Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
27 February 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**27 February 2019: 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	1425	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal
3	1428	**Declaration of conflicts of Interest** *Steve Hitchins, Chair*	Verbal
4	1430	**30 January 2019 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1435	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
6	1445	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review

Item	Timing	Title and lead	Action
Quality & patient safety			
7	1455	**Serious Incidents – January 2019** *Dr Julie Andrews, Acting Medical Director*	Review
8	1510	**Integrated Safeguarding bi-annual report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
9	1520	**Staff member story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
10	1540	**Whittington Health culture improvement plan** *Norma French, Director of Workforce*	Approval
11	1605	**Patient Experience Strategy** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Approval
12	1615	**Care Quality Commission compliance update** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
Operational performance and planning			
13	1625	**Performance dashboard – January 2019** *Carol Gillen, Chief Operating Officer*	Review
14	1640	**Financial performance – January 2019** *Stephen Bloomer, Chief Financial Officer*	Review
Governance			
15	1655	**Questions from the public on meeting items** *Steve Hitchins, Chair*	Verbal
16	1700	**Any other business** *Steve Hitchins, Chair*	Verbal

Minutes of Board of Directors of Whittington Health NHS Trust's meeting held in public on Wednesday, 30 January 2019

Present:

Steve Hitchins	Chairman
Julie Andrews	Acting Medical Director
Stephen Bloomer	Chief Finance Officer
Professor Naomi Fulop	Non-Executive Director
Carol Gillen	Chief Operating Officer
Deborah Harris-Ugbomah	Non-Executive Director (items 1-17)
Siobhan Harrington	Chief Executive
Michelle Johnson	Chief Nurse and Director of Patient Experience
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Janet Burgess MBE	Councillor and Executive Member for Health & Social Care & Deputy Leader, London Borough of Islington
Norma French	Director of Workforce
Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
Kate Green	PA to Director of Workforce (items 1-13)
Sarah Humphery	Medical Director, Integrated Care
Swarnjit Singh	Trust Corporate Secretary

1.	**Patient story**
1.1	Board members welcomed James Connell along with Emmeline Closier, David Mclean and Sharon Pilditch. Michelle Johnson informed the Board that that the patient story item would take the form of a short film which, in her view, demonstrated exemplary care being delivered and which should be shared throughout the organisation.
1.2	The film concerned the story of Justine Howe who as a patient had visited her GP, suffering with persistent leg pain. Justine was referred to physiotherapy services and had been given steroid injections, which provided some temporary relief but did not resolve the problem. Finally, it became clear that the only option was for her to have a total hip replacement and Justine was referred to the orthopaedic team.
1.3	Prior to her operation, Justine had been given an appointment to visit the Trust's 'joint school' (known also as enhanced recovery). There, she heard a great deal more about the procedure she was to undergo, and stated that she felt well informed, as well as having had the opportunity to meet the whole team; ward sister, the pain team, physiotherapy, occupational therapy and other patients. There was also an opportunity to look round the ward.
1.4	Justine explained that, after the procedure, she had recovered well. She also felt that her attendance at the 'joint school' had prepared her well for what would be expected post-operation, i.e. to get out of bed on the first day, to

	exercise – in short to help her own recovery by following the advice given, as well as ensuring she was fit and well beforehand. In response to a question put to her by James Connell, she said that she would have liked to have known about the 'joint school' earlier in the process. She also wondered about access for those patients for whom English was not their first language or with a disability.
1.5	Justine recounted that the nursing care on Thorogood ward was excellent, with all her needs well-catered for, and all her questions answered. She explained that she stayed on the ward for less than 48 hours, but arrangements for her discharge were exceptional and had included the provision of an information pack which the staff nurse had gone through with her and which included details about the risk of deep vein thrombosis. She had also been given the telephone number of Siobhan Mellett, Specialist Nurse, and was very grateful to receive a call from Siobhan after she had been at home for 24 hours asking her how she was and whether there was anything she needed.
1.6	During discussion, the following points arose: • Norma French enquired about the frequency of the 'joint school', and was told this ran weekly on the ward. Sharon Pilditch added that the team was looking at the patient pathway to see whether there was any mileage in running sessions earlier. David Mclean mentioned the work undertaken in America providing this for day case patients • Deborah Harris-Ugbomah asked about research (currently undertaken by multi-disciplinary teams from specialist centres) and spoke about the benefits of research involving the Trust's nursing staff and reputational opportunities. Michelle Johnson agreed, adding that, Colette Datt, Nurse Consultant in Children and Young People's Services, had just been appointed as a Clinical Fellow with a remit to extend research opportunities in nursing • Julie Andrews reported that she was hugely impressed at the range and breadth of research activity undertaken in the Trust • Referring back to Justine's story, Siobhan asked the team what measures were taken to make services accessible for those whose first language was not English, or patients with disabilities. David Mclean informed Board members that patients were encouraged to bring a family member or friend with them to the 'joint school', but acknowledged that this did sometimes present problems. He provided assurance that work was taking place to make information available outside the 'joint school' sessions, e.g. via the internet. Sharon Pilditch added that one-to-one sessions were made available for patients requiring special adjustments, and these could be conducted at a venue best-suited to the needs of the individual • Julie Andrews mentioned the positive feedback received from the 'Getting it Right First Time' team, adding that, when on visits to other organisations, she was often asked how Whittington Health had achieved its success in this field • Deborah Harris-Ugbomah enquired about preparation for discharge in

	terms of pain and mobility. David Mclean replied that this was thoroughly covered in 'joint school' and explained that preparation for pain in practice often went some way towards alleviating it, though patients with severe pain or discomfort did stay in hospital for longer
1.7	**The Board welcomed the patient story presentation and thanked the following members of the team for attending:** • Emmeline Closier , Senior Practice Development Nurse, Surgery & Cancer • James Connell, Patient Experience Manager • David Mclean, Orthopaedic Therapy Team Lead, MSK Physiotherapy • Sharon Pilditch, Inpatient Matron, Surgery and Cancer
2.	**Welcome and Introductions**
2.1	Steve Hitchins welcomed everyone to the meeting. He informed Board colleagues that the London Borough of Haringey had appointed a new cabinet member for Health & Social Care, Sarah James, who hoped to be able to attend Whittington Health's Board meetings, in future.
2.2	Apologies for absence were received from Tony Rice, Non-Executive Director.
3.	**Declaration of conflicts of interest**
3.1	No Board member declared any conflicts of interest for any of the items on the agenda for that afternoon's meeting.
4.	**Minutes, matters arising & action log**
4.1	Subject to the following amendment, the minutes of the public Board meeting held on 19 December 2018 were approved as a correct record: • section 6.4: add "-Ugbomah" after "Harris"
4.2	As a matter arising not covered by a substantive agenda item, in section 12.2, it was clarified that services would be provided from one integrated locality and then spread further.
4.3	Board members reviewed the updated action log and highlighted the following: • Naomi Fulop asked that the learning from the patient story at the December 2018 Board meeting be shared with the patient and the report circulated to Board members • Steve Hitchins asked that the workforce culture action plan be considered at the February Board seminar, prior to the Board meeting • Siobhan Harrington reported that she had also met with Professor Michael West this week to reflect on the culture work being undertaken and was pleased to confirm that Professor West had agreed to hold a staff event on this subject

5.	**Chairman's report**

5.1	Steve Hitchins delivered a verbal report and drew attention to the following:
	
	• he had recently acted as the independent assessor on the interview panel for the new Chair of Homerton University Hospital NHS Foundation Trust. He also informed the Board that Baroness Julia Neuberger had been appointed as the new Chair of University College London Hospitals NHS Foundation Trust
	• since the December 2018 Board meeting, he had visited the following services:
	  o the Central Islington District Nursing Team at the Goodinge Heath Centre
	  o the Social Communication Team at the Northern Health Centre
	  o Eddington and Victoria Wards
	  o the Michael Palin Centre
	  o the leg ulcer team at Lordship Lane
	• on 29 January, he had been pleased to welcome Sir Thomas Hughes-Hallett to the Trust to promote volunteering in the NHS
	• on 21 January, he attended a NHS Workforce Race Equality Standard (WRES) workshop where Yvonne Coghill OBE delivered the keynote speech
	• on 17 January, he had also attended the launch event of the staff inclusion network, attended by Joan Saddler OBE
	• he had engaged in discussions with Alex Bax of the charity, Pathways, which offered support to the homeless, saying that there were plans to hold a Grand Round to generate interest across the Trust. He had recently been briefed by Dr Restrick on the issue of patients made homeless during their hospital admissions
	• looking ahead, he was committed to participating in the following events:
	  o the annual remembrance event for children who had died before reaching their first birthday in 2018
	  o the visit by the Chief of Medical Services in the British Army regarding the armed forces covenant
	  o Whittington Health's annual cancer conference on 8th February, which he urged all Board members to attend
	  o A meeting with NHS Improvement's Chair, Dido Harding

5.2	**Board members received the Chairman's verbal report.**
6.	**Chief Executive's report**
6.1	Siobhan Harrington highlighted the following: • She briefed Board colleagues on the launch of the NHS's long term plan and explained that that Whittington Health's ethos and mission statement were reflected throughout the plan's aspirations. She drew particular attention to the workforce section on the retention and recruitment of staff and the emphasis on compassionate leadership • The 2019/20 operational planning and contracts' guidance was

	published on 10 January, and the Trust met its deadline for completion of the first submission on 14 January • The Care Quality Commission had appointed a new Chief Inspector for primary and integrated care, Rosie Benneyworth, whom she had met • Turning to quality and safety issues within the Trust, winter pressures were being experienced through high levels of demand. Emergency Department attendance in December 2018 was 6% higher than for the same time the previous year • As yet, the hospital had not seen any outbreaks of influenza. It was noted, however, that the greatest pressure experienced the previous year was during the February 2018 half-term period • Cancer targets were achieved in December 2018 • The Trust had reported a never event concerning a wrong site surgical procedure, learning from which had been shared across the organisation, with the key message being the Royal College of Anaesthetist's 'Stop Before you Block' reminder • Trust finances were broadly on plan, with a current focus on reducing pay expenditure.
6.2	During discussion, the following issues arose: • Jonathan Gardner was leading the Trust's work with local authorities on designing a prototype for services in North Islington and North Tottenham, and a successful simulation event had been held the previous week. At the same time and very much in line with these developments, the Trust was updating and refining its own clinical strategy. This was currently out for consultation through an organisation-wide survey prior to its circulation to external stakeholders. A revised strategy would be brought back to the Board in March • work on the Trust's estates strategy was also proceeding, with the objective being to gauge what the Trust's environment might look like in 5-10 years' time. Further engagement work on this would take place over the next few months • Siobhan Harrington referred to the staff inclusion network and WRES workshop mentioned by the Chairman in his report. She explained that outputs from the latter event were currently being collated, and was pleased to report that Yvonne Coghill OBE had agreed to return to the Trust on a quarterly basis to hold learning events for staff • Siobhan Harrington was particularly pleased that 48.5% of staff had responded to the annual staff survey, the highest response rate ever achieved by the Trust. Norma French confirmed that the survey results and an action plan would be brought to the March 2019 Board meeting. Siobhan Harrington congratulated the Organisational Development team on this achievement • Siobhan Harrington also expressed her thanks to Cathy Ferguson and her team for having achieved such a high take-up rate amongst staff for the 'flu vaccination – as of that day, 80.8% and the second highest

	in London • Lee Smith, Emergency Planning Officer, was also thanked for his work to help the Trust achieve full compliance with emergency preparedness requirements
6.3	Janet Burgess asked what update she might provide to London Borough of Islington colleagues on the estates' work. Siobhan Harrington replied that the Trust would welcome feedback on both the estates plan and also on the revised clinical strategy. In respect of the timetable for engagement on the estates strategy, Stephen Bloomer clarified that engagement with external stakeholders was expected to take place in April and May 2019. He added that with the sale of land to Camden & Islington NHS Foundation Trust was proceeding according to plan
6.4	**The Board received and reviewed the Chief Executive's report and congratulated the staff team for the successful flu vaccination rate of 80% achieved, so far.**
7.	**Serious Incident (SI) report**
7.1	Julie Andrews reported that a further two SIs were reported during this period: one was the never event about which the Board had been briefed at its December meeting; and, the second SI concerned a new-born baby's unexpected admission to the neonatal intensive care unit. This brought the total of SIs declared during 2018/19 to 29, a figure not dissimilar to that declared at this point in the previous year.
7.2	Julie Andrews provided assurance that work focused on tightening up and improving processes and she was pleased to report that the average time taken for the completion of investigation reports had improved. She also reported that there was widespread learning both Trust-wide and within Integrated Clinical Service Units (ICSU), including a variety of events and communications. Jonathan Gardner added that the Communications team was looking at how best to refresh the intranet pages to share not only the learning from SIs, but also lessons identified from resolutions and claims.
7.3	In addition, Julie Andrews informed the Board that investigations into SIs for mental health patients were being conducted jointly with Camden & Islington NHS Foundation Trust.
7.4	**The Board reviewed the report and was assured it demonstrated that the SI process was managed effectively and that lessons learnt as a result of SIs were being shared widely across the organisation.**
8.	**Quarter three Safety and Quality report**
8.1	Julie Andrews introduced the quarter three quality and safety report (October to December 2018) and reported that she chaired the Patient Safety Committee and routinely attended the Quality Committee. She confirmed that there had been a continued rise in the summary hospital level mortality indicator (SHMI) and work was in hand to understand the reasons for this and to provide assurance.

8.2	In terms of infection prevention and control, she reported the Trust had declared one case of MRSA in June 2018, and there had been 13 C. difficile cases against a tolerance rate of 16. On incident reporting, the Trust had moved from an average position and was now within the upper quartile, which was expected from an organisation looking to move from 'good' to 'outstanding'.
8.3	In reply to a question from David Holt about reporting by different staff groups, Julie Andrews said that nursing staff and students were particularly good about reporting and Allied Health Professionals, less so. In terms of reporting by service area, she acknowledged that there was still under-reporting in theatres. It was noted that reporting figures were scrutinised as part of the quarterly ICSU performance review meetings along with deep dives into a particular ICSU/service area.
8.4	**Board members welcomed and took assurance from the good and comprehensive report which contained a great deal of data and was also concise and clear.**
9.	**Learning from deaths report (quarter one 2018/191)**
9.1	Julie Andrews reminded Board members they were considering the quarter one 2018/19 report due to the length of time required to conduct the required reviews. She reported that 63% of all inpatient deaths had been reviewed, and provided assurance that no potentially avoidable deaths were recorded during this period. In addition, Julie Andrews informed Board members that the review had also now been extended to look at 30 day post-discharge deaths and links with end of life care services. Naomi Fulop commended this move and asked where any ensuing report would be taken? Julie Andrews replied that the learning from deaths report should in future be received by the Quality Committee as well as the Board and there was a need to reflect on both governance and timescales.
9.2	Referring back to the SHMI, Steve Hitchins enquired about next steps in this area. In response, Julie Andrews said that there was a need to scrutinise any potentially avoidable deaths amongst the 30 day post-discharge group. She had also spoken to Leon Douglas, Chief Information Officer, about the data, and was assured that the current approach was appropriate. There was a Medical Director Forum coming up soon, which would provide good opportunities for sharing approaches.
9.3	**The Board:** **i. took assurance that learning from deaths' process were well-embedded and provided themes to help us continuously improve the safety and quality provided; and** **ii. agreed that the governance/reporting line of the learning from deaths report be established, including its link to the Quality Committee.**

10.	**Nursing & Midwifery Establishment six-monthly report**
10.1	Michelle Johnson explained that the report was produced in line with National Quality Board guidance. The report was predominantly hospital-based though was being extended across the integrated care organisation, and had been brought to the Board to consider recommendations including those around skill mix. She had asked NHS Improvement's Director of Nursing to review the report, and the feedback she received was positive. Michelle Johnson reported that the position on vacancies continued to improve, with the main focus now being on staff retention through initiatives such as the strong preceptorship programme.
10.2	Michelle Johnson reported that all wards had a high occupancy rate throughout the period covered by the report, as well as high levels of patient acuity and dependency. She confirmed that escalation beds were opened in October 2018 and Cavell ward was opened in December 2018. She also highlighted the review of midwifery staffing levels using the Midwifery Plus tool which showed a level of 1:28, in line with both London and national benchmarking data. Michelle Johnson also reported that, five beds had been closed on the children's ward but staffing levels had not been reduced due to the levels of patient acuity, and that, over the next six months, there would be a review of ward managers and matrons.
10.3	Turning to community services, it was noted that a skill mix review at Simmons House had resulted in the conversion of some posts to Health Care Assistants. Michelle Johnson explained that District Nursing changes had proved particularly successful with an increasing shift towards nursing associate roles; there had also been some remodelling within Health Visiting using the Bright Start tool. She reported that there had been a comparison with model hospital data and there was ongoing work there to test the accuracy of the information. Michele Johnson also informed Board members that some financial savings had been generated, with all proposals appropriately quality impact assessed, and all efforts were being made to check that the directorate was fully managing within its means. She also highlighted the report's second appendix which identified recommendations for individual wards.
10.4	During discussion, Board members raised the following points: • The report was commended for demonstrating a good level of control. David Holt asked how the report was tested on the ground, i.e. would staff on the wards recognise the picture it illustrated? • Michelle Johnson acknowledged that Band 5 staff may not fully understand the data, but staff in Bands 6 and 7 would be able to do so and provided assurance that there was unquestionably a good grip at ward manager level. She went on to provide further assurance that ward staffing levels were reviewed three times each day, and flexed according to need • Michelle Johnson added that the report was signed off by all the ICSU Associate Directors of Nursing prior to its circulation. Norma French reported that there had been a reduction in reliance on agency staff,

	with far more nurses signed up to the staff bank
10.5	In response to a question from Naomi Fulop about ongoing training needs, Michelle Johnson referred to the work being carried out by practice development nurses across the Trust and the development of the Band 6 role. Siobhan Harrington reported she had been encouraged by the Adult Community Services ICSU's quarterly performance review that morning, which she felt demonstrated a much improved morale compared with the previous year. Stephen Bloomer confirmed the Trust's financial commitment to funding this work and highlighted the importance of a rostering system way that instilled confidence. He advised that the estates' work and positive commitment to improving the environment were also helping to increase staff morale.
10.6	Board members welcomed the report and Steve Hitchins commented that it was possible to detect a change in the mood and confidence of staff.
10.7	**The Board:** **i. reviewed and agreed that the appropriate level of detail and assessment had been undertaken to provide assurance that the clinical areas reviewed continued to be safely staffed, in line with National Quality Board guidance; and** **ii. agreed the recommendations contained in appendix two of the report relating to skill mix and registered nurse reductions.**
11.	**Performance dashboard**
11.1	Carol Gillen introduced the report and drew Board members' attention to the following: • The Emergency Department position, covered previously in the Chief Executive's report, was 85.5% - a percentage down on last year's position. In mitigation there had been a 6% increase in attendance • The Emergency Care Improvement Programme team from NHS Improvement had visited and made a number of recommendations, particularly covering the first 60 minutes and was happy to continue its work with the Trust • All cancer targets and referral to treatment time targets were met during December 2018 • The Community Services' Improvement Programme Board met on 29 January and noted significant improvements across the organisation, with performance broadly on target. There had been some concentration on Muscular-Skeletal Services, and it was felt this was to a large degree because the service had become a victim of its own success, necessitating a review of demand and capacity. The therapy review within Haringey had been completed and extremely well-received by commissioners • the importance of focusing on appraisal and mandatory training rates, with assurance that certain teams were targeted as well as testing the robustness of the data, which it was acknowledged remained

	problematic in some areas. A timeline for improvement was to be sent to Directors of Operations
11.2	During discussion, the following points arose: • In answer to a question from Steve Hitchins about the Family Nurse Partnership figures, Michelle Johnson explained that this service had been affected by the successful campaign to reduce teenage pregnancies nationally, and the Trust wished to extend the criteria of the service to seeing slightly older mothers (i.e. those in their early 20s who needed additional support) • In terms of response rates for the Friends & Family Test; it was noted that, in some areas, volunteers had been encouraging patients to complete forms, but on the whole there was no increase in response rates despite, for example, the Emergency Department having tried a number of ways to generate increased response levels. There had, however, been a tangible increase in response rates within Care of Older People services, and Carol Gillen emphasised the importance of learning from areas where such improvements had been made • Naomi Fulop highlighted an example of red-rated indicators on page 3 and asked whether it was possible to differentiate between red and amber-rated performance against targets Stephen Bloomer explained that reports were produced in this way because of their target audience, i.e. the commissioners, where services had either hit or missed the target and there was no middle ground • Naomi Fulop also stressed a need to see the actual numbers as well as percentages for performance against indicators– for example, how many new birth visits had been carried out during the month covered in the report? It was agreed to look at this as part of the dashboard review • Steve Hitchins expressed concern about some of the children's community services waits for Child and Adolescent Mental Health services (CAMHs) and also for Speech and Language Therapy (SALT) services. In reply, Carol Gillen confirmed there was a great deal of improvement work happening. She advised that a single point of access arrangement would be introduced for CAMHs from late June 2019 and commended the work carried out by Lesley Platts within SALT services. Siobhan Harrington commented that CAMHs in schools should be green-rated performance on the scorecard
11.3	**The Board:** **i. received the report and took assurance the Trust was managing performance compliance and putting in place remedial actions for areas off plan; and** **ii. agreed that the review and development of the 2019/20 Performance dashboard consider:** • **the differentiation of red and amber-rated performance against KPIs' targets**

	• **actual numbers as well as percentages e.g. the amount of new birth visits completed.**
12. 12.1 12.2	**Emergency Preparedness Resilience & Response (EPRR) report** Carol Gillen introduced the report, annual statutory requirement for all Trusts. She was pleased to provide assurance that Whittington Health had achieved compliance in all EPRR domains during the site assessment carried out in November 2018. In reply to a question from Steve Hitchins on which other London providers had also achieved good compliance, Lee Smith confirmed that University College Hospitals London (UCLH) NHS Foundation Trust and Barts Health NHS Trust also performed well. **The Board welcomed the report and took significant assurance from the positive outcome achieved through full compliance with standards 1-69 inclusive.**
13. 13.1	**EU exit contingency plan** Carol Gillen presented the report and highlighted the following: • like the previous agenda item, this had been brought to the Board to provide assurance that robust plans had been developed to cover those eventualities that might be foreseen • the team carried out a risk assurance exercise in October 2018 against the seven domains listed and also an EU planning group had been established • Whittington Health had submitted its self-assessment in on time. Alongside NHS trusts, Clinical Commissioning Groups and Local Authorities were being asked to provide the same level of information, and work was in hand to devise scenarios for testing across the system rather than by individual organisations • it was noted that the Chief Executives of UCLH and University Hospitals Birmingham Foundation Trust had voiced concerns about possible medication shortages as a result of Brexit and these had received wide media coverage. • the Department of Health had established an operational response team to monitor all logistics chains and medication suppliers and, if necessary, would centralise arrangements so there were contingency plans in place • in reply to a question from Naomi Fulop on key concerns, Lee Smith, Emergency Planning Officer, said he felt it was most important to maintain training and exercises. He agreed there was no room for complacency and there was a need to maintain communication channels in both directions but also noted that some issues - gridlocks at ports - for example, were beyond the Trust's control • the plan was a living document and would continue to be constantly updated as information came in. For security reasons, not everything was in the public domain • David Holt commented that there remained a need to be cautious as some supplies may be reduced because of fears they could not be transported

13.2	**The Board:** **i. thanked the Emergency Planning Officer for this update on contingency planning for the UK to leave the EU in the event of a no deal outcome at the end of March 2019; and** **ii. took assurance from the work that has already taken place and continues to ensure the Trust minimised any adverse impact upon services and patients.**
14. 14.1 14.2 14.3	**Seven Day Hospital Service Self-Assessment** Julie Andrews explained that this was a new quarterly report for the Board and provided full assurance for access and patients seeing a consultant with 14 hours of admission. She highlighted a finding from the self-assessment which showed a lack of consistent access at weekends for echocardiography diagnostic services and also for MRI scans. The latter were provided at Queen's Square via an agreed contract. During discussion, the following points arose in discussion: • In reply to questions from Naomi Fulop, Julie Andrews confirmed that the self-assessment tool only required confirmation if performance was above the 90% threshold, and that, a review of applicable SIs had confirmed that if echocardiography diagnostic services were in place, it would not have affected the outcome. She also assured Board members that, when echocardiography diagnostic services were absolutely necessary from a clinical perspective, patients were transferred off site to access such services • Jonathan Gardner enquired about the self-assessment against the remaining six standards and Julie Andrews was content to include this in future quarterly reports to the Board **The Board:** **i. reviewed a the Seven day Hospital Services self-assessment required by NHS Improvement and welcomed the green-rated performance for clinical standards 2, 5, 6 and 8; and** **ii. agreed that the next quarterly report in April 2019 would include a self-assessment against the remaining six core standards.**
15. 15.1	**Financial performance – month eight** Stephen Bloomer highlighted the following points to Board members: • At the end of month nine, the Trust was reporting a £1.7m surplus, including £2.1m of provider sustainability funding (PSF). This was a positive variance of £0.2m for the month. The year to date position showed a £9m surplus, including £13.9m of PSF, which was in line with the panned year-end control total • The unfunded element of the three year national agenda for change pay deal was a significant risk to the year-end position and NHS

	Improvement had been made aware of this issue
	• Despite the fact that the in-month control target was achieved, there remained key issues to resolve:
	  o the Trust was behind plan for clinical income and there was concern at the projected ICSU recovery plan, particularly for elective care
	  o continued high levels of pay expenditure through an increasing quantum of staff, rather than the needed reduction in agency and bank staffing costs. A key area to focus on was emergency medicine which was a key driver of higher than expected pay expenditure
	• The current financial position was being bolstered through recourse to non-recurrent cost improvement programme (CIP) schemes. However, this was likely to put pressure on the 2019/20 run rate and the ability to deliver the 2019/20 control total
	• The outturn for month ten was not looking advantageous as it continued to show an increased quantum of staffing expenditure along with increased length of stay and delayed transfers of care
	• Due to the low likelihood of being able to significantly influence the year-end outturn for the Emergency Integrated Medicine and Surgery and Cancer ICSUs, other organisational areas were being asked to identify greater savings to support the overall Trust position

15.2	In discussion, the following issues arose: • Siobhan Harrington reported on the performance review carried out for the Surgery and Cancer ICSU on 29 January. She highlighted that a robust and granular recovery plan was in place which provided a good degree of assurance and also relayed concerns about pay expenditure, particularly for specialist staff. She also emphasised that ICSUs were accountable for delivery of respective activity and financial plans to help the Trust meet its overall control total • In reply to a question from Naomi Fulop on trauma and orthopaedic services, Carol Gillen explained that forecast activity plans were being reviewed and clinical capacity for electives was being adjusted for the next eight weeks • Deborah Harris-Ugbomah asked about the degree of confidence on delivery of the 2018/19 CIP target. Carol Gillen provided assurance that weekly oversight on delivery was provided by the executive team and confirmed the Trust was still forecasting delivery of £13.3m of the CIP target, of which c. £12m would be recurrent. She also provided assurance that staff were clear on the key actions to take. Deborah Harris-Ugbomah congratulated the executive team for the process put in place to deliver the CIP target and its weekly monitoring of progress. In addition, Siobhan Harrington advised that, delivery of individual ICSUs' CIP targets, was included in performance reviews taking place this week • Carol Gillen confirmed that the level of unachieved CIP to be carried over to 2019/20 was c. £2.5m

