Whittington Health
NHS Trust

T R U S T B O A R D
PUBLIC

14.00 – 17:00
Wednesday 31 October 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**31 October 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

Members – Non-Executive Directors:	**Members – Executive Directors:**
Steve Hitchins, Chair Deborah Harris-Ugbomah Prof Graham Hart David Holt Tony Rice Anu Singh Yua Haw Yoe	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
Kate Green, Personal Assistant to Director of Workforce

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

AGENDA

Agenda Item		Paper	Action & Timing
Standing Items			
18/138	**Patient story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	*Verbal*	1400hrs
18/139	**Declaration of conflicts of interest** *Steve Hitchins, Chair*	*Verbal*	*Review 1420hrs*
18/140	**Apologies & welcome** *Steve Hitchins, Chair*	*Verbal*	*Review 1422hrs*
18/141	**26 September draft minutes, action log, matters arising** *Steve Hitchins, Chair*	1	*Approve 1425hrs*
18/142	**Chairman's report** *Steve Hitchins, Chair*	*Verbal*	*Review 1430hrs*
18/143	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	2	*Review 1440hrs*

Patient Safety & Quality			
18/144	**Serious Incidents month 6** *Richard Jennings, Medical Director*	3	*Review 1450hrs*
18/145	**Quarter 2 Safety and Quality report** *Richard Jennings, Medical Director*	4	*Review 1500hrs*
18/146	**2017/18 Infection Prevention and Control annual report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	5	*Approve 1510hrs*
18/147	**Freedom to Speak up Guardian report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	6	*Review 1520hrs*
18/148	**External inspection report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	7	*Review 1530hrs*
Operational Performance and Planning			
18/149	**Financial Performance month 6** *Stephen Bloomer, Chief Finance Officer*	8	*Review 1520hrs*
18/150	**Performance Dashboard month 6** *Carol Gillen, Chief Operating Officer*	9	*Review 1530hrs*
18/151	**Delivering transformation of the Trust's estate** *Adrien Cooper, Director of the Environment*	10	*Review 1540hrs*
Strategy and Governance			
18/152	**Quarter two delivery of 2018/19 Trust goals** *Jonathan Gardner, Director of Strategy, Development and Corporate Affairs*	11	*Review 1610hrs*
18/153	**Winter planning** *Carol Gillen, Chief Operating Officer*	12	*Approve 1620hrs*
15/154	**Community engagement – next steps** *Jonathan Gardner, Director of Strategy, Development and Corporate Affairs*	13	*Approve 1635hrs*
	Board Committee minutes		
18/155	**21 September 2018, Workforce Assurance Committee**	14	*Note 1650hrs*
18/156	**30 August 2018 Charitable Funds' Committee**	15	*Note 1650hrs*

18/157	**10 October 2018 Charitable Funds' Committee**	16	*Note 1655hrs*
Any other business			
	None notified 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			
27 November 2018 -1400hrs-1700hrs in the 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 by emailing swarnjit.singh@nhs.net Swarnjit Singh, Trust Secretary.

Whittington Health
NHS Trust

ITEM: 18/141
Doc: 1

Minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday, 26 September 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
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Michelle Johnson	Chief Nurse & Director of Patient Experience
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Norma French	Director of Workforce
	Naomi Fulop	Observer NED Designate
	Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
	Kate Green	Personal Assistant to Director of Workforce
	Sarah Humphery	Medical Director, Integrated Care
	Patient Jamie	Podiatry services patient (item 18/117)
	Jennifer Buchanan	Podiatry Services lead (item 18/117)
	James Connell	Patient Experience Manager (item 18/117)
	Kathryn Simpson	Research Portfolio Manager (item 18/127)

18/117 Patient Story

117.01 Michelle Johnson introduced patient Jamie to recount his experiences of the Trust's podiatry services. James Connell informed the Board that Jamie's story had first been brought to his attention as a Youtube post, and following contact with Jamie was presented to the Patient Experience Committee.

117.02 Jamie explained that he was part of a military training exercise in 1973 in Panama when his toenails were ripped out. He was then forced to march through mud, which, he subsequently learnt had almost certainly saved his feet due to its antibacterial properties.

117.03 Aged 64 and living in London, Jamie saw a GP, who immediately referred him to the Trust's podiatry service. He underwent surgery, and told Board members that the most painful part had been the needle. He described the staff involved in caring for him both during his surgery and the subsequent aftercare as professional, caring and concerned about how he was doing; he said that he had never had care like that before. His experience had been 100% positive and, when coming to the end of his treatment, staff at the clinic had said that they were going to be sad not to see him again. The longest wait he had ever experienced had been twenty minutes.

117.04 Summing up, Jamie said "I cannot express how much I appreciate every one of your staff". He had also had a good experience at UCLH, which he said reinforced his overall positive views of the NHS. His single complaint, if pressed, would have been about the automatic registration machine at the GP surgery.

117.05 Jennifer Buchanan confirmed the team had done a great deal of work on improving the time of new patient visits, and because Jamie had received nail surgery, he was eligible for weekly re-dressings. Asked by David Holt why it had been necessary for him to visit different clinics, Jamie explained he was referred to a different clinic because the specialist podiatrist had specialist training in caring for patients with diabetes. Jennifer explained there were two community ulcer clinics, one at Holloway and the other at Tynemouth Road.

117.06 Richard Jennings asked whether Jamie felt staff would have been as good at looking after patients who might, for example, not have English as a first language or in any other way present more of a challenge. Jamie replied that he had personally observed staff helping those with language problems, also assisting people with mobility problems. He was convinced that staff would do all that they could, and take the extra time to do so where necessary. Concluding, Jamie expressed his willingness to speak at the Trust again, if required.

117.07 Board members thanked Jamie for taking the time to share his experience of the Trust's podiatry service.

18/118 Declaration of Conflicts of Interest

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

18/119 Welcome and apologies

119.01 Steve Hitchins welcomed everyone to the meeting, and informed the Board that Professor Naomi Fulop, would, subject to NHS Improvement's (NHSI) confirmation, replace Professor Graham Hart as University College London's (UCL) representative on the Trust Board. She would join the meeting later that afternoon. Apologies for absence were noted for Tony Rice, Non-Executive Director (NED).

18/120 Minutes, Matters Arising & Action Log

120.01 The minutes of the Trust Board meeting held on 25 July 2018 were approved as a correct record. There were no matters arising.

Board members noted the action log and received the following updates:

Action log

120.02 35.04: The report on nursing establishment was on the agenda for that afternoon's meeting; this item could therefore be closed.

40.05: The action plans from the staff survey were on the agenda for that afternoon's meeting; this item could therefore be closed.

73.05: The role of Responsible Officer was under review in the light of Richard Jennings's new appointment.

78.07: Integration of the community dashboard had been completed; this item could therefore be closed.

90.03: A paper on end of life care (incorporating the use of opiates) was on the agenda for that afternoon's meeting; this item could therefore be closed.

93.02: The CNST maternity submission had been completed and submitted, this item could therefore be closed.

95.05: The presentation on the bed modelling work would be brought to the October Board meeting as a sub-section of the Winter Plan.

97.08: Community metrics would be highlighted in the following month's Performance Dashboard.

18/121 Chairman's report

121.01 Steve Hitchins delivered a verbal report and explained that, following a panel chaired by Professor David Lomas at UCL, Professor Naomi Fulop would be to be UCL's representative on Whittington Health's Trust Board. Until formally approved as a Board member by NHSI Professor Fulop, would attend Board meetings as an observer. Once appointed, she would take on Graham Hart's current responsibilities pending a review of all NED responsibilities in quarter four. Steve Hitchens expressed his thanks to Professor Lomas for facilitating the replacement of the UCL NED on the Trust Board.

121.02 Since the previous Board meeting in July 2018, Steve Hitchens had visited most of the wards and attended team meetings of community matrons, podiatrists, dietitians, the Haringey twilight team, Haringey health visitors, midwives and the Haringey learning disability team. He had also attended the launch of the Hackney smoking cessation service.

121.03 Referring to the Sustainability & Transformation Plan (STP) update circulated with the Board papers, Steve informed Board members that a group of Chairs from the STP's Advisory Board had started discussions on how that forum might work more effectively and also facilitate better engagement for NEDs, lay members and councillors. Consideration was being given to the appointment of an independent chair.

121.04 Looking ahead, Steve Hitchens reminded colleagues that:

- the Trust's Annual General Meeting would take place at 6.00pm following the Trust Board meeting
- On 27 September, an event was to take place to mark older people's celebration day
- On Friday, 26 October there would be a celebration as part of Black History month, which was to be attended by Trevor Philips
- The Trust's 2018/19 flu vaccination campaign was underway

121.05 Steve congratulated Richard Jennings on his appointment as Chief Medical Officer at St. George's University Hospitals NHS Foundation Trust: after twelve years at the Whittington he would be greatly missed. He also congratulated Sarah Hayes on her secondment as Deputy Chief Nurse at Epsom & St Helier University Hospitals NHS Trust.

121.06 The Board welcomed the verbal report.

18/122 Chief Executive's report

122.01 Siobhan Harrington gave an update on the government's 10 year plan for the NHS. This had now been broken down into ten distinct work streams, and she was part of the work stream on workforce, training and leadership. Siobhan also drew attention to the

recent Care Quality Commission (CQC) report on quality improvement in hospital trusts, containing many good examples of the use of Quality Improvement approaches from which Whittington Health could learn.

122.02 In relation to performance, Siobhan said that the Emergency Department target remained challenging; performance in July and August had been 90.5% and 90% respectively; however, July was one of the busiest months on record, with the eleven-week heatwave a major contributory factor. Siobhan reported that she and Carol Gillen had been in regular discussion with NHSI on this issue. She went on to report that the Trust had met its target on complaints for three consecutive months. The 62 day cancer target had not been met, and work was in hand to improve this position, further details of which were set out by Carol Gillen in the performance report on the agenda. Improvements in community service waits were described in detail in the performance dashboard. Siobhan also drew attention to the review of orthopaedic services being carried out by North London Health and Care Partners.

122.04 Siobhan Harrington reported that, while it was planned to bring the Trust's response to the cultural survey to this Board meeting, following reflection, it needed further engagement and listening to staff stakeholders and would be brought back to a future meeting. She welcomed the involvement of all Board members in engagement, and David Holt suggested there were themes from the staff survey which might be considered in parallel with this.

122.05 The financial position at the end of month 5 was slightly behind plan and details were contained in the Chief Finance Officer's report on the agenda. Siobhan Harrington reported positive news for estates, work had begun on the second obstetric theatre and would be completed by the end of March 2019. Refurbishment works were also being carried out on Cellier Ward, during which time Eddington Ward (on which some works were also taking place) would be used for postnatal care. Siobhan explained the aim to start work on the master plan for the estate in October 2018, and staff and stakeholder engagement and involvement would be included within this initiative.

122.06 Brexit was the main topic of conversation at meetings with the London Boroughs of Islington and Haringey, and Siobhan emphasised the need to reassure Trust staff at this time and to continue to ensure all our staff feel valued by the organisation.

122.07 Siobhan reported that, an extremely successful staff awards ceremony was held on the evening of 21 September and expressed congratulations, on behalf of the Board, to all of the people nominated for awards as well as those who organised the event. The Board also congratulated the complaints team on their achievement of national targets, and Siobhan on completion of her first year as Chief Executive.

122.08 The Board noted the report.

18/123 <u>Serious Incident report</u>

123.01 Richard Jennings explained that, one serious incident was reported in July, and one in August 2018. He explained the report also provided details of learning identified from closed cases. Both recent incidents involved delays in responding clinically to deteriorating patients. Richard reminded Board members he had previously alerted them to concerns about teams and the need to carry out a broader piece of work. Recently a facilitated two-day event was held to work through a number of issues. The event was very useful and had brought about some significant changes to help strengthen clinical governance arrangements. In addition, Richard also reported that, since the report was issued, a very sad unexpected neonatal death occurred, which he assured Board members, whilst tragic, was not avoidable.

123.02 The Board recognised the assurances in the report, and in particular that the serious incident process was being managed effectively and that lessons identified from investigations were being shared widely to promote learning.

18/124 Learning from mortality report

124.01 Richard Jennings thanked Julie Andrews both for her considerable work in this area and for preparing this report which covered the period January to March 2018. Richard also reminded Board members that the number of deaths tended to be higher during this period. The number recorded (162) was very much in line with national patterns.

124.02 The Trust had set its own internal targets for the number of deaths to review. This was a relatively new process, and Richard noted that he and colleagues had still to set aside the time for reviews as well as increasing the robustness of the operational administration to support the process. Advances in technology would help, but currently reviewers have to go through a significant amount of paperwork.

124.03 In terms of learning, Richard highlighted a key finding for the Trust to do more around end of life care services and acknowledged that complaints were sometimes received about this service, particularly communication issues. He explained that Anna Gorringe, Palliative medicine consultant, and Julie Andrews [insert job title] had already held discussions around improvement and the quality of end of life care treatment would be scrutinised in future reviews.

124.04 Turning to avoidable deaths, Siobhan said that the obvious aim was not to have any. Richard Jennings felt that there were more than two categories for recording deaths: sometimes the situation was ambiguous and, on occasion, it proved difficult to tell. In answer to a question from David Holt about whether there were any particular trends or patterns, Richard was confident the review was conducted with sufficient thoroughness for this not to be the case, however, reviewers were aware of the need to be vigilant. He agreed to look at this again in 12 months' time. Anna Gorringe added that the team had just begun to receive results from their recent carers' survey.

124.05 The Board accepted the report and noted that a review would take place in 12 months' time to identify any discernible trends and patterns.

18/125 2017/18 Medical appraisal and revalidation Annual Report

125.01 Richard Jennings explained that the first section of this annual report described the processes for medical appraisal and revalidation. Section 5 showed that during 2017/18 the Trust achieved 89% for consultants, and 93% for SASGs. Richard went on to explain that a (non-mandatory) charter had been introduced for SASGs, which Whittington Health had adopted, and this covered job planning processes both for SASGs and those on fixed-term contracts who were not subject to national contracts in the same way as consultants on substantive contracts.

125.02 On a positive note, Richard drew attention to the section on page 9 which detailed the positive feedback received from appraises. This was particularly pleasing as the system had not met with universal approval, when initially introduced. It was felt that, where unnecessary delays or deferrals had occurred, this might be a signal doctors might need some additional attention. Siobhan Harrington suggested the Trust's values needed to be integrated in the medical revalidation and appraisal process. Richard also agreed that the section on peer review needed some additional narrative.

125.03 In answer to a question from David Holt about reasons behind late appraisals, Richard explained there were a range of factors for this, including staff annual leave, however, it was the responsibility of the appraise, rather than the appraiser, to set dates and chase responses. Sarah Humphery informed the Board that she had worked with a process whereby appraisal dates were linked to months of birth, which enabled dates to be evenly spread out over the year. Richard replied that there had formerly been an appraisal season, which linked to revalidation.

125.04 The Board agreed the delegated authority for the Chief Executive to approve the accompanying statement of compliance (appendix E) which confirmed the Trust, as a designated body, was compliant with the regulations.

18/126 <u>End of Life Care (opioid prescribing)</u>

126.01 Anna Gorringe referred to the enquiry report published about the multiple deaths of patients at Gosport War Memorial Hospital and the subsequent criticisms of prescribing practices. It was estimated that there may have been as many as 600 preventable deaths over the 10 year period covered by the enquiry, and criticisms had been levelled not just at the hospital but also social services and others involved in the care of the patients.

126.02 Anna explained the Trust had taken part in a national survey around end of life care services, carried out local audits, looked at issues arising from reports into deaths in hospital, and carried out a bereavement survey. Local guidelines had been scrutinised and updated and the Trust had an end of life care group which met monthly. Furthermore, the district nursing team now had 24hr access to the palliative care service. A bid had been submitted to MacMillan Cancer Support for an additional member of staff for the team and Anna had delivered presentations to both the district nursing service and at the Grand Round. Additional questions around end of life care were also being added to the learning from mortality reviews.

126.03 Anna provided assurance the Trust's prescribing practices were safe, especially in light of the introduction of electronic prescribing, which was known to reduce medication errors. David Holt pointed out that the Gosport enquiry had covered a historic period in time, unlike this report, which focused on a recent period. Richard Jennings agreed this was a valid point, but one that applied equally to all organisations, and he assured the Board the Trust's use of opiates was reasonable and appropriate; he also drew the Board's attention to the procedures in place following any NPSA alert. Stephen Bloomer enquired what measures were in place to ensure anything unusual was highlighted. In response, Anna replied that the end of life care team would be notified, and any prescriptions outside the JAC prescribing system would have to go through pharmacy. In addition, prescribing patterns were scrutinised by the Drugs and Therapeutic Committee and Richard Jennings also held regular meetings with the Head of Pharmacy.

126.04 The Board took assurance that inappropriate opioid prescribing would be identified through the trust's clinical governance processes.

18/127 <u>2017/18 Research annual report</u>

127.01 Richard Jennings introduced the report detailed performance against formal targets and in comparison to peer organisations. He noted the report contained many signs of progress but also acknowledged there was still work to do in some areas, for example, he highlighted the fact that infrastructure supporting research had been strengthened, but there were some important decisions to make moving forward.

127.02 Kathryn Simpson spoke of the inherent difficulties in securing additional funding given the competition for research monies. It was noted this report was far more positive than the previous year's. Kathryn drew particular attention to the increased focus on community services such as oral hygiene and day care services. Richard Jennings mentioned the benefits gained from the Trust's status as an integrated care organisation and the innovative work the Trust was already involved in, and he paid tribute to the work of the amazing team.

127.03 The Board received the 2017/18 research annual report

18/128 <u>Financial Report</u>

128.01 Stephen Bloomer confirmed that, at month five, the Trust reported a £300k deficit, which represented a variance of £100k against the planned position. He explained the Trust had benefited in-month from a CNST (Clinical Negligence Scheme for Trusts) rebate and the release of some agency accruals - both by their nature were non-recurrent.

128.02 Stephen explained that the main driver for the poor performance was income, which was some £4m below that recorded in previous months. There was a need to work with the individual ICSUs particularly both surgery and maternity services which required attention. David Holt commented that, prior to the summer break, he was confident about income, however, this report provided some cause for concern.

128.03 Carol Gillen referred to the ICSU performance review meetings which took place earlier that day and provided assurance that clear plans to address the identified problems had been discussed. She provided assurance the plans would be reviewed at weekly Trust operational meetings and that all ICSUs had signed off their activity plans.

128.04 The Board reviewed the finance report as at month five and noted, in particular that, income delivery was below plan; the reduced 2018/19 cost improvement programme target; and, work taking place to agree a trajectory recovery.

18/129 <u>Performance Report</u>

129.01 Carol Gillen informed the Board that Emergency Department (ED) performance was recorded as 90.5% for July and 90.0% for August 2018. She explained the planned trajectory had been to reach 92% by this point and then raise this to 95% in September. However, this had proved challenging, despite the Trust being the highest performer against the ED target in the NHS North Central STP sector. It was noted that July had been one of the busiest months on record. There had also been a high number of mental health patients, and Carol was pleased to inform the Board that the mental health suite was now operational.

129.02 The Trust had performed very well on complaints, meeting the target for the third consecutive month. Cancer targets had, however, continued to present a challenge, and there was a particular focus on improvement in gynaecology services. The North London Cancer Collaboration Team had visited the Trust the previous week.

129.03 Carol Gillen reported that community performance was now been divided into reports for Haringey and reports for Islington, and the Community Services Improvement Group was functioning well, with children's services now reviewed separately. She outlined that, while performance within diagnostics was disappointing, she was aware of where problems had occurred and Saturday sessions had now been introduced to help to clear the backlog; a marked improvement was expected from the following month.

129.04 Michelle Johnson confirmed that safe staffing standards had been maintained during this period, although two red shifts were declared. In terms of care hours, she confirmed that going forward Allied Health Professional hours would also be monitored.

129.05 Carol also apprised Board members that the Trust remained one of the key implementers of ERS in the sector. Anu Singh asked whether the Board could be assured that ICSUs had access to the right data, and Carol confirmed they had and this had been addressed at a recent away day for adult community services, where they had looked not just at activity but also key performance indicators (KPIs). Anu pointed out that some attendees at Quality Committee meetings had reported they did not have access to all the data required. Carol explained she was also looking at building in some additional metrics.

129.06 The Board took assurance the Trust was managing performance compliance and was putting in place remedial actions for indicators where this was needed.

18/130 <u>Workforce Directorate Annual Report</u>

130.01 Norma French explained it was the first time that such a report had come to the Board and she was pleased with the achievements it demonstrated. Some of the indicators contained within the report were already seen by Board members on a monthly basis either as part of the performance dashboard or in the reports taken to the Workforce Assurance Committee; others had been produced specifically for this report.

130.02 Norma was particularly proud of the progress that had been made on the recruitment of nursing staff over the last year and reported that, together with Michelle Johnson she would now also be focussing on AHP recruitment. She explained that there had been little organisational development (OD) activity in the Trust prior to the establishment of the OD team, , however, they had made a significant positive impact, and achievements could best be described as 'phenomenal'. Of particular note was the improvement of the quality and depth of working with individual ICSUs and improvements to the race and inclusion agenda.

130.03 Steve Hitchins thanked Norma for her report. He was pleased to see this evidence of the achievements of the directorate. Siobhan Harrington highlighted the quarterly ICSU performance review meetings and explained she was considering the establishment of a similar process for corporate services and Norma suggested that a key area for initial review was recruitment activity.

130.04 Norma went on to describe some of the innovations taking place under the black and minority ethnic (BME) and Inclusion agenda, citing the introduction of fair treatment panels, the appointment of bullying and harassment advisors, inclusion champions and the Freedom to Speak Up Guardian. She added that, moving forward, it would be good to set targets for the ICSUs for work connected to these areas.

130.05 The Board agreed the report provided excellent evidence of progress within the Directorate, whilst still reminding colleagues of the next steps required.

18/131 <u>Nursing Establishment Review</u>

131.01 Michelle Johnson confirmed the report was based on April 2018 data and explained she wanted to introduce external scrutiny. NHSI had carried out a 'confirm and challenge' session on adult wards, and the team had also worked with finance colleagues to ensure budgets were correctly aligned. Safe staffing levels on wards had been examined and confirmed, and staffing on the neonatal unit was in line with national recommendations.

131.02 The next review was due in October 2018, and would include a review of skill mix within district nursing. In answer to a question from Steve about the use of Badgernet, Michelle confirmed she would make enquiries and report back, however, she was reluctant to ask nursing staff to carry out more data inputting. She added that, in her view, staffing ratios remained generous. The corporate approach taken by nursing teams in relinquishing posts where there was over-establishment was noted and commended.

131.03 The Board approved the proposed skill mix and reduction in registered nurse and agreed the appropriate level of details and assessment had been completed to provide assurance that wards and departments were safely-staffed, in line with guidance.

18/132 <u>National Staff Survey Action Plan</u>

132.01 Norma French highlighted that the Board had considered the staff survey results plus the corporate action plan in March 2018. She reminded colleagues that it had been agreed to focus on areas:

- where there has been no significant improvement on 2016 scores;
- where there has been deterioration in local performance;
- where the Trust compared less favourably with other combined acute and community trusts; and
- themes picked up from analysis of staff free text.

132.02 The five individual ICSU action plans were included within the paper, and Norma described the work that had been carried out between the ICSUs and HR Business Partners under the theme of 'we said, we did'.

132.03 The Board received the assurances from the report and proposed action plan. The Board also agreed that Anu Singh had been appointed the Trust's NED Champion for Equalities & Inclusion.

18/133 <u>National Inpatient Survey Action Plan</u>

133.01 Michelle Johnson reminded Board colleagues the survey outcome item was considered by the Board in July 2018, and they had requested an update. She added that the results of the maternity survey had recently been received, however, it was not possible to share them yet as they remained embargoed.

133.02 The Board agreed the action plan, particularly the recommendations relating to food quality, noise at night, privacy during medical consultations and communication.

18/134 <u>Annual Modern Slavery Act Declaration</u>

134.01 Jonathan Gardner reported that the declaration remained unchanged from that agreed by the Board the previous year.

134.02 The Board formally approved the declaration. The Board also agreed that assurance be provided that all the Trust's suppliers were fully compliant with the act.

18/135 Standing Financial Instructions

135.01 The revised standing financial instructions were formally approved by the Board.

18/136 Risk Register Summary Report

136.01 Michelle Johnson confirmed that a regular cycle of reporting was now established, with risks classified as 16 or over being brought to the Board, and those categorised as 15 or below being taken to the appropriate sub-committee. The Board Assurance Framework would be reviewed at the Audit & Risk Committee in November 2018.

136.02 Steve Hitchins informed the Board that Swarnjit Singh, the newly-appointed Trust Corporate Secretary and Business Manager, would start on 1 October 2018 and one of his first tasks would be to review sub-committee meeting cycles, work programmes and risk management. Steve asked all sub-committee chairs to make time to meet with him as part of his induction. Jonathan Gardner added there was a need for the Board to improve the methodology used to define risks, and it was agreed that this should be reviewed at sub-committees.

136.03 Naomi Fulop enquired whether the Trust had identified any risks around a no-deal Brexit, particularly in the areas of staffing and medicine supplies. Siobhan replied that this was increasingly becoming a topic of interest locally, and that the main risks to the Trust were indeed medicine supplies and recruitment. 17% of existing staff came from EU countries. Norma stated that she was closely monitoring the situation, especially given that, some nursing staff recruited just before the Brexit announcement, had subsequently withdrawn. Richard stressed the importance of not changing usual prescribing practices.

136.04 The Board received the report and agreed that adequate mitigating actions were in place to manage risk entries. The Board were advised this area would be reviewed by the Trust Corporate Secretary and agreed that, in order to assist his review, Board Committees would also review the methodology used to define risks they scrutinised.

18/137 Strategic Business Continuity Plan

137.01 The strategic business continuity plan was formally approved by the Board.

18/138 Draft Committee Minutes

138.01 Anu Singh highlighted the importance of staff engagement and learning from reports, including the most effective ways of sharing papers.

138.02 The Board received the draft minutes of the 12 September 2018 meeting of the Quality Committee.

18.139 Any other business

139.01 The Board were advised that 'flu jabs would be made available at the October 2018 Board meeting.

Action Log

Minute	Action	Date	Lead
73.05	Change of Responsible Officer / Case Management responsibilities	Closed	RS
95.05	Presentation to come to the Board on the bed modelling transformation work and NHSI good practice guides as part of the winter plan	Oct 2018	CG
97.08	Some high level community metrics should be moved to the summary slide at the top of the pack and be included in a review of the performance report	January 2019 Board seminar	CG
134.01	Board to be assured that all suppliers and contractors are compliant with the Modern Slavery Act	Dec 2018	JG
136.01	Board Assurance Framework to be discussed at the next meeting of the Audit & Risk Committee	Nov 2018	JG
136.02	All Board sub-committees to look at the methodology used to define risks.	Dec 2018	All

Whittington Health
NHS Trust

Trust Board
31 October 2018

Title:	**Chief Executive Officer's report**		
Agenda item:	**18/143**	**Paper**	**2**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to update board members on key national and local developments as well as celebrating key achievements of the Trust and its staff.		
Summary of recommendations:	Board members are invited to note the report		
Fit with WH strategy:	This report provides an update on key strategic 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:	Relevant risks are captured in risk registers and/or the Board Assurance Framework		
Date paper completed:	23 October 2018		

Authors name and titles:		**Swarnjit Singh, Trust Secretary**		**Director name and title:**		**Siobhan Harrington, Chief Executive**	
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**

Chief Executive's report
The purpose of this report is to highlight key national, regional and local developments and issues and of relevance to the Trust Board.

1. National / policy news

World mental health day and Ministerial mental health summit
On 15 October, the Secretary of State for Health & Social Care hosted a summit for Ministers and officials from more than 50 countries in London. A Minister for suicide prevention, Jackie Doyle Price, has been appointed in England.

State of Healthcare and Adult Social Care in England
On 11 October, the Care Quality Commission (CQC) published its 2017/18 assessment of the quality of health and social care in England[1]. The report showed that overall, quality has been largely maintained from the previous year, despite continuing challenges around demand and funding, coupled with significant workforce pressures. The CQC also makes clear that people's experience of care varies depending on where they live; and that these experiences are often determined by how well different parts of local systems work together. Some people can easily access good care, while others cannot access the services they need, experience 'disjointed' care, or only have access to providers with poor services.

Moreover, the CQC's reviews of local health and care systems found that ineffective collaboration between local health and care services can result in people not being able to access care and support services in the community that would avoid unnecessary admissions to hospital, which in turn results in increased demand for acute services. The most visible impact of this is the pressure on emergency departments as demand continues to rise, with July 2018 seeing the highest number of attendances on record across England.

Rethinking acute medical care in smaller hospitals
The Nuffield Trust also published this new research report[2] in October which analyses the problems facing acute medicine in smaller hospitals struggling with workforce shortages, higher costs and increasingly complex models of care for acutely ill patients. It outlines a set of radical approaches for running acute medical services and strongly advocates that assuming closure of smaller hospitals is not always the answer. The report follows the Secretary of State for Health and Social Care stating that "the era of moving all activity into fewer, larger hospitals and blindly, invariably, closing community hospitals… that is over". However, it argued their sustainability depends on significant national policy reform and local and system level practical process changes.

2. Local developments

Integrated care system simulation event
On 3 October, a simulation event was held by the North Central London (NCL) Health and Social Care partners attended by leaders from across health and social care in this sector and some local patients. A prototype for an integrated care system for NCL was discussed

[1] https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf
[2] https://www.nuffieldtrust.org.uk/files/2018-10/nuffield-trust-rethinking-acute-medical-care-in-smaller-hospitals-web-new.pdf

and this was based on a fictitious borough. A paper will be produced capturing the learning, which will be shared widely.

Quality and Safety

Emergency Department (ED) four hours' wait
Performance against the four hours' waiting time target remained slightly below target in August and September with outcomes of 90.0% and 89.6% respectively. There was a 10.5% increase in patients when comparing September 2017 and 2018. We continue to strive to achieve 95% of patients being seen within four hours. There has been a major focus on winter planning which will be discussed on the agenda today.

Complaints
The Trust continued its good performance against the target of answering 80% of complaints within 25 days. In August, the Trust achieved a 94% response rate and, in September, it was 92%.

Cancer national waiting times performance:
In August and September 2018, the Trust was compliant for all the national cancer access standards.

Community waiting times
The Trust Performance report now includes the following outcome focussed indicators specific to community:

- % of MSK patients with significant improvement in function (PSFS)
- % of Podiatry patients with significant improvement in pain (VAS)
- ICTT - % Patients with self-directed goals set at Discharge
- ICTT - %GAS (Goal Attainment Scale)Scores improved or remained the same at Discharge

All areas are meeting targets except MSK which was a data entry error and will be corrected by next month.

Diagnostic waits
In August, the Trust did not achieve the six week diagnostic wait target in August due to significant capacity issues in endoscopy services. Additional endoscopy capacity has been put in place and has helped the Trust achieve this target for September.

Flu Vaccination campaign
The Trust continues to vaccinate all staff against flu. As of 22 October, we have vaccinated 50.3% of relevant frontline staff. We continue to encourage all staff to have their vaccinations and this year every flu jab given to staff buys a homeless person in Haringey or Islington a hot meal or support to get off the streets.

Workforce and culture
Through October and November, further listening events with a wide cross-section of staff groups and at different Trust locations are taking place to help inform our action plan which is being developed for Board approval.

Medical Director
After twelve years at Whittington Health, Dr Richard Jennings will be moving on to become the Chief Medical Officer at St George's University Hospitals NHS Foundation

Trust. On behalf of the Trust Board, I would like to congratulate Richard on his new appointment, thank him for his contribution to the organisation and wish him all the best for the future. Richard's last day of service is 4 November. Following a recruitment exercise, I am happy to announce that Dr Julie Andrews will be the Acting Medical Director from 5 November. Julie has been a consultant at Whittington Health NHS Trust since 2006 and has been an Associate Medical Director for the last three years. Most recently she has been leading the development of Quality Improvement across the organisation. I am sure you will join me in congratulating Julie on her new role.

Vitals/e-observations
On 17 October, the roll out of the vital electronic patient monitoring system (Vitals E-Observations) started initially on Cloudesley and Meyrick wards and I want to say a big thank you to staff who helped ensure this great start to our implementation plan.

Maternity refurbishment
Work is underway to build our second obstetric theatre, Cellier ward, our post-natal ward, had been relocated to Eddington ward to enable us to refurbish the postnatal ward. Works are due for completion by 31 March 2019.

Financial
At the end of month six, the Trust is reporting a surplus of £4.6m against a planned £4.1m surplus. For the year to date position, the Trust is £100k ahead of is adjusted plan, with a surplus of £3.6m. At the same time, income performance was £2m off plan and work is underway on income recovery to address this variance. The predicted year-end position is to achieve a new control total of £22.7m, subject to outstanding agenda for change pay award funding being successfully resolved.

Launch day for new Whittington Health nursing badge
I am pleased to announce that Whittington Health launched a new nursing badge this month. It has been adapted from what was previously a Whittington badge and will be given to all Whittington Health nurses, health visitors and midwives.

An afternoon tea launch event for the badge took place with Michelle Johnson, Chief Nurse on Friday, 26 October, with new nurses, health visitors and midwives who started with the Trust within the last year. The badge will then be rolled out to all nurses, health visitors and midwives across Whittington Health. Each recipient will be personally presented with their badge by a Senior Nurse and this is hoped to be achieved by Christmas 2018.

NHS staff survey
All staff are currently being asked to complete the annual NHS staff survey. I cannot emphasise strongly enough how important it is for all staff to take this opportunity to

provide feedback on their experience of work; the role they are able to play in Whittington Health providing the best possible patient care and experience; and, what staff think about the NHS overall.

This annual staff survey provides extremely comprehensive information and means that we can compare our trust, both with previous years and with other organisations. All responses to the NHS staff survey are completely confidential – the survey is run by an independent organisation called 'Picker Institute Europe' on behalf of the whole NHS.

Workforce Race Equality Standard (WRES) indicator
At July's public Board meeting, the Trust reviewed this year's WRES outcomes, prior to submission to NHS England. Following further review and validation of 2017/18 data on the WRES 2 indicator which covers the relative likelihood of white staff being appointed from a shortlisted stage in comparison to their Black & Minority Ethnic (BME) counterparts, there has been a deterioration which shows that white staff are 6.95 times more likely to be appointed. (In the previous year 2016/17 the figure was 2.17). There is work underway to address this in significantly different ways this year; however we will review the WRES action plan at the November 2018 Trust Board meeting. The work of the Recruitment, Selection & Appointment Task & Finish Group and the introduction of the diverse interview panels are already in place to address this WRES finding.

Speak Up Inclusion Champions
To help promote an inclusive culture at work which allows everybody to raise concerns, the trust is seeking up to 18 Speak Up Inclusion Champions from a cross-section of the Trust to represent staff and support a variety of initiatives designed to advance equality, diversity and inclusion for all our staff throughout the Trust.

Care City and NHSE Test Bed programme
Care City has been successful in being identified as one of seven national Test Bed wave 2 sites, which aims to test combinations of innovations in real world clinical settings. Care City has been a wave 1 innovation test bed based on partners in the Barking Havering and Redbridge Boroughs in North East London. Through our relationships and work in UCLP we have been part of the wave 2 bid and are named as the North Central London trust collaborating on wave 2.

Nursing leadership awards
I wanted to warmly congratulate five fantastic Whittington Health nurses who have been awarded nursing leadership scholarships as part of the Leadership for Windrush and NHS70 initiatives: Lianta Downes, Sinead Doherty, Nikola Duncan, Nayol Santos and Frances Young. The Trust is very proud of their achievements and hard work. These programmes support nurses to develop on their leadership journey and we are extremely pleased that so many of our nurses have been recognised to have this potential.

2018 Staff Awards
I am pleased to report that in late September, the Trust held its annual staff awards event. The award judges received over 380 nominations across 15 categories which they whittled down to just five finalists for each award. The finalists and the people who had nominated them were invited to the awards ceremony where the winners were announced. The theme for the evening was "In a sky full of stars, who shines brightest?" It reflected the fact that the trust, which provides Accident and Emergency, Hospital and Community care across Islington, Haringey and beyond is blessed with thousands of hardworking and caring staff. The point of the annual awards is to find and recognise the best of the best, the people who go even further and work even harder. I am incredibly

grateful to all award winners (see list below) and also to everyone who was nominated and those colleagues who helped make the evening such a success.

Award	Winner
The Improving Patient Safety Award	The District Nursing E-Community Team
The Improving Patient Experience Award	James Connell
Outstanding Contribution to Education Award	Rebecca Sullivan
Outstanding Contribution to Developing Individuals Award	Deborah Clatworthy
Paula Mattin Emerging Leader Award	Kelly Collins
Research and Innovation Award	Kayleigh Gilbert
The Non-Clinical Team of the Year	The Security Team
The Clinical Team of the Year	LifeForce Paediatric Palliative Care Team
Volunteer of the Year	Lilian Rios
Unsung Hero	Lee Smith
Support Person of the Year	Robert German
Person of the Year in a Clinical Role	Sarah Gillis
Person of the Year in a Non-Clinical Role	Jana Kristienova
Patient Choice Award 2018	Emma Prescott
Chair's living the Values Award	The Ambulatory Care and Virtual Ward Team

The recipient of the staff award for October is Petra Prazakova, Medical Education Co-Ordinator, Postgraduate Medical Education. Petra was acknowledged for displaying the Trust's excellence value. Known for her dedicated support to trainee doctors, educational and clinical supervisors, Petra has a strong work ethic, sense of responsibility and takes pride in everything she does. Far more than an administrator, she provides information, advice and guidance. This along with her smile and positive attitude helps to remove barriers in the workplace. Consistently producing high-quality work with a positive attitude and helpful nature, she is a wonderful colleague..

Siobhan Harrington
October 2018

Whittington Health NHS Trust

Trust Board, 31 October 2018

Title:	**Serious Incidents – Month 6 (September 2018)**		
Agenda item:	**18/144**	**Paper**	**3**
Action requested:	The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely. The Board is invited to consider focussing discussion on setps being taken to improve the process of surgical inpatient handover and to. reduce the risks abnormal investigations, particularly those suggesting cancer, being overlooked.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during September 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Recommendation	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.		
Fit with WH strategy:	Integrated care; Efficient and Effective care; 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 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:	18/10/2018		

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 September 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 Quality Governance and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

The Trust declared two serious incidents during September 2018, bringing the total of reportable serious incidents to 21 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
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 the response to the initial CT scan may have been delayed.
Unexpected Admission to NICU	Sept 18	A baby was born via caesarean section in poor condition and was transferred to a tertiary unit for specialist care for total body

Category	Month Declared	Summary
Ref:22623		cooling for potential Hypoxic Ischaemic Encephalopathy (HIE).
Diagnostic Incident including delay Ref:23175	Sept 18	An elderly patient had a fall at home resulting in a fractured neck of femur and multiply rib fractures. There may have been an unwarranted delay in appropriately triaginging him and activating the trauma team. He was subsequently transferred to the major trauma centre.

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	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	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	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	Sept 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0
Apparent/actual/suspected self-inflicted	1	0		0	0	0	0	0	0	0
Confidential information leak/Information	6	3		2	0	1	0	0	0	3
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	5
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	0	1
Environment Incident meeting SI criteria	0	1		0	0	0	0	0	0	0
Failure to source a tier 4 bed for a child	1	0		0	0	0	0	0	0	0

Failure to meet expected target (12 hr	1	0		0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	3		0	0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	0	0	1	5
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0	0
Medical equipment/devices/ disposables	1	0		0	0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	0	1
Sub Optimal Care	4	2		1	0	0	0	0	0	1
Surgical/invasive procedure incident	0	0		0	1	0	0	0	0	1
Treatment Delay	3	4		0	2	0	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	0	1
Retained foreign object	1	1		0	0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**21**

4. Never Events

Never Events are defined by NHS Improvement as serious incidents which are wholly preventable if national guidance is followed and which have the potential to cause serious patient harm or death.

Our last never event occurred on 09/08/2017 (2017.20098) and was a Retained Foreign Object. The Trust reported a never event after a tampon was found in a patient after a surgical procedure. The tampon was not left in intentionally and therefore classified as a Never Event under 'the retention of a foreign object in a patient after a surgical/ invasive procedure'. The 'retention of a foreign object in a patient after a surgical/invasive procedure' is regarded as 'wholly preventable' if the WHO surgical safety checklist is followed and a full swab, instrument and sharp count is completed.

We have had no Never Events this year.

5. 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 September 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.

5.1 The Trust submitted thirteen reports to NELCSU during September 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 September 2018. The Trust had one report due for submission, two reports were submitted. One report was a late submission from August 2018.

Summary	**Actions taken as result of lessons learnt include;**
Return to theatre Ref:13332	A patient with complex co-morbidities had surgery for a hiatus hernia and there was a delay in recognising that the patient needed to return to theatre for a complication. • An education session was arranged for the anaesthetic and surgical teams regarding the management of post-operative atrial fibrillation in patients having undergone major Gastrointestinal (GI) surgery. This was to highlight the fact that new onset post-operative atrial fibrillation may often indicate deviation from an normal post-operative recovery. • A Standard Operating Procedure has been drafted detailing how handover should be performed within surgery and when it is appropriate to involve off duty consultants out of hours. The Medical Director has also reiterated the importance of the handover process to all surgical consultants. • The junior doctor cover during normal working hours is being reviewed to ensure that there is robust senior grade ward cover for elective patients.
Diagnostic Incident including delay Ref: 12811	A delay in diagnosing a lung malignancy. • A review of radiology reporting processes and procedures is being undertaking to ensure that the safety netting processes currently in place are fit for purpose. • A Reporting Management Strategy in Radiology is being developed to give managers contemporaneous oversight and assurance that key performance indicators (that align with local and national targets) are being met.

Summary	Actions taken as result of lessons learnt include;
	• Clinicians will continue to be reminded to use Anglia ICE (a patient record system) to routinely check all results they have personally requested and file them to demonstrate that actions have been completed.

6. 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.

7. Recommendation

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
NHS Trust

Trust Board
31 October 2018

Title:	**Quarter 2 2018/19 Safety and Quality Board Report (01 July 2018 – 30 September 2018)**				
Agenda item:	**18/145**		**Paper**	**4**	
Action requested:	The Board may wish to focus its discussion on the progress the trust has made against its Quality Account Priorities for 2018/19.				
Executive Summary:	This is the regular quarterly paper for the Trust Board to provide an overview of safety and quality in the organisation. This report provides an update on mortality, and the trust's HSMR and SHMI figures. On this occasion this report focusses on the progress that the trust has made against its Quality Account Priorities for 2018/19.				
Recommendation:	It is recommended that the assurances contained within this paper are recognised.				
Fit with WH strategy:	To deliver consistent high quality, safe services.				
Reference to related / other documents:	• Quality Account 2017-18 • Clinical Strategy 2015-20 • CQC standards • 7 day services clinical standards				
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Quality and safety category risks on risk register.				
Date paper completed:	23 October 2018				
Author name and title:	**Richard Jennings, Executive Medical Director**	**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Equality Impact Assessment complete?	**N/A**	**Quality Impact Assessment complete?**	**N/A**	**Financial Impact Assessment complete?**	**N/A**

Quarter 2 2018/19 Safety and Quality Board Report

1) Executive Summary

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

This report provides an update on mortality and the trust's HSMR and SHMI figures remain assuring. On this occasion this report provides an update on the progress made against its Quality Account Priorities for 2018/19.

