Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
28 November 2018

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**28 November 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

Members – Non-Executive Directors: Steve Hitchins, Chair Deborah Harris-Ugbomah David Holt Professor Naomi Fulop Tony Rice Anu Singh Yua Haw Yoe	**Members – Executive Directors:** Siobhan Harrington, Chief Executive Dr Julie Andrews, Acting Medical Director Stephen Bloomer, Chief Financial Officer 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
Kate Green, Personal Assistant to Director of Workforce
Dr Sarah Humphery, Medical Director, Integrated Care
Swarnjit Singh, Trust Corporate Secretary

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

AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	1400	**Patient story** *Sarah Hayes, Deputy Chief Nurse*	Discuss presentation
2	1420	**Declaration of conflicts of interest** *Steve Hitchins, Chair*	Review
3	1422	**Apologies & welcome** *Steve Hitchins, Chair*	Review
4	1425	**31 October draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1430	**Chairman's report** *Steve Hitchins, Chair*	Review verbal report
6	1440	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review
Quality & patient safety			
7	1455	**Serious Incidents month 7** *Dr Julie Andrews, Acting Medical Director*	Review

Item	Timing	Title and lead	Action
Strategy			
8	1510	**Equally well: Potential benefits of closer integration of physical and mental health service provision at the Whittington Heath site** *Dr Julie Andrews, Acting Medical Director* *Andy Stopher, Deputy Chief Operating Officer*	Review presentation
Operational performance and planning			
9	1535	**Performance dashboard month 7** *Carol Gillen, Chief Operating Officer*	Review
10	1550	**Financial performance month 7** *Stephen Bloomer, Chief Finance Officer*	Review
Governance			
11	1605	**Estates Strategy Delivery Committee terms of reference** *Stephen Bloomer, Chief Finance Officer*	Approve
12	1610	**Greater London Authority Memorandum of Understanding** *Stephen Bloomer, Chief Finance Officer*	Approve
13	1625	**Cyber risk update** *Leon Douglas, Chief Information Officer*	Review
14	1635	**14 November Quality Committee draft minutes** *Anu Singh, Committee Chair*	Review
15	1640	**Questions from the public on matters covered on the agenda** *Steve Hitchins, Chair*	Verbal
16	1645	**Any other business** *Steve Hitchins, Chair*	Verbal
Date of next Trust Board public meeting			
19 December 2018 -1400hrs-1700hrs in the Whittington Education Centre, room 7, 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.			

Agenda item: 4

Minutes of the meeting of the Trust Board of Whittington Health held in public on 31 October 2018 in the Whittington Education Centre

Present:

Steve Hitchins	Chairman
Stephen Bloomer	Chief Finance Officer
Naomi Fulop	Non-Executive Director
Carol Gillen	Chief Operating Officer
Deborah Harris-Ugbomah	Non-Executive Director
Siobhan Harrington	Chief Executive
David Holt	Non-Executive Director
Richard Jennings	Medical Director
Michelle Johnson	Chief Nurse & Director of Patient Experience
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Janet Burgess	London Borough of Islington
Adrien Cooper	Director of Environment
Norma French	Director of Workforce
Raul Gansu	Head of Contracting
Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
Kate Green	PA to Director of Workforce
Sophie Harrison	Assistant Director of Estates & Facilities (Strategy)
Sarah Humphery	Medical Director, Integrated Care

18/140 **Patient Story**

140.01 Patient Experience Manager James Connell introduced Deiqa, mother of Mohamood, accompanied by Tarryn Oberholzer and Vicky Matthews from the Social Communications Team. Also present was Casey Galloway, Patient Experience Officer. James confirmed that this month's patient story had already been recorded and would be circulated following the meeting.

140.02 Dakar introduced her story. Her son Mahmoud was now three years and seven months old, and had been diagnosed with autism in January this year. When Mahmoud was aged 15-16 months his parents had noticed that he appeared to be slow in learning to walk, however other aspects of his development appeared normal. When Mahmoud reached the age of two Dakar noticed that he was becoming increasingly quiet, and requested a GP referral. The GP duly referred

Mahmoud to the social development team, but it was a further seven months before he was given an appointment.

140.03 In the meantime Dakar had read up her son's symptoms and was (in her own words) 90% certain that he was suffering from autism. Her husband was not as well prepared, but attended a workshop run by the social communication team which he found extremely useful. Following his diagnosis, Mahmoud was referred to the eat-well clinic, as he had been struggling with feeding. He dealt well with pureed foods, but was unable to progress to the chewing stage, and Dakar had been told by the GP that this was just a 'fussy stage' which he would grow out of. The clinic however had found that Mahmoud suffered from a type of touching sensitivity, meaning that he was unable to tolerate even having food in front of him, let alone putting it in his mouth.

140.04 After sessions with the team over several months, Mahmoud had made significant progress; he was now able to feed himself and to sit at the table with the other children at his nursery. This meant that he was now getting appropriate nutrition, as well as a supplement to provide him with additional calories. Dakar had studied all the techniques which the team had used in order to be able to replicate them at home.

140.05 Tarryn confirmed the positive progress made by Mahmoud since she had started working with him. Speaking more generally about the service, Tarryn informed the Board that they had spent 26 months creating an eating pathway for all children in receipt of services which begins with a parent workshop to ensure that parents were ready to engage, as this is fundamentally a service centred around care at home. The challenge however was that the pathway was not funded, and the work Tarryn carried out was done in her own time. The service had received 52 referrals in the last ten months. There was also a lack of equity between services provided to Islington and to Haringey.

140.06 Michelle Johnson commented that this service was a prime example of the value of early intervention; adding that October was national AHP month therefore the presentation of this particular story to the Board was timely. David Holt suggested that 'early intervention' should ideally not include such long waits. Board members discussed the need for funding and the sustainability of the services, and Carol suggested this should be discussed at the community services improvement group.

18/141 **Welcome and apologies**

141.01 Steve Hitchins welcomed everyone to the Board, and especially Professor Naomi Fulop, whose position as a Non-Executive Director had now been formally confirmed.

18/142 **Declaration of Conflicts of Interest**

142.01 Referring to the item on Care City in the Chief Executive's report to the Board, Naomi said that she had been working as an advisor to the Nuffield Trust who were commissioned to do the evaluation

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18/143 **Minutes, matters arising & action log**

143.01 David Holt requested an amendment to minute 128.02, saying that the penultimate line should read "the Executive was confident about income…" Michelle Johnson requested an amendment to minute 131.02 – this should now read "staffing ratios remained safe".

143.02 Other than these amendments, the minutes of the Trust Board meeting held on 26th September were approved. There were no matters arising other than those already scheduled for discussion.

Action log

143.03 73.05: It was confirmed that the role of Responsible Officer would be taken on by Julie Andrews as interim Medical Director once her training had been completed; until then, Rob Sherwin would retain the responsibility. This item could therefore be closed.

143.04 95.05: Information on bed modelling was included in the Winter Plan scheduled for discussion later that afternoon; this item could therefore be closed.

143.05 All remaining items on the action log were scheduled for discussion at either Trust Board meetings or seminars later in the year.

18/144 **Chairman's report**

144.01 Steve Hitchins began by reporting on the extremely successful event he had attended to celebrate Black History Month, where Trevor Phillips had been an inspirational speaker. The event had also celebrated the two Windrush winners. Steve paid tribute to the work of Eddie Kent, who had been instrumental in organising these events for around twelve years now.

144.02 The Trust had now signed a memorandum of understanding with Ambitious about Autism, and space on site had been identified for the team.

144.03 Other events Steve had attended since the last meeting included:

- the older people's celebration day
- the launch of the MIAA better birthing initiative
- the annual dinner of the Thalassaemia Society
- world mental health day
- St Luke's day with the chaplaincy
- Haringey CCG's public meeting
- the Twilight team.

144.04 Moving on to events scheduled to take place in November, Steve informed the Board that on Sunday he would be attending a service of Remembrance for the relatives of patients who have died in the Trust's Critical Care Unit. He also planned to attend an event at Manor Gardens on 11th February. Janet Burgess added that there would be a beacon lighting ceremony in Dartmouth Park on the evening of 11 November, as part of a nation- wide tribute to those who lost their

lives in the First World War, and shortly after 7.00pm bells would be rung across the nation.

144.05 The most recent meeting of the STP Advisory Board had not been well attended, however, Steve was pleased to report that for a variety of reasons it had now been agreed to review the governance arrangements for that group.

144.06 Noting this was Richard Jennings's last Whittington Health Board meeting, Steve congratulated him on how much he had achieved during his time both as a Clinical Director and subsequently Medical Director. On behalf of the Board, he thanked him and extended every good wish for his move to St George's.

18/145 **Chief Executive's report**

145.01 Siobhan began her report by noting that the government had recently appointed a Minister for suicide prevention. She also informed Board colleagues that the CQC had recently published its report on Health & Social Care in England; the report was largely positive, but did cite some evidence of fragmentation in the system. Siobhan had attended an engagement event on the government's long-term plan for the health service with Simon Stevens and Matt Hancock. The plan itself was due to be published in late November or early December, STPs would then be required to respond and set out their local plans. An integrated care simulation event had been held in North Central London the previous month, and Siobhan would circulate the write-up of this event to Board members.

145.02 Turning to quality and safety issues within the Trust, Siobhan said that the Trust continued to struggle to meet the ED target; though Whittington Health's performance remained the highest in the sector, the constant (and not insignificant) increase in demand did present challenges. This year's flu vaccination campaign was proceeding well, with 54.7% of staff already having been vaccinated. Those who had received vaccinations elsewhere should inform the Trust as they also counted towards the figures.

145.03 Reporting on workforce and the cultural survey, Siobhan informed the Board that the Trust's response and action plan was not yet complete, since there had been a clear message from staff that the executive team needed to spend a good deal more time listening to staff, and to this end Norma had been instrumental in drawing up a programme of 'listening events', to include three events which would be open to all staff. Several had already taken place and they had generated some really rich information which would be collated into a report. Fair treatment panels had also begun to take place, and four executive directors were also participating in a 'reverse mentoring scheme'.

145.04 Responding to a question from Anu Singh about communicating with staff over the cultural survey, Norma assured the Board that regular communications had been issued, and the Trust Management Group (TMG) was receiving regular reports. It was agreed that details of the open events would be circulated to Non-Executive Directors, who might wish to attend as observers. Michelle had organised a tea party for new nurses, health visitors and midwives, at which a new nursing badge had been launched. These badges would be presented to all these staff groups

by Christmas. The next such event was scheduled to take place on 26th November.

145.05 Drawing attention to the WRES (Workforce Race Equality Standard) data which had been reviewed at the July public board meeting, Norma informed the Board that the figures presented were not accurate, and the WRES 2 figure should read 2.04 (a slight improvement on last year's 2.17 figure). The action plan would be presented to the November Board meeting. Siobhan also reminded the Board that the annual staff survey had now been launched and that all staff were being encouraged to complete it. The survey was being championed by the new ICSUs, and an element of positive competition between the ICSUs was now becoming apparent.

145.06 In answer to a question from Yua Haw about whether there was now a move for the provision of social care to sit within the NHS, Siobhan replied that there were no plans for this to happen locally, however there was a strong and positive history of collaborative working between NHS and local authority services which would stand both organisations in good stead as truly integrated care continued to be implemented. Furthermore, Jonathan added that if services that aligned with the Trust's business development strategy were tendered then consideration would always be given to whether or not the Trust should bid for them.

145.07 Locality working was being progressed and, in the following week, a meeting was scheduled for all heads of services to discuss how collaborative working in localities might be strengthened.

145.08 The board noted the report.

18/146 **Serious Incident (SI) report**

146.01 Richard Jennings informed the Board that two serious incidents were declared during September. The first concerned a baby's unexpected admission to a tertiary unit for specialist care, and the second concerned an elderly patient who had a fall which resulted in a fractured neck of femur and multiple rib fractures. Richard was pleased to report that the long-term prognosis for the baby was good.

146.02 Turning to learning from SIs, Richard referred to issues mentioned in previous reports which had prompted the Trust to look in detail and subsequently strengthen its surgical handover processes. He reminded Board colleagues that two of the surgery team would be attending the Board the following month to discuss the changes and improvements which had taken place within their team. Richard was happy to assure the Board that there was evidence of positive developments taking place.

146.03 Learning from an earlier incident had prompted a review of radiology reporting processes, and Richard informed the Board that a reporting management strategy was being developed in radiology which should result in the provision of contemporaneous reports from X-rays etc.

146.04 The board noted the report and the assurance it provided that the SI process is managed effectively and lessons learnt were shared widely.

18/147 **Quarter 2 Safety & Quality report**

147.01 Introducing this item, Richard said that the report had been produced in line with the standard format approved by the Board, beginning with mortality statistics, reporting on infection prevention and control, and finally providing an update on progress as set out in this year's Quality Account.

147.02 Richard explained that mortality was measured using two different methods, the Hospital Standardised Mortality Ration (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI). Although they follow two different processes, the basic principle is the same, i.e. gathering data from across the country and taking an average. The SHMI calculation takes into account deaths occurring within thirty days of discharge from hospital. Whittington Health's SHMI had until fairly recently been the lowest in the country; there were now three Trusts ahead and the trend was slowly on the rise. In answer to a request from David Holt for more detailed clarification, Richard suggested calling a meeting (to be led by Julie Andrews) to look at this. It was suggested the Quality Committee might scrutinise this report.

147.03 Naomi Fulop enquired about the process used by the Trust to look at avoidable deaths. Richard explained that these fell into two categories, details of which are set out in his most recent report to the Board (September 2018). The aim was to review 90% of Category A deaths and 25% of Category B.

147.04 Concluding, Richard paid tribute to the work of the Infection Prevention & Control Team and other colleagues who had worked so hard to progress the 'flu vaccination programme, including attending sites out of hours with, as he put it, 'great humour and engagement'. He also thanked Julie Andrews for all that she had achieved during her time as Director of Infection Prevention & Control (DIPC), noting that this responsibility had now been taken on by Michelle Johnson.

18/148 **Infection Prevention and Control Annual Report**

148.01 Michelle Johnson introduced the Infection Prevention and Control Annual Report, thanking its authors Julie Singleton and Martin Peache for its production. As above, it was noted that Julie Andrews had stood down as DIPC at the start of 2018/19.

148.02 Moving to specifics, it was noted that:

- MRSA Bacteraemia – the target had been no cases for the year and the Trust had declared two. To date one case had been reported for 2018/19.
- E-Coli Bacteraemia – the Trust had over-achieved on the reduction of E-coli hast year; it had been one of the top 50 in the country and had accordingly received congratulations from Celia Ingham-Clarke. This target was expected to become harder, and attention was currently focused on catheter issues.
- Clostridium difficile – there had been an issue on one particular ward last year; so far this year there had been no repeat of this.
- Surgical site infections – these had been considerably reduced, with the Trust reporting a figure well below that of the national average
- All CQUINS had been achieved.

148.03 Michelle reiterated thanks to Julie, not only for last year's performance, but also for the transformation she had effected, particularly around C. Difficile and MRSA.

18/149 **Delivering Transformation of the Trust's Estate**

149.01 Adrien Cooper informed the Board that the procurement process had now concluded and that Ryder Architecture Ltd. had been appointed to provide architectural and planning support to the Trust. The project had now entered into its mobilisation phase, and the inaugural meeting of an Estates Strategy Delivery Board had been held. Siobhan added that this Board would become a sub-committee of the Trust Board and as such would be chaired by a Non-Executive Director. This would enable decisions to be made through formal delegation by the Board.

149.02 A communications plan was also being developed, and Jonathan Gardner would be touching on this in his report on community engagement, scheduled for discussion later in the meeting. Some engagement work had already been carried out in respect of the Camden & Islington consultation into the development of an in-patient mental health unit on the Whittington Hospital site; there was now further work to do to involve stakeholders in the approach to the masterplan phase. Anu suggested that there might be some learning from the approach taken by MacMillan, and she would share details of this with Jonathan and Sophie.

149.03 Jonathan pointed out that there were some real challenges around pace and affordability, and it would be important to ensure that expectations were based on what was realistic to deliver. He also drew attention to the community engagement work that had already been carried out by the Trust, hoping that this was something that could be built upon. The aim, Steve Hitchins stressed, was to make this project a rolling programme of promoting the positive and bright future for the Trust.

149.04 The paper was formally approved by the Board, and the recommendation to convene the new sub-committee was agreed, with the fine tuning of arrangements delegated to Siobhan and Stephen Bloomer. It was agreed David Holt would chair the sub-committee.

18/150 **Freedom to Speak Up Guardian Report**

150.01 Michelle Johnson explained that the report provided a brief overview of the work of the Freedom to Speak Up Guardian between April 2017 and September 2018. It showed details of the referrals made and consequent information submitted to the national Freedom to Speak Up Guardian. Michelle also drew attention to the development of the Speak Up Inclusion Champions, a further cohort of which was due to be trained the following week.

150.02 Since his appointment as Associate Director of Nursing for the Children & Young People's Services ICSU Dorian Cole would be handing on the Guardian role to a new appointment, due to start in post on 26th November.

150.03 In answer to a question from Steve Hitchins about how the role had developed and changed in the eighteen months since its inception, Michelle replied that good and solid foundations had been built and the right processes had been put in place, there was however a need to carry out some further work around communications. Deborah expressed some concern about the reference made to the seven people who had felt they had suffered some degree of detriment due to the act of raising their concern, and Michelle undertook to look into that. Richard stressed that it was an important aspect of the Guardian's role not just to listen to concerns but to have the authority to act.

18/151 **External Inspection report**

151.01 Introducing this item, Michelle informed Board colleagues that the report summarised information on inspections carried out at the Trust and also served to prepare for the next CQC inspection, which was likely to take place somewhere between February and June next year. All outstanding actions from the CQC inspection were to be completed by the end of the calendar year. Details of the OFSTED inspection currently taking place in Haringey needed to be included, since although the inspection itself was predominantly focused on social care, the environment under inspection was one where Whittington Health staff worked and would therefore be affected by.

151.02 Steve Hitchins asked whether there were any plans to spend some time at a Board seminar looking at the 'well led' aspect of CQC's inspection regime; Norma replied that this had been built into the specification for the Board Development Programme. David Holt commented that it would be useful to have a checklist for committee chairs to help embed good practice.

151.03 It was noted that the Trust was struggling to meet its targets for appraisal and mandatory training, although Richard pointed out that feedback from doctors' appraisals had been extremely positive. It was agreed that ongoing monitoring of these targets was best undertaken through the Quality Committee.

18/152 **Financial report**

128.01 Stephen Bloomer began his report by informing the Board that. at the end of month six, the Trust was reporting a surplus of £4.6m against a planned £4.1m surplus. For the year to date position, the Trust was £100k ahead of its adjusted plan, with a surplus of £3.6m. Income performance was some £2m off plan and work was underway on income recovery to address this variance. The predicted year-end position was to achieve a new control total of £22.7m, subject to the outstanding agenda for change pay award funding being successfully resolved. Stephen Bloomer reminded Board members that the trust had offered an improved financial outturn liked to the transaction with Camden & Islington NHSFT by the end of the financial year and had received confirmation that it was accepted. This had allowed an increase in sustainability and transformation funding which, given that sector performance targets were met, had translated into the improved quarter two financial position also. Pay remained reasonably static; the main challenge was to achieve successful delivery of CIPs, and discussions were being held with all areas to see how best to achieve this. The report given at the previous day's Finance & Business Development Committee had however been largely positive.

18/153 **Performance dashboard**

154.01 Siobhan had reported on ED performance earlier in the meeting, and Carol confirmed that the Trust had not met its planned trajectory for September and attendance figures had continued to rise. There had however been improvement in minors, and paediatric performance had risen in month to 95%. Mental health continued to present a challenge, and generally there needed to be a continued focus on reducing the length of stay and resolving those issues which contributed to difficulties in discharging patients.

154.02 Complaints performance remained good. The position on cancer waits remained fragile, with challenges on the 2-week wait and diagnostic targets exacerbated by issues within endoscopy. Moving on to community indicators, Carol said that a report had just been produced for the Trust Management Group (TMG) and the Clinical Services Improvement Group. It was now possible to see outcomes, and a project lead had recently been appointed for children's services. Within adult services there had been a small 'dip' in September, but it was already possible to see improvement during October.

154.03 There was to be a review of therapy services in Haringey. Good progress had been made within Health Visiting; performance on the 2 hour wait within District Nursing was steadily improving, though for the 48 hours target Carol warned that the data needed to be rechecked. Moving to appraisal and mandatory training, Carol acknowledged that the position remained fairly static, with the expectation being that the ICSUs would draw up trajectories.

154.05 In answer to a question from Steve Hitchins about the zero figure on page 18 of the report, Carol explained that this reflected the fact that the REACH service was not provided in Haringey. It was also noticed that the Friends & Family test results were fairly low in number, and Carol explained that this was largely because encouraging completion of the survey had been dependent on the assistance of volunteers, and James Connell planned to meet with Deborah Clatworthy to see what might be done to improve the situation. Carol was also asked about the bladder and bowel service; she explained that this was a fragile service, and the team was looking to develop a more integrated pathway for the future as a long term plan was needed rather than any 'quick fix'.

18/155 **Quarter 2 Delivery of 2018/19 Trust Goals**

155.01 Jonathan Gardner informed the Board that it was felt it would be helpful to report on the objectives' sub-priorities on a quarterly basis and he presented the report. He suggested that the following year there would need to be more emphasis on developing SMART objectives, Siobhan supported this approach. David asked that future reports highlight areas where there were already concerns. He also praised the quality of the commentary.

