Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
24 April 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**24 April 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 Finance 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	1420	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal
3	1422	**Declaration of conflicts of Interest** *Steve Hitchins, Chair*	Verbal
4	1424	**27 March 2019 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1430	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
6	1435	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review
Quality & patient safety			
7	1445	**2018/19 Patient stories – actions taken and**	Review

Item	Timing	Title and lead	Action
		learning identified and shared *Michelle Johnson, Chief Nurse & Director of Patient Experience*	
8	1500	**Serious incidents –March 2019** *Dr Julie Andrews, Acting Medical Director*	Review
9	1510	**Quarter four Quality and patient safety report** *Dr Julie Andrews, Acting Medical Director*	Review
10	1525	**Safeguarding children declaration** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Approve
Performance			
11	1535	**Performance dashboard – March 2019** *Carol Gillen, Chief Operating Officer*	Review
12	1550	**Financial performance – March 2019** *Stephen Bloomer, Chief Finance Officer*	Review
13	1605	**Quarter four assurance on 7 Day Services** *Dr Julie Andrews, Acting Medical Director*	Review
14	1615	**Corporate objectives: review of quarter four** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Review
Governance			
15	1625	**2019/20 Corporate objectives** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
16	1635	**Board Assurance Framework and risk appetite** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
17	1645	**Corporate Risk Register** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Approve
18	1655	**Use of the Trust seal** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Approve
19	1705	**Questions from the public on meeting items** *Steve Hitchins, Chair*	Approve

Item	Timing	Title and lead	Action
20	1710	**Any other business** *Steve Hitchins, Chair*	Verbal

ITEM: 4

Minutes of the meeting of the Trust Board of Whittington Health NHS Trust held in public on Wednesday, 27 March 2019

Present:

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

In attendance:

Janet Burgess	London Borough of Islington
Norma French	Director of Workforce
Jonathan Gardner	Director, Strategy, Development & Corporate Affairs
Kate Green	PA to Director of Workforce (Minutes)
Sarah Humphery	Medical Director, Integrated Care
Swarnjit Singh	Trust Corporate Secretary

1. Patient story

1.1 The patient story was to take the form of a video featuring Liz, mother of Jess, a frequent patient at the hospital. James Connell, Patient Experience Manager, introduced Colette Datt, Nurse Consultant, Shadi Saramad, Ifor Ward Manager, and Casey Galloway, Patient Experience Officer.

1.2 On screen, Liz introduced herself as the mother to two daughters, Jess (aged 9) and Anna (aged 6). She explained that Jess suffered from a rare genetic disorder called Rett Syndrome (A rare genetic neurological and developmental disorder that affects the way the brain develops, causing a progressive loss of motor skills and speech). She is wheelchair bound, requires oxygen, has seizures and frequent infections, wears a spinal brace and has to be fed through a tube. She is therefore medically very complicated to manage and is frequently admitted to hospital; when at home she has a community care package funded by the Clinical Commissioning Group (CCG).

1.3 Asked about challenges to caring for Jess, Liz replied that her daughter can be admitted to hospital either via Emergency Department (ED) or planned admission.

When admitted via ED, one of the main problems was that there were no pillows available in the cubicle which meant Jess was unable to sit up unaided and therefore her Mother could not leave her for one minute. In addition, as she grows older Liz is no longer able to lift Jess so a hoist is required which was not available in ED. The cubicle in the ED which Jess was seen in had a bed with no cot sides and was situated a long way from the nurses' station, meaning that Liz was unable to leave her daughter and had no way of summoning help unless she left Jess alone. The staff, however, are 'amazing', and as accommodating as they can possibly be.

1.4 On Ifor Ward, Liz described staff as having become like friends. She had only positive things to say about the medical management of Jess's care and always felt fully included about decisions and very safe. She did mention that a shower chair would be helpful. When the family are away from home, Ifor Ward staff liaised with any local health services when intervention or admission becomes necessary.

1.5 Asked whether any improvements could be made to the care offered either to Jess or to Liz herself, Liz replied that one of the major things that affected them was that the CCG responsible for the continuing care package did not involve them enough in the decision-making and assessment processes. The carers, Liz said, were very good and knew Jess well, and were able to spot the (often very subtle) signs that she was becoming medically unwell. However, funding issues meant that her carers were unable to accompany Jess to hospital when she was admitted, where her complex needs meant that she still required one to one support. This left Liz as sole carer, and she has another daughter who needs her, which is complicated now as she had been referred to Child and Adolescent Mental Health Services (CAMHS).

1.6 Colette Datt said that, since the video was made, the team has been working with the ED to make improvements, and the Children & Young People's Integrated Clinical Service Unit (ICSU) had a Quality Improvement project group working on improvements. She acknowledged that pillows in the ED remained a problem as even though they were purchased, there was a tendency for them to 'disappear'; a hoist was now in place. Some funding had been obtained from the Mayoral office to refurbish the cubicle, and advice had been received from the community Occupational Therapy (OT) team. A portable equipment box had also been installed.

1.7 Although incidents were routinely recorded via Datix and there was a good culture of reporting on the ward, Colette acknowledged there was a slight problem of reluctance by children and families to complain due to their fondness and appreciation for the staff caring for them. They had, however, designed a sign encouraging people to tell staff about their needs and requirements with a special focus on children with autism or communications difficulties, and were trying to standardise passports across services. The following week was national autism week, and there was to be a study day.

1.8 Communication was an important issue for Jess, who had a computer to assist her via eye movement, but was unable to use it when she was unwell. This was a particular problem given that her carers (who might have been able to interpret very subtle signs) were unable to accompany her in hospital, thus meaning that ward

staff could not interpret whether she was indicating 'yes' or 'no', which could easily impact on her care. Staff aimed to purchase tools and training to assist in this area.

1.9 Siobhan Harrington asked whether the video had been shared with the CCG, and James Connell replied that it had been shown at a Patient Experience Committee meeting where a member of Haringey Healthwatch had been present. Michelle Johnson undertook to share the video with Haringey CCG's Director of Quality. Deborah Harris-Ugbomah knew of a national charity which worked with families where there were similar communications needs and offered to facilitate an introduction.

1.10 Janet Burgess said that all the patient stories brought to the Board were extremely interesting, however, the Board did not receive any updates or feedback on outcomes. Michelle Johnson replied that it was her intention to continue having patient stories at the Board, but given this was the end of the year would be working on a review of stories heard and lessons learned which would be brought back to the Board for information.

1.11 **The Board:**

- **i. welcomed the patient story;**
- **ii. agreed that the patient story video be shared with the Haringey CCG's Director of Quality; and**
- **iii. noted that a summary of patient stories highlighting, the actions taken and learning identified and shared would be brought to the next meeting.**

2. Welcome and apologies

2.1 Steve Hitchins welcomed everyone to the meeting. He introduced Duncan Wagstaff, a research student from University College London who was looking at how NHS trusts used data to inform Quality Improvement projects.

2.2 Apologies for absence had been received from Julie Andrews.

3. Declaration of conflicts of interest

3.1 Steve Hitchins drew attention to the list of interests contained within the suite of Board papers, enquiring whether Board members had any additional interests to declare. No one declared a conflict of interest pertaining to any of the items on the agenda for that afternoon's meeting.

4. Minutes, matters arising & action log

4.1 Naomi Fulop requested an amendment to minute 11.6 with the following inserted after the first sentence in section 11.6: "She suggested selecting some 'quick wins' which could be implemented rapidly to address staff needs." Subject to this change, the minutes of the public Board meeting held on 27 February 2019 were approved as a correct record.

4.2 There were no matters arising other than those already scheduled for discussion. It was noted that all items listed on the action log were either on track for discussion at future Board meetings/seminars or had already been completed.

5. Chairman's report

5.1 Steve Hitchins began his report by informing Board colleagues that the annual London Mayors' walk from the Whittington Stone to Mansion House had taken place on 10 March; the Mayor of Sutton had mentioned in passing that the Whittington Hospital had saved his life when he was just two years old. Steve Hitchins had also attended the Rotary Club charity quiz and the Haringey Youth Summit; a thought-provoking and sobering event which had focused on knife crime.

5.2 Steve Hitchins was pleased to inform the Board that Dyson had generously donated a new lighting system for the Intensive Treatment Unit. He also congratulated Siobhan Harrington on being named in the NHS's Top 50 Chief Executives.

5.3 Since the last meeting Steve Hitchins had attended a number of community services team meetings, as follows:

- Dietetics
- Bladder & Bowel
- Health Centre Managers
- Diabetes Community Nurses
- Camden Speech & Language Therapists
- Haringey District Nursing Twilight Team
- Improving Access to Psychological Therapies (IAPT)
- Musculoskeletal (MSK) pain team.

5.4 He had noted that all teams were very much focused on achieving the Care Quality Commission's (CQC) 'Outstanding' standard.

5.5 The previous Friday, Steve Hitchins had attended the weekly Muslim prayers led by Iman Suleman, and had spoken about the new security measures which had come into place since the Christchurch terror attacks. He had been struck by the degree of anxiety and fear experienced by staff, and urged everyone to do all they could to support them.

5.6 Moving on to future events, Steve Hitchins drew attention to the study day the following Monday being hosted by Ambitious About Autism as part of National Autism week.

5.7 It was noted that Steve Hitchins had circulated to all Board members the new arrangements for Board committees which were to come into force from April. There remained one vacancy – on the Charitable Funds Committee, for which an alternative solution was being sought.

5.8 **Board members welcomed the Chairman's verbal report.**

6. Chief Executive's report

6.1 Siobhan Harrington began her report by drawing attention to the publication of Health Education England's (HEE) report on staff wellbeing, which she pointed out was highly relevant for Whittington Health in terms of its work on culture. HEE's recommendations included the appointment of a workplace wellbeing guardian, and

Siobhan Harrington felt strongly that she should take on this role since looking after the wellbeing of staff was such an integral part of her role.

6.2 The Boards of NHS England (NHSE) and NHS Improvement (NHSI) were leading on an engagement piece around the legislative change that may be needed to support more integrated ways of working. NHSE and NHSI were themselves moving towards becoming a single organisation and to this end were increasingly sharing directors and creating a common infrastructure. Simon Stevens, NHSE Chief Executive, was keen however that this change was seen as the creation of a new organisation with its own approach and culture rather than a traditional merger.

6.3 Much work had been undertaken to ensure that the Trust was as well prepared as it could be for the impact of Brexit. Carol Gillen said that all necessary assurances had been completed, and the Trust was now participating in daily site reports which focused largely on medication, medical equipment and workforce. The planning group continued to meet, the Trust remained aligned with the London Regional group, and business continuity plans had been reviewed.

6.4 Moving on to Quality and Safety, Siobhan Harrington informed the Board that a national access standards review was being conducted at present, the aim being to deliver rapid assessment and treatment for those with the most serious conditions.

6.5 Within the Trust, the ED performance in February stood at 85.1%, however the average daily attendance had reached 317, the highest ever. Although the 95% target had not been achieved, Siobhan Harrington was aware how hard staff were working to deliver the best possible care, and thanked everyone for this. There had been one 12 hour trolley breach, which had involved a mental health patient awaiting informal admission to hospital. The Trust had also declared two mixed sex breaches in February caused by capacity issues; however, Siobhan Harrington provided assurance that patient privacy and dignity had been maintained at all times.

6.6 The CQC had carried out an unannounced visit to Simmons House, and the subsequent report had been felt to be very fair; it had concluded that the Mental Health Act was being used appropriately there. The staff survey results had made for stark reading, and how these were addressed would be a major focus for the Trust in the months to come. Stephen Bloomer would be reporting on the Trust's financial position in more detail, but in summary, at month 11 the Trust had been just off plan, with everyone working hard on income, delivery of cost improvement programme schemes and staffing levels.

6.7 Siobhan Harrington was pleased to inform the Board that work on the obstetric theatre should be completed in April, and she encouraged everyone to visit. There would be a formal opening event. In addition, refurbishment work was taking place on the post-natal ward and the neonatal intensive care unit. The Trust had completed the sale of the Dartmouth Building and the Education Centre, and the next phase of this work would be the design of the new education unit.

6.8 The Trust's newly-appointed Medical Director, Dr Clare Dollery, would be starting in June. Siobhan Harrington spoke of the outstanding work carried out by Julie

Andrews during her time as interim Medical Director – a post she would retain until Clare Dollery started. Referring back to the estates work, Stephen Bloomer paid tribute to the immense amount of work carried out by Adrien Cooper, Director of Environment. Steve Hitchins also commended the IAPT team for their work and dedication to the service.

6.9 **The Board:**

i. **reviewed the Chief Executive's report;**
ii. **agreed that a report on the role of the Trust's Wellbeing Guardian be brought to a future meeting;**
iii. **agreed that Board members should attend the opening ceremony for the Trust's new obstetric theatre;**
iv. **agreed that Steve Hitchins would write on behalf of the Board to thank Adrien Cooper, Director of Environment, for his work; and**
v. **noted the consultation underway by NHS Improvement on revised access standards.**

7. Serious Incident (SI) report

7.1 Michelle Johnson began her report by speaking about the benefits gained through carrying out joint investigations with Camden & Islington Mental Health Trust. Whilst this was a positive move, such investigations did take time, and it had been necessary to request extensions to the deadlines in the two current cases.

7.2 One SI had been declared in February, a very sad intrauterine death. This brought the total of SIs declared this year to 31 as against 38 for 2017/18. Michelle Johnson felt however that she would have to look at data over a number of years in order to identify any meaningful trends.

7.3 Deborah Harris-Ugbomah reported on the discussion which had taken place at the Audit & Risk Committee and stressed that, although dates for reports did occasionally slip, what was important was being confident that every investigation was carried out to the best of our ability. Michelle Johnson agreed, saying that she felt the learning process was becoming more robust. Deborah Harris-Ugbomah replied that the minutes should record the high quality of the report.

7.4 **The Board reviewed the report and took assurance that the serious incident process was being managed effectively with lessons learnt shared widely.**

8. Freedom to Speak Up Guardian report

8.1 Michelle Johnson introduced Ruben Ferreria, the Trust's Freedom to Speak Up Guardian and invited him to say a few words about his experience. Ruben Ferreria explained that he came originally from Portugal, where he had worked as a social worker, and had joined Whittington Health as an administrator for the District Nursing Team. He was delighted to have been appointed to a post where he felt he could contribute to staff wellbeing, and he hoped that with the backing of the Board there could be some positive change.

8.2 Michelle Johnson went on to introduce the six-monthly report, drawing attention to the update provided from the national guardian and from the speak up advocates' role. Section 2.1 of the report provided a summary of Ruben Ferreria's engagement to date, and showed a good balance between his being invited out to

meet teams and his promoting his role and asking to visit colleagues. He had designed new posters and a page on the intranet, and had developed a communications strategy to ensure he reached all areas of the Trust, and he had also ensured that the Trust's whistleblowing policy was up to date and accessible. Section 4 gave a summary of concerns raised, and the fact that staff had felt able to raise their concerns around bullying and harassment issues was felt to be a positive step. The report also contained Ruben Ferreria's work plan and priorities for the next six months.

8.3 Anu Singh enquired whether the picture was similar to this time last year, and Michelle Johnson replied that it was likely that having a full-time postholder was making a difference. Norma French reported on a conference she had attended the previous day where it had been apparent that, not only were Trusts recording data in different ways (e.g. some counted signposting as a contact), but also line management arrangements varied. Asked about trends, Ruben Ferreria replied that as he had only been in post for three months it was too early to say, but he would be happy to update the Board once trends became apparent.

8.4 Sarah Humphery asked whether, as part of his approach when speaking to staff, Ruben Ferreria also spoke about acceptable behaviours. Ruben Ferreria replied that he was lucky in that he had a close working relationship not only with Michelle but with the organisational development team, with whom he was working to develop a behavioural framework, some tools for managers to help them to deal with bullying and harassment cases and also some tools for staff who felt they had been on the receiving end of bullying or harassment. David Holt felt there was a lack of correlation between Whittington Health's position as set out in the report and the staff survey results, and was keen to know what further action might be taken to get staff to talk about their experiences. Ruben Ferreria said that he would greatly appreciate the help of Board members in encouraging people to engage, and he planned to develop a network of advocates (six people had already expressed an interest).

8.5 Siobhan Harrington congratulated Ruben Ferreria on all he had achieved so far, and asked him if he had had any surprises when carrying out the role. Ruben Ferreria replied that he had, one of which was the level of seniority of people who had approached him. In answer to a question from Steve Hitchins about accessing health centre staff, Ruben Ferreria replied that, for two days each week, he based himself in community premises and advertised the fact beforehand so that staff know where he could be reached.

8.6 The Board discussed Yua Haw Yoe's role as Non-Executive Director for Freedom to Speak Up. Yua Haw Yoe said that her role was to support Ruben Ferreria in his role; she would not become directly involved in casework unless pertaining to a Board member. She had already been approached by some staff who had tried to draw her into processes and this was a potential cause of difficulties, however, there was now a proper job description for the role.

8.7 **The Board welcomed the report and agreed that the next six monthly update include identified trends in referral for specific organisational areas and staff groups and actions being taken by NHS providers performing in the top quartile in this area.**

9. Performance dashboard

9.1 Carol Gillen began her report by informing the Board that there had been a slight dip in ED performance, particularly within paediatrics and minors. The overall performance for February stood at 81.5%. The emergency care intensive support team (ECIST) was now focusing on time taken to treat, particularly with regard to the London Ambulance Service pathway. Cancer, referral to treatment time and diagnostics were all compliant for February. There had been one 12 hour trolley breach, concerning a mental health patient awaiting an informal admission, and two mixed sex breaches due to a lack of capacity, but Carol Gillen assured the Board that the privacy and dignity of the patients concerned had in no way been compromised.

9.2 There had been a dip in theatre utilisation, and Carol Gillen explained that there was a significant amount of change within the service at present. There was now a clear focus on theatre improvement, and new trajectories were shortly to be approved. Data on community services continued to expand and improve, and the Trust had received positive feedback from the commissioners. Nadine Jeal had delivered a presentation to GPs the previous day which had been very well received. Good progress was also being made within children's services, and a clinical lead had been identified for CAMHS, which had now been moved across the community services improvement group which Carol Gillen felt was a positive step.

9.3 Michelle Johnson apologised for there being no data on pressure ulcers in this month's report; this was because the team was very small, and some staff had been away. In February, two avoidable pressure ulcers had been declared, and Michelle Johnson added that, from April, these were to be renamed to 'attributable'. Additionally, Trusts were now required to declare pressure ulcers which were linked to medical devices, which had not previously been the case. In answer to a question from Naomi Fulop about what action was being taken to reduce the instances of pressure ulcers given the target was nil, Michelle Johnson suggested a better picture would be shown if they were linked to activity. Siobhan Harrington said that the Trust had run a campaign 'Stop the Pressure', and perhaps this needed to be rejuvenated. It was noted that detailed reports were provided from the ICSUs to the Quality Committee.

9.4 Tony Rice noted that escalation beds were due to close at the end of March, and asked whether the service remained on track to achieve this. Whilst acknowledging that this was a challenge, Carol Gillen was optimistic about this, saying that those on Coyle ward had already been closed, the next phase would be the closure of those on COOP wards, and then Victoria. She added that winter had been better than the previous year, and there had been an improvement in length of stay.

9.5 Referring to safer staffing figures, Michelle Johnson informed the Board that two 'red' shifts had been declared in February; these had been caused by the need for specialised mental health patients. Steve Hitchins commented on the numbers of Speech & Language Therapy waits, and Carol Gillen replied that this had been discussed by the Community Services Improvement group the previous day and was to be discussed by the Trust Management Group too.

9.5 Siobhan Harrington informed the Board that further revisions were to be made to the dashboard, giving it more of a quality improvement focus in future. She added that there should also be more emphasis on monitoring and reporting on outcomes rather than transactional targets.

9.6 **The Board reviewed the performance dashboard and took assurance that remedial actions were in place, if required.**

10. Financial report

10.1 Stephen Bloomer reported that at month 11 the Trust had been £1m short of its adjusted planned target but this had now reduced to £700k. The Trust continued to have a positive income variances on activity, but pay costs continued to be above budget, particularly in the Emergency & Integrated Medicine ICSU. In order to meet the control total at year-end there had been further discussions with all teams about what was expected in terms of both income and workforce costs.

10.2 The issue of the shortfall in funding for the Agenda for Change award had not yet been resolved, but Stephen Bloomer was expecting either a further change to the control total or the receipt of some additional funding. The overall current position however would result in a more challenging financial year for 2019/20. The cash position was positive, and capital spend was expected to come in on target. This was particularly important as discussions with both London and the centre had shown that no additional capital would be made available.

10.3 **The Board reviewed the financial results for February 2019 and recognised the need to improve income delivery, to reduce agency expenditure and to improve the delivery of run rate reducing cost improvement programme schemes.**

11. NHS Staff Survey outcome

11.1 Introducing this item, Norma French informed Board members that this was the eighth year the Trust had participated in the staff survey as an Integrated Care Organisation. This year the centre had changed the way outcomes were presented to listing then by ten themes (including a new one, morale). Whittington Health's results were presented amongst a cohort of 43 combined acute and community Trusts. The response rate was significantly higher than in previous years, and at 48%, well above the national average.

11.2 The graph shown at section 3.3 of the report presented the results across the ten themes, and it was evident that the Trust's results were not good, being ranked with the lowest in four of the categories:

- Equality, Diversion & Inclusion
- Health and Wellbeing
- Bullying and Harassment, and
- Morale.

11.3 The main focus for the year ahead would be on bullying and harassment and engagement. All ICSUs had received their own reports, and the organisational development team was facilitating sessions across ICSUs and Directorates; a further update would be provided to the Board in September 2019.

11.4 Although the results of the survey had been disappointing and made for difficult reading, Siobhan Harrington reminded Board members that Professor Lewis had warned the organisation to expect this. Anu Singh commented on the fact that when topics such as bullying were spoken about they did sometimes become more visible, and Naomi Fulop pointed out that a rise in responses often correlated with an increase in negative replies.

11.5 Siobhan Harrington said that the first meeting of the 'culture steering group' had been scheduled for the following Monday, and the aim moving forwards was to focus on tangible achievements and also to build on the positive aspects shown (e.g. the rise in engagement on the medical wards).

11.6 David Holt was clear that Board members had a duty to engage in what was happening to tackle bullying and harassment, and where certain service lines or pockets of concern were identified there was a need to be seen to be taking immediate action, e.g. introducing 360° appraisals into those areas. Norma said that further discussion of these points would take place in the next round of performance reviews and at the Workforce Assurance Committee.

11.7 **The Board:**

i. reviewed the outcomes from the NHS staff survey;

ii. agreed that the major focus for priority areas would be bullying and harassment and staff engagement; and

iii. noted that a report on progress with delivery of actions would be presented at the September 2019 meeting.

12. Gender pay gap

12.1 Introducing this item, Norma French said that this was the second year such information had been published, and Whittington Health's gender pay gap had reduced from 10.6% to 9.6%. The national figure was 18.1%, and the overall figure for the NHS last year was 10.3%. This item had been placed on the agenda for the Workforce Assurance Committee in April 2019 so as to have a discussion on what action should be taking to further reduce the gap.

12.2 The Board discussed what measures might be used to determine whether sufficient action was being taken, and it was noted that software packages were available. There were however some influential factors outside the Trust's control that drove this agenda. Norma French added that the London HR team were also looking at this. Jonathan Gardner reminded colleagues that data was already a year out of date so nothing could be done to affect next year's result. It was noted that the Trust had already effected positive change in the composition of its executive team.

12.3 **The Board reviewed the gender pay gap report and approved its publication by the 30 March deadline and noted the further actions being taken to help eliminate the pay gap.**

13. Digital Strategy Update – Fast Follower

13.1 Leon Douglas, Chief Information Officer, introduced a film which illustrated the Trust's progress on implementation of its digital strategy. The first part featured Dale Carrington, Chief Nursing Information Officer speaking about the

implementation of Care Flow Vitals, and Dale spoke about the planning phase, the steps that had been taken to gain as much clinical input as possible, and the benefits derived from the roll-out. Demonstrations had been held, and a special page had been designed on the intranet which included Frequently Asked Questions. The approach taken had been to opt for a structured deployment and roll-out.

13.2 The second part of the film had featured Sam Barclay describing Care Flow Connect and the development of a new e-platform to meet the requirements of the Trust's clinical strategy mission statement. Benefits included the gift of time, the saving of paper – which also served to mitigate against information governance SIs, and the introduction of digital handover. Feedback had also shown fewer requirements for face to face meetings and a reduction in 'bleep ping-pong'.

13.3 Leon Douglas was pleased to report that Whittington Health was seen as being ahead of the curve in this field, and went on to describe future plans. It was important, he said, for the Board to be familiar with what was happening on the ground, and the opportunities for transformation which would also benefit the Trust's cost improvement programme. Although much remained to be done, a significant amount of progress had been achieved in one year. Naomi Fulop commended the achievements of the team, and was interested in hearing more about the timetable for virtual consultations. Leon Douglas said that this was at an early stage, but initial feedback demonstrated that staff were keen. Carol Gillen added that there was also a strong appetite for this amongst the GP forum; in some areas, Skype consultations were already taking place. Siobhan Harrington commented that the approach taken was an excellent model for clinical engagement.

13.4 **Board members welcomed the update on progress with digital strategy implementation.**

14. 2019/2024 Whittington Health Strategy

14.1 Jonathan Gardner informed the Board that the comments made at the previous meeting had been incorporated. There were four key objectives:

- deliver outstanding safe, compassionate care
- empower, support and develop engaged staff
- integrate care with partners and promote health and wellbeing
- transform and deliver innovative, financially sustainable services

14.2 Siobhan Harrington spoke of the importance of these being built into appraisals. She also commended the ways in which Jonathan Gardner had engaged with staff in developing the strategy.