2) Contents

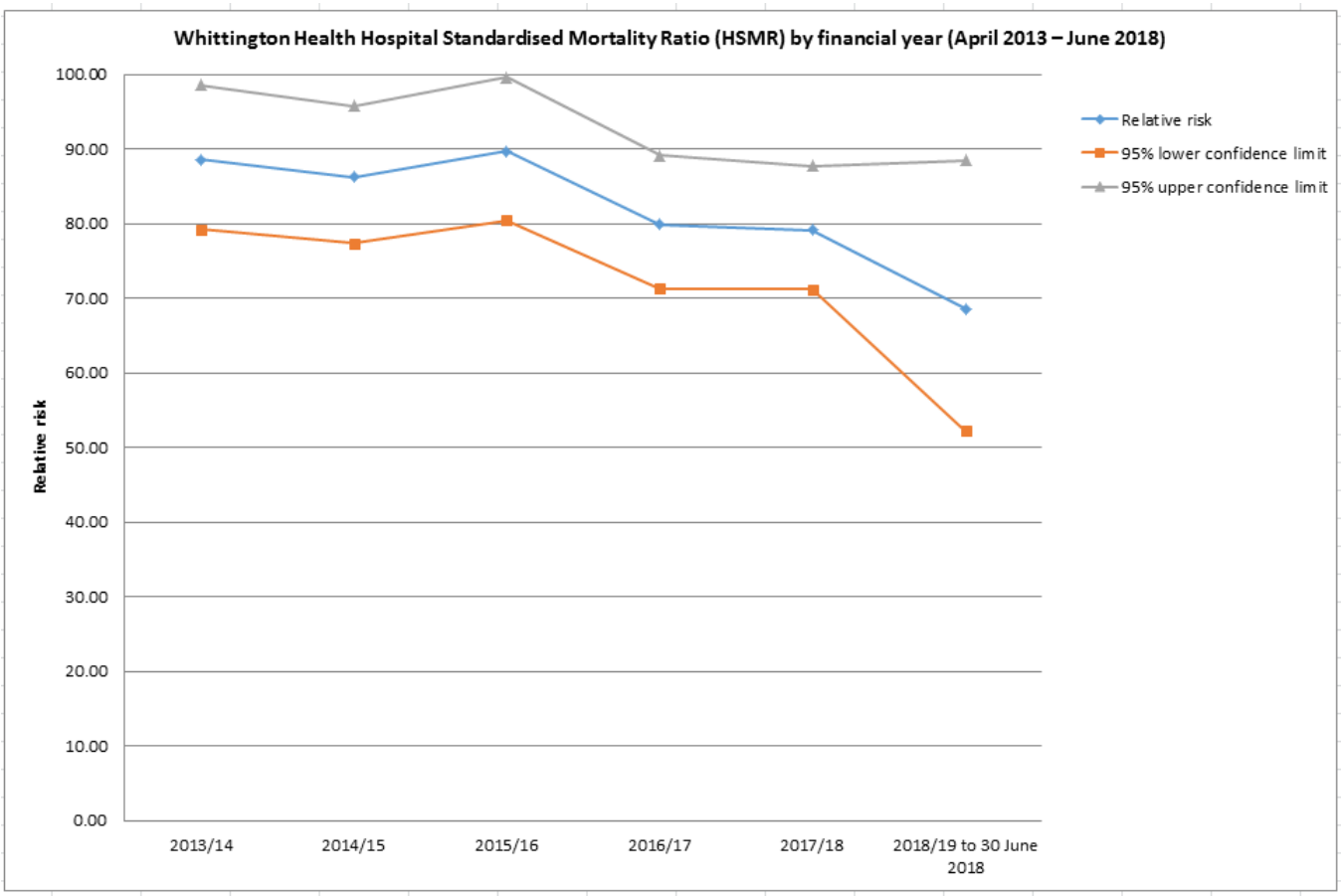
3. Mortality

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

3.1 Hospital Standardised Mortality Ratio (HSMR)

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

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



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

3.2 Summary Hospital-level Mortality Indicator (SHMI)

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

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

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

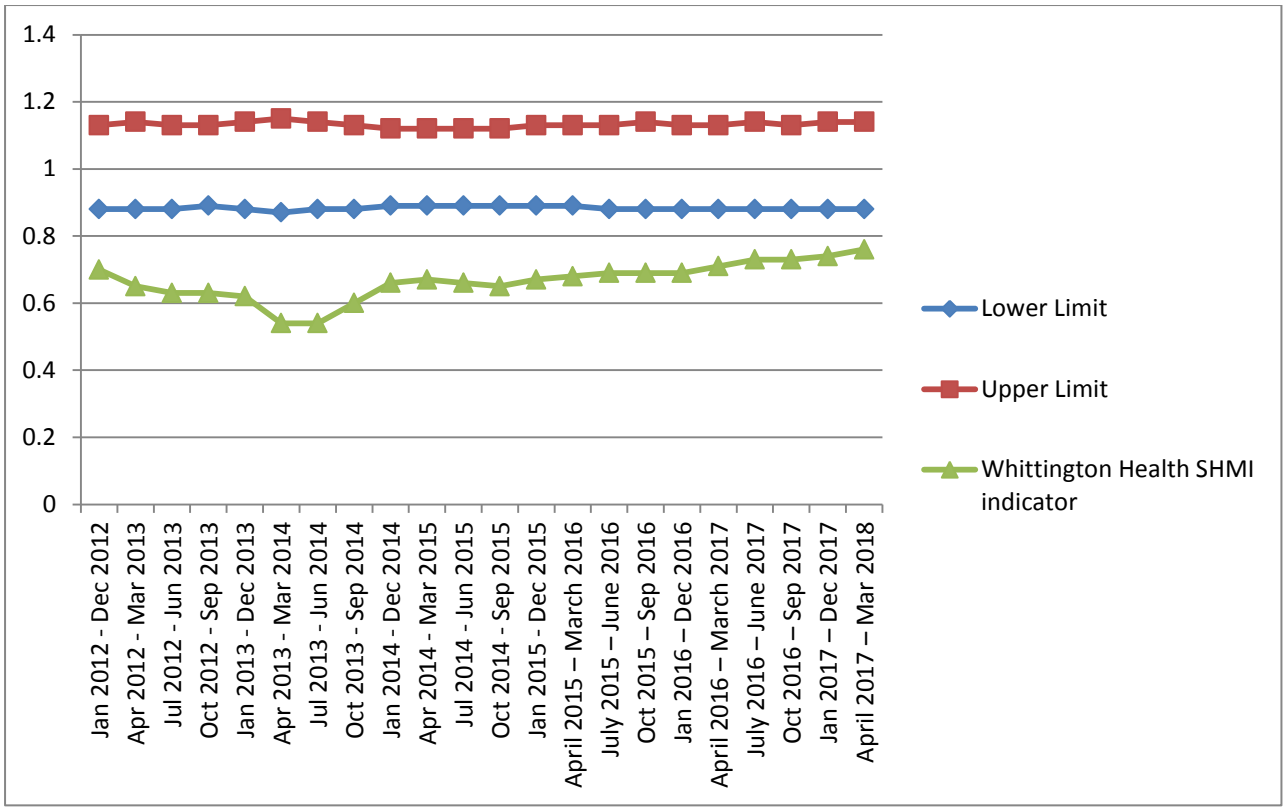
The most recent data available (released in July 2018) covers the period January 2017 – December 2017:

Whittington Health SHMI score	**0.7573**
National standard	**1.00**
Lowest national score	**0.6994 (Guy's and St Thomas' NHS Foundation Trust)**
Highest national score	**1.2321**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – March 2018)

Data Period	Lower Limit	Upper Limit	Whittington Health SHMI indicator
Jan 2012 - Dec 2012	0.88	1.13	0.70
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.60
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67
April 2015 – March 2016	0.89	1.13	0.68
July 2015 – June 2016	0.88	1.13	0.69
Oct 2015 – Sep 2016	0.88	1.14	0.69
Jan 2016 – Dec 2016	0.88	1.13	0.69
April 2016 – March 2017	0.88	1.13	0.71
July 2016 – June 2017	0.88	1.14	0.73
Oct 2016 – Sep 2017	0.88	1.13	0.73
Jan 2017 – Dec 2017	0.88	1.14	0.74
April 2017 – Mar 2018	0.88	1.14	0.76

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – March 2018)



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

4. Infection control report

4.1 MRSA

There has just been one MRSA bacteraemia since April 2018. In June 2018, an MRSA bacteraemia was found on the Coronary Care Unit. The investigation and learning from this incident was described in the previous Quarterly Safety and Quality Board Report. There have been no further instances of MRSA bacteraemia.

Table 2: Whittington Health MRSA colonisation acquisition events April 2018 – September 2018

MRSA acquisition April 2018 - March 2019													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
ITU	0	0	0	0	0	0							0
NICU	0	0	0	0	0	1							1

SCBU	0	0	0	0	0	0							0
Meyrick	0	1	1	0	0	0							2
Cloudesley	0	1	2	1	0	0							4
Bridges rehab	0	0	0	0	0	0							0
Coyle #NOF	0	1	0	0	0	0							1
Cavell	0	0	1	1	0	0							2

There has been a recent transmission of MRSA on NICU. A baby was found to be colonised with MRSA and their mother subsequently was also screened and found positive. A week after the baby was found positive, a second baby, not related but one of a set of twins was also found positive. All three specimens were sent for typing and are the same type, indicating that transmission on NICU occurred. The second baby was found negative on a subsequent screen and their twin has not been found positive. There have been no further new cases. An action plan is implemented.

4.2 *Clostridium difficile*

Since April 2018 there have been seven trust-attributable *C. difficile* cases. Consultant-led Post-Infection Reviews have been held on all cases. The reports have been disseminated to relevant parties. Outcomes of all seven cases have been discussed and agreed with the CCG. The breakdown of cases by ward is shown in table 3. The tolerance for 2018/19 has been set as 16.

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

Date	**No. of Cases**	**Ward**
April 2018	1	Bridges
May 2018	2	Bridges, Nightingale
June 2018	0	
July 2018	0	
August 2018	2	Bridges, Bridges
September 2018	2	Coyle, Mary Seacole South

The first two cases on Bridges have been determined as not connected. The two cases in August have been ribotyped by Public Health England and have been determined the same type, therefore it is probable that cross-infection occurred in these cases. An extensive action plan has been implemented including further training on *C. difficile*.

4.3 MSSA / *E. coli* Bacteraemia Episodes

There have been four trust-attributable MSSA bacteraemias for the year 2017/18. Local reviews were completed for each of these four cases and there were no deficiencies in care identified. More in-depth reviews are only completed wbere there are multiple cases within one clinical area. There are no set national or local thresholds for MSSA bacteraemia.

Table 4: Whittington Health MSSA Bacteraemia cases by ward

Date	**No. of Cases**	**Ward**
April 2018	2	Cloudesley, Coyle
May 2018	0	
June 2018	0	
July 2018	0	
August 2018	2	Thorogood, Critical Care Unit
September 2018	1	Coyle

There have been five trust-attributable *E.coli* bacteraemias for 2017-18 and short Post-Infection Reviews have been completed for all cases. We are attempting to reduce the number of *E.coli* bacteraemias by 20% this year to be on target for the national reduction by 50% by 2021. In 2016/17 there were 14 trust-attributable *E.coli* bacteraemia episodes, therefore for 2018/19 our local trajectory will be 8.

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

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

Date	No. of Cases	Ward
July 2018	0	
August 2018	1	Coyle
September 2018	1	Coyle

4.4 Carbapenemase Producing Enterobacteriaceae (CPE)

Since the beginning of April 2018 there have been two new CPE positive patients, both of which are considered non trust-attributable.

All patients admitted should be reviewed to determine if they are liable to be suspected cases and the reviewing questions are part of the paperwork for the pre-admission clinic as well as the Emergency Department. The IPCT review the ongoing screening of patients through the surgical site infection surveillance scheme for orthopaedics. Each of the patients on the scheme have their paperwork reviewed to ensure the questions have been asked and specimens taken, if required. For most quarters, around 90% of patients have been asked the questions. Most missed patients are the fractured neck of femur patients in ED. Screening for suspected cases can be low; at 75% and the patients with issues are again the fractured neck of femur patients from whom specimens cannot be taken due to their injury

4.5 Infection Prevention and Control Training

Infection Prevention and Control mandatory clinical and non-clinical training is now provided predominately via E-learning. As of 30 September 2018, 81% of Whittington Health staff has received recent (within the last 2 years) IPC training.

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

4.6 Influenza preparation for winter 2018/19

We began our staff vaccination programme on 27th September 2018 and as of 23rd October 2018 46% of staff have been vaccinated.

To help improve the uptake of the vaccination the trust:

- Is making a donation to one of two local charities to help homeless people in Haringey and Islington for each vaccination given to a member of staff;
- Has increased the number of roving clinics to wards and departments;
- Has implemented roving night clinics (between 5pm and midnight) to wards and departments;
- Will, in line with national guidance, record the reasons for frontline staff who chose not to be vaccinated.

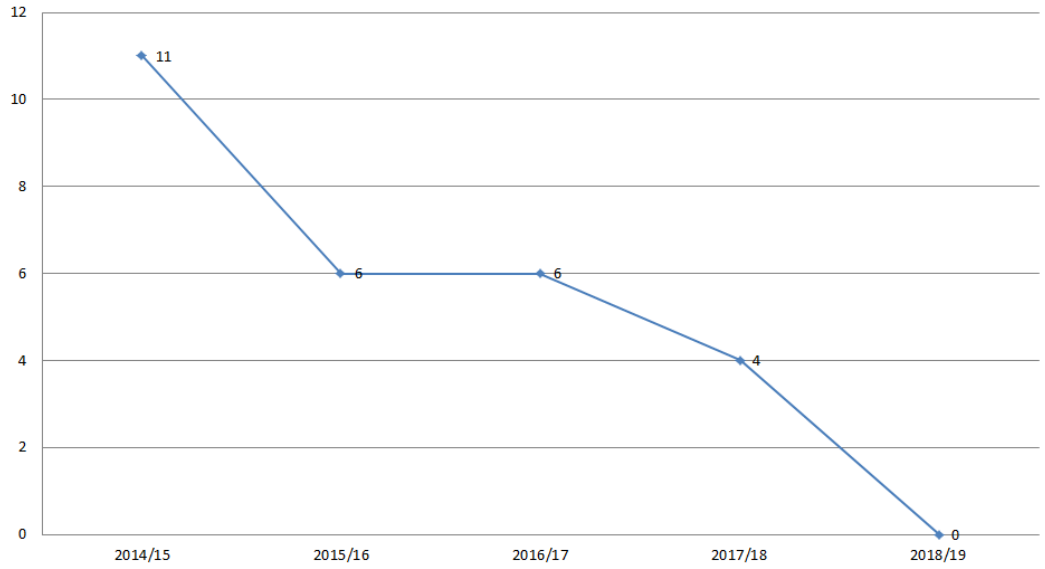
5. Update on progress against Quality Account Priorities (April – September 2018)

The following is an update on the trust's progress against the Quality Account Priorities for 2018/19.

Quality Priority 1 – We will equal or reduce the number of avoidable fall in the hospital resulting in serious harm to patients compared to 2017/18.

As Chart 3 below shows, we have made steady progress against the target to reduce the number of avoidable falls in the hospital. In 2014/15 there were 11 falls and this was reduced to 4 falls in 2017/18.

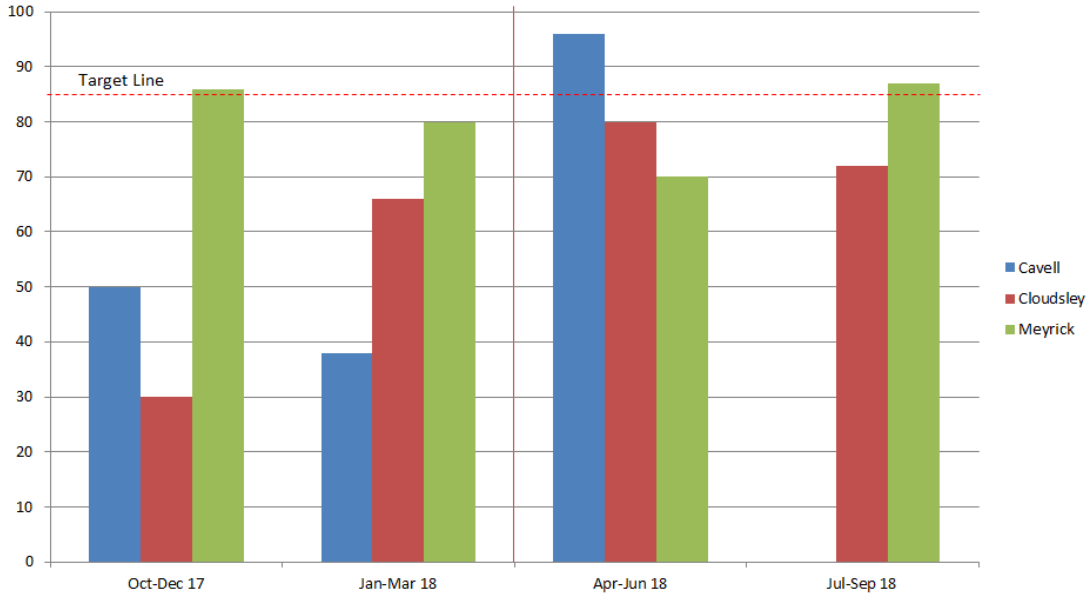
Chart 3: Number of avoidable falls in the hospital resulting serious harm to patients (April 2014 – September 2018)



Quality Priority 2 – We will increase compliance with our STOPfalls bundle to 85% in our acute assessment units and care of older people wards

Although we are not yet consistently meeting the 85% target with the STOPfalls bundle, the progress towards and focus on this compliance is evident in Chart 4.

Chart 4: Compliance with the trust STOPfalls bundle in our acute assessment units and care of older people wards (%) (October 2017 – September 2018)



Quality Priority 3 - We will develop a mandatory training package for falls prevention

Progress:

- The Falls Lead has now attended the Manual Training Leads Group.
- Executive agreement for falls training to become mandatory training.

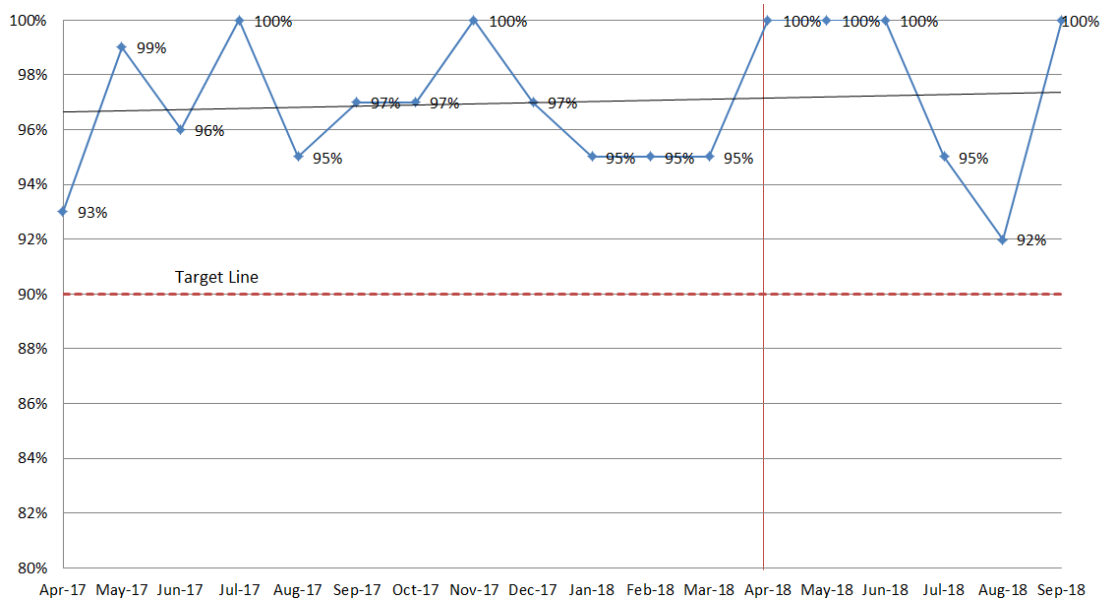
Further actions:

- The Falls Lead will develop the link with Learning & Development (L&D) to establish the logistics around rolling out the training (including whether this should be completed as face to face training or as e-learning).

Quality Priority 4 - The Critical Care Outreach Team will review 90% of patients with a grade 3 AKI within 24 hours of detection

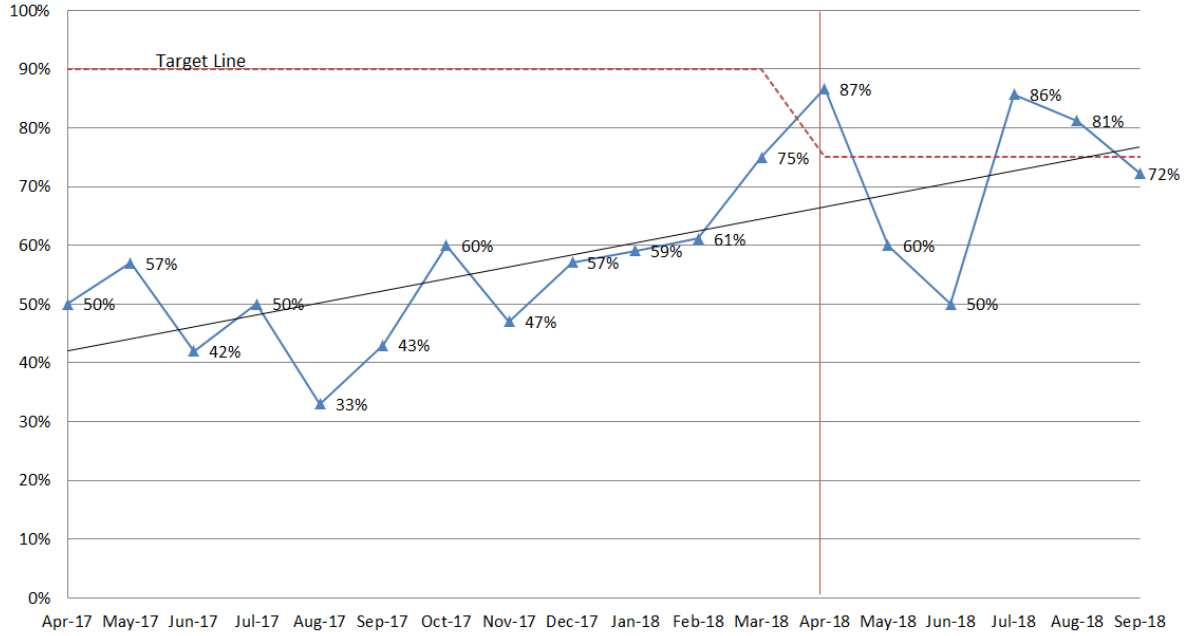
The trust has been consistently achieving over and above the 90% target for the Critical Care Outreach Team to review patients with a grade 3 AKI within 24 hours of detection.

Chart 5: The Critical Care Outreach Team will review 90% of patients with a grade 3 AKI within 24 hours of detection (April 2017 – September 2018)



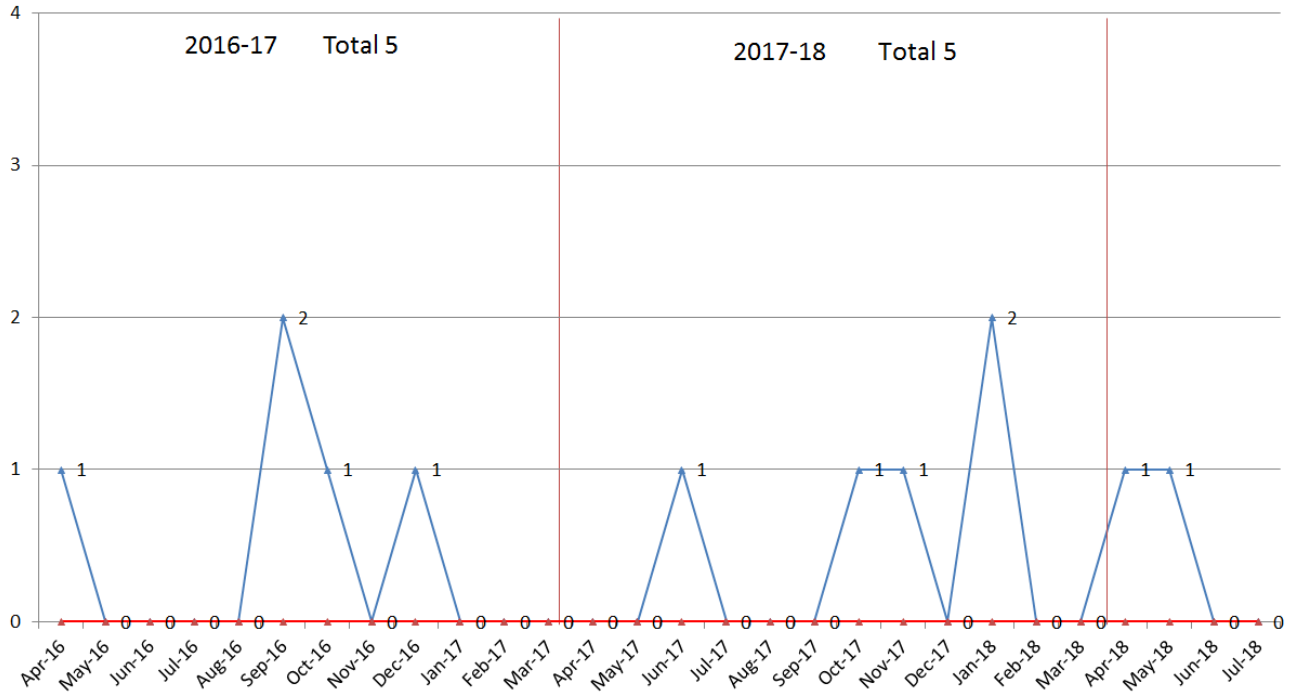
Quality Priority 5 - We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2019

Chart 6: Percentage of patients with grade 3 AKI who had a medicine safety review within 24 hours (April 2017 – September 2018)



Quality Priority 6 - We will reduce the number of avoidable category 4 pressure ulcers from 5 in the community and continue to maintain 0 within the hospital

Chart 7: Numbers of avoidable category 4 pressure ulcers (April 2016 – July 2018) in the hospital and community



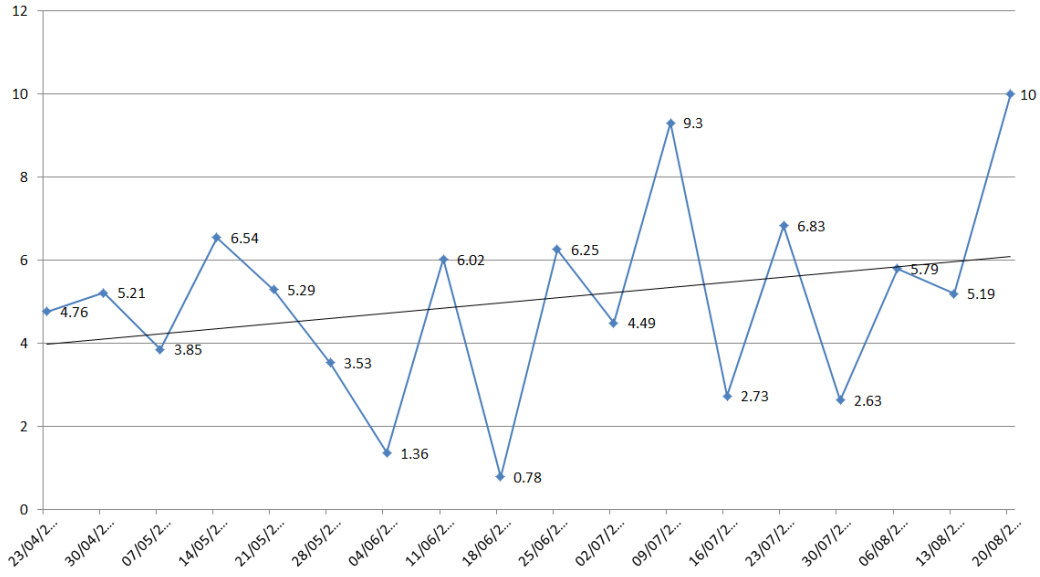
Quality Priority 7 - We will promote John's campaign – *'for the right to stay with people with dementia'* – whilst patients with dementia our in our care

Progress:

- This has now been incorporated into falls training and falls monthly MDT meeting agenda
- The Falls Lead is working with Head of Patient Experience and Dementia Lead to further develop this
- The trust have planned a visit to Homerton Hospital to see John's Campaign in practice

Quality Priority 8 - We will develop a frailty pathway that will prioritise the care of patients over 75 who have been diagnosed with frailty

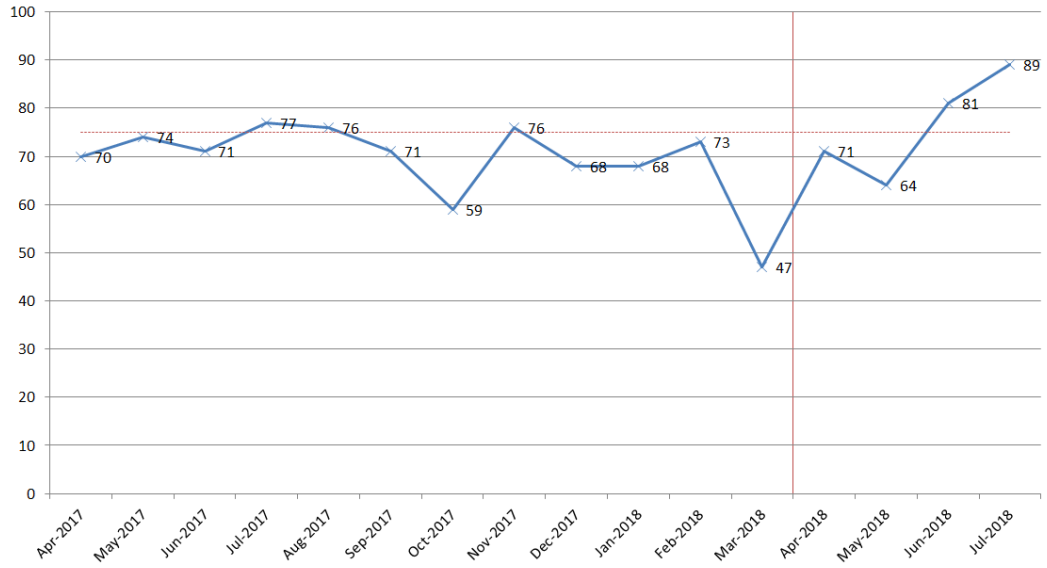
Chart 8: Percentage of Patients Over 75 attending the Emergency Department that are streamed to AEC and Gynaecology Assessment Unit (GAU)



Quality Priority 9 - Within our Emergency Department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours

Following a decline in the compliance with this target in March 2018, the trust achieved over 80% compliance in both June and July 2018.

Chart 9: Percentage of patients who have a diagnosed learning disability or an autism spectrum condition that are seen by the Emergency Department in under two hours (April 2017 – July 2018)



Quality Priority 10 - We will increase the number of people with learning disabilities (LD) involved in trust activities e.g. volunteering, hospital guides

Progress:

- Work has been undertaken by the Interim LD Lead to provide LD people with taster volunteering sessions;
- There is now an LD stall in atrium advertising for volunteers;
- Volunteers with LD are supporting and recruiting new volunteers
- The Interim LD lead is taking further actions to recruit into volunteering roles
- Volunteer team has formed a link with Samuel Rhodes school (special needs school for children aged 5-19 in Islington) and three volunteers from the school are ongoing in their application
- Volunteer team will be involved in the autism project (TAP), in offering three 10 week voluntary administrative placements to autistic service users.

6. References

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

Whittington Health NHS

www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board
31 October 2018

Title:	**2017/18 Infection Prevention & Control Annual Report**		
Agenda item:	**18/146**	**Paper**	**5**
Action requested:	To review and provide final approval for annual report, previously approved at Trust Infection Prevention and Control Committee		
Executive Summary:	For the year April 2017 to March 2018: • **MRSA Bacteraemia:** Initially 3 MRSA bacteraemias were reported, but one of these was removed as the specimen was a contaminant in a patient with a known skin condition and long-term colonisation. Another specimen was determined as a contaminant but this was not able to be removed. Therefore at the end of the year we had a total of two MRSA bacteraemia. Post Infection Reviews (PIRs) are carried out on all MRSA bacteraemia cases. There is a national annual zero tolerance for MRSA bacteraemias. • **MSSA Bacteraemia:** There were five MSSA bacteraemias in the year. There is no national annual tolerance for these. • **E. coli Bacteraemia:** There were 9 Trust attributable E. coli bacteraemias. There is no national annual tolerance. The Department of Health has stated they want a 50% reduction in E. coli bacteraemia by 2020-21. This would mean a maximum of 7 for Whittington. Our local tolerance for the year 2017-18 was 11. An E. coli bacteraemia improvement plan was created with the assistance of the local CCG. • ***Clostridium difficile*:** 11 cases of Trust attributable C. difficile were reported against a tolerance of 17. Two cases were deemed as connected as they were patients in the same bay and were of the same ribotype. All others were determined as unavoidable. Action plans were put in place. • **Carbapenemase Producing Enterobacteriaceae (CPE):** There were 12 patients diagnosed with CPE, but none were Trust attributable. • **Surgical Site Infection Surveillance:** Surveillance of all hip and knee replacements and fractured neck of femur repairs continue and for the year there were only one infection in each category and the Trust was below the national average.		

	• **Influenza:** The number of patients within the hospital found to have influenza in the winter period was 360, compared to 235 the previous year. Even with this high number, there was only one ward closure due to flu during this period. • **Occupational Health:** The number of needlestick injuries decreased to 62 from 84 continuing the downward trend. However, the number of mucotaneous contamination increased from 22 to 23 in 2017-18. There were no cases that required HIV prophylaxis during the year compared to 5 the previous year. • **Influenza vaccination:** 80.2% of staff were vaccinated for flu making the Trust second highest staff vaccinator in London. With collaboration with UNICEF under the *Get a Jab, Give a Jab* project, this meant we donated 21,610 tetanus vaccines worldwide. • **Decontamination:** The Endoscopy Decontamination unit underwent re-development and was re-opened in June 2018.
Summary of recommendations:	The Board is asked to approve the 2017/18 infection prevention and control annual report for publication on the Trust's external web pages.
Fit with WH strategy:	Fits within WH Clinical Strategy
Reference to related / other documents:	Infection Prevention & Control Strategic Action Plan 2017-18
Date paper completed:	5 October 2018

Author name and title:		**Julie Singleton, Lead Nurse Infection Prevention & Control Martin Peache, Infection Prevention & Control Nurse**		**Director name and title:**		**Michelle Johnson, Chief Nurse and Director of Patient Experience, DIPC**	
Date paper seen by EC	**No**	**Equality Impact Assessment complete?**	**Not required**	**Risk assessment undertaken ?**	**Not required**	**Legal advice received?**	**Not required**

Whittington Health NHS

Director of Infection Prevention and Control (DIPC)

Annual Report
1 April 2017 – 31 March 2018

Dr Julie Andrews
Consultant Microbiologist and
Director of Infection Prevention and Control

1.0 Executive Summary and Overview

1.1 Organisation

Whittington Health is an integrated care organisation (ICO) – providing both hospital and community care services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

Our current organisation was established in April 2011 following the merger of The Whittington Hospital and NHS Islington and NHS Haringey community health services.

In 2016/17, Whittington Health had an income of £309.3m and more than 4,000 staff delivering care across North London from in excess of 30 locations including a number of health centres and The Whittington Hospital.

During the financial year 2017/2018, the Infection Prevention and Control Team (IPCT) provided a full service to hospital and community sites under the Whittington Health remit. A single Director of Infection Prevention and Control (DIPC) covers all of Whittington Health.

Whittington Health takes the prevention and control of all infection seriously. It is part of the strategic objective to deliver efficient and effective care by delivering safe care to patients and providing a clean and safe working environment for staff employed by the organisation. Infection prevention and control continues to be everyone's business.

1.2 Activities

The focus for 2017/2018 has been to ensure:

- An ongoing reduction in incidence of healthcare associated infections (HCAI), in particular MRSA bacteraemia, *Clostridium difficile* diarrhoea, diarrhoea and/or vomiting outbreaks, E.coli bacteraemia, respiratory tract viral infection including influenza and surgical site infections.

- Our staff have the most up to date knowledge and skills to achieve excellence in infection prevention and control

In collaboration with the Microbiology team, the IPCT reviewed ward, clinic and community patients with infection related problems daily. An increasing number of infection consultations were carried out in our ambulatory care setting (walk in service where patients do not stay overnight). An on-call Infection Prevention and Control service was available 24 hours a day, 7 days a week through a joint Microbiology Speciality Registrar and Consultant rota.

We have collaborated widely with the Occupational Health and Wellbeing team this year on the delivery of influenza education and vaccination. The Trust achieved an 80.2% vaccination rate in our relevant workforce

placing us second on the London hospitals leader board after being first in London last year.

Infection Prevention and Control in the built environment

Despite financial restrictions, the Trust has recently undergone significant refurbishment in many clinical areas and has invested in equipment and projects both in the hospital and community settings. The Infection Prevention and Control Team have been involved in refurbishment projects from the planning stage and has provided expert advice on key factors within the built environment which can impact on the control of infection. The IPC Team have been able to provide expert advice on every stage which will minimise the risk of transmission of infection within the healthcare environment;

1.3 Infection Prevention and Control (IPC) Strategic Action Plan

The 2017/2018 Infection Prevention and Control (IPC) annual strategic action plan is outlined in Appendix A. The plan focused on continued zero tolerance to MRSA bacteraemia, reduced incidence of other HCAI's, developing enhanced methods to provide assurance, expanding IPC training and strengthening environmental based IPC audits.

Progress of the actions contained within the plan are monitored closely over the year through the Infection Prevention and Control Committee. As in previous years, each action area had a named lead from the senior nursing, medical or management team and an IPC team member to act as a support to ensure deliverability in a timely manner. We have strengthened the plan by providing updated evidence bi-monthly. There are new parts of the IPC action plan to accommodate the rising incidence of infection with resistant Gram negative organisms

Every MRSA bacteraemia and other significant HCAI events were reviewed using Post Infection Review (PIR) methodology and Consultant led PIR meetings held. The HCAI PIR ongoing action plan has been reviewed at regular intervals in conjunction with the annual IPC plan and presented at every IPCC meeting.

2.0 Infection Prevention and Control Arrangements

2.1 Infection Prevention and Control Team

At Whittington Health, the IPC agenda is led by the DIPC and infection prevention and control nursing team, who report directly to the Trust Board bi-monthly through the Quality Committee. The Medical Director, Director of Nursing and ICSU Clinical Directors and Heads of Nursing also have key roles in ensuring that high standards of clinical care are delivered to patients.

The IPCT comprises of one IPC lead nurse, two full-time specialist nurses, one part-time specialist nurse, one full-time trainee specialist nurse, one antimicrobial consultant pharmacist, a part-time IPC lead administrator and one full-time co-ordinator.

During 2017/2018, the IPCT worked closely with many teams including Microbiology, Facilities staff, Community Nursing Leads, Access, UCLP procurement team, Middlesex University, CCGs, Learning and Development, NHS England, Voluntary Organisations, Public Health England staff and Occupational Health and Wellbeing staff.

A group of approximately 40 IPC link practitioners, who receive enhanced training in infection prevention and control, also support ward and clinic staff.

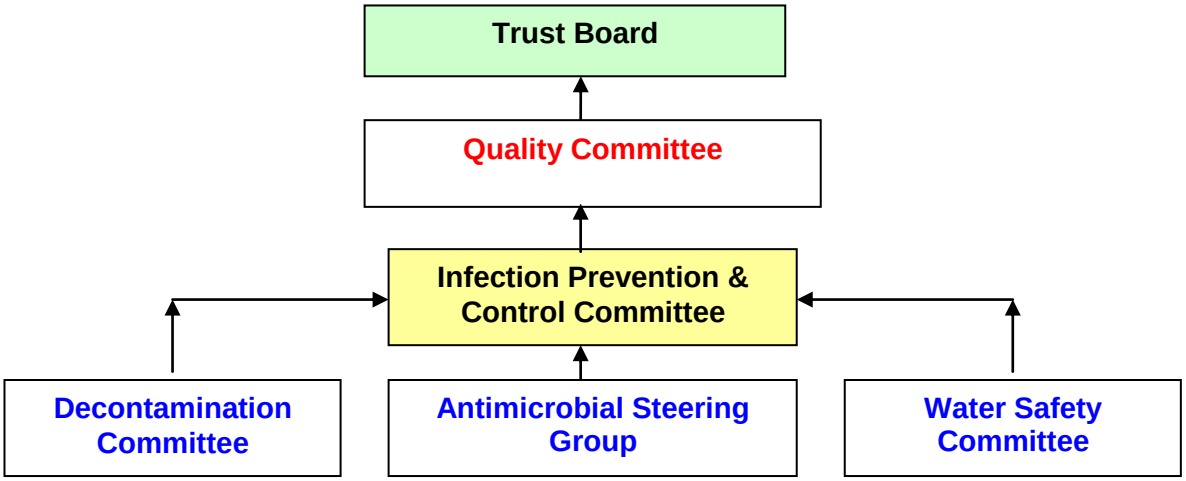
2.2 Infection Prevention and Control Committee

In March 2017, the terms of reference for the IPCC were revised to ensure widespread high level membership from all relevant areas of Whittington Health. The IPCC is chaired by the Director of Nursing and Patient Experience and meets bi-monthly.

Membership of the IPCC includes ICSU nursing and medical representatives, the Antimicrobial Pharmacist, the IPCT, Microbiology Team, Public Health England representative, representatives from higher risk community services such as Community Dental Services and District Nursing, Occupational Health and Wellbeing staff and a Learning and Development Team representative.

2.3 Reporting Line to the Trust Board

The current reporting line of the IPCC is below:



2.4 Links to Drugs and Therapeutics Committee

During the period covered within this report, the Drugs & Therapeutics Committee (DTC) and IPCC both reported to the Quality Committee, chaired by non-executive directors. Continuity was assured as the DIPC and Head of Pharmacy both provided regular updates from their areas. In addition, the chair of the DTC is a member of the IPCC.

The Antimicrobial Steering Group (ASG), chaired by the DIPC, meets twice yearly. The ASG reviews antimicrobial policies, expenditure and

audits and plans further work as required. All ICSUs are represented and the ASG reports directly both to the DTC and IPCC.

3.0 DIPC Reporting to Trust Board

Performance against ceiling targets for MRSA bacteraemia, *Clostridium difficile* and E.coli bacteraemia have been reported to Trust Board through the Quality Committee bi-monthly as part of the performance dashboard report. Reports have included as standard, the performance for the previous month against the agreed objectives for MRSA bacteraemia, *Clostridium difficile*, E.coli bacteraemia and orthopaedic surgical site infection incidence. Ongoing work to improve performance and results of IPC audits and other assurance data was also detailed. The report also includes a section on IPC training compliance.

4.0 Budget Allocation for Infection Prevention and Control Activities

4.1 Staff

The DIPC is a Consultant Microbiologist, who has one programmed activity designated for this role. As at 1 April 2018 the DIPC post transferred to the Chief Nurse.

The Infection Prevention and Control Team comprised of the following staff in 2017/2018:

1 wte Lead Nurse (band 8b)
1 wte Antimicrobial Pharmacist (band 8a)
2 wte Specialist Infection Control Nurses (band 7)
1 0.5 wte Specialist Infection Control Nurse (band 7)
1 wte Trainee Specialist Infection Control Nurse (band 6)
1 0.8 wte IPC Lead Administrator (band 5)
2 wte Co-ordinators (band 4) (with effect from 15.06.17 this was reduced to 1 wte Co-ordinator (band 4)

The allocated budget for infection prevention and control in 2017/2018 was:

Area	Pay	Non Pay
ICO infection control – budget code AALC	£ **454,825**	£ **2,309**
Total	£ **454,825**	£ **2,390**

4.2 Support

The IPCT have good support from IM&T to provide MRSA and *C. difficile* monitoring graphs to the Trust Board.

5.0 IPC Training

During 2017/2018, the IPCT provided an extensive range of education and training, through two individual full day IPC link practitioner study days, all day rolling training sessions, face to face mandatory training and bespoke sessions delivered to a variety of clinical groups. Sessions have also been held at health centres with reasonable attendance. All training materials are evidence based and updated on a regular basis. New materials are developed and made available based on PHE guidance.

Face-to-face training was also provided for Junior Doctors by the DIPC through regular education programmes, with a focus on prescribing antimicrobials, managing common infection scenarios, influenza and infection prevention. A practical procedures course was introduced in 2009 for Foundation Year 1 Doctors focusing on aseptic technique for basic procedures such as insertion of peripheral cannulae, blood cultures and urinary catheterisation. Practical aseptic skills training was also provided to relevant acute and community based nursing/midwifery staff. Student nurses from Middlesex University also received induction, mentorship and clinical skills training.