15.3	**The Board:** **i. reviewed the month nine financial performance report; and** **ii. recognised the need to improve income delivery, reduce agency expenditure and improve the delivery of CIP schemes which reduced the run rate.**
16.	**Quarter three delivery of 2018/19 strategic objectives**
16.1	The report was taken as read. Jonathan Gardner highlighted good progress with delivery of the Trust's strategic objectives. He drew attention to the following: • There was good evidence for the Trust continuing to meeting its objective to integrate and co-ordinate care in person-centred teams through its partnership work with GP Federations and local authorities in Haringey and Islington • Through the progress achieved on the Fast follower programme and the rollout of the Careflow Connect project, there was strong evidence for the delivery of innovative information technology services which, in turn, supported the delivery of clinical objectives
16.2	Board members raised the following during discussion: • David Holt suggested including a RAG rating for the year-end position against each objective. Anu Singh commented on the need for greater clarity on what constituted good performance for delivery of the strategic objectives, including the aims for each objective. She highlighted the patient experience strategy which the Quality Committee agreed to recommend for the approval to the Board, subject to it demonstrating greater ambition and a year one delivery plan. Jonathan Gardner concurred and advised that the key was to spend time devising smart metrics for the delivery of respective 2019/20 strategic objectives • In reply to questions raised by Deborah Harris-Ugbomah on how the Board's risk appetite for each objective was reflected and also the link to the Board Assurance Framework, Jonathan Gardner explained that this was bound up with work to develop the 2019/20 strategic objectives and the 2019/20 Board Assurance Framework which was scheduled for discussion in March • Steve Hitchins sought confirmation of the Trust's clinical smoking cessation lead
16.3	**The Board:** **i. received and reviewed progress with delivery of the strategic objectives during quarter three; and** **ii. agreed that the Trust's clinical smoking cessation lead be confirmed to Board members.**

17.	**Corporate Risk Register CRR)**
17.1	Michelle Johnson presented the report. She highlighted the following: • the main themes from risk register entries was workforce culture, financial sustainability and estates • the Trust Management Group had agreed a new Board Assurance Framework (BAF) entry which related the delivery of consistent, high quality, safe services' strategic objective • three entries with a total risk score of more than 16
17.2	Deborah Harris-Ugbomah sought clarification on how the BAF and CRR were used. In reply, Jonathan Gardner highlighted the strategic, longer term nature of BAF entries, while the CRR contained more operational, in-year risks and noted the need to ensure that particular CRR entries were referenced in their respective BAF entry. Deborah Harris-Ugbomah commented that the internal audit team was happy to work with the Trust on additional assurances and that, it would be helpful to track assurances against each CRR entry.
17.3	**The Board:** **i. reviewed all risks scored less than 16 and agreed there were adequate mitigating actions and assurances in place to manage them; and** **ii. agreed that the three risks scored higher than 16 not be included on the BAF; and** **iii. noted the Trust Management Group had agreed to include a BAF entry relating to the delivery of consistent, high quality, safe services' strategic objective.**
18.	**Workforce Assurance Committee**
18.1	Naomi Fulop reported that the meeting contained really interesting executive engagement and discussions. She explained that a medical education report on the GMC survey of trainees was discussed and had raised various issues which would be considered further by ICSU Boards. Steve Hitchins advised that the word "mentioning" in paragraph 10.01 be replaced with "mentoring" in the draft minutes.
18.2	**The Board received the draft minutes of the Workforce Assurance Committee meeting held on 18 January 2019 and noted the drafting amendment for paragraph 10.01.**
19.	**Quality Committee**
19.1	Anu Singh reiterated the need for the Patient Experience Strategy to be more ambitious.
19.2	**The Board received the draft minutes of the Quality Committee meeting held on 9 January 2019.**

20. 20.1 20.2	**Charitable Funds' Committee** Siobhan Harrington highlighted progress with the fundraising strategy. **The Board received the draft minutes of the Charitable Funds' Committee meeting held on 12 December 2018.**
21. 21.1	**Questions from the public** Jonathan Gardner reported that a number of questions had been emailed by one member of the public, P Richards, and they would receive a formal written response.
22. 22.1	**Any other business** There were no items reported.

Action log, Public Board meeting, 30.1.2019

Item	Action	Lead(s)	Progress
Action log, December 2018 meeting	Bring the Whittington Health culture improvement plan to the February 2019 Board seminar and public meeting	Norma French	Completed
Quarterly learning from mortality report	Establish the governance/ reporting line of the "Learning from deaths report" and how it links to the Quality committee .	Julie Andrews	Quarterly learning from deaths' reports will be discussed by the Quality Committee and its terms of reference amended at its March meeting to reflect this governance arrangement
Performance dashboard	In the review and development of the 2019/20 Performance dashboard consider including: • the differentiation of red and amber-rated performance against KPIs' targets • actual numbers as well as percentages e.g. the amount of new birth visits completed	Carol Gillen	This feedback is being included in the development of the Trust's 2019/20 scorecard which will be discussed at the April Board seminar
7 Day Services - Board Assurance	Include as a quarterly report in the 2019/20 Board forward plan Include mention of performance against the remaining six core standards within future reports	Swarnjit Singh Julie Andrews	Completed In hand for future reports
Quarter three delivery of 2018/19 strategic objectives	In the revision of strategic objectives for 2019/20, ensure they are SMART and can be rag-rated. Confirm the Trust's clinical smoking cessation lead	Jonathan Gardner Julie Andrews	Completed Completed

Meeting title	**Trust Board – public meeting**	**Date: 27 February 2019**
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 draw Board members' attention to national and local developments and also to highlight and celebrate achievements by 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 Board Assurance Framework entries	
Report history	None	
Appendices	None	

Chief Executive's report

This report provides the Board of Directors with highlights of key developments within the health and social care sector at a national and local level:

1. National news

1.1 The Fit and Proper Person's test (FPPT) was introduced in October 2014 to ensure that NHS Board members were suitable and fit and proper to be in their roles. On 6 February 2019, the Department of Health & Social Care published an independent review by Tom Kark QC of the FPPT. The review made seven recommendations. The Secretary of State for Health and Social Care has accepted the first two review recommendations (see below) and NHS Improvement is considering how the remaining five recommendations from the review can be implemented:

- All directors should meet specified standards of competence to sit on the board or any health provider organisation; and
- A central database should be created, holding relevant information about the qualifications and history about each director.

1.2 At the end of January, agreement was reached between NHS England and the British Medical Association's General Practitioners' Committee in England on a five-year framework for GP contract reform to help implement the NHS Long Term Plan[1]. The agreement features investment for primary care networks to deliver improved access to doctors, expanded services at local practices and longer appointments, where needed.

1.3 Health Education England has published an independent review commissioned by the Secretary of State for Health and Social Care – "The Topol Review – Preparing the healthcare workforce to deliver the digital future"[2]. Its recommendations aim to support the NHS Long Term Plan and inform the workforce implementation plan designed to improve the NHS over the next decade. It outlines how:

- Education and training for staff can deliver a better future for patients and the staff who care for them by implementing technologies such as genomics, digital medicine, artificial intelligence and robotics, at a greater scale and pace
- Clinical roles will change along with staff education and training
- Processes like diagnostics can be speeded up, for example, by providing patients with quicker, better treatment and freeing up additional clinical time to provide further care

1.4 NHS England has launched a suite of implementation resources as part of support to NHS trusts to implement the NHS Workforce Disability Equality Standard (WDES)[3]. The WDES is a set of ten specific measures (metrics) that will enable organisations to compare the employment experiences of disabled and non-disabled staff. It will apply to all NHS trusts from April 2019 and is a key step for NHS organisations to improve equality for the NHS workforce.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf
[2] https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-2019.pdf
[3] https://www.england.nhs.uk/about/equality/equality-hub/wdes/

2. Local news

Quality and Safety

2.1 Overall performance against the 95% four hour standard for January 2019 was 86%. In January 2019, patient attendance numbers were high at 9,594 (an average of 310 per day) when compared to January 2018 (with attendances of 8,897, averaging 287 attendances per day).

2.2 The Trust saw a sustained improvement in the number of patients experiencing a delayed transfer of care and standard patients throughout January which assists patient flow throughout the hospital and the Emergency Department. Actions being taken during quarter four following review by the emergency care improvement programme team include emergency department to observe the front of house (first 60 minutes) work in particular. Their recommendations include: ensuring a robust medical rapid assessment and treatment model is in place five days a week initially with a view to extend both days and hours, increasing ambulatory care opening hours to maximise its capacity (especially on weekends) and streamlining the front of house model to ensure the function is fit for purpose.

2.3 The overall Trust performance against cancer targets was compliant. Late referrals from the London breast screening unit resulted in non-compliance for the screening target (60/90%).

2.4 Unfortunately, two mixed sex breaches occurred in the Intensive Treatment Unit during January due to capacity issues within the Trust and no medical beds being available. However, in each instance, the patients' privacy and dignity were maintained at all times and the patients were informed and comfortable.

2.5 In January, all wards had adequate nurse staffing levels for day and night shifts.

2.6 There were increases in response rates to the family and friends test in maternity, community, outpatient and emergency department services. In January, 96% of patients responding recommending the maternity service. The Trust also responded to 90% of complaints within 25 working days. Community waiting times are monitored monthly by the Community Strategy Improvement Group.

Workforce

2.7 Vacancy rates against establishment remained stable in January (11.9%) and the Trust continues to work within local, national and international nurse recruitment initiatives. Staff turnover reduced slightly and remains above target. To help improve staff stability rates further, a cross organisational retention plan supported by NHS Improvement is currently being developed. Sickness absence for December 2018 (reported a month in arrears) reduced slightly, and is just over target at 3.34% and this is attributed to seasonal factors. Rates for staff appraisal reduced slightly in January (72.7%) and this is mainly due to block appraisals in corporate areas. The NHS staff survey rate was 48.5%, the highest response rate the Trust has achieved - the results will be available for all NHS providers in England later this quarter.

2.8 As at the first week of February, 82.55% of Trust staff had, so far, been vaccinated against winter flu. There are a few weeks to go before the winter flu vaccination campaign ends and the aim is to increase this excellent vaccination rate further.

Financial

2.9 The Trust is reporting a surplus (including Provider Sustainability Fund (PSF) income of £2.5m) of £1.6m for January 2019 which is behind plan by £1m. Year to date, the Trust is also behind the NHS Improvement adjusted plan by £1m, with a surplus of £10.6m including £16.4m of PSF income. This adverse variance needs resolution to ensure the receipt of further PSF funding to help enable our estates transformation. The Trust is taking action to control temporary pay expenditure and to deliver increased activity requirements for the final two months of the year to secure this funding and more specific support is being targeted to the Emergency & Integrated medicine Integrated Clinical Service Unit.

2019/20 annual plan submission

2.10 The Trust submitted its draft annual plan submission to NHS Improvement on 12 February. The draft plan was discussed at the 13 February Board seminar and will be refined in the light of feedback from NHS Improvement and developments at a North Central London Sustainability before the final submission is required on 4 April. The final plan will come to the March 2019 Trust Board meeting.

2019-24 Whittington Health Strategy

2.11 As part of the development of its revised clinical and organisational strategy 2019-24, the Trust Board reviewed feedback from engagement with staff stakeholders at its seminar on 13 February. Board members discussed suggested amendments to the Trust's mission and vision statements as well as proposals for its strategic objectives. The draft strategy will be sent to wider stakeholders for feedback and a draft brought to the March Board meeting for consideration. Themes from the feedback received are coalescing around four key objectives that we should:

- Deliver outstanding safe and compassionate care
- Empower, support and develop engaged staff
- Provide integrated holistic care and promote health and wellbeing
- Transform financially sustainable, innovative services

London's Top Leaders' forum

2.12 On 11 February, Sir David Sloman, London Regional Director at NHS Improvement & NHS England, held the first meeting of London's provider and commissioner Accountable Officers, and set out a vision for London to be both the healthiest global city and also the best global place in which to receive healthcare with a strategy which ensures that all Londoners can start life well, live well and age well.

Haringey inter-great event

2.13 On 6 February, commissioners, providers and partners and local people from across health and social care held a successful event at the Cypriot Centre in Wood Green as part of the Haringey Inter-great project (similar to the one in Islington in January). Attendees looked at a simulated integrated health and care system in Haringey and North Central London and the lessons to take forward in the design of an integrated approach in the sector.

Armed Forces Covenant

2.14 On 8 February, Whittington Health signed the Armed Forces Covenant[4] - its pledge acknowledging that those who serve in the armed forces and their families should be treated fairly and with respect and the same access to services, as any citizen.

Annual cancer conference

2.15 On 14 February, the Trust's annual cancer conference was held in partnership with Macmillan Cancer Support and 150 people affected by attended. The event was designed to be an opportunity for those living with, or beyond cancer, or caring for someone who is, to learn new skills to cope with the illness and to meet other people with similar experiences. The conference also allowed the Trust to showcase the support available in the hospital and the wider community as well as allowing local support services, charities and organisations to publicise their help and services. During the day, Nicola Surman-Jones, MacMillan Lead Cancer Nurse gave an insight into how the oncology service responded to patient feedback over the past year and the improvements planned for 2019/20. In addition, one of our patients shared an uplifting story about how she had learned to cope with her diagnosis and to put it into perspective thanks to "The C Factor" programme which uses acting and drama to help people to cope with cancer.

LGBT History Month

2.16 February sees Lesbian, Gay, Bisexual and Trans History Month being celebrated in the UK. The theme this year is peace, activism and reconciliation. Further details of resources and specific events can be located at: https://lgbthistorymonth.org.uk/lgbt-history-month-resources/2019-theme/

Mike Clift wellbeing room

2.17 On 19 February, the Trust formally opened the Mike Clift wellbeing room at the Whittington Health Library in honour of a former colleague and children's nurse passionate about nursing, education and mental health. The room provides a quiet space for reflection and rest for staff and students.

New clean air walking route

2.18 Jonathan Gardner, Director of Strategy, Development & Corporate Affairs, joined the Mayor of Islington, Councillor Dave Poyser, and Councillor Sheila Chapman to officially open the new "clean air walk" between Archway tube and the hospital. Clean air routes are designed to be healthier, quieter and calmer routes with less air pollution but still taking about the same amount of time between locations. The walk is brightened up by new colourful murals by artist Bryony Benge-Abbott depicting Lichens which are a great barometer of pollution levels. This route is one of a number established by the London Borough of Islington.

Staff award – Community Midwife

2.19 This month's Staff Excellence Award winner is Carmel Mulligan, a community midwife. Carmel was nominated for displaying the Trust's compassionate value. She is someone with outstanding knowledge and expertise and an innovative and can-do approach. Carmel is a very caring midwife and colleague and has been noted for her support of other staff and new team members. Last year, Carmel provided personalised and excellent care to a

[4] https://www.armedforcescovenant.gov.uk/about/

patient with a complex medical history and needs, building a strong, trusting and professional relationship and becoming the main care provider and staying beyond her regular working hours, providing an outstanding level of care. Carmel's nominator said that she is "a fantastic colleague and deserves the award for her constant effort, initiative and determination as a midwife and colleague and for this trust".

Meeting title	**Trust Board – public meeting**	**Date: 27.2.2019**
Report title	Serious Incidents Update – Month 10 (January 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 January 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	This report is presented to the Board for 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: • ensure we work with Camden and Islington NHS Foundation Trust on the shared production of Serious Incident investigations • 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	Report presented at each public Board meeting	
Appendices	None	

Serious Incidents: January 2019 report

1. Introduction

1.1 This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during January 2019. 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

2.1 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

3.1 The Trust declared one serious incident during January 2019, bringing the total of reportable serious incidents to 30 since 1st April 2018.

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

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

3.4 The table below details the Serious Incidents currently under investigation.

Category	Month Declared	Summary
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. This is a joint investigation with Camden and Islington NHS Foundation Trust.
Still Birth Ref:27813	Nov 18	An Intra uterine death was diagnosed by ultrasound following concerns raised by the pregnant woman that no fetal movements had been felt.
Unexpected Death Ref:28316	Nov 18	A patient died after deteriorating following elective surgery for a giant hiatus hernia.

Category	Month Declared	Summary
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 to date.
Wrong site surgical procedure - Never Event Ref:29134	Dec 18	A patient received a peripheral nerve block on the right side instead of the left side which was identified prior to surgery.
Unexpected admission to NICU Ref:30069	Dec 18	Baby born in poor condition at 38 weeks and 2 days gestation and required resuscitation and ventilation. The baby was transferred to tertiary neonatal unit for total body cooling.
Information Governance Breach Ref:2062	Jan 19	Confidential patient information was changed on the Trust electronic system and the patient's contact number given to an estranged family member although a safeguarding alert was present.

3.5 **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**

3.6 **The table below details serious incidents by category reported to the NELCSU between April 2016 – January 2019.**

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	Dec 18	Jan 19	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0	1	0	0	1
Apparent/actual/suspected self-inflicted harm	1	0		0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/information	6	3		2	0	1	0	0	0	0	0	0	1	4
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	2	0	0	0	7
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	1		0	0	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	0	0
Failure to meet expected target (12 hr trolley	1	0		0	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	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	0	0	1	0	1	1	0	7
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0	0	0	0	0	0
Medical equipment/devices/ disposables	1	0		0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	0	0	0	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	0	0	1	0	0	2
Sub Optimal Care	4	2		1	0	0	0	0	0	0	0	0	0	1
Surgical/invasive procedure incident meeting	0	0		0	1	0	0	0	0	0	0	1	0	2
Treatment Delay	3	4		0	2	0	0	0	0	0	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	0	0	1	0	0	2
Retained foreign object	1	1		0	0	0	0	0	0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**2**	**4**	**2**	**1**	**30**

4. Submission of Serious Incident reports

4.1 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.

4.2 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.

4.3 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.

4.4 The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in January 2019.

4.5 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, 'message of the week' in Maternity and EIM, and '10@10' in the Emergency Department. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

5. The Trust submitted three reports to NELCSU during January 2019

5.1 A request for de-escalation of one serious incident (SI) (Ref: 20462) was requested as the investigation did not identify any care and service delivery problems. The cause of the patient's death was not attributable to the care the patient was given. The request for de-escalation was approved by NELCSU & Clinical Commissioning Group (CCG).

5.2 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 December 2018. The Trust submitted one report in December 2018.

Summary	**Actions taken as result of lessons learnt include;**
Diagnostic Incident including delay. Ref:24114	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. • Dementia and delirium awareness is being embedded across the organisation, to include taking full history, pain management, and reasonable adjustments made in the care plan as an early identification of delirium and causes such as an infection could have contributed to earlier treatment and possibly prevention of sepsis. • The Trust is exploring the need for a designated person with a dedicated role in dementia in ED. • A relaunch of the Trust's Silver Trauma Pathway is being arranged to ensure staff use with for all older people presenting to ED with falls. • The learning from this case was used in teaching our ED & Radiology Doctors, due to complex visualisation of the fracture, including through musculoskeletal examination, through falls assessment in older people and the importance of attempt to mobilise the patient, when x-ray shows no fracture. This was also used as a learning tool in our training sessions, ED 10 at 10 and Grand Round.
Diagnostic Incident including delay Ref:24930	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.

Summary	Actions taken as result of lessons learnt include;
	• Training sessions were scheduled by the Alcohol Liaison team and attended by Medical Staff, focussing on alcohol withdrawal, guidance on medication and management of patient behaviour. • An audit on JAC was undertaken to show compliance with the guideline 'Alcohol withdrawal and intoxication' and 'Delirium- prevention and management. • As well as feedback to the ICSU Board and ward meetings, lessons learned from this case were shared widely in the message of the week for nurses and consultants.
Diagnostic Incident including delay/unexpected Death Ref:20462	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. There were no identified CSD problems identified from this investigation and Islington Clinical Commissioning Group has confirmed a de-escalation in this case. However the report and findings were shared with everyone involved in this patients care, the ICSU Quality and Safety Committee, the EIM ICSU Board and in the Gastroenterology Service meeting.

6. Shared learning

6.1 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; for example, learning from a community SI where a patient experienced burns following the use of an emollient cream and an information governance serious incident.

6.2 Themes from serious incidents are captured in quarterly aggregated learning reports along with 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, of which one of the three priority areas is patient safety.

6.3 Examples of learning events include:

- The Maternity service has a monthly rolling programme for all midwifery staff where a presentation is given on National Reports and initiatives as well as all incidents including Serious Incidents (SIs) and the investigation process. The aims of these sessions are to review SI reports and the outcomes from a number of various cases which are shared, including the root causes and the contributing

factors. The Root Cause Analysis (RCA) investigation process is also explained through the different stages including the importance of involving the patient/family from the onset.

- A LEAD event took place on the 6th February for junior doctors. The event focused on RCA training, with each group reviewing an SI report and how this was constructed. Following training participants are encouraged to take part in the serious incident investigation process, noting they would be supported and mentored through the process by an experience staff member, as their workloads permit. They are also encouraged to attend a SIEAG Panel meeting to understand how the full process works.

- A grand round held on 13 February focused on learning from serious incidents relating to medical errors – their causes and the consequences, looking at common / big impacting incidents from other trusts.

- We have recently been provided with our legal claims data going back 10 years from NHS resolutions (NHSR) and have been working with them to consider how best to review themes and trends from this data, as well as learning from these. The individual Integrated Care Service Units will be reviewing their data, as well as the trust looking at overall themes and trends. We are aiming to review claims which did not come from SIs in order to look at what investigation / retrospective investigation took place to see what, if any, learning there is from these. This work is on-going currently; any outcomes and learning will be shared throughout the trust.

- We are continuing to review and improve how we share our learning from all incidents, near misses and SIs to ensure we mitigate against future risks and fully embed actions and learning.

Meeting title	**Trust Board – public meeting**	**Date: 27.2.2019**
Report title	Adult and Children's Safeguarding six monthly report (April 2018 – September 2018)	**Agenda item: 8**
Executive director lead	Michelle Johnson, Chief Nurse & Executive Director of Patient Experience	
Report authors	Karen Miller, Head of Safeguarding Children, and Theresa Renwick, Head of Safeguarding Adults	
Executive summary	This report provides a summary of the work undertaken across adult and child safeguarding and covers the period between April and September 2018 and seeks to: • continue to develop the integrated reporting to the Board and Quality Committee with a biannual update on the work of the safeguarding teams • continue to provide assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care • ensure that there is confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy. The Trust's safeguarding teams continue to provide a range of services to support key areas of safeguarding work, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective and meet statutory and regulatory obligations. **Adult** • Adult safeguarding has seen a 60.6% increase in numbers of safeguarding adult concerns raised by Whittington Health staff when compared to the same period last year. Neglect and acts of omission continue to be the most used category of abuse, with more women than men identified as experiencing abuse. 47% of all safeguarding adult concerns raised were for adults over the age of 75, a very slight reduction from the 2017-2018 reporting period. The overwhelming ethnic group having a safeguarding adult concern raised for them were white. This data is in keeping with the most recent National data for safeguarding adults. • Numbers of Deprivation of Liberty (DOL) urgent authorisations have also increased in this period in comparison to the same period	

	last year, with a 34.5% increase in numbers of urgent DOL authorisations recorded. A national report looking at the period of April 2017-March 2018 was published in October 2018, and its findings are reflected in Whittington Health data for April-September 2018. • Numbers of assessments of capacity logged on Anglia Ice (trust reporting system) have fallen in comparison to the same period last year, although there has been an increase in Q2 figures. • A very successful learning disabilities awareness week was held in June 18 to support the national Mencap campaign looking to improve the experience of people with learning disabilities in acute hospitals. • Training compliance for levels 1&2 is below the required 90% target for the organisation. Level 2 training is only delivered face to face, and it is suggested the significant increase in numbers of safeguarding adult referrals is a direct result of this method of delivery. By the end of 2018, safeguarding adults' level 1 was 88% compliance and level 2 75%. WRAP 3 is 68.8%. • In September 2018, the Trust was notified of a Safeguarding Adult Review (SAR) which we were required to share information. This report is not finalised as yet and the draft report remains confidential at this time. • The Trust has been involved in a number of discussions about cases which could become SARs; however, these have not progressed to full SARs. **Safeguarding Children** • In December 2017 Haringey borough was subjected to a Joint Area Targeted Inspection (JTAI) with a specific focus on school age children and neglect. The outcome of this inspection highlighted some significant gaps within the school nursing service (gaps related to clinical as well as safeguarding practice i.e. health assessment protocol, use of RIO, record keeping). A multi-agency action plan has been developed across to address recommendations made. • The JTAI inspection also identified gaps, which had been previously recognised in previous inspections and reviews inspections, of the ability of staff to capture the voice of the child and have awareness of the child's journey. A focus of all safeguarding training and supervision has a focus on 'Think Family'. • Compliance with statutory training continues to be a focus for the Trust and was achieved across the Trust for the periods August and November 2017. Compliance remains in level 1, but for level 2 and 3 compliance levels have dipped slightly to 75% and 84% respectively. This is on account of training compliance recording for trainee doctors on rotation. A new system of recording and capturing junior doctor compliance with safeguarding training is being identified.
Purpose:	Review

Recommendation(s)	The Board is asked to review the six monthly safeguarding update agreed by the Quality Committee and to take assurance that the Trust's safeguarding processes for both children and adults are robust and effective and meet statutory and regulatory obligations.
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	January 2018 - Quality Committee, Safeguarding Children Committee and the Adults at Risk Committee. Additionally the report has been shared with Shared with local Clinical Commissioning Group leads for safeguarding
Appendices	1: Adult and Children's Safeguarding six monthly report (April 2018 – September 2018)

Appendix 1: Adult and Children's Safeguarding six monthly report (April 2018 – September 2018)

1. Introduction

1.1 This bi-annual report for safeguarding children and adults informs the Quality Committee and Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for adults and children across Whittington Health NHS Trust. It builds on the annual report submitted in July 2018, covering the period from April 2017 to March 2018. The report provides assurance around the following:

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

2. Safeguarding children

- Working Together to Safeguard Children was published in July 2018.
- The major change to safeguarding national policy and guidance is the proposed replacement of Local Safeguarding Boards (LSCB's) with new arrangements called Safeguarding Partnership Arrangements. The local CCG's will co-ordinate which local providers will be represented on the new boards and become partners in the new arrangements.
- There are also plans to review the Serious Case Review process and replace this with national Child Safeguarding Practice Review Panel. This is hoped to streamline the process and implement a system of national learning.
- The child death review process will also will be reviewed to incorporate the review process over larger geographical areas rather than current arrangements of being borough based.
- Whittington Health is actively involved in supporting the proposed changes.

