Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
31 July 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board of Directors – Public meeting**
Date & time	**Wednesday, 31 July 2019: From 2.00pm**
Venue	**Whittington Education Centre, Room 7**
Site	**Whittington Hospital, Magdala Avenue N19 5NF**

Non-Executive Director members:	**Executive Director members:**
David Holt, Interim Chair	Siobhan Harrington, Chief Executive
Deborah Harris-Ugbomah	Dr Clare Dollery, Medical Director
Professor Naomi Fulop	Stephen Bloomer, Chief Finance Officer
Tony Rice	Carol Gillen, Chief Operating Officer
Anu Singh	Michelle Johnson, Chief Nurse & Director
Yua Haw Yoe	of Patient Experience

Attendees:
Councillor Janet Burgess MBE, Islington Council
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
Councillor Sarah James, Haringey Council
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** *Chair*	Verbal
3	1422	**Declaration of interests** *Chair*	Verbal
4	1424	**26 June 2019 public meeting draft minutes, action log, matters arising** *Chair*	Approve
5	1430	**Chair's report** *David Holt, Interim Chair*	Approval
6	1440	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review
Quality & patient safety			
7	1450	**Quarterly quality and patient safety report** *Dr Clare Dollery, Medical Director*	Review

Item	Timing	Title and lead	Action
8	1500	**Serious incidents – June 2019** *Dr Clare Dollery, Medical Director*	Review
9	1510	**Quarterly learning from deaths report** *Dr Clare Dollery, Medical Director*	Review
10	1520	**Six monthly integrated safeguarding report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
11	1530	**Clinical Negligence Scheme for Trusts declaration** *Dr Clare Dollery, Medical Director*	Approve
12	1535	**Quarterly Guardian of safer working report** *Dr Clare Dollery, Medical Director*	Review
13	1545	**Quality & safety risk register** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
People			
14	1555	**Workforce Race and Disabilities Equality Standards outcomes and Equality Delivery System progress** *Norma French, Director of Workforce*	Approve
Performance			
15	1610	**Performance dashboard – June 2019** *Carol Gillen, Chief Operating Officer*	Review
16	1620	**Emergency department improvement plan trajectory** *Carol Gillen, Chief Operating Officer*	Review
17	1630	**Financial performance – June 2019** *Stephen Bloomer, Chief Finance Officer*	Review
18	1640	**National patient surveys** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
19	1650	**2018/19 Compliments and complaints annual report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Approve
20	1700	**Six monthly safe nursing and midwifery**	Review

Item	Timing	Title and lead	Action
		establishment review *Michelle Johnson, Chief Nurse & Director of Patient Experience*	
21	1710	**Medical Appraisal and Revalidation: Annual Board Report** *Dr Clare Dollery, Medical Director*	Approve
Governance			
22	1720	**Quarter one delivery of 2019/20 strategic objectives** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Review
23	1730	**Questions from the public on agenda items** *Chair*	Review
24	1735	**Any other business** *Chair*	Review

Minutes of the Board of Directors at Whittington Health NHS Trust's meeting held in public on Wednesday, 26 June 2019

Present:

Steve Hitchins	Chair
Stephen Bloomer	Chief Finance Officer
Dr Clare Dollery	Medical Director
Jonathan Gardner	Director of Strategy, Development and Corporate Affairs
Carol Gillen	Chief Operating Officer
Naomi Fulop	Non-Executive Director
Siobhan Harrington	Chief Executive
David Holt	Non-Executive Director
Michelle Johnson	Chief Nurse and Director of Patient Experience
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Janet Burgess	Councillor, London Borough of Islington
James Connell	Patient Experience Manager (item 15)
Norma French	Director of Workforce
Casey Galloway	Patient Experience Officer (item 15)
Kate Green	Personal Assistant to Director of Workforce
Sarah Humphery	Medical Director, Integrated Care
Iliana Neshkova	Quality & Risk Compliance Administrator (item 15)
Andrew Sharratt	Communications Programme Manager (items 4-7)
Bethany Sibley	Patient Experience Administrator (item 15)
Swarnjit Singh	Trust Corporate Secretary

1. Welcome and apologies

1.1 Steve Hitchins welcomed everyone to the meeting, especially Clare Dollery, newly-appointed Medical Director.

1.2 Apologies for absence were noted for Deborah Harris-Ugbomah, Non-Executive Director. `

2. Declaration of conflicts of interest

2.1 No Board members declared any personal interests in the business to be transacted at the meeting.

3. Minutes, matters arising & action log

3.1 Subject to the following amendments, the minutes of the previous meeting were agreed as a correct record:

- Julie Andrews, Acting Medical Director was present at the May Board meeting

- In section 20.1, it was noted that the following wording be included: Mr Richards had also asked a question about whether the Trust website could be made more informative for members of the public wishing to obtain copies of Board papers, and Siobhan Harrington had confirmed that this information was included on the Trust's webpages.

3.2 There were no matters arising other than those already scheduled for discussion.

3.3 The action log was reviewed and all items contained within had either been completed or were scheduled for discussion as listed. It was noted that the Standing Orders and Standing Financial Instructions would be considered at the next meeting of the Audit and Risk Committee in in October 2019.

4. Chairman's report

4.1 Steve Hitchins highlighted fundraising for the Trust's charitable funds and reported that the Trust had been offered assistance by the Mayor of Haringey and was also in touch with the Mercers' Company. He explained that good progress had been made in partnership with Tottenham Hotspur Football Club, with a view to developing an initiative around the school nursing service.

4.2 Since the previous meeting, Steve Hitchins reported he had visited the following:

- Tynemouth Road Health Centre (twice)
- the Trust's mortuary service
- community dental services, where he had been extremely impressed by the energy and commitment shown by the teams in a service described as fantastic
- the Netley campus in Camden (speech and language therapy)
- 14 hospital wards in the hospital, where he had been touched by the commitment, professionalism and caring attitude shown by all the staff, as well as their positive morale
- a meeting held by the Defend the Whittington Coalition.

4.3 Steve Hitchins paid tribute to Eileen Willis, Personal Assistant to the Chief Executive, who had worked at the Trust for 27 years. Steve was pleased to welcome Dr Clare Dollery Medical Director who said she was both proud and joyful to be part of Whittington Health and to share with colleagues the opportunity to help local people live longer healthier lives. Dr Clare Dollery explained that she had been in leadership roles for around ten years, having worked at University College London Hospitals NHSFT (UCLH) and been Deputy Medical Director at both Barts Health NHS Trust and Oxford University Hospitals NHS Trust. She was a cardiologist by background and had worked in leadership development and research, including time spent at Harvard and also on major strategic projects such as the development of the Heart Centre at Barts.

4.4 Steve Hitchins explained he had been informed that his term of office, due to end in September, would not to be renewed, and after long and careful thought, had decided to tender his resignation. Norma French responded to say that many Trust staff would wish to have an opportunity to say goodbye and to thank him for all he had contributed to the work of the organisation. Siobhan Harrington echoed this said that there should be an opportunity for staff to acknowledge his commitment to the Trust and his achievements. Councillor Janet Burgess thanked Steve Hitchins

on behalf of Islington Council, and Anu Singh paid tribute to his work on behalf of the Non-Executive Directors.

4.5 The Board noted the verbal report, in particular, the Chair's decision to stand down with effect from 6.00pm that evening.

5. Chief Executive's report

5.1 Siobhan Harrington informed Board members of the publication of the interim national NHS People Plan in early June and the appointment of Amanda Pritchard as Chief Operating Officer for NHS England and Improvement.

5.2 Emergency department performance was 88.4% in May, an improvement on the previous month. Since the last Board meeting, the Trust had held a 'Perfect Week', during which time there had been a notable improvement in patient flow throughout the hospital.

5.3 Regrettably in the last month, the Trust had declared three never events: one concerned a wrong site nerve block' and the other two had been declared as part of a national review. Dr Clare Dollery would provide further details on these in the Serious Incident report.

5.4 In terms of financial performance, Siobhan Harrington reported that, at the end of May, the Trust reported a deficit of £1.5m, £1.8m behind plan. On the positive side, income performance remained slightly ahead of plan. The main concern was the challenge to deliver the planned cost improvement programme. The executive team was focusing on developing a recovery plan with integrated clinical service units (ICSUs).

5.5 As part of the Trust's cultural agenda programme, June had seen the launch of the 'rainbow badge', an initiative developed at Guy's & St Thomas' NHSFT, to serve as an indicator that staff offered non-judgemental and supportive care for lesbian, gay, bisexual and transgender clients. The initiative had been warmly welcomed by staff.

5.6 Siobhan Harrington also reported that work had begun on the demolition of the Waterlow building.

5.7 Sodexo had been issued with a formal notice that their contract with the Trust to provide patient food was to end in September- this service was to be brought back in-house.

5.8 The Trust was working closely with UCLH on a joint bid to host the southern hub for the north central London orthopaedic service. Siobhan Harrington described this as a positive opportunity further improve the service, as well as providing new opportunities for collaborative working and learning from best practice.

5.9 With regard to the development of borough-based locality working, there had also been an extremely successful market place event in North Islington, attended by colleagues from the local authority, primary care and the voluntary sector. Councillor Janet Burgess commented that she was pleased that local authorities

would continue to commission public health services. She also said that she had been pleased to see so many senior Trust staff at the localities event.

5.10 The Trust's Annual General Meeting (AGM) would take place on 26 September and Jonathan Gardner provided assurance to Sarah Humphery that the AGM would be publicised widely to attract attendees.

5.11 In reply to a question from Naomi Fulop on the speech delivered by Simon Stevens, NHS England and Improvement Chief Executive, at the NHS Confederation's annual conference, in particular the call to increase the number of acute beds, Siobhan Harrington said that the speech had been broad-ranging and balanced, and had followed some fairly extensive demand modelling which had led to an acceptance that there could be no further reduction in beds nationally.

5.12 The Board noted the Chief Executive's report.

6. Eliminating mixed gender inpatient accommodation annual declaration

6.1 Michelle Johnson informed Board members that this submission was an annual requirement and would be published on the Trust's website. She explained that compliance with requirements was monitored through the integrated performance report and the Trust continued to work hard on privacy and dignity issues for patients who self-declared as transgender.

6.2 Reporting arrangements had changed during the year, with movement from local to national criteria. While the Trust had previously declared some breaches in the intensive treatment unit due to waits for appropriate beds, Michelle Johnson was pleased to report there had been no such breaches for many months. David Holt enquired about training for staff in dealing with patients who self-declared as transgender. Michelle Johnson said that this was currently under consideration and it was likely that there were elements of other training packages staff had received on other protected characteristics which were likely to prove of value.

6.3 **The annual declaration was formally approved by the Board.**

7. Serious incident report

7.1 Dr Clare Dollery informed the Board that there had been a recent key focus on lessons learned from patients who had absconded and outlined further details and learning in relation to the never events mentioned in the Chief Executive's report,

7.2 Dr Clare Dollery noted that none of the patients concerned had suffered any long-term harm; all were aware of the incidents and had received apologies from the Trust. Referring to the nerve block incident, she acknowledged that some checks had not taken place and that this had contributed to the administration of the block on the incorrect side. A similar event had taken place in January 2019; and considerable learning points from this had been identified and were being implemented, including renewed focus on the 'stop before you block' checklist, plus audits and a new poster and sticker campaign.

7.3 The two never events concerning fracture plates had been identified as part of a national lookback where Trusts had been asked to scrutinise procedures back to January 2018. Whittington Health had identified two incorrect procedures: one from

March 2018 and one from January 2019. In both cases, fractures had healed correctly. Changes had been made to national guidance on how to identify the correct plates, and a number of steps had been taken to guard against misuse, including separate sterilisation and storage. Staff had also been brought up to speed through new training programmes. Dr Clare Dollery added that Julie Andrews, Associate Director for Patient Safety, would convene a task and finish group to ensure that all recommendations were fully implemented and learning appropriately cascaded to staff.

7.4 Steve Hitchins challenged that, given a similar incident had taken place in January he was disappointed to see a repetition. In response, Dr Clare Dollery provided assurance that she had made it a priority to review the implementation of the guidance with clinical directors in surgery and with anaesthetists. Naomi Fulop questioned how we knew that learning from serious incidents was being applied. Dr Clare Dollery said this came from robust action plans, the empowerment of staff to take more responsibility, audits and checks which would be reported to the Patient Safety and Quality Committees. Michelle Johnson commented that there was also further work to be done on learning lessons across ICSUs as part of a drive on quality improvement activities.

7.5 **The Board received and reviewed the serious incidents' report.**

8. 2019 Heatwave plan

8.1 Carol Gillen gave the background to the production of the heatwave plan, explaining it was first produced in 2004 following deaths which occurred during the heatwave of summer 2003. The plan operated from June to mid-September, and alerts were triggered when temperatures remained at 32º Celsius or over for three days or more. She highlighted that an integral part of the plan was to scrutinise business continuity plans and confirmed that additional training for staff had also been included.

8.2 Steve Hitchins commented that, as part of his recent programme of visits to wards, he noted that Victoria ward was to be provided with a water fountain. He suggested that it would be helpful to carry out a survey of how widely these were available for all patients and staff, particularly in out-patient areas where patients might arrive thirsty after a long or difficult journey. He noted the report was helpful and Carol assured Board members that additional, granular detail was contained within individual ward or service plans.

8.3 **Board members approved the updated heatwave plan.**

9. Assurance of seven day services

9.1 Dr Clare Dollery said the report was broadly similar to that previously received by the Board in previous quarters, and the only area where the Trust was non-compliant was in the provision of an echocardiography service at weekends. She explained that recruiting scarce specialist staff to run such services presented a particular challenge and therefore it was unlikely the Trust would be able to provide a 24 hour service and mitigating actions had been put in place so that on the rare occasions when it was needed, patients were able to access this at the Bart's Heart Centre.

9.2 David Holt enquired why the Trust should be categorised 'red' when there were clear plans for patients to access an alternative echocardiography service. Dr Clare Dollery agreed, but pointed out the binary nature of the answers available for this national audit where the Trust was obliged to answer the direct question. She also confirmed to the challenge by Naomi Fulop that the Trust was meeting the requirements laid out in clinical standard five.

9.2 **The Board reviewed and endorsed the seven day services self-assessment.**

10. Performance scorecard

10.1 Carol Gillen was pleased to report that targets for cancer, referral to treatment waiting times and diagnostics had all been met in May. The summary showed that average time to recruit new staff had been over 61 days for three consecutive months. There had been no 12 hour mental health breaches during May, and henceforth, breaches would be differentiated between mental health and non-mental health patients. On theatre utilisation, Carol said that there was now a detailed programme around theatre productivity.

10.2 In terms of community services' performance, Carol Gillen said that many areas had seen sustained improvement. She noted the musculoskeletal service continued to see self-referrals increase. Within the Children & Young People's ICSU child and adolescent mental health services had been particularly successful and commissioners had expressed their support at the community services improvement group the previous day. She also confirmed that metrics for therapies' waiting times were to be discussed at by the contract monitoring group.

10.3 Norma French reported that the backlog of inputting statutory and mandatory training compliance was now clear and a trajectory was produced for each ICSU. Steve Hitchins emphasised the need to continue to improve both the number of annual staff appraisals completed along with their quality.