Despite enhanced training activity, compliance did not exceed 83% in 2017/2018.

6.0 HCAI Rates and Other IPC Surveillance

6.1 Results of Mandatory HCAI Reporting

MRSA Bacteraemia: For the period 1 April 2017 to 31 March 2018, Whittington Health initially reported three trust attributable MRSA bacteraemia episodes against an agreed objective of zero. However, two of these bacteraemia were deemed contaminants and appealed. As of 31 March 2018 it was agreed that one of these contaminants would be removed from our figures and therefore we finished the year with two trust attributable MRSA bacteraemia. All bacteraemia were fully investigated using the PIR process with wide sharing of learning at the IPCC.

There has been a marked improvement from performance in 2009/2010 and 2008/2009 when there were 8 and 23 episodes respectively and we have sustained this improved performance. There were five community attributable MRSA bacteraemia episodes within the 2017/2018 period investigated by the relevant CCG. A zero tolerance objective has again been set for trust attributable MRSA bacteraemia for 2018/2019.

MSSA Bacteraemia: There were five episodes of post-48 hour meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2017/2018. There are no set ceiling targets associated with this organism. Each case was reviewed by the IPCT to look for modifiable risk factors such as peripheral or central line insertion non-compliance.

E.coli Bacteraemia: There were 128 reported episodes of E.coli bacteraemia in 2017/2018, 119 of these were pre 48 hour episodes and 9 post 48 hour. The post 48 hour patient cases were investigated to

ascertain any obvious modifiable risk factors. 9.2% of the E. coli bacteraemia isolates demonstrated extended Beta lactamase production (ESBL) meaning they were resistant to Beta-lactam antimicrobials such as co-amoxiclav and pipercillin-tazobactam. We were successful in reducing the number of *E.coli* bacteraemias by 20% this year to be on target for the national reduction by 50% by 2021. In 2016/17 there were 14 Trust-attributable *E.coli* bacteraemia episodes, therefore for 2017/18 our local trajectory was 11, which we have achieved and for 2018/19 our local trajectory will be 8. The Trust has produced a E. coli recovery plan for 2017/18 in conjunction with the local Clinical Commissioning Group and this is embedded within the IPC Strategic Action Plan below.

***Clostridium difficile*:** From 1 April 2017 to 31 March 2018, Whittington Health reported 11 cases of Trust attributable *C.difficile* associated diarrhoea (CDAD) against a tolerance of 17 finishing the year well under trajectory. In April 2012 a new screening method for *C.difficile* was introduced which involved a more sensitive two stage procedure. Nationally a 30% increase in prevalence has been seen through the introduction of this two stage procedure.

Of the 11 cases, each was reviewed in detail using the post infection review (PIR) template and aspects of care relating to isolation, testing, communication, cleaning, use of personal protective equipment and antimicrobial prescribing were independently scrutinised.

- In summary, two out of the 11 cases of the Trust attributable *C. difficile* associated diarrhoea (CDAD) were deemed avoidable as two patients in the same bay became symptomatic at the same time and were found to have the same ribotype. This was deemed cross infection. Side rooms were not always immediately available to isolate patients however patients were suitably co-horted in a bay until a side room became available. There was one case of cross-transmission which formed part of the Cloudesley ward C.*difficile* outbreak.

The Trust-attributable *C.difficile* ceiling objective in 2018/2019 has been set at 16.

Carbapenemase Producing Enterobacteriaceae (CPE): There were 12 patients diagnosed with CPE in 2017/2018. No cases were attributable to the Trust and there was no cross-transmission. Screening for CPE commenced in October 2014 and a recent audit highlighted 87% compliance in completion of screening questionnaires.

Orthopaedic Surgical Site Infections: Surgical site infection surveillance (SSI) data for all four quarters in 2017/2018 for hip implants, knee implants and surgical repair of fractured neck of femur. This is above the expected mandatory reporting requirement of Public Health England.

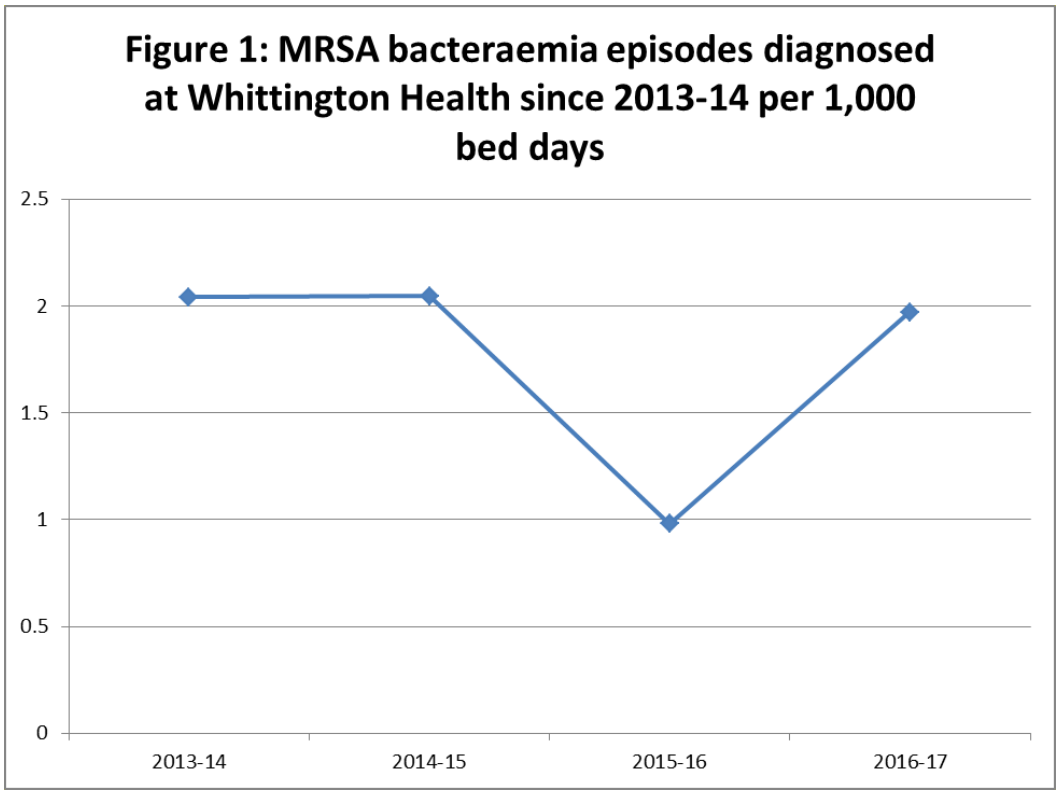
The figures for 1 January 2018 to 31 March 2018 are not finalised, but the total figures for the year from 1 January 2017 to 31 December 2017are as follows:

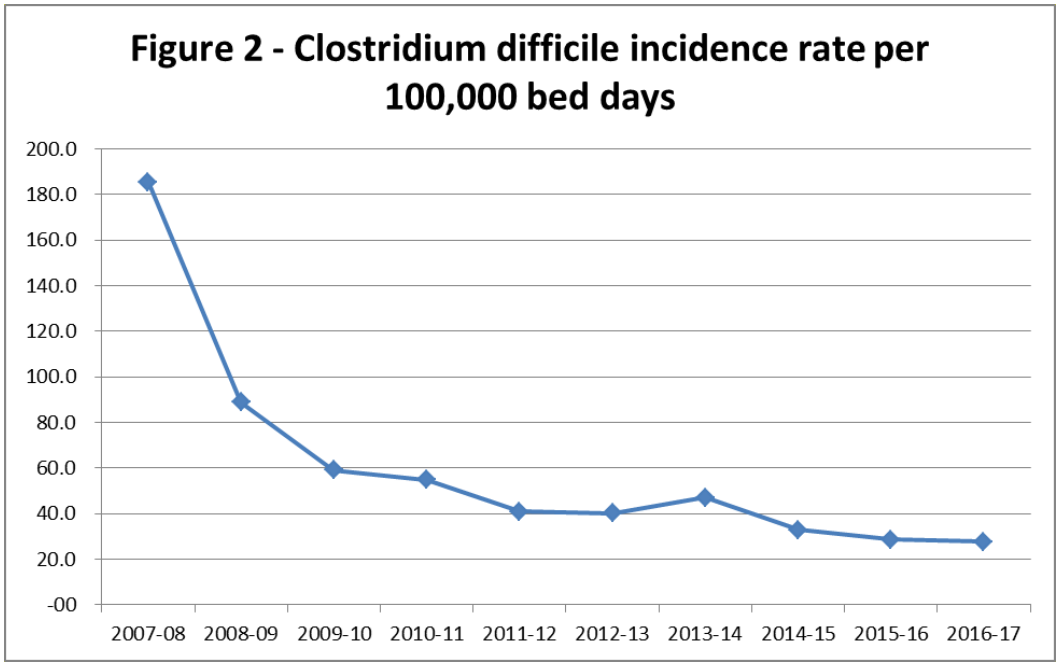
- Total Hip Replacements (THR) 0.6% against a national benchmark of 1.0% (1 infection out of 160 procedures)
- Total Knee Replacements 0.8% against a national benchmark of 1.3% (1 infection out of 131 procedures)
- Fractured Neck of Femur (#NOF) 0.9% against a national benchmark of 1.3% (1 infection out of 106 procedures).

6.2 Trends in HCAI Statistics

The Trust takes its' responsibilities for reducing HCAI very seriously; these figures are monitored weekly by the Executive Committee and reported to Trust Board.

The following trend charts detail HCAI rates year on year since the commencement of mandatory surveillance.





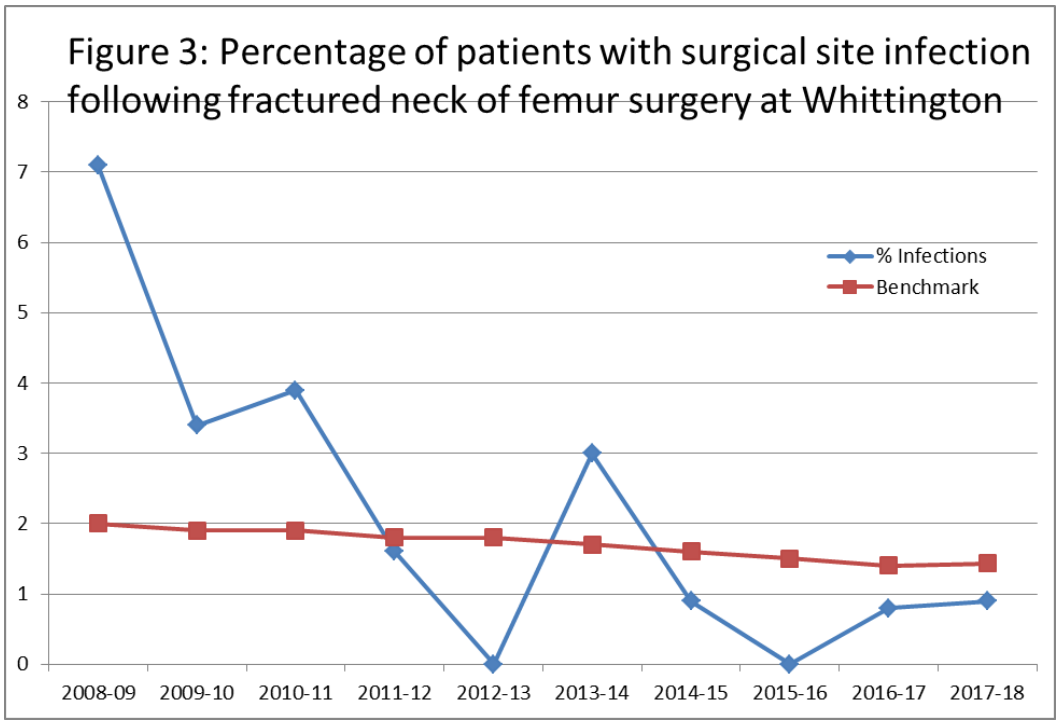


Figure 3 demonstrates the significant improvement that has been sustained since 2011 in the percentage of patients being diagnosed with surgical site infections following surgery for fractured neck of femur surgery.

6.3 Serious Untoward Incidents, Including Outbreaks

There was one Serious Incident (SI) Panel enquiry directly related to clinical infection prevention and control in the period 2017/2018 relating to MRSA bacteraemia.

There was a high prevalence of influenza, 360 laboratory diagnosed cases, but due to rapid ward response there was only one ward closure during the 2017/2018 period. In the entire influenza season there were 55 acquisitions of influenza in hospitalised patients, (up from 19 acquisitions in 2015/16 and 32 in 2016/17). There were three hospital acquired influenza deaths which have been investigated internally using the SI process.

6.4 Healthcare Worker Exposure to Blood Borne Virus

The number of needle stick injuries continue to fall from 112 in 2015/16 to 84 in 2016/17 to 62 in 2017/18. However, mucocutaneous incidents rose from 14 in 2015/16 to 22 in 2016/17 to 23 in 2017/18. Our red rated areas continue to be in ED, ITU, Theatres and Labour Ward although there were fewer incidents in these areas compared to last year. Needlestick injuries in the community dropped from 26 reported incidents down to 20. There was a rise in incidents in the laboratories which is now rated red and OH nurses will work with our IC nurses to investigate. DTC moved from coded red to green.

We will continue to focus training on high risk areas and areas were we see poor practice in the coming year.

There were two RIDDOR reported incidents in 2017/18:

1) 0 HIV incidents
2) 1 Hep C source positive splash in ED; and
3) 1 Hep B source positive needle stick in theatres.

We are still seeing incidents related to over filled sharps bins, re sheathing of needles and incorrect disposal of used needles. These will be investigated individually and followed up by OH and the infection prevention and control team using a two pronged approach.

We reviewed all sharps being used in the Trust and have removed all non-safe sharps from the Trust's ordering system. Non-safe sharps can only be ordered if they are on an agreed exemption list following risk assessment.

We did not need to issue any post-exposure prophylaxis (PEP) prescriptions in 2017/18 to reduce the risk of HIV sero-conversion compared to 5 in 2016/17.

Following tests, no staff member was found to be infected from a needle stick or body fluid splash with either HIV, Hep B or Hep C.

80.2% of staff were vaccinated against influenza placing us the second best vaccinating NHS Trust in London. The Trust supported *Get a jab, Give a jab*. For this, we committed to match every flu vaccination given with a donation of 10 tetanus vaccinations to a UNICEF project, focusing on eliminating neonatal tetanus worldwide and donated 21,610 tetanus vaccines.

7.0 Hand Hygiene and Aseptic Technique

The organisation made a concerted effort to ensure that hand hygiene compliance was still a high priority. A “Whittington Warriors” hand hygiene campaign was launched in 2014 and all phases of the campaign: new floor and wall signage in the hospitalsite together with a virtual nurse hologram for the main entrance were introduced.

The IPCT delivered face to face training on mandatory induction days. The team also offered training to services on request or when areas demonstrated poor compliance.

Hand hygiene compliance was measured through monthly hand hygiene audits (by various different staff groups) across all clinical areas. Hand hygiene compliance amongst community staff was completed and monitored by the IPCT via telephone audits. Access to hand hygiene facilities was recorded in health centres and other community sites on our regular visits.

Up to the beginning of 2017, the results had shown consistent improvements, with most clinical areas having hand hygiene compliance scores over 95%. In 2013/14 there was a reduction in the numbers of clinical areas that were compliant and a staff survey reported a perception of reduced access to hand hygiene facilities. The IPCT responded with targeted training; increased auditing by link staff and concentrating on improving access to hand hygiene stations or alcohol gel. Areas that scored below 95% were audited more frequently with targeted feedback. Results are presented to areas immediately and as part of a ward IPC performance dashboard, see Appendix B.

With regard to aseptic protocols, the ICO continues to follow the guidance set out in the Saving Lives High Impact Interventions and Essential Steps. This includes the management of central venous catheters, peripheral cannulae, urinary catheters, prudent antimicrobial prescribing, prevention of surgical site infection and *Clostridium difficile*. Evidence based guidelines can be found on the Clinical Guidelines section of the intranet. Compliance with these guidelines forms part of the ward IPC dashboard. Compliance has improved steadily since the introduction of the Saving Lives campaign and is now at a high level.

8.0 Decontamination

8.1 General arrangements

The Director of Environment is the Decontamination Lead for Whittington Health. The Decontamination Advisor who is also the designated lead manager for Decontamination supports the Decontamination Lead.

Decontamination and related matters are reported and managed at the Decontamination Committee, which is a sub-committee of the Infection Prevention and Control Committee. Records of these committee meetings are kept and made available for the CQC during an inspection.

A report from the Decontamination Committee is submitted to the IPCC on a quarterly basis. These lines of reporting are in accordance with the hygiene code and are supported by a number of policies and standard operating procedures (SOPs) which are available on the intranet. These policies are reviewed at regular intervals by the authors and the Decontamination committee. Some policies, which pertain to local facilities and services in the community, are only available in the area of use.

8.2 Committee Activities

The Decontamination Committee reports and meets quarterly. The committee agenda is arranged to ensure that over a 12-month cycle all aspects of decontamination governance and operational performance monitoring and are reviewed. Each meeting covers of the following:

- Performance Indicators; dashboard which includes incident reporting.
- Compliance Framework; equipment validation and process audits; there will be an area chosen on a rotational basis to present and discuss their audit at Decontamination Committee.
- Exception Reports; progress update on incident action plans.
- Evidence of ongoing training in regard to innovation and existing activity.
- Policy review and updates.

8.3 Audit

The following audits are carried out and results reported to the Decontamination Committee in rotation:

- Endoscope Processing Unit (EPU)
- Equipment Decontamination Unit (EDU)
- Mop washing room
- Mattress decontamination room
- The bed store
- Community Dental facilities.
- Decontamination machinery maintenance and validation

Matters arising are identified and tracked through subsequent meetings.

8.4 Incidents or failures

Recording and reporting of incidents is undertaken electronically using Datix electronic reporting system throughout Whittington Health.

The decontamination of reusable surgical instruments is carried out at an offsite facility run by In Health Sterile Services (IHSS). IHSS has now been bought out by Berendsen and has translated into minimum disruption to our service.

We continue to work with IHSS in partnership by offering experience days in theatre at the Whittington hospital and sending Whittington staff to IHSS for learning opportunities. There have been relatively few reported incidents relating to IHSS over the past 12 months. This demonstrates the success of our collaborative approach and key improvements by IHSS in quality monitoring such as the introduction of cameras monitoring all aspects of production and in spite of recent corporate upheaval at the Park Royal and Ruislip IHSS facilities.

The careful monitoring of recurrent issues is carried out by a Decontamination Users Group. This allows end users to have face to face discussions with IHSS managers facilitated by the Decontamination Advisor and IHSS Contracts Manager.

Whittington Healthcontinues to take the issue of sharps returned on used trays to IHSS very seriously; unfortunately incidents of this nature continue to occur on an occasional basis. The staff members involved in such incidents are encouraged to attend the Park Royal IHSS facility and remove the used sharp from the tray and dispose of it correctly to remind all that actions have consequences and to see the real face of our partners at the Park Royal facility. This is usually followed by a tour of the facility and meeting with the decontamination staff at the facility to reinforce our partnership working ethos. Whittington Healthreturned a total of one used sharp to IHSS Park Royal. See picture below:

We continue to offer Sharp safety training days, our most recent being in May 2017; these learning opportunities have good attendance from a wide range of disciplines and positive feedback. IHSS continue to support these study days and express gratitude to Whittington Health for their

diligent approach to this issue. We are the only Trust in the partnership to address the problem in such a proactive manner.

Decontamination reported incident table of April 2017 – March 2018

IHSS	Non IHSS	Low risk	Moderate risk	High risk	ungraded
5		2	3		

The table above details decontamination incidents for the preceding 12 month period. No high risk issues or serious incidents.

8.5 Risks associated with Decontamination

There are 2 risks under Decontamination listed on Datix risk register

250 – Return of medical equipment to Medical library incorrectly decontaminated; graded moderate.

This risk has now been transferred to the care of Medical Physics and it will be reported and monitored at the Medical Devices Committee. The Decontamination Advisor has education visits to areas of the Trust who have returned items incompletely or incorrectly decontaminated to Medical Physics planned for May and June of 2018.

ID number and initial risk rating	Risk description	Risk Review date and current rating
250 - High	If medical equipment is not decontaminated before it is returned to the library or to medical physics for repair, this presents an infection control risk to patients and staff. (This risk is now owned by Medical Physics)	18/07/2017 - Moderate
682- High	If scope re-processing unit fails scopes to treat and/or diagnose emergencies, planned scope procedures to diagnose problems in Urology, Respiratory/bowel screening and ENT will become unavailable for use. It will also mean that emergency scopes for intubation will be unavailable leading to a risk to life. This will seriously impede the work of doctors and the solution will be to re-direct patients to other hospitals leading to delay and inconvenience, with possible serious consequences. 05/05/2016. No Change	11/012/2017 - extreme

Risk 682 – Failure of Endoscopy Processing Unit

This is being addressed by the re-development of the Endoscopy Processing Unit. This project is headed by the Director of environment supported by the Decontamination Advisor and the Decontamination Re-Development Consultant.

8.6 A review of priorities for 2017/2018

The re-development project for Endoscopy Processing Unit has been commenced; the necessary building works and the new Reverse Osmosis water plant have been installed and commissioned.

The first washers were installed in January 2018; the project enables the unit to be redeveloped while maintain production, remaining compliant and utilizing existing fabric and environment to enable significant savings to be made. The project is likely to be delivered in its entirety under £700,000.00. Final completion date June 2018. See pictures below:

8.7 Priorities for 2018/2019

Complete the installation and commissioning of the Endoscopy Processing Unit re-development. Opening ceremony booked for the 21 June 2018.

Audit policies and SOP's for Decontamination and ensure all published are relevant correct and in-date.

Initiate use of cleaning efficacy challenge devices in Endoscopy Processing in order to further comply with HTM 01-06. These devices are just becoming commercially available. Trials arranged at the Whittington with the first manufacturer to commence production and have device available for purchase June 2018. Two devices have been secured initially on a cost free basis.

Continue working within the NWL partnership with IHSS to deliver a compliant and reactive service which meets legislative standards and new guidelines with particular reference to cleaning efficacy and protein residue measurements.

Continue to build, train and educate an excellent decontamination production team to meet the growing needs of Whittington Health.

9.0 Audit

9.1 Extent of Audit Programme

Audit of infection prevention and control practice is conducted as part of the ICO's main clinical audit programme as follows:

- Orthopaedic surgical site infection surveillance scheme.
- Annual large bowel surgical site infection surveillance.
- Compliance with antimicrobial policies.
- MRSA screening and interventions such as MRSA suppression.
- PLACE inspections.
- Hand hygiene.
- Environmental cleanliness including commodes.
- IPCT enhanced quality improvement audits.
- Compliance with flushing low use outlets.
- Compliance with isolation and personal protective equipment policies.

All results are presented immediately to front line staff. Specific audit results also form part of the IPC dashboard which is presented to divisional boards and Quality committee, see Appendix B.

Community locations were audited for compliance with processes and procedures, environmental cleanliness, fabric of the infrastructure and hand hygiene facilities using IPCT enhanced quality improvement audit tools. There is a work plan audit planner and the majority of areas have demonstrated improvements compared to the previous year. Action plans are disseminated after all audits and reviewed within three months for

those areas found to be non-compliant. Areas of moderate concern will be reported using the Trust risk register.

9.2 Reasons for Audit Focus

One of the many rationales for carrying out all the above audits was to help the Trust to reduce the incidence of MRSA bacteraemia, *Clostridium difficile*, surgical site infections and other HCAI. Audits are also designed for detailed measurement of all aspects of practice/environment and to measure baseline practice with standards identifying areas for improvement. Audits help raise awareness, impart knowledge and skills measure performance and enable focused actions to be taken to improve. The IPCT also have an opportunity to offer advice directly as/when necessary. The audit results form part of the assurance framework to ensure we achieve our annual IPCT strategic action plan and adhere to CQC best practice guidelines, and the Health and Social Care Act 2008.

10.0 Report from the Antimicrobial Pharmacist

There has been significant pressure on pharmacy resources to manage the high number of antibiotic shortages throughout the year in order to minimise disruption to services and to limit the risk on patient safety. Essential antibiotics including piperacillin-tazobactam, gentamicin, clindamycin, co-trimoxazole and chloramphenicol were affected. The hospital's stewardship programme as well as the attainment of the Antimicrobial Resistance (AMR) CQUIN performance targets have been impacted by the shortages.

The AMR CQUIN results for 2017/18:

CQUIN	Indicator	Target	Q1	Q2	Q3	Q4
2c	Clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	Q1 – 25% Q2 – 50% Q3 – 75% Q4 – 90%	**88%**	**88%**	**95%**	**96%**
2d	Reduction in antibiotic consumption (per 1,000 admissions):					
	Total antibiotic usage	1% reduction against 2016				**29% reduction**
	Total use of carbapenem	1% reduction against 2016				**10% reduction**
	Total use of piperacillin-tazobactam	1% reduction against 2016				**52% reduction**

The trust achieved all of the AMR CQUIN targets for 2017/18. New targets have been set for 2018/19.

All but one of the AMR CQUIN target was achieved. The use of carbapenem increased during the period of the piperacillin-tazobactam shortage. Carbapenems were used in place of piperacillin-tazobactam for various indications including the first line treatment for neutropenic sepsis and febrile neutropenia. This was reverted back to the standard practice once the piperacillin-tazobactam shortage situation improved.

The focus on antimicrobial stewardship has increased within recent years, and has been included in the Regional Medicines Optimisation Committee (RMOC) agenda. The Whittington Health NHS Trust is part of the London Antimicrobial Stewardship (AMS) Group which has been tasked to develop strategies to optimise antimicrobial prescribing to improve patient outcomes and minimise the development of antimicrobial resistance, and standardise antimicrobial stewardship services across the London area. In February 2018, the first London AMS Group benchmark survey was completed. Of note, Whittington Hospital was only one of three hospitals within London (19%) to utilise electronic prescribing system for real-time review of antibiotics prescribed on wards.

11. Conclusions

We have had many successes, for example; embedding a new invigorated hand hygiene campaign in the hospital, improving single use equipment availability introducing the new MicroGuide® mobile application, again achieving a high staff influenza vaccine rate, being under trajectory for C.diff and E.coli bacteraemia, re-introducing IPC to face to face induction training and improving the IPC audit compliance results especially in our community sites.

We failed to achieve our 2017/2018 HCAI objectives for MRSA bacteraemia but came in well under trajectory for *C. difficile* associated diarrhoea and are on target to reduce E.coli bacteraemia. The IPCC are confident that each case was fully investigated and that lessons learnt from each case have been carried forward and shaped the IPC strategy going forward. Our orthopaedic surgical site infection rates were below the national benchmark and we continue to work closely and successfully with our colleagues in theatres and orthopaedics. Our focus on improved bed placements and diagnostics in the flu season greatly assisted us in avoiding outbreaks and ward closures.

Our rates of resistant Gram negative infections have reduced as evidenced by our E. coli bloodstream infection data. We have also implemented the Public Health England guidance around the recognition, control and treatment of Carbapenemase Producing Enterobacteriaceae organisms such as E. coli and Klebsiella that can then be resistant to the carbapenem class of broad-spectrum antibiotics. The content of IPC annual strategic plan has been altered to take into account the increasing burden of resistant Gram negative infection.

The main objective going forward in 2018/2019 will be the continued zero tolerance approach to HCAI outlined in detail within the current IPC plan.

Executive Offices
Direct Line: 020 7288 3939/5959

Whittington Health NHS Trust

Whittington Health Trust Board
31 October 2018

Title:	**Freedom To Speak Up Guardian Report**		
Agenda item:	**18/147**	**Paper**	**6**
Action requested:	For discussion and agreement with next steps for the Freedom to Speak up at Whittington Health		
Executive Summary:	This paper: • provides a brief overview of the work of the Freedom To Speak Up Guardian (FTSUG) from April 2017 to September 2018 • highlights data regarding referrals to the FTSUG, with benchmarking against national data • gives an update regarding the development of the Speak Up Inclusion Champions (SUIC) network approved by the board in October 2017 • considers the messages from Professor Duncan Lewis's Workplace Behaviour Survey report and future plans for freedom to speak up		
Summary of recommendations:	The Trust Board is asked to: i. read and review this report on the current position on freedom to speak up at the Trust; and ii. agree the proposed actions and next steps		
Fit with WH strategy:	To deliver consistent high quality, safe services		
Reference to related / other documents:	http://www.cqc.org.uk/sites/default/files/20170915_freedom_to_speak_up_guardian_survey2017.pdf		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	None to note		
Date paper completed:	26 October 2018		

Author name and title:		Dorian Cole, Associate Director of Nursing and Freedom To Speak Up Guardian		**Director name and title:**		Michelle Johnson, Chief Nurse	
Date paper seen by EC		**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	

1 Background

1.1 The role of the Freedom to Speak Up Guardian was created as a result of recommendations from Sir Robert Francis' Freedom to Speak Up review, published in February 2015. Freedom to Speak Up Guardians are expected to work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

2 Local Trust background

2.1 The FTSUG was first appointed in the Trust in November 2016. Siobhan Harrington, Chief Executive, is the executive lead for FTSU and Michelle Johnson, Chief Nurse, has delegated responsibility for the Guardian role and implementation of FTSU responsibilities. Yua Haw Yoe is the Non-Executive Director with board responsibility for FTSU.

2.2 Michelle Johnson presented at the September 2018 Trust Board seminar on responsibilities of Board members for FTSU entitled 'Strengthening our Freedom to Speak Up Responsibilities'. This was in conjunction with session led by the Chief Executive on a response to Professor Duncan Lewis's survey on the trust's workplace culture and behaviours.

2.3 Michelle Johnson has linked in with National Guardian's Office and received support and advice and is planning a date for Simon to come and meet new Guardian alongside trust inclusion and speak up champions (11 across trust). In addition, Michelle has discussed work and next steps with Tom Grimes, Head of Enquiries, Complaints and Whistleblowing at London NHS Improvement.

2.4 The Trust undertakes a number of aspects of 'speaking up' such as Schwartz rounds, patient safety huddles and promotion of the Inclusion and Speak Up Champions however it is clear that we need to publicise and raise the profile of what we do and share practice across the Trust.

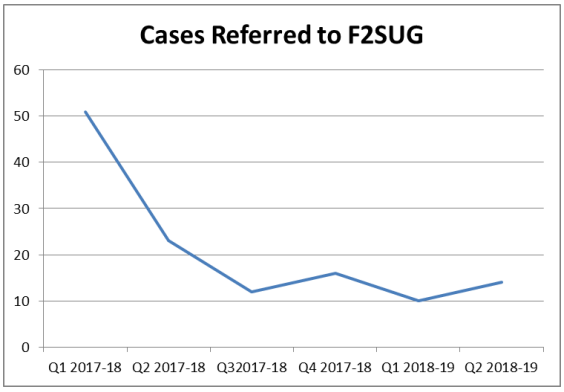
2.5 The Speak Up Guardian, in collaboration with the Trust's equalities lead, have established a network of 11 Speak Up Inclusion Champions. They are based across the Trust in a variety of roles and based in a range of community and hospital settings. Their role is to widen the accessibility of where staff can speak up with concerns.

2.6 The Trust is running a series of Speaking Up engagement events over the month of October as part of the National Guardian Office Speak Up Campaign.

2.7 As part of our review from the Lewis Report, recruitment is underway for a new Trust full time Freedom to Speak Up Guardian with interviews scheduled on 17 October 2018. This post holder will report to the Chief Nurse. Dorian Cole the existing Guardian will stand down as has been appointed into a new role within the trust.

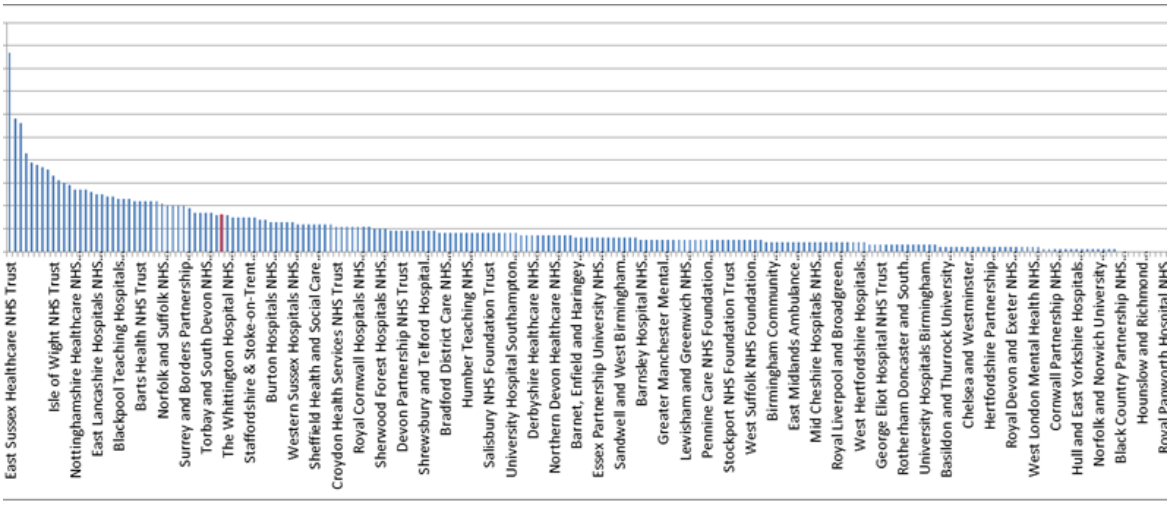
3 Data for referrals made to the FTSUG from April 2017

3.1 One hundred and two cases were referred to the FTSUG in the year 2017-18. Twenty-four cases have been referred in the first two quarters of 2018-19.



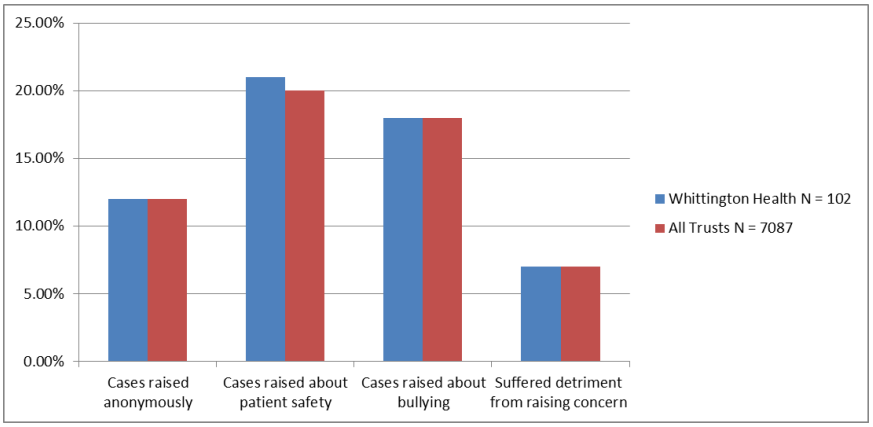
3.2 The quarterly average referral rate of 13 over the last four quarters is typical of small to medium-sized Trusts across England. The high rate reported in Q1 2017-18 was reported in the last board report, and was understood to be due to a very high use of a datix alert that did not result in any FTSU required response.

3.3 Data for Q4 in 2017-18 shows that the rate of referral ranked Whittington Health 41st out of 219 Trusts.

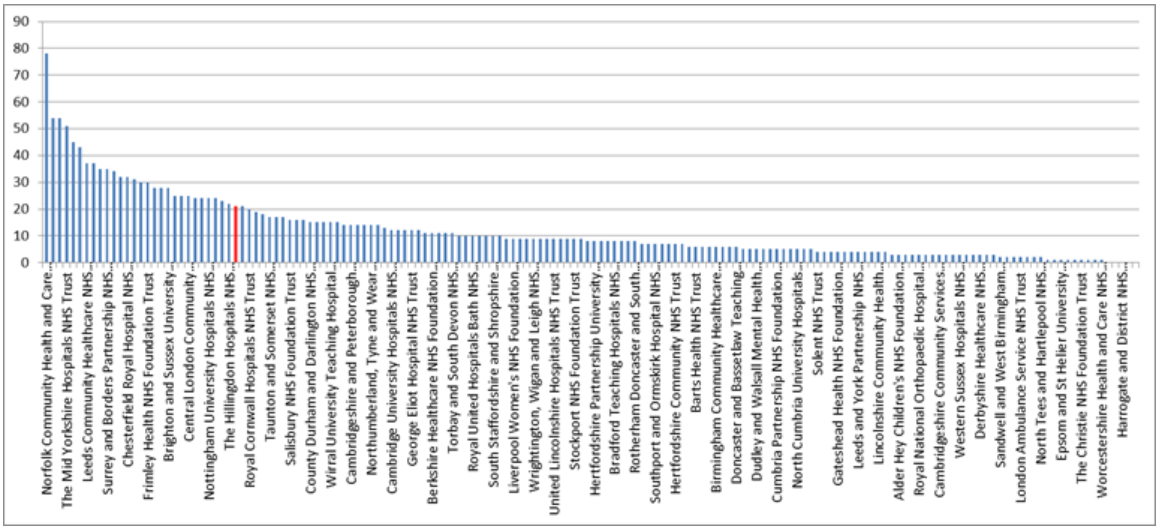


3.4 Of the 102 referrals made to the FTSUG during 2017-18, 12% were made anonymously, 21% were raised due to concerns about patient safety, and 18% concerned issues of bullying. Of those that raised a concern, 7% (seven people) said they have suffered detriment from the act of raising their concern.

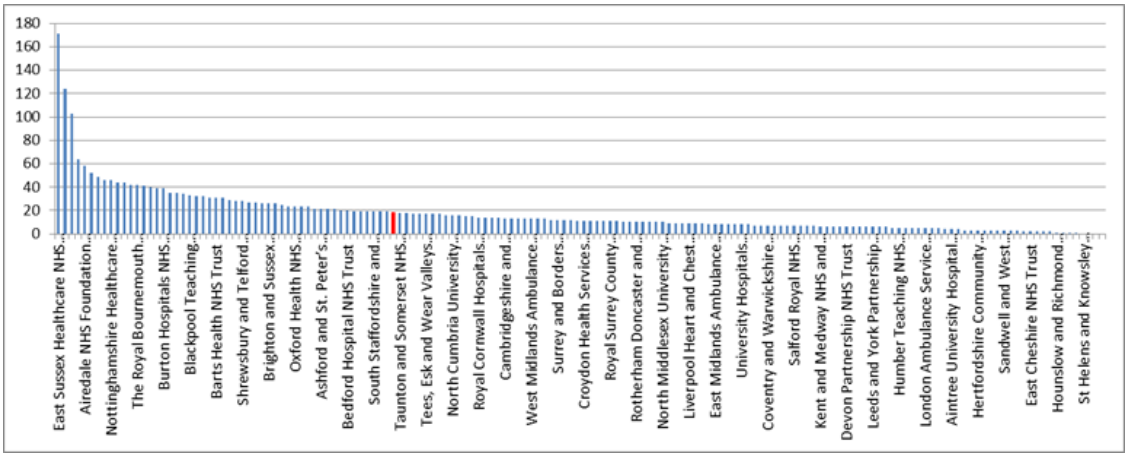
3.5 These rates are nearly identical to the rates published by the National Guardian Office from England-wide data.



3.6 For cases raised in 2017-18 concerning patient safety, Whittington Health ranked 29th out of 162 Trusts, with 21 cases (n=162 [13 trusts no data].

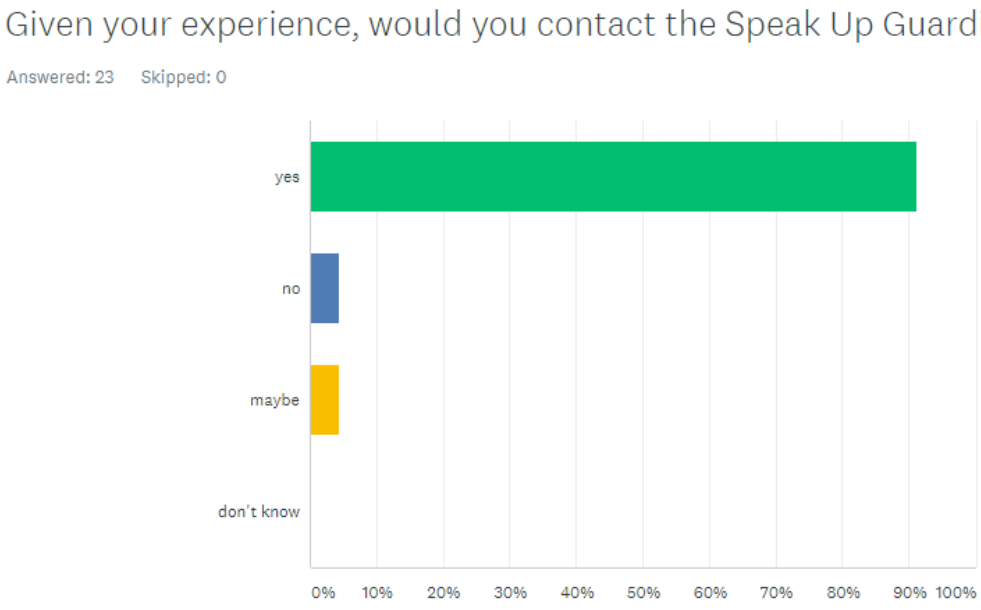


3.7 For cases raised in 2017-18 concerning bullying, Whittington Health ranked 52nd with 18 cases (n=159 [15 trusts no data].



3.8 Since November 2016, feedback has been invited from all referrals that resulted in additional FTSU Guardian intervention following the initial referral, through an anonymous survey. For 2017-18 this equated to 33 of the 102 referrals. .

3.9 Of these 33 cases, 23 people provided feedback. 91% said they would use FTSU Guardian again, with 4.5% saying no, and 4.5% saying maybe. This is in line with the national data as presented in 3.10.



3. 10 National data for all FTSUGs returned a figure of 87% yes during 2017
National Guardian Office Data - Feedback to all FTSUG in 2017

"Given your experience, would you speak up again?"

Options for response:

Yes / No / Maybe / Don't know

Quarter	Feedback received[2]	Yes	No	Maybe	Don't know
Q1	404	343	8	18	27
Q2	511	446	21	33	15
Q3	729	634	31	26	34
Q4	763	654	24	31	38
Total	**2407**	**2077**	**84**	**108**	**114**
% of total		**87%**	**4%**	**5%**	**5%**

4.0 Further actions planned

4.1 A number of actions are underway and are also planned. They include the following:

- To link with Mersey Care NHS Trust as exemplar of good practice
- Completing the FTSU self-assessment over the next three months.
- Developing a new FTSU improvement plan with the newly-appointed Guardian. The Trust is in the process of advertising and recruiting for additional champions who will undergo training within the next few months.
- Work with the Non-Executive Director with lead responsibility to ensure that Whittington Health is clear on what is required of the role in line with the NHS Improvement good practice guidance.
- Revisit redesign and republish our speaking up processes.

- Successful recruitment to Guardian post.

5.0 Recommendations

5.1 The Trust Board is asked to:

i. read and review this report on the current position on freedom to speak up at the Trust; and
ii. agree the proposed actions and next steps.

Whittington Health NHS Trust

Trust Board
31 October 2018

Title:	**External Inspection Report for Whittington Health NHS Trust (October 2018)**		
Agenda item:	**18/148**	**Paper**	**7**
Executive Summary:	The following report summarises inspection reports conducted at Whittington Health and highlights the actions that need to be taken to improve services across the trust. The paper provides an update on outcomes of: • Care Quality Commission (CQC) Inspection Actions (2018 inspection) • Joint Targeted Area Inspection – Haringey Safeguarding Services – School Aged Child (focus on issues related to neglect of a child or young person) The report provides information on trust preparations for anticipated CQC inspection in 2019.		
Recommendations:	To understand the actions and recommendations made in this report from external bodies		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	Quality Account Quality Improvement Strategy		
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:	18/10/2018		
Paper previously presented at:	N/A		

Author name and title:	**Lynda Rowlinson, Head of Quality Governance**	**Director name and title**		**Michelle Johnson, Chief Nurse and Director of Patient Experience**	
Equality Impact Assessment complete?	**n/a**	**Quality Impact Assessment complete**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

1. CARE QUALITY COMMISION INSPECTION

1.1 CQC Improvement plan 2017 - 2018

There were 34 recommended improvement actions from the CQC following the last inspection (published Feb 18), from which the trust developed 52 specific actions. 43 have been addressed and 9 remain in progress. The remaining 9 outstanding action (**included in Appendix A**) are set to be on target for completion by December 2018. It is important to record that the immediate concerns raised by the inspection team have been responded too and addressed within the required timeframe.