18/156 **Winter Plan**

156.01 This item was presented by Carol Gillen, who reminded the Board that production of a Winter Plan was an annual requirement. The paper had already been to the

Trust Management Group. The previous winter had been a very long one, and the team had reviewed things that had gone well and conversely areas that had proved difficult. An A&E Delivery Board post-winter review had also been carried out; this had included looking at data, activity and handovers.

156.02 The Plan then focused on preparation for the winter to come, and Carol informed the Board that the NHS Emergency Care Improvement Programme ECIP team had been working with the Trust on a bed modelling tool, which had proved a useful exercise. Implementation had been hampered however by the simple lack of sufficient physical space, and she made reference to the full capacity protocol, as well as the work being carried out to improve flow. It had also been decided to review the choice policy, and a series of workshops for staff were being run on this.

156.03 Emergency planning lead Lee Smith continued to work on the cold weather protocol, and a series of triggers had been identified to help in deciding when an escalation ward would need to be opened. Yua Haw commended the plan and the comprehensive nature of its content. In answer to a question about recruitment and staff numbers, Carol replied that the Trust was in a far better place than it had been this time last year, and there would be careful planning of annual leave to reduce dependency on temporary staffing, as well as ensuring rotas were produced sufficiently early.

156.04 Stephen Bloomer reminded the Board that up until this year extra funding had been made available to support the additional capacity required to ease winter pressures, however this was no longer to be the case. Steve Hutchins thanked Carol, Lee and the team for their work on winter planning.

156.05 The Board approved the winter plan.

18/157 **Community Engagement – next steps**

157.01 Jonathan began this item by extending his thanks to Juliette Marshall and the communications team. He stressed the importance of this work, which constituted a real step change compared to the approach taken by the Trust in the past. The plan now was for Whittington Health to increase its visibility within the local community and to focus more on the promotion of public health, thus providing increased benefits for the population. The approach would also help the Trust to design an improved environment from which the best services could be provided.

157.02 There would be a phased approach building up to stronger engagement, which could overtime also lead to increasing volunteers and strengthening fundraising. Jonathan acknowledged that there were risks, as with any such strategy, but he hoped that this approach would mitigate against the opposition to change experienced in the past. During discussion the following points were raised:

- there needed to be further clarity on the audiences targeted, and in particular Trust staff
- the importance of primary care needed to be emphasised
- initial focus should be on the achievable
- there was an important distinction between community engagement and patient engagement, and a strategy was already in place for the latter

- it would be important to bear in mind legal issues pertaining to GDPR
- there was an increasing need to increase the use of digital solutions and social media.

157.03 Whilst there was broad endorsement for the approach set out here, Stephen Bloomer queried the need for the additional resource described, saying he did not feel entirely comfortable with the concept of a new approach automatically requiring additional funding; a point with which Norma concurred. Siobhan was concerned however that if insufficient resource was invested in this then good comprehensive engagement would not be achievable. Naomi Fulop felt there was a need to know more precisely what was expected, and Deborah Harris spoke of the value of providing accurate and timely information. Concluding, Steve Hitchins pointed out that all Board members had a degree of responsibility for stakeholder engagement.

157.04 It was agreed that the investment required would be subject to the trust's business case process.

18/158 **Board Committee minutes**

158.01 The minutes of the Workforce Assurance Committee held on 21st September and the minutes of the Charitable Funds Committees held on 30th August and 10th October were received by the Board. Steve Hitchins commended the quality of the data received at the Workforce Assurance Committee.

Action Log

Minute	Action	Date	Lead
97.08 *(carried forward)*	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 Seminar	CG
134.01*(carried forward)*	Board to be assured that all suppliers and contractors are compliant with the Modern Slavery Act	December 2018	JG
136.01*(carried forward)*	Board Assurance Framework to be discussed at the next meeting of the Audit & Risk Committee	November 2018	DH/SB
136.02 *(carried forward)*	All Board sub-committees to look at the methodology used to define risks.	December 2018	All
145.04	Circulate dates of open events would be circulated to Non-Executive Directors who may wish to attend as observers	November 2018	NF
146.02	Two members of the surgery team to attend December 2018 Board meeting to discuss changes and improvements which have taken place in their teams	December 2018	JA
147.02	January 2019 Quality Committee meeting to review Q2 quality and safety report section on mortality and provide clarification on the reasons behind the increase in the summary hospital-level mortality indicator	January 2019	JA
157.04	Investment required for community engagement proposals/activity to be the subject of a business case	December 2018	JG

Meeting title	**Trust Board – public meeting**	**Date: 28 November 2018**
Report title	**Chief Executive's report**	**Agenda Item: 6**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	The purpose of this report is to update board members on key national and local developments as well as highlighting and celebrating achievements of the trust and its staff.	
Purpose:	Review	
Recommendation(s)	Board members are invited to review the report and its content.	
Risk Register or Board Assurance Framework	All BAF entries	
Report history	None	
Appendices	1: Modern Slavery Act update	

Chief Executive's report

This report highlights key national and local developments of interest.

1. National news

NHS leadership

1.1 On 16 November, Matt Hancock, Secretary of State for Health and Social Care, spoke at the Leaders in Healthcare conference about the importance of inspirational leadership in the NHS and its pivotal role in setting organisational culture, including the highest standards of behaviour that underpin empathetic leadership: integrity, honesty, transparency. He also published *Barriers and enablers for clinicians moving into senior leadership roles: review report*[1].

Stronger protection from violence for NHS staff

1.2 The Secretary of State for Health and Social Care also announced a new, zero tolerance approach to tackling deliberate violence and aggression from patients, their families and the public, and to ensure that offenders are punished quickly and effectively. Whittington Health takes seriously any violence and aggression suffered by its staff in the course of their duties and welcomes the new approach which includes the NHS working with the police and Crown Prosecution Service to help victims give evidence and get prosecutions in the quickest and most efficiency way and improved training and support for staff who have been the victims of violence.

2. Local developments

Quality and Safety

Emergency department hour hours' wait

2.1 Overall performance against the 95% target for September was 89.6%, and 88.1% for October. Attendance numbers were higher in October at 9,083 compared to September at 8,899. The October 2018 attendance figure was a 3% increase compared to October 2017. Despite this the 'minors' performance delivered 95.9% and Paediatrics delivered at 94.3% in October. The median wait for treatment did increase in October to 79 minutes against a national standard of 60 minutes however October 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 working on identifying those further actions that will see overall performance improve.

Complaints

2.2 During October 2018 the Trust was due to close 24 complaints; 20 complaints required a response with 25 working days and 4 were allocated 40 working days for investigation due to their complexity. With regard to the 25 working day target for 80% of complaints, the trust achieved a performance of 95%.

[1] https://www.gov.uk/government/publications/clinicians-moving-into-senior-leadership-barriers-and-enablers

Cancer national waiting times performance

2.3 The cancer 14 days to be first seen standard target was breached in September 2018 with a performance of 90.1% against a standard of 93%. This is the first time this standard has not been achieved for a number of years. Capacity issues were identified in September resulting in extended waits for endoscopy patients due to a reduction in capacity for straight to test for colorectal and upper gastrointestinal patients. In addition, incorrectly set booking gates in Haematology were, allowing patients to book their 14 day appointment outside 14 days. Action was taken to increase the number of endoscopy lists from September 2018, with a positive effect of reducing waits. As the backlog is reduced, it is envisaged the trust will be compliant with the national waiting time in November 2018. The incorrectly set booking gates in Haematology have now been reset correctly.

District nursing waiting times

2.4 This indicator has improved since last month, but is still below target at 90.3%. There were three patients who experienced a delay in receiving care. Assurance is provided that these three patients suffered no harm and, if they had been treated within normal timeframe, performance against this indicator would be 98%.

Diagnostic waits

2.5 In October, the trust was successful in achieving all its diagnostic wait targets.

Flu vaccination

2.6 As part of preparations for winter, the trust continues to vaccinate all frontline clinical and medical staff. I am pleased to report that as of 21 November, 70% of frontline staff had so far been vaccinated against winter flu.

Financial

2.7 At the end of month seven, the trust is reporting a surplus of £1.7m against a plan of £2.1m. For the year to date position, Whittington Health is £300k behind its agreed NHS Improvement plan. As reported in previous months, the main pay variance is the result of agenda for change adjustments which the trust feels were only partly-funded. The predicted end year outturn is the achievement of the new control total of £22.7m, subject to remaining agenda for change pay funding being successfully resolved.

Listening events

2.8 Senior trust leaders are continuing to hold a series of listening events to help develop a positive workplace culture through real change. The events have been well-received with staff welcoming the opportunity to help provide excellent and valuable feedback.

2018 NHS staff survey

2.9 As of 19 November, 35.4% of staff had completed the annual staff survey slightly above the average for similar Trusts. The trust's management places a great value on this annual snapshot from our staff and all staff, who have not already done so, are encouraged to take this opportunity to provide this important feedback.

Stop pressure ulcers day

2.10 To mark international Stop Pressure Ulcers Day, NHS Improvement ran a simple awareness campaign and is asking healthcare professionals to wear a red dot as a symbol of support and to start a conversation about how to prevent pressure ulcers. Alongside this, our Tissue Viability Team was also out and about to help us to focus on what we can do to prevent pressure ulcers and held an event where information was made available regarding

the categorisation of pressure ulcers, information on reporting and carers' information packs. The event was open to everyone including anybody who has a caring responsibility, works in or manages a care home or another setting where people are likely to be immobile so please do invite any colleagues, friends or community groups who could benefit. The campaign aimed to renew visibility among healthcare professionals and the public about the damaging impact of pressure ulcers and the benefits of prevention, particularly ahead of winter.

Working hard for better sleep

2.11 A quality improvement group has been working hard to find ways to allow our patients to sleep more soundly and the outputs of their work are coming to a ward near you soon. Consistent feedback from patients who take part in the annual in-patient survey is that they sometimes struggle to get a good night's sleep whilst staying with us. They tell us that not being able to sleep properly has a negative impact on their overall experience of their care here.

2.12 As part of our aim for outstanding and our commitment to acting on feedback, representatives from across the trust including Tony Rice, one of our Non-executive Directors has been busy creating a plan to tackle what leads to sleepless nights on the wards. Even at night our wards are busy places. Patient treatment does not stop at 5pm and start again at 9am. The team therefore have worked to try to identify what steps can be taken to reduce avoidable noise and barriers to sleep and have launched the following initiatives:

- Encouraging wards to adopt "night mode" from 10pm. Lights should be dimmed and new pull up banners are being given to each ward to display once the ward is in 'night mode' to remind anyone entering the ward to try their best to keep unnecessary noise to a minimum.
- Buying new eye masks and ear plugs for every ward which can be given out to patients who request them.
- Buying new headphones which can be loaned to patients who want to watch TV or play games on their mobile or tablet so they don't disturb others.
- Buying new desk lamps for reception desks so that staff can continue to work with the lights dimmed.
- Producing new (disposable) liners for our meal trays which will remind patients of the need to keep noise to a minimum at night and inviting them to request ear plugs, eye masks or headphones.

Redevelopment of St Ann's Hospital site

2.13 The redevelopment of St Ann's Hospital site starts on 19 November. Patients, visitors and staff will start to see building equipment arrive on the St Ann's site from Tuesday 13 November and work taking place from Monday 19 November to Friday 30 November. During this initial period, all the current roads around the St Ann's site will remain open and car parking along the northern road will continue to be available to staff. From 3 December, access to the Trust Headquarters in Orchard House and to the George Marsh Centre (services run by the North Middlesex University Hospital) from the rest of the site will only be possible through the existing pedestrian gate onto St Ann's Road.

Rose Hensman, Interim Associate Director of Maternity and Nursing

2.14 Congratulations to Rose Hensman who has been appointed Interim Associate Director of Maternity and Nursing, the Acute Patient Access, Clinical Support Service and Women's

Health ICSU. The trust is very grateful to Rose for stepping into this role while we wait for our new substantive appointment to start. Rose has many years of experience across the whole service and said: “I have been a midwife for 28 years and started my midwifery career at Whittington as a student midwife. I have worked in all areas of the service in both junior and senior posts. I am very pleased to have this opportunity while we wait for our new Associate Director of Midwifery, Shahida Traying, to start in the New Year”.

New Freedom to Speak Up Guardian

2.15 Congratulations and well done to Ruben Ferreira, who has been appointed as a new Freedom to Speak Up Guardian and will be taking up his post at the end of November 2018.

Nurse Leader of the Year

2.16 I am also pleased to report that Colette Datt, Nurse Consultant in Children and Young People’s Services, was named Nurse Leader of the Year at the annual Nursing Times Awards. Colette has a particular clinical specialism in asthma and allergy. The judges praised her ability to co-produce innovations alongside children and young people. She initiated and leads the asthma friendly schools project in Islington and has enabled schools to maintain key standards and reduce absences due to asthma. This has since led to the development of an under-5’s wheeze project, in conjunction with health visitors and children’s centres. The trust was delighted that it was also represented in another awards category, with Edith Aimiuwu (who also won Children and Young People’s Nurse of the Year 2018 at our own Nursing Awards in May) shortlisted for the Nurse of the Year Award. We are extremely proud to have had two members of staff shortlisted for such prestigious and highly-respected awards.

Modern Slavery Act

2.17 At the previous Board meeting, assurance was sought that contractors for the trust complied with this legislation - details are provided in the appendix to this report.

Appendix 1: Modern Slavery Act update

The board requested assurance that our contractors also abided by the slavery act. The board are asked to know that we now include a statement of requirement in all our procurement processes, and in the subsequent resulting contracts, that the covers this and which the supplier has to sign up to. Namely that the supplier shall:

(i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and

(ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains; it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy."

Where we use a framework or agreement from others, then we would expect to see a similar set of requirements that again the supplier has signed up to.

Board members are asked to receive the update in respect of the action arising from the 31 October 2018 board meeting and to agree that this action is now closed

Meeting title	**Trust Board**	28th November 2018
Report title	Serious Incidents – Month 7 (October 2018)	**Agenda item: 7**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Jayne Osborne, Quality Assurance Officer and SI Co-ordinator	
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.	
Purpose:	For information and discussion.	
Recommendation(s)	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 focus discussion on steps being taken to: • Improve the process of managing trauma patients • Reduce the risks of abnormal investigations, particularly those suggesting cancer, from being overlooked. Reduce the risks of abnormal investigations, particularly those suggesting cancer, being overlooked.	
Risk Register or 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.	
Report history	n/a	
Appendices	• 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).	

Serious Incident Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during October 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 October 2018, bringing the total of reportable serious incidents to 23 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/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 Ref:22623	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 cooling for potential Hypoxic Ischaemic Encephalopathy (HIE).
Diagnostic Incident including delay	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

Category	Month Declared	Summary
Ref:23175		unwarranted delay in appropriately triaging the patient and activating the trauma team. The patient was subsequently transferred to the major trauma centre.
Diagnostic Incident including delay. Ref:24114	Oct 18	An elderly patient had a fall at home resulting in a number of fractures (neck of femur fracture, complex right acetabular fracture and inferior pubic ramus fracture). There may have been a delay in identifying these injures.
Diagnostic Incident including delay. Ref:24930	Oct 18	A patient experiencing seizures was transferred to ITU for monitoring. The patient had a rapid deterioration and arrested; CPR, although initated was unsuccessful. The patient subsequently died.

3.2 The table below details serious incidents by category reported to the NELCSU 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	Mar18	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	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	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 NELCSU between April 2016 – August 2018.

STEIS 2017-18 Category	2016/17 Total	2017/18 Total		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0	0
Apparent/actual/suspected self-inflicted	1	0		0	0	0	0	0	0	0	0
Confidential information leak/Information	6	3		2	0	1	0	0	0	0	3
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	2	7
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	0	0	1
Environment Incident meeting SI criteria	0	1		0	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	0
Failure to meet expected target (12 hr trolley	1	0		0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	3		0	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	0	5
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0	0	0
Medical equipment/devices/ disposables	1	0		0	0	0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	0	0	1
Sub Optimal Care	4	2		1	0	0	0	0	0	0	1
Surgical/invasive procedure incident	0	0		0	1	0	0	0	0	0	1
Treatment Delay	3	4		0	2	0	0	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	0	0	1
Retained foreign object	1	1		0	0	0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**2**	**23**

4. Submission of SI reports

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

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

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in October 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 EIM, and '10@10' in Emergency Department. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted one report to NELCSU during October 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 October 2018. The Trust submitted one report in October 2018.

Summary	**Actions taken as result of lessons learnt include;**
Diagnostic Incident including delay Ref:18774	A patient presented to the Emergency Department with a 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. • The clinical leads in emergency surgery and emergency radiology to reiterate the appropriate timing for CT scans and consultant reporting. • Discussions are taking place between the emergency surgical clinical lead and the general surgical consultant body to standardize the clinical database for handover to reduce transcription, which will then minimise errors. • A Standard Operating Procedure (SOP) is being developed to improve handover practice which will include the direct review of all CT and blood test results by the on-call consultant. • The General Surgical Consultant body to discuss routine protocol practice for consultant-to-consultant handover; as a minimum, acceptable morning handover should be carried out via the telephone. • The Trust's current procedures around consent are being reviewed to include a capacity assessment being completed on Anglia ICE (the Trust electronic system used for requesting and recording clinical diagnostic test).

5. Shared learning

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

learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning. The Safety and Quality Board Report for Quarter 2 2018/19 focussed on the progress the trust has made against its Quality Account Priorities for 2018/19.

Meeting title	**Trust Board**	**Date: 28.11.2018**
Report title	Trust Performance report October 2018 (September 2018 data)	**Agenda item: 9**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	**Emergency Department (ED) four hours' wait:** Overall performance against the 95% target for September was 89.6%, and 88.1% for October. The October 2018 attendance figure was a 3% increase compared to October 2017. Despite this the 'minors' performance delivered 95.9% and Paediatrics delivered at 94.3% in October. **District Nursing visits within 2 hours and 48 hours** This indicator has improved since last month, however still below target at 90.3%. The delay in treatment for 3 patients did not cause patient harm and had the 3 patient's been seen in time the target would have been achieved at 98%. For a further 15 further patients there was a delay in the administrative process, not in patient care. **Cancer:** The Cancer 14 days breached. This is the first time this standard has not been achieved for a number of years. Reason: extended waits for endoscopy patients due to a reduction in capacity for straight to test for colorectal and upper GI patients and incorrectly set booking gates were, allowing patients to book their 14 day appointment outside 14 days. Action: increase in number of endoscopy lists with a positive effect reducing waits. It is likely that the Trust will be non-compliant for this standard again for the same reasons in October 2018 but compliant in November 2018 as the backlog is reduced. The incorrectly set booking gates have now been reset correctly. ***newly added* Cancer ITT – Inter Trust Transfers** Performance is 62.5% against a standard of 85%. This is a new standard which is being monitored very closely as evidence shows that if patients are referred to other providers for treatment they are more likely to breach the 62 day standard. Therefore local Trusts are to make sure that the local pathway for the patient is completed and the patient is transferred over by day 38, so that the receiving Trust has 24 days to treat the patient. All patients were transferred over by day 38 in September 2018 apart	

	from 2 Gynae patients. In this case there have been some delays in diagnosis in the first part of the Gynae pathway. A plan is in place and improving performance. **RTT 52 weeks wait** The 52 weeks breach is a general surgery patient who was incorrectly put on active monitoring on the 18 week pathway. ***newly added* RTT backlog** now reported on the trust performance report. In backlog is 5 patients above the baseline.
Purpose:	To receive assurance of Trust performance compliance
Recommendation(s)	That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	BAF risk 3 - meeting national and local performance targets
Report history	n/a
Appendices	Performance report

Whittington Health NHS

Integrated Performance Report

November 2018

Month 7 (2018 – 2019)

Date & time of production: 22/11/2018 16:23

Summary Page - Indicators

Category	Indicator	17_18 Target	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	Q3 Oct-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	89.1%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	82	81	75	77	95	91	87	79	74	63	75	79	78
Cancer	Cancer - 14 days to first seen	**>93%**	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%		94.1%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%		84.9%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.3%	6.1%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%		2.7%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.2%
Outpatients	Outpatients - FFT % Positive	**>90%**	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	91.3%
Community	Community - FFT % Positive	**>90%**	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	96.1%
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%**	86.7%	78.7%	96.0%	87.0%	90.2%	86.7%	88.9%	95.2%	95.5%	93.2%	90.9%	89.2%	91.7%
Community	% seen <=48 hours of Referral to District Nursing Service	**>95%**	75.0%	86.2%	91.8%	91.0%	86.7%	82.8%	91.1%	82.4%	90.8%	88.4%	87.7%	91.2%	87.6%
Community	Haringey New Birth Visits - % seen within 2 weeks	**>95%**	88.5%	85.9%	92.0%	93.4%	90.5%	89.7%	92.7%	93.4%	90.5%	91.8%	91.6%		91.7%
Community	Islington New Birth Visits - % seen within 2 weeks	**>95%**	96.6%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	92.7%	98.3%	95.3%	96.5%		95.2%

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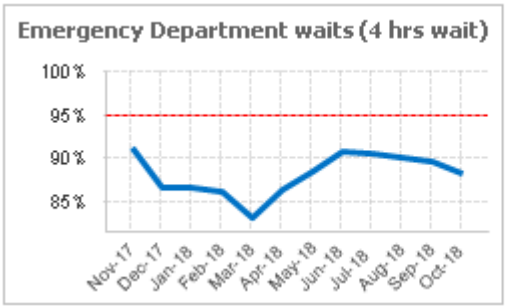
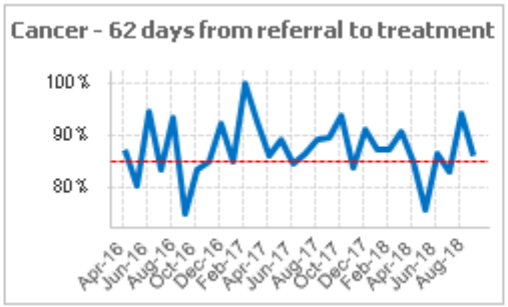
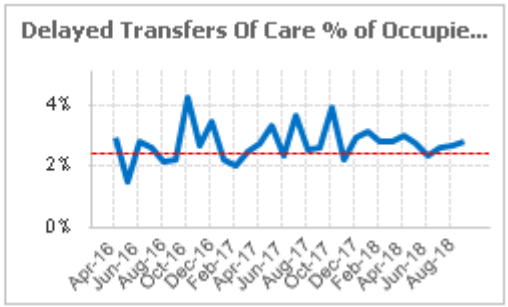
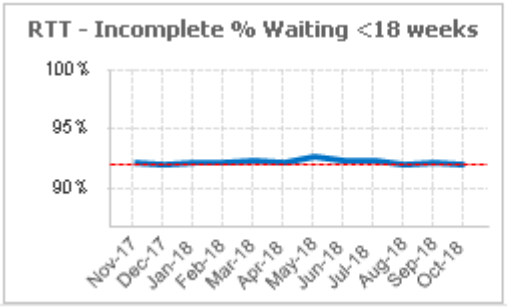
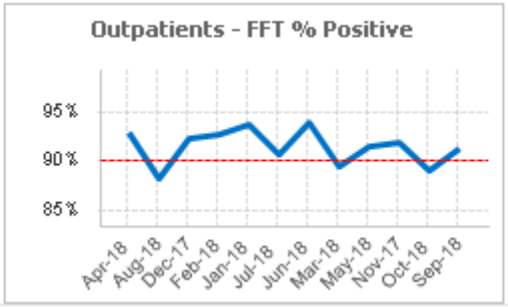
Summary Page - Indicators

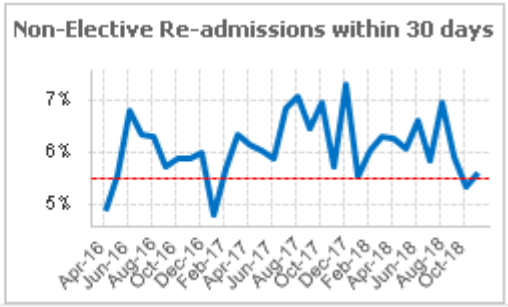












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Oct-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	0	0	0	1	0	1	2	0	0	2	2	1	8	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	28	35	38	27	43	37	52	33	33	26	28	37	246	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	3	3	9	3	3	2	4	2	1	4	0	1	14	
All Areas	Harm Free Care %	>95%	93.5%	94.2%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	96.2%	92.8%	
Maternity	Non Elective C-Section % Rate	<15%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	19.9%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	1	0	1	0	0	0	0	1	0	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	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	17.8%	
All Areas	Serious Incidents	0	2	0	7	1	2	6	8	3	1	1	2	2	23	
Admitted	VTE Risk Assessment %	>95%	96.0%	95.2%	95.1%	95.2%	96.2%	95.9%	95.1%	95.0%	96.1%	93.9%	92.7%		94.8%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	0	0	5	7	0	0	0	0	0	12	

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Safe Services - Commentary

HCAI C Difficile
C. difficile, there was one new case in October 2018 on Meyrick Ward. The review of this case continues.