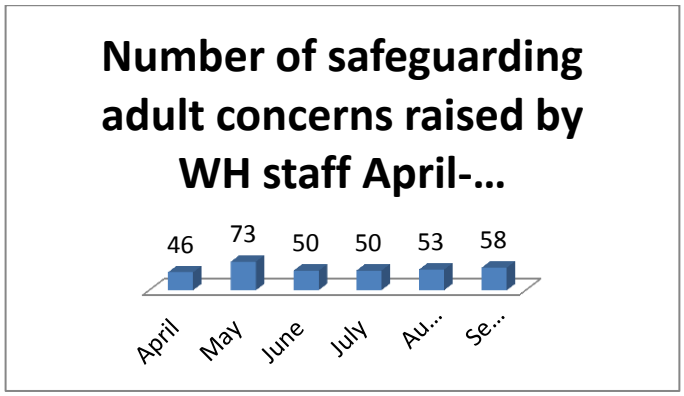
3. Safeguarding adults

3.1. The '*Safeguarding Adults Collection (SAC), Annual Report, England 2017-2018*[1,2] was published in November 2018, and found adults over the age of 75 were most likely to experience abuse. This finding is replicated by data of patients identified by Whittington Health staff as being abused, and is shown in graphs 1 and 2 below.

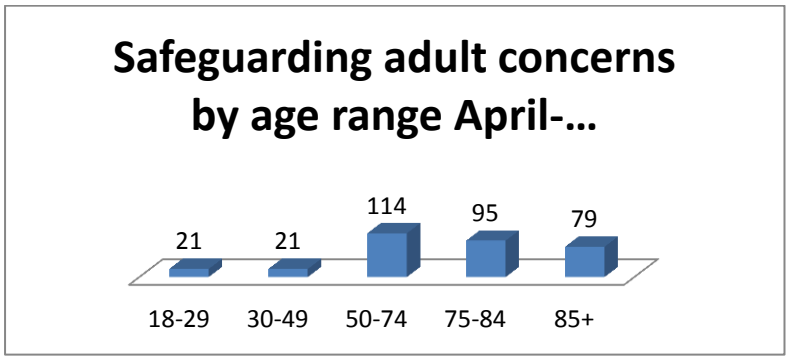
3.2 It is pleasing to note that for April 2017-March 2018, 407 safeguarding adult concerns were made by Whittington Health staff. From April 2018-September 2018, 330 safeguarding adult concerns were raised, an increase of 60.6%. Graph 1 shows there have been a 60.6% increase in numbers of safeguarding adult concerns raised by Trust staff when compared to

[1] https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf

the same reporting period of last year. Such an increase demonstrates the understanding staff has of their responsibilities in relation to safeguarding adults. It is suggested the large numbers of staff who have received level 2 face to face training in safeguarding adults has contributed to this statistic.

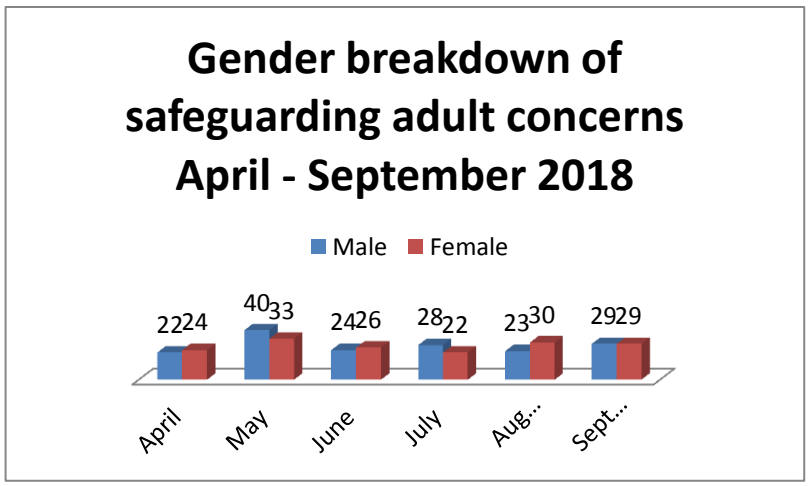


Graph 1



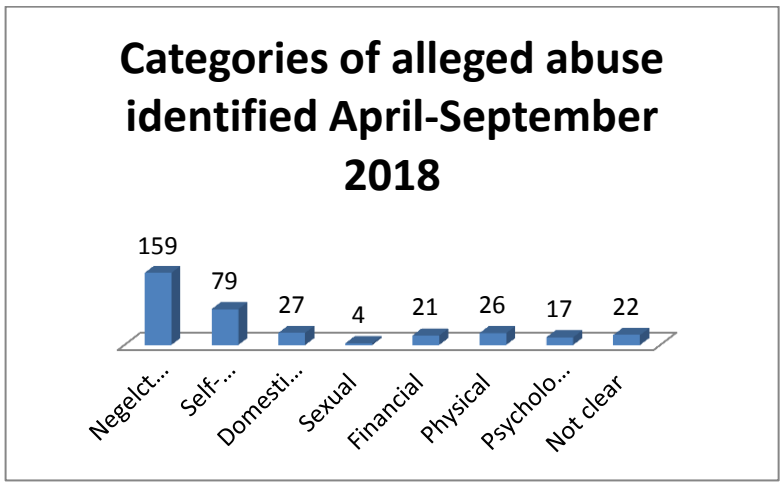
Graph 1

3.3 Graph 3 shows a fairly even split between the genders, though males were more likely to be identified than women as experiencing abuse. This bucks the trend found in the national report for April 2017-March 2018, which found woman accounted for nearly 60% of adults being abused.



Graph 3

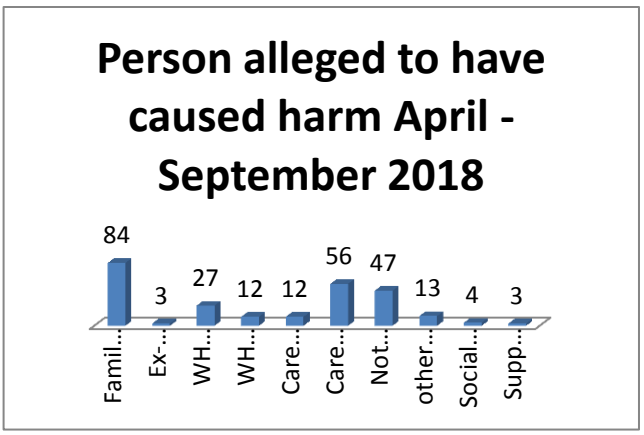
3.4. Since collection of data in relation to the ten categories of abuse (graph 4) stipulated in the Care Act 2014, neglect and acts of omission has been the category most often identified. Whittington Health data reflects this.



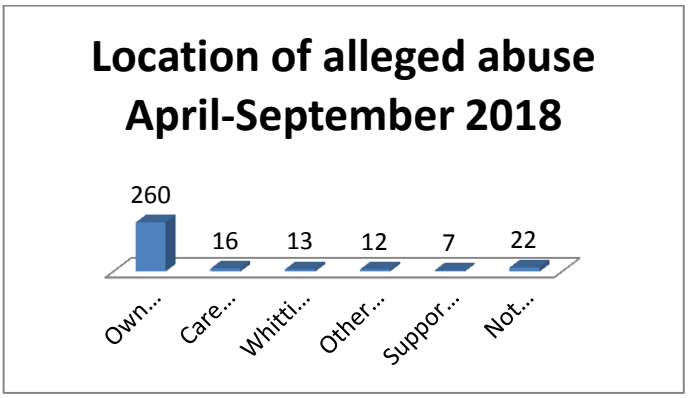
Graph 4

3.6. We can again see there are no reported cases of modern slavery, or of discriminatory abuse. The national data for 2017-2018 has modern slavery amounting to only 0.2% of identified abuse, and discriminatory abuse accounted for 0.6% of abuse. However, it is important for staff to be aware of the prevalence of both forms of abuse, and understand the need for action.

3.7 Graphs 5 and 6 reflect that the person alleged to have caused harm is very likely to know the vulnerable adult. Where Whittington Health staff have been identified as the person alleged to have caused harm, this is in relation to the development of pressure ulcers either in hospital or the community, and/or unsafe discharges. The overwhelming location of alleged abuse was found to be in the persons' own home alongside that of someone the person knows, again comparable to national findings.

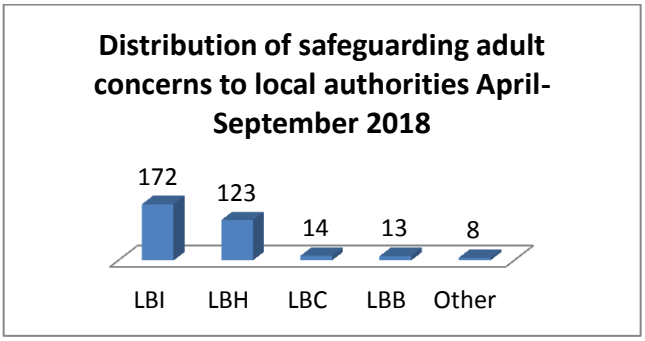


Graph 5



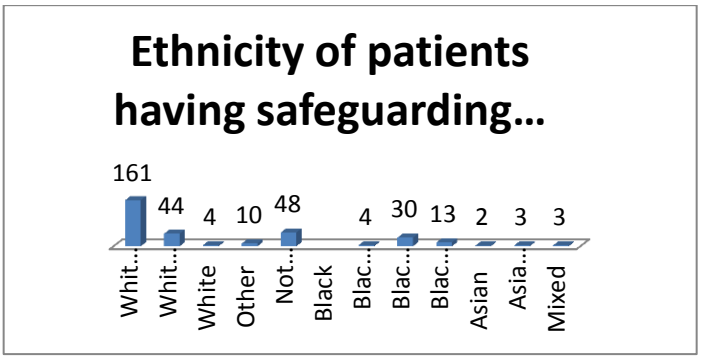
Graph 6

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



Graph 7

3.9 Graph 8 shows the ethnic makeup of safeguarding adult referrals, with the overwhelming majority being white. This is also reflected in national data.



Graph 8

EXAMPLE 1

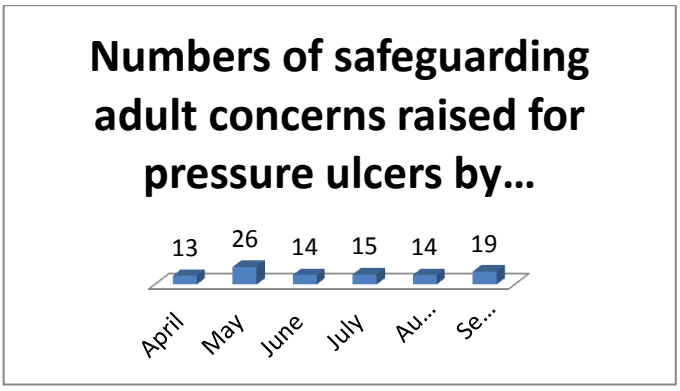
Concerns were raised by family members about how their 70 year old relative was being cared for in a residential care home. This was handed over to the local safeguarding adult team, and also safeguarding adult lead for the local authority, as there have been ongoing concerns about that care home provision.

EXAMPLE 2

The daughters of an 89 year old man living at home and in receipt of care agency visits daily, complained that the care agency were not adhering to the agreed care plan of two carers visiting each day, and the numbers of visits. The care agency denied this; the daughters had evidence in support of their concerns. This was raised as a safeguarding adult concern with the local authority and also escalated to the safeguarding adult lead, due to the numbers of vulnerable adults visited daily by the care agency.

3.10 In line with the *London Multi-Agency Adult Safeguarding Policy and Procedures,*[3] and *'Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry,' Department of Health January 2018,* pressure ulcers are only reported as safeguarding concerns if they are felt to have been avoidable, and the result of abuse and/or neglect. Whittington Health continues to play a key role in distributing information to the local community to raise awareness about prevention of pressure ulcers (Graph 9).

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



Graph 9

4. Allegations made against staff

4.1 In this reporting period there have not been any cases of staff employed by the Trust being referred to the LADO (Local Authority Designated Officer). The Allegations against Staff Policy remains in place.

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

5. Training

Children

5.1 Compliance with statutory training continues to be static.

5.2 Whittington Health secured funds to purchase the 'Rosie' simulation training package. The utilisation of safeguarding scenarios have been piloted and received postitive feedback from participants and peer evaluation from the faculty.

5.3 Level 2 compliance is heavily impacted upon by trainee doctor rotations and issues with training history captured on commencement of service within Whittington. There needs to be a more robust methodology for recording previous doctor training at induction.

5.4 Compliance (data up to 30/9/2018)

Level 1

	Total number of staff requiring level 1 training	Total number of staff up to date with training	Percentage of relevant staff trained
Q2 Sept 2017	1049	964	92%
Q3 Dec 2017	1065	965	91%
Q4 March 2018	1009	928	92%
Q1 June 2018	1019	895	88%
Q2 Sept 2018	1019	911	89%

Level 2

	Total number of staff requiring level 1 training	Total number of staff up to date with training	Percentage of relevant staff trained
Q2 Sept 2017	1832	1621	88%
Q3 Dec 2017	1815	1278	70%
Q4 March 2018	1891	1424	75%
Q1 June 2018	1905	1485	78%
Q2 Sept 2018	1921	1470	77%

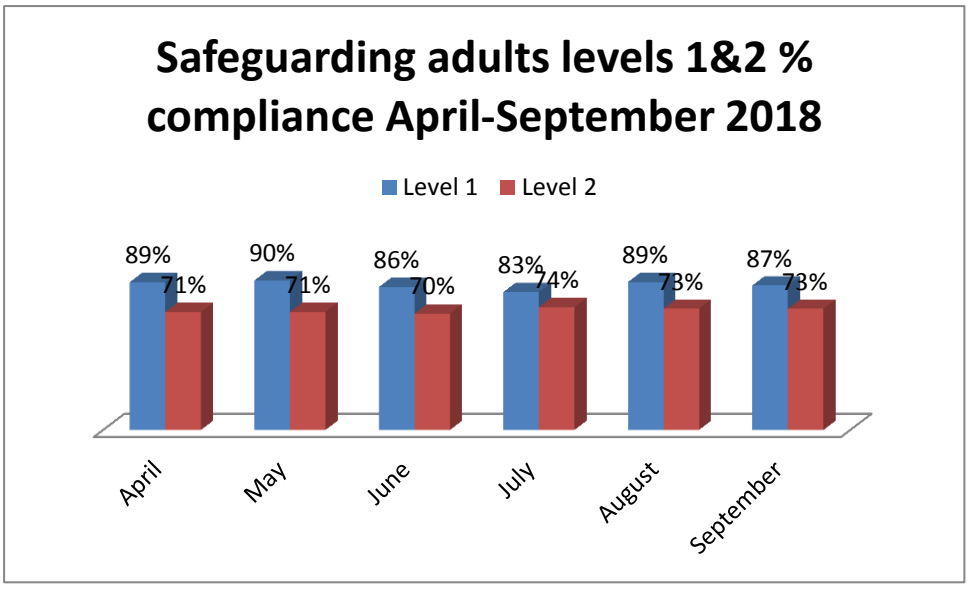
Level 3

	Total number of staff requiring level 3 training	Total number of staff trained	Percentage of staff trained
Q2 Sept 2017	1055	862	82%
Q3 Dec 2018	1141	911	80%
Q4 March 2018	1115	942	84%
Q1 June 2018	1109	941	85%
Q2 Sept 2018	1063	896	84%

Adults

5.1. It is encouraging to see compliance of safeguarding adults level 1 continues in the 80-90% range through this period.

5.2 Compliance levels for level 2 remain in the 70s% region, and over 20 face to face sessions have been offered during this period to ensure staff are able to access this training.



Graph 11

6. Learning from Serious Incidents (SI), Serious Case Reviews (SCR child), Safeguarding Adult (SAR) and domestic homicide reviews (DHR)

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

6.1 Safeguarding Children

Whittington Health has a Serious Case Review/Serious Incident action plan that is monitored by the Safeguarding Children Committee to ensure relevant learning from the SCR/SIs is implemented. Actions are also monitored through the LSCBs within the Serious Case Review sub groups.

During this quarter significant movement was seen in moving a long term action forward relating to communication between midwifery and health visitor colleagues. Midwives will now be able to access the community RIO note keeping system for easier flow of information particularly in relation to vulnerability.

There has also been a significant review of the school nurse role in relation to safeguarding children in recognition of their role in respect of children and young people. School nurses are not required to attend all review case conferences now unless they have identified a specific role or health issue they need to report on. This allows them to spend more time focusing on providing a more holistic and universal approach to the school age population rather than their work being dominated by solely spending their time with children already subject to child protection procedures.

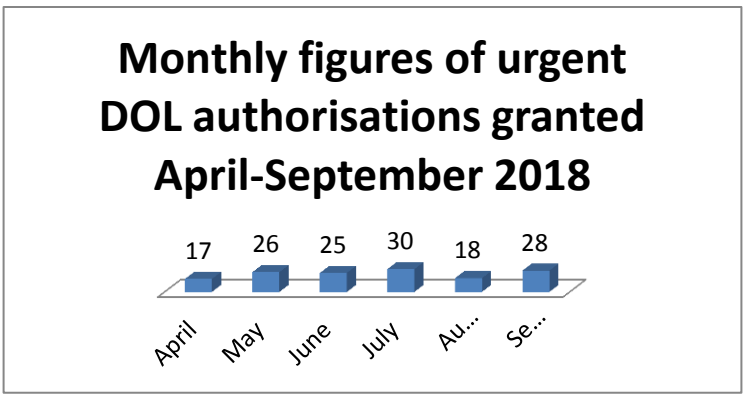
6.2 Safeguarding Adults

Section 44 of the Care Act 2014 stipulates a Safeguarding Adult Review (SAR) is to be undertaken by the Safeguarding Adults Board (SAB) when there are concerns about how partner agencies worked together, and the SAB suspects an adult has experienced significant harm, or has died as a result of abuse and/or neglect [4]. The aim of undertaking such a comprehensive review is to look at what can be learned and how practice can be influenced and developed. Whittington Health has been involved formally in one SAR during this reporting period. The report is not finalised at the time of writing, and so findings cannot be shared. The Trust has been fully cooperative in the Panel discussions.

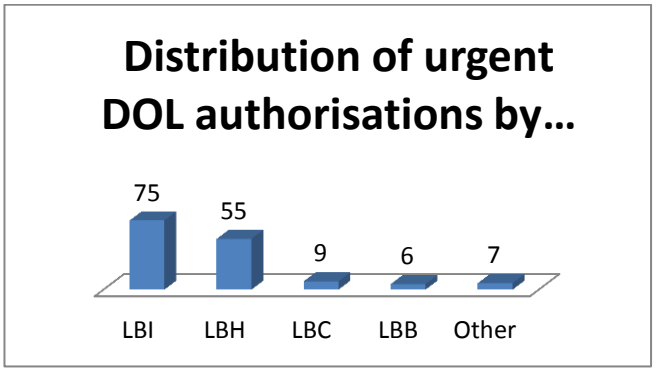
6. Deprivations of liberty safeguards

Graphs 12 and 13 below show the numbers of Deprivation of Liberty (DOL) urgent authorisations applied for within Whittington Health. This data is further broken down into gender, race and age range, before looking at the distribution of urgent applications to local authorities, and the originating ward of the hospital. The NHS digital report *'Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2017-18'* published in October 2018 had a slight increase in numbers of DOL of 4.7%. Whittington Health saw a 34.5% increase in numbers of urgent DOL applications when compared to April-September 2017.

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



Graph 12



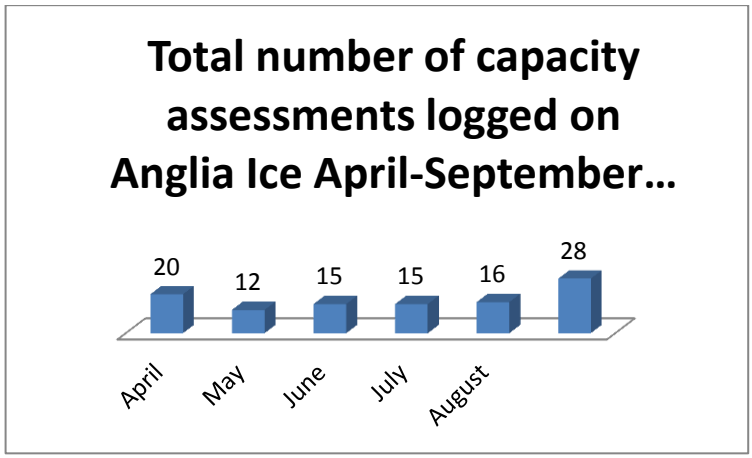
Graph 13

8.0 Mental Capacity Act (MCA)

8.1 The Mental Capacity Act (2005) is applicable for people aged 16 and above, and who have "an impairment of, or disturbance in the functioning of, the mind or brain"[5]. As graph 14 below shows, numbers of capacity assessments logged on Anglia Ice were fairly consistent throughout this period, showing an increase in September. These figures represent a 27% reduction in numbers of assessments recorded on Anglia Ice in comparison to the same period 2017-2018. The figures are not a true reflection of numbers of capacity assessments undertaken.

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

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



Graph 14

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

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

8.5 Whittington Health has been at the forefront of training delivered across the Camden, Islington and Haringey Community Education Partnership Networks (CEPNs). The first two sessions ran in June and July 2018, and attracted a wide ranging audience from the health and social care economy. Representation was made from diverse sections of the professional workforce, from GPs to police, social workers, health care assistants, Registered nurse (RN) mental health, RN adult RGNs, Occupational Therapists and care home and home care staff. So successful were the sessions that funding has been secured for a further six sessions.

9 Learning disabilities

9.1 In June 2018, the Trust held a number of events to raise awareness of the needs of patients with a learning disability. The awareness raising sessions included training, a talk from the author of *'A very special parent'*, Yvonne Newbold, and an awareness raising stall in the atrium, supported by colleagues from both Islington and Haringey Community Learning Disability Partnerships. In July 2018, the Learning Disability acute liaison nurse post was successfully recruited to.

10 Progress against 2018/19 priorities

Children

- To continue to provide high level safeguarding training packages whilst aiming to achieve compliance across all three levels
- To work with Learning & Development and the Medical directorate to improve trainee doctor training compliance recording

- To deliver on the safeguarding actions and recommendations emerging from JTAI Inspections.
- To embed the safeguarding agenda fully across the Integrated Care Organisation by moving safeguarding team from under the Children's ICSU to sit under corporate structure in September 2018.
- To contribute and develop practice across the organisation with regards to emerging themes around contextual safeguarding e.g. Think Family and voice of the child
- Develop health strategies in relation to gangs, adolescent mental health and child sexual exploitation
- To further develop partnership working between midwifery and health visiting services
- To continue to develop pathways within MASH teams that support the transmission of proportionate health data across the partnership to help protect children and young people effectively

Adults

- Ensure compliance for safeguarding adults levels 1&2, and WRAP 3
- Complete a training needs analysis in line with the Intercollegiate document for safeguarding adult training
- Complete an audit in use of the MCA

11 Recommendation

The Board is asked to review the six monthly safeguarding update agreed by the Quality Committee and to take assurance that the Trust's safeguarding processes for both children and adults are robust and effective and meet statutory and regulatory obligations.

Meeting title	**Trust Board – public meeting**	**Date: 27.2.2019**
Report title	**Whittington Health Culture Improvement plan**	**Agenda item: 10**
Executive director lead	Siobhan Harrington, Chief Executive Officer	
Report author	Norma French, Director of Workforce	
Executive summary	In the annual staff survey at Whittington Health (WH), staff have consistently reported they are experiencing bullying and harassment (B&H) at work for a number of years. To understand staffs' experience of B&H more clearly, Professor Duncan Lewis, from Plymouth University Business School, was commissioned to undertake an independent review of the workplace culture at Whittington Health in 2018. The findings of this survey were reported to the Trust Board in July 2018 and disseminated to all staff. The Trust immediately set about delivering actions in response to the 14 recommendations within the report. Alongside this staff also expressed a strong desire to have further input into the actions the Trust would take and a series of 'Listening Events' were subsequently held across the Trust. 550 staff took the opportunity to contribute their views through this process. This report: • Details the work that has been underway since July 2018, and provides the current action plan that addresses the 14 recommendations made by Professor Lewis • Outlines the themes that have emerged following the listening exercise undertaken in the Autumn 2018 • Details the upcoming NHSI/UCLP Culture and Leadership Collaboration of which the Trust has been accepted as one of four London Trusts to undertake the Programme this year The work to date, and the development work that will happen as a result of the NHSI/UCLP Culture and Leadership Collaboration provide the organisation with a new approach to establish a social movement to enable cultural change across the Trust and reset its leadership and organisational culture towards more compassionate collective leadership.	
Purpose:	Approval	

Recommendations	The Board is asked to: i. Discuss the work that has been undertaken since the Culture Survey ii. Note the themes that emerged from the 'Listening Events' and agree the actions to address these iii. Endorse the proposed approach to using the NHSI/UCLP Culture and Leadership Collaborative to develop a new social movement approach to culture change at the Trust, with oversight by a Steering Group reporting into the Workforce and Assurance Committee.
Risk Register or Board Assurance Framework	Risk entry 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 ultimately patient care suffers as a result.
Report history	Trust Board Seminar 12th February 2019 Trust Management Group 26th February 2019
Appendices	Workplace Culture at Whittington Health NHS Trust: Key Findings and Recommendations, Professor Duncan Lewis July 2018 NHSI Culture and Leadership toolkits

1.0 Introduction

This report updates Board members with:

- the actions taken since Professor Lewis's review of workplace culture
- feedback from the listening exercise from last year
- details of the NHSI/UCLP Collaboration and the Trust's acceptance as one of four London NHS providers on that programme in 2019

2.0 Immediate Actions Taken to address the 14 recommendations in Professor Lewis' report

Appendix 1 of this report provides the Board with the current detailed action plan, including KPIs and expected outcome measures, that addresses the 14 recommendations in Professor Lewis' report. The recommendations are taken from the seven detailed in the Executive Summary of Professor Lewis's report, and the seven detailed at the end of the report. Where there are similarities between these recommendations these have been grouped to enable key actions to address the group of recommendations.

The initial response presented to the Trust Board, following Professor Lewis' report, set four immediate actions that would be undertaken whilst further engagement was underway. A brief update on progress of on these four immediate actions is presented below:

2.1 Immediate Action One - Behavioural Standards

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

Drawing upon the evidence-based actions in an NHS Employers case study: 'Tackling Bullying in Ambulance Trusts' to establish a culture in which staff are more able to challenge negative behaviours and insist upon positive behaviours, a Behavioural Framework has been developed and approved at the Trust Management Group. The Behaviour Framework:

- Offers staff a defined and explicit statement of what constitutes bullying and harassment at Whittington Health
- Provides explicit examples of what the Trust deems acceptable and unacceptable behaviours
- Provides accessible and practical advice on how to manage the experience of bullying or harassment either as the perceived victim or witness

To provide assistance to those experiencing bullying the Trust has:

- Revised the role of the Freedom to Speak up Guardian and recruited substantively to the role

- Begun a process of developing a network of Speak up Inclusion Champions, Bullying and Harassment Advisors and Mental Health First Aiders to make available a wider group of trained staff who can help to provide confidential support within the Trust, signpost those reporting bullying to the Employee Assistance Programme for additional confidential support outside the Trust.