10.4 There had been a discussion about appraisal at the previous day's Trust Management Group, and Siobhan spoke about the link between appraisals and the cultural work being undertaken by the Trust. Norma added that Whittington Health was amongst the nationally highest rated in terms of the quality of its appraisals. Naomi Fulop welcomed the work being done to produce a trajectory for pressure ulcers and looked forward to receiving it. Steve Hitchins commended the progress that had been made with volunteers' welcome packs; Michelle Johnson said that a paper on the volunteers' strategy would be brought to the Board's next meeting.

10.5 **The Board reviewed the performance scorecard for May and took assurance the Trust was managing performance compliance and implementing remedial actions where required.**

11. Emergency department improvement plan

11.1 Carol Gillen introduced this item, saying that a whole system plan was now in place which included detailed plans for those leaving the hospital and had been agreed by the A&E Delivery Board. She explained that each element of the plan was to be headed up by a senior responsible officer, and that a whole systems resilience manager was now in place.

11.2 Steve Hitchins highlighted the need to amend the target for super-stranded patients in the commentary to 21 days. David Holt noted the plan contained some good initiatives and asked for sight of the emergency department trajectory and whether we would hit it. Carol agreed and provided assurance that the Board could expect improvements to be visible from late August/early September and also drew Board members' attention to the fact that this was very much a whole systems approach and was therefore also reliant on primary care services and also the London Ambulance Service on delayed transfers of care.

11.3 It was noted that the emergency department had achieved 95% compliance twice within recent weeks; and had been the second highest performer in London. On behalf of the Board, Steve Hitchins thanked all who had contributed to this achievement.

11.4 The Board:

- **i. received and reviewed the 2019/20 whole system improvement plan and took assurance it would help to deliver the required improvements in the emergency pathway;**
- **ii. agreed that the super-stranded patients' target in the report's commentary be amended to 21 days; and**
- **iii. agreed that the emergency department's trajectory discussed at the A&E Delivery Board be brought to the July meeting of the Trust Board.**

12. Financial report

12.1 Stephen Bloomer reported the Trust had a year-to-date deficit of £1.5m, which was £1.8m behind plan. He added that this figure included an assumption that the Trust would not achieve its first quarter provider and sustainability funding. He remained confident, however, that the Trust was still on target to achieve control total at year-end. He explained that the prime factor for the current position was underachievement of the cost improvement programme within both pay and non-pay areas and with agency staffing expenditure remaining higher than planned. Stephen Bloomer gave assurance that work had begun on a recovery plan with key priorities forming the basis of individual ICSU recovery plans and included additional support for the Emergency & Integrated Care ICSU.

13.2 Board members were informed that all winter escalation beds were closed and income remained broadly on track. Capital spending was slightly behind plan due to the fact that the Trust had not received approval for all planned schemes. It was expected that planned capital expenditure on the fast follower programme, theatres and clearance of the Hospital site should accelerate the level of spending.

12.3 Siobhan Harrington reported that there had been a good discussion at the Trust Management Group the previous day, and she assured the Board that the senior leadership of the Trust was focussed on delivering the financial recovery plan. David Holt suggested that if there was insufficient improvement within two months, it would be helpful for the leadership of the organisational areas experiencing difficulties to explain to the Board the challenges they faced. Tony Rice supported the proposal and Steve Hitchins raised the need to measure delivery against the recovery plan.

12.4 **The Board:**

i. **noted the financial results relating to performance during May 2019 and supported the need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing cost improvement programme plans;**
ii. **agreed, that over the next three months there should be a review of how financial grip in the organisation is demonstrated to the Board; and**
iii. **agreed that, once finalised, the financial recovery plan would be brought to the Finance & Business Committee.**

13. 2018/19 Annual Report and Accounts

13.1 Jonathan Gardner presented the Annual Report which would be published on the Trust's webpages following approval. He thanked all the colleagues who had contributed. Siobhan Harrington welcomed the hard work of staff in helping to make 2018/19 a positive year for Whittington Health in the face of increasing demand across a range of service. Naomi Fulop commended the infographics used within the report and highlighted a change to her attendance.

13.2 **Board members welcomed and approved the 2018/19 annual report and accounts for publication, subject to the amendment to Naomi Fulop's attendance record at Board meetings.**

14. Staff story

14.1 James Connell introduced staff story for Iliana Neshkova, originally from Bulgaria, who had come to England in order to study languages and literature at university. After completing her studies, Iliana established her own business. However, in 2016 she was diagnosed with breast cancer. Her diagnosis meant that she saw and became familiar with the way that hospitals worked, and she became a volunteer, initially with MacMillan Cancer and latterly with Whittington Health.

14.2 Iliana Neshkova was encouraged to become a volunteer at Whittington Health by the mother of her son's best friend, who had acted as an informal mentor to her while she improved her office skills. James Connell had also encouraged and supported her, and once sufficiently confident, Iliana Neshkova was able to join the staff bank and secured a post, initially in central booking. Asked by James Connell whether she could identify any areas of improvement, Iliana replied that she was unsure about rights of access to training courses for those on bank staffing arrangements, and Norma French undertook to look into this.

14.3 Steve Hitchins commended the work carried out by the Patient Experience Team around volunteering at the Trust. James Connell reported that the volunteer strategy was to be presented at the next Patient Experience Committee and would then be brought to the Board in September. He confirmed that information for volunteers on the webpages was also being redesigned and there were now 175 volunteers at the Trust. Siobhan Harrington informed the Board that one of the Trust's longest-standing volunteers had announced his retirement, and it was agreed she should write to him on behalf of the Board thanking him for his long and devoted service.

14.4 The Board:
i. **thanked Iliana Neshkova and the Patient Experience Team for sharing this staff story; and**

ii. agreed that accessibility to training courses for volunteers be clarified.

15. Risk management strategy review and 2019/20 risk appetite statement

15.1 Michelle Johnson informed the Board that the strategy had been reviewed and updated in line with recommendations made by the internal audit team. Jonathan Gardner reported that the risk appetite statement had entailed a good discussion at the last Board seminar, and had been revised with suggestions incorporated. The key was to that the Board had had a good debate and agreed around its appetite for the various levels of risk. David Holt emphasised the challenge to embed the agreed level of risk appetite within ICSUs and Steve Hitchins stressed the need for a consistent approach to scoring risk entries. Michelle Johnson gave assurance that, going forward, she and others senior risk leads would attend ICSU Board meetings to help support them through constructive challenge.

15.2 The Board approved the revised risk management strategy and the 2019/20 risk appetite statement.

16. Questions from the public on agenda items

16.1 Referring to paragraph 2.10 in the Chief Executive's report, Mr Richards raised the issue of non-emergency patient transport services being standardised across North Central London. Jonathan Gardner said that the new contract was to come into force on 1 July, and would go live at Whittington Health from 1 September. Mr Richards spoke of the concerns that had been raised about the Royal Free service, and asked for assurances that Whittington Health patients would not experience similar problems. Steve Hitchins (himself a user of the service) agreed and said that it was important the service was closely monitored and the service providers held to account. It was hoped nonetheless that a standard service across North Central London would lead to a good level of service for patients who required it. David Holt asked that the criteria governing accessibility to the service be circulated; Naomi Fulop echoed this, saying the Board needed to see both the current criteria and that which would be used once the new contract was implemented.

16.2 The Board:

i. noted the concern raised by Mr Richards; and

ii. agreed that patient transport eligibility criteria be circulated to Board members.

17. Any other business

17.1 There were no items raised

Item	Action	Lead(s)	Progress
May meeting action log	Review standing orders, standing financial instructions at the next meeting of the Audit & Risk Committee in October	Jonathan Gardner and Stephen Bloomer	On track
Emergency department (ED) improvement plan	1. Amend super-stranded patients' target in commentary to 21 days 2. Bring the ED trajectory discussed at the A&E Delivery Board to the July meeting	Carol Gillen Carol Gillen	Completed Completed
Finance report	1. Over the next three months there should be a review of how financial grip in the organisation is demonstrated to the Board 2. Once finalised, bring the financial recovery plan to the Finance & Business Committee	Stephen Bloomer Stephen Bloomer	Competed - ICSUs presenting to Finance & Business Development Committee Completed
2018/19 Annual report and accounts	Amend Naomi Fulop's attendance at Board meetings to 6/6	Jonathan Gardner	Completed
Staff story	Clarify accessibility to Trust courses for volunteers	Norma French	Completed
2019/20 Risk appetite statement	Help to communicate the Board's risk appetite statement to ICSUs and corporate areas through attendance at their risk discussions	Michelle Johnson, Clare Dollery, Jonathan Gardner	Completed risk appetite has been disseminated and meetings booked
Patient transport service	Circulate patient transport eligibility criteria to Board members	Stephen Bloomer	Completed

Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Chair's report**	**Agenda item: 5**
Director lead	David Holt, Interim Chair	
Report author	Swarnjit Singh, Trust Corporate secretary	
Executive summary	Following Steve Hitchin's resignation in June, NHS England and Improvement appointed David Holt as Interim Chair of Whittington Health while a substantive new Chair is recruited. It is proposed that David Holt's replacement as Senior Independent Director of the Trust will be Professor Naomi Fulop, Non-Executive Director. The Trust Board is asked to approve this proposal. David Holt will also stand down as Chair of the Trust's Audit and Risk Committee and will be replaced by Deborah Harris-Ugbomah, Non-Executive Director. The Trust Board is asked to note the change in the Chair of the Audit and Risk Committee.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to: i. agree the appointment of Professor Naomi Fulop as Senior Independent Director; and ii. note the change in the Chair of the Audit and Risk Committee.	
Risk Register or Board Assurance Framework	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 of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	None	
Appendices	None	

Meeting title	**Trust Board – public meeting**	**Date: 31 July 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 alerts Board members' to recent national and local developments and also highlights and celebrates achievements by the Trust and its staff.	
Purpose:	Review	
Recommendation(s)	The Trust Board is invited to review the report and its content.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting	
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

NHS Long Term Plan implementation framework

1.1 The NHS Long Term Plan Implementation Framework[1] underpins the long term plan and requires system partners to create five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24. The Implementation Framework sits alongside NHS England's recently published briefing "Designing integrated care systems in England"[2] which sets out a description of the possible functions of partnerships at different levels of population within an integrated care system and emerging regional and national arrangements to support and oversee systems. It also includes the new maturity matrix intended to help system leaders to assess their own progress and a chart of the proposed freedoms and flexibilities that NHS England/Improvement plan to award to mature systems. A draft gap analysis for Whittington Health will be discussed with the Board.

Primary care networks

1.2 An important proposal in the Long Term Plan that is already going forward is the development of primary care networks (PCNs) with populations of 30,000 to 50,000. These are designed to take forward enhanced health in care homes scheme, rapid response community re-ablement services, and anticipatory care services led by PCNs in collaboration with community providers. 4 PCNs for Islington and 8 for Haringey have now been agreed and clinical directors appointed for each. Whittington Health is working closely with them and the federations and the commissioners to ensure alignment.

NHS Patient safety strategy

1.3 NHS England and NHS Improvement published the NHS Patient Safety strategy[3] and outlined a vision for the NHS to continuously improve patient safety. It sets out plans to use new digital technologies to support learning and create the first patient safety curriculum, training and education framework. Three key strategic objectives are identified to achieve this vision:

- to improve understanding of safety (insight)
- to equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the system (involvement)
- to design and support programmes to deliver effective and sustainable change in the most important areas of safety (improvement)

[1] https://www.longtermplan.nhs.uk/implementation-framework/
[2] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
[3] https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

2 Local news

Trust Chair

2.1 Following the decision by Steve Hitchins to step down as Chair after more than five years of service to Whittington Health with effect from 26 June, NHS England and Improvement have appointed David Holt, one of the Trust's Non-Executive Directors to be our Interim Chair. They have also started a recruitment and selection exercise to identify a new substantive Chair for the Trust, with final interviews scheduled for mid-September. The advert can be found here https://improvement.nhs.uk/news-alerts/chair-whittington-health-nhs-trust/

Quality and safety operational performance

2.2 In June, overall performance against the 95% four hour standard was 90.1% (an increase from last month's 88.4%), against a trajectory of 92% in the NHS Improvement plan. During the first week of June, there was a significant improvement in performance with four consecutive days when over 95% of patients were seen within four hours. June also saw an increase of 17.5% in the number patients over the age of 75 attending the emergency department compared to the same period in 2018/2019. The Trust experienced a spike in the rate of delayed transfers of care (DTOCs) patients, increasing from 2.5% to a consistent 4.5% from 13 June 2019. This high level of DTOCs continued into July 2019 and the Trust has engaged with it local partners to manage and reduce this level.

2.3 Overall, waiting times for children's community services were delivering progress against the 95% target, with the exception of occupational therapy. In particular, improvements were noted for the following services: community paediatric, school nursing and the family nurse partnership. Adult community services experienced pressures in relation to waiting times in June 2019 in services such as bladder and bowel, community rehabilitation and podiatry. The Community Services Improvement Group continues to monitor remedial action put in place to address these waiting times.

2.4 The mental health compact has been in place since June and the counting of waits for mental health patients has changed. There were seven mental health patient 12 hour trolley breaches in the emergency department in June: four patients were delayed as a result of waiting for an external bed; three patient delays occurred due to a wait for an approved mental health practitioner; and one patient delay was caused by a wait for transport. We are working with partners in North Central; London to focus on improvements to the pathway.

Financial performance

2.5 The Trust is reporting a year to date deficit of £2.5m which is £2.7m behind plan. The Trust is not expecting to achieve the quarter one financial target and therefore has prudently not assumed any provider sustainability funding resulting in a negative variance of £0.7m.

2.6 The year-to-date pay costs are in excess of budget by £1.4m. Expenditure on bank staffing is broadly consistent each month with £1.9m incurred in June. At

the same time, agency staffing expenditure was almost £0.9m, representing a decrease of £35k from May's outcome. Agency staffing costs at the end of June amount to £2.9m and will be tightly managed to ensure the Trust remains within the NHS England and Improvement annual agency ceiling of £8.8m. Non-pay expenditure was £100k overspent in June and was £1.2m above plan for the year-to-date.

2.7 The primary driver for the adverse variance in our financial position remains the failure to achieve the cost improvement programme with delivery of £300k in June helping to achieve a total cost improvement programme delivery so far this year of £700k against a £3.1m target. The cost improvement programme variance is broadly equal within both pay and non-pay. A financial recovery plan is in place with additional resource deployed to support delivery.

2.8 At the end of June, the Trust spent £2.3m on capital expenditure against a plan of £3.3m. The Trust is currently liaising with NHS Improvement to confirm its capital allocation for the financial year but it was anticipated that there will be a c. £3m reduction.

Our people

2.9 In June, the level of completed staff appraisals rose slightly to 71.4% and compliance with mandatory training requirements was 79.9%. The Assistant Director, Learning & Organisational Development is leading delivery of action plans which aim to recover performance for both of these important indicators in line with their targets. The time taken to hire new staff fell to 60 days last month against a target of 63 days.

2.10 The main initiative in relation to agency and bank usage this year has been the move to Bank Partners, a model in collaboration with other acute providers in north central London. This change uses modern technology and will deliver benefits such as improved fill rates and recurrent savings through:

- growing bank capacity through recruitment,
- reducing agency by close engagement between Bank Partners and the Trust to manage requests for temporary staff,
- maximised bank usage and reduced agency usage in key areas.