Pressure Ulcers
There was one avoidable pressure ulcers reported in October 2018. A Category 3 avoidable pressure ulcer developed on the Haringey Central District Nurse caseload. Following investigation the service delivery issue identified was that the patient's needs had not been reassessed regularly, therefore a changed in preventative care plan or equipment was not identified. Pressure relieving equipment was not ordered in a timely fashion.

Non elective C-section
Target not achieved, however, improving trend and below the yearly average.
Our work with UCLH continues, increase in referrals for high risk pregnancies (twins) and ELCS (Elective Caesarean Section) continue.

Serious Incidents
There were 2 SIs declared in October 2018

1.2018.24114 [EIM] Delayed Diagnosis (fracture not identified and patient discharged back to care home)
2.2018.24930 [EIM] Delayed Diagnosis (delay in completing observations and escalation of the deteriorating patient on Victoria Ward)

Both SIs are under investigation.

VTE Risk assessments
VTE not available for reporting this month, due to delays in manual validation. VTE nurse now in place. Expected to be within target next quarter.

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Oct-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	81.6%	
ED	ED - FFT Response Rate	>15%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	13.6%	
Admitted	Inpatients - FFT % Positive	>90%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.1%	
Admitted	Inpatients - FFT Response Rate	>25%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	16.5%	
Maternity	Maternity - FFT % Positive	>90%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	94.9%	
Maternity	Maternity - FFT Response Rate	>15%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	52.0%	
Outpatients	Outpatients - FFT % Positive	>90%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	91.3%	
Outpatients	Outpatients - FFT Responses	400	593	336	420	461	249	327	445	348	310	223	138	328	2119	
Community	Community - FFT % Positive	>90%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	96.1%	
Community	Community - FFT Responses	1500	638	605	875	1157	779	1206	1181	1148	869	890	1122	1159	7575	
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%	95.0%	87.1%	
All Areas	Complaints (including complaints against Corporate division)	N/A	0	0	30	21	33	33	30	39	27	21	14	24	188	

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

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Caring Services - Commentary

FFT

The friends and family tests (FFT) response rates in **maternity** remained higher than the Trust set KPIs. The Maternity teams recorded an overall positive response rate of 95% (KPI: 90%), and a response rate of 40% (KPI: 15%). The sustained success here is due to staff awareness around collecting FFT (staff utilise iPads and telephone call-backs to collect FFT) through the displaying of FFT comments and data via team display boards and newsletters.

There was a slight rise in response rate in **ED** for October (13.1% in comparison to 12.8% in September), though a dip in recommend rate (81% for October; 83% for September). The patient experience team are now sending the monthly comments to the ED Matron who is disseminating these comments to staff, and has created a poster displaying feedback for the ED team in order to raise awareness around FFT collection. Patient experience action plan include; installing a working television in the waiting room to display waiting times (expected to be installed in December 2018) and making the relative's room more welcoming.

Outpatients saw a marked increase on September, with 328 responses returned in October to September's 138. This has been due to increased efforts among the volunteer team in supporting the outpatient teams with inputting. The volunteer team are working to sustain this improvement.

Inpatient FFT responses remain below the Trust set KPI, with a 12% response rate in October against the Trust KPI of 25%. Action: explore whether SMS FFT links can be sent to patients discharged from day surgery. Day surgery discharges account for more than half of inpatient and day case discharges.

Community FFT continue to perform strongly, with another month of over 1,000 responses in October (1,159). The recommend rate also remains high, at 96%. From April – October 2018/19, the Trust's community teams have collected 7,575 FFT. This is an improvement on the corresponding period of 2017/18, where the Trust's community teams collected 6,640 FFT. Ongoing actions to improve FFT pick-up have been focused on the CYP community teams, where the patient experience team is working with IT to allocate an iPad to the CDC at St Ann's, expected to be installed in December 2018.

Caring Services - Commentary

Complaints

During October 2018 the Trust was due to close 24 complaints; 20 complaints required a response with 25 working days and 4 were allocated 40 working days for investigation due to their complexity.

In regard to the 25 working day target of 80%, the Trust achieved a performance of 95%.

- Of the four complaints allocated 40 working days, three were within target dates.
- At the time of reporting, 1 complaint response remains outstanding (Surgery & Cancer).

The majority of complaints were allocated to S&C 42% (10), EIM 30% (7) and ACW 21% (5).
Severity of complaints: 46% (11) were designated 'low' risk; 50% (12) were designated 'moderate' and 4% (1) was designated as 'high risk'.

A review of the complaints for October shows that 'communication' 25% (6), 'medical care' 21% (5) and 'appointments' 13% (3) were the main issue for patients.

- In regard to 'communication', 50% (3) of complainants raised concerns about a 'lack of information', 33% (2) raised concerns about 'no reply to telephone contact' and 17% (1) felt that there was a 'conflict of information between health professionals'
- In regard to 'medical care', 40% of complainants (2) felt that 'inadequate treatment' had been provided, 40% of complainants (2) felt that 'poor treatment' had been provided and 20% (1) felt that 'incorrect treatment' had been provided
- In regard to 'appointments', 100% of the complaints were concerned about long waits for an appointment.

Of the 23 complaints that have closed, (including those allocated 40 working days), 39% (9) were 'upheld', and 52% (12) were 'partially upheld' meaning that, currently, 91% have been upheld in one form or another.

Caring Services - Commentary

PALS
During October 2018, the Trust received 184 PALS enquiries.

34% (63) related to Surgery & Cancer, 28% (51) related to Emergency & Integrated Medicine, 16% (30) related to Women's Health, Outpatients & Diagnostics, 11% (21) related to Adult Community Health Services and 3% (5) related to Children & Young People Services, the remainder related to other Trust service and areas.

Themes – the top three themes were as follows;

38% (70) related to 'Communication' with 'clarity/confusing' and 'no reply to telephone contact' (of which 6 in Endoscopy) cited as the main reasons
22% (40) related to 'Appointments' with 'long waits', 'cancellations' and 'delays' cited as the main reasons
10% (18) related to 'Delay' with 'delay in test results', delay in operation' & 'delay in being seen' cited as the main reasons.

GP concerns
During October 2018, the Trust received 21 concerns from GP Practices relating to individual patient concerns

62% (13) of these related to concerns around 'Communication' with 'clarity/confusing' & 'delays with written communication' cited as the main reasons – the main areas involved were 'Endoscopy' and 'ED Adults'.

Compliments
During October 2018, 28 compliments were logged onto Datix.

32% (9) related to Surgery & Cancer, 21% (6) related to Emergency & Integrated Medicine, Surgery & Cancer, 14% (4) related to Adult Community Services, 14% (4) related to Women's Health, Outpatients & Diagnostics, 11% (3) related to Patient Relations, 4% (1) related to Children & Young People Services and 4% (1) related to Facilities & Estates.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Oct-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	92.5%	90.7%	92.7%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	92.9%	
Maternity	Smoking at Delivery	<6%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	3.4%	5.9%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.7%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.4%	6.1%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	92.5	77.5	76.4	75.9	99.6	88.4	67.1	75.1					77.1	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	101.6	38.7	88.2	77.2	110.6	92.2	55.9	76.7					74.5	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14		0.74			0.76			0.76					0.76	
Admitted	Mortality rate per 1000 admissions in-months	14.4	8.5	12.0	9.4	10.0	10.3	7.3	7.7	6.4	5.3	4.7	5.0	5.5	6.0	
Community	IAPT Moving to Recovery	>50%	53.0%	50.9%	47.5%	51.4%	59.4%	56.3%	53.4%	58.2%	52.4%	55.7%	57.0%		55.4%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	86.7%	78.7%	96.0%	87.0%	90.2%	86.7%	88.9%	95.2%	95.5%	93.2%	90.9%	89.2%	91.7%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	75.0%	86.2%	91.8%	91.0%	86.7%	82.8%	91.1%	82.4%	90.8%	88.4%	87.7%	90.6%	87.5%	
Community	% of MSK pts with a significant improvement in function (PSFS)	>75%			89.3%	82.7%	78.1%	80.1%	74.0%	69.5%	76.5%	81.7%	68.5%	83.0%	76.8%	
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%	83.7%	82.4%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	77.3%	85.7%	76.5%	70.4%	78.5%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	76.8%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	92.9%	92.2%	93.4%	96.0%	96.8%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	93.2%	

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Effective Services - Commentary

Breastfeeding initiated

Increased to 93.2%.

- Audit of Mother's carried the end of October 18. The results are being analysed, recommendation will be put in in readiness to be submitted to Baby Friendly Initiative by 5th December and to present to the senior team.
- Monthly updates at the senior team meeting continue.

Smoking at delivery

3.4%, a great improvement from last month. Senior team continues to work with Smoking Cessation Team to receive feedback about referrals and percentage of women who quit smoking in pregnancy.

Non-elective re-admission

Achieved for October 2018

District Nursing 48hr

This indicator has improved since last month, however still below target at 90.3%. The delay in treatment for 3 patients did not cause patient harm and had the 3 patient's been seen in time the target would have been achieved at 98%. For a further 15 patients there was a delay in the administrative process, not in patient care.

The total of 18 patients were affected as follows:

6 patients were signposted to another service / clinic and were seen by them. The patients did not meet the DN criteria, 1 patient was in hospital and this was not inputted, 1 patient refused treatment within the 48hour timeframe, however it was not put on the system with the timeframe, 1 patient was a Hackney patient and referred back cross border, 1 patient was seen within 72 hours and as planned, 1 patient was actually seen in hospital after admission, 6 patients were not entered on RiO; this was an agency nurse without a RiO card and access to RiO. This has since been discussed with the Service Managers (DN & Temp Staffing) communication to the nurses and Agencies has been made with follow-up by PD to ensure compliance with record keeping and 2 patients have no NHS numbers in the system. They were found to be phlebotomy and not outcome on time.

Responsive Services - Indicators and Performance

			Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3		
Category	Indicator	18_19 Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	89.1%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	82	81	75	77	95	91	87	79	74	63	75	79	78	
ED	Ambulance handovers waiting more than 30 mins	0	15	34	34	37	69	22	41	16	18	9	12		118	
ED	Ambulance handovers waiting more than 60 mins	0	3	11	12	3	18	8	0	1	0	10	2		21	
ED	12 hour trolley waits in A&E	0	0	0	0	0	0	0	0	0	2	0	0	0	2	
Cancer	Cancer - 14 days to first seen	>93%	96.1%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%		94.1%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	97.9%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%	95.8%	100.0%		98.5%	
Cancer	Cancer - 62 days from referral to treatment	>85%	83.6%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%		84.9%	
Cancer	Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%											89.5%		89.5%	
Cancer	Cancer ITT - % of Pathways sent before 38 Days	>85%											62.5%		62.5%	
Cancer	Cancer - % Pathways received a Diagnosis within 28 Days of Referral							65.2%	61.9%	50.0%	93.0%	93.0%	80.4%		82.2%	
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%									
Cancer	Cancer - 62 Day Screening	>90%									100.0%	100.0%			100.0%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	98.9%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
Access	RTT - Incomplete Waiters Backlog at Month End	16227	14831	15251	15224	15648	16227	16158	16502	16716	16567	16363	16260	16232	114798	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3		
Indicator	17_18 Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	2018-2019	Performance
Breast	>85%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%	100.0%	86.7%			
Gynaecological	>85%	0.0%	100.0%	100.0%	100.0%	0.0%	33.3%		40.0%		100.0%	66.7%			
Haematological (Excluding Acute Leukaemia)	>85%					100.0%		50.0%	100.0%	100.0%	100.0%	60.0%			
Lower Gastrointestinal	>85%	76.9%	85.7%	75.0%	66.7%	100.0%	72.7%	66.7%		71.4%	100.0%	100.0%			
Lung	>85%	100.0%	100.0%	100.0%	50.0%		100.0%	50.0%	100.0%	100.0%	100.0%	0.0%			
Other	>85%					100.0%				100.0%					
Skin	>85%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%			
Testicular	>85%							100.0%			100.0%				
Upper Gastrointestinal	>85%	0.0%	66.7%	0.0%	50.0%		66.7%	100.0%	100.0%	0.0%	0.0%	100.0%			
Urological (Excluding Testicular)	>85%	100.0%	83.3%	100.0%	100.0%	66.7%	90.0%	58.8%	81.8%	68.4%	77.8%	100.0%			
Sarcoma	>85%	0.0%				50.0%									

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3		
Indicator	17_18 Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	2018-2019	Performance
Breast	>93%	97.3%	99.0%	98.8%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%	97.5%	96.4%		97.7%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	100.0%	100.0%	96.2%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%	98.0%	97.4%		97.2%	
Haematological	>93%	88.9%	100.0%	100.0%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%	37.5%	62.5%		63.0%	
Lower Gastrointestinal	>93%	93.9%	90.6%	87.2%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%	88.2%	82.4%		91.6%	
Lung	>93%	84.2%	100.0%	96.2%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%	100.0%	90.0%		95.0%	
Other	>93%														
Skin	>93%	100.0%	100.0%	98.0%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%	98.8%	97.4%		97.7%	
Upper Gastrointestinal	>93%	78.8%	60.0%	73.5%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%	55.0%	20.6%		68.6%	
Urological	>93%	98.5%	100.0%	98.9%	97.3%	95.5%	93.6%	98.0%	89.0%	89.8%	94.7%	97.4%		93.7%	

Responsive Services - Commentary

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

Overall performance against the 95% target for September was 89.6%, and 88.1% for October. Attendance numbers were higher in October at 9,083 compared to September at 8,899. The October 2018 attendance figure was a 3% increase compared to October 2017.

Despite this the 'minors' performance delivered 95.9% and Paediatrics delivered at 94.3% in October. The median wait for treatment did increase in October to 79 minutes against a national standard of 60 minutes however October 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 working on identifying those further actions, including Quality Improvement projects around flow in CDU and early escalation for speciality response, that will see overall performance improve.

Ambulance activity has also continued to increase but performance against the 15 and 30 minute handover time standards has remained good. In October over 99% 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. A focussed LAS Handover action plan has been developed with the aim to meet the national KPI of 15 minutes ambulance arrival to handover.

The trust has seen sustained improvement in the number of DTOC patients and stranded patients throughout September and October.

Actions:
The Emergency Department are continuing to focus on the 'first 60 minutes' of a patients journey and have embedded a new streaming process which is being supported by a Medical enhanced Rapid Assessment and Treatment Model with the aim to meet the national 95% 4 hour standard.

Diagnostic waits

Achieved

Responsive Services - Commentary

Cancer

The Cancer '14 days to be first seen' standard has been breached in September 2018 with a performance of 90.1% against a standard of 93%. This is the first time this standard has not been achieved for a number of years.

Capacity issues were identified in September resulting in extended waits for endoscopy patients due to a reduction in capacity for straight to test for colorectal and upper GI patients. Incorrectly set booking gates in Haematology were, allowing patients to book their 14 day appointment outside 14 days.

Action: increase in number of endoscopy lists from September 2018, with a positive effect reducing waits. It is likely that the Trust will be non-compliant for this standard again for the same reasons in October 2018 but compliant in November 2018 as the backlog is reduced, which will be reported in January 2019. The incorrectly set booking gates in Haematology have now been reset correctly.

14 days to be first seen report: 89.95% against the national standards of 93%
Area of concern:
Colorectal: 82.35%, 18 breaches out of 102
Haematology: 62.50%, 3 breaches out of 8
Lung: 90%, 1 breach out of 10
Upper GI: 20%, 28 breaches out of 35

62 day report: 86.2% and with reallocation performance we have an improved 62 day compliance of 89.5%.

Breast: 1 breach, patient was found to have a 2nd lesion on the day of surgery.
Gynaecology: 3 x 0.5 breach, ITT were within 38 day.
Haematology: 1 breach, complex case, patient was transferred from Colorectal to Haematology following multiple investigations.
Skin: 0.5 breach, ITT within 38 day.

Responsive Services - Commentary

Cancer ITT – Inter Trust Transfers

Performance is 62.5% against a standard of 85%.

This is a new shadow standard which is being monitored very closely as evidence shows that if patients are referred to other providers for treatment they are more likely to breach the 62 day standard. Therefore local Trusts need to make sure that the local pathway for the patient is completed and the patient is transferred over by day 38, so that the receiving Trust has 24 days to treat the patient.

All patients were transferred over by day 38 in September 2018 apart from 2 Gynae patients. In this case there have been some delays in diagnosis in the first part of the Gynae pathway. A plan is in place with expected improvement in performance as this will be monitored from April 2019 onwards.

RTT 52 weeks wait

The 52 weeks breach is a general surgery patient who was incorrectly put on active monitoring on the 18 week pathway. This stopped the 18 week clock. This meant that this patient was not visible as waiting to be treated. The administrative error was picked up by the regular validation checks. Two pathways were created for the patient in error.

The patient's referral has been reviewed by a consultant surgeon and there is no clinical harm. The patient has been contacted and has been booked a diagnostic test date of choice. All stopped clocks are being reviewed to assure there are no further breaches.

RTT backlog

The size of the backlog of RTT is the number of patients waiting to be treated on an 18 week pathway.

The value that the Trust is being measured against is the size of the backlog at the end of March 2018.

The table shows this is triggering red for October 2018; however it is only 5 higher than the baseline.

Monitoring in place on a regular basis and the current trajectory is downwards; as all specialities are working hard to a) deliver the contracted activity plan and b) each individual sub speciality will be compliant for 18 weeks.