Work is also in progress to review the 2016 action plan to ensure that we are still achieving the recommendations made following the last comprehensive inspection held 8-11th December 2015.

1.2 Next Inspection

Using the CQC inspection methodology which indicates that all services rated as good will be re-inspected within 3.5 years, we can expect our next inspection to be conducted between January and June 2019. The new methodology also includes Use of Resources which will be undertaken by NHS Improvement alongside CQC.

The well led inspection is usually carried out annually, however it normally comes after a service inspection.

12 weeks prior to any inspection we will receive a Provider Information Request (PIR), which at present we have not received. In addition, notification of the annual announced well-led inspection has not yet been received.

1.3 Improvement work 'business as usual' *Good to Outstanding*

A trust wide CQC steering group has been set up and meetings held monthly with representation from each Integrated Care Service Unit (ICSU), estates, finance, HR, corporate and communications teams. We have also opened the group to ward managers/team managers to join.

All 'core services', as defined by the CQC, are undertaking self-assessments of their services. These will be reviewed at ICSU and steering group meetings to help form the well-led preparation document that will be sent to executives and non-executives in advance of their annual well-led interview.

Communications will begin to distribute messages around improvement work and key information for staff to help prepare for an inspection. This will include themes that have been identified from other trusts which currently hold an outstanding rating. There will also be a focus on driving a culture of ownership, and what 'you' as an individual can do to improve care for the patient rather than 'the trust'.

Our Quality Assurance service peer reviews entitled '**Next Steps to Outstanding'** continue across the trust and have increased to one per week. The peer review teams recently included two of our commissioners, and will also have

service user representation over the coming weeks. Health Watch are also willing to join visits depending on their availability. Following the inspections ward managers, matrons and Associate Directors of Nursing (ADON) are provided with targeted improvement actions that will help to bring the ward or department up to outstanding when addressed. The trust quality governance team are providing support required in order to overcome barriers the may prevent the action from being completed.

A project is underway to provide every ward and community site with a standardised '*how we are doing'* noticeboard, which comprises of clear information and monthly performance run charts for staff and patients on, staffing levels, you said: we did, falls/PUs and infection rates etc. The majority of hospital wards have now been completed and the next phase is to work towards standardisation across the community sites.

2. HARINGEY JOINT AREA TARGETED INSPECTION - JTAI SAFEGUARDING SCHOOL AGED CHILDREN (FOCUS ON NEGLECT) DECEMBER 2017

As reported in previous Trust Board papers Whittington Health has a number of actions which are being monitored at a partnership implementation group which meets monthly to oversee the Haringey overarching action plan and provide support and challenge to partner agencies involved. Whittington Health provided an exception report for 25 actions specific to the Trust. The end of September was the deadline for a number of actions - December 2018 is the final deadline for all actions across the partnership to be completed. Significant progress has been against the actions:

- 15 actions have been completed
- 5 are on track
- 5 are not on track and rated as 'red' (described in detail in 6.1 and further assurance is required before the action turns green)

2.1 Key outstanding areas include:

- Clear referral criteria for MASH referrals requiring health input
  - WH engaged in re-design
  - Dedicated health practitioner in place
  - Referral threshold & criteria in place
  - Designated doctor undertaking further work on criteria

- School nurses to use clearly defined health assessment tool
  - Service has a clearly defined tool; however, electronic patient record template delayed until October 18
  - Quality Practice Audit undertaken in September 18 showed tool is not always used; action plan in place to address and further audits to be undertaken

- Whittington Health to establish 'Alerts' system for electronic patient record case records
  - Standard Operating Procedure not yet completed and approved by ICSU

- GP/SN information to be shared with HV
  - Health Visitor (HV) /School Nurse (SN) lead meeting with named child protection General Practitioner (GP) in October 18

- Single Point of Access now in place for email contact/referrals from primary care (GPs and GP Practice Nurses)
- GP/SN link meetings/liaison discussion ongoing

- Community dentists are aware of current safeguarding concerns when treating children
  - Head of Safeguarding working with dental leads
  - Change to referral form needs agreement across dental network

3. RECOMMENDATIONS FOR TRUST BOARD

To understand the actions and recommendations made in this report from external bodies

APPENDIX A: OUSTANDING CQC ACTIONS

Ref	CQC Recommendation	Service	Progress	Completion date
OP2	The trust should ensure staff are alerted to patients who may have a communicable disease or a challenging need	Outpatients	First stage discussions held 21 March to discuss process. Second stage discussions held 14th April with senior nursing staff. Third stage involving infection control and implementation in progress.	30.11.2018
OP6	The trust should minimise the frequency with which patient appointments are cancelled at short notice	Outpatients	Outpatient transformation plan Underway - looking at centralisation and partial booking for follow ups to reduce cancellations	30.11.2018
CYP1	The trust should ensure staff meet the trust's target for staff completing mandatory and safeguarding training	Community health services for CYP and families	Mandatory training: ongoing piece of work that is monitored at weekly senior management meetings. Director of Operations working with Human Resources ensure accurate and timely reporting on electronic staff record and for each ICSU to have trajectory to achieve target Monitored at ICSU performance reviews	31.10.2018
CYP2	The trust should ensure staff meet the trust's target for appraisal rates	Community health services for CYP and families	Appraisals – same action as above CYP1	31.10.2018
CYP5	The trust should ensure that the national referral to treatment times are met	Community health services for CYP and families	Community Service Improvement Group Children and Young People sub group established which includes local commissioners with a priority focus on waiting times. Work underway around demand /capacity modelling and benchmarking to support services to address waiting times. Director of operations for the ICSU implemented with service leads weekly process to validate waiting time data.	31.10.2018

Ref	CQC Recommendation	Service	Progress	Completion date
CYP6	The trust should ensure the environment meets the needs of children and young people	Community health services for CYP and families	Part complete. Date established for estates review of Islington Northern Health Centre (children's health centre). Lift repairs at Northern Health Centre complete. Discussions ongoing for the development of children's health services based at St Ann's Hospital, Haringey	31.12.2018
CC4	Patients requiring total parenteral nutrition sometimes had to wait 48 hours to start receiving nutritional support.	Critical care unit	This action was an immediate action which has been met and CQC satisfied with work undertaken by the trust and patients can now access parenteral nutrition when assessed and prescribed. The action remains open until the final standard operating procedure guidance has been formally approved and signed off.	30.11.2018

Trust Board, October 2018

Title:	**September (Month 6) 2018/19 – Financial Performance**		
Agenda item:	**18/149**	**Paper**	**8**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	During the month the Trust has adjusted its planned year end surplus following the confirmation that the Trust will target an additional surplus of £6m from the anticipated transfer of land to Camden and Islington NHS Foundation Trust. This planned increased surplus will result in an additional payment of £12m Provider Sustainability Fund (PSF) flowing to the Trust. NHS Improvement have recalibrated the mechanism for calculating PSF relating to the Emergency Department performance metric. This has resulted in the Trust now earning £0.4m of PSF which it previously did not achieve. The Trust is reporting a surplus of £4.6m for the month of September (month 6) against a planned £4.1m surplus, a positive variance of £0.5m. Year to date the Trust is £0.1m ahead the NHS Improvement adjusted plan, with a surplus of £3.6m. Income performance excluding PSF income and agenda for change funding is £2m off plan. A deterioration in month of £0.7m. An immediate focus on income recovery is required to address this significant variance. For the period to the end of September the Trust has lost 4,445 bed days through patients who are either medically optimised or delayed transfers of care. This is on average 24 beds per month. The main pay variance in month, as with previous months, is the result of the agenda for change adjustment which the Trust believes is partly unfunded. The Trust was reporting to NHSI a funding gap of £0.9m between the cost and funded position, NHSI have provided additional funding of £0.1m to close this gap. The agency costs to the end of month 6 are £6.8m. Based on the existing agency trajectory, the Trust could be on course for c.£14m year end outturn for agency. A critical action to address the spend is required along with the action of addressing and reconciling the nursing establishments to the Allocate rostering system. The Trust is forecasting CIP delivery of £12.4m. The predicted forecast out-turn is the achievement of the new control total of £22.7m subject to the remaining agenda for change pay funding being resolved. The Trusts planned capital expenditure remains at £14.8m.		

Summary of recommendations:	To note the financial results relating to performance during September 2018 recognising to need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans.
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:	13 October 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 £4.6m surplus for the month of September month 6 against a planned surplus of £4.1m. The year to date position of a £3.5m surplus is £0.2m ahead of the control total plan.

The positive in month performance is as a result of £4.2m of additional PSF after the Trust improved its financial position by £6m and earned £12m income from 'Incentive PSF'. In addition, following the revision of PSF ED metrics, the Trust has recovered £0.4M PSF it had previously missed.

Clinical income is now £1.9m behind plan after a further £0.5m deterioration in month. There is a positive income variance relating to income for Agenda for Change funding of £1.7m as the offset for this variance is within pay. 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. The trend from previous months has been further improved by a review of maintenance contracts within medical physics and revised rental charges relating to the Trusts dental estate.

The pay spend is again in excess of budget, this is as a result of the agenda for change payment. The cumulative agency spend is £6.8m

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	23,857	23,311	(546)	144,216	142,367	(1,850)	268,253
Other Non-Patient Income	2,173	2,054	(119)	12,858	12,708	(150)	47,536
Pay Award Funding	0	359	359	0	1,679	1,679	0
Total Income	**26,030**	**25,724**	**(306)**	**157,074**	**156,753**	**(321)**	**315,789**
Pay	(18,635)	(18,849)	(214)	(111,842)	(113,168)	(1,326)	(222,445)
Non-Pay	(6,865)	(6,235)	630	(41,818)	(40,103)	1,715	(82,109)
Total Operating Expenditure	**(25,500)**	**(25,084)**	**416**	**(153,660)**	**(153,272)**	**388**	**(304,554)**
	530	**640**	**110**	**3,414**	**3,481**	**67**	**11,235**
Depreciation	(542)	(517)	25	(3,248)	(3,260)	(12)	(6,500)
Dividends Payable	(432)	(471)	(39)	(2,584)	(2,599)	(15)	(5,263)
Interest Payable	(280)	(289)	(9)	(1,669)	(1,632)	37	(3,341)
Interest Receivable	1	9	8	6	35	29	12
P/L on Disposal of Assets	0	0	0	0	0	0	6,000
Total	**(1,253)**	**(1,268)**	**(15)**	**(7,495)**	**(7,456)**	**39**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(723)**	**(628)**	**95**	**(4,081)**	**(3,975)**	**106**	**2,143**
Provider Sustainability Fund (PSF)	4,826	5,248	422	7,483	7,483	*0*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**4,103**	**4,620**	**517**	**3,402**	**3,508**	**106**	**23,523**
Add back							
Impairments	0	0	0	0	0	*0*	51
IFRS & Donate	(18)	6	25	(20)	39	*59*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**4,085**	**4,627**	**542**	**3,382**	**3,547**	**165**	**22,675**

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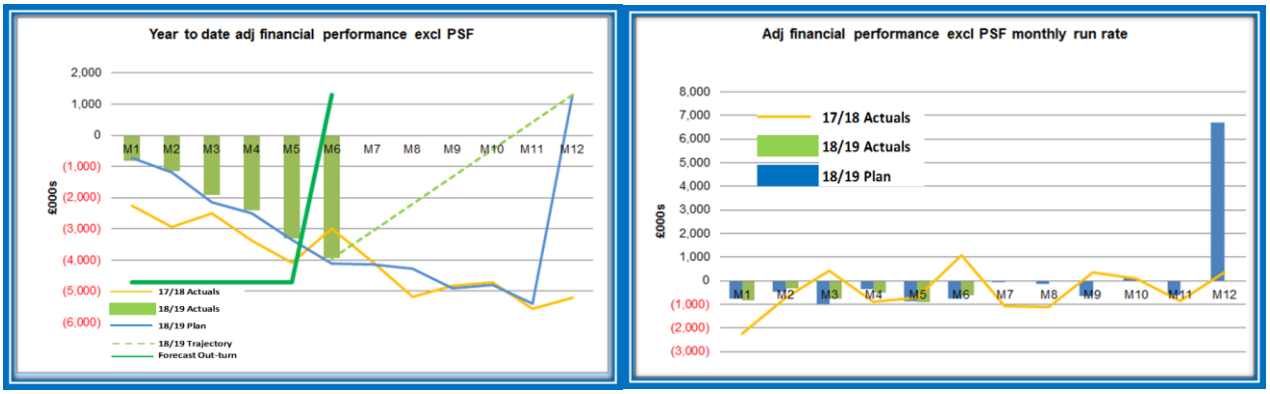


Income & Activity

The Trusts reported income position excluding Agenda for Change funding and Provider Sustainability Funding is a year to date adverse variance of £2m

In month 6, the activity target for all planned care reflected the lower working days in September, however Day Case and Elective activity continue to under-perform with an in month adverse variance of £0.1m which is slight improvement on run rate, with the year to date adverse variance of £1.1m. Trauma & Orthopaedics are significantly behind plan, and Urology and General Surgery also behind plan. Endoscopies performed significantly above plan in Month, showing a partial recovery of the previous under-performance.

Within maternity services, both deliveries and pathways continue to under-perform against plan, with a £0.7m adverse variance year to date. September is usually a high birth month, but the Trust has not seen this uplift for 18/19.

Outpatients continue to perform well overall, and are ahead of plan in month by £0.1m. The under-performance in follow ups is still offset by over performance in first attendances and procedures. There is still considerable under-performance in follow ups across all ICSUs, with the highest under-performance seen in Paediatrics, Trauma & Orthopaedics and Gastroenterology. September was also a very low month for Outpatient Urology, down to staffing issues.

Unplanned care in A&E & UCC was above plan in month, and on plan year to date, ambulatory care remains above planned levels. Non-electives under-performed in month continuing the trend of last month and meaning this is now behind plan year to date by £0.2m.

All clinical support services are performing well against year to date plan.

Although the Trust did not hit the required target for A&E in Quarter 2, at the delivery board level it did achieve the target so the Trust have earned the full PSF for the quarter. Due a change in NHSI methodology, the Trust will now also receive Q1 A&E income of £0.4m previously not achieved.

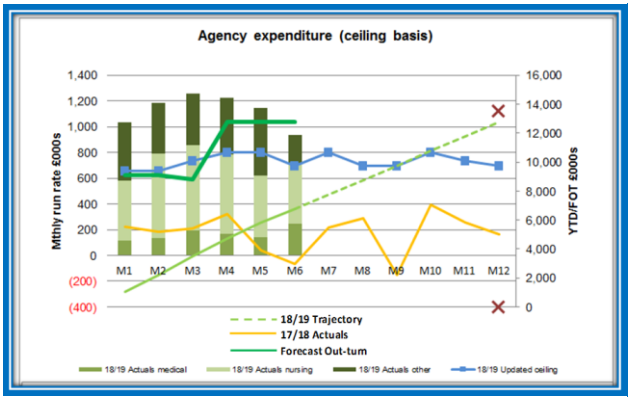
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,150	1,187	38	7,014	7,069	55	8,492	8,900	408	51,807	52,922	1,115
Ambulatory Care	325	426	101	2,045	2,393	347	1,400	1,682	282	8,800	9,574	774
Adult Critical Care	619	404	(215)	3,776	3,111	(665)	1,463	1,067	(396)	8,926	7,596	(1,330)
Community Block	5,857	5,857	0	35,143	35,142	(0)	0	0	0	0	0	0
Day Cases	1,082	1,166	84	6,816	6,507	(309)	1,394	1,547	153	8,778	9,381	603
Diagnostics	236	282	45	1,490	1,784	294	2,396	3,012	616	15,095	17,769	2,674
Direct Access	927	1,025	98	5,843	6,308	465	90,415	94,923	4,508	569,762	571,003	1,241
Elective	744	572	(172)	4,687	3,922	(765)	190	149	(41)	1,190	1,028	(162)
High Cost Drugs	656	727	71	3,936	3,842	(94)	0	0	0	0	0	0
Maternity - Deliveries	1,132	1,037	(95)	4,604	4,237	(367)	310	298	(12)	1,893	1,820	(73)
Maternity - Pathways	700	628	(73)	4,412	4,063	(349)	661	595	(66)	4,164	3,944	(220)
Non-Elective	3,320	3,111	(209)	22,557	22,338	(219)	1,556	1,573	17	9,487	9,644	157
OP Attendances - 1st	838	854	16	5,280	5,665	384	4,505	4,479	(26)	28,429	30,805	2,376
OP Attendances - follow up	748	716	(32)	4,711	4,558	(153)	11,929	10,754	(1,175)	75,191	72,652	(2,539)
OP Procedures	360	439	80	2,266	2,573	308	2,054	2,562	508	12,946	15,815	2,869
Other Acute Income	1,150	1,246	96	7,496	7,624	128	6,520	5,646	(874)	41,028	39,079	(1,948)
CQUIN	465	545	80	2,863	2,820	(43)	0	0	0	0	0	0
Total SLA	**20,309**	**20,223**	**(86)**	**124,937**	**123,955**	**(982)**	**133,287**	**137,187**	**3,900**	**837,495**	**843,032**	**5,537**
Marginal Rate	0	0	0	0	0	0						
	20,309	**20,223**	**(86)**	**124,937**	**123,955**	**(982)**						
Other Clinical Income	3,548	3,088	(484)	19,279	18,411	(892)						
Other Non Clinical Income	2,173	2,414	264	12,858	14,387	1,553						
Total Other	**5,721**	**5,502**	**(220)**	**32,137**	**32,798**	**661**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**26,030**	**25,725**	**(306)**	**157,074**	**156,754**	**(321)**	**133,287**	**137,187**	**3,900**	**837,495**	**843,032**	**5,537**
PSF	4,826	5,248	422	7,482	7,482	-						
Revised Total	**30,856**	**30,972**	**116**	**164,557**	**164,236**	**(321)**						

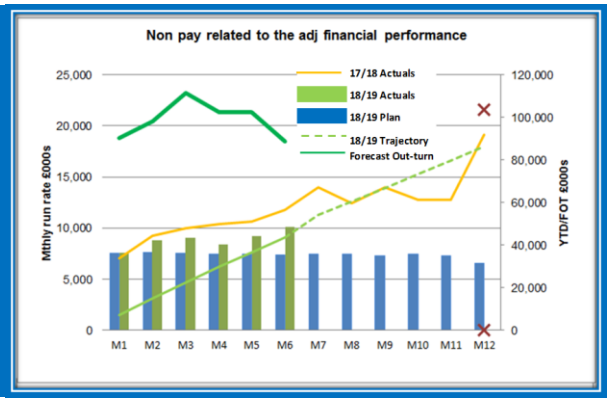
Monthly Run Rates – Expenditure

The year to date combined expenditure position is £0.4m ahead of plan. Key points of note include:

- **Pay**
  - Total pay expenditure for August was £18.8m. The Trust is reporting a cost pressure of £0.8m generated by the underfunded pay award down from £0.9m following a revision by NHSI on the funding calculation. The Trust has been assured that the agreement of the new control total was based on the assumption that this funding gap would be resolved either by new funds or a reduced control total.
  - Within total pay expenditure, agency costs were £0.9m. The total agency spend is £6.8m, 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.
  - The Trust needs to expedite this work to ensure that it mitigates any further agency bookings to stay within the agency cap but to also provide the necessary reduction in its cost run rate.

- **Non Pay**
  - Non pay expenditure for September was £6.2m, in line with the spend in August
  - The in-month position is significantly below plan due to a review of maintenance contracts within medical physics resulting in a reduction of accruals and similarly a review of rental agreement within the dental services





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

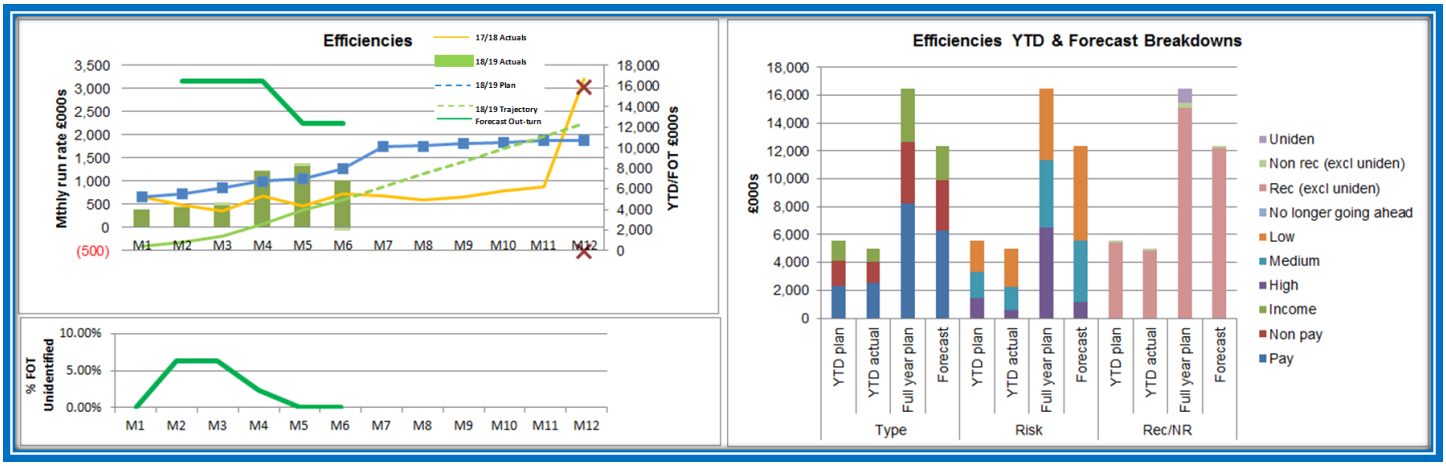
In-year delivery – Month 6

At the end of month 6 the Trust's planned delivery was £5.6m of CIP, against which £5m has been delivered, equating to c89%. Analysed by programme area:

- Flow Through – £1.3m
- ICSU 2% targets – £1.9m
- Transformation Schemes – £1.8m

Plan requirement & Forecast Delivery

As can be seen from the graphs below the required rate of delivery for CIP increases from Month 6. The Trust needs to focus on the delivery of CIP plans that contribute to the reduction of run rate spend.



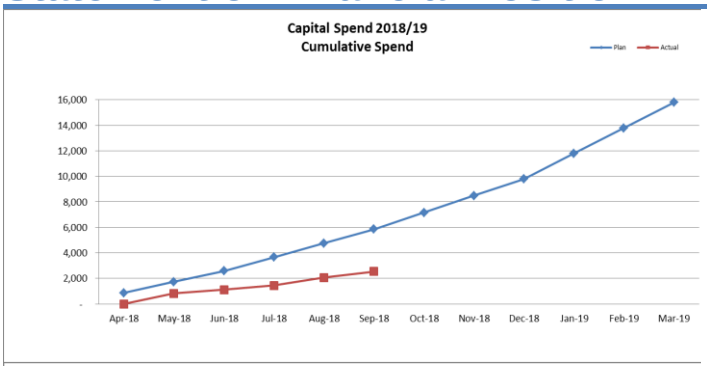
As reported previously the forecast delivery of planned schemes is £12.4m, representing a £4.1m shortfall against the original target.

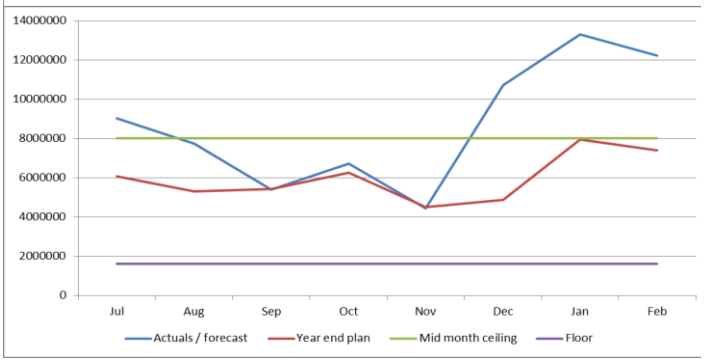
Forecast by programme area:

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

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

	Year to Date		
	As at 30 Sept 2018	Plan 30 Sept 2018	Plan variance 30 Sept 2018
	£000	£000	£000
Property, plant and equipment	214,216	218,594	(4,378)
Intangible assets	4,344	4,597	(253)
Trade and other receivables	1,116	656	460
Total Non Current Assets	**219,676**	**223,847**	**(4,171)**
Inventories	1,526	1,355	171
Trade and other receivables	33,124	31,202	1,922
Cash and cash equivalents	5,398	5,432	(34)
Total Current Assets	**40,048**	**37,989**	**2,059**
Total Assets	**259,724**	**261,836**	**(2,112)**
Trade and other payables	38,678	37,044	1,634
Borrowings	19,316	19,418	(102)
Provisions	1,105	1,391	(286)
Total Current Liabilities	**59,099**	**57,853**	**1,246**
Net Current Assets (Liabilities)	**(19,051)**	**(19,864)**	**813**
Total Assets less Current Liabilities	**200,625**	**203,983**	**(3,358)**
Borrowings	38,151	41,107	(2,956)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**41,949**	**(2,959)**
Total Assets Employed	**161,635**	**162,034**	**(399)**
Public dividend capital	64,679	65,679	(1,000)
Retained earnings	(1,394)	(2,218)	824
Revaluation reserve	98,350	98,573	(223)
Total Taxpayers' Equity	**161,635**	**162,034**	**(399)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

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

- **Property, Plant & Equipment (PPE)** is £4.4m lower than plan. Capital spend has consistently tracked behind plan throughout the year to date. Whilst the Trust expects spend to accelerate significantly in the second half of the year in all areas, it now appears unlikely that the Trust will spend its full capital allocation in year. Following the Capital Monitoring Group meeting in early September, the Trust has informed NHSI that we are likely to undershoot our capital limit by £1.0m.

- **Receivables (Debtors)** have seen some significant movements between months 5 and 6. At month 5, debtors were £4.5m below plan. At the end of September, these are now £2.4m above plan. This movement results from two key factors:

    - Raising of debtor for quarter 3 income from Health Education England. This debtor was settled on 10 October; and
    - The Trust has moved its control total and is therefore now eligible for additional Provider Sustainability Funding (PSF) based on its month 6 financial performance. The Trust has raised a debtor for an additional £4.2m of PSF and expects this to be paid in December 2018.

- **Liabilities (creditors and borrowings)** are currently £1.3m below plan. With the familiarity of users with the PECOS system improving the Trust has been able to clear some longstanding creditors.

- **Cash and cash flow:** the Trust is holding £5.4m in cash as at the end of September 2018. This is as plan.

  The Trust has modelled its cash flow for the whole of 2018-19 and has concluded that no cash support should be required during 2018/19. As a result of the Trust's revised control total, we expect cash balances to be significantly higher than expected balances in the Trust's initial operating plan for the rest of 2018-19. As such, the Trust will explore options by which it can generate interest from these cash balances.

Executive Office
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Whittington Health
NHS Trust

Whittington Health Trust Board
31 October 2018

Title:	**Trust Performance report October 2018 (September 2018 data)**		
Agenda item:	**18/150**	**Paper**	**09**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Overall performance against the 95% target for August was 90.0%, and 89.6% for September. Attendance numbers were higher in September at 8,899 compared to August at 8,164. The September attendance figure was a 10.52% increase compared to September 2017. Despite this the 'minors' performance delivered 96.63% and Paediatrics delivered at 96.62% for September. **Complaints:** Achieved for 4th consecutive month. Narrative for PALS, GP Concerns and Compliments have now been added to the report. **Cancer:** The trust has overall achieved the cancer targets for September 18. **Community indicators** The Trust Performance report now included the following outcome focussed indicators specific to community: • % of MSK patients with significant improvement in function (PSFS) • % of Podiatry patients with significant improvement in pain (VAS) • ICTT - % Patients with self-directed goals set at Discharge • ICTT - %GAS (Goal Attainment Scale)Scores improved or remained the same at Discharge All areas are meeting targets except MSK which was a data entry error and will be corrected by next month. **Diagnostic waits** The Trust did not achieve the 6 week diagnostic wait target for the month of August due to significant capacity issues in Endoscopy. Additional endoscopy capacity has now been put in place and at the time of writing we can confirm that they are compliant for September 2018. **Health Visiting New birth visits and Health Reviews** Islington: Achieved. Haringey: Improvement continued in line with trajectory agreed with commissioners.		

	Good progress on mandated parts of Healthy Child Programme. Drops noted in Health Reviews 1 targets which is likely due to be seasonal effect. **District Nursing visits within 2 hours and 48 hours** 48 hours target not achieved, plan is in place to exclude inappropriate referrals, for example; patients still not discharged from hospital.
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 October 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**

Whittington Health NHS

Integrated Performance Report

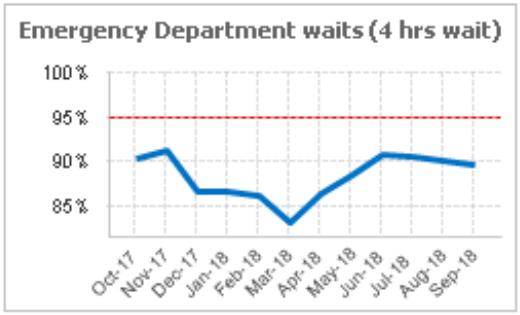
October 2018

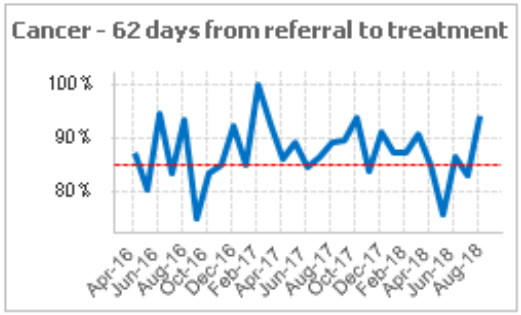
Month 6 (2018 – 2019)

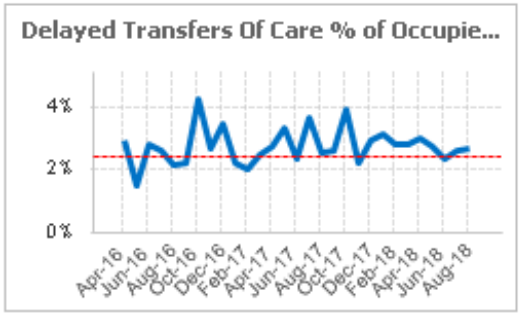
Summary Page - Indicators

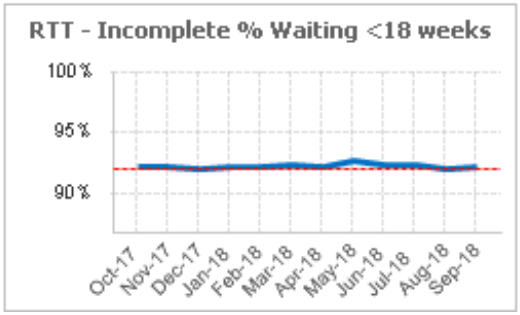
Category	Indicator	17_18 Target	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	89.2%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	82	82	81	75	77	95	91	87	79	74	63	75	78
Cancer	Cancer - 14 days to first seen	**>93%**	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%		94.8%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.3%		84.6%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	7.0%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	6.0%	6.3%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%		2.7%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.3%
Outpatients	Outpatients - FFT % Positive	**>90%**	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	91.7%
Community	Community - FFT % Positive	**>90%**	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	96.2%
Staff	Staff - FFT % Recommend Care	**>70%**			70.6%			75.0%			77.3%			77.4%	77.3%
Community	% seen <=2 hours of Referral to District Nursing Night Service	**>80%**	93.5%	86.7%	78.7%	96.0%	87.0%	90.2%	86.7%	88.9%	95.2%	95.5%	93.2%	90.9%	92.1%
Community	% seen <=48 hours of Referral to District Nursing Service	**>95%**	52.7%	75.0%	86.2%	91.8%	91.0%	86.7%	82.8%	91.1%	82.4%	90.7%	89.0%	87.7%	87.1%
Community	Haringey New Birth Visits - % seen within 2 weeks	**>95%**	91.6%	88.6%	86.1%	91.6%	93.4%	90.5%	89.7%	92.7%	93.4%	90.5%	91.9%		91.7%
Community	Islington New Birth Visits - % seen within 2 weeks	**>95%**	92.1%	96.6%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%		95.0%

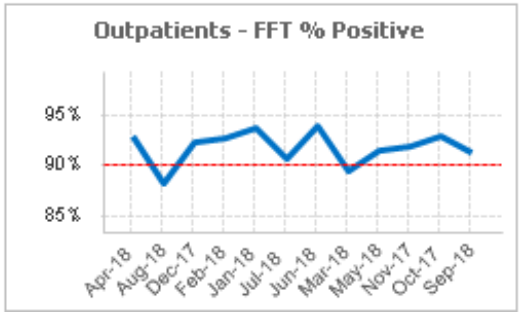
Summary Page - Indicators

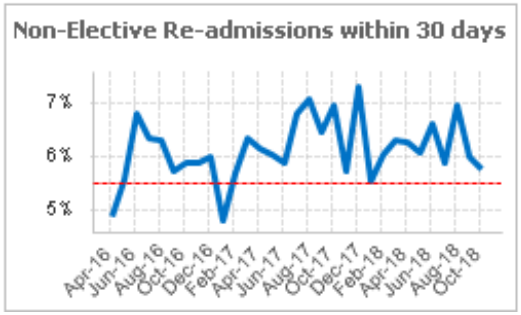












Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	3	0	0	0	1	0	1	2	0	0	2	2	7	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	34	28	35	38	27	43	37	52	33	33	26	28	209	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	3	3	3	9	3	3	2	4	2	1	4	0	13	
All Areas	Harm Free Care %	>95%	94.1%	93.5%	94.2%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	92.5%	
Maternity	Non Elective C-Section % Rate	<15%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	20.0%	
All Areas	Medication Errors causing serious harm	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	0	1	0	1	0	0	0	0	1	0	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	16.7%	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	17.6%	
All Areas	Serious Incidents	0	5	2	0	7	1	2	6	8	3	1	1	2	21	
Admitted	VTE Risk Assessment %	>95%	95.3%	96.0%	95.2%	95.1%	95.2%	96.2%	95.9%	95.1%	95.0%	96.1%			95.5%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	0	0	0	5	7	0	0	0	0	12	

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 September which occurred on two wards, Coyle & Victoria. Both were classified as unavoidable following Post Infection Reviews.

Pressure Ulcers
There were no avoidable pressure ulcers reported in September 2018

Non elective C-section
In September the trust recorded a Non-Elective C-section rate of 19.2%, 0.7% down from the previous month and under the average of 20%.The overall C-section declined by 3% from previous month 30% (high number of cases in July). The highest rate was seen in July (40%) at Whittington Health and an audit has just been completed on the 14th Oct and results are being analysed and results will be shared with any learning outcomes
Our work with UCLH continues and has seen an increase in 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.

Serious Incidents
Whittington Health declared two Serious Incidents in September 2018

1. 2018.22623 – Unexpected Admission to NICU [WHOD]
2. 2018.23175 – Delayed Diagnosis / treatment [EIM]

Both SIs are under investgation.

VTE Risk assessments
July 2018: compliant. Figure not yet finalised for August and will be reported in November 2018

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	81.8%	
ED	ED - FFT Response Rate	>15%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.7%	
Admitted	Inpatients - FFT % Positive	>90%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	97.1%	
Admitted	Inpatients - FFT Response Rate	>25%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	17.3%	
Maternity	Maternity - FFT % Positive	>90%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	94.8%	
Maternity	Maternity - FFT Response Rate	>15%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	53.9%	
Outpatients	Outpatients - FFT % Positive	>90%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	91.7%	
Outpatients	Outpatients - FFT Responses	400	569	593	336	420	461	249	327	445	348	310	223	138	1791	
Community	Community - FFT % Positive	>90%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	96.2%	
Community	Community - FFT Responses	1500	731	638	605	875	1157	779	1206	1181	1148	869	890	1122	6416	
Staff	Staff - FFT % Recommend Care	>70%			70.6%			75.0%			77.3%			77.4%	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%	92.3%	85.8%	
All Areas	Complaints (including complaints against Corporate division)	N/A	0	0	0	30	21	33	33	30	39	27	21	14	164	

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

Caring Services - Commentary

FFT

The friends and family (FFT) responses for ED in September 2018 are slightly lower than the year to date average (12.8% in September in comparison to the 2018/19 average of 13.7%). The recommend rate for September 2018 exceeds the year to date average (September recommend rate 82.8% in comparison to the 2018/19 average of 81.8%). The matron in ED continues to work with the patient experience team on the patient experience action plan for the area. Work is still ongoing for the paediatric ED specific questionnaire. The matron has created posters advertising the FFT in ED and displayed these throughout the department. These posters also contain a QR code for the ED FFT questionnaire. Volunteers now support with the library trolley in ED, and also support in a new initiative in the area: reading hour for patients. This is being trialled in CDU. The patient experience team are working with the ED Matron to install a working television in the waiting area, where waiting-times can be displayed, and also to improve the relatives' room.

Maternity FFT results continue to exceed both targets for recommend and response rate. This is due to the vigilance of staff in ensuring patients are asked to complete FFT questionnaires, and also in the follow-up telephone calls that have been ongoing in the ward areas from 2017. The teams on the postnatal wards have redesigned and displayed their new 'Going Home' noticeboard, which also contains information such as FFT results and You Said We Did.

The inpatient areas reported another month of high recommend rates (97% for September) though a low one for response rate (13.6% for September). One area that has been actioned is introducing a new format for the 'How are we doing?' noticeboards that are displayed on each ward. The quality and compliance and patient experience team are now leading to update these monthly on the wards.

The outpatient areas reported above the target for recommend rates (91.3% in September) but considerably lower than the bulk target for FFT responses (138 in September against the target of 400). A large part of this was due to lack of volunteer support in the inputting of FFT cards. The patient experience team will work with the Out Patient Department teams to pick up the response numbers for FFT. This work will be tracked through the patient experience committee.

Caring Services - Commentary

FFT cont.

Community responses have increased from 869 and 890 in July and August 2018, to 1122 last month (September 2018). Further improvement works for Community FFT includes the continued work to support CYP community teams in collecting FFT. One aspect of this work is introducing an iPad stand to the Child Development Centre in St Ann's, which is forecast to be in place in October 2018.

Complaints

During September 2018 the Trust was due to close 14 complaints; 13 complaints required a response with 25 working days and 1 was allocated 40 working days for investigation due to its complexity.

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

- The 1 complaint allocated 40 working days was completed within time.
- At the time of reporting, 1 complaint remains outstanding (Estates & Facilities).

The majority of complaints were allocated to EIM 36% (5), Adult Community Services 21% (3) and S&C 21% (3).

Severity of complaints: 50% (7) were designated 'low' risk; 50% (7) were designated 'moderate' – there were no 'high risk' complaints.

A review of the complaints for September shows that 'medical care' 29% (4) and 'communication' 21% (3) and 'attitude' 21% (3) were the main issue for patients.

- In regard to 'medical care', 50% of patients (2) felt that 'poor treatment' had been provided, 25% of patients (1) felt that 'inadequate treatment' had been provided and 25% (1) felt that 'inadequate rehabilitation' had been provided
- In regard to 'communication', 33% (1) raised concerns about an 'inadequate information about an appointment', 33% (1) felt that 'incorrect details' had been used, and 33% (1) felt that there was 'inadequate information about an operation'
- In regard to 'attitude', 33% (1) felt that the attitude shown was 'sharp/harsh/abrupt', 33% (1) felt the attitude shown was 'discriminatory' and 33% (1) felt the attitude shown was 'inconsiderate/uncaring/dismissive'

Of the 13 complaints that have closed, (including those allocated 40 working days), 38% (5) were 'upheld', and 46% (6) were 'partially upheld' meaning that, currently, 84% have been upheld in one form or another.

Caring Services - Commentary

PALS
During September 2018, the Trust received 172 PALS enquiries.

34% (59) related to Emergency & Integrated Medicine, 30% (52) related to Surgery & Cancer, 14% (23) related to Women's Health, Outpatients & Diagnostics, 8% (13) related to Adult Community Health Services and 5% (5) related to Children & Young People Services, the remainder related to other Trust service and areas.

Themes – the top three themes were as follows;

35% (61) related to 'Communication' with 'clarity/confusing' and 'no reply to telephone contact' (of which 5 in Endoscopy) cited as the main reasons
20% (35) related to 'Appointments' with 'long waits', 'cancellations' and 'delays' cited as the main reasons
9% (15) related to 'Attitude' with 'rudeness' and 'inappropriate behaviour' cited as the main reasons.

GP concerns
During September 2018, the Trust received 11 concerns from GP Practices relating to individual patient concerns

91% (10) of these related to concerns around 'Appointments' with 'delays' and 'poor communication' cited as the main reasons – the main areas involved were 'Endoscopy' and 'Urology'.

Compliments
During September 2018, 34 compliments were logged onto Datix.

38% (13) related to Emergency & Integrated Medicine, 26% (9) related to Surgery & Cancer, 15% (5) related to Adult Community Services, 9% (3) related to Women's Health, Outpatients & Diagnostics, 9% related to Patient Relations, and 3% (1) related to Children & Young People Services.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.5%	89.4%	92.5%	
Maternity	Smoking at Delivery	<6%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	6.3%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	6.0%	6.3%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	89.7	92.9	77.8	76.5	76.0	98.8	85.9	66.7	43.4				68.6	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	103.9	102.1	38.8	88.5	77.3	109.5	87.9	55.5	39.3				62.7	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.74			0.76								
Admitted	Mortality rate per 1000 admissions in-months	14.4	8.6	8.5	12.0	9.4	10.0	10.3	7.3	7.7	6.4	5.3	4.7	5.0	6.1	
Community	IAPT Moving to Recovery	>50%	50.8%	53.0%	50.9%	47.5%	51.4%	59.4%	56.3%	53.4%	58.2%	52.4%	55.7%		55.1%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	93.5%	86.7%	78.7%	96.0%	87.0%	90.2%	86.7%	88.9%	95.2%	95.5%	93.2%	90.9%	92.1%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	52.7%	75.0%	86.2%	91.8%	91.0%	86.7%	82.8%	91.1%	82.4%	90.7%	89.0%	87.7%	87.1%	
Community	% of MSK pts with a significant improvement in function (PSFS)	>75%				89.3%	82.7%	78.5%	80.1%	74.0%	69.5%	76.5%	81.7%	68.5%	75.4%	
Community	% of Podiatry pts with a significant improvement in pain (VAS)	>75%					18.9%	51.5%	77.8%	77.4%	84.8%	84.8%	90.0%	77.8%	82.1%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	84.9%	77.3%	85.7%	76.5%	70.4%	78.5%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	77.5%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	94.9%	92.9%	92.2%	93.4%	96.0%	96.8%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	93.6%	

Effective Services - Commentary

Breastfeeding initiated

Just below target at 89%. The team are caring out audits in October;

- Mother's audit being carried out and it is due for completion at the end of October 18
- The staff audit will commence in November 18
- Neonatal audit for Baby Friendly Initiative November 18

The data from these audits will be submitted to Baby Friendly Initiative by 5th December and presented to the senior team.

- Any issues arising will be addressed in time for re-accreditation in June 2019
- There will be monthly updates at the senior team meeting from early Jan, increasing in frequency if necessary.

Smoking at delivery

Just above target at 7% in September 2018

Smoking status and the offer of CO screening are a mandatory field on maternity Medway at booking. We are 100% compliant with the offer.

Midwives have access to yearly Level 1 training for smoking cessation in order to offer CO monitoring at booking and 28 weeks gestation.

All the teams have access to CO monitoring devices and are trained to use them.

All referrals for smoking cessation following positive antenatal screening are sent via ICE to the external provider, who then a have responsibility to contact women to offer smoking cessation support.