Organisational culture and development

2.11 The following updates are available on work being taken forward under the #CaringforThoseThatCare programme of work:

- **challenging bullying and harassment training** - the Trust has launched a new programme for c. 330 staff with line management responsibilities to be trained from September onwards. This will highlight behaviours expected at work in line with our values and executive directors will attend this training to lead by example
- **talent management** - a pilot is being run to help managers identify how best to support staff career development
- **reverse mentoring** - a second programme of reverse mentoring is being commissioned for the autumn to support the inclusion agenda
- **equality, diversity and inclusion** - Charles Rukwengye has joined the Trust as its lead in this area and brings over 25 years' experience in the

field of equality, diversity and inclusion, having worked previously for the Citizen's Advice, the United Nations and Barts Health NHS Trust

- **Affina project** - 20 teams are working their way through a journey based on the research of Michael West to maximise the benefits of working in a real team (for example, lower mortality rate, higher productivity, shared objectives)
- **staff engagement** - Whittington Hospital Charitable Funds has kindly agreed to resource the development of a Staff App (staff engagement platform) to act as a comprehensive communications channel for new joiners and existing staff, on both the hospital site and across community services. This work will commence in the Autumn

NHS Values week

2.12 15 July, saw the launch of NHS Values Week 2019, designed to celebrate NHS values and encourage staff to talk about how they bring these to life on a daily basis. At Whittington Health, staff received a daily blog on the importance of our values (innovation, compassion, accountability, respectful and excellence), what they mean in practice and how they can be embodied in daily practice. As part of local activities, the Trust also launched the next phase of its journey to create a compassionate and inclusive leadership culture, including the development of a staff charter.

20th anniversary of our first nurses from the Philippines

2.13 A reunion was held to mark a very special milestone in the life of the Whittington Health family as it is 20 years since the first Whittington Hospital nurses recruited from the Philippines joined us. Since then they have all made an enormous contribution to caring for patients and have been wonderful colleagues. Eleven of these nurse recruits remain with Whittington Health, with the rest working elsewhere in the NHS or in the US and Canada.

Estates and facilities update

2.14 During 22-26 July, the Trust has had a focus on fire safety with key messages highlighting the following:

- it is everyone's business to be aware of fire safety to help ensure that patients, visitors, colleagues and buildings are protected from the risk of fire
- fires are rare but can have catastrophic consequences. It is important that we all avoid complacency and keep fire safety at the front of our minds at all times. That is why we are having a fire safety week as a useful reminder to us all with staff drills being undertaken and skills training provided
- all staff have a responsibility to complete mandatory fire safety training and be aware of the fire evacuation plan for their respective area
- the Estates and Facilities Team can be contacted at any time for further advice around fire safety for wards or services

2.15 The Trust's new obstetrics theatre will be formally available for use from 9 August.

2.16 The standardised contract for non-emergency patient transport across the north central London sector would now go live from a revised date of 9 September 2019.

Community engagement

2.17 On 17 July, the Trust held a community engagement event that had been advertised in the local newspaper, our own newsletter and in the Bridge Renewal Trust newsletter. As well as updating local people about the Trust's work and plans for the development of its estate, clinical colleagues talked about spotting potential skin cancer and ensuring that frail people stayed well in the heat. The Trust values the attendance at this event by the local community and their important feedback. Going forward, the focus will be on increasing the size of future events and encouraging more local people to participate.

Department of cardiovascular medicine award

2.18 The Department of Cardiovascular Medicine has been accredited with an independently audited customer service excellence award for the twentieth consecutive year. The department has a tradition of developing high quality customer service in its field, having held successive charter mark awards since 1999.

Pride 2019

2.19 Whittington Health colleagues came together on Saturday, 6 July to take part in this year's Pride in London parade. It was a fantastic day with over 30,000 people from all parts of the LGBT+ community celebrating diversity, championing equality and marking the 50th anniversary of the Stonewall riots.

Staff excellence awards - the Security team

2.20 The nomination for the Security team recognised an outstanding level of caring, compassionate, safe and excellent support that they provided to the patients and staff of IFOR ward earlier this year. They consistently provided a high level of care to young distressed people, managing a very difficult and challenging situation with a calm, compassionate and ever present approach. The citation said that they were an inspiration to the ward staff and demonstrated how to manage this level of unpredictable aggression in a caring way.

2.21 Jason Woodbyrne also received a nomination as a selfless, dependable and efficient manager of the Security team, who always goes above and beyond. His willingness to take on difficult projects and tasks and see them to successful completion has repeatedly impressed people at the trust. The respect that all team members and colleagues across the Trust have for Jason comes from his close support of the team whilst still enabling them to work independently, leading to high morale. Jason will always make time for his staff and colleagues and his knowledge of his field is second to none. He also projects a warm, cheerful attitude to his team and colleagues and resolves conflicts and handles difficult situations with remarkable patience and admirable tact.

Meeting title	**Trust Board – public**	**Date: 31 July 2019**
Report title	**Quarterly Safety and Quality Board Report Quarter 1 2019/20 (1 April 2019 – 30 June 2019)**	**Agenda item: 7**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report author	Dr Clare Dollery, Executive Medical Director	
Executive summary	This is the regular quarterly paper 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. This report provides a focus on medicines management. The Medical Director will work with colleagues to refresh the content of this report prior to the next quarterly report to board.	
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		
Appendices	none	

1. Executive Summary

This is the regular paper to provide an overview of safety and quality in the organisation. The paper provides an update on mortality and SHMI position. This report provides a focus on medicines management and the recent Quality Improvement celebration.

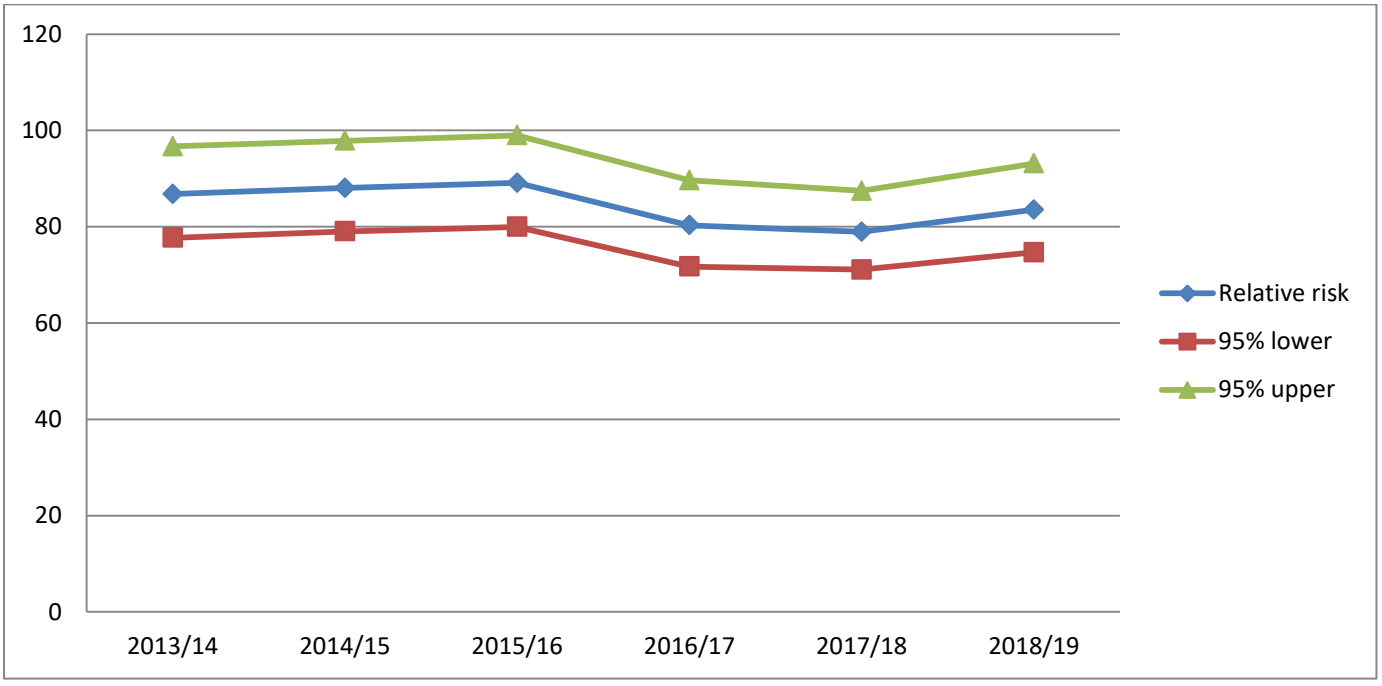
2. Mortality

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

2.1 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 – March 2019)



The blue diamonds on Chart 1, above, represent this Trust's HSMR, which is 'lower than expected'. The green triangles above and the red squares 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.

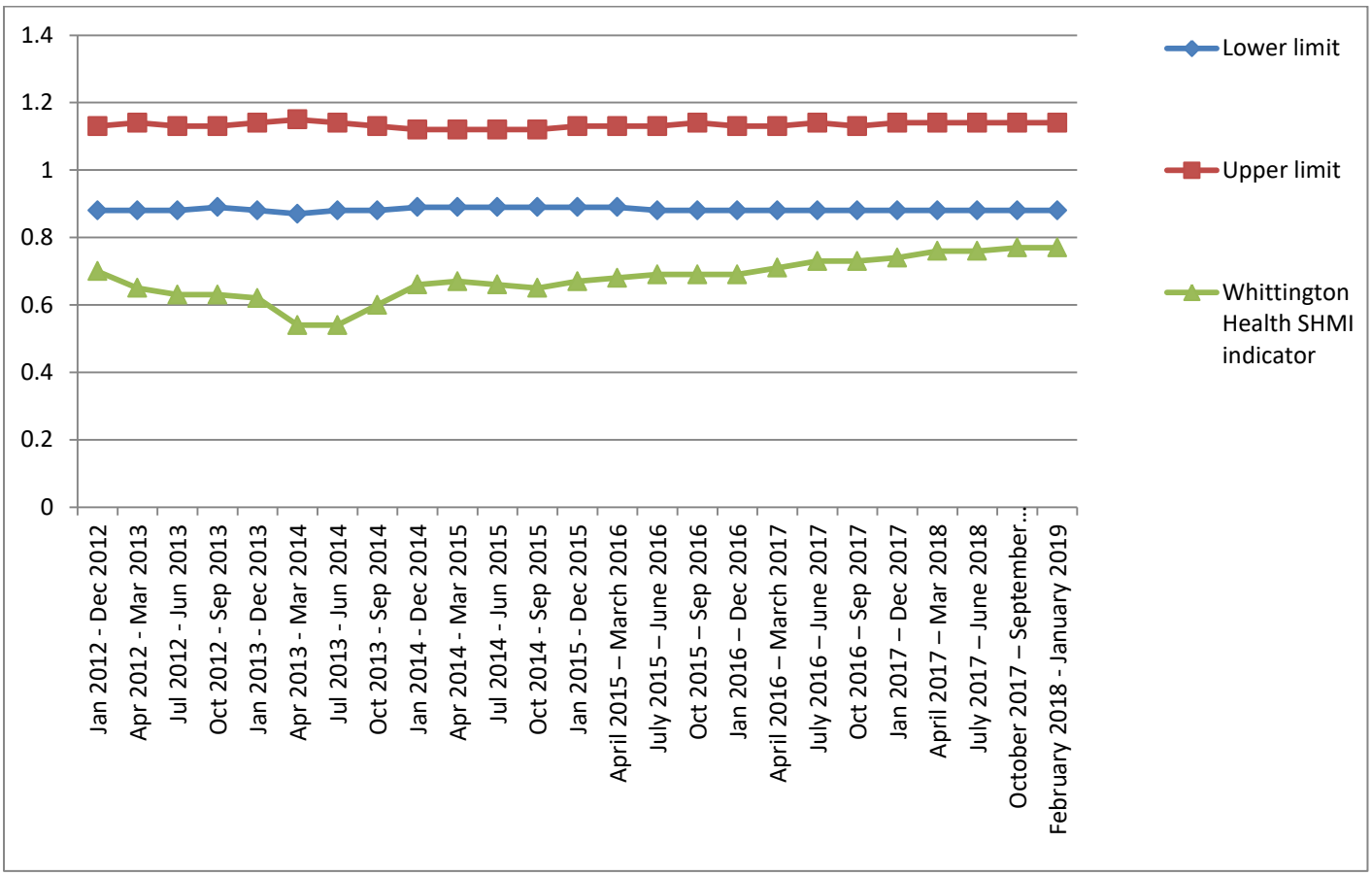
2.2 Summary Hospital-level Mortality Indicator (SHMI)

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 February 2018 to January 2019:

Whittington Health SHMI score	**0.7712**
National standard	**1.00**
Lowest national score	**0.7052 (Guy's and St Thomas')**
Highest national score	**1.2073**

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

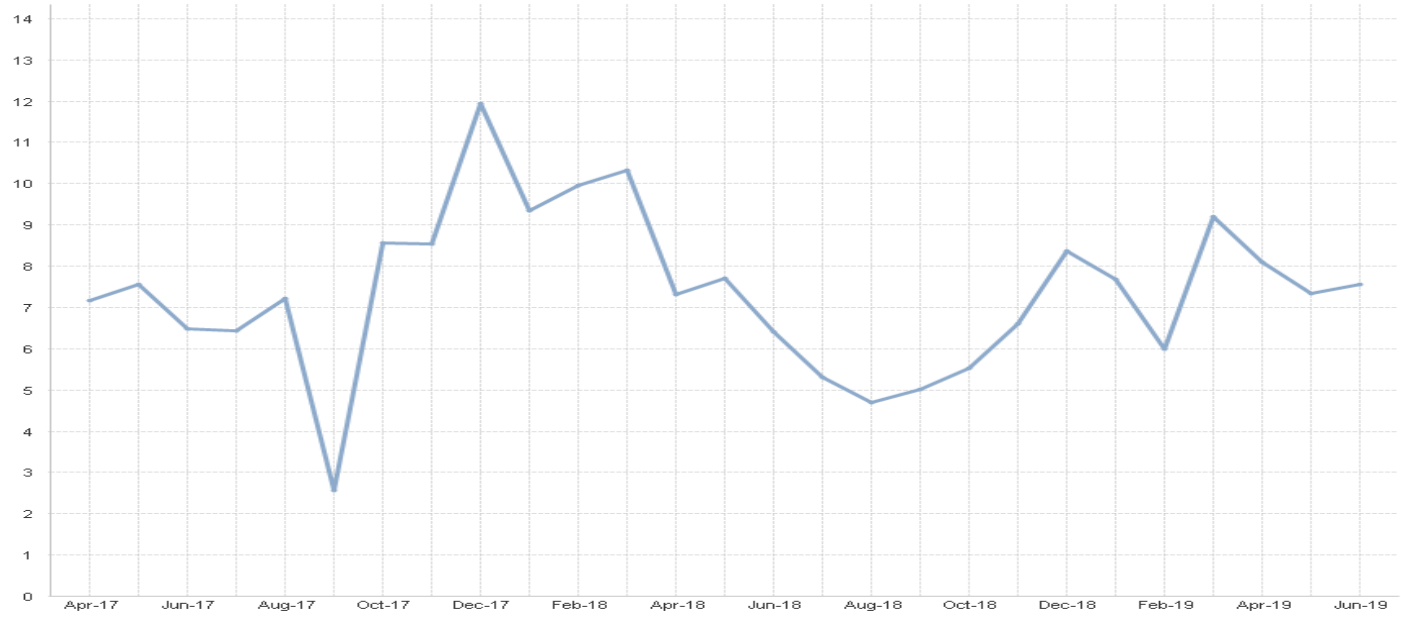


In the above Chart 2 the lower limit (blue diamonds) represents the lower 95% confidence limit from the national expected value; the upper limit (red squares) represents the upper 95% confidence limit from the national expected value.