Community Average Waits

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	85.70%	28.60%	45.50%	13.7	22	>95%						0
Community Matron	>95%	6	98.00%	88.40%	96.20%	1.5	53	>95%	2	100.00%				0
Adult Wheelchair Service	>95%	8	97.10%	87.10%	95.00%	3.2	40	>95%	2	100.00%				0
Community Rehabilitation (CRT)	>95%	12	93.90%	91.40%	92.70%	4.2	110	>95%	2	45.70%	38.50%	60.00%	3.2	40
ICTT - Other	>95%	12	94.50%	89.60%	92.60%	5.4	243	>95%	2	34.20%	54.00%	78.00%	1.8	59
ICTT - Stroke and Neuro	>95%	12	57.10%	78.00%	93.10%	5.8	58	>95%	2	64.00%	67.60%	73.90%	1.6	23
Intermediate Care (REACH)	>95%	6	80.40%	78.60%	89.80%	4.4	88	>95%	2	62.10%	90.00%	82.90%	1.9	76
Paediatric Wheelchair Service	>95%	8	87.50%	66.70%	100.00%	2.8	8	>95%						0
Bladder and Bowel - Adult	>95%	12	49.60%	46.00%	43.20%	18.9	146	>95%						0
Musculoskeletal Service - CATS	>95%	6	86.20%	80.90%	70.00%	4.7	414	>95%						0
Musculoskeletal Service - Routine	>95%	6	82.50%	78.00%	72.90%	4.5	1581	>95%	2			33.30%	3.6	<5
Nutrition and Dietetics	>95%	6	94.80%	80.20%	90.10%	3.2	272	>95%	2		80.20%	90.10%	0.7	<5
Podiatry (Foot Health)	>95%	6	85.50%	76.20%	83.40%	4.5	710	>95%	2	100.00%	100.00%			0
Lymphodema Care	>95%	6	94.40%	92.60%	100.00%	3.2	31	>95%						0
Tissue Viability	>95%	6	100.00%	100.00%	92.90%	1.5	85	>95%						0
Cardiology Service	>95%	6	90.50%	95.80%	100.00%	2.5	22	>95%	2	100.00%	100.00%	83.30%	1.6	6
Diabetes Service	>95%	6	76.70%	84.90%	100.00%	1.9	56	>95%	2	100.00%	100.00%			0
Respiratory Service	>95%	6	89.10%	93.80%	100.00%	1.8	78	>95%	2	66.70%	100.00%	100.00%	0.1	<5
Spirometry Service	>95%	6	46.30%	53.80%	76.10%	4.6	46	>95%	2	0.00%				0

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Haringey Adult Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12					0	>95%						0
Community Matron	>95%	6	100.00%	83.30%	100.00%	1.2	12	>95%	2					0
Adult Wheelchair Service	>95%	8	97.10%	86.70%	94.90%	3.1	39	>95%	2	100.00%				0
Community Rehabilitation (CRT)	>95%	12	100.00%		100.00%	1.4	<5	>95%	2			100.00%	1	<5
ICTT - Other	>95%	12	94.30%	89.50%	92.10%	5.6	229	>95%	2	32.40%	56.40%	78.20%	1.8	55
ICTT - Stroke and Neuro	>95%	12	56.10%	77.80%	92.90%	5.6	56	>95%	2	65.20%	63.60%	72.70%	1.6	22
Intermediate Care (REACH)	>95%	6	100.00%	0.00%	100.00%	3.7	<5	>95%	2	0.00%	100.00%	100.00%	0.5	<5
Paediatric Wheelchair Service	>95%	8	87.50%	62.50%	100.00%	2.8	8	>95%						0
Bladder and Bowel - Adult	>95%	12	29.80%	42.90%	37.30%	20.8	51	>95%						0
Musculoskeletal Service - CATS	>95%	6	81.60%	77.90%	73.20%	4.5	224	>95%						0
Musculoskeletal Service - Routine	>95%	6	80.30%	78.90%	77.90%	4.3	823	>95%	2					0
Nutrition and Dietetics	>95%	6	94.70%	78.70%	89.90%	3.3	159	>95%	2					0
Podiatry (Foot Health)	>95%	6	86.90%	72.00%	80.50%	4.6	348	>95%	2					0
Lymphodema Care	>95%	6	85.70%	92.30%	100.00%	3.6	19	>95%						0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	1.2	15	>95%						0
Cardiology Service	>95%	6	83.30%	94.40%	100.00%	2.5	12	>95%	2			100.00%	0.7	<5
Diabetes Service	>95%	6	61.90%	79.40%	100.00%	2.1	36	>95%	2		100.00%			0
Respiratory Service	>95%	6	100.00%	95.70%	100.00%	2.1	29	>95%	2	50.00%				0
Spirometry Service	>95%	6	46.30%	53.80%	75.60%	4.7	45	>95%	2	0.00%				0

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Islington Adult Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Avg Wait (Oct-18)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	75.00%	25.00%	20.00%	17.3	10	>95%						0
Community Matron	>95%	6	97.00%	90.30%	95.20%	1.6	42	>95%	2	100.00%				0
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	93.30%	91.00%	92.40%	4.3	105	>95%	2	48.50%	36.80%	58.80%	3.4	34
ICTT - Other	>95%	12		100.00%	100.00%	0.6	3	>95%	2			0.00%	3	1
ICTT - Stroke and Neuro	>95%	12		100.00%			0	>95%	2			100.00%	0.9	1
Intermediate Care (REACH)	>95%	6	81.00%	80.30%	90.00%	4.5	80	>95%	2	62.50%	89.50%	81.70%	2	71
Paediatric Wheelchair Service	>95%	8					0	>95%						0
Bladder and Bowel - Adult	>95%	12	75.40%	53.70%	52.30%	16.6	65	>95%						0
Musculoskeletal Service - CATS	>95%	6	92.10%	85.00%	65.60%	4.9	186	>95%						0
Musculoskeletal Service - Routine	>95%	6	87.00%	79.30%	67.10%	4.8	635	>95%	2			50.00%	1.6	2
Nutrition and Dietetics	>95%	6	95.40%	84.00%	92.90%	2.9	98	>95%	2			100.00%	0.7	1
Podiatry (Foot Health)	>95%	6	84.30%	79.70%	86.50%	4.3	356	>95%	2	100.00%	100.00%			0
Lymphodema Care	>95%	6	100.00%	92.90%	100.00%	2.5	12	>95%						0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.7	42	>95%						0
Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.4	10	>95%	2	100.00%	100.00%	80.00%	1.7	5
Diabetes Service	>95%	6	93.00%	100.00%	100.00%	1.7	20	>95%	2	100.00%				0
Respiratory Service	>95%	6	82.10%	92.90%	100.00%	1.7	49	>95%	2	75.00%	100.00%	100.00%	0.1	2
Spirometry Service	>95%	6					0	>95%	2					0

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Children's Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
Service	Team Group	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Average Wait (Oct)	No. of Initial Contacts (Oct)	% Target	Target Weeks	Aug-18	Sep-18	Oct-18	Average Wait (Oct)	No. of Initial Contacts (Oct)
CAMHS	CAMHS Core - Islington	>95%	8	63.40%	61.50%	51.30%	8.6	158	>95%	2	66.70%	85.70%	100.00%	0.8	10
	CAMHS NDT / ADHD - Islington	>95%	8	33.30%	50.00%	0.00%	28.1	10	>95%	2					0
	CAMHS Schools - Islington	>95%	8	33.30%	57.10%	70.00%	6.6	10	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	100.00%	100.00%	100.00%	1.6	1	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	87.30%	87.40%	85.00%	1.3	100	>95%	1	100.00%	100.00%	100.00%	0.2	7
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	0.00%	0.00%	42.3	4	>95%	1	0.00%	0.00%	0.00%	32.6	8
	Community Paediatrics - Haringey (NDC)	>95%	12	66.70%	83.30%	66.70%	9.8	3	>95%	1	0.00%	9.10%	0.00%	9.5	24
	Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	92.30%	100.00%	0.2	36	>95%	1	100.00%	0.00%	100.00%	0	1
	Community Paediatrics - Haringey (Other)	>95%	12		100.00%	100.00%	3.1	3	>95%	1	33.30%	0.00%	20.00%	4.6	5
	Community Paediatrics - Islington	>95%	12	63.60%	61.50%	58.10%	11.3	31	>95%	1	100.00%	0.00%	100.00%	0.1	6
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	100.00%	100.00%	66.70%	10.6	6	>95%						0
	Family Nurse Partnership - Islington	>95%	12	100.00%	66.70%	33.30%	10.7	3	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.5	28	>95%						0
IANDS	IANDS	>95%	8	83.30%	89.50%	64.30%	6.6	14	>95%						0
	IANDS - SCT	>95%	8	0.00%	0.00%	6.30%	17.7	16	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	81.80%	100.00%	82.40%	3.6	17	>95%						0
	Looked After Children - Islington	>95%	4	87.50%	50.00%	83.30%	2.7	12	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	66.70%	42.90%	38.10%	14.8	21	>95%	2			0.00%	3	1
	Occupational Therapy - Islington	>95%	8	70.00%	53.30%	100.00%	1.6	10	>95%	2					0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	0.00%	100.00%	75.00%	6.4	4	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	68.40%	81.80%	66.70%	5.8	15	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	8	66.70%	33.30%	63.00%	6.6	27	>95%						0
	Physiotherapy - Islington	>95%	8	65.10%	67.20%	80.30%	5	147	>95%						0
PIPS	PIPS	>95%	12	100.00%	100.00%	100.00%	3.8	26	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	6	21.10%	18.00%	34.10%	11.8	85	>95%	2	100.00%	66.70%	100.00%	1.9	1
	SALT - Islington	>95%	6	64.10%	49.10%	38.30%	9.3	60	>95%	2		100.00%			0
	SALT - MPC	>95%	6	25.90%	65.20%	57.70%	6.7	26	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	100.00%	76.50%	85.20%	5.3	88	>95%						0
	School Nursing - Islington	>95%	12	100.00%	87.50%	87.00%	5.4	23	>95%						0

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Responsive Services - Commentary

Community waiting times Adult Services

Service	Summary of improvement work undertaken during October2018. Was CSIG Waiting Time Improvement Target / Was Trust Board KPI met? If not, please give reasons.	Mitigating actions being taken (if target was not met)	What improvement measures are planned for the next 3 months? Expected date for target to be achieved.
Bladder and Bowel	• CSIG target of 65% for October not met. • • 46.1% of patients receiving routine appointment in 6 weeks. • • The fragility of the service has been recognised and proposals are being developed alongside improvement work, to develop a new integrated pathway. •	• Regular monitoring of the Patient Tracker List (PTL) to review longest waiting patients and to prioritise scheduling of appointments for these patients. • • Opt-in letters sent on a weekly basis to longest waiting patients to offer first appointments. • • Patients on PTL waiting from 18 – 52 weeks all now have appointments or waiting for discharge as not responded to opt- in letter. • • A physiotherapist currently seconded to team for one day per week has agreed to increase time to two days per week. • • This will help to increase the capacity available for new patients and first appointment slots. It is anticipated that this will have an impact on performance with respect to this in November/December.	• As described under mitigating actions; the doubling of time that the seconded physiotherapist is able to provide, from one to two days per week, will mean more first appointments can be offered. • • Camden's withdrawal, in January 2019, will mean that greater capacity is available to increase clinic time for patients from Haringey and Islington. This will mean that patients are seen more quickly. • • Alongside the mitigating actions set out in the previous column, proposals for a new integrated Continence pathway, with a single point of access are also being developed. • • Process Mapping sessions are being held in December to map the 'as is' picture with respect to Adult and CYP Continence services. A joint session to co-design the new pathway is being held in January.

Nutrition and Dietetics	• CSIG target of 95% not met in October. • • October saw a 9.6% improvement in wait times compared to August. Now at 90.8% seen within 6 weeks. • • Main reason for a drop was due to a Camden clinic waiting list that had lost capacity and a delay in triage.	• Extra clinics opened up to reduce long waits in Camden clinics. Backlog now removed and there are not patients currently waiting for this clinic. • • Mental Health patient waiting list in Islington targeted with extra clinic slots opened to reduce number of patients seen beyond 6 weeks. • • Weekly clinical diary management to ensure all appointment slots are utilised. • • Weekly checks by admin to ensure that opt in letters sent in a timely manner (noticing delays of up to 2 weeks). • • Weekly checks by admin that housebound patients have appointments booked within 6 weeks. • • Weekly checks to ensure that triage undertaken on a daily basis with minimal delay.	• A review of the triage process to ensure that only patients that meet the triage criteria are accepted. • • Focusing on reducing DNA rates to increase capacity further. Currently ay 14% for October 2018. Will be delegating telephone reminders to dietetic assistants who we are currently in process of recruiting. • • Staff are attending a group consultation training session to enable Haringey and Islington to create group consultations – will increase productivity and further reduce wait times.
Lymphedema	• CSIG target of 95% exceeded. Waiting times target met for both Haringey and Islington at 100% for routine appointments.	• Not applicable – target met.	• Continuing with current measures of bringing new referrals forward into cancellation slots where possible (if contact details for patients are available for short notice telephone contact.) • Continued flexible working between Islington and Haringey sites to respond to any increases in referrals for each area, rather than specific fixed clinic dates for each area regardless of demand.
Podiatry	• CSIG target of 90% for October not met. • However, service has achieved 83.5% of patients seen within 6 week target. This is 7.2% up on September. • Appointment slots were lost last month due to sickness, which resulted in a loss of planned capacity last month. Extra slots planned to any impact during November.	• Close monitoring of opt in interactive worksheets, which currently indicate that '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.	• Blitz clinic for new patients to take place through the majority of December to ensure capacity does not fall due to Christmas holidays. • Service is confident that the CSIG target of 95% for December 2018 will be achieved.

Diabetes	• CSIG target of 85% - 90% for October exceeded, with 100% of patients waiting for routine appointments seen within the 6-week target. • Triage was done within 24 hours of getting the GP referral • Extra additional pre-assessment clinics were open at Haringey. • Extra efforts for all members of the team to record face-to-face and first telephone consultations appropriately.	• Not applicable. Target met.	• To consolidate and maintain 100% waiting times target. • • Embedding triaging within 24 hours of getting GP referrals. • • To ensure all patients are seen within 2-3 weeks after GP referral • • To ensure all face to face appointments are recorded appropriately and telephone clinical advice before first appointment for a new patient is recorded as 1st telephone consultation achieve.
Respiratory	• CSIG target of 85% for October exceeded with 100% achieved for routine appointments. • (Note: Spirometry separated from Respiratory for CSIG reporting, i.e. Community Services Dashboard). • Consistent improvement seen in waiting times for routine appointments in September, October and into November •	• Not applicable. Target met. • (See separate commentary for Spirometry).	• Daily triaging of new referrals. Patients contacted the same or following day on receipt of referral to discuss referral and accepted/discharged as necessary. • If criteria met next appointment offered where waiting times are lowest. • All patients booked at any venue with capacity to be seen within 6 weeks regardless of where the exercise venue is. • Patients who cannot commit programme, but would like to attend in the next 3 months now discharged and can self-refer by contacting the service when ready to start. • If unable to contact patient the referral is discharged 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 with in next 3 months • 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	• CSIG targets tbc. Performance at 75.6% for routine appointments, a 21.8% increase from September. • For patients that have gone beyond 6 weeks this is generally because they have cancelled or chosen a later clinic date. We continue to check PTLs weekly to help reduce those that go over 6 weeks. • Patients often referred to the service when exacerbating and spirometry should only be done 6 weeks post exacerbation. • This impacts significantly on the 6 week Patient Tracker	• Patients returning phone calls post CUBY (Contact Us By) several weeks after discharge. The admin team is then reversing the referral multiple reasons, (most often exacerbation or not well enough to attend). • All urgent referrals now removed and no longer being incorrectly sent to CRAT (Central Referral Assessment Team). • Improvement in performance is due to above measures. There will be patients that are unwell and cannot attend their appointment.	• Monitoring output of LTC admin and action plan being complied. • Weekly review of Patient Tracker List (PTL). • Continuing to ensure triaging is undertaken three days per week. • Explore potential automated SMS from RiO - liaise with RiO. • Recruitment of Band 3 post-recruit post ASAP. Cover will be provided as necessary and in order to limit impact on clinic capacity.

	List (PTL) and we are unable to change this. •	• The service continues to triage 3 days per week so that CUBY letters can be sent by admin for the patient to book appointments quickly. LTC admin has dedicated time for respiratory so that CUBYs are discharged at the correct time avoiding long waits building up in the PTL.	• Winter period/flu season- our patient cohort most affected at this time of year and we should expect to see missed appointment and/or DNAs. • We hope to achieve CSIG target of 80% of patients waiting for routine appointments seen within 6 weeks by November.
REACH	• CSIG target of 88% for routine appointments exceeded, with 90.4% achieved in October. • Productivity workshop held with Speech and Language Therapy (SLT) staff to review current processes of working and to identify areas for improvement. • Action plan is being updated accordingly – opt in letters introduced from 29 October	• Measures and an action plan to improve performance with respect to target times for urgent appointments are being developed. • Leadership session held with Organisational Development (OD) for Head of Service, Team Leaders, Band 7 OTs and physiotherapists, to improve ways of working as leadership team. • Action plan for physiotherapy and OT being updated accordingly.	• Service managers for REACH and C&I meeting to discuss the dementia pathway. • Meeting with Clinical Commissioning Group (CCG) on 12 November on SLT capacity. • Continued implementation of agreed measures detailed in action plan. • On track to meet CSIG target of 95% with respect to routine appointments by March 2019.
ICTT **(Other)** **(Stroke and Neuro)**	• CSIG target of 92% for October met. • Other, which reached 92.2% with respect to routine appointments, exceeding the CSIG target of 92% for October. • ICTT Stoke and Neuro saw an improvement of 14% improvement since September, with the service achieving 92.9%.	• Booking into vacant slots and filling cancelled slots at short notice. • Proactive management of the waiting lists by team leads and admin staff to avoid breach of waiting times. • Extra slots for new clients requested and given by therapy staff.	• Expectation is to meet the 95% target in November and maintain in December. • It is anticipated that some of the vacancies will be filled by November and effects on team performance realised by December. •
CATS **MSK Physiotherapy**	• CSIG target of 89% for October not met • 70.1 % of MSK CATS patients were seen in the 6 weeks. • Increased referral rate from practices not in the Single Point of Access (SPOA) pilot have impacted on waiting times not calculated for in the SPOA project planning • Since the SPOA pilot number of referrals received has increased by approximately 200/ month from 2016/17 baseline data	• New Advanced Physio Practitioners (APP) starting between September 2018 and January 2019 linked with SPOA funding • One extra APP post to be created to allow for increased referral rate not anticipated in non-pilot practices over the last year. Hope to have staff in post in 4 months • MSK CATS service has created extra capacity to see patients while not impacting on keeping triage up to date. Started from 7 November 2018. • Extra Admin support from bank B2 to ensure no unnecessary delays linked to triage and allocation of patients to the correct service. • New APP staff to CATS service complete induction before working at full capacity.	• As described under mitigating actions • Start recruitment process for additional APP to the CATS service • Induct new APPs to role as they start and increase individuals capacity as appropriate • Continue to maximise capacity using current staff • Hope to achieve 75% of patients seen within 6 weeks by end of November with further improvement anticipated in subsequent months • Capacity and Demand study currently being repeated.

Routine **MSK Physiotherapy**	• CSIG target of 87% for October was not met • 78% of patients in MSK routine physiotherapy were seen in 6 weeks • Changes to the administration team resulting in slots not always being filled and some patients offered appointments beyond the 6 week target even when some appointments available	• Support with central booking administration and additional admin staff to ensure booking to maximum capacity each day • Agency physiotherapy staff employed again vacancies and MSK SPOA pilot funding • Improved efficiency of fulling all available diary gaps to ensure there are no delays with triage and allocation of patients to the correct service • Improve timing of triage and service allocation to prevent unnecessary delays – supported by bank B2 admin role • Moving staff locations to ensure staffing levels at each site reflects the demand for appointments at these sites • Bank b2 admin employed to support prompt booking of appointments • Telephone appointments offered to patients with longer waiting time to ensure they receive useful advice and guidance prior to attending • Recruiting to vacant posts	• As described under mitigating actions • Improve efficiency of triage and allocation to correct service, with close monitoring on daily basis and liaison with central booking. • Continue to fill available gaps in diaries, with dedicated admin time to call patients and fill these even at short notice. • Working closely with central booking service with regular meetings • Staff moving sites over next few weeks as current diary bookings allow • Plan to achieve 82% within 6 weeks by end of November