2.2 Immediate Action Two - New approaches to resolution

To address the grievance culture highlighted by Professor Lewis, the Trust has further developed its ability to deliver informal resolution wherever possible.

To improve our capacity to deliver informal resolution the Trust has:

- Trained 29 coaches from across the Trust from both clinical and non-clinical roles, and at a variety of levels of seniority. These staff coach staff to manage their circumstances and set personal goals, including how to change relationships where they were not working well.

- Trained 10 mediators to work with colleagues to improve the way staff address issues of concern and communicate with each other.

- Joined with several other London Trusts in a reciprocal agreement to provide external independent mediation. The Trust has already accessed this service for staff who feel that they would prefer external mediation.

- An electronic employee relations case management system was procured in summer 2018. This has allowed greater monitoring and traction on all cases and as a result in January 2019 it was reported to the Workforce Assurance committee that there were no non-medical cases that had not been resolved with the 90 days target.

- The Trust Grievance Policy update, which had deliberately been left until the outcome of the Culture Survey was known, is being negotiated in partnership with our trade unions.

2.3 Immediate Action Three - Pulse checks

Annual staff surveys and the staff friends and family test do not offer the organisation a real time mechanism for knowing whether the culture of the organisation is changing. Other NHS organisations have started to undertake quarterly “pulse checks” to explore other elements of staff satisfaction at work. Whittington Health has adopted this approach and has added an additional question to the Staff Friends and Family Test.

Staff are being asked:

“How satisfied are you in Whittington Health's response to tackling issues of bullying and harassment' (rated very dissatisfied to very satisfied). Staff can comment on why they rated the response as they did.

The first revised Staff FFT pulse check is underway at present. The questions can be re-worded as necessary going forward

It is intended that the collaborative change team engage staff in developing a different set of Pulse check questions with staff. The following are examples of pulse check statements used by other Trusts.

Example pulse check statements:

- I know what is expected from me in my job
- I can recite our organisation's values
- I use these three words to describe our culture (free text responses)
- I feel we authentically deliver our organisational values
- I feel co-workers treat each other with compassion and fairness
- When we finish our work, we collectively reflect on what went well and what could be improved on next time
- If given the chance I would reapply to my current job
- I give feedback to my manager what I am thinking or feeling or notice
- I believe the leadership team takes my feedback seriously
- I frequently receive recognition from my manager
- I give my team and members of my team/ my manager frequent recognition

Although responses to the Pulse Checks are anonymous, staff will state their staff group and ICSU. Staff will score the responses to enable analysis of results and inform the work of the culture change programme.

2.3.1 *Listening Events*

Following publication of Professor Lewis' report staff expressed a strong desire to have further input. The Trust Management Group decided to run a series of 'Listening Events' across the Trust. 550 staff, of all grades and disciplines, took this opportunity to contribute with their views. Working in either groups or as individuals, staff were asked to consider five questions:

- Think of a time when you valued a truly positive culture at work. What was it that made it so good?
- What changes have we already implemented and how do we sustain them?
- What changes could we put in place and how do we evaluate them?
- Think of a time we were working together at our best and decision making was at its most efficient. What made it good?
- What could any group of staff do differently tomorrow that would make the most impact?

A thematic review of the questions found the following themes:

- Staff want inappropriate behaviours to be challenged and managed;
- Staff would like to feel listened to;
- Staff want greater clarity over roles and responsibility for themselves and others;
- Staff want an end to top down change management, moving instead to co-designed and delivered change involving all staff groups;
- Staff would like to feel more valued and feel more equal;

- Staff would prefer less micro-management and more freedom to find solutions or new ways of working themselves;
- Staff would like more definitive ways of knowing “what good looks like”.

Section 3.0 of this paper sets out the development work that will happen as a result of the NHSI/UCLP Culture and Leadership Collaboration that will provide the organisation with an opportunity to engage with staff to ensure the changes needed to address their concerns are designed and created by them to enable the Trust and reset its leadership and organisational culture towards more compassionate collective leadership.`

2.3.1 *Staff Focus September*

At the same time as the Listening Events were underway, there was a recognition that there are a number of disparate pieces of activity being undertaken across the trust to enhance the health and wellbeing offer, to equip staff to deal with mental health issues, to support staff to raise concerns about unsafe practices or unacceptable behaviour, to encourage diversity, and to allow all staff to be their authentic self at work. However, it was felt that there was a lack of coherence around these activities, potentially diluting the impression that staff may have of the Trust as a supportive, listening and responsive organisation.

In response, the Trust ran “Staff Focus September, bringing together the range of activities in train together, to create one powerful; impactful story around staff support, encouraging a positive culture and promoting health and wellbeing.

Packaged together, the Trust showcased the many and varied ways the organisation is responding to feedback and improving the culture within the organisation, the support that staff have available, the breadth of opportunities offered to enhance mental and physical health and the range of ways the Trust supports staff to be themselves and to create safe spaces for them to raise constructive challenge where things go wrong.

Additionally, staff were asked to suggest actions that the Trust could immediately affect to improve staff experience in tangible and visible ways. The following table provides the list of issues raised by staff.

Issues raised
Provide email access for all
Have computers installed for the Porters
Decorate staff toilets and staff rooms
Host an Amazon collection point in key sites
Provide more secure bicycle access
Develop a nursery
Pay everyone inner London Weighting
Long service awards

2.4 Immediate Action Four - Leadership Development

The culture survey report recommended that leaders and senior managers develop a ‘more robust and purposeful leadership style to support colleagues and tackle issues in a timely and well-ordered fashion’.

Since the Culture Survey report, the Trust has revised the ICSU leadership and operating framework and in some cases, there are new postholders in key leadership roles. The new ICSU triumvirates have been supported in their development through a dedicated coaching and organisational development (OD) programme delivered by NHS Elect and the Trust's OD team. This process has ensured greater clarity on role responsibilities, helped the triumvirate to agree their ICSU priorities, improved communication and teamwork by developing shared purpose and openly identified team strengths and weaknesses to develop strategies to support high levels of team functioning, build confidence and resilience.

Additionally, following leadership and management developments have been delivered since the culture survey report:

- Executive Team Development
- Visible Leadership
- LEAD – medical leadership development sponsored by the Medical Director
- Leader and Influencer pilot – project based paired leadership development
- Band 6 & 7 clinical leaders programme
- iCARE values-based leadership development

A new 'workbook' has been developed to support managers to achieve a 'passport to manage' over a period of time. This has been created for the band 6 and 7 clinical leaders' programme and will be developed with other programmes to create the 'passport' for all managers and used with performance appraisal.

3.0 What next?

3.1 Staff feedback

A staff feedback campaign is to be developed in conjunction with our communications Team to advise staff of the actions that have been taken in the six months since the Culture Survey Report and outlining the decisions on actions the Trust will take following the thematic review of the Listening Events feedback from staff.

3.2 NHSI/UCLP Culture and Leadership Collaborative

Professor Lewis' review evidences that our organisational climate is strongly influenced by the behaviours and values of managers and clinical leaders, and their commitment to supporting the wellbeing of staff. To address these and the other issues raised in the report the Trust will continue to deliver the actions included in the action plan at Appendix 1.

To further develop our capability to positively impact our culture change journey, the Trust successfully bid to be one of the four London Trusts to join the new NHSI/UCLP Culture and Leadership Collaboration that commenced in January 2019 and runs until 2020.

This new Collaborative builds on the NHS Improvement Culture Programme which was developed in 2016 in partnership with The King's Fund and has since helped trusts across the country through online resources and support from NHS Improvement colleagues. The Collaborative will offer direct teaching, action learning, expert and experienced speakers as well as change team coaching to support the teams to grow as cultural couriers within their organisations. By the end of the programme, Trust teams will have explored their current

culture, diagnosed areas for improvement, created a strategy for developing a positive and inclusive culture, and started to implement the changes.

To maximise impact and the benefits of the Collaborative, participating Trusts engage internal collaborative change teams who are supported to understand the tools, engage with the Board in a constructively challenging way; run effective focus groups to learn about the current cultural state; synthesise the information they find and build an effective strategy for leadership and cultural change which has meaning across the system.

The collaborative change teams should be multidisciplinary from across the organisation – championing a compassionate and inclusive leadership approach. The change teams should cover different areas, occupational groups, levels of seniority and demographics. It is important to include those with operational responsibility for delivery as well as influencers and administrative support. A diverse change team helps the Trust to capture views of those who feel marginalised in the workforce. The senior change team will comprise of the following:

- The CEO as executive sponsor
- The Executive Director with responsibility for organisational development
- Project manager or individuals with similar expertise
- Organisational development and HR representation
- Medical/clinical/service leads
- Communications professional
- Analytical resource
- Patient experience lead or similar
- Administrative support
- As appropriate people from estates and facilities, other clinical, administrative or managerial staff.

Several staff from different backgrounds have already expressed their desire to be part of the wider Change Team

It is our intention that although the NHSI/UCLP Culture and Leadership Collaborative framework is used by the Trust to guide the approach to the work, we will use this programme to kick start a social movement for cultural change at Whittington Health. We will start this by Staff deciding what the work programme will be known as at Whittington Health.

Research suggests that social movements start with emotion — a diffuse dissatisfaction with the status quo and a broad sense that the current institution and power structure will not address the problem. The combined findings of the Culture Survey and the listening events clearly lay out the staffs' views of what they would like to see change at Whittington Health.

In social movements brewing discontent turns into a movement when voices arise that provide a positive vision and a path forward that is within the power of the crowd. Social movements begin with a group of passionate enthusiasts who deliver a few modest wins. While these wins are small, they are powerful in demonstrating efficacy to nonparticipants, and they help the movement gain momentum. The movement really gathers force and scale once this group successfully co-opts existing networks and influencers. Eventually, in successful movements, leaders leverage their momentum and influence to institutionalise the change in the formal power structures and rules of society.

NHSI/UCLP Culture and Leadership Collaboration provides the Trust with an opportunity to engage with a group staff who are passionate enthusiasts; to support them to deliver a few modest wins, and to provide the positive vision and a path forward that is within the power of the staff.

4.0 How will we know things are different?

Practical measures for the early identification of bullying behaviours are critical. The Trust already collates information from the annual staff survey and the staff Friends and Family Test, as well as confidential 'consequence free' exit interviews, and information on diversity and inclusion. The action plan at appendix 1 details the metrics and outcome measures that will also demonstrate improvement. These may be added to as the Trust designs and delivers its Culture and Leadership Collaborative "*Title to Be Staff Determined*" change programme.

4.1 Culture and Leadership Steering Group

It is recommended that a Culture and Leadership Steering Group is established chaired by the CEO, with Executive Director responsibility to oversee the delivery of the collaborative change programme. The Steering Group will ensure delivery is on track and, through performance review process, scrutinise data to identify and remediate drift from plan.

4.2 Workforce Assurance Committee

The Trust has a Workforce Assurance Committee which is a subcommittee of the Trust Board. It is recommended that the Culture and Leadership Steering Group reports to the committee to provide further assurance on delivery of the action plan that forms a direct response to each recommendation within Professor Lewis' report and progress with delivery of the collaborative change programme.

5.0 Conclusion

The Trust Board and trust Management Group received Professor Lewis' Culture Survey report in July 2018. Since then the Trust has implemented the initial actions outlined in the response to the report. Additionally, further staff engagement has taken place through listening events and the Staff Focused September campaign.

The Trust has developed a detailed action plan attached at appendix 1 with KPIs and outcome measures. It has been successful in its bid to join the NHSI/UCLP Culture and Leadership Collaborative Programme which commenced in January 2019.

6.0 Recommendations

The Board is asked to:

i. discuss the work that has been undertaken since the Culture Survey;
ii. note the themes that emerged from the 'Listening Events' and agree the actions to address these;
iii. endorse the proposed approach to using the NHSI/UCLP Culture and Leadership Collaborative to develop a new social movement approach to culture change at the Trust, with oversight by a Steering Group reporting into the Workforce and Assurance Committee.

Culture Survey Action Plan - February 2019

Culture Survey recommendations:
- 1. Adopt robust and purposeful leadership
- 10.1 Leadership culture
- 10.5 Supporting and Developing Managers

Action Ref No.	Activity	Tasks, Milestones, Outcomes	KPIs	Current performance	Stretch target	Lead/Support	Timescale
	Board development	**The Board will take ownership of** learning from delivering action plan, leading by example in the journey towards a more compassionate and inclusive culture, and act upon the findings from the culture change collaborative. (NHSI / UCLP)	**Staff survey - to review all questions under 3 of the 10 new staff survey themes 'Equality, diversity & inclusion', 'safe environment - bullying & harassment' and safe environment - violence'** such as: % staff 'Communication between senior management and staff is effective' % experiencing harassment, bullying or abuse at work from managers in the last 12 months % saying they had experienced discrimination from their manager/team leader or other colleagues in the last 12 months	**to be updated when 2018 Survey results available**	**Top decile for engagement performance/Outstanding Trust Scores**	Chairman and CEO	Ongoing
	Executive Team Development	**Evidence of enhanced teamwork between the Trust's most senior leaders** **Developed Executive team priorities and shared purpose** **Evidence of improved communication and constructive challenge** **Undertake appropriate development to identify team strengths and weaknesses and develop strategies to support high levels of team functioning** **Undertake a team diagnostic to demonstrate increased confidence and resilience** **Each Board/Exec member become the Trust sponsor for one of the EDI or Bullying & harassment performance targets and take personal ownership for improving it** **Publish WH definition of bullying & harassment with explicit details of**				CEO	Ongoing

	Triumvirate Coaching for Role Development	Greater clarity on role responsibilities Develop triumvirate priorities Improve communication and teamwork Develop shared purpose, confidence and resilience Openly identify team strengths and weaknesses and develop strategies to support high levels of team functioning			COO, MD and CN	Ongoing
	Visible Leadership Programme	Executive are seen to lead and spend time on the shop floor **on a monthly basis** promoting participation and involvement Executive **develop new ways to meet and listen to staff** to encourage "Staff Voices" and **provide regular feedback to staff on action taken** Executive celebrate staff commitment and successes **by (e.g. corporate and local Staff Awards, case studies in newsletters and articles across the STP)**			Executive	Ongoing
	Michael West Top Compassionate Leaders	A cohort of leaders in the organisation hear about **compassionate and** inclusive leadership, discuss what would support **compassionate and** inclusive leadership in their teams and feed into the NHSI/UCLP Culture and Leadership Collaborative programme			Director of Workforce	May-19
	Increase number of Coaches in organisation	Create an internal team of 18 Affina Team Coaches who can support Team Leaders across the trust to develop their own teams, using a suite of tools and techniques By increasing access to coaching at all levels - improve team-based knowledge, skills, attitudes and problem-solving interactions among staff. Ensure teams learn together, reflect together and apply their learning to their individual and joint work			OD	Ongoing

	B6 and 7 clinical leadership programme	Deliver cohort 3 leadership programme for nursing, health visitors and therapies. To continue to offer the new Open Space sessions providing the delegates opportunities to discuss diversity and Whittington culture and leading compassionately and collectively				OD	Sep-19
	Leaders and Influencers pilot	To review cohort 1 at end of programme and propose next steps				AD Learning and OD	Apr-19
	Align leadership development programmes to the CQC well-led domain in the inspection	Intranet document that can be referenced by managers on intranet				Director of Workforce	31-Mar-19
	Development workbook for 'Passport to Manage' programmes	Record of modules from a variety of programmes that form the passport: each module signed off as complete.				**HRBPs**	30-Jun-19
	Share good practice of 'excellent leaders and teams' via the buddy model	Programme of events well-attended by variety of staff and managers				AD Learning and OD and COO	01-Jul-19
	Lunch and learn events delivered internally or externally	Periodic events well-attended by variety of staff and managers				AD Learning and OD and COO	01-Jul-19
	Recommendation: **- 2. Medical body to role model organisational effectiveness and appropriate behaviours**						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	New consultant Development Programme	**Deliver a programme for all newly appointed (or in post for less than two years) consultant medical staff**				**Medical Director**	**commenced January 2019**
	review operating management framework and make changes to the clinical leadership structure within the ICSUs	**Clarity of role and purpose for clinical leaders. Clinical leaders role modelling ICARE values**				**Medical Director**	

	Engage the Medical Committee to consider the value of incorporating it into the Trust's governance framework	**An effective partnership model with positive engagement by a wider group of the consultant body with the development of the organisation that encourages mutual constructive challenge to support the delivery of the Trust objectives**				**Medical Director**	
	LEAD medical leadership development programme	**Deliver a new leadership programme offering quality improvement learning and personal development in line with compassionate and inclusive leadership**			**Top decile performance/Outstanding Trust Scores - which ever is the highest**	**Medical Director**	**Ongoing**

	Recommendations **- 3. Ensure grievance processes are fair and clear and address grievance issues more speedily** **- 10.2 HR/Workforce** **- 10.7 Grievance Management**						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	Revise policies on disciplinary process and grievance process	Revised policies agreed and launched	**% staff 'During the last 12 months have you felt unwell as a result of work related stress?'** % saying their organisation definitely takes a positive action on health and wellbeing **Local KPIs** Time to resolve X% improvement Reduction in disciplinary and grievances Increase in mediation **and facilitated conversations** Engagement rates	To be updated when 2018 Staff Survey Results available	**Top decile performance/Outstanding Trust Scores - which ever is the highest**	Workforce Teams with Partners	TBC
	Review and revise anti-bullying policy and procedures including its name	Agreed policy and procedures launched				Workforce Teams with Partners	01-Mar-19
	Development of external reciprocal mediation arrangement	**Increased capacity to mediate without additional cost**				Head of OD	Ongoing
	Train staff like mediators to offer facilitated conversations	Pool of trained mediators in place Increased **facilitated conversations and** mediation and reduction in grievances				Head of OD	Ongoing
	Fair Treatment Panel to ensure the cases going forward into the	Evidence of Panel sitting				Workforce ER Team	01-Oct-18 and ongoing

	disciplinary or grievance processes are appropriate, redirecting where beneficial	Agreement on its usefulness between users, Partners and Workforce				Partners, members of the panel	
	Improve time to resolve	Shorter time from start to end of process				Workforce Teams, Partners, investigating managers	31-Mar-19
	Develop Whittington Health Framework on bullying and harassment unacceptable behaviours	Provide staff with a defined and explicit statement of what constitutes bullying and harassment at Whittington Health Provide explicit examples of what the Trust deems acceptable and unacceptable behaviours Provide accessible and practical advice on how to manage the experience of bullying or harassment either as the perceived victim or witness To link to the support and advice already available to staff including the Trust policy.				Head of OD	Definitions Complete Published on intranet by Apr-19
	Embed leadership and management behavioural framework Performance appraisals values based recruitment	(i) Pilot with AHP Executive Team and refresh wider launch of framework, (ii) Inclusion of values during scheduled review of policies and procedures (iii) introduce values based recruitment				(i) OD (ii) Inclusion Team with ER (ii) Workforce Teams and Partners	Each reportable from now, on ongoing basis
	HR engagement cycle	HR staff regularly engage staff from different groups within their own work areas to hear their experiences Themes are reviewed and actions agreed with timescales for intervention Thematic review reported to TMG				Director of Workforce	TBC

	Recommendation: **- 4. Develop a new partnership model empowered to drive change and to provide greater scrutiny of data** **- 10.3 Scrutiny of existing data and power to drive change**						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	Promote reporting of all incidents through infographic posters	Evidence of posters on walls in different sites and screensavers on staff PCs	% staff 'My organisation treats staff who are involved in an error, near miss or	to be added when 2018 Staff Survey results available	Top decile performance/Outstanding Trust Scores - which ever is the	Director of Workforce	TBC

		Score for willingness to report increased as measured in NHS Staff Survey	incident fairly' % staff 'When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again' % staff ability to contribute towards improvements at work **Local KPIs** Increased reporting of incidents of B&H Increased FSUG activity Improved FFT scores Pulse check scores Staff turnover Staff sickness/ absence	highest		
	Define and clarify FSUG role to enable staff to discuss concerns with patient safety	Statement on role purpose agreed and shared			Director of Workforce	31-Oct-18
	Develop a FSUG webpage and link to B&H webpage	Staff accessing the webpage			FSUG, OD and Head of Comms	01-Apr-19
	Develop a network of support for staff by bringing together the B&H advisors, SUICs and MH 1st aiders	Clarity of roles and ease of access for all staff			FSUG	01-May-19
	Increase reporting using 'it's good to talk'	Increase in reporting			FSUG and Communications Team	TBC
	Promote and monitor use of 'speak up inclusion champions'	Evidence of increased use (preferably with no increase in the level of incidence of bullying)			Communications Team Inclusion Team	TBC
	Introduce 'staff stories' at Trust Board every quarter or at seminars	First story heard			Communications Team supported by Inclusion / OD / HRBPs	TBC
	Staff Council / People Committee reporting to the WAC/Board Enable front-line staff to express expectations about their managers	Membership and governance agreed First meeting held			CEO, Exec Team, TMG, Workforce Teams	TBC
	Undertake quarterly staff Pulse Check	New question each Qtr based on previous staff feedback Quarterly Pulse Checks carried out Continuous improvement in scores over time			Head of OD	01-Jan-19

	Identify "Hotspots" from triangulation of **-staff survey - low morale** - sickness absence - poor scores on quality KPIs - high vacancy rates - poor pulse check scores - above average numbers of grievances/disciplinaries	**Number Teams gone through Affina Team Journey** Hotspots identified and reported quarterly at TMG Remedial action plan in place Improvement in all relevant KPIs for the hotspot area				Director of Workforce CNO COO MD	TBC

#NAME?

	Recommendations: **- 5. Support managers to better manage conflict** **- 10.4 Managers and PDR reviews**						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	Upskill managers to de-escalate issues, through variety of training modules (e.g. Coaching Conversations, ActEd, Conflict Coaching, Conflict Management, ad hoc training events)	% of staff in management roles having attended the variety of training modules that include development and practice of skills for having difficult conversations Number of Team Leaders/managers who have taken their teams through Affina Team Journey	**% saying 'My immediate manager asks for my opinion before making decisions that affect my work'** % reduction in staff saying 'Relationships at work are strained' % saying their appraisal definitely helped them improve how they do their job % saying their appraisal definitely helped them agree clear objectives for their work **Local KPIs** % of staff in management roles attending leadership training Reduction in grievances Increase in appraisal	to be added when 2018 Staff Survey results available	Evidence of improvements in staff survey responses	L&D, OD, HRBPs and all managers with staff	Ongoing
	Review of appraisal policy	Appraisal linked to delivering corporate objectives Values based appraisals in place Easier to follow appraisal documentation promoting the quality of conversation and values based development plans				ADL&OD	31-Mar-19
	iCare Values Based Leadership Programme	Numbers of staff who have attended an ICARE programme including ICARE Team Player				OD	Ongoing
	Link "Passport to Manage" workbook to appraisal process and Trust objectives during review of appraisal process	Revised agreed appraisal launched and used				Workforce Teams with Partners	31-Mar-19

	Recommendations: - 6. Staff should understand their roles and their contribution to organisational objectives through performance appraisals						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	Develop Values Based Appraisals	ICARE values in appraisal template, creating basis for discussion between manager and staff, celebrating success as well as areas for future development specifically in relation to behaviours / unconscious bias / inclusivity / supporting career development / innovation etc	**Staff survey - local metrics on values** % staff that have opportunities to show initiative in their role % staff that are able to make suggestions to improve the work of their team department % saying their appraisal definitely made them feel their work was valued by the organisation	to be added when results of 2018 Staff Survey available	Top decile performance/Outstanding Trust Scores - which ever is the highest		
	Team appraisals - pilot Affina team diagnostics as team appraisals and then review	**Evidence of impact of team development based on diagnostics**				OD	Dec-19

	Recommendations - 7. Deliver an anti-discrimination strategy built around diversity and inclusion, with scrutiny at Executive level - 10.6 Tackling Discrimination						
Action Ref No.	**Activity**	**Tasks, Milestones, Outcomes**	**KPIs**	**Current performance**	**Stretch target**	**Lead/Support**	**Timescale**
	Deliver the WRES Programme	Able to report on all 9 indicators Report quarterly to Board Apply learning from NHSI / UCLP Culture Collaborative	Use all nine WRES indicators and corss-refernece into WRES Improvement Plan approved by Trust Board in December 2018. Staff believing the trust provides equal opportunities foir career progression and promotion	**To be added when staff survey result indicators available**		**Inclusion Team**	**Annual reporting (June)**
	Reverse mentoring - junior BME staff trained to confidently mentor executive and Board members	**Exec Board and mentors share learning with the wider organisation and extend offer to next tier down**				**Head of Inclusion**	**Ongoing**
	Launch mental health guidance for managers to enable staff access to appropriate support	Guidance launched				Occupational Health Team	Completed.
		Evidence of use (e.g. access to support identified in guidance and anecdotal reports)					
	BAME representative on interview panels for B8+	All panels include BAME representative				Head of Inclusion and Deputy Director of Workforce	24-Dec-18
	Email etiquette	Evidence of use and reference to its use				Workforce, all staff	Launched

	Develop ‘zero tolerance’ to bullying (reduce and eradicate bullying year on year)	Year on year reduction (NHS Staff Survey)				HRBPs, Head of Inclusion & OD	TBC
	Promote and monitor use of anti-bullying advisors	Evidence of increased use (preferably with no increase in the level of incidence of bullying)				Head of Inclusion and Deputy Director of Workforce	TBC

Meeting title	**Trust Board – public meeting**	**Date: 27 February 2019**
Report title	**Patient Experience Strategy 2019-21**	**Agenda item: 11**
Executive director lead	Michelle Johnson, Chief Nurse & Executive Director of Patient Experience	
Report author	Phillipa Alston, Head of Patient Experience	
Executive summary	There is increasing evidence that positive patient experiences lead to positive clinical outcomes. The success of this strategy is dependent on every member of staff, irrespective of their position or profession, contributing to the delivery of this work. Since publication of the Trust's previous patient experience strategy, significant progress has been made in ensuring the Trust listens and responds to patients, service users, carers and families. There is now a need to strengthen and expand on this to enable staff and services to truly work in partnership with patients and carers. To facilitate this, three ambitions have been developed that describe how we will drive this change to improve our patients' experience and ensure patients, families and carers are actively involved in our quality improvement and service redesign projects. The ambitions are: **Ambition 1**: We will improve the information we provide to patients and carers to enhance two-way communication **Ambition 2:** We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement **Ambition 3:** Improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care The ambitions were developed through discussions with people who use the Trust's services about what is important to them and analysis of existing information and feedback regarding patient experience. The ambitions are also linked to the strategic aims set out in the Trust's current Clinical Strategy. The ambitions of this strategy apply to all services in the hospital and throughout community services and to all those accessing care.	