2.3 Crude Mortality Rate

Crude mortality gives a contemporaneous but not risk-adjusted view of mortality at Whittington Health. It shows expected seasonal variations with fewer deaths in winter of 2018/19 than in the previous year. This reflects on the sustained quality of care and a smaller effect of flu in 2018/19.

Chart 3: Whittington Health Crude Mortality Rate per 1000 admissions (April 2017 – June 2019)



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3. Infection control report

3.1 Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemias

There have been no Trust-attributed MRSA bacteraemia cases in 2019/20.

3.2 Clostridium difficile *(C. difficile)*

There have been no Trust-attributable *C. difficile* cases identified year to date. For 2019/20 our ceiling has been set at 19 cases. The reason this has been increased, is because, nationally, the time between admission and a specimen being determined as Trust attributable has been decreased by 24 hours raising the possibility that attributable cases could increase. A review of the cases from 2018/19 determined that there would have been no more Trust-attributable cases under the revised system.

The national objectives for 2019/20 are published by NHS Improvement.

3.3 *E.coli* bacteraemias (bloodstream infections)

The Trust plans to reduce the number of E.*coli* bacteraemias by 20% this year to be on target for the national reduction of 50% by 2021. In 2016/17 there were 14 Trust-attributable E.coli bacteraemia episodes, 2017/18 and 2018/19 both had 9 Trust-attributable. The 2019/20 local ceiling has been set at 8.

Between April – June 2019 there have been 5 Trust-attributed E.*Coli* bloodstream infections. To enable the trust to work towards the target for national reduction by 2021, a work programme has been developed for April 2019 – March 2020 that sets out the proposed activities for the Infection Prevention & Control service (IPC) at Whittington Health to support achievement of the reduction in bacteraemias. This work programme is currently out for consultation among members of staff, but is due to be in use from August 2019.
Actions within the draft work programme for 2019/20 include the following:

- Measuring Trust performance using the gram-negative BSI system overview tool and using this to steer work programme for 2020/21.
- Enhancing the interim case review form to capture community input.
- Exploring a joint Quality Improvement project with the Community Matron to engage with nursing home / residential home patrons.
- ICSU's to display E. coli rates on wards making them visible to patients and visitors data from quality indicators.
- Rolling out 5 Moment hand hygiene auditing across the Trust.

Table 2: Trust-attributed E.*Coli* bloodstream infection cases by ward (April – June 2019)

E.Coli	Apr-19	May-19	Jun-19	Total
ITU	1	0	0	1
Meyrick	0	1	0	1
Cavell	0	1	0	1
Cloudesley	0	0	1	1

3.4 Carbapenemase Producing Enterobacteriaceae (CPE)

There have been no CPE positive cases in this quarter.

3.5 Measles

Between April – June 2019 Whittington Health have investigated 9 unrelated cases of measles, none of which required further treatment. Collectively over 100 contacts were sent a 'warn and inform' letter should they become ill within the timeframe of communicable infection. As the Trust is aware of on-going outbreaks across Haringey and Islington, communications in the form of information banners and posters have been created. Further communications educating staff on their responsibilities and how to recognise measles have been disseminated via the Trusts' April Noticeboard as well as a clinical alert notification to affected clinical areas where these cases were recognised.

3.6 Infection Prevention and Control (IPC) Training

Mandatory Training Compliance by Team as at 31/05/19 is 79% according to the reported Education and training portal on the Intranet. Increased efforts have been made to improve compliance on IPC mandatory training through adding Mandatory sessions in the hospital clinical areas weekly over the last two months and these will continue until compliance improves. Mandatory training has been monitored at the ICSU quarterly performance meetings with the executives to ensure a focus on improvement and sharing of best practice.

4. Medicines Safety

4.1 Medicines Safety Group

The Medicines Safety Group (MSG) meets every two months and reports to the Drug and Therapeutics Committee (DTC) and Patient Safety Committee. The Group consists of representatives of different staff groups and services.
Standing items on the agenda are review of medication incidents reported on Datix, e-prescribing update, MHRA and company drug alerts, NHS England Patient Safety Alerts. The Group has continued themed meetings for 2018/9: topics included have been prescribing in palliative care, never events and insulin prescribing

4.2 Medication incidents reported on Datix

The Medicines Safety Officer (MSO) sends monthly reports to the Clinical Directors and Safety Leads for the Integrated Clinical Service Units (ICSUs) and presents a bi-monthly combined summary to the Medicines Safety Group (MSG) for discussion: these reports themes and trends.

Table 3: Medication incidents received - April 2018- March 2019 (These figures are as reported at the month end)

Month	Number of medication incidents reported	Number of incidents causing moderate or greater harm
April	43	0
May	61	3
June	58	1
July	67	0
August	46	0
September	46	0
October	36	0
November	55	0
December	48	0
January	61	0
February	42	0
March	53	2
Total	**623**	**7**

There were 623 medication incidents reported on Datix from April 2018 to March 2019. Seven incidents (1% of the total) caused moderate or greater harm.

This compares with 615 incidents reported from April 2017 to March 2018. Six incidents (1% of the total) caused moderate or greater harm.

All medication safety incidents are reviewed by the Trust MSO and trend identification and subsequent learning shared throughout the organisation via the Trust MSG.

The highest number of incidents were reported by hospital nurses (32%) followed by pharmacy staff (25%) and district nurses (19%) and medical staff (18%).

Incidents involving the administration of drugs continue to be the most frequently reported type of incident, followed by incidents concerning controlled drugs, prescribing incidents and dispensing by pharmacy incidents.

The Emergency and Integrated Medicine ICSU reports the greatest number of medication incidents – in line with other incident reporting on Datix. High numbers of incident reports are generally a sign of a good safety culture.

4.3 Learning from incidents

Learning from incidents occurs in the following ways:

- Articles in 'Medicines Matter'. This is a quarterly Pharmacy publication that is sent to all staff and available on the intranet. Each edition has a medicines safety section.

  Areas covered in 2018/9 included:
  - Prescribing and administering furosemide infusion
  - Management of hyperkalaemia
  - Sodium valproate safety information

- Articles in Spotlight on Safety. This is a bi-monthly publication produced by the Risk Department and available on the intranet. The January 2019 edition featured an article on the risk of burns with emollients

- Presentations to the monthly Patient Safety Forum (PSF). These are usually undertaken by junior medical staff who present and reflect on an incident they have been involved in. This is coordinated by the Associate Medical Director for Patient Safety. Recent topics have included: safe prescribing of gentamicin, prescribing drugs for Parkinson's disease and VTE.

- Feedback is provided to individuals via Datix.

- Feedback to ward staff is provided via the ward pharmacy network.

- Feedback to the local MSO & Medical Devices Safety Officer network – this includes

community colleagues as well as other local hospitals

- Local learning also occurs via ward meetings, governance meetings, audit days and ICSU board meetings.

4.4 NHS England Patient Safety Alerts (PSA)

The MSG and MSO work with the Trust Compliance Officer to develop action plans and ensure completion dates are adhered to. Details of all PSAs can be found on Datix

In 2018-19 the Trust received one medication related Patient Safety Alert:

- ***Resource alert- Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)***

  The Trust has a potassium guideline. This has been reviewed to ensure that the Trust is compliant with this alert.

4.5 Controlled drug (CD) report

The Pharmacy Department has responsibility for the governance surrounding the safe and secure handling of controlled drugs within the Trust in order to fulfil current UK legislation such as the Misuse of Drugs Act 1971 and Controlled Drugs (Supervision of Management and Use) Regulations 2013 DOH.

The governance arrangements in place currently include:

- Three monthly audit on all wards and departments in Whittington Hospital
- LIN (Local Intelligence Report) report every 4 months to NHS England CD Officer
- CD incidents are reported on Datix and classed as high risk
- CD Datix incidents are escalated to the Chief Pharmacist and reviewed by the Clinical Governance Pharmacist and Medication Safety Officer
- Incidents of concern are investigated and if considered appropriate our allocated Police CD Liaison Officer is contacted for further advice
- Controlled Drug Policy (MP9) as part of Trust Medicine Policy in place and up to date
- Trust Controlled Drug Accountable Officer (CDAO) is the Medical Director supported by the Chief Pharmacist, Clinical Governance Pharmacist and Medication Safety Officer

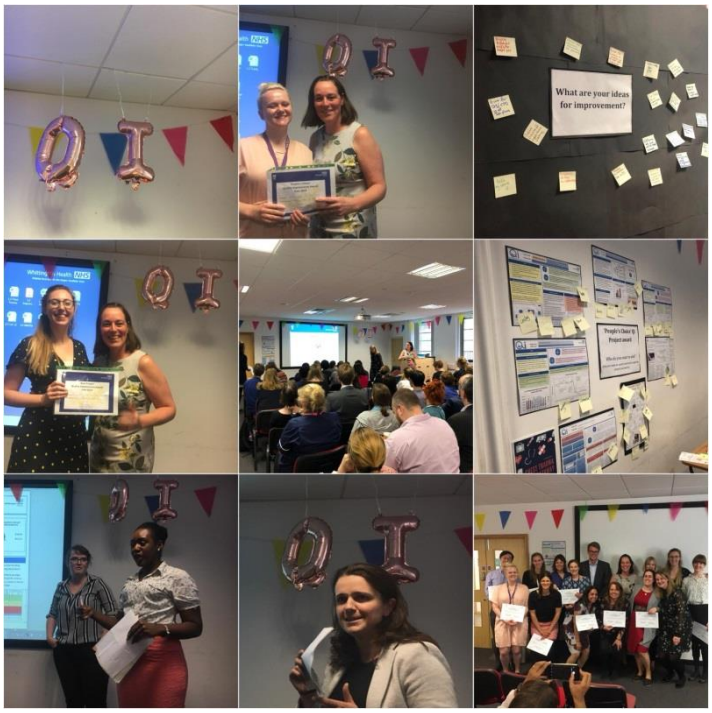
In 2018/19 there were 93 CD related incidents reported (compared with 97 in 2017/18). CD related incidents are more commonly reported due to the associated significance of these medicines and any associated concerns. All incidents are reviewed by the Medicines Safety Officer and Clinical Governance Lead Pharmacist and communicated externally to NHS England via the Local Intelligence Networks for shared learning across the sector and country.

5. Whittington Health Quality Improvement Celebration Event

The Trust held its second annual Quality Improvement Celebration Event on Friday 14th June 2019. The event was well-attended with just under 90 colleagues from across the Trust.

The year presenters were selected as part of a competitive selection process. Of the 25 applicants, 7 were selected to present on an established QI project and 6 from on-going projects.

Photograph 2: Whittington Health Quality Improvement Celebration Event 2019



Presentations on established QI projects:

- Mindful Eating
- CCU Delayed Discharges
- Development of a pathway for Chest Trauma
- Improving Access to Postgraduate Medical Education
- VTE Assessments in General Surgery
- 48 hour review for children presenting with wheeze
- Frailty Pathway

Presentations of ongoing projects with identified next steps:

- Management of neonatal jaundice
- Reducing same day theatre cancellations
- Continuity of carer within midwifery
- 'What matters to me?'
- Induction of Labour
- Discharge Summaries

The ‘Development of a pathway for Chest Trauma’ was selected to win the overall prize for Best Project, and the ‘Improving Access to Postgraduate Medical Education’ was selected by attendees to win the People’s Choice Award.

The celebration event also served as an opportunity to celebrate the recent graduates of the Trust’s Leadership Education through Active Development (LEAD) course. The LEAD course has been run at the Trust to provide various local leadership development opportunities for all levels of junior doctors (FY1 – ST8).

6. Quality Account Targets

The quality account was published in June 2019 and the first update on progress against the priorities will be presented to the next Quality Committee.

7. Recommendation

The committee is asked to review the contents of this report for assurance.

Report compiled by Ashleigh Soan, Medical Director Portfolio Manager on behalf of Dr Clare Dollery, Medical Director.

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. Clostridium *difficile* infection objectives for NHS organisations in 2019/20 (February 2019, NHS Improvement), available from https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/

Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Serious Incidents update – July 2019**	**Agenda item: 8**
Executive director lead	Dr Clare Dollery, 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 June 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	Assurance	
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.	
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 root cause analysis investigations.	
Report history	Report presented at each Public Board meeting	
Appendices	None	

Serious Incidents: July 2019 Board report

1. Introduction

1.1 This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) in June 2019, as well as a summary of the key learning from serious incident reports completed in June.

2. Background

2.1 The Serious Incident Executive Approval Group (SIEAG), comprising the Executive 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 for a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared two serious incidents in June. These were declared as Never Events and were therefore included by exception in the June Trust Board report. This brings the total number of reportable serious incidents to seven since 1st April 2019.

Table 1: Serious Incidents declared since the last report

Category	Month declared	Summary
Wrong implant/prosthesis – Never Event Ref:12724 *(Reported by exception in June Trust Board report)*	June 19	This incident was identified as part of a systematic review following the national Patient Safety Alert NHS/PSA/D/2019/001. A patient had a reconstruction plate fitted instead of a dynamic compression plate (DCP) whilst undergoing surgery in January 2019 for a forearm fracture following a traumatic injury. Healing has been good and no further intervention is expected to be needed.
Wrong implant/ prosthesis– Never Event Ref:12735 *(Reported by exception in June Trust Board report)*	June 19	This incident was identified as part of a systematic review following the national Patient Safety Alert NHS/PSA/D/2019/001. A patient underwent surgery in March 2018 after a fall at home causing a forearm fracture. A reconstruction plate was fitted instead of a DCP. Healing has been good and no further intervention is expected to be needed.

Table 2: Other serious incidents currently under investigation

Category	Month declared	Summary
Unexpected admission to NICU Ref:30069	Dec 18	A baby was born in poor condition at 38 weeks and two days gestation and required resuscitation and ventilation. The baby was transferred to the tertiary neonatal unit for total body cooling (HSIB Investigation – clock stop for completion date).
Maternal Death Ref: 5255	Mar 19	An 18 weeks pregnant woman was brought in to Emergency Department (ED) via blue light ambulance in cardio-respiratory arrest having suffered a major haemorrhage; resuscitation attempts were unsuccessful and the woman died. (HSIB Investigation – clock stop for completion date).
Assault on staff Ref:8646	April 19	A mental health patient became agitated and tense and proceeded to randomly attack staff in the ED department.
Delayed surgical intervention Ref:9259	April 19	A patient who had recurrent breast cancer after two breast conserving operations and radiotherapy treatments required further surgical intervention (mastectomy); the patient declined initially. An agreed different procedure was carried out resulting in the patient having to return for a third surgical operation.
Pressure Ulcer Ref:9470	April 19	A community patient developed multiple pressure ulcers and sepsis resulting in patient having to be admitted to hospital.
Wrong site surgical procedure –Never Event Ref:11437	May 19	A patient received a paravertebral analgesic nerve block on the unintended side.

3.2 **Never Events**
Never Events occurring in the NHS are defined as “serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.”