14.3 **The Board approved the 2019/24 Whittington Health strategy.**

15. Patient Experience Strategy

15.1 Michelle Johnson informed Board colleagues that changes made were listed in the executive summary, and that work was to begin on implementation of the strategy the following week. It was noted there had been some very good feedback from external stakeholders.

15.2 **The Board approved the 2019/21 Patient Experience Strategy.**

16. Delegated authority for final 2018/19 accounts

16.1 The Board approved the recommendation to delegate responsibility to the Audit & Risk Committee to approve the financial statements for 2018/19.

17. Declarations of interest

17.1 The paper setting out Trust Board members' declarations of interest was noted.

18. 2019/20 Forward plan

18.1 The 2019/20 Forward Plan was approved, although it was noted there might be some minor amendments moving forward, and that comments made in that day's Board meeting would need to be incorporated.

19. Minutes of the Quality Committee held on 13 March 2019

19.1 Anu Singh commented on the amount of work on quality improvement projects, and suggested that this be built into a Board seminar as soon as possible. Michelle Johnson agreed to take this forward.

20. Any other business

20.1 Sarah Humphery informed Board members that she was planning an exchange programme between GPs and consultants, which would include the completion of a reflective template. This was to take place between May and September, and if successful could be extended to other staff groups. Consultants were already very keen to participate.

Action log, Public Board meeting, 27.3.2019

Item	Action	Lead	Progress
Items carried forward from the action log for the, February 2019 meeting	1. 2019/20 performance scorecard to be discussed at April Board seminar	Carol Gillen	Completed
	2. Standardised terms of reference for Board Committees to come to the April Board meeting	Committee Chairs, lead executive directors, Swarnjit Singh	Deferred to May Board meeting
	3. Accountability framework and escalation arrangements to be considered at the April Board seminar	Carol Gillen, Jonathan Gardner	A draft accountability framework, including self-assessment has been developed and shared with executives and ICSUs. It is being reviewed prior to being used as part of quarterly performance reviews
Patient story	Bring a summary of the patient stories to the April 2019 meeting showing the cases considered during 2018/19, actions taken in response and learning shared with staff and service areas.	Michelle Johnson	Completed – on agenda
	Share the video with Haringey CCG's Director of Quality	Michelle Johnson	The video is being converted into a suitable format for sharing with the CCG.
Chief Executive's report	1. Bring back a report on the role and appointment of the Trust's Wellbeing Guardian to a future Board meeting	Siobhan Harrington	The aim is to bring this report to the June 2019 Board meeting

Item	Action	Lead	Progress
	2. Attend the opening ceremony for the Trust's new obstetric theatre	All Board members	An opening ceremony date is being confirmed in advance of the theatre coming into use from 17 June
	3. Write to Adrien Cooper, Director of Environment to thank him on behalf of the Board for his work	Steve Hitchins	Completed
Freedom to Speak Up Guardian	In the next six monthly report to the Board, include: 1. Identify and report any trends in referrals for specific organisational areas and staff groups 2. Identify actions from other providers performing in the top quartile in this area that the Trust might adopt	Michelle Johnson	Both actions are in hand for the next Freedom to Speak up Guardian's report to the Board in September 2019
Performance scorecard	Review our communication and awareness campaign for pressure ulcer prevention and look at performance by ward and community area	Michelle Johnson	This work is being taken forward in Q1
NHS staff survey	Bring a paper to the April Board meeting to highlight actions being taken in response to the survey outcomes	Norma French	Deferred – an update report will be brought to the September 2019 Board meeting and this has been included on the Board forward plan
Quality Committee meeting minutes	Include a Board seminar item on Quality Improvement as soon as possible	Michelle Johnson	Quality improvement is a standing item at the Quality Committee for 2019/20 and this action item will be reviewed at that forum before being brought to a Board seminar

Meeting title	**Trust Board – public meeting**	**Date: 24 April 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	This report brings to Board members' attention recent, key 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 Board directors with highlights of key developments within the health and social care sector at a national and local level:

1. National news

2019/20 Better Care Fund framework

1.1 The Better Care Fund continues to have a positive impact on the integration of services and improved joint working between health and social care bodies. On 10 April, the Department of Health & Social Care and the Ministry of Housing, Communities and Local Government published the policy framework[1] to accompany implementation of the Better Care Fund (BCF). The policy framework sets out the level of funding for 2019 to 2020, conditions of access to the fund, the applicable national performance metrics together with the assurance and approval process.

NHS Assembly

1.2 An NHS Assembly has been created to advise the Boards of NHS England and NHS Improvement on delivery of the improvements in health and care outlined in the Long Term Plan. The Assembly will be co-chaired by leading GP Dr Claire Gerada, and Professor Sir Chris Ham, former head of the King's Fund think tank. The 55 Assembly members were drawn from national and frontline clinical leaders, patients and carers, staff representatives, health and care system leaders and the voluntary, community and social enterprise sector and a full list can be seen via the link below[2].

2. Local news

Quality and safety performance

2.1 In March, overall performance against the 95% four hour standard was 86.6%. There was a 5.2% increase in attendances compared to March 2018 with the average number of attendances per day at 312, in March 2019. 'Minors' performance delivered 94.2% and paediatrics was at 93.9%. The median wait for treatment in March was 92 minutes against a national standard of 60 minutes with an average of 69.4% of patients being triaged within 15 minutes of registration. Ambulance activity was 1818 and performance against ambulance handover targets has remained good with 96.9% of patients 'offloaded' within 30 minutes of arrival to hospital.

2.2 The Emergency Department (ED) saw an 11.8% increase in mental health activity in March (237) when compared to February (209). Our March four hour % for mental health patient was 41.3% with an average time in the department of 8.6 hours. Mental Health breaches accounted for 10% of the total ED breaches. There were no 12 hour trolley breaches in March 2019.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795314/Better_Care_Fund_2019-20_Policy_Framework.pdf

[2] https://www.england.nhs.uk/2019/03/nhs-assembly-announced-to-help-deliver-the-long-term-plan/

2.3 In March, NHS Improvement's emergency care improvement team visited the ED to observe the front of house (first 60 minutes) work, in particular and will be supporting the ED team with focused work at the front of house which includes:

- 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;
- looking at increasing ambulatory care opening hours to maximise its capacity (especially on a weekend);
- streamlining the front of house model (streaming, redirection, RAT, ambulance handover) to ensure the function is fit for purpose; and
- conducting a deep dive into the Mental Health pathways in ED with a view to reduce time spent in ED.

Family and Friends Test (FFT)

2.4 Maternity services continued their excellent track record of exceeding both the response and recommend rate in March 2019. For March, they recorded 94% positive FFT (Friends and Family Test) responses (the target is is 90%), and 52.4% for response rate (target is 15%). The positive upwards movement in response rate for inpatients also continued in March 2019 and was the highest response rate recorded for inpatients across 2017/18 and 2018/19.

Complaints

2.5 During March 2019, 86% of 25 day complaints were issued with a substantive response against a target of 80%. Of the five complaints allocated 40 working days due to their complexity, one case achieved its target. At the time of reporting, six complaint responses remain outstanding (four '40' day complaints and two '25 day' complaints.

Workforce

2.6 Staff turnover reduced from 11.4% to 10.8% though it remains above target; a cross organisational retention plan supported by NHS Improvement has been agreed and is being implemented. Sickness absence (reported a month in arrears) reduced, and is just below the Trust target at 3.49%. Staff appraisals rates increased to 74%, however, they remain below the Trust target, and there is a current drive to improve data quality and raise rates. Mandatory training rates were 81% in March, a slight increase from the February position.

Finance

2.7 Details of the year-end outturn are contained in the separate finance report on the Board meeting's agenda. It is important that the Trust maintains financial discipline as we progress into the new financial year and continues to have good delivery of its expected cost improvement programme, each month.

Staff survey

2.8 Each corporate directorate and Integrated Clinical Service Unit (ICSU) has now had the opportunity to review the staff survey results for their own areas/ department. They all conducted feedback and listening events and developed local action plans which will be driven by the Trust Board agreement to focus corporately on two areas:

1. Reducing bullying and harassment;
2. Increasing staff engagement

2.9 The corporate directorates presented their individual results and actions at the corporate performance review day on 5 April 2019. The ICSUs have done the same throughout April at their performance review meetings. Key themes arising were, as follows:

- Simplifying the design and improving the conversations of appraisals;
- Promotion of positive mental health;
- Base and environment improvements;
- Visible leadership;
- Starters and leavers breakfast sessions;
- Development programme of administration staff;
- Reinforcing the need for team / department meetings; and
- ICSU-based staff forum

2.10 These are just a few of the issues being taken forward. Over the summer, there will be wider publicity of the "We said: We Did" campaign and a full report of the actions plans will be presented to the September Trust Board meeting.

Organisational culture and development

2.11 On 1 April, the Trust's Culture Improvement Change Group held its inaugural meeting involving staff from across the organisation representing a wide range of clinical and non-clinical roles and experience. This forum is the start of a social movement to develop a culture of compassion and inclusion across the Trust, improving staff morale and the working environment, as we move from good to outstanding. This cohort of around 20 colleagues will report to the Trust Board and will be supported by a wider reference group. All staff will be invited to be part of the reference group to help steer the work offering different perspectives and voices. To launch the work there will be a hashtag (#) competition inviting all staff to agree a "brand name" for this initiative. In addition, the Trust Board development programme commenced in April.

Update on improvements in surgery

2.12 Improvements to surgery continue following a mediation process last year. The work has focused on improving teamwork, clinical governance and outcomes for patients. This work is formally monitored by the Medical Director and ICSU Clinical Director. There is evidence of good engagement with staff, and a full report will come to Quality Committee in June 2019.

Data security and protection toolkit declaration

2.13 The Trust completed its Data Security and Protection toolkit (DSP) submission for 2018/19 and successfully provided 100% of the mandatory evidence items required. Overall, the Trust achieved a 'Standards Met' rating.

Better frailty care across Haringey and Enfield

2.14 On 3 April, colleagues from Whittington Health, North Middlesex University Hospital, Barnet, Enfield and Haringey Mental Health Trust, Enfield Clinical Commissioning Group (CCG) and Haringey CCG met for the first frailty network workshop. The aim was for people involved in delivering services to elderly people across Enfield and Haringey to get together and to identify how they would work better together.

Discharge summary templates

2.15 After feedback from patients and colleagues in primary and community care, improvements are being made to the Whittington Health discharge summary template so that:

- patients' understanding and ability to manage their own health after an acute admission is improved
- the handover of care to primary care and community services is made safer
- the time it takes to write summaries is reduced

2.16 The improved summary templates will also support GPs by being clear about diagnoses and changes in medication, so the handover back to primary care is made as safe as possible and ensures that unnecessary information is not sent inappropriately to GP colleagues

Transition collaborative

2.17 The Trust was successful in its application to join the first cohort of the NHS Improvement's Children and Young People Transition Collaborative. This aims to support and improve clinical practice improvement by providing a structured programme, utilising quality improvement theory and methodology, and working with peer organisations. The Trust's, "Our programme", will build on existing work which has been undertaken by colleagues in the Children and Young People's Services ICSU to improve the transition from paediatric to adult services for people with long term conditions but with a particular focus on mental health transition.

Creating the future healthcare environment

2.18 Work to refresh the Trust's estate to ensure that all of our patients receive the best possible care in the most appropriate and up-to-date environment continues. The following developments can be reported:

- Engagement and planning work with staff from across the organisation has continued and a paper on next steps is likely to be considered at the June 2019 Board meeting
- The new obstetric theatre is due to be in use this June and a formal opening ceremony is being arranged
- A new community dental facility in Uxbridge will also open in June 2019
- Demolition of the Waterlow building is planned to take place in late June/early July 2019 and a new education centre facility is due to open in February 2020. Tender bids have been received for the education centre and a successful contract award will be made in May 2019
- Work has already started on the refurbishment of the post-natal ward, Cellier
- During April and May 2019, some essential maintenance work will be taking place on Level 1 of the atrium in the hospital. A temporary wall will be in place

outside the pharmacy near the top of the escalators to protect the area whilst this happens. However, there will be no impact on access by staff and patients to the pharmacy, the food court and the ramp and steps that lead into K block (outpatients). This work is expected to be finished within 6-8 weeks.

Radia Benmauna

2.19 On 29 March, the Trust bid a fond farewell and happy retirement to one of our longest serving and most loved colleagues - Radia Benmauna – who worked here at Whittington Health on Coyle and Thorogood wards for over 36 years. Her colleagues paid tribute to her constant smile, warmth, dedication, generosity and pride in her work.

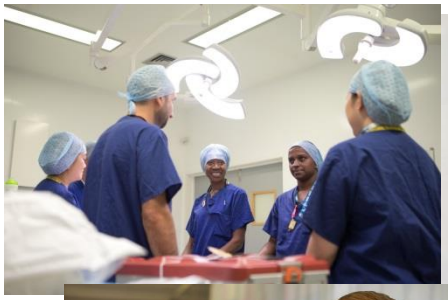
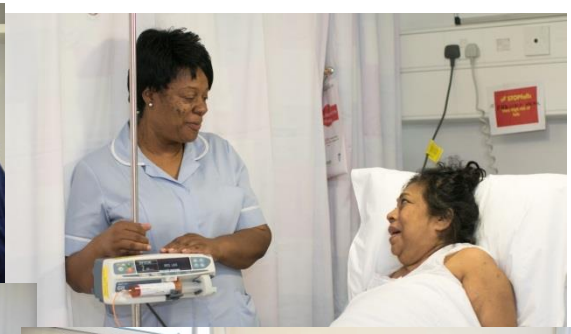
Staff excellence award

2.20 The Haringey Children's Safeguarding Team were selected as the staff excellence award winners for April. The nominator noted that "All the team provide excellent specialist advice to professionals, ensuring that there is the best outcome for the children and young people. It is lovely to work with such supportive and professional colleagues who always go that extra mile. They often work outside their contracted hours to provide the very best supervision in order to provide the best outcome for the children and young people of Haringey and to support the professionals in their roles. All the team were and continue to be very supportive and are excellent communicators - it is a pleasure to work in such a professional team".

NHS
Whittington Health
NHS Trust

24th April 2019
James Connell
Michelle Johnson

Trust Board 2018-19 Patient Stories '*You Said We Did*'



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Summary of Stories Presented

Whittington Health NHS Trust

Trust Board patient Stories 2018-19	
Jan-18	Maternity
Feb-18	Integrated Medicine Hospital
Mar-18	Endoscopy
Apr-18	Urgent emergency care
May-18	Heart failure
Jun-18	LD (National LD day)
Jul-18	MSK
Aug-18	No Board
Sep-18	Podiatry (AHP) National AHP Day
Oct-18	Islington Additional Needs (AHP)
Nov-18	Parkinson's (National Parkinson's Day)
Dec-18	Maternity
Jan-19	Orthopaedic Elective
Feb-19	Cancer
Feb-19	Staff Story (James Landi Nursing Associate)
Mar-19	CYP LD

- Range of services featured, across ICSUs
- Mixture of face to face (6) and film (7)
- Link to national awareness days and events
- Chair's briefing
- Balance of positive and challenging experiences
- Story shared across trust as well as externally – Herman's story shared with NHSI
- Patient stories now shared at sub-board committee meetings

Patient Experience Strategy

Whittington Health NHS Trust

The three ambitions for the new Trust three year Patient Experience Strategy

Ambition 1: We will improve the information we provide to patients and carers to enhance two-way communication

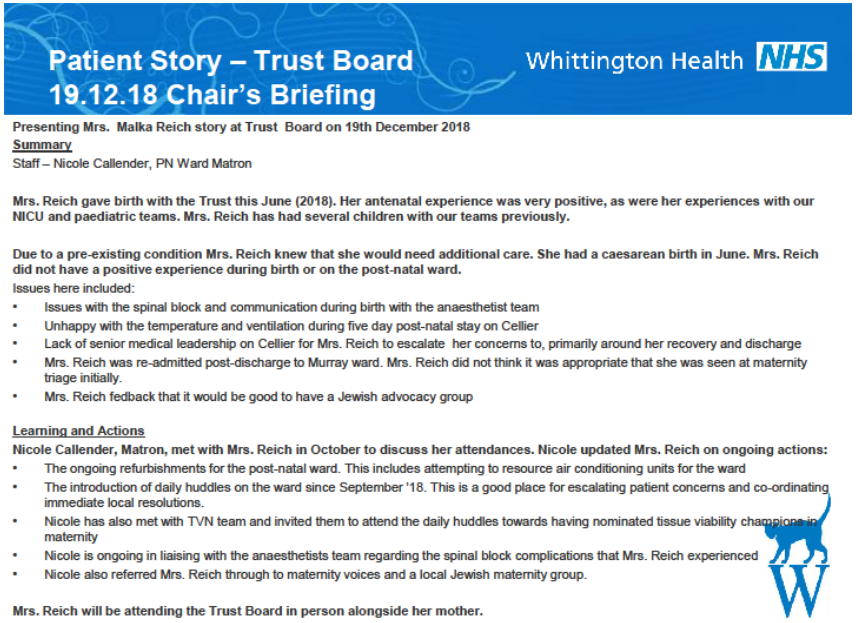
Ambition 2: We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement

Ambition 3: Improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care

Key Learning

Whittington Health NHS Trust

- Importance and impact of patient and/or family presenting (as opposed to film)
- Staff involved in service to join the Board
- Link to ICSU – important
- Feedback to patient and staff involved
- Use of filming and the value of empowering staff to film stories – more patients engaged and accessible – story also can be shared across Trust



Patient Story – Trust Board
19.12.18 Chair's Briefing

Whittington Health NHS

Presenting Mrs. Malka Reich story at Trust Board on 19th December 2018

Summary

Staff – Nicole Callender, PN Ward Matron

Mrs. Reich gave birth with the Trust this June (2018). Her antenatal experience was very positive, as were her experiences with our NICU and paediatric teams. Mrs. Reich has had several children with our teams previously.

Due to a pre-existing condition Mrs. Reich knew that she would need additional care. She had a caesarean birth in June. Mrs. Reich did not have a positive experience during birth or on the post-natal ward.

Issues here included:

- Issues with the spinal block and communication during birth with the anaesthetist team
- Unhappy with the temperature and ventilation during five day post-natal stay on Cellier
- Lack of senior medical leadership on Cellier for Mrs. Reich to escalate her concerns to, primarily around her recovery and discharge
- Mrs. Reich was re-admitted post-discharge to Murray ward. Mrs. Reich did not think it was appropriate that she was seen at maternity triage initially.
- Mrs. Reich fedback that it would be good to have a Jewish advocacy group

Learning and Actions

Nicole Callender, Matron, met with Mrs. Reich in October to discuss her attendances. Nicole updated Mrs. Reich on ongoing actions:

- The ongoing refurbishments for the post-natal ward. This includes attempting to resource air conditioning units for the ward
- The introduction of daily huddles on the ward since September '18. This is a good place for escalating patient concerns and co-ordinating immediate local resolutions.
- Nicole has also met with TVN team and invited them to attend the daily huddles towards having nominated tissue viability champions in maternity
- Nicole is ongoing in liaising with the anaesthetists team regarding the spinal block complications that Mrs. Reich experienced
- Nicole also referred Mrs. Reich through to maternity voices and a local Jewish maternity group.

Mrs. Reich will be attending the Trust Board in person alongside her mother.

I·CARE

You Said We Did - Actions

Whittington Health NHS Trust

Actions Taken

- Involving service users in improving children's Emergency Department (ED) Learning Disability room
- Learning from maternity story taken back to women's health clinicians and retold at daily huddles and local supervision
- Enhanced Recovery Programme (hip replacement surgery) recorded story shared with local team to use with patients also undergoing the programme
- Utilised 15 step toolkit to assess children's ED, and children's inpatient ward. 15 step undertaken with young people to assess OPD.
- Escalated community care package and hospital crossover with local CCG

Actions ongoing include

- Work ongoing to expand 'Parkinson's Disease warrior' physical rehabilitation classes to Haringey
- Investigating introducing orthodox Jewish advocate

Next Steps Trust Board 2019-20

Whittington Health NHS Trust

Patient Stories

- Monthly
- Blend of face to face and film presentations
- Positive and challenging experience

Staff Stories

- Quarterly story presented
- New roles
- Non clinical as well as clinical

What next?

- Launch of a revised internal and external patient story webpage
- Develop an updated release form for patients
- Create a shared I drive for internal sharing of patient stories
- Identify patient story leads within each ICSU

Meeting title	**Trust Board – public meeting**	**Date: 24.04.2019**
Report title	**Serious Incidents Update – Month 12 (March 2019)**	**Agenda item: 8**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Jayne Osborne, Quality Assurance Officer and Serious Incident (SI) Co-ordinator	
Executive summary	This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during March 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	Review	
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: March 2019 report

1. Introduction

1.1 This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during March 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 March 2019, bringing the total of reportable serious incidents to 32 since 1st April 2018. There were 6 less reported SI's in 2018/19 compared to the previous year.

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
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.
Intrauterine Death Ref: 3556	Feb 19	A pregnant woman reporting reduced fetal movements attended the Maternity Assessment Unit. Following review, no foetal heart rate could be located and fetal demise (intrauterine death) was confirmed on ultrasound scan.
Maternal Death Ref: 5255	Mar 19	An 18 weeks pregnant woman brought in to ED via blue light ambulance in cardio-respiratory arrest, suffered a major

Category	Month Declared	Summary
		Haemorrhage. Resuscitation attempts were unsuccessful and the woman died.
Pressure Ulcer Ref: 8029	April 19	A community patient developed two grade 3 pressure ulcers which became infected resulting in patient having to be admitted to hospital for further treatment.

3.5 **The table below details serious incidents by category reported to the NELCSU between April 2017 and 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 – March 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	Feb 19	Mar	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0	1	0	0	0	0	1
Apparent/actual/suspected self-inflicted	1	0		0	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	0	0	4
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	2	0	0	0	0	0	7
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	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	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	0	0
Failure to meet expected target (12 hr	1	0		0	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	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	1	0	8	
Maternity/Obstetric incident mother only	2	1		0	0	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	0	0	
Medication Incident	0	1		0	0	1	0	0	0	0	0	0	0	0	0	1	
Nasogastric tube	1	0		0	0	0	0	0	0	0	0	0	0	0	0	0	
Pressure ulcer meeting SI criteria	0	0		0	0	0	0	0	0	0	0	0	0	0	1	1	
Slip/Trips/Falls	7	6		1	0	0	0	0	0	0	1	0	0	0	0	2	
Sub Optimal Care	4	2		1	0	0	0	0	0	0	0	0	0	0	0	1	
Surgical/invasive procedure incident	0	0		0	1	0	0	0	0	0	0	1	0	0	0	2	
Treatment Delay	3	4		0	2	0	0	0	0	0	0	0	0	0	0	2	
Unexpected death	10	4		0	1	0	0	0	0	0	1	0	0	0	0	2	
Retained foreign object	1	1		0	0	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	0	0	
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**2**	**4**	**2**	**1**	**1**	**1**	**32**	

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 March 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 two reports to NELCSU during March 2019

5.1 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 March 2019. The Trust submitted two reports in March 2019.

Summary	Actions taken as result of lessons learnt include;
Ref:28441	Patient absconded whilst detained under the Mental Health Act section 2. • The level of observation required for MH patients will now be documented clearly in the patient's clinical notes and discussed in the daily bed meetings to ensure ward staff are aware and the appropriate level of enhanced care is provided. An audit will be undertaken of patient notes to ensure this is being followed. • Additional Mental Health training by Camden & Islington NHS Trust (C&I) has been arranged to support and educate ward nurses on the legality of MH sections and how best to support and interact with patients. • A review is being undertaken of the Enhanced Nursing care team (specialing team) to ensure that there is appropriate provision to provide the level of care required for therapeutic intervention to patients, reducing risk and maintaining their overall safety. • Behavioural charts will be maintained and reviewed regularly to ensure any changes are identified and the appropriate interventions are put in place.
Ref:27817	Patient absconded from Emergency Department and fell through window on an Adult Medical Ward. • Whittington Health and C&I are working together to review local processes in Mental Health Referral and Escalation to identify any gaps and training requirements. • Clinical Leads are reviewing the current pathway in light of this incident and are exploring the feasibility of referral pathways to alternative departments to ED for the appropriate care of mental health patients' medical needs when considered medically advisable e.g. Ambulatory Care Unit (ACU). A revised protocol will be disseminated across both services and briefing sessions arranged. • A simulation training package is being developed by the Trust health and safety team to provide security and clinical staff with the opportunity to enhance their skills in dealing with unpredictable patient behavior.

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 an Information governance breach and new categorisation of pressure ulcers.

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. 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: 24.4.2019**
Report title	**Quarterly Safety and Quality Board Report Quarter 4 2018/19 (1 January 2019 – 31 March 2019)**	**Agenda item: 9**
Executive director lead	Dr Julie Andrews, Acting Medical Director	
Report author	Dr Julie Andrews, Acting Medical Director	
Executive summary	This is the regular quarterly paper for the Trust Board to provide an overview of safety and quality across the organisation. It is informed by reporting directly from the patient safety committee and the quality committee. This report provides an update on mortality and the trust hospital standard mortality ratio (HSMR) and summary hospital level mortality indicator (SHMI) figures. There is the regular infection prevention control report which demonstrates that we achieved our HCAI objectives for Clostridium difficile associated diarrhoea and E.coli bloodstream infection reductions in 2018/2019. There was one trust attributable MRSA bloodstream infection diagnosed in 2018/19. There is an end of year position update on Influenza demonstrating there were no healthcare acquired influenza deaths and a record number of staff were vaccinated in 2018/2019 at over 83%. Also included are updated positions from the trust sepsis group and the medicines safety committee.	
Purpose:	Review	
Recommendation(s)	It is recommended that the assurances contained within this paper are recognised.	
Risk Register or Board Assurance Framework	Quality and safety category risks on risk register	
Report history	Quarterly report to Board	
Appendices	None	

1. Executive Summary

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

The paper provides an update on mortality and SHMI position and recommendations on how to provide further assurance on the rising (but well below average SHMI).