Community waiting times Children Services

Service	Summary of improvement work undertaken during October2018. Was CSIG Waiting Time Improvement Target / Was Trust Board KPI met? If not, please give reasons.	Mitigating actions being taken (if target was not met)	What improvement measures are planned for the next 3 months? Expected date for target to be achieved.
CYP Continence	• Part of wider review of continence services, no specific actions undertaken in October	• Process mapping is scheduled to take place in December	• Completion of wider continence review – February 2019
CAMHS (Islington)	• Additional interim capacity recruited into Emotional Behaviour Pathway Team; to increase Choice Appointment Capacity and reduce current backlog • Realignment of substantive capacity to deliver treatment pathway appointments following backlog reduction • Improvements to administrative processes and commencement of data quality support via newly	• Implementation over next period of improvement work already noted • Trust continues to meet monthly with commissioners as part of Contract Performance Notice process, which oversees a range of more detailed service level actions • Agreement with commissioners that current waiting time will not be met sustainably once short-term capacity is withdrawn and in the absence of SPA which is key to controlling demand for Tier 2 CAMHS services	• Additional short-term resource will be put into service to support reduction of historic backlog of choice appointments (anticipate that this will be cleared by 31 December 2018) • Realigned substantive capacity will be used to maintain expected demand for treatment pathway appointments, to keep this within an acceptable waiting timeframe prior to SPA implementation

	appointed Project Manager • DNA Policy being reviewed to support reduction in lost capacity which currently equates to 20% • Discussions on-going with commissioners around early adoption of key roles within new SPA, i.e. Care Navigators and Strengthened Intake Team • Recruited for key vacancies both in Consultant Psychiatry and Clinical Psychology now approved by VSP	• SPA is planned for implementation in June 2019	• In addition, the CAMHS workforce consultation has ended and is expected to be implemented over the next 3 months. This will create additional clinical capacity through a reduction in WTE management across the 7 new teams • Finally, the ICSU will be recruiting an Associate Director of CAMHS / Mental Health who will oversee the improvements in the longer term, anticipated completion of recruitment, February 2019
Community Children's Nursing (Haringey & Islington)	• Following historic issues around data entry and management of clinical systems, the service is now working with newly appointed Project Manager to improve data quality • Urgent referrals have now achieved 100%	• Routine referral waiting times have seen a marginal improvement • The issue is impacting on performance is a stand-alone Eczema Nurse who has long waits and the service has suggested to commissioners a solution, which would involve merging this service with the Paediatric Nurse in Primary Care Service who also see CYP with the same condition • This should dramatically reduce the waiting time and improve the aggregate position for Children's Community Nursing which is a combination of Life Force Palliative Care Nursing, CHC, Hospital at Home and Paediatric Nurses in Primary Care	• Merging stand-alone nursing service with wider team – February 2019 (awaiting confirmation from commissioner) • Continuation of Data Quality improvement support – February 2019
Community Paediatrics Service	**Haringey:** • Social Communication – continues to be the area of concern as consultant led assessment of ASD for all CYP up to the age of 12 • Project commenced looking at moving to a therapy led assessment model for 0-5's and suggestion to commissioner that 5-12's move to a CAMHS led model (included in Provider Intentions Letter) • Waiting Time will remain 52w+ until the review and new model is agreed and historic backlog cleared • Neuro-developmental – Waiting time impacted by long-term sickness of substantive consultant, currently being covered by remaining establishment **Islington:** • Following historic issues around data entry and management of clinical systems, the service is now	**Haringey:** • Completion of ASD assessment model project • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager **Islington:** • Improvements in data quality processes as part of new project • Re-assessing demand and capacity when new consultant comes into post • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager	• Completion of ASD assessment model project – February 2019 (benefits not expected for 12 months) • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager – March 2019 • Improvements in data quality processes as part of new project in both Haringey and Islington as part of project above – March 2019 • Re-assessing demand and capacity when new consultant comes into post in Islington – March 2019

	working with newly appointed Project Manager to improve data quality • Long-term consultant vacancy now recruited into		
Family Nurse Partnership (Haringey & Islington)	**Islington:** • The target is achieved for this month October 100% **Haringey:** • 66.7%, this is a direct result of unexpected sick leave. • Service made up of small establishment, which has had a negative impact on performance which is ordinarily 100%	**Islington:** • The target is achieved for this month October 100% **Haringey:** • Staff member due back end of November, anticipated return to good performance	**Islington:** • Monitor and review next month **Haringey:** • Monitor and review next month
Haematology Service (Islington)	• The target is achieved for this month October 100%	• The target is achieved for this month October 100%	• Monitor and review next month
IANDS (Islington)	• Service has achieved the 20 week waiting time target for social communication assessment in under 5s. • This is being monitored as the additional resource introduced by commissioners has now been withdrawn. • The model we presented was based on 12 new referrals a month; this however has increased to 16 over the last 4 months, so there is an increase in pressure to maintain this target.	• Service and commissioners continue to meet regularly to review impact of additional resource reduction, anticipated to feature in contract discussions for 2019/20	• Improvements in data quality processes will also be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project
Looked After Children (Haringey & Islington)	**Islington:** • The target improved from 33.3% to 81.8%, significant improvement on previous month **Haringey:** The target dipped from 100% to 83.3%, this was a result of delays in assessing a child fostered out of borough	Both boroughs continue to be challenged by the pitfalls of predominantly being an outreach service, there are often peaks and troughs throughout the year which invariably can be out of the control of the service	• Monitor and review next month
Occupational Therapy (Haringey and Islington)	**Haringey:** • Performance fell to 35%, this has been a result of on-going capacity issues within the service • The service has recently recruited a Band 7 OT which will support improvements in performance over the coming months **Islington:** • Target achieved 100%	**Haringey:** • Haringey Therapy Review, which is nearing completion with recommendations expected to CSIG in December 2018 **Islington:** • Target achieved 100%	**Haringey:** • Once known, implement recommendations of Haringey Therapy Review – April 2019 **Islington:** • Monitor and review next month

Paediatrics Nutrition and Dietetics (Haringey and Islington)	**Haringey:** • Target achieved 100% **Islington:** • Significant improvement from 45.5% to 80%	**Haringey:** • Target achieved 100% **Islington:** • Improvements in data quality processes will be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project	**Haringey:** • Monitor and review next month **Islington:** • Improvements in data quality processes will be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project – February 2019
Physiotherapy (Haringey and Islington)	**Haringey and Islington:** • Further deterioration in performance • Haringey service fully engaged in Therapy Review and awaiting conclusions to this process • On-going recruitment issues in both boroughs, despite repeated efforts to fill vacancies substantively, part-time locums being used to support gaps	• Completion of Haringey Therapy Review	• Completion of Haringey Therapy Review – December 2019 • Substantive Recruitment – March 2019
PIPS (Haringey)	• The target is achieved for this month, 100%	• The target is achieved for this month, 100%	• Monitor and Review Next Month
School Nursing (Haringey and Islington)	**Haringey:** • The target has declined from 82.4% to 72.7% • Data quality issues have been identified and the service is now working with newly appointed Project Manager • In addition long term substantive vacancies have now been appointed into for Band 5, Band 7 and Team Leader positions **Islington:** • The target has declined from 97.1% to 87.1% • Service currently experiencing high vacancy rates and depending on bank / agency staff which has had a knock on effect around performance • Data quality issues have been identified and the service is now working with newly appointed Project Manager	• Both boroughs will see improvements in performance when recruitment pipelines are completed and data quality processes are improved	• Performance expected to be at 95% by February 2019
SALT (Haringey/Islington and MPC)	**Haringey:** • Further deterioration in performance • Service fully engaged in Therapy Review and awaiting conclusions to this process • Clinical Director also working with service to look at skill mix and different use of capacity to meet demand across the different pathways	• Completion of Haringey Therapy Review • Skill-mix and other minor adjustments identified by Clinical Director to be agreed and implemented in both Haringey and Islington	• Completion of Haringey Therapy Review – December 2019 • Skill-mix and other minor adjustments identified by Clinical Director to be agreed and implemented in both Haringey and Islington – December 2019

	• Patient feedback indicates service is highly regarded, but limited in terms of universal offer, resulting in high numbers of children being identified for targeted and specialist levels of intervention **Islington:** • Improvement from 40% to 51% **MPC:** • Specialist service is not working to 6w target • Dashboard to be adjusted to reflect commissioned waiting time of 18w		

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Oct-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	9	10	8	2	8	3	5	1	4	1	2	8	24	
Theatres	Cancelled ops not rebooked < 28 days	0	5	1	1	0	0	0	0	0	0	0	0	1	1	
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	211	282	334	269	312	292	281	212	230	238	236		1489	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%		2.7%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	49.4%	54.7%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	97.5%	94.5%	95.0%	93.6%	94.5%	93.9%	92.7%	93.4%	93.3%	96.1%	95.1%		94.1%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	88.5%	85.9%	92.0%	93.4%	90.5%	89.7%	92.7%	93.4%	90.5%	91.8%	91.6%		91.7%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	96.6%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	92.7%	98.3%	95.3%	96.5%		95.2%	
Community	Haringey - HR1 % carried out before child aged 15 months		61.8%	60.2%	66.9%	67.6%	63.9%	64.4%	73.6%	66.0%	71.6%	62.4%	72.1%		68.1%	
Community	Haringey - HR2 % carried out before child aged 30 months		43.9%	38.1%	60.3%	68.3%	59.5%	57.0%	62.6%	59.3%	65.1%	67.6%	64.3%		62.5%	
Community	Islington - HR1 % carried out before child aged 15 mths		69.7%	66.8%	70.0%	79.3%	83.5%	69.8%	81.3%	76.5%	81.9%	79.5%	87.5%		79.1%	
Community	Islington - HR2 % carried out before child aged 30 mths		75.1%	70.1%	71.6%	69.7%	76.1%	78.1%	75.1%	77.6%	79.8%	80.4%	81.7%		78.7%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		64.2%	74.8%	64.1%	72.0%	84.2%	69.9%	78.4%	80.7%	83.1%	82.5%	80.5%		79.9%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		81.1%	85.3%	79.1%	85.6%	78.0%	80.4%	86.2%	92.8%	91.8%	95.5%	97.5%		90.7%	

Responsive Services - Commentary

Cancelled Operations – October 2018

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

General	3 patients	2 x anaesthetist unavailable, 1 x admin error (HDU bed not booked)
T&O	4 patients	1 x anaesthetist unavailable, 2x theatre list overran, 1 x admin error
Urology	1 patient	anaesthetist unavailable

Delayed Transfer of Care (DToC)

The performance for September was 2.8% (up slightly from August's 2.7%). This good performance is slightly above the Trust internal stretch target of 2.4%, and we continue to achieve the National Target of less than 3%. DToC issues are now predominantly relating to external bed availability, waiting for intermediate or care home beds, or other complexity. The bi-weekly MADE events continue to support the proactive management of DToC. The North London partners in Health and Care have launched the new Choice Policy which reviews place of discharge for the patient and staff training on the new policy has begun.

Women seen by HCP/Midwife within 10 weeks

Improvement from September 18, however still 0.4% off target. Issue: Appointments offered but declined and not put onto Medway Live to indicate patient choice. Action: Working with midwives and admin teams to put all offered appointments onto Medway Live and outcome appropriately. Ongoing work to validate the report and correct errors. Expected to be within target in February 2019.

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.

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Oct-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	69.0%	70.7%	70.8%	71.6%	68.9%	70.2%	70.8%	71.5%	73.6%	73.2%	74.7%	77.0%	73.0%	
HR	Mandatory Training % Rate	>90%	80.1%	80.5%	81.1%	80.8%	82.6%	82.9%	83.0%	82.8%	82.5%	83.7%	82.2%	82.4%	82.8%	
HR	Permanent Staffing WTEs Utilised	>90%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.2%	86.2%	86.3%	86.7%	86.4%	87.3%	86.8%	
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%	3.57%	3.65%	4.01%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%	3.10%	3.52%		3.38%	
HR	Staff turnover %	<10%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	12.8%	12.7%	13.3%	
HR	Vacancy % Rate against Establishment	<10%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.8%	13.8%	13.7%	13.3%	13.6%	12.7%	13.2%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	83.0%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	136.0%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	88.7%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	125.0%	
HR	Safe Staffing Alerts - Number of Red Shifts		16	33	31	12	19	18	8	0	1	1	2	0	30	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.6	8.4	8.2	8.4	8.6	8.7	9.3	9.4	10.0	9.0	8.8	9.2	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).

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	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	Trend
Medical	Average staff cost per patient		94	93	98	104	96	101	88	92	97	101	103	
Nursing	Average staff cost per patient		167	198	167	182	181	182	172	181	174	180	183	
Other	Average staff cost per patient		193	214	191	195	166	203	179	196	226	234	208	

Well Led Services - Commentary

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. There are further Nurse Recruitment open days planned and a revised International recruitment plan imminent. Turnover has remained stable, 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 remained steady and is on line with the Trust target. Appraisal rates, though still below target, have remained steady at 74.7%, and work is underway to improve the rates, and the quality of the data. Mandatory training has remained steady.

October 2018

% day fill rate-nurses
All wards received adequate staffing levels during October 2018. Staff are moved between wards to ensure sufficient and safe cover. The Lead Nurse for safer staffing now in post is continuing to work to improve this data capture with the site management team when staff are moved between wards. This also continues to be impacted by the use of Band 4 Assistant Practitioners in place of Band 5 nurses (see below).

% day fill rate-HCAs
The trend of increasing numbers of patients needing enhanced one to one care including those at risk of falls and those with mental health needs has continued. 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 has been addressed by the Lead Nurse for safer staffing this month and there is a national steer that these will be embedded into the current band 5 allocation on each roster in January 2019 when the first nursing associates are registered with the NMC.

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 finalising the review of 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.

% night fill rate-HCAs
The factors detailed above for day fill rate apply for night fill rate in all areas except for Thorogood and Ifor wards. Thorogood has needed fewer HCAs overnight due to the nature of the patients receiving care (planned post-surgical) and the size of the ward. Ifor (paediatric ward) has flexed down the number of open beds at times during the month due to decreased demand and has therefore not needed HCAs during some night shifts. Shifts have therefore been cancelled within a day or few days of the shift. This has impacted on the overall reported rate. Over November 2018 the Lead Nurse for Safer Staffing will work with the matrons and Associate Directors of Nursing for these areas to improve forward planning of rosters.

Average Tariff by Point of Delivery (POD)

Category	Indicator	18_19 Target	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	Q3 Oct-18	Activity
ED	ED Attendances	8285	8549	8579	8897	8082	9217	8645	9226	8699	9287	8157	8897	9082	
ED	ED Admission Rate %		16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	15.0%	
Community	Community DNA Rate %	<10%	8.0%	6.8%	7.6%	7.5%	7.7%	7.8%	8.0%	8.0%	8.4%	8.1%	7.6%	7.7%	
Community	Community Face to Face Contacts		60705	50518	60063	54265	60385	55877	63876	62438	61330	54844	57664	63295	
Admissions	Elective and Daycase		2004	1587	1944	1735	1879	1720	1840	1880	1763	1819	1917	2259	
Admissions	Emergency Inpatients		2369	2180	2218	1904	2241	2181	2338	2237	2217	2194	2163	2185	
Referrals	GP Referrals to an Acute Service		7638	5928	7874	7362	7891	7165	7689	7625	7570	7080	6912	8314	
Referrals	% of GP Referrals that were completed via ERS		34.5%	37.2%	46.0%	44.1%	47.0%	58.2%	73.7%	79.6%	82.6%	83.0%	84.7%	87.2%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	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	337	332	321	253	315	291	323	282	297	321	312	296	
Maternity	Maternity Bookings	377	385	302	405	375	370	400	369	317	376	330	334	398	
Outpatients	Outpatient DNA Rate % - New	<10%	10.2%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	10.1%	10.6%	11.2%	11.3%	10.7%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.2%	10.7%	12.1%	10.0%	10.9%	10.2%	12.1%	10.2%	10.3%	10.6%	10.2%	10.5%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	10.2%	10.9%	11.6%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	10.8%	10.7%	10.6%	
Outpatients	Outpatient New Attendances		10122	8012	10506	9224	9629	9309	10245	9665	9652	9098	8887	10414	
Outpatients	Outpatient FUp Attendances		19258	15892	18893	16594	17804	17408	18731	18306	18780	18099	17252	19660	
Outpatients	Outpatient Procedures		7449	5837	7409	6828	7097	6786	7422	7204	7556	6899	7360	8149	
Theatres	Theatre Utilisation	>85%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	

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Average Tariff for Inpatient PODs

Category	Point of Delivery (POD)	17_18 Target	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	Trend
Average Tariff	Daycases		717	710	697	684	614	740	686	678	703	653	655	
Average Tariff	Elective		3525	3526	3403	3550	3710	4033	3831	3778	3857	3210	2963	
Average Tariff	Non-Elective		2180	2561	2670	2362	2194	2484	2511	2564	2272	1684	1590	

Activity - Commentary

DNA

Continued improvement in DNA rate observed.

Activity - Commentary

Births-

This indicator remains off target at 296 (down by 16 births in September). A marketing strategy meeting, with communications to increase births at Whittington Health, is planned for 14th November 2018. 2nd maternity theatre and the upgrade of the postnatal ward will allow Whittington Health to be more attractive to women in the local area. Social media to be developed to promote Whittington Health maternity unit to a wider audience. Meeting planned with UCLH in November to discuss twins' pathway; where UCLH will transfer the care of 100 twin pregnancies per year to Whittington Health along with the current elective Caesarean pathway.

eRS

Data for eRS slot issues for November 2018 not available, due to technical issues. Database procedures failed to run. This is being investigated and is expected to be solved by next month.
GP referrals completed in eRS continue to increase.

Theatre Utilisation

Theatre utilisation over the last five months, however below target, has stayed between 80 -85%.
Issue: There have been ongoing issues identified in the admissions booking team. This has affected the number of patients ready to be booked for surgery into a suitable slot in a timely manner. Vacancies in the Anaesthetic medical team have affected capacity and demand, including a number of cancellations on the day.
Action: there is currently an improvement plan (consultation) for the Admissions team. Daily scrutiny in place to ensure compliance with the contracted plan. Recruitment in place for vacant Consultant Anaesthetic posts. Locum positions organised in the meantime in order to ensure the theatre activity meets the agreed plan.
Timescale: it is expected that the utilisation figures for November 2018 will demonstrate an improvement with the objective of being +85% in December 2018.

Meeting title	**Trust Board – public meeting**	**Date:** 28.11.2018
Report title	October (Month 7) 2018/19 – Financial Performance	**Agenda item:** 10
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a surplus (including Provider Sustainability Fund (PSF) income of £2.1m) of £1.7m for the month of October (month 7) against a planned £2.1m surplus, an adverse variance of £0.4m. Year to date the Trust is £0.3m behind the NHS Improvement adjusted plan, with a surplus of £5.2m including £9.6m of PSF income. There is a further deterioration in month of Income by £0.3m. The year to date performance excluding PSF income, agenda for change funding and High Cost Drug recharges is £2.3m off plan. With excess bed days, calculated using delayed transfers of care and medically optimised patients, accounts for almost 5,200 days year to date. 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 agency costs to the end of month 7 are £7.6m. The last 3 months has seen an improved trajectory than the first 4 months of the year but still in excess of the original levels required to meet the NHS Improvement agency cap. Using the average agency spend of the last 3 months the likely year end agency costs will be £12.5m. The current internal agency review meetings with Integrated Clinical Service Units (ICSUs) must continue to ensure the Trust addresses the spend. In addition, the work to reconcile the nursing establishments to the Allocate rostering system is critical to mitigating any further overspends. The Trust is forecasting Cost Improvement Programme (CIP) delivery of £11.9m down from £12.4m reported previously. The main change is as a result of a reduced forecast from the Outpatient Transformation plan. 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. To ensure delivery, the ICSUs need to deliver the necessary activity and Cost Improvement Targets, mitigating any	

	existing budget variances. The Trust has spent £3.7m to date of its capital allocation with planned capital expenditure remaining at £14.8m.
Purpose:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.
Recommendation(s)	To note the financial results relating to performance during October 2018 recognising to need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans.
Risk Register or Board Assurance Framework	BAF risks 5 and 10
Report history	Executive team, 19 November
Appendices	1 – month seven finance report

Appendix 1: October (Month 7) 2018/19 – Financial Performance

Financial Overview

The Trust is reporting a £1.7m surplus for the month of October against a planned surplus of £2.1m. The year to date position of a £5.2m surplus is £0.3m behind the planned control total.

The in month surplus position is as a result of the achievement of £2.1m of PSF, the Trust has earned and is reporting £9.6m of PSF in its year to date position.

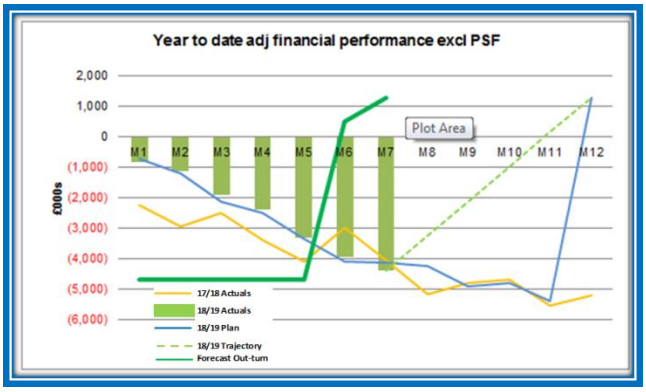
The Clinical Income is £2m behind the year to date plan after a further deterioration of £0.2m in month. There are positive income variances relating to income for High Cost Drugs and Devices of £0.4m and Agenda for Change funding of £1.9m although these variances are offset within non-pay and pay. The under achievement is attributed to maternity services and day cases procedures primarily within the Surgery ICSU.

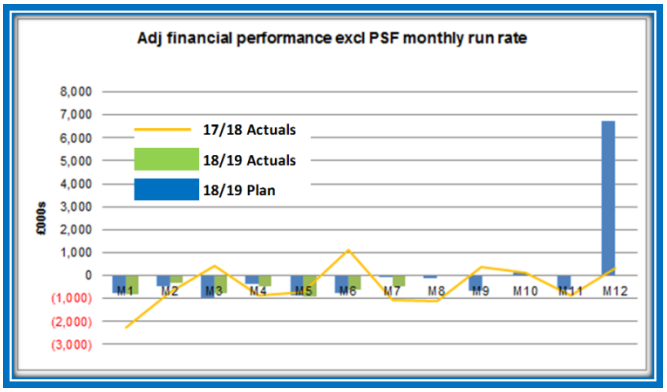
The Trust, in contrast to its year to date position, is reporting a negative variance for non-pay this month. This increase in expenditure is attributed to the increased theatre activity and the out-sourcing of endoscopy procedures. The out-sourcing is reducing the waiting list and recovering some of the previously lost day case activity but is achieved at lower contribution levels to the organisation than the in-house provision.

As with previous months, the October pay spend is in excess of budget, this is a result of the agenda for change payment being in excess of the original planned budgets. The cumulative agency spend is £7.6m, in month the spend was £0.8m with the average of the year being £1.1m. The Trust must continue to pursue the reconciliation of the Safer Staffing levels, funded establishment and the Allocate rostering system to mitigate any further escalation of agency costs.

