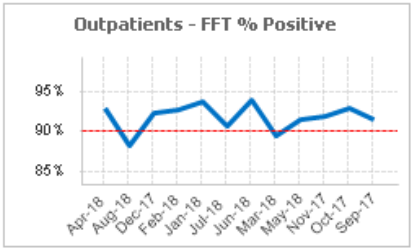
Category	Indicator	17_18 Target	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.2%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	72	82	82	81	75	77	95	91	87	79	74	63	79
Cancer	Cancer - 14 days to first seen	**>93%**	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%		95.3%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%		82.4%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.8%	7.1%	6.4%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%		2.7%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.3%
Outpatients	Outpatients - FFT % Positive	**>90%**	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.7%
Community	Community - FFT % Positive	**>90%**	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	96.4%
Staff	Staff - FFT % Recommend Care	**>70%**	69.4%			70.6%			75.0%			77.3%			77.3%

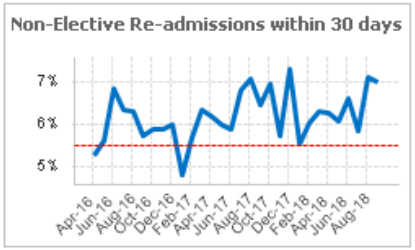












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	Q2 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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	1	3	0	0	0	1	0	1	2	0	0	2	5	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	27	34	28	35	38	27	43	37	52	33	33	26	181	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	3	3	3	3	9	3	3	2	4	2	1	4	13	
All Areas	Harm Free Care %	>95%	95.1%	94.1%	93.5%	94.2%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	92.4%	
Maternity	Non Elective C-Section % Rate	<15%	19.8%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	20.2%	
All Areas	Medication Errors causing serious harm	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	0	0	1	0	1	0	0	0	0	1	0	0	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	17.1%	16.7%	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.6%	
All Areas	Serious Incidents	0	2	5	2	0	7	1	2	6	8	3	1	1	19	
Admitted	VTE Risk Assessment %	>95%	96.0%	95.3%	96.0%	95.2%	95.1%	95.2%	96.2%	95.9%	95.1%	95.1%			95.3%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	0	0	0	0	5	7	0	0	0	12	

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Safe Services - Commentary

HCAI C Difficile
The Infection Prevention and Control Team (IPCT) have reported two trust attributable Clostridium difficile cases for the month of August which occurred on one ward, it is considered to be a cross infection incident as they are of the same ribotype.

A thorough Consultant led Post Infection Review has already taken place in line with the agreed national guidelines and a robust action plan formulated to ensure learning is shared amongst all staff within the trust.

Pressure Ulcers
The trust reported 1 avoidable pressure ulcer in July 18:
District Nursing Service did not report the pressure ulcer, a prevention plan was not completed and information for the carer's was not provided to support prevention of pressure ulcers developing.

The trust reported 4 avoidable pressure ulcers in August 18:
There have been 3 avoidable Category 3 pressure ulcers within district nursing and one avoidable Category 3 within the Hospital.

The three avoidable pressure ulcers within District Nursing had no complete assessment showing a lack of holistic and visual assessment of the skin. There is a review of the documentation of the assessments within District Nursing to enhance the timeliness of reporting and streamline the process.

The Category 3 within the Hospital setting resulted in the ward failing to e-mail the District Nurse referral when the patient was discharged home. The patient had a Category 2 sacral pressure ulcer which deteriorated within a few days as the District Nursing team was not aware of the patient being at home. The ward has created an area on the handover sheet to be completed when the referral has been e-mailed.

Safe Services - Commentary

Non elective C-section

The indicator declined by 6% (high number of cases in July). This indicator is based on non –elective singleton cephalic. Whittington Health is working with UCLH and has increase referrals for high risk pregnancies (twins) and ELCS (Elective Caesarean Section). It is difficult to benchmark as it depends on caseload, including in utero transfers from other units.

Saving Babies lives' Bundle audits are submitted quarterly which we are compliant is all 4 categories listed below:

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.

Serious Incidents

July 2018

1. 2018.18774 – [S&C] Delayed diagnosis/treatment

August 2018

1. 2018.20462 – [EIM] Delayed Diagnosis - A failure to escalate a subacute bowel obstruction following a targeted CT scan.

VTE Risk assessments

July 2018 figure not yet finalised and will be reported in October 2018.

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	80.4%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	81.5%	
ED	ED - FFT Response Rate	>15%	12.6%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	13.9%	
Admitted	Inpatients - FFT % Positive	>90%	97.7%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.1%	
Admitted	Inpatients - FFT Response Rate	>25%	16.0%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	18.0%	
Maternity	Maternity - FFT % Positive	>90%	92.4%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	94.7%	
Maternity	Maternity - FFT Response Rate	>15%	18.5%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	54.9%	
Outpatients	Outpatients - FFT % Positive	>90%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.7%	
Outpatients	Outpatients - FFT Responses	400	433	569	593	336	420	461	249	327	445	348	310	223	1653	
Community	Community - FFT % Positive	>90%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	96.4%	
Community	Community - FFT Responses	1500	940	731	638	605	875	1157	779	1206	1181	1148	869	890	5294	
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%					76.9%	87.5%	92.0%	71.4%	78.3%	92.6%	95.0%	93.8%	85.1%	
All Areas	Complaints (including complaints against Corporate division)	N/A	0	0	0	0	30	21	33	33	30	39	27	21	150	

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

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Caring Services - Commentary

FFT

The friends and family (FFT) responses for Maternity in August 2018 continue the trend in the area for collecting a high proportion of feedback (response rate for August: 67.2%) and maintaining a high recommend rate (95.3%). Maternity FFT collection has exceeded both targets for response and recommend rate each month from July 17 through to this current month, August 18. The maternity teams successfully employ follow-up telephone calls to discharged patients, primarily from the Maternity Birth and Maternity Ward FFT touchpoints.

Results in ED remain consistent with those received through 2018/19 thus far. For August, the recommend rate was at 84% - the joint highest the area has achieved since July 2017 – and a response rate of 14.1%. The patient experience team continue to work with the ED matron on a patient experience action plan. Ongoing actions towards improving the recommend and response rates include the implementation of an FFT survey for ED paediatrics that enhances accessibility for children. This will be hosted on the handheld iPad used for FFT collection. The ED matron has also introduced a library trolley to CDU to enhance the range of activities offered to patients in the area.

For inpatients (16% for August, down from 18% in July), outpatients (223 collected in August, down from 310 in July) and community (890 in August, down from 1148 in June), the numbers of FFT collection was down on previous months. The primary reason for this dip in responses has been due to reduced volunteer support with inputting FFT postcards across the summer holiday. The patient experience and volunteer team are working to induct more administrative support volunteers, and allocate them towards supporting with FFT inputting, as well as other patient experience feedback projects.

Other ongoing actions taken in response to FFT feedback includes:

- Coyle Ward have obtained, through ward charitable funds, Reminiscence Interactive Therapy and Activities (RITA) for patients to use, and staff training is ongoing towards using the equipment. This action has been taken from feedback where patients and visitors have asked for more activities to be made available on the ward.
- Cloudesley ward are engaging with the Mouth Care Matters initiative in response to patient feedback around dental hygiene on the ward.
- Cellier ward are re-designing their ‘going home’ noticeboard in response to patients and visitors who said that would like the discharge information to be simplified.

Caring Services - Commentary

Complaints

During July 2018 the Trust closed 27 complaints; 20 complaints required a response with 25 working days and 7 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 of94%

- Of the 7 complaints allocated 40 working days, 57% hit their target (4).
- At the time of reporting, 4 complaints remain open; 1 x 25 days and 3 x 40 days, i.e. EUC (1), IM (1), CSS (1) and S&C (1).

The majority of complaints were allocated to S&C 30% (8), WH 26% (7) and EUC 18% (5).

Severity of complaints: 52% (14) were designated 'low' risk; 30% (8) were designated 'moderate'; and 18% (5) were designated 'high'.

- During July, of the 5 complaints designated 'high' risk, 2 related to 'nursing care' (i.e. poor standard of care provided) and 3 related to medical care (i.e. 2 complaints cited 'inadequate treatment' and one cited 'poor treatment').

A review of the complaints for July shows that 'medical care' 22% (6) and 'nursing care' 22% (6) were the main issue for patients. In July this was followed by 'communication' 15% (4).

- In regard to 'medical care', 33% of patients (2) felt that 'inadequate treatment' had been provided and 33% of patients (2) also felt that 'poor treatment' had been provided.
- In regard to 'nursing care', 50% % of patients (3) stated that a 'poor standard of care' had been provided.
- In regard 'communication', 50% (2) raised concerns about 'no reply to telephone contact'.

Of the 23 complaints that have closed, (including those allocated 40 working days), 26% (7) were 'upheld', and 37% (10) were 'partially upheld' meaning that, currently, 63% have been upheld in one form or another.

Caring Services - Commentary

Complaints Cont'

During August 2018 the Trust closed 21 complaints; 16 complaints required a response with 25 working days and 5 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 94%.

- Of the 5 complaints allocated 40 working days, 40% hit their target (2).
- At the time of reporting, 2 complaints remain 2 x 40 days, i.e. Pre-July 2018 - IM (1) and EIM (1)

The majority of complaints were allocated to EIM 33% (7), Pre-July IM 19% (4) and S&C 14% (3).

Severity of complaints: 38% (8) were designated 'low' risk; 52% (11) were designated 'moderate'; and 18% (2) were designated 'high'.

- During August, of the 2 complaints designated 'high' risk, 1 related to 'nursing care' (i.e. inadequate monitoring provided) and 1 related to 'delay' (i.e. delay in test results).

A review of the complaints for August shows that 'nursing care' 22% (5) and 'communication' 22% (4) were the main issue for patients.

- In regard to 'nursing care', 40% of patients (2) felt that 'inadequate monitoring' had been performed, 20% of patients (1) felt that a 'poor standard of care' had been provided, 20% of patients (1) felt that there had been a 'failure to follow prescribed care' and 20% of patients indicated that 'poor pressure area care' had been delivered.
- In regard 'communication', 50% (2) raised concerns about a 'lack of information to patients; 25% (1) indicated that 'incorrect details' had been used and 25% (1) indicated that there had been 'a lack of information to patients'.

Of the 19 complaints that have closed, (including those allocated 40 working days), 31% (6) were 'upheld', and 42% (8) were 'partially upheld' meaning that, currently, 73% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	93.2%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.1%	93.1%	
Maternity	Smoking at Delivery	<6%	7.1%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	6.1%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.8%	7.2%	6.4%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	45.8	90.5	93.8	78.3	77.0	75.6	96.0	80.0	64.5				72.7	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100														
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.73			0.74			0.76							
Admitted	Mortality rate per 1000 admissions in-months	14.4	2.6	8.6	8.5	12.0	9.4	10.0	10.3	7.3	7.7	6.4	5.3	4.7	6.3	
Community	IAPT Moving to Recovery	>50%	55.1%	50.8%	53.0%	50.9%	47.5%	51.4%	59.4%	56.3%	53.4%	58.2%	52.4%		55.0%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	84.2%	93.5%	86.7%	78.7%	96.0%	87.0%	92.5%	86.7%	88.9%	95.2%	95.5%	93.2%	92.3%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	29.0%	52.6%	75.0%	86.1%	91.7%	91.0%	86.7%	83.1%	91.1%	82.4%	90.7%	88.9%	87.1%	

Effective Services - Commentary

Smoking at delivery

Just above target at 6.6% in August 2018

- Continued meetings with smoking cessation providers to strengthen our referral pathways and reporting mechanisms.
- Training for staff is ongoing with support from smoking cessation team.

Non-elective re-admission

There was a decrease in non-elective readmission percentage in July 2018 down to 5.8% however this has increase to 7.2% in August 2018. The ongoing data does not show any clear trend but further analysis to understand the spike in August is required.

Review of Speech and Language Therapy re-admission rate has shown an increase in August to 7% since pilot of increased capacity ceased. The cause of this is largely due to the demand on community services and responsiveness. This is currently being reviewed at CSIG. Additional resources were temporarily allocated for Islington REACH from the end of July and has been agreed until the end of September. Approval has been requested to extend this until end of December.

District Nursing

Seen within 48 hrs: July 18 improved and August 18 decreased slightly. The DN lead is training new starters in triaging new referrals to the correct category. In addition some visits have to be delayed due to a reliance on temporary staff. The DN service has completed a skill mix review and will be recruiting to a different grade of staff which will reduce the reliance on agency staff. A caseload review is in progress to ensure focus on self-management approach in District Nursing and increasing patient independence.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.2%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	72	82	82	81	75	77	95	91	87	79	74	63	79	
ED	Ambulance handovers waiting more than 30 mins	0	35	38	15	34	34	37	69	22	41	16	18		97	
ED	Ambulance handovers waiting more than 60 mins	0	1	0	3	11	12	3	18	8	0	1	0		9	
ED	12 hour trolley waits in A&E	0	3	0	0	0	0	0	0	0	0	0	2	0	2	
Cancer	Cancer - 14 days to first seen	>93%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%		95.3%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	98.1%	98.9%	100.0%	100.0%	97.9%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%		98.8%	
Cancer	Cancer - 62 days from referral to treatment	>85%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%		82.4%	
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%							
Cancer	Cancer - 62 Day Screening	>90%											100.0%		100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	97.7%	98.8%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.3%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	1	0	0	0	0	0	0	0	0	0	0	0	0	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2		
Indicator	17_18 Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	2018-2019	Performance
Breast	>85%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%			
Gynaecological	>85%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	33.3%		40.0%				
Haematological (Excluding Acute Leukaemia)	>85%		100.0%					100.0%		50.0%	100.0%	100.0%			
Lower Gastrointestinal	>85%	100.0%	71.4%	76.9%	85.7%	75.0%	66.7%	100.0%	72.7%	66.7%		71.4%			
Lung	>85%	0.0%	100.0%	100.0%	100.0%	100.0%	50.0%		100.0%	50.0%	100.0%	100.0%			
Other	>85%							100.0%				100.0%			
Skin	>85%	100.0%	94.7%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Testicular	>85%									100.0%					
Upper Gastrointestinal	>85%	100.0%	100.0%	0.0%	66.7%	0.0%	50.0%		66.7%	100.0%	100.0%	0.0%			
Urological (Excluding Testicular)	>85%	57.1%	94.1%	100.0%	83.3%	100.0%	100.0%	66.7%	90.0%	58.8%	81.8%	68.4%			
Sarcoma	>85%			0.0%				50.0%							

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2		
Indicator	17_18 Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	2017-2018	Performance
Breast	>93%	98.3%	98.7%	97.3%	99.0%	98.8%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%		97.4%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%		100.0%	
Gynaecological	>93%	100.0%	96.5%	100.0%	100.0%	96.2%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%		97.9%	
Haematological	>93%	85.7%	100.0%	88.9%	100.0%	100.0%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%		88.2%	
Lower Gastrointestinal	>93%	89.7%	79.7%	93.9%	90.6%	87.2%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%		89.2%	
Lung	>93%	90.5%	100.0%	84.2%	100.0%	96.2%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%		94.2%	
Other	>93%														
Skin	>93%	98.7%	97.1%	100.0%	100.0%	98.0%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%		98.7%	
Upper Gastrointestinal	>93%	57.7%	77.8%	78.8%	60.0%	73.5%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%		79.2%	
Urological	>93%	95.9%	100.0%	98.5%	100.0%	98.9%	97.3%	95.5%	93.6%	98.0%	89.0%	89.9%		98.0%	

Community Average Waits

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen	% Target	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen
CAMHS	>95%	8	60.30%	43.80%	62.20%	6.7	111	>95%	2	83.30%	100.00%	66.70%	3.7	6
Child Development Services	>95%	8	88.50%	83.90%	65.00%	7.6	20	>95%						0
IANDS	>95%	8	15.00%	20.00%	40.00%	13.1	25	>95%						0
Community Children's Nursing	>95%	2	81.30%	76.20%	90.00%	0.7	70	>95%	1	100.00%	100.00%	100.00%	0.1	14
Community Paediatrics Services	>95%	12	83.30%	81.10%	72.70%	12.7	22	>95%	1	40.00%	31.10%	12.50%	12.7	24
Haematology Service	>95%	12	100.00%	100.00%	100.00%	0.7	11	>95%						0
Looked After Children	>95%	4	90.00%	86.20%	88.90%	2.3	18	>95%						0
Occupational Therapy	>95%	8	28.60%	36.40%	69.20%	6.2	13	>95%						0
Physiotherapy	>95%	8	53.80%	76.70%	64.60%	6.4	147	>95%						0
PIPS	>95%	12	66.70%	100.00%	100.00%	5.5	18	>95%						0
School Nursing	>95%	12	79.30%	91.20%	100.00%	2.4	39	>95%						0
Speech and Language Therapy	>95%	6	43.10%	52.60%	42.40%	10.6	85	>95%	2	33.30%	100.00%	100.00%	1.7	<5
Bladder and Bowel - Children	>95%	12	26.70%	50.00%	85.70%	9.8	7	>95%						0
Community Matron	>95%	6	100.00%	96.30%	98.00%	1	49	>95%	2			100.00%	0	<5
Adult Wheelchair Service	>95%	8	86.70%	94.20%	97.10%	3.9	35	>95%	2			100.00%	0.1	<5
Cardiology Service	>95%	6	100.00%	100.00%	90.50%	3.5	21	>95%	2	81.80%	83.30%	100.00%	1.7	<5
Community Rehabilitation (CRT)	>95%	12	92.60%	94.00%	93.90%	4.1	99	>95%	2	68.80%	48.80%	45.70%	3.7	35
Community Rehabilitation (ICTT)	>95%	12	89.20%	86.60%	89.40%	5.4	312	>95%	2	44.00%	30.60%	40.60%	2.5	96
Diabetes Service	>95%	6	80.60%	65.10%	76.50%	4.3	119	>95%	2	100.00%		100.00%	0	<5
Intermediate Care (REACH)	>95%	6	73.20%	68.40%	80.40%	3.5	168	>95%	2	45.80%	55.20%	61.50%	4.4	65
Paediatric Wheelchair Service	>95%	8	66.70%	100.00%	87.50%	6.4	8	>95%						0
Respiratory Service	>95%	6	64.60%	65.70%	71.80%	4.6	103	>95%	2	100.00%	50.00%	50.00%	4.2	8
Bladder and Bowel - Adult	>95%	12	61.00%	55.90%	50.40%	15.8	129	>95%	2		0.00%			0
Musculoskeletal Service - CATS	>95%	6	89.60%	90.40%	86.20%	4	326	>95%	2	100.00%	100.00%			0
Musculoskeletal Service - Routine	>95%	6	92.60%	87.80%	82.50%	4.2	1530	>95%	2	42.90%	83.30%			0
Nutrition and Dietetics	>95%	6	89.60%	92.20%	94.80%	2.8	172	>95%						0
Podiatry (Foot Health)	>95%	6	72.70%	76.20%	85.50%	4.1	463	>95%	2	33.00%	0.00%	100.00%	2	<5
Lymphodema Care	>95%	6	95.00%	100.00%	94.40%	3.4	18	>95%						0
Tissue Viability	>95%	6	99.00%	94.00%	100.00%	1	91	>95%	2	100.00%				0

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Haringey Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service Name	% Threshold	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen	% Threshold	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen
CAMHS	>95%	8	66.70%				0	>95%	2					0
Child Development Services	>95%	8	100.00%	100.00%	0.00%	20.3	<5	>95%	2					0
IANDS	>95%	8					0	>95%	2					0
Community Children's Nursing	>95%	2	90.90%	50.00%	100.00%	0.1	6	>95%	1					0
Community Paediatrics Services	>95%	12	90.50%	95.20%	77.80%	13.5	9	>95%	1	16.70%	25.00%	8.70%	13.5	23
Haematology Service	>95%	12	100.00%	100.00%	100.00%	0.3	<5	>95%	2					0
Looked After Children	>95%	4	100.00%	75.00%	100.00%	1.9	8	>95%	2					0
Occupational Therapy	>95%	8	11.10%	13.30%	66.70%	6.3	<5	>95%	2					0
Physiotherapy	>95%	8	77.80%	83.30%	51.90%	7.6	79	>95%	2					0
PIPS	>95%	12	63.60%	100.00%	100.00%	4.8	15	>95%						0
School Nursing	>95%	12	76.70%	86.00%	100.00%	3	17	>95%						0
Speech and Language Therapy	>95%	6	30.40%	43.90%	23.50%	11.7	17	>95%	2	50.00%	100.00%			0
Bladder and Bowel - Children	>95%	12					0	>95%						0
Community Matron	>95%	6	100.00%	92.30%	100.00%	1	16	>95%	2					0
Adult Wheelchair Service	>95%	8	89.70%	94.10%	97.10%	3.9	35	>95%	2			100.00%	0.1	<5
Cardiology Service	>95%	6	100.00%	100.00%	83.30%	4.1	12	>95%	2	0.00%	0.00%			0
Community Rehabilitation (CRT)	>95%	12	100.00%	100.00%	100.00%	1.8	<5	>95%	2	100.00%	0.00%			0
Community Rehabilitation (ICTT)	>95%	12	88.40%	86.80%	89.00%	5.5	301	>95%	2	44.20%	27.70%	39.30%	2.5	89
Diabetes Service	>95%	6	75.00%	51.40%	61.30%	5	62	>95%	2					0
Intermediate Care (REACH)	>95%	6	0.00%	83.30%	100.00%	1	<5	>95%	2			0.00%	12.3	<5
Paediatric Wheelchair Service	>95%	8	66.70%	100.00%	87.50%	6.4	8	>95%	2					0
Respiratory Service	>95%	6	56.40%	54.40%	65.60%	5.2	64	>95%	2		0.00%	25.00%	7.8	<5
Bladder and Bowel - Adult	>95%	12	59.30%	41.80%	30.40%	19	46	>95%	2					0
Musculoskeletal Service - CATS	>95%	6	88.30%	85.90%	81.60%	4.5	185	>95%	2					0
Musculoskeletal Service - Routine	>95%	6	92.10%	87.40%	80.30%	4.2	822	>95%	2	33.30%	80.00%			0
Nutrition and Dietetics	>95%	6	91.90%	89.50%	94.70%	3.1	94	>95%	2					0
Podiatry (Foot Health)	>95%	6	74.80%	80.30%	86.90%	4.1	214	>95%	2	100.00%				0
Lymphodema Care	>95%	6	91.70%	100.00%	85.70%	3.9	7	>95%	2					0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.8	22	>95%	2					0

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Islington Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service Name	% Threshold	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen	% Threshold	Target Weeks	Jun-18	Jul-18	Aug-18	Avg Wait (Aug-18)	No of Pts First Seen
CAMHS	>95%	8	60.00%	42.50%	62.40%	6.7	109	>95%	2	83.30%	100.00%	66.70%	3.7	6
Child Development Services	>95%	8	81.30%	73.70%	66.70%	7.2	18	>95%	2					0
IANDS	>95%	8	10.50%	14.80%	31.80%	14.5	22	>95%	2					0
Community Children's Nursing	>95%	2	80.50%	76.90%	91.50%	0.7	59	>95%	1	100.00%	100.00%	100.00%	0.1	12
Community Paediatrics Services	>95%	12	75.00%	60.00%	70.00%	7.9	10	>95%	1	92.90%	83.30%	100.00%	7.9	<5
Haematology Service	>95%	12	100.00%		100.00%	0.9	6	>95%	2					0
Looked After Children	>95%	4	90.00%	92.30%	100.00%	1.9	6	>95%	2					0
Occupational Therapy	>95%	8	50.00%	58.80%	70.00%	6.1	10	>95%	2					0
Physiotherapy	>95%	8	45.00%	71.40%	81.00%	5	63	>95%	2					0
PIPS	>95%	12	100.00%		100.00%	8.9	<5	>95%						0
School Nursing	>95%	12	83.30%	100.00%	100.00%	2	19	>95%						0
Speech and Language Therapy	>95%	6	53.60%	58.90%	59.10%	7.5	44	>95%	2	0.00%	100.00%			0
Bladder and Bowel - Children	>95%	12	50.00%	42.90%	75.00%	10.3	<5	>95%						0
Community Matron	>95%	6	100.00%	100.00%	97.00%	1	33	>95%	2			100.00%	0	<5
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.4	8	>95%	2	90.00%	100.00%	100.00%	1.7	<5
Community Rehabilitation (CRT)	>95%	12	92.90%	94.30%	93.30%	4.2	89	>95%	2	66.70%	50.00%	48.50%	3.7	33
Community Rehabilitation (ICTT)	>95%	12	100.00%	100.00%			0	>95%	2	0.00%				0
Diabetes Service	>95%	6	89.10%	91.40%	92.90%	3.6	56	>95%	2	100.00%		100.00%	0	<5
Intermediate Care (REACH)	>95%	6	73.50%	67.40%	81.00%	3.4	163	>95%	2	47.80%	51.90%	61.30%	4.4	62
Paediatric Wheelchair Service	>95%	8					0	>95%	2					0
Respiratory Service	>95%	6	82.40%	88.20%	82.10%	3.6	39	>95%	2	100.00%	100.00%	75.00%	0.6	<5
Bladder and Bowel - Adult	>95%	12	78.00%	73.50%	76.70%	9.8	60	>95%	2					0
Musculoskeletal Service - CATS	>95%	6	91.00%	94.60%	92.10%	3.4	139	>95%	2	100.00%	100.00%			0
Musculoskeletal Service - Routine	>95%	6	94.00%	88.80%	87.20%	4.1	600	>95%	2	50.00%				0
Nutrition and Dietetics	>95%	6	86.50%	95.50%	95.40%	2.4	65	>95%	2					0
Podiatry (Foot Health)	>95%	6	71.20%	72.80%	84.30%	4.2	242	>95%	2	0.00%			2	<5
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.1	11	>95%	2					0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.4	32	>95%	2					0

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Responsive Services - Commentary

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

Overall performance against the 95% target for July 2018 was 90.5% and for August was 90.0%. July was one of the busiest months ever and saw 9,287 attendances which was an 8.79% increase compared to July 2017. Despite this there was further improvement in July and August in our 'minors' performance that delivered 96.82% and 97.29% respectively. The median wait for treatment also saw further improvement down to 63 minutes in August against a national standard of 60 minutes. There is further improvement required in the 'majors' or admitted stream and senior staff are working on identifying those further actions that will see overall performance improve.

Ambulance activity has also continued to increase but performance against the 15 and 30 minute handover time standards has remained good. There is further improvement work underway to focus on the first 60 minutes of a patient's arrival that also includes refinement to the streaming model and the enhanced RAT (Rapid Assessment and Treatment) model that we currently offer.

Actions:

The trust has embedded bi-weekly MADE (Multi-Agency Discharge Events), attended by all wards and senior representatives from both Haringey and Islington. Senior medical staff also attend when able which is proving valuable.

There is a continued focus on reducing 'stranded patients' (over 7 days) with the expectation for the trust is to reduce long stay patients by a further 25% by December 2018 which 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 and are part of the 'First 60 minutes' project. 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 overall cancer standards have been achieved by the Trust. The areas which are under the standard as individual tumour groups are:

2ww report: 94.29% overall performance
Haematology: 91.67%, 1 breach out of 12
Lung: 92.86%, 1 breach out of 14
Upper GI: 78.26 %, 10 breach out of 46
Urology: 89.02%, 9 breach out of 82

62 day report: 86.5% overall performance
Gynaecology: 1.5 breaches out of 2.5. Patient delayed diagnostic test by 28 days & the 2nd breach was a shared breach with ULCH; patient ITT sent within 38 day.
Urology: 1.5 breaches out of 12. 1st patient was a full breach due to complex pathway and 2nd patient delayed the oncology appointment due to holiday.
Actions: work in progress with Gynaecology team to improve patient pathway.

Diagnostics

Significant capacity issues in Endoscopy. Additional resources are now in place for September to address shortfall. To be expected to be compliant next month.

Responsive Services - Commentary

Community Waiting Times

Service	Why below target	What in place to improve	Expected date for target to be achieved
CAMHS (Islington) (No change in narrative this month)	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.	Contract Performance Notice received – action plan has been shared with CCG. CCG, LA and WH have submitted 2 trailblazer applications for national funding: 1. To develop Mental Health Support teams in schools to deliver low level interventions for anxiety and depression (which will reduce referrals to community CAMHS) 2. To introduce a single point of access model for social, emotional and mental health support in the borough.	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 (No change in narrative this month)	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.	Urgent referrals achieved 100% Routine referrals improved to 90%	
Community Paediatrics Service (No change in narrative this month)	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.
Haematology Service	Achieved target		

Service	Why below target	What in place to improve	Expected date for target to be achieved
Looked After Children	Haringey: 100% Islington: 100%	Overall target below as the children from other CCG's are not seen within the timeframe.	
Occupational Therapy/ Physiotherapy (Haringey) (No change in narrative this month)	OT: Performance for OT significantly improved from 13.3% to 66.7% PT: Physio performance has gone down from 83.3% to 51.9%	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 58.9% to 70.0% PT: Physio performance has improved from 71.4% to 81%	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	Target achieved		
School Nursing (Haringey)	Target achieved		
School Nursing (Islington)	Target achieved		
Speech and Language Therapy (Haringey)	Decreased from 43.9% to 23.5% 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)	Increase from 58.9% to 59.1% 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

Service	Why below target	What in place to improve	Expected date for target to be achieved
Bladder and Bowel – Children and Adults	Part of CSIG and performance improvement. Capacity - Vacancies have been long standing unable to recruit.	• Interventions, including, the introduction of education classes, new clinic templates, appointments moving to the CBT and the reviewing of DNA and cancellation rates, saw a gradual improvement in performance between April, May and June. • However, given the fragility of the service and the impact any staff absence has upon waiting times, CSIG has established a time limited working-group to scope different models of care and the potential for integrating continence services. • First meeting on 26 September.	6 months (February 2019)
Community Matron	Achieved target		
Adult and Paeds Wheelchair Services	Achieved target		
Cardiology Service	Urgent referrals achieved target Routine referrals just below target at 90.5%		September 2018
Community Rehabilitation (CRT) and (ICTT)	The main issue for both boroughs is SALT, insufficient capacity. Minor gap in physio recruitment.	No new update	November 18
Diabetes Service	Urgent only 2 patients, 1 was unable to contact. Routine – Capacity issues, high DNA rates.	• During the last week of August, blitz clinics held to clear the backlog of patients waiting for routine appointments. • The triaging process was also reviewed and tightened to ensure that triaging is undertaken on a daily basis. • These initial interventions have achieved an 11% rise in performance at the end of August.	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.	• Review clinic templates and explore potential of adding in follow up appointment slots. • Move to admin to booking appointments rather than clinical staff. • Weekly checks by Service Manager to ensure new patient slots filled. • Review joint referral form with CRT to improve quality of referrals and reduce number of inappropriate referrals to REACH • Service Manager to produce monthly activity report for individual staff against target and challenge where underperforming • A Band 8a physio 0.6 WTE begins on 1st October. • In recruitment process for x1 Band 6 and x1 Band 5 physio vacancies.	September 2018 (if staffing level continues to improve)
Respiratory Service	Reduced the exercise programmes by 2 classes due to reduced staffing	New programme opened up in June this year at hospital site -extra venue being sourced for PR	November 18
Musculoskeletal Service CATS and Routine (No change in narrative this month)	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.	• The services has improved on a month-by-month basis and in August reached the 95% target.	December 18

		• The Service Manager made interventions, including the introduction of new clinic templates and robust challenge over diaries and appointment length.	
Podiatry (foot health)	Part of CSIG and performance improvement.	• The service has seen a month on month performance since the project work commenced. • Interventions such as weekly diary checks of all staff by the Service Manager, productivity session with staff, new process for booking follow up appointments and a review of DNA and cancellation rates have been made. • A new education class on heel pain starts on 3 September and these will be rolled out if successful. • A new website also went live in August.	December 18
Lymphodema	Just below target	• Use of blitz clinics to clear backlog of appointments and review of clinician's use of RIO/data recording. • Cancellations and DNA rates reviewed and patients discharged where appropriate. • The target of 95% reached in June and in July.	October 18
Tissue Viability	Achieved target		

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	8	15	9	10	8	2	8	3	5	1	4	1	14	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	5	1	1	0	0	0	0	0	0	0	0	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	247	398	211	282	334	269	312	292	281	212	230		1015	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%		2.7%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	59.0%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	58.5%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	98.8%	95.0%	97.5%	94.5%	95.0%	93.6%	94.5%	93.9%	92.7%	93.4%	93.3%		93.4%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	89.4%	91.6%	88.6%	86.1%	91.6%	93.4%	90.5%	89.7%	92.7%	93.4%	90.5%		91.7%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.8%	92.1%	96.6%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%		94.9%	
Community	Haringey - HR1 % carried out before child aged 15 months		33.0%	68.1%	61.8%	60.3%	67.1%	67.1%	64.3%	64.7%	73.9%	66.6%	71.4%		68.7%	
Community	Haringey - HR2 % carried out before child aged 30 months		50.8%	44.6%	44.2%	38.2%	60.0%	68.6%	59.9%	57.3%	63.0%	59.3%	65.1%		61.1%	
Community	Islington - HR1 % carried out before child aged 15 mths		72.9%	67.3%	69.5%	67.6%	70.9%	78.9%	83.4%	69.8%	80.6%	76.8%	80.5%		76.6%	
Community	Islington - HR2 % carried out before child aged 30 mths		72.0%	63.7%	75.1%	70.1%	71.3%	70.3%	76.1%	78.2%	75.1%	78.0%	79.9%		77.7%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		35.2%	31.9%	32.9%	32.9%	26.6%	27.6%	40.3%	42.9%	50.2%	54.2%	61.6%		52.8%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		41.9%	55.7%	60.6%	60.3%	56.0%	71.5%	66.0%	69.8%	74.7%	79.0%	77.3%		75.3%	

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Responsive Services - Commentary

Cancelled Operations

There was 4 cancelled patients in July, 2 were urgent.
2 patients cancelled in urology, 1 x theatre flooding, 1 x broken scope.
1 patient cancelled in T+O as second surgeon needed for procedure.
1 Gynaecology patient cancelled because of decom problems and scope not available.
All patients booked within 28 days of their cancellation.