There is an ongoing issue with the uptake of services once women are referred and feedback received as to the success of the support to quit.

The trust has met with both Islington and Haringey Smoking Cessation services and requested monthly data on referrals and uptake of service breakdown. This will allow targeting practice areas that need addressing and training needs.

Non-elective re-admission

There was a decrease in non-elective readmissions in September 2018 compared to August (down to 6% from 7%). This is still 0.5% above the target, but below the average for the year of 6.3%. A retrospective audit of the August readmission data is being undertaken by relevant clinical teams and this will inform what further improvement actions are needed.

Effective Services - Commentary

DN – 48hrs (87.7% (target 95%)

24 out of 195 referrals are showing as not seen on time.

- 6 of these were patients who did not answer at their first visit within 48 hours. They were subsequently seen face to face after 48 hours.
- 1 patient was seen urgently, and referral was sent after first visit
- 2 patients were discharged after they did not answer
- 8 visits were not made within 48 hours due to capacity issues within the team. The delays did not cause patient harm.
- 3 have not yet been outcomed on eCommunity (escalated to nursing agency)
- 4 have not been seen due to delayed discharge from hospital/hospice.

In summary only 8 of these 24 referrals are real delays.

Actions to be taken in relation to these issues

- Remove the 48hrs visits which should not be included in the data sets, for example; patients still not discharged from hospital.

Newly added:

The Trust Performance report now included the following outcome focussed indicators specific to community:

- % of MSK patients with significant improvement in function (PSFS)
- % of Podiatry patients with significant improvement in pain (VAS)
- ICTT - % Patients with self-directed goals set at Discharge
- ICTT - %GAS (Goal Attainment Scale)Scores improved or remained the same at Discharge

Patient reported outcomes now added to the Trust report to allow sight of patient outcomes. Other services are in development to add to this performance report.

All areas are meeting targets except MSK which was human data entry error and this will be corrected by next month. Training has been put in place.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	89.2%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	82	82	81	75	77	95	91	87	79	74	63	75	78	
ED	Ambulance handovers waiting more than 30 mins	0	38	15	34	34	37	69	22	41	16	18	9		106	
ED	Ambulance handovers waiting more than 60 mins	0	0	3	11	12	3	18	8	0	1	0	10		19	
ED	12 hour trolley waits in A&E	0	0	0	0	0	0	0	0	0	0	2	0	0	2	
Cancer	Cancer - 14 days to first seen	>93%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%		94.8%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	98.9%	100.0%	100.0%	97.9%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%	95.8%		98.4%	
Cancer	Cancer - 62 days from referral to treatment	>85%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.3%		84.6%	
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%								
Cancer	Cancer - 62 Day Screening	>90%										100.0%	100.0%		100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	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%	92.1%	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	0	0	0	0	0	0	0	0	0	0	0		0	

Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2		
Indicator	17_18 Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018-2019	Performance
Breast	>85%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%	100.0%			
Gynaecological	>85%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	33.3%		40.0%		100.0%			
Haematological (Excluding Acute Leukaemia)	>85%	100.0%					100.0%		50.0%	100.0%	100.0%	100.0%			
Lower Gastrointestinal	>85%	71.4%	76.9%	85.7%	75.0%	66.7%	100.0%	72.7%	66.7%		71.4%	100.0%			
Lung	>85%	100.0%	100.0%	100.0%	100.0%	50.0%		100.0%	50.0%	100.0%	100.0%	100.0%			
Other	>85%						100.0%				100.0%				
Skin	>85%	94.7%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Testicular	>85%								100.0%			100.0%			
Upper Gastrointestinal	>85%	100.0%	0.0%	66.7%	0.0%	50.0%		66.7%	100.0%	100.0%	0.0%	0.0%			
Urological (Excluding Testicular)	>85%	94.1%	100.0%	83.3%	100.0%	100.0%	66.7%	90.0%	58.8%	81.8%	68.4%	77.8%			
Sarcoma	>85%		0.0%				50.0%								

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2		
Indicator	17_18 Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018-2019	Performance
Breast	>93%	98.7%	97.3%	99.0%	98.8%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%	97.5%		98.0%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%		100.0%	
Gynaecological	>93%	96.5%	100.0%	100.0%	96.2%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%	98.0%		97.2%	
Haematological	>93%	100.0%	88.9%	100.0%	100.0%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%	37.5%		63.0%	
Lower Gastrointestinal	>93%	79.7%	93.9%	90.6%	87.2%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%	88.2%		93.1%	
Lung	>93%	100.0%	84.2%	100.0%	96.2%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%	100.0%		95.7%	
Other	>93%														
Skin	>93%	97.1%	100.0%	100.0%	98.0%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%	98.8%		97.8%	
Upper Gastrointestinal	>93%	77.8%	78.8%	60.0%	73.5%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%	55.0%		77.2%	
Urological	>93%	100.0%	98.5%	100.0%	98.9%	97.3%	95.5%	93.6%	98.0%	89.0%	89.9%	94.7%		93.0%	

Community Average Waits

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen
CAMHS	>95%	8	43.80%	60.50%	56.10%	7.7	148	>95%	2	100.00%	66.70%	71.40%	2.6	7
Child Development Services	>95%	8	83.90%	65.00%	85.70%	4.3	14	>95%	2					0
IANDS	>95%	8	20.00%	40.00%	46.90%	13.1	32	>95%	2					0
Community Children's Nursing	>95%	2	76.50%	87.70%	90.70%	0.9	75	>95%	1	100.00%	100.00%	100.00%	0.1	5
Community Paediatrics Services	>95%	12	78.90%	70.80%	78.40%	9.5	51	>95%	1	31.10%	12.50%	5.30%	9.5	19
Haematology Service	>95%	12	100.00%	100.00%	100.00%	0.5	21	>95%	2					0
Looked After Children	>95%	4	86.20%	84.20%	80.00%	2.1	10	>95%	2					0
Occupational Therapy	>95%	8	36.40%	69.20%	48.60%	10	35	>95%	2					0
Physiotherapy	>95%	8	76.70%	65.30%	63.40%	6.8	142	>95%	2					0
PIPS	>95%	12	100.00%	100.00%	100.00%	3.7	5	>95%						0
School Nursing	>95%	12	91.20%	100.00%	81.80%	6.3	77	>95%						0
Speech and Language Therapy	>95%	6	52.90%	42.40%	33.70%	10.4	172	>95%	2	100.00%	100.00%	75.00%	4.8	<5
Bladder and Bowel - Children	>95%	12	50.00%	85.70%	28.60%	14.1	14	>95%						0
Community Matron	>95%	6	96.30%	98.00%	87.80%	1.8	41	>95%	2		100.00%			0
Adult Wheelchair Service	>95%	8	94.20%	97.10%	85.20%	5.2	27	>95%	2		100.00%			0
Cardiology Service	>95%	6	100.00%	90.50%	95.80%	2.5	24	>95%	2	83.30%	100.00%	100.00%	0.9	<5
Community Rehabilitation (CRT)	>95%	12	94.00%	93.90%	92.30%	6	104	>95%	2	48.80%	45.70%	38.50%	4.6	39
Community Rehabilitation (ICTT)	>95%	12	86.60%	89.40%	87.60%	5.6	241	>95%	2	30.60%	41.20%	59.60%	2	99
Diabetes Service	>95%	6	65.10%	76.70%	84.70%	3.5	85	>95%	2		100.00%	100.00%	0.4	<5
Intermediate Care (REACH)	>95%	6	68.40%	80.40%	78.60%	5	126	>95%	2	55.20%	62.10%	90.00%	1.4	60
Paediatric Wheelchair Service	>95%	8	100.00%	87.50%	66.70%	6.6	9	>95%	2					0
Respiratory Service	>95%	6	82.90%	88.90%	93.80%	2.6	65	>95%	2	100.00%	66.70%	100.00%	0.3	<5
Spirometry Service	>95%	6	15.40%	46.30%	53.80%	6.3	39	>95%	2	0.00%	0.00%			0
Bladder and Bowel - Adult	>95%	12	55.40%	49.60%	46.00%	19.4	100	>95%	2	0.00%				0
Musculoskeletal Service - CATS	>95%	6	90.40%	86.20%	80.80%	4.3	349	>95%	2	100.00%				0
Musculoskeletal Service - Routine	>95%	6	87.50%	82.50%	78.00%	4.3	1377	>95%	2	83.30%				0
Nutrition and Dietetics	>95%	6	92.20%	94.80%	80.00%	4.2	175	>95%	2			80.00%	0.4	<5
Podiatry (Foot Health)	>95%	6	76.20%	85.50%	76.20%	4.9	581	>95%	2	0.00%	100.00%	100.00%	1.1	<5
Lymphodema Care	>95%	6	100.00%	94.40%	92.60%	4	27	>95%	2					0
Tissue Viability	>95%	6	94.00%	100.00%	100.00%	1.2	71	>95%	2					0

Haringey Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service Name	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen
CAMHS	>95%	8			100.00%	3.4	<5	>95%	2					0
Child Development Services	>95%	8	100.00%	0.00%	100.00%	0.6	<5	>95%	2					0
IANDS	>95%	8			100.00%	0.6	<5	>95%	2					0
Community Children's Nursing	>95%	2	33.30%	100.00%	100.00%	0	<5	>95%	1					0
Community Paediatrics Services	>95%	12	95.20%	77.80%	80.00%	10.7	30	>95%	1	25.00%	8.70%	5.60%	10.7	18
Haematology Service	>95%	12	100.00%	100.00%	100.00%	0.8	5	>95%	2					0
Looked After Children	>95%	4	75.00%	100.00%	100.00%	2	<5	>95%	2					0
Occupational Therapy	>95%	8	13.30%	66.70%	44.40%	11	18	>95%	2					0
Physiotherapy	>95%	8	83.30%	53.70%	27.60%	9.7	58	>95%	2					0
PIPS	>95%	12	100.00%	100.00%	100.00%	3.7	5	>95%						0
School Nursing	>95%	12	86.00%	100.00%	70.70%	9.8	41	>95%						0
Speech and Language Therapy	>95%	6	44.60%	23.50%	19.30%	13.5	88	>95%	2	100.00%		66.70%	6	<5
Bladder and Bowel - Children	>95%	12					0	>95%						0
Community Matron	>95%	6	92.30%	100.00%	83.30%	2.7	12	>95%	2					0
Adult Wheelchair Service	>95%	8	94.10%	97.10%	84.60%	5.3	26	>95%	2		100.00%			0
Cardiology Service	>95%	6	100.00%	83.30%	94.40%	2.6	18	>95%	2	0.00%				0
Community Rehabilitation (CRT)	>95%	12	100.00%	100.00%			0	>95%	2	0.00%				0
Community Rehabilitation (ICTT)	>95%	12	86.80%	89.00%	87.60%	5.7	225	>95%	2	27.70%	40.00%	59.30%	2	86
Diabetes Service	>95%	6	51.40%	61.30%	79.40%	4.1	63	>95%	2			100.00%	0.4	<5
Intermediate Care (REACH)	>95%	6	83.30%	100.00%	0.00%	21	<5	>95%	2		0.00%	100.00%	1.9	<5
Paediatric Wheelchair Service	>95%	8	100.00%	87.50%	62.50%	6.5	8	>95%	2					0
Respiratory Service	>95%	6	78.60%	100.00%	95.70%	2	23	>95%	2		50.00%			0
Spirometry Service	>95%	6	15.40%	46.30%	53.80%	6.3	39	>95%	2	0.00%	0.00%			0
Bladder and Bowel - Adult	>95%	12	41.10%	30.40%	42.90%	22.3	28	>95%	2					0
Musculoskeletal Service - CATS	>95%	6	85.90%	81.60%	77.90%	4.4	213	>95%	2					0
Musculoskeletal Service - Routine	>95%	6	87.40%	80.30%	78.90%	4.1	790	>95%	2	80.00%				0
Nutrition and Dietetics	>95%	6	89.50%	94.70%	78.30%	4.3	115	>95%	2					0
Podiatry (Foot Health)	>95%	6	80.30%	86.90%	72.40%	5	268	>95%	2					0
Lymphodema Care	>95%	6	100.00%	85.70%	92.30%	4.2	13	>95%	2					0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	2.1	15	>95%	2					0

Islington Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service Name	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen	% Target	Target Weeks	Jul-18	Aug-18	Sep-18	Avg Wait (Sep-18)	No of Pts First Seen
CAMHS	>95%	8	42.50%	60.70%	55.60%	7.8	142	>95%	2	100.00%	66.70%	71.40%	2.6	7
Child Development Services	>95%	8	73.70%	66.70%	80.00%	5.2	10	>95%	2					0
IANDS	>95%	8	14.80%	31.80%	41.40%	14.2	29	>95%	2					0
Community Children's Nursing	>95%	2	77.20%	88.70%	89.10%	1.1	64	>95%	1	100.00%	100.00%	100.00%	0.1	5
Community Paediatrics Services	>95%	12	56.30%	66.70%	70.60%	8.5	17	>95%	1	83.30%	100.00%	0.00%	8.5	1
Haematology Service	>95%	12		100.00%	100.00%	0.7	6	>95%	2					0
Looked After Children	>95%	4	92.30%	100.00%	50.00%	2.7	4	>95%	2					0
Occupational Therapy	>95%	8	58.80%	70.00%	50.00%	10.5	12	>95%	2					0
Physiotherapy	>95%	8	71.40%	81.00%	88.10%	4.7	84	>95%	2					0
PIPS	>95%	12		100.00%			0	>95%						0
School Nursing	>95%	12	100.00%	100.00%	93.10%	2.7	29	>95%						0
Speech and Language Therapy	>95%	6	58.90%	59.10%	55.00%	6.5	60	>95%	2	100.00%		100.00%	1.3	1
Bladder and Bowel - Children	>95%	12	42.90%	75.00%	25.00%	15.4	8	>95%						0
Community Matron	>95%	6	100.00%	97.00%	89.70%	1.5	29	>95%	2		100.00%			0
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.1	6	>95%	2	100.00%	100.00%	100.00%	0.9	4
Community Rehabilitation (CRT)	>95%	12	94.30%	93.30%	91.90%	6.1	99	>95%	2	50.00%	48.50%	36.80%	4.7	38
Community Rehabilitation (ICTT)	>95%	12	100.00%		100.00%	2.6	4	>95%	2					0
Diabetes Service	>95%	6	91.40%	93.00%	100.00%	2	22	>95%	2		100.00%			0
Intermediate Care (REACH)	>95%	6	67.40%	81.00%	80.30%	4.7	117	>95%	2	51.90%	62.50%	89.50%	1.5	57
Paediatric Wheelchair Service	>95%	8					0	>95%	2					0
Respiratory Service	>95%	6	88.20%	82.10%	92.90%	3	42	>95%	2	100.00%	75.00%	100.00%	0.3	1
Spirometry Service	>95%	6					0	>95%	2					0
Bladder and Bowel - Adult	>95%	12	73.50%	75.40%	53.70%	15.3	41	>95%	2					0
Musculoskeletal Service - CATS	>95%	6	94.60%	92.10%	84.80%	4.3	132	>95%	2	100.00%				0
Musculoskeletal Service - Routine	>95%	6	88.30%	87.00%	79.30%	4.4	508	>95%	2					0
Nutrition and Dietetics	>95%	6	95.50%	95.40%	84.00%	4	50	>95%	2					0
Podiatry (Foot Health)	>95%	6	72.80%	84.30%	79.70%	4.8	311	>95%	2	0.00%	100.00%	100.00%	1.1	1
Lymphodema Care	>95%	6	100.00%	100.00%	92.90%	3.8	14	>95%	2					0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.7	36	>95%	2					0

Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time
Overall performance against the 95% target for August was 90.0%, and 89.6% for September. Attendance numbers were higher in September at 8,899 compared to August at 8,164. The September attendance figure was a 10.52% increase compared to September 2017.

Despite this the 'minors' performance delivered 96.63% and Paediatrics delivered at 96.62% for September. The median wait for treatment did increase in September to 75 minutes against a national standard of 60 minutes however September saw an improvement in the 'Time to triage' metric which has reduced following the implementation of a new streaming model. There is further improvement required in the 'majors' and admitted stream and senior staff are focussed on those that will bring about the expected improvements.

Ambulance activity has also continued to increase but performance against the 15 and 30 minute handover time standards has remained good. In September 98.24% of Ambulances were 'offloaded' within 30 minutes of arrival. 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 Medical 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 National Waiting Times Performance

For August 2018 the Trust was compliant for all the national cancer access standards.
However the breakdown by non-compliant tumour group for 62 days and 2ww performance is shown below.

62 day standard – 85%

Upper GI	0%	1 patient referred on colorectal pathway initially, complex pathway and diagnostics needed.
Urology	77.8%	4.5 treats, 2 x 0.5 breaches, one patient diagnostics at the longer end of norm so was sent to UCLH day 45. Second patient did not attend correct OP clinic initially and had subsequent wait for diagnostics.

Action: urology pathway now in place to get prompt diagnostics as soon as possible and radiology to report MRI scan promptly. Issues with prostate pathway across NCL and meeting 9th November 2018 to address in particular MDT arrangements.

2ww standard – 93%

Haematology	37.5%	The booking gates were incorrectly adjusted for haematology patients and, as such, a number of patients waited longer for their appointments when they arranged their appointment. This has now been rectified and further staff training put in place.
Lower GI	88.2%	Two week waits have been affected by the capacity issues in endoscopy as this speciality is predominantly straight-to-test. There is a plan in place to address this through insourcing additional capacity which is already having a positive impact.
Upper GI	55%	Two week waits have been affected by the capacity issues in endoscopy as above. Similarly this speciality is predominantly straight-to-test. There is a plan in place to address this through insourcing additional capacity which is already having a positive impact.

Diagnostic waits

As expected, the Trust did not achieve the 6 week diagnostic wait target for the month of August due to significant capacity issues in Endoscopy. Additional endoscopy capacity has been put in place and at the time of writing we can confirm that we achieved the target for September 2018.

Responsive Services - Commentary

Community Waiting Times

Service	Why below target	What in place to improve	Expected date for target to be achieved
CAMHS (Islington)	Historical backlog despite CCG investment. Increase in referrals during May and June is compounding the issue of clinical capacity – annual pattern of increase due to exam pressures and external teams referring to ensure support is in place for the summer holidays. Team structures not necessarily allocated for maximum effectiveness.	Changes to the intake process to reduce screening time; Intake Meeting twice-weekly with screening for risk on the day of referral. Allocation of clinical time to provide additional Choice appointments (an additional 30 per month June – Sept). Expectation of reduction of service demand over the summer holidays enables the service to process some of the backlog.	Proposed new team structure will support the achievement of waiting times in the longer term. 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. Consultation closed and responded to. Implementation phase to commence on 5th November 2018. Additional short-term resource will be put into service to support reduction of historic backlog. Agreement that backlog will be cleared by December 31st, though acknowledgement that a sustained reduction in waiting times dependent on implementation of SPA, scheduled to be in place June 2019.
Child Development Services	Haringey: Achieved target Islington: Underachieving. Social Communication Team waiting times are over 30 weeks due to	Islington: Additional investment received from CCG to reduce waiting times.	Islington: The target was actually 20 weeks which was due to be achieved in July 18 and which was reached in June, July, Aug

Service	Why below target	What in place to improve	Expected date for target to be achieved
	clinical capacity.		and Sept. However increase to 22 weeks in October as 2 members of staff from investment money have finished. We also based our sustainability on 12 referrals per month however this has increased for the last 3 months to 16. A paper has been sent to CCG re risks due to non -continuation of funding which was discussed at last engagement meeting and will be further discussed at next meeting in 2 weeks.
Community Children's nursing (Islington)	Administrative issues around inputting contacts correctly.	Urgent referrals achieved 100% Routine referrals improved from 88.7% to 89.1%	Waiting times need to be separated out by team, as Life Force, CHC, Primary Care Nursing, and other CNS teams working to different waiting times. Discussion required with commissioners to ensure specifications for each outline agreed waiting time with each service and waiting times reporting is split based on agreed target determined by clinical need.
Community Paediatrics Service	Haringey: ASD current wait 52 weeks; urgent waits due limited clinical capacity. Service for children Under 5 / Over 5. Islington: Average time for ASD is 52 weeks. Service is for Over 5 only.	Haringey: Process and pathway changes, as recommended by UCLP have been made to alleviate pressures. Business case has been submitted to CCG for additional investment. Islington: recruitment in process.	Haringey: Service continues to make changes to processes and pathways to reduce backlog within existing capacity. Provider Intentions sets out plans to move ASD to therapy led model and Project Resource now identified for implementation of UCLP recommendations. ASD and general community paediatric waits to be separated for

Service	Why below target	What in place to improve	Expected date for target to be achieved
			reporting purposes moving forward. Islington: Target agreed with CCG to reach 18 weeks by March 19.
Haematology Service	Achieved target		
Looked After Children	Haringey: 100% Islington: 50%	Overall target below as the children from other CCG's are not seen within the timeframe.	Islington – Number of older children refusing assessment or missing, in addition to unaccompanied asylum seekers placed in Birmingham contributing to this month's position.
Occupational Therapy/ Physiotherapy (Haringey)	OT: Performance for OT gone down to 44% from 66% last month. Longer waits in school team due to timing of referrals in school holidays. PT: Physio. Activity is reduced – vacancies are hard to recruit into – B7 has been advertised 4 times. We are working with the recruitment team to review the text and reach of the advert.	Haringey Therapies Review. This was commissioned by the CCG and they have indicated that they want the review to be completed by the end of the year. The Haringey health teams (OT, PT and SLT) have completed inputting all of the caseload and workforce data that was required of them.	Following therapy review commissioners will agree on the priorities and agree waiting times and staffing levels. Report outlining recommendations expected to be presented to CSIG in December 2018. This will also provide indication of expected waiting time targets moving forward. ICSU Clinical Director is working with Therapy Team to explore interim measures to use capacity differently to support improvement against target. Measures and expected impact to be presented to November Board.
Occupational Therapy/ Physiotherapy (Islington)	OT: Performance for OT decreased from 70.0% to 50% Longer waits in school team due to timing of referrals in school holidays.	OT: Two initiatives; monthly parent workshops and fortnightly drop in clinics. PT: Group sessions and a locum youth gym have been set up and	OT: October 2018 (OT Clinical Specialist started in September which will support improvement against target). PT: October 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
	PT: Physio performance has further improved from 81% to 88%	this increased capacity significantly	
PIPS	Target achieved		
School Nursing (Haringey)	Reduced from 100% to 70.7% due to no school nursing service in the school holidays.		Expected to be back on target in October 2018
School Nursing (Islington)	Reduced from 100% to 93.1% due to no school nursing service in the school holidays.		Expected to be back on target in October 2018
Speech and Language Therapy (Haringey)	Decreased from 23.5% to 19.3% Increase in referrals due to introduction of healthy child programme. Longer waits in school team due to timing of referrals in school holidays.	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. Report outlining recommendations expected to be presented to CSIG in December 2018. This will also provide indication of expected waiting time targets moving forward. ICSU Clinical Director is working with Therapy Team to explore interim measures to use capacity differently to support improvement against target. Measures and expected impact to be presented to November Board.
Speech and Language Therapy (Islington)	Reduced from 59.1% to 55% 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	To be expected to be on target by December 18
Community Rehabilitation (ICTT)	•	• Triaging - review of triaging	December 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
	• Minor gap in physio recruitment.	system within the team to reduce unnecessary visits and freeing up time for new visits. • Trialling telephoning referred clients for a month to filter out inappropriate referrals • Review of administration and booking system. • Creation of additional new patient slots for rehab techs- x1/week – 6 extra slots • Weekly review of waiting lists by leads of the different streams • Service Manager monitoring productivity of staff and actions around improvement. • Pilot use of electronic assessment forms to reduce admin time needed for processing.	
Bladder and Bowel	• Part of CSIG and performance improvement. • Capacity - Vacancies have been long standing unable to recruit.	• 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 18. • Outline timetable for establishing new integrated pathway and single point of access being considered by CSIG on 30 October. • Process mapping sessions are being held in December/January.	January 2019 new integrated pathway being developed.
Diabetes Service	•Urgent – two patients unable to	• Improvement seen in waiting	November 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
	attend. •Routine – clearing backlog seen in August and high DNA rates.	times for routine appointments in September. • New clear guidelines given to the team In terms of triaging GP referrals and time scale to book appointments. • Time scale to triage GP referral by specialist diabetes nurse was reduced from one week after receiving the referral to 24 hours max. • Two extra pre-assessment diabetes clinics a month have been moved from Islington to Haringey in order to see patients within two to three weeks of receiving the referral (the Islington caseload is much smaller than Haringey). • To continue to outcome all appointments appropriately and maintain improvement made.	
Intermediate Care (REACH)	• Inappropriate referrals and use of staff time. • The main issue for both boroughs is SALT, insufficient capacity.	• Work with the Central Bookings Team (CBT) to move booking of appointments to CBT. • Weekly diary 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. • Service Manager to produce monthly activity report for all	December 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
		staff. • Recruitment process underway for several posts during October.	
Respiratory Service	• Reduced number of exercise programme due to loss of capacity. • Inappropriate triaging. • High DNA rates.	• Improvement seen in waiting times for routine appointments in September. • Discharge referral but to ease the workload of asking GP to refer back a letter is sent to both the GP/Referrer and patient offering a self-referral if contacts on next 3 months. • Patients who cannot commit programme but would like to attend in the next 3 months are discharged and can self ref by contacting the PR team when ready to star • Daily triaging of new referrals. If meet criteria off soonest appointment at venue were waits are minimal- exceptions are made if nearest venue is the only venue they can attend for mobility/Transport reasons. Patients are contacted the same or following day to discuss referral and accepted/discharged as necessary • All patients can be booked at any venue with capacity to be seen within 6 weeks regardless of where the	November 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
		exercise venue is. • Ad hoc clinic appointments can be added throughout week if there is capacity at any of the sites, which does not clash with another service.	
Spirometry Service	•Performance is currently being reviewed and improvement work will be developed on the basis of this.	• Recently separated from overall Respiratory category. • Improvement work in planning.	Target to be agreed at CSIG on 30 October
Nutrition and Dietetics	High levels of annual leave during August and clearing resulting backlog.	• The services has improved on a month-by-month basis and in August reached the 95% target. • September saw a small drop, but service still averaging 95% over last 3 month period. • Creating a new weekly/fortnightly clinic in Camden to reduce the wait times linked to caseload. • Establishing a mechanism for mental health patients to "over-flow" from mental health clinics to general clinics (more capacity) with the appropriately trained clinicians. • Reinstating weekly checks on empty clinic slots to bring patients forward. • Reinstating weekly checks on whether CBS have sent opt in letters in a timely manner (noticing delays of up to 2 weeks). • Initiating weekly checks that	October 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
		housebound patients have appointments booked within 6 weeks.	
Podiatry (foot health)	• Issue in resilience in the service, for example, staff sickness caused cancellations of new patient clinics, resulting in a loss of appointments, which would have caused breaching. • Triage time breached in mid sept due to staff sickness but was back on track before the end of the month	• Recruitment plan in place – this will recover lost capacity through mat leave and start of clinical rotations. • Blitz clinic for new patients to take place through the majority of December to ensure capacity does not fall due to Christmas holidays. • Close monitoring of opt in interactive worksheets, which currently indicate contact us letters are not being sent as quickly as possible. This causes unnecessary delays in patients contacting us back and new patient slots go unfilled. • Continuing to keep triage up to date to ensure unnecessary delays are minimised. • Continue with robust clinical diary management to ensure all appointment utilised.	December 2018
Lymphodema	Routine appointments – due to two patients waiting for 1 week over the target of 6 weeks. Issues now resolved.	• Small dip in performance around routine appointments seen in September, from xx to xx. • No further improvement work Recruitment plan in place - planned at present as average wait over last 3 months is still at 95%	October 2018

Service	Why below target	What in place to improve	Expected date for target to be achieved
Tissue Viability	Achieved target	• No further improvement work planned. Service consistently achieving 100% of been seen for routine appointments within target time.	Achieved target

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	15	9	10	8	2	8	3	5	1	4	1	2	16	
Theatres	Cancelled ops not rebooked < 28 days	0	0	5	1	1	0	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	398	211	282	334	269	312	292	281	212	230	238		1253	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%		2.7%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	55.7%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	95.0%	97.5%	94.5%	95.0%	93.6%	94.5%	93.9%	92.7%	93.4%	93.3%	96.1%		93.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.6%	88.6%	86.1%	91.6%	93.4%	90.5%	89.7%	92.7%	93.4%	90.5%	91.9%		91.7%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	92.1%	96.6%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%		95.0%	
Community	Haringey - HR1 % carried out before child aged 15 months		68.0%	61.8%	60.3%	67.7%	67.6%	64.0%	64.5%	73.9%	66.4%	71.4%	62.6%		67.4%	
Community	Haringey - HR2 % carried out before child aged 30 months		44.7%	44.0%	38.1%	60.3%	68.5%	59.6%	57.1%	62.8%	59.3%	65.1%	67.8%		62.2%	
Community	Islington - HR1 % carried out before child aged 15 mths		66.7%	69.9%	67.8%	70.9%	78.9%	83.5%	70.1%	81.2%	77.2%	81.4%	79.7%		77.7%	
Community	Islington - HR2 % carried out before child aged 30 mths		63.7%	75.1%	70.1%	71.6%	70.0%	76.1%	78.2%	74.8%	77.7%	79.9%	79.9%		78.0%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		65.2%	63.9%	74.6%	64.9%	72.0%	84.3%	69.7%	78.3%	80.6%	81.9%	82.8%		79.4%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		81.5%	81.0%	85.6%	79.1%	85.6%	77.9%	80.4%	86.0%	92.8%	91.8%	95.5%		89.3%	

Responsive Services - Commentary

Cancelled Operations – September 2018

There were two cancelled operations in September 2018 for non-clinical reasons against a threshold of zero.

Gynae	1 patient	theatre list overran
T&O	1 patient	theatre list overran

Action: continue to ensure that theatre lists booked correctly and signed off by consultant a week in advance.

Delayed Transfer of Care (DToC)

August performance is 2.7% 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. The North London partners in Health and Care have instigated the new Choice Policy which reviews place of discharge for the patient. The main change is for the patient to be placed in first available place instead of place of choice. This is now launched and training is in place across the organisation.

New Birth Visit

Islington: Achieved.

Haringey: Improvement continued in line with trajectory agreed with commissioners.

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

Good progress on mandated parts of Healthy Child Programme. Drops noted in Health Reviews 1 targets which is likely due to be seasonal effect.

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	70.9%	69.0%	70.7%	70.8%	71.6%	68.9%	70.2%	70.8%	71.5%	73.6%	73.2%	74.7%	72.3%	
HR	Mandatory Training % Rate	>90%	79.1%	80.1%	80.5%	81.1%	80.8%	82.6%	82.9%	83.0%	82.8%	82.5%	83.7%	82.2%	82.8%	
HR	Permanent Staffing WTEs Utilised	>90%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.2%	86.2%	86.3%	86.7%	86.4%	86.7%	
HR	Staff FFT % recommended work	>50%			59.5%			58.6%			60.8%			64.4%	61.9%	
HR	Staff FFT response rate	>20%			39.1%			17.8%			16.5%			8.0%	12.3%	
HR	Staff sickness absence %	<3.5%	3.61%	3.57%	3.65%	4.01%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%	3.10%		3.35%	
HR	Staff turnover %	<10%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	12.8%	13.5%	
HR	Vacancy % Rate against Establishment	<10%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.8%	13.8%	13.7%	13.3%	13.6%	13.3%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	84.1%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	137.1%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	89.2%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	135.7%	
HR	Safe Staffing Alerts - Number of Red Shifts		32	16	33	31	12	19	18	8	0	1	1	2	30	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		7.4	8.6	8.4	8.2	8.4	8.6	8.7	9.3	9.4	10.0	9.0	8.8	9.2	

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

Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	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	Trend
Medical	Average staff cost per patient		95	94	93	98	104	96	101	88	92	97	101	
Nursing	Average staff cost per patient		165	167	198	167	182	181	182	172	181	174	180	
Other	Average staff cost per patient		196	193	214	191	195	166	203	179	196	226	234	

Human Resources

Vacancy rates during September have remained stable; newly qualified nursing staff are beginning to start in post from September so the impact of these is starting to be seen. 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. The pilot is underway, and completes in December.
Sickness (reported a month in arrears) has decreased and is below the Trust target.
Appraisal rates, though still below target, have improved to 74.7%. Mandatory training has decreased slightly to 82.2%. The friends and Family test response rate has decreased, and there will be a focus on all areas below target in the next month.

Well Led Services - Commentary

% day fill rate-nurses
All wards received adequate staffing levels during September 2018. Staff are moved between wards to ensure sufficient and safe cover. There has been some improvement in recording but these moves are still not always being adequately recorded on the safe care and health roster systems and the Lead Nurse for safer staffing now in post is continuing to work to improve this data capture with the site management team. 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 continues 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. The 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 continues not to be 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. This is being addressed by the Lead Nurse for safer staffing this month and it is anticipated that by the end of November 2018 these will be embedded into the current band 5 allocation on each roster.

In addition, some shifts booked via nursing agencies where trained nurses were required were not filled and a health care assistant was used in the place of a trained nurse which impacted on percentage health care assistant fill rate in addition to the factors below. Safety was maintained through senior nurse oversight at all times. The Deputy Chief Nurse, Associate Directors of Nursing and Lead Nurse for Safer Staffing are currently reviewing all health roster and safe care templates against the staffing ratios recommended in the last establishment review which recommended a reduction in trained nurse and increase in health care assistant posts.

Red shifts
There were 2 red shifts reported since the last Trust Performance report. The Deputy Chief Nurse is working with the Associate Director of Nursing and matron for surgery and cancer to embed the nursing staff escalation and management process for red shifts. Both of the reported shifts were continually monitored by the senior nurse and site management team and safety was maintained.

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 continued higher level of CHPPD in comparison to this time last year continues to be related to increased patient dependency and enhanced one to one care to patients on wards.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	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	Q2 Sep-18	Activity
ED	ED Attendances	8285	8816	8549	8579	8897	8082	9217	8645	9226	8699	9287	8157	8897	
ED	ED Admission Rate %		17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	
Community	Community DNA Rate %	<10%	8.1%	8.0%	6.8%	7.6%	7.6%	7.7%	7.8%	8.0%	8.0%	8.4%	8.0%	7.5%	
Community	Community Face to Face Contacts		57647	60685	50489	60032	54232	60343	55794	63802	62400	61192	54766	57189	
Admissions	Elective and Daycase		1908	2004	1587	1944	1735	1879	1719	1840	1880	1762	1818	1919	
Admissions	Emergency Inpatients		2455	2369	2180	2218	1906	2244	2181	2337	2237	2214	2190	2169	
Referrals	GP Referrals to an Acute Service		7602	7638	5926	7874	7362	7892	7166	7692	7624	7590	7086	6797	
Referrals	% of GP Referrals that were completed via ERS		32.7%	34.5%	37.2%	46.0%	44.1%	47.0%	58.2%	73.7%	79.7%	82.7%	83.0%	84.6%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	18.2%	12.2%	10.1%	8.8%	10.5%	11.9%	
Maternity	Maternity Births	333	347	337	332	321	253	315	291	323	282	297	321	312	
Maternity	Maternity Bookings	377	420	385	302	405	375	370	400	369	317	376	330	334	
Outpatients	Outpatient DNA Rate % - New	<10%	11.0%	10.2%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	10.1%	10.5%	11.2%	11.4%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.2%	10.2%	10.7%	12.1%	9.9%	10.9%	10.2%	12.1%	10.2%	10.3%	10.6%	10.4%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	10.5%	10.2%	10.9%	11.6%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	10.8%	10.9%	
Outpatients	Outpatient New Attendances		9781	10122	8012	10500	9217	9622	9308	10243	9665	9651	9095	8643	
Outpatients	Outpatient FUp Attendances		19457	19256	15891	18884	16584	17792	17404	18727	18302	18771	18089	16585	
Outpatients	Outpatient Procedures		7097	7450	5837	7409	6826	7093	6786	7423	7205	7555	6899	7239	
Theatres	Theatre Utilisation	>85%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	

Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	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	Trend
Average Tariff	Daycases		687	717	710	697	684	614	740	686	678	703	653	
Average Tariff	Elective		3959	3525	3526	3403	3550	3710	4033	3831	3778	3857	3210	
Average Tariff	Non-Elective		2188	2180	2561	2670	2362	2194	2484	2511	2564	2272	1684	

Activity - Commentary

DNA

DrDoctor is now fully rolled out in outpatients for text reminders and rescheduling, excluding Urology for now (shortages of Registrars). The roll out plan was ahead of schedule and a few specialties within the Access Centre were successfully trialled. All remaining specialties were switched on without any hurdles. There are still a few clinics that need auditing and verifying in order to add them on to DrDoctor and that currently relies on co-operation from the services.

Since turning on DrDoctor we have seen a small reduction in DNA rates across the board. July/Aug/Sept 2017-2018 (last year) had a DNA rate of 11.73%, July/Aug/Sept 2018-2019 current DNA rate is 10.70%. Obviously this reduction is not solely credited to DrDoctor but we can assume some contribution. Full integration of DrDoctor with Medway (System C) has come across some challenges and work is ongoing to solve this. The aim is for patients to autonomously manage their outpatient appointments online. This will only be possible once this piece of integration work is complete.

DrDoctor and Trust IT are looking into introducing text reminders to patients booked into theatres. There is a high DNA rate in theatres and the possibility of sending text reminders to patients could have a positive effect. Time scale: Trail to start mid November 2018

Activity - Commentary

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. Weekly PTL meeting and e-RS Implementation Groups meeting bi-weekly. ASI are currently at 11.9% for September. It is expect that the figures will alternate slightly from month to month and a 1% increase from 11% to 12% would be considered to be within the limits of reasonable fluctuation for eRS ASI activity at this time.

Theatre Utilisation

Theatre utilisation over the last five months has dropped below 85%.

Issue: There have been ongoing problems in both pre-operative assessment and the admissions booking team. This has affected the number of patients ready to be booked for surgery and the ability to book patients into a suitable slot in a timely manner therefore making sure theatre capacity is fully used.

Action: there has been an improvement plan for pre-operative assessment and this has delivered a better staffing model and has increased the number of patients having pre-operative assessment per month. At month 6 the actual activity was above plan and this is being closely monitored. There is ongoing development work with the admissions team to ensure that it is able to function in an optimum level. An action plan is in place and there is daily scrutiny to ensure the activity is being booked to get to year end compliance with the contracted plan.

Timescale: it is expected that the utilisation figures for October 2018 will demonstrate an improvement with the objective of being +85% in November 2018.

Whittington Health NHS

www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board
31 October 2018

Title:	**Delivering Transformation of the Trust's Estate**		
Agenda item:	**18/151**	**Paper**	**10**
Action requested:	For approval		
Executive Summary:	The purpose of this paper is to: provide an update on progress with the Estates Transformation programme; to seek approval for the proposed governance arrangements for the programme; and to seek approval for the continuation of work with CIFT to formalise the arrangements for the provision of mental health beds on the hospital site. This estates transformation programme begins with an initial project to deliver a Trust estate masterplan, revised estates strategy, and strategic outline case by April 2019. A project team has been established which includes a Trust Project Manager and Trust Finance Lead, and a number of additional specialist resources. The current project budget is £350,000. The outline project programme and project elements are described in more detail in the paper. The masterplan will be driven by our clinical strategy; patient and staff needs; and the health and wellbeing needs of our local communities. It is supported and informed by a number of important partnerships, relationships and networks that have been developed over a number of years. We will both build on these, and establish new ways, to engage widely to develop viable solutions that maximise the benefits for our local communities. In addition, we are working with Camden and Islington NHS Foundation Trust to facilitate the co-location of mental health services with acute physical health services on our hospital site, to support the provision of better, co-ordinated care for patients. Funding received by Whittington Health for use of its site for provision of mental health inpatient beds would also help fund the transformation of our community and Archway estate to ensure that we can provide outstanding services from fit for purpose facilities.		
Summary of recommendations:	The Trust Board is asked to: i) Consider the progress with the Estates Transformation programme ii) Approve the establishment of the Estates Strategy Delivery Board as a sub-committee of the Trust Board iii) Note the arrangements established to deliver the masterplanning, estates strategy and strategic outline case project iv) Receive the current budget position		

	v) Approve the continuation of work with CIFT to formalise the arrangements for the provision of mental health beds on the hospital site, which would include the transfer of part of the site to CIFT.						
Fit with WH strategy:	Delivery of Trust's Estate Strategy						
Reference to related / other documents:	Estates Strategy						
Reference to areas of risk and corporate risks on the Board assurance Framework	BAF15 – Failure to modernise Trust Estate RR 817, 680, 820, 750 and 746 – Current red risks on the corporate Risk Register which relate to primarily back log maintenance but would be addressed by moving forward with the Estate Strategy						
Date paper completed:	24 October 2018						
Author name and title:		**Sophie Harrison Assistant Director of Estates**		**Director name and title:**		**Stephen Bloomer Chief Finance Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Financial Impact Assessment complete?**	

Whittington Health - Delivering Transformation of the Trust's Estate

1.0 Introduction

The purpose of this paper is to: provide an update on progress with the Estates Transformation programme; to seek approval of the proposed governance arrangements for the programme; and to seek approval for the continuation of work with CIFT to formalise the arrangements for the provision of mental health beds on the hospital site.

This estates transformation programme begins with an initial project to deliver a Trust estate masterplan, revised estates strategy, and strategic outline case by April 2019. The masterplan will be driven by our clinical strategy; patient and staff needs; and the health and wellbeing needs of our local communities. It is supported and informed by a number of important partnerships, relationships and networks that have been developed over a number of years. We will both build on these, and establish new ways, to engage widely to develop viable solutions that maximise the benefits for our local communities.

In addition, we are working closely with Camden and Islington NHS Foundation Trust to facilitate the co-location of mental health services with acute physical health services on our hospital site, to support the provision of better, co-ordinated care for patients.

2.0 Establishing the transformation programme - governance

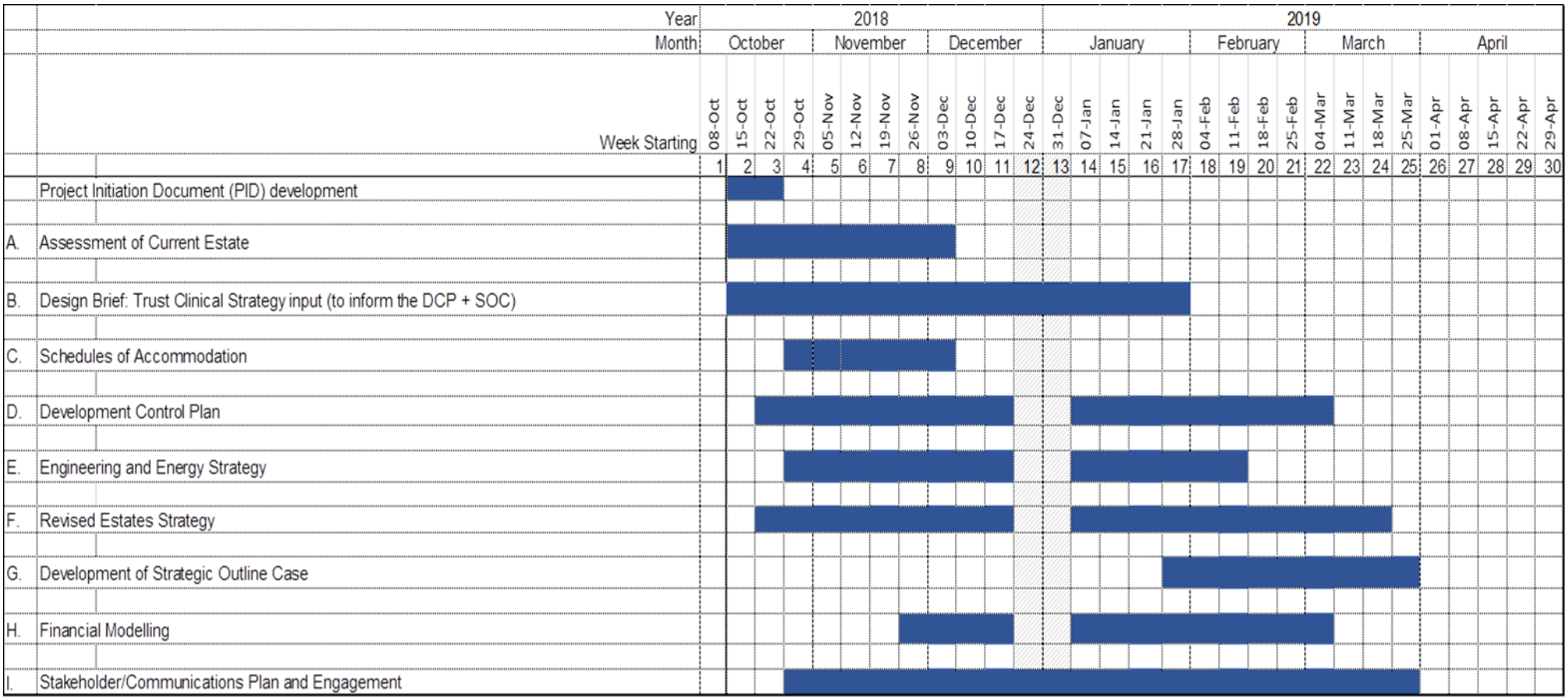
The Trust has recently established an Estates Strategy Delivery Board (ESDB) to oversee the delivery of the transformation programme. The Board is chaired by the Senior Responsible Officer, (Stephen Bloomer, Chief Finance Officer). Membership includes: a Non-Executive Director; a number of the Trust Directors; Service representation from each ICSU; staff representation; and communications.