Purpose:	Approval
Recommendation(s)	The Trust Board is asked to approve the Patient Experience Strategy 2019-21
Risk Register or Board Assurance Framework	There are no BAF entries that specifically relate to patient experience however the strategy provides evidence that the Trust is maintaining a focus on delivering high quality, safe and compassionate care for our patients
Report history	Service User Stakeholder Meeting Patient Experience Committee (including Health Watch partners) Quality Committee, January 2019
Appendices	1: 2019-21 Whittington Patient Experience Strategy

I·C A R E

INNOVATION COMPASSIONATE ACCOUNTABLE RESPECTFUL EXCELLENT

NHS
Whittington Health
NHS Trust

Patient Experience Strategy 2019 -2021

Our mission is clear: help local people live longer, healthier lives by providing safe, personal, coordinated care for the community we serve.

This document sets out Whittington Health's strategy for ensuring that patients are at the heart of everything we do to achieve this.

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01

Why This Matters

There is increasing evidence that positive patient experiences lead to positive clinical outcomes. The success of this strategy is dependent on every member of staff, irrespective of their position or profession, contributing to the delivery of this work.

Since publication of our previous patient experience strategy significant progress has made towards ensuring we listen and respond to our patients. We now need to strengthen and expand on this to enable our staff and services to truly work in partnership with patients and carers.

To facilitate this, three ambitions have been developed that describe how we will drive this change to improve our patients' experience and ensure patients, families and carers are actively involved in our quality improvement and service redesign projects.

The ambitions were developed through discussions with patients about what is important to them and analysis of existing information and feedback regarding patient experience. The ambitions are also linked to the strategic aims set out in the Trust's Clinical Strategy.

Whittington Health was one of the first in the country to be established as an Integrated Care Organisation, joining community services with hospital care. The ambitions of this strategy apply to all services in the hospital and throughout our community services and to all those accessing our care.

The patient experience team will work in partnership with corporate services, the integrated clinical services units and patients, families and carers to support successful outcomes.

There is a clear national focus on improving patient experience and there are numerous national policies, publications and recommendations to support this work. The following guidance and recommendations have been considered as part of the development of this strategy:

- **Equity and Excellence: Liberating the NHS (2010) p**ut patients at the heart of the NHS, through an information revolution and greater choice and control. Shared decision making will become the norm: “no decision about me, without me”.

- The National Institute for Health and Care Excellence (NICE) **Quality Standards for patient experience** in adult NHS Services (2012) and service user experience in adult mental health (2011) outline a range of areas for best practice, definitions of high-quality care and the standards that people using NHS Services should expect to receive.

- NHS National Quality Board published the NHS **patient experience framework** in 2012. This outlines those elements that are critical to the patients’ experience and guides the measurement of patient experience across the NHS.

- **The Francis Report in 2013** emphasises the requirement for openness and for transparency enabling patients to raise concerns and complaints freely and to have their questions answered. Recommendations refer to the need for qualitative information to be made available in as near real-time as possible.

- **NHS England Five Year Forward View In October 2014**, NHS England (NHSE) described the ambition of the NHS, to introduce a transformational approach to healthcare. In relation to patient experience, providers plans must include ambitions to:
  o Reduce poor experience of inpatient care
  o Assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients.
  o Demonstrate improvements from the Friends and Family Test (FFT), complaints and other forms of feedback.
  o Deliver all the NHS Constitution patient rights and commitments.
  o Increase transparency of patient outcomes data to promote choice of where and how patients receive care.

- **NHS Constitution (2015)** establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

- **The Accessible Information Standard (2015)** sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

- **NHS Outcomes Framework (2015/16)** improves quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes. There are five domains. Domain 4: ‘ensuring that people have a positive experience of care’.

- **NHS Improvement: Patient experience improvement framework (2018)** supports trusts to achieve good and outstanding in their CQC inspections. The framework integrates policy guidance and good practice frequently identified in CQC reports of trusts rated as ‘outstanding’.

- **Care Quality Commission: Equally outstanding. Equality and human rights – good practice resource** demonstrates how services that have improvement of equality and recognition of human rights at their core, provide better services. This document demonstrates how trusts rated as ‘outstanding’ have developed practices that deliver equality and safeguard human rights and their expectation that this be a mainstream part of health and social care.

02

What have we achieved?

The 2014 patient experience strategy included objectives to ensure that we listen, learn and act on patient feedback and embed an effective and responsive complaints process.

There have been many successes during the previous four years and this strategy builds on those achievements and the foundations in place.

Successes include:

Every Public Trust Board meeting starts with a patient story

Putting patient experience at the heart of the meeting and sharing learning across the organisation.

Introduction of a new, trust-wide system to collect patient feedback

The number of surveys collected has increased by 143% to 41,910 since its implementation in 2015.

Response to complaints faster

We responded to 83% of complaints within 25 days in 2017/18 compared with 64% in 2014/15.

Kissing it Better

We been working with the Kissing it Better charity to enhance patient care in a variety of ways including singing, art therapy, pet therapy and beauty therapy.

Care Quality Commission

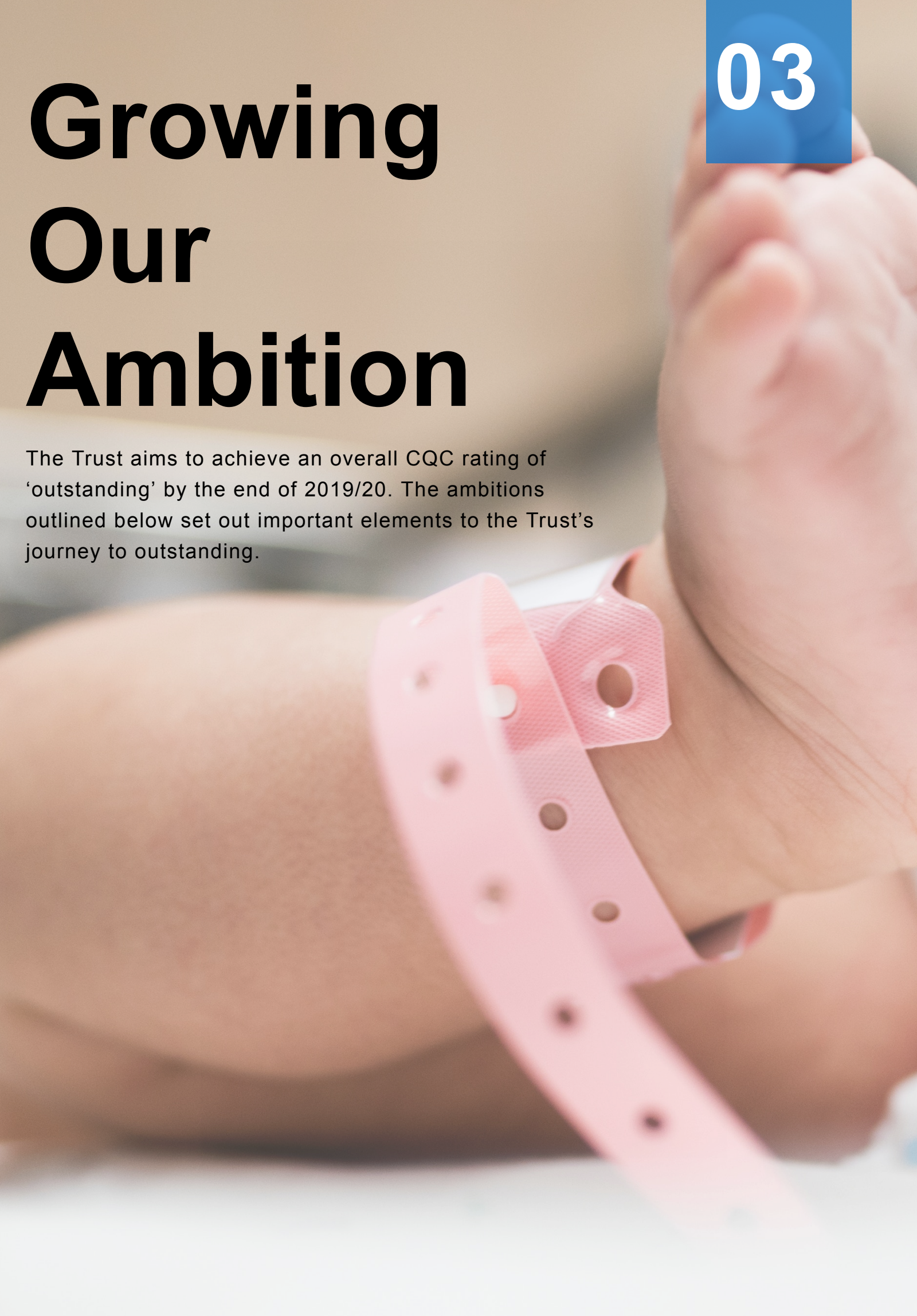
Rated as ‘good’ for responsive and ‘outstanding’ for caring in the 2018 inspection

The CQC found staff involved patients and those close to them in decisions about their care and treatment and that the trust took account of patients’ individual needs.

03

Growing Our Ambition

The Trust aims to achieve an overall CQC rating of ‘outstanding’ by the end of 2019/20. The ambitions outlined below set out important elements to the Trust’s journey to outstanding.



Ambition 1:

We will improve the information we provide to patients and carers to enhance two-way communication

Our patients, families and carers tell us that we need to be clearer and more accessible with regards to our communications and the information we provide. This includes providing information in different languages and meeting the needs of people with sensory impairment.

How will we achieve this?

- We will review patient information leaflets available across the organisation and ensure these are up to date, available in accessible formats and in different languages.

- We will utilise the **'Hello my name is...'** campaign throughout the Trust. This is a campaign for more compassionate care based on the importance of introductions to make a human connection and build trust.

- We will provide timely responses to concerns raised through our PALS and complaints service.

- We will improve information for patients with sensory impairments.

- We will develop a welcome pack for inpatients in conjunction with patients.

- We will display quarterly feedback for patients, families and carers across Whittington Health, highlighting what changes we have made in response to concerns '**you said we did**'.

How will we measure success?

- We will work towards achieving a deaf charter mark.

- Information is available in accessible formats.

- Implementation of the accessible information standard.

- A targeted approach will be taken to identify and address areas of priority.

- Reduction in the number of PALS contacts relating to information. 39% of PALS contacts in 2017/18 related to requests for information.

- 90% of PALS to be responded to within 5-7 working days by year 3.

- We will continue to respond to 80% of our complaints within 25 working days.

- We will respond to 80% of our complex complaints within 40 working days.

- You said we did displays across hospital and community sites, included on our website and communications to patients and stakeholders.

- Improvement in the national survey (emergency department, inpatients, children & young people, cancer and maternity) questions regarding conflicting or contradictory information.

Ambition 2:

We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement

Whittington Health has developed robust systems and processes to ensure we listen and respond to our patients. The next steps are to develop ways to truly work in partnership with patients, families and carers to improve our services.

How will we achieve this?

- We will invite complainants/those who have raised concerns to participate in the **fifteen steps challenge.** This is an approach to quality improvement that focuses on first impressions.

- We will utilise the **always events toolkit** as a method to increase partnership working.

- We will ensure patient representatives are full members on board sub committees

- We will ensure patients representatives are included in quality improvement projects and service redesign

- We will increase the number of service lead patient and carer focus groups throughout the Trust and ensure their feedback influences practice and policy.

How will we measure success?

- Build and maintain a database of patient and carers who would like to work as partners with the trust

- Maintain a record of focus groups and patient forums

- Evidence of patient representatives on committees, projects and toolkits as outlined

- Evidence of involvement of Healthwatch

- Increased number of volunteers

- Improvement in the national survey (emergency department, inpatients, children & young people and maternity) question regarding involvement in decisions about care and treatment

Ambition 3:

Improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care

There are number of core themes apparent in the feedback we receive from patients (for example through patient stories, national surveys, complaints, concerns and the friends and family test). It is clear we need to improve in these areas and we are committed to achieving this in collaboration with patients, families and carers.

How will we achieve this?

- We will improve the booking administration process for patients accessing outpatients and community health services
- We will reduce outpatient clinic cancellations
- We will improve the care of patients with dementia by implementing John's campaign to enable carers to visit patients according to their needs rather than visiting hours. We will implement John's campaign for all carers in all areas of the Trust
- We will improve the experience of people with a learning disability or an autism spectrum condition
- We will improve the quality of food
- We will reduce noise at night for inpatients
- We will improve the transport service
- We will improve the continuity of care from district nursing for patients of concern (palliative care patients, those in receipt of continuing healthcare funding, safeguarding concerns and patients with pressure ulcers)
- We will promote the spiritual and pastoral care service to ensure patients, families and carers are aware of the spiritual, pastoral and religious support available and how they can access this
- We will expand our volunteer service to enhance patient experience and support clinical services
- We will continue to develop and increase local survey collection and methods of collection throughout the Trust. This will include collecting feedback from patients who do not speak English

How will we measure success?

- Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours .
- We will increase the number of people with learning disabilities involved in trust activities e.g. volunteering, hospital guides.
- Outcomes of the outpatient transformation programme.
- Outcomes of the Community health services improvement project.
- Improvement in the national inpatient survey questions regarding respect and dignity, quality of food and noise at night.
- Reduction in complaints and concerns about appointments.
- 95% of patients arrive 15 minutes prior to their appointment. 95% of patients are picked up within one hour of their appointment ending.
- Menus and information regarding food visibly accessible on the wards.
- Increased number of volunteers.
- Volunteers supporting Trust services across community teams and during weekend and evening hours.
- Increase in the number of local surveys collected (including Friends and Family Test).
- Achieve at least 90% recommend rate through Friends and Family Test feedback.

04

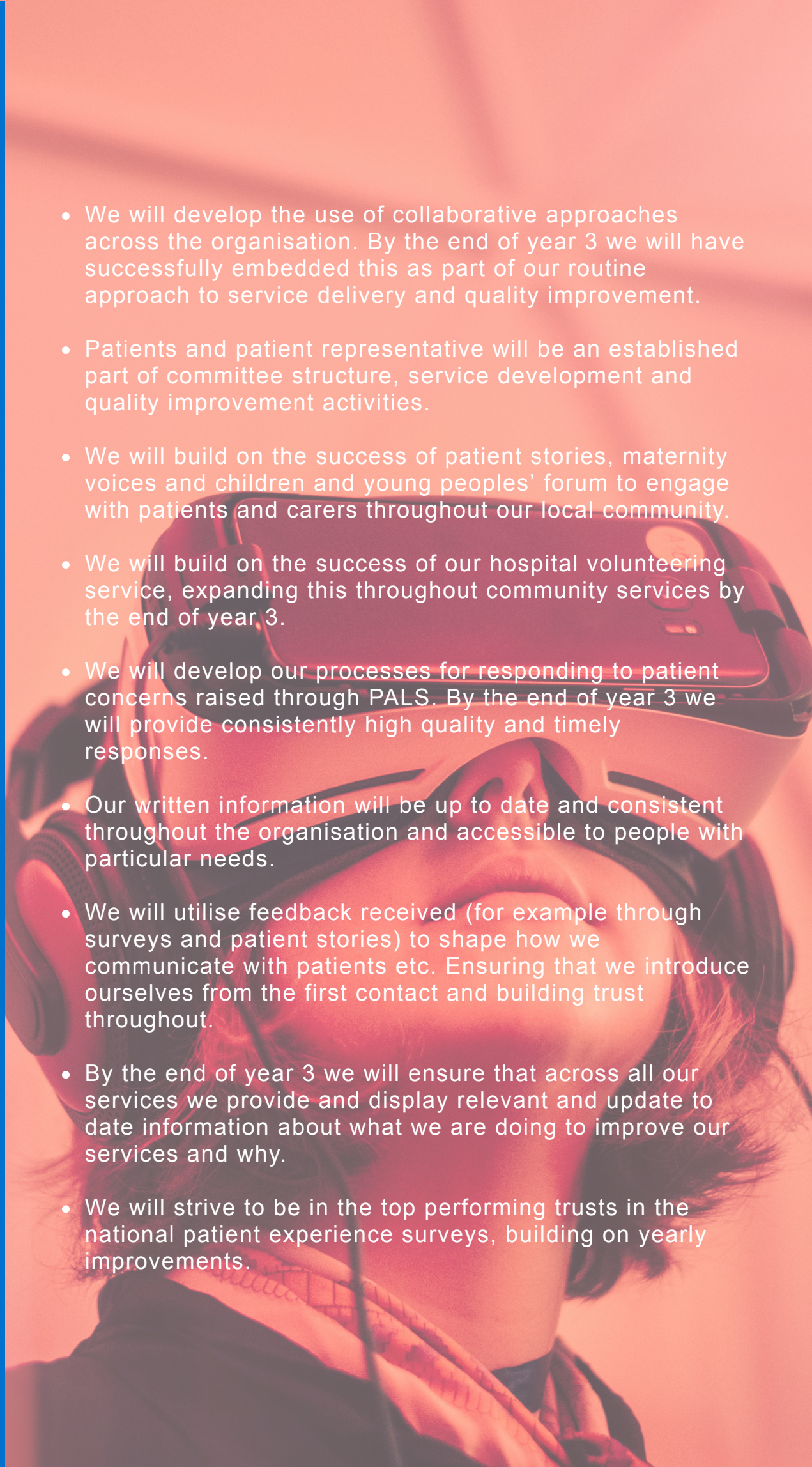
Monitoring Our Progress

The patient experience team will develop an annual action plan to support implementation and monitoring of the strategy ambitions. Progress will be reported on a quarterly basis to the Patient Experience Committee and Quality Committee as part of the patient experience report.

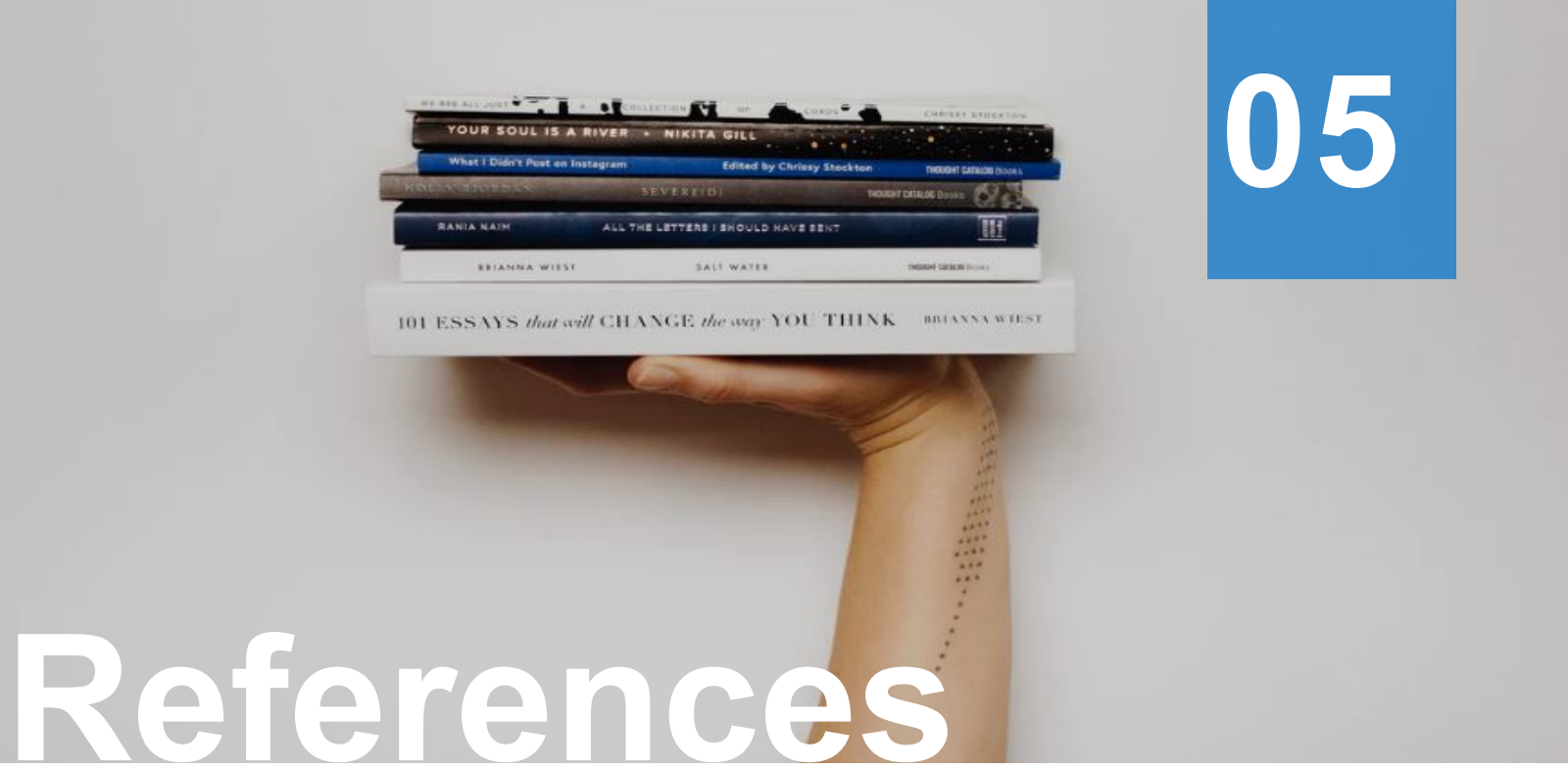
Services presenting updates to the Patient Experience Committee will be required to structure this in line with the ambitions and share local action plans.

Annual updates with also be produced in conjunction with the communications team to highlight key achievements to staff, patients, families and carers.

What will success look like?



- We will develop the use of collaborative approaches across the organisation. By the end of year 3 we will have successfully embedded this as part of our routine approach to service delivery and quality improvement.
- Patients and patient representative will be an established part of committee structure, service development and quality improvement activities.
- We will build on the success of patient stories, maternity voices and children and young peoples' forum to engage with patients and carers throughout our local community.
- We will build on the success of our hospital volunteering service, expanding this throughout community services by the end of year 3.
- We will develop our processes for responding to patient concerns raised through PALS. By the end of year 3 we will provide consistently high quality and timely responses.
- Our written information will be up to date and consistent throughout the organisation and accessible to people with particular needs.
- We will utilise feedback received (for example through surveys and patient stories) to shape how we communicate with patients etc. Ensuring that we introduce ourselves from the first contact and building trust throughout.
- By the end of year 3 we will ensure that across all our services we provide and display relevant and update to date information about what we are doing to improve our services and why.
- We will strive to be in the top performing trusts in the national patient experience surveys, building on yearly improvements.



05

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Meeting title	**Trust Board -– public meeting**	**Date: 27.2.2019**
Report title	**Care Quality Commission compliance update**	**Agenda item: 12**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Kat Nolan-Cullen, Compliance and Quality Improvement Manager	
Executive summary	The Trust Board is presented with an update covering: • Compliance with Care Quality Commission inspection recommendations and readiness • Joint Targeted Area Inspections (JTAI) completed for Haringey and Islington	
Purpose:	Discussion and review	
Recommendation(s)	Board members are invited to review and discuss the update on compliance with CQC recommendations and also the two, local Joint Targeted Area Inspections completed for Islington and Haringey	
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	Previous report presented to Trust Board in October 2018	
Appendices	None	

Care Quality Commission (CQC) inspection compliance update

1. CQC improvement plan 2017/18

1.1 There were 34 recommended improvement actions from the CQC following the last inspection (published in February 2018), from which the trust developed 52 specific actions. 45 of the actions have been addressed and seven remain in progress. These are now over their completion date, but are regularly reviewed and updated by the relevant Integrated Clinical Service Units (ICSUs) and are reviewed at the Trust's CQC steering group's meetings. There is a clear plan in place for the completion for each action. It is important to note that the immediate concerns raised by the inspection team have been responded to and addressed within the required timeframe.

1.2 Work is also in progress reviewing the 2016 action plan and CQC reports to ensure that are still achieving the recommendations made following the last comprehensive inspection held 8-11 December 2015.

Next Inspection

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

1.4 The Well Led inspection is usually carried out annually and normally follows shortly after the core services' inspection.

1.5 12 weeks prior to any inspection we will receive a Provider Information Request (PIR), which at present we have not received. In addition, notification of the annual announced well-led inspection has not yet been received.

Improvement work – CQC 'Good to Outstanding' prep meetings

1.6 A trust wide CQC steering group has been set up and meetings held fortnightly with representation from each ICSU, estates, finance, human resources, corporate and communications teams.

1.7 All 'core services', as defined by the CQC, are undertaking self-assessments of their services. Action plans are being developed to address areas of concern highlighted in the self-assessments. The self-assessments and supporting action plans will be reviewed at ICSU and steering group meetings to help form the well-led preparation document that will be sent to executives and non-executives in advance of their annual well-led interview. 40 completed service self-assessments have been received from the ICSUs so far. There are 93 services still to complete their self-assessments. The ICSUs have been tasked with ensuring these are completed in a timely manner.

1.8 Communications have launched the 'Better Never Stops Hub' which has tools, tips, resources and advice available on the intranet to assist services in their journey to outstanding.

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

1.10 Our Quality Assurance service peer reviews entitled '**Next Steps to Outstanding'** continue across the Trust and have increased to two per week. The peer review teams recently included two of our commissioners. Health Watch are also willing to join visits depending on their availability. Following the inspections, ward managers, matrons and Associate Directors of Nursing/Midwifery are provided with targeted improvement actions that will help to bring the ward or department up to outstanding when addressed. The trust quality governance team are providing support required in order to overcome barriers the may prevent the action from being completed.

1.11 A project is underway to provide every ward and community site with standardised noticeboards, which comprise clear information and monthly performance run charts for staff and patients on, staffing levels, you said: we did, falls/PUs and infection rates etc.

1.12 We have also been conducting targeted walk rounds with Estates and Facilities looking at the décor and general upkeep of the Trust and community sites. This aids in identifying areas which need painting and decoration – these will be split into two areas – overdue maintenance works and CQC Improvement works.

1.13 We also have a reciprocal agreement with the North Middlesex University Hospital (NMUH) Trust to carry out a mock inspection of their Trust on 28 February 2019 – and plan for NMUH to reciprocate this at the Whittington once we have received our PIR.

2. Haringey Joint Targeted Area Inspection (JTAI) - Safeguarding school-aged children (focus on neglect) December 2017

2.1 As reported in previous Trust Board papers Whittington Health has a number of actions which are being monitored at a partnership implementation group which meets monthly to oversee the Haringey overarching action plan and provide support and challenge to partner agencies involved. In November 2017 a Joint Targeted Area Inspection focusing on Neglect occurred across Haringey LSCB area. The formal response to this inspection was provided in February 2018, and an extensive action plan with 132 actions has been produced through the LSCB partnership, which has been being implemented throughout 2018. All Whittington Health actions in the LSCB action plan are now on track for completion or complete, with no red actions remaining. Whittington Health is undertaking a section 11 LSCB audit in February which will test the evidence for completion of a range of our actions.