There was 1 patient cancelled in August, this patient was routine.
1 patient cancelled in General Surgery; theatre list overran. This patients was booked within 28 days of their cancellation date (21.08.18)
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)

July performance is 2.6% and is below the average for the year. Although slightly above the Trust internal target of 2.4%, we have achieved the National Target of less than 3%. DToC issues are now predominantly relating to external bed availability, waiting for intermediate or care home beds. The bi-weekly MADE events continue to support the proactive management of DToC.

New Birth Visit

Islington: Achieved
Haringey: Good Progression on mandated parts of Healthy Child Programme. New Birth 10 -14 days 91% (n=258 within time frame). Increase this month (n=7) in access to parents (parent forgot apt, mix up in booking, family unable to see HV in timescale . 1 family moved into borough at day 20, 2 were due to errors on MTP or RIO which have been reviewed, 6 in hospital and 3 in Hackney mother and baby unit for Orthodox Jewish Families.

Actions: Review 2 error cases. Commissioners aware of growing Orthodox Jewish Community in East Haringey and impact in relation to New Birth Visits if women in Mother and baby unit. Continued building of relationships with midwives locally. Drive for antenatal review by HV

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

All targets improving trend.

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	75.2%	70.9%	69.0%	70.7%	70.8%	71.6%	68.9%	70.2%	70.8%	71.5%	73.6%	73.2%	71.9%	
HR	Mandatory Training % Rate	>90%	78.9%	79.1%	80.1%	80.5%	81.1%	80.8%	82.6%	82.9%	83.0%	82.8%	82.5%	83.7%	83.0%	
HR	Permanent Staffing WTEs Utilised	>90%	87.3%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.2%	86.2%	86.3%	86.7%	86.8%	
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%	3.30%	3.61%	3.57%	3.65%	4.01%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%		3.42%	
HR	Staff turnover %	<10%	14.4%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	13.6%	
HR	Vacancy % Rate against Establishment	<10%	12.7%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.8%	13.8%	13.7%	13.3%	13.2%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		79.6%	85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	84.4%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		122.8%	133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	136.5%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		102.8%	96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	89.7%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		136.7%	146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	135.2%	
HR	Safe Staffing Alerts - Number of Red Shifts		55	32	16	33	31	12	19	18	8	0	1	1	28	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.3	7.4	8.6	8.4	8.2	8.4	8.6	8.7	9.3	9.4	10.0	9.0	9.3	

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

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Average Staff Cost Per Patient

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

Well Led Services - Commentary

Human Resources

There has been little change in vacancy rates during July/August; newly qualified nursing staff are due to commence from September so the impact of these should be seen in future months. Turnover has slightly decreased though it remains above target and, as previously reported, a relaunched approach to exit interviews will enable more focused action to be directed on particular turnover hotspot areas and enable attention to be directed to these.

Sickness (reported a month in arrears) was slightly above target.

Appraisal rates, though still below target, have improved to 74% and mandatory training has slightly improved to 84% following a refreshed focus on both of these areas.

Well Led Services - Commentary

% day fill rate-nurses

All wards received adequate nurse staffing levels during August18. 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 continuing to work to improve this data capture. 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 continued to be 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. 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 were 2 red shifts reported since the last Trust Performance report. One in July on NICU and one in August on Coyle Ward.

Overall Care hours

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. The increase in CHPPD continues to be related to enhanced one to one care to patients on wards.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Jul-18	Q2 Aug-18	Activity
ED	ED Attendances	8285	8051	8816	8549	8579	8897	8082	9217	8645	9226	8699	9287	8157	
ED	ED Admission Rate %		16.5%	17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	
Community	Community DNA Rate %	<10%	7.7%	8.1%	8.0%	6.8%	7.6%	7.6%	7.7%	7.8%	8.0%	8.0%	8.4%	8.0%	
Community	Community Face to Face Contacts		57519	57646	60681	50488	60028	54229	60337	55786	63757	62366	61120	54572	
Admissions	Elective and Daycase		1828	1907	2004	1587	1944	1735	1879	1719	1840	1880	1760	1805	
Admissions	Emergency Inpatients		2238	2455	2369	2180	2218	1906	2245	2180	2337	2237	2221	2207	
Referrals	GP Referrals to an Acute Service		6908	7602	7638	5926	7874	7362	7892	7167	7698	7635	7644	7015	
Referrals	% of GP Referrals that were completed via ERS		30.3%	32.7%	34.5%	37.2%	46.0%	44.1%	47.0%	58.2%	73.7%	79.6%	81.9%	81.8%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	22.4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	18.2%	12.2%	10.1%	8.8%	10.5%	
Maternity	Maternity Births	333	344	347	337	332	321	253	315	291	323	282	297	321	
Maternity	Maternity Bookings	377	338	420	385	302	405	375	370	400	369	317	376	330	
Outpatients	Outpatient DNA Rate % - New	<10%	11.4%	11.0%	10.2%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	10.1%	10.5%	11.3%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	11.1%	10.2%	10.2%	10.7%	12.1%	9.9%	10.9%	10.2%	12.1%	10.2%	10.4%	10.8%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	11.2%	10.5%	10.2%	10.9%	11.6%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	11.0%	
Outpatients	Outpatient New Attendances		8884	9777	10121	8011	10497	9214	9613	9305	10235	9657	9625	8844	
Outpatients	Outpatient FUp Attendances		17420	19455	19253	15889	18885	16577	17783	17394	18713	18267	18670	17165	
Outpatients	Outpatient Procedures		6470	7095	7450	5837	7409	6826	7086	6787	7419	7200	7542	6716	
Theatres	Theatre Utilisation	>85%	81.2%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	

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Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	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	Q2 Jul-18	Trend
Average Tariff	Daycases		693	687	717	710	697	684	614	740	686	678	703	
Average Tariff	Elective		4042	3959	3525	3526	3403	3550	3710	4033	3831	3778	3857	
Average Tariff	Non-Elective		1693	2188	2180	2561	2670	2362	2194	2484	2511	2564	2272	

Activity - Commentary

Maternity bookings and births

Bookings: increase in July to 376, August figures are 330. Attrition from referrals to booking was high at 20%. Referral for antennal care have remained constant however referral to Bookings have reduced, this is the same across London and the sustainability and transformation partnerships (STP) team have been informed of this trend. There is current work with the NCL Better Births work stream, to have a single point of access to reduce referrals to multiple hospitals.

Births: were lower than expected in June (280) and July (297), however increased in August to 321, attrition bookings to births was 3% (low than July 2018 at 22%) Similar pattern regarding reduction in deliveries has been observed across London, the birth Rate has fallen by 2.5% in England. Compared to last year however complexity of care has increased, requiring increase of appointments and assessments.

Whittington Health second theatre and postnatal refurbishment work is starting at the end of September 2018.

DNA

Roll out for DrDoctor, with reminders and rescheduling, within the Access Centre is ahead of schedule (October 2018). General Surgery department trial has started and the number of requests made by patients is being tracked. We have noted a minimal decrease in DNA's in services since we migrated text reminders from Remind+ to DrDoctor and predict this should improve once the rescheduling feature is turned on.

eRS

Weekly PTL meetings ongoing and e-RS Implementation Group meet bi-weekly. The full paper switch off is due to take place in October. The Trust's new eRS lead has been identified and is in post.

Theatre Utilisation

Theatre utilisation fell from 83% to 77% for July 2018. A high number of patients DNA was noted in July (21 patients), compared to 8 patients in March.

- General surgery from 86% to 84%
- T+O from 81% to 78%
- Urology from 77% to 68%

Activity - Commentary

Theatre Utilisation cont.

Theatre utilisation increased from 77% in July to 82% for August 2018. An Improvement project is currently being undertaken in order to ensure we can deliver the agreed activity for the remaining of the year.

- General Surgery from 84% to 89%
- T+O from 78% to 85%
- Urology has remained at 68%

Whittington Health NHS

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Trust Board

26th September 2018

Title:	Workforce Directorate Annual Report 2017-2018		
Agenda item:	**18/129**	**Paper**	**10**
Action requested:	The Board is asked to receive the Workforce Directorate Annual Report and note the contents.		
Executive Summary:	The Workforce Annual Report gives a detailed summary of work carried out over the past year and demonstrates some of the developments and particular successes achieved by the Directorate. These include: • improvements in the recruitment and retention of staff • equality and inclusion initiatives • workforce statistics • innovation in OD and staff development and wellbeing • demonstrable support to the ICSUs and clinical teams.		
Summary of recommendations:	To endorse the approaches and methodology used to develop the work of the Directorate and support proposals for its vision for the future.		
Fit with WH strategy:	As a key corporate directorate, services provided by the Workforce Directorate underpin all elements of the Trust's strategy and its aim of delivering outstanding care to our local population.		
Reference to related / other documents:	• Trust Strategy • Workforce Strategy • Recruitment & Retention Strategy • Health & Wellbeing Strategy • Corporate Objectives		
Reference to areas of risk and corporate risks on BAF	Risk 4 (workforce capacity) Risk 17 (junior doctors' rotas)		
Date paper completed:	12th September 2018		

Author name and title:		**Norma French Director of Workforce**		**Director name and title:**		**Norma French Director of Workforce**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

WORKFORCE DIRECTORATE ANNUAL REPORT 2018

Contents

Tables

1. INTRODUCTION

This report gives an overview of the Trust workforce as at 31st March 2018, whilst simultaneously addressing the equality and inclusion requirements of the Equality Act 2010.

The Trust has established HR targets and these targets are used to identify progress for a number of key indicators. The workforce composition is compiled by ICSU / Directorate, pay and staff groups.

The main workforce priorities throughout the year were to:

a) Strengthen the Trust's capacity for strategic workforce and organisational development;
b) Ensure the effective management of the workforce;
c) Recruit and retain high calibre staff;
d) Ensure policies and procedures developed in partnership with trade unions are in place to support the workforce and management of staff;
e) Enhance the health and wellbeing of the Trust's workforce.

The structure of the Directorate has evolved over the last three years with the introduction of the business partnering model, workforce information resource, medical staffing expertise and a small organisational development (OD) department and equality and inclusion resource.

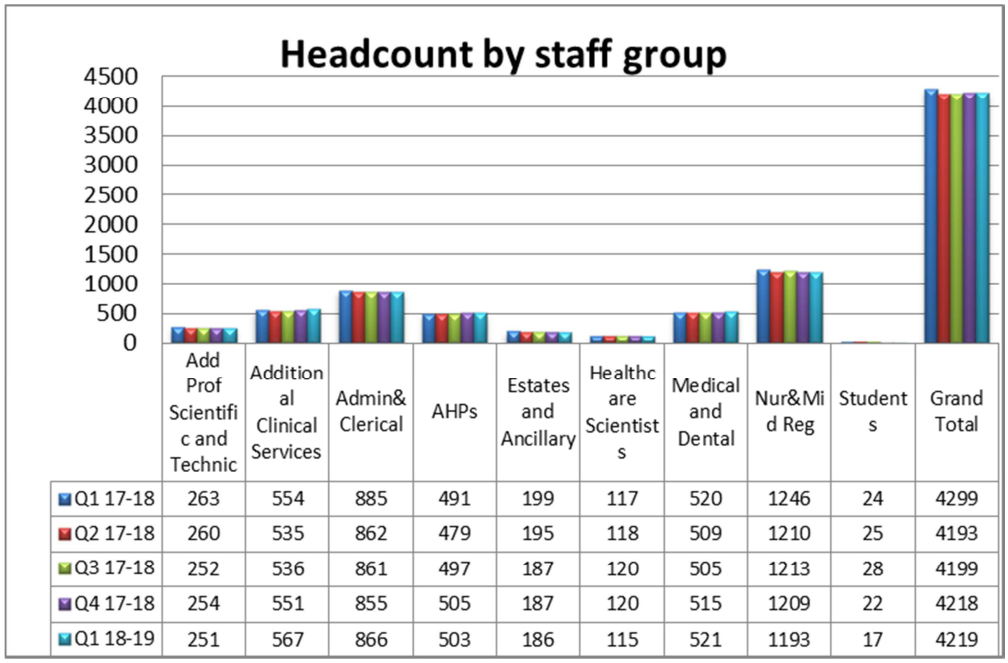
The quality of workforce information has improved immensely in this time, particularly since the alignment of the electronic staff record (ESR) and the general ledger. ICSUs and directorates receive a suite of workforce indicators for their areas and their dedicated HR Business partner is integral to the ICSU management team. The "people issues" agenda presented in the quarterly performance review meetings have expanded and the depth and quality of discussion has become a large focus for the executive team.

The four HR Business Partners (one wholly deployed into medical HR matters trust-wide) undertake the pivotal role within the Workforce Directorate to align the workforce agenda for the trust alongside the needs of each ICSU. HRBP roles continue to evolve to ensure that they remain both a strategic enabler to identify and tackle critical workforce issues, alongside adapting and responding to local service needs and priorities, as these emerge. HRBPs are increasingly responsible for proactively managing both strategic workforce requirements and the oversight of organisational change for their areas, alongside ensuring the effective day to day operational delivery of HR services for their ICSUs.

2. WORKFORCE DEMOGRAPHICS

The total headcount over the five quarters reported here is set out in the chart below. The overall pattern of workforce distribution has not changed significantly over this period.

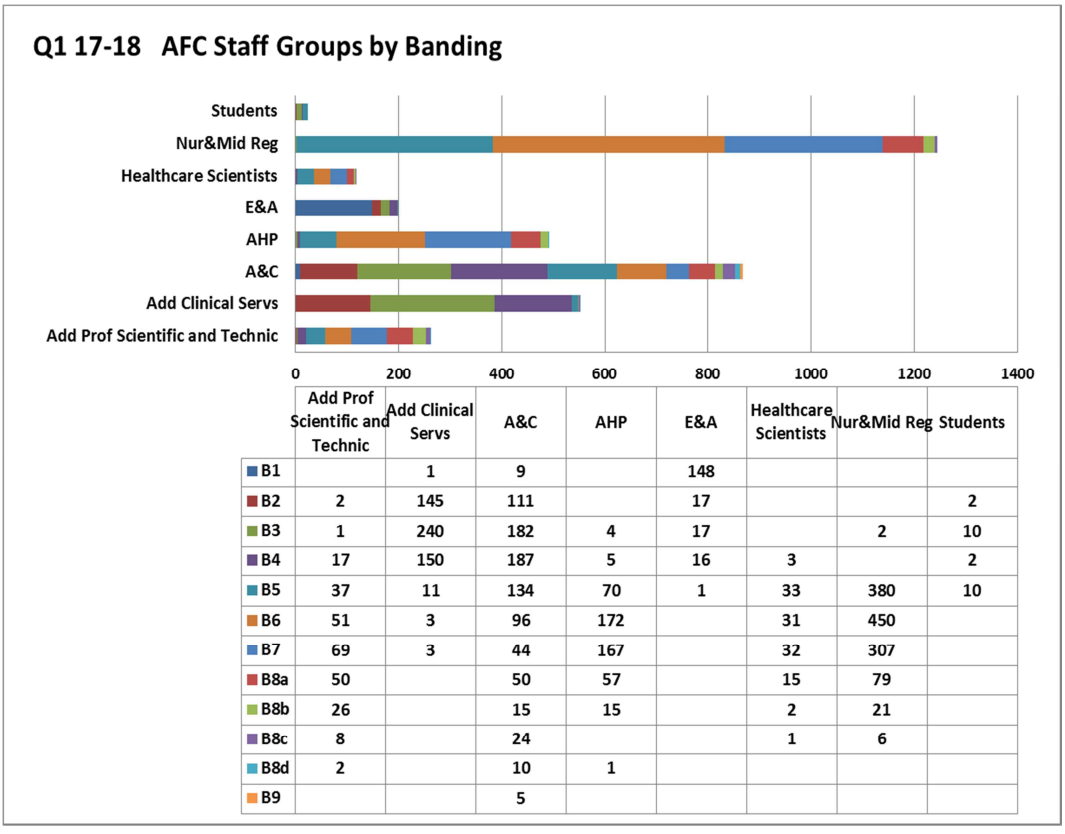
Table 1



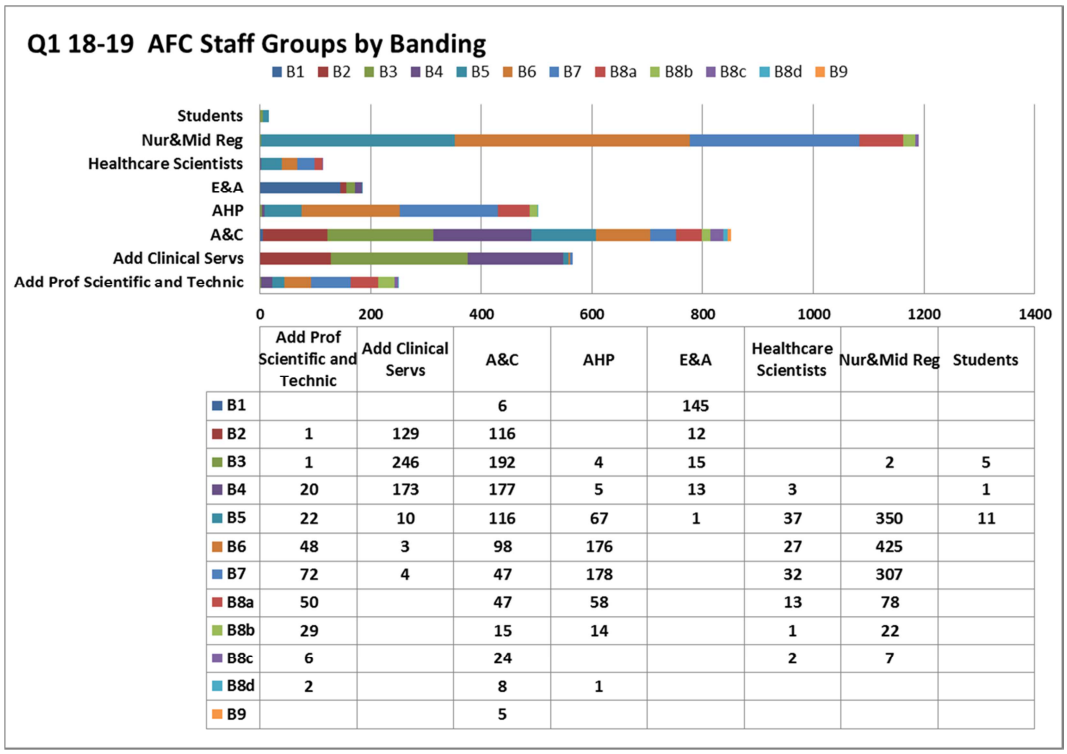
	Add Prof Scientific and Technic	Additional Clinical Services	Admin& Clerical	AHPs	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nur&Mid Reg	Students	Grand Total
Q1 17-18	263	554	885	491	199	117	520	1246	24	4299
Q2 17-18	260	535	862	479	195	118	509	1210	25	4193
Q3 17-18	252	536	861	497	187	120	505	1213	28	4199
Q4 17-18	254	551	855	505	187	120	515	1209	22	4218
Q1 18-19	251	567	866	503	186	115	521	1193	17	4219

Below are two snapshots – one from Q1 17/18 and one from Q1 18/19 - for Agenda for Change banded staff only - of the distribution by banding. Of note is the reduction in band 5 nursing staff in post over that period, along with the concentration of band 6 and 7 posts as a proportion of workforce in AHPs over both periods.

Table 2



	Add Prof Scientific and Technic	Add Clinical Servs	A&C	AHP	E&A	Healthcare Scientists	Nur&Mid Reg	Students
B1		1	9		148			
B2	2	145	111		17			2
B3	1	240	182	4	17		2	10
B4	17	150	187	5	16	3		2
B5	37	11	134	70	1	33	380	10
B6	51	3	96	172		31	450	
B7	69	3	44	167		32	307	
B8a	50		50	57		15	79	
B8b	26		15	15		2	21	
B8c	8		24			1	6	
B8d	2		10	1				
B9			5					



	Add Prof Scientific and Technic	Add Clinical Servs	A&C	AHP	E&A	Healthcare Scientists	Nur&Mid Reg	Students
B1			6		145			
B2	1	129	116		12			
B3	1	246	192	4	15		2	5
B4	20	173	177	5	13	3		1
B5	22	10	116	67	1	37	350	11
B6	48	3	98	176		27	425	
B7	72	4	47	178		32	307	
B8a	50		47	58		13	78	
B8b	29		15	14		1	22	
B8c	6		24			2	7	
B8d	2		8	1				
B9			5					

***Please note that the inclusion of 2 x band 3 posts under N&M registered indicates those who are attached to a band 5 nursing post while awaiting adaptation and substantive appointment to band 5 .**

3.0 WORKFORCE INDICATORS

3.1 Sickness

Table 3

Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19
3.42%	3.29%	2.83%	3.04%	3.40%

The sickness rate has remained relatively stable over the five quarters reported, ranging between 2.83% in Q3 to 3.40% in Q1 18/19.

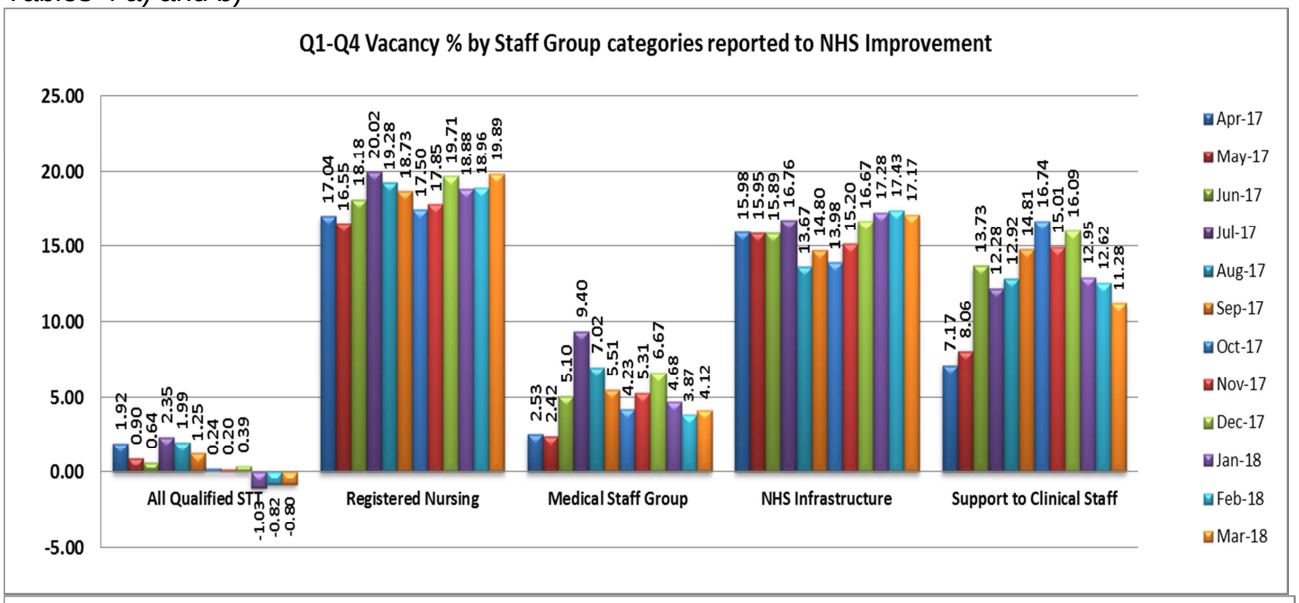
3.2 Vacancies

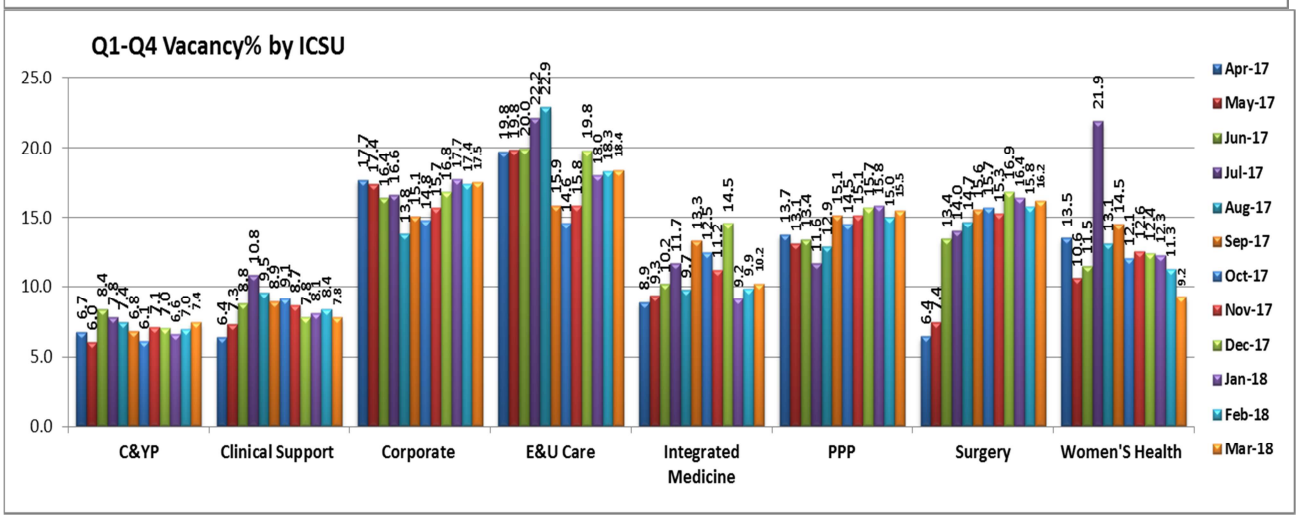
Table 4

Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19
12.59%	12.73%	13.71%	12.75%	13.84%

The overall vacancy factor has fluctuated between 12.59% and 13.84% in Q1 18/19. There are however significant variations in vacancy factors between professional groups and different clinical areas, as the two charts (4 A) and b)) below evidence.

Tables 4 a) and b)





3.3 Turnover and stability

Information below on starters and leavers, labour stability and turnover rate is set out below for the the five quarters reported here. These indicate that WH's ability to retain our workforce and also to recruit at the rate required to retain a stable workforce remain the most significant workforce challenges facing us.

a) Starters and Leavers Table 5 (Headcount)

	Q1 17-18		Q2 17-18		Q3 17-18		Q4 17-18		Q1 18-19	
Staff Group	**Starters**	**Leavers**	**Starters**	**Leavers**	**Starters**	**Leavers**	**Starters**	**Leavers**	**Starters**	**Leavers**
Add Prof Scientific and Technic	22	10	17	18	14	9	14	9	12	12
Additional Clinical Services	28	25	26	34	21	19	21	19	32	14
Administrative and Clerical	35	34	29	60	26	42	26	42	33	22
Allied Health Professionals	20	13	21	32	27	16	27	16	14	18
Estates and Ancillary	0	1	0	3	3	5	3	5	3	3
Healthcare Scientists	4	3	4	1	6	5	6	5	4	5
Medical and Dental	36	16	140	68	49	20	49	20	26	6
Nursing and Midwifery Registered	36	35	39	62	52	31	52	31	26	30
Students	1	3	10	3	1	1	1	1	0	5
Total	**182**	**140**	**286**	**281**	**199**	**148**	**199**	**148**	**150**	**115**

b) Labour Stability Table 6

Headcount	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19
Start	3,698	3676	3576	3564	3559
End	3684	3581	3568	3577	3583
Remain	3576	3444	3412	3400	3427
Index (employees retained in period - calculation 'Remain' figure/'Start'figure x 100)	**96.70%**	**93.69%**	**95.41**	**95.40%**	**96.29%**

c) Turnover rate Table 7

Covers rolling year period as at end of each quarter.

Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19
14.02%	14.42%	14.46%	14.57%	13.99%

We have experienced an increasing trend in turnover during the year 2017-18 against a target of 13%; but there is a welcome slight reduction reported for the first quarter of 2018-19. The factors influencing staff turnover are being tackled through a range of work on staff retention and also with a renewed emphasis on direct immediate findings from exit interviews to identify and tackle turnover "hotspots".

4.0 EQUALITY AND INCLUSION

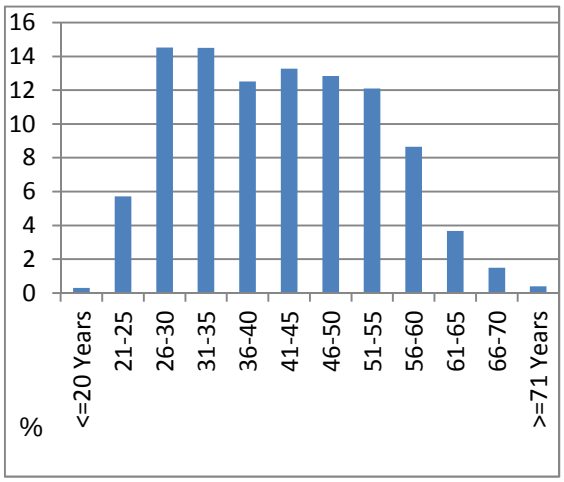
4.1 Previous equalities legislation was superseded by the Equality Act 2010, which protects people in nine protected characteristic groups from discrimination in the use of services and in their employment. The nine groups are:

- Age
- Disability
- Gender Reassignment
- Marriage, same-sex Marriage and Civil Partnership
- Pregnancy and maternity
- Religion or belief
- Sex
- Sexual orientation
- Race- this includes ethnic or national origins, or nationality

4.2 In order to monitor performance it is necessary to maintain records relating to staff demographics, enabling the reporting necessary to undertake the necessary scrutiny. The Trust demographic profile in this report is a snapshot taken from 31 March 2018 and is summarised in the tables below.

4.3 **Age** – Table 8 below shows that the largest proportion of our staff come from the age bands from 26-55 years old, with a lower percentage from age 21-25 and from 56-60. The lowest percentage of staff is younger than 20 years and over 71 years old. Less than 2% of staff are aged between 66 and 70 years old.

Table 8

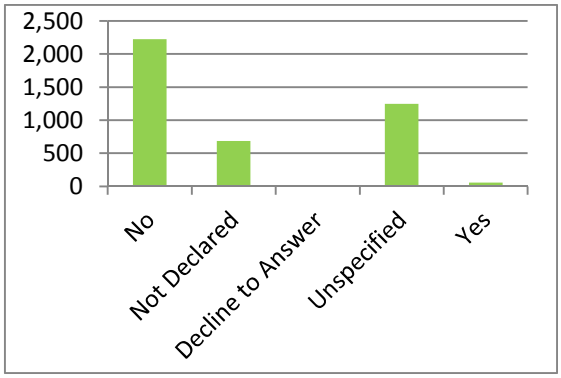


Age Band	Headcount	%	FTE
<=20 Years	13	0.31	12.6
21-25	241	5.72	237.27
26-30	612	14.52	589.2
31-35	611	14.5	553.12
36-40	527	12.51	459.67
41-45	559	13.27	483.61
46-50	541	12.84	487.11
51-55	510	12.1	459.01
56-60	365	8.66	332.73
61-65	155	3.68	134.9
66-70	63	1.5	49.97
>=71 Years	17	0.4	12.32
Grand Total	**4,214**	**100**	**3811.5**

The figures show that only 1.9% of staff are working beyond the state pension age. There is a significant drop of almost 4% from the 51-55 to the 56-60 age bands, and a more significant drop of just under 5% from the 56-60 to the 61-65 age bands, with 98.11% of staff falling into the ages from less than or equal to 20, up to 65 years old. The Office for National Statistics 2015 report demonstrates that the main reason (50%) people work beyond the state pension age is because they are not ready to give up work. The figure is slightly higher for men (52.4%) than for women (47.6%).

4.4 **Disability** – table 9 shows that almost 53% of staff have reported that they do not have a disability, whilst almost 31% have indicated that they do whether specified or not. We do not know about the 16% who have not recorded a positive or negative response to the question on disability in the staff electronic record (ESR) system. It is important that we encourage staff to record their ability/disability profile in order to ensure we can target appropriate support to enable reasonable adjustments to be made.

