Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
19 December 2018

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**19 December 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

Non-Executive Director members:	**Executive Director members:**
Steve Hitchins, Chair Deborah Harris-Ugbomah David Holt Professor Naomi Fulop Tony Rice Anu Singh Yua Haw Yoe	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** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
2	1435	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal update
3	1436	**Declaration of conflicts of Interest** *Steve Hitchins, Chair*	Verbal update
4	1437	**28 November 2018 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1440	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
6	1450	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review

Item	Timing	Title and lead	Action
Quality & patient safety			
7	1500	**Serious incidents – November 2018** *Dr Julie Andrews, Acting Medical Director*	Review
Operational performance and planning			
8	1515	**Performance dashboard – November 2018** *Carol Gillen, Chief Operating Officer*	Review
9	1530	**Financial performance – November 2018** *Stephen Bloomer, Chief Financial Officer*	Review
10	1545	**Capital plan update** *Stephen Bloomer, Chief Financial Officer*	Review
Strategy			
11	1600	**NHS workforce race equality standard improvement plan** *Norma French, Director of Workforce*	Approve
12	1615	**Section 75 London Borough of Islington annual report** *Carol Gillen, Chief Operating Officer*	Review
Governance			
13	1625	**Board Assurance Framework** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Review
14	1635	**Questions from the public on meeting items** *Steve Hitchins, Chair*	Review
15	1640	**Any other business** *Steve Hitchins, Chair*	Review

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Agenda item: 4

Minutes of the meeting of the Trust Board of Whittington Health NHS Trust held in public on Wednesday, 28 November 2018

Present:

Steve Hitchins	Non-Executive Director (Chair)
Julie Andrews	Acting Medical Director
Stephen Bloomer	Chief Financial Officer (items 1-14)
Janet Burgess MBE	Executive Member for Health & Social Care & Deputy Leader, Islington Council
Naomi Fulop	Non-Executive Director
Carol Gillen	Chief Operating Officer
Deborah Harris-Ugbomah	Non-Executive Director
Siobhan Harrington	Chief Executive
Tony Rice	Non-Executive Director (items 1-9)
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

James Connell	Patient Experience Manager (item 1)
Leon Douglas	Chief Information Officer (item 13)
Norma French	Director of Workforce
Casey Galloway	Patient Experience Officer (item 1)
Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
Sandra Glynn	Parkinson's Clinical Nurse Specialist (item 1)
Sarah Hayes	Deputy Chief Nurse
Sarah Humphery	Medical Director, Integrated Care
Juliette Marshall	Director of Communications, Engagement & Fundraising
Katie Sidle	Consultant for Neurology (item 1)
Andy Stopher	Director of Operations, Community Adult Services (items 8-9)
Swarnjit Singh	Trust Corporate Secretary

1.	**Patient story**
1.1	James Connell explained to Board members they were to consider an edited video of a patient regarding their experience of Trust services and that should any Board member wish to do so, they could receive a link to see the full, unedited video. The patient highlighted the following: • In 1962, she arrived in the UK from Germany • In 1992, she was diagnosed with multiple sclerosis and, in 2016, she was diagnosed with Parkinson's disease • David Lincoln, community matron, helped her enormously and introduced her to the Parkinson's unit in Edgware and to Sandra

	Glynn, Parkinson's Clinical Nurse Specialist, who was such an important part of her life now. She praised the latter for being so positive in her outlook • The Older People's Celebration Day held on 27 October 2018 was a great success as hospital and community services promoted the health and social care services available for local older people know across Haringey and Islington • The need for interaction on a daily basis, with other patients as well as health and social professionals, was cited as an area to end patients' social isolation and improve their experience
1.2	During discussion, the following points were made: • Parkinson's disease resulted in significant cognitive impairments such as anxiety and hallucinations • It was thought that, nationally 1 in 350 people are affected by Parkinson's disease; locally, there were between 400-500 patients • Katie Sidle explained that the neurology team would try to tailor drugs to each patient's needs to see which were the most appropriate. There was some evidence that one drug can slow down the onset of Parkinson's. There was also very good evidence that exercise, especially dance, can improve Parkinson's patients enormously through bypassing cortical pathways in the brain • Sandra Glynn explained that she had worked for the Trust as a community nurse for fifteen years and worked across both Islington and Haringey working with therapy teams, holding clinics and seeing patients in nursing homes. She emphasised the importance of co-ordination with local health and social care partners to help deliver more person-centred care • In reply to a concern raised by Deborah Harris-Ugbomah about having more capacity within the service, Siobhan Harrington explained that the Parkinson's UK had provided funding for two years and Carol Gillen reported that an Integrated Clinical Service Unit (ICSU) business case was being developed to help secure a future model • Katie Sidle highlighted guidelines from the National Institute for Clinical Excellence which said that Parkinson's patients should have access to a Parkinson's disease nurse specialist • Sarah Humphery welcomed the aim for Haringey and Islington to have joint therapy services and joint training as a fantastic example of integration in practice. It was important for patients to link with community rehabilitation teams and to ensure that GPs were fully aware of the services provided for Parkinson's patients
1.3	The Board: i. thanked the patient with Parkinson's disease for sharing their experience; ii. agreed that the Chair would write to David Lincoln, Specialist Nurse, Frailty Team;

	iii. agreed that any Board member wishing to see the whole patient story video should contact the Patient Advice & Liaison team for the link; and iv. welcomed the development of the ICSU business case to determine the future model.
2. 2.1	**Welcome and apologies** Steve Hitchins welcomed all attendees. Apologies were noted for David Holt, Non-Executive Director, and Michelle Johnson, Chief Nurse & Director of Patient Experience; Sarah Hayes, was welcomed as a deputy for the latter.
3. 3.1	**Conflicts of interest** There were none reported in respect of the agenda items to be covered.
4. 4.1 4.2	**Minutes of the board meeting held on 31 October** The minutes of the previous meeting were agreed as an accurate record. The updated action log was reviewed. Deborah Harris-Ugbomah commented that the Board Assurance Framework at the Trust was one of the best she had seen in the NHS. Julie Andrews reported that, while work was taking place to review the quarter two quality and safety report section on mortality, it may not be possible to have that report ready for review by the Quality Committee in January 2019 and, if so, this would be considered at the next Committee meeting in March.
5. 5.1 5.2	**Chairman's report** Steve Hitchins reported the following: • On 4 November, he attended a Remembrance Day event which was warmly-welcomed • On 11 November, he attended a memorial service at held by the Manor Gardens Welfare Trust • Along with Siobhan Harrington, he had received visits from the Rt. Hon. Jeremy Corbyn MP and also Joseph Ejiofor, the new Leader of Haringey Council • He had attended the opening of a new haematology unit on Victoria ward which had received positive patient feedback • The surgery team held a very successful open evening last week which attracted excellent interest, particularly in terms of enquiries to the nurse recruitment team • On 3 December, the Trust would be joined by the Mayor of Haringey and Deputy Mayor of Islington to formally switch on the Christmas tree lights. In addition, Ambitious about Autism, a strategic Trust partner would be fundraising at the event • On behalf of the Trust Board, he thanked Sarah Hayes who was joining Epsom & St Helier NHS Trust, on secondment and sent warm wishes to Fiona Isacsson, Director of Operations, Surgery & Cancer, who was taking a planned absence Carol Gillen confirmed that an interim replacement for Fiona Isacsson was in

	place to support the Surgery & Cancer ICSU.
5.3	**The Board received the items contained in the Chairman's verbal report.**
6.	**Chief Executive's report**
6.1	Siobhan Harrington drew Board members' attention to the following: • Sir Ron Kerr, former Chief Executive of Guy's & St Thomas' NHSFT, had just launched a report on Empowering NHS Leaders to lead organisations and tackle bullying and harassment. In addition, the zero tolerance of violence and aggression against NHS staff was very relevant in terms of the all the work taking place at the Trust on improving workplace culture • Performance against the four hour wait in the emergency department needed to improve and chimed with feedback from NHS Improvement which recognised the Trust's commitment to quality and safety but highlighted a concern regarding delivery of the plan • The Trust's Board would consider a report in December 2018 on the workforce race equality standard (WRES) improvement plan and then a report on workforce culture at its January 2019 meeting. She had attended a national WRES expert programme launch and the Trust had secured two places for this initiative • There was a good turnout at the staff inclusion network meeting held earlier today • As of today, 41% of staff had completed their annual NHS staff survey; 42% of staff responded in 2017/18 and the target for 2018/19 was a 45% response rate • The working hard for better sleep project had started in response to inpatient survey findings. This work would include a focus on shifting culture at night to minimise any unnecessary noise • Reuben Ferreira had been appointed as the Trust's new Freedom to Speak Up Guardian and a number of Champions would be trained to support him • Colette Datt, Nurse Consultant for Children and Young People's Services was lauded for being named Nurse Leader of the Year at the annual Nursing Times awards • A response to a query on compliance with Modern Slavery Act requirements by Trust contractors was included as an appendix to the report
6.2	Julie Andrews explained that the working hard for better sleep project was being taken forward in conjunction with work which also looked at staff rest periods in the evenings. Steve Hitchins welcomed this work and suggested the next area of focus might be patient food.
6.3	**The Board received the Chief Executive's report and congratulated Colette Datt on her Nurse Leader of the Year award.**

7.	**Serious Incidents**
7.1	Julie Andrews reported there were a further two serious incidents in October which brought the total to 23 so far in 2018/19 against a total of 39 in 2017/18. She explained that the themes identified were trauma in older people and delays in reacting to abnormal diagnostic results and provided assurance that learning from serious incidents was being shared across the organisation in a variety of ways. In addition, Julie Andrews alerted Board members to the actions being taken for a case involving a diagnostic incident and delay.
7.2	In reply to a question from Steve Hitchins on how assurance was obtained that the actions and learning highlighted for cases were completed, Julie Andrews clarified this was done in a number of ways: the action plan for each formal serious incident was reviewed; and, serious incidents was a standing item at all ICSU Board meetings and meetings of the Patient Safety Committee. She confirmed to Norma French that action plans were signed off by respective ICSU risk managers and their delivery was monitored by the Chief Nurse's quality governance team.
7.3	Steve Hitchins reported that the inclusion of learning from incidents in the internal audit work plan was discussed at a meeting of the Audit & Risk Committee earlier that day.
7.4	**The Board reviewed the serious incident's report and received assurance of the portfolio of approaches being taken to share and learning from serious incidents across the Trust.**
8.	**Equally well**
8.1	Siobhan Harrington explained that the presentation allowed Board members to see the potential benefits of better work between physical and mental health. Board members received a presentation delivered by Julie Andrews and Andy Stopher.
8.2	The following points arose in discussion: • There were approximately 3,000 people in the local population with a serious mental illness • Councillor Burgess asked for the presentation slides to be sent to her • Stephen Bloomer confirmed to Councillor Burgess that staff training and development services in the Whittington Education Centre would be provided elsewhere on the site • Steve Hitchins raised the need to promote this development as one which increased the quality of medical care for all patients, including those accessing mental health services • Julie Andrews reported that clinical staff were really positive about this development and excited about the parity of esteem principles so that all patients had access to high quality physical and mental health services • Andy Stopher highlighted the importance of engaging with primary and social care and other local bodies. He cited the need for mental

	health services to be included in the diabetes hubs being established in each local borough • Siobhan Harrington explained there was support from commissioners for this development and regular meetings were being held with the Medical Director and Chief Nurse at Camden & Islington NHSFT • Sarah Humphery suggested there was a need for effective co-ordination between partners and to tailor communication to patients. Andy Stopher reported that every patient on the serious mental illness register in Islington would receive an annual mental health check • In reply to a question from Jonathan Gardner, Julie Andrews explained that the impact on emergency department patient flows was unclear at present. Andy Stopher advised that the proportion of s136 mental health patients who attended Accident & Emergency services as a proportion of all mental health patients was low • Steve Hitchins reported that when he attended the Manor Gardens Welfare Trust's Remembrance Day service, he met the local police borough commander who would visit the Trust in January 2019; he would circulate the date to colleagues
8.3	**Board members:** **i. thanked Julie Andrews and Andy Stopher for the presentation;** **ii. agreed the presentation be emailed to Councillor Burgess;** **iii. supported the direction of travel to improve physical and mental health integration; and** **iv. noted that Steve Hitchins would circulate the date of the local police borough commander's visit to the Trust in January 2019.**
9.	**Performance dashboard**
9.1	The report was taken was read. Carol Gillen highlighted the following: • It was important to recognise that a lot of good work had taken place on patient flow and escalation • Emergency department performance was around the 90% mark and the Emergency Care Improvement Programme team from NHS Improvement was helping the Trust • Stranded patients and delayed transfers of care had reduced significantly • The Trust had not yet opened a winter pressure ward unlike this stage last year • Professor Matthew Cooke completed a workforce review and commended the Trust on the capacity tool developed with the Cass Business School
9.2	In discussion, Board members raised the following points: • In response to a query from Steve Hitchins on staffing, Carol Gillen confirmed that the emergency department's nursing complement was

	fully-recruited to; Emergency Nurse Practitioners (ENPs) would, from 1 December 2018, work until midnight now; and middle grade doctor posts were more problematic • Julie Andrews confirmed that all safety issues in the emergency department were tracked and provided assurance that the trend there was one of a reduced number of incidents and harm; overall, there had not been a serious incident in the emergency department for almost two years. In addition, she reported that wellbeing work in that department had resulted in lower staff sickness absence and also less turnover • In reply to a concern raised by Andy Stopher, Carol Gillen gave assurance that taxis and parking, where needed by ENP staff were being arranged • Steve Hitchins asked when the emergency department performance on four hour waits would be at 95%. Siobhan Harrington suggested this level could be reached by the end of March 2019, provided there was consistent performance above 90% each month from now. Carol Gillen gave assurance that the Trust knew the areas to focus on. In reply to a challenge from Deborah Harris-Ugbomah on plans to achieve a 95% performance level, Carol Gillen confirmed that the Trust was close to meeting the four hour wait target and was transferring mental health patients to the onsite mental health lounge to help • Carol Gillen reported that the breach of the standard 14 days cancer target was predominantly related to the endoscopy backlog. She provided assurance that the backlog would be cleared by the end of the first week of December 2018 and this performance indicator was expected to be back on track in January 2019. Carol Gillen also confirmed to Normal French that issues with the telephone system for endoscopy had been resolved with the IT team • Carol Gillen also reported that there was one breach against the 52 weeks' referral to treatment time indicator. This patient was inadvertently missed. Assurance was provided that the patient suffered no harm and had been offered an appointment. In addition, patient lists were being reviewed to see if any other patients were affected and none had, so far, been identified • There was a good, sustained improvement against adult community service indicators. In response to a query from Steve Hitchins, Carol Gillen reported that there had been very positive feedback from Haringey commissioners as the Trust had overachieved its target for seeing patients with diabetes
9.3	**Board members received and reviewed the performance dashboard report and took assurance the Trust was managing performance compliance and putting in place remedial actions, where they were required.**
10. 10.1	**Financial performance** Stephen Bloomer highlighted the following:

	• At month seven, the Trust was £3m behind plan • Clinical income was also behind plan although plans were in place to recover this position • There was a continuing trend of increased staffing expenditure which needed to be set alongside success in reducing agency staffing costs • There was an increase in non-pay expenditure due to theatre and drug costs resulting from increased clinical activity • The predicted outturn was the achievement of a £22.7m control total, subject to the remaining agenda for change pay funding being resolved. He emphasised that to help ensure this outcome, the ICSUs needed to deliver cost improvement plan targets and to recover activity and income targets, while also mitigating any existing budget variances
10.2	In discussion, Board members raised the following points: • Stephen Bloomer agreed with a suggestion from Steve Hitchins that the Trust needed to do more to market services such as maternity to help increase income and commented that the challenge for that Integrated Clinical Service Unit (ICSU) remained managing a drop in income with a staffing complement which required review • Sarah Humphery said she could promote local maternity services in her GP newsletter • Tony Rice suggested that, for a small investment, the maternity department could be refurbished to attract new expectant mothers • In reply to a question from Yua Haw Yoe on when ICSUs would be in a better financial position, Carol Gillen explained that work had taken place to focus on activity and meeting cost improvement plan targets and provided assurance that there was weekly oversight by the executive team and improvements had been seen in some areas e.g. bariatrics. Siobhan Harrington confirmed that the 4 December meeting of the Trust's Management Group would review the forecast positions for ICSUs and corporate areas
10.3	**The Board reviewed the finance report for month seven and recognised the need to improve income delivery, to reduce agency spend and to improve the delivery of the run rate including the cost improvement programme plans.**
11.	**Estates Strategy Delivery Committee draft terms of reference**
11.1	The report was taken as read. In discussion, the following issues arose: • Stephen Bloomer confirmed to Norma French that the aim was frontline, ICSU clinical staff representation on the committee rather than staff side representatives • Steve Hitchins suggested deleting either of paragraphs 4.3 or 4.4 to avoid duplication; to include monitoring or project costs and delivery on page five; and, to include an annual review of the committee's terms of reference and its effectiveness, in line with good governance

	practice. He also proposed that the committee's draft minutes, approved by the Chair, be brought to the private meeting of the Board
11.2	**The Board agreed the committee's terms of reference, subject to the following amendments:** • **Draft minutes to be presented to the next Private Board meeting** • **Include Greater London Authority representative as a member** • **Integrated Clinical Service Unit representation, with an emphasis on clinical post holders attending meetings** • **An annual review of the committee's effectiveness and terms of reference**
12. 12.1	**Greater London Authority Memorandum of Understanding** Stephen Bloomer reported that this was an exciting development and a good demonstration of working in partnership with local authorities. He confirmed that revised wording had been agreed around social housing provision.
12.2	**The board agreed the memorandum of understanding and delegated authority for the Chief Executive to sign it on behalf of the Trust.**
13. 13.1	**Cyber risk update** Leon Douglas reported that the biggest risk was medical devices which did not have compliant operating systems. He did not however recommend amending the score for this Board Assurance Framework risk entry's score. Julie Andrews welcomed the positive transformation being achieved through the roll out of the Vitals project.
13.2	**The Board:** **i. received the update on cyber risks and reviewed the progress achieved to date; and** **ii. thanked Leon Douglas for the progress made on implementation of the Vitals project.**
14. 14.1	**14 November 2018 Draft Quality Committee meeting minutes** Anu Singh drew Board members' attention to two areas: first, there was a need for all risk owners to update their entries in a timely fashion; and secondly, the committee would carry out a deep dive into learning from complaints.
14.2	**The Board reviewed the draft committee minutes.**
15. 15.1	**Questions from the public on agenda items** There were none received.
16. 16.1	**Any other business** There were no items raised.

Action log, Public Board meeting, 28.11.2018

Item	Action	Lead	Progress
Patient story	Inform the Patient Advice & Liaison team if you would like to be sent a link to the whole patient story video, of which an excerpt was shown at the November Board meeting	All	Completed
	Write to David Lincoln, Specialist Nurse, Frailty Team	Steve Hitchins	Completed
Minutes, 31 October meeting	Bring workforce race equality standard improvement plan to November Board meeting	Norma French	Completed – on agenda
Equally well presentation	Send Councillor Janet Burgess, an electronic version of the presentation	Swarnjit Singh	Completed
	Circulate to Board members details of the visit of the Islington Borough Police Commander to the Trust in January 2019	Steve Hitchins	Completed
Finance report	Promote Trust maternity services within practice newsletter	Dr Sarah Humphery	Completed – included in GP Connect newsletter issued in week commencing 17 December
Draft Estates Strategy Delivery Committee terms of reference	Amend terms of reference to include the following: • Draft minutes to be presented to the next Private Board meeting	Stephen Bloomer	Completed

Item	Action	Lead	Progress
	• Include Greater London Authority representative as a member • Integrated Clinical Service Unit representation, with an emphasis on clinical post holders attending committee meetings • An annual review of the committee's effectiveness and terms of reference		
Greater London Authority Memorandum of Understanding (MoU)	Delegated authority to sign the final MoU	Siobhan Harrington	Completed on 7 December 2018

Meeting title	**Trust Board – public meeting**	**Date: 19 December 2018**
Report title	**Chief Executive's report**	**Agenda Item: 6**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Corporate 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	None	

Chief Executive's report

This report provides the Board of Directors with highlights of initiatives within the national health and social care sector as well as providing an update on key local developments of interest in our local health and social care community.

1. National news

Improving the lives of autistic adults and children

1.1 On 5 December, the government announced a review of services and support for autistic people. It will collect evidence from autistic children and adults, families, carers and professionals on how to improve services and support. Supporting people on the autism spectrum or with learning disabilities is one of the four clinical priority areas in the NHS long term plan.

Mental health service reform

1.2 Following publication of the final report from the independent review of the Mental Health Act (1983)[1], the government announced its aim to introduce a new Mental Health Bill including recommendations to modernise mental health services so that people:

- detained under the Act will be allowed to nominate a person of their choice to be involved in decisions about their care; and
- will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.

Brexit preparations

1.3 As part of planning for all outcome scenarios, on 7 December, the Secretary of State for Health and Social Care wrote to NHS bodies. The letter provides an update on what the health and care system needs to consider in the period leading up to March 2019. It includes plans relating to the continued supply of:

- medicines and vaccines
- medical devices and clinical consumables
- blood and other products of human origin
- non-clinical consumables, goods and services

NHS England and NHS Improvement senior leadership team

1.4 On 11 December, NHS England and NHS Improvement announced a new joint senior leadership team – the NHS Executive Group – which will be chaired by the Chief Executives of both bodies[2]. I would like to congratulate Sir David Sloman, Group Chief Executive of the Royal Free London NHS Foundation Trust (and former Chief Executive of Whittington Hospital NHS Trust and NHS Haringey) on being appointed as the new London Regional Director.

[1] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review
[2] https://www.england.nhs.uk/2018/12/nhs-england-and-nhs-improvement-announce-new-senior-leadership-posts/

2. Local developments

Quality and Safety

2.1 The Trust is experiencing increased demand for services as we have entered the winter period and staff are continuing to work hard and to deliver safe care and patient experience. Emergency department performance has been challenged and in November, we achieved 88% (target 95%) for patients being seen within four hours.

2.2 The trust experienced one breach against the 52 week referral to treatment time target in November which covered the same patient reported to the Board last month. No clinical harm has been caused in this case.

2.3 In November, the Trust's performance overall against the two week wait national cancer was 89.6% (target 93%) this is still mainly due to endoscopy delays which have now improved and we should see impact on performance going forward. In respect of the 62 day waiting time for cancer treatment, the Trust achieved 83.1% (target 85%). Urology is still experiencing delays, and a plan is in place to implement a nurse led clinic in quarter four which should help.

2.4 A potential never event was declared in December 2018 and is being reviewed to see if it meets the applicable criteria and to share learning. It is referenced in the serious incidents' report on this meeting's agenda as a separate item.

Flu vaccination

2.5 The Trust continues to vaccinate all frontline clinical and medical staff. I am pleased to report that, as of 11 December, 72% of frontline staff had been vaccinated against the winter flu virus.

Financial

2.6 At the end of month eight, the Trust is reporting a surplus of £2m against a plan of £2m. For the year to date position, Whittington Health is £237k behind its agreed NHS Improvement plan. As reported in previous months, the main adverse variances relate to clinical income performance and pay overspends as a result of agenda for change adjustments for the three year pay deal. The predicted end year outturn is the achievement of the control total of £22.7m, subject to remaining agenda for change pay funding being successfully resolved.

Integrated Care

2.7 Staff have been involved in multi-agency workshops in North Islington and NE Haringey to develop our integrated care locality working. The Trust has also responded to North Central London (NCL) Care and Partners' work on 'Intergreat' welcoming the move towards integrated care in NCL with a borough focus. Whittington Health continues to encourage the work of the Islington & Haringey Wellbeing Partnership

Estates master planning

2.8 The process to engage in planning our future estate across community and hospital sites continues. Integrated Clinical Service Units have attended workshops and stakeholders will

be involved from January 2019. This process will continue through to the end of March 2019.

2018 NHS staff survey

2.9 As of 7 December, 45.7% of staff had completed the annual staff survey. This is our highest ever staff survey completion rate. The Trust's management places a great value on this annual snapshot from staff; the outcome will be made available in quarter four.

Reverse mentoring

2.10 Four executive directors have commenced their reverse mentoring programme. This will run for the next six months.

Workforce Race Equality Standard

2.11 NHS England's national Workforce Race Equality Standard (WRES) team comes to the Trust on Monday, 21 January 2019 to facilitate a workshop to outline best practice which will help the Trust enhance its WRES outcomes further. There is a paper on this meeting's agenda which presents the Trust's updated WRES improvement plan.

Staff networks

2.12 The Trust has also just set up three new Inclusion Network Facebook groups. The first to launch was the LGBT+ (Lesbian, Gay, Bisexual, Trans and others) group last week, followed this week by the Disability Group, which is open to any member of staff who has a disability or an interest in disability issues. A new group for Black & Minority Ethnic (BME) staff and for those with an interest in race and equalities issues is also now live and will be officially launched at the new BME Staff network on 17 January.