It is proposed that the ESDB should report directly to the Trust Board, and report regularly to the Trust Management Group.

3.0 Project 1: the Masterplanning, Estates Strategy and Strategic Outline Case Project

3.1 Project programme

An initial outline programme has been developed. This will be reviewed and finalised during the project initiation phase (first two weeks).


Year
2018
2019
Month
October
November
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March
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01-Apr
08-Apr
15-Apr
22-Apr
29-Apr
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
Project Initiation Document (PID) development
A. Assessment of Current Estate
B. Design Brief: Trust Clinical Strategy input (to inform the DCP + SOC)
C. Schedules of Accommodation
D. Development Control Plan
E. Engineering and Energy Strategy
F. Revised Estates Strategy
G. Development of Strategic Outline Case
H. Financial Modelling
I. Stakeholder/Communications Plan and Engagement

3.1 Project Elements

The project will include the following elements:

i. Project Initiation Document (PID) development

The PID will be drafted during the first two weeks and will define the scope of the project, project organisation and deliverables and success criteria. It will include information on the project such as context, scope, team, programme, risks, dependencies and communications and stakeholder involvement

ii. Assessment of Current Estate

The assessment of the estate will include: collection, organisation and review of existing information; site visits & photographic records; transportation overview; planning & legal background review; occupation analysis; estate performance, including engineering review; and identification of further required information

iii. Design Brief

The preparation of the design brief will include the preparation of a draft strategic clinical and non-clinical brief and associated area schedules. These will be generated, with healthcare/architectural planning support, through a range of meetings; clinical activity analysis and modelling; and consideration of the wider system transformation programmes. An initial viability assessment will be undertaken.

iv. Schedules of Accommodation

Following the preparation of the strategic clinical and non-clinical brief and area schedules, a functional content (schedules of accommodation) will be prepared and signed off.

v. Development Control Plan (DCP)

Preparation of the DCP will include: identification of all the requirements from the clinical strategy and other future developments; preparation of existing area schedules; high level review of building suitability and space utilisation; review of partnership/opportunities; review of planning/housing policy requirements; issue of existing and proposed areas; preparation of cost estimates for healthcare development; incorporation of engineering requirements; preparation of phasing approach/programme; incorporation of a transport plan; review of options; engagement with Islington Council; report on viability/market issues; development of preferred option; and preparation of a final masterplan

vi. Engineering and Energy Strategy

The engineering and energy strategy will be prepared as the DCP develops.it will include: the collection of information about existing sites; assessment of existing sites and infrastructure and back-log maintenance; identification of any surveys that may be necessary; review of relevant utilities information incl. service capacities; assessment of future requirements for DCP; analysis of requirements for any future developments; assessment of infrastructure capacity/constraints; development of services strategy and loads for new developments; identification of any upgrades or major new services infrastructure provisions required; and preparation of an energy strategy.

vii. Revised Estates Strategy

A revised estates strategy will be prepared to support the strategic outline case. It will be informed by the work undertaken to develop the DCP.

viii. Development of Strategic Outline Case

A strategic outline case will be developed, using the relevant national guidance, to present the case for the estates transformation described in the DCP. It will be informed by the work undertaken to develop the DCP.

ix. Financial Modelling

Financial modelling will be undertaken to demonstrate the deliverability of the estate transformation. This will be informed by: capital costs; income and expenditure for the options; land valuations (if appropriate); and timings for each option.

x. Stakeholder/Communications Plan and Engagement

A stakeholder communication and engagement plan will be developed within the initial weeks of the project. The initial focus of the project will be on developing the design brief. This will include discussions with the Trust's clinical and non-clinical services; commissioners; and co-providers of care in the community. The design brief will inform the preparation of estate options which will generate further discussion

3.2 Project Resources

The masterplanning, estates strategy and strategic outline case project will be delivered by a Project Team, which, in addition to a Trust Project Manager and Trust Finance Lead, will include the following specialist resources: design, health planning, cost consultancy, engineering and energy; town planning and communications. The specialist resources have been procured via a mini competition using the Shared Business Services framework, with Ryder Architecture appointed as the preferred lead supplier.

The Trust is also being actively supported by the GLA Land and Housing team, who are members of the Estates Strategy Delivery Board.

The current project budget to fund the internal and external resources required to deliver the masterplanning, estates strategy and strategic outline case project is £350,000. This sits within the indicative figures presented to the Trust Board in April 2018.

Additional funding may be required for communications support and town planning response capacity.

4.0 Supporting the Delivery of Better Mental Health Care

Public consultation has recently taken place on proposals to improve mental health care for people living in the London Boroughs of Camden and Islington. These proposals include the relocation of inpatient mental health facilities and the creation of community mental health hubs.

Whittington Health has supported the proposal to create a new purpose built facility on the Whittington health hospital site, as we believe that the co-location of mental health

services with acute physical health services will lead to better care for patients through improved co-ordination and collaboration between the Trusts.

Funding received by Whittington Health for use of its site for provision of mental health inpatient beds would also help fund the transformation of our community and Archway estate to ensure that we can provide outstanding services from fit for purpose estate.

The Trust is currently working with Camden and Islington NHS Foundation Trust (CIFT) to formalise the arrangements for the provision of mental health beds on the hospital site, which would include the transfer of part of the site to CIFT and secure funding to enable the relocation of any services affected by the development. A final agreement would be brought back to the Trust Board for approval.

5.0 Estates Transformation – Communication, Engagement, Co-production

To prepare a deliverable vision for the future estate we need to work with our patients; staff; local communities; fellow providers of care; and service commissioners to deliver solutions that support the delivery of outstanding clinical care; integrate health and social care; and improve the health and well-being of our local populations.

The Trust has already established a number of important partnerships, relationships and networks, and will both build on these, and establish new ways, to engage widely to develop viable solutions that maximise the benefits for our local communities.

The Trust has identified a number of key priority areas and will further consider our estate transformation requirements through the project. Key priorities identified to date include: modern, fit-for-purpose maternity and neonatal facilities; child-centred community children's facilities; modern community-based facilities that support and deliver integrated care, closer-to-home; and high quality staff accommodation.

We have recently presented our approach to the transformation of the estate to the Islington Health and Social Care committee and to the Haringey and Islington CCG Governing Bodies.

6.0 Recommendations

The Trust Board is asked to:

i) Consider the progress with the Estates Transformation programme
ii) Approve the establishment of the Estates Strategy Delivery Board as a sub-committee of the Trust Board
iii) Note the arrangements put in place to deliver the masterplanning, estates strategy and strategic outline case project
iv) Receive the current budget position
v) Approve the continuation of work with CIFT to formalise the arrangements for the provision of mental health beds on the hospital site, which would include the transfer of part of the site to CIFT.

Trust Board
31 October 2018

Title:	**Quarter two delivery of 2018/19 strategic goals**		
Agenda item:	**18/152**	**Paper**	**11**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Background** Board members Executive Team members are presented with the quarter two outcome for the delivery of 2018/19 strategic goals.		
Summary of recommendations:	The Trust Board is asked to: i. review the outcome at quarter two against progress with delivery of key Trust goals; and ii. note that the quarter three report will be amended to include metrics, where possible.		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	Board Assurance Framework and Integrated Performance Report		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Relevant risks are captured in risk registers and/or the Board Assurance Framework		
Date paper completed:	23 October 2018		

Authors name and titles:		Swarnjit Singh, Trust Secretary and executive director leads		**Director name and title:**		Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Date paper seen by EC		**Equality Impact Assessment complete?**	n/a	**Quality Impact Assessment complete?**	n/a	**Financial Impact Assessment complete?**	n/a

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

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

Our Values:

Our objectives:

2018/19 Strategic Goals' scorecard

Whittington Health Strategic Goals	Sub priorities	Comments
1. To secure the best possible health and wellbeing for all our community	Improve our clinical effectiveness as outlined in the quality account.	1. Patient Flow – some of the priorities achieved, more work to embed criteria led discharge from hospital wards. 2. Clinical Research - more work needed around number of nurses, midwives and AHPs identified as being involved in clinical research. Reporting to quality committee 3. Education and learning – progress made on education survey more work to do
	Deliver the better births action plan	WH is part of LMS (local maternity services) and are leading on one of 'continuity of care' which is one of the elements of the LMS action plan. Target by March 2019 is for 20% (aggregated across the sector) of women booked onto continued care pathway. The key challenge will be around intrapartum care and will inevitably involve review of staffing model. Funding available for project management on submission of action plan (December 2018). On track with timescale.
	Move community children's services from 'Requires Improvement' to Good	Out of the 62 actions for Children & Young People (CYP) Integrated Clinical Service Unit (ICSU) in the Care Quality Commission (CQC) action plan, 7 are currently rated yellow. These are: meeting mandatory training targets; meeting appraisal targets; community service wait times; redesign of community paediatric services; improving condition of estates – Northern Health Centre and St Ann's; separate area for CYP in outpatients' department; Simmons House Incident Reporting Policy.
2. To integrate and coordinate care in person-centred teams	Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP	The Chief Executive now leads the North Central London (NCL) workforce group. We are now working with councils and GPs on locality focussed population health transformation in Haringey & Islington.
	Develop our community teams around the emerging neighbourhoods and CHIN networks	We have now nominated a WH lead for each Closer to Home Integrated Network (CHIN) and are setting up team workshops for the CHINs.
	Collaborate with UCLH and other NHS providers to improve efficiency and resilience	Maternity teams are meeting to go further with the collaboration, breast service change stalled due to business case difficulties but is beginning again, joint Lower Urinary Tract Service (LUTS) consultant appointed. Further work being done with bariatrics

Whittington Health Strategic Goals	Sub priorities	Comments
	Maintain treatment and waiting time standards for our mental health patients	• Ongoing weekly monitoring of mental health waits – update and assurance at A&E Delivery Board meeting. • Maintain and monitor correct escalation processes are maintained in hours and out of hours • Optimise use of Mental Health suite – instigated weekly teleconference with senior Camden & Islington team to monitor progress against expected improvement.
3. To deliver consistent, high quality, safe services	To move from Good to 'Outstanding' in our CQC rating.	Reporting to Quality Committee and the Trust Board on quarterly basis on preparation for future CQC inspections. Prep planning meeting underway. Building information pack on how to get to outstanding by using the key lines of enquiry. Integrated Clinical Service Units are completing self-assessments. Internal Audit on CQC actions to be completed 2018/19
	Improve patient safety through achieving the priorities of the quality account	• These improvements are monitored through the monthly Patient Safety Committee • Assurances provided to the Trust Board through the Quarterly Quality and Safety Board Report • Significant measurable progress is being made with all of the Quality Account priorities, as reported in the public Trust Board paper Quarter 2 2018/19 Quarterly Quality and Safety Board Report
	Deliver actions to meet CQC areas for improvement	A small number of actions remain amber-rated.
	Improve community services	Community services improvement group (CSIG) in place since March – good progress with adult community services supported by dedicated project management resource. Separated CYP from Adults CSIG so that more focus can be given to specific challenges within CYP community. Increased Project management resource in place from 22nd October
	Deliver quality improvement plans to support achievement of four-hour target	Focus on key improvement at front of house to improve time to treat and flow through department. Focus on reducing length of stay through a number of improvement initiatives including MADE, SAFER and whole systems working, Year to date performance is 89.2%

Whittington Health Strategic Goals	Sub priorities	Comments
	Achieve cancer and referral to treatment national standards	• Key focus on diagnostic capacity more specifically endoscopy. Part of Cancer collaboration Quality Improvement (QI) action learning set to support improvement in pathway. • 62 days prostate cancer – working with NCL CC to reduce variation - plan to get agreement in early November • Refocus cancer PTL, supported by weekly dashboard with monitoring at trust operational meeting • Cancer 2 weeks compliant in Q1; 62 days non-compliant
4. To support our patients and users in being active partners in their care	To deliver the refreshed patient experience strategy	Some delay to delivery reporting to the next Patient Experience Committee meeting
	Ensure patients representatives are included in quality improvement projects and service redesign	Work underway to engage people with lived experience in Q4 (2018/19)
	Ensure patient representatives are equal members on board sub committees	Patient representative on Quality committee and patient experience committee further work needed for other Trust Board sub committees.
	Expand our supported self-management approach to one or more additional areas within Whittington Health (e.g. rheumatology) and measure impact	Business manager for prevention due to start on November 1st. AS and service to agree capacity for Whittington Health prevention projects.
	Become a recognised expert provider of prevention and supported self-management services in adults and children	• Appointed Trust Smoking Cessation Lead. • Business manager for prevention due to start November 1st. Capacity for new business and income target to be agreed at CIP board and Trust Board Challenge Day

Whittington Health Strategic Goals	Sub priorities	Comments
5. To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research	Continue to host the Haringey and Islington CEPN.	Community Education Provider Network (CEPN) procurement is complete and contracts have now been signed
	Develop the multi-professional integrated education work for WH and others	• An increasing number of multi-professional educational meetings and initiatives are being held, and these are often explicitly linked with patient safety learning • Moodle is being continuously improved and developed as a platform for multi-professional education • The Whittington Health Library Service provides initiatives both within and outside. Whittington Health to promote multi-professional learning; a recent example is work with Islington Council and its Library Services.
	Continue to be recognised as an excellent education provider	A joint initiative has been led by the medical, nursing and workforce directorates to refresh the Whittington Health Educational Strategy; it is anticipated that this work will proceed through 2018/19.
6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	Expand Quality Improvement training	• The trust has created and appointed to Associate Director of Quality Improvement • The trust continues to roll out the Quality Improvement strategy • The number of staff being training in Quality Improvement is continually increasing
	Develop the generic worker roles with the local authorities	This is going to be part of the locality working groups for East Haringey and North Islington but it is a longer term issue.
	Begin to integrate physical and mental health roles and services	Developing further relationships with Camden & Islington and Barking Enfield & Haringey. to possibly move onto our land. Locality work to include mental health.
7. To recruit and retain high quality engaged staff	Plan and deliver actions to deal with the issues raised in the culture survey	Listening events being undertaken through October and November with an agreed action plan to be ratified by Trust Board by December 2018.
	Recruit and maintain	Ongoing recruitment initiatives for nursing and midwifery staff with resources for

Whittington Health Strategic Goals	Sub priorities	Comments
	sustainable workforce reducing turnover and maintaining at lower levels	dedicated team and overseas recruitment identified for 2019. A new Clinical Recruitment and retention Group co-chaired by the Chief Nurse and Director of Workforce meets in October and will identify a calendar of initiatives for all non-medical staff
	Reduce sickness and absence rates	Targeted challenge at quarterly performance review meetings along with monthly action by ICSU and Directorate Boards
	Improve quality of appraisals	Targeted challenge at quarterly performance review meetings along with monthly action by ICSU and Directorate Boards. Each ICSU now has its own trajectory and appraisal paperwork being reviewed
8. To deliver efficient and financially sustainable services	Deliver £16.5m savings through CIPs to deliver 2018/19 control total	£5m savings at month 6. Schemes up to £16.5m identified – risk adjusted to £12.5 -
	Reduce agency / bank spend	Trajectory to achieve agency ceiling has been agreed with each ICSU. Continued weekly monitoring by executive team
	Use Carter measures to improve productivity, including e-rostering and back office	Carter measure used by Programme Management Office (PMO) and wider corporate services to identify potential productivity gains
	Use GIRFT and Model Hospital to identify improvement priorities	Model Hospital & Getting It Right First Time programme used by PMO and wider corporate services to identify potential productivity gains
9. To deliver innovative estate, IT and other support services that enable the clinical objectives	Deliver strategic estates plan and link to NCL STP	Estates Master Plan being developed and the Trust is working with the NCL Sustainability & Transformation Partnership (STP) on wider Estates Strategy
	Progress digital fast follower projects	On the 17 October the Trust went live, as planned, with the first element of the Fast Follower programme recording observations electronically in Careflow Vitals using mobile devices within the Care of the Older Adult Unit. The roll-out will continue through the Autumn to cover inpatient areas. The programme will also start to ramp up as planned to develop the systems for clinical noting, closed loop medicines management and clinical communications and handover.

Trust Board
31 October 2018

Title:	**2018/19 Winter Plan**		
Agenda item:	**18/154**	**Paper**	**12**
Action requested:	For agreement		
Executive Summary:	The winter plan describes Whittington Health's preparedness for the winter 2019/20 and provides assurance that the organisation will be able to respond to any seasonal pressures working collaboratively with key partners. The main components of the plan include: 1. Review of Winter 2017/18 2. Winter Preparation 18/19 part 1 / part 2 3. Building Resilience		
Summary of recommendations:	The Trust Board are asked to agree the contents of the plan.		
Fit with WH strategy:	Deliver consistent, high quality, safe services		
Reference to related / other documents:	Full Capacity Protocol		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risk assessment attached within appendices		
Date paper completed:	22 October 2018		

Author name and title:		**Carol Gillen, Chief Operating Officer**		**Director name and title:**		**Carol Gillen, Chief Operating 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**

Whittington Health
NHS Trust

Winter Plan 2018/2019

Version Control	
Version 1	Trust Operations Meeting – 11th October 2018
Version 2	Executive Team – 15th October 2018
Version 3	Trust Management Team - 16th October 2018
Final version	Trust Board - 31st October 2018

Carol Gillen, Chief Operating Officer - October 2018

Contents

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Section

1.0 Introduction

This Winter Plan describes Whittington Health's preparedness for the winter season. Winter presents a variety of challenges that require additional consideration and planning to maintain flow and keep patients safe. This plan has been developed by engaging with the Associate Directors of Nursing, Clinical Directors, Operational Directors and the Emergency Planning Officer. The Winter Plan is a system wide approach and is focused on ensuring that internal operational functions are coordinated with support from external partners. The Winter Plan's elements include monitoring and managing patient surge; protocols for opening emergency capacity; operational initiatives; service improvement innovation; digital technology and monitoring; command and control mechanisms; integrated communication groups and work force planning.

1.1 Aims

Keep patients safe and provide high quality care during the winter months within Whittington Health. Ensure that patients are cared for by the right team in the right place.
Minimise any disruption to operational delivery.

1.2 Scope

The scope of this plan is focused on Winter Planning within Whittington Health and partner agencies. The Winter Plan will include aspects such as leadership and surge management, coordination with the A+E Delivery Board (AEDB), the improvement plan, NHS Elect winter review 2017/2018, winter capacity, key system enablers, and risks.

1.3 Objectives

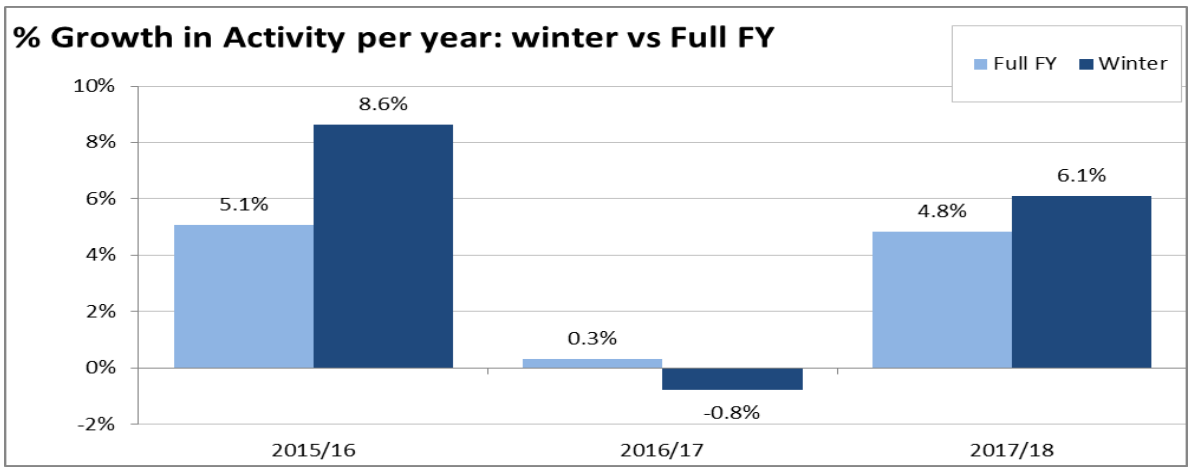
- Avoid unnecessary admissions during the winter months by providing care pathways that deliver safe and efficient care
- Ensure appropriate capacity is available during the winter months
- Monitor and regularly engage with the CCGs, Islington A+E Delivery Group and NHS to provide information, identify risks, communicate plans, monitor sector wide pressures, escalate issues, and challenges to performance and operational delivery.
- Support and focus on performance management of the system to sustain, quality, delivery against plan and good patient experience.
- To clearly identify and direct resources to respond to surges and peaks in demand for services 24/7.
- Coordinate operations efficiently and effectively within and between ICSU teams.
- To maintain flow and optimise safe discharge within the ICO.
- Provide timely communication to all stakeholders.

2.0 Review of winter 2017/18

	Key elements winter 17/18	Impact
1	Better coordination and escalation across the system with system partners	Improved flow and engagement with partners
2	Better planning and definition of key responsibilities e.g. flow coordinators, medical teams for escalation beds.	Better support and engagement with clinical teams More coordinated care
3	Developed and embedded full capacity protocol	Supported ED department in terms of flow and optimizing space. Teams able to anticipate operational challenge through regular SitRep.
4	Flu campaign	Positive uptake with Whittington Health staff
5	Additional funding (Q4)	Increased capacity to support flow and primary care capacity in ED Grip on pressures post bank holiday
6	Perfect Week – post bank holiday (peak pressure). Implemented weekly MADE events with partners	Better coordination of delayed transfer of care and significant reduction of super stranded patients in Q4.
7	System Wide Operational Escalation	Regular situation reporting within the Emergency Department Setting. Specific roles and actions in relation to operational escalation.

2.1 EUC Activity/4hr Target

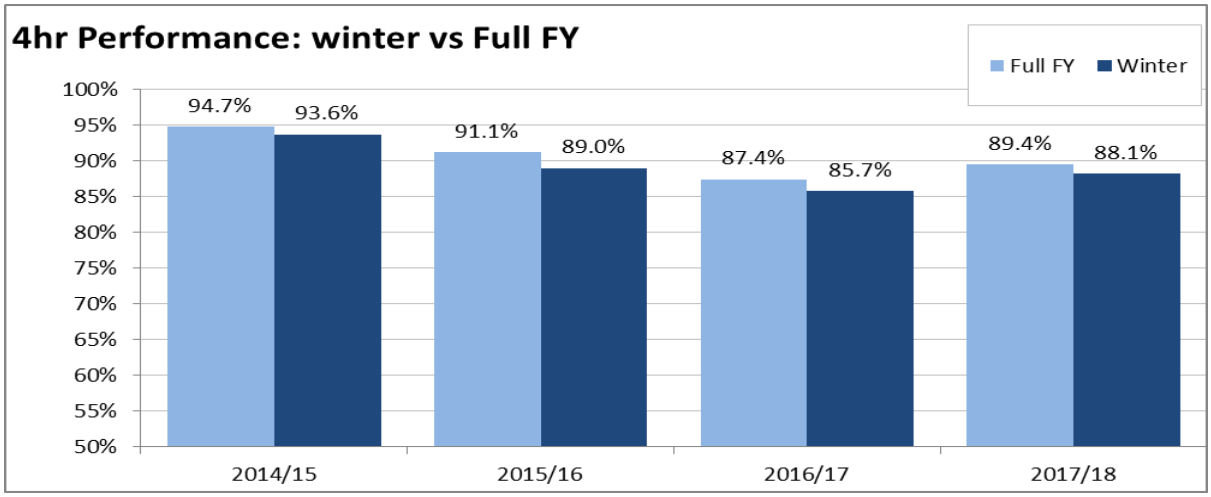
Fig 1



Since 2015 there has been an 11% increase in presentations to the EUC. There has been has an overall increase in winter presentations to the EUC of 14% since 2015. Since 2017 to winter 2018 there has been a 6.1% increase in presentations to the EUC.

2.2 4hr Performance: Winter vs Full FY

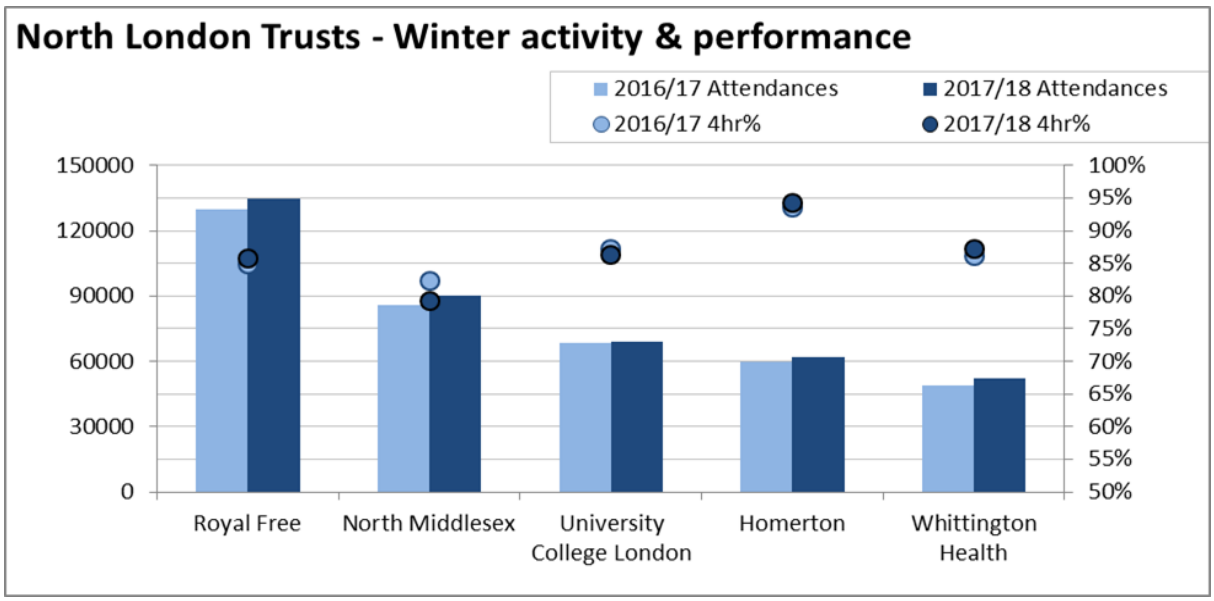
Fig 2



The average 4hr target to be seen and discharged from the EUC has decreased by 6% since 2015. Last winter 2017/2018 there was a 2.8% improvement in performance of 88.1% when compared against 2016/2017.

2.3 North London Trusts – Winter activity & Performance

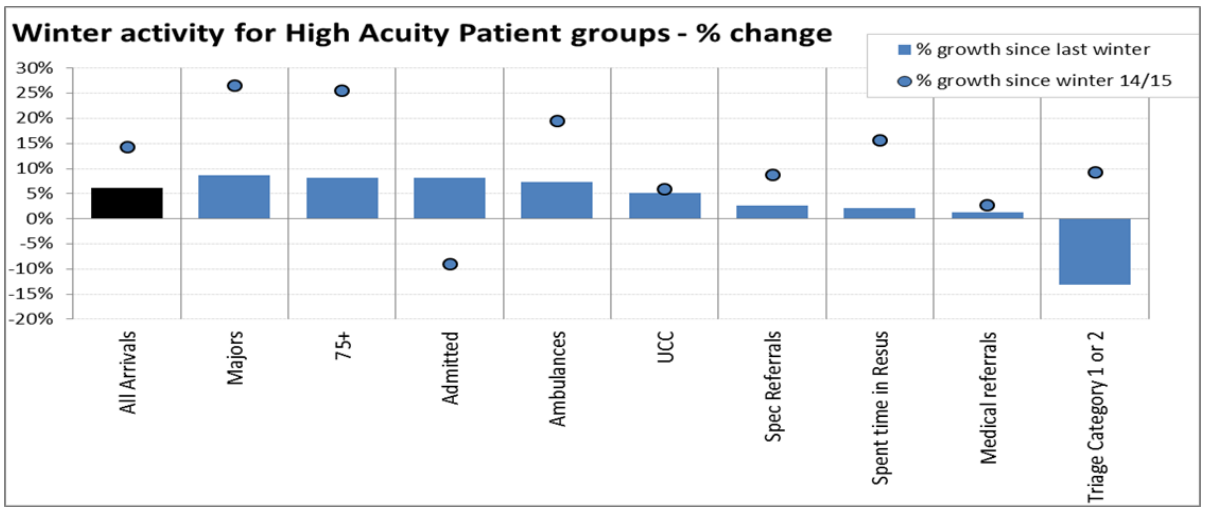
Fig 3



All hospitals in North Central London had an increase in patients to EUC in 2017/2018. Whittington Health NHS Trust, The Royal Free Hospital and Homerton Hospital show improved performance during winter in 2017/2018 when compared to the previous year.

2.4 Attendance by High Acuity Patient Groups

Fig 4



2.5 Attendance by High-Acuity patient groups (Winter only Oct-Mar)

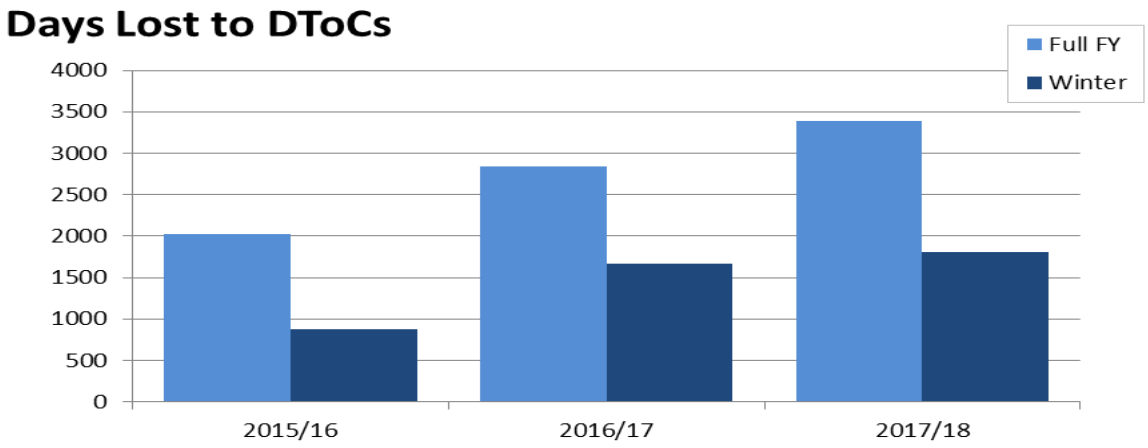
Fig 5

	Activity				% change			
	2014/15	2015/16	2016/17	2017/18	2015/16	2016/17	**2017/18**	**since 14/15**
All Arrivals	37539	40778	40455	42926	8.6%	-0.8%	**6.1%**	**14%**
Majors	15389	16097	17918	19464	4.6%	11.3%	**8.6%**	**26%**
75+	3171	3310	3682	3981	4.4%	11.2%	**8.1%**	**26%**
Admitted	7482	6276	6293	6804	-16.1%	0.3%	**8.1%**	**-9%**
Ambulances	7400	7808	8240	8841	5.5%	5.5%	**7.3%**	**19%**
UCC	21850	24303	22012	23135	11.2%	-9.4%	**5.1%**	**6%**
Spec Referrals	7910	8086	8384	8606	2.2%	3.7%	**2.6%**	**9%**
Spent time in Resus	1928	1897	2182	2230	-1.6%	15.0%	**2.2%**	**16%**
Medical referrals	3076	3095	3116	3158	0.6%	0.7%	**1.3%**	**3%**
Triage Category 1 or 2	2906	3270	3656	3177	12.5%	11.8%	**-13.1%**	**9%**

In 2017/2018 there was a 7.3% increase in London Ambulance Service presentations since the previous year. Overall there was a 6.1% increase in presentations since 2016/2017. Since 2014/2015 there has been 9% increase in high acuity CAT1 and CAT2 patients, although last year from 2016/2017 saw a decrease of 13.1% high acuity patients. There was an increase in attendances in the over 75 age group.

2.6 Days lost to DTOCs

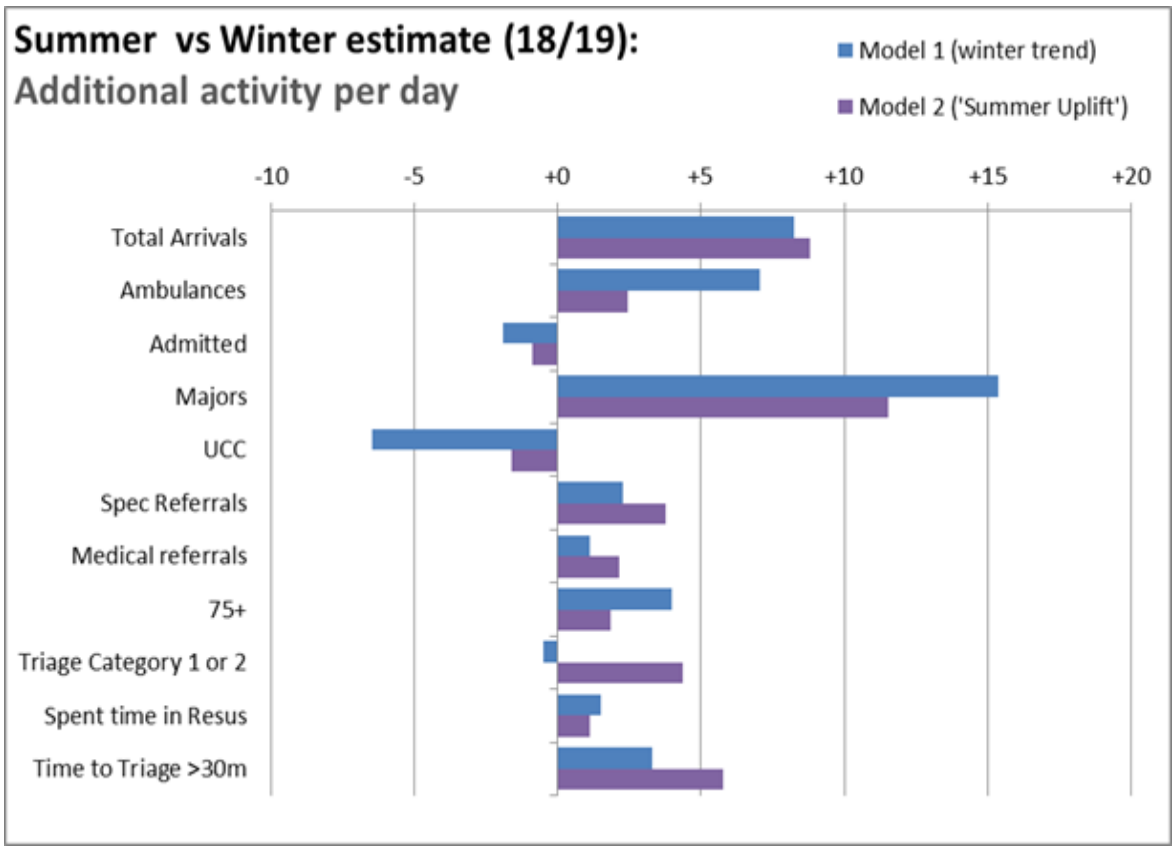
Fig 6



In the 2017/2018 winter period there was a 8.7% increase in days lost from Delayed transfer of Care. Since 2015 there has been a 105% increase in days lost from Delayed transfer of Care.

2.7 Additional Activity Summer Vs Winter

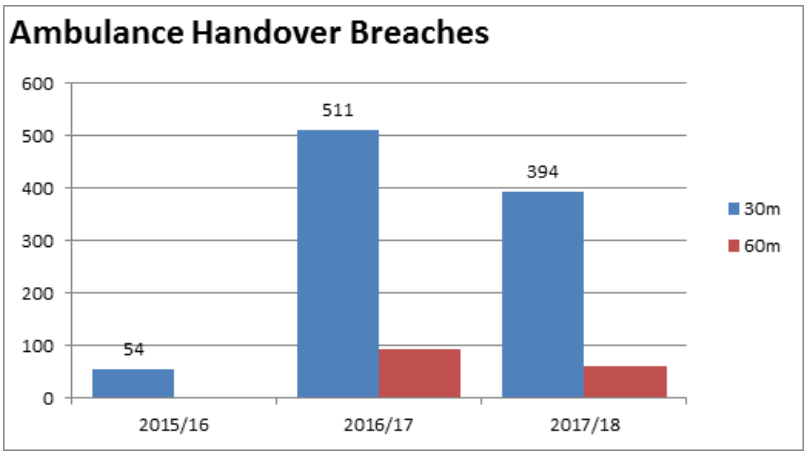
Fig 7



Inferential statistics estimate that activity this winter will increase on the previous year. On average it is estimated that there will be an increase of (n) 8 patients per day during 2018/2019 winter. It is estimated that Majors will see and additional (n) 15 patient per day during 2018/2019 winter. The statistics indicate that there will be an increase in specialty referrals, medical referrals, over 75 years presentations and increase demand for the use of the resuscitation area.

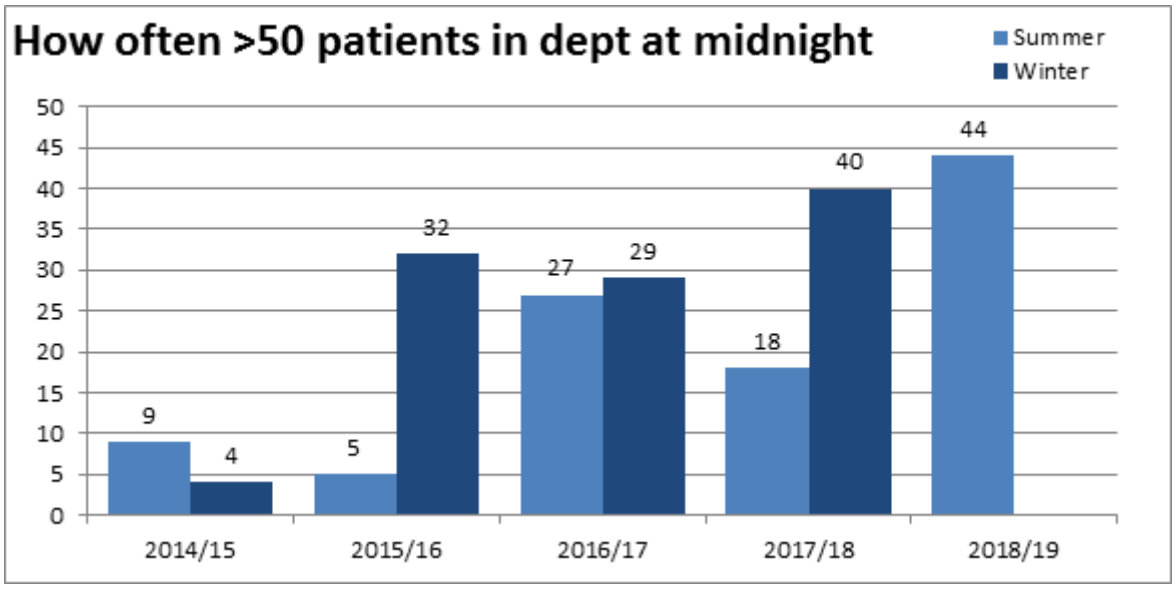
2.8 Ambulance Handover Performance

Fig 8



2.9 Increased Numbers of Patients in the EUC at Midnight

Fig 9



The frequency of patient numbers greater than (n) 50 has increased from (n) 29 occurrences in 2016/2017 to (n) 40 occurrences in 2017/2018 showing a 27.5% increase.

2.10 Review of Winter Performance 2017/2018

- Attendances rose by 6.1% when comparing October to March 2016/2017 with October to March 2017 total EUC.
- The number of patients triaged for ED (Majors) rose by 8.1% in 2017/2018
- There have been an increase in presentations in winter 207/2018 in comparison to the previous year. Ambulance activity increased by 7.3%, UCC activity increased by 5.1%, time that patients spent in the resuscitation area 2.2% and Increased patient presentations over the age of 75 year 8.1%.
- A&E data shows a 8.1% increase in the total number of patients admitted in winter 2017/2018 compared to the previous year.
- Bed days lost to Delayed Transfers of Care rose by 8.7% in the 2017/2018 winter period when compared to the previous year.
- Year-end performance for 4-hour wait showed improvement of 2.8% with an average of **88.1%** during 2017/2018 winter when compared to the previous year**.**

3.0 Winter Preparation 18/19 *(part 1)*

In developing our overarching winter plans, Local A&E Delivery Boards were asked to focus on the following:

- Demand and capacity plans
- Front door processes and primary care streaming
- Flow through the UEC pathway
- Effective discharge processes
- Planning for peaks in demand over weekends and bank holidays
- Ensuring the adoption of best practice as set out in the NHS Improvement guide: *Focus on Improving Patient Flow.*
  17-18-winter-planning-letter.pdf *(letter from Pauline Philip, National Urgent & Emergency Care Director, NHS England and NHS Improvement)*

3.1 Demand and Capacity

The Trust worked with ECIP Bed Modelling in early Q1 to better understand Demand and Capacity and to inform the 18/19 bed plan. This identified a gap in care of the elderly beds given the demographic changes. The bed modelling tool informed the configuration of beds for this winter with the plan to do further work that will require structural change which will inform a more flexible and efficient bed plan for 2019/20.

The Trust repeated the bed modelling exercise in the summer period which showed that there is a gap in care of elderly beds. Based on LoS, and factoring in some improvement, the EIM ICSU require a total medical bed complement of ~160 beds with an ability to manage periods of surge. Pending further work is ongoing regarding a longer term refashioning of in-patient wards, the agreed in-patient bed profile for the winter period is summarised below.

Ward	Main specialty	No. of beds	Consultant cover	Lead Clinician	Comments
AAU (Mary Seacole N&S)	Acute Medicine	34	Acute Physicians	Dr Ip	Will be managed as an single unit
Nightingale	Respiratory	21	Respiratory Physicians	Dr Lock	
Montuschi	Cardiology	16	Cardiology Physicians	Dr Brull	
Victoria	Haematology Gastroenterology + Gen Medicine 'Step down'	10 16 7	Haematologists Gastroenterologists	Dr Davis Dr Lerman	
COOP unit (Incorporating Cloudsley, Meyrick, and Cavell)	Care of Older People	63 with flex capacity to 73	COOP Physicians	Dr Law	Will be managed as an integrated unit

Coyle	Surgery	31			Medical outliers will be managed by the COOP team unless additional COOP beds opened in which case it will be the Endocrine team (tbc)
Mercers	Surgery	16			
Thorogood	Surgery	10			

3.2 Criteria for opening additional bed capacity

From the 1st October the additional beds are in a state of readiness however the intention is to delay opening until required. The trust will monitor the need for any additional capacity using the following metrics: - (*captured in the daily SitRep report*)

- More than 8 patients in AAU with a LOS >48 hours
- 2 or more critical care patients delayed more than 4 hours for transfer to a ward
- DTOC rate of >3%
- 7 day stranded patient rate of >40%
- 21 day stranded patient rate of >15%

More than 5 patients in ED with a DTA without an allocated bed

***Sustained over 5 days*

3.3 Full Capacity Protocol Update (EMERGO)

Training sessions started in September and will be continuing throughout October.