3.3 Never Events have the potential to cause serious patient harm or death but this does not necessarily need to have occurred to be categorised as a Never Event.

3.4 All Never Event incidents require a full root cause analysis investigation, it is important regardless of the outcome that the problems in care are identified and analysed to help understand how and why they occurred, so that effective and targeted action can be taken to prevent recurrence. It is crucial that learning from these incidents are identified and shared to prevent any future harm to patients.

3.5 All serious incidents/Never Events 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).

3.6 All serious incidents/Never Events are uploaded to the National Reporting and Learning Service (NRLS) in line with National Guidance and CQC statutory notification requirements.

3.7 The Trust this year has declared three Never Events all of which are under investigation. Immediate actions have been taken to prevent repetition. These events were reported by exception and discussed at the June public board.

3.8 **Wrong site surgical procedure**, where a patient received a paravertebral analgesic nerve block on the wrong side. The patient was not seriously harmed by this and therefore it was deemed to be a low harm incident.

3.8.1 The immediate actions following this incident are:

- The Royal College of Anaesthetists Guideline 'Stop before you block' is being embedded into clinical practice which includes an additional stop moment in addition to the WHO checklist, so immediately before needle insertion when performing a nerve block the anaesthetist and anaesthetic assistant must recheck the surgical site mark of the site and side of the block.
- 'Stop before you block' posters have been put up in theatres as a reminder to staff.
- Labels are being used to enable staff to document the performance of the 'Stop Before You Block'
- An audit of the stop before you block process is being undertaken to ensure compliance.
- A meeting was held with theatre staff (Anaesthetists, Anaesthetic nurses and ODP's to discuss this incident and the lessons learned.
- The wrong-side block was included in the 'Big 4', which is a weekly message containing the 4 most important things that colleagues need to know about within the theatre complex.
- The learning from this incident was included in our spotlight on safety newsletter that is circulated to all staff via our communications department and available on our Staff Intranet Site.

3.9 **Wrong implant/prosthesis.** These **i**ncidents were highlighted following a national Patient Safety Alert - wrong selection of orthopaedic fracture fixation plates (NHS/PSA/D/2019/001) - issued by NHS Improvement in February 2019. In response to this alert the Trust Trauma and Orthopaedic team carried out a review of 287 radiographs for patients who underwent fixation of fractures with plates in the year following 01/02/2018. Two cases were identified where the unintended fixation plates were used one in January 2019 (last financial year) and one in March 2018 (FY 2017/18).

3.9.1 One further incident was identified where the initial surgery using the wrong fixation plates took place at another Trust, however follow-up care was given at The Whittington where it was found the surgery had been unsuccessful and a further operation was required to insert the correct plate. This has been communicated to the Surgical and Executive Team at the relevant Trust.

3.9.2 <u>Immediate actions following detection of this incident.</u>

- Reconstruction plates are rarely used, however education regarding the difference between reconstruction and dynamic compression plates need to be highlighted and care taken when using either plate to ensure the appropriate one is utilised. Training is provided annually by the company who make the

fixation plates. An additional session is being arranged to allow all T&O staff to become familiar with the plates.

- Reconstruction fracture plates are clearly labelled and now stored separately. All reconstruction plates were removed from the small fragment sets and will be packed into a dedicated reconstruction plate set. Sterile services are to provide tags to allow the team to send them for sterilisation (labels are awaiting delivery currently).
- Communication regarding the removal of the reconstruction plates from the small fragment sets was included in the BIG 4 (communication tool within Theatres) to inform all surgical staff of the change.
- The safety alerts, incidents and all learning is to be disseminated within the surgery team to prevent future incidents occurring.
- Further communication will be circulated to the team when changes are fully implemented.

Table 3: Serious incidents by category reported to the NELCSU between April 2016 and June 2019

SI 2019-20 Category	2016/17 Total	2017/18 Total	2018/19 Total		Apr 19	May 19	June 19	Total 19/20 YTD
Safeguarding	5	1	1		0	0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI	1	0	0		0	0	0	0
Confidential information leak/information governance breach	6	3	4		0	0	0	0
Diagnostic Incident including delay	8	7	7		1	0	0	1
Disruptive/ aggressive/violent behaviour	0	1	1		1	0	0	1
Environment Incident meeting SI criteria	0	1	0		0	0	0	0
Failure to source a tier 4 bed for a child	1	0	0		0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0	0		0	0	0	0
HCAI/Infection control incident meeting SI	0	3	0		0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus	7	2	8		0	0	0	0
Maternity/Obstetric incident mother only	2	1	0		0	0	0	0
Medical equipment/devices/ disposables incident meeting SI	1	0	0		0	0	0	0
Medication Incident	0	1	1		0	0	0	0
Nasogastric tube	1	0	0		0	0	0	0
Pressure ulcer meeting SI criteria	0	0	1		2	0	0	2
Slip/Trips/Falls	7	6	2		0	0	0	0
Sub Optimal Care	4	2	1		0	0	0	0
Surgical/invasive procedure incident meeting SI criteria	0	0	2		0	1	2	3
Treatment Delay	3	4	2		0	0	0	0
Unexpected death	10	4	2		0	0	0	0
Retained foreign object	1	1	0		0	0	0	0
HCAI\Infection Control Incident	0	1	0		0	0	0	0
Total	**58**	**38**	**32**		**4**	**1**	**2**	**7**

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 June 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. Shared learning from a report submitted to NELCSU during June 2019

5.1 A pregnant woman reporting reduced fetal movements attended the Maternity Assessment Unit (MAU). Following review no fetal heart rate could be located and fetal demise (intrauterine death) was confirmed on ultrasound scan (This report is also being investigated by the Healthcare Safety Investigation Branch-HSIB Investigation – clock stop for completion date).

The following recommendations and actions have been made by the investigation panel;

- Reinforcement in the use of the Management of Reduced Fetal movements (RFM) checklist post 28 weeks of pregnancy when attending MAU. This will be audited by the area leads to ensure compliance.
- The reduced fetal movements' information and stickers will be used consistently to discuss the monitoring of fetal movements with parents and an alert has been added to the Medway maternity systems this will be monitored to ensure staff are complying.
- A business case is currently being reviewed to make available computerised CTGs in all areas where antenatal CTG is performed (antenatal ward and the MAU).
  Emergency skills and drills training for multi-disciplinary teams has been arranged in the MAU/Triage area to deal with escalation processes. This has been added to the Emergency drill curriculum.
  The 'Management of women presenting with altered or reduced fetal movements' guideline and the Fetal Monitoring in all care settings have been updated and now include the use of computerised antenatal CTG.

5.2 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.

5.3 Themes from serious incidents are captured in quarterly aggregated learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning.

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

6. Recommendation

6.1 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.

Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Quarterly "Learning from deaths" report Quarter 3, 2018/19 (1 October to 31 December 2018)**	**Agenda item: 9**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report author	Dr Julie Andrews, Associate Medical Director, learning from deaths clinical lead	
Executive summary	This "learning from deaths" report reflects the third quarter of 2018 (1st October 2018 to 31st December 2018). The report describes: a) How we are performing against our local and national expectations in reviewing the care of patients who have died whilst at the acute site of Whittington Health (inpatient and emergency department (ED) deaths); b) What learning and actions we are taking from the themes that emerge from these reviews to improve the care and experience of our patients and their families/carers. In Quarter 3 of 2018/19, 1st October 2018 to 31st December 2018, there were 115 inpatient/ED deaths. In Q3, 97% of all "category A" deaths (33 out of 34) were reviewed using a structured judgement review (SJR) process (or equivalent) as compared with 93.1% in Quarter 2 2018/19. Each SJR was presented at a departmental mortality meeting. In addition each SJR had a final review by the learning from deaths clinical lead to ensure all possible learning had been captured and shared across the organisation. 41.9% (34 out of 81) of category B deaths were reviewed in Q3 (compared to 45.5% in Q2) using a mortality review form with an avoidability of death judgement score plus presentation at a departmental mortality meeting. One patient death in Q3 (out of the 67 that were reviewed) was assessed as being a potentially avoidable death assessed as having strong evidence of avoidability. This event was recognised as a serious incident at the time and an investigation initiated with Duty of candour carried out in a contemporaneous timescale. This was the intra-uterine death of a 37-week old foetus where the serious incident investigation found the root cause of the intra uterine death	

	of the baby was underlying placental abnormality which could not be prevented. However the panel identified several opportunities when this could have been predicted and detected. Had this occurred, a plan for increased monitoring and potentially early delivery would have been undertaken. The report demonstrated care and service delivery problems related to failure to organise serial growth ultrasound scans and to interpret “gap grow” charts correctly. As part of a detailed action plan the team have reviewed and updated the training program for the Growth Assessment protocol including mandatory attendance at induction and a database of training for existing staff. We will be holding an overarching mortality review group in July 2019 which will run immediately after the End of Life Care Group. This will review overarching themes of learning, review 3 structured judgement mortality reviews, and consider the mortality process as a whole with a view to continuous improvement. This paper gives assurance that this process to strengthen governance, learning and transparency around inpatient death is now developed and relatively robustly embedded, and that progress continues to be made in developing ways to disseminate the learning and continue to improve the quality of our care. The Medical Examiner process will become statutory by 1 April 2020. Medical Examiners will act independently from the trust to ensure that all deaths not referred to the coroners service have as accurate death certificate as possible and that the family/carers are kept fully informed of the processes around the death of their loved ones. We are in discussions with our local clinical commissioning groups and neighbouring trusts to consider how we contribute to this service as it will require a 7/7 service to be developed.
Purpose:	Review
Recommendation(s)	Board members are invited to: • recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	This quarter’s report not previously presented. Previous quarters from April 2017 onwards have been presented to Trust Board
Appendices	Appendix 1: NHS England Trust mortality dashboard

Quarterly "Learning from deaths" report Quarter 3 2018/19 (covering 1st October 2018 to 31st December 2018)

1. Introduction

This report reflects quarter 3 of 2018/19 to Trust Board on learning from deaths. It is necessary that there is an interval between a death and the reporting of thorough structured mortality review – the interval in local guidance is 12 weeks. It is however intended that quarterly board reports could reflect the prior quarter and the Medical Director will be meeting with the learning from deaths lead to explore the support needed to bring forward reporting at Whittington Health.

These reports describe:

a) performance against local and national expectations in reviewing the care of patients who have died whilst in this hospital (inpatient and emergency department deaths),
b) the learning taken from the themes that emerge from these reviews,
c) actions being taken to both to improve our care of patients and to improve the learning from deaths process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with General Medical Council *Good Medical Practice*, for many years. Following the launch of the NHS Quality Board "*National guidance on learning from deaths*[1]" (March 2017) we introduced a more systematised approach to reviewing the care of patients who have died in hospital from category A deaths.

Category A deaths are:

- Deaths where families, carers or staff have raised concerns about the quality of care provision;
- All inpatient deaths of patients with learning disabilities;
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths following elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall;
- All inpatient paediatric, neonatal and maternal deaths;
- Deaths that are referred to HM Coroner's Office.

Category B deaths are:

- All deaths of inpatients that do not meet any of the criteria of Category A deaths.

Table 1 shows the reasons for deaths being assigned as category A in Quarter 3

	Number of deaths in Q3	Comments
Staff raised concerns about care	3	Investigated as a serious incident or internal RCA investigation
Family/carers raised concerns about care	1	Investigated as a serious incident or internal RCA investigation
Death of a patient with Learning	0	

[1] "*National guidance on learning from deaths*" (NHS Quality Board, March 2017) available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

disabilities		
Death of a patient with SMI	0	
Paediatric/maternal/neonatal/intra-uterine deaths	4	Investigated as a serious incident or internal RCA investigation
Deaths referred to coroner's office	21	Excludes deaths in other categories. 10 of these were formal inquests.
Deaths related to specific patient safety or QI work e.g. sepsis	5	All were sepsis deaths, these are additionally investigated by the sepsis QI team One sepsis death did not have a SJR completed
Total	34	

Category A deaths are reviewed by an individual independent clinician using a structured judgement mortality review form (or equivalent) then this is reviewed and agreed on in departmental mortality meetings.

The aims of this review process are to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify, and learn from, episodes relating to problems in care;
- Identify, and learn from, notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patients' and carer's wishes were identified and met;
- Enable informed and transparent reporting to the Public Trust Board, with a clear methodology;
- Identify potentially avoidable deaths and ensure these are fully investigated through the serious incident (SI) process, and are clearly and transparently recorded and reported.

The Trust has set an internal target that 90% of all category A deaths and 25% of all category B deaths should be reviewed.

2. NHS Mortality Dashboard

The *National Guidance on Learning from Deaths* gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1. This dashboard shows data from 1 April 2018 onwards.

There were 115 deaths recorded in Quarter 3. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation.

The dashboard (appendix 1) shows that in Quarter 3, 67 of the 115 patient deaths were systematically reviewed. 97% of the category A deaths were reviewed using structured mortality judgement methodology or equivalent and 41.9% of category B deaths were reviewed using either similar methodology or a comprehensive case note review with an assigned avoidability of death score. These reviews occurred within 12 weeks following the death of the patient apart from three late reviews by the COOP team, the delays mainly due to limited administrative support.

48 patient deaths out of 115 in Q3 (42%) were not reviewed, but the majority of these (47 out of 48) were category B deaths. One category A patient death was not reviewed by SJR; this was a patient under the care of the older person (COOP) team who died from sepsis. Departments and

teams are reminded when category A reviews are outstanding but further work is needed and is ongoing to embed the support structures, including project management support to ensure that the risk of category A reviews being overlooked is minimalised and reviews are carried out within expected timeframes.

The dashboard outlines the avoidability of death judgement scores for inpatient deaths in Quarter 3, 2018/2019 and this is summarised below, in table 2. There were no deaths in patients with learning disabilities this quarter.

Table 2 – Avoidability of death judgement scores for Q3: 2018/19

Avoidability of death judgement scores (of deaths reviewed)	Number of patients with each avoidability score
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	1
3 - Probably avoidable, more than 50/50	0
4 - Possibly avoidable but less than 50/50	2
5 - Slight evidence of avoidability	2
6 - Definitely not avoidable	62

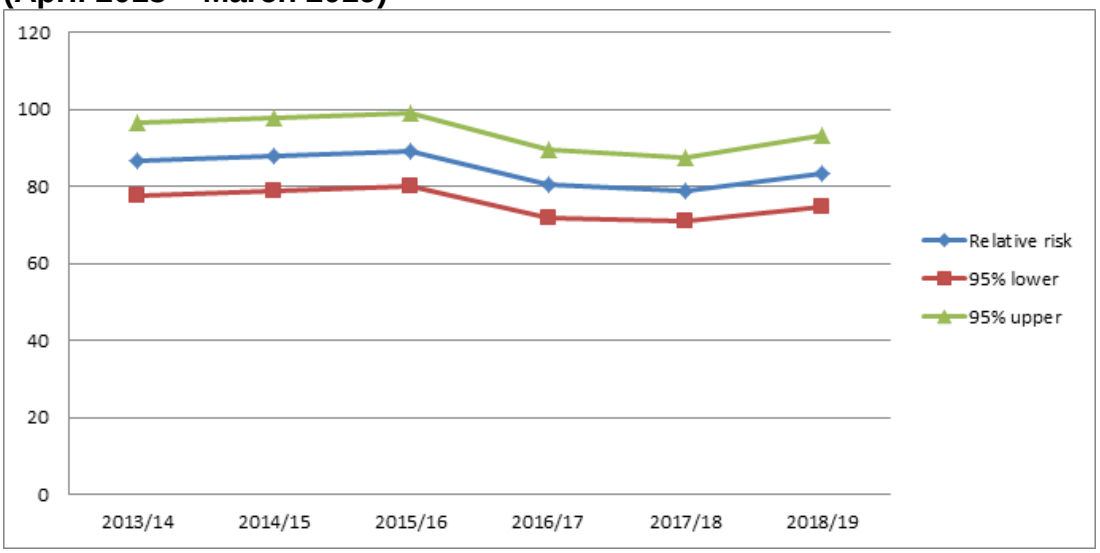
There was one potentially avoidable patient death recorded in Quarter 3 2018/19 (where potentially avoidable is taken to mean patient deaths with avoidability scores of between 1 and 3). This was the intra-uterine death of a 37-week old foetus where the serious incident investigation demonstrated care and service delivery problems related to failure to organise serial growth ultra-sound scans and to interpret gap grow charts correctly. A sustained programme of “on the job” education highlighting gap grow chart interpretation has commenced since this incident. There has also been a minor revision to the serial growth ultrasound protocols to ensure they are as clear as possible to staff.