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	23,789	23,609	(180)	164,066	162,042	(2,024)	260,376
Other Non-Patient Income	2,141	2,054	(87)	14,999	14,762	(237)	47,536
High Cost Drugs	656	1,028	372	4,595	4,962	366	7,877
Pay Award Funding	0	264	264	0	1,943	1,943	0
Total Income	**26,586**	**26,955**	**369**	**183,660**	**183,709**	**49**	**315,789**
Pay	(18,455)	(18,768)	(313)	(130,297)	(131,936)	(1,639)	(214,393)
Non-Pay (excl HCD)	(6,262)	(6,418)	(156)	(44,044)	(42,691)	1,353	(82,109)
High Cost Drugs	(669)	(1,014)	(345)	(4,705)	(4,844)	(139)	(8,052)
Total Operating Expenditure	**(25,386)**	**(26,200)**	**(814)**	**(179,046)**	**(179,472)**	**(426)**	**(304,554)**
	1,200	**755**	**(445)**	**4,614**	**4,237**	**(377)**	**11,235**
Depreciation	(542)	(517)	25	(3,790)	(3,777)	13	(6,500)
Dividends Payable	(431)	(416)	15	(3,015)	(3,015)	0	(5,263)
Interest Payable	(277)	(296)	(19)	(1,946)	(1,928)	18	(3,341)
Interest Receivable	1	9	8	7	44	37	12
P/L on Disposal of Assets	0	0	0	0	0	0	6,000
Total	**(1,249)**	**(1,220)**	**29**	**(8,744)**	**(8,676)**	**68**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(49)**	**(465)**	**(416)**	**(4,130)**	**(4,439)**	**(309)**	**2,143**
Provider Sustainability Fund (PSF)	2,138	2,138	0	9,621	9,621	*0*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**2,089**	**1,673**	**(416)**	**5,491**	**5,183**	**(308)**	**23,523**
Add back							
Impairments	0	0	0	0	0	*0*	51
IFRS & Donate	8	6	(2)	(12)	45	*57*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**2,097**	**1,680**	**(417)**	**5,479**	**5,228**	**(251)**	**22,675**





Income and activity

The Trust's reported income position, excluding High Cost Drugs and Devices and Agenda for Change funding, is a year to date adverse variance of £2.3m. This is a further deterioration of the income performance.

In month 7, although there have been improvements in Day Case and Elective activity, Trauma & Orthopaedics, Urology and General Surgery specialties are now £1.3m behind plan.

Maternity deliveries and pathways continue to under-perform against plan with a £1m adverse variance year to date.

Outpatients' continue to over perform and is £0.2m in month and £1.3m ahead of the year to date plan. The main other year to date over-performances are within Diagnostics imaging £0.3m, Gynaecology £0.1m and Trauma & Orthopaedics £0.1m. However, there is underperformance in Paediatrics, Dermatology and Gastroenterology.

Unplanned care in Accident & Emergency & Urgent Care Centre is above plan both for in month and year to date, ambulatory care remains above planned levels by £0.2m year to date. Non-electives are over performing with a variance of £0.6m to date, mainly in Gastroenterology £0.5m, Accident & Emergency £0.3m and Endocrinology £0.2m.

Although the Trust did not hit the required target for A&E in Quarter 3, at the delivery board level it did achieve the target so has earned the full PSF for the quarter.

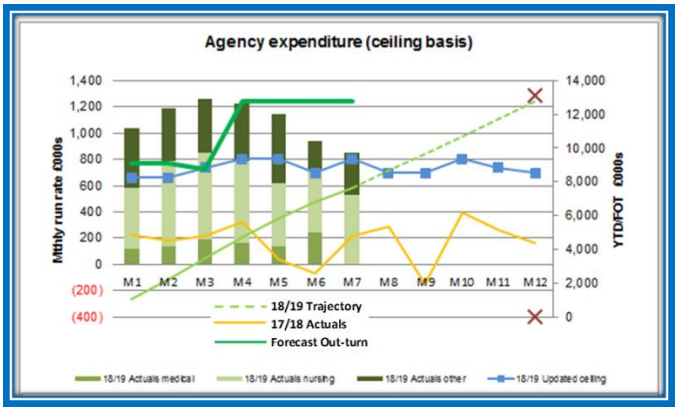
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,188	1,192	4	8,202	8,261	59	8,740	9,083	343	60,327	62,004	1,677
Ambulatory Care	373	404	31	2,418	2,797	378	1,610	1,638	28	10,472	11,207	735
Adult Critical Care	640	401	(239)	4,416	3,512	(904)	1,512	1,167	(345)	10,438	8,871	(1,567)
Community Block	5,857	5,857	0	41,076	40,999	(77)	0	0	0	0	0	0
Day Cases	1,244	1,355	110	8,060	7,862	(199)	1,601	1,889	288	10,379	11,450	1,071
Diagnostics	272	299	27	1,762	2,083	322	2,755	3,180	425	17,849	20,767	2,918
Direct Access	1,067	1,027	(40)	6,910	7,335	425	104,050	95,242	(8,808)	673,812	658,816	(14,996)
Elective	856	943	87	5,543	4,865	(677)	216	244	28	1,406	1,269	(137)
High Cost Drugs	656	1,012	356	4,592	4,854	262	0	0	0	0	0	0
Maternity - Deliveries	1,170	1,037	(133)	8,075	7,494	(582)	321	289	(32)	2,214	2,102	(112)
Maternity - Pathways	805	741	(65)	5,217	4,807	(410)	760	697	(63)	4,924	4,651	(273)
Non-Elective	3,431	3,314	(118)	23,686	23,428	(257)	1,606	1,618	12	11,092	11,255	163
OP Attendances - 1st	964	1,096	132	6,244	6,760	516	5,204	5,755	551	33,632	36,763	3,131
OP Attendances - follow up	860	887	27	5,571	5,445	(126)	14,223	13,963	(259)	92,285	90,716	(1,569)
OP Procedures	414	473	60	2,679	3,047	368	2,366	2,887	521	15,312	18,631	3,319
Other Acute Income	1,214	1,426	212	8,632	9,192	559	7,493	5,970	(1,524)	48,678	45,652	(3,026)
CQUIN	492	482	(11)	3,355	3,302	(54)	0	0	0	0	0	0
Total SLA	**21,501**	**21,945**	**443**	**146,438**	**146,042**	**(396)**	**152,457**	**143,622**	**(8,835)**	**992,820**	**984,154**	**(8,666)**
Marginal Rate	0	0	0	0	(142)	(142)						
	21,501	**21,945**	**443**	**146,438**	**145,900**	**(538)**						
Other Clinical Income	2,944	2,693	(250)	22,223	21,081	(1,142)						
Other Non Clinical Income	2,141	2,317	176	14,999	16,728	1,729						
Total Other	**5,085**	**5,011**	**(74)**	**37,222**	**37,809**	**587**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**26,586**	**26,955**	**369**	**183,660**	**183,709**	**49**	**152,457**	**143,622**	**(8,835)**	**992,820**	**984,154**	**(8,666)**
PSF	2,138	2,138	0	9,621	9,621	0						
Revised Total	**28,724**	**29,093**	**369**	**193,281**	**193,330**	**49**						

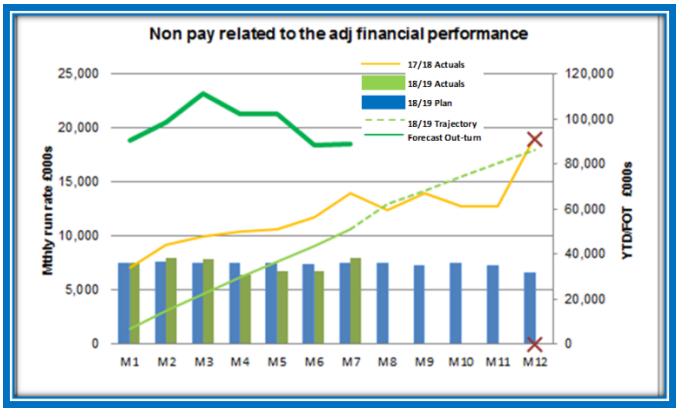
Monthly run dates – expenditure

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

- **Pay**
  - Total pay expenditure for October was £18.8m which is in line with the year to date average spend. The Trust is anticipating year end cost pressure of £0.8m generated by the underfunded pay award from the AFC 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 £0.8m. The total agency spend is £7.6m. If the Trust can maintain the average spend of last 3 months it will come under the revised internal agency cap target of £12.8m but clearly still in excess of the £8.8m originally set by NHSI. However, with the Trust entering the Winter period, additional controls and improvements may be required to prevent this spend escalating further
  - The Trust continues to review its electronic rota system to ensure all rotas reflect the establishment and actual staffing levels match the plan.
  - The Trust needs to ensure that this work continues so it mitigates any further agency bookings to stay within the agency cap but to also reduce its cost run rate.

- **Non Pay**
  - Non pay expenditure for October was £7.4m, including High Cost Drugs. The average spend per month for the year to date is £6.8m,
  - The in-month position is significantly higher than this average because of an increase £0.4m of High Cost Drugs (offset in income), £0.2m of increased costs due to the outsourcing of Endoscopy procedures and additional theatre consumable spend due to higher activity levels.





Integrated Clinical Service Units' (ICSUs) position

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

		In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)	Full Year Budget (£000s)
Adult Community	Income	(450)	(336)	(114)	(2,826)	(2,785)	(41)	(4,994)
	Pay	1,970	2,014	(44)	14,270	14,110	160	24,383
	Non-Pay	344	380	(36)	2,220	2,180	40	3,939
Adult Community Total		**1,864**	**2,058**	**(194)**	**13,664**	**13,505**	**159**	**23,328**
Children & Young People	Income	(2,142)	(2,200)	58	(14,921)	(14,356)	(565)	(25,249)
	Pay	3,831	3,888	(57)	27,775	27,396	379	47,193
	Non-Pay	189	260	(71)	1,329	1,536	(207)	2,268
Children & Young People Total		**1,878**	**1,948**	**(70)**	**14,183**	**14,576**	**(393)**	**24,212**
Emergency & Integrated Medicine	Income	(5,900)	(5,938)	38	(40,032)	(39,479)	(553)	(68,072)
	Pay	3,547	3,765	(218)	25,532	28,244	(2,712)	43,516
	Non-Pay	427	606	(179)	2,905	3,261	(356)	5,032
Emergency & Integrated Medicin Total		**(1,926)**	**(1,567)**	**(359)**	**(11,594)**	**(7,974)**	**(3,620)**	**(19,524)**
Surgery & Cancer	Income	(4,901)	(4,470)	(432)	(32,748)	(30,244)	(2,504)	(55,604)
	Pay	2,929	3,164	(234)	20,706	21,530	(824)	35,305
	Non-Pay	817	972	(154)	5,747	5,394	353	9,820
Surgery & Cancer Total		**(1,155)**	**(334)**	**(820)**	**(6,295)**	**(3,321)**	**(2,975)**	**(10,479)**
Women's Health Diag & Outp	Income	(4,666)	(4,677)	12	(31,185)	(30,290)	(895)	(52,913)
	Pay	3,054	3,061	(7)	21,825	21,597	228	37,285
	Non-Pay	1,554	2,073	(519)	10,909	12,109	(1,200)	18,603
Women'S Health Diag & Outp Total		**(58)**	**456**	**(514)**	**1,549**	**3,415**	**(1,866)**	**2,975**
Corporate Services	Income	(727)	(647)	(80)	(5,087)	(4,917)	(170)	(8,720)
	Pay	2,989	2,818	171	19,450	18,700	750	33,198
	Non-Pay	3,188	3,189	(1)	22,135	20,999	1,136	37,784
Corporate Services Total		**5,450**	**5,360**	**90**	**36,498**	**34,782**	**1,716**	**62,262**
Other Total		**(8,142)**	**(9,594)**	**1,451**	**(53,496)**	**(60,166)**	**6,671**	**(106,296)**
Grand Total		**(2,089)**	**(1,673)**	**(416)**	**(5,491)**	**(5,183)**	**(308)**	**(23,523)**

The primary drivers for their material variance to plan are:

Emergency& Integrated Medicine

- Resilience beds remaining open until the summer to cope with the length of stay, delayed transfers of care and co-morbidity of patients resulting lower income achieved per day
- Higher bed number, up to 14 additional beds, causing a significant overspend in pay relating to agency staff, averaging 10% of the ICSUs pay bill

Surgery and Cancer

- Surgery are currently over 4% behind the agreed activity plan
- High levels of agency staff - c.£106k per month

Women's Health & OD

- Materially reduced levels of births and maternity pathway activity (down over 10% on plan) which is partly offset by improved income in clinical support areas
- Non pay overspends driven by Drugs spend including High Cost Drugs

The Executive Team have requested mitigation plans from each of the ICSU leadership teams to ensure the Trust meets its year end control total.

Cost Improvement Programme (CIP)
The original Cost Improvement Programme target was £16.5m, split by programme area being:

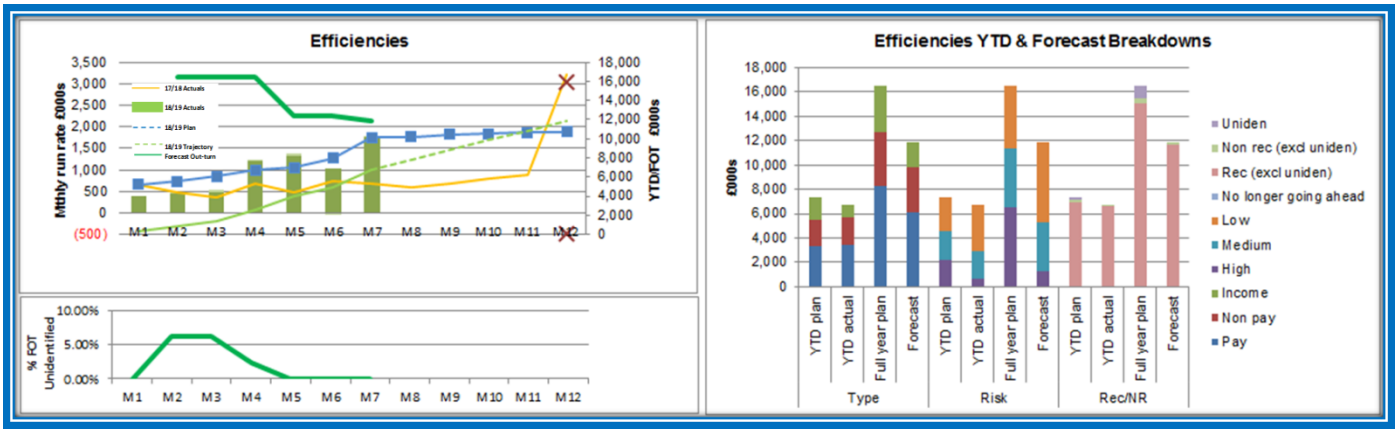
- Flow Through – £2.7m
- ICSU 2% targets – £5.5m
- Transformation Schemes – £8.3m

The Trust is forecasting CIP delivery of £11.9m, a shortfall of £4.6m from the original target.

In-year delivery – Month 7
At the end of month 7 the Trust's planned delivery was £7.3m of CIP, against which £6.8m has been delivered, equating to c93%. Analysed by programme area:

- Flow Through – £1.9m
- ICSU 2% targets – £2.8m
- Transformation Schemes – £2.1m

Plan requirement & forecast delivery
During October the Trust has reduced its forecast CIP delivery from £12.4m down to £11.9m. The £0.4m of this reduction relates to the Outpatient initiative. Performance against the Outpatient Transformation programme in Month 6 was adverse against target. Whilst this has improved in Month 7, and the issues from Month 6 have been corrected, it is not sufficient to recover the shortfall in Month 6. This together with a delay in implementing certain aspects of the programme has led to a reassessment of the full-year forecast, leading to a reduction when compared to the previous forecast.



Forecast by programme area:

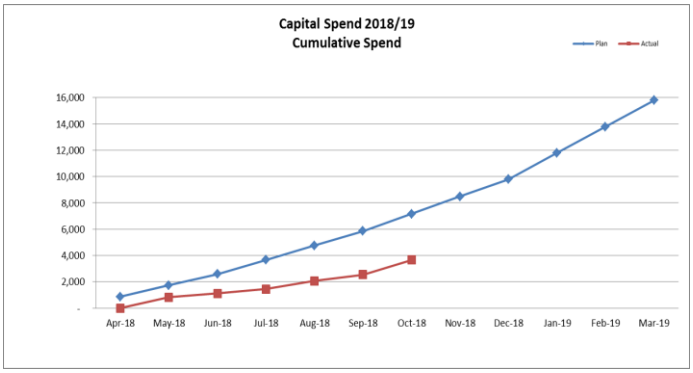
- Flow through – £2.7m (100%)
- ICSU 2% targets – £4.2m (77%)
- ICSU 2% target delivered non recurrently - £0.6m
- Transformation Schemes – £4.9m (50%)

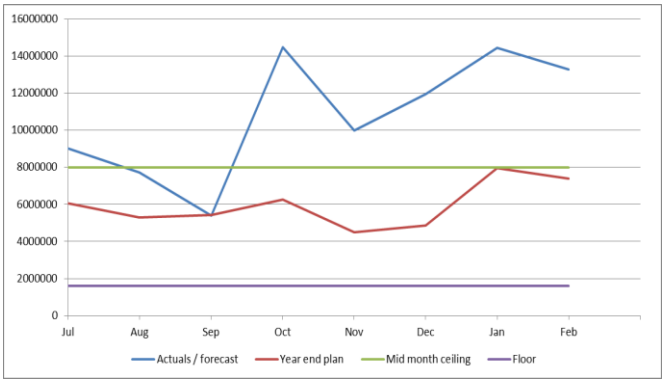
Within the ICSUs, the key areas of focus will be for Surgery & Cancer, Children & Young People and Adult Community as the furthest away from plan in terms of forecast delivery, and within the Transformation Schemes, looking at those in relation to Outpatients, Community and Improving Medical Value.

Statement of financial position

THE WHITTINGTON HEALTH NHS TRUST
Statement of Financial Position

	As at 30 Oct 2018 £000	Plan 30 Oct 2018 £000	Year to Date Plan variance 30 Oct 2018 £000
Property, plant and equipment	214,793	219,263	(4,470)
Intangible assets	4,301	4,701	(400)
Trade and other receivables	1,229	656	573
Total Non Current Assets	**220,323**	**224,620**	**(4,297)**
Inventories	1,522	1,355	167
Trade and other receivables	31,421	31,827	(406)
Cash and cash equivalents	14,500	6,269	8,231
Total Current Assets	**47,443**	**39,451**	**7,992**
Total Assets	**267,766**	**264,071**	**3,695**
Trade and other payables	45,267	37,495	7,772
Borrowings	19,141	19,263	(122)
Provisions	1,061	1,391	(330)
Total Current Liabilities	**65,469**	**58,149**	**7,320**
Net Current Assets (Liabilities)	**(18,026)**	**(18,698)**	**672**
Total Assets less Current Liabilities	**202,297**	**205,922**	**(3,625)**
Borrowings	38,151	41,107	(2,956)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**41,949**	**(2,959)**
Total Assets Employed	**163,307**	**163,973**	**(666)**
Public dividend capital	64,679	65,679	(1,000)
Retained earnings	326	(279)	605
Revaluation reserve	98,302	98,573	(271)
Total Taxpayers' Equity	**163,307**	**163,973**	**(666)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**





Overall, the value of the balance sheet is £0.7m away from plan. Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £4.5m lower than plan. Capital spend in month 7 was at plan (£1.0m), indicating that the Trust has the capacity to accelerate its spending towards the end of the year. Capital spend has previously consistently tracked behind plan throughout the year to date. While the Trust expects spend to accelerate significantly for the remaining months of the financial year, the Trust has advised NHSI that it will undershoot its capital limit by £1.0m.

- **Receivables (Debtors)** are £0.4m lower than plan at the end of month 7. Key movements between months 6 and 7 are:

    - Collection of quarter 3 income from Health Education England (£3.8m); and

- Increased accrual of £2.2m for Provider Sustainability Funding (PSF) based on month 7 and forecast year-end financial performance. Up to and including month 7, the Trust has £8.6m of PSF owed to it. NHSI is expected to clarify by the end of the calendar year how this will be distributed.

- **Liabilities (creditors and borrowings)** are currently £4.3m below plan. At month 6, they were £1.3m below plan. Key movements between months 6 and 7 are:

  - The Trust has now made the decision to invest this cash with the National Loans Fund, and will earn some additional interest
  - A general increase in supplier balance £0.8m

- **Cash and cash flow:** the Trust is holding £14.5m in cash as at the end of October 2018. This is £8m higher than plan.

Meeting title	**Trust Board**	**Date: 28.11.18**
Report title	Estates Strategy Delivery Committee – draft terms of reference	**Agenda item: 11**
Executive director lead	Stephen Bloomer, Chief Finance Officer	
Report author	Sophie Harrison, Assistant Director of Estates (Strategy)	
Executive summary	The purpose of this paper is to ask the Trust Board to approve the terms of reference for the Estates Strategy Delivery Committee, This committee is being established to provide oversight of the Trust's estate transformation programme.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to approve the terms of reference for the Estates Strategy Delivery Committee.	
Risk Register or 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	
Report history	Estates Strategy Delivery Committee 20th November 2018	
Appendices	1: Draft committee terms of reference	

Whittington Health NHS

Appendix 1: **Estates Strategy Delivery Committee Terms of Reference**

Ratified by:	**The Trust Board**
Date ratified (current version):	
Name of originator/author:	**Sophie Harrison, Assistant Director of Estates (Strategy)**
Name of responsible committee/individual	**Estates Strategy Delivery Committee/ Committee Chair**
Date issued (current version):	**22 November 2018**
Review date:	**March 2019**

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Estates Strategy Delivery Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference and any such powers that may be directed in future by the Board.

2. Authority

2.1 The Estates Strategy Delivery Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

2.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

2.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The Estates Strategy Delivery Committee shall deliver the transformation of the Whittington Health Estate that will:

- support the delivery of the Whittington Health Clinical Strategy and wider local health and social care integration objectives.
- deliver creative, innovative estate solutions to support and enhance clinical services provision, building on UK and international best practice.
- enable improvements in: the quality, efficiency and effectiveness of the estate; reduce estate backlog and maintenance costs, environmental impact and revenue costs associated with the operation of premises; and releasing resources for investment.
- support Trust financial sustainability.
- engage and secure support from local strategic health and social care stakeholders, including staff, the community, the Health & Wellbeing Board and the NCL STP. to deliver a transformation that meets expectations and earns support and approval
- seek assurance, mitigations and recovery action plans where appropriate.