The Escalation and Full Capacity Protocol is designed to facilitate command and control functions within the Emergency Department and Urgent Care Centre (EUC) to ensure delivery of high quality care in a safe environment for all patients. It stipulates the process for monitoring operational performance within the EUC. The monitoring of operations by key personnel within a command structure will trigger actions to be considered and applied when there is increased service demand that is over and above that expected *(i.e. crowding in the department).*This may be driven by patient number or acuity or a mixture of both. The demand for service will be quantified within specific escalation ranges. The escalation ranges are Green, Amber, Red and Black. In the event of overcrowding in ED there are **9 Plus One Beds** that can be opened under exceptional circumstances, to maintain patient safety. The process for using the 9 Plus One Beds is outlined within the Full Capacity Protocol

In the event of a significant patient surge in winter triggering OPEL Level 3, Associate Directors of Nursing will be able to open 9 Plus One Beds to reduce overcrowding in the ED

The Plus One beds are located in the following areas:

Location	Number of Beds
MSS-Side Room 16	1 Bed
Mercers + Nightingale **	(1 Bed each bay =4 Beds) HDU excluded opening
Meyrick staff room	1 Bed
Cavell day room	1 Bed
Coyle staff room	1 Bed
Monthuschi day room	1 Bed

In the event of ED triggering RED in the operational escalation levels, staffs have been trained to establish an Incident Coordination Team in hours, with the aim of system wide response to reducing overcrowding within the EUC. The Director of Operations for EIM will task Associate Directors of Nursing, Directors of Operations and Clinical Directors to lead the response and implement actions from the Full Capacity Protocol in their respective areas.

3.4 Community Winter Resilience Response

During this winter there will be additional contingency in place for community providers to enhance flow throughout the system. The community and system will have Operational Pressure Escalation Levels in place. Within the system and community there will be triggers for OPELs (Operational Escalation Levels 1-4). OPEL levels will specify what actions are required to focus on delivering safe and timely dis charge into the community. Key community members will be integrated into the winter escalation communication system, which will provide contemporaneous alerts. The alerts will notify community staff of OPEL Levels which will be the impetus to initialise the actions required on each level. There will continue to be resilience workshops and simulation exercises to test Operational Escalation in the lead up to winter for community providers.

3.5 Front door improvements – (Emergency Department Streaming and Rapid Assessment and Treatment Model (RAT)

An enhanced streaming model is in place led by the lead ENPs. The pathway allows for a quick assessment of every patient (0800 – 2000) by a senior nurse with the aim to ensure they are streamed to the most appropriate treatment area (UCC, AEC, Primary Care, RAT). This creates flow within the department allowing for the timely treatment of patients and an enhanced patient experience.

Medical led RAT – Patients who arrive by ambulance have access to a Doctor on arrival between the hours of 1100 and 1700. This allows for increased streaming to Ambulatory care, timely initiation of the frailty pathway and timely initiation of any necessary diagnostic tests and treatments. An occupational therapist is part of this MDT to provide holistic care at the front door.

There is increased capacity of GPs in the UCC in the evenings in order to meet the demand on primary care services.

Increased capacity in the Ambulatory Care unit at a weekend has been identified for the winter period. This is to allow for increased streaming to AEC over the weekends creating more flow throughout the department.

Plans to reduce barriers and differences in service provision in the Virtual Ward and rapid Response teams across Islington and Haringey are in place to maximise attendance and admission avoidance and facilitated discharge meaning patients can remain in their own home and receive the necessary treatment, where clinically appropriate.

3.5.1 Acute Frailty

The Acute frailty pathway is in place and is currently being embedded into normal practice. The pathway consists of patients being given a Rockwood score at Triage, being assessed with a 'home first' approach and then moved to Ambulatory Care (AEC) if not for clear admission. In AEC the patients are reviewed by a MDT with the aim to avoid an admission and put in place appropriate care plans for the patient to remain at home where clinically appropriate.

3.5.2 Occupational therapy at front of house

ED has access to the START team who assess patients with frailty and other therapy needs in the department with a 'Home First' attitude with the aim to avoid admission.

3.5.3 Mental Health Recovery Suite

The Mental Health Recovery Suite is in operation for 24 hours per day allowing for suitable patients to be assessed and referred / treated away from the main Emergency Department. This facilitates flow in the ED and gives a therapeutic environment for people to be in when they attend the ED with a MH concern. There is a designated lead nurse for the MH suite in order to ensure maximum utilisation of the suite.
Weekly operational calls are in place to monitor activity and optimisation of unit

3.6 Effective Discharge Processes

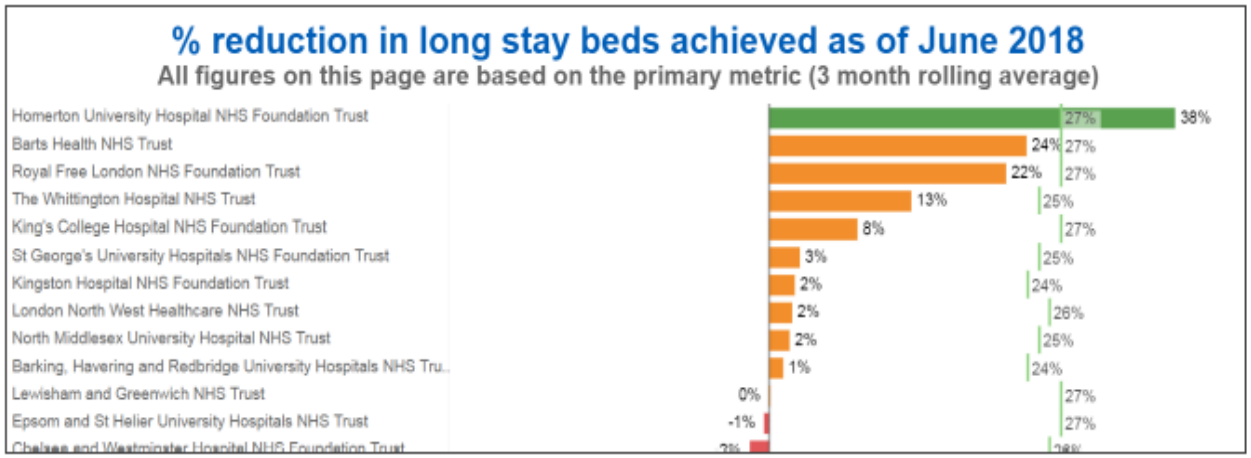
3.5.1 MADE events

The Trust has been using Multi Agency Discharge Events (MADE) since December 2017. The aim of the MADE is to review "Stranded patients" (including delayed transfers of care (DTOC) to understand what the plan is and what is the next thing that these patients are waiting for on the day of review. The review captures both qualitative and quantitative information on the reasons for the wait, with a report compiled from all the material gathered, and should aim to:

- Understand why patients are in hospital for seven days or more
- Identify themes, where possible
- Identify patient characteristics so patient groups can be identified early
- Identify areas of good practice
- Identify areas requiring focus where there is the opportunity for improvement.
- Number of improvements have been made since January 2018:
    - *Internal assessment delays have reduced*
    - *More patients are being identified for discharge for the following day*
    - *Identified that external beds delays e.g. waiting for a care home bed contribute to 35.7% of all delays*
    - *Reduction in DTOC average beds days lost from 12.8 days December 2017 to 7.1 days by June 2018.*
    -

3.6.2 Length of Stay Reduction

Fig 10



The Trust has an ambition to reduce the number of beds occupied by patients in hospital for 21 days or more. In April 2017, The Trust had 48 such beds by December 2018 it aims to have 36.

Last validated data (June 2018) shows that there were 42 beds occupied, which is equivalent to a 13% progress towards achieving the target. The Trust is progressing at a relatively fast pace towards the ambition compared to other trusts in London. (*Healthy London Partnership Report august 2018*)

3.6.3 Flow Co-ordinators

Using best practice the Trust has now fully embedded a team of Flow Co-coordinators FLO (W) s to work between key wards and the clinical site team using **'Red to Green'** methodology. This approach helped the FLO(W) team identify factors contributing to reduced movement; proactively troubleshoot and remove blockages; and to provide appropriate information and escalation to enable clinical and operational teams to deliver safe and timely discharge and admissions. These posts are the main part of the discharge planning team and support the overall patient flow function. The Flow co-ordinators have a discharge checklist for each patient that is used to identify any barriers that may impede flow. Daily reviews of patients are carried out using MADE principles and national codes to identify delays. (Appendix 4 - EDD).
The role of the Flow Co-ordinator is to:-

- Escalate delays with DTOC's and MO's to key stakeholders.
- Escalate delay issues and actions to partners internal and external to Whittington Health.
- Participate and support discharge planning processes.
- Establish daily and next day lists of patients to be discharged.
- Communicate with Site Practitioners when beds become available in wards.
- Highlight patients whom have a length of stay over 7 days
- Highlight patients whom have a length of stay over 2 days on the Seacole wards.
- Prepare the whiteboard and attend the board round
- Establish situation reports and continually update Medway
- Complete any urgent actions from the access sitreps meeting.

4.0 Adopting Best Practice – Gap Analysis

The Gap analysis.docx conducted over the summer months (see link) is based on the NHS Improvement Guide to Reducing Long Hospital Stays and examines how the Trust is currently using the schemes it suggests or how we could implement schemes we are not currently using. This has and will continue to be the focus of sustained improvement.

4.1 Intermediate Care

Improvements in discharge planning

Refresher training including CRIB sheets will be provided to all wards over the next four weeks given the many improvements that have been progressed through the pan sector Simplified Discharge working group. This includes Discharge to Assess (D2A), Single point of access (SPA) and the Choice policy.

Information will also be refreshed on the Whittington Health intranet discharge planning page http://whittnet.whittington.nhs.uk/default.asp?c=6874 by mid/end of October and also cascaded to staff groups involved in discharge process.

Communication for patients will also be provided reflecting the above improvements and including changes to the STP agreed Choice Policy.

A number of workshops have been held with key stakeholders over the summer months to progress plans to fully optimise equal access to all Haringey and Islington Intermediate Care Beds. The expectation is that this will be in place by the middle of November.

Islington	**Beds**	**Haringey**	**Beds**
St Pancras	**21**	Bridges	**14**
St Anne's	**5**	Priscilla Wakefield	**10**
Mildmay	**12**	Protheroe	**10**

5.0 Cold weather plan

This winter the Cold Weather Plan V 1.6 will be insitu. This will instruct the acute and community teams within Whittington Health NHS Trust on how to prepare, respond and recover from Cold Weather. The Cold Weather Plan identifies how the trust will escalate, communicate and coordinate mitigations during any prolonged cold weather conditions. When the Cold Weather Plan is activated it enables staff to activate business continuity arrangements, receive and cascade Met Office Notifications, comply with external reporting requirements, identify and respond to vulnerable patients and support staff to access and deliver safe quality care.

As in previous years, the Cold Weather Plan for England is also supported by a series of Information Guides published online which aim to provide an authoritative source of additional information about the effects of severe cold weather on health for:

- Making the case: why long term strategic planning for cold weather is essential to health & well being
- GP in hours bulletin
- Action Card for provider organisations
- Keep warm keep well booklet

These can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/652564/Cold_Weather_Plan_2017.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561101/Keep_warm_keep_well_leaflet_2016.pdf

https://www.gov.uk/government/publications/gp-in-hours-bulletin

https://www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465111/Top_tips_to_keep_warm_keep_well.pdf

www.nice.org.uk/guidance/ng6

http://whittnet.whittington.nhs.uk/default.asp?c=6988

6.0 Winter Preparation 18/19 *(part 2)*

6.1 (NHSI Emergency 4 hour trajectory and (STF) requirements)

NHSI STF monthly trajectories

In March 2018 the organisation agreed monthly trajectories for the four hour wait target with NHSI in line with the national communications from NHSE/I The trajectories were met in M01; M02 however the trajectories were not met in the following months up to and including September.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan %	91.1	93.5	92.4	92.2	91.0	90.0	90.0	90.0	90.0	90.0	90.0	95.0
Actual %	86.3	88.4	90.6	90.5	90.0	89.6	-	-	-	-	-	-

The STF guidance for 18/19 was issued to the Trust in July 18. Based on this guidance, in order to meet the 15% performance element tied to the ED 4hour wait target, the Trust needs to achieve the following quarterly performance target.

Q	4hr requirement	Achieved	£'s
Q1	92.36%	88.40%	422,100
Q2	90.89%	90.02%	562,800
Q3	90.00%	-	844,200
Q4	95.00%	-	984,900

7.0 Winter Resilience Funding 2018/19

Schemes funded through winter resilience schemes were approved at the A& E Delivery Board in August .The aim of the resilience funding was specifically aimed at community, social care and mental health providers – see below.

The expectation is that Whittington Health will use 2.3% growth funding in the 18/19 contract baseline to ensure staffing requirements from extra PbR income.

Islington Funding Proposals	**Project**	**Projected Costs**
Admission Avoidance	Additional capacity to treat people with primary care needs within the Urgent Care Centre	**£270,000**
Mental Health	Front door triage to support the acute psychiatric liaison officer	**£100,000**
Additional	Housebound flu vaccination programme	**£55,000**
Additional	System Resilience Manager for Islington CCG	**£30,000**
Total		**£455,000**
Haringey Funding Proposals		
	Support posts: out of hospital commissioner and link worker	**£168,000**
	Therapy staff to support P1 D2A (specifically for Whittington patients)	**£60,000**
	Community Therapy staff to support discharges (weekend cover)	**£84,000**
	Community nursing support for CHC discharges	**£98,000**
Total		**£410,000**

8.0 Workforce

Nursing

A total of 50 Graduate nurses have been recruited to the Trust and will be starting in clinical areas during October, November and January. This will be a considerable boost to our nursing workforce through winter.

There is ongoing recruitment of Band 5 nurses. We have always advertised these posts both for community and for the hospital. We also have targeted recruitment as required.

We have a dedicated nurse recruitment team who work closely with all clinical areas to act swiftly to clinical staffing needs. This team understands the whole landscape and works very closely with the Senior Nurse team.

We actively recruit International Nurses, and we have a contract with an agency to ensure monthly arrivals of these nurses. During the winter we expect to have around 20 international nurse arrivals.

We also have Band 4 Associate Nurses joining the Trust. We are very active in terms of nurse recruitment effectively using social media platforms such as , twitter, LinkedIn and Facebook.

Retention is a top priority for the trust, recruitment must be partnered with retention. We have many recruitment strategies including:-

- *career clinics*
- *focus groups*
- *health and wellbeing approaches*
- *length of service recognition*

Additionally we offer flexible working approaches and rotation and transfer schemes.

The trust continually acts on service needs running targeted adverts and recruitment events.

ED Middle Grade

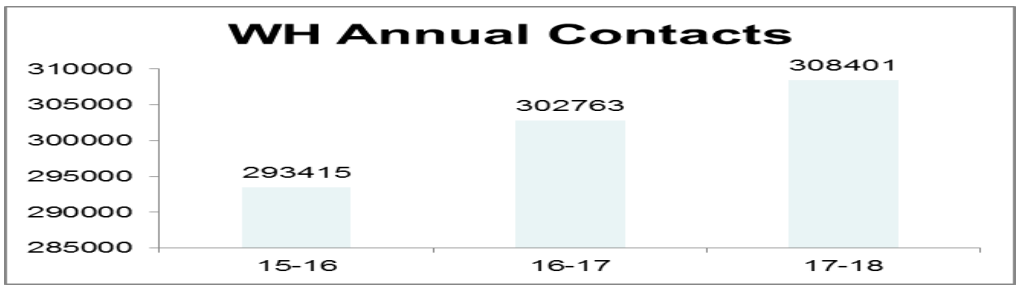
- The senior clinical and operational leads are working with medical staffing in exploring further options for fixed term middle grades to provide further resilience in middle grade rotas.

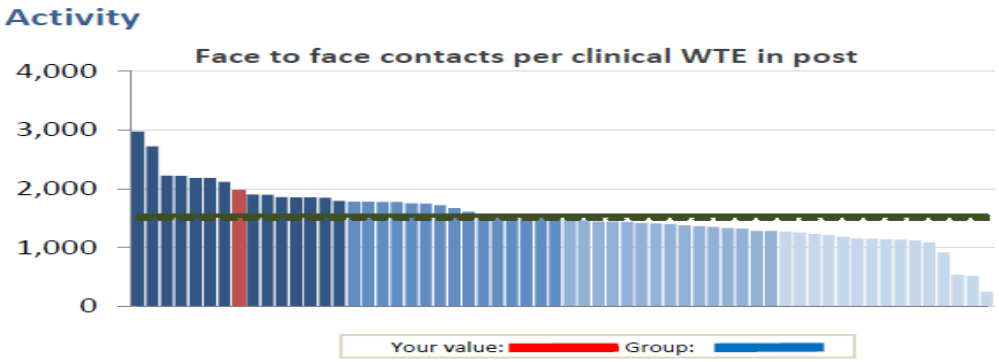
ENPs

- Following consultation with key staff from ENP from November will work to 12 midnight with the option of doing a night shift

9.0 District Nursing

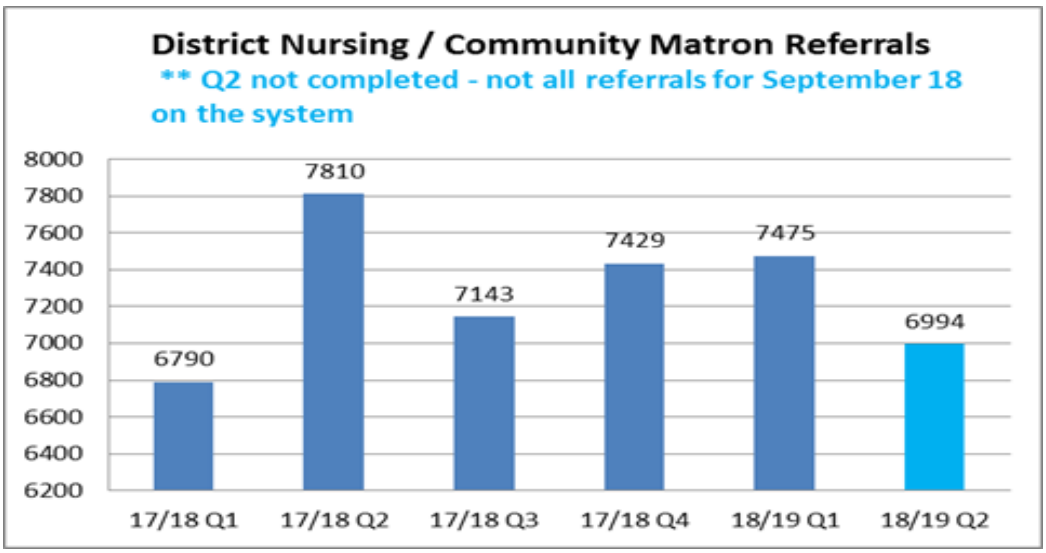
Fig 11 Activity Contacts

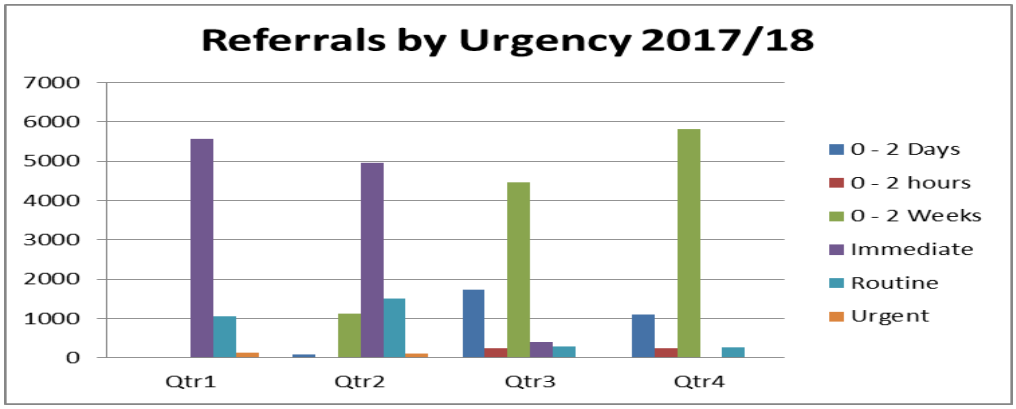




F2F Contacts per Clinical WTE post			
Service Line	Whittington Health	Mean	Percentage variance
District Nursing	1979	1541	22.13%

Fig 12 District Nursing- Activity Referrals 18/19 (to date)





The District Nursing service has completed a skill mix review and are currently recruiting in preparation for winter. In addition all teams are carrying out caseload reviews to:-

- Ensure that all patients' care is optimised.
- Encouraging a self-care approach and involving family members where appropriate.
- Moving patients who can transport to the leg ulcer clinic
- Completing a catheter audit to reduce the incident of catheter blocks
- Revising assessment paperwork to ensure this is as streamlined as possible.
- Ensure all staff to have appropriate equipment including IPads, glucometers, Sphygmomanometers.

The senior team are completing roaming flu vaccination clinics to optimise uptake. Haringey District Nursing Service have been given £96k for winter monies following a successful bid to recruit additional nurse capacity for a late to twilight shift to capture new referrals later in the day.

Islington care home team are recruiting a Trusted Assessor for care homes to allow one nurse to assess for all homes in Islington.

10.0 Community Rehabilitation Teams

The aim of the winter plan is to ensure resilience in the team, manage continuous flow from acute to the community and stop the unnecessary use of acute hospitals by clients in the community during the winter months and beyond.

The following are expected to be in place from October 2018 - March 2019

1. Close management of annual leave to ensure that services are adequately covered each day
2. Additional therapists to support D2A pathway 1 coming out of Whittington Hospital
3. Additional therapy staff to increase Haringey therapy community support and support non D2A hospital discharges within 24 hours. (Haringey resilience funding)
4. Weekend therapists to provide support for clients discharged late on Fridays and on Saturdays to prevent readmission.

Both community teams will work closely with the Haringey and Islington Community Ambulatory Care (CAC) to support the acute hospitals in supporting patients to remain at home and avoid unnecessary hospital admissions.

10.1 Community capacity – admission avoidance (CAC)

Following a service review a significant amount of work has been undertaken over the summer months looking at specific pathways across Haringey and Islington. This has led to a much more integrated service across Islington and Haringey with investment for GP capacity in Haringey.

The three elements of Admission Avoidance, Rapid Response have now been merged which will give flexibility and ease of access from both a community and acute step down perspective.

The proposal is to have a simple and concise service to provide a joint up integrated service available to those within the boroughs of Haringey and Islington, now called Community Ambulatory Care (CAC) the aim is to avoid/reduce

- Unplanned hospital admission and A&E attendances
- Reduce inpatient length of stay
- Provide sub-acute care in community setting
- Optimise patient care involving an integrated multi-professional team

The service is working specifically with GPs across Islington and Haringey to raise the profile of the team with LAS and improving the interface with District Nursing and Social Care teams. The expectation is that the team will make a real contribution on admission avoidance and reduction of length of stay over the winter period.

11.0 Elective Plan

The elective plan for 18/19 has been profiled to increase in day case activity over pinch period (post new year period) in anticipation of demand on bed capacity.

Monday I7th December – 21st December	Normal working - ratio of inpatient and day case
Saturday 22nd and Sunday 23rd December	Normal weekend working hours
Monday 24th December	Urgents only from weekend and any urgent electives such as cancer if needed
Tuesday 25th December	Public Holiday
Wednesday 26th December	Public Holiday
Thursday 27th December	Normal working both Inpatient Patient and Day Case
Friday 28th December	Normal working both Inpatient Patient and Day Case
Saturday 29th and Sunday 30th December	Normal weekend working hours
Monday 31st December	Urgents only from weekend and any urgent electives such as cancer if needed
Tuesday 1st January 2019	Public Holiday
Wednesday 2nd January – Friday 4th January 2019	Day cases to be booked only in light of probably winter pressure on beds for that particular week.
Saturday 5th & Sunday 6th January 2019	Normal weekend working
Monday 7th January 2019 onwards	Business as usual

In the event of having to cancel surgical inpatients the following protocol will be adhered to:-

All potential cancellation of surgical elective Inpatients will be reviewed by a Senior Clinician, and Director of Operations/and or Associate Director of Nursing for Surgery. This is to ensure that no patient who has already been cancelled is cancelled again, that no cancer patient is cancelled, no patient who has an extended wait for surgery, i.e.long waiter, or a patient who is at risk of breaching 52 weeks is cancelled. Before any patient is cancelled the consultant in charge of the patient will be contacted to ensure that all information in regards to the patient is known and understood so that the cancellation while although not ideal, is undertaken in a safe manner. All patients will be telephoned in advance of their surgery date and given a date as soon as possible afterwards, unless there is a problem on the day of surgery and patients have to be cancelled on the day, where normal processes for rebooking will be maintained.

12.0 Building Resilience

12.1 Winter Wash up session by NHS Elect

On the 5th June a Winter Wash up session was held and facilitated by NHS Elect, The session was well attended by various stakeholders who were able to reflect on the lessons learned from winter 17/18.

In summary there were 6 priority areas for the Trust which included:-

1. Workforce
2. Frailty
3. Overcrowding in ED
4. Winter Funding
5. Improving internal flow
6. Work with external partners

The output from the workshop informed the planning for 2018/19

12.2 Leading a Resilient Team Workshop

In preparation for the winter pressure or 2017, the Organisational Development Team were asked to put on a series of 6 resilience workshops. These workshops allowed staff members to explore their inner resilience and values, develop tools and techniques to support themselves and understand how to lead a psychologically healthy team.

	Session	Date, Time and Location
1	Understanding Resilience and Business Continuity	Tuesday 13th Nov, 12-2pm, WEC Room 6
2	Self-resilience and harnessing your energy and Business Continuity	Monday 19th Nov, 12-2pm, WEC Room 13
3	Knowing and using your strengths and Business Continuity	Tuesday 27th Nov, 1-3pm, WEC Room 11
4	Promoting team resilience and a positive mind set and Business Continuity	Wednesday 5th Dec, 1-3pm, WEC Room 1
5	Analysing emotions and Business Continuity	Monday 10th Dec, 11:30am – 1:30pm, WEC Room 4
6	Being valued for your contribution and Business Continuity	Wednesday 19th Dec, 12 – 2pm, WEC Room 4

12.3 Additional Resilience post New Year - (Silver on Site)

With the aim of supporting Red to Green events in the New Year we will have additional resilience support by having Silver on Site between the 2nd of January to the 8th of January. Silver on site will support the site team and clinicians to maintain flow and operational standards during this challenging week.

Senior operational and clinical staff will clear diaries (meeting amnesty) across the organisation following the bank holiday (2nd January 2019).

12.4 Before Action Review (BAR) Winter Workshop

The session was held on the 11th October and was attended by various stakeholders including primary care, local authority and CCG colleagues.

The purpose of the sessions is to bring the system team together to reflect on experience from last winter experience from elsewhere and what we can take forward into this winter.

Some key areas to be taken forward include:-

- Better communication across teams and organisations including use of SBAR
- Focus on prevention and admission avoidance

- System wide understanding of workforce challenges and capacity.

13.0 Staff Flu vaccination programme 2018/19

This year's flu programme was launched on 27th Sept and will run until Feb 2018.
We are planning to achieve a universal uptake of 100% unless an individual is clinically exempt. The CQUIN for this year is 75%. The Chief Nurse has agreed to be our board champion.

During the 2017/18 campaign the Trust supported the '***Get a jab, Give a jab'*** initiative. We donated 21,690 tetanus jabs by committing to match every flu vaccination given with a donation of 10 tetanus vaccinations to a UNICEF project, focusing on eliminating neonatal tetanus worldwide.

This year we plan to support our local homeless population in Haringey and Islington.

The Trust has 90 flu champions across the community and hospital site.
They are 70 booked flu clinics on site at the Whittington and 25 across the community sites and the plan is to offer more night and roving clinics, as these proved successful last year.
There is also a plan attend any event where a large group of staff are intending to gather to be informed by relevant manager...

PGDs for the quadrivalent (QIV) and consent forms (aligned to the new ICSUs) have been finalised and were circulated to champions on the 26th Sept. Training is available for new champions or for those wanting a refresher.
Staff over 65 years will be advised that they can go to their GP for Ativ, if they chose to, but they can opt for the QIV if under 75 years and healthy.

The plan also includes introducing some healthy competition between ICSUs and with the help of our communications team will re-launch the jab-o-meters featuring syringes (one per ICSU) with numbers on to donate uptake. These will be displayed on a screen saver and counted and updated weekly. The volunteers have kindly offered to help us with counting and data inputting.

The District Nursing Service is jointly working with both GP Federations to deliver flu vaccinations to housebound patients. The campaign commenced on Monday 8th October.

14.0 Escalation with External Partners

The NHS Improvement Team and NHS England have provided clear guidance in relation to the daily Winter Rhythm, Data Information & Intelligence, Bank Holiday/Weekend Assurance and Escalations.

Winter Rhythm	• Day to day management of local U & EC systems • Daily system surge calls that inform the national command and control centre.
Data, Information and Intelligence	• Daily Sitrep collected and distributed by NHS Improvement • Weekend Plans • LASD/111 data sources • Winter Intelligence bulletin
Bank Holiday/Weekend Assurance	• Assurance of Acute, Primary Care, LAS, 111, CAMHS in advance of Christmas/New Year period • Intermittent assurance of acute systems
Escalations	• 12 hour breaches • ED redirects in exceptional cases only • Beds lost to infection control • Workforce update and early recognition of rising tide • Performance against ED trajectory • Beds occupied by DTOC's /MO/Stranded patients • Ambulance handover delays • LAS Resource Escalation Action Plan (REAP) levels • Bespoke plans for weekends +BH • Primary care and out of hospital capacity • Availability and responsiveness of community services.

External monitoring is part of a pan North Central London resilience system known as Surge Management & Resilience Toolset SMART.

15.0 Communications Plan

The communications leads will be using all the key messaging and resources from the National Campaign. This year's theme: ***'Help us help you'*** the other themes include:-

- Self Help Winter Preparation
- Vaccination Campaign
- Resilience BCP Work Shops. 20 Participants per workshop, Managers, BCP
- Owners, Senior Clinicians (Mala)
- Wellness work across ED and wider trust

The key messages will be developed to deliver the priorities for winter plan

These messages will be used across various materials and channels, to ensure consistency of messaging.

As winter progresses, the plan will be revised and updated to react to any current or predicted issues, such as the weather conditions, health outbreaks, or pressures on services.

Current communications materials and channels:

- Posters, flyers, screensavers
- Hand-outs at key events and meetings
- Social media - Facebook and Twitter
- Noticeboard (staff and GP newsletter), intranet updates
- A&E leaflets, posters
-

Activity	Timing	Audience
Content included on staff intranet: Flu campaign: **Don't waste it**. How many staff vaccinated, photos of senior management getting vaccinated. Flu Jab clinics timetable – on intranet	28/09/18	All staff
Content included on staff intranet: lessons learned from last winter, severe weather, flexible working for staff – staffing resilience	10/18	All staff
Screensavers	11/18	Staff
Posters - avoidance of A&E attendance/admissions	11/18	Patients, Potential Patients, visitors, stakeholders our community.
Noticeboard content letting people know about winter plans campaign	10/18 Updates monthly until	All Staff

	winter completion	
Social Media posts with flu messages and how many staff vaccinated	28/09/18 winter completion	Patients, Staff, stakeholders our community

Appendix 1

Winter Risk Assessment 2018/2019

Number	Risk	Initial Risk Rating	Actions	Post Intervention Risk Rating
1	System wide interventions do not have the anticipated impact on hospital flow	3 X 4 = **12**	• Regular SitRep and robust monitoring of the outcomes • System wide interventions at weekly AEDB teleconference • MADE meetings twice a week • Robust escalation to surge	3x2=**6**
2	Insufficient resources available to maintain resilient services during peaks in demand	4x4=**16**	• Key enablers • Full Capacity Protocol • Discharge to Assess • Escalation Externally (surge) • EUC/System Wide Escalation Actions	3x2=**6**
3	Insufficient workforce on wards and community	4x4=**16**	• Agreed plan sign off by ADON Nursing for Escalation Beds • Daily review of staff for unfilled shifts Retaining effective and regular locum staff (ED) • Flu Vaccination of Staff and Community • Staff escalation as per SOP • Red Hit list	3x2=**6**

Appendix 2: Emergency Department Situation Report 2018

EMERGENCY DEPARTMENT SITREP: ASSESSOR : Date : Circle 0900, 1200, 1500, 2000, 23:59

	INDICATORS	GREEN OPEL 1	AMBER OPEL 2	RED OPEL 3	BLACK OPEL 4
CAPACITY	Capacity	<50 Patients	50-70 Patients	71-90 Patients	>90 Patients
	Resus/Majors Capacity	<20 Patients	20-25 Patients	26-30 Patients	>30 Patients
ARRIVALS	LAS handover	<20 Minutes	20-30 Minutes	31-45 Minutes	>45 Minutes
	Time to Triage	<15 Minutes	15-20 Minutes	21-40 Minutes	>40 Minutes
	Number of Arrivals in last hour	<15 Day <6 Night	15-18 Day 6-7 Night	19-25 Day 8-10 Night	>25 Day >10 Night
ASSESSMENT	Number of Patients to be seen	<20 Patients	20-30 Patients	31-40 Patients	>40 Patients
	ED waiting Times	<60 Minutes	60-100 Minutes	101-180 Minutes	>180 Minutes
REFERRALS	Specialty Referral/ Number to be seen	<30 Minutes	30-60 Minutes	61-90 Minutes	>90 Minutes
		< 5 patients waiting	5-8 patients waiting	9 patients waiting	10+ waiting
	Imaging Time: from order to completion	<30 Minutes	30-60 Minutes	61-90 Minutes	>90 Minutes
	General Blood Results	<45 Minutes	45-60 Minutes	61-90 Minutes	>90 Minutes
	Mental Health Patients in ED/ Moderate to High Risk patients in ED	<60 Minutes	60-120 Minutes	121-180 Minutes	>180 Minutes
		1 Moderate risk patient. Suitability Check MH Suite	2 Moderate risk patients	2 high risk / sectioned patients	4+ high risk / sectioned patients
ADMISSION	DTAs	<4 Patients	4-8 Patients	9-14 Patients	>14 Patients
	CDU 8 beds 4 chairs	<6 Patients	6-9 Patients	10 Total/ 8 Bedded Patients	10 Patients under other teams
95%	4 hr standard breaches since midnight	<6 Patients	6-15 Patients	16-25 Patients	>25 Patients
TOTALS					
ED STATUS IS		GREEN Business as usual	AMBER if ≥4 TRIGGERS	RED if ≥4 or ≥2 FULL CAPACITY TRIGGERS	BLACK if ≥3 or ≥2 FULL CAPACITY TRIGGERS

SERVICE RESPONSE STANDARDS FOR ACUTE INPATIENT WARDS

Appendix 3

Please consider whether investigations are discharge dependent or could be done in an outpatient setting at a later date

General rule of thumb if no agreed standard below a wait of 6 hours is red on main wards and 4 hours on AAU

SERVICE	THEME	WHAT WOULD BE GREEN?	WHAT WOULD BE RED?	Escalation
Ward	Senior Review	Review before 12 noon (Board Round/ Face to Face)	Review post noon/ no review	Contact Lead Consultant responsible for Ward at noon Further escalation to CD if no response 12.30pm
	EDD	Set on admission to the ward* Based on ideal recovery and timely processes * EDD should be updated/ confirmed following daily Senior Clinician Review and Core Criteria for discharge documented in the notes	Not set on admission to the ward Based on probable delays e.g. can only get a renal ultrasound on a Thursday	Contact Ward Manager/Charge Nurse to confirm with local medical team and confirm EDD within 14 hours of admission.
	TTAs Request Please Note: Ward staff should notify pharmacy via telephone if pharmacist not on the ward; and should check the pharmacy tracker rather than phoning the pharmacy department for status update	Prescribed 24 hours in advance* of planned discharge (48 hours in advance for blister packs) where EDD is expected the next day Written by 4p.m. for planned next day discharges based on current EDD Written by 12 noon for evening discharge * In exceptional prescribing circumstances 80% of same day discharge requests should be in pharmacy by 9a.m.	Prescribed less than 24 hours prior to discharge where EDD is expected the next day Written after 4p.m. for planned next day discharges based on current EDD Written after 12 noon for same day discharge	
	Transport Booking	Where transport is required, where possible it should be booked 24 hours ahead of planned discharge time – stipulating any specialist requirements and collection no later than 11a.m.* * Other than by exception for clinical reasons/ patient safety	Booked post 11a.m. based on potential delays such as TTAs* * Where safe patients can be seated in day room	
	Completion of D/C paperwork Please Note: Paperwork completion should commence at earliest opportunity and where possible in tandem with treatment phase	For non-complex patients paperwork to be turned around within 24 hours More complex patients requiring significantly more attention e.g. CHC requirements paperwork to be turned around within 4 working days	For non-complex patients paperwork not turned around within 24 hours More complex patients requiring significantly more attention e.g. CHC requirements paperwork not turned around within 4 working days	
Therapies	Routine Patients Urgent Patients	Patients are reviewed and where required have a treatment plan in place within 24 working hours from referral; with delivery of treatment as per plan Patients are reviewed with a treatment plan in place within 4 working hours from referral; with delivery of treatment as per plan	Patients are not reviewed and where required do not have a treatment plan in place within 24 working hours from referral or treatment plan not delivered Patients not reviewed with a treatment plan in place within 4 working hours from referral or treatment plan not delivered	
Cardiology	Non-Emergency Echo Emergency Echo	Undertaken and reported within 48 hours Undertaken and reported same day if request	Not undertaken and reported within 48 hours Not undertaken and reported same day if request	

4.1 dated 13th August 2018

		received before noon. Otherwise undertaken and reported before noon the following day	received before noon/ otherwise undertaken and reported before noon the following day	
	Treadmill Test	Undertaken and reported within 48 hours	Not undertaken and reported within 48 hours	
	Non-Emergency In-patient Angiography	Patient transferred within 72 Hours of request	Patient not transferred within 72 Hours of request	
Diagnostic Imaging	**Urgent X-RAY**	Response within 2 hours and report within 4 hours	Response more than 2 hours/ report not available within 4 hours	
	Urgent Scan	Response within 4 hours and report within 2 hours	Response more than 4 hours/ report not available within 2 hours	
	Routine work	Same day response and report within 24 hours	Next day response/ report not available within 24 hours	
Pathology	**Discharge Bloods**	If clearly identified as 'urgent D/C' bloods and dropped to the lab by 7a.m. tests reported by 10a.m.	Tests not reported by 10a.m. if bloods clearly labelled as 'urgent D/C' and dropped to the lab by 7a.m.	
Pharmacy	**TTA Turnaround**	TTAs on the ward to facilitate pre 11a.m. discharge if the request has been made by the ward before 4p.m. for planned next day discharges	TTAs not available on the ward to facilitate pre 11a.m. discharge if the request has been made by the ward before 4p.m. for planned next day discharges	
		TTAs available on the ward (> 6pm) to support same day discharge if the request has been made by the ward before noon	TTAs not available on the ward (> 6pm) to support same day discharge if the request has been made by the ward before noon	
		Blister packs available if 48 hours' notice provided by the ward	Blister packs not available if 48 hours' notice provided by the ward	

Data improvement

Over 90% of Whittington Health patients now have an Estimated Date of Discharge (EDD)

Current Bed State – updated on		01/10/18	16:20:00		Opel Statu	1	Total beds open 240+18		258
Ward	Funded/ Flex,	Empty Beds	Discharges Today	? Discharg	Criteria Led D/C	Predicted pre 11am	Staffing	Number over 7 days	Number => 21 days	Comments
CCU	10	3	1	0			G			3 (Level3)
Mary Seacole North	16	0	2	0	0	1	A	0	0	
Mary Seacole South	18	0	0	2	0	0	A	0	0	
Montuschi	16+1	0	0	0	0	1	A	9	4	
Nightingale	21+2	0	1	0	0	0	A	12	9	ost 4 planned discharges
Victoria	26+7	0	0	1	0	1	A	13	5	ost 2 planned discharges
Meyrick	25+1	0	1	0	0	0	A	10	8	
Cloudesley	25	0	1	1	0	0	A	12	6	
Coyle	24+7	3	3	3	0	1	A	6	3	6 Medical
Mercers	16	2	2	0	0	0	A	3	1	
Total		5	10	7	0	4		69	43	
Bridges	14	1	0	0		0	A	3	7	5R 4 Blocked due to Cdiff
Thorogood	10+1	1	3	2		1	A	1	0	
NICU	23	7					G			
Ifor	19	12					A			
Maternity	55	15								
Mental Health Su	2	2								
Simmons House	12	0								

CDU ED	4	1F	Chairs:	2	specialities	1Med

LOS > 7/7	43.41%	LOS > 21/7	16.7%	MO numbers	23	MO %	8.9%	DTOC numbers	9
DTOCs:	3.5%	3 SS and 6 NHS (3 Islington; 4 Haringey, 1Barnet, 1 Hackney)							

Community:	
St. Anne's	1
Mildmay	4
St Pancras	0
Protheroe	1

District	
Islington	4
Haringey	30
Staffing	
Rapid response	Capacity
Virtual ward	Capacity
care	Capacity
Staffing	

Mental health	3 - 1 Coyle, 1 Meyrick, 1 Ifor
DOLS	10 -1 Vict, 3 Cloudsley, 4 Coyle , 2 Meyrick
LD	2 - 1 Bridges, 1 Meyrick,
Sickle cell	8 - 3 Vict, 1 Cloudsley , 1 MSN, 2 MSS, 1 Coyle ,1 CCU, 4 Victoria (1 extra in Vict not in crisi
Infection control	7 - C. diff - 1 MRSA - 3rd CPE-HIGH RISK 2 unconfirmed diarrhoea on 2 Cloudesley in
Mixed sex breaches	NIL

Discharges:	
Pre 12 predicted 01/10/18	4
Pre 12 confirmed 01/10/18	4
Discharges 01-10-18	15
Predicted discharges 30/ 09/2018	7

Mental Health Patient in ED / Suite

TIME IN ED	INITIAL	PLAN	TIME IN ED	INITIAL	PLAN
9hrs 52mins	NME	first recommendation for			
13hrs 41mins	OB	Bed identified -coral ward. F			
3hrs 42mins	DM	N70DG-awaiting AMPH to			

Emergency Department

Yesterday's performance %	86.1%	Today's performance	90.4%
No.of attend.	295	No. of Attend.	208
Breaches	41	Breaches	20
Ambulances from MN 29/09/		40	
Number of Ambulances held over greater than 15 mins		0	

	Patients	TBS	Waiting time	
Majors	22	1	01:34	2FFD
Paediatrics	17	6	00:55	2FFD
UCC	38	16	01:33	10FFD
Staffing			A	
Beds required (Emergency & Elective		33+5+1+2+1	42	
Emergency Admissions FMN		12	30	
Available Beds Now		5	25	
Electives Bedded		4	21	
Predicted Discharges		10	11	
?? Beds		7	4	
			-4	

AAU waiting more than	9 MSN & 5 MSSO

Gold	Carol Gillen	
Silver	Alison Kett	
Bronze/ CSP	Chen	
ED Shift Leader	Fiona	
A&E Consultant	Lucy	
Acute Medical Consultant	Murdoch	
MAU	Lulillis/Jennings	
Paediatrics	TBC	
Gynaecology	Nandy	
Surgery	Chohda/J. wilson	
Orthopaedics	William Bartlett	
Urology	Maneesh Ghei	38

Repats

Repats In			Repats Out		
Initials	ward/hsp	Cons	Initials	ward	Cons
MIBR	RLH				
CB	RLH				

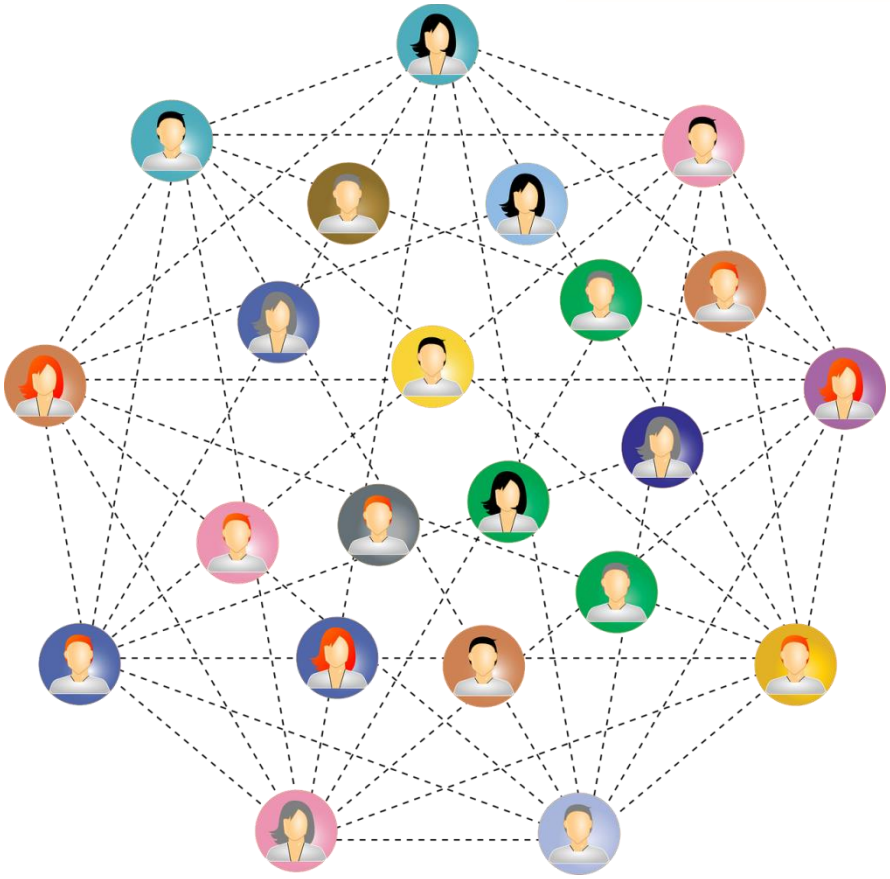
ELECTIVES 29-03-18	Nil		
Surgical	0	Gynaecology	0
Orthopaedic	2	Urology	2
Medical	0	Breast	0

Whittington Health
NHS Trust

Trust Board
31 October 2018

Title:	Community Engagement – Next Steps		
Agenda item:	**18/154**	**Paper**	**13**
Action requested:	The board is asked to discuss and endorse our proposed approach to future community engagement.		
Executive Summary:	Communications and engagement with the community we serve, our staff, local partners and other stakeholders should be fundamental in informing how we provide our services now and in the future. We want local people to get involved in our organisation – to do so we need to develop how we inform our local communities and move this towards contributing and collaborating. With the imminent need to talk to our local community – as well as our staff – about developing plans for the future of our estate, there is an opportunity to bring this activity together with broader work to increase our community engagement more generally. This engagement will evolve over time and we need to listen to our community on how they wish to be engaged with as we look towards a long-term strategy. This paper sets out an approach, proposed activity and the resource needed to deliver it to move forward with our community engagement as well as setting out some principles for future community engagement.		
Summary of recommendations:	In order to effectively engage with local communities, we need to not only invite our community in to talk about our plans and ideas, but also go out to them and engage existing community groups, voluntary organisations and community representatives. The suggested activity set out in the paper will need to be resourced in order to deliver it effectively.		
Fit with WH strategy:	Effective community engagement will allow us to reflect the needs and views of our local community in the decisions we make and the care we provide, directly contributing to our vision of 'providing safe, personal, co-ordinated care for the community we serve'.		
Reference to related / other documents:			

Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risk 15 (estate)					
Date paper completed:		23 October 2018					
Authors name and titles:		**Juliette Marshall, Director of Communications, Engagement and Fundraising**		**Director name and title:**		**Jonathan Gardner, Director of Strategy**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	



Whittington Health NHS Trust

Community Engagement – Next Steps

Providing safe, personal, coordinated care for the community we serve

Background
Communications and engagement with the community we serve, our staff, local partners and other stakeholders should be fundamental in informing how we provide our services now and in the future.