Two patient deaths were given an avoidability death judgement score of 4; these were deaths in surgical patients and were fully investigated as an internal root cause analysis investigations and findings shared with family/carers and staff.

3. Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (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. 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 – March 2019)



The blue diamonds on Chart 1, above, represent this Trust's HSMR, which is 'lower than expected'. The green triangles above and the red squares below represent the 95% confidence interval, which means that the actual HSMR has a 95% chance of falling between the higher and lower values. The Trust HSMR is 'lower than expected'.

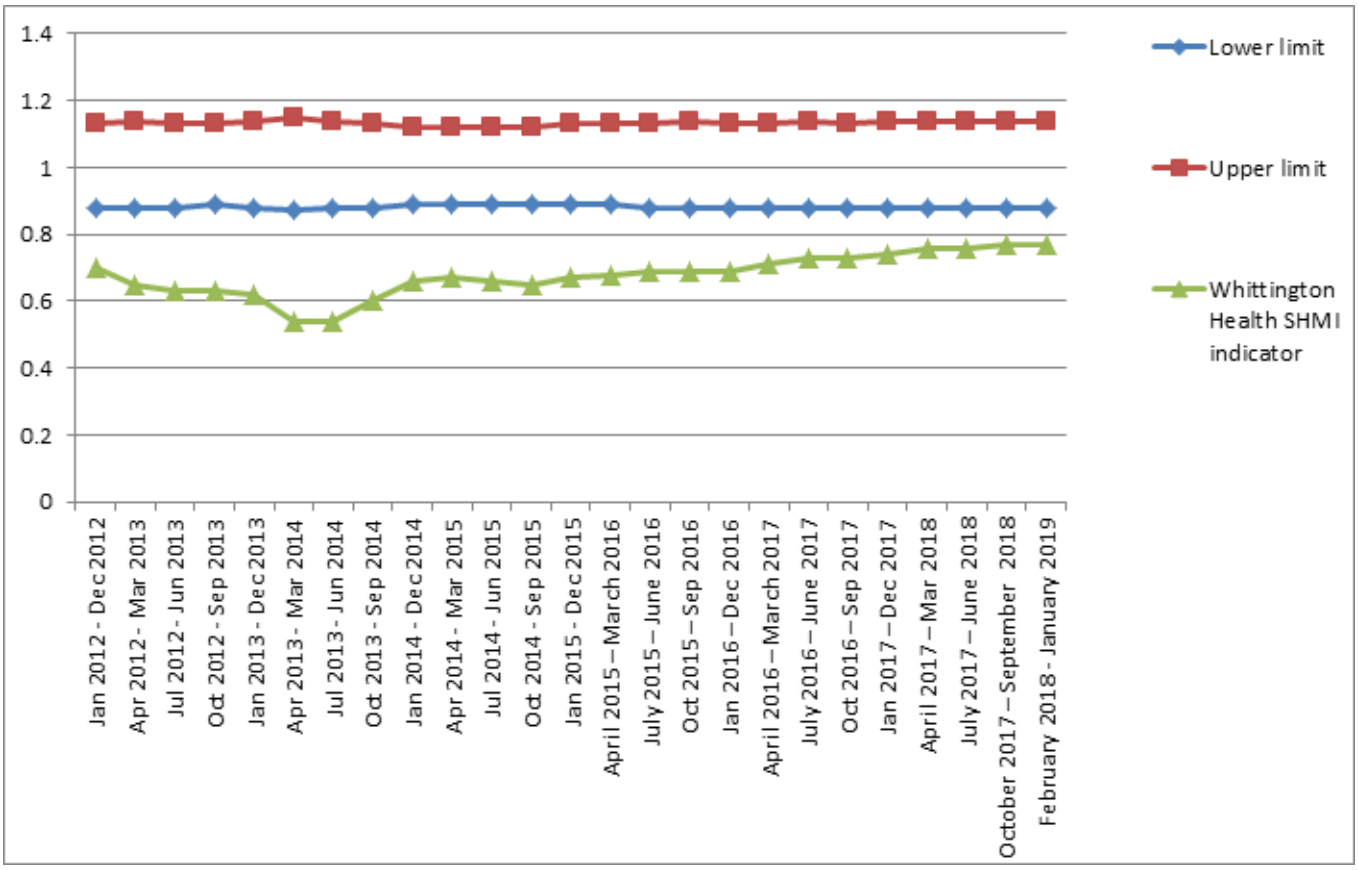
4. Summary Hospital-level Mortality Indicator (SHMI)

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 February 2018 to January 2019- the Trust's SHMI is lower than expected.

Whittington Health SHMI score	**0.7712**
National standard	**1.00**
Lowest national score	**0.7052 (Guy's and St Thomas')**
Highest national score	**1.2073**

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



5. Key points of learning and actions from Mortality Reviews

a) New/revised protocols, pathways and checklists

Silver trauma pathway – as a result of feedback from internal RCA's and mortality reviews there have been revisions to the silver trauma pathway to ensure all low impact trauma patients are referred to the correct teams initially and also that staff "think trauma" on initial assessments even if the presentation is atypical for trauma.

Earlier referral from surgery and ITU to palliative care teams – a number of reviews have shown that there have been delays in patient referral to our acute site based palliative care team. These mortality reviews have been shared with the palliative care teams and they have been working with local teams to ensure access to earlier referrals is achieved through an active inreach service.

Challenging DNACPR discussions - Acute medicine, COOP, ITU and palliative care teams have highlighted a number of cases where it would have more appropriate to have had earlier discussions about Do not attempt cardiopulmonary resuscitation (DNACPR) with patients. All admission documentation has been altered to ensure that this is discussed as the earliest point and further education sessions are planned to ensure decisions are revisited during a patient's admission. A trustwide "death café" was recently held to promote more open discussions of death amongst staff.

Management of patients requiring giant hiatus hernia surgery standard operating protocol (SOP) - this was introduced to ensure all relevant pre-operative checks were carried out before this higher risk surgical procedure. Multiple teams (surgical, anaesthetics and

cardiology) have worked on developing this protocol and it was introduced following several educational events.

b) Clinical audits and QI work

Following the introduction of NEWS2 scoring using e-observations and the recognition in 2 mortality reviews that there were delays in escalating patient's management following high NEWS2 scores. The deteriorating patient committee are developing ongoing QI work to more rapidly provide feedback data to ward areas about escalation timeliness and appropriateness.

There is an ongoing QI project around surgical VTE prophylaxis following a review showing VTE assessment had been delayed. This has demonstrated a rise in VTE assessment from 35% to 85% with ongoing performance monitoring.

c) Training and education

There has been refinement of the "gap grow" education programme for relevant obstetric staff to ensure the learning is delivered in a "10 at 10" style (10 minutes of intense frontline training at 10 am) on the wards/clinics as well as in classroom and simulation environments.

2 mortality reviews demonstrated delayed responses to patient observations. There has been further education delivered by various teams using in situ simulation for the revised NEWS2 scoring systems.

A grand round and ongoing education programme has been devised to ensure medical staff consider all surgical differentials in ED as well as medical differentials; this is following a review demonstrating delayed diagnosis of a femoral hernia.

6. Conclusion and recommendations

The board is asked to recognise the significant work from frontline teams to learn from deaths in order to improve care and note the contents of the report.

Appendix 1: NHS England Trust Mortality Dashboard

Whittington Health: Learning from Deaths Dashboard - December 2018-19

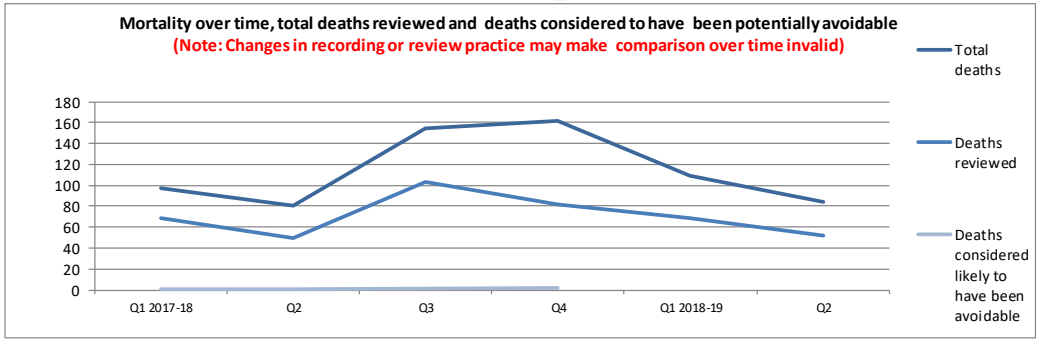
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
44	40	25	26	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
115	84	67	52	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
308	494	188	304	1	4

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

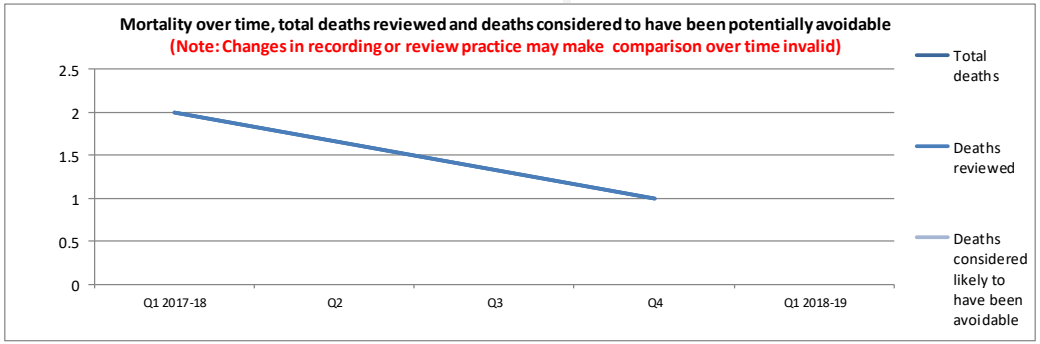
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	4.0%	This Month	24	96.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.5%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	3.0%	This Quarter (QTD	64	95.5%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.5%	This Year (YTD)	0	0.0%	This Year (YTD)	3	1.6%	This Year (YTD)	16	8.5%	This Year (YTD)	168	89.4%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	3	0	3	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Meeting title	**Trust Board – Public**	**Date: 31 July 2019**
Report title	**Adult and Children's Safeguarding six monthly report (October 2018 – March 2019)**	**Agenda item: 10**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report authors	Karen Miller, Head of Safeguarding (Children), and Theresa Renwick, Head of Safeguarding (Adults)	
Executive summary	**Executive summary** This report provides a summary of the work undertaken across adult and children's safeguarding and covers the period between October 18 and March 2019. The Trust's safeguarding teams continue to provide a range of services to support key areas of safeguarding work, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective and meet statutory and regulatory obligations. **Adult** • The upward trajectory seen in numbers of safeguarding adult concerns continues in the six month period from October 2018 – March 2019. Overall, there has been a 51% increase in numbers of safeguarding adult concerns raised by Trust staff over the year when compared to the same period the previous year. This increase is in line with national data found in '*Safeguarding Adults England, 2017-18, Experimental Statistics*'.[1] • Numbers of Deprivation of Liberty Safeguard (DOLS) urgent authorisations have also increased in this period in comparison to the same period last year, with a 30% increase in numbers of urgent DOLS authorisations recorded. Given the legislative change on the DOLS framework, the new Liberty Protection Safeguards, to be introduced in late 2020, there will be a significant change to legal responsibilities for the Trust in administering this legislation. • Numbers of assessments of capacity logged on Anglia Ice have fallen by 8% in comparison to the same period	

	last year • Training compliance for levels 1&2 is below the required 90% target for the organisation. Level 2 training is only delivered face to face (11 sessions during this reporting period), and continues to be well evaluated by attendees. • 19 sessions have also been delivered for WRAP 3 (Workshop to Raise Awareness of Prevent), with compliance sitting at 75% • In September 2018, the Trust was notified of a Safeguarding Adult Review (SAR) for which we were required to share information. The report was published in February 2019, and recommendations for the Trust have formed part of an action plan with the District Nursing service • Additional clinical supervision provision is now in place for with the Community Matrons, aiming to look at those cases which are the most complex. The safeguarding adult lead accompanies staff on joint visits when this is identified as a useful way forward. **Children & Young People** • Safeguarding training figures remain just below compliance. The team have begun offering face to face sessions and campaigns to raise awareness of online training for levels 1 and 2. • We remain just under statutory compliance rates for levels 1 and 3 training, while level 2 compliance sits at 78%. The vast majority of non-compliance reporting is with junior doctors. The work around the NCL Statutory/Mandatory records pass porting is work in progress and will address this issue. • Serious Case Review (SCR) activity is busy with Haringey having commissioned the rewrite of an SCR. Three other SCR's are underway with final publication over the coming months, depending on criminal proceedings. • Staff supervision compliance has remained high. Health visitors report being involved with far more complex cases of neglect and emotional abuse with domestic violence being a prevalent factor in their caseloads. • Formalised supervision has been extended to allied health professionals including IAPT and the therapies teams.
Purpose:	Review
Recommendation(s)	The Trust Board is asked to: (i) receive assurance that there are systems in place to protect children and vulnerable adults from abuse and

	neglect whilst in our care; and (ii) be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.
Risk Register or Board Assurance Framework	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 of income, an adverse impact upon staff retention and damage to organisational reputation
Report history	Quality Committee 10 July 2019; Trust Integrated Safeguarding Committee 25 July 2019
Appendices	1 - Biannual Integrated safeguarding report to Trust Board (October 2018 – April 2019)

Appendix One

BIANNUAL INTEGRATED SAFEGUARDING REPORT TO TRUST BOARD (FORMALLY PRESNETED TO QUALITY COMMITTEE) OCTOBER 2018 – APRIL 2019

1. INTRODUCTION

1.1 This bi-annual report for safeguarding children and adults informs the Trust Board of activity and progress in improving and strengthening the safeguarding arrangements for adults and children across Whittington Health NHS Trust. The report has previously been discussed at the trust Quality Committee who approved it for presentation to the Trust Board. It covers the period from October 2018 to March 2019. The report provides assurance around the following:

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

2. SAFEGUARDING CHILDREN

2.1. Working Together to Safeguard Children was published in July 2018. The major change to safeguarding national policy and guidance is the proposed replacement of Local Safeguarding Boards (LSCB's) with new arrangements called Safeguarding Partnership Arrangements. The local CCG's hold responsibility as the lead health representative in the new partnership arrangement and Whittington Health have been working closely with CCG colleagues to contribute in the working of the new arrangements. Work is well underway across the partnerships to establish the new Safeguarding Partnership Arrangements for September 2019.