Breeda McManus, Interim Deputy Chief Nurse

2.13 Breeda McManus joins the Trust as our interim Deputy Chief Nurse from Barts Health NHS Trust. She is an experienced nurse with an extensive background in adult nursing and nephrology, including leading the development of a frailty pathway. Breeda starts on the 31 December 2018 and we look forward to welcoming her.

Staff award – Information Management & Technology (IM&T) team

2.14 I want to congratulate the Careflow Vitals team for receiving the staff excellence award. They introduced a new electronic observation system, 'Vital Signs Monitoring', across all ward areas and worked with clinical teams to introduce new working practices. With excellent team working, this large scale project was delivered within deadline and budget and gained a lot of positive feedback from users. The new system reduces the amount of time it takes to complete a set of patient observations and minimises the likelihood of recording errors. It will also help to identify deteriorating patients more rapidly, allowing specialist care to be provided quicker.

The Autism Project at Whittington Health

2.15 I want to report that, since September this year, Whittington Health has been in partnership with The Autism Project (TAP) http://nationalautismproject.org.uk/ This has resulted in several TAP students starting work placements within the hospital. TAP is a two-year programme, which aims to support young autistic adults (aged between 18-25 years) to develop relevant employability skills and I am immensely proud of the Trust's participation in this initiative to help improve the health inequalities faced by young people with autism.

2.16 Finally, I want to wish everyone a Merry Christmas and a Happy New Year, especially to those colleagues who will be working over the festive period, caring for patients and keeping our services running.

Meeting title	**Trust Board – public meeting**	**Date: 19.12.2018**
Report title	Serious Incidents – Month 8 (November 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 November 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	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 • Investigate and learn from a Never Event	
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	To each public Board meeting	
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 Incidents' monthly report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during November 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 four serious incidents during November 2018, bringing the total of reportable serious incidents to 27 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.

Never Event

The Trust declared a Never Event in December 2018, a wrong site surgical procedure. A patient received a peripheral nerve block on the right side instead of the left side. This was discovered before any surgery was performed and there was no repeated on-going harm to the patient.

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.
Diagnostic Incident including delay Ref:23175	Sept 18	An elderly patient had a fall at home, resulting in a fractured neck of femur and multiple rib fractures. There may have been an unwarranted delay in appropriately

Category	Month Declared	Summary
		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 initiated was unsuccessful. The patient subsequently died.
Patient fall Ref:27817	Nov 18	A mental health patient absconded from ED prior to being admitted; fell from the roof into the window of a ward resulting in cuts and lacerations to himself and to a patient's relative.
Still Birth Ref:27813	Nov 18	An Intra uterine death was diagnosed by ultrasound following concerns raised by the woman that no fetal movements had been felt.
Unexpected Death Ref:28316	Nov 18	A patient died after deteriorating following an elective surgery for a giant hiatus hernia.
Absconded Patient Ref:28441	Nov 18	A patient under section absconded from a ward whilst staff were attending to another patient. The patient has not been located.

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	Mar 18	Total
Safeguarding	0	0	0	0	0	0	0	1	0	0	0	0	1
Attempted self-harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG	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 – November 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	Nov 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0	1	1
Apparent/actual/suspected self-inflicted harm	1	0		0	0	0	0	0	0	0	0	0
Confidential information leak/Information	6	3		2	0	1	0	0	0	0	0	3
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	2	0	7
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	1		0	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	0
Failure to meet expected target (12 hr trolley	1	0		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	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	0	0	1	0	1	6
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0	0	0	0
Medical equipment/devices/ disposables	1	0		0	0	0	0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	0	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	0	0	1	2
Sub Optimal Care	4	2		1	0	0	0	0	0	0	0	1
Surgical/invasive procedure incident meeting	0	0		0	1	0	0	0	0	0	0	1
Treatment Delay	3	4		0	2	0	0	0	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	0	0	1	2
Retained foreign object	1	1		0	0	0	0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**2**	**4**	**27**

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 November 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 November 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 November 2018. The Trust submitted one report in November 2018.

Summary	**Actions taken as result of lessons learnt include;**
Unexpected Admission to NICU Ref: 22623	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). • The maternity records template design is being considered to make newly identified risks easier to identify. • Maternity staff are aware of the importance of highlighting antenatal concerns in patient records and staff have been reminded to document this is the correct place within the records to ensure this is easily identifiable when required. • The Fetal Monitoring Teaching and Guideline is being reviewed to emphasise the increased risks to fetus' that are affected by maternal sepsis as well as overall situational awareness. • The timeframe for ultrasound scans is being reviewed as part of a trust imaging action plan.

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 – public meeting**	**Date: 19 December 2018**
Report title	**Integrated performance report**	**Agenda Item: 8**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	Due to the Board meeting scheduled in the 3rd week instead of the 4th week of the month the following data is not yet available: • Number of avoidable pressure ulcers • Improving access to psychological therapies moving to recovery • Staff performance appraisal % rate • Statutory and mandatory training % rate • Permanent staffing • Vacancy % rate against establishment **Emergency Department (ED) four hours' wait:** Overall performance against the 95%, four hour standard for November was 88.5%, which was an improvement on October's performance of 88.1%. Attendance numbers were higher in November at 9,245 compared to October at 9,083. The November 2018 attendance figure was an 8.1% increase compared to November 2017 (8,549 attendances). Daily attendances in November averaged at 308 attendances per day. **District Nursing visits within two hours and 48 hours** Achieved **Cancer:** Cancer targets not achieved (14 days to first seen, 62 days from referral to treatment). An action plan is in place in Haematology to cover the clinic from December 2018. In Urology, the Prostate pathway is being reviewed to improve diagnostic waiting times and an action plan is in place to implement nurse led clinic by January/February 2019. **Delayed transfers of care** October's performance was 2.5% and is only 0.1% above the target. Overall, this is an improving trend.	

	Referral to treatment time 52 weeks' wait One 52 week breach in October, no clinical harm to the patient. This patient will also appear in the November data.
Purpose:	Review and 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	The following BAF entries are linked: risk 3 – failure to hit national and local performance targets risk 4 – failure to recruit and retain high quality substantive staff risk 14 – failure to provide robust urgent and emergency pathway for people with mental health needs risk 17 – organisational culture
Report history	Trust Management Group, 18 December 2018
Appendices	None

Whittington Health NHS

Integrated Performance Report

December 2018

Month 8 (2018 – 2019)

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Summary Page - Indicators

Category	Indicator	17_18 Target	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	Q3 Nov-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	89.0%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	81	75	77	95	91	87	79	74	63	75	79	88	79
Cancer	Cancer - 14 days to first seen	**>93%**	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%		93.4%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%		84.6%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.4%	5.0%	6.0%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%		2.7%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	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%**	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.5%
Community	Community - FFT % Positive	**>90%**	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	96.2%
Staff	Staff - FFT % Recommend Care	**>70%**	70.6%			75.0%			77.3%			77.4%			77.3%
Community	% seen <=2 hours of Referral to District Nursing Night Service	**>80%**	82.2%	96.0%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	91.1%
Community	% seen <=48 hours of Referral to District Nursing Service	**>95%**	87.4%	91.8%	92.2%	88.2%	84.2%	91.5%	85.7%	93.8%	89.7%	90.8%	93.8%	95.0%	90.2%
Community	Haringey New Birth Visits - % seen within 2 weeks	**>95%**	85.7%	91.8%	93.3%	90.5%	89.7%	92.6%	93.4%	90.4%	92.1%	91.8%	90.9%		91.6%
Community	Islington New Birth Visits - % seen within 2 weeks	**>95%**	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%	96.5%	92.5%		94.9%

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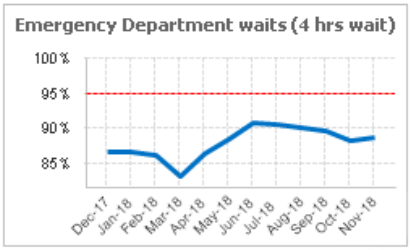
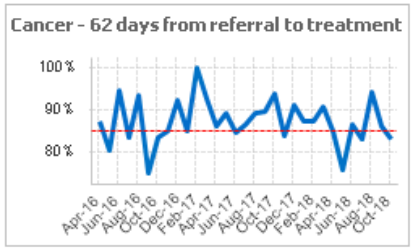
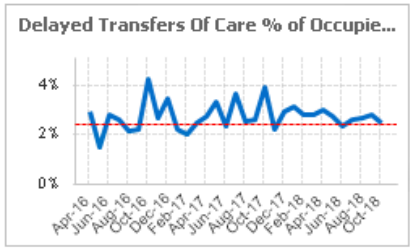
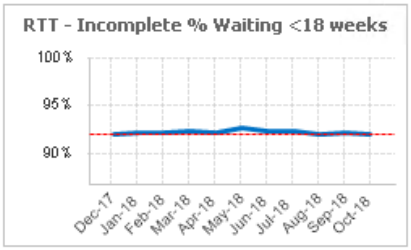
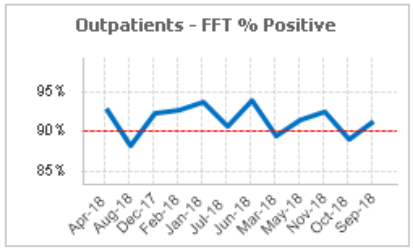
Summary Page - Indicators

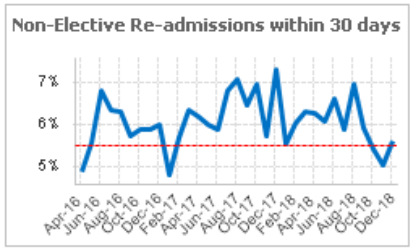












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Nov-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	1	0	1	2	0	0	2	2	1	1	9	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	35	38	27	43	37	52	33	33	26	28	36	31	276	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	3	9	3	3	2	4	2	1	4	0	1		14	
All Areas	Harm Free Care %	>95%	94.2%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	92.8%	
Maternity	Non Elective C-Section % Rate	<15%	21.7%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	21.8%	20.1%	
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	0	1	0	0	0	0	1	0	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	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	17.6%	
All Areas	Serious Incidents	0	0	7	1	2	6	8	3	1	1	2	2	4	27	
Admitted	VTE Risk Assessment %	>95%	95.2%	95.1%	95.2%	96.2%	95.9%	95.1%	95.0%	96.2%	94.5%	94.9%	95.2%		95.2%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	0	5	7	0	0	0	0	0	0	12	

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Safe Services - Commentary

HCAI C Difficile
C. difficile, there was one new case in November 2018 on Meyrick Ward. This is the second one on Meyrick Ward in the consecutive month. There has been a review of the situation and we are awaiting bacteria strain typing to confirm if there has been cross infection.

Pressure Ulcers
Due to the Trust Board meeting having been brought forward a week in December 2018, information is not yet available. Two months will be reported in January 2019.

Non elective C-section
Rate has increased by 3% from last month, to 21.8%.
An audit was carried out for July 2018 data as this month also showed an increase in CS rate overall. It indicated that the non-electives C/S were done appropriately in each case however there was a concern regarding lack of senior (consultant) input at the time of the decision to deliver. The labour ward lead consultant and Labour Ward Matron are formulating an action plan to address this concern and define if this is an issue with documentation or if there is a lack of actual requesting support from junior staff groups. For the July data, it was not felt to have affected any of the outcomes for the births.

Serious Incidents
There were 4 incidents declared as SIs in November 2018.
1. 2018.27817 [EIM & C&I] Mental Health Patient fell through a window into Victoria ward.
2. 2018.27813 [WHOD] Intra-uterine Death (Still Birth)
3. 2018.28316 [S&C] Unexpected Death - Sub optimal care
4. 2018.28441 [EIM & C&I] Patient absconded from ward whilst under section 2 Mental Health Act

All SIs are under investigation.

Safe Services - Commentary

VTE Risk assessments (reported in arrears)
VTE achieved target in October. Q2 has reached target after validation and a revision request has been raised to correct the submitted Q2 data, including August 18 and September 18.

Caring Services - Indicators and Performance

new slide coming

Category	Indicator	18_19 Target	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	Q3 Nov-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.7%	
ED	ED - FFT Response Rate	>15%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	13.4%	
Admitted	Inpatients - FFT % Positive	>90%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	97.2%	
Admitted	Inpatients - FFT Response Rate	>25%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	17.1%	
Maternity	Maternity - FFT % Positive	>90%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	94.7%	
Maternity	Maternity - FFT Response Rate	>15%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	50.9%	
Outpatients	Outpatients - FFT % Positive	>90%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.5%	
Outpatients	Outpatients - FFT Responses	400	336	420	461	249	327	445	348	310	223	138	328	484	2603	
Community	Community - FFT % Positive	>90%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	96.2%	
Community	Community - FFT Responses	1500	605	875	1157	779	1206	1181	1148	869	890	1122	1159	998	8573	
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%	95.8%	88.3%	
All Areas	Complaints (including complaints against Corporate division)	N/A	0	30	21	33	33	30	39	27	21	14	24	30	218	

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

Caring Services - Commentary

FFT

There has been a noted rise in the friends and family test (FFT) response rate for Inpatient areas in November 2018. The response rate for November was 22%; this is a large improvement from October where the response rate was 12%. The improvements here are, in large part, due to the increased number of completed tests collected from day-case patients. The teams in DTC have increased their response rate from 3% in 11% from October and November. The team in DTC are investigating also employing SMS FFT alerts to patients in order to further improve the response rate here.

The KPI for responses and recommend rate was met by Outpatient areas in November 2018 (recommend rate, 92.6%; response numbers, 484). One of the primary drivers for this was an enhanced number of responses collected from the imaging service (180 in November as compared to 8 in October). The improvement here has been due to actions undertaken by the Imaging team, including enhanced advertising around FFT and also increasing the stock of FFT cards accessible to patients.

The response rate in ED for November 2018 was below the set KPI (11.9% for November) as was the recommend rate (82%). The patient experience manager continues to meet with the ED Matron to work on the patient experience action plan. The ED Matron has escalated the works to resource a television for the waiting area to senior management in the department for support with this. A volunteer has agreed to provide artwork for the relative's room and the ED Matron is utilising You Said We Did posters in order to publicise FFT comments and actions taken to improve patient experience.

Community services met their KPI for recommend rate in November (97%), though were below the response rate target (998). One outstanding action is the allocation of two iPad kiosks to St Ann's, for audiology and CDC respectively. There has been a delay in allocating these due to delays with the IT team in the maintenance of the available iPads. This work has been escalated in order to complete this action.

The Maternity team continues to exceed both response rate and recommend rate KPIs (42.9% response rate, and 93% recommend for November). More volunteers have been allocated to the Maternity team to support with signposting and befriending in the area; both of these have been identified as actions for improving patient experience in the area.

Caring Services - Commentary

Complaints

During November 2018 the Trust was due to close 30 complaints; 24 complaints required a response with 25 working days and 6 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 95.8%.

- Of the six complaints allocated 40 working days, one hit its target.
- At the time of reporting, 4 complaint responses remain outstanding (all 40 day complaints, one each for CYP, EIM, S&C & Acute Patient Access, Clinical Support Services and Women's Health (ACW)

The complaints were allocated to EIM 40% (12), S&C 23% (7), ACW 13% (4), Adult Community Service (ACS) 10% (3), CYP 10% (3) & Estates & Facilities 4% (1).

Severity of complaints: 53% (16) were designated 'low' risk; 37% (11) were designated 'moderate' and 10% (3) were designated as 'high risk'.

A review of the complaints due a response in November shows that 'attitude' 23% (7), 'medical care' 20% (6) and 'communication' 13% (4) were the main issue for patients.

- In regard to 'attitude', 57% (4) complainants raised concerns about 'rudeness or disrespect', 29% (2) of complainants were concerned about 'inappropriate behaviour' and 14% (1) complainant raised a concern about a 'sharp, harsh or abrupt' attitude
- In regard to 'medical care', 83% of complainants (5) felt that there had been a 'missed diagnosis', and 17% (1) complainant felt that 'poor treatment' had been provided
- In regard to 'communication' 25% (1) complainant was concerned about 'a breach of confidentiality', 25% (1) complainant was concerned about 'lack of information being provided', 25% (1) complainant was concerned about 'poor communication between professionals', and 25% (1) complainant was concerned about 'poor verbal communication'.

Of the 26 complaints that have closed, (including those allocated 40 working days), 42% (11) were 'upheld', and 27% (7) were 'partially upheld' meaning that, currently, 69% have been upheld in one form or another.

Caring Services - Commentary

PALS

During November 2018, the Trust received 161 PALS enquiries.

34% (55) related to Surgery & Cancer, 30% (48) related to Emergency & Integrated Medicine, 16% (26) related to Acute Patient Access, Clinical Support Services and Women's Health (ACW), 11% (17) related to Adult Community Health Services and 3% (4) related to Children & Young People Services, the remainder related to other Trust service and areas.

Themes – the top three themes were as follows;

36% (58) related to 'Communication' with 'clarity/confusing' and 'no reply to telephone contact' cited as the main reasons
32% (51) related to 'Appointments' with 'long waits', 'cancellations' and 'appointment time/date unsuitable' cited as the main reasons
6% (9) related to 'Medical Care' with 'poor treatment' and 'incorrect treatment' cited as the main reasons.

GP concerns

During October 2018, the Trust received 12 concerns from GP Practices relating to individual patient concerns

67% (8) of these related to concerns around 'Communication' with 'written communication delay' cited as the main reason – the main areas involved were 'Outpatients (Surgical Specialties)' and 'Outpatients (Medicine Specialities)'.

Compliments

During October 2018, 19 compliments were logged onto Datix.

37% (7) related to Emergency & Integrated Medicine, 32% (6) related to Surgery & Cancer, 16% (3) related to ACW, 11% (2) related to Adult Community Services, 4% (1) related to Children & Young People Services.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Nov-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	90.7%	92.7%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	91.8%	92.8%	
Maternity	Smoking at Delivery	<6%	4.3%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	3.4%	6.1%	5.9%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	7.3%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.4%	5.0%	6.0%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	77.5	76.4	76.0	100.0	89.7	70.2	76.6	91.6					81.7	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	38.7	88.0	77.3	111.0	93.6	58.6	77.7						76.4	
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	12.0	9.4	10.0	10.3	7.3	7.7	6.4	5.3	4.7	5.0	5.5	6.8	6.1	
Community	IAPT Moving to Recovery	>50%	50.9%	47.5%	51.4%	59.4%	56.3%	53.4%	59.0%	52.4%	55.7%	57.0%	62.5%		56.5%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	82.2%	96.0%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	91.1%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	87.4%	91.8%	92.2%	88.2%	84.2%	91.5%	85.7%	93.8%	89.7%	90.8%	93.8%	95.0%	90.2%	
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%	82.6%	77.9%	
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%	95.1%	84.1%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	85.7%	76.5%	70.4%	78.5%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	77.3%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	92.2%	93.4%	96.0%	96.8%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	93.8%	
Community	REACH - % BBIC Scores improved or remained the same at Discharge	>75%					100.0%	100.0%	85.7%	57.1%	100.0%	100.0%	100.0%	100.0%	93.0%	

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Effective Services - Commentary

Breastfeeding initiated
Above target at 91.8%. The annual audit of Mothers and staff, carried out at the end of October 18 (covering January –September 2018), highlighted that many of the baby friendly standards have been embedded within the Whittington Hospital maternity services and, although this is not the case with all of them it has encouraged us to believe the BFI Gold award is achievable in the future following re-accreditation in June 2019. The results were submitted to Baby Friendly Initiative on 5th December 2018 with an action plan.

Smoking at delivery
6.1%, an increase from last month and just above the target of <6%. CO Screening is being offered at booking and 28weeks of pregnancy. Referrals are made to smoking cessation services; however the data shows that not all women are taking up the smoking cessation support. Meeting planned on January 24th 2019 with smoking cessation providers to discuss this. Public Health Islington are proposing that we use Baby Clear strategy across North Central London and are awaiting to see if funds will be available from the London Maternity Services (LMS).

Non-elective re-admission
Achieved for October 2018

DN – 48hrs
Target achieved

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Nov-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	89.0%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	81	75	77	95	91	87	79	74	63	75	79	88	79	
ED	Ambulance handovers waiting more than 30 mins	0	34	34	37	69	22	41	16	18	9	12	18		136	
ED	Ambulance handovers waiting more than 60 mins	0	11	12	3	18	8	0	1	0	10	2	0		21	
ED	12 hour trolley waits in A&E	0	0	0	0	0	0	0	0	2	0	0	0	0	2	
Cancer	Cancer - 14 days to first seen	>93%	96.0%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%		93.4%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	97.9%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%	95.8%	100.0%	100.0%		98.8%	
Cancer	Cancer - 62 days from referral to treatment	>85%	91.2%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%		84.6%	
Cancer	Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%										89.5%	81.4%		85.3%	
Cancer	Cancer ITT - % of Pathways sent before 38 Days	>85%										62.5%	60.0%		61.5%	
Cancer	Cancer - % Pathways received a Diagnosis within 28 Days of Referral						65.2%	61.9%	50.0%	93.0%	93.0%	80.4%	83.6%		82.9%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%	100.0%	100.0%										
Cancer	Cancer - 62 Day Screening	>90%								100.0%	100.0%		100.0%		100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.1%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	98.9%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	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	1		1	
Access	RTT - Incomplete Waiters Backlog at Month End	16227	15251	15224	15648	16227	16158	16502	16716	16567	16363	16260	16232		114798	

Date & time of production: 18/12/2018 11:26

Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3		
Indicator	17_18 Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	2018-2019	Performance
Breast	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%	100.0%	86.7%	100.0%			
Gynaecological	>85%	100.0%	100.0%	100.0%	0.0%	33.3%		40.0%		100.0%	66.7%	100.0%			
Haematological (Excluding Acute Leukaemia)	>85%				100.0%		50.0%	100.0%	100.0%	100.0%	60.0%	100.0%			
Lower Gastrointestinal	>85%	85.7%	75.0%	66.7%	100.0%	72.7%	66.7%		71.4%	100.0%	100.0%	100.0%			
Lung	>85%	100.0%	100.0%	50.0%		100.0%	50.0%	100.0%	100.0%	100.0%	0.0%	100.0%			
Other	>85%				100.0%				100.0%						
Skin	>85%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%			
Testicular	>85%						100.0%			100.0%					
Upper Gastrointestinal	>85%	66.7%	0.0%	50.0%		66.7%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%			
Urological (Excluding Testicular)	>85%	83.3%	100.0%	100.0%	66.7%	90.0%	58.8%	81.8%	68.4%	77.8%	100.0%	44.4%			
Sarcoma	>85%				50.0%										

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3		
Indicator	17_18 Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	2018-2019	Performance
Breast	>93%	99.0%	98.8%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%	97.5%	96.4%	94.0%		97.2%	
Childrens	>93%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	100.0%	96.2%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%	98.0%	97.4%	95.6%		97.0%	
Haematological	>93%	100.0%	100.0%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%	37.5%	62.5%	92.9%		69.1%	
Lower Gastrointestinal	>93%	90.6%	87.2%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%	88.2%	82.4%	73.0%		88.8%	
Lung	>93%	100.0%	96.2%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%	100.0%	90.0%	80.0%		94.1%	
Other	>93%														
Skin	>93%	100.0%	98.0%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%	98.8%	97.4%	98.0%		97.8%	
Upper Gastrointestinal	>93%	60.0%	73.5%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%	55.0%	20.6%	59.6%		66.8%	
Urological	>93%	100.0%	98.9%	97.3%	95.5%	93.6%	98.0%	89.0%	89.8%	94.7%	97.4%	97.9%		94.3%	

Responsive Services - Commentary

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

Overall performance against the 95% 4 hour standard for November was 88.5%, which was an improvement on October's performance of 88.1%. Attendance numbers were higher in November at 9,245 compared to October at 9,083. The November 2018 attendance figure was an 8.1% increase compared to November 2017 (8,549 attendances). Daily attendances in November averaged at 308 attendances per day.

Despite this the 'minors' performance delivered 96.5% and Paediatrics delivered at 92.7% in November. November 2018 saw a 15% increase in Paediatric attendances compared to October 2018. The median wait for treatment did increase in November to 88 minutes against a national standard of 60 minutes however further improvement has been made 'Time to triage' metric which has reduced following the implementation of a new streaming model. There is further improvement required in the 'majors' area and in the front of house area. The team are working with the Emergency Care Intensive Support Team (ECIST) to develop this action plan.