Table 9

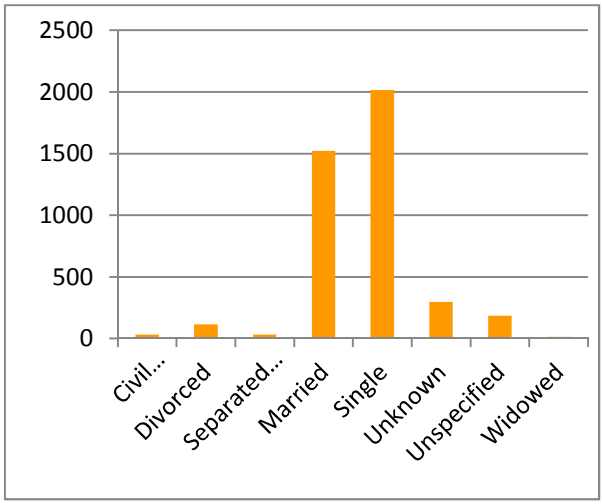


Disability Flag	Headcount	%	FTE
No	2,223	52.8	2061.52
Not Declared	686	16.3	584.8
Decline to Answer	1	0	1
Unspecified	1,248	29.6	1113.46
Yes	55	1.3	49.76
Grand Total	**4,213**	**100**	**3810.54**

4.5 **Gender Reassignment** – we have no data for gender reassignment; it is currently not an available field in ESR and its development is being discussed with users and the provider.

4.6 **Marriage and Civil Partnership** – Table 10 shows the main categories of responses in ESR as 'single' (almost 48%) and 'married' (36%) with only 16% in total covering six categories: 'unknown', 'unspecified', 'separated', 'divorced', in 'civil partnership' or 'widowed'.

Table 10

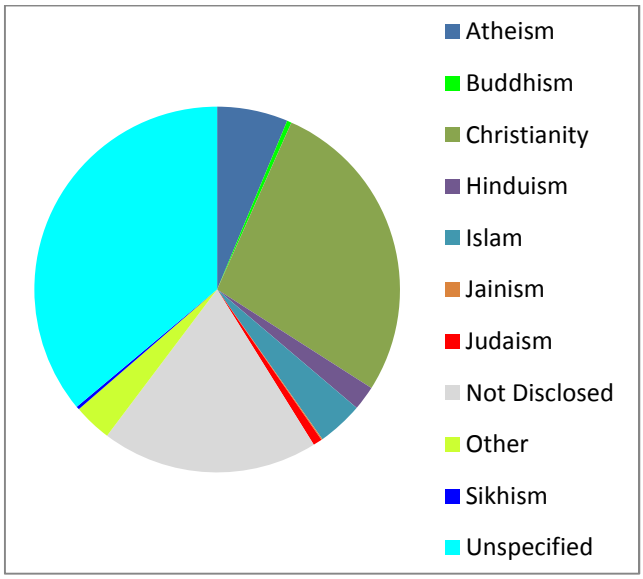


Marital Status	Number	%	FTE
Civil Partnership	32	0.76	28.5
Divorced	114	2.71	102.98
Separated (legal)	32	0.76	27.8
Married	1,521	36.1	1330.3
Single	2,016	47.8	1868.8
Unknown	298	7.07	277.07
Unspecified	186	4.41	163.52
Widowed	15	0.36	12.61
Grand Total	**4,214**	**100**	**3811.5**

4.7 **Pregnancy and Maternity** – at 31 March 2018, 156 women were recorded on ESR as pregnant, which is 4% of the organisation. It is not possible to know the number of all women in the Trust who are pregnant because there is no requirement to record it until the Maternity Certificate can be issued after 20 weeks of pregnancy: ESR will only record those who have completed and submitted their Maternity Certificates.

4.8 **Religion or Belief** – Christianity is the main religion reported at over 27%, with just over 4% Islam and over 2% Hindu. Other significantly large groups, but smaller than the Christian group include those who do not want to disclose (19%) and unspecified (36%). There is no other religious group who have reported on ESR their beliefs at the same rate as Christianity. There are nine religious categories recorded in ESR, not including the non-disclosure categories. Table 11 shows the workforce profile for religion.

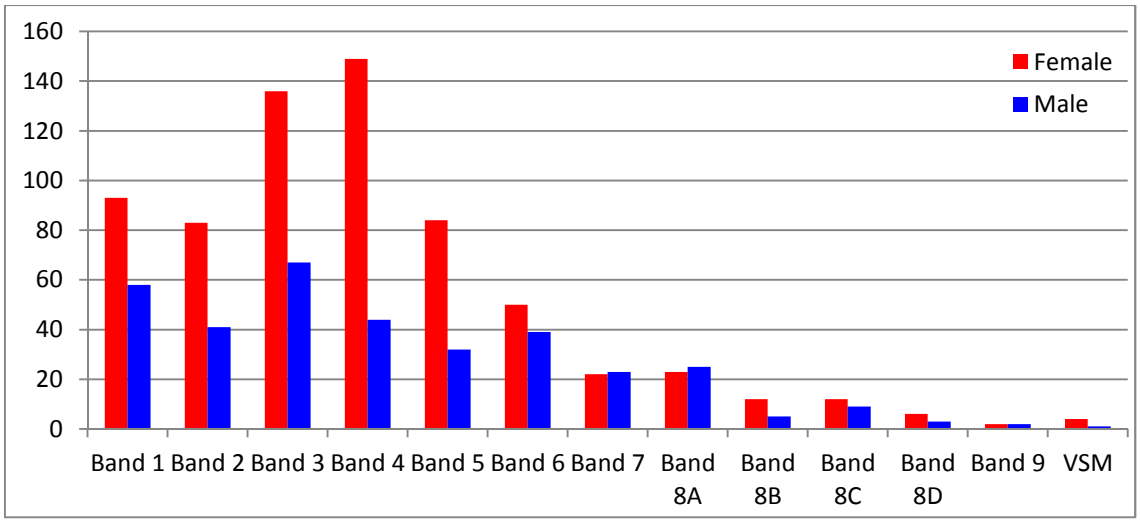
Table 11



Belief	Number	%	FTE
Atheism	264	6.26	242.59
Buddhism	17	0.4	16.7
Christianity	1,153	27.4	1062.4
Hinduism	91	2.16	85.12
Islam	171	4.06	160.17
Jainism	4	0.09	2.79
Judaism	33	0.78	28.61
Not Disclosed	807	19.2	696.44
Other	142	3.37	126.91
Sikhism	12	0.28	11.11
Unspecified	1,520	36.1	1378.7
Grand Total	**4,214**	**100**	**3811.5**

4.9 **Gender** – The charts and tables below provide information on gender by pay band, for (i) non-clinical, (ii) clinical (minus medical and dental), and (iii) medical and dental staff.

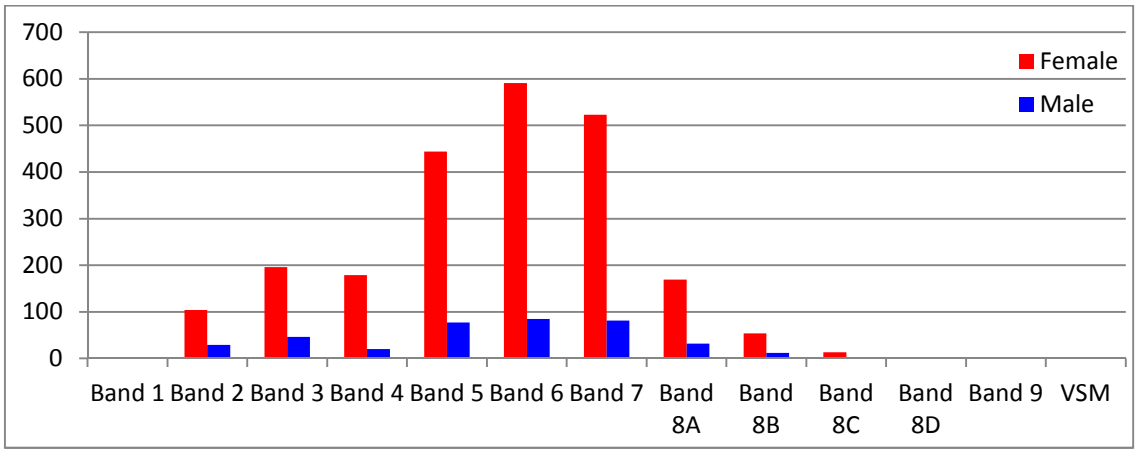
Table 12



4.9.1 Table 12 shows that whilst there appears to be a similar level of representation of women and men in the higher bands, this is disproportionate to the numbers of female and male staff throughout the organisation. For example, there are 1,025 non-clinical staff of whom two thirds are women, whilst the representation of women at the higher bands (8, 9, VSM) is only 57%: a gap of 9%.

4.9.2 Table 13 shows gender by pay band for (ii) clinical staff (minus medical and dental).

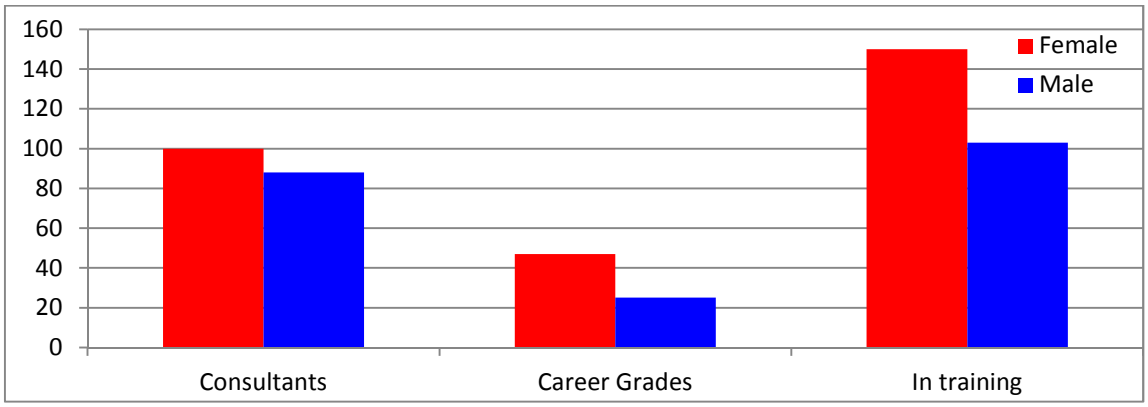
Table 13



4.9.3 Table 13 shows a slightly closer relationship of gender representation at higher bands and overall: female representation for clinical staff is 85% overall with 83% representation at higher bands, and males are slightly more highly represented at higher levels (17%) compared with overall representation at 15%.

4.9.4 Table 14 shows gender by pay band for (iii) medical and dental staff.

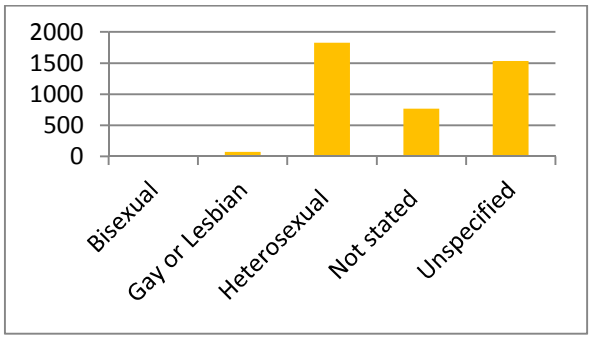
Table 14



4.9.5 The picture for medics and dentist is similar to clinical non-medical and non-dental staff. Whilst 58% of medics and dentists are female, whilst only 53% of consultants are female: a gap of 5%

4.10 **Sexual Orientation** – Table 15 the data held on ESR for sexual orientation. It suggests that for those who are heterosexual, recording that in ESR is not an issue. However, there is a large proportion (almost 55%) of the workforce whose ESR record states either 'unspecified' or nothing.

Table 15



Orientation	Headcount	%	FTE
Bisexual	8	0.19	7.69
Gay or Lesbian	73	1.73	68.51
Heterosexual	1,827	43.4	1681.02
Not stated	769	18.3	659.95
Unspecified	1,536	36.5	1393.36
Grand Total	**4213**	**100**	**3810.54**

4.11 **Race** – Table 16 shows the classic X-shape of lowering BME representation and rising White representation as the band level increases. The following three graphs are for non-clinical, clinical (excluding medical and dental), and medical and dental staff.

Table 16

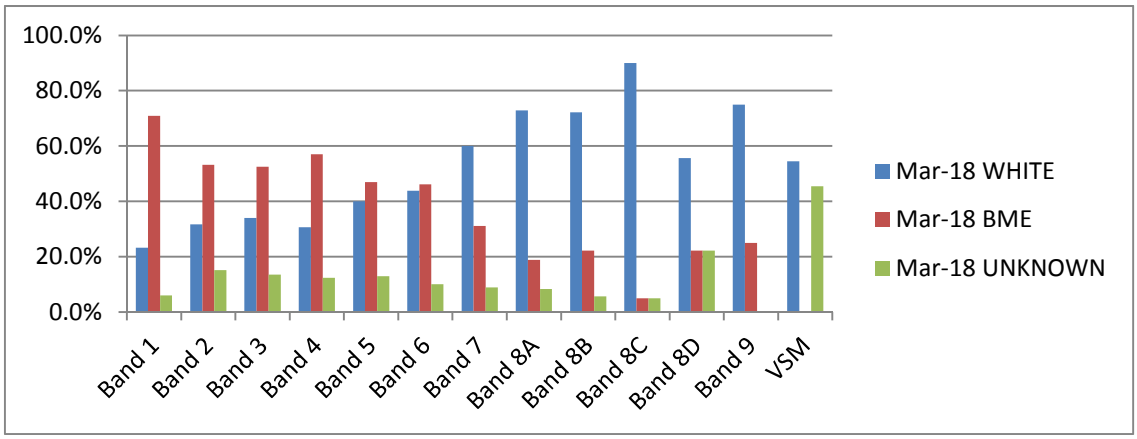
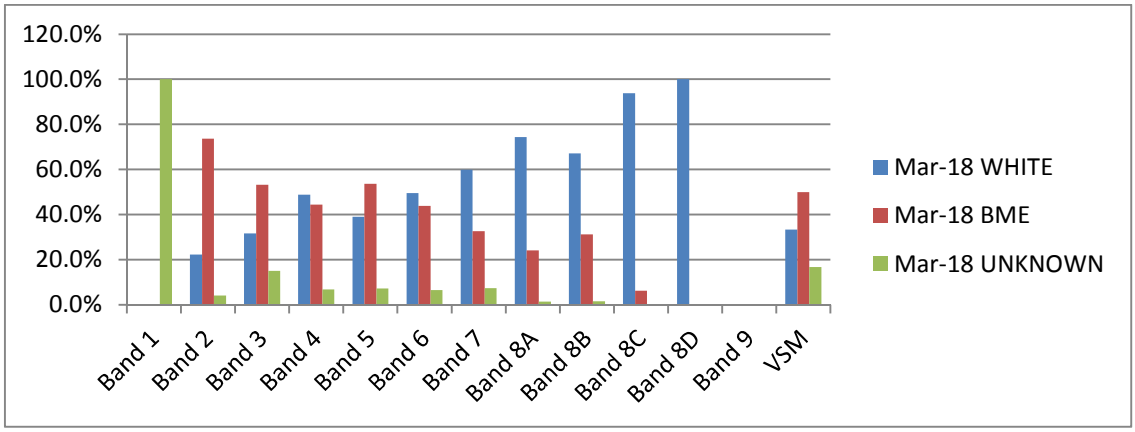


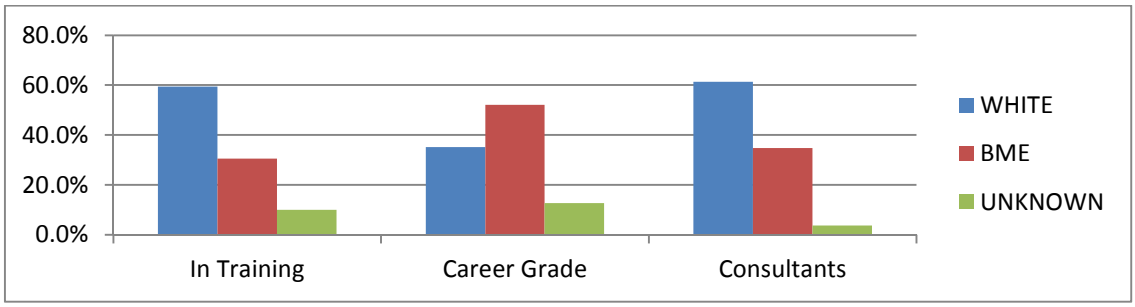
Table 17 shows Race for Clinical Staff Excluding Medical and Dental Staff.

Table 17



4.11.1 Table 18 shows Race for Medical and Dental Staff.

Table 18



4.12 Workforce Race Equality Standard (WRES)

The Trust Board and Trust Management group received a report on the WRES metrics for 2017/1018 at its meeting in July 2018. That report summarised the progress made with the 2017 Action Plan and provided an action plan for the forthcoming year which included ongoing work streams from 2017 as well as new projects for 2018 /2019.

4.13 Equality and Inclusion Staff Networks

The inaugural meeting of a general staff network took place on 25 January 2018 with the attendance of 35 individuals. The next two meetings took place with 11 individuals attending in February, and 6 in March. The meetings are held on changing days and at different times, in order to maximise attendance, and are currently being held at the WEC, in a downstairs room for accessibility reasons. So far the meetings have been structured with participative activities to engage attendees in sharing what they want from the network. Dates for meetings have been set until January 2019. The dates can be found on the dedicated intranet page. An update of the Network is sent to directors and senior colleagues also.

There have been three area network meetings. Interested parties represented the network at the London Regional WDES Engagement Event and are supporting planning of Equalities and Inclusion Week.

A six-weekly bulletin of research, reports and events is sent to 132 members of staff on issues of interest. These are also hosted on the EDI intranet pages, and the sign-up to receive them by email is publicised via all-staff noticeboard.

We are now working towards creating a BME network, and members will be invited to be trained as interview panel members to ensure appropriate representation on senior panels.

4.14 Inclusion Events

The Inclusion team, with the support of the Staff Inclusion Network, hosted events during Equality and Inclusion and Learning at Work Week, 14-18 May. This included “Realising our potential - an opportunity to reflect, reconnect around our values and renew our commitment to Outstanding Patient Care” delivered by Mitzi Wyman as part of the Inclusion Labs pilot.

The Staff Inclusion Network represented Whittington Health at Pride in London in July 2018. The Inclusion Team, Communications Team and Inclusion Network worked together to design and co-ordinate the Trust’s entry. And there is a planned Schwartz Round with a focus on Equality and Inclusion to take place in October.

4.15 Anti-Bullying Scheme

Whist it is good news that one of the Trust's top five results is the high percentage (49% in comparison to the average 47%) of willingness to report experiences of bullying, harassment or abuse. However, 31% of staff reported experiencing bullying, harassment or abuse from colleagues in the last 12 months in comparison with the national 2017 average (for combined acute and community trusts) reporting 24%, a difference of 7%, causing this to be one of our bottom five scores.

The Anti-Bullying and Harassment Scheme was launched in June 2016 with 17 trained Anti-Bullying and Harassment Advisors. Since that time the scheme has seen a fluctuation in activity in the use and access. The numbers are still too low to report, however the emerging themes have included conflict with line manager; bullying by line manager, and conflict/bullying by colleague.

During 207/18 there has been an attrition of Anti-Bullying Advisors. Whilst there is a waiting list of individuals interested in becoming Anti-Bullying & Harassment Advisors, recruitment of more Advisors was delayed pending receipt of Professor Duncan Lewis' culture survey report. Now that we have the report the recommendations have been incorporated into the Inclusion Action Plan. It is clear that the scheme needs to be more widely promoted and routes to access the scheme embedded in our processes to signpost staff to support.

4.16 Speak Up Inclusion Champions

A total of nine Speak Up Inclusion Champions (SUICs) were trained to become representatives of the Freedom to Speak Up campaign and promoting Equality, Diversity and Inclusion (EDI) throughout the Trust. The training was co-designed and delivered by the Freedom to Speak Up Guardian, the Inclusion Team and BRAP, the independent Equality Charity. More recruitment will be taking place in the coming year; currently the SUICs come from Community, Women's Health and Emergency Department as shown in Table 19.

Table 19

ICSU or Department	Number of SUICs
Community Health Services for Adults	3
Women's Health, Outpatients and Diagnostics	3
Surgery and Cancer	0
Emergency and Integrated Medicine	1
Children and Young People's Services	0
Corporate Departments	0

The SUICs will be discussing the role at their ISCUs Boards and will be working towards embedding their roles throughout the Trust during 2018/19. There is a waiting list of staff interested in becoming SUICs to be trained later in 2018/19.

5. RECRUITMENT AND RETENTION

Ensuring we have sufficient staff is the key challenge for WH, as evidenced in section 2 of this report on workforce demographics. To provide a framework for this, in 2016 the Workforce Assurance Committee agreed an ambitious recruitment and retention strategy, with a supporting work programme set out under five headings for recruitment:

- Building and maintaining a professional recruitment presence
- Improving recruitment processes
- Developing innovative recruitment solutions particularly to
- Areas of specific recruitment difficulty
- Tackling specific recruitment challenges
- Developing the Trust as a socially inclusive employer

The strategy also set out identified priorities for the retention work for WH including:

- Improved career planning,
- Support for staff development and progression
- Improving and maintaining staff health and wellbeing
- Attention to both pay and non-pay benefits
- Improved staff engagement and listening to and acting on staff views.
- Improving working conditions for staff
- Managing the consequences of "working longer" and changes to pensions schemes.

An update on progress to date and a refreshed and streamlined work programme was adopted for 2018-19, pending a substantive review of the entire Strategy and development of new action plan, planned for 2019.

Some of our most notable achievements since 2016 have been:

- Creation of professional nurse recruitment team to focus on issues critical to nursing recruitment success
- Establishment of a strong presence for student nurses and newly qualified nursing staff with universities; graduate nursing recruitment events; 46 graduate nurses due to commence in September 2018
- Two large cohorts of international nursing recruits, 94 from the Philippines and 138 from India and managed progress through the recruitment pipeline, into post and extensive support for rapid adaptation
- Recruitment open days and "on the day" assessment
- Active recruitment and retention review group chaired by Director of Workforce
- Merger of temporary staffing recruitment and main recruitment in 2017 to enable consistent processes and standards to be applied
- Online VSP now fully functional for all nonmedical recruitment
- Consultant medical recruitment has new process for approvals and tracking to replace the need for VSP approval
- Pooled applications – this approach has been tested with bank recruitment
- Relaunched community open days
- "Introduce a friend" proposal agreed to pilot for nursing staff in April 2018, to evaluate
- effectiveness after August
- Adoption of shared recruitment and selection policy for North Central London with common standards enabling greater portability of staff throughout the candidate experience and the portability of staff across the patch
- A new project to focus on the particular challenges of Allied Health Professional recruitment and retention.

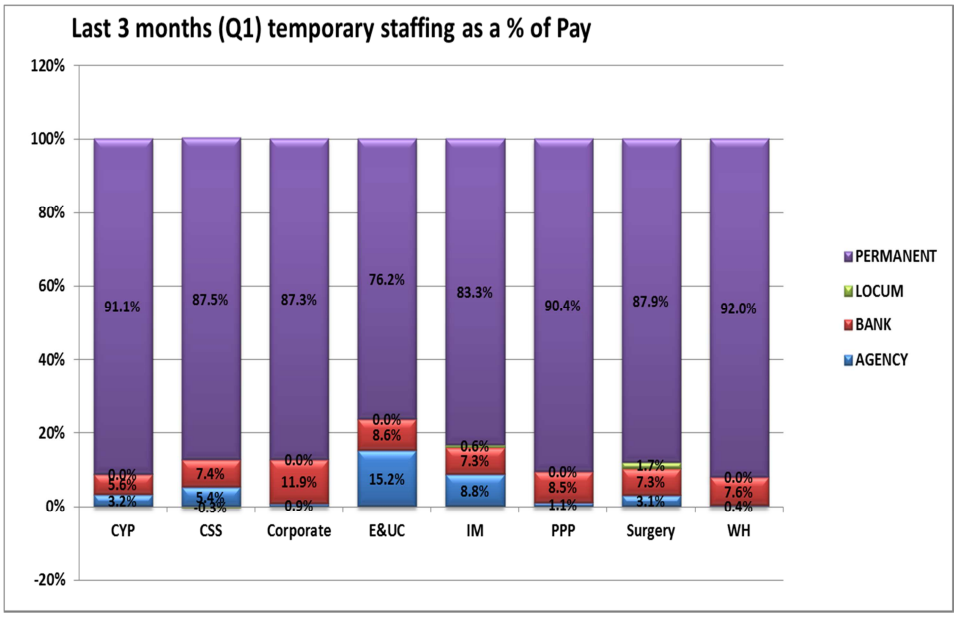
6. TEMPORARY STAFFING

While the Trust remains committed to continuing to improve the recruitment and retention of permanent substantive staff the use of temporary staffing remains an important adjunct to ensuring safe staffing; the issue is minimising reliance on agency and achieving best value from our agency provision when necessary. Particularly with other challenges such as an ageing workforce; sustaining adequate permanent staffing numbers will be a persistent and recurring challenge.

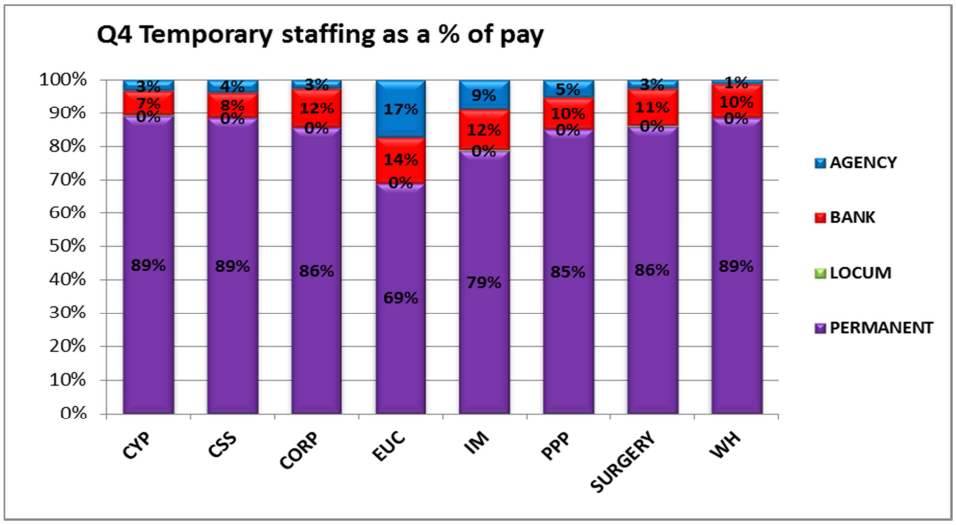
The greatest proportion of temporary staffing deployment and expenditure relates to bank staff. The two diagrams below from quarter 1 and quarter 4 indicate that, for the most part bank usage has increased and agency has reduced.

Table 20

Quarter 1 temporary staffing as proportion of pay bill (April – June 2017)

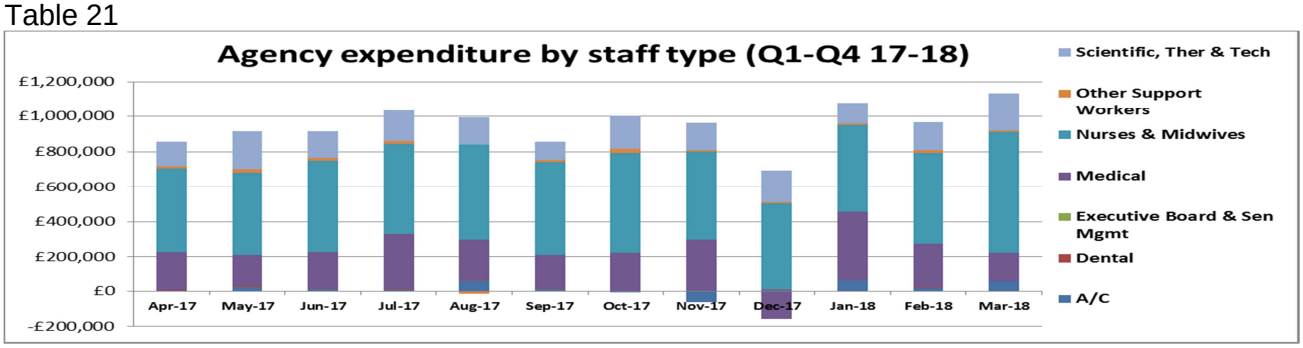


Quarter 4 temporary staffing as proportion of pay bill (January to March 2018)



With regard to agency expenditure, the chart below highlights the split of agency expenditure by staff type over the four quarters of 17-18. The two most significant areas of agency use are nursing, which is the largest proportion of the workforce, and medical staff where, in some areas, the services rely on agency staff to maintain safe services and to cover rota gaps.

Table 21



Other improvements in temporary staffing management and deployment have been as follows:

- In response to new rules from NHSI, the Trust has issued tighter guidelines on the booking of agency with a view to ensuring all shifts are booked through the Temporary Staff Office (TSO). Where bookings which breach either the capped rate or require off framework usage are made out of hours, authorisation is given by Gold On Call.
- A review of staff bank rates was completed and implemented for nursing, medical and AHPs, and will be further (re)considered in light of the national AfC contract refresh.
- A Temporary Staffing Office (TSO) Transformation Plan is being implemented to standardise the number of local booking procedures, systems, and processes currently experienced within the TSO, to modernise and upgrade in order to realise the benefits offered by Allocate processes through BankStaff, and where agreed and mapped, through connectivity to Healthroster.
- Improving our website presence and responsiveness for temporary staffing applications.
- Proactive management of agency relationships, including agreement of a tiered service level agreement with selected nursing agencies and regular monitoring meetings.
- We implemented the local London rates for agency medical locums in October 2017 and the local London rates for bank medical locums on 9 April 2018. The Trust has seen success with implementing the local London Bank rates. We will also be piloting an app in October 2018 which aims to improve recruitment into the bank for medical locums and improve bank medical locum staff experience.
- Following a task and finish group set up to review agency usage within Emergency Medicine, a number of long term agency posts were moved successfully into bank or fixed term employment within the Trust.

Future challenges include:

- Ensuring that we are able to comply with new more onerous reporting requirements to NHSI and that proper controls and scrutiny is exercised under this regime.
- Explore future opportunities for greater collaboration within the NCL STP across on a range of temporary staffing related issues including collaboration on bank rates and exploring long term options for shared bank services.
- Greater automation and streamlining of booking processes, including launching the agency booking module to improve timeliness and responsiveness for booking.
- Improved agency to bank transfer processes.

7. STAFF DEVELOPMENT

The information below highlights performance against the target rates for compliance in both appraisal and statutory and mandatory training indicators.

The target for both indicators is 90%; and particularly in respect of appraisal, the overall reducing trend over the period reported is a source of concern which is being addressed managerially. Appraisal compliance has also reduced but this has demonstrated a slight improvement in the most recent quarters reported.

	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19
Trust Mandatory Training compliance rate	82%	79%	81%	83%	83%
Trust Appraisal compliance rate	79%	75%	71%	69%	71%

7.1 Appraisal

When conducted well, appraisals are an important part of an individual's development, supporting ambition, a desire for improvement and help to align people's ambitions to organisational goals. It is pleasing, therefore, that our National Staff Survey score for the quality of appraisals has been maintained since last year, and compares well at 3.27 against the national average of 3.11. It is therefore essential that we increase our compliance rate in completing appraisals to ensure we achieve the benefits.

The latest National Staff Survey results for 2017 shows an increase in staff being appraised in the last 12 months, 85% in comparison to 81% in 2016. The national 2017 average for combined acute and community trusts was 86%.

The quality of appraisals scored at 3.27 (in comparison to 2016 at 3.85) against the national 2017 average of 3.11; the best score was 3.46. Whittington Health's results is ranked in the top 5 scores of acute and community trusts, which is considered to be "better than" the average.

We have continued to offer appraisal training for managers, Coaching Conversations, and appraisal training for staff throughout the year. Table 22 below shows the number of delegates who attended during 2017/18:

Table 22

Title of Course	Number of sessions	Number of Attendees
Appraisal Training	10	100
Coaching Conversations	8	92
Appraisals Training for Appraisees	7	51

Appraisal compliance has been steadily consistent with an average of 76% throughout 2017. Improvements in the ESR portal have led to automated notification for when the next appraisal is due, therefore all staff in post of excess of twelve months will be informed three months in advance.

Learning and Development continues to work with line managers to support them in completing appraisals and recording details on the ESR in a timely fashion to be published on a monthly basis.