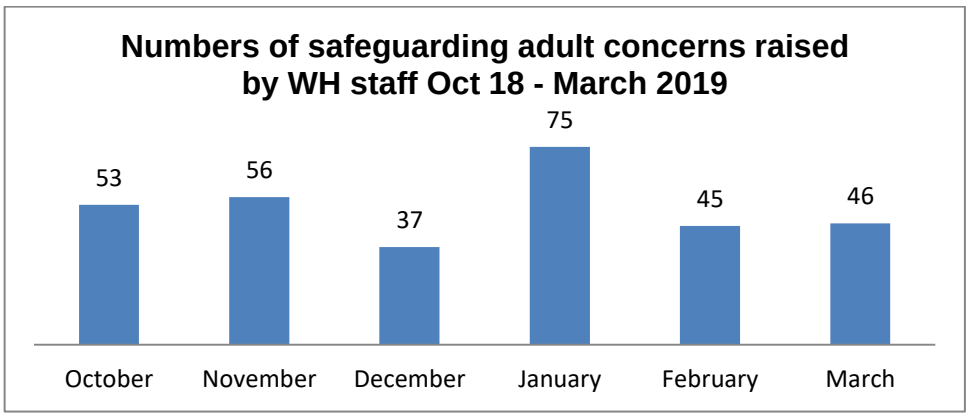
2.2. There are plans to review the Serious Case Review process and replace this with national Child Safeguarding Practice Review Panel. This is hoped to streamline the process and implement a system of national learning.

2.3. The child death review process will also will be reviewed to incorporate the review process over larger geographical areas rather than current arrangements of being borough based. Working groups across the North Central London cluster are underway to ensure the changes are implemented in September 2019.

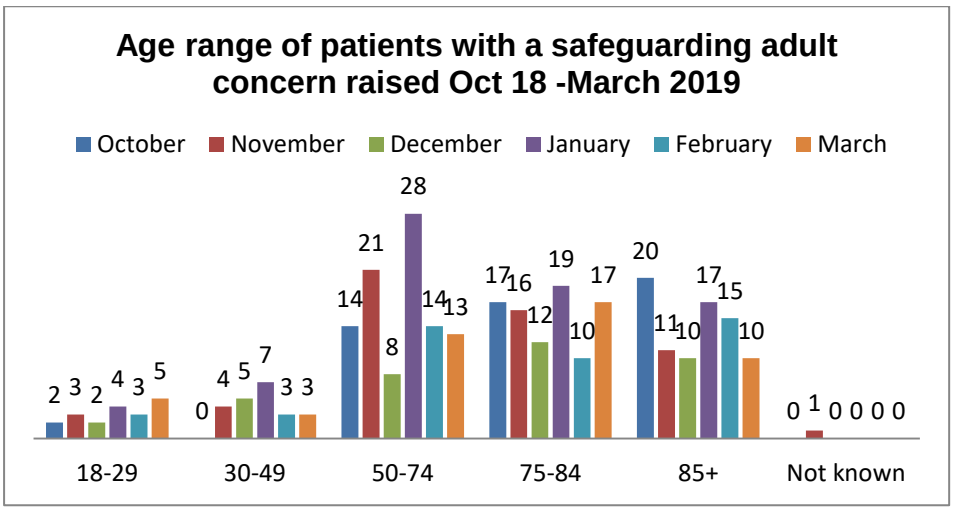
3. SAFEGUARDING ADULTS

3.1. The '*Safeguarding Adults Collection (SAC), Annual Report, England 2017-2018*[2, 3] was published in November 2018, and its national reporting around demographics has been replicated by Whittington health activity and data.

3.2. It is important to recognise the sustained increase in numbers of safeguarding adult concerns raised by Whittington Health staff, and reflects staff understanding of their responsibilities and duties in identifying potential cases of harm to vulnerable adults. More frequent safeguarding adult training has been delivered to assist staff in understanding their safeguarding responsibilities. Graphs 1 and 2 show the number of concerns raised across Whittington Health and also the age demographic of referrals which is in line with the National data.



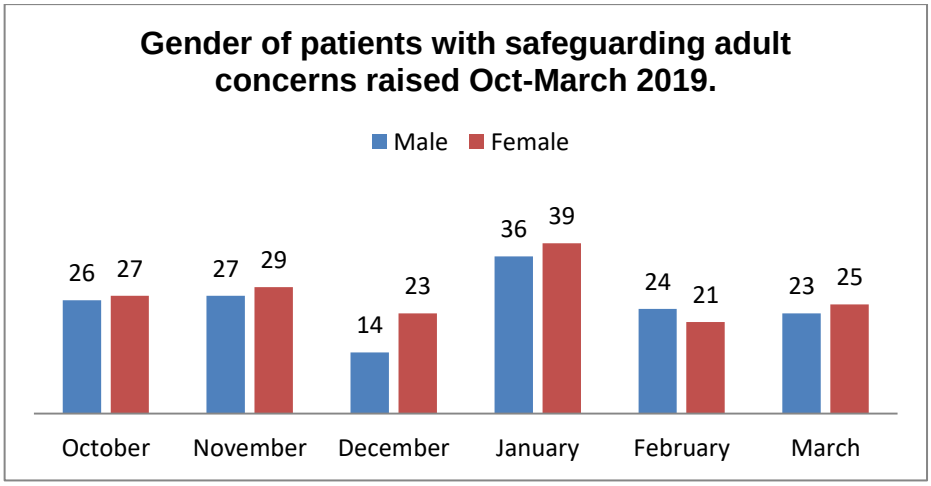
Graph 1



Graph 1

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

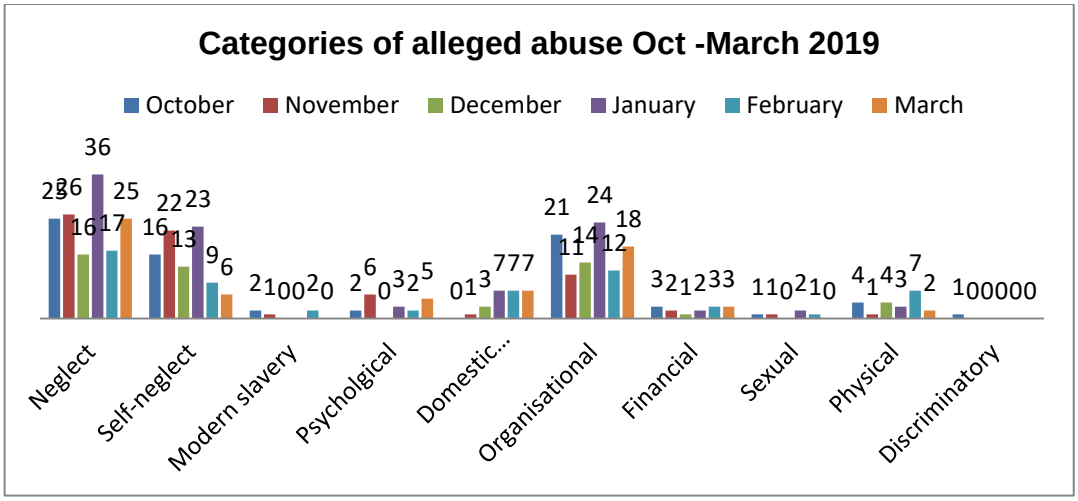
3.3. Graph 3 shows a fairly even split between the genders, though women were more likely to be identified than as experiencing abuse. This is in line with the trend found in the national report for April 2017-March 2018, which found woman accounted for nearly 60% of adults being abused.



Graph 3

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

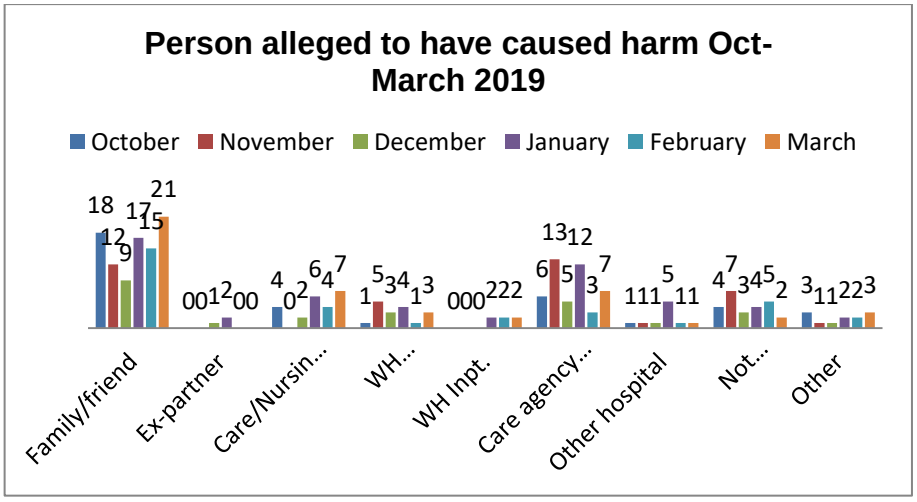
3.5. There has been an increase in the number of concerns involving organisational abuse, which will need to be monitored by both Safeguarding Adult Boards (SABs) to ensure robust protection plans are in place, and appropriate, proportionate responses in place to protect vulnerable adults.



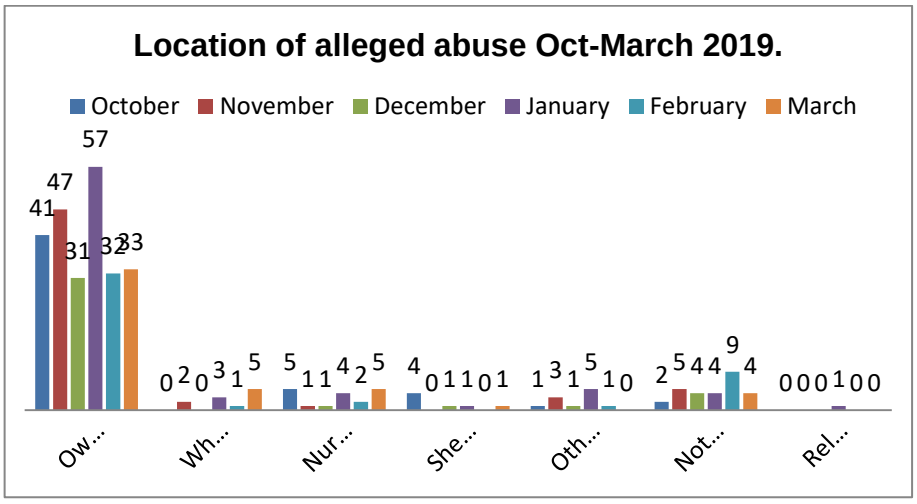
Graph 4

3.6. An area of focus is the continuing low numbers of modern slavery reported and no reported cases of discriminatory abuse. The national data for 2017-2018 has modern slavery amounting to only 0.2% of identified abuse, and discriminatory abuse accounted for 0.6% of abuse. However, it is important for staff to be aware of the prevalence of both forms of abuse, and understand the need for action.

3.7. Graphs 5 and 6 reflect that the national findings that a person alleged to have caused harm are very likely to know the vulnerable adult. The overwhelming location of alleged abuse was found to be in the persons' own home alongside that of someone the person knows, again comparable to national findings.

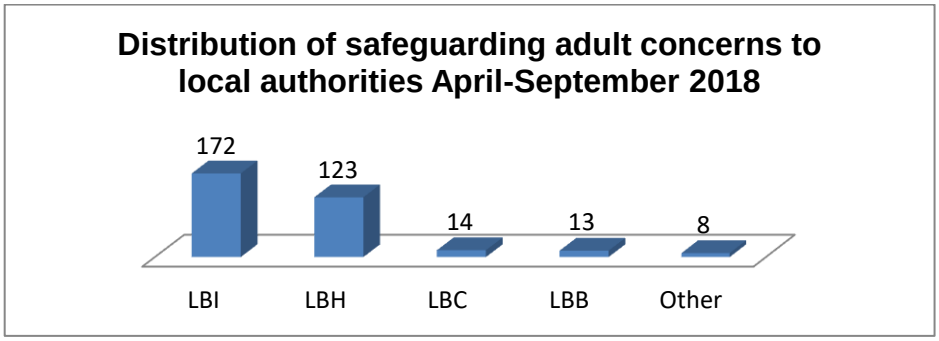


Graph 5



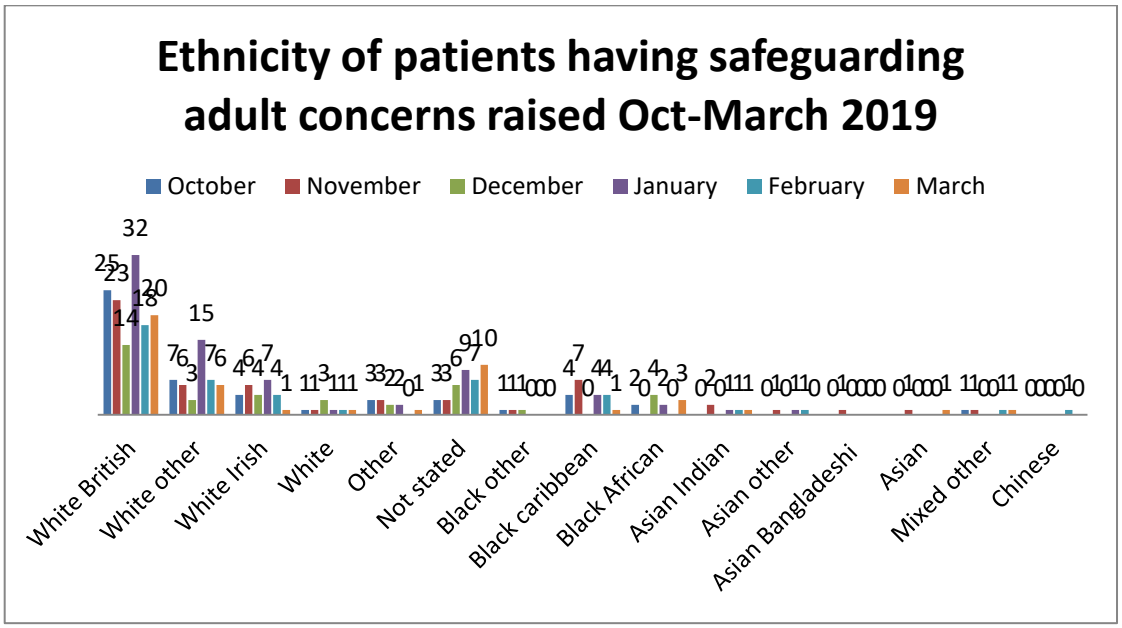
Graph 6

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



Graph 7

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



Graph 8

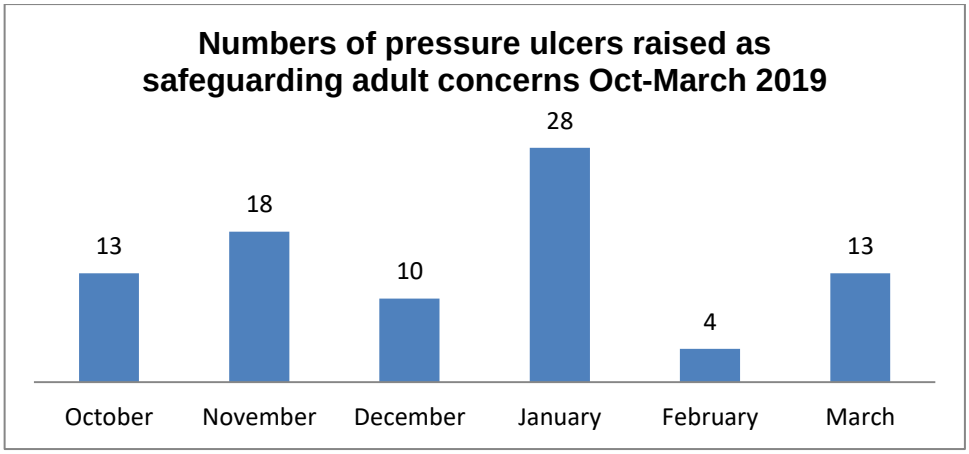
3.10 The learning lesson described below provides an opportunity to share learning across the Trust around the care of people who are homeless and vulnerable.