We want local people to get involved in our organisation – we need to continue to develop how we **inform** our local communities and move this towards **contributing** and then, where appropriate, **collaborating**.

A clear and deliverable engagement approach will be owned, delivered and adapted not only by the communications team, but also by the broad leadership of the organisation. Our engagement will be clear, consistent and courteous, with messages delivered through the best channel(s) for the audience. We will make sure that people can see how their input has influenced our decisions. Our engagement will evolve over time and we need to listen to our community on how they wish to be engaged with as we look towards a long-term strategy.

We will soon be in a position to talk to our local community, as well as our staff, about the future of estate. As well as being an area where we are keen to engage people in developing our plans, this also provides us with a platform for strengthening our engagement with our community.

Purpose
While the benefits of community engagement are widely recognised, it is important that we are clear on the purpose and objectives specific to Whittington Health, namely:

- to have greater input from our community to inform our decisions
- to encourage our community to work collaboratively with us on future decisions and/or changes
- to inform our local community about what Whittington Health is doing and encourage them to join in celebrating our successes
- to play a more visible role in the community
- to promote public health messages and help people live healthier lives

Benefits
There are key benefits in taking a new approach to engagement.

For the population:

- By being seen as part of the community we will gain trust and ensure our messages have greater authority. This should in time lead to improved impact on population health.
- Public awareness of the right health resources available should lead to improved care outcomes.
- Being more trusted in the community should lead to better adherence to advice and better use of resources and services.
- By being more involved in the decisions we take in organising health services, our population will benefit from us designing services which best meet their needs.

For Whittington Health

- Greater engagement of the population will help us design better services.
- Greater engagement with the population will lead to a more informed debate.
- Greater trust and being seen as part of the community could have a positive impact on local recruitment and retention.
- More volunteers.
- Financial benefits may be limited, but better designed services, along with any improvements in recruitment/retention and any increase in our volunteers, should help reduce costs, as should a healthier population; and greater presence and awareness should improve fundraising.
- Strategic benefits are large in that this approach should cement us as the trusted provider and partner of choice both for patients and GPs.

Approach

We want to both push out into our community to actively seek their engagement as well as draw in views and use developing relationships to encourage greater involvement of individuals or groups within our community.

While a significant number of local groups and organisations have been identified, we also need to explore the ability for individuals to give their view – and, in the longer term, how we can gain engagement on both a quantitative and qualitative basis from a large representative group of our local community on a regular basis.

Principles

Our communications and engagement approach and all of our activity will be governed by a set of key principles, regardless of the audience or channel.

- Be honest, open and transparent – even when there may be risks attached
- Be clear, accurate, consistent and timely
- Be proactive and reach into the community, not expect them to come to us
- Build and maintain positive relationships with individuals and their representatives within our community
- Provide opportunities to our community and their representatives to have their say so that we can listen and act
- Use a range of channels – including face-to-face – to be as open and accessible as possible, using translated materials and alternative formats when necessary
- Respect each other's point of view and be honest and open where we do not agree
- Be clear about the action we have taken to respond to feedback so people can see the impact that they have had

Audiences

Our key audience and stakeholder groups will be:

- Local residents
- Community Groups and Charities
- Healthwatch
- Local representatives – including MPs and councillors

- People in key council positions – Chief Executive, Leader and Health representative
- Commissioners
- Local voluntary sector organisations
- Local campaign groups
- Schools
- Patients (past and present)
- Our own staff (and their representatives)

Channels and Products
We are committed to providing various ways for people to engage with us, using technology as well as valuing face-to-face communication and relationships. Different channels may require different content, but our messages will always be consistent.

- **Face-to-face communication** – attending meetings of community groups and capturing information received and feedback given at existing meetings. Revising the current Community Forum membership to find those individuals who still wish to be involved and looking to build it up again from that base. Holding meetings in our own venues and in others'.

- **Existing networks and events** – attending local voluntary organisations and groups and local meetings

- **Website** – broadcasting information and signposting to engagement opportunities

- **Social media and networks** – broadcasting opportunities to have a view and capture responses from individuals or groups who wish to use this as a channel for engagement. The nature of interaction on Twitter allows for conversation, but it is short and doesn't provide the chance for in-depth views. Facebook has traditionally been more of a broadcast channel, but with the major growth in recent years of local community group pages, its capacity for engagement is likely to grow significantly (although there are currently technical restrictions on organisations and their 'Page' joining local groups). There is also a dedicated locality network platform, Nextdoor (formerly Streetlife).

- **Written digital communication** – concentrating relevant information and news into regular and concise newsletters which allow interactivity wherever possible. The intention would be to produce high quality and regular content, but on a low frequency basis (eg, three to four times per year).

- **Local media** – broadcasting opportunities for engagement.

- **Website** – we will over time need to revise our website which will require further resource

Activity
The need to engage our communities in the development of plans for the future of our estate mean that we need to move swiftly into a delivery stage. We can also use this to determine from our local community how they wish to be engaged with on an ongoing basis to refine our strategy and how we deliver it.

'Push' activity	'Pull' activity

Phase 1: Seek views on imminent projects (eg, estates) and increase our visibility within our local community

Activity	Frequency	Purpose	Metric(s)
Invite in for face-to-face engagement meetings – Community Forum and local voluntary groups. Linking information sharing on health topics and public health messaging with topics for feedback.	4 times per year, in the evenings and a variety of venues/localities	While we shouldn't rely on bringing a large group of people together for our community engagement, this could be a forum to discuss major issues and get views on strategic direction as well as disseminating information of interest to the public (e.g. health advice). Our first session could commence engagement on estates and ask attendees about how and what they wish to hear from us on. We would suggest holding these using a World Café methodology to ensure meaningful discussion and interaction rather than broadcasting information.	• Number of attendees • Feedback from attendees on content of the meeting • Feedback from attendees on how well they believe their views have been heard (for later meetings)

Activity	Frequency	Purpose	Metric(s)
Attend meetings of local community and voluntary groups.	Dependent on external groups	We need to go to where members of our community already engage and develop our relationships with local groups. This would require either a significant amount of research to ensure we identified every group or to engage a local organisation who already has contacts with groups to work in partnership with us.	• Number of individuals reached (total number of attendees at meetings where we played an active role) • Feedback from local groups on how useful their attendees found our contribution
Newsletter	4 times per year	This would set the stage for the Community Forum meeting and provide broadcast information (and updates on other opportunities to engage) between meetings. However, it should be a professional product, produced using a platform which will allow us to track engagement with the content.	• Number of recipients who opened the newsletter • CTR (click-through rate) to related web content • CTR to specific content within the newsletter (dependent on product functionality)

Phase 2: Consolidate our attendance at and involvement in community activity and seek views on specific proposals on our estate

Activity	Frequency	Purpose	Metric(s)
Attend community events	Dependent on external groups but likely to be focussed around Christmas, Easter and the summer	Combine the opportunities for taking part in local events (eg, local market, local school events) with increasing visibility of our charity. This also has the advantage of visibly supporting our local community, but would require resource on weekends.	• Number of individuals engaged with at events

Activity	Frequency	Purpose	Metric(s)
Engagement and comment platforms (eg, Crowdicity's idea management software) for qualitative feedback	TBC but ongoing from point of launch	To provide easy access to give qualitative feedback on key issues and questions – but works best with regular response and engagement from the host organisation. Has functionality for users to vote on other people's responses.	• Quantity and quality of users and comments • Quantity of engagement from individuals in WH leadership team (comments, replies, questions)
Set up display boards with proposals in the atrium and waiting areas of the hospital and entrances and/or waiting areas of all freehold buildings (specific to estates engagement)	N/A – to be updated as proposals developed and any new views sought/decisions taken	To allow people to see proposals/options and provide their views. Feedback sheets would be available and stands should be manned at regular intervals.	• Number of individuals engaged in discussion • Response rate
Take proposals and questions out to local areas of population concentration, such as community centres, supermarkets, shopping centres (specific to estate engagement)	TBC dependent on number of centres and resource	Take displays and key questionnaires out to where our population goes – this is a direct marketing approach, but would also be used to draw people in to wider participation	• Number of individuals engaged in discussion • Response rate
Key questions sent out through social networks and social media (including promoted posts) [NB: this would follow embedding face-to-face engagement]	TBC dependent on questions, but no more than once per fortnight	Give people the opportunity to feed in through the platforms they already use. Questions should be short (unless linked to a survey platform) and answers would be limited. Would have a particular impact in drawing people in to wider participation. Would also be used to advertise engagement events.	• Platform analytics (eg, reach) • Response/CTR rate • Quality of responses (given limitations of platforms) • Sign-up to engagement events

Phase 3: Demonstrate how the input of our community has had an impact

Activity	Frequency	Purpose	Metric(s)
Web stories/blogs following up on engagement sessions	Defined by engagement sessions	To demonstrate what we heard at engagement sessions and reflect on comments and the involvement of local people.*	• CTR from channel advertising content (eg, social media/networks, website front page, newsletter)

*Messages to also feed into previously mentioned activity, eg, events, meetings, newsletters, social media/networks, etc.

'Push' activity	'Pull' activity

Barriers and Risks

We need to be clear from the outset of any community engagement about what is possible and what our constraints are, in order to ensure that local people and groups can give realistic and influential views that we can consider in our decision-making. We also need to ensure that our community understand that we balance their views with those of our staff and other local partners and stakeholders.

The nature of working with community groups is that we risk missing the views of others in the community. Longer term we need to look at whether individuals are getting enough of an opportunity to express their view and consider how we can be certain that the views we hear are demographically representative of our community.

We need to be cautious of over-reliance on digital platforms – while valuable, there are limitations in how effective these are as engagement tools as opposed to broadcast tools. While we should harness the opportunities that the digital environment provides, we should continue to include face-to-face opportunities to engage in our plans.

Resources

There is a recognised need to invest in engagement and make sure that this work moves forward in a meaningful way which is demonstrably responsive to the views of our local population and to sustain a significant increase in engagement activity. If we decide on all of the activity above (both immediate engagement on estates and informing the wider engagement approach), it is likely to take up 1.5 WTE (a full time senior post 8b with junior and logistical support). This should service initial research to identify events, logistical arrangements for attending, design and print of materials and building up further relationships on behalf of the organisation. This resource would allow us to focus on the estates work and use it as a springboard for our broader community engagement. It would require wider support, e.g. attendance at events, including out of hours.

There will also be an impact on others in the organisation:

- the wider Communications Team, in dealing with follow-up media queries, monitoring social media platforms, production of materials, etc;
- the Estates Team, in attending internal and external engagement events in relation to developing plans for the future of our estate, manning stands, providing content for written and online materials and active involvement in engagement platforms; and
- the wider Leadership Team, in attending internal and external engagement events and providing content for written and online materials

The cost for using an engagement platform such as Crowdicity would depend on the number of users (the size of our engagement audience), but it has been shown to be an effective engagement tool if used properly. It is likely to cost upwards of £10k per year but final costs would depend on detailed conversations with the platform.

Promoted social media posts can be used to serve our content to people who have an interest but who do not actively follow us. Spend is dynamic depending on how many people we wanted to reach but an indicative c£500 per exercise or question across Facebook and Twitter could be used for budgeting purposes. This can be targeted well at local people who have an interest in health and healthcare or people who have a specific interest in a health condition or issue.

As a comparison, Haringey CCG have a community engagement partnership with the Bridge Renewal Trust and Healthwatch, which give them an extremely broad reach into their local community groups. They invest around £22k per year for this service, which provides the logistical support for community engagement and advises on agendas for meetings. In addition, three members of their team cover community engagement as part of their roles, including a B8b, a B8a and a B7.

The below are indicative costs and a starter for ten. We do not have a funding source but it is important we discuss if this plan is worth the investment it would require and which pieces we want to prioritise.

Resource	**Year 1 cost**	**Recurrent cost**
1.0WTE B8b – to lead the work reporting to Director of Comms, able to engage with senior colleagues and present a WH face in engagement meetings	£80k (inclusive of estates requirement)	0.5 WTE once the majority of the engagement on the estates programme is complete. £40k
0.5WTE B4 – admin support to arrange meetings and materials	£15k	£15k
Crowdicity (Phase 2)	£10k	£10k
General event and social media costs	£10k	£5k
Total:	**£115k**	**£70k**

Issues to be addressed

- IT – we will need to work out the detailed costs and procurement of IT solutions and will need IT support to do this.

- Database – we will need to be clear about how we maintain a database of contacts, who will do that and what the resource required is.
- DPA 2018 – we will need to check everything is compliant with the latest data protection legislation.
- Routes to get contacts – we need to use our existing contacts via council mailing lists, Healthwatch, Bridge Renewal Trust, Voluntary Action, etc., to advertise our new approach and get people interested.
- Governance – we need to understand whether an internal group is created to monitor and lead engagement and if so what its membership should be.
- Staff engagement – this plan by nature is focussed on the community, however, our staff are also part of our community and we need to ensure that our internal and cultural work is aligned with our community engagement work.
- Fundraising – there are some opportunities for this alongside our community engagement and we need to ensure it is linked in appropriately.

Next steps action plan

October

- Approval of next steps approach and resource via TMG
- Discussion at public board

November

- Contact existing members of Community Forum and local volunteer groups in anticipation of first engagement event (via new Newsletter or direct communication)
- Soft launch via existing social networks and media by offering chance to sign up to the Community Forum
- Identify community/voluntary group meetings/events/engagement opportunities over the next 3 months

December

- First engagement event
- Attend community Christmas events
- Invite community/school groups (eg, choirs) in to hospital and major community centres over Christmas period
- Commence procurement of external suppliers

January/February/March

- Commence estates engagement across relevant WH sites (if ready)
- Take estates engagement out to areas of population concentration (if ready)
- Wider promotion of Community Forum
- Hold second Community Forum event

Recommendations

The Board is asked to:

- Discuss and endorse the overall approach
- Agree that resource is required to deliver effective community engagement
- Agree the priorities in the next steps action plan
- Discuss how this work reports into the governance of the organisation

Whittington Health NHS

Item No:	**18/155**
Paper No:	**14**

WORKFORCE ASSURANCE COMMITTEE

Minutes of the meeting held on Friday 21st September 2018

Present:

Stephen Bloomer	Chief Finance Officer
Norma French	Director of Workforce
Carol Gillen	Chief Operating Officer
Steve Hitchins	Trust Chairman (in the Chair)
Michelle Johnson	Chief Nurse & Director of Patient Experience
Helen Kent	Assistant Director of Learning & OD
Jana Kristienova	Assistant Director of Integrated Care Education
Tony Rice	Non-Executive Director
Kate Wilson	Acting Deputy Director of Workforce

In attendance:

Lawrence Anderson	Medical HR Business partner
Kate Green	PA to Director of Workforce (minutes)

18/23 Welcome and Introductions

23.01 Steve Hitchins welcomed everyone to the meeting. He explained that Graham Hart (Committee Chair) had now resigned from the Board. Arrangements were in hand to appoint his successor, and the plan was for that person to hold the same positions as Graham until the end of the financial year, whereupon a review of NED responsibilities would be conducted. He thanked Tony Rice for attending on this occasion, and also welcomed Kate Wilson, congratulating her on her appointment as Acting Deputy Director of Workforce.

18/24 Minutes of the meeting held on 24th May

24.01 The minutes of the Workforce Assurance Committee (WAC) held on 24th May were approved.

18/25 Matters arising

25.01 Referring to minute 13.03, Norma explained that Richard Jones had been invited to attend the meeting, but was delivering a training course. Kate Wilson would therefore cover this item under the Employee Relations Activity report.

18/26 WAC Terms of Reference

26.01 Steve Hitchins informed the committee that the new Trust Secretary was due to start at the Trust next month. It had been agreed that all Board sub-committee terms of reference would be reviewed annually, and in time for approval at the March Trust Board; the Workforce Assurance Committee terms of reference should therefore be brought to a meeting in the New Year.

26.02 In the meantime Norma requested the committee's agreement to changing just the membership. It was agreed to remove the Director of Strategy/Deputy CEO from the list, and to remove the Assistant Director of Nursing Education and Workforce and replace her with the Chief Nurse and Director of Patient Experience.

18/27 Quarter 1 Workforce Report

27.01 Introducing this item, Kate Wilson apologised for the formatting, which would be corrected prior to the production of the next report. She then took committee members through the report as follows:

27.02 Bank and agency – there had been an increase in the use of temporary staffing since the last quarter. The overall increase in bank staff was positive and represented a move from agency to bank, but the rise in agency usage was of concern. The rise in the Children & Young People's Services ICSU was largely attributable to the need to bring in additional Health Care Assistants (HCAs) to care for adolescents with challenging behavior (particularly in Simmons House). Norma had discussed this with Associate Director of Nursing Dorian Cole, who was conducting a review of establishment. Carol suggested approaching Camden & Islington Mental Health Trust, and Michelle would pick this up with Dorian.

27.03 In answer to a question from Tony Rice about what might be seen as an appropriate target to work towards in terms of a permanent versus temporary staff ratio, Norma replied that ideally this should be at 80:20, however a 75:25 ratio would be acceptable. She noted that the former Women's Health ICSU had achieved 95:5. She informed the committee that she was holding meetings with each ICSU triumvirate (supported by finance colleagues and HR Business Partners) in order to drill down into bank and agency usage. She paid tribute to the achievements Alison Kett had already made through her plans for a nursing skill mix review within the District Nursing Service. Michelle was also holding fortnightly meetings focused on bank and agency control, and it was noted that HCAs were now to be recruited centrally rather than by each ICSU, which she hoped would make a difference to the speed and efficiency with which HCAs were recruited.

27.04 Norma explained to the committee that bank staff accrue annual leave but are not permitted to carry over any days forward to the next financial year. This in part explained the spike in agency usage towards the end of the year. It was also noted that Whittington Health does not pay an EWTD premium (rather it allows workers to take paid time off), which made Royal Free bank rates appear more attractive, even though there is no difference in real expenditure. Michelle suggested that a recommendation to alter this position be prepared for Trust Management Group (TMG).

27.05 Moving on to recruitment, Kate said there was a positive message to report around graduate nursing recruitment in that of the 56 recruited, 52 are expected to start at the Trust next month. This is in contrast to the usual loss rate, and attributable to the work carried out by colleagues to 'keep them warm' by staying in regular contact and offering advice and support as well as news and information. The focus now

would be on the preceptorship programme and how to retain them for the second year.

27.06 There had been no significant change to vacancy figures since the last quarter, with (in clinical areas) a decrease of 1% in HCAs and an increase of 2% in nursing. Both Norma and Michelle were confident about nurse recruitment, however, and discussions were starting to take place about the next planned phase of overseas recruitment. There were district nurse recruits in the pipeline, and a recruitment campaign was due to start shortly. Some of the overseas recruited nurses were also joining the district nursing team.

27.07 Steve Hitchins commented that vacancies in corporate areas seemed high (particularly in finance and IT). Norma acknowledged that they had been, however Leon Douglas had carried out a significant amount of work to reduce the number of temporary staff working in IM&T, and Kevin Curnow had also been working to reduce temporary staffing in finance.

27.08 Sickness rates for Quarter 1 were 3.45%, which was marginally higher than those recorded at the end of 2017/18's Quarter 4. Long-term sickness had increased, but decreased again slightly since the report had been written. Michelle Johnson enquired why the percentage recorded as 'unknown cause' was so high (28%) and Kate replied that this was often due to unwell staff telephoning in to a central point e.g. a reception desk, where staff taking the call felt it inappropriate to ask for that level of detail. Some staff reporting sickness on ESR did not ask for details due to confidentiality issues. Managers were able to log on to ESR and add details, but in practice this rarely happened. There had been a number of staff in estates and facilities who had been on long-term sick leave, but this number had decreased. Fortnightly meetings were held at which every individual case was reviewed.

27.09 The staff turnover rate was recorded as 13.99%, a reduction of 0.6% from the previous quarter. A new pilot for exit interviews had been introduced, where staff leaving the Trust were offered face-to-face interviews. Commenting on the stability index, which she had found useful, Michelle asked whether information could be shown in the form of an SPC chart.

27.10 Turning to appraisal and mandatory training rates, it was acknowledged that there was work to do in both areas, and Helen Kent would be addressing this. It was noted that the Children & Young People's ICSU was conducting a deep dive into the reasons for non-compliance, the results of which would be fed back to the ICSU Board. The next round of ICSU performance reviews would shortly be taking place.

18/28 <u>Employee Relations Activity</u>

28.01 Kate began by informing committee members that there was currently a strong focus both on the informal resolution of grievances and on the time taken to resolve cases. An escalation panel had recently been introduced, and Norma explained how the team was working to look at solutions for moving 'blocked' cases. She also informed the committee that Helen Gordon had put in place arrangements for a fair treatment panel, which was scheduled to meet weekly and would be led by Michelle and Carol, with Medical Director involvement as appropriate. In answer to a

question from Steve about staff involvement, Kate replied that regular meetings took place with the staff side chairs, who had an open opportunity to voice opinions or raise any concerns.

28.02 The electronic case management system had now been installed; current cases had been entered, and historic ones would have been recorded by the end of the month. A graduate trainee was working with the team on this.

18/29 Workforce Annual Report

29.01 The Workforce Annual Report for 2017/18 was due to be presented at Trust Management Group and the Trust Board meeting the following week. This committee had already received most of the data contained within the report in different guises, including the data on equality and inclusion. Steve Hitchins had observed that some of the tables contained within the report appeared to show a greater number of starters than leavers; did this mean an overall increase in staff numbers?

29.02 Norma would ask for these figures to be checked. The tables also showed the proportion of staff who returned to work following maternity leave. It was noted that the Vacancy Scrutiny Panel process was now almost exclusively on line.

29.03 Looking at staff development, the meeting discussed what additional measures needed to be put in place to increase numbers, and it was agreed there should be an incremental plan. In answer to a question from Steve Hitchins about apprenticeships, Helen replied that there was currently no-one in post to lead this work as Astrid Von Volckamer was now on maternity leave and her post was being kept vacant temporarily in order to contribute to the directorate's CIP target. The team was still progressing this work, however; some information days were imminent, and the steering group was being relaunched. Helen informed the committee that any unspent funding would be transferred to local GPs.

29.0 The meeting discussed developments in training initiatives and the Trust's interaction with universities, and committee members were pleased to learn of the improvements made at Middlesex University. Steve Hitchins enquired how much progress had been made with the Ambitious about Autism group, and Helen replied that progress had been made on the autism project, work with Ambitious about Autism was not scheduled to start until 2019.

29.05 Stephen Bloomer suggested that the annual report might benefit from the addition of an executive summary which might highlight areas about which the directorate was particularly proud, and Norma concurred. Tony Rice commended the work of the team as reflected in the report, and it was agreed that the introduction was over-modest and understated the immense progress that had been made. Norma voiced her pride in the team for all they had achieved.

18/30 Annual Report from the Guardian of Safe Working

30.01 This item was introduced by Lawrence Anderson, who explained that he was doing so on behalf of the Guardian of Safe Working Caroline Fertleman. The report,

which all Trusts had a statutory duty to provide and make publically available, consolidated the four quarterly reports produced during the year, and so covered the period April 2017 to March 2018.

30.02 The Trust had received just over 500 exception reports during the year, the majority of which had been submitted by FY1 doctors working in general medicine. A total of 681 additional hours had been paid for. It was noted that the majority of those submitting exception reports were working in hospitals for the first time, and it was suggested that more might be done at induction to brief junior doctors about expectations of them and when they might challenge being asked to work additional hours. First year doctors were also generally very keen to be seen to be doing things correctly; there was a notable reduction in exception reporting in year 2.

30.03 Michelle Johnson commented that if this working pattern had occurred within nursing, she would have considered it totally unacceptable, and asked that measures were being taken to address it. Lawrence replied that this was the key responsibility of the Guardian, working with the other clinical leaders in the Trust. Steve asked what was being done to drill down further into the reasons for this situation, and Carol agreed that a clearer picture was needed, remembering that phlebotomy had been a major contributory factor the previous year.

30.04 The committee also questioned the role of the educational supervisors and their responsibilities, and Lawrence replied that the Guardian was expected to liaise with those holding these posts. He added that there was also a need to encourage attendance at the Junior Doctors' Forum.

30.05 Norma suggested there was scope for redesigning the profile of the Guardian, and with the advent of a new Medical Director there was likely to be a review of all areas covered by that Directorate.

30.06 The committee discussed the possible reasons for junior doctors' being asked to work additional hours, including staff sickness and maternity leave. Kate Wilson was aware of a specific problem within the urology service, but was under the impression this had been resolved. There had been some successful conversion of agency to bank within ED. A group had also been established to look at innovative ways to recruit.

18/31 <u>Date of next meeting</u>

31.01 It was noted that a date had been set for the next meeting of the committee, however this was likely to change. Kate Green would be in contact accordingly.

Whittington Health NHS

Minutes of the Whittington Health Charitable Funds Committee held on 30 August 2018

Item No: 18/156
Paper No: 15

Present:	Tony Rice	TR	Non-Executive Director
	Steve Hitchins	SH	Chairman
	Stephen Bloomer	SB	Chief Finance Officer
	Adrien Cooper	AC	Director of Environment
	Jonathan Gardner	JG	Director of Strategy, Development & Corporate Affairs
	Siobhan Harrington	SH	Chief Executive Officer
	Michelle Johnson	MJ	Chief Nurse & Executive Director of Patient Experience
	Juliette Marshall	JM	Interim Director of Communications, Engagement & Fundraising
	Naomi Scott	NS	Charitable Funds Accountant
	Jon Ware	JW	Head of Financial Services
	Vivien Bucke	VB	Business Support Manager, Finance

Item	Discussion
18/011	**Welcome, Apologies for Absence** & **Declarations of Interest**
11.1	No Declarations of Interest were received.
18/012	**Approval of Minutes of the meeting held on 21 March 2018**
12.1	The minutes were agreed as an accurate record apart from 6.5.4 which will be amended to: *GB was asked to provide examples of district general hospital legacy packs for the Committee to consider before the proposed legacy pack was completed*.
18/013	**Action Notes**
13.1	1. Kanitz Fund monies: JW had spoken to Sarah Gillis and there had been two recent new bids with the value being fairly low at £20k. The balance remained at £750k. SB reminded the Committee that nothing had been actioned on the IT and lighting systems and it was agreed that TR would discuss with the fund-holders to ensure action by a particular date or the monies will be reallocated. MJ suggested this should be a multidisciplinary discussion. **Action: TR** 3. Viability of Patient Area Screens: MJ said in addition to the screens there are a number of patient leaflets in ED that are produced by lawyers and the contract is being viewed/sought with the aim to remove the Trust from this. However, there will be cost implication for the Trust to then produce patient leaflets. **Action: MJ** 6. Introduction of Text donations information added to the OPD Letters: JM confirmed these have been added for several months now and there is a need to evaluate the impact. **Action: JM**
18/014	**Terms of Reference**
14.1	MJ was keen to include an Allied Health Professional and it was agreed that an

appeal for medical representatives would be made via the Trust Newsletter & SH to think about a NED representative. With that proviso the Terms of Reference were agreed. **Action: JM**

18/015 Financial Report Month 4 2018/19

15.1 JW stated the paper set out income and expenditure and balance sheet for the Charity, as at the end of month 4 (July 2018) and draft figures for 2017-18. I&E headlines as follows:

- Income for 2017-18 was £185,000, a slight increase on 2018-19. Income in
  2018-19 to date is in line with this.
- Expenditure for 2017-18 was £435,000, a small decrease on 2016-17. The most significant items of expenditure in the year to date are in medical and other equipment (£219,000) through the bids previously brought to this Committee, and also £116,000 in fundraising costs. There had not been any significant bids received during 2018-19 to date.
- The draft total fund balance as at 31st July was £3.74m, which is £0.01m lower than the draft balance at the end of 2017-18.

15.2 JW stated creditors were reducing due to the settlement of salary recharges.

15.3 The Committee noted the report.

18/016 Fund Balances

16.1 JW presented the paper setting out the breakdown of funds by various categories and taking into account significant movements in those balances. The total fund balance as at 31 July was £3,736k. There had been an increase in expenditure leading the balance to fall by £140k during 2017-18. For the current year fund raising had been in line with the previous year but expenditure lower with the staff awards the first item of size in the year to date. The General fund remained steady following the Committee decision last November to reallocate salary recharges to all funds rather than just the General Fund.

16.2 SB said there was still a training issue with bids received that should be funded centrally with the need for the Trust communicate what is over and above and SH suggested this should be part of the ICSU training. TR was happy that 37 bids had been received (see the following paper). JG asked if the Trust could start to reduce the ability for people to fund raise for a particular area rather than general fundraising and SH felt the Trust should allow staff to express a preference but shouldn't let separate funds be set up. The point to be made for any fundraising is that a percentage goes to the running cost of the charity and it should be included in the small print that if not used within x months the money will be transferred to the general fund. SB suggested it is worth getting together a group of fund-holders as the Trust had tried several times to streamline the funds but as part of the engagement with the fund-holders the Trust could ask them what they would like to do with local engagement. **Action: JW**

18/017 Applications for Funding

17.1 The paper set out bids for funding and since the last Committee the Trust had processed 37 bids for funding while the value of these was relatively small. Two were over £5k and required formal Committee approval:

- Staff Awards ceremony £27.5k JM said this was quite an important staff engagement process and was very popular last year. SB felt the Committee did need to think about future years funding from the general fund and TR said originally the Committee agreed to look at sponsorship for future years. SH felt there was a need to say on menus etc. that the event was sponsored by the Charitable Funds. **Approved**
- Workshops for people going through Cancer. MJ stated this had proved most successful with a lot of good feedback. **Approved**

17.2 It was agreed that JM would discuss examples of good bids with JW and NS. **Action: JM**

17.3 MJ raised the bids for attendance at awards and TR felt a sense test on cost should always be undertaken and MJ confirmed this did happen. TR felt there was a need to agree clarity for scope on awards ceremonies to decide where the funds come from. **Action: JW**

17.4 TR queried the Specialist Study Day and whether this should be core NHS expenditure and SB agreed there was a need for rules for training /development expenditure from the charitable funds. This would allow a framework on what can be funded with the need for a statement for staff on how we fund this area, perhaps linked to leadership. **Action: JW/SB** to bring a group of people together to discuss.

17.5 JW highlighted Sing for your lungs and the suggestion to move money from Nightingale fund. TR was keen to support and JG said there is a need when people come along to market that this is funded by the charitable funds. SH asked if this has been discussed with Nigel Kee before making the decision. **Action : JW Approved subject to** agreement by the fund holder and the clinical lead to negotiate ongoing cost with Angela Reith for the commitment for 2 years.

17.6 TR asked for an Analysis of bids turned down to be presented as part of this paper to future meetings. **Action: JW**

18/018 General Fundraising

18.1 JM took the Committee through the paper highlighting there will be a ballot for Marathon places in October. The marathon raised just over £10k this year.

18.2 SH suggested the Parent Fundraising Group should be the start of a database while being aware of data protection issues.

18.3 JM said she wanted to source school fairs to market Charitable funds merchandise and market the Charity at community events but there is a need to increase the capacity to man the stands. MJ suggested charity champions and TR was keen for the Whittington to hold its own event.

18.4 SH said that feedback from Chelsea and Westminster was that the most effective information in legacy packs were case studies and felt currently the draft did not include very many.

18.5 With regard to contactless giving it was felt there was a need to increase the opportunity for the giving of small amounts.

18.6 The Committee discussed recruitment of a Fundraiser. SB said he felt there was a need to think about the grade of the post and he was not comfortable with actually recruiting another person to the position. He felt that the previous position on a parity with clinical staff was heavily over graded. JG suggested three options:

1 a senior staff member who creates the strategy with a team below, 2 a lower grade staff who fundraises but does not handle the big relationships and strategy 3 outsource.

18.7 SB spoke of the Kingston Smith organisation who fundraise for the NHS and who help evaluate Trust requirements. It was agreed this will give the Trust the opportunity to look at fundraising overall and KS offer a 2 hour meeting for an initial look. TR said he was happy to attend any meetings with external firms. **Action JM.** JG emphasised there is pressure at the moment as the team doesn't exist to progress ongoing schemes.

18.8 SH raised the issue of Black history month and should the Committee encourage an application to Charitable Funds and he would take this forward. **Action : SH**
MJ asked that at Simmonds house members of the neighbouring estate can look in and she asked that this be looked at. **Action : AC**

18/019 Ifor Play Terrace Update Report

19.1 JG reported the Trust had received the design and costs they are more than were originally with a total of £202k excluding VAT and a funding gap of £157k. It was proposed however, that the Trust should go ahead and progress with Bright Horizon and continue with fundraising. JG asked that the Committee agree for Charitable funds to underwrite the gap while continuing to fundraise. Currently the Trust had approached Arsenal FC at present.

19.2 AC said that the scheme should have been subject to a full feasibility at the start but the Trust does now have a full scheme that has been checked by cost consultants. The Trust does have to market test the scheme and he suggested a tender process in winter, build in spring with the play terrace to be open in summer. However, JG felt that as the paper proposed other fund sources to underwrite the project the Trust should go ahead as soon as possible with the tender process. AC suggested tendering in the Autumn. SB said he was in agreement to proceed but reluctant to push ahead of the backlog maintenance programme as this is not critical to the Trust. He suggested the Trust start the tender process and then proceed slowly and plan this within the programme of critical works on fire/water etc. MJ cautioned that the Trust had to be realistic that this will not be used in the winter as the patient average stay is 0.8 days. MJ also asked about viewing and blinds from other wards and AC confirmed this has been included.

19.3 MJ queried why the John Waldron fund with 50% for NICU had not been spent and all agreed that all spend should go on the play terrace for Ifor. **The Committee decided to fund the project and to aim for an opening on the 1st August or before and if this was not possible to delay until March 1st . Permission to take to Tender was given to AC and to close off £25k of expenditure on the scheme. JM to provide narrative on the scheme.**

Whittington Health
NHS Trust

Agenda item:18/157
Paper 16

Draft minutes of
The Whittington Health Charitable Funds Committee
held on 10th October 2018

Present:	Tony Rice	TR	Non-Executive Director
	Steve Hitchins	SH	Chairman
	Stephen Bloomer	SB	Chief Finance Officer
	Jonathan Ware	JW	Head of Financial Services
	Jonathan Gardner	JG	Director of Strategy
	Siobhan Harrington	SMH	Chief Executive Officer
	Juliette Marshall	JM	Director or Communications
	Vivien Bucke	VB	Business Support Manager, Finance

Item **Discussion**

18/021 **Welcome, Apologies for Absence** & **Declarations of Interest**

21.1 Apologies were received from Michelle Johnson & Naomi Scott. No Declarations of Interest were received.

18/022 **Approval of Minutes of the meeting held on 30th August 2018**

22.1 The minutes were agreed as an accurate record.

18/023 **Action notes**:

23.1 The Committee discussed the Kanitz Fund; concerns were raised over processes by the ITU and Finance teams and were assured that a combined paper on the bid would come to the next meeting. **Action 1: HM/JW to bring paper.**

4. Medical/NED Representatives for the Committee - JM reported she is awaiting responses from the newsletter for a medical representative on the Committee. SH stated appointment of an additional NED will be made in March when reorganisation of all committees takes place. **Action 2: JM/SH to confirm to December Committee.**

6. Meeting on 'what a good bid looks like' – Booked for next week.

9. Analysis of bids turned down: presented in paper 5. Action Closed.

11.Black History Month – Staff involved had been fundraising and they will not be applying for charitable funds. Action Closed.

12.Simmonds House – SH reported that he will discuss alternative fundraising with David Holt. Action Closed.

Costed website proposal – JM stated the fundraising leadership paper discusses resource to take this forward. **Action 3: JM to bring proposal to December Committee.**

18/024 **Financial Report Month 5 2018/19**

24.1 JW reported on the latest financial position of the charity. Key areas to note were:

- Income a little higher than in previous year. One off donation for £37k that was processed through Finance from Friends of St. Luke's for distributing money around community sites at Christmas. **Action 4: Finance to give the details of the donor to Communications and they can write to thank them.**
- Expenditure, as reported in August is much lower than previous years and planned levels. Reductions are across the board, but largest variance on last year is on equipment. In 2017-18 we had approx. £220k of equipment bought in year, so far this year £20k. **Action 5: Finance to contact areas with plans and ask them to push ahead with expenditure.**

24.2 Other points to raise are in relation to balance sheet:

- Cash deposit due to be renewed. The Charity has sufficient cash to absorb the impact of the donation for the maternity unit and the planned Kanitz fund expenditure.
- The Committee reiterated that it has made the commitment to make the donation for maternity, so no formal decision note should be required. The donation will be made in Q4.

18/025 **Fund Balances**

25.1 The Paper set out the breakdown of funds by the various categories. It was noted that there has not been material movement. The Committee discussed how to encourage ICSUs to spend their funds and future fund raising.

20.2 **The Committee noted the report and the recommendation was agreed**

18/026 **Applications for Funding**

26.1 JW outlined the bids received all of which were within the CFO delegated limits. The Committee were happy with those approved and rejected.

26.2 TR spoke of development of an App for staff. SB felt it sounded like something over and above trust expenditure. **Action 6: The Workforce Director to bid to the next Committee**.

26.3 SMH was keen for an application to be made to provide a display of long serving staff. The Committee were supportive. **Action 7: JM to pull together a bid for the next committee.**

26.4 SB felt that kit purchased by the Charitable Funds should so say on the kit . The Committee agreed.

26.5 The Committee discussed the process for applying for funds and SB confirmed this was included in the budget holder training. **Action 8: JW/JM to report at the next Committee with a revised proposal.**

18/027 **Fundraising Updates**

27.1 JM stated that she would redesign the report in future to be more forward looking and TR asked for goals to be included. JM had examples of legacy packs and provided for SH to view. She felt the draft pack was in line with the best packs however agreed, as

previously noted, that SH wanted examples included. SH reiterated the packs should say where the money will be spent on for example, improving patient care and experience and with the need to consider which group of patients to target; what is the demographic. **Action 9: JM to include case studies.**

27.2 With regard to maintaining a level of activity, JM mentioned the good work of Jo Condon who is looking at contactless giving points; the Trust had been offered two trial devices.

18/028 Update on Fundraising Leadership

28.1 JM had sought advice from the Association of Charities and asked the Committee to agree for membership to be taken up to provide access to additional resource such as attendance from a member of the association on any interview panels. The Committee approved.

28.2 JM stated four providers of fundraising functions had been identified and she felt the creation of the Charitable Funds strategy should be outsourced. The Committee agreed. **Action 10: JM to bring quotes to the Chair of the Committee and the CFO for approval.**

28.3 The Committee discussed how to organise and resource for fundraising going forward.The discussion covered short term need and longer term ambitions and the committee discussed options. JG preferred the option of one supplier for strategy and then contract fundraising for Ifor and other projects. SB felt that the previous, wholly internal arrangement had not delivered expectations as it had not hit the projected target, therefore a new arrangement was preferable as the Trust can set proper targets and can put in contract clauses for what will be needed and JG said this should be reviewed to see demand on internal time. SH warned that the Charity must avoid putting short term gain ahead of long term relationship building. The conclusion was that we engage specialist external help to conduct a strategic review of the options and then consider whether the ongoing resourcing and execution was done by internal or external resource working with the Charity's internal operational team

28.4 **The Committee agreed to outsource the strategy development plus Ifor fundraising for 6 months. In addition a bridging capacity is to be reviewed at each committee.**

28.5 SH felt that Maternity has to be self-contained as is such a large project and JG agreed that a supplier will put all that into the strategy plus a delivery plan.

18/029 **Appointment of clinical representative**

29.1 Discussed under Action notes

18/030 **Maternity NICU Campaign**

30.1 Discussed under Action Notes.

18/031 **Ifor Play Terrace update report**

31.1 JM reported that the Director of Estates and Environment had reviewed the timescales for tendering with the intention of work to start in April and the terrace to be ready for the summer. SH challenged who is the lead for the project. SB confirmed that Estates would manage the build element. SMH felt the relationship with Bright Horizons and fundraising will be with Communications plus ICSU involvement. **Action 11: Update report in Q4.**

18/032 **AOB**

32.1 No other business was reported.