Going forward we will continue to offer appraisal training for managers and staff, alongside Coaching Conversations during 2018/19, including bespoke training. The appraisal intranet page will be reviewed during 2018/19 to become more relevant.

7.2 Mandatory Training

More than six years ago Whittington Health was one of eight trusts joined a working group to align recruitment and training to standardise training across London, known as the Streamlining Programme. Streamlining is about working collaboratively to embed and deliver consistency through human resources (HR) best practice and excellence. The aim is to deliver a quality recruitment experience in an efficient and timely way, reducing duplication and unnecessary delays in getting the successful candidate started in the workplace. Streamlining engages professionals from the four key HR work streams to support and deliver best practice: occupational health, medical staffing, statutory and mandatory training, and recruitment.

The programme was started following a campaign by Doctors who, on rotation, found they were required to repeat study recently undertaken. Due to the nature of training, regular movement between employing trusts is a fundamental part of their training programme. Over a ten-year training career, doctors in training move organisation an average of ten times, however for some doctors this could be as many as 16 times. This high frequency of movement reinforces the need to get the rotational process right to ensure a good experience for the trainees while enabling trusts to run an efficient and effective process.

Health Education England's report 'Enhancing Junior Doctors' Working Lives - a progress report' highlighted the need for improvement in employers' approaches to induction and mandatory training. Specifically, the report stated that recruitment and induction processes need to reduce duplication of pre-employment checks, mandatory training and induction when employees move from one NHS organisation to another, without any break in service.

Whilst the programme started with Doctors, the intention was to streamline recruitment, induction and training for all staff to save an estimated £64 million, across London, wasted in duplicated work and study time.

Although trusts across London were in agreement with the intention, many found that aligning processes, with the variety of standards and software programmes used, became too difficult to achieve, and the programme trailed off without achieving its initial goals. The programme is now being revitalised and North Central London (NCL) STP is ahead of other London STPs in forging ahead with this work. So far, data has been collected on where the NCL trusts are on aligning with the Core Skills Training Framework, establishing competencies according to a variety of levels (from 'whole organisation' to 'role') and not only enable automated intra-authority transfers (IATs) but use them fully to reduce duplication. The Whittington Health 'heap map' used to monitor progress of all the participant trusts is 'green' in all cases: either having implemented or is in the process of implementing all the requirements to enable streamlining.

Sub-groups have been formed to drive forward work in other areas including 'Administrative Excellence', 'Course Redesign' and 'Productivity and Efficiency', and groups are looking at both recruitment, and statutory and mandatory training (now known as Core Skills training), including induction. This section focuses on Core Skills training and the standardisation of expectation across the STP.

Current Streamlining Position at Whittington Health - In order to align, the Core Skills Training Framework (is being used. The Subject Guide can be found at http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework.

The Subject Guide provides the recommended refresher periods for training. Whittington Health mandatory training adheres to the refresher periods in all but five cases as follows:

- Health and Safety – over and above requirement at every two-years instead of three-years
- Resuscitation – Level 1 – below requirement as not delivered

- Resuscitation - Level 2 – below requirement at 2 intervals instead of 1
- Infection Prevention Level 1 - over and above requirement at two-year refreshers instead of three-year
- Infection Prevention Level 2 – below requirement at two-year refreshers instead of yearly

After speaking with the subject matter experts (SMEs) about the differences, agreement has been given to bring Health and Safety into alignment.

7.2.1 *Health and Safety*

The subject matter expert (SME) agrees that the Core Skills Framework frequency can be applied, which means that staff moving to Whittington Health who are compliant in Health and Safety will not be required to repeat training more frequently than other STP colleagues.

7.2.2 *Resuscitation*

Following discussion with the SME, it was agreed that we can quickly and easily achieve alignment with Level 1 by including a fifteen minute slot in induction. We are also confident that Level 3 is aligned because our policy identifies the relevant personnel who are trained at this level.

Aligning Level 2 is more of a challenge. We currently are not requiring refresher training with enough frequency to be aligned with the STP, and capacity to do this is a challenge. The Resus Council guidance for staff training is one Resus team member for 750 staff. The SME has recently filled one vacancy, however, in line with the Resus Council guidance would like another team member. This is therefore still a work in progress.

7.2.3 *Infection Prevention and Control*

To align Level 1 training we reduced refresher training from every two years instead of every three years. The converse is true for Level 2 because the Trust's current requirement is for refresher training two years and it should be every year. The SME and the Director of Infection Prevention and Control agree that capacity to deliver is not a concern; we now need an internal communications campaign to alert staff to the changing requirement to give them time to undertake refresher training before the change is made to the compliance reporting.

7.2.4 *Administrative Excellence*

Of the ten organisations in NCL, Whittington Health did well in terms of completing the tasks-list to maximise the electronic staff record (ESR) system functionality, which in turn supports staff portability. The substantial project to load competencies onto ESR met with an obstacle before the deadline, however, this was recovered largely through the dedication of the Learning and Development Manager to complete the project and enable participation
in the STP testing of staff portability.

7.2.5 *Whittington Staff Training Compliance*

The Learning and Development team provide administrative support for mandatory and non-mandatory training across the Trust. Ten of the mandatory training courses are monitored, reported and published on a monthly basis as part of the wider NHS Core Skills Training Framework (CSTF). The overall compliance rate for those mandatory training subjects have been consistent throughout 2018/19, but below expectation at an average of 82%.

Table 23 illustrates the variety of non-mandatory training available from Learning and Development to staff during 2017/18.

Table 23

Course	Number of Sessions	Number of Attendees
Moving Forward Leadership programme	1	10
Stepping Stones Leadership programme	1	17
Absence Management	6	60
Becoming an Inclusive Organisation (Unconscious Bias)	5	59
Frontline Leadership Programme	2	38
Capability (Performance Management) Probation Workshop	5	59
Change Management	2	14
Dealing with Grievance and Bullying & Harassment	5	42
Employee Relations Investigations	3	24
Clinical Leadership & Management Programme	1	17
Band 7 Nurses Clinical Leadership Programme	1	16
British Sign Language (BSL) Level 1	1	6
Customer Care for a Diverse Client Group	8	227
ESR Manager & Administrator Self-Service Training	11	50
Mindfulness Meditation Training	4	101
Personal Effectiveness Training	2	10
Pre-Retirement Awareness Seminar	2	64
Professional Manager as a Trainer Award	3	18
Quality Improvement Silver	1	22
Report Writing	1	9
Type in Two Days	1	9
Workshop for Raising Awareness of PREVENT (WRAP 3)	71	1995
Preparing for Interviews	3	37
Interviewing Skills Workshop	1	4

7.3 Talent for Care – Apprenticeships

Whittington Health, along with all organisations whose pay bill is more than £3 million, pays a levy at 0.5% (approximately £850,000) of our total pay bill. We are entitled to use these funds to train existing or new staff under the new apprenticeships scheme. The funding must be claimed by the training provider registered to deliver programmes accredited to the relevant apprenticeship standards. Whittington Health is not a registered provider of the apprenticeship qualifications offered, and therefore these funds will be provided to suitably qualified colleges to train our apprentices. Alongside this funding provision, we are given a target of recruiting 414 apprentices over four years.

7.3.1 *Tenders and Strategic Engagements for Apprenticeships*

The old apprenticeship 'frameworks' (which result in NVQ and BTEC qualifications) are gradually being phased out as the new standards are being developed. Until the new standard is published, it is necessary to continue to procure for the framework. We are currently tendering or have completed tendering for the following (Table 24):

Table 24

Subject	Framework	Progress	Provider
Business Administration level 2	Framework	Completed	GP Strategies
Business Administration level 3	Standard	Completed	GP Strategies
Customer Service level 2	Standard	Completed	GP Strategies
Healthcare Support Worker level 2	Standard	Completed	CONEL/CCCT
Senior Healthcare Support worker level 3	Standard	Completed	CONEL/CCCT
Team Leader/Supervisor level 3	Standard	Underway	TBC
Operational/Departmental Manager level 5	Standard	Underway	TBC
Associate Project Manager level 4	Standard	Underway	TBC

Discussions have started with the provider for the first three apprenticeships which will be promoted under the I:CARE values branding ("I:CARE Business Administration" and "I:CARE Customer Service") to align with the branding used for our OD leadership development programmes.

In order to progress the nursing apprenticeship workstream, as members of the working group for the NCL Nursing Associate Test Site Partnership, we regularly attend workshops and meetings. The Trainee Nursing Associate (TNA) Apprenticeship Pilot 2018 is likely to commence at Whittington in November 2018 with 20 TNAs.

7.3.2 *Participation in Strategic Networks*

Our Talent for Care Lead has participated in, contributed to, and engaged clinicians the following groups:

- Member of NCL STP Apprenticeship Policy development group (The policy now in place and we are working through its implementation)
- Part of Trailblazer standard development group for Occupational Therapy and Physiotherapy (first meetings, then ensured internal subject matter expert engagement)
- Encouraged Whittington Health participation in various Trailblazers, including the following:
    - Occupational Therapy
    - Physiotherapy
    - Health records
    - Specialist Community Public Health Nurse
    - Midwife
    - Screening Technician
    - Speech and Language Therapy
    - District Nurse
    - Clinical coding
- Working with training suppliers to integrate Stepping Stones Programme into Team Leader level 3 apprenticeship (standard)

7.3.3 *Provision of Apprenticeship Support*

Celebration Events for apprenticeship achievements have been introduced, and take place once per quarter, also incorporating the celebration of achievement in other qualifications and programmes. Whilst these events are short in duration, we invite senior colleagues to present certificates, and offer refreshments, to demonstrate that the Trust values those who invest in their development.

The Talent for Care Lead provides support for managers including conducting interviews and further recruitment support by liaising with candidates, colleges, managers and recruitment advisors, in order to make the apprentices' joining as smooth as possible, and reducing the workload for the recruiting manager.

Thirty apprentices started in 2017-18. Thirteen of these starts are new entrants and up to twenty can be counted as contributing to Whittington Health public sector target of approximately 414 starts over four year period ending in March 2021.

Support has been provided to managers with other apprentice related issues, such as sickness absence, maternity, conduct, and transition to permanent employment as well as providing pastoral support and advice to apprentices, and support to staff interested in career development.

To ensure we attract future apprentices to be able to meet the requirements of potential courses, we have set up and managed Functional Skills classes for those who need additional support for maths and English. We are currently exploring a model to help internal candidates interested in applying for the Trainee Nurse Associate to gain relevant functional skills in time for application process.

7.3.4 *Work Experience, Widening Participation and Youth Engagement*

To ensure we develop a pipeline of potential apprentices we engage in a variety of activities and groups. These include the following:

- Membership of the Health and Social Care Sector Employment Steering Group (NCL)
- Part of HEE led NCL STP Work experience Policy working group (until December 2017 and currently temporarily suspended)
- Working with CEPN to find placements for traineeship participants and provided hospital tours for two cohorts including radiology, pharmacy, maternity, pathology, medical physics IAPT & district nursing
- Exploring the possibility of becoming a main employer site for Project Search, The Autism Project (TAP), and Ambitious About Autism. We were not successful in securing a main site position with Project Search, however, we are working with them to provide placements for students on their third rotation (working interviews)
- Engagement with Armed Forces Covenant to work towards Bronze status in the short term and Silver status in the next one or two years
- Supporting managers who provide work placements, engaged with departments to source further work placements, engaged with students and those interested in accessing WH work placements via email, face to face at career fairs and over the phone
- Engaged with potential apprentices via:
  - Whittington Health Open Day and during national apprenticeship week and other internal events
  - Careers Fairs in local colleges, schools and larger exhibitions (e.g. Alexandra Palace) (approximately 3-4 events per quarter), engaging with an average of around 100 students and potential apprentices on each occasion
  - Delivered a presentation to over 150 6th Form students on the variety of apprenticeships and career pathways into the NHS (Q4 16/17)

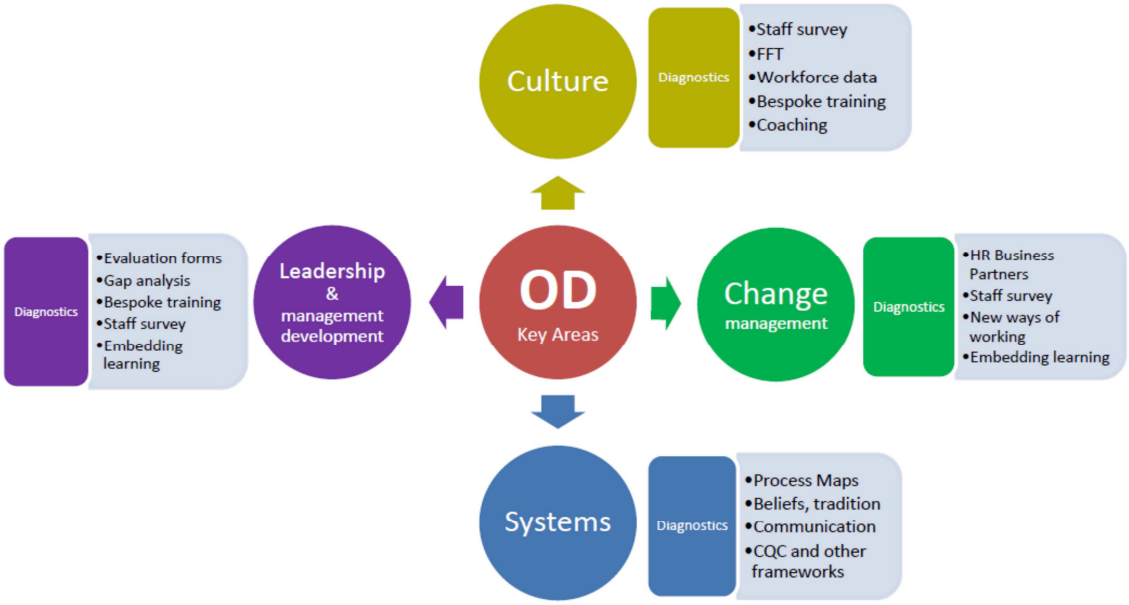
- Schools careers advisors (attended training day organised by Islington council and caught up with individuals).

- Organised participation of WH in pilot work experience for upcoming T-levels (pharmacy placement, likely to be widened to include other departments in the future).

Progress with the Public Sector Target - A significant amount of activity has been undertaken over the last year, and whilst we have started thirty apprentices only twenty can count towards our public sector target. This is a disappointing return for the effort.

8.0 ORGANISATION DEVELOPMENT

The Organisational Development (OD) Team was established in May 2017 as a key enabler for delivering the workforce and wider Trust strategy. In the first year the OD team set out 4 clear priorities to support the vision to provide excellent care delivered by expert and caring staff. Within these four areas the team have asked how they can ensure staff have the capability to perform excellently within the realms of capacity, competence and confidence. The type of diagnostics and qualitative information used is detailed below alongside the 4 focus areas.



To help users understand the OD offering and how to access it the team provided the following:

i. An OD strapline “enhancing staff experience in service of our patients” - alluding to the growing evidence that staff morale has a direct correlation with patient outcomes

ii. An explicit OD offering ‘Working with staff to find bespoke solutions for improved staff experience. Working with I.C.A.R.E. values when supporting staff so that they may provide safe, personal, co-ordinated care for the community we serve. Using the learning to respond to and inform strategic direction of the Trust

iii. An OD web page detailing the offerings.

In the first year the team has primarily focused on the development of the culture and leadership and management development to improve confidence and competence. Working as internal consultants, they have provided diagnostic insight, support and a variety of resources to managers and teams to enable them to enhance the working environment. This has taken the form of devising bespoke workshops, creating programmes and referring people to coaching, mentoring or mediation where appropriate.

In a short time the OD Team has developed an excellent reputation, receiving praise and high evaluation scores from users. From the bespoke programmes, 98% of participants scored the presentation and delivery at four out of five or above; 98% scored the workshop content at four out of five or above; and 96% scored the relevance to their roles at four out of five or above.

8.1 **Staff Survey**

The 2017 Staff Survey was open to all staff this year with a target response rate of 40% from 36% in 2016. Responding to Picker advice the team visited a number of community sites and went to the areas in the hospital where staff traditionally don't get engaged to highlight the importance of the survey and to share how the organisation has responded to staff comments in the past. Working closely with the Workforce team the response rate this year was 42.4%

The 'We Said We Did' campaign continues and HRBPs, OD and inclusion are running 4 events in the community and acute settings to ensure staff solutions are incorporated into the 2017 action plan.

The OD commitment is to support 'hot spot' areas and offer a suite of tools to struggling teams so that they are better able to improve their areas in the ways that they choose. This has included working with one senior team of clinicians alongside their Clinical Director to improve their collaborative working and individual leadership skills as per Michael West's 8 key factors in effective team working.

Whittington Health conducted its seventh national staff survey as an integrated care organisation (ICO). The survey was distributed to all staff, rather than a sample, who met the criteria, and achieved a response rate of 42.4% which is an increase of over 6% from last year's 36% response rate. The survey asks members of staff a number of questions on their jobs, managers, health and wellbeing, development, the organisation, and background information for equality monitoring purposes. The purpose is to give staff a voice and provide managers with an insight into morale, culture and perception of service delivery. Appraisals & support for development

The Staff Survey results and associated Action Plan have been presented separately to the Trust Board, TMG and Partnerships Group.

8.2 Staff Family and Friends Test

We are now in our third year of running the national Staff Friends and Family Test (FFT). On a quarterly basis Trusts survey all staff and ask two questions:

- How likely are you to recommend Whittington Health to friends and family if they needed care or treatment?
- How likely are you to recommend Whittington Health to friends and family as a place to work?

There is also a free text section where staff can give comments.

The survey is online and staff are encouraged to give feedback which gives an indication on staff engagement. Staff engagement is a key indicator for the Trust in measuring how well it manages and engages staff and the FFT test is just one mechanism of measuring our progress on a quarterly basis. These results are presented to the Trust Board and TMG on a quarterly basis.

8.3 Leadership Development

In the first few months of its inception the OD team surveyed 28 key stakeholders across the trust to better understand the current gaps in clinical leadership development. The findings highlighted 6 themes

1. Whittington has examples of excellent leadership learning opportunities but there are gaps
2. A matrix style of delivery sometimes hinders a cohesive and accessible service for end users
3. Learning & development offerings could play a bigger part in helping to develop clear career pathways and succession planning for a range of Whittington clinical staff
4. Learning & development opportunities could play a part in helping with a number of clinical roles that are not perceived as attractive to staff
5. There aren't explicit and/or consistent 'Whittington Clinical Leader' models
6. There aren't developmental opportunities for enabling/skilling clinicians to work within systems such as STP/NCL.

As a response to the findings, a recent co-authored paper with the Chief Operating Officer, Clinical Directors, Deputy Director of Nursing and Medical Director has been approved at Trust Management level and the organisation will develop a clinical and operational leaders' competency framework in line with the Trust ICARE values. The OD team will support its development and roll out the first iteration at Clinical, Nursing and Operational Director level.

The development of training and learning opportunities will be informed by the coaching opportunities offered to clinical leaders at all levels. This year the OD team have coached over 30 members of staff, the majority of which have been clinical or operational leaders. To ensure this type of support continues, particularly for new managers and leaders, OD have commissioned the training of 22 members of staff to become accredited coaches. They will qualify by July 2018 and are committed to each coaching a minimum of 3 members of staff in the following 12 months.

Aligning the Trust ICARE values with staff's day to day work has been a focus in the last year and will continue to be in 2018. Below are some of the programmes that have been developed to increase the competence and confidence of staff to be excellent in what they do and make the trust values meaningful in that development:

- I:CARE Leadership Programme (for Band 5 – 7 staff)
- I:CARE B7 Clinical Leadership programme (for nursing and Health Visiting staff)
- I:CARE Team Player (for all staff)
- I:CARE Senior Operational and Clinical Programme (for the senior new ICSU triumvirates)
- I:CARE Leaders and Influencers Programme (for all staff, starting in September 2018)
- I:CARE Senior Nursing Team Programme (for the new, cross ICSU senior nursing team, starting in September 2018).

9 EMPLOYEE RELATIONS

9.1 Policy Development

The Employee Relations team within the Workforce Directorate continues to work closely with staff side to review and ensure the development of best practice employment policies and procedures.

Recent and ongoing policy reviews include:

- Pay protection
- Pay progression policy and procedure
- Probation policy and procedure
- Recruitment and selection policy (part of NCL partners)
- Disciplinary policy and procedure
- Annual leave
- Parental Handbook

Currently the Grievance policy and procedure is being reviewed, along with Sickness Absence and the Bullying and Harassment Procedure.

Going forward, a review of the Partnership Agreement is also scheduled. In addition, any changes required to implement the contract refresh of Agenda for Change relating to pay progression, access to consistent child bereavement lead and enhanced shared parental care and consistency with a national framework for buying and selling annual leave, will also be undertaken in partnership, once the national guidance on these is published.

9.2 Fair Treatment Panel

The Equality and Diversity Annual report at WH 2015/16 indicated the relative likelihood of staff from BME backgrounds entering the formal disciplinary process was 2.67 times greater than that of white counterparts. In 2016/17 the figure decreased slightly (improved) to 2.41 times greater. To address this, we have introduced a two stage process of triage for disciplinary procedures; firstly, the application of a decision tree, a tool comprising an algorithm with accompanying guidelines and posing a series of structured questions to help managers decide whether formal action is essential or whether alternatives might be feasible, and secondly, a pre-formal action check by a Director or Deputy Director level member of staff. The first of these is scheduled to take place in August.

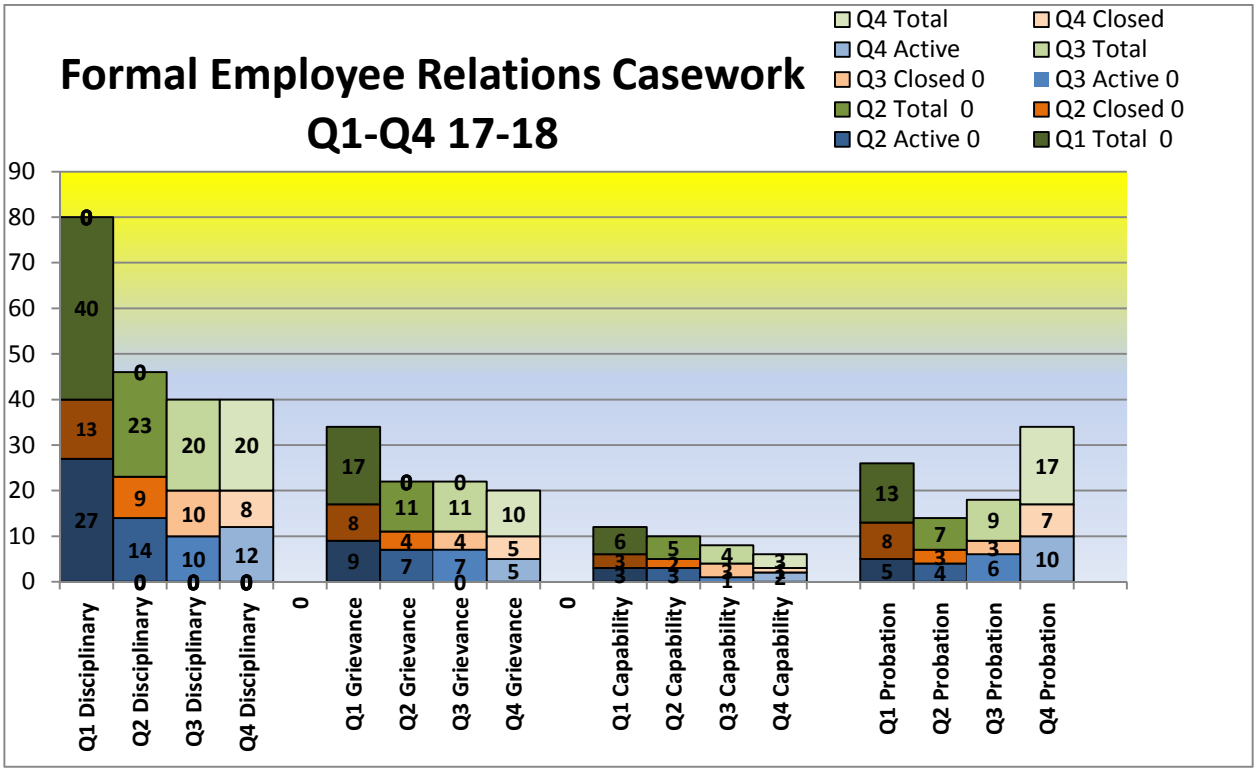
10.3 Partnership Group

The Partnership Group continues to meet on a monthly basis to discuss issues affecting staff.

10.4 Case Management

Table 25 shows the total formal employee relations casework management undertaken by the ER team for 2017-18, including disciplinary cases, grievances, capability and probation cases.

Table 25



Detailed employee relations oversight and performance is undertaken at the Workforce Assurance Committee. Overall, the critical challenge in ER casework is to improve time to resolve. Only 44% of total ER casework (disciplinary, grievance, bullying and harassment cases) were completed within the target 90 day time to resolve target in the last quarter reported here (q.4).

During 2018 the Employee Relations team have purchased a case management system which will provide greater visibility and support improved compliance with HR policies and timeframes to resolve cases. Benefits include:

- A real time dashboard to aid prioritisation of cases.
- All case notes and documents are stored against the employee record via the cloud.
- Proactive reminders advising when a task is required to be undertaken; this will also enhance escalation procedures when delays are caused by investigation officers
- More cost effective service provided by the ER Team as management of cases will be streamlined and duplication of data entry cut down.
- Greatly enhanced data accuracy and integrity by having employee demographic information imported and enabling statutory compliance with the Public Sector Equality Duty in respect of reporting on grievances and disciplinaries against the nine protected characteristics.
- Greater visibility of medical HR cases covered through Maintaining High Professional Standards enabling more rapid resolution and oversight of potential delays.

11. MEDICAL WORKFORCE

The medical workforce team is led by the HRBP for Medical Workforce and incorporates both the medical recruitment team and the medical workforce advisor supporting all issues relating to junior doctors' rotas and exception reporting.

Some key metrics and highlights relating to medical workforce are reported overleaf:

11.1 **Medical workforce establishment and staff in post**

Table 26

Grade	Q1		Q2		Q3		Q4		Q5	
	Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE	Headcount	WTE
Consultant	165	150.64	159	144.64	163	146.19	164	146.89	165	147.5
Locum Consultant	23	17.85	24	20.28	23	19.18	23	19.3	27	21.3
Associate Specialist	7	4.45	6	3.85	6	3.85	6	3.95	6	3.95
Specialty Doctor	13	11.8	13	12.25	12	12	11	11	10	10
Specialty Registrar (Trainee and Trust Grade)	197	183.69	213	198.04	197	186.64	202	191.96	201	189.89
Foundation Year 2	28	27.2	30	29.7	27	26.7	30	29.3	31	30.3
Foundation Year 1	31	30.21	31	30.5	31	30.5	31	30.5	31	30.5
Others (Clinical Assistant, Salaried GP)	6	2.11	6	2.11	6	2.11	6	2.72	6	2.72
TOTAL	470	427.95	482	441.37	465	427.17	473	435.62	477	436.16

The medical workforce establishment has remained fairly constant throughout the five quarters reported here. On closer examination, although the total headcount of the Trust's substantive Consultant body has remained at 165, there has been a reduction of 3.14 wte. The trust has increased the number of locum consultants employed on Fixed Term Contracts from a headcount of 23 to 27.

The Trust has seen a small increase in Junior Doctor establishment since Q1, this can mainly be attributed to improved trainee allocations and placements at the Trust by Health Education England.

11.2 **Consultant Job Planning**

A revised Job Planning toolkit was negotiated with the Trust's MNSC and implemented in January 2018. This has made the process for job planning clearer, and introduced an Executive Level sign off for Trust Job plans. The Trust has also introduced Electronic Job Planning Software through Allocate to act as the central depository for Trust Job plans, and also allow for great analysis and data.

Of note is the fact that the current medical workforce is currently being paid a total 68.09 additional programmed activities. The majority (53.59 APAs) are provided by Consultants, with the majority of APAs provided by the Surgery & Cancer and Emergency and Urgent Care ICSUs.

11.3 **Junior Doctor Workforce**

In August 2016, the 2016 Junior Doctor Contract came into force, with a planned gradual migration to the new Terms and Conditions. This transition, for the vast majority, was completed by October 2017 (Q3). While there were concerns that the introduction of this contract may result in trainee posts being unfilled and resulting rota gaps, analysis of the data to date shows that these fears did not come to fruition. Numbers of junior doctor numbers have remained fairly constant.

The introduction of the 2016 Contract has led to the requirement on trusts to enable Junior Doctors in Training to report centrally where they are working hours that are additional to those rostered as exception reports. During this reporting period the Trust has seen a total of 509 exception reports raised by trainees, with the vast majority of those at Foundation Year 1 level, within the Integrated Medicine ICSU.

11.0 OCCUPATIONAL HEALTH AND WELLBEING SERVICES

The Occupational Health (OH) department is a confidential, unbiased clinical service. Our aim is to protect and promote the health of Whittington Health employees, independent contractors and our external contactors.

We mainly operate a pre-booked appointment service; however, we will treat emergency clients e.g. following a needle stick injury or assault incident. Our opening hours are 9.00am – 5.00pm Monday to Friday and we are based on two sites – one in the Old Police House at the Whittington site and another at Tynemouth Road which serves our Haringey-based community staff and our biggest contract, Haringey Council. We are a nurse-led service but with access to an Occupational Health Physician who is on site one day per week.

We offer a range of services such as: -

- Triaging and assessing all new employee's health status when they join Whittington Health (pre-employment health assessment screening)
- Sickness absence management and fitness to return to work health interview assessments following periods of absence due to illness, with advice on any adjustments/support required to assist the employee back into work and on how avoid or make their health condition worse
- Health promotion and protection services e.g. vaccination and health/environmental surveillance programmes tailored to the individual worker including the annual flu campaign
- Infection control advice and contact tracing and treatment following exposure to infections
- We signpost to expert advice e.g. counselling, physiotherapy and specialist advice such as post exposure prophylaxis
- Staff support/counselling and accident follow up
- Health promotion/education
- Health and safety advice/COSHH support
- Income generation.

This list is not exhaustive.

Physiotherapy
We have a service level agreement with our own in-house physiotherapy department and we referred 127 Whittington Health employees between April 2017 and March 2018 (4 sessions each).

Counselling
We engage an external Employee Assistance Programme provider, People at Work, who provide our counselling service, resilience training and a range of other support/advice services. 106 individuals were referred for counselling (4 face to face sessions each) between April 2017 and March 2018.

Needle stick injury follow up
The total number of 85 incidents recorded between April 17 and March 18 included 65 sharp injuries and 20 splash incidents**.** This is a reduction from 106 in the previous year, following an audit of all sharps used across the Trust, which were replaced with safety sharps wherever possible. The main areas where all sharps could not be replaced with safer alternatives were theatres, labour ward, ED and ITU (usually for suturing and scalpels) and these areas remain our high risk red RAG rated areas. A rolling training programme was put in place for these areas. Training for ward areas now focuses more on PPE and prevention of splash incidents.

Flu
This year was another success, with a final flu tally of 80.2% of the workforce being immunised, the number of HCWs involved with direct patient care: (total HCWs): was 2694. We linked this to a UNICEF project which aims to eradicate neo-natal tetanus worldwide by donating 10 tetanus vaccines for every flu jab given to a member of our staff.

This total places us second in London for flu vaccines.

Health Promotion
We put on several Health Promotion events throughout the year, usually linked to giveaways provided by "work perk". This proved to be a successful way to gain staff engagement at the events. For example we used "mug shot" during the flu campaign as a treat for having the jab, we used porridge to promote the importance of having a healthy breakfast (in conjunction with our dieticians), Innocent bubbles drinks to encourage staff to stay hydrated during warm weather and cream eggs as an Easter treat.

Health and Wellbeing
We hosted the Healthy Living ambassador on the wave 1 pilot cohort programme. Progress since then has included:

- Introduction of 12 Health & well-being ambassadors
- Step challenges with porters and district nurses,
- Take the stairs initiative,
- ITU fitness challenge, and an upcoming running club in the community.

We successfully bid for £40,000 pounds from the HENCEL retention funding.

We surveyed staff about what initiatives they wanted to see in place, and implemented the findings, namely:

- 247 people have attended resilience workshops and 14 departments have had individual workshops.
- Provision of mindfulness training
- A comfortable rest area in the staff area of the restaurant where staff can relax during breaks
- Ping pong table
- Provision of a staff picnic and rounders equipment
- We branded our Whitfit logo with 2 pop-up banners and a table cloth for our promotions
- We gave a pedometer to everyone who took part in the lunch time walks, and a branded water bottle to those who did three walks.
- We also gave pedometers and bottles to all who took part in the step challenge both in the hospital (porters) and in the community (district nurses).
- We purchased 15 Fit bits which we are still giving out to enterprising employees who introduce local healthy initiatives and encourage their team to get involved.
- We also introduced massage, yoga, aromatherapy and lunchtime walks.