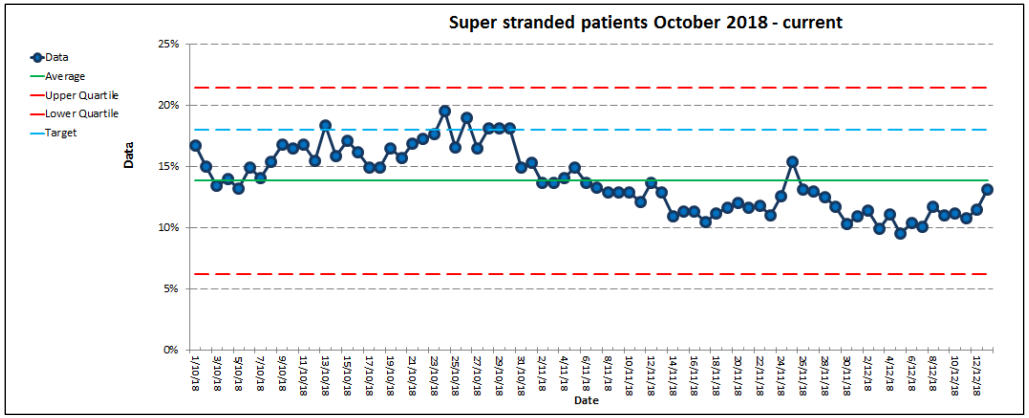
Ambulance activity has also continued to increase but performance against the 15 and 30 minute handover time standards has remained good. In November over 99% of Ambulances were 'offloaded' within 30 minutes of arrival. A focussed LAS Handover action plan has been developed with the aim to meet the national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

The trust has seen sustained improvement in the number of DTOC patients, stranded and superstranded patients throughout October and November which assists flow throughout the hospital and the Emergency Deportment.

The Trust has made a 25% reduction in superstranded patients, see chart below.

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.



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Responsive Services - Commentary

Cancer

Both 2 week wait and 62 days targets breached for October 2018. Initial reports for November data are within target.

2ww performance: 89.6% against the national target of 93%

Area of concerns: Colorectal: 72.99%, 34 breaches out of 137. Haematology: 92.86 %, 1 breaches out of 14. Lung: 80%, 1 breach out of 5. Upper GI: 59.65%, 33 breaches out of 57

62day performance: 83.1% against the national target of 85%

Area of concerns: Urology: 5.5 breaches, 4 internal breaches and 1.5 shared breach

Internal breach: 1. Patient had cardiology issues and was unfit for diagnostic tests.
2. MRI reporting delayed by 13 days.
3. Patient delayed diagnostic tests and oncology appointment.
4. Patient was too ill and cancelled bone scan twice - delayed by 38 days

Action: Colorectal – Endoscopy waiting times has improved to 14 days, impact will be reflected in November / December performance. Haematology - Plan in place to cover clinic from December 2018. Urology – Prostate pathway is being reviewed to improve diagnostic waiting times. Plan in place to implement nurse led clinic by January / February 2019.

Pathway sent before 38 day:

Urology – 4 shared patients, 2 referrals sent within 38 day & 2 referral over 38 day. Haematology – referral sent within 38 day

Late ITT was due to delay in diagnostic in Urology.

Referral to treatment 18 weeks – 52 Weeks Wait

One 52 week breach in October, no clinical harm to the patient. The patient deferred treatment in December therefore will still show as a breach in November 18 performance report.

Community Average Waits

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	28.60%	45.50%	90.50%	10	21	>95%						0
ACS	Community Matron	>95%	6	88.40%	96.40%	96.50%	1.1	57	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	87.10%	95.00%	90.50%	4.1	21	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	91.40%	92.90%	95.10%	4	102	>95%	2	38.50%	60.00%	69.00%	1.8	42
ACS	ICTT - Other	>95%	12	89.70%	92.70%	91.90%	4.4	258	>95%	2	54.70%	78.00%	64.40%	1.7	87
ACS	ICTT - Stroke and Neuro	>95%	12	78.00%	93.20%	85.40%	4.4	48	>95%	2	67.60%	73.90%	73.70%	1.7	38
ACS	Intermediate Care (REACH)	>95%	6	78.60%	90.20%	80.90%	3.9	136	>95%	2	90.00%	84.30%	82.20%	1.3	73
ACS	Paediatric Wheelchair Service	>95%	8	66.70%	100.00%	100.00%	5.1	6	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	46.00%	42.90%	40.30%	18.3	139	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	80.90%	69.90%	59.70%	5.2	534	>95%				66.70%	3.1	3
ACS	Musculoskeletal Service - Routine	>95%	6	78.00%	72.70%	69.60%	4.7	1630	>95%	2		33.30%	100.00%	1.6	1
ACS	Nutrition and Dietetics	>95%	6	80.20%	90.10%	94.20%	3	257	>95%	2	100.00%	100.00%	100.00%	0	1
ACS	Podiatry (Foot Health)	>95%	6	76.20%	83.20%	87.40%	4.3	677	>95%	2	100.00%		100.00%	1	3
ACS	Lymphodema Care	>95%	6	92.60%	100.00%	100.00%	2.2	27	>95%						0
ACS	Tissue Viability	>95%	6	100.00%	93.00%	100.00%	1.3	79	>95%						0
EIM	Cardiology Service	>95%	6	95.80%	100.00%	100.00%	2.5	17	>95%	2	100.00%	83.30%	100.00%	1.2	8
EIM	Diabetes Service	>95%	6	84.90%	100.00%	100.00%	1.6	41	>95%	2	100.00%				0
EIM	Respiratory Service	>95%	6	93.90%	100.00%	100.00%	2.2	76	>95%	2	100.00%	100.00%	100.00%	0.3	3
EIM	Spirometry Service	>95%	6	53.80%	76.10%	84.80%	4.8	46	>95%	2					0

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Haringey Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen
ACS	Speech and Language Therapy	>95%	6	18.70%	32.10%	39.40%	9.7	99	>95%	2	66.70%	100.00%			0
ACS	Bladder and Bowel - Children	>95%	12					0	>95%						0
ACS	Community Matron	>95%	6	83.30%	100.00%	92.30%	1.4	13	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	86.70%	94.90%	90.50%	4.1	21	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12		100.00%			0	>95%	2		100.00%	0.00%	3.7	1
ACS	ICTT - Other	>95%	12	89.60%	92.20%	91.20%	4.4	238	>95%	2	56.40%	78.20%	65.40%	1.6	81
ACS	ICTT - Stroke and Neuro	>95%	12	77.80%	93.00%	87.00%	4.2	46	>95%	2	63.60%	72.70%	75.70%	1.7	37
ACS	Intermediate Care (REACH)	>95%	6	0.00%	100.00%	100.00%	0.9	1	>95%	2	100.00%	100.00%			0
ACS	Paediatric Wheelchair Service	>95%	8	62.50%	100.00%	100.00%	5.1	6	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	42.90%	37.30%	40.00%	19.6	55	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	77.90%	73.20%	61.00%	5.1	246	>95%				50.00%	3.7	2
ACS	Musculoskeletal Service - Routine	>95%	6	78.90%	77.90%	68.60%	4.6	877	>95%	2			100.00%	1.6	1
ACS	Nutrition and Dietetics	>95%	6	78.70%	89.90%	97.00%	2.9	132	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	72.00%	80.50%	86.00%	4.5	329	>95%	2			100.00%	1.1	2
ACS	Lymphodema Care	>95%	6	92.30%	100.00%	100.00%	1.9	15	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	100.00%	100.00%	2	9	>95%						0
EIM	Cardiology Service	>95%	6	94.40%	100.00%	100.00%	2	8	>95%	2		100.00%	100.00%	1.5	2
EIM	Diabetes Service	>95%	6	79.40%	100.00%	100.00%	1.9	24	>95%	2	100.00%				0
EIM	Respiratory Service	>95%	6	95.80%	100.00%	100.00%	2.2	29	>95%	2			100.00%	1	1
EIM	Spirometry Service	>95%	6	53.80%	75.60%	84.80%	4.8	46	>95%	2					0

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Islington Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Avg Wait (Nov-18)	No of Pts First Seen
ACS	Speech and Language Therapy	>95%	6	57.10%	39.10%	56.50%	7.3	62	>95%	2	100.00%				0
ACS	Bladder and Bowel - Children	>95%	12	25.00%	20.00%	90.00%	10.4	10	>95%						0
ACS	Community Matron	>95%	6	90.30%	95.30%	97.60%	1	41	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8					0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	91.00%	92.50%	95.00%	4	100	>95%	2	36.80%	58.80%	69.40%	1.8	36
ACS	ICTT - Other	>95%	12	100.00%	100.00%	100.00%	5.2	9	>95%	2		0.00%	33.30%	3.7	3
ACS	ICTT - Stroke and Neuro	>95%	12	100.00%				0	>95%	2		100.00%	0.00%	2.4	1
ACS	Intermediate Care (REACH)	>95%	6	80.30%	90.40%	81.00%	3.9	126	>95%	2	89.50%	83.10%	81.20%	1.3	69
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	53.70%	52.30%	54.20%	14.7	48	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	85.00%	65.20%	57.80%	5.3	282	>95%				100.00%	2	1
ACS	Musculoskeletal Service - Routine	>95%	6	79.30%	66.60%	69.50%	4.8	642	>95%	2		50.00%			0
ACS	Nutrition and Dietetics	>95%	6	84.00%	92.90%	96.00%	3	100	>95%	2		100.00%			0
ACS	Podiatry (Foot Health)	>95%	6	79.70%	86.20%	88.80%	4	340	>95%	2	100.00%		100.00%	1	1
ACS	Lymphodema Care	>95%	6	92.90%	100.00%	100.00%	2.7	12	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.9	33	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	3	9	>95%	2	100.00%	80.00%	100.00%	1.1	6
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.3	17	>95%	2					0
EIM	Respiratory Service	>95%	6	92.90%	100.00%	100.00%	2.2	47	>95%	2	100.00%	100.00%	100.00%	0	2
EIM	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	Sep-18	Oct-18	Nov-18	Average Wait (Oct)	No. of Initial Contacts (Oct)	% Target	Target Weeks	Sep-18	Oct-18	Nov-18	Average Wait (Oct)	No. of Initial Contacts (Oct)
CAMHS	CAMHS Core - Islington	>95%	8	63.33%	53.71%	62.42%	7.5	157	>95%	2	85.70%	100.00%	78.60%	2.4	14
	CAMHS NDT / ADHD - Islington	>95%	8	50.00%	8.33%	17.65%	31.9	17	>95%	2					0
	CAMHS Schools - Islington	>95%	8	57.14%	80.00%	91.18%	4.5	34	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	100.00%	100.00%	100.00%	0.6	4	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	88.24%	86.84%	95.79%	0.5	95	>95%	1	100.00%	100.00%			0
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	0.00%	0.00%	62.8	2	>95%	1	0.00%	0.00%	0.00%	21.2	13
	Community Paediatrics - Haringey (NDC)	>95%	12	83.33%	75.00%	100.00%	5.1	2	>95%	1	9.10%	0.00%	0.00%	8.6	24
	Community Paediatrics - Haringey (Child Protection)	>95%	12	92.31%	100.00%	100.00%	0.6	26	>95%	1	0.00%	100.00%	0.00%	2.8	4
	Community Paediatrics - Haringey (Other)	>95%	12	100.00%	100.00%	100.00%	9.7	4	>95%	1	33.30%	25.00%			0
	Community Paediatrics - Islington	>95%	12	61.54%	52.78%	40.00%	13.3	15	>95%	1	0.00%	100.00%	100.00%	0.1	1
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	100.00%	66.67%	100.00%	0.9	7	>95%						0
	Family Nurse Partnership - Islington	>95%	12	66.67%	33.33%	100.00%	2.8	5	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.7	21	>95%						0
IANDS	IANDS	>95%	8	91.30%	64.29%	14.29%	10.6	14	>95%						0
	IANDS - SCT	>95%	8	0.00%	6.25%	33.33%	15.8	12	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	100.00%	83.33%	91.67%	2.8	12	>95%						0
	Looked After Children - Islington	>95%	4	42.86%	64.71%	78.57%	8.4	14	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	42.86%	43.48%	50.00%	10.3	10	>95%	2		0.00%			0
	Occupational Therapy - Islington	>95%	8	53.33%	100.00%	70.00%	7.7	20	>95%	2			0.00%	7.6	1
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	100.00%	75.00%	87.50%	3.7	8	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	83.33%	66.67%	64.29%	7.8	14	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	8	33.33%	62.96%	56.52%	8.6	23	>95%						0
	Physiotherapy - Islington	>95%	8	67.19%	79.87%	92.31%	3.6	117	>95%						0
PIPS	PIPS	>95%	12	100.00%	100.00%	100.00%	2.5	4	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	6	18.00%	35.96%	39.81%	9.7	108	>95%	2	66.70%	100.00%			0
	SALT - Islington	>95%	6	50.00%	37.70%	56.90%	6.9	58	>95%	2	100.00%				0
	SALT - MPC	>95%	12	71.43%	74.14%	74.58%	7	59	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	76.47%	85.56%	88.19%	4.2	127	>95%						0
	School Nursing - Islington	>95%	12	88.24%	79.31%	89.47%	4.1	38	>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 70% for November, with respect to waiting times for routine appointments, not met. • 46.6% of patients received routine appointment in 6 weeks during November. • 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. • All long wait patients now have appointments (on PTL until outcomed) or been discharged as 'non-responders'. • The service intends to write to patients on referral list informing of current waiting times and advising they will contacted when appointments become available *(this approach was suggested by patients through feedback).* • A physiotherapist currently seconded to team for one day per week has increased working hours from one to two days per week. • This will help to increase the capacity available for new patients and first appointment slots.	• Camden's withdrawal 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	• The service achieved 96.5% of patients being seen within the 6 week target time for routine appointments in November. • The CSIG target of 95% was exceeded.	• 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 administrative support to ensure that housebound patients have appointments booked within 6 weeks. • Weekly checks to ensure that triage undertaken on a daily basis with minimal delay.	• For the next month the service is assigning a dietetic assistant to call patients on the waiting list and ensure that last minute empty slot are filled. • The dietetic assistant is also targeting the clinics with the worst DNA rate to increase attendance and further improve efficiency of service. • In the next three months the service plans to design and begin to implement group consultations with the aim of moving patients out of 121 appointments and instead see them as groups, increasing capacity in both new and follow up clinics and improving patient care.
Lymphedema	• CSIG target of 95% with respect to waiting times for routine appointments, was exceeded in November, with 100% being achieved.	• 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 95% for November, with respect to waiting times for routine appointments, was not met. • The service achieved 87.4% end of November 2018, an improvement of 4% on October. • A high DNA rate of 12.5% led to lost capacity for new patient clinics during November. This margin would mean the target of 95% would have been met without this level of DNAs.	• To avoid DNAs wherever possible, appointments are being booked with patients when patients call to arrange appointments therefore DNAs should not be occurring but these have continued. • 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	• The service plans to 'overbook' some New Patient sessions to allow for DNAs and reduce lost capacity as a result of these. • Looking at slotting patients into new patient appointments rather than waiting for opt ins. • The use of phone call reminders for new patients and to fill gaps is being looked at the service manager. • Continued service planning in line with demand

		unnecessary delays are minimised. • Continue with robust clinical diary management to ensure all appointment utilised.	versus capacity analysis. • 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	• The service achieved 100% with respect to achieving the target waiting time of six weeks for routine appointments. • This is the second month that the service has achieved 100% and exceeded its CSIG target.	• 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 90% for November, with respect to waiting time target for routine appointments, was exceeded with 100% achieved for routine appointments. • *(Note: Spirometry separated from Respiratory for CSIG reporting, i.e. Community Services Dashboard).*	• 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 target of 80% with respect to waiting times for routine appointments, during November, was exceeded. • The service achieved 84.8% in November, an improvement of 9.2% from October when 75.6% was achieved.	• Patients returning phone calls post Contact Us By (CUBY) 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. • Improvement in performance is due to above measures. There will be patients that are unwell and cannot attend their appointment. • 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.	• 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.

REACH	• CSIG target of 90% for routine appointments was not met in November. The service achieved 80.5% for routine appointments during November. • The physiotherapy team is currently operating at 50% reduced capacity due to vacant posts and annual leave. This has impacted on the service's ability to meet the CSIG target this month. • REACH performance, excluding SLT would be 89%, which highlights the need to focus improvement work around SLT.	• Measures and an action plan to improve performance with respect to target times for urgent appointments are being developed. • Band 6 SLT post recruited to; however, they cannot start until March due to the notice period they are required give.	• Service managers for REACH and C&I meeting to discuss the dementia pathway. (SLT) • The service manager is meeting with the C&I service manager in December to discuss options with regard to the dementia pathway. • Testing new diary templates in December to create more capacity in team • On track to meet CSIG target of 95% with respect to routine appointments by March 2019.
ICTT **(Other)** **(Stroke and Neuro)**	• ICTT Other - The service achieved 91.4% with respect to the target waiting time of twelve weeks for routine appointments. The CSIG target of 95% for November was not reached. • ICTT Stroke Neuro – The service achieved 87% with respect to the target waiting time of twelve weeks for routine appointments. The CSIG target of 95% for November was not reached.	• 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 December. • It is anticipated that some of the vacancies will be filled by December and benefits of this reflected in performance.
MSK CATS **Physiotherapy**	• CSIG target of 92% with respect to waiting times for routine appointments, was not met in November. • 59.3% of MSK CATS patients were seen within the target waiting for routine appointments, of 6 weeks. • An increase in overall referral rates from practices (i.e. those not in the SPOA pilot, where an increase in referral rates was anticipated), has impacted on waiting times and this was not anticipated. • Since the SPOA pilot began, the number of referrals received has increased by approximately 200 per month in comparison with the 2016/17	• New APPs starting between September 2018 and January 2019 linked with SPOA funding will improve capacity. • One extra APP post is being established to provide additional capacity and to address the increased referral rate not anticipated in non-pilot practices over the last year. The service will recruit to this new within four months. • From 7 November APPs in the MSK CATS service are working additional bank shifts (using vacant post money) to create additional capacity and to ensure triaging is undertaken on a daily basis. • Extra administrative support from bank B2 is also	• As described under mitigating actions. • Start recruitment process for additional APP to the CATS service. • Induction of new APPs to role completed and now on normal capacity. • Continue to maximise capacity using current staff. • Expected to achieve 6 week target with respect to waiting times for routine appointments by using current strategies over December with more significant improvements in January with new starters all fully inducted and at full capacity.

	baseline data.	being provided to ensure no unnecessary delays linked to triage and allocation of patients to the correct service are avoided.	• Substantive staff working bank hours to maintain triage and increase clinical activity levels. • Plan to achieve 70% of patients seen within 6 weeks by end of December with further improvements in subsequent months.
Routine **MSK Physiotherapy**	• CSIG target of 91% with respect to waiting times for routine appointments, was not met for November. • 69% of patients in MSK routine physiotherapy were seen within the 6 week waiting time for routine appointments. • There has been a 15% increase in referral rates to MSK physiotherapy in last three months, compared to data for the same period in the last two years. Again, there has been a greater referral rate than anticipated from SPOA pilot, in addition to the increase anticipated as a result of the pilot.	• Support with central booking administration and additional admin staff to ensure booking to maximum capacity each day. • Agency physiotherapy staff are being used to cover vacancies while recruitment is underway. MSK SPOA pilot funding to provide additional capacity. • Improved efficiency is being achieved by filling all available diary gaps. The service manager is also undertaking robust daily checks to ensure that there are no delays with triage and allocation of patients to the correct service. • Improved 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 administrative support is being used to support prompt booking of appointments. • Telephone appointments offered to the longest waiting patients to ensure that they receive useful advice and guidance prior to attending clinic.	• 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 and this has improved over the l4 weeks. • Working closely with central booking service with regular meetings to improve efficiencies in management of referrals prior to booking initial appointments • Staff moving sites over next few weeks as current diary bookings allow. • The service anticipates that 75% of patients seen within 6 weeks by end of December.

Children's 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	• Significant improvement in performance from 20.0% to 90.0% • 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. • All long wait patients now have appointments (on PTL until outcomed) or been discharged as 'non-responders'. • The service intends to write to patients on referral list informing of current waiting times and advising they will contacted when appointments become available *(this approach was suggested by patients through feedback).* • A physiotherapist currently seconded to team for one day per week has increased working hours from one to two days per week. This will help to increase the capacity available for new patients and first appointment slots.	• Camden's withdrawal 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.
CAMHS (Islington)	• Additional 10 choice appointments per week to reduce the backlog of initial assessments. Agency staff recruited to start 22nd of November until March 2019 (Locum Consultant Psychiatrist). • The increase in initial assessments has created an increase in wait times for treatment pathway appointments. Some capacity lost through removal of the transformation funding. We will need to realign the substantive capacity following the re-structuring and consultation to address the wait times. Agency spend can be re-directed to pathway work once initial assessments are addressed. • Implementation of SPA underway. Scheduled to launch	• 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 • SPA is planned for implementation in June 2019	• Agency staffing in place to support reduction of historic backlog of choice appointments (anticipate that this will be cleared by mid-January 2019) • Realigned substantive capacity and redirect agency capacity as required to manage expected demand for treatment pathway appointments, to keep this within an acceptable waiting timeframe prior to SPA implementation • 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

	June 2019. Agreed that CAMHS CWP team will be located in this team, to support CAMHS Intake team and provide interventions for mild-moderate presentations. • Recruitment: Shortlisted for key vacancy in Consultant Psychiatry/Clinical Lead post		
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 **Haringey** • Target achieved this month, 100% **Islington** • Improvement from 87.4% to 95.5% which is now within target, the service is still working on the actions and will aim to further improve their performance	• Performance for both Haringey and Islington is now within target	• Merging stand-alone nursing service with wider team – February 2019 (awaiting confirmation from commissioner) • Continuation of Data Quality improvement support – February 2019 • Monitor and review progress
Community Paediatrics Service	**Haringey SCC, NDC, Child Protection and Other:** • NDC, Child Protection and others performed 100% in November • 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 **Islington:** • Target not met: decrease in performance from 48.5% to 35.7% due to long term consultant vacancy now recruited into • 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	**Haringey:** • Completion of ASD assessment model project • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager and support of Service Improvement Lead (PMO) • NDC consultant sickness and phased return • Explore Streamline Admin Process with Service Managers and 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 • Fortnightly appointment meetings with Admin	• 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/Service Improvement Lead – 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 • Reduction in waiting times: improvement within 3- 4 months (March 2019) • Streamlined admin processes will be measured by clinic data outcomes 3- 4 months improvement March 2019

		team and disseminating to clinical lead demand the and capacity issues • Exploration into Admin referral processes and capacity issues with Service Managers and Project Managers	
Family Nurse Partnership (Haringey & Islington)	**Islington:** • The target is achieved for this month November 100% **Haringey:** • Significant improvement from 66.7% to 100%	**Islington:** • The target is achieved for this month November 100% **Haringey:** • The target is achieved for this month November 100%	**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 November 100%	• Monitor and review next month
IANDS (Islington)	• Service has achieved the 20 week waiting time target for social communication assessment in under 5s. • 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. • There have been improvements in terms of staffing with one member of staff is back at work from LTS • In SCT the average wait for assessment for children from October to November remains the same at 22 weeks. • Waiting times in SCT are due to increase - there is a steady increase of referrals, CCG funded post coming to an end and gaps is SLT time due to staffing changes within the service.	• Service and commissioners continue to meet regularly to review impact of additional resource reduction, anticipated to feature in contract discussions for 2019/20 • Implementation of a new model to streamline assessment and diagnostic pathway is underway	• Improvements in data quality processes will also be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project. The data sources will be reviewed by the next report. • We will monitor the impact of the implementation of new service model, which will continue to be reviewed over the nexy 3-6 months with commissioners at on-going engagement meetings
Looked After Children (Haringey & Islington)	**Islington:** • Slight decrease from 83.3% to 80.0% **Haringey:** • The target is back to 100%	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:** • Slight increase in performance from 40.9% to 55.6%, still underperforming due to capacity issue • The service has recently recruited a Band 7 OT which will support improvements in performance over the	**Haringey:** • Haringey Therapy Review, which is nearing completion with recommendations expected to CSIG in January 2019.	**Haringey:** • Performance has risen to 55.6% which reflects some operational changes implemented by the new Team Lead and an ongoing effect of being fully staffed.

	coming months **Islington:** • Dipped from 100% to 75.0%	**Islington:** • Initial discussion with the Rio team to improve data entry and resolve errors in Rio recording. Lesley Platts to further discuss this with the service leads to plan and mandate.	**Islington:** • Improvement of data entry (local service) and follow up meeting with the Rio team to recommend changes.
Paediatrics Nutrition and Dietetics (Haringey and Islington)	**Haringey:** • Increased from 66.7% to 85.7% **Islington:** • Target decrease from 66.7% to 64.3% due to recruitment lag • Induct new staff can cause an increase in waiting times. There have also been issues with staff members requiring certificate of sponsorship and work visa's which has meant they have been out of post while they are sorting this out. There have been some delays on the HR side of this. • There is minimal administrative cover which causes delay booking into appointments and rebooking if families cancel.	**Haringey:** • With stable staffing now in place a month on month improvement is anticipated **Islington:** • Improvements in data quality processes will be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project	**Haringey:** • Performance has improved from previous month to 85.7%, this reflect the return of the dietician whose working visa was temporarily stopped. **Islington:** • Improvements in data quality processes will be undertaken as part of wider CYP ICSY Data Quality and Productivity Improvement Project – February 2019 • The team is considering doing parent information sessions for selective eaters/fussy eaters which would mean parents came to the information session for initial advice and can then opt into a 1 to 1 appointment. • There is currently potential for a new post under medicines management to provide a rapid access clinic for babies/children with Non IgE mediated cows milk protein allergy, this would reduce community wait times and also reduce hospital allergy clinic waiting times.
Physiotherapy (Haringey and Islington)	**Haringey and Islington:** • Islington performance continues to improve now at 92.3% against 95% target • Haringey service fully engaged in Therapy Review and have now established a stand alone MSK service for those children who require urgent physio services which is achieving a 6 week wait • However, mainstream physio service still has 3 WTE vacancies, which are presently being covered by agency	• Completion of Haringey Therapy Review, due to be presented at CSIG in January • Discussions with commissioners around continued developed of Haringey MSK services	• Implementation of new model of physiotherapy and MSK service will be undertaken over the next 3-6 months in line with review recommendations • Consideration for Band 6 physiotherapy rotation across Whittington Health with adults and children's service to support recruitment and retention • Further development of student programme across CYP services