There is a focus on sepsis and influenza.

2. Contents

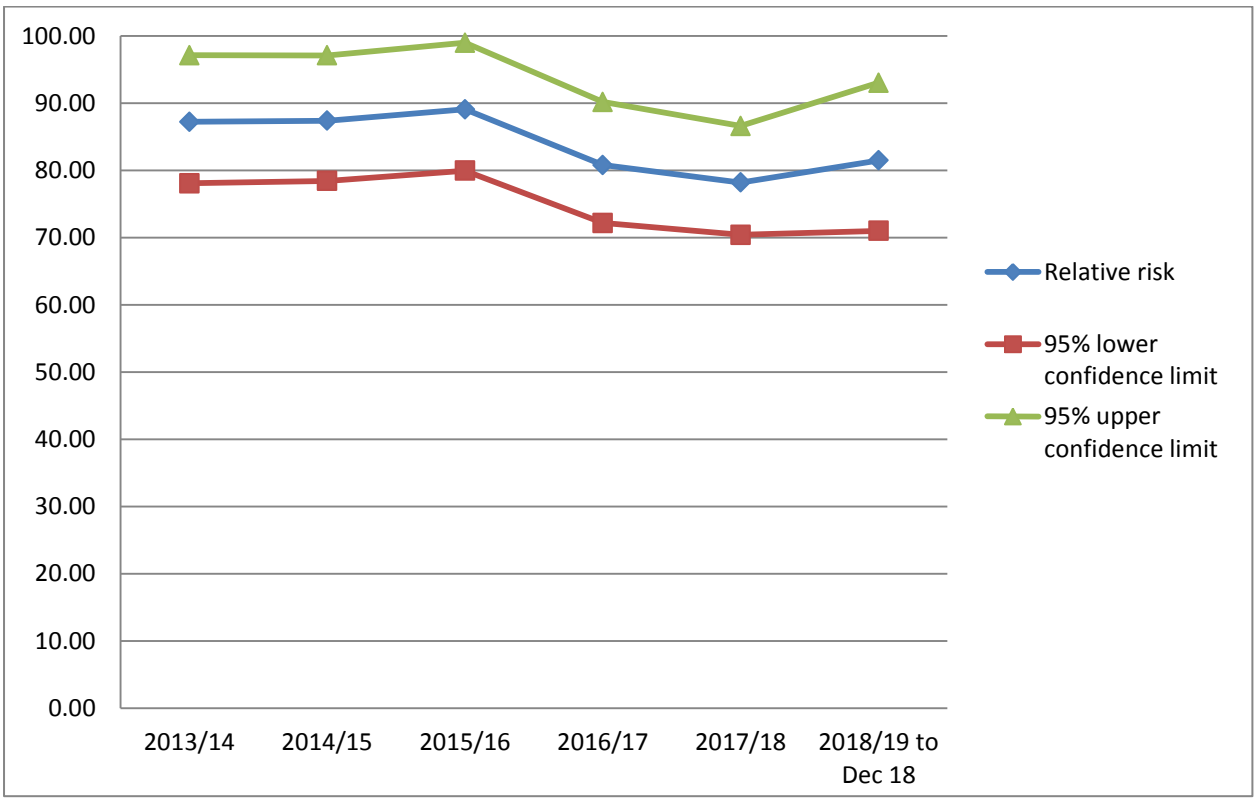
3. Mortality

This trust's HSMR and SHMI have both been 'lower than expected' since 2004/05.

3.1 Hospital Standardised Mortality Ratio (HSMR)

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

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



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

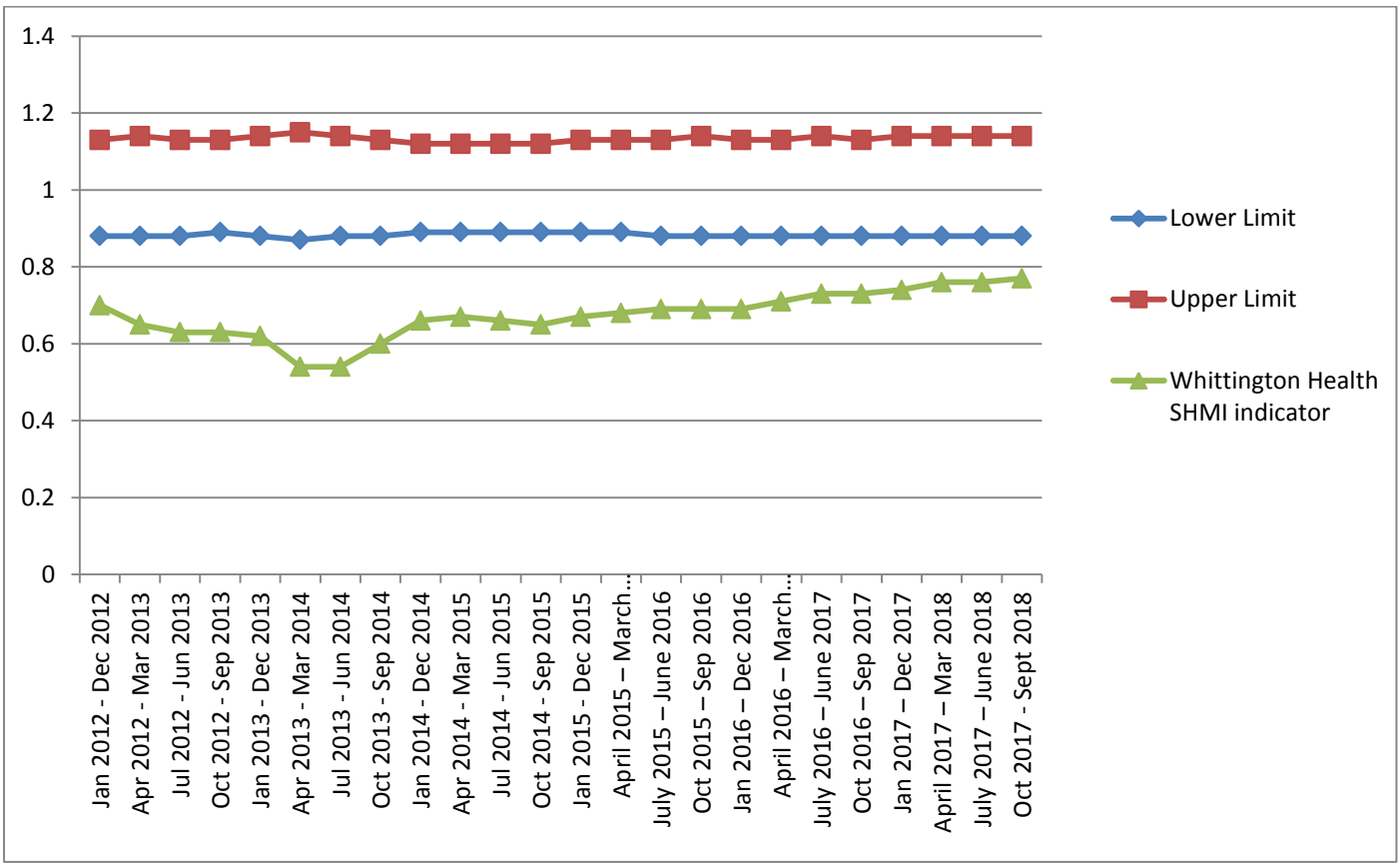
3.2 Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations. National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator that may suggest the need for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths. The most recent data available (released in December 2018) covers the period October 2017 – September 2018:

Whittington Health SHMI score	**0.7703**
National standard	**1.00**
Lowest national score	**0.6917 (Homerton)**
Highest national score	**1.2681**

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



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

There is a slow rise in the Whittington Health SHMI since it reached its lowest point in June 2014. To try to understand this rise the following actions have been taken:

a) Ensuring current process for Learning from death and departmental patient mortality reviews is used to its maximal potential to ensure all possible learning is captured, shared and embedded. At present around 70% of inpatient deaths are systemically reviewed and there is evidence of cross departmental sharing of learning. The sharing of learning could be enhanced with the development of a trustwide mortality review group, which will start in April 2019.
b) Ongoing project across Information team, national SHMI advisory body, ICSU's and medical directorate to work collaboratively to ensure the coding and other information around SHMI data entry is as accurate and reliable as possible. Recent changes in how palliative care deaths have been coded may have attributed to our rising SHMI rate and further analysis is planned.
c) Systemic and ongoing reviews of patient deaths that occur in the first 30 days post discharge is continuing. Early feedback from this as a pilot has demonstrated that more than 97% of patient deaths in the first 30 days are "expected and therefore "unavoidable" leaving a remaining 3% of patient deaths needing further detailed systematic review between the trust, community teams and the patient's GP practice; this work is ongoing.

4. Infection control report

4.1 MRSA

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

Table 1: Whittington Health MRSA colonisation acquisition events April 2018 – February 2019

Ward	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
ITU	0	0	0	0	0	0	0	0	1	0	0		1
NICU	0	0	0	0	0	2	0	3	0	0	0		5
SCBU	0	0	0	0	0	0	0	0	0	0	0		0
Meyrick	0	1	1	0	0	0	0	1	1	0	0		4
Cloudesley	0	1	2	1	0	0	0	0	0	1	0		5
Bridges	0	0	0	0	0	0	0	0	1	0	2		3
Coyle #NOF	0	1	0	0	0	0	0	1	0	1	0		3
Cavell	0	0	1	1	0	0	0	0	0	2	0		4
Montuschi	0	0	0	0	0	0	0	0	1	0	0		1

There was a localised outbreak of MRSA colonisation on the NICU which has been resolved and is now closed with no new cases reported despite ongoing high vigilance.

4.2 *Clostridium difficile*

Since April 2018 there have been 13 trust-attributable *C. difficile* cases against a tolerance objective of 16. A multi-disciplinary clinical review of all cases and rapid feedback of lapses in care to prompt ward-level learning has been adopted. The robust clinical review process is being supported by the CSU and all outcomes are reported to the CCG. The breakdown of cases by ward is shown in table 2.

Table 2: Whittington Health *Clostridium difficile*–associated diarrhoea cases by ward

Ward	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Bridges	1	1	0	0	2	0	0	0	0	0	0		4
Nightingale	0	1	0	0	0	0	0	0	0	0	0		1
Coyle	0	0	0	0	0	1	0	0	0	1	0		2
Mary Seacole South	0	0	0	0	0	1	0	0	0	0	0		1
Meyrick	0	0	0	0	0	0	1	1	0	0	0		2
Cloudesley	0	0	0	0	0	0	0	0	3	0	0		3

There were three cases of Clostridium difficile associated diarrhoea (CDAD) on Cloudesley ward in December 2018. These have been separately investigated and then any possible overlapping themes discussed. There were minor lapses in care related to the speed of isolation of 2 of the patients. Typing results suggest two out of the three CDAD patient cases on Cloudesley ward are likely to be related to cross infection.

4.3 *E.coli* bacteraemias (bloodstream infections)

There have been 8 Trust-attributed E.coli bacteraemia episodes so far in 2018/19. The Trust are attempting to reduce the number of E.coli bacteraemias by 20% this year to be on target for the national reduction by 50% by 2021. In 2016/17 there were 14 Trust-attributable E.coli bacteraemia episodes, therefore for 2018/19 our local threshold will be 8.

Table 3: Whittington Health *E. coli* Bacteraemia cases by ward

MSSA	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
CCU	0	0	0	0	1	0	0	0	0	0	0		1
Cloudesley	1	0	0	0	0	0	0	0	0	0	0		1
Coyle	1	0	0	0	0	1	0	0	0	0	0		2
Mary Seacole South	0	0	0	0	0	0	0	1	0	0	0		1
Thorogood	0	0	0	0	1	0	0	0	0	0	0		1
Victoria	0	0	0	0	0	0	0	1	0	0	0		1
ITU	0	0	0	0	0	0	0	0	0	0	1		1

4.4 Carbapenemase Producing Enterobacteriaceae (CPE)

Since the beginning of April 2018 there have been seven CPE positive patients which were considered non trust-attributable.

4.5 Infection Prevention and Control Training

Infection Prevention and Control mandatory clinical and non-clinical training is now provided predominately via E-learning. As at 28 February 2019, 88% of Whittington Health staff has received recent (within the last 2 years) IPC training.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff. IPC Link Practitioner study days are held twice a year. The next study day is to be held in June 2019. Face to face IPC training is provided monthly for all staff.

5. Sepsis position update

All sepsis pathways have been amended to meet the NEWS2 scoring system and were introduced to adult inpatient areas between October and December 2018 and to ED in March 2019. NEWS2 is the latest version of the National Early Warning Scores (NEWS) that was first produced in 2012 as a system to standardise the assessment and response to acute illness.

Awareness and education is ongoing for all staff that will be utilising the pathway. All relevant areas have had new pathway implemented. The Sepsis Grand Round took place in December 2018 highlighting the new NEWS2 Adult Sepsis Pathway. Regular teaching slots have also been

established across various programmes in the hospital and community for all clinical staff including students. Sepsis grab bags are now sealed and checked monthly on the same day as crash trolley audit.

Recent published data from the UCLP sepsis collaborative demonstrates that there was a 20% reduction in sepsis mortality rates over the 18-month study period from data provided by acute provider trusts (including Whittington Health). Our local data shows that length of stay for patients with sepsis has reduced by 1.6 days over a two-year period suggesting that we are getting it right first time because of our high compliance figures in our emergency department.

Future work planned is to continue our patient/public sepsis awareness campaign with help from UK sepsis trust, our patient group and collaborative work with our sepsis partners in the sector including CCG leads.

Chart 3: Sepsis antibiotic compliance in the Emergency Department (January 2017 – December 2018)

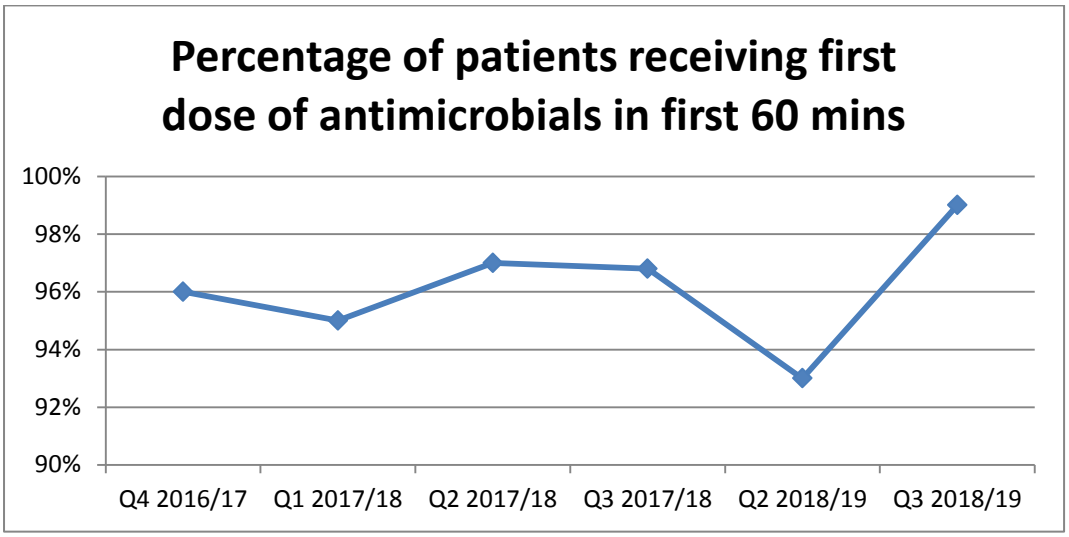
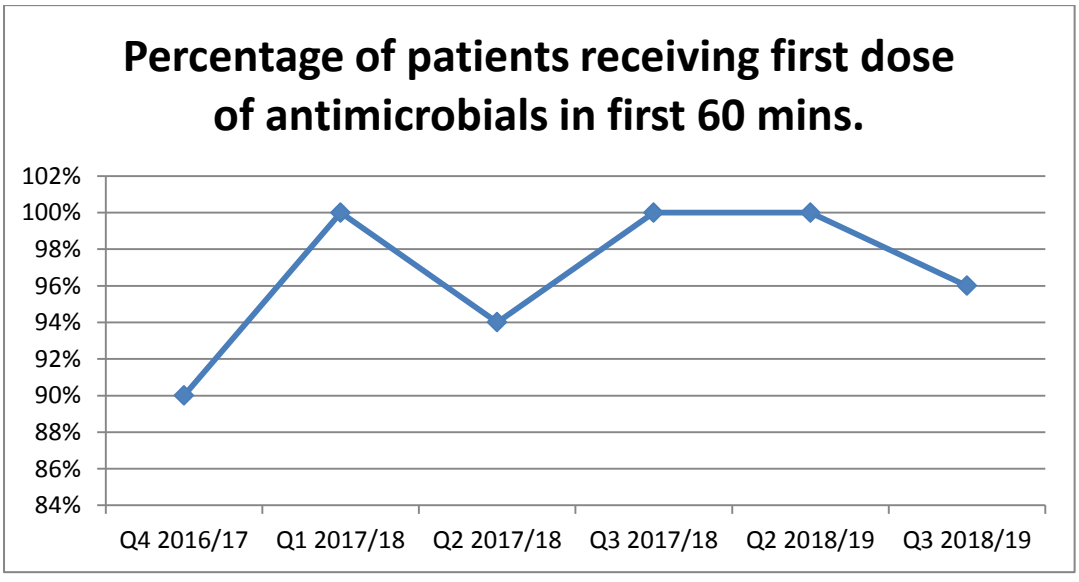


Chart 4: Sepsis antibiotic compliance on wards (January 2017 – December 2018)



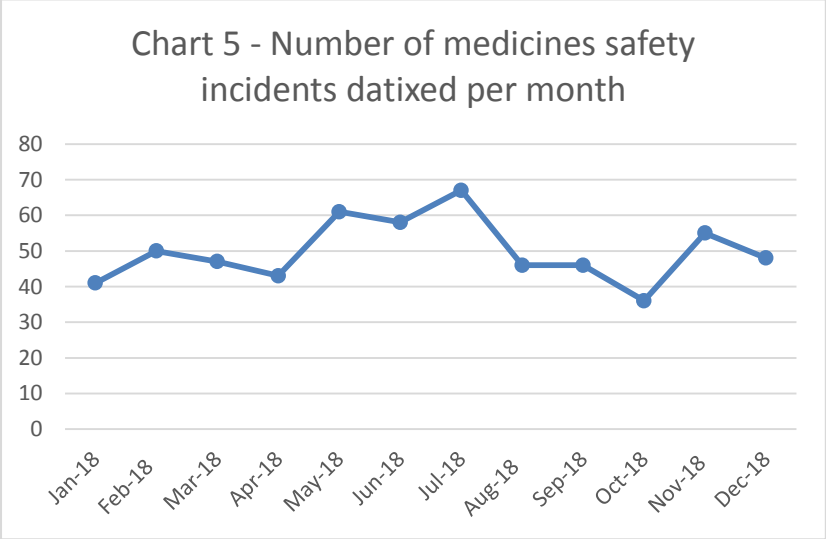
6. Influenza

By 18th January 2019 79.3 % of our frontline staff had received influenza vaccination as part of our innovative MDT "jab on the job" approach. As at 31st March 2019 83.4% of frontline staff had received the vaccination. In total 95% of doctors, 93.5% of allied health professionals, and 65.2% of nurses, midwives and health visitors were vaccinated. This is an increase of 3.2% on last year's vaccination rate. The Trust had the third highest vaccination rate in London. The most common reason given for the decision not to be vaccinated was that the vaccination had previously either made the person feel ill so a lot of work was done on flu myth busting.

There were no recorded healthcare acquired influenza deaths declared in the 2018/19 influenza season and in total there was 38 cases of healthcare acquired influenza compared to 43 in the previous year.

7. Medicines safety committee update position

Medicines safety committee meets six times a year and reports both to the patient safety committee and the Drugs and therapeutics committee. Each meeting has a themed section on learning and the focus of the last meeting was on palliative care medications. Previous themes have included insulin, warfarin and controlled drugs. Attendance at Medicine Safety meetings has increased with regular involvement from junior doctors via the L.E.A.D. program.



Medicines safety incidents represent 8.2% of the patient safety incidents reported to Datix this year which is in line with national reporting. Overall there was a 5% reduction in the number of medicine safety incidents reported across the trust in 2018/19 compared to the previous year 2017/18. With an average of 50 medicine safety incidents reported each month (believed to represent underreporting) further targeted work is being carried out to ensure we capture the majority of medicines safety incidents in order to maximise learning. Nursing staff report more than 60% of incidents so targeted work is being focused on medical and pharmacy staff to consider reporting. 12.3% of medicine safety incidents in 2018/2019 were associated with harm (mainly low harm) in 2018/19 which is in line with national reporting and similar to previous years reporting. All medicines safety incidents that are significant near misses or involved with moderate harm and

above are fully investigated using case note review approach by the clinical teams in collaboration with our dedicated medicines safety pharmacist. The learning from these investigations are shared in departmental meetings, at patient safety forum and through both medicines matters and spotlight in safety newsletters.

8. References

1. NHS Digital Indicator Portal, (July 2018, NHS Digital), available from https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current
2. Royal College of Physicians, National Early Warning Score 2 (NEWS2), available from https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

Meeting title	**Trust Board – meeting in public**	**Date: 24 April 2019**
Report title	**2019/20 Safeguarding Children Declaration**	**Agenda item: 10**
Executive director lead	Michelle Johnson, Chief Nurse and Executive Director of Patient Experience	
Report authors	Karen Miller, Head of Safeguarding (Children)	
Executive summary	• Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment • The Chief Nurse holds the position as Executive Lead for safeguarding children and the Head of Safeguarding professionally reports to the Chief Nurse • Safeguarding Annual Report is produced which is reviewed by the Trust Board (covers both children and vulnerable adults) • Whittington Health is an active member of two local LSCB's in Haringey and Islington. Local Safeguarding Board Section 11 audits into safeguarding compliance across the Trust are completed as required • The Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to child protection including serious case review recommendations	
Purpose:	Approval	
Recommendation(s)	The Board of Directors is asked to: i. receive and understand the Trust's responsibility for safeguarding children; ii. be assured that the Trust continues to follow statutory requirements (Children's Act 2004, Local Safeguarding Children Boards procedures and Pan London Safeguarding Children Procedures) to protect children at risk of abuse and neglect; and iii. approve the annual statement of assurance.	
Risk Register or Board Assurance Framework	Board Assurance Framework risk 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	The responsibilities declared are contained within the joint Safeguarding Committee Terms of Reference	
Appendices	None	

2019/20 Annual safeguarding children declaration

1. Summary declaration

1.1. Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment.

1.2. The WH Safeguarding Children team works closely with the Safeguarding Adults lead to ensure a 'joined up' approach exists to safeguard the entire population the Trust serves. This includes fully embedding strategies linked to protection from domestic abuse, child sexual exploitation and adhering to the PREVENT strategy in protecting vulnerable groups from radicalisation.

1.3. Safeguarding and promoting the welfare of children is of paramount importance to the organisation. The welfare of children is embedded across every part of the Trust and in every aspect of our work. The Trust has clear controls and arrangements in place through regular audit, review and quality improvement led by skilled and competent named professionals, supported and challenged by the Trust Board and Clinical Commissioning Groups.

1.4. The Board Director responsible for safeguarding is the Chief Nurse and Director of Patient Experience. Joint Safeguarding Committee meetings are held with accountability to the Trust Board through the Quality Committee. The committee reviews the Trust's responsibility across children and vulnerable adults.

2. Systems and processes

2.1. Disclosure and Barring Service (DBS) checks (formally known as Criminal Records' Bureau) are carried out on all staff commencing employment. Staff working with children and/or vulnerable adults requires an enhanced level of check.

2.2. A Designated Officer (currently the Head of Safeguarding Children post holder) is employed to investigate and advise regarding safety within the workforce.

2.3. The Designated Officer works closely with Local Authority Designated Officers (LADO) in Local Authorities' Children's Social Care to escalate concerns regarding staff behaviour in respect of potential risks posed by their behaviour in relation to their employment.

3. Policies

3.1. The Trust has clear up-to-date child protection and safeguarding policies and systems which are reviewed regularly. These are overseen by our Quality Committee and Joint Safeguarding Committees, both of which report into Trust Board.

3.2. The Trust has a process in place for following up children who miss

appointments and systems for identifying children where there are safeguarding concerns. A policy called 'Was not Brought' Policy supports staff in this area.

3.3. Safeguarding training is a priority for all staff, with different levels of training depending on their role. Training is provided in accordance with the Safeguarding Intercollegiate Document (2019). This is designed to ensure our staff possess the correct knowledge, skills and competencies to carry out their duties in relation to safeguarding children. Whittington Health is working towards Care Quality Commission compliance at 90% at levels 1-3 with a robust training programme in place to ensure this is achieved.

4. Assurance

4.1. The Chief Nurse holds the position as Executive Lead for safeguarding children and the Head of Safeguarding professionally reports to the Chief Nurse.