3. Islington Joint Area Targeted Inspection (JTAI) - Safeguarding school-aged children (focus on sexual abuse in the family home) November 2018

3.1 A Joint Targeted Area Inspection focusing on Sexual Abuse in the Family Home occurred across Islington LSCB area in November 2018. The formal response to this inspection was released on 29th January 2019 by the lead inspectors Ofsted. Whittington Health Services were inspected by a CQC team as part of this process. Services specifically reviewed included Children's Emergency Department, Community Child and Adolescent Mental Health Services (CAMHS), and School Nursing and Maternity, as well as arrange of other agency and multi-agency services. The Whittington Health involvement in this inspection was led by the Head of Children and Young People's (CYP) Islington Services.

3.2 The CYP ICSU were mindful of the lessons learned from the 2017 Haringey JTAI, and ensured that staff across the Islington Teams and hospital were well prepared, supported, and encouraged to speak with honesty and passion about the work that each team is delivering. The initial verbal feedback from the inspectors was positive, with particular praise given to the strengths observed in Children's ED and CAMHS services. The Islington JTAI inspectors noted verbally how they were pleased to see evidence of cross organisational learning from the 2017 Haringey JTAI Inspection.

3.3 A multi-disciplinary action plan is being developed to address the areas for improvement noted in the report.

4. Recommendations

4.1 Board members are invited to review and discuss the update on compliance with CQC recommendations and also the two, local Joint Targeted Area Inspections completed for Islington and Haringey.

Meeting title	**Trust Board – public meeting**	**Date: 27 February 2019**
Report title	**Integrated performance report**	**Agenda Item: 13**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	**Emergency Department (ED) four hours' wait:** Overall performance against the 95% 4 hour standard for January 2019 was 86%. January 2019 attendance numbers were high at 9594 (an average 310 per day) when compared to January 2018 (with attendances of 8897, averaging 287 attendances per day). The 'minors' performance delivered 94.9% and Paediatrics delivered at 92.2% in January. **Mixed sex breaches** Two breaches occurred due to capacity issues within the Trust and no medical bed available. However, privacy and dignity were maintained at all times and patients were informed and comfortable.	
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	
Appendices	None	

Whittington Health NHS

Integrated Performance Report

February 2019

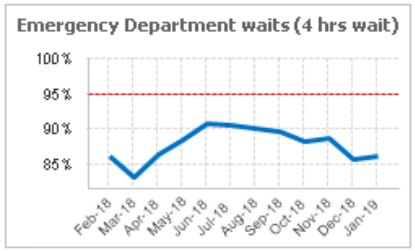
Month 10 (2018 – 2019)

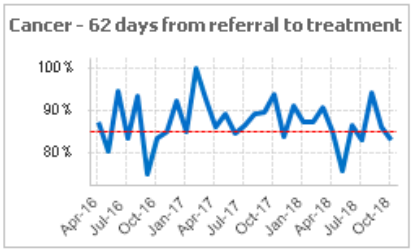
Date & time of production: 21/02/2019 15:01

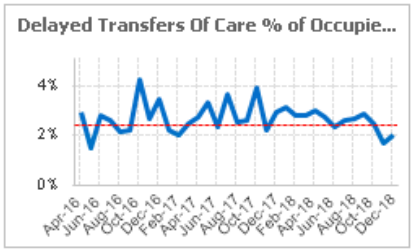
Summary Page - Indicators

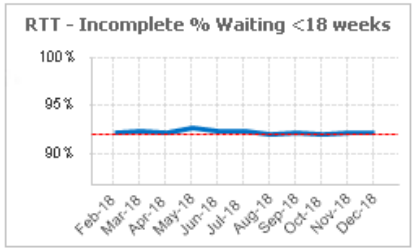
Category	Indicator	17_18 Target	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	Q4 Jan-19	2018-2019
ED	Emergency Department waits (4 hrs wait)	>95%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	88.3%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	76	95	91	87	79	74	63	75	79	88	91	85	81
Cancer	Cancer - 14 days to first seen	>93%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%		93.9%
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%		86.0%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.03%	6.33%	6.25%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.88%	5.44%	5.91%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%		2.5%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.2%
Outpatients	Outpatients - FFT % Positive	>90%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	91.7%
Community	Community - FFT % Positive	>90%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	96.4%
Staff	Staff - FFT % Recommend Care	>70%		75.0%			77.3%			77.4%					77.3%
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	90.5%
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	92.2%	88.2%	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	95.7%	91.0%
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.7%	90.3%	87.8%	92.0%	92.0%	88.3%	90.3%	90.9%	90.1%	90.3%	89.8%		90.3%
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.6%	95.6%	93.5%	94.1%	90.9%	97.5%	94.9%	96.1%	93.1%	92.5%	92.4%		93.9%

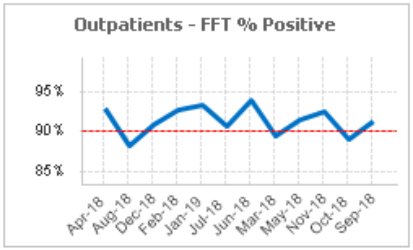
Summary Page - Indicators

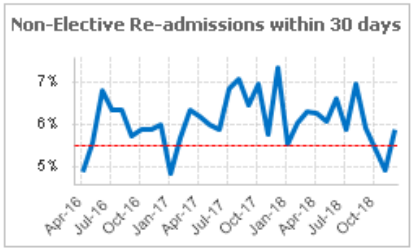












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	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	1	0	1	2	0	0	2	2	1	1	3	1	13	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	27	43	37	52	33	33	26	28	36	31	35	44	355	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	3	3	2	4	2	1	4	0	1	2	2		18	
All Areas	Harm Free Care %	>95%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	93.5%	90.1%	92.6%	
Maternity	Non Elective C-Section % Rate	<15%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	21.5%	25.5%	20.1%	20.6%	
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	0	0	0	1	0	0	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	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	20.9%	18.3%	
All Areas	Serious Incidents	0	1	2	6	8	3	1	1	2	2	4	2	1	30	
Admitted	VTE Risk Assessment %	>95%	95.2%	96.2%	95.9%	95.1%	95.0%	96.2%	94.5%	94.9%	95.2%	96.9%	95.3%		95.4%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	5	7	0	0	0	0	1	0	0	2	15	

Safe Services - Commentary

HCAI C Difficile

There has been one new Trust attributable C. difficile in January 2019 on Coyle Ward. An investigation is taking place. From Q3 and Q4 (to date) 3/6 cases have shown the following trends:

a) Failure to isolate as per national set standard (i.e isolate within two hours of diarrhoea).
   a. Whittington caveat (to the national guidance to isolate all patients with diarrhoea) – isolate within two hours of suspecting infectious diarrhoea.

b) Antibiotic stewardship was not in line with Trust policy
   a. i.e. no indication, no review date, no duration.

Pressure Ulcers

Data for January 2019 not yet available.

Non elective C-section

Rate has decreased to 20.1%. Matron for labour ward and obstetric lead have regular reviews of non -elective caesarean sections, including a review of mother and baby outcomes to see if there are any lessons to be learned. Expected completion of review is February 2019.

Action: From next month the target is going to be changed to 18%, as this is the target agreed on the NCL Maternity dashboard.

Serious Incidents

One incident was declared in January 2019.

1. 2019.2062 – A58565 – IG Incident – Access Centre, patient confidential details were changed at request of family member and telephone number although a safeguarding alert was present.

Mixed sex breaches

Two breaches occurred due to capacity issues within the Trust and no medical bed available. However privacy and dignity were maintained at all times and patients were informed and comfortable.

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	2018-2019	Performance
ED	ED - FFT % Positive	>90%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	82.8%	81.7%	
ED	ED - FFT Response Rate	>15%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	13.2%	
Admitted	Inpatients - FFT % Positive	>90%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	95.5%	97.1%	
Admitted	Inpatients - FFT Response Rate	>25%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	14.1%	16.8%	
Maternity	Maternity - FFT % Positive	>90%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	95.6%	94.6%	
Maternity	Maternity - FFT Response Rate	>15%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	53.1%	50.9%	
Outpatients	Outpatients - FFT % Positive	>90%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	91.7%	
Outpatients	Outpatients - FFT Responses	400	461	249	327	445	348	310	223	138	328	484	233	423	3259	
Community	Community - FFT % Positive	>90%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	96.4%	
Community	Community - FFT Responses	1500	1157	779	1206	1181	1148	869	890	1122	1159	998	622	1014	10209	
Staff	Staff - FFT % Recommend Care	>70%		75.0%			77.3%			77.4%					77.3%	
All Areas	Complaints responded to within 25 working day	>80%	87.5%	92.0%	71.4%	78.3%	92.6%	95.0%	93.8%	92.3%	95.0%	95.8%	84.2%	90.0%	88.1%	
All Areas	Complaints (including complaints against Corporate division)	N/A	21	33	33	30	39	27	21	14	24	30	24	26	268	

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Caring Services - Commentary

FFT

Maternity areas continue to excel with the collection of FFT. For January 2019, Maternity recorded a 96% positive recommend rate (a high for 2018/19 thus far) and a response rate of 53.1%, exceeding the KPIs for both of these measurements (above 90% for positive recommendations; above 15% for response rate). The maternity teams have successfully integrated FFT into their daily work over a sustained period of time. They use iPads, follow-up telephone calls and the paper post cards to collect FFT, and publicise these results in their team newsletters. The success of their approach has persisted: only twice since April 2016 has the area returned a response rate lower than the 15% target; only three times since April 2016 has a positive recommend rate below 90% been returned.

There was a drop in the response rate among **Inpatient** areas. A contributing factor around this has been a decrease in the number of FFT collected in DTC (down from 239 in November 2018 to 55 in January). The patient experience team will be working with the inpatient ward managers to enhance the level of volunteer support on the wards, and also around raising awareness for collecting FFT. The team will be exploring supporting the introduction of FFT newsletters and engaging ward/service managers to be monitoring FFT using Meridian.

There were increases in the response total across both **Community** and **Outpatient** FFT for January 2019 (Outpatients saw an increase to 423 from December's 233; Community 1,014 from December's 622). This increase was largely driven by the introduction of additional volunteers supporting chiefly with the inputting of paper FFTs.

ED saw an increase in response rate to 13.2% with a corresponding positive recommend rate of 83% - both are highs in the area since August 2018.

Caring Services - Commentary

Complaints
During January 2019 the Trust was due to close 26 complaints; 20 complaints required a response within 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 90% (18/20).

- Of the five complaints allocated 40 working days, one achieved its target.
- At the time of reporting, 5 complaint responses remain outstanding (one '25' day (EIM) and four '40' day complaints, two for EIM, one for S&C and one for ACW)

The complaints were allocated to EIM 39% (10), S&C 19% (5), ACW 15% (4), ACS 15% (4) & CYP 12% (3).

Severity of complaints: 35% (9) were designated 'low' risk; 58% (15) were designated 'moderate' and 7% (2) were designated as 'high risk'.

A review of the complaints due a response in January shows that 'communication' 27% (7), 'nursing care' 19% (5) 'medical care' 15% (4) were the main issue for patients.

- In regard to 'communication', 44% (3) complainants raised concerns about 'poor communication between professionals/patients', 14% (1) of the complainants was concerned about 'inadequate communication about an operation', 14% (1) was concerned about 'lack of information to patient', 14% (1) was concerned about 'lack of information to relatives', and 14% (1) raised a concern about a 'no diagnosis or insufficient information given'.
- In regard to 'nursing care', 60% (3) complainants felt that a 'poor standard of care' had been provided, 20% (1) complainant was concerned about 'low staffing', and 20% (1) complainant cited 'failure to help mobilise patient' as the reason.
- In regard to 'medical care', 50% (2) complainants were concerned about 'poor treatment being provided', 25% (1) complainant was concerned about 'inadequate treatment being provided' and 25% (1) complainant was concerned about 'a missed diagnosis'

Of the 21 complaints that have closed, (including those allocated 40 working days), 19% (4) were 'upheld', 67% (14) were 'partially upheld' and 14% (3) were 'not upheld' meaning that, currently, 86% were upheld in one form or another.

Caring Services - Commentary

PALS

During January 2019, the Trust logged 193 PALS enquiries.
28% (55) related to Emergency & Integrated Medicine, 27% (53) related to Surgery & Cancer, 23% (45) related to ACW, 11% (22) related to Adult Community Health Services and 2% (3) related to Children & Young People Services, the remainder related to other Trust service and areas.

Themes – the top three themes of those PALS queries that have been logged were follows;
39% (75) related to 'Communication' with 'clarity/confusing' and 'no reply to telephone contact' cited as the main reasons
18% (35) related to 'Appointments' with 'cancellation' and 'long wait for an appointment' cited as the main reasons.
11% (21) related to 'Delay' with 'delay in test results' and 'delay in being seen for an appointment' cited as the main reasons

GP concerns

During January 2019, the Trust logged 12 concerns from GP Practices relating to individual patient concerns

50% (6) of these related to 'Communication' with 'clarify/confusing' cited as the main reason
25% (3) of these related to 'Appointments' with 'long wait for an appointment' and 'cancellation' cited as the reasons
8% (1) of these related to 'Delay' with 'delay in being seen' cited as the reason
8% (1) of these related to 'Personal Records' with 'incorrect information' cited as the reason
8% (1) of these related to ''Failure to follow agreed procedure' in regard to process cited as the reason

Compliments

During January 2019, 29 compliments were logged onto Datix.

41% (12) related to Emergency & Integrated Medicine, 17% (5) related to ACW, 17% (5) related to Surgery & Cancer, 10% (3) related to Children & Young People, 7% (2) related to Adult Community Services, & 7% (2) related to Patient Experience.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	93.2%	89.2%	90.7%	92.4%	
Maternity	Smoking at Delivery	<6%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	3.4%	6.1%	5.0%	6.9%	5.9%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.03%	6.33%	6.25%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.88%	5.44%	5.91%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	75.3	99.4	89.5	70.9	80.3	100.6	81.1	82.5					83.7	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	224.2	195.7	225.8	133.5	197.8								192.9	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14		0.76			0.76			0.77						
Admitted	Mortality rate per 1000 admissions in-months	14.4	10.0	10.3	7.3	7.7	6.4	5.3	4.7	5.0	5.5	6.6	8.4	7.5	6.5	
Community	IAPT Moving to Recovery	>50%	51.4%	59.4%	56.3%	53.4%	59.0%	52.4%	55.7%	57.0%	62.5%	57.4%	58.2%		56.7%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	90.5%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	92.2%	88.2%	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	95.7%	91.0%	
Community	% of MSK pts with a significant improvement in function (PSFS)	>75%	82.7%	78.1%	80.1%	74.0%	69.5%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	85.1%	78.5%	
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%	81.5%	89.7%	84.5%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	70.4%	78.5%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	73.8%	76.9%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	96.0%	96.8%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	93.3%	93.9%	
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%	88.9%	100.0%	93.0%	
Community	Nutrition & Dietetics - Obesity % Weight Loss achieved at Discharge	>65%				100.0%	0.0%	100.0%	60.0%	66.7%	66.7%	100.0%	76.9%	33.3%	68.5%	
Community	Nutrition & Dietetics - nutrition support % weight gain/maintained	>70%			66.7%	60.0%	100.0%	87.5%	83.3%	80.0%	91.7%	100.0%	72.7%	77.8%	82.8%	

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Effective Services - Commentary

Smoking at delivery
Increased to 6.9%. Smoking at delivery for all births is now a mandated field. The first quarterly report from smoking cessation provider is due in February 2019.

Action: The point in time when the question is asked is being reviewed, as immediately following the birth is not appropriate. Plans drawn up to ask this question and record it just prior to transfer home, this will mean that information given to the mother at transfer can meet women needs.

Non-elective re-admission
Achieved target at 5.5%

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	88.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	76	95	91	87	79	74	63	75	79	88	91	85	81	
ED	Ambulance handovers waiting more than 30 mins	0	37	69	22	41	16	18	9	12	18	15	23	18	192	
ED	Ambulance handovers waiting more than 60 mins	0	3	18	8	0	1	0	10	2	0	0	2	2	25	
ED	12 hour trolley waits in A&E	0	0	0	0	0	0	2	0	0	0	0	1	0	3	
Cancer	Cancer - 14 days to first seen	>93%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%		93.9%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%		99.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%		86.0%	
Cancer	Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%								89.5%	81.4%	93.3%	93.8%		88.6%	
Cancer	Cancer ITT - % of Pathways sent before 38 Days	>85%								62.5%	60.0%	81.8%	50.0%		67.9%	
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%	86.1%	93.9%		86.0%	
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%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%												
Cancer	Cancer - 62 Day Screening	>90%						100.0%	100.0%		100.0%	75.0%	60.0%		76.5%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	99.0%	98.9%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	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	1	1	0	0	2	
Access	RTT - Incomplete Waiters Backlog at Month End	16227	15648	16227	16158	16502	16716	16567	16363	16260	16232	16202	16042	16258	163300	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4		
Indicator	17_18 Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018-2019	Performance
Breast	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%	100.0%	86.7%	100.0%	93.3%	100.0%			
Gynaecological	>85%	100.0%	0.0%	33.3%		40.0%		100.0%	66.7%	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%	100.0%	100.0%			
Lower Gastrointestinal	>85%	66.7%	100.0%	72.7%	66.7%		71.4%	100.0%	100.0%	100.0%	80.0%	100.0%			
Lung	>85%	50.0%		100.0%	50.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%				
Other	>85%		100.0%				100.0%								
Skin	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%			
Testicular	>85%				100.0%			100.0%							
Upper Gastrointestinal	>85%	50.0%		66.7%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%		75.0%			
Urological (Excluding Testicular)	>85%	100.0%	66.7%	90.0%	58.8%	81.8%	68.4%	77.8%	100.0%	44.4%	100.0%	66.7%			
Sarcoma	>85%		50.0%												

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	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	Q3 Dec-18	Q4 Jan-19	2018-2019	Performance
Breast	>93%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%	97.5%	96.4%	94.0%	97.3%	98.6%		97.3%	
Childrens	>93%	100.0%		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Gynaecological	>93%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%	98.0%	97.4%	95.6%	96.4%	97.8%		97.0%	
Haematological	>93%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%	37.5%	62.5%	92.9%	91.7%	95.0%		77.0%	
Lower Gastrointestinal	>93%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%	88.2%	82.4%	73.0%	87.3%	98.3%		89.7%	
Lung	>93%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%	100.0%	90.0%	80.0%	100.0%	100.0%		94.9%	
Other	>93%														
Skin	>93%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%	98.8%	97.4%	98.0%	97.5%	98.6%		97.8%	
Upper Gastrointestinal	>93%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%	55.0%	20.6%	59.6%	89.2%	98.0%		73.3%	
Urological	>93%	97.3%	95.5%	93.6%	98.0%	89.0%	89.8%	94.7%	97.4%	97.9%	86.4%	94.9%		93.5%	

Responsive Services - Commentary

ED

Overall performance against the 95% 4 hour standard for January 2019 was 86%. January 2019 attendance numbers were high at 9594 (an average 310 per day) when compared to January 2018 (with attendances of 8897, averaging 287 attendances per day).

The 'minors' performance delivered 94.9% and Paediatrics delivered at 92.2% in January. The median wait for treatment in January was 85 minutes against a national standard of 60 minutes. January 2019 ambulance activity was 1893. Performance against ambulance handover targets has remained good with 98.9% of patients 'offloaded' within 30 minutes of arrival to hospital.

The trust has seen sustained improvement in the number of DTOC patients and standard patients throughout January which assists flow throughout the hospital and the Emergency Department.

There were no 12 hour trolley breaches in January 2019.

Actions:

ECIST attended the emergency department to observe the front of house (first 60 minutes) work in particular. Their recommendations included the following:-

- Ensuring a robust medical rapid assessment and treatment (RAT) model is in place 5 days a week initially with a view to extend both days and hours
- Look at increasing ambulatory care (AEC) opening hours to maximise its capacity (especially on a weekend)
- Streamline the front of house model (streaming, redirection, RAT, ambulance handover) to ensure the function is fit for purpose

Work is ongoing in the department to ensure the above points are actioned throughout Q4 with the aim of improving performance against the 4 hour target and patient experience. ECIST are supporting the ED 1 day per week starting February 2019.

Cancer

The overall Trust cancer targets were compliant. Late referrals from the London breast screening unit resulted in non-compliance for the screening target (60/90%).

Community Average Waits

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	90.50%	81.30%	60.00%	10	15	>95%						0
ACS	Community Matron	>95%	6	96.60%	97.10%	97.60%	0.7	42	>95%	2		100.00%	100.00%	0.6	4
ACS	Adult Wheelchair Service	>95%	8	91.70%	86.70%	100.00%	3.3	33	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	95.10%	96.40%	92.60%	5.1	94	>95%	2	69.00%	55.60%	46.40%	5.1	56
ACS	ICTT - Other	>95%	12	91.70%	84.30%	88.20%	5	263	>95%	2	65.20%	71.90%	63.90%	2	83
ACS	ICTT - Stroke and Neuro	>95%	12	85.40%	75.00%	68.20%	8.9	44	>95%	2	73.70%	76.50%	41.70%	3.6	24
ACS	Intermediate Care (REACH)	>95%	6	80.90%	81.70%	88.00%	3.3	125	>95%	2	82.20%	93.30%	86.20%	1.3	58
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	62.50%	6.9	8	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	43.20%	47.20%	58.50%	15.9	135	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	60.00%	63.40%	72.00%	4.6	717	>95%		66.70%	0.00%	100.00%	0.7	1
ACS	Musculoskeletal Service - Routine	>95%	6	70.00%	71.80%	65.80%	4.9	1679	>95%	2	100.00%		0.00%	4.1	1
ACS	Nutrition and Dietetics	>95%	6	94.20%	100.00%	97.10%	2.6	238	>95%	2	100.00%		100.00%	1	1
ACS	Podiatry (Foot Health)	>95%	6	87.50%	84.80%	86.10%	4.2	568	>95%	2	100.00%		0.00%	5	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.9	22	>95%						0
ACS	Tissue Viability	>95%	6	100.00%	94.60%	93.40%	1.5	76	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	88.00%	3.3	25	>95%	2	100.00%	100.00%	75.00%	1.4	4
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	2.3	50	>95%	2		100.00%	80.00%	2	5
EIM	Respiratory Service	>95%	6	100.00%	97.90%	100.00%	2.2	61	>95%	2	100.00%	100.00%			0
EIM	Spirometry Service	>95%	6	83.30%	76.50%	70.20%	5.3	47	>95%	2					0

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Haringey Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12					0	>95%						0
ACS	Community Matron	>95%	6	92.30%	100.00%	100.00%	0.7	13	>95%	2			100.00%	1.1	2
ACS	Adult Wheelchair Service	>95%	8	91.70%	86.20%	100.00%	3.3	33	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12		100.00%	100.00%	1.9	1	>95%	2	0.00%	0.00%			0
ACS	ICTT - Other	>95%	12	91.30%	84.20%	88.00%	5.1	242	>95%	2	66.30%	71.70%	62.20%	2	74
ACS	ICTT - Stroke and Neuro	>95%	12	87.00%	75.90%	67.40%	9	43	>95%	2	75.70%	78.60%	45.50%	3.5	22
ACS	Intermediate Care (REACH)	>95%	6	100.00%	100.00%	100.00%	1.4	3	>95%	2					0
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	62.50%	6.9	8	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	40.00%	42.90%	56.50%	16.5	62	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	61.00%	61.60%	77.10%	4.4	432	>95%		50.00%				0
ACS	Musculoskeletal Service - Routine	>95%	6	68.70%	70.10%	62.70%	5	928	>95%	2	100.00%		0.00%	4.1	1
ACS	Nutrition and Dietetics	>95%	6	97.00%	100.00%	97.40%	2.7	153	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	85.70%	82.50%	84.80%	4.3	276	>95%	2	100.00%		0.00%	5	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.4	10	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	100.00%	100.00%	1	20	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	78.60%	3.7	14	>95%	2	100.00%	100.00%	100.00%	1	2
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	2.5	32	>95%	2		100.00%	75.00%	2.3	4
EIM	Respiratory Service	>95%	6	100.00%	96.30%	100.00%	2.7	25	>95%	2	100.00%				0
EIM	Spirometry Service	>95%	6	84.80%	75.80%	70.20%	5.3	47	>95%	2					0

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Islington Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Avg Wait (Jan-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	90.00%	85.70%	83.30%	8.8	6	>95%						0
ACS	Community Matron	>95%	6	97.60%	96.40%	96.60%	0.7	29	>95%	2		100.00%	100.00%	0	2
ACS	Adult Wheelchair Service	>95%	8					0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	95.00%	96.10%	91.90%	5.3	86	>95%	2	69.40%	56.00%	46.40%	5.1	56
ACS	ICTT - Other	>95%	12	100.00%	71.40%	100.00%	2.4	3	>95%	2	33.30%		75.00%	0.8	4
ACS	ICTT - Stroke and Neuro	>95%	12		100.00%			0	>95%	2	0.00%	60.00%			0
ACS	Intermediate Care (REACH)	>95%	6	81.00%	80.60%	88.00%	3.3	117	>95%	2	81.20%	93.30%	86.00%	1.3	57
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	58.30%	62.50%	67.40%	15.1	46	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	57.80%	65.90%	63.50%	4.9	274	>95%		100.00%	0.00%	100.00%	0.7	1
ACS	Musculoskeletal Service - Routine	>95%	6	69.80%	76.60%	71.10%	4.7	626	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	96.00%	100.00%	96.10%	2.6	77	>95%	2			100.00%	1	1
ACS	Podiatry (Foot Health)	>95%	6	89.40%	87.30%	87.50%	4.1	281	>95%	2	100.00%				0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.6	12	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	94.70%	95.20%	1.3	21	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.7	11	>95%	2	100.00%	100.00%	50.00%	1.8	2
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	2	18	>95%	2			100.00%	1.1	1
EIM	Respiratory Service	>95%	6	100.00%	100.00%	100.00%	1.8	35	>95%	2	100.00%	100.00%			0
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	Nov-18	Dec-18	Jan-19	Average Wait (Jan)	No. of Initial Contacts (Jan)	% Target	Target Weeks	Nov-18	Dec-18	Jan-19	Average Wait (Jan)	No. of Initial Contacts (Jan)
CAMHS	CAMHS Core - Islington	>95%	4	36.10%	47.90%	21.60%	9.8	153	>95%	2	76.90%	100.00%	85.70%	1.8	14
	CAMHS NDT / ADHD - Islington	>95%	8	23.80%	20.00%	15.40%	35.5	13	>95%	2					0
	CAMHS Schools - Islington	>95%	8	88.90%	95.50%	77.80%	5.8	18	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	100.00%	33.30%	33.30%	1.7	3	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	96.60%	87.60%	78.60%	1.2	103	>95%	1		100.00%	100.00%	0.1	4
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	0.00%	0.00%	69.5	6	>95%	1	0.00%	0.00%	0.00%	23.9	10
	Community Paediatrics - Haringey (NDC)	>95%	12	100.00%	100.00%	80.00%	9	5	>95%	1	0.00%	0.00%	0.00%	10.2	25
	Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	95.50%	100.00%	1	15	>95%	1	0.00%				0
	Community Paediatrics - Haringey (Other)	>95%	12	100.00%	85.70%	50.00%	18.2	4	>95%	1			0.00%	54.9	1
	Community Paediatrics - Islington	>95%	12	47.40%	45.80%	65.20%	9.1	23	>95%	1	100.00%	100.00%	80.00%	1.4	5
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	100.00%	83.30%	75.00%	6.6	8	>95%						0
	Family Nurse Partnership - Islington	>95%	12	100.00%	60.00%	100.00%	3.5	2	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	1.1	23	>95%						0
IANDS	IANDS	>95%	14	16.70%	71.40%	100.00%	1.6	7	>95%			100.00%	100.00%	1	1
	IANDS - SCT	>95%	20	41.70%	12.50%	22.20%	23.3	9	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	88.90%	100.00%	54.50%	4.2	11	>95%						0
	Looked After Children - Islington	>95%	4	87.50%	92.90%	88.90%	2.9	9	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	50.00%	28.60%	52.20%	9.3	23	>95%	2			0.00%	4.4	1
	Occupational Therapy - Islington	>95%	8	70.00%	83.30%	50.00%	9.7	12	>95%	2	0.00%				0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	87.50%	100.00%	100.00%	0.7	3	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	64.30%	100.00%	40.00%	11.8	25	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	8	56.50%	68.20%	53.80%	9.2	26	>95%						0
	Physiotherapy - Islington	>95%	8	93.10%	96.20%	70.60%	6.2	136	>95%						0
PIPS	PIPS	>95%	12	100.00%	100.00%	100.00%	4.4	8	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	8	40.20%	33.30%	21.10%	11.2	95	>95%	2		0.00%	0.00%	3.4	1
	SALT - Islington	>95%	8	56.30%	64.30%	60.20%	6.5	88	>95%	2					0
	SALT - MPC	>95%	18	80.00%	72.70%	71.90%	14.6	57	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	87.60%	91.20%	96.20%	2.6	53	>95%						0
	School Nursing - Islington	>95%	12	89.50%	100.00%	87.00%	4.6	23	>95%						0