PIPS (Haringey)	• The target is achieved for this month, 100% • Waiting for new psychologists to join in the new year which will bring more capacity to increase our new referrals	• 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 • Agency staff in situ to help with capacity • Data Quality issues within team and RIO refresher required along with systemisation of processes within service. The service is now working with newly appointed Project Manager to improve data quality **Islington:** • Performance improved from 80.0% to 89.2% • Service currently experiencing high vacancy rates and depending on bank / agency staff which has had a knock on effect around performance (on risk register) • Recruitment of 2 band 5s posts this week, advert for Band 7 and 6 in position. • Second TNA agreed • 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 • Recruitment: 2 new Band 5s community nurses joined team and a Band 7 appointed to start in February 2019 • Data Quality will be part of Haringey and Islington SN practice development group remit.	• Review of all roles if unsuccessful in further recruitment efforts & consider introduction of Band 4 community nursery nurses to support primary school provision. • Consideration of international students (in discussion with recruitment team) • As above and in addition continued work with recruitment team e.g. SN will feature in a recruitment video • 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 • Patient feedback indicates service is highly regarded, but limited in terms of universal offer, resulting in high	• 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 • Increase in demand as a result of the HV implementation HCP continues to be a challenge as the short term increase in temporary staffing has now ceased	• 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 • SALT MPC target will be adjusted in Qlikview, Information Team already been informed.

	numbers of children being identified for targeted and specialist levels of intervention • Small improvement to 38.8% noted **Islington:** • Improvement from 40% to 51% **MPC:** • Dashboard to be adjusted to reflect commissioned waiting time of 18 weeks – this has been passed on to Information team to action so expect improvement in data/performance		

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Nov-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	10	8	2	8	3	5	1	4	1	2	8		24	
Theatres	Cancelled ops not rebooked < 28 days	0	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	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	282	334	269	312	292	281	212	230	238	236	233		1722	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	3.0%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%		2.7%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	49.4%	50.0%	54.1%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.5%	95.0%	93.6%	94.5%	93.9%	92.7%	93.8%	93.3%	96.1%	95.1%	96.8%		94.5%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	85.7%	91.8%	93.3%	90.5%	89.7%	92.6%	93.4%	90.4%	92.1%	91.8%	90.9%		91.6%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		75.0%	64.1%	71.7%	84.2%	69.9%	78.0%	80.7%	83.2%	82.6%	80.5%	89.6%		81.6%	
Community	Haringey - HR1 % carried out before child aged 15 months		60.2%	66.9%	67.3%	64.0%	64.5%	73.6%	66.4%	71.6%	62.4%	71.5%	71.8%		68.6%	
Community	Haringey - HR2 % carried out before child aged 30 months		49.2%	64.0%	71.8%	59.1%	60.1%	59.9%	56.7%	61.2%	64.3%	69.4%	55.6%		61.0%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	95.8%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%	96.5%	92.5%		94.9%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		85.3%	78.7%	85.7%	78.0%	80.4%	86.2%	92.8%	91.8%	95.5%	97.0%	96.6%		91.4%	
Community	Islington - HR1 % carried out before child aged 15 mths		67.1%	70.1%	79.2%	83.5%	69.8%	81.3%	76.5%	82.4%	79.5%	87.4%	77.9%		79.0%	
Community	Islington - HR2 % carried out before child aged 30 mths		70.5%	77.2%	78.2%	77.9%	75.8%	78.8%	85.9%	73.5%	68.2%	68.6%	70.7%		74.1%	

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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

One patient was not booked within 28 days, due to patient choice. The procedure has now been completed.

Vacant shifts to be covered by locum bank pending recruitment of substantive posts.

Delayed Transfer of Care (DToC)

October performance is 2.5% and is only 0.1% above the target. Overall improving trend. DToC issues continue to be predominantly relating to external bed availability, waiting for intermediate or care home beds. The bi-weekly MADE events continue to support the proactive management of DToC. The North London partners in Health and Care have instigated the new Choice Policy which reviews place of discharge for the patient. The main change is for the patient to be placed in first available place instead of place of choice. This is now launched and training is in place across the organisation.

Women seen by HCP/Midwife within 10 weeks

Improvement from October 2018, now at 50% and on target. Issue remain as described: Appointments continue to be offered and staff reminded to put all declined and onto Medway Live to indicate patient choice. Action: Continue 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.

Responsive Services - Commentary

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.
Health Visiting	**Haringey:** • New Birth Visits, slight deterioration from last month to 90.0% against the 95% target • Challenges recruiting to Band 6 vacancies within service, discussions underway around new solutions to recruitment challenges jointly with Islington • 8 week review sees a continues improvement from 80.5% to 89.6% • HR1 remains at 71.8% • HR2 deterioration to 55.4% from 69.4% previous month **Islington:** • New Birth Visits, slight deterioration from 96.5% to 92.5% • 8 week review continues to exceed target at 96.6% • HR1 within 15 months sees deterioration from previous month from 87.4% to 77.9%, which is only slightly below of target of 80% • HR2 within 30 months slight improvement from 68.6% to 70.9%, against a target of 80%	**Haringey:** • Service has undertaken analysis to identify specific team issues contributing to performance challenges • Targeted work underway to support specific teams in the East of Haringey with data quality and team leader arrangements are being adjusted in light of issues identified **Islington:** • Brightstart model has been implemented this month • Commissioners are expecting there to be a bedding in period which may impact on performance	**Haringey:** • Continue work with Islington on skill mix options to alleviate vacancy issues in both boroughs for Band 6 HV positions • Discussions now underway to look at implementing a Bright Start model in Haringey to align our approach to universal services to across both boroughs **Islington:** • Continue to implement Bright start model • Service is engaging in ICSU Data Quality project to ensure validation of notes and outcoming of appointments is improved from current position

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Nov-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	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%	80.5%	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%	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%	3.65%	4.01%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%	3.10%	3.52%	3.92%		3.46%	
HR	Staff turnover %	<10%	14.5%	14.4%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	12.8%	12.7%	12.7%	13.2%	
HR	Vacancy % Rate against Establishment	<10%	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		80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	82.2%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	135.3%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	88.2%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	118.6%	
HR	Safe Staffing Alerts - Number of Red Shifts		33	31	12	19	18	8	0	1	1	2	0	0	30	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.4	8.2	8.4	8.6	8.7	9.3	9.4	10.0	9.0	8.8	9.2	8.8	9.1	

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

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	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	Trend
Medical	Average staff cost per patient		93	98	104	96	101	88	92	97	101	103	86	
Nursing	Average staff cost per patient		198	167	182	181	182	172	181	174	180	183	168	
Other	Average staff cost per patient		214	191	195	166	203	179	196	226	234	208	185	

Well Led Services - Commentary

Human Resources

Vacancy rates during October have remained stable; newly qualified nursing staff have started in post and the impact of this is starting to be seen. There are further Nurse Recruitment open days planned and a revised International recruitment plan is 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 had a slight increase, and is just over the Trust target at 3.9%. This is attributed to seasonal illnesses. Appraisal and Mandatory Training rates are unavailable for November due to the Trust Board meeting having been moved to a week earlier. A training pilot for improving data on appraisals and mandatory on ESR is going ahead from January. The Staff survey rate is over 45%, which was the target for this year. We are waiting final confirmation of the rate.

Well Led Services - Commentary

% day fill rate-nurses

All wards received adequate staffing levels during November 2018 and no Red shifts were reported. The Lead Nurse for safer staffing continues to work with the ward managers to ensure that data quality is improved as staff are moved between wards to flex capacity. Band 4 Assistant Practitioners continue to cover Band 5 nurses (see below) and this will have an impact on the % fil data. It is anticipated that the data template submitted to NHSI will change in 2019 to accommodate nursing associates (band 5) who will be on the NMC register from beginning of January. This will mean they will not be put against band 5 staffing.

% 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 (including assessment, and evaluation of care) 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. The national steer for the Band 4 Assistant Practitioners to be embedded into the current band 5 allocation, on each roster, by January 2019 continues and changes will be made to the templates in line with 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 review of all HealthRoster and safe care templates against the staffing ratios recommended in the last establishment review continues to be underway.

% 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 the number of open beds at times during the month in line with demand. There are very few HCA staff within the establishment and this has an impact on fill rates, when enhanced care is required. During November 2018 the Lead Nurse for Safer Staffing has worked 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 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	Q3 Nov-18	Activity
ED	ED Attendances	8285	8579	8897	8082	9217	8645	9226	8699	9287	8157	8897	9082	9245	
ED	ED Admission Rate %		15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	15.0%	16.2%	
Community	Community DNA Rate %	<10%	6.8%	7.6%	7.5%	7.7%	7.8%	8.0%	8.0%	8.4%	8.1%	7.6%	7.6%	7.4%	
Community	Community Face to Face Contacts		50522	60072	54274	60391	55892	63901	62489	61380	54864	57755	63793	63360	
Admissions	Elective and Daycase		1587	1944	1735	1879	1720	1840	1880	1763	1820	1921	2266	2215	
Admissions	Emergency Inpatients		2180	2218	1904	2241	2181	2338	2237	2217	2194	2163	2185	2323	
Referrals	GP Referrals to an Acute Service		5928	7874	7361	7891	7164	7688	7621	7569	7062	6898	8291	7955	
Referrals	% of GP Referrals that were completed via ERS		37.2%	46.0%	44.1%	47.0%	58.2%	73.7%	79.6%	82.6%	82.9%	84.8%	87.5%	89.0%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	10.3%	13.3%	16.8%	17.4%	18.2%	12.2%	10.1%	8.8%	10.5%	11.9%	13.0%	12.7%	
Maternity	Maternity Births	333	332	321	253	315	291	323	282	297	321	312	296	299	
Maternity	Maternity Bookings	377	302	405	375	370	400	369	317	376	330	334	398	363	
Outpatients	Outpatient DNA Rate % - New	<10%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	10.1%	10.6%	11.2%	11.3%	10.7%	10.7%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.7%	12.1%	10.0%	10.9%	10.2%	12.1%	10.2%	10.3%	10.6%	10.2%	10.5%	10.7%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	10.9%	11.6%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	10.8%	10.6%	10.6%	10.7%	
Outpatients	Outpatient New Attendances		8012	10507	9224	9630	9309	10246	9667	9649	9097	8888	10459	10019	
Outpatients	Outpatient FUp Attendances		15893	18893	16594	17806	17411	18731	18306	18788	18104	17271	19857	18164	
Outpatients	Outpatient Procedures		5837	7410	6828	7096	6786	7421	7206	7607	6900	7359	8156	7894	
Theatres	Theatre Utilisation	>85%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	

Date & time of production: 18/12/2018 11:26

Average Tariff for Inpatient PODs

Category	Point of Delivery (POD)	17_18 Target	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	Trend
Average Tariff	Daycases		710	697	684	614	740	686	678	703	653	655	701	
Average Tariff	Elective		3526	3403	3550	3710	4033	3831	3778	3857	3210	2963	3483	
Average Tariff	Non-Elective		2561	2670	2362	2194	2484	2511	2564	2272	1684	1590	1850	

Activity - Commentary

DNA

DNA rate for November 2018 was recorded as 10.7% for the Trust which is a 0.1% increase from October 2018 and 0.5% increase for November 2017. Although the DrDoctor system is implemented throughout the Trust there has not been any improvement to the DNA rates. The plan is to continue using the reminder service for a period of three months to see if DNA rates improve and then make a decision as to what the next steps should be. As previously mentioned, unless patients are given the option to change and cancel their appointments themselves online we will not see the desired reduction in DNA (pending full integration with System C, which is in working progress).

Activity - Commentary

Births-
This indicator remains off target at 299 (however did increase by 3 births in November). A marketing strategy meeting, with communications to increase births at Whittington Health, and collaborative working with UCLH (increase births by 100/year by taking twins 20-36 weeks from UCLH) meeting both planned for 10th December 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.

eRS
Slight improvement for November 2018 Weekly PTL meetings ongoing and e-RS Implementation Group meet bi-weekly. It is expect that the figures will alternate slightly from month to month for eRS ASI activity at this time.

Theatre Utilisation
Averaging 81.78 % Theatre utilisation Year to date, 1% dip in November compared with October accounted for by difficulties covering Anaesthetic sickness/ vacancies, resulting in a reduction in Theatres utilisation. There continues to be a continued upward trend in the growth of Elective and Non-elective activity compared with 17/18 Quarter 3 and 4 performance. Continued emphasis on meeting 85% by year end.
Issue: Anaesthetic cover has remained an area of challenge for the ICSU and has forced some theatres lists to be merged to support case mix and clinical urgency this particular challenge impacted on theatre utilisation via Emergency overrunning into elective sessions.
Improvements on October: The ICSU has recruited to the substantive Anaesthetic consultant vacancy and also a locum anaesthetist. Locum commencing January 2019 and Substantive February 2019 (TBC). As an interim arrangement until Locum/ Substantive staff commence employment, the ICSU has agreed to use Substantive staff for WLI cover arrangements in a bid to drive down the occurrence of dropped theatres lists. Admission consultation and interview completed. Four staff put in permanent post, 3 vacant posts out to advert. Bank cover supporting vacant substantives posts.
Ongoing actions: Daily meeting on contract plan remains in place. Continued emphasis on theatre utilisation and uptake of vacated theatres session is placed within the weekly 6-4-2 meeting in order to continue the drive on improving theatre utilisation.

Meeting title	**Trust Board – public meeting**	**Date:** 19.12.2018
Report title	**November (month 8) 2018/19 – Financial Performance**	**Agenda item: 9**
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 £2m for the month of November (month 8) which is on plan. Year to date, the Trust is £0.2m behind the NHS Improvement adjusted plan, with a surplus of £7.3m including £11.8m of PSF income. There has been an improved Income performance in month, however pay costs remain above budget with an increase in agency spend. The agency spend in month is £1.1m, £0.2m more than the last 3 month average. The year to date agency costs are now £8.7m. The Trust is forecasting Cost Improvement Programme (CIP) delivery of £12.3m against a £16.5m target, with £7.8m delivered to date. The Trust has spent £4.8m to date of its capital allocation with planned capital expenditure remaining at £14.8m and does not have a cash flow risk.	
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 November 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	18 December 2018 Trust Management Group	
Appendices	1 – month 8 finance report	

Appendix 1: November (Month 8) 2018/19 – Financial Performance

Financial Overview

The Trust is reporting a £2m surplus in November including £2.1m of PSF, which is on plan for the month. The year to date position of a £7.3m surplus including £11.8m of PSF, is £0.2m behind the planned control total.

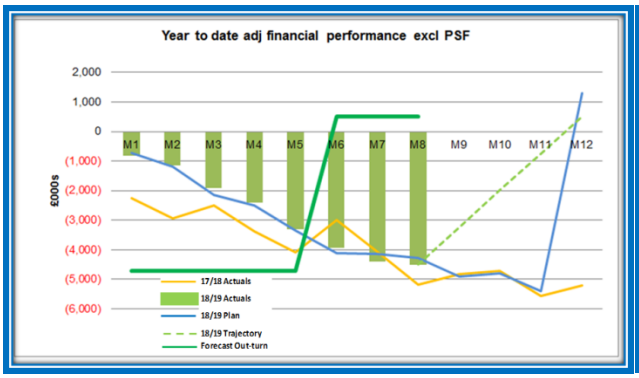
In month, total Income was £0.7m ahead of plan. There were positive income variances relating to High Cost Drugs and Devices of £0.3m and Agenda for Change funding of £0.3m although these variances are offset within non-pay and pay. There was an improvement in clinical activity in month which if carried forward would mean that the Trust would achieve its income plan for the remainder of the year.

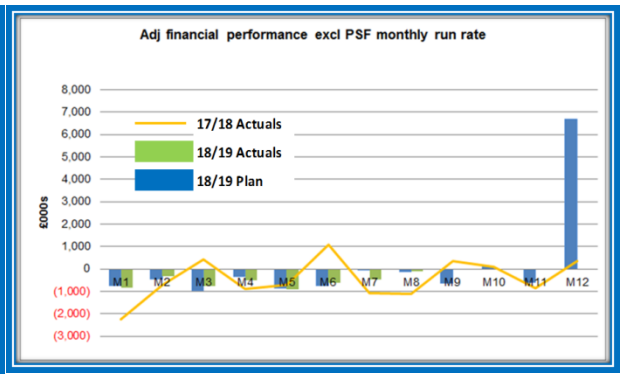
Non-pay is underspent in month by £0.3m as a result of a further CNST premium rebate.

The November pay spend continued its trend of being in excess of budget due to the usual agenda for change payment but more worryingly November has seen a 15% increase in agency spend compared to the 3 month average. The cumulative agency spend is £8.7m, in month, the spend was £1.1m. The Trust has challenged each ICSU to cap agency spend at £11.4m for the year. This will require action to reduce spend to less than £0.7m a month.

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	23,693	24,046	353	187,759	186,088	(1,671)	260,376
Other Non-Patient Income	3,001	2,840	(160)	18,000	17,602	(397)	47,536
High Cost Drugs	656	928	272	5,252	5,890	638	7,877
Pay Award Funding	0	264	264	0	2,207	2,207	0
Total Income	**27,350**	**28,079**	**729**	**211,010**	**211,787**	**777**	**315,789**
Pay	(18,453)	(19,072)	(619)	(148,750)	(151,009)	(2,259)	(214,393)
Non-Pay (excl HCD)	(6,245)	(5,971)	274	(50,289)	(48,662)	1,627	(82,109)
High Cost Drugs	(669)	(933)	(264)	(5,374)	(5,778)	(403)	(8,052)
Total Operating Expenditure	**(25,367)**	**(25,977)**	**(610)**	**(204,413)**	**(205,448)**	**(1,035)**	**(304,554)**
	1,983	**2,102**	**119**	**6,597**	**6,339**	**(258)**	**11,235**
Depreciation	(543)	(516)	27	(4,333)	(4,293)	40	(6,500)
Dividends Payable	(431)	(431)	0	(3,446)	(3,446)	0	(5,263)
Interest Payable	(279)	(283)	(4)	(2,225)	(2,211)	14	(3,341)
Interest Receivable	1	14	13	8	59	51	12
P/L on Disposal of Assets	0	0	0	0	0	0	6,000
Total	**(1,252)**	**(1,215)**	**37**	**(9,996)**	**(9,891)**	**105**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**731**	**888**	**157**	**(3,399)**	**(3,552)**	**(153)**	**2,143**
Provider Sustainability Fund (PSF)	2,138	2,138	0	11,759	11,759	*0*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**2,869**	**3,026**	**157**	**8,360**	**8,207**	**(153)**	**23,523**
Add back							
Impairments	0	0	0	0	0	*0*	51
IFRS & Donate	(851)	(994)	(143)	(863)	(948)	*(85)*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**2,018**	**2,032**	**14**	**7,497**	**7,259**	**(238)**	**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 £2.1m. This is an improvement of £0.2m on the October performance.

Overall the NHS clinical income is £0.6m higher than month 7 even with one calendar day less. In month 8, Day Case and Elective activity has over performed by £0.2m, however year to date the activity is still at an adverse variance of £0.7m. With Trauma & Orthopaedics, Urology and General Surgery specialties influencing this variance.

Maternity deliveries and pathways continue to under-perform against plan with a £1.1m adverse.

Outpatients' continue to over perform by £0.2m in month and £0.8m for the period to the end of November. The outpatients' over-performance is within Diagnostics imaging, Gynaecology and Trauma & Orthopaedics specialties. However there is underperformance in Paediatrics, Dermatology and Gastroenterology.

Unplanned care in A&E & UCC is above plan both in month and year to date, ambulatory care remains above planned levels by £0.4m.

Although the Trust did not hit the November target for A&E on an individual basis it did however achieve the target at the delivery board level and therefore will earn the full PSF for the quarter.

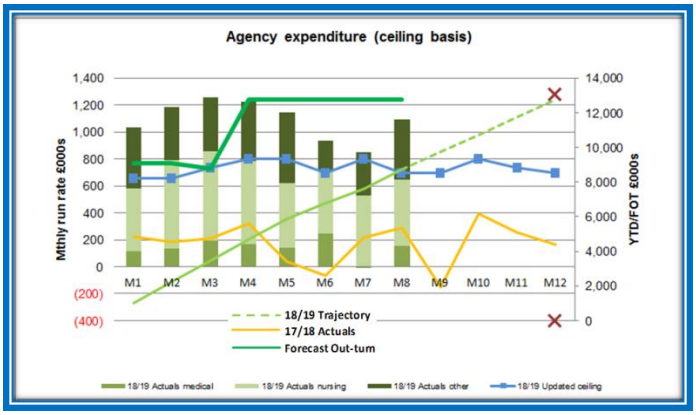
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,150	1,262	112	9,352	9,523	171	8,455	9,245	790	68,782	71,249	2,467
Ambulatory Care	357	324	(33)	2,776	3,121	345	1,482	1,247	(235)	11,537	12,452	915
Adult Critical Care	619	490	(129)	5,035	4,002	(1,033)	1,463	1,333	(130)	11,901	10,244	(1,657)
Community Block	5,857	5,857	0	47,010	47,010	0	0	0	0	0	0	0
Day Cases	1,190	1,371	181	9,250	9,233	(17)	1,532	1,917	385	11,911	13,459	1,548
Diagnostics	260	295	35	2,022	2,378	357	2,635	3,120	485	20,485	23,703	3,218
Direct Access	1,020	1,325	305	7,930	8,660	730	99,505	96,816	(2,689)	773,318	766,555	(6,763)
Elective	818	811	(7)	6,361	5,677	(685)	207	217	10	1,613	1,462	(151)
High Cost Drugs	656	920	264	5,248	5,773	526	0	0	0	0	0	0
Maternity - Deliveries	1,132	1,008	(124)	9,208	8,574	(634)	310	286	(24)	2,524	2,405	(119)
Maternity - Pathways	770	660	(110)	5,987	5,480	(507)	727	615	(112)	5,651	5,290	(361)
Non-Elective	3,320	3,947	627	27,006	27,290	284	1,556	1,843	287	12,649	13,090	441
OP Attendances - 1st	922	996	74	7,166	7,757	591	4,971	5,236	265	38,603	42,132	3,529
OP Attendances - follow up	823	802	(21)	6,394	6,247	(146)	13,135	12,159	(976)	92,285	99,353	7,068
OP Procedures	396	492	96	3,075	3,538	464	2,262	3,033	771	17,573	21,793	4,220
Other Acute Income	1,512	677	(835)	9,686	11,036	1,351	7,700	8,309	609	69,931	58,978	(10,953)
CQUIN	484	498	14	3,839	3,800	(40)	0	0	0	0	0	0
Total SLA	**21,287**	**21,736**	**449**	**167,343**	**169,099**	**1,757**	**145,941**	**145,376**	**(565)**	**1,138,763**	**1,142,164**	**3,402**
Marginal Rate	0	0	0	0	(240)	(240)						
	21,287	**21,736**	**449**	**167,343**	**168,859**	**1,517**						
Other Clinical Income	3,063	3,238	175	25,668	23,095	(2,573)						
Other Non Clinical Income	3,001	3,105	104	18,000	19,833	1,834						
Total Other	**6,063**	**6,343**	**729**	**43,667**	**42,928**	**(739)**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**27,350**	**28,079**	**729**	**211,010**	**211,787**	**777**	**145,941**	**145,376**	**(565)**	**1,138,763**	**1,142,164**	**3,402**
PSF	2,138	2,138	-	11,759	11,759	0						
Revised Total	**29,488**	**30,217**	**729**	**222,769**	**223,546**	**777**						

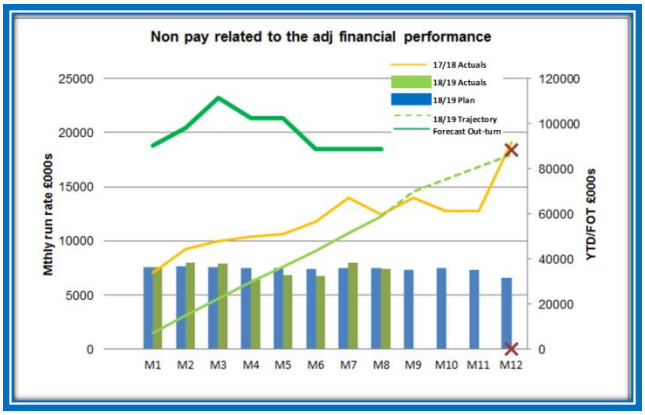
Monthly run dates – expenditure

The year to date combined expenditure position is £1m adverse to plan. Key points of note include:

- **Pay**
  - Total pay expenditure for November was £19.1m which is over £0.2m higher than the year to date average and the highest individual monthly spend except for August when the Agenda for Change back pay payment was made.
  - Within total pay expenditure, agency costs were £1.1m. The total agency spend is £8.7m. This unexpected spike in agency spend, over £0.2m on the 3 month average is a concern. Although the in month spend has been influenced by some late shift notifications being paid, with the Trust entering the Winter period, additional controls and improvements are 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 is also reviewing its shifts that remain 'open' on the staff booking system to correctly record the agency liability.