4.2. An annual safeguarding report is produced which is reviewed by the Trust Board and covers both children and vulnerable adults.

4.3. Whittington Health is an active member of three local Local Safeguarding Children Boards in Haringey, Hackney and Islington. Local Safeguarding Board Section 11 audits into safeguarding compliance across the Trust are completed, as required.

4.4. The Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to child protection including serious case review recommendations.

5. Declaration

5.1. This summary provides the Board with assurance that the Trust is meeting its statutory requirements in relation to safeguarding children in its care.

Meeting title	**Trust Board – public meeting**	**Date: 24 April 2019**
Report title	**Integrated performance report**	**Agenda Item: 11**
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 March 2019 was slightly up at 86.6%. (February was 85.1%) **Cancelled operations:** There were 14 cancelled operations of which one was urgent. Nine were in T&O - there was no surgeon available due to the previous day on call activity. The entire theatre session was cancelled on the day. All patients have been given a new 'To Come In' (TCI) dates. **Theatre Utilisation:** Overall theatre utilisation for February was 77.5%. (down from 78.5%) partly due to capacity in staffing in the bookings team. The Theatre Improvement programme is now in place. The team will be fully staffed by the end of April 2019. Mitigating actions: The Theatre scheduling dashboard is used daily to monitor the theatre bookings. Extra Pre-Operative Assessment clinics have been scheduled during the week and Saturdays. **Staff – FFT % recommended care:** Trust achieved 74% which is above the target of 70% The Trust was compliant with performance on **cancer**, **diagnostic waits** and **referral to treatment** time targets. **Complaints** target has also been achieved for 10 consecutive months.	
Purpose:	Review	
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 Trust

Integrated Performance Report

April 2019

Month 12 (2018 – 2019)

Date & time of production: 17/04/2019 13:39

Summary Page - Indicators

Category	Indicator	17_18 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	87.9%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	91	87	79	74	63	75	79	88	90.5	85	92	97	83
Cancer	Cancer - 14 days to first seen	**>93%**	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%		94.2%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%		86.4%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	6.25%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.45%	5.92%	6.36%	5.95%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	3.7%	1.3%		2.5%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%		92.2%
Outpatients	Outpatients - FFT % Positive	**>90%**	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	91.9%
Community	Community - FFT % Positive	**>90%**	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.6%
Staff	Staff - FFT % Recommend Care	**>70%**			77.3%			77.4%			65.9%			74.0%	70.5%
Community	% seen <=2 hours of Referral to District Nursing Night Service	**>80%**	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	90.5%
Community	% seen <=48 hours of Referral to District Nursing Service	**>95%**	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	95.7%	98.7%	98.7%	92.1%
Community	Haringey New Birth Visits - % seen within 2 weeks	**>95%**	87.5%	92.0%	92.0%	88.3%	90.3%	90.9%	90.1%	90.3%	89.8%	91.9%	95.2%		90.7%
Community	Islington New Birth Visits - % seen within 2 weeks	**>95%**	93.5%	94.1%	90.9%	97.5%	95.3%	96.1%	93.1%	93.0%	92.9%	95.4%	91.2%		93.9%

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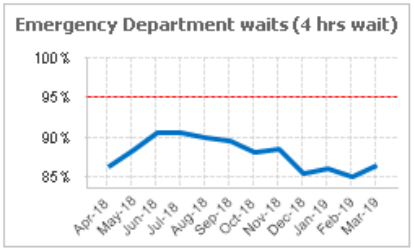
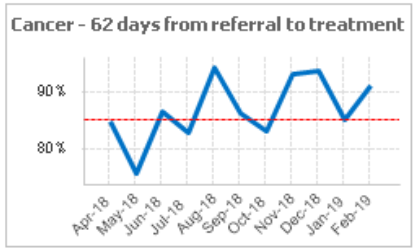
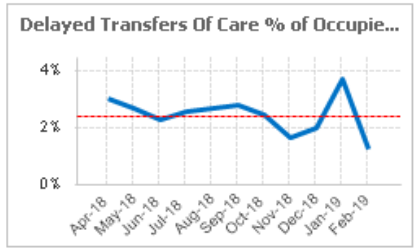
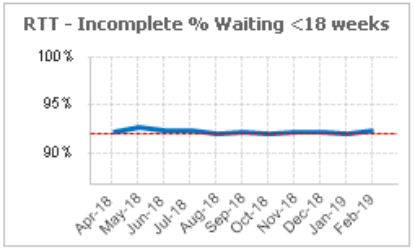
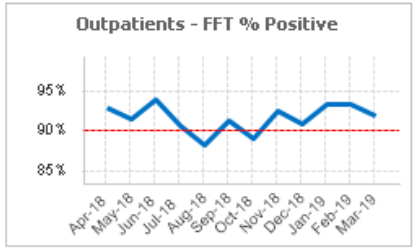
Summary Page - Indicators

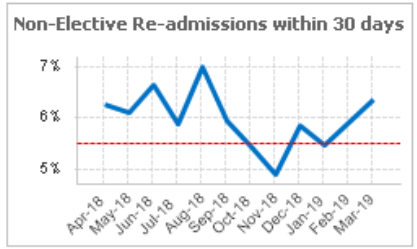












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-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	2	0	0	2	2	1	1	3	1	0	0	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	37	52	33	33	26	28	36	31	35	44	43	34	432	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	2	4	2	1	4	0	1	2	2	1	2		21	
All Areas	Harm Free Care %	>95%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	93.5%	90.1%	91.2%	94.2%	92.6%	
Maternity	Non Elective C-Section % Rate	<19%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	21.0%	
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	1	0	0	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	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.7%	
All Areas	Serious Incidents	0	6	8	3	1	1	2	2	4	2	1	1		31	
Admitted	VTE Risk Assessment %	>95%	95.9%	95.1%	95.0%	96.2%	94.5%	94.9%	95.2%	96.9%	95.3%	95.2%	95.1%		95.4%	
Admitted	Mixed Sex Accomodation Breaches	0	5	7	0	0	0	0	1	0	0	2	2	0	17	

Safe Services - Commentary

Pressure Ulcers
Data not yet available

Non elective C-section
The new governance manager started in late March19 and is working with the consultants to set up dates for of non -elective caesarean sections reviews, which will be multidisciplinary.
The dates will be set up in the next two weeks and feedback from the reviews will be at the monthly clinical governance meetings and will feed into the board report and to the CCGs

Serious Incidents
One SI was declared in March.

1. 2019.5255 (ACW) Maternal Death

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019	Performance
ED	ED - FFT % Positive	>90%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	81.0%	
ED	ED - FFT Response Rate	>15%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	13.0%	
Admitted	Inpatients - FFT % Positive	>90%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	97.2%	
Admitted	Inpatients - FFT Response Rate	>25%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	17.8%	
Maternity	Maternity - FFT % Positive	>90%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	94.7%	
Maternity	Maternity - FFT Response Rate	>15%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	51.0%	
Outpatients	Outpatients - FFT % Positive	>90%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	91.9%	
Outpatients	Outpatients - FFT Responses	400	327	445	348	310	223	138	328	484	233	423	389	421	4069	
Community	Community - FFT % Positive	>90%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.6%	
Community	Community - FFT Responses	1500	1206	1181	1148	869	890	1122	1159	998	622	1014	1028	953	12190	
Staff	Staff - FFT % Recommend Care	>70%			77.3%			77.4%			65.9%			74.0%	70.5%	
All Areas	Complaints responded to within 25 working day	>80%	71.4%	78.3%	92.6%	95.0%	93.8%	92.3%	95.0%	95.8%	84.2%	90.0%	100.0%	86.4%	88.6%	
All Areas	Complaints (including complaints against Corporate division)	N/A	33	30	39	27	21	14	24	30	24	26	22	27	317	

**Staff FFT % Recommended Care for Dec-18 is based on the Staff Survey results (not the Staff FFT).

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Caring Services - Commentary

FFT

Maternity have continued their excellent track record of exceeding both the response and recommend rate in March 2019. For March, Maternity recorded 94% positive FFT (Friends and Family Test) responses (KPI is 90%), and 52.4% for response rate (KPI is 15%). The positive upwards movement in response rate for **Inpatients** continued in March 2019 (24% against the 25% KPI). This is the highest response rate recorded for Inpatients across 2017/18 and 2018/19. **Outpatients** also exceeded both of their KPIs for March – recording 91.9% for positive recommend rate and 421 for total of responses.

Community responses totalled a slight dip with comparison to previous months (953 for March, to January's 1014 and February's 1028). Throughout 2018/19 there was an almost 15% increase from 2017/18 in the number off FFT collected throughout community teams. A large part of this success has been due to employing SMS FFT links in the Trust's podiatry service. This was arranged following the successful implementation of this method of collection for MSK Physiotherapy in 2017. The patient experience team are working with other community services to introduce similar processes. The **Emergency Department** reported year-lows for response rate and recommend rate: 76% against the 90% recommend rate target; 11.7% against the 15% response rate target. The patient experience manager will be meeting with the patient experience lead in ED to urgently address this and develop actions towards improving both of these measures. Improvement expected from May 2019

Complaints

During March 2019 the Trust was due to close 27 complaints; 22 complaints required a response within 25 working days and 5 were allocated 40 working days for investigation due to their complexity.

In regard to the target of 80% for '25 day' cases, the Trust achieved a performance of 86% (19/22).

- Of the five complaints allocated 40 working days, one hit its target
- At the time of reporting, six complaint responses remain outstanding (four '40' day complaints (three for EIM and one for Estates & Facilities) and two '25 day' complaints (both for S&C)

Complaints cont.

The complaints were allocated to EIM 33% (9), S&C 30% (8), ACS 15% (4), ACW 11% (3), Estates & Facilities 7% (2) & CYP 4% (1).

Severity of complaints: 44% (12) were designated 'low' risk; 44% (12) were designated 'moderate' and 12% (3) were designated as 'high risk'.

A review of the complaints due a response in March shows that 'medical care' 22% (6), 'nursing care' 15% (4) & 'attitude' 15% (4) were the main issue for patients.

- In regard to 'medical care', 67% (4) complainants were concerned about 'poor treatment' and 33% (2) were concerned about 'missed diagnosis'
- In regard to 'nursing care' 75% (3) complainants raised concerns about 'poor standard of care' and 25% (1) raised a concern about 'inadequate monitoring being provided'
- In regard to 'attitude', 25% (1) complainant felt staff had been 'rude & disrespectful', 25% (1) complainant felt staff had been 'abusive/aggressive', 25% (1) complainant felt staff had been 'uncaring/dismissive', and 25% (1) complainant felt that staff had been 'sharp/harsh or abrupt'

Of the 21 complaints that have closed, (including those allocated 40 working days), 33% (7) were 'upheld', 43% (9) were 'partially upheld' and 24% (5) were 'not upheld' meaning that, currently, 76% were upheld in one form or another.

PALS

During March 2019, the Trust logged 205 PALS enquiries. 94% (192) were concerns and 7% (13) were information/signposting requests.

Caring Services - Commentary

PALS cont.

35% (72) related to Surgery & Cancer, 28% (58) related to Emergency & Integrated Medicine, 20% (41) related to ACW, 11% (23) related to Adult Community Health Services and 1% (2) related to Children & Young People Services, the remainder related to other Trust service and areas.

Themes – the top four themes of those PALS queries that have been logged were follows;

30% (61) related to 'Appointments' with 'delay in being seen' and 'long wait for an appointment' cited as the main reasons
19% (39) related to 'Communication' with 'clarity & confusing' and 'lack of information to patient' cited as the main reasons
18% (36) related to 'Delay' with 'delay in notification of appointment date, referral' and 'delay in test results' cited as the main reasons
6% (13) related to 'Attitude' with 'rudeness/disrespectful' and 'inconsiderate, uncaring, dismissive' cited as the reasons

GP concerns

During March 2019, the Trust logged 8 concerns from GP Practices relating to individual patient concerns

38% (3) of these related to 'Delay' with 'delay in test results' and 'delay in notification of appointment date' cited as the reasons
38% (3) of these related to 'Communication' with 'no reply to telephone contact' and 'clarity/confusing' cited as the reasons
24% (2) of these related to 'Appointments' with 'delay in notification of appointment' and 'delay in being seen' cited as the reasons

Compliments

During March 2019, 16 compliments were logged onto Datix.

50% (8) related to Emergency & Integrated Medicine, 19% (3) related to S&C, 13% (2) related to ACW, 6% (1) related to Adult Community Services, 6% (1) related to Patient Experience and 6% (1) related to Estates & Facilities.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	95.8%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	92.6%	
Maternity	Smoking at Delivery	<6%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	3.4%	6.1%	5.0%	6.9%	4.2%	5.7%	5.8%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.25%	6.09%	6.62%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.45%	5.92%	6.36%	5.95%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	88.5	70.5	80.0	102.1	85.7	89.9	61.6	84.7					81.9	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	89.5	59.2	81.4										76.8	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.76			0.77								
Admitted	Mortality rate per 1000 admissions in-months	14.4	7.3	7.7	6.4	5.3	4.7	5.0	5.5	6.6	8.4	7.7	6.0	8.8	6.6	
Community	IAPT Moving to Recovery	>50%	56.3%	53.4%	59.0%	52.4%	55.7%	57.0%	62.5%	57.4%	58.2%	62.3%	65.1%		57.9%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	90.5%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	95.7%	98.7%	98.7%	92.1%	
Community	% of MSK pts with a significant improvement in function (PSFS)	>75%	80.1%	74.0%	69.5%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	80.5%	
Community	% of Podiatry pts with a significant improvement in pain (VAS)	>75%	77.8%	77.4%	84.8%	84.8%	90.0%	77.8%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	85.1%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	76.6%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	94.0%	
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%	100.0%		93.6%	
Community	Nutrition & Dietetics - Obesity % Weight Loss achieved at Discharge	>65%		100.0%	0.0%	100.0%	60.0%	66.7%	66.7%	100.0%	71.4%	33.3%	76.9%	100.0%	72.0%	
Community	Nutrition & Dietetics - nutrition support % weight gain/maintained	>70%	66.7%	60.0%	100.0%	87.5%	78.6%	80.0%	91.7%	93.3%	72.7%	77.8%	100.0%	90.0%	83.5%	

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Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	87.9%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	91	87	79	74	63	75	79	88	90.5	85	92	97	83	
ED	Ambulance handovers waiting more than 30 mins	0	22	41	16	18	9	12	18	15	23	18			192	
ED	Ambulance handovers waiting more than 60 mins	0	8	0	1	0	10	2	0	0	2	2			25	
ED	12 hour trolley waits in A&E	0	0	0	0	2	0	0	0	0	1	0	1	0	4	
Cancer	Cancer - 14 days to first seen	>93%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%		94.2%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	97.6%	96.3%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%		86.4%	
Cancer	Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%						89.5%	81.4%	93.3%	90.6%	88.9%	90.2%		88.5%	
Cancer	Cancer ITT - % of Pathways sent before 38 Days	>85%						62.5%	60.0%	81.8%	50.0%	100.0%	40.0%		68.4%	
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%	88.3%	88.2%		86.7%	
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%														
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%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	98.9%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%		92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	1	1	0	0	0		2	
Access	RTT - Incomplete Waiters Backlog at Month End	16227	16158	16502	16716	16567	16363	16260	16232	16202	16042	16258	16733		180033	

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Responsive Services - Commentary

ED
Overall performance against the 95% 4 hour standard for March 2019 was 86.6%. There was a 5.2% increase in attendances compared to March 2018. The average number of attendances per day was 312 in March 2019.

In March the 'minors' performance delivered 94.2% and Paediatrics at 93.9%. The median wait for treatment in March was 92 minutes against a national standard of 60 minutes. In March we average 69.4% of patients being triaged within 15 minutes of registration.

March ambulance activity was 1818 and performance against ambulance handover targets has remained good with 96.9% of patients 'offloaded' within 30 minutes of arrival to hospital.

ED noted an 11.8% increase in mental health activity in March (237) when compared to February (209). Our March 4hr % for mental health patient was 41.35% with an average time in the department of 8.6 hours. Mental Health breaches account for 10% of the total ED breaches.

There were zero 12 hour trolley breaches in March 2019.

Actions:
In March 2019 ECIST visited the emergency department to observe the front of house (first 60 minutes) work in particular. Following on from their previous visit they will be supporting the ED team with focused work at the front of house which includes:-

- 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.
- Conducting a deep dive into the Mental Health pathways in ED with a view to reduce time spent in ED.

Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4		
Indicator	17_18 Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018-2019	Performance
Breast	>85%	100.0%	100.0%	100.0%	90.5%	100.0%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%		95.6%	
Gynaecological	>85%	33.3%		40.0%		100.0%	66.7%	100.0%	66.7%	100.0%	66.7%	0.0%		63.3%	
Haematological (Excluding Acute Leukaemia)	>85%		50.0%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%		100.0%		85.2%	
Lower Gastrointestinal	>85%	72.7%	66.7%		71.4%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%		85.5%	
Lung	>85%	100.0%	50.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		100.0%	85.7%		89.2%	
Other	>85%				100.0%						100.0%			100.0%	
Skin	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	85.7%	100.0%		98.5%	
Testicular	>85%		100.0%			100.0%						100.0%		100.0%	
Upper Gastrointestinal	>85%	66.7%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%		75.0%	100.0%			68.4%	
Urological (Excluding Testicular)	>85%	90.0%	58.8%	81.8%	68.4%	77.8%	100.0%	44.4%	100.0%	66.7%	64.7%	80.0%		72.5%	
Sarcoma	>85%										100.0%			100.0%	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019	Performance
Breast	>93%	97.8%	98.7%	97.3%	98.2%	97.5%	96.4%	94.0%	97.3%	98.6%	98.5%	93.7%		97.1%	
Childrens	>93%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%		100.0%	
Gynaecological	>93%	89.9%	97.7%	100.0%	100.0%	98.0%	97.4%	95.6%	96.4%	97.8%	97.1%	91.8%		96.6%	
Haematological	>93%	100.0%	70.0%	91.7%	11.1%	37.5%	62.5%	92.9%	91.7%	95.0%	100.0%	91.7%		80.6%	
Lower Gastrointestinal	>93%	92.5%	96.6%	96.5%	87.2%	88.2%	82.4%	73.0%	87.3%	98.3%	92.8%	94.2%		90.4%	
Lung	>93%	100.0%	100.0%	92.9%	92.0%	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%		95.5%	
Other	>93%														
Skin	>93%	97.4%	97.8%	94.6%	99.5%	98.8%	97.4%	98.0%	97.5%	98.6%	97.6%	99.3%		97.9%	
Upper Gastrointestinal	>93%	81.8%	97.6%	78.3%	72.4%	55.0%	20.6%	59.6%	89.2%	98.0%	87.2%	98.2%		77.6%	
Urological	>93%	93.6%	98.0%	89.0%	89.8%	94.7%	97.4%	97.9%	86.4%	94.9%	91.8%	92.4%		93.3%	

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Community Average Waits

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12		0.00%			0	>95%						0
ACS	Community Matron	>95%	6	100.00%	71.40%	100.00%	1	10	>95%	2	100.00%	100.00%			0
ACS	Adult Wheelchair Service	>95%	8	100.00%	91.30%	100.00%	3.3	28	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	100.00%		100.00%	3.9	1	>95%	2	46.40%	54.20%	90.00%	1.8	20
ACS	ICTT - Other	>95%	12	88.10%	98.20%	92.20%	3.9	256	>95%	2	63.90%	70.10%	53.50%	2.3	71
ACS	ICTT - Stroke and Neuro	>95%	12	65.20%	88.90%	74.30%	6.4	35	>95%	2	41.70%	51.40%	34.80%	2.8	23
ACS	Intermediate Care (REACH)	>95%	6	100.00%	100.00%	100.00%	5.7	1	>95%	2	86.90%	86.90%	89.70%	0.9	68
ACS	Paediatric Wheelchair Service	>95%	8	62.50%	100.00%	100.00%	5.6	5	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	56.50%	37.00%	51.90%	11.4	104	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	77.10%	92.50%	91.40%	4	268	>95%		100.00%				0
ACS	Musculoskeletal Service - Routine	>95%	6	62.90%	81.30%	78.80%	4.5	805	>95%	2	0.00%				0
ACS	Nutrition and Dietetics	>95%	6	97.40%	99.10%	100.00%	2.8	104	>95%	2	100.00%				0
ACS	Podiatry (Foot Health)	>95%	6	84.70%	91.50%	89.50%	4.1	220	>95%	2	0.00%	0.00%	100.00%	0	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2	10	>95%						0
ACS	Tissue Viability	>95%	6	100.00%	87.50%	100.00%	1.3	8	>95%						0
EIM	Cardiology Service	>95%	6	78.60%	90.00%	100.00%	2.1	9	>95%	2	75.00%	83.30%	100.00%	1.1	1
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.8	32	>95%	2	80.00%	0.00%			0
EIM	Respiratory Service	>95%	6	100.00%	100.00%	100.00%	2.8	29	>95%	2		100.00%	100.00%	0.1	1
EIM	Spirometry Service	>95%	6	70.20%	78.10%	77.30%	5	44	>95%	2					0

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Haringey Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12		0.00%			0	>95%						0
ACS	Community Matron	>95%	6	100.00%	71.40%	100.00%	1	10	>95%	2	100.00%				0
ACS	Adult Wheelchair Service	>95%	8	100.00%	91.30%	100.00%	3.3	28	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	100.00%		100.00%	3.9	1	>95%	2					0
ACS	ICTT - Other	>95%	12	88.10%	98.20%	92.20%	3.9	256	>95%	2	62.20%	71.00%	55.10%	2.2	69
ACS	ICTT - Stroke and Neuro	>95%	12	65.20%	88.90%	74.30%	6.4	35	>95%	2	45.50%	51.60%	38.90%	2.7	18
ACS	Intermediate Care (REACH)	>95%	6	100.00%	100.00%	100.00%	5.7	1	>95%	2		100.00%	100.00%	0.7	3
ACS	Paediatric Wheelchair Service	>95%	8	62.50%	100.00%	100.00%	5.6	5	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	56.50%	37.00%	51.90%	11.4	104	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	77.10%	92.50%	91.40%	4	268	>95%						0
ACS	Musculoskeletal Service - Routine	>95%	6	62.90%	81.30%	78.80%	4.5	805	>95%	2	0.00%				0
ACS	Nutrition and Dietetics	>95%	6	97.40%	99.10%	100.00%	2.8	104	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	84.70%	91.50%	89.50%	4.1	220	>95%	2	0.00%	0.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2	10	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	87.50%	100.00%	1.3	8	>95%						0
EIM	Cardiology Service	>95%	6	78.60%	90.00%	100.00%	2.1	9	>95%	2	100.00%	50.00%			0
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.8	32	>95%	2	75.00%	0.00%			0
EIM	Respiratory Service	>95%	6	100.00%	100.00%	100.00%	2.8	29	>95%	2					0
EIM	Spirometry Service	>95%	6	70.20%	78.10%	77.30%	5	44	>95%	2					0

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Islington Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	83.30%	50.00%	42.90%	13.9	7	>95%						0
ACS	Community Matron	>95%	6	96.90%	95.70%	96.20%	0.7	26	>95%	2	100.00%	100.00%			0
ACS	Adult Wheelchair Service	>95%	8		100.00%			0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	91.90%	71.30%	85.40%	6.3	130	>95%	2	46.40%	56.50%	90.00%	1.8	20
ACS	ICTT - Other	>95%	12	100.00%	100.00%	85.70%	3.8	7	>95%	2	75.00%	100.00%	0.00%	4.3	1
ACS	ICTT - Stroke and Neuro	>95%	12		100.00%	50.00%	10.1	2	>95%	2		100.00%	0.00%	3.1	1
ACS	Intermediate Care (REACH)	>95%	6	88.10%	97.20%	97.10%	2.3	140	>95%	2	86.70%	85.50%	89.10%	0.9	64
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	67.40%	60.90%	55.10%	11.8	69	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	63.50%	82.30%	78.90%	4.8	213	>95%		100.00%				0
ACS	Musculoskeletal Service - Routine	>95%	6	71.10%	87.80%	83.70%	4.2	614	>95%	2					0
ACS	Nutrition and Dietetics	>95%	6	96.20%	100.00%	100.00%	2.5	60	>95%	2	100.00%				0
ACS	Podiatry (Foot Health)	>95%	6	87.50%	94.30%	94.00%	4	234	>95%	2			100.00%	0	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.3	6	>95%						0
EIM	Tissue Viability	>95%	6	95.20%	100.00%	95.20%	1.9	21	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	1.6	11	>95%	2	50.00%	100.00%	100.00%	1.1	1
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.9	16	>95%	2	100.00%				0
EIM	Respiratory Service	>95%	6	100.00%	92.90%	100.00%	2.1	38	>95%	2		100.00%	100.00%	0.1	1
EIM	Spirometry Service	>95%	6		100.00%			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	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen	% Target	Target Weeks	Jan-19	Feb-19	Mar-19	Avg Wait (Mar-19)	No of Pts First Seen
CAMHS	CAMHS Core - Islington	>95%	4	20.80%	31.50%	37.80%	7.2	156	>95%	2	93.80%	87.50%	78.60%	1.7	14
	CAMHS NDT / ADHD - Islington	>95%	8	21.40%	36.40%	12.50%	28.9	8	>95%	2					0
	CAMHS Schools - Islington	>95%	8	76.00%	75.00%	79.30%	6.3	29	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	33.30%	100.00%	100.00%	0.1	3	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	80.40%	80.30%	77.80%	1.2	81	>95%	1	100.00%	100.00%	100.00%	0.1	8
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	14.30%	0.00%	47.3	9	>95%	1	0.00%	0.00%	0.00%	70.9	2
	Community Paediatrics - Haringey (NDC)	>95%	12	80.00%	72.20%	50.00%	10	32	>95%	1	0.00%	0.00%			0
	Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	100.00%	100.00%	1.4	28	>95%	1					0
	Community Paediatrics - Haringey (Other)	>95%	12	50.00%	66.70%	100.00%	2.1	6	>95%	1	0.00%				0
	Community Paediatrics - Islington	>95%	12	66.70%	75.90%	71.40%	6.7	21	>95%	1	85.70%	100.00%			0
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	75.00%	78.60%	77.80%	4.4	9	>95%						0
	Family Nurse Partnership - Islington	>95%	12	100.00%	87.50%	83.30%	3.7	6	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.3	30	>95%						0
IANDS	IANDS	>95%	14	100.00%	75.00%	50.00%	9.6	8	>95%		100.00%				0
	IANDS - SCT	>95%	20	30.00%	18.20%	28.60%	22.1	14	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	50.00%	55.60%	31.30%	5.1	16	>95%						0
	Looked After Children - Islington	>95%	4	81.80%	57.10%	81.80%	4.2	11	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	52.20%	47.80%	26.70%	11.9	15	>95%	2	0.00%				0
	Occupational Therapy - Islington	>95%	8	53.80%	50.00%	35.00%	8.3	20	>95%	2					0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	100.00%	100.00%	100.00%	2.2	3	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	44.40%	92.30%	84.00%	4.4	25	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	8	40.50%	52.40%	70.00%	7.3	60	>95%						0
	Physiotherapy - Islington	>95%	8	92.90%	88.90%	98.20%	3.5	55	>95%				0.00%	6	1
PIPS	PIPS	>95%	12	100.00%	100.00%	100.00%	2.6	9	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	8	21.20%	33.90%	36.70%	10.5	109	>95%	2	0.00%		100.00%	0.4	1
	SALT - Islington	>95%	8	60.20%	34.60%	31.40%	8.1	51	>95%	2					0
	SALT - MPC	>95%	18	75.70%	80.60%	99.20%	6.7	125	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	98.30%	85.70%	86.20%	4	152	>95%						0
	School Nursing - Islington	>95%	12	87.50%	100.00%	90.90%	3.6	55	>95%						0