We have several external contracts in place for the provision of OH services; please see Table 27 for a summary.

Table 27

ORGANISATION
Haringey council
The Bridge Renewal Trust
Berendsen UK Ltd
Hail
Haringey Schools
Haringey Schools GP reports
Haringey School Counselling re charge
Islington Council Flu Campaign
Highgate School
Oliver Bonas
North Middlesex Hospital
Health Foundation
Haringey Council
FES FM Ltd
Sodexo
Prior Weston School - Flu (Islington)
Solicitors
Highgate & Holly House
The Kings Fund

12.0 CONCLUSIONS

The Trust has met its statutory obligations to monitor and report on equality and diversity issues and provides assurance that action is being taken and planned to address issues of note.

As a result of our analysis there are no significant areas of concern that are unique to this organisation, although there are a number of issues which continue to be raised which require further understanding and investigation and / or specific action

There are some significant workforce issues that the trust is facing currently in an uncertain and shifting political and economic climate. There are also a number of opportunities that the trust can maximise with the strong foundation of a stable workforce that is highly committed, well-motivated and fairly managed.

Whittington Health NHS

Trust Board

26th September 2018

Title:	**Nursing establishment review – 6 months (April 2018)**		
Agenda item:	**18/130**	**Paper**	**11**
Action requested:	Approval recommendation on change to skill mix and reduction in registered nurse establishments		
Executive Summary:	1. A review of the wards was undertaken using April 2018 as the reference period. 2. There were high occupancy rates on the medical wards. 3. The current ratio of midwife to births is 1:28 4. The neonatal unit establishment is in line with national recommendations 5. The emergency department took part in the national pilot of a new safer nursing care tool for the area. 6. Overall the establishment is sufficient and there are recommendations for changes to RN: patient ratios, and aligning the establishments to the agreed staffing ratios for current bed model		
Summary of recommendations:	1. Review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure that wards and departments are safely staffed 2. Recommendation by chief nurse to approve the skill mix and RN reduction as presented in **Appendix one**		
Fit with WH strategy:	Efficient and effective care.		
Reference to related / other documents:	Francis Report recommendations Trust Safer Staffing Nursing Establishment Policy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	12 September 2018		

Author name and title:		**Lisa Smith ,Assistant Chief Nurse**		**Director name and title:**		**Michelle Johnson** **Chief Nurse**	
Date paper seen by EC	yes	**Equality Impact Assessment completes?**	NA	**Quality Impact Assessment complete?**	TBC	**Financial Impact Assessment ?**	TBC

SIX MONTHLY REVIEW OF THE HOSPITAL INPATIENT AND EMERGENCY DEPARTMENT NURSING STAFFING ESTABLISHMENTS

1.0 INTRODUCTION

1.1 This paper provides an update on current ward nursing and midwifery staffing levels following a review of nurse ward/department establishments undertaken in April 2018. This paper should be considered alongside the information shared each month in the Nursing and Midwifery Safer Staffing Reports. Currently there is only a National requirement to report formally on hospital inpatient and Emergency department establishment. Future reviews will start to include community nursing services e.g. Health visiting, school nursing, community children's nursing and district nursing.

2.0 OUR APPROACH TO ENSURING SAFE STAFFING LEVELS

2.1 Ward nursing establishments are formally reviewed every six months to ensure the ward based nursing workforce meets the demands of clinical care provision and delivers safe care with a positive patient experience. For the purpose of this review data for wards was collected via Allocate Healthroster for the month of April 2018. Acuity is assessed and recorded into the SaferCare module of Healthroster three times a day, and the patient census is recorded at midnight. The calculation for the recommended establishment is based on the Safer Nursing Care Tool multipliers (Shelford Group 2012). The application of recommended nurse patient ratios was also applied as appropriate. Professional judgement by ward managers and matrons and challenge is then applied by associate directors of nursing to the outcome of the data. The April 2018 outcome was also exposed to further internal and external (NHSI) challenge and confirm. The final recommendations are approved by the associate directors of nursing.

2.2 NHS Improvement published improvement resources in the past year including maternity, neonatal care and children and young people's services, urgent and emergency care, mental health services, learning disability services and adult inpatients in acute care. They recommended that there is also a six monthly review of the establishments of the neonatal unit and maternity.

3.0 VACANCY LEVELS

3.1 There has not been a significant change in the vacancy levels for registered nurses and midwives between October 2017 and March 2018 (See table below).

ICSU	October 17 %	March 18 %	Trend
CYP	10.27	14.09	⇑
CSS	33.33	33.33	⇔
EUC	17.46	18.98	⇑
IM	31.65	30.63	⇓

PPP	29.67	31.29	⇧
Surgery	26.64	25.71	⇩
WH	10.02	8.02	⇩

3.2 The challenge and risk for the organisation will be ensuring our nursing and midwifery vacancy levels do not significantly rise above current levels.

3.3 Turnover of registered nurses and midwives was 12.7% in the clinical ICSUs at the end of March 2018. This represents a small improvement from October 2017 (See table below) Retention and growing our own talented staff within the organisation is a key area of focus over the next year. This will assist with stabilising and retaining our existing workforce.

4.0 FINDINGS

4.1 **Adult Wards**
During the review period there were high occupancy levels on the all medical wards, which consistently reported bed occupancy rates of 95% and above.

4.2 In April 2018, additional winter pressure beds continued to be open on Coyle and Cavell wards above the funded bed/nursing establishment and in addition to this on some days there were also extra “plus one” beds opened on wards in line with the Emergency Department escalation protocol.

4.3 Cavell Ward, the winter pressure older people’s ward had a high recommended establishment in the review compared to the agreed establishment. Staffing was increased by one HCA at each shift as a result of the last review. During the reference period, there was particularly high acuity and dependency on the ward alongside a high number of patients requiring enhanced care. This ward, which was opened to relieve winter pressures, has now closed (July 2018).

4.4 Mary Seacole South and North (Acute Assessment Unit) both had a lower recommended establishment (following review) compared to the funded nursing establishment. During the reference period (taken at midnight) the bed occupancy was lower than expected at 84% and 86% respectively, however, during the day the occupancy rates are generally over 95%. The rates were taken from the midnight census as required which is a point where the bed management and operational management team have freed beds to improve flow through ED.

4.5 **The findings of the review of the adult inpatient wards have indicated skill mix and RN variations to the current ward establishments (Appendix two) which have been recommended following internal review through chief nurse and deputy chief nurse and NHSI London director of nursing at a challenge and confirm session held on 6/09.18.**

4.6 Maternity
The current ratio of midwife to births is 1:28 based on 3,800 births a year, which the Head of Midwifery confirms is a safe ratio for the current client group.

4.7 The ratio is reviewed monthly by the Head of Midwifery using the North Central London calculator.

4.8 There will be a full Birthrate Plus staffing assessment carried out in the next six months. This is the method recommended via the NHS Improvement resource, which was last updated on 30 January 2018.

4.9 Neonatal Intensive Care Unit (NNU)
The British Association of Perinatal Medicine (BAPM) recommended establishment is 61.54 wte and the establishment at the start of the reference period was 62.68. This indicates that the establishment is sufficient.

4.10 BAPM is one of the tools supported in the recent improvement resource published by NHSI in November 2017.

4.11 The occupancy increased since the last review from 71.3% to 76.38%.

4.12 There were nine red shifts on the Badgernet safe staffing system for the month of April 2018. On one occasion this was because there was one less nurse who had undertaken the neonatal course according to the BAPM recommendations. There were three occasions when the unit was short of one nurse/nursery nurse/HCA, and the other occasions were fractional shortages either related to the total number of staff on shift or the qualifications of staff.

4.13 **Emergency Department**
The Trust was invited by NHS Improvement to take part in testing of a new Safer Nursing Care Tool for use in the Emergency Department. The Trust has expressed an interest in obtaining a license to use the system when it is published.

4.14 The tool requires acuity scoring of each patient in the department across six different measures at a set time over a minimum of twelve days.

4.15 On receipt of the license, the tool will be tested fully. Reliability and validity of the tool as it stands has not been confirmed.

4.16 In the absence of this assurance, it is confirmed that the establishment is in line with NICE recommendations.

5.0 MODEL HOSPITAL DATA

5.1 Some key model hospital data was refreshed in June 18 and has been included in the review data available from April 18 and is shown in **Appendix one**.

5.2 The care hours per patient day remains in quartile 4. This may indicate that some wards are unproductive and will be considered in more detail in the October 18 establishment review.

5.3 The cost per care hour remains in quartile 2 and suggests value for money.

5.4 The proportion of harm free care is in quartile two and close to the national median. It should be noted however that this graph illustrates all participant Trusts, and not just ICOs. Trusts with significant community services are expected to have a lower performance in this indicator as it is taken from the Safety Thermometer which counts old as well as new episodes of harm using a point prevalence method.

5.5 In the future, the Trust will be piloting a new Model Hospital System which splits out hospital and community data. The benchmarking for this data is underway across England.

6.0 RECOMMENDATIONS

6.1 Adult inpatient ward recommendations are summarised in **Appendix two.** In the majority of adult ward areas, this will result in nurse staffing levels during the day being at a previously published "amber" rating, which is considered safe.

6.1 The maternity unit undergoes a full Birthrate Plus© assessment October 2018.

6.2 Appropriateness of staffing in NICU continues to be reviewed on a daily basis using the Badgernet system and safe care tool.

6.3 The Emergency Department conducts a full pilot of the safer nursing care tool at the earliest opportunity.

7.0 NEXT STEPS

7.1 The next establishment review will take place in October 2018, with data checks, validation and teaching where necessary, for the adult wards.

7.2 Other hospital areas that will be reviewed are:

- Maternity using Birth Rate Plus©
- Neonatal Unit
- Ifor Children's Ward
- Emergency Department
- Day Treatment Centre and outpatients.

7.3 Ward based Allied Health Professionals who are part of the roster will be included as part of the Care Hours per Patient Day (CHPPD) data

7.4 Community areas will also be reviewed including skill mix of district nursing and methodology established for school nursing, health visiting and community children's nursing.

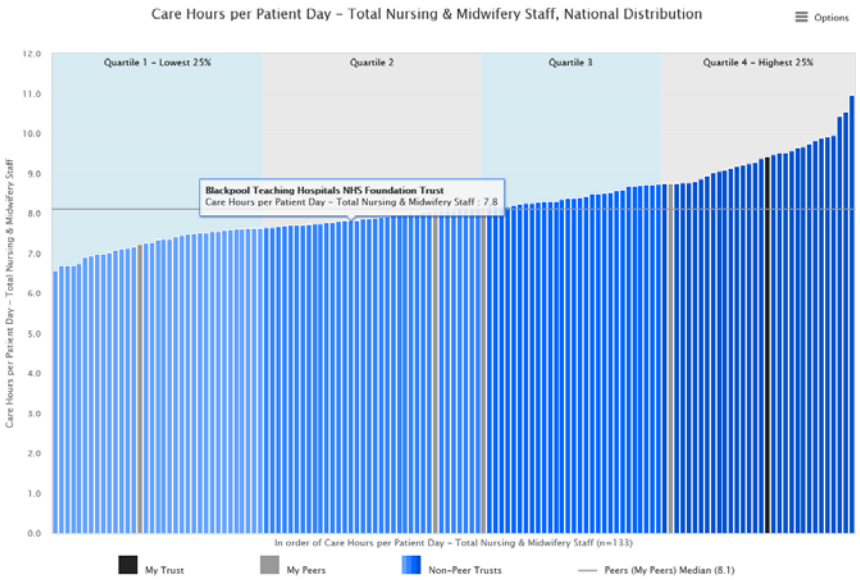
7.5 Work will take place to align the budgeted establishment with the safer staffing requirement on Healthroster. The demand template on Healthroster and the budget will be aligned following adjustment to uplift of 21%.

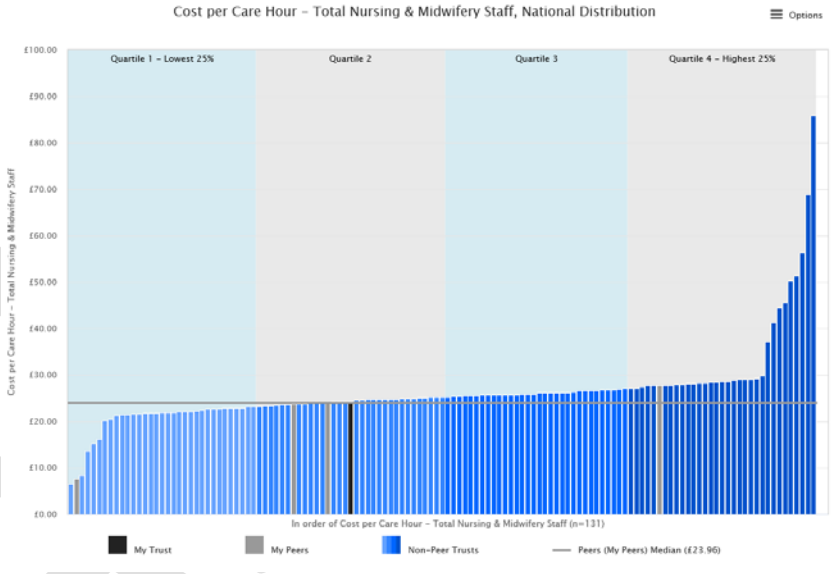
8.0 THE TRUST BOARD IS ASKED TO:

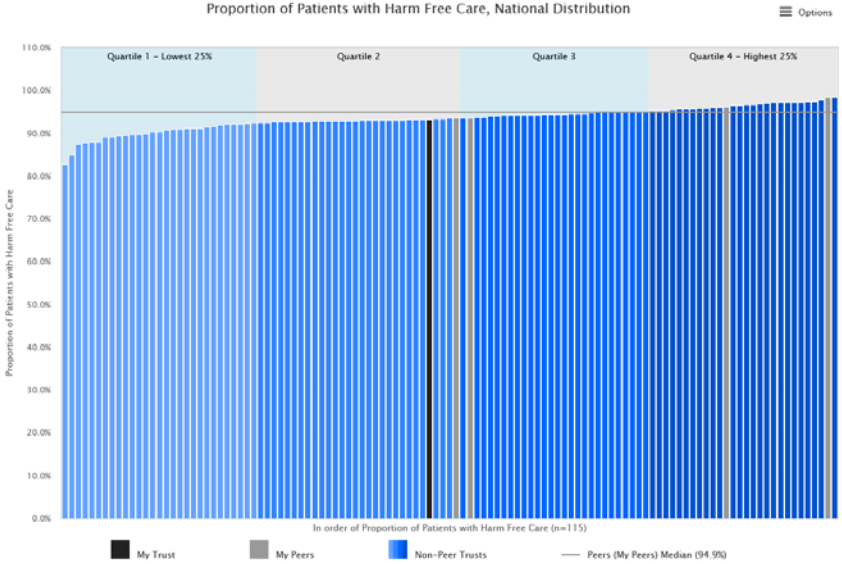
- Review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure itself the wards and other clinical areas reviewed continue to be safely staffed.

- Recommendation by chief nurse to approve the skill mix and RN reduction as presented in **Appendix two**

Appendix one: Model Hospital Data – June 2018 Refresh







Appendix two: Summary of Inpatient Adult Nursing Establishment Review Recommendations April 2018 (implemented September 2018)

Ward	Funded Establishment April 2018 (wte)	SNCT April 18	Ratio RN to Patients		Staff to Bed Ratio	Comments	Recommendations following internal and NHSI challenge	Proposed wte Change	ADON Approval
			Day	Night					
SURGICAL WARDS									
Coyle	37.03	42.89	1:5	1:8	1.19	High level of dependency	Move to a RN ratio of 1:6 during the day. Broaden skill mix. Keep overall numbers of WTE	Convert 2.60wte RN to 2.60wte HCA	Yes
Thorogood	14.00	11.46	1:5	1:5	1.4	Small ward therefore higher ratio – unable to realise economies of scale	Move to a ratio of 1:8 during the day and night – Replace one RN with NA	Convert Band 7 1wte to Band 6 1wte No change to RN numbers until q4 when new qualified nursing associates in place.	**No - 11.09.18. Revised change agreed - Band 7 wte to be reduced to Band 6 wte with immediate effect The use of Nursing Associates (NA) would not be implemented until NMC PINs received in January 2019 and consensus around NA**

Ward	Funded Establishment April 2018 (wte)	SNCT April 18	Ratio RN to Patients		Staff to Bed Ratio	Comments	Recommendations following internal and NHSI challenge	Proposed wte Change	ADON Approval
			Day	Night					
									being the second checker for CD drug administration. There are concerns regarding safety at night and leaving an NA alone during breaks etc.
Mercers	25.20	22.94	1:3	1:5	1.56	Four high dependency beds receiving patients who may normally be cared for in ITU. High number of side rooms.	Move to a ratio of 1:4 RN during the day	Convert RN x 2 wte to AP/NA (band 4)	**No – 11.09.18 revised change agreed to skill mix and to review in q4 once nursing associates on NMC Register**
MEDICAL AND COOP WARDS									
Cloudesley	33.28	33.36	1:6	1:8	1.33		Watch and wait as level of dependency and acuity to be reviewed in Oct 18		**Yes 12.09.18**
Meyrick	32.08	36.36	1:6	1:8	1.28		Watch and wait as level of dependency and acuity to be		**Yes 12.09.18**

Ward	Funded Establishment April 2018 (wte)	SNCT April 18	Ratio RN to Patients		Staff to Bed Ratio	Comments	Recommendations following internal and NHSI challenge	Proposed wte Change	ADON Approval
			Day	Night					
							reviewed in Oct 18		
Bridges Rehabilitation	19.30	18.40	1:7	1:7	1.38	Low acuity pre - discharge ward	Change skill mix to 1RN+ 1NA	Convert 5.2wte RN to 5.2wte NA	**Yes 12.09.18**
Nightingale	30.58	31.94	1:5	1:5	1.46	Four respiratory high dependency beds. Receive patients on non-invasive ventilation. Side rooms on opposite side of the wards.	Watch and wait as level of dependency and acuity to be reviewed in Oct 18		**Yes 12.09.18**
Montuschi	21.60	24.80	1:5	1:5	1.35	Four cardiac high dependency beds. Receive patients requiring inotropic support; Single or two organ failure. Rhythm disturbances	Watch and wait as level of dependency and acuity to be reviewed in Oct 18		**Yes 12.09.18**
Victoria	41.54	40.98	1:5	1:6	1.50	Ward receives high acuity/dependency sickle cell patients	Move to an RN ratio of 1:6 during the day	Reduce RN wte by 2.6	**Yes 12.09.18**
Mary Seacole North	29.62	24.42	1:5	1:5	1.85	High flow ward receiving patients for ED for assessment and treatment		Convert 2.60wte RN to 2.60wte NA at night	**Yes 12.09.18**
Mary Seacole South	29.62	24.45	1:4	1:4	1.65	High flow ward		Convert 2.60wte	**Yes 12.09.18**

Ward	Funded Establishment April 2018 (wte)	SNCT April 18	Ratio RN to Patients		Staff to Bed Ratio	Comments	Recommendations following internal and NHSI challenge	Proposed wte Change	ADON Approval
			Day	Night					
						with six high dependency beds		RN to 2.60wte NA at night	

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Trust Board
26 September 2018

Title:	**National Staff Survey 2017 Action Plan**		
Agenda item:	**18/131**	**Paper**	**12**
Action requested:	To discuss and approve the action plan proposed in response to the 2017 staff survey.		
Executive Summary:	In response to the 2017 Staff Survey the trust committed to a focused response that ensures the organisation can make significant and positive changes in direct correlation to staff feedback. The action plan highlights how that is being actioned and demonstrates the ICSU level commitment to staff feedback in relation to the 'We Said We Did' campaign		
Summary of recommendations:	To discuss and agree/add to the action plan.		
Fit with WH strategy:	• To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population • To deliver consistent, high quality, safe services		
Reference to related / other documents:	Culture Survey Family & Friends Test		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	23/08/18		

Author name and title:		**Eleanor Clarke, Head of OD**		**Director name and title:**		**Norma French, Director of Workforce**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

National Staff Survey 2017 Action Plan

Summary

This is the seventh year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey. This year the Trust opted to invite all eligible staff to complete the staff survey. One of the elements to celebrate in this year's survey is the increase in response rate by staff from a 2016 response rate of 36% to 42.4% in 2017. Of Whittington Health's (WH) 4102 eligible staff, 1704 staff took part in this year's survey.

The results for the survey are broken down into 32 Key Findings and all trusts are rated against each other. Whittington Health is compared to other combined acute and community trusts in England of which there are 43, below are Whittington Health NHS Trust's five highest ranking scores

KF	Key Findings	Score Type	Trust	National
12	Quality of appraisals	1-5 scale summary – the higher score the better	3.27	3.11
22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	% score – the lower score the better	11%	14%
28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	% score – the lower score the better	27%	29%
4	Staff motivation at work	1-5 scale summary – the higher score the better	3.94	3.91
27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	% score – the higher score the better	49%	47%

This year the Trust committed to focus on improvement areas that meet the following criteria:

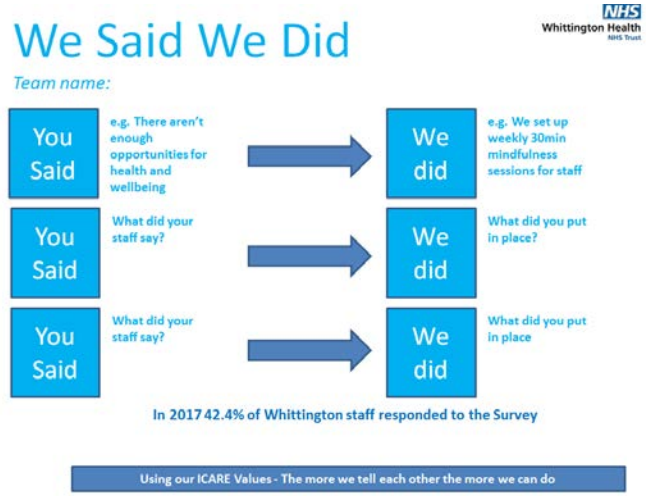
- where there has been no significant improvement on 2016 improvement areas
- where there has been deterioration in local performance
- where the Trust compares less favourably with other combined acute and community trusts
- themes picked up from analysis of staff free text

Using the agreed criteria and acting upon NHS England and NHS Employers advice to 'focus on less to achieve more' the organisation at the highest level is committed to focusing its efforts on:

1. **Equality and Diversity**
2. **Health and Wellbeing**
3. **Job Satisfaction**
4. **Violence, Harassment and Bullying**

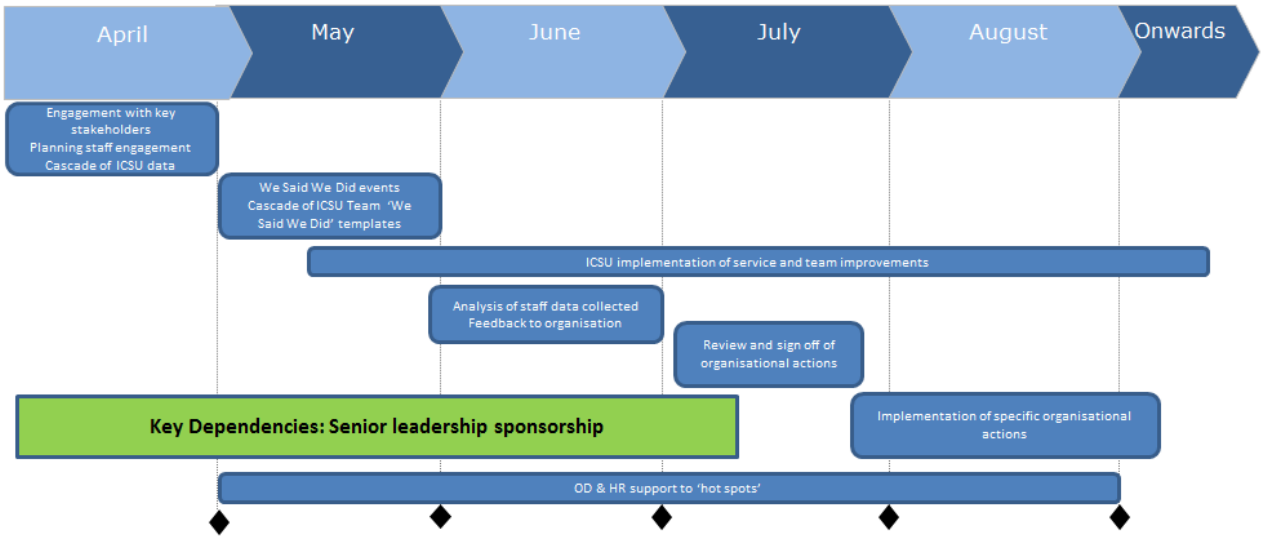
This year's action plan has been designed to ensure all staff are kept aware of, and are part of initiatives responding to staff feedback, underpinned by a 'We Said We Did' campaign which invites every member of staff to look at staff survey findings and develop their own solutions in priority areas. The HRBPs are working with all ICSU leads to ensure that this is cascaded throughout their service. The results are reported back to ICSU leads on a monthly basis and the developing ICSU action plans have been appended at Appendix 1

'We Said We Did template' provided by HRBPs



At an organisational level, Workforce staff organised four 'We Said We Did' events in acute and community sites inviting staff to share their thoughts on how the organisation can make meaningful changes in regards to the four key areas. Executives, inclusion champions, union reps and Occupational Health attended the events to enrich the conversations. The events took place in May and the solutions have been shared with the Executive team with suggestions about next steps.

<u>2017 Staff Survey Action Plan – on a page</u>



Workforce HRBPs and the OD team are working together to identify and support the 'hot spot' areas where staff reported poor experiences in one or more of the key areas. The team are creating a series of bespoke solutions that ensure ownership remains within the service area and focuses on skilling up staff rather than 'doing it to them'.

To highlight how the organisation is positively and dynamically responding to staff feedback there is a planned package of all staff communications throughout the month of September

Appendix 1

Emergency & Integrated Medicine

Team	We Said	We Did	Lead	Status
Bridges Rehab Unit	"red score" for friends & family question	Added for discussion as a priority agenda item on spring training 4/5 and 8/5/18 Together will devise an action plan to make Bridges Rehab unit a place: -you would be happy for relative to be admitted for treatment -Where staff feel supported by each other and their managers	John Gilbey	08/05/18 Completed
	"red score" for experiencing bullying, harassment & discrimination from patients, relatives or members of the public	Together will devise an action plan to make Bridges Rehab unit a place: -you would be happy for relative to be admitted for treatment -Where staff feel supported by each other and their managers	John Gilbey	18/07/18 Completed with ongoing plan being actioned
Hospital OT/PT	"red score" for training to help you do your job well/to keep up to date professionally	Discussed the staff surveys at March and April staff and senior meetings	Suzanne Roberts	19/04/18 Completed
	"red score" for feeling secure to raise concerns around unsafe clinical practices, errors and near misses	Proposed prioritising reviews of: -in house training -reporting and learning from errors and near misses -ways to improve health and well-being in the dept	Suzanne Roberts	16/08/18 Completed with ongoing plan being actioned
Speech & LT	Increase Health & wellbeing for staff around nutrition	During Nutrition and Hydration Week held 1:1 sessions for staff for personalised nutrition education with up to 60 staff members attending	Rebecca Youngman	Completed
	Improved staffing for Clinical Nutrition team	New structure now in place for team that allows better access for patients and improved career ops with B6 posts that will lead to improved retention rates	Rebecca Youngman	Completed
	Improved access to CPD	Agreed income generated monies can be partly used for	Mark Livingstone	Ongoing

		training ops Developed regular ops for shared learning including CPD meetings and joint dietitian and SLT CPD		
	Team morale was down due to internal changes of team structure within SLT	Agreed away day to focus on team building & develop long-term plans Developed peer supervision across community and acute teams Developed mentor scheme for new staff	Mark Livingstone	completed

Children & Young People Services

Team	We Said	We Did	Lead	Status
IFOR ward	We don't know how to use Datix	We organised risk manager to do teaching on the ward. We organised teaching sessions on "Duty of Candour". Ward manager and PDN to do adhoc teaching sessions on how to do a Datix	Ward Manager	Complete
	We felt bullying was an issue in our area	HoN to attend staff meetings they can discuss any concerns. HoN organised HR representative to attend staff meetings to allow staff to express their feelings. HoN organised weekly breakfast clubs to allow staff to discuss matters that concerns them.	Head of Nursing	Ongoing
	We don't get feedback from Datix when completed	HoN started a monthly ward bulletin to identify feedback from Datix completed. Changed format of staff meetings to a generic layout which includes Datix feedback which is facilitated by HoN at present.	Head of Nursing	Ongoing
Roses Day Care	We don't know how to use Datix	We organised risk manager to do teaching on the ward. We organised teaching sessions on "Duty of Candour". Ward manager and PDN to do adhoc teaching sessions on how to do a Datix.	Ward Manager	Complete
	We felt bullying was an issue in our area	HoN to attend staff meetings they can discuss any concerns. HoN organised HR representative to attend staff meetings to allow staff to express their feelings. HoN organised weekly breakfast clubs to allow staff to discuss matters that concerns them.	Head of Nursing	Ongoing
	We don't get feedback from Datix when completed	HoN started a monthly ward bulletin to identify feedback from Datix completed. Changed format of staff meetings to a generic layout	Head of Nursing	Ongoing

		which includes Datix feedback which is facilitated by HoN at present.		
Camden SLT Service	Staff morale and stress levels can get too high to make us productive workers	Weekly mindfulness sessions for staff Fun in and out of work – bean growing, petanque in the park	SLT Managers All	ongoing
	We regularly over work and come in to work when ill	Managers to reiterate that if you are ill – best to stay at home. Encourage each other to leave on time	SLT Managers All	ongoing
	It's hard to provide a good level of clinical service	Working parties linked to service development. Await Camden SLT Service review findings Monitor referrals etc Request more admin/IT support via SLT	SLT Managers	Ongoing
IANDS	We are concerned about the high level of work related stress	Provide resilience team training with and wellbeing team	IANDS leads	Ongoing
	We don't feel that we have the time to provide the care that we aspire to	Provide the team with more resources to undertake job more effectively such as iPads and looking at models of service such as selling training schools and a schools brochure	IANDS leads	Ongoing
	We don't feel that we receive feedback once a DATIX incident is completed	Introduce a standard template to feed back all DATIX incidents in staff team meetings	IANDS leads	Ongoing
South Islington HV Bright Start	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Offer Leadership training program to all B7's, Stepping stone & moving forward program for B3-4 staff SCPHN training to B5 Learning sets to NQHV's WH trailblazer for the SCPHN apprenticeship Brought up in appraisal and reviewed in 121 meetings	Team Leads	Ongoing
	Percentage of staff feeling unwell due to work related stress in the last 12 months	Discussed at Locality & Team leader and 1 to 1 meetings – work /life balance – offered compressed hours/ flexi working where appropriate Disseminated the flexible working policy Support with sickness absence- undertake RTW and offer OH support as required	Locality & Team leads	Ongoing
	Staff feel supported by manager to receive training, learning or development definitely identified in appraisal	Discussed in locality meetings, 121 : overall compliance 87% All additional training is added to TNA	Managers	Ongoing

Central Locality HV Islington	We were less confident regarding bullying and discrimination from each other.	Locality Manager and Operational Lead for CYPS at Locality meetings. Team Leaders to meet regularly with Locality Manager. Team Leaders to offer regular supervision. All staff to be sent the bullying and harassment policy and HR contacts.	Locality Manager	Ongoing
	Some of us felt that our appraisal did not identify our learning and development needs.	Line managers to attend an up to date preparatory session for managers delivering appraisals and all staff encouraged attend appraisal for appraisee sessions. Always provide opportunity for reflection after the appraisal from both sides.	Line Managers	Ongoing
	We didn't feel confident that the Organisation takes action following errors reported.	Complaints and incidents including action plans and lessons learnt will be discussed at Locality and Team Leader meetings. Team Leaders will manage incidents on Datix for their teams and feedback at local level to smaller teams.	Team Leaders	Ongoing

Community Health Services for Adults

Team	We Said	We Did	Lead	Status
	We have hot spot areas	Id hot spot areas and work with them to improve - OD interventions - Measure via anecdotal evidence from staff, survey monkey and interventions	OD, CD, ADoN	Part completed Up to April 2018
	Difficulty in feeding back improvement in local areas	Have a specific agenda item on local departmental meetings - Measure via suggestion box in staff areas	Local managers	Underway
	Staff sometimes feel that abuse from patients and carers is not taken seriously	Committed to: - Real time examples escalated to senior managers - Case studies on real examples in depts. - Resilience training encouraged - Specific agenda item on local departmental meetings	Senior managers Local managers	Ongoing
	Simple processes can be made complicated and they contribute to work related stress	Committed to: - Specific agenda item on local departmental meetings with escalation to appropriate manager - Discussion with OH regarding targeted and specific support - Circulation of OH support available, including EAP scheme, B&H advisers, mindfulness training	Local managers Kate Wilson	Ongoing
	Senior managers visibility	Senior managers to enhance community presence	CD, OD, ADoN	Ongoing
	Mandatory training is cancelled	To raise with L&D and HR to run regular feedback workshops with management	Kate Wilson	Ongoing
MSK	Training for professional requirements	Recently In service training was changed to try and facilitate this. A survey was sent around on survey monkey to gather staff's opinion on how the change is working for them and to gather any suggestions they may have on how to change and improve it.	MSK leads	Ongoing
	Knowing who senior managers are. Staff aren't clear on the roles of the different Directors within the ICSU.	Staff will be given the opportunity to ask questions about different roles at the next BIG meeting on the 1st of August, this will provide clarity	MSK leads	01/08/18