- **Non Pay**
  - Non pay expenditure for November was £6.9m, including High Cost Drugs. The Trust received a rebate of almost £0.3m on its CNST premium during the month which reduced the reported spend
  - Without this rebate the spend is higher than the £6.8m average because of an increased £0.3m over plan of High Cost Drugs (offset in income) and £0.1m of increased costs due to the insourcing of Endoscopy procedures.





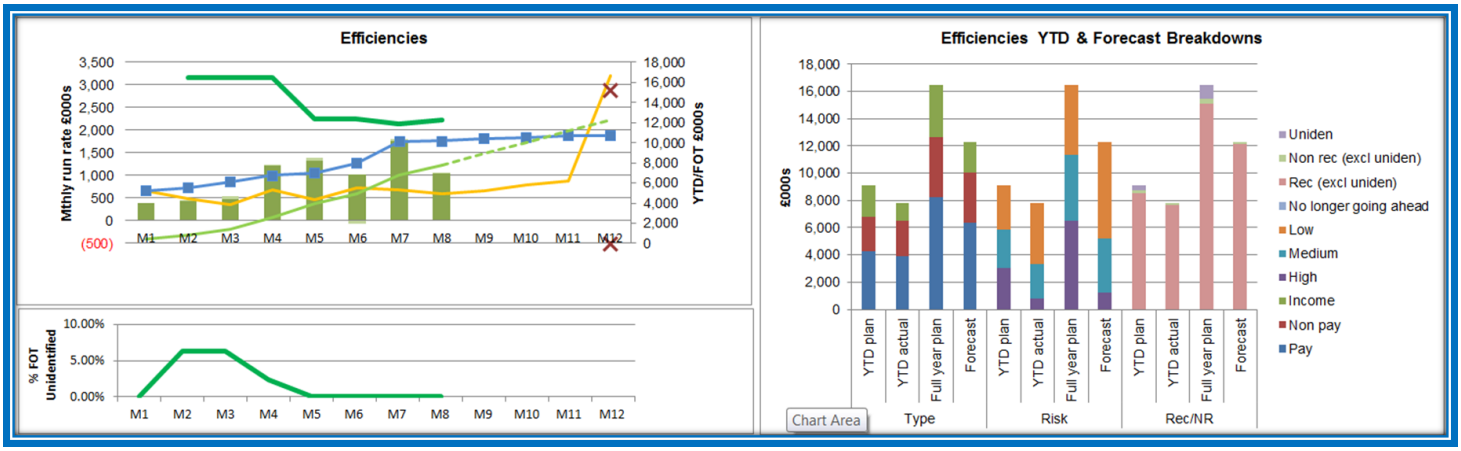
Cost Improvement Programme (CIP)
The original Cost Improvement Programme target was £16.5m, split by programme area being:

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

The Trust is forecasting CIP delivery of £12.3m, a shortfall of £4.2m from the original target.

In-year delivery – Month 8
At the end of month 8 the Trust's planned delivery was £8.7m of CIP, against which £7.8m has been delivered, equating to 90%. Analysed by programme area:

Forecast delivery
During November the Trust has forecast that it will deliver £12.3m of CIPs for the year.

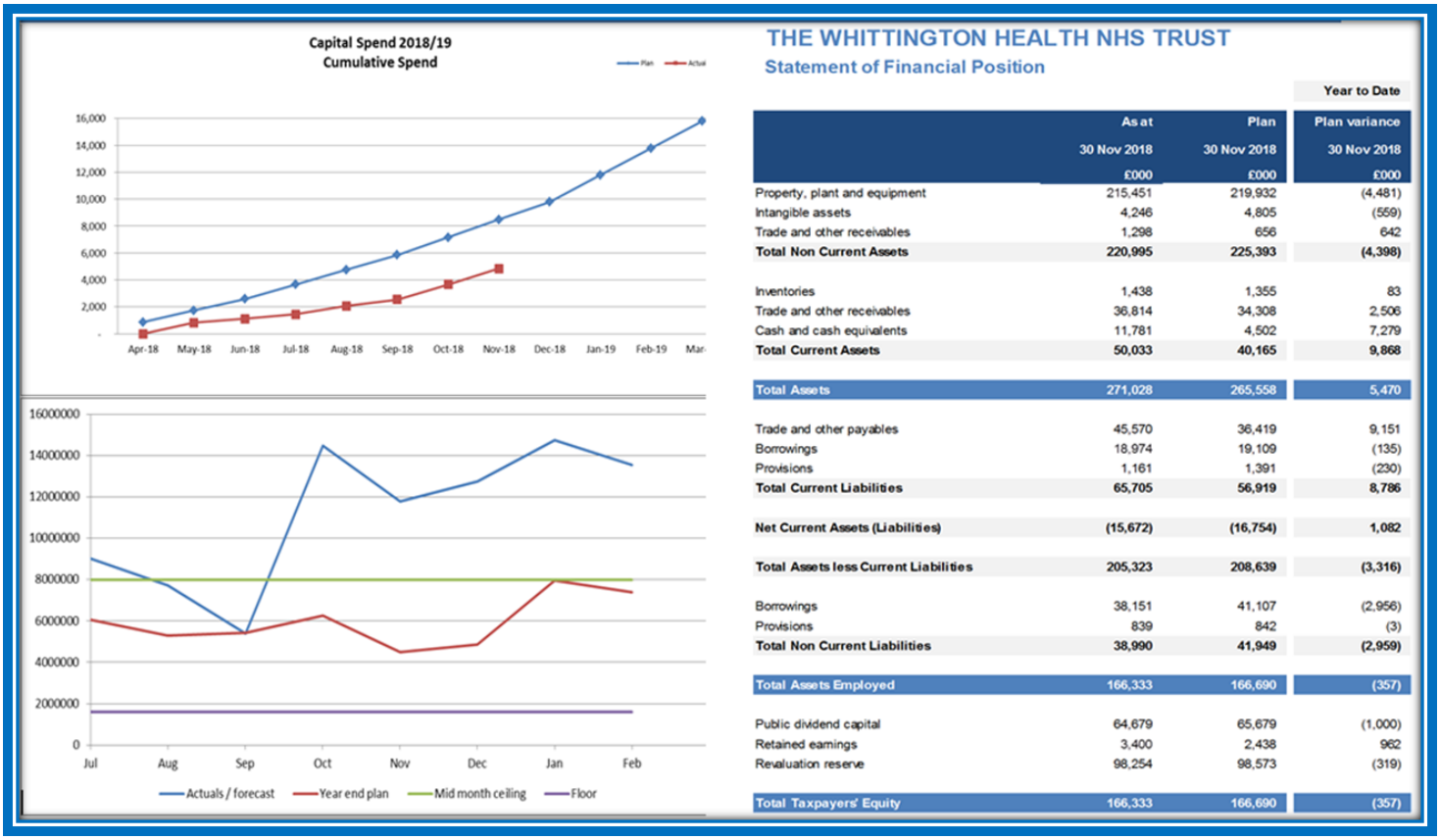


Forecast by programme area:

- Flow through – £2.7m (100%)
- ICSU 2% targets – £4.3m (80%)
- ICSU 2% target delivered non recurrently - £0.5m
- Transformation Schemes – £4.8m (54%)

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 Nov 2018 £000	Plan 30 Nov 2018 £000	Year to Date Plan variance 30 Nov 2018 £000
Property, plant and equipment	215,451	219,932	(4,481)
Intangible assets	4,246	4,805	(559)
Trade and other receivables	1,298	656	642
Total Non Current Assets	**220,995**	**225,393**	**(4,398)**
Inventories	1,438	1,355	83
Trade and other receivables	36,814	34,308	2,506
Cash and cash equivalents	11,781	4,502	7,279
Total Current Assets	**50,033**	**40,165**	**9,868**
Total Assets	**271,028**	**265,558**	**5,470**
Trade and other payables	45,570	36,419	9,151
Borrowings	18,974	19,109	(135)
Provisions	1,161	1,391	(230)
Total Current Liabilities	**65,705**	**56,919**	**8,786**
Net Current Assets (Liabilities)	**(15,672)**	**(16,754)**	**1,082**
Total Assets less Current Liabilities	**205,323**	**208,639**	**(3,316)**
Borrowings	38,151	41,107	(2,956)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**41,949**	**(2,959)**
Total Assets Employed	**166,333**	**166,690**	**(357)**
Public dividend capital	64,679	65,679	(1,000)
Retained earnings	3,400	2,438	962
Revaluation reserve	98,254	98,573	(319)
Total Taxpayers' Equity	**166,333**	**166,690**	**(357)**

Overall, the value of the balance sheet is £0.4m away from plan. Variance explanations in each of the main categories are:

- **Property, Plant & Equipment (PPE)** is £5.1m lower than plan. Capital spend in months 7 and 8 were in line with plan but did not reduce the slippage carried forward from previous periods. However, each area of spend (Estates, IM&T, Medical Equipment and PMO) all have robust plans to spend their allocations. The Trust advised NHSI in month 5 that we would likely undershoot our plan by £1.0m; we are on target to reach the revised target of £12.7m.

- **Receivables (Debtors)** are £2.5m higher than plan. The increase does not relate to an increase in bad or old debt; it is being driven by the accrual of core and incentive Provider Sustainability Funding (PSF). Based on the assumption that year end control totals will be met, the Trust accrued a further £2.2m in month, and is now owed £11.7m in total. £2.7m of this is expected in month 9, but the incentive element (amounting to £12m at year end) is not expected to be settled until July 2019.

- **Liabilities (creditors and borrowings)** are currently £5.8m above plan. As in month 7, the Trust is investing spare cash rather than paying creditors in advance - this is inflating the creditor figure by approximately £5m.

- **Cash and cash flow:** the Trust is holding £11.8m in cash at the end of November 2018. This is £7.3m higher than plan, and is a result of the capital plan slippage and better creditor management.

The Trust has modelled its cash flow for the whole of 2018-19 and has concluded that no cash support should be required during 2018/19.

Meeting title	**Trust Board – public meeting**	**Date:** 19.12.2018
Report title	**Capital plan update**	**Agenda item:** 10
Executive director lead	Stephen Bloomer , Chief Finance Officer	
Report author	Jonathan Ware, Head of Financial Services	
Executive summary	This is the report from the Capital Monitoring Group following the 3 December meeting. Main headlines are, as follows: • Approximately 47% of the Trust's capital programme has been spent or committed in the year to date. All areas (Estates, IM&T, medical equipment, Programme Management Office) are forecasting to spend up to revised plans. • The Committee was satisfied that the material red risks are funded in the current capital programme and the latest completion is 2019/20	
Purpose:	To update the Trust Board on progress on the 2018/19 plan and the methodology for allocating resources in 2019/20	
Recommendation(s)	The Trust Board is asked to note the progress on the capital in the year to date and endorse the current capital allocation process for 2019/20	
Risk Register or Board Assurance Framework	Board Assurance Framework risks on estates infrastructure and cyber security; Corporate risk register entries on estates and information management and technology	
Report history	Not applicable	
Appendices	1: Capital Programme 2018/19	

Capital Plan update

1. Background

The Trusts total capital spend in 2018/19 is planned to be £15.8m which is reduced to a capital programme of £13.7m after removing commitments associated to committed contracts for Private Finance Initiative and Managed Equipment Service.

The Trust's initial capital resource limit (CRL) was calculated at £12.8m. This is £1.0m lower than the capital programme, because the CRL does not take into account the planned expenditure of £1.0m on the maternity redevelopment funded by Charitable Funds.

Capital funding for 2018/19 was calculated as:

- Depreciation: £6.5m
- NHS Digital Fast Follower Funding: £2.0m
- Prior year bonus STF funding: £2.7m
- Charitable fund donation: £1.0m
- Other internal funding: £1.5m

The following contractual commitments are deducted from the total available funding:

- PFI: £0.9m
- MES: £1.2m

In month 5, following the September Capital Monitoring Group (CMG), the Trust reduced its forecast outturn by £1.0m to £12.7m; as a result of slippage in Estates of £1.2m. £12.7m is therefore the revised CRL.

2. Detail

Capital funding has been a scarce resource for a number of years and therefore there is a high need for investment within the Trust. There are a number of competing priorities which address legacy issues e.g. backlog maintenance as well as emerging risks e.g. cyber security. In this environment it is essential that there is a fair and transparent methodology for allocating capital resource. The methodology used is based on risk to ensure that the Trust prioritises resource effectively and the order of commitment is:

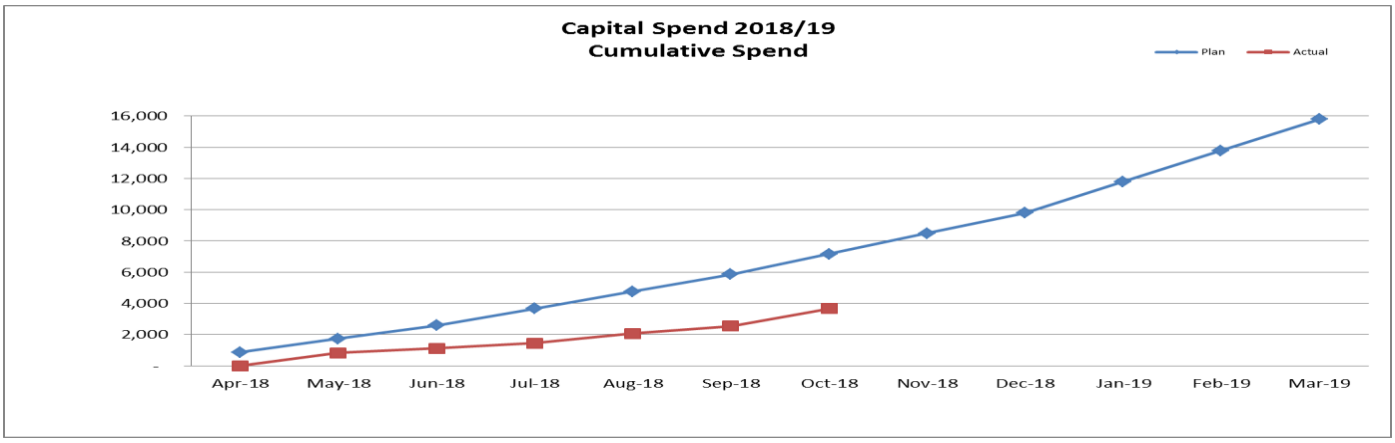
- Expenditure is contractually committed (e.g. GDE Fast Follower, PFI and MES);
- Expenditure addresses significant patient safety risks (in the case of Estates capital expenditure on the maternity redevelopment, some medical equipment);
- Expenditure ensures that the Trust continues to comply with regulatory requirements (in the case of Estates capital expenditure on fire, water and electrical safety);
- Expenditure ensures continued service provision (in the urgent replacement of medical equipment); and
- Service development (e.g. PMO expenditure)

Risk reporting is strong in Estates and IMT and the Capital Monitoring Committee is satisfied that the significant risks, are being adequately captured and being addressed. The process of identifying risks in ICSU risk registers particularly relating to medical equipment has been more challenging so the Medical Physics team have undertaken an exercise looking at equipment age and have spoken to ICSU leads to ensure the biggest risks are funded and based on that assurance the Capital Monitoring Committee is satisfied that the significant risks, are captured and dealt with.

The detailed capital plan is included in appendix 1.

Capital spend in the year to date is £2.8m, representing 56% of plan as at the end of month 7 which represents 22% of the full year plan. In additional to the recognised expenditure £3.1m has been committed.

As stated above, in month 5, the Trust revised its capital plan to £12.7m. Following an exercise with project leads, the Capital Monitoring Committee was satisfied that despite the low level of spend in the first 7 months of the year, plans are in place to deliver the full plan and the Trust has not revised its plan further.



The table below shows forecast spend by area excluding PFI and MES.

Area	Revised allocation (£m)	YTD	Expected outturn (£m)
Estates			
Maternity	2.1	0.3	2.1
Imaging lifecycle	1.1	0.6	1.1
Community dental	1.0	0.1	1.0
Engineering backlog projects	0.7	0.5	0.7
Fire remediation	0.5	0.1	0.5
Nurses' home	0.4	0.1	0.4
Northern Health Centre	0.4	0.1	0.4
Cellier Ward	0.2	0	0.2
Building fabrics	0.1	0.1	0.1
NICU	0.1	0	0.1
Staff costs	0.5	0.2	0.3
Contingency	0.1	0	0.1
IM&T			
Fast Follower (including staff costs)	2.9	0.3	2.9
Infrastructure upgrades	1.4	0.2	1.4
Other areas of spend			
Medical equipment	0.9	0.2	0.9
PMO	0.3	0	0.3
TOTAL	**12.7**	**2.8**	**12.5**

3.0. Recommendations

The Trust Board is asked to note the progress on the capital in the year to date and endorse the current capital allocation process for 2019/20.

Appendix 1: Capital Programme 2018/19

	2018/19	
FUNDING		
Internal funding	8,086	
Additional sources of funding	6,700	
Contractual commitments:		
MES lifecycle	1,150	
PFI lifecycle	948	
Funding after contractual commitments	**12,688**	
EXPENDITURE		
High and Strategic Risk Items		
Maternity: Obstetrics Theatre and NICU	2,174	
GDE Fast Follower commitments	2,964	5,138
Commitments		
Imaging replacement programme	1,064	
Community dental	1,000	2,064
Estates: High Risk		
Fire safety	500	
Engineering backlog (water, electric, asbestos)	700	
Building fabrics	150	
Nurses' home upgrade	464	
Northern Health Centre upgrade	350	
Cellier ward upgrade	198	2,362
Estates: High Risk		
Infrastructure upgrade and refresh	1,371	1,371
Medical Equipment: High Risk		
Endoscopy	179	
Camera stacks	120	
Anaesthetic recovery monitors	112	
Dental equipment	101	
Ultrasound	60	
NICU incubators	48	
Urology	42	
Cardiology	35	
Women's Health diathermy	24	
Ventilators	20	
Audiology	20	
General replacement	142	903
Other		
Estates team costs	300	
PMO	250	550
Contingency	300	
Total forecast expenditure	**12,688**	

The Trust's detailed capital plans excluding Estate Development for 2019-20 and 2020-21 are currently being developed. In addition, the size of future capital plans depends significantly on the achievement of the financial control total in 2018-19, as well as subsequent agreement with NHSI. Estates masterplanning work is also ongoing and will require funding in excess of a CRL level that

NHSI would usually allocate to the Trust. Ideally, the Trust will self-fund the proposed estates development, but it may require additional DH funding requests.

Present indicative values reported to NHSI for 2019-20 and 2020-21 are as follows:

Area	**Planned capital spend**	
	2019-20 (£m)	**2020-21 (£m)**
IM&T	2.9	1.1
Estates	5.1	2.3
Medical equipment	1	1.5
PMO	0.3	0.3
Private Finance Initiative	0.9	0.9
Managed Equipment Service	0.4	0.3
TOTAL	**10.6**	**6.4**

Meeting title	**Trust Board – public meeting**	**Date:** 19.12.2018
Report title	Workforce Race Equality Standard improvement plan 2019/2020	**Agenda item:** 11
Executive director lead	Norma French, Director of Workforce	
Report author	Norma French, Director of Workforce	
Executive summary	The Workforce Race Equality Standard (WRES) is a NHS national standard used by Whittington Health to conduct root cause analysis of the differences in data for black and minority ethnic (BME) and white staff as reported in the annual WRES report to the Trust Board (over the past two years). Some, if not all of the indicators will provide challenges as the Trust begins to drill down into the data for which the WRES has been designed to do. The overall focus will be to improve equity for all staff, particularly for our BME staff, thus improving the working experiences and treatment of our most valuable assets. The WRES improvement plan is designed to tackle some of the Trust's cultural and organisational behaviours in the interest of improving organisational performance and patients/service users' outcomes. It reflects the desired outcomes as articulated in the organisation's workforce strategy and clinical strategy. Therefore, the WRES improvement plan for 2019/2020 will focus on the key issues that have arisen over the past twelve months. The plan will be reviewed over the year to closely monitor the closing gap and differences between the treatment and experiences of BME and white staff. Progress against delivery of the plan will be monitored by the Workforce Assurance Committee.	
Purpose:	Approval.	
Recommendation(s)	The Board is asked to approve the WRES improvement plan.	
Risk Register or Board Assurance Framework	Board Assurance Framework risk 4 (failure to recruit and retain high quality staff) and risk 17 (failure to improve organisational culture impacts on staff retention, morale and patient care)	
Report history	Trust Management Group, 18 December 2018	
Appendices	None	

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
INDICATOR 1: **Percentage of staff in each of the Agenda for Change Bands 1-9 and Very Senior Managers (including executive Board members) compared with the percentage of staff in the overall workforce.**	The total amount of non-clinical Black & Minority Ethnic (BME) staff as at March 2018 was 515 out of a total of 1042. **<u>Band 1</u>** BME staff increased to 70.8%, a total of 107 out of 152, an increase of 1.9% from March 2017. **<u>Band 2</u>** BME staff decreased to 53.0%,a total of 67 out of 127, a decrease of 2.7 % from March 2017. **<u>Band 3</u>** BME staff decreased to 52.40%, a total of 105 out of 201, a decrease of 4.8% from March 2017. **<u>Band 4</u>** BME staff increased to 56.9%, a total of 110 out of 194, a decrease of 2.5 % from March 2017. **<u>Band 5</u>** BME staff increased to 46.80%, a total of 54 out of 116, an increase	Conduct analysis of data by department, profession to assist in identifying specific areas of concern and barriers to career progression. Measures agreed for addressing the over representation of BME staff at lower bands Incorporate unconscious bias dimensions into HR core skills training to influence recruitment and people management practices. Continue to deliver unconscious bias training to all staff	The ethnic staff profile reflects the proportion of BME staff in the workplace at pay bands 7 and above. Increased uptake of apprenticeships by BME staff Interview skills training packages to address empowerment and cultural issues to be explored. Staff who undertake interviewing to have undertaken unconscious bias training. Quarterly audit of all interviewers undertaking training	Assistant Director of Organisational Development (OD) and Deputy Director of Workforce [supported by Head of Inclusion and Development & Inclusion Lead] Head of Resourcing [supported by Head of Inclusion and Development] Inclusion Lead with support from Head of	January 2019 March 2019 Jan – Mar 2019 Ongoing April 2019

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	of 5.1% from March 2017 **Band 6** BME staff increased to 45.8%, a total of 41 out of 90, a decrease of0.4 % from March 2017. **Band 7** BME staff decreased to 30.7%, a total of 14 out of 46, a decrease of 8.5% from March 2017 **Band 8A** BME staff increased to 18.5%, a total of 9 out of 49, no change from March 2017 **Band 8B** BME staff decreased to 21.4% with a total of 4 out of 19, a decrease of 4.1% from March 2017 **Band 8C** BME staff decreased to 4.8% with a total of 1 out of 21, a decrease of 3.9% from March 2017 **Band 9** BME staff increased to 21.10% with a total of 1 out of 5, an	Work with Staff Inclusion Network to develop and showcase case studies of BME staff to profile career progression successes and encourage managers and individuals to raise aspirations in career pathways. Identify positive role models to promote across the Trust Continue to take a targeted approach to key leadership programmes, proactively encouraging BME candidates. Reverse mentoring to be in place, audited and rolled out Target development programmes at lower	Introduce diverse interview panels for all bands 8A and above. Improved demographics of development programmes	Resourcing Head of Inclusion and Learning Assistant Director of OD Assistant Director of OD Head of Inclusion and Learning Head of Inclusion and Learning Assistant Director of OD	December 2018 April 2019 April 2019 Ongoing November 2018 Current

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	increase of 3.9% from March 2017 **VSM** BME staff was at 0.0% with a total of 0 out of 12, a decrease of 18.2% from March 2017 Data for overall non-clinical BME staff indicated a total decrease of 29.2% from March 2017. The total Clinical (AfC), medical and dental BME staff as at March 2018 was 1318 of a grand total of 3194. **Band 1** BME staff was at 0.0% with a total of 0 of 1. There was no Indication of movement from March 2017. **Band 2 Clinical (Afc)** BME staff increased to 77.90% with a total of 103 out of 132, an	banded roles To continue the work to include sessions on diversity, culture and race and extend to all ICARE Leadership programmes WRES Workshop led by NHS National WRES team targeting at least 100 staff across the Trust; a cross section of bands, staff groups, professions and roles such as Speak Up Inclusion Champions plus participants of I.CARE Leadership programmes. 3 x follow up sessions - "Teach & Learn" led by Yvonne Coghill – NHS National WRES team Interventions to include the "Thinking Environment" methodology offered by LLA. Inclusion Labs pilot – creating a more inclusive	Increase equality of opportunity to foster good relations.	Head of OD Head of Inclusion and Learning Head of Inclusion and Learning Head of Inclusion and Learning Head of Inclusion and Learning	Current – Dec 2019 Feb, Mar and April 2019 November 2018 – March 2019 Ongoing

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	increase of 4.3% from March 2017 **Band 3** BME staff decreased to 50.7% with a total of 124 out of 244, a decrease of 2.6% from March 2017 **Band 4** BME staff increased to 44.6% with a total of 89 out of 199, an increase of 0.2% from March 2017 **Band 5 Clinical (AfC)** BME staff decreased to 48.0% with a total of 251 out of 522, a decrease of 5.6% from March 2017 **Band 6** BME staff increased to 44.4% with a total of 301 out of 678, an increase of 0.5% from March 2017 **Band 7** BME staff decreased to 32.6% with a total of 197 out of 603 a decrease of 0.1% from March 2017 **Band 8A**	environment to facilitate Equality, diversity and inclusion becoming a "golden thread" in everything the Trust does in delivering good patient care. Part of WRES North Central London CCGs & Providers Group – working collaboratively across the sector, e.g. Equality & Diversity Week in May 2019 (to be confirmed).	Eliminate any form of discriminatory practice, process and system within the intention to increase a more inclusive culture.		