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Responsive Services - Commentary

Community Waiting times Adults

Service	Summary of improvement work undertaken during March 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	• The service achieved 51.9% of patients received routine appointment in 12 weeks during March. This represents a 4.7% improvement in performance of 13.9% since February. • CSIG target of 75% for March with respect to waiting times for routine appointments, not met. • The lack of capacity within the team during periods of annual leave is recognised and a new integrated pathway is currently being designed. • A District Nurse is providing additional management capacity, thereby freeing the service manager to spend more time undertaking	• Regular monitoring of the Patient Tracker List (PTL). • All long waiting patients now have appointments, or been discharged under the category 'non responder', where appropriate. • The routine appointments for new patient slots are now fully booked until May 2019 and therefore we are no longer sending out opt- in letters. • Group clinics have been successful and will continue every week	• Proposals for a new integrated Continence pathway, with a single point of access, for uro-gynae patients, are being developed. • Camden's withdrawal in July will mean that clinic time for patients from Haringey and Islington can be increased. This will mean that patients are seen more quickly.

	clinical work.	• The District Nurse manager starts a secondment full time for six months from April 2019 (Although is on leave for the first three weeks)	
Nutrition and Dietetics	• The service achieved 100% of patients being seen within the 6 week target time for routine appointments in March.	• Not applicable – target met.	• Not applicable – target met.
Lymphedema	• The service achieved 100% of patients being seen within the 6 week target time for routine appointments in March.	• Not applicable – target met.	• Not applicable – target met.
Podiatry	• The target set by CSIG of 95% for March, with respect to routine appointments, was not met. The service achieved 91.9%. However, a statistical step-change in performance was achieved in February, the continued focus on improvement within the service. • The loss of a Band 6 podiatrist (under the probationary period who left with reduced notice period) contributed to a reduction in capacity. • In addition, DNA rates increased from 11.3% to 11.9%.	• Additional clinical capacity has been created in April and non-urgent meetings have been cancelled to allow for new patients to be seen. • From May additional capacity within the team. Recent recruitment has been successful, with a vacant Band 6 and a new Band 6 post, being filled. • Extra capacity put into triage to keep within 48 hour triage time target.	• Post-holders recently recruited to the Band 6 roles will be in place in April. There may continue to be an impact on performance until May. • It is anticipated that the 95% target will be achieved in May 2019.

Diabetes	• The service achieved 100% with respect to achieving the target waiting time of six weeks for routine appointments. • This is the third month that the service has achieved 100% and exceeded its CSIG target.	• Not applicable – target met.	• Not applicable – target met.
Respiratory	• The service achieved 100% in February, with respect to the 6 week waiting time target for routine appointments. . • The service has consistently made an Improvement in waiting times for routine appointments since September 2018. *(See separate commentary for Spirometry).*	• Not applicable – target met.	• Not applicable – target met.
Spirometry	• The service achieved 77.3% with respect to waiting time target for routine appointments.	• Patients attending Spirometry without bronchodilators and/or aero chambers now perform the diagnostic testing in line with BTS guidelines. • The service continues to triage 3 days per week so that Contact Us BY letters can be sent by admin for the patient to book appointments quickly. LTC admin has dedicated time for respiratory so that CUBYs are discharged at the correct time	• In order to improve the quality of the service regular meetings with admin team and healthcare team performing Spirometry. • Weekly review of Patient Tracker List (PTL). • Continuing to ensure triaging is undertaken three days per week. • Explore potential automated SMS from RiO – liaise with RiO.

		avoiding long waits building up in the PTL.	
REACH	• The service achieved 97.1% for routine appointments in March. Out-performing the 95% target set by CSIG for the month. • Speech and Language Therapy (SLT) remains the area of the service where the target is most difficult to reach. There were three breaches of the 95% in this area as team still working through backlog of patients on wait list.	• SLT – a new Band 6 member of staff starts on 18 March. • Specific training for Rehabilitation Assistants continues to be worked through. • Job plans have been completed for all staff which will increase clinical capacity within the team as a whole. • The Winter Pressures fund has paid for a locum who is focusing in acute hospital discharges.	• SLT – a new Band 7 post is being established and it is intended that the current locum will provide cover whilst the post is recruited to. • Discuss recommendations from dementia mapping meeting with Islington CCG Commissioner. • Central Bookings Team to take over responsibility for booking urgent appointments. • Testing new diary templates (with a view to creating additional capacity within the team). • Work to streamline the clinical pathway for VF clinics and provision of LSVT programmes continues (to establish direct referrals to VF

			clinics).
CRT	• The service achieved 85.4% for routine appointments in March. The target set by CSIG for March was 95%.	• The physio team is now fully staffed and includes an additional Band 6 winter pressure funded locum post until the end of March. Consequently waiting times have improved.	• Opt in letters will be sent to patients on physio and Occupational Therapy waiting lists to check still need therapy. • Occupational Therapy assessment clinics have been set up, in order to increase capacity in the team and to help clear waits. These are being developed as part of CBS action plan and will start date in May • Assessment clinics are being set up to increase capacity in team and clear waiting lists.
ICTT **(Other)**	• The service achieved 92.5% against the 12 week target for routine appointments, in March. The CSIG target for March was 95%. • This represents a 5.7% fall in performance in comparison with February. • CSIG has asked the service lead to produce a 'deep dive' review, which will be presented to CSIG at the end of May, looking at the reasons for variation in performance within the team.	• Work with booking staff regarding priority change as appropriate. • Greater vigour in screening to avoid unnecessary domiciliary visits. • Increased flexibility and movement of staff between post codes in order to increase capacity in the areas most in need. • Where clients ask not to be seen for a specified period of time, they will now be discharged and advised to self-refer, if necessary,	• As previously stated, the service lead is undertaking a detailed 'deep dive' review during April, to look at the causes of variation within the team. • The use of opt-in letters for patients at the 10 week waiting point has been successful and the team will continue using this measure. • Close monitoring of the Patient Tracking list (PTL) and same for each of ICTT stream waiting lists.

		within three months.	
ICTT **(Stoke and Neurology)**	• The service achieved 74.3% for routine appointments in March. The target set by CSIG for March was 95%. • This represents a 14.8% reduction in performance in comparison with February.	• As above.	• As above.
MSK CATS **Physiotherapy**	• CSIG target of 95% with respect to waiting times for MSK CATS appointments was not met in February 2019. • 85.9% MSK CATS patients were seen within the target waiting time of 6 weeks. There has been a 1.8% lower compared to last month.	• New APPs starting between October and December 2018 linked with SPOA funding have improved capacity. • Two additional APP posts are 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 these new posts within three • Improvements in referral management have helped to reduce delays between receiving referrals and offering appointments.	• As described under mitigating actions. • Recruiting additional APPs to the CATS service. • Continue to maximise capacity using current staff and working paid overtime (funded against vacant posts). • Expected to continue to maintain our target of 6 week wait in April. Next new APP started mid-March 2019 Plan to maintain improvement in targets over the next month, with further improvements in subsequent months.

Routine **MSK Physiotherapy**	• CSIG target of 95% with respect to waiting times for routine appointments was not met for February 2019. • 80.9% of patients in MSK routine physiotherapy were seen within the 6 week for routine appointments. This was 3% lower compared to last month.	• 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. • 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 • Creation of extra new patient clinics each month to increase capacity in the service.	• As described under mitigating actions. • Improve efficiency of triage and allocation to correct service, with close monitoring on daily basis and liaison with central booking. • Continue to fill available gaps in diaries; with dedicated admin time to call patients and fill these even at short notice and this has improved over the l4 weeks. • Working closely with central booking service with regular meetings to improve efficiencies in management of referrals prior to booking initial appointments. • Plan to maintain improvement in targets over the next month, with further improvements in subsequent months.

Community Waiting times Children

Service	Summary of improvement work undertaken during March 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	• The service achieved 42.9% of patients received routine appointment in 12 weeks during March. This represents a decline in performance of 1.5% since February.	• Group clinics have been successful and will continue every week • Additional management capacity from DN service put in place to support a redistribution of clinical capacity.	• Proposals for a new integrated Continence pathway, with a single point of access are being developed.
CAMHS (Islington)	• Target not achieved for the following teams – CAMHS Core 38.2% with an increase of 7.6% since February; CAMHS NDT/ADHD performed 12.5% with a decline of 23.9% since February and CAMHS School 80.0% with a slight improvement of 7.3% since last month. • CAMHS Core Choice was 10.5 weeks and partnership was 15 weeks.	• Additional clinical capacity recruited using NHS England waiting list initiative funding. Appointments per week to reduce the backlog of initial assessments. • New leadership team recruited, starting in May / June respectively. • Re-structure of clinical teams completed.	• Implementation of SPA underway. First stage scheduled to launch June 2019, to include multi-agency (3rd sector and CSC) Intake meeting. Agreed that CAMHS CWP team will be located in this team, to support CAMHS Intake team and provide interventions for mild-moderate presentations.

Community Children's Nursing (Haringey & Islington)	• Community Children's Nursing Islington achieved 78.7%	• Commissioners have requested the Trust Dashboard for CCN be broken down by team for Islington, as currently aggregated position masks the variable waiting time targets for each team and the positive performance	• The service continues to improve collection and recording of data.
Community Paediatrics Service (Haringey and Islington)	Haringey: • Social Communication – continues to be the area of concern as consultant led assessment of ASD for all CYP up to the age of 12. • Project commenced looking at moving to a therapy led assessment model for 0-5's and suggestion to commissioner that 5-12's move to a CAMHS led model (included in Provider Intentions Letter). Waiting time will remain 52w+ until the review and new model is agreed and historic backlog cleared. Islington: • Islington Target increased form 75.0% to 70.0%	Haringey: • Project commenced looking at moving to a therapy led assessment model for 0-5's and suggestion to commissioner that 5-12's move to a CAMHS led model (included in Provider Intentions Letter). Waiting time will remain 52w+ until the review and new model is agreed and historic backlog cleared. Islington: • 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.	• Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager – June 2019.

Family Nurse Partnership (Haringey & Islington)	Islington • Achieved 83.3% this month with slight decline of 4.2% since February. Nature of population served will always mean peaks and troughs. Haringey: • Achieved 75.0% an increase of 5% since February 2019.	Islington: • Continue working with whole team to understand and manage data more systematically. Staff attended series of quality data workshops. Haringey: • The new family nurse has started to build a caseload. It is expected that her caseload will gradually increase to full caseload towards the end of the year.	Islington • Review of whole service planned with public health LBI, supported by FNP national unit. Planning at initial stages. Haringey: • Continue to build caseload of new staff member.
IANDS (Islington)	• A decline in performance from 75.0% to 50.0%. Recruitment challenges with SLTs.	• Project Lead and Clinical Director are looking at changing naming convention in Rio to capture true activities.	• CCG Governing Bodies considering waiting time proposal by Trust which would bring target in line with professional guidance.
IANDS SCT	• The model we presented to meet the 20 week target was based on 12 new referrals a month; this however has increased to 16 over the last 4 months. Furthermore fixed term funding of 1.0 OT has come to an end; given the above waiting times in SCT are forecast to continue to increase	• Implementation of a new model to streamline assessment and diagnostic pathway is underway including transdisciplinary working and OTs to trial running drop in sessions (as in the Mainstream Service).	• The service will continue to work proactively reduce waiting times. However, with the current staffing resource given the pressures highlighted we are expecting a steady increase in referrals.

Occupational Therapy (Haringey and Islington)	Haringey: • Still underperforming against the target; achieved – 28.6% this month, a decrease in performance since last month due to clearing of historic clinics. Islington • 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: • Following Haringey Therapy Review, the next step would be looking at benefits and impact of the review – this will be presented to April CSIG. Islington • We have been attempting to get agency cover but have not been able to find paediatric OT locums.	Haringey: • Staffing level and recruitment remain a challenge. • Project initiated to map pathways in mainstream and special school with the aim of releasing capacity, clear episode of care, equitability of service and discharge protocol. Islington • An Occupational Therapist has now been appointed but is not expected to start until June of 2018. We have extended the contract of a therapy assistant which to help lower the workload of existing staff.
Looked After Children (Haringey and Islington)	Islington • Achieved 87.5% this month, due to a patient cancellation which pulled the performance down from 100% last month. Haringey • It will always be challenging to see children for an initial health assessment within the 20 day target. Most breaches are due to circumstances beyond the teams	Islington • 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. Haringey • The team have recently gained access to systems used by social care and are able to proactively	Islington • CYP Project lead to invest time with the service and review triage, referral pathways and ensure that local PTL in place (March – May 2019). Haringey • Additional clinics will be in place from April 2019. • Continue to work with social care

	control – e.g. team not informed in a timely manner that child has been taken into care, child/young person refusing to attend, booked appointments not attended and errors in interpreter bookings by social care	identify when children are taken into care. This mitigates the ongoing delays in notifications from social care. • The number of clinics for initial assessments will be increased from April 2019.	to highlight issues around notifications when a child is placed in care – the delay in transfer of information impacts on team ability to meet 20 day initial health assessment target.
Paediatrics Nutrition and Dietetics (Haringey and Islington)	Islington • The service performed 83.3%, a slight decline of 9% since February 2019.	Islington • CYP Project lead to invest time with the service and review triage, referral pathways and ensure that local PTL in place (March – May 2019).	Islington • The service anticipates improvement in data, RTT and PTL in the following months.
Physiotherapy (Haringey and Islington)	Haringey • Achieved 71.2% with an improvement 18.8% since February 2019. Only 2/18 children waiting longer than 18 weeks. Those waiting longer are children in early years where there is current vacancy.	Haringey • Following Haringey Therapy Review, the next step would be looking at benefits and impact of the review – this will be presented to April CSIG.	Haringey • Implementation of new model of physiotherapy and MSK service will be undertaken over the next 3-6 months in line with review recommendations.
School Nursing (Haringey and Islington)	Haringey • The waiting time target of 95% seen within 12 weeks was not achieved in March 2019 however there is an increase in performance from 85.7% to 88.1%. The long waits that skew	Haringey • The waiting times data will be shown differently in future – the waits for the Enuresis clinic will be addressed as part of the changes to the wider continence service	Haringey • Discussion with commissioners around targets and outcomes for the service are underway – a further meeting to finalise the KPIs & specification is scheduled for early May

	the overall figures for school nursing all relate to the Enuresis service. Islington • Achieved 89.1% this month; The service continues to clear backlogs	Islington • Agency Band 5 SN employed to clear backlog of A&E referrals. Now cleared and anticipating to improve performance in April 2019.	Islington • Recruitment plan continues, Band 6/5//3 adverts are out again. • Development of 1 x band 4 TNA recruited to start April 2019.
SALT (Haringey/Islington and MPC)	Haringey/Islington: • 38.8% seen within 6 weeks, an increase of 4.9% from previous month • 10/90 children seen within 18 week target; All children in mainstream schools seen within one term of referral	Haringey/Islington • Clinical Director working with service to look at skill mix and different use of capacity to meet demand across the different pathways	Haringey/Islington: • 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)

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	3	5	1	4	1	2	8	10	4	5	14		57	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	1	2	0	1	2		6	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	292	281	212	230	238	236	233	157	207	380	123		2589	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	3.7%	1.3%		2.5%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	49.4%	50.0%	58.8%	43.9%	55.1%	57.4%	53.9%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	93.9%	92.7%	93.8%	93.3%	96.1%	95.1%	96.8%	95.8%	96.6%	95.6%	95.4%		94.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	87.5%	92.0%	92.0%	88.3%	90.3%	90.9%	90.1%	90.3%	89.8%	91.9%	95.2%		90.7%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		69.3%	78.3%	80.1%	82.6%	82.3%	80.4%	89.4%	86.2%	92.0%	83.9%	92.3%		84.2%	
Community	Haringey - HR1 % carried out before child aged 15 months		63.5%	73.6%	66.2%	71.1%	62.0%	71.3%	70.9%	72.3%	75.0%	77.0%	78.0%		70.8%	
Community	Haringey - HR2 % carried out before child aged 30 months		57.0%	62.7%	59.0%	65.0%	66.8%	64.1%	61.4%	60.1%	62.5%	67.6%	71.1%		63.4%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	93.5%	94.1%	90.9%	97.5%	95.3%	96.1%	93.1%	93.0%	92.9%	95.4%	91.2%		93.9%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		80.4%	86.4%	92.3%	91.8%	95.1%	96.5%	96.7%	92.5%	90.7%	86.5%	90.8%		90.9%	
Community	Islington - HR1 % carried out before child aged 15 mths		69.3%	80.6%	76.5%	82.5%	79.5%	87.4%	77.8%	80.8%	82.7%	73.6%	73.9%		78.4%	
Community	Islington - HR2 % carried out before child aged 30 mths		78.5%	75.1%	78.0%	79.5%	79.7%	81.4%	80.2%	82.0%	86.3%	76.8%	75.8%		79.3%	

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Responsive Services - Commentary

Hospital Cancellations

February 2019

There was 1 target/urgent cancelation in general surgery for running out of allocated time within the theatre session. The case been rebooked and completed in March.

Non target cancellations – 1 x general surgery where the HDU bed was not available on day of surgery.

1 x general surgery – out of time due to previous complex case on theatre session

9 x T&O - The entire theatre session was cancelled on the day. There was a late cancelation of the shift the day before the theatre list (Sunday) which was covered by the registrar who was due to cover the theatre list on Monday. This was escalated to Silver and the decision was made to cancel the theatre list on the Monday.

2 x T&O – surgeon off sick.

All patients have been given a new 'To Come In' (TCI) dates.

New Birth Visits

Service	Summary of improvement work undertaken during March 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	Islington • NBV, monthly rate of 66.4%, quarterly 84.5% explained by anomaly of data in March – should see improvement by end of April 2019. • Re-organisations of teams impacting on Q4 data for total HCP as caseloads only corrected completely end Feb 2019. • 8 week review 77.7%; quarterly 74% - below KPI target of 75% but continued improvement over year. • HR1 within 15 months 83.6.%, quarterly 76.9% just below target of 75% • HR2 within 30 months seen improvement with monthly rate at 73.7% and quarterly75.5% just below target of 75%. Haringey: • 8 week Review - 80.9%; 12 M Review - 79.4%; 24M Review - 72.1%	Islington • Staffing - recruitment strategy being revised; Adverts to extend to students due to qualify. Bank employed to manage 'hotspots'. Haringey: • The service has identified specific teams/practice issues that contribute to performance challenges. New locality management arrangements are in place and leads will be focused on ensuring teams are supported to deliver improvement against targets. • The service is developing a more consistent approach to antenatal contacts. Work with NMUH will help to ensure all women booking at NMUH are offered an appointment,	Islington • Improvement in the recruitment of Band 6 /7 HV, this will release more capacity and improve overall team's performance. The effect will be seen after a few months. Haringey • A new process has been introduced across Haringey CYP services to support teams to improve data quality. Activity figures will be more robust and reflect the work completed in month – impact to be seen after Quarter 1.

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-19	2018-2019	Performance
HR	Appraisals % Rate	>90%	70.2%	70.8%	71.5%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	73.1%	
HR	Mandatory Training % Rate	>90%	82.9%	83.0%	82.8%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%	80.8%	80.8%		82.1%	
HR	Permanent Staffing WTEs Utilised	>90%	87.4%	87.2%	86.2%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.2%	
HR	Staff FFT % recommended work	>50%			60.8%			64.4%			57.4%			61.8%	59.4%	
HR	Staff FFT response rate	>20%			16.5%			8.0%			47.8%			16.5%	22.3%	
HR	Staff sickness absence %	<3.5%	3.27%	3.47%	3.41%	3.52%	3.10%	3.52%	3.92%	3.81%	3.35%	3.71%	3.69%		3.52%	
HR	Staff turnover %	<10%	13.9%		14.0%	13.5%	13.1%	12.8%	12.7%	12.7%	12.0%	11.7%	11.4%	10.8%	12.6%	
HR	Vacancy % Rate against Establishment	<10%	12.6%	12.8%	13.8%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.8%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	89.3%	87.4%	86.1%	82.8%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	112.6%	117.1%	112.6%	128.6%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	92.2%	90.8%	88.6%	87.8%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	134.5%	124.4%	115.7%	121.4%	
HR	Safe Staffing Alerts - Number of Red Shifts		18	8	0	1	1	2	0	0	0	0	2	1	33	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.7	9.3	9.4	10.0	9.0	8.8	9.2	8.8	10.2	9.0	9.0	9.1	9.2	

**Staff FFT % Recommended Work and Staff FFT Response Rate for Dec-18 is based on the Staff Survey results (not the Staff FFT).

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	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	Q4 Feb-19	Trend
Medical	Average staff cost per patient		101	88	92	97	101	103	86	94	101	90	95	
Nursing	Average staff cost per patient		182	172	181	174	180	183	168	168	182	182	176	
Other	Average staff cost per patient		203	179	196	226	234	208	185	192	209	196	201	

Well Led Services - Commentary

Human Resources

Vacancy rates against establishment have remained stable, and the work within local, national and international nurse recruitment continues. Turnover has reduced from 11.4% to 10.83% though it remains above target and a cross organisational retention plan supported by NHSI has been agreed and is being implemented. Sickness (reported a month in arrears) has reduced, and is just below the Trust target at 3.49%. Appraisals rates have increased to 74% however remain below the Trust target, and there is a current drive to improve data quality and raise rates. Mandatory Training rates are 81%, which is a slight increase from February. The Staff survey rate was 48.5%, which is the highest response rate the Trust has had. Corporate and local action plans are being developed.

Well Led Services - Commentary

% day fill rate-nurses
There were 14 Red shifts reported on Health Roster across the hospital. The risk was mitigated with staff deployment of clinical and non-clinical registered nurses; however one shift in ITU remained red. A number of unfilled registered shifts were contributed to 1) unfilled vacant shifts that were covered with non-registered staff (in Medicine) and 2) reduced bed occupancy (in surgery and women's health). A number of additional registered shifts (above establishment) were contributed to mental health 1:1 and Tracheostomy care 1:1

% 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. Safety was maintained through senior nurse oversight at all times. 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 March 2019. There were no Red shifts. A number of unfilled registered shifts were contributed to 1) unfilled vacant shifts that were covered with non-registered staff and 2) reduced bed occupancy. A number of additional registered shifts (above establishment) were contributed to mental health 1:1 and Tracheostomy care 1:1.