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Responsive Services - Commentary

Adult Community Services

Service	Summary of improvement work undertaken during January 2019. 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 % for January with respect to waiting times for routine appointments, not met. • 61.1% of patients received routine appointment in 6 weeks during January. This represents an improvement of 8.5% since December. • The fragility of the service has been recognised and proposals are being developed alongside improvement work, to develop a new integrated pathway.	• Process mapping and continence co-design session which was held on 31st of January identified recommendations and action plan in developing a new model and pathway – follow up meeting in March to review progress • Regular monitoring of the Patient Tracker List (PTL). • The service has written 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.	• Proposals for a new integrated Continence pathway, with a single point of access are also being developed. • Group work in developing the new model and pathway will continue to identify further improvement plan and recommendations. The staff from Whittington Health, the Clinical Commissioning Groups (CCGs) and service users will reconvene in March 2019 for another session. • Blitz clinic happening in March 2019 for Haringey and Islington

Service	Summary of improvement work undertaken during January 2019. 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.
Nutrition and Dietetics	• Target was met, service achieved 97.0% • There was a slight dip of 3.0% since December performance of 100% - this was due to patient's choice, delaying/declining their appointments during Christmas break and created a knocked on effect in the January performance.	• The below actions will continue to be implemented: • 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 that housebound patients have appointments booked within 6 weeks. • Weekly checks to ensure that triage undertaken on a daily basis with minimal delay.	• Further improvement in productivity such as monthly focus on DNA rates and to reduce DNA rates below 10%, current DNA rate is 13.8% with 10.8% in December 2018. • The service is looking at implementing group consultations, the effect in performance will have an impact in productivity in the next 3-12 months
Lymphedema	• CSIG target of 95% with respect to waiting times for routine appointments was exceeded in December, with 100% being achieved.	• Not applicable – target met.	• Continuing with current measures of bringing new referrals forward into cancellation slots where possible. • 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	• Target of 95% not met; target achieved in January was 86.2%; an improvement of 1.3% since December 2018. The service is intending to achieve 90% in the next month	• The below actions will continue to be implemented: • 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 that housebound patients have appointments booked within 6	• If improvement in DNA rates continues, we anticipate to reach 90% in the following month • The service is hoping to get an apprentice who can be utilised in admin tasks such as phoning new patients, 1-2 days before their appointments with the hope to reduce DNAs.

Service	Summary of improvement work undertaken during January 2019. 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.
		weeks. • Weekly checks to ensure that triage undertaken on a daily basis with minimal delay. • Focus on reducing DNA (18.2%), phoning patients 1-2 days prior to the appointment	
Spirometry	• The service achieved 70.2%, a decline in the performance since December 2018 which was 75.8% • Patients are often referred to service when exacerbating and spirometry should only be done 6 weeks post exacerbation.	• A weekly PTL review and to ensure triaging 3 days per week • Automated SMS from Rio- Liaise with Rio team as a possibility • Vacancy band 3 post-recruit to this post ASAP. The service will cross cover as necessary and aiming not to reduce clinic capacity • Winter period/flu season- patient cohort are most affected at this time of year and the service should expect to see missed appointment and/or DNAs	• The service is looking into possibility of being able to discharge referrals and consider the phone call back as a self-referral to the service.
REACH	• The service performed 87.9% for routine referrals against target of 90% - not met but would be 91% if SLT breaches excluded • Anticipate that service will meet 95% target by March 2019 • Physio team capacity has increased with new staff in team, only reduced by 12.5% by end of January. Breaches due to clearing patients off waitlist & patient choice - declining appointments within 6 week period. No waitlist currently.	• Recruitment: The service is trying to recruit 0.5 WTE Physiotherapist vacant Band 5 post using temporary staffing • New band 6 SLT starts on 18th of March , approval for locum cover to cover gap but struggling to recruit • The service will clarify guidance for managing patient choice breaches • The service will continue to work through action plan	• Discuss recommendation from dementia mapping meeting with Commissioners. • Continue testing new diary templates to create more capacity in team • Working with acute SLT lead to streamline clinical pathway for VF clinics & provision of LSVT programmes – SLTs able to refer directly to VF clinics now

Service	Summary of improvement work undertaken during January 2019. 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.
CRT	• Predominant waits were for SLAT, with reduced Physio therapy capacity.	• Band 5 physio locum covering mat leave due to start on 11th February which will help clear waits • Struggling to recruit to additional band 6 physio locum from winter pressure funds	• Review OT waiting list by contacting patients • Set up assessment clinics to increase capacity in team & help clear waits • The service is in discussion with (Central Booking Service) CBS to pilot opt in letters for clinics which would save staff time booking appointments –will be part of review of CBS processes
ICTT (Other)	• January KPI of 95% for routine appointments was not met but was up by +4% (88.1%)from the December figures of 84.1% • Team has vacant posts which are yet to be filled but recruitment in progress.	• Team has vacant posts which are yet to be filled but recruitment in progress. • Some of the clients are already seen by one profession and need to wait to achieve certain goals before input from others.	• Continue with improvement plan
ICTT (Stoke and Neurology)	• January KPI of 95% for routine appointments was not met. The KPI was -6.8% (68.2%) on the previous month which was 75%.	• Start date for new stroke OT and SLT – 11th February. This will increase the team ability for new assessments. • Opt in letters to be used for neuro clients. • Pull from other streams to cover neuro when needed.	• The KPI is expected to improve to 75% as in previous month and continue to improve in March.
MSK CATS Physiotherapy	• CSIG target of 95% with respect to waiting times for routine appointments was not met in January. • The service achieved 71.8 % there was an increase of 8.3% since December 2018 which was 63.5% • There has been an increase in referral by approximately 200 per month since	• New APPs starting between September 2018 and January 2019 linked with SPOA funding have improved capacity. • Two additional 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	• As described under mitigating actions. • Expected to continue to maintain our target of 6 week wait in February. Next new APP starting mid-March 2019

Service	Summary of improvement work undertaken during January 2019. 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.
	the SPOA pilot began in comparison with the 2016/17 baseline data.	these within four months. • Improvements in referral management have helped to reduce delays between receiving referrals and offering appointments.	
Routine MSK Physiotherapy	• CSIG target of 95% with respect to waiting times for routine appointments was not met for January. • The service achieved 66.1%, there was a slight decrease of 6.9% since December 2018 which was 73.0% • 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, this is anticipated due to SPOA 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 appointments. 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 referral management helping to reduce delays between receiving referrals and offering appointments • Increase in waiting time compounded by patient choice over the holiday season, where sooner appointments offered were not taken. • Creation of extra now patient clinics each month to increase capacity in the service	• As described under mitigating actions. • The service anticipates that 75% of patients seen within 6 weeks by end of January.

Service	Summary of improvement work undertaken during January 2019. 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.
Cardiology	• Haringey CSIG target of 95% with respect to waiting times for ROUTINE appointments was not met in January. Achieved 100% for Nov/Dec & all Urgent patient seen with 2 weeks (100%) • Islington CSIG target of 95% with respect to waiting times for URGENT appointments was not met in January Achieved 100% for Nov/Dec All routine Referral seen within 6 week (100%)	• Haringey 3 Routine referrals not seen within 6 week target Routine referrals are sent CUBY (Contact Us By) letters - Patients are then given choice regarding the timing of their appointment. In all 3 cases patients delayed their apt due to the following reasons: holiday x2 & 1 attending hospital appointment • Islington Urgent referral x1 not seen within 2 week target period. Patient was offered a first appointment within 1 week of DC (referral) but DNA their appointment. Rebooked outside 2 week target period.	• Haringey Liaise with Central Booking Team to ensure that all patients are encouraged to book within the 6 week time period or referred to Heart Failure team if unable to book in a timely manner. • Islington Heart Failure Nurse will contact urgent patient to confirm appointment prior to clinic/home visit

Children's Community Services

Service	Summary of improvement work undertaken during January 2019. 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	• CSIG target of % for January with respect to waiting times for routine appointments, not met. • 83.3% of patients received routine appointment in 6 weeks during January. This represents a slight dipped in performance of 2.4% since November. • The fragility of the service has been recognised and proposals are being developed alongside improvement work, to develop a new integrated pathway.	• Process mapping and continence co-design session which was held on 31st of January identified recommendations and action plan in developing a new model and pathway – follow up meeting in March to review progress • Regular monitoring of the Patient Tracker List (PTL). • The service has written 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).*	• Proposals for a new integrated Continence pathway, with a single point of access are also being developed. • Group work in developing the new model and pathway will continue to identify further improvement plan and recommendations. The staff from Whittington Health, the Clinical Commissioning Groups (CCGs) and service users will reconvene in March 2019 for another session. • Blitz clinic happening in March 2019 for Haringey and Islington
CAMHS (Islington)	• Target not achieved - CAMHS core 21.3%, NDT/ADHD 15.4% and CAHMS school 77.8% •	• 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	• 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,

		June 2019 • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations • 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). • Recruitment: Vacancy in Consultant Psychiatry/Clinical Lead post – waiting for approval	anticipated completion of recruitment, February 2019 • Continue monthly CYP Waiting Time Improvement meeting and monitor performance
Community Children's Nursing (Haringey & Islington)	**Haringey** • Target was not met. No change in performance since December 2018. The service achieved 33.3% • CCN Life Force – delayed in seeing a patient due to patient choice; some patients do not require imminent support from service hence RTT time can exceed 14 days **Islington** • A decrease in performance from 87.4% to 77.1%. • Generalist, Hospital at Home and Neonates achieved 100% however overall performance was pulled down by Life Force and Primary care.	• CCN Haringey Life Force – the team will review data recording i.e. what to put when patient requested to be seen beyond the 14 days period and what outcome to put in Rio. • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations	• Merging stand-alone nursing service with wider team – February 2019 (awaiting confirmation from commissioner) • Continuation of Data Quality improvement support – February 2019 • Continue monthly CYP Waiting Time Improvement meeting and monitor performance

Community Paediatrics Service	**Haringey:** • Child Protection achieved 100.0% • SCC achieved 0.0%, NDC 80.0% and other 50.0% due to following reason: • Social Communication – continues to be the area of concern as consultant led assessment of ASD for all CYP up to the age of 12 • Project commenced looking at moving to a therapy led assessment model for 0-5's and suggestion to commissioner that 5-12's move to a CAMHS led model (included in Provider Intentions Letter) • Waiting Time will remain 52w+ until the review and new model is agreed and historic backlog cleared • Neuro-developmental – waiting time impacted by long-term sickness of substantive consultant, currently being covered by remaining establishment • Phased return for sick Consultant NDC **Islington:** • There was a slight improvement in performance from 45.8% to 65.2% • 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 • Long-term consultant vacancy now recruited into	**Haringey:** • NDC consultant sickness and phased return • Explore Streamline Admin Process with Service Managers and Project Manager • NDC target 80% due to Junior Drs Rota and annual leave **Islington:** • Improvements in data quality processes as part of new project • Re-assessing demand and capacity when new consultant comes into post • Fortnightly appointment meetings with Admin 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 • Deputy Service Manager to attend NHS improvement Course Breach and root cause analysis RTT, demand and Capacity duration 3 Months for six sessions	• The implementation of new ASC model in Haringey – First phase April 2019 and completion September 2019; following completion, it will take 12-18 months to see the benefits of the new model • 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 reductions improvement within 3- 4 months March 2019 • Streamlined admin processes will be measured by clinic data outcomes 3- 4 months improvement March 2019. • Haringey-NDC and Haringey-Others will review data around RTT pathway, contacts, referrals with the support of senior admin and project manager

Family Nurse Partnership (Haringey & Islington)	**Islington:** • Performance improved to 100%, last month the performance was 60.0% ; that was 40.0% increase in performance • The team is fully staffed but is managing planned long term sick leave of one full time nurse and the additional work of supporting clients during the decommissioning of the Camden service as both practitioners have now left. **Haringey:** • A decline in performance from 83.3% to 71.4% • Clients can remain on waiting list up until 28th week of pregnancy. The service attempts to contact clients by telephone, text message throughout the period before securing a face to face contact. This can often take a long time due to client vulnerability, chaotic lifestyle, and frequent change of contact details • A new FN has commenced in post to cover maternity leave. The new FN caseload will build gradually to full caseload towards the end of the year where the new FN staff will have further residential training throughout the year. • All patients from the FN caseload have gone on maternity leave who wished to remain on the FNP programme were accommodated into existing FN caseloads prior to new FN coming into post.	**Islington:** • Work plan in place to support Camden decommissioning process and management of last 6 Camden clients on the programme. **Haringey:** • New Nurse appointed and joins team in February 2019. This will gradually improve the service performance	**Islington:** • Review and monitor performance • The service will continue to be supported by project lead to ensure data quality improvement **Haringey:** • New nurse builds cases incrementally as she has to train to be a family nurse, improvement will then take place. • Cases being reviewed with a possibility of graduating families earlier from the programme if appropriate - this will have an impact on releasing capacity.

IANDS SCT	• Target was not met with respect to waiting times for routine appointments, however there was a slight improvement from 12.5% to 22.2%	• 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. • The service will monitor the impact of the implementation of new service model, which will continue to be reviewed over the next 3-6 months with commissioners at on-going engagement meetings
Looked After Children (Haringey & Islington)	**Islington:** • A slight decline in performance from 90.9% to 85.7% • The service received 18 new referrals and 2 referrals were not seen on time • Managing staff vacancy and introduction of cover arrangements. **Haringey:** • Significant decline in performance from 100.0% to 50.0% • The services seen 18 new patients in January and only 12 were seen on time • The initial health assessments have been a cause of concern with only 13 % being achieved within 20 days in January which is our aim. Most of the breaches are due to circumstances beyond the teams' control. • 2 foster carers were unable to make the first appointment they were seen at 24 days. • There were 4 children not seen within 20 days due to not being notified in a	• 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

	timely fashion by social care so we were unable to see the children within the required timescale. • One OOB patient returning to London – appointment was arranged but refused to attend - contacted mother for background information and a desktop completed at 87 days. This is a complex case and was documented as failed to attend. • Difficulty/issue with booking interpreter and patient end up seeing beyond the target week. • A couple of patients were not seen on time due to no appointment available.		
Occupational Therapy (Haringey and Islington)	**Haringey:** • The service still underperforming against the target, there was slight improvement in the performance from 25.0% to 50.0%; the service is anticipating a steady increase in performance. • The service seen 17/22 children within 18 weeks which is the agreed target week within the service specification **Islington:** • A decline in performance from 80.0% to 54.5% • The mainstream Islington occupational therapy team is understaffed by 0.8 WTE band 6 OT. Recruitment has been ongoing since December but there have not been suitable applicants.	**Haringey:** • Haringey Therapy Review, next steps are action planning following report. • Average waits are reducing due to full staffing and review of systems **Islington:** • Unsuccessful attempt in getting paediatric OT agency cover and the gap in affected the productivity of the service.	**Haringey:** • Staffing level continues to drive improved performance. • Involvement in data entry improvement to enable all data to be captured effectively. **Islington:** • Improvement of data entry (local service) and follow up meeting with the Rio team to recommend changes • We are continuing with recruitment efforts for both a band 6 OT and agency **Haringey and Islington:** Local data quality meeting i.e. Rio/data entry took place January 9, 2019, actions to

			be implemented especially around access, data entry and Rio SOP.
Paediatrics Nutrition and Dietetics (Haringey and Islington)	**Islington:** • A significant decline in performance from 100.0% to 47.6% • The team has been short staffed by a full time dietician due to delays with renewing her work visa **Haringey:** • CSIG target of 95% with respect to waiting times for routine appointments was met with 100% being achieved.	• Visa issues for member of staff now resolved by HR so team fully staffed. **Haringey :** • The target is achieved for this month, 100%	• The service will anticipate gradual improvement in productivity due to staffing improvement. **Haringey:** • Monitor and review next month
Physiotherapy (Haringey and Islington)	**Islington:** • Target was not met. The service achieved 71.4% in January and a decline of 24.7% since December 2018. • Recruitment: The service is understaffed due to maternity leave. Recruitment in January was not successful and post is out to advert again. **Haringey:** • Haringey service at 52% which is a decline from previous month. Only 8/25 children waiting longer than agreed 15 weeks wait. Those waiting longer are children in early years where there is current vacancy. • Fully engaged in Therapy Review and have now established a stand-alone MSK service for those children who require urgent physio services which continues to achieve an 8 week wait.	• Completion of Haringey Therapy Review, now awaiting action plan • Ongoing commitment to Haringey stand-alone MSK service. • Continued use of agency/Bank and aiming to recruit to vacancies. • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations	**Islington:** • Recruitment in January was not successful and post is out to advert again. **Haringey:** • 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.

	• However, mainstream physio service still has vacancies, which are presently being covered by agency		
School Nursing (Haringey and Islington)	**Haringey:** • Target was achieved from 90.2% to 95.9% **Islington:** • Target was not met, 85.7% performance in January 2019. • Team challenged by significant long term sickness of 2 staff members including team lead.	• Both boroughs will see improvements in performance when recruitment pipelines are completed and data quality processes are improved. **Islington:** • Management of sick leave according to policy. • One Band 5 community nurse started Feb 2019. • Recruitment process of another Band 5 and 1 x Band 7 in place – anticipate starting date of April 2019.	• 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 (dependant on outcome of the review). **Islington:** • Work plan as above.
SALT (Haringey/Islington and MPC)	**Haringey:** • The service achieved 20.5% within 6 weeks, a 13.6% drop from previous month **Islington:** • The target date of 8 weeks is extremely challenging for the mainstream SLT service and not in line with national standards which are higher.	• Completion of Haringey Therapy Review, now moving onto action planning • 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. • Continued work on Rio data cleansing	• Skill-mix and other minor adjustments identified by Clinical Director to be agreed and implemented in both Haringey and Islington – December 2019 • Recommendations/actions from Rio Recording meeting will have a positive impact on data quality and better picture of patient's referral to treatment (patient journey). • The service will anticipate improvement in the wait list once tighter DNA policy in

		and ensuring accurate inputting across teams	place; this will also provide capacity and opportunity for clinicians to offer cancelled appointment to other patient waiting on the list.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	2	8	3	5	1	4	1	2	8	10	4	5	43	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	1	2	0	0	3	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	269	312	292	281	212	230	238	236	233	157	207		2086	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%		2.5%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	49.4%	50.0%	58.8%	43.9%	53.4%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	93.6%	94.5%	93.9%	92.7%	93.8%	93.3%	96.1%	95.1%	96.8%	95.8%	96.6%		94.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.7%	90.3%	87.8%	92.0%	92.0%	88.6%	90.3%	90.9%	90.1%	90.3%	89.8%		90.3%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		71.7%	84.8%	69.9%	78.4%	80.3%	82.9%	82.6%	80.5%	89.6%	86.2%	92.3%		83.5%	
Community	Haringey - HR1 % carried out before child aged 15 months		66.9%	63.9%	63.6%	73.6%	66.3%	71.5%	62.2%	71.6%	71.2%	73.1%	75.8%		69.7%	
Community	Haringey - HR2 % carried out before child aged 30 months		68.1%	59.5%	56.9%	62.5%	58.8%	65.2%	66.8%	64.1%	61.8%	60.1%	60.5%		61.8%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.6%	95.6%	93.5%	93.6%	90.9%	97.5%	95.0%	96.1%	93.1%	92.5%	92.4%		93.9%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		85.7%	77.9%	80.4%	86.1%	92.7%	91.8%	95.0%	96.5%	96.7%	92.4%	90.7%		91.4%	
Community	Islington - HR1 % carried out before child aged 15 mths		79.0%	83.9%	69.7%	80.8%	76.5%	82.1%	79.5%	87.4%	77.8%	81.2%	83.1%		79.6%	
Community	Islington - HR2 % carried out before child aged 30 mths		69.3%	76.4%	78.5%	75.1%	77.3%	79.5%	79.7%	81.3%	80.6%	81.7%	86.2%		79.9%	

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Responsive Services - Commentary

Hospital Cancellations
There was 1 target/urgent cancelation in general surgery due to HDU bed not being available on the day of the surgery was planned. The case has not yet been rebooked yet as the patient is not fit for surgery.
Non target cancellations – 1 x General surgery (surgeon off sick) and 3 x Trauma & Orthopaedics (list overrun x 1, instruments not available on shelf as Trust procedure was not followed x1, admin error x1). Three of these cases were rebooked and completed within 28 days. For the fourth case, surgery is delayed due to patient choice.

Delayed Transfer of Care (DToC)
January performance is 2.5% and is below the average for the year. Although very slightly above the Trust internal target of 2.4%, we have achieved the National Target of less than 3%. DToC issues in January have been predominantly related to external bed availability, (waiting for intermediate or care home beds). The bi-weekly MADE events continue to support the proactive management of DToC and are invaluable at identifying potential discharge issues that can be addressed sooner.

Work also continues on streamlining the NCL Discharge to Assess (D2A) Pathways 0 to 3, which will continue to reduce the amount of assessments and paperwork required within the acute environment thus increasing the flow and ease of discharge for medically optimised patients.

Women seen by HCP/Midwife within 10 weeks
A drop in January 2019 to 43.9%.

Action: review and validate the data to ensure accuracy. Expected to have improved in February 2019. (March 19 Performance report)

Responsive Services - Commentary

Service	Summary of improvement work undertaken during January 2019. 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** • Haringey HV data up to January 2019 • Antenatal contacts continues to maintain an overall increasing trajectory, in line with expectations of commissioners • Slight drop due to outstanding templates, which will be updated throughout February once data templates cleansed data expected to meet 80% + • Target 80%. Trajectory moving in right direction as per improvement plan. • Target 80%. Work recently completed in SPOC to improve hence big increase from 60.7 to 67.8% **Islington:** • New Birth Visits monthly decrease 76% although quarterly figure of 93%. High number of hospital admissions impact on numerator. • 8 week review at 73% although rises to almost 90% if those completed after 56 days included. • HR1 within 15 months sees continued fall from previous months from 77.9% to 74%.	**Haringey:** • Service has undertaken analysis to identify specific team/practice issues contributing to performance challenges • Targeted work underway to (1) support specific teams in the East of Haringey with local processes and data quality (2) target clinics with highest WNB/DNA rate e.g. Triangle Children's centre area(process in place). **Islington:** • Commissioners are expecting a bedding period following the transfer of clinical records to the new caseloads which may impact on performance and this is being borne out in Q3 and Q4 figures.	**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 continues to engage in ICSU Data Quality project to ensure validation of notes and outcoming of appointments is improved from current position.

Service	Summary of improvement work undertaken during January 2019. 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.
	• HR2 within 30 months continued improvement from 70.9%, to 77% against a target of 80%.		

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	2018-2019	Performance
HR	Appraisals % Rate	>90%	71.6%	68.9%	70.2%	70.8%	71.5%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	72.7%	73.3%	
HR	Mandatory Training % Rate	>90%	80.8%	82.6%	82.9%	83.0%	82.8%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%		82.4%	
HR	Permanent Staffing WTEs Utilised	>90%	87.3%	87.3%	87.4%	87.2%	86.2%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	88.1%	87.1%	
HR	Staff FFT % recommended work	>50%		58.6%			60.8%			64.4%					61.9%	
HR	Staff FFT response rate	>20%		17.8%			16.5%			8.0%					12.3%	
HR	Staff sickness absence %	<3.5%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%	3.10%	3.52%	3.92%	3.81%	3.35%		3.48%	
HR	Staff turnover %	<10%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	12.8%	12.7%	12.7%	12.0%	11.7%	12.9%	
HR	Vacancy % Rate against Establishment	<10%	12.7%	12.7%	12.6%	12.8%	13.8%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	11.9%	12.9%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	89.3%	82.0%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	112.6%	131.5%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	92.2%	87.5%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	134.5%	121.7%	
HR	Safe Staffing Alerts - Number of Red Shifts		12	19	18	8	0	1	1	2	0	0	0	0	30	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.4	8.6	8.7	9.3	9.4	10.0	9.0	8.8	9.2	8.8	10.2	9.0	9.2	

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	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	Q3 Dec-18	Trend
Medical	Average staff cost per patient		104	96	101	88	92	97	101	103	86	94	101	
Nursing	Average staff cost per patient		182	181	182	172	181	174	180	183	168	168	182	
Other	Average staff cost per patient		195	166	203	179	196	226	234	208	185	192	209	

Human Resources

Vacancy rates against establishment have remained stable, and the work within local, national and international nurse recruitment continues. Turnover has reduced slightly though it remains above target and a cross organisational retention plan supported by NHSI is currently being drafted. Sickness (reported a month in arrears) has reduced slightly, and is just over the Trust target at 3.34%. This is attributed to seasonal illnesses. Appraisal rates have reduced slightly but this is mainly attributed to block appraisals in corporate areas. A training pilot for improving data on appraisals and mandatory training on ESR is underway. The Staff survey rate was 48.5%, which is the highest response rate the Trust has had. Results will be released from March 2019 and are currently under embargo.