	Confidence on the organisation addressing unsafe clinical practice – no feedback from some teams	awaiting feedback from the freedom to speak guardians- offered a survey monkey questionnaire to staff but staff feel that the freedom to speak guardian is sufficient .	All staff	Ongoing
	Organisation treats staff involved in errors fairly – no feedback from some team	We understand that staff might be worried about what happened in the past and would like to extend the freedom to speak up guardian's invitation to staff so management can understand how this can be improved.	Service Managers	Ongoing
	Satisfaction with opportunities for flexible working patterns	We are including staff in our decision making activities relating to site working hours. This will enable staff to mould the service as well as help us find solutions to mitigate risks arising out of facilitating some flexible working patterns being suggested that go out of the normal working hours. TOIL- the service manager will look into this with site leads- there is a need to understand whether there is an agreement for anyone to take TOIL and what is the local process for this.	Service Managers/Site leads	Ongoing
	In last 3mths, have not attended work when not feeling well enough to perform duties.	We would like to encourage staff to take sick leave if they don't feel well enough to be at work. A new process has been created with the CBS leads and we will continue to pilot this. Waiting times for the service are now down to 4 weeks meaning that we would be able to offer patients a second New appointment well within the expected 6 week time frame.	Service Managers	Ongoing
	Satisfied with quality of care I give to patients/service users, my role makes a difference, I provide the care I aspire to and to a standard I am pleased with. I am able to meet conflicting demands	Band 7s have applied for a charity fund for new equipment to be sought for the service. We invite all staff to let us know if the follow up slots go beyond the 1 week waiting time. The away day will be discussed with senior management once a new Operational Director is in post. Covering maternity and long term sickness is something that will also be brought to the attention of the new Ops Director.	Operational Director	Ongoing

IAPT	Staff supervision on a positive note	We'll discuss with all supervisors and the management team to ensure all understand the value of starting supervision on a positive note, and to start implementing this asap for those that don't already practice this.	IAPT leads	Ongoing
	Separate case management from clinical supervision-either by having the clinical supervisor be different from the manager or by scheduling different times for each	At present we are unable to make any changes to the current structure & process for supervision and case management, but we ensure to regularly review this model to make sure it is most practical and effective.	IAPT leads	Complete
	More focus on professional development (CPD)	We will continue to invite speakers and fund training events at both the All Service meetings (held every 2 months), and during local Wednesday team activities.	IAPT leads	Ongoing
	Decisions made without full appreciation of implication for staff	We will make a stronger effort to involve staff members in key decisions about the service, its policies, and the evolution of the service. We will ensure to consult staff in any major decisions we make either during team meetings or at planned events	IAPT leads	Ongoing
	Lower targets & less pressure	Recruitment is a huge challenge across most IAPT services. Trying to fill vacant posts is a never ending task in this highly competitive field. The good news is that we have recently been provided funding by our commissioners to recruit 2 additional fulltime CBT Therapists, and 1 full time PWP to help manage the increased access target to 19% which starts later this financial year. Once we have filled all vacant posts we plan to review the targets and hopefully lower some of them if we can.	IAPT leads	Ongoing
	Fewer emails team-wide	We will remain conscious of trying to send fewer emails and aim to strike the difficult balance between what absolutely needs to be disseminated by email, and what can wait and be shared via other ways (e.g. in team meetings)	All staff	Ongoing

	Can we have a wellbeing budget and more team related events	We are absolutely committed to our team members and their wellbeing. We are keen to develop new and exciting staff well-being activities. As part of that planning we will look for alternative sources of revenue to develop a staff well-being budget. As part of his role Harry is sometimes invited to speak at conferences or deliver workshops. Effective immediately, Harry has offered to donate the entire fee he receives for these speaking engagements to the newly created staff wellbeing fund. He will next be speaking at a conference in October and will donate that money to the fund. In addition, our new Senior PWP Mitchell has been attending 'Active IAPT' and he will be looking into getting guidance on how to apply for Grants related to wellbeing and physical activity	IAPT leads	Ongoing
	Regular admin time	Each supervisor/line manager will be encouraged to discuss this with their individual supervisees and help find ways of protecting some time for admin	IAPT supervisors/line managers	Ongoing
Podiatry	Protected time for stock management to reduce waste/over-ordering	One hour protected time monthly set up for clinical stock management	Senior Podiatry team	Complete
	Leave request responses delayed	Review and amendment of process to ensure timely responses	Senor Podiatry team	Ongoing
	Set up a departmental staff awards to acknowledge good work	Agreed to set up process and start Aug/Sept 2018	Senior Podiatry team	Sept 2018
	Rebooking of high risk patients takes up too much clinical time	Arranged for admin staff at HCs to rebook appointments for patients where needed	Senior Podiatry team	Complete
	IT issues causing PCs to run slow at some sites	Issues escalated to IT director and logged with IT	Podiatry Service Managers	Ongoing
	Regular clinical group supervision sessions requested	Group supervision time has been allocated before every 6 weekly staff meeting	Podiatry Service Managers	Complete

Women's Health, Outpatients & Diagnostics

Team	We Said	We Did	Lead	Status
	Staff should not/ or do not experience pressure from manager to come into work when not well – *Sickness Management should be fair and consistent'*	Committed to maintain healthy workforce and support staff H&WB - Resilience training - Embed sickness management benefits and importance - Bullying & Harassment zero tolerance/ Advisors	CD, OD, ADoN	Ongoing
	Team members do not have set objectives, and communicate closely to achieve team objectives	-Weekly message of the week and newsletter -Cats Eyes and 'Going the extra mile launched in Feb 18' - Regular team meetings and re-launch Huddles - Standard Agenda Item for team meetings.	Team leads	Ongoing
	Job satisfaction and support from managers is required	Committed to developing all staff and to ensure Band 7 and above possess leadership skills aligned to their role.	CD, OD, ADoN	Ongoing
	Appraisal did not help me do my job properly	Committed to maintain meaningful appraisal and staff development -exploring opportunities of using the difficult conversation training -increase appraisal compliance		Ongoing
	Staff experienced bullying and harassment or discrimination	Zero tolerance to bullying & harassment -embed expected behaviours and standards -Identify Speak Up Champion within ICSU -Communicate support available via Bullying & Harassment Advisors and how to report incidents	CD, OD, ADoN	Ongoing
	Staff work additional hours above contracted hours	Embed team engagement and different ways of working -share outcome of staff survey with teams to generate conversation and engagement (pharmacy and radiology). -Pathology to be arranged.	CD, OD, ADoN	Ongoing
Pharmacy, Imaging & Pathology	Appraisal did not help me do my job properly	Committed to maintain meaningful appraisal and staff development - Exploring opportunities of using the 'difficult conversation training' being made available - Increase appraisal compliance	CD, OD, ADoN	Ongoing
	Staff experienced bullying &	Zero tolerance to bullying & harassment	CD, OD, ADoN	Ongoing

	harassment, or discrimination	Embed expected behaviours and standards - Identify Speak Up Champion within ICSU - Communicate support available Bullying & Harassment advisors and how to report		
	Staff work additional hours above contracted hours	Embed team engagement and different ways of working - Share outcome of staff survey with teams to generate conversation and engagement (pharmacy and radiology. Pathology to be arranged	CD, OD, ADoN	Ongoing
Central Booking Service	Visibility of senior management	Arrange to have service managers come to team meetings	Service Managers	Ongoing
	Delay to leave request – responses and number of staff allowed	Update existing processes especially in the light of the growing team	Team lead	
	Lines of communication	Seek ways of improving communication lines such as making emails more succinct .	All staff	Ongoing
MDU/Triage	Job satisfaction & support from managers	Band 7 management day includes one per month only, therefore ensuring this is protected for Band 7 at all times. Formalising 1;1 meetings with Matron on each management day. Matron and leads being more accessible for all staff and can increase communication: per month open drop in meetings for Band 6 and Band 2, 3 and 5 Restorative clinical Supervision facilitated by PMA working with hot spot areas to support and coach staff / groups. embedded the new management structure since the 2017 staff survey results Away day for Band 7 and Band 6 compulsory floater to enable an element of flexibility to flex up in busy periods. Seek protective space for all band 7 to work on there management day	Jane Laking	Ongoing

Surgery & Cancer

Team	We Said	We Did	Lead	Status
	ICSU does not encourage reporting of errors and acts on concerns raised by patients	Committed to encouraging staff to report errors, action plans for feedback to individuals and ember wider learning - Feedback to staff in 'Big 4' - High level action plan at ICSU level – in progress	CD, OD, ADoN	Ongoing
	ICSU and immediate manager do not take positive action on H&WB and staff put pressure on self to come into work	Various OD interventions to support staff to be resilient and communicate effectively: Medical Physics, Theatres, scheduled for ITU -sickness management fair and consistent -targeted plan with Dental and Surgical wards	CD, OD, ADoN	Ongoing
	Unsure what my work responsibilities are and to use my skills Don't feel trusted to do my job and feeling undervalued	Developed managers in key areas: Stepping Stones and leadership programmes. Appointed GM to support Theatres Committed to developing managers to role model and lead teams. Support them in acquiring leadership skills aligned to their role	CD, OD, ADoN	Ongoing
Dental	Staff do not feel valued and supported by the management team (includes senior managers and immediate managers).	Appointment of staff into management structure, and communication of this to staff so they know who their immediate manager is to contact Training and mentoring of managers in good management, including appraisal and coaching skills, sickness and absence procedures. Access the internal training courses such as Coaching Conversation, Leadership, I.CARE Team Player. External coaches available for staff through Connex.com Ensure staff are aware that they can self-refer to Occupational Health or access support via People at work (Employee Assistant Programme EAP). For more information http://whittnet.whittington.nhs.uk/default.asp?c=10756&q=occupational health Senior managers to organise regular team and staff meetings, with agenda items promoting staff involvement. Follow up by written	Dental leads	Ongoing

		communications summarising issues raised Think about rotating the chairing of the meetings with all staff – supporting collaborative leadership Appraisal discussion and personal objectives to link to organisational values as well as service goals, and all staff have PDP Have managers received the internal appraisal training? We can organise bespoke appraiser and appraisee training to be delivered in the community please let me know dates and time when suitable and we can plan accordingly Ensure managers organise appraisals in good time, and achieve 95% of current staff having had appraisal within last 12 months		
	To not experience: harassment, bullying from colleagues, managers. violence from managers and colleagues. discrimination from managers / colleagues	Ensure the bullying and harassment policy, and related policies , are disseminated to all staff Use the bullying vs firm management framework to support staff in understanding the difference. HR can deliver HR skills workshop in this area and this can be arranged and scheduled accordingly to fit the needs of service . Ensure staff are aware of their right to work free from abuse, discrimination and violence from patients or public, and encourage reporting of and learning from incidents which involve these behaviours Senior managers to act on incidents involving abuse, discrimination and violence. We can deliver bespoke HR skills workshops.	Dental leads	Ongoing
	To improve team working and staff involvement	Senior managers to organise regular team meetings to: 1. ensure clarity of service and team objectives 2. promote staff involvement and facilitate staff suggestions to improve services 3. promote discussion and staff involvement regarding service changes 4. Reflect on service and team achievements Consider team away day to further develop these actions – Think about doing this every 6 months to keep up the learning (if practical) or annually	Dental leads	Ongoing

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Trust Board
26 September 2018

Title:	**National Inpatient Survey 2017 Action Plan**		
Agenda item:	**18/132**	Paper	**13**
Action requested:	To discuss the action plan and receive assurance on the actions that are being undertaken by the Trust.		
Executive Summary:	The 2017 National Inpatient Survey results were presented to the Trust Board in July 2018. Attached is the action plan which outlines how the Trust is addressing the key areas requiring improvement. It should be noted that vacancies and temporary staffing issues being experienced during the survey period would have had an impact on individual patient experience and the overall results. Since the survey, the Trust has a comprehensive recruitment and retention plan in place with newly qualified UK nurses and overseas nurses now coming into post. The Trust has worked hard to ensure appropriate staffing is in place and the quality of temporary staffing is monitored. There are now a number of controls in place and these are being monitored by the Deputy Chief Nurse. It should also be noted that the national survey results are regularly reviewed at the Patient Experience Committee and Quality Committee alongside other quality data.		
Summary of recommendations:	The board is asked to agree to the recommendations relating to: - Quality of food: choice and assistance with - Noise at night - Privacy during medical consultations - Communication: dignity & respect, lack of information& lack of emotional support		
Fit with WH strategy:	Patient experience relates to all areas of the WH Strategy		
Reference to related / other documents:	Patient Experience Strategy 2014		
Date paper completed:	18 September 2018		

Author name and title:		Lynda Rowlinson, Head of Quality 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 complete?**	**N/A**	**Risk assessment undertaken**	**N/A**	**Legal advice received?**	**N/A**

Action plan

Whittington Health NHS

2017 National Inpatient Survey Results (published April 2018)

No	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
1	The trust scored significantly worse on quality of food. Choice of food and assistance with meals was also identified as an issue in the survey	Food focus group underway with representatives from catering, nutrition and dietetics, wards and patient experience. **Current actions include:** - The introduction of a nutrition newsletter for staff - Ward displays for patients about the availability and choice of food on the wards. - Full menu booklets being widely displayed on wards - Nutrition and SLT to train ward befriender volunteers to assist with mealtimes. Review of current catering specification and recommendations for future service provision	The group is ongoing October 2018 (for current actions) October 2018	Rebecca Youngman, Clinical Lead Dietitian (Chair) Phillipa Alston, Head of Patient Experience and Cecil Douglas, Assistant Director of Facilities Cecil Douglas, Assistant Director of Facilities and Rebecca Youngman, Clinical Lead Dietician	The care of older people (COOP) wards' displays are complete Meeting planned to discuss specification which includes ward and patient experience representation.	The first nutrition newsletter has been circulated. COOP ward displays complete.

2017 National Inpatient Survey Results (published April 2018)

No	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
2	The trust improved significantly on noise at night from staff; however, further improvement is required as noise at night from patients did not show significant improvement.	Working group underway with representatives from nursing, AHPs, communications and patient experience. **Current actions:** - Screensaver and posters being designed with communications (to highlight the importance of keeping the noise down) - Stickers to be applied to items that can be used more quietly at night (for example not slamming lids etc.) - Eye plugs, eye masks and headphones to be made available to all patients - Communications to	November 2018	James Connell, Patient Experience Manager and Phillipa Alston, Head of Patient Experience	Charitable funding has been secured. Actions now in progress. The campaign launch is dependent on items being received in time and will be adjusted accordingly if necessary.	

2017 National Inpatient Survey Results (published April 2018)

No	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
		launch campaign w/c 22nd October 2018.				
3	Some patients felt they did not have enough privacy, including during consultations.	Coyle Ward has created a new room for visitors and also a multi-disciplinary area for medical staff. Mary Seacole – previous patient history discussed at handover away from patient bed to minimise discussion on the open ward.	May 2018 July 2018	Sharon Pilditch, Matron Kelly Collins, Matron	This is completed This is completed	
4	The trust performed worse on some questions that related to communication (this includes dignity and respect, conflicting or lack of information, lack of confidence in staff, lack of emotional support, not sure who to discuss concerns with and overall experience.	Inpatient welcome pack being developed (this is for adult inpatients – please note maternity and Ifor ward already have welcome packs in place). **Actions include:** - Daily conversations with patients on inpatient wards throughout June to clarify what information would be	December 2018	James Connell, Patient Experience Manager	Daily conversations completed (conversations led by patient experience, volunteers and PALS & complaints team) Content for the pack agreed and first draft underway.	

2017 National Inpatient Survey Results (published April 2018)

No	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
		helpful for patients - Virtual working group set up with multi-disciplinary input from the wards and supported by patient experience team				
	As above	Spiritual and pastoral care leaflet to be updated and distributed so that patients are aware of the religious and non-religious support they can provide	September 2018	Tola Badejo, Chaplain	Leaflet going through final approval	
		ED, Victoria, Mary Seacole – over reliance on pads for incontinence issues rather than time taken to encourage mobilisation: to link dignity issues with the emerging themes of the PJ Paralysis work. Action plan being developed to address these themes as part of the PJ Paralysis work.	September 2018	Kelly Collins, Matron	Further discussions taking place at a ward level and local action plans will be finalised by end of September 2018	

Action plan

2017 National Inpatient Survey Results (published April 2018)

No	Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
		'Hello my name is..' campaign - Action plan and communication launch in development	November 2018	Phillipa Alston, Head of Patient Experience and James Connell, Patient Experience Manager		
5	Learning from patient feedback	Mary Seacole has weekly governance meetings to discuss learning from complaints and patient feedback.	Ongoing	Kelly Collins, Matron	Further discussions taking place at a ward level and local action plans will be finalised by end of September 2018	

Whittington Health NHS

Trust Board

26th September 2018

Title:	**Annual Modern Slavery Act Statement**		
Agenda item:	**18/133**	**Paper**	**14**
Action requested:	Approve the statement		
Executive Summary:	The Trust is required to produce a statement setting out compliance with the provisions of the Modern Slavery Act ('the Act'), namely the prevention of modern slavery and human trafficking in its business and supply chains. The Act applies to every organisation in the UK with a total turnover in excess of £36m. The statement must be agreed by the Trust Board and published within six months following the financial year end. The Trust will publish this statement on the Whittington Health website in accordance with the Act. The Act does not require organisations to introduce new policies, or amend existing policies if they are deemed to be adequate. The Trust Executive and Trust Management Group have agreed that our existing policies, procedures and controls are fit for purpose and that a regular cycle of review and amendment is in place through the Trust Board governance framework and structures for strategies, policies and standard operating procedures.		
Summary of recommendations:	The board is asked to review and approve the statement below.		
Fit with WH strategy:	Effective engaged workforce		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board			
Date paper completed:	18 September 2018		

Author name and title:		**Jonathan Gardner**		**Director name and title:**		**Jonathan Gardner Director of Strategy**	
Date paper seen by EC	yes	**Equality Impact Assessment**	NA	**Quality Impact Assessment complete?**	N/A	**Financial Impact**	TBC

Modern Slavery Act Whittington Health NHS Trust Board Statement 2018

Whittington Hospital NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015, and we expect our staff and suppliers to comply with the legislation. The Trust has updated relevant Trust policies to highlight obligations where any issues of modern slavery or human trafficking might arise, particularly in our guidelines on safeguarding adults and children, tendering for goods and services, and recruitment and retention. The procurement process has been reviewed to ensure that human trafficking and modern slavery issues are considered at an early stage, with certification for potential suppliers that their supply chains comply with the law. We procure many goods and services under frameworks endorsed by the Cabinet Office and Department of Health, under which suppliers adhere to a code of conduct on forced labour. We uphold professional practices relating to procurement and supply, and ensure procurement staff attend training on changes to procurement legislation. The Trust requires all new staff to complete a safeguarding course, which covers obligations under the Act. We also require external agencies supplying temporary staff to demonstrate compliance with the legislation. All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices. The Trust Board believes that the Trust is following good practice in implementing steps to prevent slavery and human trafficking.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board
26 Sept 2018

Title:	Standing Financial Instructions		
Agenda item:	18/134	**Paper**	15
Action requested:	For Decision		
Executive Summary:	The Board is required to approve changes to governance documentation on an annual basis. We tabled an update to the Trust's integrated governance documentation at Audit and Risk Committee meetings in March and May 2018. The document contains the Trust's standing orders (SOs), scheme of delegation and standing financial instructions (SFIs). Changes were made for the following reasons: • In the interim period while Whittington Pharmacy develops its own SFIs, the Trust's SFIs were adjusted to reflect the existence of the Pharmacy and to state that the Trust's governance arrangements apply equally to the Pharmacy until further notice. • Changes to upper limits of approval for Executive Directors to harmonise levels with requirements in the scheme of delegation for Board sign-off of contracts over £1.5m in value.		
Summary of recommendations:	The Board should approve the updated governance document as reviewed at Audit and Risk Committee in May 2018.		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meeting statutory duties.		
Reference to related / other documents:	Updated Integrated Governance document circulated previously.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A		
Date paper completed:	17 September 2018		

Author name and title:	**Jonathan Ware Head of Financial Services**	**Director name and title:**	**Steve Bloomer CFO**

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

1 Background

The Board is asked to approve revised governance documentation tabled at Audit and Risk Committee.

1.1 It is good practice for the Trust's governance documentation (standing orders, standing financial instructions and scheme of delegation) to be updated and approved by the Trust Board on an annual basis or when significant changes occur that impact the document. Updates were last presented to the Board for approval in April 2017.

1.2 The established process is for governance documentation to be updated and reviewed at the Audit and Risk Committee, and in turn presented to the Trust Board for approval. Changes were last presented to Audit and Risk Committee in May 2018.

2 Detail

Main changes to documentation are to:
1. Harmonise sign-off limits with Board contract sign-off responsibilities.
2. Clarify that the document applies equally to the Trust's subsidiaries as well as the Trust.

2.1 The main changes to the Trust's governance documentation are as follows:

- In March 2018, we made an update, as part of the transition from eProcurement to PeCOS, to formalise the maximum limit on orders and requisitions that can be signed off in the system by the Chief Executive and Chief Finance Officer. This needed to be reflected in the Trust's governance documentation. As a result, we therefore documented that the limit for CEO and CFO is £1.5m to make this consistent with the requirement for the Board to approve proposals for individual contracts likely to be in excess of £1.5m in value.

- In May 2018, it became apparent that a further update was necessary to reflect the existence of Whittington Pharmacy ("the Pharmacy") which was incorporated in January 2017, and opened in July 2017. As such, as part of this brief update, we reflected in the Trust's governance documentation the fact that they apply equally to the Trust and all its subsidiaries, including Whittington Pharmacy.

We also made minor changes to the document to:

- show approval dates and to reflect when the document next requires its annual update; and to
- ensure that titles, roles and responsibilities are internally consistent throughout the document.

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Trust Board

26 September 2018

Title:	**Risk Register Summary Report**		
Agenda item:	**18/135**	**Paper**	**16**
Action requested:	To discuss this paper and receive assurance of appropriate risk management.		
Executive Summary:	This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥16) currently on the Risk Register in August 2018. The Trust has set a low threshold for risks reviewed at Board sub-committee level (≥15) to ensure Non Executive oversight. NED chairs will escalate any ≥15 risks to the Trust Board as required. All risks <15 are managed at an ICSU and Corporate level and escalated to the relevant Board sub-committee as required.		
Summary of recommendations:	• The Trust Board are asked to review all ≥16 risks and agree there is adequate mitigating actions and assurance to manage these risks • The Trust Board are asked to consider if any ≥16 risks not currently on the Board Assurance Framework, should be added to the BAF		
Fit with WH strategy:	Clinical Strategy, Estates Strategy, Recruitment and Retention strategy		
Reference to related / other documents:	As above		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Board Assurance Framework		
Date paper completed:	14.09.18		

Author name and title:		**Lynda Rowlinson Head of Quality Governance**		**Director name and title:**		**Michelle Johnson Chief Nurse and Director of Patient Experience**	
Date paper seen by EC	**23/4/18**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

RISK REGISTER SUMMARY REPORT, SEPTEMBER 2018

1. INTRODUCTION

1.1 Risk is an inherent part of the delivery of healthcare. Whittington Health is therefore committed to ensuring that there is a robust organisational governance structure, with clear lines of reporting and accountability for risks. This paper provides a brief overview of the risk management structure and a summary of the high level risks currently on the Trust Risk Register.

2. RISK MANAGEMENT OVERVIEW

2.1 The Trust maintains a central database for all risks on DATIX, an electronic incident and risk management system. In order to maintain consistency across the Trust, all risks are collated by ICSU, Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as an organisation wide risk. All risks are then categorised under key headings and given a risk grading. This process ensures that risks can be automatically collated and filtered through DATIX to ensure they are reviewed by the appropriate leads. All ICSUs/Directorates/Board Committees are responsible for ensuring there are clear risk management structures and processes in their areas.

3. ≥ 15 RISK REGISTER

3.1 The Trust has set a threshold of ≥15 risk grading for review at Board sub-committees. This is to ensure that there is Non-Executive oversight of these risks and a clear escalation process to Board.

3.2 To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of high level Committees with responsibility for risk. The Trust Board sub-committees; Audit and Risk Committee, Quality Committee, Finance and Business Committee, and the Workforce Assurance Committee; all have a critical role in monitoring risk and providing assurance to the Trust Board that there are systems in place to effectively identify, manage and escalate risks across the Trust.

3.3 Each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information flows quickly to the Board as required. In this way the Trust can identify patterns and promote best practice throughout the organisation.

4. RELATIONSHIP BETWEEN RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

4.1 The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

4.2 While the Risk Register may help to inform the BAF, they are two distinct risk tools with different purposes. The fundamental difference between the Risk Register and the BAF is that the Risk Register is an operational tool focused on the day to day management of the organisation. The BAF focuses on the strategic, long-term priorities of the Trust. At times the operational risks affecting the day to day management of the Trust will have implications for the delivery of the Trust's strategic objectives. These risks are escalated for inclusion on the BAF via the Board sub-committees and the Executive team meeting and Trust Management Group. All the key risks that are identified in achieving the Trust's strategic goals or corporate annual objectives will be recorded on the BAF and reported to the Board.

5. RISK REGISTER UPDATE: AUGUST 2018

5.1 As at 01.09.18, the Trust currently has five risks graded as ≥20 and fourteen risks graded as 16. There are seventeen risks graded as 15 which are monitored at Board sub-committee level.

5.2 Following the re-configuration of the quality improvement, risk and patient safety teams, it is recognised there is a need to review all the risks ≥15; as such, the Head of Quality Governance will be working with the ICSU Risk Managers and Associate Directors of Nursing to review current risk grading and related action plans.

5.3 There are three key themes from the current high level risks on the risk register:

- Workforce and recruitment
- Facilities and estates
- Financial

5.4 These risks have all been escalated for inclusion on the BAF due to the strategic implications and are monitored by the Trust Board through this assurance mechanism; however, a brief summary of the risks and key mitigating actions are outlined below.

5.4.1 Workforce and Recruitment

DATIX	ICSU	Category	Title	Current risk grading
693	Emergency and Medicine ICSU	HR and Workforce	Nurse Staffing Levels in IM ICSU	20
859	Emergency and Medicine ICSU	HR and Workforce	High vacancy rate in DN	16
797	Emergency and Urgent Care ICSU	HR and Workforce	Inadequate consultant provision AAU (Acute Assessment Unit)	16
913	Surgery & Cancer ICSU	HR and Workforce	Gaps in consultant cover for on call rotas	16
881	Children & Young People ICSU	HR and Workforce	Whittington Health will not have CYP psychiatric cover from July 2018	16

Each ICSU has a specific action plan to mitigate the current risk, including short-term provision such as the use of temporary staffing and recruitment initiatives to fill substantive posts. Across the Trust, this has been identified as a risk to our strategic objective to 'Develop and support our people and teams' and captured on the BAF **(Ref: BAF 4 *Inability to increase substantive workforce capacity).*** Trust wide actions to address this concern are reflected in the Recruitment and Retention strategy and include regular recruitment days, overseas recruitment drive, and bank and agency rates review.

5.4.2 Facilities and Estates

DATIX	ICSU	Category	Title	Current risk grading
91	Women's health, outpatients and diagnostics ICSU	Estates or Infrastructure	Labour ward has 1 obstetric theatre.	20
697	Women's health, outpatients and diagnostics ICSU	Patient Safety and Quality	Maternity and neonatal redevelopment	20
817	Facilities and Estates	Estates or Infrastructure	Building environmental planned preventative regime for heating, ventilation and air conditioning systems	16

DATIX	ICSU	Category	Title	Current risk grading
807	Facilities and Estates	Estates or Infrastructure	Works arising from fixed electrical installation testing	16
892	Facilities & Estates	Patient Safety	Fire Safety Management System needs to implement all elements within a new Fire Safety Policy	16

There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our corporate objective to 'deliver quality, patient safety and experience' (**BAF 15: Failure to modernise the Trust's estate**). The Trust Board monitor actions against this risk through the BAF process, including implementation of the Estates Strategy.

5.4.3 Financial

DATIX	ICSU	Category	Title	Current risk grading
784	Finance	Financial	Failure to deliver CIPs and savings to £16.5m 2018/19	20
780	Finance	Financial	Budget Control	16
723	Emergency and Medicine ICSU	Financial	Finance deficit in EUC ICSU	16
772	Surgery and Cancer ICSU	Financial	Not meeting CIP target and financial balance for 2018/19	16

Each ICSU and Corporate Department has a specific plan in place to manage their budget and meet the required Cost Improvement Plan savings required for 2018/19. This has been identified as a strategic risk to our corporate objective to 'Develop our business to ensure we are financially sustainable.' (**BAF 5: Failure to deliver CIPS and transformation savings**), which is monitored through this assurance process.

6. Other ≥16 risks which are reflected on the BAF and monitored by Trust Board through this mechanism

Risk Title	Grading	Reflected on BAF	Key actions
683: Overcrowding ED	16	BAF 3: Failure to meet performance targets in ED. BAF 14: Failure to deliver safe and high quality urgent and emergency pathway	• MH ECIP recommendations to be implemented system wide. • CD oversight on clinical rotas. • Consultant recruitment continues. • ANP appointed. • Associate Director of Nursing attending daily bed meets to review capacity. • Introduction of ED checklist. • Introduction of Fit to Sit. • Introduction of Nurse Led Rapid assessment of patients coming via Ambulance. • Twilight shifts sustained. • Increased nursing numbers on both day and night. Additional Mitigations added: • Full capacity protocol • Staff training including mental health first aid • Mental health work stream and improved use of the mental health suite - 15 patients through the suite last week and only 2 shifts not covered which is a good improvement; but more to do • Improved escalation processes • Successful nurse recruitment (very few vacancies at present)

≥16 risks not currently on BAF

Risk	Department	Category	Title	Grading	Comments and Key actions
728	Organisation wide	Information Governance	Medical records not located in medical files	16	There are currently some patient records that have not been filed within the patient case notes and are held loosely in Health Records or other areas of the trust. • Project in progress to file all loose notes in the appropriate record. • Ongoing filing of high risk documentation while project work is completed to introduce more robust process.
903	Maternity	Diagnostics	Ineffective communication pathway for screening samples	16	Communication pathway for screening samples between UCLH & Whittington maternity units is ineffective. Mitigation in place: • Daily correspondence between screening co-ordinators. • All delayed cases followed up by additional service provision. • Fortnightly operational meetings being held. • Reported to National Screening QA.
897	Children & Young People	Patient Access	Haringey CYP MSK service will be out of contract December 2018	16	CYP MSK service has not been commissioned. Whittington's adult MSK service provided a Haringey CYP MSK service, although it had been commissioned, until May 2018. To mitigate the lack of

Risk	Department	Category	Title	Grading	Comments and Key actions
					provision: • An interim service is being provided by Islington's CYP MSK service until December 2018. • A Business Case is being put forward to the Commissioner.

End of paper

Whittington Health NHS

Emergency Planning
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Emergency Planning Officer
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TRUST BOARD

26th September 2018

Title:	Strategic Business Continuity Policy		
Agenda item:	**18/136**	**Paper**	**17**
Action requested:	Trust Board are requested to sign off the proposed changes to the policy		
Executive Summary:	The Strategic Business Continuity Plan is reviewed in Linde with NHS EPRR Best Practice Guidelines. Please find the following updates. 1.0 Review dates p. 1 2.0 COO Liaise with NELCSU p. 8 3.0 PageOne response groups via switchboard p. 11 4.0 2 Way Pager and Page One 5.0 Contacts Updated p.30 6.0 p.81 Main Domestic Supplier Bywaters/Sharpsmart p.82 Patient Transport FALCK MSL- name change p.82 Incident Response and Recovery Plan- rename p.83 Major Incident Pagers-Pageone 7.0 p. 44-47 List of services rearranged into correct ICSU. 8.0 p 55 Page One contact for Pager failure 9.0 p 61 Addition of FES on call number. 10.0 p 61 IT Disaster Plan renamed IT Incident Response and and Recovery Plan 11.0 p74 Correction or Pager Number for NCLCSU 12.0 p74 Floodline number updated 13.0 *To be included*: Head of Communications Updates. • Mitel Voip Telephony now present in Haringey sites. • Netcall Contact Centres, & Voice mail now Quad server. • Decrease in Analogue phones and increase in newer • Mitel Voip technology across sites • Page One Major Incident Pagers superseding outdated Vodafone air call paging.		
Summary of recommendations:	That the updates highlighted above are approved.		
Fit with WH strategy:	This policy is complimentary to Whittington Health's aims of providing safe quality care.		
Reference to related / other	Business Continuity Policy 2018		

documents:							
Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risk items identified in the Business Continuity Policy 2018					
Date paper completed:		17/09/2018					
Author name and title:		**Lee Smith: Emergency Planning Officer**		**Director name and title:**		**Carol Gillen: Chief Operating Officer and Accountable Emergency Officer**	
Date paper seen by EC	**Yes**	**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Strategic Business Continuity Plan

Subject:	Strategic Business Continuity Plan
Ratified By:	Emergency Management Steering Committee
Date Ratified:	14th July 2014
Version:	3.3
Policy Executive Owner:	Chief Operating Officer – Accountable Emergency Officer
Designation of Author:	Emergency Planning and Business Continuity Officer
Name of Assurance Committee:	Executive Committee
Date Issued:	1 August 2014
Review Date:	July to September 2018
Next Review:	July 2019
Target Audience:	All staff
Key Words:	Business Continuity
Document Purpose	This plan has been developed to ensure that the Acute and Community Services of the Trust is capable of responding to significant emergencies.
Related Document	Major Incident Plan Pandemic Influenza Plan, Severe Weather Plans.