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	BME staff increased to 24.2% with a total of 49 out of 202, an increase of 0.1% from March 2017 **Band 8B Clinical (Afc)** BME staff decreased to 24.7% with a total of 16 out of 64, a decrease of 6.6% from March 2017 **Band 8C Clinical (Afc)** BME staff increased to 11.20% with a total of 2 out of 17,an increase of 4.9% from March 2017 **Band 9** There have been no appointments to this band in either 2017 or 2018. **VSM Clinical (Afc)** BME staff decreased to 31.00% with a total of 3 out of 9, indicating a decrease of 19% from March 2017 **Doctors in training** BME staff decreased to 30.5% with a total of 73 out of 239, indicating a decrease of 7% from March 2017				

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	Career grade BME staff decreased to 51.9% with a total of 37 out of 71, indicating a decrease of 6.2% from March 2017 **Consultants** BME staff decreased to 34.7% with a total of 73 out of 210, indicating a decrease of 0.2% from March 2017 **Overall Clinical (AfC), Medical and Dental BME staff decreased by 37.3% across bands 1-9/VSM**				

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
INDICATOR 2: **Relative likelihood of staff being appointed from shortlisting across all posts**	The indicator shows a significant gap in the likelihood of White and BME staff being appointed from shortlisting. The data shows that White staff are 2.04 times more likely to be appointed from shortlisting than BME staff across all posts.	Investigate this trend further and consider if there are differences between professions, departments and pay bands both from application to shortlisting stage. Director of Workforce to oversee all 8A and above appointments and to personally check the shortlist, panel and who is appointed. Complete an audit of a sample of interview	Narrow the gap in relative likelihood of white staff being appointed compared to BME staff by 0.25 Increase % of panel members who have attended unconscious bias training to 70% in addition to 95% having completed equality and inclusion training. Develop a statement to be included in job adverts about the Trust taking Positive Action. Question included in quarterly applicant survey around impact. A record kept of all interviewers	Head of Resourcing Head of Inclusion and Development Deputy Director of Workforce with support from Head of Resourcing Deputy Director of Workforce	Autumn 2019 April 2019 January 2019 March 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
		scoring sheets for BME and with candidates Continue to deliver recruitment and selection training including impact of unconscious bias. Ensure this is a pre-requisite for those taking part in the process Ensure that all Band 8A and above panels have a BME representative Where a BME candidate has not been appointed following interview, the recruiting manager to write to Director of Workforce setting out reasons why?	undertaking training Minimum of one panel member to have unconscious bias training Quarterly workforce assurance reports	Acting Head of resourcing with support from Head of inclusion Director of Workforce	1 December 2018 1 December 2018 January 2019
INDICATOR 3: **Relative**	There appears to be a significant change, however, the data is not directly comparable. In 2016-17	Analyse the disciplinary data to understand whether the likelihood of BME staff	Reduce overall representation of BME staff in formal	Deputy Director of Workforce	December 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
likelihood of staff entering the formal disciplinary process	all formal cases were included (grievance, disciplinary, probation, performance), while the data for 2017-18 includes disciplinary only. The 2017-18 data shows BME staff are 0.75 times less likely to enter formal disciplinary processes than White staff.	exiting the formal disciplinary process with a sanction is greater than for white staff. Evaluate the outcome of the Fair Treatment Panels Analyse disciplinary offence by ethnicity to consider if there are specific issues relating to particular groups, departments or pay bands Ensure that panel members have had unconscious bias training. Promote the role of facilitated conversations and mediation in the earlier stages of resolution of	disciplinary processes by 25%. Increase capacity of mediation by working with other organisations who are similarly trained and share the resource whilst developing the internal team to manage issues relating specifically to diversity and race Minimum of one panel member to have unconscious bias training	Deputy Director Workforce with Head of Employee Relations Head of OD and Deputy Director of Workforce Head of Inclusion and Development Head of OD/OD Practitioner	March 2019 Quarterly January 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
		conflict that can lead to formal processes. Participant of Pan-London WRES Project 3 – improving equalities outcomes through better practices	Increase OD offer to facilitate staff disputes (before reaching mediation/disciplinary) proceeding) by developing an internal team of staff facilitation experts who are representative of the diverse workforce and able to use the principles of mediation in a less formal and time intensive setting Bench mark progress against other participating Trusts, including the academic research findings.	Head of Development and Inclusion	March 2019 April 2019
INDICATOR 4: **Relative likelihood of staff accessing**	There is currently no data to report. *A review to improve collection of data commenced in April 2018*	Hold a workshop with Staff Inclusion Network and staff side to identify opportunities to promote fairness to career progression or	Increase recording of continual professional development (CPD) and development opportunities or	Head of Inclusion and Development	March 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
non-mandatory training and CPD.	*working with Clinical Education/Professional Development Nurses (PDNs) to identify gaps and report as of April 2019 on available data for 2018-2019.*	promotion as the staff survey results (KF21) reveal that 85% of white staff stated that they believe the Trust provides equal opportunities for career progression. The figure for BME staff was 61%, a drop from 70% in 2016	qualifications on the electronic staff record (ESR) by Professional Development Nurses (PDNs)/Educational/Training Leads Explicit/focussed attention to the personal development plan (PDP) part of annual appraisal with outcomes. Bi-annual reports sent to Integrated Clinical Service Units (ICSUs)/directorates as part of key performance indicators (KPI) & Training Needs Analysis (TNA) planning		

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
INDICATOR 5: **KF25. % staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months**	The data shows that the percentage of White staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months is 28%, while for BME staff it is 29%.	Continue to monitor annual Staff Survey responses against workforce data (e.g. recorded harassment, bullying or abuse from patients, relatives and the public in the last 12 months) and work with the Staff Inclusion Network to understand any discrepancies. Analyse data by department, pay band and profession – KF 21 and Q17.	To offer staff training on personal resilience and management of conflict (including harassment, bullying or abuse) specifically to staff who may receive abuse from patients, relatives or the public. Collate information regarding “hot spots”, bands, roles, etc and produce targeted interventions as part of staff survey action plans.	Head of OD / and Deputy Director of Workforce/ Director of Environment Inclusion lead	Mar – July 2019 June 2019
INDICATOR 6: **KF26. % staff experiencing harassment, bullying or abuse from staff in the last**	The data shows that the percentage of White staff experiencing harassment, bullying or abuse from staff in the last 12 months is 27%, while for BME staff it is 33%.	Promote methods for ensuring personal safety and security. Develop managers to be confident in approaching staff to resolve issues sooner rather than later.	Four sessions delivered Four sessions of critical conversation training delivered. Four sessions	Assistant Director of OD Inclusion Lead Head of OD/ OD Practitioner	Current – Dec. 2019 By end Dec 2019

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
12 months **INDICATOR 7:** **KF 21. % Staff believing that the organisation provides equal opportunities for career progression or promotion**	The data shows the % of White staff that believe the organisation provides equal opportunities for career progression or promotion is 85% while for BME staff it is 61%. Not only is there a fall when looking at the 2017 (White 87% and BME 70%) data for White and BME staff in believing there are career opportunities, there is a widening gap between White and BME staff.	Training in holding difficult conversations Run stress management courses and well-being sessions for all staff Hold a workshop with the Staff Inclusion Network and staff side to understand the staff survey data, to identify root causes and potential solutions to address the less positive results Train managers in career development and career management. Introduce development	delivered Four sessions delivered Four sessions delivered Scope requirements for running internal development centres	Assistant Director of OD Assistant Director of OD Head of OD	By end December 2019 From Jan 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
	The data shows in White staff it is 8% while in BME staff it is 17%. When looking at 2017 data (White 7% and BME 17%) there is a closing gap moving in the right direction, but the gap remains large and the experience of discrimination is too high for both White but especially BME staff.	centres to support career and role development. Full evaluation of role, impact and re launch Directory available on intranet Handbook and managers' passport in place			

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
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WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
INDICATOR 8: **Q 17. In the last 12 months have you personally experienced discrimination at work from manager, team leader, or other colleague**		Continue to support the Staff Inclusion Network to provide opportunities for sharing experiences. Continue conflict resolution training and enhance mindfulness Review the role of anti-bullying and harassment advisers. Consider re-branding the role to reflect a range of support, and relaunch comms package Publicise the wide range of bullying and harassment tools and pathways to staff using a range of media. Develop a new managers' handbook to include unconscious bias, difficult conversations and resolution. Create a managers network under the umbrella 'culture corner		Deputy Director of Workforce Deputy Director of Workforce Deputy Director of Workforce and Assistant Director of OD	March 2019 March 2019 April 2019

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
		for managers'. All managers will be invited to find a 30/60min slot each month to meet a colleague from another part of the trust and talk about cultural issues and there will be sessions every 6 months for everyone to attend and feedback their conversations. To pilot with Band 7s.			
INDICATOR 9: Percentage difference between the organisations' Board voting membership and its overall workforce	By the voting membership of the board: the data shows that 25% of the Trust board voting members are BME compared to 43% BME workforce. The percentage difference is therefore -18% (i.e. 25% - 43%) By executive membership of the board: the data shows that there are no BME Executive members and the percentage difference is -43% (i.e.0% - 43%= - 43%)	Board development Programme commissioned. Encourage Board members to update protected characteristic information Ensure that positive action statements are included in recruitment processes Specify to recruitment agencies working with the	ESR information update to accurately reflect Board membership All external recruitment for senior posts to include positive action statement. Internal checklist for	Head of Workforce Information Director of Workforce Head of Resourcing Director of	Feb 2019 Jan 2019 1 December 2018 April 2019

Whittington Health NHS Trust: Workforce Race Equality Standard (WRES) – Improvement plan 2019/2020
(Progress with delivery of this action plan will be monitored by the Workforce Assurance Committee)

WRES Indicator	What our WRES Data tells us	Actions (how will we improve)	Success criteria and means of measurement (how will we know our changes will be an improvement)	Responsible Officer	Timescale
		trust that candidate lists are expected to be of a diverse background	instructions to external agencies to include information of expectation of diverse candidate lists.	Workforce	

Meeting title	**Trust Board – public meeting**	**Date: 19.12.2018**
Report title	**2017/18 Section 75 Annual Report in Islington**	**Agenda item: 12**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report authors	Carole MacGregor, Head of Islington Community Rehabilitation Service, and Paul Attwal, Director of Operations, Integrated Medicine	
Executive summary	The report highlights the main service developments between the London Borough of Islington and Whittington Health during the 2017/18 financial year in the provision of integrated services for adults and older people, and identifies the key priorities for 2018/19	
Purpose:	Discussion	
Recommendation(s)	Board members are asked to discuss the content of the 2017/18 section 75 annual report and agree on the direction of travel indicated between the organisations	
Risk Register or Board Assurance Framework	None currently identified	
Report history	Reported presented to London Borough of Islington Executive Board in June 2018	
Appendices	1: 2017/18 section 75 Annual Report in Islington	

Appendix 1: 2017/18 s75 annual report for Islington

ISLINGTON

In partnership with

Whittington Health NHS

Report on Section 75 (National Health Service Act 2006) Partnership Working between

London Borough of Islington and Whittington Health NHS Trust

1. Introduction

This report covers the main achievements of during the financial year of 2017/18 in the provision of integrated services for adults and older people, and identifies the key priorities for 2018/19.

2. Key areas of achievement IN 2017-18

2.1 Integrated Locality Team Working - Where we are now

The adult social care access team has moved to Contact Islington. This move has seen a 30% improvement in abandoned calls to Social care. Adult social care screening and urgent response team processes all new and Safeguarding referrals received from Contact Islington. There is work ongoing exploring options of an integrated approach to processing referrals.

North and South integrated community teams continue to be co-located with the REACH services. Although there are no integrated processes the teams do offer each other support and advice as required. All teams continue to work together to ensure that the services are delivered in partnership where possible and are sustainable and able to respond to the increasing number of people being supported to remain in their own homes and independent for as long as possible. The future aim is to revisit the integration agenda at a later date this year within the Intermediate Care Strategy Programme.

Discharge to Assess pathways have been implemented. Referrals are received via an integrated single point of access where all referrals are triaged before progressed to the most appropriate pathway.

Collaboration between Whittington Health and Islington continues in the following areas:

- Integration in line with healthcare priorities
- The implementation of discharge to assess
- Growth in the use of Enhanced Telecare services
- Growth in the number of GPs involved with the integrated network meetings

2.2 Developing the locality-based model with GPs

There is a commitment to participation in the locality-based multi-disciplinary team working within GP localities. The participation of staff from both social services, and community health teams, e.g. therapists, district nurses and community matrons, and hospital consultant geriatricians, in a fortnightly primary care led teleconference brings together information and expertise from a wide range of professionals, and from acute, primary, community care and the voluntary sector. This supports development of a coordinated care plan to support better management of people's well-being within a community setting. Whittington operationally manages the Islington integrated networks (multiagency teams wrapped around primary care) through the Integrated Network Coordination (INC) infrastructure.

The development of locality based teams of health and social care staff support effective links with the primary care localities, and development of multidisciplinary work to support management of patients most at risk of hospital admission or premature entry in to long term care.

Whittington Health has been a central part to the implementation of the Integrated Networks across Islington. The roll out of the programme began in February 2016 and Whittington Health have operationally managed and provided the ongoing infrastructure for the Integrated Networks. There are now 12 Integrated Networks running across Islington with 97% of GP practices. In 2017/18 a total of 1666 patients were discussed via the Integrated Networks. Whittington Health also provide the community matron service to the Integrated Networks who form part of the core Integrated Network team alongside GP's, mental health, social services, Age UK and secondary care. The service is fundamental in Whittington's vision of providing integrated care.

2.3 Care Closer to Home – reducing the time people have to spend in hospital

Discharge to Assess

'Discharge to assess' is a new approach to hospital discharge which supports people who are medically ready to be discharged from hospital to get home more quickly by having their social care needs assessed at home rather than on the ward. This approach to discharge will help to improve patient flow through the hospital, ease demand on hospital beds and staff, and make better use of our community services and deliver better outcomes for patients.

Patient outcomes the approach supports include the following examples:

- Lower risk of getting a hospital acquired infection;
- Retain independence for longer
- Less reliance on long term care and receive care that is most appropriate to their needs
- Likely to live longer.

Implementation in Islington

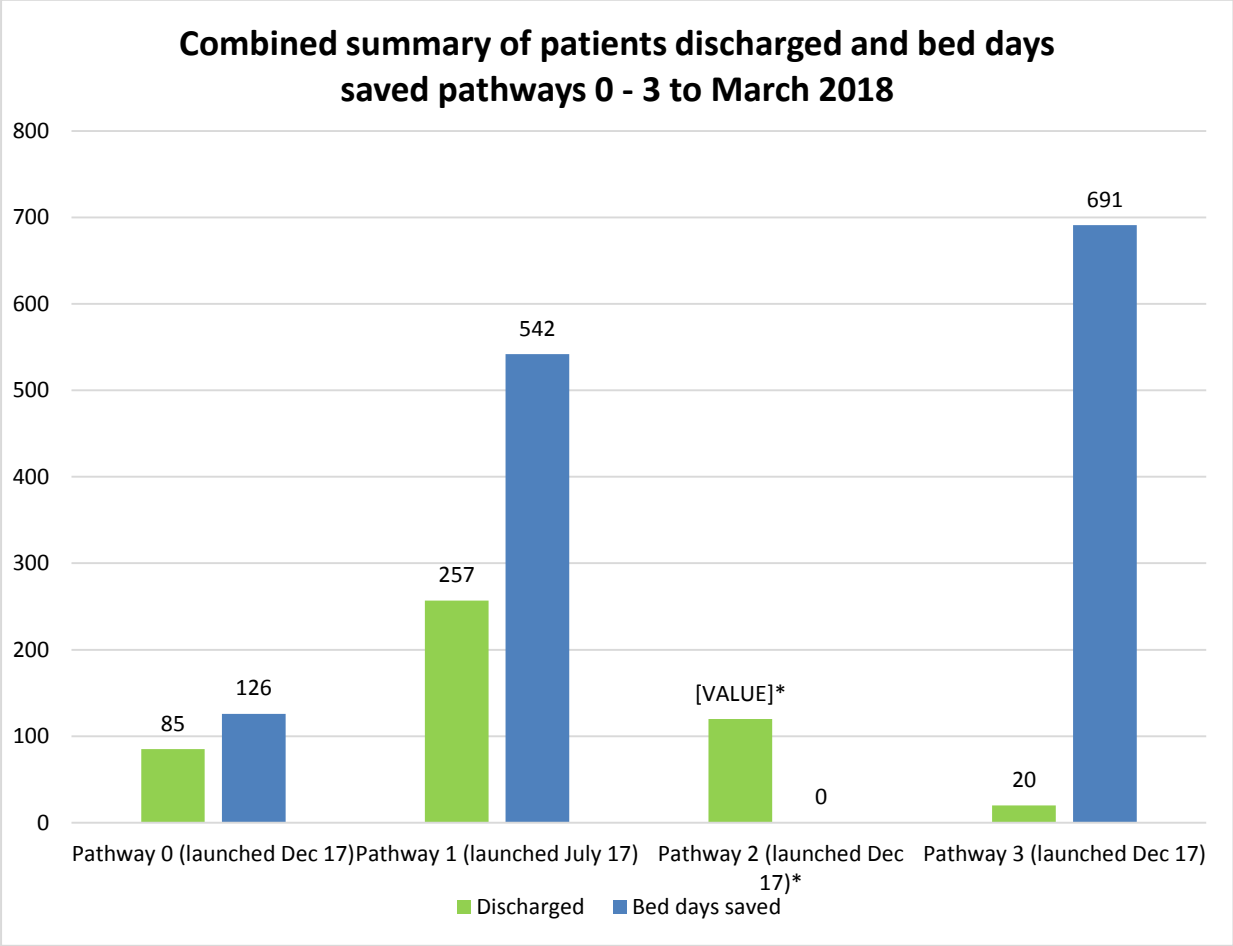
Discharge to Assess (D2A) pathways have been operational in Islington for patients from UCLH and Whittington throughout winter 2017/18, supported by a single point of access team. Single NCL referral forms have also been developed for all pathways, supporting clear governance and referral processes for all referrers.

The table below outlines the current scope of the Islington pathways. Development work is underway locally and through our participation in the NCL Simplified Discharge Working Group and Health and Wellbeing partnership with Haringey in particular, to scale up these pathways and the single point of access in the coming year.

Pathway	In scope	Out of scope (currently)
0	All patients requiring a restart to an existing package of care (POC)	Any patients requiring a variation to an existing POC.
1	All patients with reablement potential.	Patients with no reablement potential requiring a long term POC. Majority of patients with therapy only needs.
2	All patients requiring bed based intermediate care.	None.
3	Patients who have triggered positive Continuing Health Care (CHC)	Patients who have triggered CHC **but do not have** nursing needs that require

Pathway	In scope	Out of scope (currently)
	checklists **and have** nursing needs requiring up to 24 hour nursing care in a residential setting.	residential support. Patients who have not triggered CHC but require residential support.

Impact in Islington



The key metric for assessing the impact of Discharge to Assess programmes is the number of hospital bed days saved per patient.

Working with NCL partners we have agreed a bed day saving methodology for all pathways except pathway 2. Work is underway to address this. The graph below provides an overview of the monthly bed day savings and number of patients discharged through the D2A pilots up to March 2018. A total of 1359 bed days have been saved as of 31st March 2018, which initial anecdotal evidence from the hospitals suggests is having a positive impact on patient flow pressures.

Wider impacts of D2A include initial indications that lengths of stay in our bed based intermediate care settings have reduced significantly – down by as much as 34% in one setting in March 2018. There has also been a really positive culture of joint working between health and social care partners throughout the development of the project.

“The successful delivery of this pilot has meant a really noticeable streamlining of the discharge pathway with fewer people in the borough waiting in hospital unnecessarily.

This is better for patients and frees up much needed bed spaces in the hospital. These initial positive results are in no small part down to the excellent collaborative working between health and social care partners, which will underpin the ongoing work to further refine and improve the pathways." Dr Suzanne Roberts, In Patient Therapy Manager at Whittington Hospital, and clinical lead for the D2A project.

2.4 Delayed Transfers of Care

The graph included here is drawn from the NHS England DTOC data and presents data for all delays (NHS and social care) in Islington during the period. Though the source is the same as the graph presented in last year's report, the data set for 2016/17 has been revised by LBI performance team to draw on mid-2016 ONS population data, rather than the mid-2015 data originally used by NHS England for the 2016/17 graph (this was used originally at the time of publication this was all that was available). For this reason, data from both 2016/17 and 2017/18 has been included above to enable accurate comparison[1].

Whilst Islington's individual performance has remained consistent across the period at 9.2 delays per 100,000 patients, the London and England averages have reduced in 2017/18, meaning that comparatively, Islington's performance has declined slightly.

It has been a very challenging period across both health and social care in Islington. In particular, challenges in social care provider market including embargos on care agencies and closures of residential homes in the latter part of the year have had an impact. In addition, as has been acknowledged previously, there is an ongoing improvement plan underway in Islington's in-house reablement to ensure it is able to support discharges with maximum capacity.

Action has been taken to stabilise the market by reviewing fees, putting intensive support into underperforming sites and in April 2018 there was an expansion in the contracted homecare providers available in the borough. A process has also been established and successfully implemented when it's been necessary to deliver reablement support via external providers where our in-house service has been at capacity. This activity has contributed to ensuring there will be increased capacity in the system to address issues with DTOC figures going forward.