% night fill rate-HCAs
There has been significant increase in enhanced care in the Medical wards. Thorogood has needed fewer HCAs overnight due to the nature of the patients receiving care (planned post-surgical) and the size of the ward. Ifor (paediatric ward) has flexed the number of open beds at times during the month in line with demand.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	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	Q4 Feb-19	Q4 Mar-19	Activity
ED	ED Attendances	8285	8645	9226	8699	9287	8157	8897	9082	9245	9219	9595	8868	9720	
ED	ED Admission Rate %		15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	15.0%	16.2%	15.9%	14.9%	14.3%	15.0%	
Community	Community DNA Rate %	<10%	7.9%	8.1%	8.0%	8.5%	8.1%	7.7%	7.8%	7.5%	8.0%	7.5%	7.3%	6.7%	
Community	Community Face to Face Contacts		55955	64008	62580	61486	54967	57940	64073	63968	51457	62437	56204	59699	
Admissions	Elective and Daycase		1722	1839	1880	1763	1821	1923	2267	2221	1813	2149	1989	2129	
Admissions	Emergency Inpatients		2181	2338	2237	2218	2193	2164	2185	2289	2230	2268	2035	2299	
Referrals	GP Referrals to an Acute Service		7161	7687	7615	7564	7057	6883	8283	7967	6684	8153	7919	8550	
Referrals	% of GP Referrals that were completed via ERS		58.2%	73.7%	79.6%	82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.7%	87.6%	88.4%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	18.2%	12.2%	10.1%	8.8%	10.5%	11.9%	13.0%	12.7%	10.7%	7.6%	7.1%	10.3%	
Maternity	Maternity Births	320	291	323	282	297	321	312	296	299	281	295	246	300	
Maternity	Maternity Bookings	377	400	369	317	376	330	334	398	363	327	420	379	419	
Outpatients	Outpatient DNA Rate % - New	<10%	10.0%	10.9%	10.1%	10.6%	11.2%	11.2%	10.7%	10.7%	10.5%	10.5%	10.5%	10.0%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.2%	12.1%	10.2%	10.3%	10.6%	10.2%	10.4%	10.4%	10.1%	9.6%	10.7%	9.8%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	10.1%	11.6%	10.2%	10.4%	10.8%	10.6%	10.5%	10.5%	10.2%	10.0%	10.6%	9.9%	
Outpatients	Outpatient New Attendances		9309	10246	9666	9650	9098	8888	10476	10173	8464	10113	9290	9000	
Outpatients	Outpatient FUp Attendances		17412	18731	18307	18789	18104	17273	20237	19179	16461	19964	17266	17566	
Outpatients	Outpatient Procedures		6784	7422	7208	7607	6901	7359	8161	7969	7100	8375	7511	7755	
Theatres	Theatre Utilisation	>85%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	80.4%	78.5%	77.5%	

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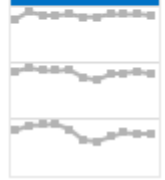
Average Tariff for Inpatient PODs

Category	Point of Delivery (POD)	17_18 Target	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	Trend
Average Tariff	Daycases		614	740	686	678	703	653	655	701	696	702	683	
Average Tariff	Elective		3710	4033	3831	3778	3857	3210	2963	3483	3565	3717	3488	
Average Tariff	Non-Elective		2194	2484	2511	2564	2272	1684	1590	1850	2087	2007	2031	

Activity - Commentary

e-RS

In March eRS Paper referrals went down to 3% and ASI in March went up to 10.3%. However the number of GP referrals received rose from 7920 in February to 8525 in March (7.5%).

Births

300 in March 2019 (20 below planned). Marketing and publicity events completed March in Wood Green and Hackney. Positive responses from received from families. Planning is well under way to have a film shown in Islington GP surgeries and another roadshow in Islington.

Theatre Utilisation

Overall theatre utilisation for February was 77.5%. (down from 78.5%) partly due to capacity in staffing in the bookings team. The Theatre Improvement programme is now in place. The team will be fully staffed by the end of April 2019. Mitigating actions: The Theatre scheduling dashboard is used daily to monitor the theatre bookings. Extra Pre-Operative Assessment clinics have been scheduled during the week and Saturdays.

Meeting title	**Trust Board**	**Date:24 April 2019**
Report title	March (Month 12) 2018/19 – Financial Performance	**Agenda item: 12**
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust delivered against its year end control total, excluding Agenda for Change funding, and in doing so qualified for additional PSF of £6.2m. For the year the Trust is reporting an adjusted surplus of £28.2m including £27.6m of PSF income. Income performance is ahead of plan in month with a positive variance of £2.4m after removing the agenda for change funding and High Cost Drugs. The year end income performance is £1.2m ahead of plan. Pay costs remain above budget, £1.2m in month (£5.9m year to date) with spend in month adversely impacted by £0.5m of accrued holiday entitlement being paid for temporary workers. The Trust's Cost Improvement Programme (CIP) delivery is £13.3m (£11.6m recurrently) against a £16.5m target. The Trust has spent £14.6m of its capital allocation with planned capital expenditure of £14.8m.	
Purpose:	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 March 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	*TMG 23 April 2019*	
Appendices		

March (Month 12) 2018/19 – Financial Performance

Financial Overview

The year end position is a £28.2m surplus including £27.6m of PSF.

In month, income was £2.4m ahead of plan and £1.2m at the year end, excluding High Cost Drugs, PSF and Agenda for Change income. For the year there were positive income variances relating to Non elective activity £1.8m, Direct Access £0.6m, Emergency Department (including Ambulatory Care) £1.3m. The largest negative variance to plan was Maternity deliveries which underperformed against plan by £1.5m with Elective activity also below plan by £1m.

The pay spend in March is in excess of budget by £1.2m due in part to the agenda for change uplift payment but more importantly £0.5m adverse to the usual run rate. The reason for this variance in March is a result of a cost of £0.5m relating to accrued annual leave claims for bank staff. The cumulative agency spend for the year is £12m against the NHSI cap of £8.8m.

Non-pay is overspent in month by £1.8m and £0.4m for the year. The reason for the overspend in month relates firstly to a £0.7m variance for the CNST CIP target which is a result of budget phasing. In addition, £0.4m spend for Community Matters, £0.2m for impairments on asset valuations and the remaining movements were in the corporate and estate functions costs. These variances were included with the Trusts forecast out-turn position from month 8 but not the initial budget submission.

The table below shows the summary position for the month and the final year end position.

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	Full year Budget (£000s)	Full Year Actuals (£000s)	Variance (£000s)	FULL YEAR BUDGET (£000s)
Clinical Income	23,694	25,208	1,514	281,277	281,571	294	260,376
Other Non-Patient Income	2,176	3,022	846	26,635	27,541	906	47,536
High Cost Drugs	656	634	(22)	7,877	8,648	771	7,877
Pay Award Funding	0	264	264	0	3,263	3,263	0
Total Income	**26,527**	**29,128**	**2,601**	**315,789**	**321,023**	**5,234**	**315,789**
Pay	(18,418)	(19,645)	(1,227)	(222,445)	(228,313)	(5,868)	(222,445)
Non-Pay (excl HCD)	(5,375)	(7,222)	(1,847)	(74,006)	(74,361)	(354)	(74,057)
High Cost Drugs	(669)	(638)	31	(8,052)	(8,375)	(324)	(8,052)
Total Operating Expenditure	**(24,462)**	**(27,505)**	**(3,043)**	**(304,503)**	**(311,049)**	**(6,546)**	**(304,554)**
	2,065	**1,623**	**(442)**	**11,286**	**9,974**	**(1,312)**	**11,235**
Depreciation	(593)	(904)	(311)	(6,551)	(6,722)	(171)	(6,500)
Dividends Payable	(521)	(266)	255	(5,263)	(5,008)	255	(5,263)
Interest Payable	(282)	(129)	153	(3,341)	(3,192)	149	(3,341)
Interest Receivable	1	9	8	12	96	84	12
P/L on Disposal of Assets	6,000	6,141	141	6,000	6,141	141	6,000
Total	**4,605**	**4,851**	**246**	**(9,143)**	**(8,686)**	**457**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**6,670**	**6,474**	**(196)**	**2,143**	**1,288**	**(855)**	**2,143**
Provider Sustainability Fund (PSF)	2,495	8,741	6,246	21,380	27,626	*6,246*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**9,165**	**15,215**	**6,050**	**23,523**	**28,914**	**5,391**	**23,523**
Add back							
Impairments	51	201	150	51	201	*150*	51
IFRS & Donate	(26)	6	32	(899)	(923)	*(24)*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**9,190**	**15,423**	**6,233**	**22,675**	**28,193**	**5,518**	**22,675**

The Trusts target underlying deficit was £5.1m but the final position is £10m driven primarily by the shortfall in recurrent CIP achievement from original plan and these were predominantly workforce and pay related efficiencies.

Income and activity

The Trust's reported income position, excluding High Cost Drugs and Devices, PSF and Agenda for Change funding, is a year end positive variance of £1.2m. This is a positive performance of £2.4m in month.

Including pass through income streams, the income has over performed by £5.2m for the year and £2.6m in month.

Day Case and Elective activity combined has performed 13% ahead of the annual plan however price actuals are £0.4m behind plan as a result of variations in the case mix. The underperformance continues to be within Trauma & Orthopaedics, Urology and General Surgery specialties valued at £1.9m.

Non elective activity excluding maternity activity delivered ahead of plan, £1.8m for the year in monetary value and activity at 4%. Maternity deliveries and pathways payments under-performed against plan with a £1.5m 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', including procedures, over perform by £0.3m in month, £1.8m for the year with activity at 5% ahead of plan. The over-performance is within Diagnostics Imaging, Gynaecology and Trauma & Orthopaedics specialties. However there is underperformance in General Medicine, Dermatology and Gastroenterology.

Unplanned care in A&E & UCC activity finished 4% ahead of the annual activity plan, £0.6m ahead of price plan and ambulatory care was above planned levels by £0.7m and 14% ahead of activity plan.

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	1,292	104	13,989	14,540	550	5,968	6,529	561	70,264	73,397	3,133
Ambulatory Care	341	395	54	4,074	4,790	716	1,418	1,617	199	16,957	19,335	2,378
Adult Critical Care	640	337	(303)	7,531	6,861	(671)	1,512	978	(534)	17,803	16,230	(1,573)
Community Block	5,857	5,857	0	70,744	70,438	(306)	0	0	0	0	0	0
Day Cases	1,136	1,306	170	13,578	14,115	537	1,486	1,807	321	17,487	20,259	2,772
Diagnostics	248	317	69	2,967	3,575	607	2,516	3,345	829	30,070	35,629	5,559
Direct Access	974	1,103	129	11,640	12,195	556	94,960	101,393	6,432	1,134,979	1,137,996	3,017
Elective	781	559	(222)	9,337	8,363	(974)	199	174	(25)	2,372	2,175	(197)
High Cost Drugs	654	568	(86)	7,852	8,456	604	0	0	0	0	0	0
Maternity - Deliveries	1,170	1,094	(76)	13,774	12,611	(1,163)	321	307	(13)	3,776	3,531	(245)
Maternity - Pathways	735	799	64	8,788	8,418	(370)	694	675	(19)	8,294	7,946	(348)
Non-Elective	3,431	4,089	657	40,398	42,204	1,805	1,606	1,739	133	18,924	19,679	755
OP Attendances - 1st	880	987	107	10,519	11,509	991	4,738	5,295	557	56,625	62,618	5,993
OP Attendances - follow up	785	799	13	9,385	9,306	(79)	12,532	11,537	(995)	149,780	147,325	(2,455)
OP Procedures	378	511	133	4,513	5,432	919	2,158	3,000	842	25,788	33,507	7,719
Other Acute Income	1,389	1,729	340	15,718	15,913	195	10,190	8,746	(1,444)	121,091	118,076	(3,015)
CQUIN	480	497	17	5,720	5,748	27						
Total SLA	**21,067**	**22,238**	**1,171**	**250,528**	**254,473**	**3,946**	**140,297**	**147,142**	**6,844**	**1,674,211**	**1,697,703**	**23,492**
Marginal Rate	0	0	0	0	(1,100)	(1,100)						
	21,067	**22,238**	**1,171**	**250,528**	**253,373**	**2,846**						
Other Clinical Income	3,284	3,604	321	38,627	36,644	(1,982)						
Other Non Clinical Income	2,176	3,286	1,110	26,635	31,006	4,371						
Total Other	**5,460**	**6,890**	**1,431**	**65,261**	**67,650**	**2,389**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**26,527**	**29,128**	**2,601**	**315,789**	**321,023**	**5,234**	**140,297**	**147,142**	**6,844**	**1,674,211**	**1,697,703**	**23,492**
PSF	2,495	2,495	-	21,380	21,380	-						
Revised Total	**29,022**	**31,623**	**2,601**	**337,169**	**342,403**	**5,234**						

Monthly run rates – expenditure

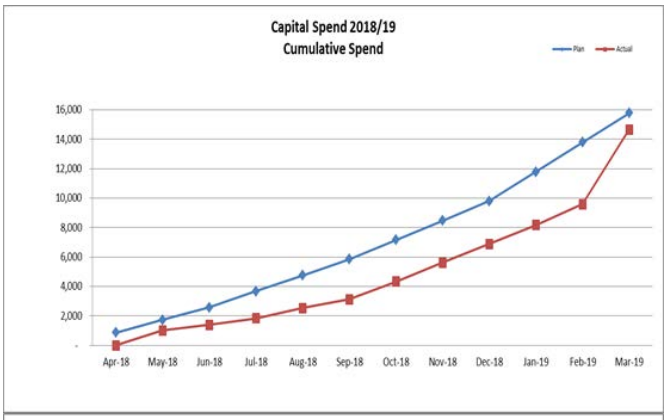
The final combined expenditure position is £6.5m adverse to plan. Key points of note include:

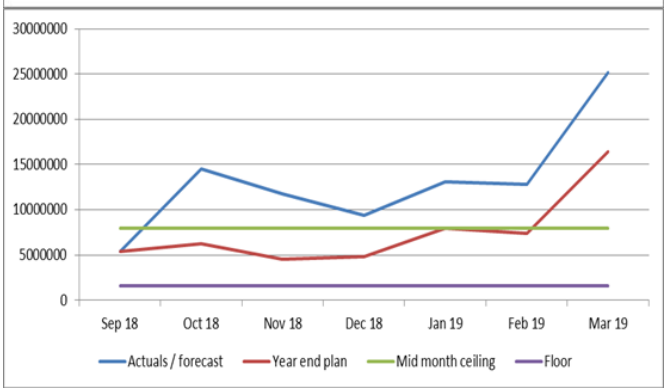
- **Pay**
  - Total pay expenditure for March was £19.6m which is £1.2m in excess of budget and circa £0.5m higher than the recent average expenditure
  - Within total pay expenditure, agency costs were £0.7m. The total agency spend is £12m. Total temporary spend in month was £3.3m.
  - Claimed accrued annual leave, resulting in a cost pressure of £0.5m in month
  - Ward establishments are over staffed due to winter escalation beds and enhanced one to one care of patients. There has been increased focus by the Chief Operating Officer and Chief Nurse to ensure appropriate staffing levels are adopted and the enhanced support ceased at the right time
  - The adverse year end pay overspend is £5.9m. As reported previously, this exit run rate adds further pressure on the ability to achieve the 19/20 financial targets for the organisation.

- **Non Pay**
  - Non pay expenditure for March was £7.9m, including High Cost Drugs.
  - This spend is £1m more than usual run rate. This is as a result of £0.4m relating to the payment to Community Matters for educational pass-through funding, £0.2m impairment adjustment with the remaining £0.4m from multiple corporate function increased cost, predominately from legal fees.
  - In addition to the run rate increase, the budget in month 12 is £0.7m lower due to the CNST CIP target being phased all in this final month of the year, creating a larger than usual variance

- **Cost Improvement Programme (CIP)**
  - The Trust CIP delivery was £13.3m, a shortfall of £3.2m from the original target. Of the £13.3m, £11.6m was 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

Statement of Financial Position





THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 March 2019 £000	Plan 31 March 2019 £000	Year to Date Plan variance 31 March 2019 £000
Property, plant and equipment	210,701	205,184	5,517
Intangible assets	6,799	5,520	1,279
Trade and other receivables	1,581	656	925
Total Non Current Assets	**219,081**	**211,360**	**7,721**
Inventories	1,448	1,355	93
Trade and other receivables	34,192	32,521	1,671
Cash and cash equivalents	25,165	29,512	(4,347)
Total Current Assets	**60,805**	**63,388**	**(2,583)**
Total Assets	**279,886**	**274,748**	**5,138**
Trade and other payables	41,782	39,687	2,095
Borrowings	28,407	20,293	8,114
Provisions	1,031	1,391	(360)
Total Current Liabilities	**71,220**	**61,371**	**9,849**
Net Current Assets (Liabilities)	**(10,415)**	**2,017**	**(12,432)**
Total Assets less Current Liabilities	**208,666**	**213,377**	**(4,711)**
Borrowings	28,024	41,182	(13,158)
Provisions	839	842	(3)
Total Non Current Liabilities	**28,863**	**42,024**	**(13,161)**
Total Assets Employed	**179,803**	**171,353**	**8,450**
Public dividend capital	66,691	66,679	12
Retained earnings	18,052	4,103	13,949
Revaluation reserve	95,060	100,571	(5,511)
Total Taxpayers' Equity	**179,803**	**171,353**	**8,450**

Overall, the value of the balance sheet is £8.5m higher from plan. In relation to the taxpayers' equity section of the balance sheet, the main reason behind this is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF). This has been partially offset by decreases in the revaluation reserve following the valuation of the Trust's land and buildings portfolio, which indicated an average decrease of approximately 2%.

- **Property, Plant & Equipment (PPE) and intangible assets** are £6.8m higher than plan. This variance against plan largely arises from the revaluation decreases mentioned above. Capital spend had been behind plan consistently through the financial year, but recovered to spend 99% of a revised target of £14.8m.

- **Cash and cash flow:** the Trust is holding £25.2m in cash at the end of March 2019. Although this is a significant level of cash, it is £4.3m lower than plan. However, the balance reflects the completion of the land transaction to Camden and Islington NHS FT. £18m of the balance is invested with the National Loans Fund.

  The Trust expects that it most significant debtor, for approximately £15m with NHS England for Provider Sustainability Funding (PSF) will be settled in July 2019.

- **Receivables (Debtors)** are £2.6m higher than plan. This increase is being driven by the continued accrual of core and incentive PSF. As stated above, the Trust expects this to be settled in July 2019. As such, the fact that receivables are only £1.7m higher than plan hides strong collection of old and current year debts.

- **Payables (Creditors)** are currently £2.0m above plan. The main reason behind this variance to plan is an ongoing dispute with a non-clinical supplier where we are withholding part payment of invoices until resolution. The value of the disputed invoices is approximately £1.5m.

- **Borrowings**: it is worth noting that the Trust has reclassified £8.9m of DH loans from long term to short term (due within 12 months) for the purpose of preparing the financial statements.

Key Actions to deliver 1st Quarter Control Total

As discussed and requested at the board meeting on 27 March 2019, four of the key metrics to be monitored have been set out below.

These metrics, along with any others identified, will be presented in each finance report to the Board to allow an assessment of the performance.

MEASURE	TARGET	ACTUAL	RAG	RESPONSIBLE OFFICERS
Beds at funded establishment	197	213		DOO - Surgery & Cancer & EIM
CIP schemes identified at end of April 19	100%	82%		Head of PMO
CIP schemes delivery	100%	TBD		Head of PMO
Elective Activity planned delivered	100%	TBD		DOO - Surgery & Cancer

The two indicators that are able to be presented are the numbers of beds currently open within the organisation (as at 18 April) and the percentage of Cost Improvement Programme (CIP) Schemes identified. Both are these indicators are currently as RED as they are not at the required target level.

A verbal update will be provided at the Board meeting to ensure the most recent information is available. However, it should be noted that with additional bed capacity open, there will be costs in excess of budget causing a cost pressure. Additionally, if the Trust is still to identify 18% of its CIP programme it is logical to suggest that the CIP delivery will not be on plan for month 1 of the 2019/20 financial year.

Additional support, including increased capacity and enhanced financial and operational scrutiny to improve activity performance and cost reductions, will be required if the Trust is not delivering on its plan and will be targeted to areas under pressure following the recent round of quarterly performance reviews.

Meeting title	**Trust Board – public meeting**	**Date: 24.4.2019**
Report title	**7 Day Hospital Services Self-Assessment**	**Agenda item: 13**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Julie Andrews, Acting Medical Director	
Executive summary	The 7 Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. This work is built on ten clinical standards, four of which were prioritised for delivery to ensure that patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review every day of the week. •Standard 2: Time to initial consultant review •Standard 5: Access to diagnostics •Standard 6: Access to consultant led interventions •Standard 8: Ongoing daily consultant-directed review We are not fully compliant with our access to 7DS for Echocardiograms and this has been risk assessed, discussed with relevant clinical leads and escalated to the CCG's via Clinical quarterly review group. A repeat audit looking at compliance with standards 2, 5, 6 and 8 will be carried out by June 2019. There is a self-assessment for the remaining standards 1, 3, 4, 7, 9 and 10. We are fully compliant with these standard 1,3, 7, 9 and 10. We are partially compliant with standard 4 about handover of patients, our move to electronic systems of patient handover in the next 12 months we allow us to be fully compliant.	
Purpose:	Guidance from NHS Improvement askes provider Boards to review self-assessment against the 7 Day Services' standards twice a year	
Recommendation(s)	The Trust Board is asked to consider the 7 day hospital services self-assessment at appendix 1, in particular the green-rated performance against clinical standards 2, 5, 6 and 8 and to discuss any required	

	changes.
Risk Register or Board Assurance Framework	BAF risk entry 3 - Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – is being reviewed and updated to include the operational performance requirements of 7 day services
Report history	None. The requirement is for provider Boards to review self-assessment against the standards twice a year in the spring and autumn
Appendices	1: Self-assessment template

7 Day Hospital Services Self-Assessment

Organisation	**The Whittington Hospital NHS Trust**
Year	**2018/19**
Period	**Autumn/Winter**

The Whittington Hospital NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	This occurs for all emergency admissions including all surgical specilaities, medicine and COOP services, obstetric admisisons and paediatric admissions. The aasurance of this coms from 7DS audits and knowledge of rotas and work patterns and job plans. Some of our non-compliances in audit work has come from failire to document time on admission clerkings and post take ward rounds rather than actual non comliance of patients not being reviewed by a consultant post take.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	With regards to CT there is access of off site reporting within the timeframes described although the actual scan occurs on site. There is not access to ECHO at the weekends unless a cardiology or trained ITU team member is on call which occurs about 30-40% of the time. THe assurance for this data comes from 7DS audits.	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Assurance from 7DS audits plus review of clinical pathways as part of Quality imporvement work	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	All patients in our HDU (ITU and NNU) are reviewed twice a day by a senior clinical decision maker. The assurance for this comes from 7DS audits. Previous non-compliances in this area come from non-compliance with recording times or names of senior decision maker rather than non-compliance with twice daily reviews.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10 Clinical standard 1 shared decision making - fully compliant (evidence from mortlaity review audits and other internal audits). Clinical standard 3 MDT involvement fully compliant. Clinical standard 4 partially compliant, currrent issues with reliance on paperwork for handover but moving to electronic solutions within the next 12 months. Clinical standards 7, 9 and 10 fully compliant.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Standards met

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Meeting title	**Trust Board – public meeting**	**Date: 24.4.2019**
Report title	**2018/19 strategic objectives – quarter four outcome**	**Agenda item: 14**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report authors	Swarnjit Singh, Trust Corporate Secretary and respective Executive Directors	
Executive summary	The Board is presented with the outcome for the delivery of 2018/19 strategic goals in quarter four. Board members' attention is drawn to the following highlights: • Good progress on integrating and co-ordinating care through the localities work • Monitoring of quality and safety through the Patient Safety Committee and Quality Committee • Maintained performance of key targets, however the Trust remains challenged in its Emergency Department performance against the 95% four hour target • Further work needed on "supporting patients and users to be active partners" • Continued development of Quality Improvement and education work streams • Delivery of control total • The only objective not delivered was the agency cap in 2018/19 Following the agreement at the March 2019 Board meeting the strategy has been refreshed for 2019/20 and the corporate objectives developed with measurable performance indicators that will be reported to the July board.	
Purpose:	Review	
Recommendation(s)	The Trust Board is asked to receive and review the quarter four outcome for progress with delivery of the Trust's 2018/19 strategic objectives.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Quarterly report to Board	
Appendices	1: Whittington Health 2018/19 strategic objectives 2: 2018/19 Q4 strategic objectives' scorecard	

Appendix 1: Whittington Health 2018/19 strategic objectives

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

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

Our Values:

Our objectives:

- To deliver consistent, high quality, safe services
- To secure the best possible health and wellbeing for all our community
- To support our patients and users in being active partners in their care
- To integrate and coordinate care in person-centred teams
- To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population -

Enabled by:

- To recruit and retain high quality engaged staff
- To deliver efficient and financially sustainable services
- To deliver innovative estate, IT and other support services that enable the clinical objectives

Appendix 2: 2018/19 Strategic priorities' scorecard – quarter four

Whittington Health Strategic Goals	Sub priorities	Progress
1. To secure the best possible health and wellbeing for all our community	Improve our clinical effectiveness as outlined in the quality account. (MJ)	Patient Flow - The Trust has a robust improvement plan in place which is designed to optimise patient flow, allow the organisation to respond to the increase in demand for its services and to support achievement of the Emergency Department target. This work has included this quarter in embedding the SAFER bundle across all the adult inpatient wards. There is still some work to do to embed Criteria Led Discharges but numbers reported increased in Q4. Significant work has been undertaken around discharge planning. Clinical research – The trust has exceeded the local clinical research network patient recruitment objective and for the first time has recruited in excess of 1000 patients over the year into a wide range of quantitative and qualitative research projects. There have been several successful bids including £2.5m grant for research into latent tuberculosis. Education and learning - On-going work continues to ensure compliance with Statutory & Mandatory training. Each ICSU have a monitoring programme in place to monitor performance. A joint programme led by the medical, nursing and workforce directorates is being developed to refresh the Whittington Health Integrated Education Strategy; it is anticipated that this work will proceed through 2019/20. A training needs analysis for clinical staff (nurses and AHPs) was completed in Q4.
	Deliver the better births action plan (CG)	The Maternity Transformation Programme has asked maternity providers and commissioners across England to come together as Local Maternity Systems (LMS), and deliver local plans so that most women receive continuity of carer by March 2021. Continuity of carer in midwifery has a leading role to play in the NHS's efforts to improve safety and outcomes for women and babies, to address stark inequalities between communities, and to realise the efficiencies associated with safer care.