Well Led Services - Commentary

% day fill rate-nurses
All wards received adequate staffing levels during January 2019. There were no Red shifts reported. A number of unfilled registered shifts were contributed to reduced bed occupancy. 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 and this will have an impact on the % fil data. It is anticipated that the data template submitted to NHSI will change when Band 4 nursing associates will be on the NMC register.

% 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. Enhanced Care shifts are scrutinised and authorised by the Associate Directors of Nursing. The wards in Medicine continued to have a significant increase in enhanced care for patients at risk of fall and under Mental Health. Safety was maintained through senior nurse oversight at all times. The review of all Health Roster and safe care templates against the staffing ratios recommended in the last establishment review is in progress. A senior nurse is on secondment to relaunch and implement the decision and authorisation process of enhanced care (including assessment and evaluation of care).

% night fill rate-nurses
All wards received adequate staffing levels during January 2019 and there were no Red shifts reported. Band 4 Assistant Practitioners continue to cover Band 5 nurses and this will have an impact on the % fill rate for registered and un-registered. It is anticipated that the data template submitted to NHSI will change in 2019 to accommodate nursing associates who will soon be on the NMC register.

% night fill rate-HCAs
There has been significant increase in enhanced care in Acute Assessment Units for patients under Mental Health and falls risk.
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. Ifor also had an increase on enhanced care due to mental health care needs

Activity - Indicators and Performance

Category	Indicator	18_19 Target	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	Q3 Dec-18	Q4 Jan-19	Activity
ED	ED Attendances	8285	8082	9217	8645	9226	8699	9287	8157	8897	9082	9245	9219	9595	
ED	ED Admission Rate %		14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	15.0%	16.2%	15.9%	14.9%	
Community	Community DNA Rate %	<10%	7.6%	7.7%	7.9%	8.1%	8.0%	8.5%	8.1%	7.7%	7.8%	7.5%	8.0%	7.5%	
Community	Community Face to Face Contacts		54305	60446	55908	63946	62540	61451	54925	57914	63923	63936	51425	62119	
Admissions	Elective and Daycase		1735	1879	1721	1839	1880	1763	1821	1922	2267	2219	1800	2141	
Admissions	Emergency Inpatients		1903	2241	2181	2338	2237	2218	2193	2163	2185	2289	2230	2266	
Referrals	GP Referrals to an Acute Service		7362	7890	7161	7687	7618	7564	7061	6886	8287	7968	6687	8138	
Referrals	% of GP Referrals that were completed via ERS		44.1%	47.0%	58.2%	73.7%	79.6%	82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.8%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	16.8%	17.4%	18.2%	12.2%	10.1%	8.8%	10.5%	11.9%	13.0%	12.7%	10.7%	7.6%	
Maternity	Maternity Births	320	253	315	291	323	282	297	321	312	296	299	281	295	
Maternity	Maternity Bookings	377	375	370	400	369	317	376	330	334	398	363	327	420	
Outpatients	Outpatient DNA Rate % - New	<10%	10.9%	10.7%	10.0%	10.9%	10.1%	10.6%	11.2%	11.2%	10.7%	10.7%	10.5%	10.4%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.0%	10.9%	10.2%	12.1%	10.2%	10.3%	10.6%	10.2%	10.4%	10.4%	10.0%	9.9%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	10.8%	10.6%	10.5%	10.5%	10.2%	10.1%	
Outpatients	Outpatient New Attendances		9224	9631	9309	10246	9667	9649	9098	8888	10473	10170	8444	9950	
Outpatients	Outpatient FUp Attendances		16595	17808	17411	18731	18306	18790	18105	17274	20235	19173	16380	19092	
Outpatients	Outpatient Procedures		6828	7095	6783	7421	7206	7607	6900	7359	8159	7969	7085	8282	
Theatres	Theatre Utilisation	>85%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	80.4%	

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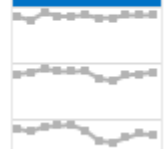
Average Tariff for Inpatient PODs

Category	Point of Delivery (POD)	17_18 Target	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	Q3 Dec-18	Trend
Average Tariff	Daycases		684	614	740	686	678	703	653	655	701	696	702	
Average Tariff	Elective		3550	3710	4033	3831	3778	3857	3210	2963	3483	3565	3717	
Average Tariff	Non-Elective		2362	2194	2484	2511	2564	2272	1684	1590	1850	2087	2007	

Activity - Commentary

e-RS
eRS ASI and paper referrals have both decreased, ASI is down from 11% in December to 8% in January and paper referrals have also gone down from 4% in December to 3% in January.

Births
At 295 this is an increase of births from December 2018, however remains off target by 25 for the month. Marketing and publicity work is continuing with filming already completed by the maternity team.

Bookings
Increased to 420 (43 over the target for the month) births

DNA
To date, more than 8,500 appointment requests have been made through the DrDoctor portal and 99% of these requests have been actioned by booking teams within 33 hours. There was a minimal decrease in DNA rate for January at 10.4% (0.1% reduction from December 2018). DrDoctor has had a significant impact in only a few services like Imaging, Paediatrics and Trauma & Orthopaedics, but has yet to have a substantial effect amongst all other services. Before the end of February 2019 the wording in the texts will be amended to incorporate empathy and cost implication of a DNA'd appointment to see if this has a positive impact/response.

Theatre Utilisation
Overall for January was 78%. (down from 80%). The expectation was that Theatre Utilisation would be at 85% for January 2019. Issues identified in staffing in admission, pre-assessment efficiency around staffs annual leave and sickness. Actions: Daily management's tasks focus on Pre-Operative Assessments and Admissions. The Theatre scheduling dashboard is also used daily to monitor the theatre bookings.

Meeting title	**Trust Board – public meeting**	**Date: 27.2.2019**
Report title	January (Month 10) 2018/19 – Financial performance	**Agenda item: 14**
Executive director lead	Stephen Bloomer, Chief Finance Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a surplus (including Provider Sustainability Fund (PSF) income of £2.5m) of £1.6m for the month of January (month 10) which is behind of plan by £1m. Year to date the Trust is also behind the NHS Improvement adjusted plan by £1m, with a surplus of £10.6m including £16.4m of PSF income. Income performance is ahead of plan in month with a positive variance of £0.5m after adjusting for agenda for change funding and High Cost Drugs. Year to date income performance is £1.6m off plan. Pay costs remain above budget, £1.5m in month (£4.1m year to date) £0.8m of the in month variance relates to an increase in temporary bank payments including £450k of 'Bank Bonus' payments. The Trust is currently forecasting to achieve its control total but this will require significant cost reductions in the remaining weeks and the settlement of the Agenda for Change £0.8m current funding shortfall. The Trust is forecasting Cost Improvement Programme (CIP) delivery of £13.4m (£12m recurrently) against a £16.5m target, with £10.5m (£9.5m recurrently) delivered to date. The Trust has spent £7.2m 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 January 2019 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		
Appendices	1 – month 10 finance report	

Appendix 1: January (Month 10) 2018/19 – Financial Performance

Financial Overview

The Trust is reporting a £1.6m surplus in January including £2.4m of PSF, which is a negative variance to plan of £1m for the month. The year to date position of a £10.6m surplus including £16.4m of PSF, is also £1m behind the planned control total.

In month, total Income was £0.8m ahead of plan. There were positive income variances relating to Non elective activity £0.4m, Day cases £0.2m, Emergency Department (including Ambulatory Care) £0.3m and Agenda for Change funding of £0.3m, although this variance is offset in pay.

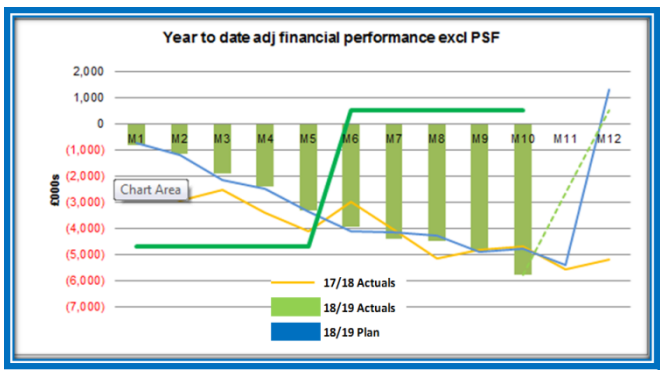
Non-pay is underspent in month by £0.3m as a result of the increased costs of drugs spend.

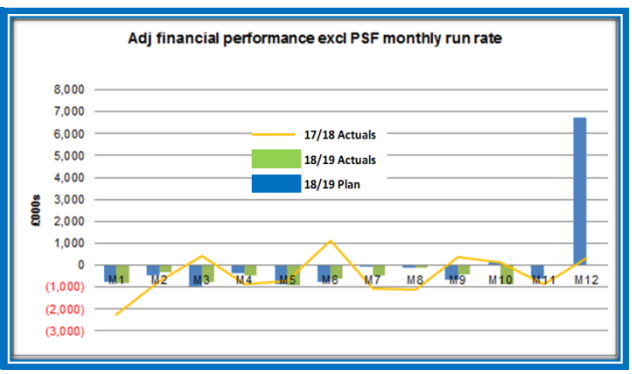
The pay spend in January is significantly in excess of budget due to the usual agenda for change payment but also significant pressures relating to bank spend resulting from the 'Bank Bonus' scheme. The scheme did not achieve the planned reduction in overall pay expenditure. The cumulative agency spend is £10.3m, in month, the spend was £0.9m.

The EIM ICSU, continues to be spending significantly in excess of budget with month 10 having costs of £4.5m with a budget of £3.6m. Without a reduction in the pay spend the risk of the organisations ability to achieve its control total for 2018-19 is significantly increased.

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	23,864	24,206	341	234,592	232,994	(1,598)	260,376
Other Non-Patient Income	2,141	2,304	163	22,317	22,269	(48)	47,536
High Cost Drugs	656	718	62	6,565	7,197	633	7,877
Pay Award Funding	0	264	264	0	2,735	2,735	0
Total Income	**26,662**	**27,492**	**830**	**263,474**	**265,196**	**1,722**	**315,789**
Pay	(18,409)	(19,886)	(1,477)	(185,615)	(189,716)	(4,101)	(222,445)
Non-Pay (excl HCD)	(6,229)	(6,527)	(298)	(62,569)	(60,884)	1,685	(74,057)
High Cost Drugs	(669)	(733)	(64)	(6,713)	(7,103)	(390)	(8,052)
Total Operating Expenditure	**(25,307)**	**(27,146)**	**(1,839)**	**(254,897)**	**(257,703)**	**(2,806)**	**(304,554)**
	1,355	**346**	**(1,009)**	**8,577**	**7,493**	**(1,084)**	**11,235**
Depreciation	(542)	(509)	33	(5,416)	(5,310)	106	(6,500)
Dividends Payable	(432)	(432)	0	(4,309)	(4,309)	0	(5,263)
Interest Payable	(279)	(297)	(18)	(2,782)	(2,797)	(15)	(3,341)
Interest Receivable	1	9	8	10	77	67	12
P/L on Disposal of Assets	0	0	0	0	0	0	6,000
Total	**(1,252)**	**(1,229)**	**23**	**(12,497)**	**(12,339)**	**158**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**103**	**(884)**	**(987)**	**(3,920)**	**(4,847)**	**(927)**	**2,143**
Provider Sustainability Fund (PSF)	2,494	2,494	0	16,391	16,391	*0*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**2,597**	**1,610**	**(987)**	**12,471**	**11,544**	**(927)**	**23,523**
Add back							
Impairments	0	0	0	0	0	*0*	51
IFRS & Donate	9	6	(3)	(881)	(935)	*(54)*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**2,606**	**1,617**	**(989)**	**11,590**	**10,609**	**(981)**	**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 £1.6m. This is a positive performance of £0.5m in month.

Overall NHS clinical income has over performed by £4.7m year to date and £0.9m in month.

Day case and electives remain behind plan (£0.5m) for the year to date but improved £0.1m in month. The case-mix variance is driven by repeated poor performance in surgical specialities Trauma and Orthopaedics, Urology and General Surgery. The continued failure for surgical specialities to achieve agreed activity plans means that the Trust is routinely over providing expensive capacity and failing to address waiting list issues.

Non elective activity excluding maternity activity is ahead of plan year to date, £0.3m and activity is 2% ahead of the year to date plan. Uncoded activity continues to increase from previous months, £3.6m for 1,932 spells for Month 10. Maternity deliveries and pathways payments continue to under-perform against plan with a £1.4m adverse variance. The volume of maternity delivery is not matched by a reduction in expenditure with flexible staffing being an opportunity to improve the position.

Outpatients' continue to over perform by £0.1m in month, £1.4m year to date and year to date activity continues at 26% ahead of plan. The 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 and Ambulatory Care activity continues at 5.7% ahead of the year to date plan and income is above planned levels at £0.6m year to date.

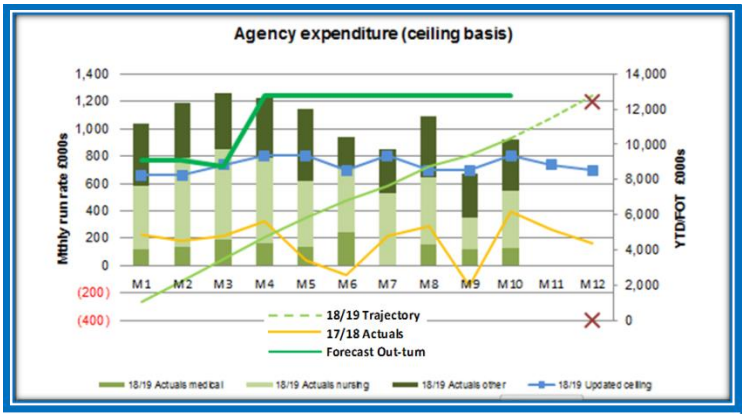
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,188	1,302	114	11,728	12,060	332	8,740	9,594	854	86,263	90,062	3,799
Ambulatory Care	357	543	186	3,409	3,998	590	1,482	1,719	237	14,184	16,081	1,897
Adult Critical Care	640	421	(219)	6,314	5,949	(365)	1,512	1,288	(224)	14,925	13,829	(1,096)
Community Block	5,857	5,857	0	58,877	58,724	(153)	0	0	0	0	0	0
Day Cases	1,190	1,386	195	11,360	11,616	256	1,532	1,946	414	14,630	16,977	2,347
Diagnostics	260	315	54	2,483	2,971	488	2,635	3,300	665	25,158	29,614	4,456
Direct Access	1,020	923	(97)	9,738	10,001	263	99,505	100,885	1,379	949,603	942,875	(6,729)
Elective	818	739	(79)	7,812	7,086	(726)	207	211	4	1,984	1,835	(149)
High Cost Drugs	654	715	61	6,543	7,081	538	0	0	0	0	0	0
Maternity - Deliveries	1,170	983	(187)	11,547	10,614	(933)	321	291	(29)	3,166	2,977	(188)
Maternity - Pathways	770	762	(8)	7,353	6,891	(462)	727	684	(43)	6,939	6,639	(300)
Non-Elective	3,431	3,871	440	33,869	34,446	578	1,606	1,794	188	15,861	16,515	654
OP Attendances - 1st	922	982	60	8,800	9,605	805	4,971	5,333	362	47,381	52,156	4,775
OP Attendances - follow up	823	790	(32)	7,852	7,772	(79)	13,135	12,646	(489)	92,285	123,410	31,125
OP Procedures	396	499	104	3,776	4,450	674	2,262	3,062	800	21,577	27,533	5,956
Other Acute Income	1,530	1,131	(399)	12,696	13,136	440	7,730	5,866	(1,863)	107,069	70,278	(36,791)
CQUIN	489	519	31	4,781	4,792	11	0	0	0	0	0	0
Total SLA	**21,515**	**21,738**	**223**	**208,937**	**211,195**	**2,258**	**146,364**	**148,619**	**2,255**	**1,401,025**	**1,410,781**	**9,756**
Marginal Rate	0	0	0	0	(738)	(738)						
	21,515	**21,738**	**223**	**208,937**	**210,457**	**1,520**						
Other Clinical Income	3,006	3,079	73	32,220	29,533	(2,687)						
Other Non Clinical Income	2,141	2,675	533	22,317	25,206	2,889						
Total Other	**5,147**	**5,754**	**606**	**54,537**	**54,739**	**202**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**26,662**	**27,492**	**830**	**263,474**	**265,196**	**1,722**	**146,364**	**148,619**	**2,255**	**1,401,025**	**1,410,781**	**9,756**
PSF	2,494	2,494	-	16,391	16,391	-						
Revised Total	**29,156**	**29,986**	**830**	**279,865**	**281,587**	**1,722**						

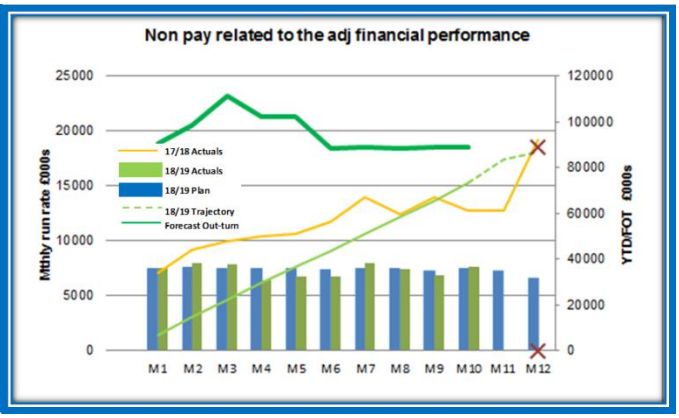
Monthly run rates – expenditure

The year to date combined expenditure position is £2.8m adverse to plan. Key points of note include:

- **Pay and Activity Correlation**
  - Total pay expenditure for January was £19.9m which is over £1.5m in excess of budget
  - Within total pay expenditure, agency costs were £0.9m. The total agency spend is £10.3m. Total temporary spend in month was £3.6m. The highest month of the year, £0.5m more than the previous highest month
  - The majority of this variance can be attributed to the 'Bank Bonus' scheme where payments of £0.45m were made for the six week period covered. The scheme was intended to reduce agency spend and the over pay cost quantum. It can be seen that pay has risen in recent months and therefore the scheme failed. The level of payments were in excess of that expected and a review into the rules and process
  - The Trust has completed the review of its electronic rota system on ward areas to ensure all rotas reflect the establishment and actual staffing levels match the plan. This should reduce spend in M11/12
  - Ward establishments are over staffed due to winter escalation beds and specialing/one to one care of patients. The data suggests there has not been a material increase in co-morbidities that require enhanced care so the use of specialing is the subject of review.
  - The adverse pay spend threatens to jeopardise the Trusts ability to meet its year end control total and is creating an exit run rate which makes the achievement of the 19/20 financial targets materially more difficult.

- **Non Pay**
  - Non pay expenditure for January was £7.3m, including High Cost Drugs.
  - This spend is £0.5m more than the £6.8m average because of a higher than planned High Cost Drugs spend (offset in income) and other tariff drugs expenditure

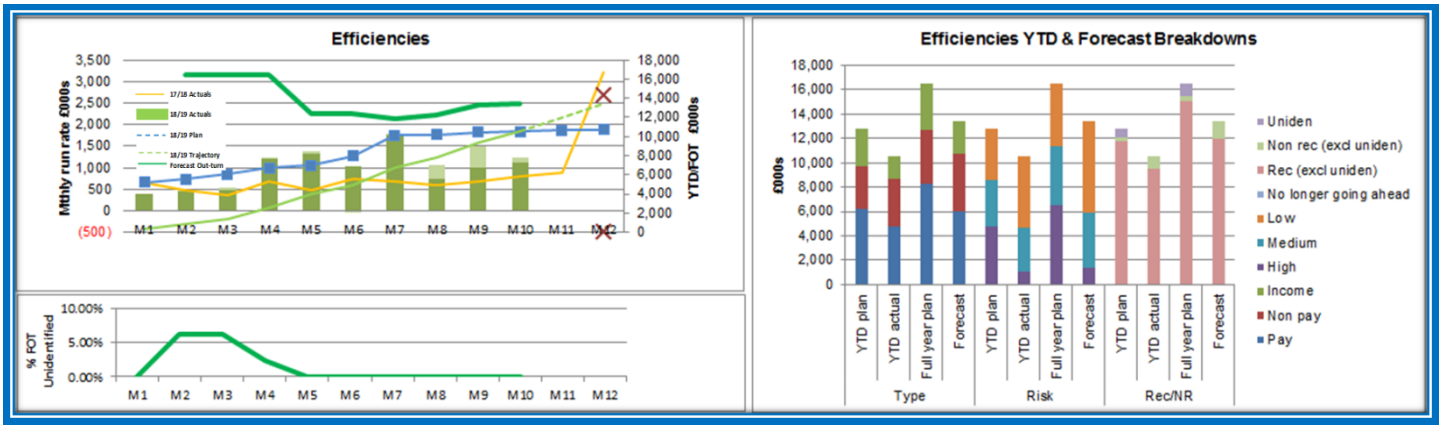




Cost Improvement Programme (CIP)
The Trust is forecasting CIP delivery of £13.4m, a shortfall of £3.1m from the original target. Of the £13.4m, £12m is forecast to be delivered recurrently. This means the exit run rate for the Trust is materially worse than planned and is driving an increase in the CIP requirement next year.

At the end of month 10 the Trust's planned delivery was £12.8m of CIP, against which £10.5m (£9.5m recurrently) has been delivered, equating to 82%.

During January the Trust has forecast that it will deliver £12m of recurrent CIPs for the year with a further £1.3m non recurrently. The Trust continues to encourage ICSUs to deliver non recurrent mitigations to close any gap in delivery of the original target, and to identify additional, recurrent CIP plans to replace those that have either not delivered or not delivered to the levels originally intended.

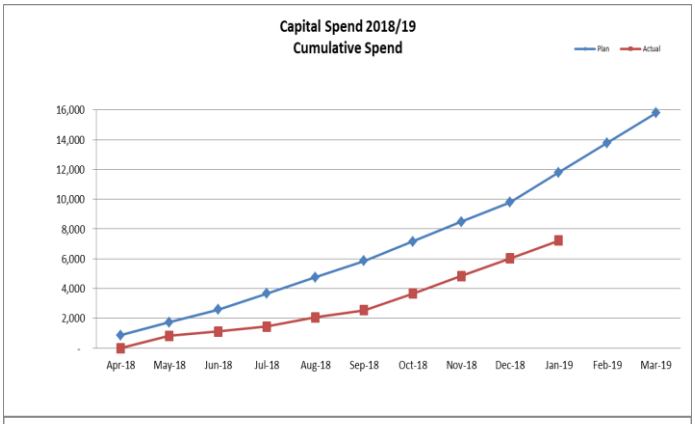


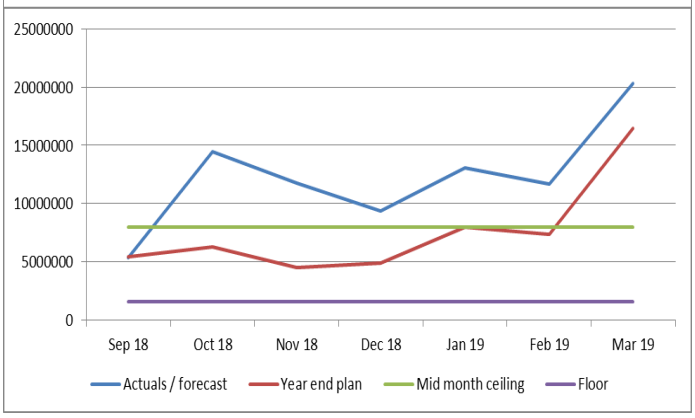
Forecast by programme area:

- Flow through – £2.7m (100%)
- ICSU 2% targets – £4.6m (94%)
- ICSU 2% target delivered non recurrently - £1.3m
- Transformation Schemes – £4.7m (57%)

Within the ICSUs, the key areas of focus will be for Adult Community and Children & Young People as the furthest away from plan in terms of forecast delivery. However, attention also needs to be given to Surgery & cancer as 36% of their forecast is delivered via non-recurrent means rather than true CIPs. Within Transformation Schemes key areas for focus are those in relation to Outpatients, Community and Improving Medical Value.

Statement of Financial Position





THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 Jan 2019 £000	Plan 31 Jan 2019 £000	Year to Date Plan variance 31 Jan 2019 £000
Property, plant and equipment	215,484	221,910	(6,426)
Intangible assets	5,440	5,112	328
Trade and other receivables	1,463	656	807
Total Non Current Assets	**222,387**	**227,678**	**(5,291)**
Inventories	1,471	1,355	116
Trade and other receivables	32,961	32,080	881
Cash and cash equivalents	13,094	7,951	5,143
Total Current Assets	**47,526**	**41,386**	**6,140**
Total Assets	**269,913**	**269,064**	**849**
Trade and other payables	41,528	39,123	2,405
Borrowings	19,778	18,799	979
Provisions	1,093	1,391	(298)
Total Current Liabilities	**62,399**	**59,313**	**3,086**
Net Current Assets (Liabilities)	**(14,873)**	**(17,927)**	**3,054**
Total Assets less Current Liabilities	**207,514**	**209,751**	**(2,237)**
Borrowings	37,005	41,107	(4,102)
Provisions	839	842	(3)
Total Non Current Liabilities	**37,844**	**41,949**	**(4,105)**
Total Assets Employed	**169,670**	**167,802**	**1,868**
Public dividend capital	64,679	66,679	(2,000)
Retained earnings	6,832	2,550	4,282
Revaluation reserve	98,159	98,573	(414)
Total Taxpayers' Equity	**169,670**	**167,802**	**1,868**

Overall, the value of the balance sheet is £1.9m higher from plan. The main reason behind this is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF). Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £6.1m lower than plan. Capital spend between months 7 and 10 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 it would likely undershoot the plan by £1.0m; the Trust is still planning to reach the revised target of £12.7m.

- **Receivables (Debtors)** are £1.7 higher than plan. This increase is being driven by the continued accrual of core and incentive Provider Sustainability Funding (PSF). The Trust expects this to be settled in July 2019. The Trust accrued a further £2.5m in month. As such, the fact that receivables are only £1.7m higher than plan hides excellent collection of old and current year debts.

- **Payables (Creditors)** are currently £2.4m above plan. This variance has increased by £0.9m in month, largely due to an increase in deferred income as month 10 is the first month of the quarter.
- **Cash and cash flow:** the Trust is holding £13.1m in cash at the end of January 2019. This is £5.1m higher than plan, and reflects the Trust's strong debt management performance. £5m of the balance is invested with the National Loans Fund.

  The Trust will not require any cash support during the rest of 2018/19. Cash modelled as part of the draft 2019/20 planning submission indicates higher cash balances in 2019/20, especially following the settlement of the PSF debtor mentioned above.