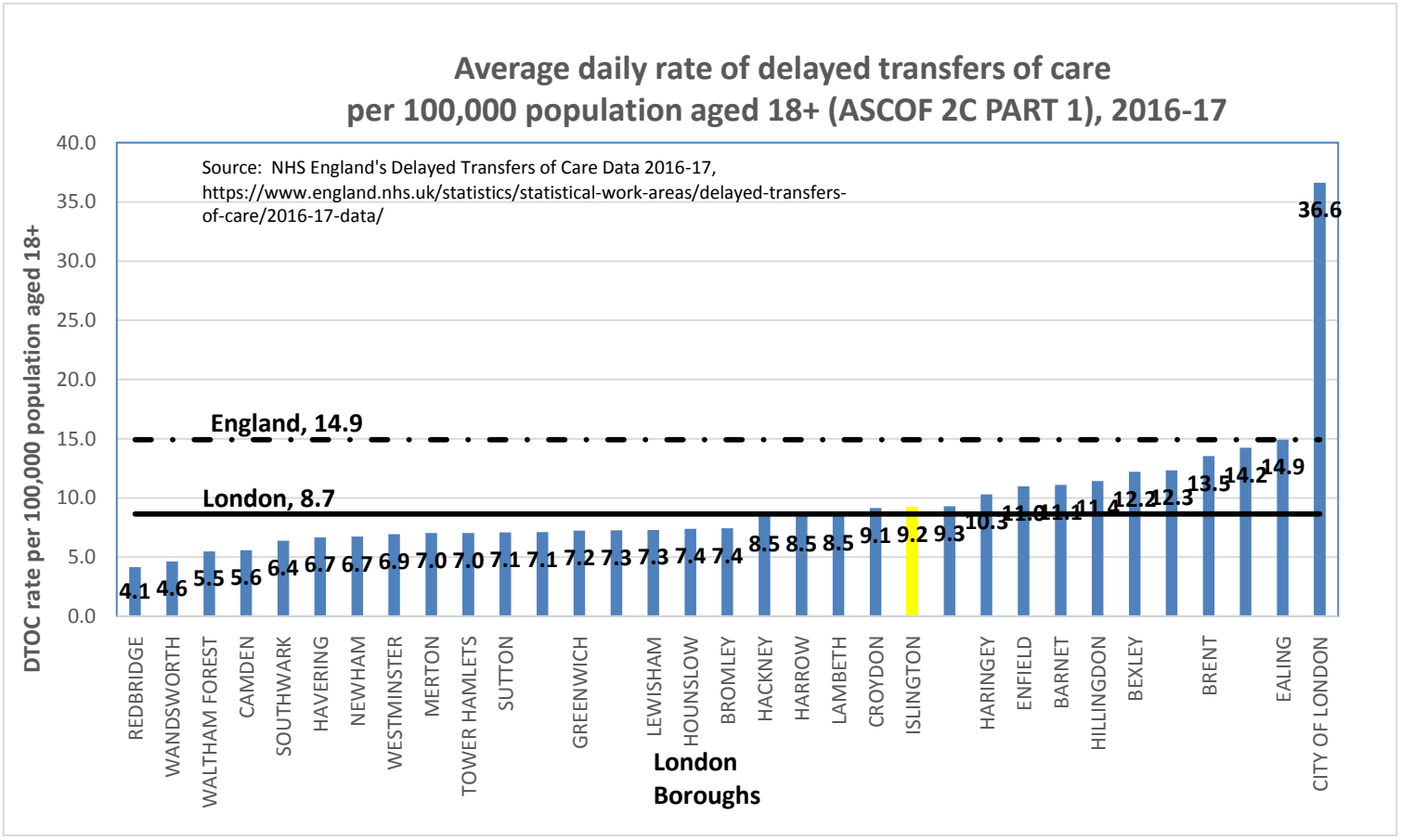
Beyond this, work is ongoing to ensure patients are discharged in a timely way and wherever possible back to their homes. Key activity includes;

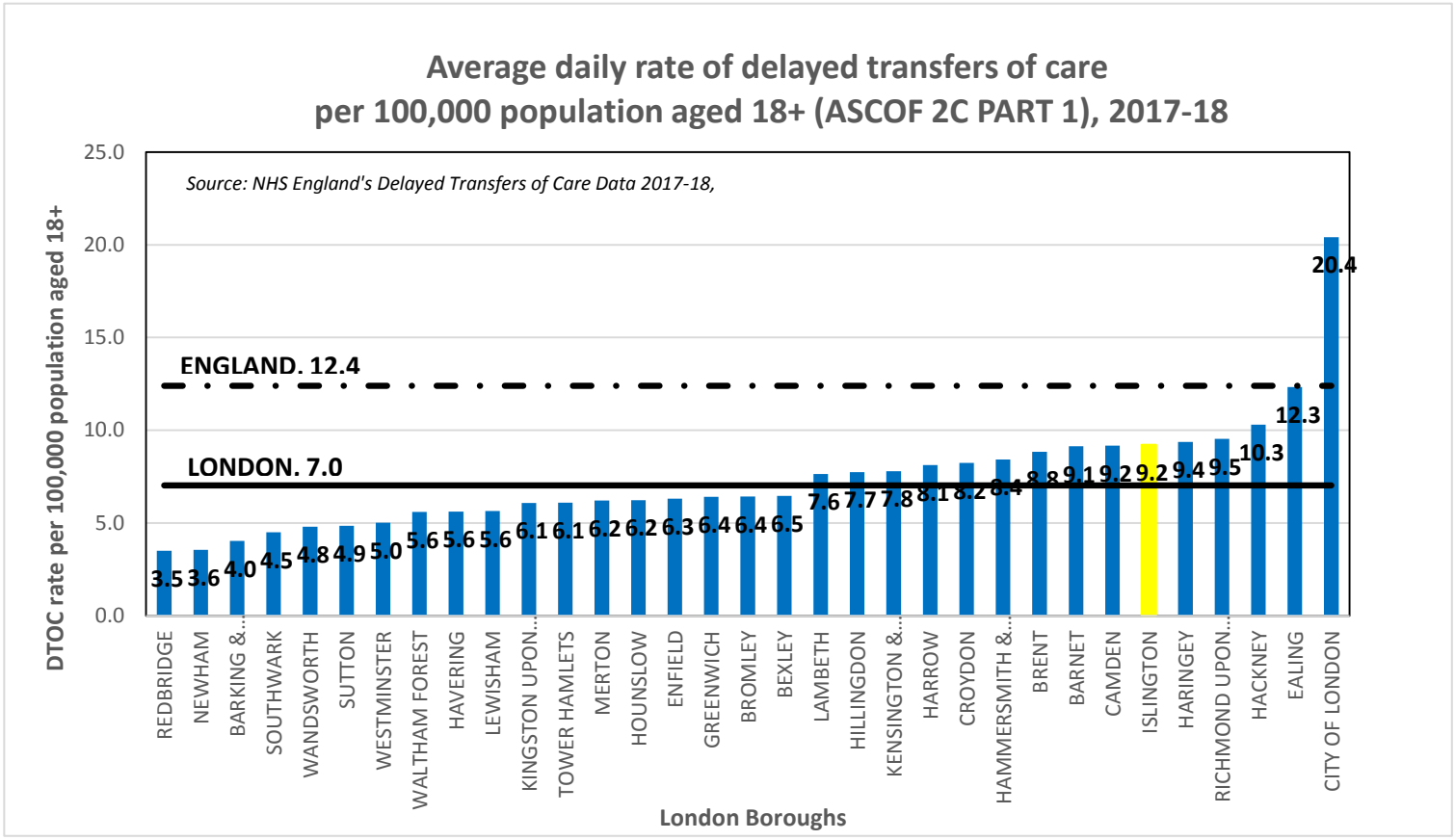
- Development of the discharge to assess pathways, which as of March 2018 had facilitated discharges for 482 patients saving an estimated total of 1359 bed days.
- Ongoing work to ensure the throughput in our bed based intermediate care settings is as efficient as possible to support a good flow for patients transferring from acute to intermediate care. This work is ongoing but improvements delivered through closer partnership working with housing has been demonstrating a significant impact.
- Changes to the setup of our hospital social work team is also playing an important role, ensuring social workers are embedded in the acute and working closely with ward staff to facilitate discharges.

Improving both DTOC performance and length of stay in hospital for our residents

[1] *The rates for 2016-17 are calculated using the mid-2016 population estimates, not mid-2015 population estimates (used by NHS England in their 2016-17 DTOC SFR). Meanwhile, the rates for 2017-18 are calculated using the projected mid-2017 population data (mid-2016 based subnational population projections). These rates will need to change once the mid-2017 population estimates (final estimates) are released by the ONS on 30 June 2018.*

continues to be an absolute priority going forwards both at an operational and strategic level.





2.5 Avoiding Hospital Admission

Evidence shows that older people 'decompensate' and lose their independence during an extended hospital stay. Hospitals are an unfamiliar environment and patients lose their routine impacting on their ability to keep active and maintain muscle strength. There is a continued focus on supporting and caring for people at home in line with current clinical best evidence if they do not need an admission for acute medical care.

2.5.1 The **Specialised Therapy and Rapid Treatment Team (START)** based at the Whittington Hospital is a team of therapists working in the Emergency Department, Clinical Decision Unit, Acute Assessment Units and Ambulatory Care aims to work with key partners to prevent unnecessary admission to hospital.

The aim of the team is to screen all patients who require therapy intervention as part of a full MDT assessment within 12 hours of admission. The assessment will determine the needs of the person and if they can be supported to return home safely. Early therapy assessment and intervention can significantly reduce the time the person is in hospital for reducing the risk of decompensation and hospital acquired infection.

The team along with colleagues in the Emergency Department aim to identify frail patients who require comprehensive geriatric assessment as early as possible. Using the frailty pathway, patients can be directed to the most appropriate place to receive the assessment and intervention they require. Ideally this occurs in the Ambulatory Care Department where staff works closely with the Specialist Frailty Nurse or where a person's medical needs are such that they require admission the team can recommend transfer to a Care of Older People Specialist Ward.

From January to March 2018, winter health funding was provided for an Occupational Therapist to be based in the Emergency Department (ED). This post worked closely with the London Ambulance Service (LAS) to receive comprehensive handover of patients aged over 75. The aim was to provide rapid assessment for this client group who historically have long waits in A&E and are then more likely to be admitted to hospital. The results of the initial pilot were positive in terms of early decision making for patients requiring admission, reduced waiting time for frail elderly patients to be seen through better collaborative working with the ED staff, better direction of patients into ambulatory care, urgent care or towards the frailty pathway when appropriate, a higher number same day of discharges from the ED and reduced overall length of stay for some patients as issues were identified so much earlier creating additional bed capacity over this period. Moving forward it is hoped this post will be funded permanently with a Senior Occupational Therapist to build on the success of the pilot.

The START team work closely with the Virtual Ward service, Social Services and Reablement to support a person leaving the hospital and returning home with the right support. Equipment that is required to promote independence, maintain function or improve safely can be rapidly accessed through a loan provider or via local pharmacy's using a prescription system.

The team also includes a technician who can undertake further assessment in the home environment immediately post discharge, for example, to complete a home safety check, practice with new equipment in the home setting, assess for non-urgent equipment such as bathing aids or outdoor mobility equipment and make onward referrals to both statutory and voluntary sector services when required.

A social worker is linked to the team on weekdays to provide assistance and support with assessing the more complex patients who present for example with, a higher level need or safeguarding concerns. At the weekends the team link closely with the duty social worker based in EDT for the same purpose.

These initiatives are successfully minimising the time people spend in hospital, supporting them to remain as independent as possible and providing the support they need to remain in their own homes.

We have continued to progress the Discharge to Assess works both with our community and social service colleagues in Islington (and the in the wider NCL network). Hospital therapy staffs are now able to refer patients into one of 4 pathways depending on the patient requirements and this has become main stream as far as capacity within the pathways allows. We expect progression of these various pathways to continue in 2018/19 working closely with our community partners.

2.5.2 **Lead Nurse Clinical Standards, Quality & Assurance**

The work of the Lead Nurse for Clinical Standard, Quality and Assurance; a jointly funded post that sits in the Older Adults Commissioning Team within the Council, continues to improve the quality of care and clinical competency within the care homes, to prevent hospital admissions and to support reductions in hospital length of stay.

The Lead Nurse for Quality Assurance of care homes continues to support collaborative and partnership working into and across the homes. Focus remains:

- Further development of positive, collaborative working relationships;
- Monitoring the quality of care delivered;
- Bridging gaps in knowledge, ensuring that concerns with practice preventing good care are addressed proactively
- Engaging relevant professionals to build a systematic response that is implemented and sustained.

Currently, all Care Homes have permanent Home Managers in post and for the exception of one Home, clinical leads, this has enabled effective working relationship with the GP and the wider MDT to manage the increasingly frail and complex residents and support the sustainability of the training and input being provided into the homes. All homes are operating well except Lennox, which is going through a Provider Concern Process, which had resulted from lack of consistent/stable management and clinical leadership.

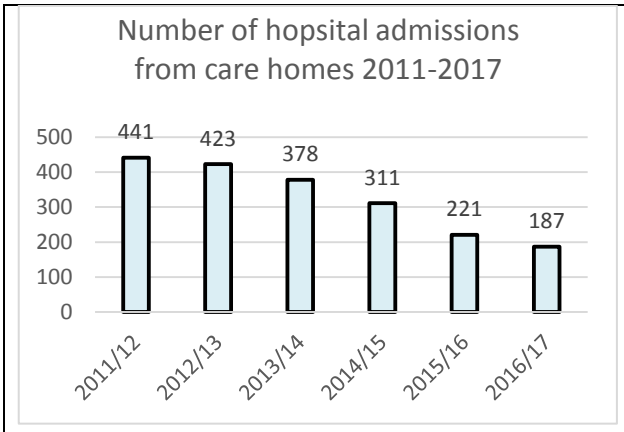
All care homes in Islington were inspected by the Care Quality Commission (CQC) over 2016/17. As noted above in Table 1, Bridgeside Lodge achieved the highest possible rating of ‘Outstanding’ from the CQC whereas Cheverton Lodge, St Anne’, Stacey St and Highbury New Park have maintained a ‘Good’ rating following their respective inspections.
In contrast two homes Muriel St and Lennox House operated by Care UK have been highlighted by the CQC as ‘Requiring improvement’.

It is increasingly apparent that the issues related to recruitment and retention of staff has impacted adversely on the knowledge and the skills required to provide care to

increasingly complex residents making the wider MDT (multi-disciplinary team) input a positive effort to support the care homes and prevent hospital admission.

Hospital admissions

The incidence of hospital admissions from cares homes***** as illustrated in **Figure 1** below continues to reduce in comparison to previous years.



Year	Numbers of hospital admissions	% difference on the previous year
2011/12	441	
2012/13	423	-4%
2013/14	378	-11%
2014/15	311	-18%
2015/16	221	-29%
2016/17	187	-15%

Figure 1: Incidence of hospital admissions [** *includes data from extra care sheltered housing schemes***]**

Islington care homes reported the majority of these admissions as unavoidable and due to significant changes in the resident's condition i.e., the resident became unwell and the outcome of the clinical assessment indicated the need for a hospital admission.

Where hospital admissions were deemed to be avoidable, treatment escalation plans were typically not in place or the home had been advised to convey the service user to hospital primarily by the out of hours GP service. Consequently, work is underway to ensure that the local GP and specialist palliative care nurses supporting the home implement comprehensive End of Life Care Planning (Advanced Care Plans- **ACP**) and Treatment Escalation Plans (**TEP**).

To support these mitigating actions, the Lead Nurse continues to support care home staff to develop the knowledge and skills required to meet care needs

Quality Improvement Initiatives

In support of safe and high quality of care, over time, a number of quality improvement initiatives have been implemented. These initiatives were developed in part to address gaps identified and to improve quality of care and improve the experience of residents in the homes and are noted.

They are supporting patient-centric pathway based approaches to education, improve workforce planning and support care home providers to develop a more skilled workforce that is able to meet the challenges of providing care to residents with complex health and social care needs. In addition to initiatives progressed in 2015/16, 2016/17 and onwards focus remain to prevent avoidable hospital admission.

The initiatives undertaken in 2017 include:-

Are You Concerned About a Resident Poster: The use of 111 systems and the

'*Are Your Concerned about a Resident*?' poster have been fully introduced. The poster highlighted provides service information and contact details to escalate clinical concerns both within and out of hours. It also provides clear directions for staff when to call out an ambulance. Within this context, staff are required to make reference to the Treatment Escalation Plan prior to ambulance call out and ensure that individual wishes are well represented in end of life care plans.

Training & Staff Development: The development of enhanced clinical skills e.g. management of syringe drivers and urinary catheterisation in an effort to arrest the need to admit residents for catheter change or use of syringe drivers. This includes, bespoke staff training for areas identified in action plans e.g. acute sector falls prevention and management training.

Red Bag Scheme: An integrated Care pathway to establish a Hospital Transfer Pathway 'Red bag' initiative pioneered by Sutton Vanguard has been rolled out between acute and care home settings.

The Red Bag is being used as part of the transfer process of residents being admitted to hospital from Islington care homes. The bag contains specific documentation with information to support clinical assessment; medical treatment and nursing care plan both for admission and discharge from hospital.

The implementation of the 'Red Bag' has enabled compliance with the NICE guidelines '*Transition between inpatient hospital settings and community or care home setting for adults with social care needs*'.

Quality Improvement Initiatives in 2018/2019

The focus in 2018/19 has been to ensure that care homes are featured in cross sector quality improvement initiatives. The primary aim is to empower and support the care homes to manage within the home, the increasingly complex needs of its service users, reducing the likelihood of hospital admission and contributing to reductions in length of stay and delayed discharge from hospital. The quality improvement initiatives underway for 2018/2019 include:

CPEN - Secondary Sector Training

Secondary sector training to deliver extended clinical skills in support of Advance Care Planning and Treatment Escalation Plan

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) – Pilot Project

In support of the care closer to home agenda, three Islington care homes (Bridgeside Lodge, Highbury New Park and Muriel Street are supporting the UCLP pilot of ReSPECT.

Delayed Transfers of Care (DTOC)

There remains an ongoing commitment to engage the care home providers in the various initiatives and projects designed to prevent unnecessary hospital admissions. Two care home managers have made successful applications to take part in the Capital Nurse Senior Leadership programme. Alongside the Lead Nurse, the home managers will be focussing their project on 'Care homes internal infrastructure which will in turn support the 'Trusted Assessor' and secondary sector care clinical training objectives.

Trusted Assessor
As a key aim described in Next Steps on the NHS five year forward view, there are plans to implement the 'Trusted Assessor' model to improve hospital discharges into care homes, reduce the numbers and waiting times of people awaiting discharge from hospital and help them to move from hospital back home or to another setting speedily, effectively and safely. Whilst care homes have fully supported 7 days' discharge for known residents, there is work underway to introduce the 'Trusted Assessor' initiative. The Lead Nurse has been working closely with the care homes to create a trusted assessor model suited to Islington. Work is underway to develop a protocol for assessments, documentation and measures through which concerns or issues arising could be addressed. The longer term aim is for homes to accept new placements on the basis of an assessment of clinical need made by the Trusted Assessor.

Capital Nurse
The Lead Nurse has been instrumental in engaging the care homes in the various Capital Nurse projects i.e., Cross Sector Senior Management Leadership Programme, the Carers to Nurses intensive programme and more recently, the Passport in Leadership programme.

These programmes aim to equip the care home manager with the skills to better influence integrated working across our health and social care sector. To date, the London Leadership Academy and Health Education England (HEE) has funded all costs.

Home Managers Clinical Care Improvement Group (HMCCIG)
The group set up in 2014 continues to meet bi-monthly and work collaboratively with the wider MDT i.e., SALT, Dietician, OT, Physiotherapist Team, Tissue Viability Nurses, Service for Ageing and Mental Health, District Nursing, and other relevant resources to both deliver and sustain clinical changes that have been implemented as well as those being proposed by specialist groups. The group remain the forum through which clinical concerns are highlighted, clinical improvement, Capital Nurse and national public health objectives e.g.: flu vaccination, wound formulary, care home move from the use of blister packs etc., have been progressed.

RADAR
The RADAR group was established to monitor the quality of care or service provided within the care homes and other care providers. The group continues to scrutinise areas of concern as well as engage the wider MDT and share intelligence. The group comprises operational and commissioning leads from both Health and Social Care including Safeguarding leads from the Council and CCG and key members of the Home Manager Clinical Care Improvement Group i.e., SaLT (Speech and Language Therapy). The Lead Nurse provides monthly updates on current potential clinical risks and concerns to the RADAR group and leads on the coordination of soft intelligence presented to the group.

This collaborative approach has ensured that safeguarding concerns or investigations following complaints or feedback from the wider MDT with a clinical practice component are addressed quickly and effectively.

3. Planned developments

3.1 Developing the locality-based model with GPs

With the progression of the Care Closer to Home Integrated Network (CHIN's) model, there will be a reconfiguration of the Networks to be implemented from September 2018. This will see the current 12 Networks reduce to 3 Networks. The new formation will ensure that the Integrated Networks are better aligned to the boundaries of the CHIN's. The new structure will also allow standardisation of Networks in terms of population size. The Integrated Network Coordination (INC) Admin Service will be central to the implementation and delivery of this change.

Over the next year, the INC admin service will support a research project to evaluate the outcomes of the multi-disciplinary working via the Integrated Networks.

The INC admin team continue to provide a teleconference service for adults and children. Over the coming months, the team will work alongside colleagues to develop the children's teleconferences to increase participation, appropriate use and outcomes for children and young people.

3.2 Discharge to assess

Upcoming priorities for delivery

Working with partners across NCL, and Haringey in particular scaling up the work to date on discharge to assess is going to be a key priority for 2018/19.

In January, the Haringey and Islington Health and Wellbeing Sponsor agreed the following vision for Intermediate Care across the two boroughs;

- A much simpler system with a single point of access that can be accessed regardless of location
- Combined with changes to the discharge pathways, to work on a 'home first whenever possible' basis and have an emphasis on preventing people being unnecessarily admitted to hospital and increasing independence
- Community urgent response and intermediate care teams will support out of hospital services to quickly tailor the level of support, in response to changing level of need of the person

The following components have been set out to deliver this vision;

- Co-located single access point and triage point for all clients requiring home based or bed based intermediate care/rapid response services
- One flexible team providing home based rapid response and bed based or home based rehab/reablement including nursing, therapies and social care/reablement elements
- Integrated staffing and management structure across both Haringey & Islington.
- Service is potentially co-located
- One operational budget for intermediate care (long-term aim)
- Same IT system (longer-term aim)

Workshops are taking place in June/July 2018 to further develop this programme of work and establish timescales for implementation.

4. Conclusion

The strong partnership working between Islington Social Services and the health services within Whittington Health NHS Trust continues to move in a positive direction. Ongoing work such as Discharge to Assess will further develop local and locality services that are truly 'joined up' and delivered in a way that offers integrated care and support, to the benefit of Islington residents.

It is important to preserve the benefits of integrated working, and to use the opportunities to develop further integration of front-line teams over the coming year, as this will provide a better coordinated service to vulnerable people, and ensures that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

Carole MacGregor, Head of Islington Community Rehabilitation Service

Paul Attwal, Director of Operations, Integrated Medicine

June 2018

Meeting title	**Trust Board – public meeting**	**Date: 19.12.2018**
Report title	**Board Assurance Framework (BAF)**	**Agenda item: 13**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs and respective executive director risk leads	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	Board members are presented with an updated version of the Board Assurance Framework following review by the Audit and Risk Committee on 28 November 2018. Minor changes have been incorporated for scoring and wording, especially the inclusion of first, second and third line assurances following feedback at the Audit and Risk Committee. The version of the BAF that was seen by ARC included risk 10 about potential financial risks relating to tariff changes. Following assurances from commissioners, the risk owner has reviewed this and downgraded the likelihood and impact such that it is now felt not to warrant inclusion on the BAF and therefore has been removed.	
Purpose:	Review, discussion and approval	
Recommendation(s)	Board members are asked to: i. receive and discuss the updated BAF; ii. review risk controls and assurances and scores; and iii. approve the BAF and agree that effective actions are being taken to mitigate the identified risks to delivery of the trust's strategic objectives.	
Risk Register or Board Assurance Framework	All BAF entries and linked entries on the corporate risk register	
Report history	28.11.2018 Audit and Risk Committe 27.11.2018 Trust Management Group meeting 19.11.2018 Executive team meeting	
Appendices	Appendix 1: Board Assurance Framework	

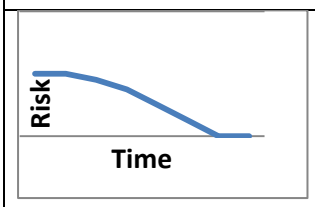
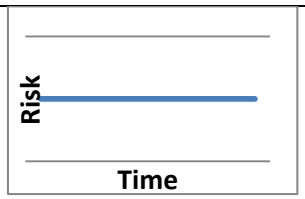
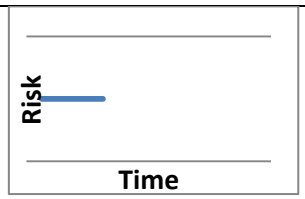
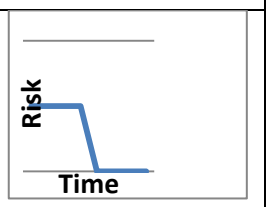
Appendix 1: Board Assurance Framework (BAF) as at December 2018

Risk Scoring Matrix					
	Likelihood				
Consequence	1: Very Unlikely	2: Unlikely	3: Likely	4: Very Likely	5: Almost Certain
1: Negligible	1	2	3	4	5
2: Minor	2	4	6	8	10
3: Moderate	3	6	9	12	15
4: Major	4	8	12	16	20
5: Catastrophic	5	10	15	20	25

Summary of principal BAF risks:

Risk ID	Risk description	Current score	Risk appetite score / target score	Change since Q2
2	Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service, Breast, Bariatrics).	8	8	↔
3	Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department, community etc.)	16	6	↕
4	Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. Nursing, junior doctors, medical posts)	12	8	↔
5	Failure to deliver savings plan for 2018/19 leads to adverse financial position, not hitting control total, loss of STF and reputational risk	20	10	↕
9	That the long term financial viability of the trust is threatened by changes to the environment, long term plan, social care	8	6	↔

Risk ID	Risk description	Current score	Risk appetite score / target score	Change since Q2
	risks, political changes, organisational form changes			
14	Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.	12	4	↔
15	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience	12	6	↔
16	Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised	9	9	↔
17	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result	9	4	new risk

Approaches to risk: (What are the four ways in which we could choose to manage risk?)			
Treat	**Tolerate**	**Transfer**	**Terminate**
			

Risk ID:	2
Risk	**Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service (LUTS, Breast, Bariatrics).**

CQC Domain	Effective; Responsive ; Safe
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	Deliver consistent high quality safe services
Board Lead	Medical Director
Risk register codes	w32973 Steis 2015 33773 Surgery ICSU

Risk scores	
Initial risk score:	4 x 4 =16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite / target score	2 x 4 = 8 (terminate)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
LUTS: One-handed consultant. We have made a joint appointment with UCLH. We have an agreed service specification with the commissioners. Associate medical directors attend MDT. Breast: Small team leads to risk of decommissioning. Joint working with UCLH to create a joint MDT. Bariatrics: lack of medical service may lead to surgical service losing referrals. Integrated Clinical Service Unit (ICSU) is creating a business case for tier three	2nd tier - LUTS: Regular meeting with the commissioners on delivery of service specification. New protocols going through Drugs and Therapeutics committee. Meeting in February with new clinician to confirm new protocol proposals. 1st tier - Breast: 2 monthly partnership board with UCLH to track progress. 1st tier - Bariatrics: progress of business case reported to ICSU board

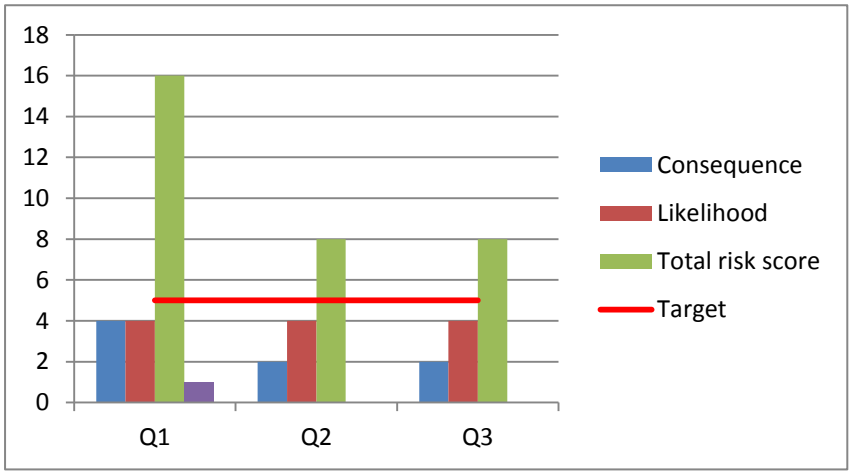
Gaps in controls & assurances: (What additional controls and assurances should we seek?)