Whittington Health Strategic Goals	Sub priorities	Progress
		NHS Planning Guidance for 2019/20 continues the programme's trajectory with a new deliverable for 35% of women to be booked on continuity pathways by March 2020. However, the North Central London (NCL) LMS has agreed the following trajectory with NHS England: • 10% by March 2019 • 15% by March 2020 and • 20% by March 2021 These figures are lower than the national ones as the starting rates within NCL were only at 1% in Q1 & Q2. A small amount of funding has been given to Whittington Health by commissioners to assist with the implementation of Better Births. The key challenge will be providing continuity in intrapartum care. A new midwifery team focusing on continuity has been set up and this will come into effect from 3 June 2019. As a maternity service, we continue to submit continuity rates to our commissioners on a monthly basis.
	Move community children's services from 'Requires Improvement' to Good (CG)	Out of the 62 actions for Children & Young People (CYP) Integrated Clinical Service Unit (ICSU) in the Care Quality Commission (CQC) action plan, five are currently rated yellow. These are: meeting mandatory training targets; meeting appraisal targets; community service referral to treatment times; redesign of community paediatric services; improving condition of estates – Northern Health Centre and St Ann's; separate area for CYP in outpatients' department. 1. The ICSU has continued to make positive progress towards delivering the Trust-wide target for both mandatory training and appraisals. The ICSU Board reviews the progress monthly and the ICSU Risk Manager and Business Manager have targeted specific services / teams with low compliance. The ICSU Board continues to identify

Whittington Health Strategic Goals	Sub priorities	Progress
		anomalies between service / team records and ESR which the HR Business Partner has been tasked with resolving. These issues have been identified across all professional groups. 2. The ICSU now has a dedicated project manager working the Community Paediatric Teams both in Haringey and Islington to begin implementing the recommendations of the UCLP Review of both services. ASD services are being redesigned and are in the process of developing a therapy-led service to bring down waiting times for paediatrics Redesign has been proposed through CSIG restructure of the assessment and diagnostic pathway for CYP 0-5 years with ASD. This will transfer to a therapy-led service between April 2019 and September 2019, with the aim to reach the 18 week target over the next year. The 5-12 years' service is currently under review and likely to transfer to CAMHS led service. A paper to review the current standard waiting times and requesting revision in line with professional colleges recommendations to be presented at March 2019 CSIG with effect from April 2019. 3. The Trust has identified the remedial works required to improve the physical state of the Northern Health Centre which forms part of the 2018/19 capital programme. Lift repairs at the Northern Health Centre are complete. A new kitchen and staff area has been built on the 3rd floor. Larger estate strategy for community means that internal works currently on hold until location of new build or conversion is agreed. The St Ann's site will also be redeveloped as part of the Camden and Islington Foundation Trust estates transformation programme. The Trust is also in the process of completing the Master Planning for the wider Estates Strategy which will include re-looking at the community estates requirements in line with future clinical models and service change.
2. To integrate and coordinate care in	Develop Haringey and Islington Wellbeing Partnership and actively participate	We continue to work closely with the partnership at all levels and developing locality working and how we will support primary care networks. We are fully engaged in the 'inter-great' events as they begin to design what an integrated care system might look like.

Whittington Health Strategic Goals	Sub priorities	Progress
person-centred teams	in NCL STP (JG)	
	Develop our community teams around the emerging neighbourhoods and CHIN networks (JG)	We are working closely with partners on leading the locality prototypes in North Tottenham and North Islington. We have created a leadership team in North Islington that have met on several occasions. We also have a monthly framework group which is designing the operating model. Also internally we are engaging with all the integrated care teams to ensure alignment.
	Collaborate with UCLH and other NHS providers to improve efficiency and resilience (JG)	Progress is being made on all the projects of Breast, Maternity and Chronic Lower Urinary Tract infection service. We are also making progress with UCLH on a joint response to the NCL orthopaedic reconfiguration plans. We have signed a Memorandum of Understanding with NMUH also and are beginning to meet to discuss detailed opportunities.
	Maintain treatment and waiting time standards for our mental health patients (CG)	Average wait for Mental health patients in ED is 8 hours. 10 % of ED breaches are for patients presenting with mental health needs (MH is 2% of all ED activity) Average of 40% of Mental health patients transferring to the Mental Health. The model has been evaluated from a patient experience perspective and has many positive outcomes however further work from a whole system perspective on the economic evaluation of the suite. Will be presented to the AEDB in Q1. An audit of the Mental health pathway is scheduled for the 8th May overseen by ECIST to look at potential other changes that may impact favourably on the waiting times for Mental Health patients in the ED.
3. To deliver consistent, high quality,	To move from Good to 'Outstanding' in	In order for the trust to move from Good to Outstanding #BetterNeverStops there is a robust ongoing peer review process in place, we are holding fortnightly CQC preparation meetings that has ISCU representation. A CQC focus group for staff and patients has been established,

Whittington Health Strategic Goals	Sub priorities	Progress
safe services	our CQC rating. (MJ)	there are monthly meetings for reviewing policies, guidelines and procedures to ensure all up to date. All ICSU's are focusing on increasing mandatory training compliance and action plans completion from previous inspection. CQC notices have been addressed with clear evidence to support sustainability. Risks on risk register have been reviewed and updated and are reflective of current risks to organisation. In quarter 4 the trust has established a clear process for a timely response to the CQC notification of an inspection with information gathered for the Provider Information Request (PIR) when requested with supporting evidence Estates preparation and improvement plans are in place to improve both patient and staff environments. For the well-led review, the Trust Board is completing a self-assessment against requirements and areas for action and improvement.
	Improve patient safety through achieving the priorities of the quality account (MJ)	Preparation is underway for the development of the 2018/19 Quality Account with a stakeholder event held in January 2019. There is a clear timeline for completion of the Account. Quality Priorities for 19/20 have been draft and shared with CCG. A committee of the Trust's Board, the Quality Committee, provides assurance on the quality priorities and ensures the maintenance of effective risk management and quality governance systems. This includes reviewing key areas identified in the Trust Patient Safety Committee and Patient Experience Committee, and undertaking two deep-dives per annum into each of the ICSUs. Monitoring of the Quality Account Priorities is presented to Trust Quality Committee at every meeting. Continuing the work of developing the Quality Improvement methodology in Q4 with a focus going forward into 2019/20 on experience-led improvement approaches such as 'The Start, Stop' model to collect ideas from staff and widen patient and public participation in the Patient Safety Forum.

Whittington Health Strategic Goals	Sub priorities	Progress
	Deliver actions to meet CQC areas for improvement (MJ)	All six outstanding actions are on track and have clear timelines identified.
	Improve community services (CG)	Maintained good progress with adult community services under the Community services improvement group (CSIG) with a majority of services achieving or exceeding trajectory (see Trust Board performance dashboard report). The focus on Children's & Young People's services has been on cleaning data and this part of the improvement programme is expected to be completed by end of April 2019. Several work streams to progress improvement that have been seen in adult services with dedicated project management capacity.
	Deliver quality improvement plans to support achievement of four-hour target (CG)	Focus on key improvement at front of house to improve time to treat and flow through department, in particular for non-admitted pathway. This is supported by ECIST. A continued focus on optimising FLOW – to support improvements in the admitted pathway. Key focus following review includes – reducing variation in RAT with consistent Medical staffing from 11- 17.00 Reduce variation in streaming Fully optimising pathways including AEC – Year-end performance – 87.9%
	Achieve cancer and referral to treatment national standards (CG)	Diagnostic endoscopy compliance has been achieved which has contributed to compliance in 2 cancer waits 62 days prostate pathway updated by commissioners (part of NCL cancer collaborative work)

Whittington Health Strategic Goals	Sub priorities	Progress
		implementation within next 2 weeks Nurse cystoscopist training near completion which will create additional capacity to support the prostate pathway. Compliant in both standards for Q3.
4. To support our patients and users in being active partners in their care	To deliver the refreshed patient experience strategy (MJ)	The 2019-2021 Patient Experience Strategy was approved at Trust Board in March 2019. A first year implementation plan has been completed and progress will be monitored at the Trust Patient Experience Committee and the Quality Committee. Key milestones for quarter four achieved.
	Ensure patients representatives are included in quality improvement projects and service redesign (JA)	• Work underway to engage people with lived experience in Q4 (2018/19). Patient co-production in key patient safety/pathway QI work including falls, sepsis, asthma and COPD. • Children and young persons' division and Womens' health have led the way in ensuring sustainable user/patient co-production is core business. • Further work required in other divisions to ensure this is regular sustained practice.
	Ensure patient representatives are equal members on board sub committees (JG)	Patient representative on Quality committee and patient experience committee. This is also highlighted on the draft patient experience strategy. Plans include Building and maintaining a database of patient and carers who would like to work as partners with the trust; Maintaining a record of focus groups and patient forums;
	Expand our supported self-management approach to one or more additional areas within Whittington Health	Full review and impact of rollout of self-management programmes to be updated in Q2 2019/210 when the new Director of Operations for Adult Community Health Services commences in post (May 2019)

Whittington Health Strategic Goals	Sub priorities	Progress
	(eg rheumatology) and measure impact (CG)	
	Become a recognised expert provider of prevention and supported self-management services in adults and children (CG)	Whittington Health NHS Trust scored 7/7 and is rated as GREEN (public health England audit). This means that the trust is considered to have demonstrated positive steps towards comprehensive smoke-free status, defined as: • every frontline professional discussing smoking with their patients • stop smoking support offered on site or referral to local services • no smoking anywhere in NHS buildings or grounds The new Director of Operations, Adult Community Health services will assume the role of smoke free operational lead from May 2019, when in post.
5. To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research	Continue to host the Haringey and Islington CEPN (JG)	Community Education Provider Network (CEPN) procurement complete and contracts have now been signed.
	Develop the multi-professional integrated education work for WH and others (JA)	• An increasing number of multi-professional educational meetings and initiatives are being held, and these are often explicitly linked with patient safety learning • Moodle is being continuously improved and developed as a platform for multi-professional education • The Whittington Health Library Service provides initiatives both within and outside. Whittington Health to promote multi-professional learning; a recent example is work with Islington Council and its Library Services.

Whittington Health Strategic Goals	Sub priorities	Progress
	Continue to be recognised as an excellent education provider (JA)	A joint initiative has been commenced by the medical, nursing and workforce directorates to refresh the Whittington Health Integrated Education Strategy; it is anticipated that this work will continue with pace through 2019/20.
6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	Expand Quality Improvement training (JA)	• The trust has created and appointed to Director of Quality Improvement and operational lead for QI • The trust continues to roll out the Quality Improvement strategy • The number of staff being training in Quality Improvement is continually increasing and training is now delivered in house 6 times a year. • We have joined QI networks across NCL and continue to run a monthly QI forum group. • There is another trust-wide QI celebration day planned in June 2019
	Develop the generic worker roles with the local authorities (JG)	This is part of the locality working groups for North Tottenham and North Islington. The Islington Health and Care Academy is being developed and chaired by the CEO.
	Begin to integrate physical and mental health roles and services (JG)	This is part of the locality working groups as above. The 'rising risk' MDT continues to meet successfully. We are now designing a new operating model more concretely with the whole system.
7. To recruit and retain high quality engaged staff	Plan and deliver actions to deal with the issues raised in the culture survey (NF)	Listening events complete and Trust Board and Trust Management Group approved an improvement plan in February 2019. Actions now being taken forward and to be monitored through Workforce Assurance Committee. First "Culture Steering Group" event held on 1 April 2019.
	Recruit and maintain	Ongoing recruitment initiatives for nursing and midwifery staff with resources for dedicated team and overseas recruitment identified for 2019. The Clinical Recruitment and Retention

Whittington Health Strategic Goals	Sub priorities	Progress
	sustainable workforce reducing turnover and maintaining at lower levels (NF)	Group co-chaired by the Chief Nurse and Director of Workforce meets monthly and is identifying a calendar of initiatives for all non-medical staff. There is a calendar of events planned for 2019. A recovery plan for the recruitment service is underway with a newly established team and head of resourcing role identified.
8. To deliver efficient and financially sustainable services	Deliver £16.5m savings through CIPs to deliver 2018/19 control total (CG)	The Trust is forecasting to achieve £13.3m of CIP delivery (£12m recurrently) against a target of £16.5m, with £9.3m (£8.4m recurrently), delivered to date. The primary focus to make £1.34m non-recurrent initiatives recurrent to bolster CIP position.
	Reduce agency / bank spend (CG)	Agency cap total not achieved
	Use Carter measures to improve productivity, including e-rostering and back office (CG)	Carter measures are used by the Programme Management Office (PMO) and wider corporate services to identify potential productivity gains. Pharmacy services are fully compliant and the introduction of e-rostering has been extended to help assist the medical value project.
	Use GIRFT and Model Hospital to identify improvement priorities (CG)	A number of GIRFT reviews have taken place at the end of Q4 including Anaesthetics, Radiography, ED, T&O. Supported by GIRFT London project team in developing a robust governance infrastructure to ensure traction in delivery during the current financial year. The 2019/20 cost improvement programme includes a cross-ICSU programme on achieving efficiencies through GIRFT /model hospital.

Whittington Health Strategic Goals	Sub priorities	Progress
9. To deliver innovative estate, IT and other support services that enable the clinical objectives	Deliver strategic estates plan and link to NCL STP (SB)	Estates Master Plan being developed and the Trust is working with the NCL Sustainability & Transformation Partnership (STP) on wider Estates Strategy
	Progress digital fast follower projects (SB)	The Trust has made quick progress implementing Careflow Vitals across adult inpatient wards over Q4. In addition a successful implementation of Careflow Connect communications tool has taken place in the Flow team and is now being expanded to other early adopters. Additional improvements and data sources have been added to both the shared care record, CareCentric, and the PACS image store to improve clinical decision making. Finally, the Emergency Department has made good progress on the journey to paperless by mapping processes and designing the data capture prototypes.

Meeting title	**Trust Board – public meeting**	**Date: 24.4.2019**
Report title	**2019/20 Corporate objectives**	**Agenda item: 15**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report authors	Swarnjit Singh, Trust Corporate Secretary and respective Executive Directors	
Executive summary	The Board is presented with the draft corporate objectives for 2019/20. Board members attention is drawn to the fact that these objectives are linked to the strategic objectives previously agreed by the board. Board members are asked to consider these objectives as to whether they show a rounded and sufficient programme of activities to deliver the strategy for the coming year.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to comment on and approve the proposed corporate objectives for 2019/20.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Quarterly report to Board	
Appendices	None	

Corporate objectives draft with measures

Deliver outstanding safe and compassionate care in partnership with patients

Partner with those who use our services to deliver outcomes that matter to them through experience led design and delivery of services and the objectives set out in the quality account

- *To move from Good to 'Outstanding' in our Care Quality Commission rating including moving community children's services and safety from 'Requires Improvement' to Good*
- *Deliver our clinical effectiveness priorities as outlined in the quality account*
- *Work with patients and people who use our services to develop meaningful clinical outcomes, hear patient stories at Trust Board and at Trust and Integrated Clinical Service Unit committees*

Ensure timely and responsive care that is seamless between services

- *Meet constitutional standards or agreed trajectories*
- *Improve treatment and waiting time standards for our mental health patients within emergency department*
- *Continually improve the waiting times and outcomes for people who need community health services*
- *Deliver improved Child & Adolescent Mental Health service*

Improve patient experience through delivery of the patient experience strategy ambitions

- *We will improve the information we provide to patients and carers to enhance two-way communication*
- *We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement*
- *We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care*

Continually learn through our Quality Improvement (QI)strategy building a curious workforce that strives to use evidence

- *Embed a QI culture throughout the organisation from Board to ward/team*
- *Offer training to all staff*
- *Increase the number of QI initiatives across the Trust*

Empower support and develop engaged staff

Provide outstanding inter-professional education and inclusive, fair development opportunities

- *Roll out diverse interview panels for senior staff roles, consultants and bands 8A and above*
- *Continue to host the Community Education Provider Network and develop educational opportunities*
- *Complete the Workforce Race Equality Standard improvement plan*

Focus on the health and wellbeing of staff including improving the environment

- *Increase our offer of health and wellbeing to staff and promote well-being*
- *Create the events calendar to promote to staff on intranet by June 2019*
- *Develop a staff engagement and wellbeing social media platform*

Be the employer of choice recruiting and retaining and recognising the best

- *Continue work with capital nurse and capital midwife*
- *Implementation of the NHS Improvement retention plan*
- *Recruitment service recovery plan*

Create a kind environment of honesty and transparency where all staff are listened to and feel engaged

- *Take forward staff survey action plans locally and corporately*
- *Audit the Fair Treatment panels for reduction in Black & Minority Ethnic staff disciplinary cases*

Promote compassionate leadership, accountability and team working where bullying and harassment is not tolerated

- *Implement the cultural survey action plan including leadership programmes*
- *Implement the cultural survey focussing on improving engagement and reducing bullying and harassment*

Integrate care with partners and promote health and well-being

Partner with social, primary, mental health care, and the voluntary sector around localities to make an impact on population health outcomes and reduce inequalities

- *Develop and begin to implement a new model of care around localities*
- *Work with GP Federations, councils and others to develop and deliver an integrated care system governance in Haringey and Islington*
- *Collaborate with other NHS providers to improve efficiency and resilience and reduce fragile services (University College London Hospitals, North Middlesex University Hospital, North West London pathology, Camden & Islington)*

Improve the joining up of teams across and between community and hospital services

- *Progress work of the 'integrated forum'*
- *Support roll out of 'careflow connect'*

By working collaboratively, coordinate care in the community to get people home safely faster and keep people out of hospital where appropriate

- *Design and implement new intermediate care pathway*
- *Consider our approach to step-down beds including opportunity at Osborne Grove*

Prevent ill-health and empower self-management by making every contact count and engaging with the community and becoming a source of health advice and education

- *Continue to grow the self-management service*
- *Restart 'make every contact count' model*
- *Deliver new approach to community engagement*
- *Expand smoking cessation offer to staff*

Transform and develop financially sustainable innovative services

Transform patient flows and models of care (outpatients, same day emergency care, community localities, children's pathways) • *Operate within funded bed base by optimising discharge to assess and reducing length of stay* • *Develop locality working and create locality leadership teams* • *Complete radical outpatient redesign, develop new virtual clinic models and increase advice and guidance* • *Deliver theatre transformation programme* • *Improve same day emergency care and ambulatory care (adult and children)*
Reduce system cost and improve clinical productivity and financial literacy everywhere • *Deliver savings through cost improvement programme and deliver to budgets to deliver the 2019/20 control total* • *Reduce agency spend across all services* • *Roll out programme of financial awareness to key staff* • *Implement new intermediate care pathway* • *Restructure therapy and autism pathways for children*
Transform our estates and Information Technology to enable new ways of working • *Create the case and plans for a transformed estate* • *Deliver estates improvement programme including new education centre, refurbished maternity and neo-natal intensive care unity* • *Deliver the fast-follower programme*

Meeting title	**Trust Board – meeting in public**	**Date: 24.4.2019**
Report title	**Board Assurance Framework and risk appetite**	**Agenda item: 16**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs and respective executive director risk leads	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	This report presents board members with the following for review and approval: 1. the final 2018/19 Board Assurance Framework (BAF) register as risk leads have 'closed down' respective entries and rolled over any actions needed as part of the continued mitigation of risks to the delivery of our strategic priorities in quarter one of 2019/20; 2. a BAF register for 2019/20 based on the strategic objectives agreed for the Whittington Health 2019/24 strategy which was approved at the March 2019 meeting. The new BAF's entries are a re-ordering of the 2018/19 BAF risks under the new four strategic objective areas; and 3. a draft 2019/20 risk appetite statement.	
Purpose:	Review, discussion and approval	
Recommendation(s)	Board members are asked to: i. review the final, updated BAF for Q4 in 2018/19; ii. receive and review the draft 2019/20 BAF based on the new agreed strategic objectives and confirm whether they are correct and should be included in this year's BAF and also whether there should be any additional entries that are not currently captured; iii. note the board assurance committees will review respective BAF entries a standing items at their meetings; and iv. review and approve the 2019/20 risk appetite statement.	
Risk Register or Board Assurance Framework	All BAF entries and linked entries on the corporate risk register	
Report history	Executive Team, 8 April; Trust Management Group, 23 April	
Appendices	Appendix 1: 2018/19 Q4 Board Assurance Framework Appendix 2: 2019/20 Board Assurance Framework	

PART 1: 2018/19 Board Assurance Framework quarter 4 and closure

Summary:
The board are asked to review appendix one which is the BAF with the risks for March 2019 updated. It remains in the format of 2018/19.

Recommendation:
The board are asked to approve the final scores of the year and to note progress in that we have delivered against many of the national and local performance targets and care quality. We expect to hit our financial control total but have not managed to control pay spend.

PART 2: New 2019/20 Board Assurance Framework

Summary:
The board are asked to review the draft BAF for the new financial year, 2019/20. This includes a revised framing in line with the new strategic objectives. The key risks from 2018/20 have where appropriate been carried across and a few minor changes have been made.

Recommendation:
The board are asked to approve the new BAF for 2019/20

PART 3: New 19/20 Risk Appetite Statement

Risk Appetite
Risk appetite is the level of risk, the Trust Board deems acceptable or unacceptable based on the specific risk category and circumstances/situation facing the Trust. This allows the Trust to measure, monitor and adjust, as necessary, the actual risk positions against the agreed risk appetite.

Using the Good Governance Institute risk appetite matrix, the Trust Board has adopted a risk appetite statement which is the amount of risk it is willing to accept in seeking to achieve its strategic ambitions. As well as the overall risk appetite statement, separate statements are provided for each, in the table below.

2019/20 Risk Appetite Statement
Whittington Health NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, it will not accept risks that materially provide a negative impact on quality.

However, Whittington Health has a greater appetite to take considered risks in terms of their impact on organisational issues. It also has a greatest appetite to pursue commercial gain, partnerships, clinical innovation, financial/value for money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Category	Risk appetite	Risk appetite score
Clinical innovation	**MODERATE** risk appetite for clinical innovation that does not compromise quality of care	**12-16**
Compliance / regulatory	**LOW** risk appetite for compliance/regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements	**6-10**
Financial / value for money	**MODERATE** risk appetite for financial/value for money which may grow the size of the organisation whilst ensuring we minimising the possibility of financial loss and comply with statutory requirements	**12-16**
Partnerships	**HIGH** risk appetite for partnerships which may support and benefit the people we serve	**20-25**
Reputation	**MODERATE** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation	**12-16**
Quality effectiveness	**LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**
Quality experience	**LOW** risk appetite for risks that may affect the experience of our service users	**6-10**
Quality safety	**VERY LOW** risk appetite for risks that may compromise safety	**1-5**
Workforce	**MODERATE** risk appetite for actions and decisions taken in relation to workforce	**12-16**
Commercial	**HIGH** risk appetite for commercial gain whilst ensuring quality and sustainability for our service users	**20-25**

Below, the table shows risk appetite tolerance scores for level of each risk appetite. When a risk exceeds a risk appetite tolerance score this will be used as a framework for a risk to be communicated and reported upwards. A suggested target risk is also added to help inform target risk scoring discussions. The target risk is provided as a guide and not an absolute expectation.

Appetite	None	Very low	Low	Moderate	High
Risk tolerance score	n/a	1-5	6-10	12-16	20-25
Target risk score	n/a	0	4	9	15

Recommendation:
The board are asked to review and approve the risk appetite statement.

Appendix 1: Board Assurance Framework (BAF) as at end March 2019

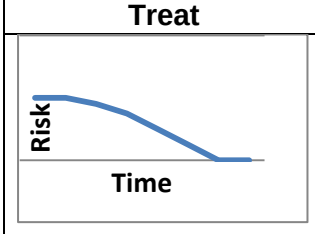
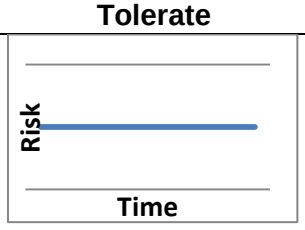
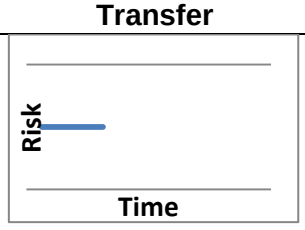
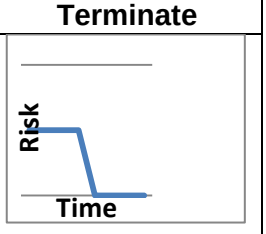
Risk Scoring Matrix					
	Likelihood				
Consequence	1: Very Unlikely	2: Unlikely	3: Likely	4: Very Likely	5: Almost Certain
1: Negligible	1	2	3	4	5
2: Minor	2	4	6	8	10
3: Moderate	3	6	9	12	15
4: Major	4	8	12	16	20
5: Catastrophic	5	10	15	20	25

Summary of principal BAF risks:

Risk ID	Risk description	Current score	Risk appetite score / target score	Change since Q2
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.	12	6	↔
2	Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service, Breast, Bariatrics).	8	8	↔
3	Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department, community etc.)	8	6	↓

Risk ID	Risk description	Current score	Risk appetite score / target score	Change since Q2
4	Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. Nursing, junior doctors, medical posts)	12	8	↔
5	Failure to deliver savings plan for 2018/19 leads to adverse financial position, not hitting control total, loss of STF and reputational risk	10	10	↔
9	That the long term financial viability of the trust is threatened by changes to the environment, long term plan, social care risks, political changes, organisational form changes	8	6	↔
14	Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.	12	4	↔
15	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience	8	6	↔
16	Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised	9	9	↔
17	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result	12	4	↔

Approaches to risk: (What are the four ways in which we could choose to manage risk?)