EMERGERNCY RESPONSE – notification, escalation and activation

- If a problem can be dealt with at a ward, departmental level or within a community based service, it should be managed by implementation of their Business Continuity Plan (BCP).
- If there is an activation of a BCP then this must be escalated.
- Any incident which affects building continuity, patient access to care or staff safety must be escalated.

In normal hours 09.00- 17.00 Mon- Fridays		**Out of hours 17.00- 09.00 Weekend & Public holidays**	
Escalation to	**Required action**	**Escalation to**	**Required action**
Manager of service / head of department, Facilities team, IT team. ⇩	• Initial assessment in liaison with person reporting, support department and department head. Will it affect service delivery? • Manage incident and the recovery within department • Minor or Moderate Incidents	Manager of service / head of department, Estates on call, IT on call. ⇩	• Initial assessment in liaison with person reporting, support department and department head. Will it affect service delivery? • Manage incident and the recovery within department
Clinical Site Manager ⇩	• Support department to assess impact in liaison with site support lead as necessary Is impact significant? • High impact business continuity incident • Critical or Major Incident	**BRONZE** (Clinical Site Manager) ⇩	• Support department to assess impact in liaison with site support lead as necessary Is impact significant? • High impact business continuity incident • Critical of Major Incident
Divisional Director of Operations ⇩	• Implement service Business Continuity Plan in liaison with specialist personnel as required • Consider a need to involve external agencies • NB regular report and major developments must be communicated. • Agree incident response plan • Form an Incident Control Team in the Incident Control Centre. Notify EPO • Keep a log of all decisions and actions • Consider activation of Strategic Business Continuity Plan or Major Incident Plan	**SILVER** Commander ⇩	• Implement service Business Continuity Plan in liaison with specialist personnel as required • Consider a need to involve external agencies • NB regular report and major developments must be communicated. • Conduct a risk assessment of unforeseen events. • Engage specialist staff to plan and mitigate against risk items. • Gold to agree on plan
		GOLD Commander ⇩	Consider activation of Strategic Business Continuity Plan or Major Incident Plan
Chief Operating Officer EPLO (Emergency Planning Liaison Officer) and or CEO		**Chief Operating Officer (EPLO) and or CEO**	

Distribution list

Department /Role	Format
Major Incident Control Room Cupboard	Hard copy
Access Room emergency management box	Hard copy
Whittington Health Intranet Major Incident Policies folder	Electronic copy
Silver and Gold dropbox	Electronic
Bronze, Silver & Gold shared 'I' Drive	Electronic

Amendment Record

This document is a controlled document. It replaces all previous versions. This document will be updated annually or as a result of lessons learnt following an activation or exercise of this plan. The issue date is shown in the footer, if the issue date is more than one year ago please speak to the Emergency Planning & Business Continuity Officer to obtain the latest version.

Change History				
version	**Status**	**Date**	**Author/Editor**	**Details of Change**
1.1	Draft	22-02-2012	Richard Moss for WHNHST	New draft
1.2	Draft	26-03-2012	Richard Moss for WHNHST	Amendment to s.10 & 12 to form a closer link between the main plan and service/departmental plans
1.3	Draft	26-04-2012	Richard Moss for WHNHST	Amendments requested by Mary Jamal to sections: • 13.1; 13.2;13.3 reference to the Silver and Gold on call in and out of hours to ensure effective communication • 13.13 requirements for BC manager clarified • P.20 ref to MI plan added
1.4	Draft	01-05-2012	Richard Moss for WHNHST	Additional appendices added: • Serious infectious disease plan • Disruption to road fuel supply • Water supply failure
1.5	Final/Issued	11/06/2012	Mary Jamal	Approved at Executive Committee
1.6	Draft	April 2013	Rebecca Blake	Updates on escalation and contacts due to changes in health system from April 2012.
2.6	Final/Issued	July 2014	Rebecca Allsopp	Full revision and rewrite of plan following updated NHS England (London) guidance
2.7	Final/issued	16/02/2015	Rebecca Allsopp	Updated contacts
2.8, 2.9 3.0-3.2 3.3	Draft Final/issued Final/issued	08/2016 27/02/2017 25/05/2017	Lee Smith Lee Smith Lee Smith Lee Smith	Updates from Directors Updated NHS England BC Toolkit Updates essential services Updates all services and suppliers

Approval

This plan has been approved by the Emergency Management Steering Committee, Trust Management Group and the Trust Executive Committee.

Consultation

To comply with the requirements of the Business Continuity Management Strategy and Emergency Preparedness, Resilience and Response Policy this document has been consulted with the following internal and external partners:

- Whittington Health NHS Trust Emergency Management Steering Committee
- North East and North Central London Commissioning Support Unit
- NHS England (London)
- London Boroughs of Islington and Haringey

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Background

Business Continuity Management (BCM) is a system that helps to identify risks and provide clear mitigations with the aim of maintaining services and critical functions in the event of a disruptive challenge. BCM also aims to provide clear direction on when and how an organisation can recover from disruptive events. Whittington Health is legally obliged to fulfil the duties set out by the Civil Contingencies Act (CCA) 2004. The CCA 2004 says that Category 1 responders are to implement plans that can maintain health services, especially critical functions so far as reasonably practicable. When Whittington Health is exercising its function so far as reasonably practicable there are the aspects to consider in accordance with the CCA 2004; Criticality, Service Levels and Balance of Investments.

SECTION 1: Managing an Incident

1.1 Command and control structures

During the initial assessment phase of an incident the Chief Operating Officer or the Gold On-call out of hours, should decide on the most suitable management approach to the incident, this will be based upon the type of incident and the frequency of action monitoring and issuing of new actions. For rising tide emergencies or those with a slow "battle rhythm" there will be no requirement for a continuous command and control structure to be in place.

1.1.1 Incident Control Team

During a business disruption the Incident Control Team can be used to manage the response. Any meetings of this team should have a Loggist (Major Incident Plan) and record actions and decisions relating to the incident. This structure follows the standard Gold, Silver, Bronze approach without the requirement to establish a control room see the command and control arrangements in the Major Incident Plan including a breakdown of all roles (Section 2 page 9). The Chair of the group is responsible for arranging an appropriate meeting facility such as the Access Room depending on the incident.

Where established the Incident Control Team will be responsible for any mutual aid requests and support arrangements required by the incident.

1.2 Incident Control Room

1.2.1 Location

The Trust's Control Room is initially in the Access Room (next to Ambulatory Care) and can be transferred to the main Incident Control Room in the Emergency Department Seminar Room if deemed necessary by the Gold or Silver Commander.

1.2.2 During normal working hours

The rooms may be used for meetings or training sessions; in the event of an emergency those using the room will need to be displaced to enable the room to be used as the Incident Control Room.

The first member of the Incident Control Team to arrive at the room should inform those using it that:

- The Incident Control Room is being activated
- They will have to leave the room and carry on their work elsewhere

1.2.3 Access, Set-up & Processes

There are instructions on how to access the Incident Control Room, how to set it up, and the processes to be used in its operation. Copies are held:

- In the On-Call Information Pack of every member of On-Call staff
- In Major Incident cupboard
- Access room emergency management box
- On-call handbook in the shared I drive
- On-call dropbox facility

1.3 Definition of an 'Critical Incident' and 'Major Incident' -

From the NHS England (London) EPRR framework 2013 a significant incident or emergency can be described as any event that cannot be managed within routine service arrangements. Each require the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority.

1.3.1 Business Continuity Incident

A business continuity incident is an event of situation that may or does cause disruption to Whittington Health's service delivery. This event implies that there has been a decrease in service standards below predefined levels, in which case special arrangements must be employed to return service levels to an acceptable standard.

1.3.2 Critical Incident

A critical incident is any event within Whittington Health that causes temporary or permanent ability to provide critical services. This event could cause harm to patients and cause the environment to be unsafe which would require special measures and cooperation from supporting agencies to restore normal functions

1.3.3 Major Incident - (Standby, declared, stand down)

Number or type of casualties overwhelm or threaten to overwhelm normal services or pose threat to the health of the community, special arrangements are needed to deal with them. These may include multiple casualty incidents, terrorism or national emergencies such as pandemic influenza. (Refer to Trust major incident plan).

The Civil Contingencies Act (2004) defines a Major Emergency as:

'An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, war or terrorism which threatens serious damage to the security of the UK.'

SECTION 2: KEY ROLES AND RESPONSIBILITIES

In the event of a disruption that affects multiple services, a Trust-wide response may be necessary. This response will be led by the Gold on-Call (or an equivalent level replacement called out by the Gold on-Call). Should they decide it is necessary, on-call staff may choose to call out an Incident Control Team and use the Trust's Incident Control Room to co-ordinate the response and recovery to the disruptive event.

2.1 Incident Control Team

The team will consist of the following:

Table 1: Incident Control Team membership

Core Emergency Management Members	Role	Responsibilities
Chief Operating Officer	Accountable Emergency Officer Emergency Planning Liaison Officer	Support the Incident Control Team review and scrutinise the plan for the response to and recovery from the disruption. Liaise with NELCSU Liaise with the Communication Team Communicate with NHS 01 when there is a high impact business continuity, critical or major incident Participate in the Strategic Coordination Group as requested at a regional level.
In hours: Director of Operations or Directors with specialist knowledge external to ICSU's Out of hours: Gold on-Call Refer to **ACTION CARD** in Major Incident Plan	Tactical controller of the disruptive event. Logs all decisions and actions with Loggist	• Lead the Trust's response to the disruptive event • Set the Trust's strategy for managing the response to the incident • Initiate services' status reporting process (if deemed necessary) for Bronze to manage • Allocate all necessary resources to maintain the Trust's essential services • Prioritise the deployment of resources; including the allocation of alternative work locations • Initiate the recovery planning process, appointing Recovery Managers as required • Keep the Executive Team informed of service delivery status • Keep Commissioners informed of service delivery status
In hours: Director of Environment (or deputy in absence) for a critical or major incident Out of hours: Facilities and/or	Logistics	Estates, facilities and security: Identify what resources are required to achieve the priorities and ascertain their availability.

Estates on-call as well for business continuity disruptions Refer to **ACTION CARD** in Major Incident Plan		
Communications Team representative Refer to **ACTION CARD** in Major Incident Plan	Communications	• Support the Gold on-call in preparing and disseminating communications to staff, partners and the public as required • Advise the Incident Control Team on communications matters
In hours: Manager of service or department/ Operational Director Out of hours: Silver on-Call Refer to **ACTION CARD** in Major Incident Plan	Planning – Response & Recovery	• Support the Gold on-call in managing the Trust's incident response • Retain responsibility for non-incident related operational management issues out-of-hours
In hours: Clinical Site Manager Out of hours: Site Manager Operational Bronze Commander Refer to **ACTION CARD** in Major Incident Plan	Status reporting of Trust	See section 6 Response on page 14
Emergency Planning and Business Continuity Officer (in office hours **only**)	Support to Incident Control Team	• Undertake tasks in support of the Incident Control Team as requested by the leading tactical commander
Loggist Refer to **ACTION CARD** in Major Incident Plan	Recording of actions and decisions of the Gold Commander	• Record the Gold and Silver on-Call's decisions, actions and information received for the duration of the response • Once the response has been stood down, review the log with the Silver and Gold on-Call and make any annotations necessary • Pass the log to the Emergency Planning Lead
Any other person deemed necessary for the management of the incident		

Contact numbers for the Incident Control team and key leads are listed at Appendix 1.

SECTION 3: Activation

3.1 Initial activation

This plan will be activated by the Gold on-Call and or the Chief Operating Officer in the event of a disruptive incident that:

- affects building continuity or patient access to care.
- is of a serious nature (i.e. an event that completely disrupts a service's essential or critical functions and requires substantial support from other services)

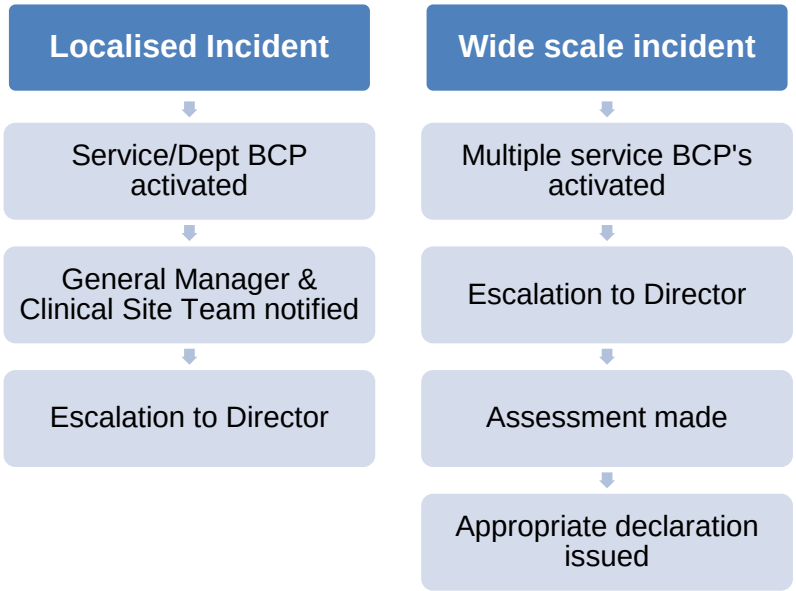
3.2 Activation Process

The driver for activating this plan will be notification by a service or services of a disruption that affects their ability to deliver their essential services.

The Gold on-Call and or Chief Operating Officer will decide whether the plan should be activated and, if the decision is to activate it, will notify the Trust's senior management of this decision (see contact details at Appendix A).

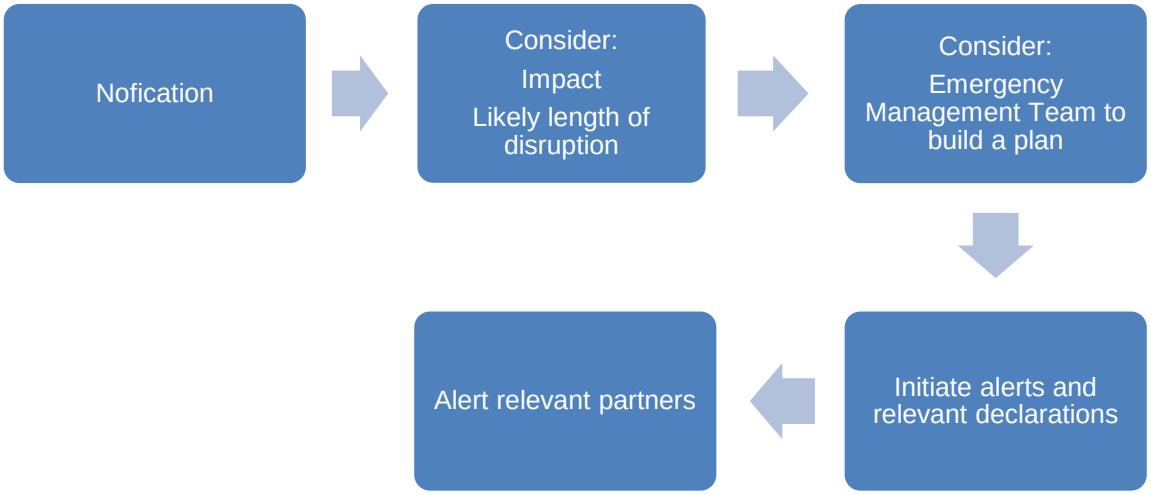
This plan will be triggered following activation by the Gold On-call and or Chief Operating Officer in the following circumstances:

- Failure of a major utility requiring on-going monitoring
- Loss of an essential service impacting on patient safety beyond the capacity of the individual service plan
- In anticipation of an event that will potentially disrupt services and require coordinated management



3.3 Assessment

Following the notification of an incident the Gold On-call or nominated deputy should assess the situation. At this time a decision should be taken on alerting staff, defining the management structure to be implemented and if a "significant or major incident" is to be declared. When considering the incident the Director should take into account the number of services impacted and the likely length of disruption.



3.4 Immediate actions

Upon activation the Gold On-call and or the Chief Operating Officer or in their absence the Clinical Site Manager/Silver On-call will:

- Issue an appropriate declaration message to pager holders, and ensure Service Continuity Leads are notified
- Conduct an impact assessment
- Use PageOne via switchboard to request support internally to form an Incident Control Team
- Establish how the incident will be controlled
- Inform the Chief Executive, nominated Deputy, or other senior officer
- Act on any additional information received.

3.4.1 Use during a declared "critical or major incident"

This plan may be used during a "significant, critical or major incident" to support the reallocation of resources for an extended response. In these circumstances the Chief Operating Officer, or Gold On-call, will decide how the business continuity response will be managed in accordance with this plan.

3.5 Declaration of a 'Critical Incident' or 'Major Incident'

The Chief Operating Officer or nominated deputy (Gold On-call) is responsible for declaring a Critical Incident or Major Incident for Whittington Health NHS Trust.

The Silver On-call may declare an incident for the hospital on discussion with the Gold On-call or Chief Operating Officer.

3.5.1 Service / Department Continuity Plans

All services across the Trust have a local Service/Department Continuity Plan; this can be used to manage the impact of a disruption locally, and contains actions so the continuity of the service can be maintained. These plans are activated by the Service/Department Planning Leads in the event of a disruption. Plans can be requested for activation by Gold or Silver to support responses outside of the service.

3.5.2 Functional Plans

In addition to the Trust Strategic Business Continuity Plan (this document) and the Service/Department Continuity Plans, there are the following functional Business Continuity Plans:

- IM & T Incident Response Recovery Plan.
- Facilities Business Continuity Plans and Specific Project Plans

- Emergency Department Escalation Plan
  - Emergency Department Full Capacity Protocol

These plans will be used to:

- Manage specific aspects of an incident under the direction of the appropriate lead Trust (e.g. network recovery, generator use).
- Take overall control of a premises or IT related incident.

3.6 Staff alerting

If, after assessing the situation, the Gold On-call decides that the incident is, or might, progress into an Emergency, he/she will implement such parts of the Strategic Business Continuity Plan as are appropriate, advise the Chief Operating Officer, Chief Executive or appointed Deputy accordingly and similarly advise all other key staff.

Initial Alerting of staff may be achieved through the use of the Major Incident Alerting System accessed via switchboard. This allows the alerting of predetermined staff groups based upon the type of incident to be declared. This will include General Managers and Service Leads as identified in the Service Department Continuity Plans. Service Leads will then call out further staff as may be required via their own staff alerting processes in hours. Critical and Business continuity incidents can be communicated via the PageOne communication system. Please refer to the Gold on call handbook in relation to communicating to the smart groups. Out of hours the Operational Commander (Bronze) will call staff relevant to respond and escalate their plan to the Tactical Commander (Silver). The Tactical Commander will escalate all decisions and actions to the Strategic Commander (Gold).

3.6.1 Alerting messages

The following messages may be issued via switchboard. It may be necessary to vary the alerting level across the Trusts hospital sites depending on the impact on hospital services. Alerts sent via the alerting system are sent via text, 2 way pager, PageOne, bleep and email. This alert must be authorised by the Chief Operating Officer, Gold or Silver On-call. High Impact business continuity and critical incidents will be escalated via switch board.

'**Incident** Please acknowledge with switchboard.
Report to **department** and activate your service continuity plan. This is not a test.'

If you receive a "Business Continuity Incident" message – an Internal Incident is occurring at the Trust and affected departments may have to activate their service continuity plans.

'Business Continuity Incident **Stand down'**

On receiving a "Business Continuity Incident Stand Down" message - Departments will return to their normal service delivery procedures.

3.6.2 Alerting partners & mutual aid

The Gold On-call will inform partners of the declaration of an incident. This notification should be a call to the appropriate On-call Director. They should inform the following organisation as required depending on the impact of the disruption:

- NHS England (London)

- Commissioning Support Unit
  - London Ambulance Service NHS Trust
  - London Borough of Islington & Haringey

Contact numbers for the external partners are listed at Appendix 2.

3.7 Stand down

Activity from the incident is likely to gradually decline over time, however the Trust needs to be preparing for the stand down from the initial incident declaration and should establish a recovery group as per section 9 of this plan. At the point where activity has declined to a point it can be managed as business as usual or the coordination of response is no longer required a stand down should be issued.

SECTION 4: Resource Management

4.1 Service Delivery Priorities

Each service business continuity plan details the individual services:

- service activities
- minimum resources required over time
- dependencies, and
- the impact should the essential function not be delivered
- options for replacing unavailable essential resources

Service activities are prioritised as one of the following:

Essential – An activity that cannot be stopped

Critical – An activity that can be delayed up to 4 hours (4 hours)

High – An activity that can be delayed up to 8 hours (24 hours)

Medium – An activity that can be delayed up to 24 hours (72 hours)

Low – An activity that can be suspended for up to 3 days (1 week)

Within the services, these will be used determine the deployment of resources to ensure that service identified essential functions receive the resources they need during the disruption. See appendix 5 for list of services categorised for their priority.

4.2 Resource Management

The Trust's resources may need to be redeployed to ensure that essential functions are re-established or maintained during an incident; the COO or Gold on call out of hours has the responsibility of leading and managing this during a serious disruptive incident.

4.3 Staff

Where a service's essential functions have been disrupted due to a loss of staff (e.g. flu, D&V etc.), the COO or Gold on-Call has the authority to re-deploy staff from other services to ensure that the Trust can meet its essential functions.

In the event of a widespread and serious incident affecting staff availability (e.g. flu pandemic) the COO or Gold on-Call has the authority to decide which essential functions will be restricted or stopped in order to free staff to enable other essential functions staffing needs to be met.

4.4 Premises

In the event of a loss of services' premises, either short-term[1] or longer term[2], the COO or Gold on-Call has the authority to displace staff from their work space to provide work space for staff from the affected service(s) in order to maintain their essential functions.

4.5 Utilities

For loss of utilities, services are to implement their own business continuity plans whilst on-call staff should liaise with management contractors who will lead on restoring the service. In the event that the loss of electricity or water is an extended one, consideration should be given to establishing an Incident Management Team and deciding whether this is a Major Incident for the Trust. It is the responsibility of each ICSU director to ensure that management contractors provide recovery time objectives within their contract of service which are in accordance to Whittington Health NHS Trust objectives for response and recovery.

4.6 IT

Should an incident cause significant disruption to the Trust's IT network, the IT Incident Response and Recovery Plan is likely to have already been activated - this would have been triggered by IT staff (in office hours). The services will have to implement their 'work-around' continuity options (detailed in service level plans) until IT support staff business as usual.

Incident Control Team should use the Incident Management Plan for loss of IT service in Appendix 5.

4.7 Mutual Aid

Should the Trust be unable to sustain essential functions due to a major incident - i.e. an inability to source additional / replacement staff, equipment or other resources, the Gold on-Call should consider requesting mutual aid assistance.

[1] e.g. Police cordon preventing access, water damage requiring clean-up and maintenance to make safe
[2] e.g. loss due to fire, serious flood or serious structural damage

The need for mutual aid must be notified to NHS England (London) who will broker the arrangement. The principle of 'shared risk' recognises the fact that the risk of a major incident occurring, which results in the need for mutual aid, is equal amongst all NHS providers.

4.7.1 Charging Arrangements for Mutual Aid

Any mutual aid provided by one provider to another will be on the basis of 'shared risk' and costs will lie where they fall unless otherwise negotiated. Consequently, there will be no immediate cross charging for mutual aid between providers.

As part of the risk sharing agreement, the provider requesting and receiving mutual aid is to collate all associated mutual aid costs for audit purposes.

If any supplying provider wishes to discuss associated costs of supplying mutual aid with the receiving provider, then discussions may take place between the relevant Finance Directors once the Incident has been stood down.

4.7.2 Information Needed before Request is made

The form at Appendix 4 should be completed to ensure that the appropriate information is available to support the request for mutual aid before the initial contact is made.

SECTION 5: Response

5.1 Impact assessment & responding to threats

Following the initial assessment it will be necessary for more detailed impact assessments to be carried out according to the information available. This information should be used to ensure the appropriate management system is used to control and respond to the incident. Upon meeting the Incident Control Team should use the following agenda to assess the situation and develop a response strategy:

1. Situation assessment/summary. Risk Assessment
2. Agreement of strategic priorities (Review of actions and priorities in subsequent meetings)
3. Service continuity measures
4. Service reporting
5. Welfare and vulnerable people
6. Staff concerns
7. Public information
8. Recovery Management

It may also at times be necessary to establish a response group where there is a perceived threat from an event or hazard which may or may not be realised. This allows the development of mitigation prior to any impact occurring. Such events may include industrial action, disruption to other hospitals and services, or civil disturbances. Also where support is required on a project or planned works the Emergency Planning & Business Continuity Officer will liaise directly with services to review Service Continuity arrangements which may be required to produce an emergency plan providing information on any anticipated impacts.

5.2 Tracking of the incident and recovery progress

To manage an incident successfully it will be necessary to collate information from each of the services within the Whittington Health NHS Trust. This can be achieved through situation reporting, these reports should be established to monitor service impact. Situation reports are required for the planning of the recovery process for the Trust, with a focus on the individual recovery requirements of each service. Where required this can be a verbal update to the control or recovery group rather than a written report.

5.3 Record Keeping

The immediate demands of an incident can easily fully occupy staff to the point where no records are kept, and people try to remember what they did “after the event”. This is not acceptable as we are required to keep detailed logs / records of our individual actions, decisions, communications and instructions, which should be timed, dated and initialed.

This is to help following a Significant Incident as the Trust may be invited or required to provide evidence to an appropriate enforcement agency (e.g. the Health & Safety Executive), a judicial inquiry, a coroner's inquest, the police or a civil court hearing compensation claims. Under no circumstances must any document which relates or may in any way relate (however slight) to the incident, be destroyed, amended, held back or mislaid. Records will also be used to improve the way we respond to emergencies in the future. All decision and actions made in the community in response to a Business Continuity Disruption will be communicated to the Incident Control Team (Relevant Lead, Community Manager, Emergency Planning Officer and Emergency Planning Liaison Officer)..Contemporaneous written records will be needed and it is ideal for the Incident Coordination Centre (Site Office/Access Room) to have a Loggist at all times to record what was said, to whom and what decisions were made. See Loggist action card.

5.4 Loggist

The Loggist role is to capture decisions, actions and attendee's during an incident or emergency. A comprehensive record should be kept of all events, decision, reasoning behind key decisions and actions taken. After any high impact business continuity incident, a review will be conducted to identify any lessons so that future planning and response can be improved. In some cases, inquiries may be conducted into the management of the business continuity, critical and major incident. There may be requests made for evidence to support the course of events. Records should be kept in order to facilitate the identification of lessons and actions needed to improve the management of significant incident as well as to support any inquiries.

***Notepads/Incident Log Sheets*:** A numbered log book will be issued to each control room where a detailed and timed record of all instructions received, actions taken and other events which may enable the Trust to assess the success of the emergency response and provide evidence to any enquiry which may follow. The log book should remain intact; no part should be destroyed or erased because, no matter how trivial notes may appear, the total content may form an important contribution in later assessment of the continuity of response. The log books are to be handed on if the holder is relieved during the incident and following stand-down all log books from both the Gold and Silver Control rooms should be returned to the Major Incident Control Room with a receipt being obtained.

Apart from the log books, every scrap of paper must be kept, including notes, post-it notes audio and video tapes, electronic documents, memos and message pads. A simple box file into which all such documents can be temporarily stored will be sufficient during the incident. Email messages should be printed out so that a written record of all emails is available. Email is a well

utilised communications mechanism, but is, by its nature, ephemeral and messages could be accidentally erased.

SECTION 6: Communications

6.1 Internal communications

Internal communications messages will be issued by the Communications Team, via an appropriate method during an incident. The appropriate method will be decided by the Communications Team during the assessment phase. Internal communications should briefly describe the situation, what is being done to resolve it, and actions that staffs need to take or be reminded of.

Keep staff informed/updated via the Communications Team: all staff email and novel broadcast message (pop up) – message to be agreed with Emergency Management team and always go through the Communications team.

6.1.1 Use of RAGW Status Reporting

The Gold on-call may choose whether to require all services to report their status or only selected ones. Bronze should contact the service management and require them to report their status to the Trust's emergency e-mail account whh-tr.majorincident@nhs.net

The reports may be asked for as a one off request or as part of an on-going information gathering process. For an on-going information gathering process, the following information must be specified in the initial communication:

- Frequency of reporting (e.g. daily or twice daily, weekdays only etc.)
- Deadline for reports (e.g. 10:00)
- Whether second and subsequent reports should be exception only, i.e. only report when service is Red or Amber

Each report should give the service's RAGW rating (see box below) and a brief summary of any staffing or service delivery issues, i.e.

- whether the service is Red, Amber, Green or White (as per the definitions set out below)
- the challenges being faced, service delivery affected and support required

RAGW Rating	Description
RED	Essential activities have been affected/ are not being maintained
AMBER	Only essential activities are being maintained/ other activities are affected
GREEN	Some non-essential activities have been affected the impact
WHITE	Service is operating normally/ is unaffected by the incident

6.2 Partner & stakeholder communications

This section lists the stakeholders with which the Trust has key relationships, and gives guidance on who will communicate with each. The Incident Control Team responsibility is to manage all communication needs.

Stakeholder type	Organisation or group	Communication method	Responsibility
Patients	The public Businesses/ voluntary organisations and their employees	Media information Call centre / PALS Website	Communications Team Communications Team to brief PALS Communications & IT
Trust Board	Members of the Trust Board	Briefing as required	Chief Executive or nominated deputy
Commissioners	NHS England (London) CSU CCG	NHS01 NELCSU1	Gold on-call
Partners	Other public bodies and agencies	As required	As required
Suppliers	Contractors Agencies Voluntary sector	Email or phone call	Service with responsibility for contact/ relationship
Trades Unions	Unison, NUT, etc.	Briefing as required	Human Resources
The media	TV Radio Newspapers etc.	Press release, press conference, selective briefings etc.	Communications Team

6.3 Media management

Activation of business continuity measures may result in the requirement to establish media management protocols as described in the Major Incident Plan. As part of the assessment process the Communications Team will indicate the likely interest and establish an appropriate response. All incidents will be notified to the NHS England (London) Gold, and where necessary NHS England (London) Communications Team.

6.4 Helplines

During business continuity incident it may be necessary to establish a helpline for staff to contact, this process should follow that outlined in section 7 pages 31 of the Major Incident Plan.

SECTION 7: Recovery Management

Once the initial response to the incident has been managed, the COO or Gold out of hours is responsible for initiating the recovery process. Dependent upon the seriousness of the incident, it may require the establishment of a Recovery Management Group. The COO will appoint a Director of Senior Manager deputy to lead the group. Membership of a Recovery Management Group should encompass representatives from all areas of the Trust affected as well as involving Finance, IT, HR, Estates & Facilities and Communications, as necessary. Recovery planning should include the elements in table 2 below.