- LUTS: We are considering a second joint appointment with UCLH
- Further review of other fragile services to be undertaken in next few months.

Mitigating action(s)	Lead Assurance Committee	Deadline
Ongoing regular review and update of the action plan.	Executive Team Trust Board	In place and ongoing

Actions complete:
• Appointment of LUTs Consultant

Risk score trajectory



Risk ID:	3
Risk	**Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department (ED), community etc.)**

CQC Domain	Effective; Responsive; Well-led
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	Deliver consistent high quality safe services
Board Lead	Chief Operating Officer
Risk register codes	683

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	4 x 4 = 16
Risk appetite / target score	2 x 3 = 6 (treat)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Robust performance management • Embedding and monitoring ED improvement plan including workforce plan • Embedding and monitoring length of stay and Delayed Transfers of Care reductions and the SAFER bundle	• 1st tier - ICSU improvement group • 1st tier - Community services improvement group Monthly performance reports to Trust Management Group (1st tier) and Trust Board (2nd tier) • 2nd tier - Serious Incident reports to Trust Board • 2nd tier Monthly A&E Delivery Board (AEDB) 'touch in'

Gaps in controls & assurances: (What additional controls and assurances should we seek?)
• ED trajectory not met for Q1 or Q2

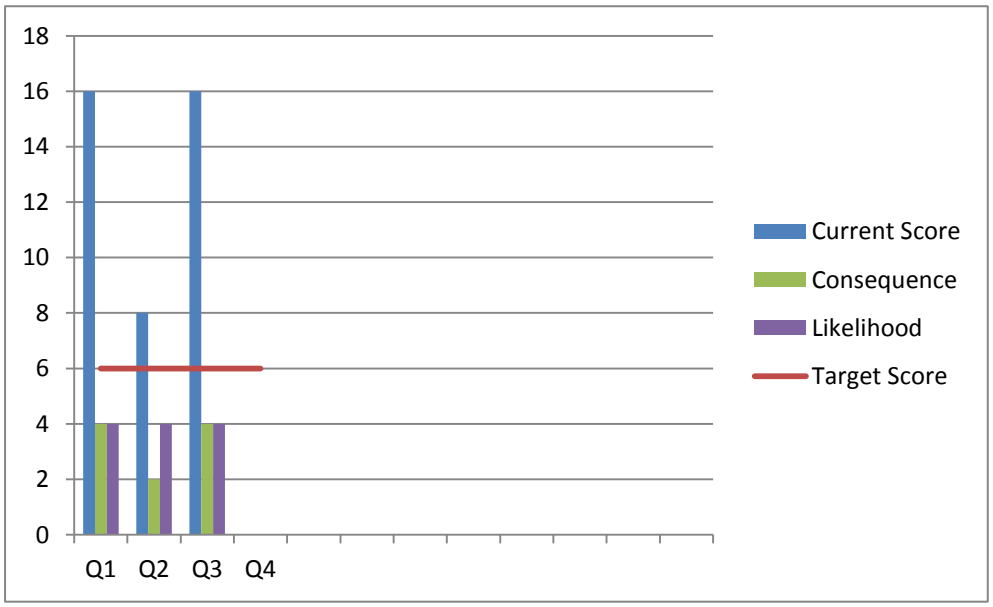
Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
GAP analysis against NHSI Improvement Resource Guide – reducing long hospital stays	ICSU performance reviews	In place and ongoing
Oversight of whole system improvement plan.	Trust Operational meetings AEDB	In place and ongoing
Ongoing recruitment of consultants for Emergency Department	Trust Management Group/ICSU Board	In place and ongoing
Bed management and escalation policies all in place	Trust Management Group	In place and ongoing

Mitigating action(s)	Lead Assurance Committee	Deadline
SAFER bundle, MADE (biweekly), discharge to assess (D2A) in place	AEDB ICSU Improvement Group	In place and ongoing
Emergency Care Improvement Programme support – focus on first 60 minutes and out of hours	ICSU Board TMG AEDB	In place – report end of December 2018

Actions completed

- Biweekly MADE events which have been a significant impact on superstranded patients
- Progressing workforce changes – consultant extended working. Extended working D2A fully embedded
- Super week 15/07/18 to embed key front of house initiatives
- Robust reporting and escalation in place.

Risk score trajectory



Risk ID:	4
Risk	**Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. nursing, junior doctors, medical posts).**

CQC Domain	Well-led
CQC Outcomes	Requirements relating to workers; staffing; supporting workers
Corporate Objective	To recruit and retain high quality engaged staff
Board Lead	Director of Workforce
Risk register codes	693, 859, 797, 868

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	4 x 3 = 12
Current risk score	4 x 3 = 12
Risk appetite / target score	4 x 2 = 8 (treat)
Date last reviewed	December 2018

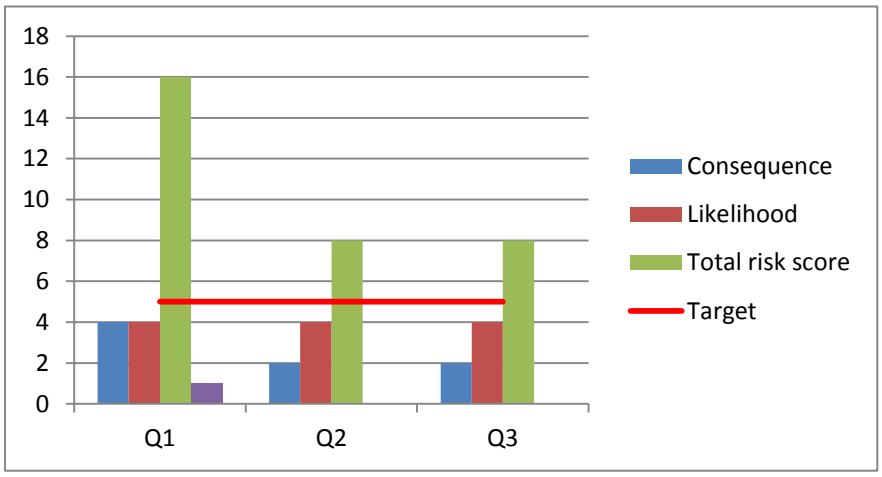
Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Recruitment and retention strategy and updated action plan for 2018-19 in place • Safe staffing reports (nursing staff) and exception reports (junior doctors) • Staff survey action plans ("we said….we did") • International recruitment successful • Nurse recruitment team in place • Continued tracking of agency spend • Continued tracking of appraisal rates • Revised exit interview process • Listening events following culture review • Workforce Race Equality Standard improvement plan agreed by Trust Management Group and due for Board consideration in December 2018	• 1st tier - weekly Vacancy Scrutiny Panel • 1st tier - monthly nursing, midwifery and Allied Health Professionals' recruitment meeting • 1st tier – monthly nurse recruitment tracker and update to Executive Team • 1st tier - weekly temporary staff utilisation tracker by Executive Team • 1st tier – ICSU level workforce indicators explored at quarterly Performance review Group meetings • 2nd tier - Workforce Assurance Committee • 3rd tier – recruitment and retention indicators on performance dashboard presented monthly to Trust Board

Gaps in controls & assurances: (What additional controls and assurances should we seek?)
•

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Engagement across North Central London and with Capital Nurse to tackle retention issues, including rotation, career management, over 55s work programme.	Trust Management Group	In place and ongoing
Development of nursing retention strategy	NMEC/ Trust Management Group	To be confirmed

Actions completed:
• Regular recruitment days held including some international recruitment • New bank rates agreed • Director input into overseas recruitment • Calendar of recruitment events • Exit interviews conducted • Started to bring overseas recruits into post • Updated and annual plan for recruitment and retention strategy

Risk score trajectory



Risk ID:	5
Risk	**Failure to deliver savings plan year on year leads to adverse financial position, not hitting control total, loss of Provider Sustainability Funding and reputational risk**

CQC Domain	Well-led
CQC Outcomes	Financial position
Corporate Objective	To delivery efficient and financially sustainable services
Board Lead	Chief Operating Officer
Risk register codes	784,780,880,723,772

Risk scores	
Initial risk score:	4 x 5 = 20
Previous risk score	4 x 5 = 20
Current risk score	4 x 5 = 20
Risk appetite / target score	2 x 5 = 10 (treat)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• PMO in place • Quarterly performance reviews • Monthly Cost Improvement Programme (CIP) delivery board • Joint Programme Management Office (PMO)/Finance CIP tracker • ICSU deep dives at Finance & Business Development Committee • Quality Impact Assessment process in place	• 1st tier – weekly updates to executive team • 1st tier – monthly reports to Trust Management Group • 2nd tier - Finance and Business Development Committee • 3rd tier - Internal audit reports and recommendations

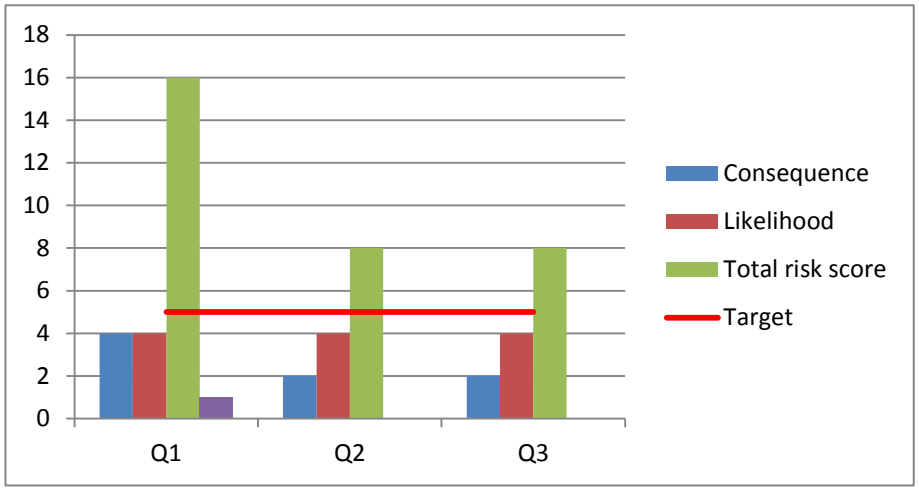
Gaps in controls & assurances: what additional controls and assurances should we seek?
• More robust plans required to address unidentified CIP • More traction with ICSUs required for transformation schemes

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Close monitoring of activity in Surgery and Cancer	TMG	Started in Sept

Actions completed:
• Monitoring and governance in place • Weekly check–ins with management accounts • Monthly CIP delivery board • Senior Finance Support for the PMO

Actions completed:
• Outpatient Transformation Project – BCG appointment made • Pathology proof of concept with NWLP April-Dec18 • Each ICSU identified 2% saving – PMO support where required • CIP delivery dashboard developed

Risk score trajectory



Risk ID	9
Risk	**That the long term viability of the trust is threatened by changes to the environment long term plan, social care risks, political changes, organisational form changes**

CQC Domain	Well-led
CQC Outcomes	Care & welfare of people who use services; effective collaboration with other providers
Corporate objective	Further develop and expand our partnership and engagement
Board Lead	Director of Strategy
Risk register codes	

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite / target score	2 x 3 = 6 (treat)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Close liaison with the councils and driving integrated care ourselves will help increase our influence and reduce the risk • Revising the long term strategy and plans after publication of the Long term plan will help us be flexible in our response • Engagement with NCL STP process • Clinical collaboration with UCLH and NMUH and councils and GP federations	• 1st tier - Trust Management Group • 2nd tier - Trust Board • 2nd tier - NCL Strategy Directors Group • 2nd tier - UCLH and WH Clinical Collaboration Board • 2nd tier – monthly meeting with GP Federations • 3rd tier - Health and Wellbeing Partnership Sponsor Board • 3rd tier – NHS Improvement oversight meetings • 3rd tier – Joint Overview and Scrutiny Committees

Gaps in controls & assurances: what additional controls and assurances should we seek?
• Public engagement not fully developed.

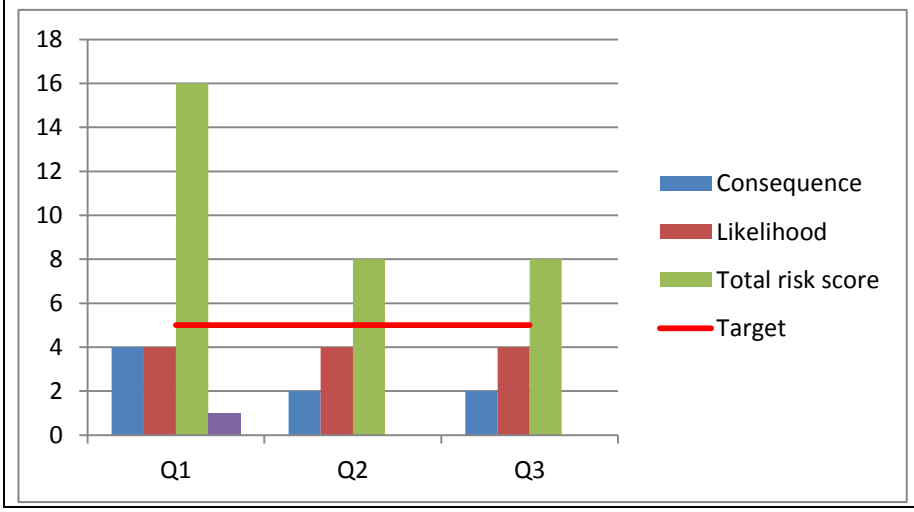
Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Progress the work Haringey and Islington	Trust Board	In place and

Mitigating action(s)	Lead Assurance Committee	Deadline
Wellbeing partnership	H&I WB Partnership Sponsor Board	ongoing
Engage Fully with primary care	Trust Board Trust Management Group	In place and ongoing
Review ICSU business plans re integrated care And Care Closer to Home	Trust Board	In place and ongoing
Build integration at all levels into the core of how we do business	Trust Management Group	Ongoing

Assurance progress:

- Joint governance in place and Programme Director for Haringey and Islington Wellbeing Partnership in place.
- Community improvement project underway jointly chaired by partnership and WH COO.

Risk score trajectory



Risk ID	14
Risk	**Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk**

CQC Domain	Caring ; Effective; Responsive; Well-led
CQC Outcomes	Care and welfare of people who use services
Corporate objective	Deliver quality patient safety and patient experience
Board Lead	Chief Operating Officer
Risk register codes	683

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	3 x 4 = 12
Current risk score	3 x 4 = 12
Risk appetite / target score	2 x 2 = 4 (treat)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Emergency Care Improvement Programme review identified areas of improvement and action plan in place • Working with Camden & Islington NHSFT to improve pathways including optimisation of mental health recovery suite • Embed recommendations from the Veritas report and other identified improvements, working collaboratively with Camden & Islington NHSFT • North Central London- wide review of liaison services	• 1st tier – Trust Management Group • 2nd tier - A&E Delivery Board • 2nd tier - ILAT contract meeting • 2nd tier - Quality Committee

Gaps in controls & assurances: what additional controls and assurances should we seek?
• Shortage of mental health beds and resultant delays for mental health patients in ED

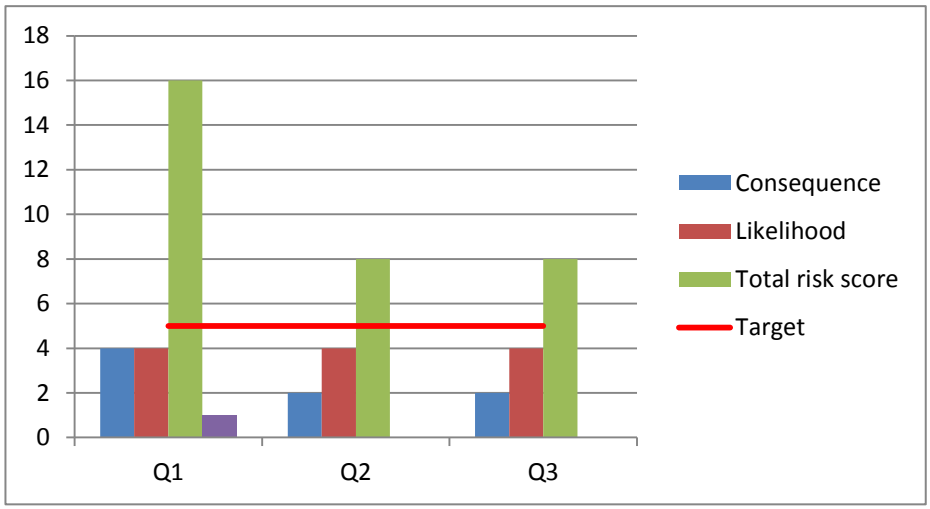
Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
C&I and ED operational meeting to address key operational issues	ICSU performance reviews	In place and ongoing
Oversight of mental health waits at AEOB	AEDB	In place and ongoing

Quarterly contract meetings – to include risks, safety issues and performance metrics	Trust Board	In place and ongoing

Assurance progress:

- Implement new service model – mental health suite (from May 2018) – weekly operational meeting to monitor patient flow to the suite
- External review of mental health pathway and learning from recent incidents - Completed
- CEO chair of AEDB
- Monitor and review mental health suite model.
- Audit of quality checks in Emergency Department

Risk score trajectory



Risk ID	15
Risk	**Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience**

CQC Domain	Safe
CQC Outcomes 4	Care & welfare of people who use services; safety and suitability of premises
Corporate objective	Deliver quality patient safety and patient experience
Board Lead	Chief Financial Officer
Risk register codes	91, 697, 817, 680, 820, 807, 750, 746

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	3 x 4 = 12
Current risk score	2 x 4 = 8
Risk appetite	2 x 2 = 4 (tolerate)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Capital programme addresses all red risks. • Development of an estates development plan	• 2nd tier – Trust Board • 2nd tier – Finance & Business Development Committee

Gaps in controls & assurances: what additional controls and assurances should we seek?

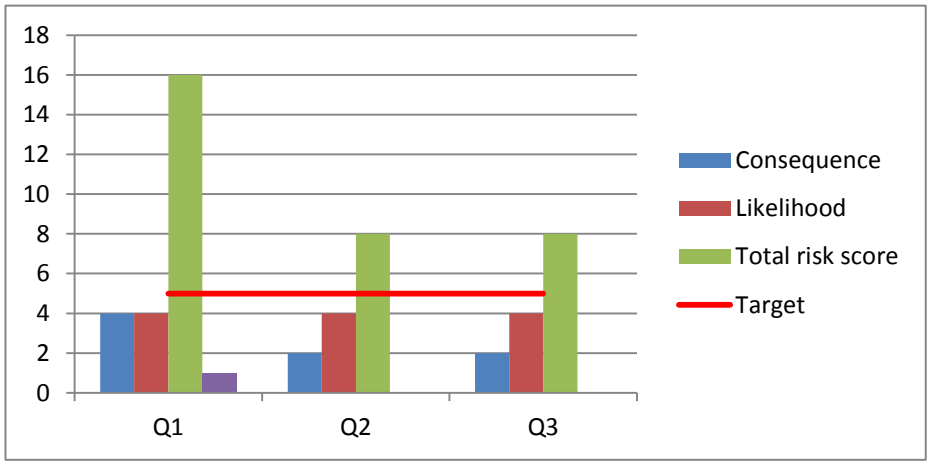
- Signed off estates development plan

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Ensure capital plan addresses all red risks	Capital monitoring Finance & Business Development Committee	in place
Board Committee established	Trust Board	in place
Stakeholder engagement and public engagement strategy to support estates development plan.	Trust Board	Sept 2018

Assurance progress:

- Contractor appointed and project underway
- GLA MOU in place which has been well-received by stakeholders and press
- Clinical engagement in defining services of the future is underway

Risk score trajectory



Risk ID	16
Risk	**Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised**

CQC Domain	Safe; Well-led
CQC Outcomes 4	Care & welfare of people who use services
Corporate objective	Deliver quality patient safety and patient experience
Board Lead	Chief Financial Officer
Risk register codes	796

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	3 x 3 = 9
Risk appetite / target score	3 x 3 = 9 (tolerate)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Ongoing regular patching programme embedded in Emergency Planning Procedures • Investment plans in infrastructure - capital programme • Pro-active replacement and refresh of hardware • CIO & CNIO in place to provide clinical leadership • Engagement with national action systems	• 1st tier - Capital Monitoring Group • 1st tier - ICSU quarterly performance • 1st tier - Information Governance Committee • 1st tier – Trust Management Group • 2nd tier - Audit and Risk Committee

Gaps in controls & assurances: what additional controls and assurances should we seek?
• Contract management - Some equipment suppliers not providing adequate patching • Ongoing external/peer audit support to develop and review plans

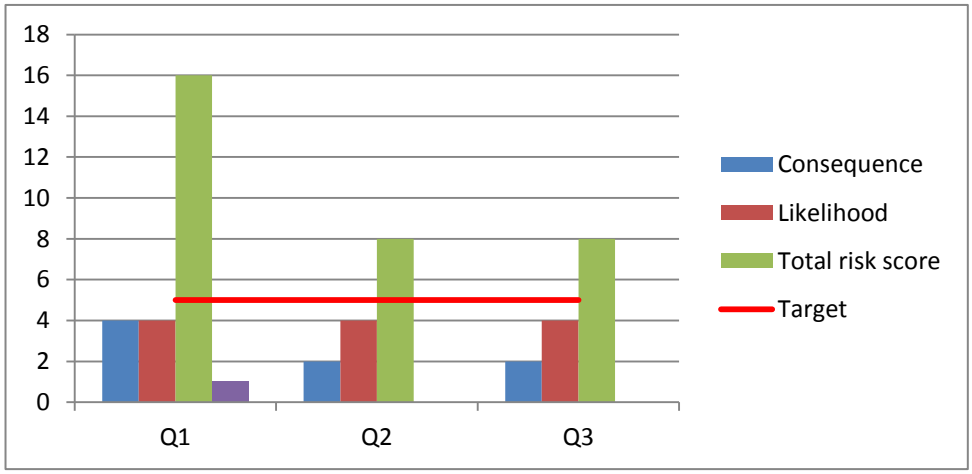
Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Delivery of digital strategy-fast follower exemplar programme	Trust Management Group Finance& Business Development Committee	Started April2018
Continue to network with other Trusts to	ICSU Leadership	In place and

Mitigating action(s)	Lead Assurance Committee	Deadline
ensure shared learning		ongoing
Escalation protocol across NCL	Trust Management Group	Autumn 2018
Contract Management – hold suppliers to account	Trust Management Group	Ongoing

Assurance progress:
• Trust board have undergone cyber security training. • Investment in the latest technologies to strengthen cyber security. • Monthly patches rolled out across the organisation to mitigate vulnerabilities. • Engagement with national teams on Advanced Threat Protection capability.

Additional comments on performance trajectory:

Risk score trajectory



Risk ID	17
Risk	**That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result**

CQC Domain	Safe; Well-led
CQC Outcomes 4	Requirements relating to workers; supporting workers
Corporate objective	Develop and support our people and teams
Board Lead	Director of Workforce

Risk scores	
Initial risk score:	3 x 3 = 9
Previous risk score	New risk from November 2018
Current risk score	3 x 3 = 9
Risk appetite / target score	2 x 2 = 4 (terminate)
Date last reviewed	December 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
• Staff focussed September • Culture survey listening events	• 1st tier – Trust Management Group • 2nd tier - Workforce Assurance Committee

Gaps in controls & assurances: what additional controls and assurances should we seek?
• Action plan resulting from listening events in development

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Action plan due to be discussed at 27.11.18 Trust Management Group meeting	Workforce Assurance Committee	January 2019 for Trust Board

Assurance progress:
• Rich feedback from listening events has helped identify key areas for action

Risk score trajectory