Treat	Tolerate	Transfer	Terminate
			

Risk ID:	1
Risk	**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**

CQC Domain	Safe; Caring, Effective; Responsive; Well-led
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	To deliver consistent, high quality, safe services
Board Lead	Chief Nurse & Director of Patient Experience
Risk register codes	none

Risk scores	
Initial risk score:	4 x 3
Previous risk score	4 x 3
Current risk score	4 x 3
Risk appetite / target score	3 x 2
Date last reviewed	March 2019

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
Robust peer review process	1st tier - Incident and SI reporting policies
CQC preparation meetings	1st tier – clinical audit programme in place
CQC focus groups for staff and patients	2nd tier – mortality dashboard reviewed by Board
Review of policies, guidelines and procedures to ensure all up to date	2nd tier - Trust Risk Register reviewed by Quality & Safety Committee, Audit & Risk Committee and Board
Increase mandatory training completion	3rd tier – quarterly CQC engagement meetings
Ensure action plan completion from previous inspection and evidence to support this	3rd tier – Quality Review Group meetings with CCGs
All CQC notices addressed and evidence to support this	3rd tier – peer review visits include NHSI and CCG leads
All risks on risk register updated and reflective of current risks to organisation	
All incidents investigated and closed where appropriate (Many older incidents still open on Datix)	
Mortality review process and reporting	
Estates preparation and improvement to patient and staff environments	

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
Well–led assessment underway	
Board development programme	

Gaps in controls & assurances: (What additional controls and assurances should we seek?)
• Develop a CQC reporting pack • Develop an application to support peer review • Include NHSI and CCG participants on peer review process

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
	Quality Committee	

Actions complete:

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

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

Risk scores	
Initial risk score:	4 x 4 =16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite / target score	2 x 4 = 8 (terminate)
Date last reviewed	March 2019

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

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

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

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

Actions complete:
• Appointment of LUTs Consultant

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite / target score	2 x 3 = 6 (treat)
Date last reviewed	March 2019

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

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

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

Mitigating action(s)	Lead Assurance Committee	Deadline
SAFER bundle, MADE (biweekly), discharge to assess (D2A) in place	AEDB ICSU Improvement Group	In place and ongoing
Emergency Care Improvement Programme support – focus on first 60 minutes and out of hours	ICSU Board TMG AEDB	From April 2019

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

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	4 x 3 = 12
Current risk score	4 x 3 = 12
Risk appetite / target score	4 x 2 = 8 (treat)
Date last reviewed	March 2019

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

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

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

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

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

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

Risk scores	
Initial risk score:	4 x 5 = 20
Previous risk score	4 x 5 = 20
Current risk score	2 x 5 = 10
Risk appetite / target score	2 x 5 = 10 (treat)
Date last reviewed	March 2019

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

Gaps in controls & assurances: what additional controls and assurances should we seek?
• We expect to hit control total but pay is not controlled effectively • More robust plans required to address unidentified CIP • More traction with ICSUs required for transformation schemes

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

Actions completed:
• Monitoring and governance in place • Weekly check–ins with management accounts • Monthly CIP delivery board

Actions completed:
• Senior Finance Support for the PMO • Outpatient Transformation Project – BCG appointment made • Pathology proof of concept with NWLP April-Dec18 • Each ICSU identified 2% saving – PMO support where required • CIP delivery dashboard developed • CIP delivery not met but control total met

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite / target score	2 x 3 = 6 (treat)
Date last reviewed	March 2019

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

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

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

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

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

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	3 x 4 = 12
Current risk score	3 x 4 = 12
Risk appetite / target score	2 x 2 = 4 (treat)
Date last reviewed	March 2019

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

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

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

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

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

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	2 x 4 = 8
Current risk score	2 x 4 = 8
Risk appetite	2 x 2 = 4 (tolerate)
Date last reviewed	March 2019

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

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

- Signed off estates development plan

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

Assurance progress:

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

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

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

Risk scores	
Initial risk score:	4 x 4 = 16
Previous risk score	3 x 3 = 9
Current risk score	3 x 3 = 9
Risk appetite / target score	3 x 3 = 9 (tolerate)
Date last reviewed	March 2019

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

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

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

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

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

Additional comments on performance trajectory:

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

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

Risk scores	
Initial risk score:	3 x 3 = 9
Previous risk score	3 x 3 = 9
Current risk score	3 x 4 = 12
Risk appetite / target score	2 x 2 = 4 (terminate)
Date last reviewed	March 2019

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Action plan discussed at TMG and Trust board	Workforce Assurance Committee	January 2019 for Trust Board

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

Appendix 2: 2019/20 Board Assurance Framework entries and detail

Each of our four new strategic objectives has been summarised as:

Strategic objective	Summary
Deliver outstanding safe, compassionate care in partnership with patients	**Quality**
Empower, support and develop an engaged staff community	**People**
Integrate care with partners and promote health and wellbeing	**Integration**
Transform and deliver innovative, financially sustainable services	**Sustainability**

The 2019/20 BAF document also takes each of the nine 2018/19 BAF entries and re-orders them under the four new strategic objective headings, as follows:

Risk Ref	Risk description	Current score			Target score	Score trend				Date risk added	Lead director (s)
		C	L	R		Previous month	3 months ago	6 months ago	Direction of travel		
Strategic objective 1: (Quality)	**Deliver outstanding safe, compassionate care in partnership with patients**										
Quality 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	**4**	**3**	**12**	6	12	12	12	↔	Apr-19	MJ

Risk Ref	Risk description	Current score			Target score	Score trend				Date risk added	Lead director (s)
		C	L	R		Previous month	3 months ago	6 months ago	Direction of travel		
	of income, an adverse impact upon staff retention and damage to organisational reputation.										
Quality 2	Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department, community etc.)	**3**	**4**	**12**	6	16	16	16	↓	Apr-19	CG
Quality 3	Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.	**3**	**4**	**12**	4	12	12	16	↔	Apr-19	CG
Strategic objective 2: (People) Empower, support and develop an engaged staff community											
People 1	Failure to recruit and retain high quality substantive staff could	**4**	**3**	**12**	8	12	12	16	↔	Apr-19	NF

Risk Ref	Risk description	Current score			Target score	Score trend				Date risk added	Lead director (s)
		C	L	R		Previous month	3 months ago	6 months ago	Direction of travel		
	lead to reduced quality of care, and higher costs (e.g. Nursing, junior doctors, medical posts)										
People 2	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result	**3**	**4**	**12**	4	9	9	n/a	↑	Apr-19	NF
Strategic objective 3: (Integration) Integrate care with partners and promote health and wellbeing											
Integration 1	Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned,	**2**	**4**	**8**	8	8	8	8	↔	Apr-19	JA

Risk Ref	Risk description	Current score			Target score	Score trend				Date risk added	Lead director (s)
		C	L	R		Previous month	3 months ago	6 months ago	Direction of travel		
	or Trust reputation is damaged (e.g. Lower Urinary Tract service, Breast, Bariatrics).										
Integration 2	That the long term financial viability of the trust is threatened by changes to the environment, long term plan, social care risks, political changes, organisational form changes	**2**	**4**	**8**	6	8	8	8	↔	Apr-19	JG
Strategic objective 4: (Sustainability) Transform and deliver innovative, financially sustainable services											
Sustainable 1	Failure to deliver savings plan year and control in operational budgets leads to adverse underlying financial position that cannot be mitigated by non-recurrent measure. This will lead to not hitting control total, loss of	**4**	**5**	**20**	10	10	20	20	↑	Apr-19	SB/CG

Risk Ref	Risk description	Current score			Target score	Score trend				Date risk added	Lead director (s)
		C	L	R		Previous month	3 months ago	6 months ago	Direction of travel		
	Provider Sustainability Funding, greatly reduced capital resource to address other BAF risks and reputational risk										
Sustainable 2	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience	**2**	**4**	**8**	4	8	8	12	↔	Apr-19	SB
Sustainable 2	Breach of established cyber security arrangements results in IT services failing, data being lost and care being compromised	**3**	**3**	**9**	9	9	9	8	↔	Apr-19	SB

Risk ID:	Quality 1
Risk	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

CQC Domain	Safe; Caring, Effective; Responsive; Well-led
CQC Outcomes	Care & welfare of people who use services
Corporate Objective	To deliver consistent, high quality, safe services
Board Lead	Chief Nurse & Director of Patient Experience
Risk register codes	none

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee:** (How do we know if the things we are doing are having an impact?)
Robust peer review process	1st tier - Incident and SI reporting policies
CQC preparation meetings	1st tier – clinical audit programme in place
CQC focus groups for staff and patients	2nd tier – mortality dashboard reviewed by Board
Review of policies, guidelines and procedures to ensure all up to date	2nd tier - Trust Risk Register reviewed by Quality & Safety Committee, Audit & Risk Committee and Board
Increase mandatory training completion	3rd tier – quarterly CQC engagement meetings
Ensure action plan completion from previous inspection and evidence to support this	3rd tier – Quality Review Group meetings with CCGs
All CQC notices addressed and evidence to support this	3rd tier – peer review visits include NHSI and CCG leads
All risks on risk register updated and reflective of current risks to organisation	
All incidents investigated and closed where appropriate (Many older incidents still open on Datix)	
Mortality review process and reporting	
Estates preparation and improvement to patient and staff environments	
Well–led assessment underway	
Board development programme	

Gaps in controls & assurances: (What additional controls and assurances should we seek?)
• Develop a CQC reporting pack • Develop an application to support peer review

• Include NHSI and CCG participants on peer review process

Mitigating action(s)	Lead Assurance Committee	Deadline
	Quality Committee	

Actions complete:

Risk ID:	Quality 2
Risk	Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – (e.g. Emergency Department (ED), community etc.)

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

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
GAP analysis against NHSI Improvement Resource Guide – reducing long hospital stays	ICSU performance reviews	In place and ongoing
Oversight of whole system improvement plan.	Trust Operational meetings AEDB	In place and ongoing
Ongoing recruitment of consultants for Emergency Department	Trust Management Group/ICSU Board	In place and ongoing
Bed management and escalation policies all in place	Trust Management Group	In place and ongoing
SAFER bundle, MADE (biweekly), discharge to assess (D2A) in place	AEDB ICSU Improvement Group	In place and ongoing
Emergency Care Improvement Programme support – focus on first 60 minutes and out of hours	ICSU Board TMG AEDB	In place – report end of December 2018

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

Risk ID	Quality 3
Risk	Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk

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

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
C&I and ED operational meeting to address key operational issues	ICSU performance reviews	In place and ongoing
Oversight of mental health waits at AEOB	AEDB	In place and ongoing
Quarterly contract meetings – to include risks, safety issues and performance metrics	Trust Board	In place and ongoing

Assurance progress:
• Implement new service model – mental health suite (from May 2018) – weekly operational meeting to monitor patient flow to the suite • External review of mental health pathway and learning from recent incidents -

Completed

- CEO chair of AEDB
- Monitor and review mental health suite model.
- Audit of quality checks in Emergency Department

Risk ID:	People 1
Risk	Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. nursing, junior doctors, medical posts).

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

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Engagement across North Central London and with Capital Nurse to tackle retention issues, including rotation, career management, over	Trust Management Group	In place and ongoing

Mitigating action(s)	Lead Assurance Committee	Deadline
55s work programme.		
Development of nursing retention strategy	NMEC/ Trust Management Group	To be confirmed

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

Risk ID	People 2
Risk	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result

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

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Action plan in place and being progressed	Workforce Assurance Committee	ongoing

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

Risk ID:	Integration 1
Risk	Failure to support fragile services adequately, internally or via partnership with other providers leads to further instability where quality is reduced, or vital service decommissioned, or Trust reputation is damaged (e.g. Lower Urinary Tract service (LUTS, Breast, Bariatrics).

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

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

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

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

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

Actions complete:

- Appointment of LUTs Consultant

Risk ID	Integration 2
Risk	That the long term viability of the trust is threatened by changes to the environment long term plan, social care risks, political changes, organisational form changes

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

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

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

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

Mitigating action(s)	Lead Assurance Committee	Deadline
of how we do business	Group	

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

Risk ID:	Sustainable 1
Risk	Failure to deliver savings plan year and control in operational budgets leads to adverse underlying financial position that cannot be mitigated by non-recurrent measure. This will lead to not hitting control total, loss of Provider Sustainability Funding, greatly reduced capital resource to address other BAF risks and reputational risk

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

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

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

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

Actions completed:
• Monitoring and governance in place • Weekly check–ins with management accounts • Monthly CIP delivery board • Senior Finance Support for the PMO • Outpatient Transformation Project – BCG appointment made • Pathology proof of concept with NWLP April-Dec18 • Each ICSU identified 2% saving – PMO support where required • CIP delivery dashboard developed

Risk ID	Sustainable 2
Risk	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience

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

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

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

- Signed off estates development plan

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

Assurance progress:

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

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

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

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

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

Mitigating action(s)	**Lead Assurance Committee**	**Deadline**
Delivery of digital strategy-fast follower exemplar programme	Trust Management Group Finance& Business Development Committee	Started April2018
Continue to network with other Trusts to ensure shared learning	ICSU Leadership	In place and ongoing
Escalation protocol across NCL	Trust Management Group	Autumn 2018
Contract Management – hold suppliers to account	Trust Management Group	Ongoing

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

Additional comments on performance trajectory:

Risk ID	Sustainable 3
Risk	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised and staff morale affected and ultimate patient care suffers as a result

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

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

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

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

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

Meeting title	**Trust Board – meeting in public**	**Date: 24.4.2019**
Report title	Quality and Safety Risk Register summary report	**Agenda item: 17**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Lynda Rowlinson, Interim Head of Quality Governance	
Executive summary	This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥16) currently on the Risk Register in April 2019. The Trust has set a threshold for risks reviewed at Board Committee level (≥15) to ensure Non-Executive Director oversight. The Non-Executive Director who chairs the committee will escalate any ≥15 risks to the Trust Board as required. All risks <15 are managed at an Integrated Clinical Service Unit (ICSU) and corporate directorate level and escalated to the relevant Trust Board Committee as required. **The following changes to the risks are summarised** 1. **Risks closed -** One risk was closed within the last period: 847 - Pressurised Gas Manifolds used in Microbiology 2. **Downgraded risks -** 609 - Whittington Health lease issue regarding estate with Simmons House downgraded to 9 3. **New risks -** One new risk 970 – Central Booking Team staffing	
Purpose:	The Board are requested to review and approve this paper.	
Recommendation(s)	• The Trust Board are asked to review all ≥16 risks and agree there is adequate mitigating actions and assurance to manage these risks • The Trust Board are asked to consider if any ≥16 risks not currently on the Board Assurance Framework (BAF), should be added	
Risk Register or Board Assurance Framework (BAF)	Whittington Health Risk Register & BAF	
Report history	The information in this report is presented at the relevant Committee of the Board (Quality, Workforce Assurance, Finance & Business, Audit & Risk)	
Appendices	None	

Quality and Safety Risk Register summary report

1. Introduction

1.1 Risk is an inherent part of the delivery of healthcare. Whittington Health is therefore committed to ensuring that there is a robust organisational governance structure, with clear lines of reporting and accountability for risks. This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥16) currently on the Trust Risk Register in April 2019.

2. Risk management overview

2.1 The Trust maintains a central database for all risks on DATIX, an electronic incident and risk management system. In order to maintain consistency across the trust all risks are collated by ICSU, Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as an organisation wide risk.

2.2 All risks are categorised under key headings and given a risk rating. This process ensures that risks can be automatically collated and filtered through DATIX to ensure they are reviewed by the appropriate leads. All Integrated Clinical Service Unitss (ICSUs)/Directorates/Board Committees are responsible for ensuring there are clear risk management structures and processes in their areas.

2.3 A review of the current risk around preparation for Care Quality Commission (CQC) inspection in the near future is being completed and will be added to the risk register following approval process. The initial review suggests this will be rated as moderate grading. A recommendation of entry onto the BAF will also be made as a risk to achievement of the corporate objectives of the trust.

3. ≥ 16 RISK REGISTER

3.1 The Trust has set a threshold of ≥15 risk grading for review at Board Committees. This is to ensure that there is Non-Executive oversight of these risks and a clear escalation process to Board.

3.2 To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Committees with responsibility for risk. These include:

- Audit and Risk Committee
- Quality Committee
- Finance and Business Committee
- Workforce Assurance Committee

3.3 All have a critical role in monitoring risk and providing assurance to the Trust Board that there are systems in place to effectively identify, manage and escalate risks across the Trust. Each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information flows quickly to the Board as required. In this way the Trust can identify patterns and promote best practice throughout the organisation.

4. Relationship between the Quality & Safety Risk Register and the Board Assurance Framework

4.1 The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

4.2 While the Risk Register may help to inform the BAF, they are two distinct risk tools with different purposes. The fundamental difference between the Risk Register and the BAF is that the Risk Register is an operational and dynamic tool focused on the day to day management of the organisation. The BAF focuses on the strategic, long-term priorities of the Trust. At times the operational risks affecting the day to day management of the Trust will have implications for the delivery of the Trust's strategic objectives. These risks are escalated for inclusion on the BAF via the Board Committees and the Trust Management Group. All the key risks that are identified in achieving the Trust's strategic goals or corporate annual objectives will be recorded on the BAF and reported to the Board.

5. Risk register update: April 2019

5.1 As at 12 April 2019, the Trust currently has five risks graded as ≥20 and 15 risks/graded as 16. There are nineteen risks graded as 15 which are monitored at Board Committee level.

5.2 There remain three key themes from the current high level risks on the risk register:

- Workforce and recruitment
- Facilities and estates
- Financial (equipment/building work etc.)

5.3 These risks have all been escalated for inclusion on the BAF due to the strategic implications and are monitored by the Trust Board through this assurance mechanism.

5.4 A brief summary of the risks and key mitigating actions is outlined below.

Workforce and Recruitment

DATIX	ICSU / Directorate	Category	Title	Current risk grading
970	Surgery & Cancer	HR & Workforce	Staffing for Central Booking Team not adequate & risk of activity & income being affected	20 (new risk)
913	Surgery & Cancer	HR and Workforce	Gaps in consultant cover for on call rotas: Reviewed on 22.03.2019 – no gaps in general surgery; however, awaiting CCU replacement & urology rota review	16
950	Surgery & Cancer	HR and Workforce	Lack of middle grade doctors on the rota leading to a lack of senior cover on CCU. Reviewed 18.01.2019; no change continues to be a high level of vacancies	16
951	Acute Patient Access Clinical Support Services	HR and Workforce	Lack of psychologists to cover maternity clients with perinatal psychology needs. Reviewed 19.02.2019; no change	16

DATIX	ICSU / Directorate	Category	Title	Current risk grading
	and Women's Health			

5.2 Each ICSU has a specific action plan to mitigate the current risk, including short-term provision such as the use of bank and agency staff as well as recruitment initiatives to fill substantive posts. Across the Trust, this has been identified as a risk to our strategic objective to 'develop and support our people and teams' and captured on the BAF **(Ref: BAF 4 *Inability to increase substantive workforce capacity).***

5.3 Trust wide actions to address this concern are reflected in the Recruitment and Retention strategy and include regular recruitment days, overseas recruitment drive, and bank and agency rates review.

Facilities and Estates

Datix ID	ICSU / Directorate	Category	Title	Current risk grade
91	Acute Patient Access Clinical Support Services and Women's Health	Estates or Infrastructure	Labour ward has 1 obstetric theatre. Review 13.03.2019; no change	20
697	Acute Patient Access Clinical Support Services and Women's Health (ACW)	Patient Safety and Quality	Maternity and neonatal redevelopment; no change	20
817	Facilities and Estates	Estates or Infrastructure	Building environmental planned preventative regime for heating, ventilation and air conditioning systems. Reviewed 10.04.2019; report received & works being considered by Capital works	16
807	Facilities and Estates	Estates or Infrastructure	Works arising from fixed electrical installation testing. Reviewed 10.04.2019; testing contract implemented since January 2019	16
892	Facilities & Estates	Patient Safety	Fire Safety Management System needs to implement all elements within a new Fire Safety Policy. Reviewed 02.04.2019; implementation of audit recommendations	16

Datix ID	ICSU / Directorate	Category	Title	Current risk grade
			commenced.	
907	Trust wide	Estates / Infrastruc -ture	High ambient temperatures of ward/treatment rooms affecting quality of medicines. Reviewed 10.04.2019 – risk increased	16

5.5 There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our corporate objective to 'deliver quality, patient safety and experience' (**BAF 15: Failure to modernise the Trust's estate**). The Trust Board monitors actions against this risk through the BAF process, including implementation of the Estates Strategy.

Financial

DATIX	ICSU / Directorate	Category	Title	Current risk grading
784	Finance	Financial	Failure to deliver CIPs and savings to £16.5m 2018/19; no change	20
780	Finance	Financial	Budget Control; no change - to be reviewed Q1 2019/20	16
723	Emergency Integrated Medicine	Financial	Finance deficit in EUC ICSU; no change – to be reviewed Q1 2019/20	16
772	Surgery and Cancer	Financial	Not meeting CIP target and financial balance for 2018/19. Reviewed 19.03.2019; actions in place to mitigate the risks	16
880	Finance	Financial	Failure to achieve planned activity levels. No change – to be reviewed Q1 2019/20	16

5.6 Each ICSU and Corporate Department has a specific plan in place to manage their budget and meet the required Cost Improvement Plan savings required for 2018/19. This has been identified as a strategic risk to our corporate objective to 'Develop our business to ensure we are financially sustainable.' (**BAF 5: Failure to deliver cost improvement plan and transformation savings**) which is monitored through this assurance process.

6. ≥16 RISKS NOT CURRENTLY ON BAF

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and key actions
866	Emergency & Integrated Medicine	Patient Safety & Quality	GE holter analysis system (MARS & MUSE)	20	System for analysing ambulatory ECG monitors is over 10 years old and no longer supported by manufacturer. Reviewed 07.03.2019; no change to risk
728	Trust wide	Information Governance	Medical records not located in medical files.	16	Project in progress to file all patient notes in the appropriate record with filing underway. No change in risk level – to be reviewed Q1 2019/20

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and key actions
760	ACW	Patient Safety & Quality	Radiology systems interface	16	Radiology works across several systems for which there is a parallel paper system; if paper system does not change unlikely to meet cancer targets without significant costs incurred. Reviewed 10.01.2019 – no change
903	ACW	Diagnostics	Ineffective communicat-ion pathway for screening samples.	16	Communication pathway for screening samples between UCLH & Whittington maternity units requires further improvement. There are clear mitigating actions in place to reduce risk. No change to risk; in depth work underway to improve performance for this service being provided by UCLH
945	Surgery & Cancer	Patient Safety & Quality	Coverage issues for Multitone paging signal in Theatres	16	Upgrade of system targeted for Q4 2019/20. Reviewed 14.01.2019; contractor to deal with faults to mitigate.

7. Recommendations

7.1 The Trust Board are asked to review all ≥16 risks and agree there is adequate mitigating actions and assurance to manage these risks.

7.2 The Trust Board are asked to consider if any ≥16 risks not currently on the Board Assurance Framework (BAF), should be added.

Meeting title	**Trust Board – public meeting**	**Date:** 24.4.2019
Report title	**Register of Deed of Execution and Seal**	**Agenda item:** 18
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Corporate Secretary	
Executive summary	A report to the Board of the use of the Trust Deed of Execution / Seal which is recorded on the Whittington Health NHS Trust formal Register for the period 1 April 2018 to 31 March 2019	
Purpose:	Approval for the latest Register of Deed of Execution and Seal	
Recommendation(s)	Board members are invited to review the use of the Trust seal during 2018/19 and to take assurance that its use was administered in accordance with Trust's Standing Orders	
Risk Register or Board Assurance Framework	No identifiable risk currently captured.	
Report history	Annual report to Trust Board	
Appendices	None	

Use of Trust seal in 2018/19

Reference	Details	Date
19/01	Whittington Hospital NHS Trust and Mr Hermant Patel – Underlease of part of Crouch End Health Centre, 45 Middle Lane, London N8 8PH	20.4.18
19/02	Replacing previous lease with Hornsey Central reducing in space occupied. (and surrendering the old lease)	19.9.18
19/03	Community Health Partners Limited & WH : Ealing, Hammersmith & Fulham and Hounslow NHS LIFT underlease for part of Thelma Golding Health Centre (also known as Hounslow Centre for Health)	25.10.18
19/04	Ryhurst/Rydon – Ryhurst/Whittington Hempsons Escrow Deed 7.12.18	7.12.18
19/05	Lease relating to first floor, 1 Redford Way, Uxbridge UB8 1SZ between Sonia Mary Leno and Whittington Health NHS Trust	16.1.19
19/06	Licence to carry out works relating to first floor, 1 Redford Way, Uxbridge UB8 1SZ between Sonia Mary Leno and Whittington Health NHS Trust	16.1.19
19/07	Camden & Islington NHSFT land sale	13.3.19
19/08	Artelia Uxbridge Community Dental Contracts document	20.3.19
19/09	Whittington Health NHS Trust & Royal Voluntary Service – Lease of Unit 1 Whittington Court	20.3.19
19/10	Whittington Health NHS Trust Cearns Maternity Theatre – JCT Intermediate with CDP 2016 2032226 17 January 2019	26.3.19
19/11	JCT – ICD 2016 Intermediate building contract with contractors design 2016	11.4.19