3.2 The Committee will work with the CEO and Executive Management to ensure the organisation has the structure, resources and capacity for estate strategy that will deliver Trust objectives.

3.3 The Board may request that the Committee reviews specific aspects of estate strategy delivery matters where the Board requires additional scrutiny and assurance.

4. Membership

4.1 The Committee shall be appointed by the Trust Board and be composed of:

- Non-Executive Directors (3)

- Chief Finance Officer (Senior Responsible Officer)
- Director of Environment
- Director of Strategy
- Director of IT/Chief Information Officer
- Director of Procurement
- Deputy Chief Operating Officer
- ICSU Representation (5)

Also in attendance:

- Staff Representation
- Finance Lead
- Communications Lead
- Project Manager
- GLA representation
- External Advisers

4.2 One Non-Executive member of the Board will be appointed as the Chair of the Committee and one as the vice-Chair by the Trust Board.

4.3 A quorum shall be three members: at least two of whom should be Non-Executive members of the Trust Board and the Senior Responsible Officer.

4.4 The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executive or associate directors.

5. Attendance

5.1 The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.

5.2 The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.

5.3 The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.

6. Agenda & papers

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

6.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five working days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

7. Minutes of committee meetings

7.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

7.2 Approved committee minutes will be forwarded to the next private meeting of Board of Directors for noting and the minutes of all meetings shall be formally recorded and approved at the subsequent meeting. A formal summary report or draft minutes will be submitted to the Trust Board following each meeting, thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.

7.3 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

7.4 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

7.5 The Committee will also work with the Trust Management Group and Finance & Business Development Committee, as necessary.

8. Frequency of meetings

8.1 There will be monthly meetings of the committee. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

9. Review

9.1 The terms of reference shall be reviewed by the Estates Strategy Delivery Committee and approved by the Trust Board annually at the March Board meeting.

10. Committee duties:

- Establish project management arrangements for the delivery of an estate masterplan and strategic outline case
- Agree project budget and secure approval by the Trust Board
- Recruit and procure project team resources with external resources procured where required
- Create and maintain project risk register with mitigations
- Identify key service models for delivery of the Trust Clinical Strategy
- Identify and develop partnership and development opportunities where appropriate
- Agree the design brief
- Produce the Development Control Plan (including site optimisation, design strategy, phasing approach and schedules of accommodation) for approval by Trust Board
- Agree engineering and energy strategy
- Revise and secure Trust Board approval for the estates strategy as required
- Develop strategic outline case for NHSI
- Develop the communications and engagement plan for Trust Board approval
- Identify any agreed consultation requirements and duties

10.1 Review Trust performance against in-year delivery of the Trust's estates strategy including contractor performance, financial controls, timetable, while recognising

that the primary ownership and accountability for the Trust's rests with the full Trust Board.

10.2 Request and receive training and development to assist the Committee in its responsibilities. This may include sessions where appropriate from external sources.

10.3 Address any specific requests by the Trust Board in relation to estate development matters or requirements.

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

10.5 Examine any matter referred to the Committee by the Trust Board.

Meeting title	**Trust Board**	**Date: 28.11.18**
Report title	Greater London Authority - Whittington Health Memorandum of Understanding	**Agenda item: 12**
Executive director lead	Stephen Bloomer, Chief Finance Officer	
Report author	Sophie Harrison, Assistant Director of Estates (Strategy)	
Executive summary	The purpose of this paper is to ask the Trust Board to formalise a working relationship between the Greater London Authority (GLA) and the Trust through the signing of a Memorandum of Understanding. This relationship has been developed to support the Trust's' estate transformation programme. The working relationship has been developed to support improvements to the health and wellbeing of residents in Islington and Haringey through: the transformation of the Trust estate and improved clinical services; and by considering possible opportunities to deliver housing. It is proposed that the GLA is represented on the Trust's Estates Strategy Delivery Committee.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to approve the Memorandum of Understanding, and delegate the signing of the MOU to the Chief Executive.	
Risk Register or 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	
Report history	Estates Strategy Delivery Committee 20th November 2018	
Appendices	A: GLA memorandum of understanding	

Whittington Health-Greater London Authority Memorandum of Understanding

1.0 Introduction

The purpose of this paper is to ask the Trust Board for approval to formalise a working relationship between the Greater London Authority (GLA) and the Trust through the signing of a Memorandum of Understanding. The relationship has been developed to support the Trust's' estate transformation programme.

The working relationship will support improvements to the health and wellbeing of residents in Islington and Haringey through: the transformation of the Trust estate and improved clinical services; and by considering possible opportunities to deliver housing.

2.0 Objectives of the Relationship

The overarching objectives of the working relationship, as set out in the Memorandum of Understanding at Appendix A, are:

- To improve the delivery of clinical services and the health and wellbeing of the populations of Islington and Haringey, by transforming the Whittington Health estate; and
- To improve the health and wellbeing of the populations of Islington and Haringey by identifying possible opportunities to deliver housing which will meet the aspirations of the draft London Plan, London Housing Strategy, and local planning policy.

This partnering approach will bring benefits to the Trust's estate transformation programme, specifically GLA knowledge and expertise in strategic housing delivery and development procurement; and relationships with key stakeholders including the London Borough of Islington, the London Borough of Haringey, GLA Planning, and Transport for London.

It is proposed that the GLA is represented on the Trust's Estates Strategy Delivery Committee (see agenda item x).

3.0 Recommendation

The Trust Board is asked to approve the Memorandum of Understanding, and delegate the signing of the MOU to the Chief Executive.

Appendix A: Memorandum of Understanding

Partnering arrangements between the Greater London Authority (GLA) and Whittington Health NHS Trust

This Memorandum of Understanding ("MoU") is made between the Greater London Authority (GLA) and Whittington Health NHS Trust.

1. Background

GLA Housing and Land are proposing a new way of working with partners to help achieve the Mayor's affordable housing targets and to increase overall housing supply. This sees the GLA taking a more hands-on role to build new homes, and where necessary to intervene in the market.

The GLA's objective is to support the delivery of 116,000 affordable housing starts by March 2022, and to meet the London Plan's broader housing targets.

The draft London Plan identifies an important role for surplus public-sector land in delivering new housing, and much needed affordable homes. Draft policy H1 promotes the redevelopment of surplus public-sector sites, to meet London's housing supply needs, and aims to achieve at least 50% affordable housing on these sites.

GLA Housing and Land are actively working with public sector landowners to identify opportunities for housing development and to help co-ordinate and accelerate affordable housing delivery, and the meeting of shared objectives.

The Whittington Health NHS Trust is undertaking an estates masterplanning project, with the intention of preparing a Strategic Outline Case for the transformation of the Trust's estate by April 2019.

This masterplan will be led by: future delivery plans for clinical care including the move to deliver care closer to home; and the need to support improvements in the health and wellbeing of the populations of Haringey and Islington. The Trust believes that in developing the masterplan, it may be possible to identify opportunities for housing development.

It has been agreed in principle between both parties that the GLA will partner with the Trust to fill a knowledge gap, relating to strategic housing delivery and act in a 'facilitative and supporting capacity to provide advice. This MOU formalises this approach and sets out the scope of facilitation the GLA is able to offer and the roles and responsibilities for both parties

2. Interpretation

In this MoU the defined terms have the following meaning:

"Consultant Team" means the multi-disciplinary team, appointed by the Trust to deliver the core outputs in Section 5 of the MoU.

"Whittington Health Estate Strategy Delivery Committee (ESDC)" means a committee established by the Whittington Health NHS Trust that reports to the Trust Board with the following key members: Non-Executive Director (Chair), Trust Senior Responsible Officer (Chief Finance Officer); Director of Environment; Director of Strategy; Director of IT; Director of Procurement; Clinical Service representation; Staff representation; Trust Project Manager; Communications Lead. The objectives of the ESDC are to deliver the transformation of the Whittington Health Estate. GLA representatives will sit on the ESDC for governance and reporting.

3. Objectives

The working relationship between the GLA and Whittington Health NHS Trust is intended to bring benefits to both parties and support the delivery of upgraded clinical facilities and housing.

The overarching objectives of the working relationship are to:

- To improve the delivery of clinical services and the health and wellbeing of the populations of Islington and Haringey, by transforming the Whittington Health estate, noting the six assurances that the Mayor requires to give his support to Sustainability Transformation Plans (attached as Appendix One) ; and

- To improve the health and wellbeing of the populations of Islington and Haringey by identifying possible opportunities to deliver housing, which will meet the aspirations of the draft London Plan, London Housing Strategy, and borough local plans.

Both parties are working jointly to achieve the aim of 50% affordable housing contained within the draft London plan.

GLA and Whittington Health NHS Trust will work together to achieve these objectives.

4. Benefits

Both parties recognise the benefits of a working relationship which will bring together the transformation of the health estate, with the GLA knowledge and expertise in strategic housing delivery and brokerage of relationships with key stakeholders including LB Islington, LB Haringey, GLA Planning and TfL.

The Trust is preparing a masterplan for Whittington Health estate, which will form part of a NHSI compliant Strategic Outline Case. The GLA will provide support to the masterplanning project to identify possible deliverable opportunities for the development of housing.

GLA input throughout project development will help to identify risks and provide support to the relationships across the GLA family and Local Authorities.

The GLA will benefit from the identification of opportunities for housing development, including affordable housing delivery that will help to meet Mayoral targets.

5. Working relationship

Partnering will bring together the Whittington Health NHS Trust masterplanning project, with GLA skills, knowledge and relationships.

The working relationship is outlined below:

Description of Task	Role and Responsibility
Preparation of the following core outputs, to inform a NHSI compliant Strategic Outline Case: • Design Brief; • Assessment of current estate; • A deliverable Development Control Plan (including site optimisation, realisation of value of the estate, a design strategy and a phasing and massing approach, with town planning support;) • Schedules of accommodation; • A revised Estate Strategy. • A Strategic Outline Case An architectural-led team (Consultant team) will be appointed by the Trust to support the development of the masterplan. This will form a key element of the Strategic Outline Case which will be presented to the Trusts' Board in Q1 2019/20.	*NHS* - The Trust is the client for the Consultant team. - The Trust is responsible for drafting and presenting the Strategic Outline Case. - The Trust will share the project programme to the GLA and keep the GLA informed of relevant project meetings where GLA input would add value. *GLA* - GLA Officers will sit on the evaluation panel that will be responsible for appointing the Consultant team - GLA Officers will provide feedback throughout the development of the core outputs, in particular the Development Control Plan. This will include attendance at relevant project meetings and reviewing draft outputs. - GLA Officers will identify relevant statutory consultees, including GLA Planning, LB Islington Planning and TfL, and help the Trust set up meetings between the Trust and the relevant stakeholder.

6. Governance

The Whittington Health Estates Strategy Delivery Committee is an established Committee that has been set up to deliver the transformation of the Whittington Health Estate. Upon signing of the MoU, GLA representatives will attend and sit on the Estates Strategy Delivery Committee throughout the lifetime of this MoU. This Group will make decisions related to this MoU; and be able to make any amendments to the MoU as necessary.

7. Recovery of GLA costs

Costs incurred by the GLA, agreed by the Trust in advance, shall be recovered and paid by the Trust. Likely relevant costs include: revenue funding in the appointment of any consultants, and GLA Officer time involved in carrying out duties in Section 5, or otherwise agreed by the Trust.

The GLA shall monitor the number of days spent on the projects and will invoice the Trust on completion of each Stage, or as otherwise agreed by the Trust. The day rate for GLA Officers will cover GLA costs and will not generate a profit. The day rate will be agreed between the GLA and the Trust.

8. General

This MoU shall commence on the date of signature by both parties and shall expire on the completion of its objectives, or if earlier at such time as the parties agree that it shall expire.

This MoU is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from this MoU. The parties enter into the MoU intending to honour all their obligations. Nothing in this MoU is intended to or shall be deemed to establish any legal partnership between the parties.

This MoU will be supplemented with further detail after the appointed Consultant Team has delivered the core outputs.

Signed

…… Dated…….
On behalf of the Greater London Authority

……. Dated…….
On behalf of Whittington Health NHS Trust

Appendix 1

The six assurances the Mayor requires to give his support to the STPs plans are:

1. Patient and public engagement – Proposals must show credible, widespread and ongoing patient and public engagement including with marginalised groups.

2. Clinical Support – Proposals must demonstrate improved clinical outcomes, widespread clinical engagement and support, including from frontline staff.

3. Impact on health inequality – The impact of any proposed changes to health services in London must not widen health inequalities. Plans must set out how they will narrow the gap in health equality across the capital.

4. Impact on social care – Proposals must take into account the full financial impact any new models of healthcare, including social care, would have on local authority services, particularly in the broader context of the funding challenges councils are already facing.

5. Hospital capacity – Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently reviewed to ensure all factors have been taken into account. Any plans to close beds must be an absolute last resort, and must meet at least one of the NHS' 'common sense' conditions[1].

6. Sufficient investment – Proper funding must be identified and available to deliver all aspects of the STP plans.

[1] NHS England's newly introduced 'common sense' conditions are to provide:

Sufficient alternative provision (such as increased GP or community services) is being put in place ahead of bed closures and/or

Specific new treatments or therapies will reduce specific categories of admissions and/or

Where a hospital has been using beds less efficiently than the national average there is a credible plan to improve performance without affecting patient care.

Meeting title	**Trust Board**	**28 November 2018**
Report title	Cyber risk update	**Agenda item: 13**
Executive director lead	Dr Leon Douglas, Chief Information Officer	
Report author	Dr Leon Douglas, Chief Information Officer	
Executive summary	This report offers progress highlights on mitigating the Cyber Risk on the Risk Register and highlights a few remaining areas of work. It also makes some straight-forward recommendations to ensure the cyber risk remains mitigated.	
Purpose:	Review Fit with WH Strategy: • To deliver consistent, high quality, safe services • To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population • Delivery of the Digital Strategy	
Recommendation(s)	1. Acknowledge the progress to date 2. Acknowledge the recommendations	
Risk Register or Board Assurance Framework	Cyber security risk	
Report history	ETM 29 October 2018; TMG 13 November 2018	
Appendices	Appendix A – Cyber Security Update Paper Supporting material can also be located via these links: Driving Digital Maturity programme - https://www.england.nhs.uk/digitaltechnology/info-revolution/ddm/ Whittington Health Digital Strategy http://whittnet.whittington.nhs.uk/document.ashx?id=11212	

Cyber risk update

Context

The paper updates the Leadership Team on progress against the identified Cyber Security risks, as well as highlights the final elements of the current plan.
Overall excellent progress has been made in mitigating and resolving risks identified through the various audits and analyses that have been undertaken. It should be recognised that the Trust has made consistent and significant investment in this area to deliver a much higher level of security.

Progress

In summary the major areas of progress are this:

- **End User Hardware** - Computers running out of date operating systems have been eradicated and all connected computers are automatically patched regularly.
- **Servers** – all running compliant, fully patched operating systems with the exceptions noted in this paper
- **Networks** – new firewalls and scanning software including anti-encryption technology deployed
- **Processes** – revised and improved procedures from day to day maintenance up to emergency planning level
- **Staff** – excellent development of knowledge and skills in this area with clear ownership and interest within IM&T. Board awareness session delivered by Templar Executives on behalf of NHS Digital

The current areas of focus are:

- Rolling out windows 10 before the end of Windows 7 support. Currently 480 machines upgraded from approximately 4300.
- Moving data server farms from Server 2008 to newer versions
- Roll out of Microsoft ATP as part of the Enterprise Wide Agreement for Windows 10

Areas of risk

- **Staff** – while generally our staff are vigilant and do their best to engage with IM&T on threats or potentially suspicious items we must recognise that they are, for the most part, the target of the most common attacks and the most common source of incidents. The majority of these come from either clicking on content on the web or in emails that give a threat access to their machine or by leaving their machines unlocked and therefore available for others to access. We do have quite extensive secondary protective mechanisms such as traffic scanning systems and anti-virus they will never completely remove the threat from new variants of viruses and worms.

  Recommendation:
  1. Continue to support the engagement with Information Governance and Data Security Training for all staff
  2. Continue to communicate with staff about the importance of vigilance for such threats

- **Medical Devices** – WH use a wide array of devices as is the case in most healthcare organisations. Our overall aim is to be able to connect these to integrate the data they capture for clinical use, back it up for legal and safety reasons and to ensure a productive and efficient experience for both staff and patients. The current estate is very mixed with many devices which would be considered insecure if connected to the network. However, significant progress was made in 2017/2018 in assessing as many devices as possible, replacing or upgrading those where connectivity was essential or highly desirable and putting procedures in place around the backlog. It should be noted that a number of pieces of key radiology equipment do fall into this category. Given their essential nature and the challenge of replacing these, a temporary secure network has been set up for these. This is an expensive and resource heavy mitigation which we will aim to close as soon as is feasible. It should be noted that considerable ongoing focus and effort will be needed in this area to reduce the risk adequately.

  Recommendation –
  1. Effort and focus continued in working through the backlog
  2. New devices are assessed for their security both inherent and contractual

- **New Threats** – the support and information available to Trusts has improved since the WannaCry incident. One challenge that remains is the ability to deal with innovative new threats. While our defences comply and in some areas exceed the national standards there are regular reports of novel threats, many of which have no initial protection or remediation protocol. This makes it incumbent upon the IM&T team to remain vigilant to new threats, engage with the national information warnings and to refresh their skills as required. It's crucial the Trust maintain sight on Cyber risk and continue to invest in this area as required.

  Recommendation
- 1. continue to recognise the risk of Cyber Threats
  2. Support the ongoing skills and investment required to respond to new threats.

While this report draws out some key areas for the reader it is intended that in future we use the report attached in Appendix A to provide ongoing assurance to all levels of the Trust leadership. It is based on the National Cyber Security Centre guidance and should therefore be recognisable both within the NHS and outside.

Conclusion

The Trust should be satisfied while not complacent that it has made significant demonstrable progress in mitigating its cyber risk status. The leadership team should note that focus will need to be maintained in this area. The leadership team are also asked to consider the recommendations as relevant to their areas of responsibility and to confirm there are happy with the regulator return options.

Whittington Health NHS

Whittington Health IM&T - Cyber Security Update

Oct 2018

Authors:
Steve Illingworth, Assistant Director of IM&T (Technical Services)
Tino Goncalves, Network Manager

1.0 Introduction

Whittington Health IM&T have reviewed its cyber security status following guidance from the '10 steps to Cyber Security' produced by the National Cyber Security Centre (part of GCHQ). The following areas are covered:

Set up your Risk Management Regime
Monitoring
Malware Prevention
User education and awareness
Managing user privileges
Network security
Secure configuration
Removable media controls
Incident management
Home and mobile working

These ten steps demonstrate that cyber security is multi-layered and ever evolving, requiring constant review and updating of internal processes.

2.0Whittington Health's Current Cybersecurity Status

Set up your Risk Management Regime	

Description	Assess the risks to your organisation's information and systems with the same vigour you would for legal, regulatory, financial or operational risks. To achieve this, embed a Risk Management Regime across your organisation, supported by the Board and senior managers.
Risk	The Trust requires a corporate owned risk management regime for cybersecurity.
Mitigation	1) IM&T risk register maintained. 2) Key risks transferred to DATIX. 3) BAF/Board risk maintained

Network Security	

Description	Protect your networks from attack. Defend the network perimeter; filter out unauthorised access and malicious content. Monitor and test security controls.
Risk	We need to make sure we have current valid technologies to block against continuous evolving external threats.
Mitigation	1) All Firewalls are the latest generation. The Firewalls get updated every two months with patches unless there are any critical patches released. 2) Intrusion Detection has been installed to monitor internal network traffic for threats. 3) Web proxies scan non encrypted traffic for malware. 4) Firewall rules have been reviewed and updated. 5) The MTI IT security firm in 2017 -18 conducted external penetration tests of WH's network. Outcome successful - MTI failed to penetrate WH's systems. 6) Network Security Policy in place: http://whittnet.whittington.nhs.uk/search/?q=network+security+policy

Monitoring

Description	Establish a monitoring strategy and produce supporting policies. Continuously monitor all systems and networks. Analyse logs for unusual activity that could indicate an attack.
Risk	No software in place to assist IM&T to monitor attempts of external attacks through internet hosted servers e.g. Moodle, CareCentric and EmployeeOnline
Mitigation	1) Advanced traffic monitoring has been implemented (2017) on new firewalls. 2) Application specific logs eg. webserver logs to be collected and analysed by dedicated software to inspect for intrusion attempts. Software solution has been implemented (2018) and usage is being progressively extended. 3) Network vulnerabilities scanning, being routinely performed, looking for network connected devices that could be at risk from Malware. 4) Log management of user and administrator activities via ManageEngine configured and implemented (2017).