Table 2: Recovery Planning Process

Recovery Planning Process
Understanding Losses and Impacts
Undertake gap analyses for • Staffing - numbers and core skills available v's needed • Service delivery - current levels of delivery v's commissioned levels • Resources - current v's required (e.g. clinical consumables, equipment etc.)
Undertake an impact assessment based upon the gaps identified
Identify staff affected by: • bereavement • stress/ anxiety/ fear
Assess (with partners) the impact upon community health
Assess the impact upon performance and financial targets
Assess the impacts upon budgets across the Trust
Impact Management
Staffing: • co-ordinate redeployment/ recruitment of staff to fill gaps identified in numbers/ core skills • arrange staff training where appropriate to fill skill gaps • ensure sufficient availability of and access to Occupational Health/ counselling services for all staff that need it; publicise it widely • ensure service managers/ team leaders provide what support that can be provided to staff in their teams • ensure support for line managers is put in place
Resources: • replenish stock of clinical supplies • identify premises/ areas within premises requiring deep-cleaning/ decontamination • undertake routine/ required maintenance of equipment and replace as necessary • plan the return of facilities to normal use
Service delivery: • Establish a prioritised list of services/ functions to be recovered – the priorities listed in Business Continuity Plans may form the basis of this – see appendix 5. • re-establish core functions first then work outwards to peripheral functions • service managers/ team leaders to draw up plans for re-establishing functions within their services/ teams in line with the prioritised list: o manage flow of patients o review appointments/ waiting lists for services – establish priorities o manage the backlog

- ensure resources are managed across services towards re-establishment of the priority functions
- Group Managers to provide regular updates to the Recovery Manager on progress against plan

Community Health:

- participate in multi-agency recovery group led by Local Authority (if established)
- agree joint priorities and develop action plans to meet required outcomes
- integrate requirements of multi-agency community recovery with internal service delivery recovery planning
- deploy staff and resources to undertake agreed actions

Management and Finance:

- ensure rigorous financial controls are/ remain in place
- negotiate reduction in targets/ performance indicators for current business year with commissioners
- assess expenditure required based upon revised targets/ performance
- identify income streams to meet anticipated expenditure
- identify any shortfall between income and expenditure due to the response
- identify actions to be taken to remedy any shortfalls in finance

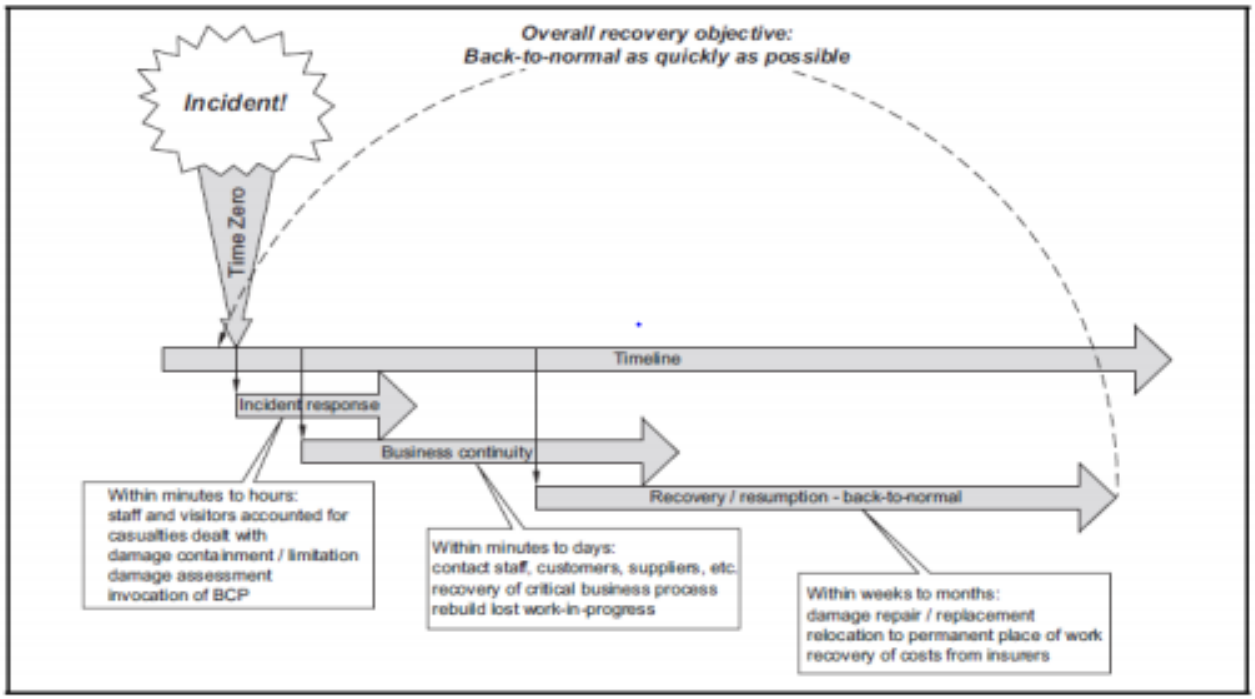
Identification of Opportunities

Collate lessons learned from debriefs

Consideration to be given to the possibility of improving upon what was in place previously. Service/ senior managers to consider:

- procedures
- processes
- resilience
- redundancy
- cost effectiveness
- value for money

Incident Timeline



BS 25999:2006 BRITISH STANDARD Business Continuity Management Part 1: Code of Practice [19]

SECTION 8: Stand Down & Post Incident Debrief

Once the response to the disruption has been controlled to the point that the Business Continuity response may be stood down, the COO or Gold on call out of hours will issue the 'Business Continuity Incident Stand-down' command and initiate the post-incident debrief.

Two types of debrief can be carried out for business continuity incidents:

1. **Hot Debrief**

The Hot Debrief should be run immediately after the incident; however should the incident end during the night it may be undertaken the following day; captures the thoughts of those involved at the point that they are highest in their minds. The format for the hot debriefing should be as follows:

- What went well?
- What did not go as well as would be expected?
- How can we improve?

Areas to be explored include:

- the activation process
- communications
- resource availability and suitability
- welfare
- command and control

A record of the debriefing should be made and disseminated to all who took part. The Hot Debrief notes will inform the subsequent Cold Debrief process.

2. **Cold Debrief**

The Cold Debrief should take place within three weeks of the incident response being stood down; captures the thoughts of those who were involved in the response once they have had time to reflect upon what had happened. Responsibility for organising it rests with the Emergency Planning and Business Continuity Officer. The debriefing should be carried out in a manner that will enable open and frank contributions from attendees. There must be no blame apportioned during the debrief; its only purpose is organisational learning. Attendees should be those who participated in the incident response. The chair will invite representatives from outside agencies as deemed appropriate in order to discuss the incident. The format of the debriefing is set out as described in table 3 below:

Table 3: Format of debrief

Item	Action	Description
1	Introductions	
2	Outline of debrief objectives	
3	Incident details	Date, time & description
4	Walk through of incident timeline	• How notified • How information obtained • Response activities • Incident stand down • Aftermath
5	Review of Incident Logs	Agreement of sequence of events
6	Identify problems experienced/ issues and their causes	Gather all information needed to draft the Post-Incident Report Draw up an Action Plan allocating actions to individuals Consideration to be given to: • Activation process – timeliness/ effectiveness • Communications - internal/ external/ media • Resources – availability/ suitability • Command & Control – effectiveness/ appropriateness • Welfare - issues
7	Identify: • What went well • What didn't go well & lessons learned • Agree actions, who will be responsible for them and timescale for resolution	
8	Identify areas for improvement/ areas to be researched	
9	Any Other Business	
10	Summarise key points/ actions	
11	End of debrief	

Post incident report

After the debriefing, the Emergency Planning and Business Continuity officer will draft the Post-Incident Report and distribute both it and the Post-Incident Action Plan to the Emergency Management Steering Committee for approval and to monitor progress and the Trust Operational Board and Executive Committee for information. .

SECTION 9: Psycho-Social Support

9.1 Staff Support and Wellbeing Following the Event

The welfare and wellbeing of all staff during a Major Incident is highly important. Major Incidents can be traumatic events, and staff will probably need some additional support in the time following the incident. Many members of staff could find the experience of dealing with an incident extremely stressful. An incident is managed as a team and all members of the team maybe affected and have the right to be considered equally. The first step in dealing with a stressful situation is to talk through it with someone you trust and who can listen. In the first instance this is likely to be a work colleague. But no-one has to talk about how they feel, some will choose not to disclose or express personal feelings. If you have concerns about a colleague you should consider sharing your concerns with your line manager.

Managers are asked to note any particular needs of staff and in extreme cases to refer to Health and Wellbeing department for help with stress related issues.

The Trust has access to a full range of support service to support patients, relatives and staff post incident. This includes access to the following key services, see section 8.10 of the Major Incident Plan for more details:-

- Health & Well Being Department
- Employee Support Service
- Fast Track Access to Clinical Services
- Improving Access to Psychological Therapies (IAPT)

SECTION 10: Purpose, Scope, Aim & Objectives

10.1 Purpose

This plan documents the response of Whittington Health NHS Trust to an incident that impacts directly on the provision of multiple Trust Services. This plan:

- Establishes a framework for the management of disruption caused by an incident, and the use of business continuity measures to support incident response
- Describes the roles and responsibilities with regard to a business disruption, and the interrelations between service level plans
- Outlines roles required to effectively respond to an incident
- Establishes the priority of services for recovery across the organisation
- Sign posts the reader to other useful documents as required

10.1.1 Background

The Trust is required to put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act 2004, the NHS Emergency Preparedness Framework 2013, and NHS Core Standards for Emergency Preparedness, Resilience and Response 2013. The Civil Contingencies Act (2004) requires Category 1 responders to: *"Maintain plans to ensure that they can continue to perform their functions in the event of an emergency, so far as is reasonably practicable."* Whilst the NHS Core Standards requires *"suitable plans which set out how each organisation will maintain continuity of its services during a disruption… in line with ISO22301".* Business Continuity Management (BCM) is a system that helps to identify risks and provide clear mitigations with the aim of maintaining services and critical functions in the event of a disruptive challenge. BCM also aims to provide clear direction on when and how an organisation can recover from disruptive events.

10.2 Scope

This plan deals with the management and recovery of services during a disruption to normal business. This plan may be supported by the use of elements of the Major Incident Plan where coordination requirements dictate the requirement of a control room. This document considers:

- Critical activities across all Services
- External suppliers on whom these activities depend
- Resources and all staff involved.

The arrangements for responding to external major incidents are described in the Major Incident Plan, and are not part of this document.

10.3 Supporting documents

This plan is supported by the following additional documents and files:

- Major Incident Plan
- Service / Department Continuity Plans

10.4 Aim

The aim of this Strategic Business Continuity Plan is:

- To enable the delivery of the Trust's critical/essential services in the event of a serious disruption

10.5 Objectives

To meet the aim of this plan, the objectives are:

- To establish an effective command and control structure for the management of incidents
- To identify the critical/essential functions and activities that the Trust must maintain through-out disruptive events
- To identify resources that may be deployed in support of essential activities
- To establish the communication and reporting processes necessary for the management of an incident
- To provide tools to support the management of a business continuity incident requiring corporate level co-ordination.

SECTION 11: Insurance

In the event of an incident that may expose the Trust to litigation, the Gold on-Call should inform the Chief Finance Officer who will give direction on these matters
The Trust has insurance cover from the NHS Litigation Authority for the following areas:

Insurance	Cover	Contact No.
Employers Liability	unlimited cover	Vivien Bucke, Finance Business Support Manager, Tel: ext. 3190.
Public Liability	unlimited cover	
Product liability	unlimited cover	
Professional Indemnity	unlimited cover	

SECTION 12: Training and Testing

In line with the Trust's Business Continuity Management Policy, business continuity training workshops will be undertaken on an annual basis. These workshops will be followed by an exercise to test the Trust's Business Continuity Plans.

SECTION 13: Statute, Policy & Guidance

This plan has been drawn up to meet the requirements of the following legislation, policies and guidance:

Civil Contingencies Act 2004

Health and Social Care Act 2013

CQC Essential Standards for Quality and Safety, standards 4B, 6D & 10E

NHS Commissioning Board Business Continuity Management Framework (service resilience) 2013

NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2013

ISO 22301:2012 International Standard for Societal Security - Business Continuity Management Systems – Requirements

PAS 2015:2010 Framework for Health Services Resilience

NHS England Emergency Preparedness Resilience and Response Framework 2015

SECTION 14: Governance

The Emergency Management Steering Committee has a responsibility to assure the Trust Operational Board and Executive Committee of the Trust's state of emergency preparedness. Business Continuity plans must therefore be reviewed and signed off by the Emergency Management committee as fit for purpose. To ensure that this plan remains current, it will be reviewed and updated by the Emergency Planning and Business Continuity officer annually or in the event of a change in circumstances rendering a part of the plan out-of-date and ineffective.

SECTION 15: Publication of Plan

A sanitised version of this plan will be publicised on the Trust intranet to provide staff and managers with an understanding of how a large scale business continuity incident would be managed.

Whittington Health NHS Trust

Trust Board
26 September 2018
ITEM 18/137
Doc 18

Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 12th September 2018
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS), Non-Executive Director
Members Present:	Michelle Johnson (MJ), Chief Nurse & Director of Patient Experience Carol Gillen (CG), Chief Operating Officer Tony Rice (TR) Non-Executive Director (for Yua Haw Yoe) Steve Hitchins (SH) Chairman (part of the meeting for Deborah Harris-Ugbomah) Rob Sherwin (RS) Associate Medical Director (deputising for Richard Jennings)
In attendance:	Andy Stopher (ASt) Director of Operations Adult Community Services ICSU James Connell (JC), Patient Experience Manager Lynda Rowlinson (LR) Interim Head of Governance and Risk Leanne Rivers (LRi) Patient Representative Alison Kett (AK), Associate Director of Nursing Adult Community Services ICSU Wayne Blowers (WB), Quality Improvement and Compliance Manager Jonathan Gardner (JG) Director of Strategy, Development & Corporate Affairs Nicola Surman-Wells (NSW) Lead Cancer Nurse Surgery and Cancer ICSU Nadine Jeal (NJ) Clinical Director Adult Community Services ICSU Nigel Kee (NK) Director of Operations, Emergency & Integrated Medicine ICSU Sita Chitambo (SC) Associate Director of Nursing Emergency & Integrated Medicine ICSU Zoe Tribble (ZT) Matron CCNT – CYP ICSU Emmeline Closier (EC) PDN Surgery & Cancer ICSU Helen Taylor (HT) Clinical Director, Women's Health, Outpatients & Diagnostics ICSU Adrien Cooper (AC) Director of Environment James Ward (JW) Health & Safety Adviser

Agenda items

1.1	**Welcome & Apologies**	**Chair**
	AS welcomed the Committee. Apologies were received from Deborah Harris-Ugbomah (DHU), Non-Executive Director, Richard Jennings (RJ), Medical Director Yua Haw Yoe (YHY), Non-Executive Director	

1.2	**Declaration of Conflicts of Interest**	
	No conflicts of interest were noted.	
1.3	**Minutes of the previous meeting**	Chair
	No amendments were requested to be made to the minutes of the previous meeting held on 11th July Action log. 11/7/18 – QIA of CIPs – MJ advised that there were currently no updates. CIPs level 2 QIA have been presented at the CIP Panel and spot check of level 1 QIAs undertaken. Further work required to review any shared themes or risks associated with QIAs. RJ to update at the next Quality Committee. Sita met with Stuart Richardson and advised there will be jobs in pharmacy for advanced clinical practitioners. – Action Closed.	

Actions	**Deadline**	**Owner**
RJ to present a quarterly QIA of CIPs at the November Quality Committee	14/11/2018	RJ/MJ

1.4	**Matters Arising**	Chair
	No matters were raised	

Actions	**Deadline**	**Owner**
None		

2.1	**Trust Strategy Annual Plan – Update**	
2.1.1	JG Referred to the Trust Objectives and Strategy paper which had already been presented at Trust Board Seminar.	
2.1.2	He added that the 6 clinical objectives remain the same with three clear objectives as enablers. These are now the trust corporate objectives with each Integrated Clinical Service Unit (ICSU) required to break these down to become localized meaningful objectives and that all staff should be aware of them.	
2.1.3	MJ referred to the revised template for objectives for appraisals and asked if this had been updated on the appraisals template on the intranet. JG replied that Norma French is currently reviewing this but agreed to check that this would be completed. JG then referred to the key priorities for focus. This would include joining up Trust strategic and corporate objectives with the Quality Account priorities. Additional ambition to move the organisation's CQC rating from good to outstanding. One aim clearly to support the Children's community health services from Requires Improvement to Good. All present confirmed they were familiar with these objectives.	
2.1.4	Process – JG attending ICSU Away Days to discuss the strategic/corporate objectives. Also reviewing what the Trust strategy and the clinical strategy should be and where we should be in 5 years' time. A revision to the trust strategy is planned for November Trust Board. It will then go to external stakeholders for sign off in January/February.	
2.1.5	JG went through the Strategy objectives and stated that everyone is confident that	

	these are the right objectives. MJ stated how the quality objectives are aligned with the Clinical Strategy objectives. It was agreed that JG would check in at stages to ensure that this is going in the right direction. JG added that going forward we need to think about the Quality Account (QA) next year and how we can join up with the objectives and simplify. The QA process for 2019/20 will commence soon.
2.1.6	LRi asked whether this would result in a major shift or have little impact. JG replied that it will moderate changes rather than a major shift. There is more work needed in how the Trust objectives become more embedded and Johnathan felt that it was not clear that most staff could recount the 6 objectives. He added that the Trust needs to secure its position as a local provider and improve efficiency.
2.1.7	NK added that we have to ensure that we are integrating services for the right reasons in the right way. This also needs monitoring in order to deliver and demonstrate good quality and care, which is a challenge. AS thanked JG for presenting to QC.

Actions	**Deadline**	**Owner**
2.1.3 JG to check with NF that the objectives are included in the appraisals template.	January 2019	JG
2.1.5 Quality Account preparation plan/Clinical Strategy to return to Quality Committee in January. Feedback to be sent to JG.	January 2019	All

3.1	**Emergency & Integrated Medicine Performance Report**
3.1.1	AS referred to the paper and commented that it is the first time the ICSU report has been presented in this format since the ICSU restructure. She queried whether there is now a single template for all ICSU reports. It was noted that this report template had come from the Patient Safety Committee. All agreed that this template should be used for all future ICSU reports for Quality Committee but some changes required to reflect patient experience, clinical effectiveness and workforce highlights. MJ to agree template ahead of next committee meeting.
3.1.2	Sita referred to the EIM report which was taken as read. She stated that she and NK are excited to be in the new ICSU, although there are lots of challenges. They are currently working on finalizing a number of Serious Incidents (SIs) and pleased to report that the current complaint response rate is 100%. NK added that it had been a busy summer and staff had worked hard throughout. The focus is now on preparing for the coming winter and trying to keep staff engaged and energised. Nigel & Sita regularly visit front line staff to deal promptly with any issues. There is also a monthly newsletter to keep all staff updated, which highlights good things as well as bad.
3.1.3	Referring to the headline patient safety assurance percentages, TR queried the figures and asked if there is process issue that the Committee should be concerned about. NK replied that it was a good review of SIs and the actions recorded were the correct ones which have now been implemented. With regard to incidents, he added that more work was required to ensure that they are correctly documented and investigated thoroughly. There had been a few recent staff changes but things were settling down. A message would go throughout the ICSU to ensure that risks are managed on a day to day basis.
3.1.4	MJ thanked NK/SC for the first merged report from the ICSUs and was satisfied that all Datix/Meridian reporting structures are now in alignment. MJ raised the question of

	whether the ICSU were sighted on the new NHSI categorisation for Pressure Ulcers as "unavoidable" had now been replaced with "where it is attributable to". SC replied that she will be meeting up with Jane Preece to discuss further. AS pointed out the mandatory training and appraisals hadn't been included in the report. It was agreed that the new template should include Mandatory Training, Appraisals and Patient Experience data.

Actions	**Deadline**	**Owner**
3.1.1 MJ to agree template ahead of next committee meeting	Sept 2018	MJ
3.1.4 ICSUs to be made aware that Mandatory Training, Appraisals and Patient Experience data should be included in the report	Sept 2018	MJ
3.1.4 NHSI Pressure Ulcer document to be circulated to the Committee	Sept 2018	MJ

3.2	**Adult Community Services Performance Report**
3.2.1	AK referred to the report that was taken as read. She advised that there is currently no risk manager in place since the ICSU merger and that they are reviewing structures and sharing resources until this is resolved. AS informed that there is standard data that is included in the Trust Performance report although some areas are more specific. AK replied that as the data is run for all of adult community services, some of these are not included in the ICSU at present so it's not quite like for like at the moment.
3.2.2	AK stressed that the main issue is the data around abuse and violence towards staff in the community and SI incidents which are one third of the total risks. This had been discussed at the recent Patient Experience Committee and more work on this is required. The data is being reviewed and Datix training will be provided for the teams. This also applies to pressure ulcers and they will be drilling down data on grade 2 pressure ulcers focusing on assessment and also working with partners for prevention. There is a financial risk associated with agency staff in the community. This will be addressed at the next agency reduction meeting.
3.2.3	AS queried whether continuity of care for district nursing care was being included and AK responded that this would be dependent on staff numbers. A meeting with Allocate has been scheduled to improve the E-Community system which comprises many components. Within district nursing the aim to ensure that the appropriate skill of staff see the appropriate patients.
3.2.4	MJ asked if there were any risks to the bladder & bowel services demand and capacity and whether more this would reduce resource and capacity, in view of Camden recommissioning of services. AK replied that it should actually reduce the risk as we should now be fully staffed. She added that there are plans to the work on bladder and bowel referral and clinical pathways. NJ referred to the Quality Improvement plans and QI training stating that there has been improvement in the access time and outcomes in the dashboard.
3.2.5	The Patient's story video which had been to Trust Board was presented to the Committee. (This had also been used by NHSI). AS commented that it was good to get a sense of the patient perspective at Quality Committee. The video was of a gentleman at home being interviewed by JC with regard to the service he had received from the District Nurses for his long term condition. His daughter also commented on his care. AS thanked NK/AK & NJ for the report and video.

Actions	Deadline	Owner
None		

4.1	Health & Safety Report – Update	
4.1.1	AC advised the Committee that this was the first time this report had come to the Quality Committee as it had previously gone through the Audit Committee. The report was taken as read.	
4.1.2	AC highlighted that there was one RIDDOR SI which was a fire event that occurred on 17th January 2018. He is currently working on high risks and there are 4 new RIDDOR risks.	
4.1.3	2.4 Safety Notices – there is one estates safety alert which is an assessment for all clinical areas regarding the provision of anti-barricade doors across the trust. A list of location and rooms and support would be required for this piece of work that is likely to take 6 months. ASt informed that in his experience the level of risk across hospital and community services was reviewed with community sites lower risk. He would be keen to share this with Adrian to review across WH sites. It was agreed that ASt would meet with AC and JW for further discussion outside the committee.	
4.1.4	2.6 Inspection and Audit - AC advised that with regard to the review of security risks, all departments carry out their own audits to be able to identify different risks in the environment. MJ requested that the baby security arrangements currently in place are tested and suggested that a multi-disciplinary baby abduction exercise be arranged to include the police and others. Lee Smith to be invited to join the planning for this.	
4.1.5	AC reported that fire safety and improvements from the serious incident are ongoing and the trust now has 515 trained fire wardens throughout the Trust. There have been 2 scenario drills with water in outpatient settings and a further one in Pathology will take place in October. A December scenario drill with the London Fire Brigade is also scheduled.	
4.1.6	AC highlighted to the Committee that with regard to challenging behaviour towards security staff there isn't a forum for security staff with regard to mitigation and improvement. CG stated that Lesley Platt had formed an informal working group on lone working and conflict management training and personal alarm devices were with each ICSU.	
4.1.7	AC advised that the clinical buy in to fire safety had been successful and was working well but emphasised the necessity for the same support for Health and Safety. It was agreed that all ICSUs are required to participate with this and AC to send out the Terms of Reference to each ICSU. AC to report back to Quality Committee in 6 months.	
4.1.8	LRi queried the challenges that may result from the C&I Mental Health team moving to the Whittington Health site and that local residents were concerned. 90-100 extra beds would be moving over to WH. She added that C&I are not engaging with local residents and there seemed to be no public consultation process AC assured LRi that security staff would be increased to facilitate the extra patients. It was recommended that ASt contact SH with a view to highlighting the proposals in the Community Forum. AS thanked AC/JW for attending and presenting the report.	

Actions	Deadline	Owner

4.1.3 Discussion regarding community clinical area safety requirements	Sept 2018	ASt/AC/W
4.1.4 Test current baby security arrangements - Lee Smith to be invited to join the planning for this	Sept 2018	AC
4.1.7 TOR to go to all ICSUs for Health & Safety with request for full participation	Sept 2018	AC
4.1.8 Proposed C&I MH move to WH to be included in the Community Forum.	Sept 2018	ASt/SH

4.2	**Q1 Aggregated Learning Report**	
4.2.1	LR referred to the report which was taken as read. The purpose of the report is to pull together some of the data and learning detailing where we are with complaints, inquests, PALS and compliments on a quarterly basis. Anu queried the 16% increase in medication reporting and LR replied that this was part of the quality account to increase reporting and that the level of harm from medication incidents was low which is a sign that we are an organisation that is appropriately reporting on medication incidents.	
4.2.2	National Learning Reporting System – April – September data almost identical to last year's reporting and showed 80% hospital and 20% community. MJ said that if there was benchmarking available we would understand if this was something that was to be expected. It was requested that more comparisons with the national average are	
4.2.3	included in the next report.	
4.2.4	MJ referred to the Preventing Future Deaths letter received from the Coroner's Court. Although very rare this one related to the death of a baby. The Coroner requested that the Family Nurse Partnership change the referral criteria. As it is a national programme we are not in a position to amend and it can only be changed by the National team.	
4.2.5	The majority of complaints (35%) relate to medical care. 20 complaints received were regarding staff attitude. AS queried how this is being addressed. LR replied that we are focusing on attitudes of staff and role modelling within the ICSUs. In addition various methods of shared learning have been implemented as detailed on page 9 of the report. NK stated that face to face meetings with patients and carers resulted in more positive outcomes. AS asked that this report be shared via Quality Committee to all ICSU representatives and that it becomes a standing item on each ICSU Board as it has key messages on aggregated learning.	
	LRi asked what the timeline is from when an action is raised at Quality Committee to when it is actually implemented. MJ replied that she had examples of learning reaching from committee to front line took up to 6 months in a previous Trust and it had been acknowledged that this wasn't quick enough. Trusts could do more to learn from other industries how safety alerts and changes are shared e.g. flight industry. ASt suggested a quicker result could be achieved including social media.	

Actions	**Deadline**	**Owner**
4.2.2 National average comparisons on incidents included in next Aggregated report.	January 2018	LR
4.2.4 Aggregated report to become a standing item on all ICSU board agendas.	October 2018	CDs/ODs ADONs

4.3	**Q1 2018-19 Patient Safety Quarterly Report**	
4.3.1	RS referred to the patient safety Q1 Report which was taken as read. MJ highlighted	

	item 4.2 infection prevention, and explained that the C-diff cases were noted and that investigation was underway for each case to determine root cause. 2 C-diff cases had been reported on Bridges Ward. Much work has been done on the ward and long term estate issues are now being resolved. MJ asked for escalation awareness to ensure that staff are aware how to escalate safety risks and estates works that need attention. Adrien is also working on this. Item 4.3 E-Coli – an improvement plan has been approved and is now in place and monitored at trust IPC committee.
4.3.2	AC queried the impact of anti-microbial and medication shortages. HT replied that we are prioritising areas where vaccines are required. It was acknowledged that there could be a Brexit impact on medication distribution (regulation will not be affected) and Trusts will not be allowed to stockpile drugs. There is a transition plan which also applies to medical equipment and nuclear medicine. CG stated that this is part of the Emergency Preparedness, Resilience and Response (EPPR) and Lee Smith will be coordinating a plan.
4.3.3	Learning from incidents - drug miscalculations featured in the Governance Department's publication Spotlight on Safety (available on the Trust Intranet). Medication related incidents are often used for teaching at the Patient Safety Forum. It was agreed that Quality Account priorities should be rag rated.
4.3.4	Item 7 – New initiatives to disseminate learning from SI's, near misses, inquests, complaints and claims. More sessions of the MH SIM training was planned as the two pilot sessions in June and July received excellent feedback. Key learning from the Mental Capacity Act to be disseminated appropriately.
4.3.5	SH referred to estates repairs and the protocol for putting these on Datix. It was noted that if a clinical risk is identified then the facilities helpdesk should be called. MJ stated that there is more work to be completed and that AC is aware. HT referred to the example of RJ's top 3 learning things from SIs and it was agreed that this should feature in the spotlight of the aggregated learning report.

Actions	**Deadline**	**Owner**
4.3.3 Rag rate Quality Account priorities	Nov 2018	LR
4.3.4 Mental Capacity Act key learning to be disseminated	Oct 2018	MJ
4.3.5 Clinical risks to feature in the "Spotlight" section of the Aggregated Learning Report	Oct 2018	WB

4.4	**Q1 Quality Impact of Assessment (QIA) of CIPS**	
	This item was deferred.	

4.5	**Patient Experience Report**	
4.5.1	The report was taken as read. JC updated on volunteering activities and highlighted that the number of ward friendly volunteers and those participating in volunteer training had doubled. We also now have a Care of Older People Champion volunteer. Accessibility for volunteers with learning disabilities is in hand and JC is meeting with the Autism Project team with a view to taking on one of their students. JC also working with local colleges and universities to develop cohorts of disciplines for volunteers who will commit to volunteering for a minimum of 6 months. Also engaging with C&YP Forum in a 6 month programme. 2 students from Haringey and 2 students from Camden to include Sexual Health, Mental Health and Patient Experience. This will be included in their work plans. Volunteers in the community mainly take up admin roles and 2 key factors	

	were identified: 1. Craft volunteer roles of interest and tailor these roles. 2. To recruit directly from the community to the area specific to where the vacancies are.
4.5.2	AS raised the issue that volunteering opportunities usually do not seem particularly attractive. JC replied that his team are cataloguing and updating role descriptions. AS recommended JC explores the HelpForce website as they are working on a national template for new volunteer roles. HelpForce is a new Community Interest Company founded and led by Sir Tom Hughes-Hallett. MJ stated that other Trusts encourage volunteers to help patients at mealtimes and referred to our survey that flagged food is often served cold which could be a challenge for nursing staff as they are responsible for serving food as well as distributing drugs (and the times for both can clash)
4.5.3	SH pointed out the biggest success point in our volunteering is where it leads to employment to the temporary staffing bank. He suggested we advertise in the community for local volunteers specifically in that area. He highlighted the good relationship the Trust has with St Aloysius College. HT recommended that we advertise to attract student volunteers by displaying posters in the Whittington Education Centre.
4.5.4	AS asked JC if there is a strategy for volunteers and JC replied that he is creating a work plan and will bring this back to the Quality Committee when it has been finalized.
4.5.5	LRi congratulated JC and his team for the increase in volunteers. LR informed the Committee that one of the volunteers helping the legal team found it really helpful for his law degree. It was suggested that a Volunteers Story promotion is considered. AS thanked JC for his efforts with the volunteers.

Actions	**Deadline**	**Owner**
4.5.4 Volunteer work plan to return to Quality Committee on completion	Nov 2018	JC

4.6	**Quality & Safety Risk Register**	
4.6.1	Lynda Rowlinson updated that none of the corporate risks are closed. Since July 2018: • 2 risk reductions within Paediatric Mental Health and NICU Medical Staffing • 1 increase in Haringey Children's Therapy Services. • 3 new risks: 1. Failure in maternity screening due to communication between WH and UCLH. 2. Appointment booked outside timeframe – late cancer diagnosis 3. Gaps in consultant on call rotas.	
4.6.2	LR advised that the Trust is working to have risk managers within each ICSU. Risk awareness in each ICSU had increased significantly since the re-structure. LR confirmed that she had worked with cancer and surgery ICSU to review the results and further reviews will be scheduled for all ICSUs.	
4.6.3	AS referred to ED and waiting times. NK replied that it is about ensuring that we have good patient flow through the hospital supported by social care in the community. The full capacity protocol was reviewed last year and extensive training had been completed. There is a need to reflect what has been done for the summer to gauge how we will fair in the winter. NK confirmed that this was reviewed weekly and included in a 3 month data review. It is also presented to CQRG every month.	

Actions	**Deadline**	**Owner**
None		

4.7	**Trust Policies Update**	
4.7.1	WB stated that there were 34 new policies and that the number of outdated policies had also increased due to clinical demand. He added that all policy authors have been made aware that their policy reviews are outstanding. It was requested that Operational Directors for all ICSUs highlight the policies in their areas that need reviewing.	
4.7.2	AS suggested that policy expiry dates should be rag rated, but SH was concerned that this may not be the most appropriate way to highlight this. MJ stated that there currently isn't capacity in the corporate division to specifically focus on policies but agreed to review imminently.	
4.7.3	MJ suggested that Standard Operating Policies (SOP) sit within the relevant ICSU and should not be included with policies.	

Actions	**Deadline**	**Owner**
4.7.1 ICSUs to review outstanding policies	Nov 18	ICSU ODs
4.7.2 Review time management allocated to policies	Nov 18	MJ

5.1	**Minutes from Reporting Groups – for information only**	
	No comments were made.	
6.1	**Any Other Business**	
	No other business was discussed	

The meeting closed at 4pm. The next Quality Committee is scheduled for **Wednesday 14th November 2018**, from 2pm-4pm in WEC Room 6.

Future dates:

- 14th November 2018
- 9th January 2019
- 13th March 2019
- 8th May 2019
- 10th July 2019
- 11th September 2019