Malware

Secure Configuration

Description	Apply security patches and ensure the secure configuration of all systems is maintained. Create a system inventory and define a baseline build for all devices.
Risk	**Patching:** i) Internal – The current IM&T 'patch' update process for internally maintained software had problems with co-ordination across the multiple stakeholders. ii) External – a) Suppliers - Some suppliers (e.g. Astral for Imaging) are refusing to allow internal patching of externally maintained systems (threat of making existing warranties invalid if internal patching occurs although the supplier will not perform the required patches themselves). b) NHS Digital provided programmes e.g. ESR which require old unsupported vulnerable software versions (e.g. Java) in order to operate. Outside Trust's remit as national system. **Unsupported operating systems:** i) Medical devices attached to the network running unpatched or unsupported operating systems still an issue. Principally in pathology and imaging. These represent a cyber threat. ii) Support for Windows 7 devices and 2008 severs (the current main operating system for most devices and servers) only available until January 2020. iii) Ongoing purchasing of new medical devices with out-of-date or near end of life Windows operating systems with no provision for upgrade/patch protection.
Mitigation	1) The Trust Network Security Policy has been updated to include mandatory monthly update of all operating system security patches. 2) A Trust wide co-ordinated patching schedule for all servers has been implemented (with locally maintained agreements on when patching should occur within the one month time limit). Pathology was an exception this is now part of monthly patching.

	3) Isolation Firewall solution has been installed to protect internal networks from unpatched and unsupported system this is particularly targeted at medical devices. This is now live and running (early 2018), but some systems still need to be migrated onto the isolation network. 4) Residual unsupported 2003 servers have been upgraded or removed. 5) Review and/or renegotiate contracts with suppliers which do not meet Trust's standard for maintenance of patching supported software. 6) Planning in place for replacement of all PCs and laptops from Windows 7 to windows 10 by Jan 2020. Capital procurement program in place, and upgrade work underway x600 PCs already migrated to windows 10 by Oct 2018. 7) Planning to upgrade all windows 2008 Servers by Jan 2020 is underway, associated licencing procurement and upgrade work has commenced.

Malware Prevention	

Description	Produce relevant policies and establish anti-malware defences across your organisation.
Risk	Active anti-malware defences required across organisation.
Mitigation	1) AV solution has been standardised across the whole organisation to a new version of Sophos (until 2017 community was running McAfee). 2) Perimeter protection scanning of web traffic for malware on the proxy gateway. 3) Sophos Anti encryption-ware protection implemented across network 4) Microsoft Advanced Threat Protection (ATP) to be implemented across estate to provide enhanced threat alerting and response. Pilot already in place, projected to be rolled out by Dec 2018.

Removable media controls	

Description	Produce a policy to control all access to removable media. Limit media types and use. Scan all media for malware before importing onto the corporate system.
Risk	Potential for software viruses to be brought into Trust network by 'removable media' used by staff e.g. memory stick.
Mitigation	1) Antivirus solution in place that scans all removable media for software viruses before user is allowed to access memory stick. The policy for their use can be found here - http://whittnet.whittington.nhs.uk/document.ashx?id=2569

User education and awareness	

Description	Produce user security policies covering acceptable and secure use of your systems. Include in staff training. Maintain awareness of cyber risks.
Risk	Training on cybersecurity for all staff at WH. Nor is there a consistent regular campaign on maintaining staff awareness of cyber risks.
Mitigation	1) Mandatory annual training is now provided as part of the new Annual IG training which has been extended to include security awareness (implemented

	2017). 2) Work with Communications Team on raising cyber risk awareness and basic protective measures for staff. Content to be owned and updated by IM&T technical services, communications team to advise on best communication routes for staff to be made aware.

Managing user privileges	

Description	Establish effective management processes and limit the number of privileged accounts. Limit user privileges and monitor user activity. Control access to activity and audit logs.
Risk	Users should only have the access rights that they need to do the job. Any elevated or administrator rights are particularly dangerous if compromised by malware due to the access they permit.
Mitigation	1) A review of existing user privileges has been undertaken, to limit the number of staff with administrative rights, and ensure privileges granted are appropriate to work requirements. 2) User accounts now disabled after 60 days inactivity on a regular basis. 3) A log monitoring software (Manage Engine) has been implemented (2017) to enable monitoring of network domain activities by users.

Incident Management	

Description	Establish an incident response and disaster recovery capability. Test your incident management plans. Provide specialist training. Report criminal incidents to law enforcement. Report cyber incidents to CareCert.
Risk	In the event of a major incident important that incident response and disaster recovery plans have been carefully worked up to minimise impact.
Mitigation	1) Revised Incident response plan signed off by emergency planning group. 2) Planned incident response scenario training has been undertaken facilitated by Lee Smith (2017). 3) Procedures are in place, and routine technical fail over testing/training is undertaken for disaster recover procedures within IM&T.

Home and Mobile Working	

Description	Develop a mobile working policy. Apply the secure baseline and build to all devices. Protect data both in transit and at rest.
Risk	Risk of insecure devices being used for mobile and remote working.
Mitigation	1) Secure Citrix access to trust systems for remote users. 2) Secure Direct Access solution for remote access from trust laptops 3) Encryption of all Laptops. 4) Mobile Device Management Policy which can be found here – http://whittnet.whittington.nhs.uk/document.ashx?id=7602 *all the above are in place at the Trust.

4.0 Summary

Whittington Health was not affected by 'WannaCry' Ransomware in May 2017, and this is largely due to measures which have been put in place since the KPMG audit in 2016.
However there are still gaps within Whittington Health's cyber security which do need to be addressed on an ongoing basis to ensure all reasonable measures are in place. The biggest work areas going forwards are.

- Upgrading and refreshing PCs, servers and software, to ensure that they fully supported and cyber safe, this requires ongoing capital investment.
- Working with 3rd party suppliers to ensure that Medical devices are kept patched and cyber safe and are isolated from the main network where appropriate.
- User education and awareness raising of cyber safety

National advice is given by NHS Digital, in the form of the Data Security Centre - CareCert initiative. This provides best practice guidance, an advisory service, and a helpline in the event of incidents around threats. We are fully signed up to the Carecert threat advisory service.

Whittington Health NHS Trust

Agenda Item: 14

Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 14th November 2018
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS), Non-Executive Director
Members Present:	Michelle Johnson (MJ), Chief Nurse & Director of Patient Experience Deborah Harris-Ugbomah (DHU), Non-Executive Director Yua Haw Yoe (YHY), Non-Executive Director Julie Andrews (JA) Acting Medical Director Andy Sopher (ASo) Director of Operations Adult Community Services (attending for Carol Gillen, COO)
In attendance	Steve Hitchins (SH) Chairman James Connell (JC), Patient Experience Manager Lynda Rowlinson (LR) Interim Head of Governance and Risk Leanne Rivers (LRi) Patient Representative Alison Kett (AK), Associate Director of Nursing Adult Community Services Nicola Surman-Wells (NSW) Lead Cancer Nurse Nigel Kee (NK) Director of Operations, Emergency & Integrated Medicine Sita Chitambo (SC) Associate Director of Nursing Emergency & Integrated Medicine Stuart Richardson (SR) Chief Pharmacist Deborah Clatworthy (DCl) Associate Director of Nursing – Surgery & Cancer Eleanor Mirzaians (EM) Clinical Governance Manager – Women's Health Louise Roper (LR) Interim Clinical Governance Manager – Surgery & Cancer Dorian Cole (DCo) Associate Director of Nursing – Children & Young People Services Swarnjit Singh (SS) Trust Corporate Secretary Carolyn Stewart (CS) Minute taker

Agenda items

1.1	Welcome & Apologies	Chair
	AS welcomed the committee. Apologies received from Carol Gillen (CG), Chief Operating Officer Fiona Isacsson (FI) Director of Operations – Surgery & Cancer	

1.2	Declarations of Conflicts of Interests	Chair
	No conflicts of interest were noted.	

1.3	Minutes of the previous meeting	Chair
	No amendments were requested to be made to the minutes of the previous meeting held on 12th September. The minutes were approved.	

Actions	Deadline	Owner
See action tracker		

1.4	Matters Arising	Chair
1.4.1	MJ referred to the Terms of Reference (TOR) that had been reviewed at the last Quality Committee and it was agreed that it would be reviewed again in March 2019 in preparation for 2019/20	
1.4.2	Siobhan Harrington, Jonathan Gardner & MJ had met recently with Health Watch Islington and asked the Committee for approval for an observer from Health Watch to regularly attend Quality Committee. This was agreed. This will be reflected in the current TOR	

Actions	Deadline	Owner
1.4.1 Quality Committee Terms of Reference to be reviewed at March 19 meeting	March 2019	LR
1.4.2 MJ to contact Health Watch to advise that a member can attend Quality Committee as an observer. MJ to amend TOR in light of above point	January 2018	MJ

2.1	Surgery & Cancer Performance Report	
2.1.1	**Patient Story** JC presented a video to the Committee involving a patient who had a hip	

	replacement at Whittington Health 6 weeks previously. She spoke of the Enhanced Recovery Programme (ERP), now referred to as 'Joint School'. The patient described how she had met with the whole team prior to the operation (nursing staff, physiotherapists, occupational health and the pain team). She was fully informed of the procedure as well as after procedure. She reported a recovery that exceeded her expectations. . She stated that she had felt a part of the team and that the exercise programme she had been set before the operation considerably enhanced her swift recovery from the operation. She added that the nursing care on Thorogood Ward had been excellent and all her needs and questions had been addressed. She was discharged within 48 hours.
2.1.2	She further advised that she was given an information pack and the staff nurses went through all the information in the pack before she left. The enhanced recovery CNS, Siobhan, provided the patient with her mobile number and said she could contact her directly if required. She also rang the patient after she had been discharged to ensure she was recovering well.
2.1.3	DCl reassured the Committee that the information pack is provided in several languages and that the ERP is also provided for patients undergoing colorectal surgery (Colorectal Education Service). There is particular regard for patients with Learning Disabilities, including one to ones or small groups of 5-10 people for the Joint School. She confirmed that all patients are invited to the ERP. There is currently a pilot scheme working with virtual ward to aim to achieve earlier discharge and ensuring patients are ready and fully prepared both mentally and physically before surgery.
2.1.4	The Committee agreed that this was a very good video with excellent feedback from the patient. It will be shared at the Surgery and Cancer ICSU Quality Board.
2.1.5	**Surgery & Cancer Report** Referring to the report template, AS stated it was excellent and asked the Committee for comments. MJ stated that with regard to complaint responses, the ICSUs were within target but that there were 3 which missed the targets response time. DCI re-assured the committee that this was an improvement on the previous year. DCl added that the risk rating on complaints is also much lower than the previous year and the focus is on recurring issues. A Quality Improvement project is also in place to further reduce complaints.
2.1.6	AS asked if staffing vacancies was going in the right direction. DCl confirmed that it is on track, although there are still some vacancy hot spots. They are currently working around a skill mix of existing staff. New staff will be arriving soon as a result of the overseas recruitment drive. The team is holding a Surgical event evening. 56 have registered so far, and nurses or others interested in working in Surgery and Cancer will be shown the patient pathway, which will showcase theatres, recovery, anaesthetics, resuscitation and generally provide them with an understanding of the scope and range on offer at Whittington Health for surgical nurses and operating theatre practitioners.

2.1.7	LRi queried why there is a nurse staffing problem and was advised that there is a National shortage of nurse (e.g. 20,000 nurse vacancies across London) and that Whittington Health was working hard to ensure that the trust is an employer of choice and that we retain the nurses working for the trust. NHSE are helping to address the problem with national advertising campaigns.
2.1.8	AS queried section 6 of the report with regard to safeguarding concerns. DCl advised that the safeguarding issue related to a Serious incident investigation with regard to a consent form. She reassured the Committee that the consent form had subsequently been reviewed and amended to prevent this from recurring.
2.1.9	DCl advised that the cancer patients' survey 2017-18 results were now available. MJ referred to a concern regarding patients not being asked what they would like to be called as well as concerns that staff didn't introduce themselves. The "Hello My Name is…." Campaign is something that the trust is keen to promote further. The trust is re-launching this campaign and has asked for costings for all staff to have name badges with the logo. It was noted that a change of culture is required. The Committee was reassured that NSW & her team are working on this. It was also suggested that patients should be asked what name they would prefer to be addressed by.
2.1.10	DHB referred to yellow standard name badges for patients and relatives who may have visual impairments as well as for patients with dementia. The trust is looking to introduce "Hello my name is…." yellow name badges for staff. LRi suggested that any other language the nurse can speak could be added under their name. This was considered to be an excellent idea.
2.1.11	It was confirmed that the cancer survey action plan was updated with the outcome of the 2017/18 results. NK asked where it is monitored before Quality Committee and was advised that it is a joint action plan between Cancer Services and Patient Experience. The action plan will be updated and monitored though the ICSU board and PEC. ASt advised that we have agreed to host the Macmillan and the Health Psychology teams and they will be attending the ICSU board meetings. He suggested that anyone requiring further information on this should contact AK.

Actions	**Deadline**	**Owner**
Surgery & Cancer staffing issues to be reviewed at QC in May 2019	May 2019	DCl/FI

2.2	**Women's Health**
2.2.1	MJ reported that EM had been asked to report on the themed review of the three serious incidents (SI) relating to babies born at term who experienced harm. AS thanked Eleanor for attending the meeting and presenting the report.

Actions	**Deadline**	**Owner**

None		

3.1	Clinical Audit	
3.2.1	LR advised the Committee that the report was not available for today's meeting and gave apologies for Sarah Crook not attending the meeting. MJ advised that the Quality Account is now a public document and most of the information is picked up in the QA report. The end of the year QI improvement annual update will be available shortly. AS stated that the Quality Committee should have overview of clinical audits. MJ replied that the Clinical Governance (clinical effectiveness) team would be attending future Quality Committee meetings. JA stressed a preference to have the ICSU reports to include national and local clinical audits as well as compliance against NICE guidance/standards. This is within the agreed quality committee template. DHO referred to the clinical audit with regard to quality improvement and that this is not part of the audit committee. It was agreed that the template needs to be clear to capture both framework and content.	

Actions	Deadline	Owner
3.2.1 MJ/JA to discuss QA report template	January 2019	JA/MJ

3.2	Annual Serious Incident Reviews	
3.2.1	LR referred to the overview of SI investigations undertaken in 2017/2018 and recorded on Strategic Executive Information System (StEIS). 38 SI reported on StEIS and 1 never event. 58 previous year plus 1 never event. There has been an increase in reporting of incidents (no harm/low level harm) across the trust. AS asked specifically around the reduction in incidents relating to falls and whether there was a link with this and the STOPfalls initiative. JA confirmed that it is directly related. Staffing levels have also improved on the hospital wards which support the care and management of patients at high risk of falls.	

Actions	Deadline	Owner
None		

3.3	Aggregated Learning Report Quarter 2 2019/2020	
3.3.1	JA explained that the report provides an update on learning, complaints, inquests and legal claims. AS asked if there is an awareness of the increase in reporting and JA replied that there has been targeted training and all staff are reporting on Datix. She added that the Trust is now in the top 10% of trusts for reporting. There are still changes to be made but there has been considerable improvement. It was noted that Pharmacy does not report many incidents but are learning from what is reported. Band 5 nurses have been reporting the most. The staff groups who report the least are junior doctors and the importance of reporting is being highlighted at grand rounds, Patient Safety Forums and Inductions for Junior Doctors.	
3.3.2	MJ explained that there has been a lot of learning from PALS concerns, which	

	was welcomed, particularly in relation to concerns raised around staff attitude. There is additional focus and work specifically with reception and administrative staff to focus on customer service training.
3.3.3	Complaints are being dealt with well in Q2 with 94% of complaints being responded to within 21 days. (The target is 80 %).
3.2.4	DHU referred to non-clinical awareness and the clinical learning around managing expectations as well as the understanding of the patients' needs in relation to medical or nursing care. MJ replied that this is work in progress. She added that with the "You Said – We Did" campaign, the trust has reviewed concerns and complaint. It was agreed that the learning from PALS should be put forward for ICSUs to disseminate. LR agreed to carry out a deep dive. NK to provide feedback on the PALS data.

Actions	**Deadline**	**Owner**
3.2.4 Feedback on the ICSU response to PALS concerns data to be sent to PALS.	January 2019	NK

3.3	**Q2 Patient Safety Quarterly Report**	
3.3.1	JA advised that the paper covers Q2 of this year in relation to Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI). It covers mortality in patients 30 days after discharge. The Trust has had 4 avoidable deaths this year which is down from 7 last year. Currently 75% of hospital patient deaths have been through a mortality review. There is currently no focus on patients dying 30 days after discharge and this is being addressed.	
3.3.2	Hospital acquired infections - there has been 1 MRSA case and a recent MRSA colonization in neonatal unit (currently under investigation) 8 Clostridium Difficile cases to date. Staff flu vaccinations – programme going well and latest available figure puts the trust at 64% uptake.	
3.3.3	JA referred to the key Quality Priorities and the update provided in the report. MJ advised the Committee that there is a "Stop the Pressure" Day tomorrow which will focus on community risks of pressure ulcers as well as focus within the hospital.	
3.3.4	The Quality Account priority in relation to learning disability was raised and how success or lack of achievement was being reported (less quantifiable than the other priorities). Work with people with Autism – JC advised that he has a student volunteer working from The Autism Project (TAP) currently working within patient experience.	

Actions	**Deadline**	**Owner**

None		

3.4	Q2 Quality Impact Assessment (QIA) of CIPS	
3.4.1	MJ advised the Committee that the purpose of the paper is to describe the QIA CIP process and the current performance. Delivery is currently disappointing as QIA's have not been reported up to the Programme Management Office (with over 120 level 1 CIPS schemes which have not been reported as going through the QIA process). Data is currently being updated and cleansed. MJ/RJ have carried out two 'dip sample' of CIP schemes since April 2018 and have not picked up any quality concerns. MJ is confident that this was a robust feature of the assurance of CIP programmes. MJ & RJ reviewed every CIP QIA level 2 (rated as potentially at higher quality risk) scheme.	
3.4.2	MJ confirmed that this would come back to the Quality Committee in January for further update on level 1 CIPS and Level 2 CIPSA that have gone through the QIA process.	

Actions	**Deadline**	**Owner**
QIA of CIPS to be presented to the Quality Committee	January 2019	MJ

3.5	Q2 Patient Experience Report	
3.5.1	JC advised the Committee that the report is being refreshed with changes to include more information on patient voices and PAL concerns. **It was noted that the maternity survey was not for circulation until the embargo had ended.** Picker is providing a workshop for maternity staff ahead of the launch of the report. An action plan will be in place before the January meeting.	
3.5.2	MJ referred to the Noise at Night programme which is launching on 22nd November. It is being advertised via social media and trust communications and a floor standing banner has been produced for each ward. This includes Maternity; Surgery & Medical Wards. A Welcome pack will be trialled on Coyle Ward. YHY raised the issue of patients trying to get to sleep but being woken up for tests. AS requested that this is linked into the next Patient Experience report.	
3.5.3	Deb C requested that the National Cancer Patients' Survey results be included in the PE report. Deb Harris queried whether the Trust has a system for nominating exemplary staff for the National Honours List. MJ replied that this was a random and sporadic process which would become more systematic over the near future. MJ advised the Committee that Colette Datt, nurse consultant children and young people's services, had won the Nurse Leader Award from the Nursing Times. Deb Harris asked for a focus on Queen's Honours.	

Actions	**Deadline**	**Owner**
3.5.3/4 Noise at Night document & National Cancer Patients Survey to be included in next PE report	January 2019	JC/CD/DCl

3.6	**Never Event Gap Analysis**	

3.6.1	LR advised that Committee that this report had previously been to the SI panel in response to internal work and NHSI asking for safety alerts to be reviewed. The Never Events related to nasal gastric tubes and oxygen and air flow. All 15 Never Events were reviewed to ensure that the necessary assurance is in place. The figures cannot compare with other Trusts as it is a national table and doesn't reflect the size of each Trust. Appendix A lists all the gaps that have been identified. Assurance is in place for all of these gaps and is monitored through the Patient Safety Committee.

Actions	**Deadline**	**Owner**
None		

3.7	**Quality & Safety Risk Register Quarter 2**	
3.7.1	LR updated the Committee regarding the overview of risk management and high level risks above 15 from October 2018. There are currently 3 at 20+; compared to 5 in the last Board Report. The Quality & Safety risk register is monitored through the Quality Governance Team. It is the risk owner's responsibility to update risks.	
3.7.2	MJ advised that the 7 high risks that have not been updated are being followed up. It was noted that risks are discussed in the ICSU performance reviews. LR agreed to work with the ICSUs to go through all the ICSU risk.	
3.7.3	YHY queried item 189 with regard to the Emergency & Integrated medicine ICSU in relation to the controlled measures and the process for recruiting consultants. NK replied that 10 consultants have been recruited so far (and have a budget for 12). Locums are currently covering the vacancies until the posts have been filled. He added that there is sufficient consultant cover at present and he is working with ICSU risk managers for a further update. He is due to review the risk post committee meeting.	
3.7.4	It was requested that Adrien Cooper attends the next Quality Committee to update regarding violence and aggression. AC also required to report on risk 847 with regard to gas manifolds.	

Actions	**Deadline**	**Owner**
AC to update Quality Committee	January 2019	AC

3.8	**Trust Policies**	
3.8.1	LR reiterated to the Committee that the Policy Approval Group (PAG) is aware that there are out of date policies and this is a focus for the quality governance team. The frequency of the PAG meetings has been increased to monthly. This is part of the CQC preparation. LR is working with each ICSU to ensure that all are aware of the difference between a Policy and a SOP. The Compliance manager has a database control for the policies. It was reported that the Policy on writing Policies is now out of date and requires immediate attention. AS requested that the Policy on Policies be updated in time for the next Quality Committee.	

Actions	Deadline	Owner
3.8.2 Policy on Policies to return to next Quality Committee	January 2019	LR

4.1	Minutes from Reporting Groups – for information only	
4.1.1	The minutes from reporting groups were taken as read.	

Actions	Deadline	Owner

5.1	Any Other Business	
5.1.1	No other business was discussed.	

The next Quality Committee is scheduled for **Wednesday 9th January 2019**
Future dates:

- 13th March 2019
- 8th May 2019
- 10th July 2019
- 11th September 2019