LEARNING LESSON

Fred is in his 40s and homeless. He abuses substances, and has refused offers of accommodation, instead living under a bridge locally.
Concern about Fred's cognition increased especially as the weather became cooler and Fred wore inadequate clothing. The local safeguarding adult team contacted the Trust safeguarding adult lead as Fred had gone missing. Through good multi-agency working, when Fred did come to be admitted, the team around him were able to ensure he was discharged to an appropriate provision, with continued good communication between hospital and community services.

3.11. The *London Multi-Agency Adult Safeguarding Policy and Procedures,*[4] and *'Safeguarding Adults Protocol Pressure Ulcers and the interface with a Safeguarding Enquiry,' Department of Health January 2018, both indicate that* pressure ulcers are only reported as safeguarding concerns if they are felt to have been avoidable (now referred as attributable to the Trust), and the result of abuse and/or neglect. Whittington Health continues to play a key role in distributing information to the local community to raise awareness about prevention of pressure ulcers (Graph 9).

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



Graph 9

4. ALLEGATIONS MADE AGAINST STAFF

4.1. In this reporting period there has been one case of a member staff employed by the Trust being referred to the LADO (Local Authority Designated Officer). The Allegations against Staff Policy remains in place.

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

5. TRAINING

Children

5.1. Compliance with statutory training remains static but improvements have been achieved at level 3 which is notable. There is a significant amount of foucs and attention to this by the Ingergrated Clinical Service Units (ICSU).

5.2. Local Safeguarding Children Board (LSCB) training has recommenced in Haringey, and this will provide an additional area in which staff can access training outside of Whittington Health. a number of Whittington Health staff provide sessions within this training. Islington LSCB already provides a comprehensive multi agency training package that our staff access.

5.3. Level 2 compliance is heavily impacted upon by trainee doctor rotations and issues with training history captured on commencement of service within Whittington. Work is contiuning with the North Central London StatMand Training record streaming (passporting) process.

5.4. **Compliance (data up to 30/3/2019)**

Level 1			
	Total number of staff requiring level 1 training	**Total number of staff up to date with training**	**Percentage of relevant staff trained**
Q2 Sept 2018	1019	911	89%
Q3 Dec 2018	1032	911	88%

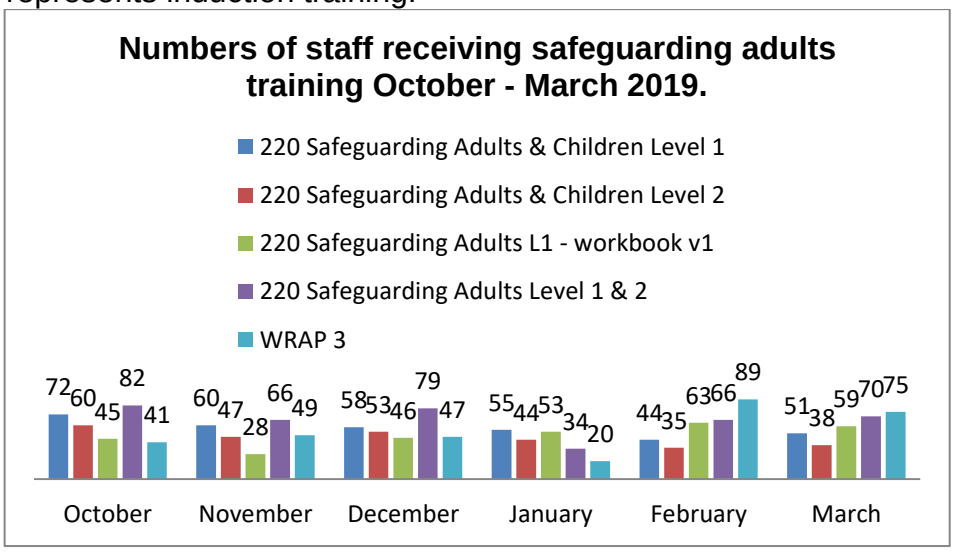
Q4 March 2019	1041	931	89% ⇧
Level 2			
	Total number of staff requiring level 1 training	**Total number of staff up to date with training**	**Percentage of relevant staff trained**
Q2 Sept 2018	1921	1470	77%
Q3 Dec 2018	2004	1486	74%
Q4 March 2019	2023	1528	76% ⇧
Level 3			
	Total number of staff requiring level 3 training	**Total number of staff trained**	**Percentage of staff trained**
Q2 Sept 2018	1063	896	84%
Q3 Dec 2018	1057	812	77%
Q4 March 2019	1038	846	82% ⇧

Adults

5.6. Between October 2018 and the end of March 2019, 11 face to face refresher sessions were offered for safeguarding adult's levels 1&2. These were in addition to the seven inductions (two in March 2019).

5.7. Nineteen face to face WRAP 3 sessions were offered for the same period, and compliance stands at 75%.

5.8. Where safeguarding adults and children are represented together below, this represents induction training.



Graph 11

5.9 Compliance for safeguarding adult's level 1 stood at 89% at end of March March 2019, and 76% for level 2.

6. LEARNING FROM SERIOUS INCIDENTS (SI), SERIOUS CASE REVIEWS (SCR CHILD), SAFEGUARDING ADULT (SAR) AND DOMESTIC HOMICIDE REVIEWS (DHR)

Learning and action plans from the SCRs and relevant SI's are presented to the Integrated Safeguarding Committee and through sub groups of the

relevant LSCB and SAPB.

6.1. **Safeguarding Children**
A Joint Area Targeted Inspection (JTAI) took place in December 2018 within Islington Local Authority to inspect the multi-agency approach to sexual abuse that occurred within the home. The staff across both hospital and community worked hard to ensure that we showcased the hard work undertaken. The overall inspection was very positive and highlighted strong areas of practice in children and young people's (including maternity, hospital and community) and safeguarding supervision. An action plan has been developed to further strengthen the approached across the partnership.

6.2. Work continues in Islington to further focus the school nursing service into a 'needs led' service based on vulnerability rather than focusing finite resources with the cohort of children already subject to child protection plans where the school, children's social care and partners play a significant role. This work is supported and reinforced through the JTAI learning.

6.3. Whittington Health has a Serious Case Review/Serious Incident Action Plan that is monitored through the Integrated Safeguarding Committee to ensure relevant learning from the SCR/SI's is implemented. Actions are also monitored through the LSCB's within the Serious Case Review sub groups.

6.4. During October 2018 an audit took place to examine the effectiveness of pathways through the Haringey Multi Agency Safeguarding Hub (MASH). This was as a result of findings from the December 2017 JTAI inspection. This audit identified that over 80% of referrals coming through the MASH were linked to domestic abuse. This figure really demonstrates the chronicity of domestic abuse and the impact it has on both children and adults that's we work with.

6.5. Within children's safeguarding we do not count the number of referrals we make as services are spread out across a number of clinical teams and sites and referrals are made directly to Children's Social Care (the importance of timely referrals is key therefore appropriate for staff to make direct referrals rather than through centralised place). It would be difficult to generate this data for Whittington Health, however, Children's Social Services departments quality check referrals, and those of poor quality are re-directed back to Whittington Health via the safeguarding team for support and training purposes.

6.6. **Safeguarding Adults**
Section 44 of the Care Act 2014 stipulates a Safeguarding Adult Review (SAR) is to be undertaken by the SAB when there are concerns about how partner agencies worked together, and the SAB suspects an adult has experienced significant harm, or has died as a result of abuse and/or neglect. [5]The aim of undertaking such a comprehensive review is to look at what can

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

be learned and how practice can be influenced and developed. Whittington Health has been involved formally in one SAR during this reporting period. The report is not finalised at the time of writing, and so findings cannot be shared. The Trust has been fully cooperative in the panel discussions.

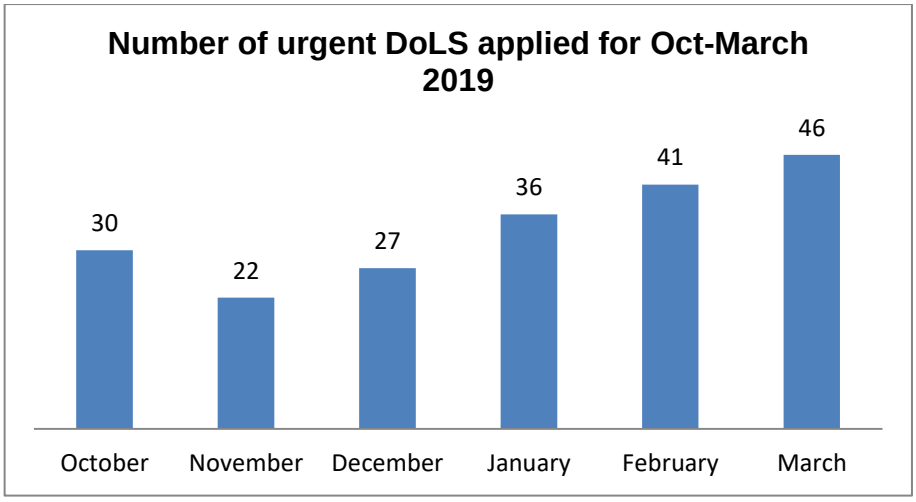
6.7. The Safeguarding Adult Review into Ms A, from Haringey, looked at the care provided to a bed bound woman in her 70s, who was also a smoker. Ms A had been discharged from the District nurse caseload at the time of her death. Learning points for agencies including Whittington Health focused on escalation protocols, referrals for fire safety checks to the London Fire Brigade, use of the Mental Capacity Act 2005 and the education of both staff and patients in the dangers of using paraffin based emollient creams when smoking and bed bound. Information has been widely shared across the whole Trust.

6.8**.** With the growing awareness of the increase in numbers of homeless people, there is now a legal requirement for staff to refer all patients who are homeless and/or at risk of homelessness in the subsequent 56 days (with their consent), to local housing departments. In addition, housing services can commission *Homelessness Fatality Reviews*. Whittington Health was involved in one such Review, with learning for the Trust centring on the need for clinicians to have telephone conversations with GPs for complex discharges, rather than rely solely on the discharge summary.

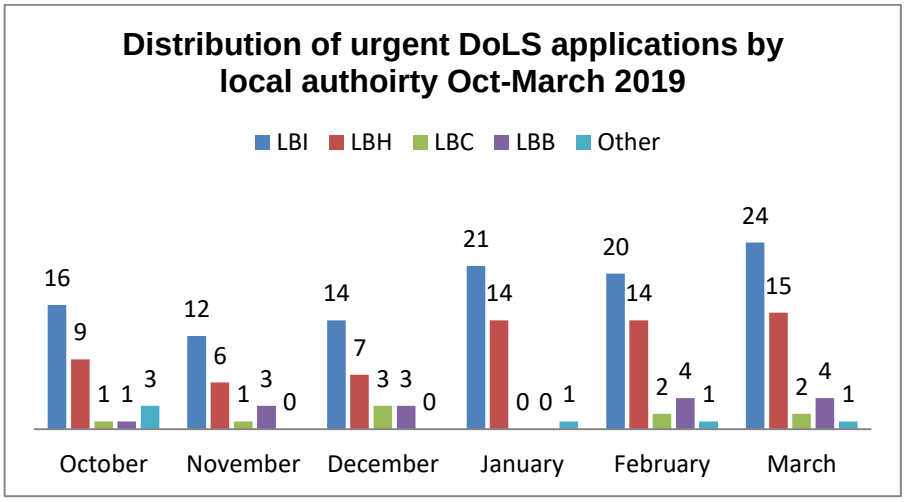
7. DEPRIVATIONS OF LIBERTY SAFEGUARDS

7.1. Graphs 12 and 13 show numbers of Deprivation of Liberty urgent authorisations applied for within Whittington Health. This data is further broken down into gender, ethnicity and age range, before looking at the distribution of urgent applications to local authorities, and the originating ward of the hospital.

7.2. There has been much discussion about the difficulties faced by local Authorities in administering the DOLS framework. As such, the scheme has been subject to reforms, known as the Liberty Protection Safeguards. Whilst there is no confirmed date for their introduction, implementation is expected to be in late 2020. Given the changes to the responsibilities placed on hospitals (for example, it is the hospital who will now agree or not to the deprivation rather than the local authority, and being applicable from age 16), and these changes will require a robust system to ensure adherence to legislative requirements. Work has already begun to alert staff to changes, and to plan for possible implications. These plans are currently tentative until National guidance is published. The Trust is represented in the local implementation network which is looking at the implications for various organisations.



Graph 12



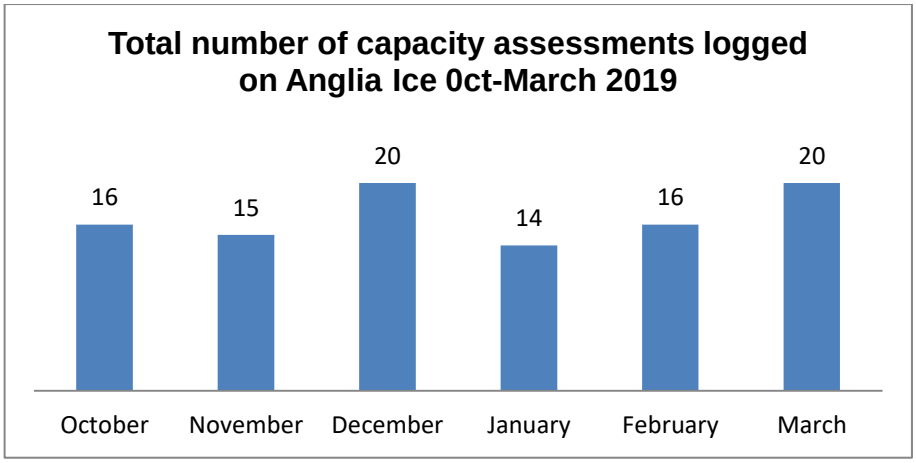
Graph 13

8.0 MENTAL CAPACITY ACT (MCA)

8.1. The Mental Capacity Act 2005 is applicable for people aged 16 and above, and who have "an impairment of, or disturbance in the functioning of, the mind or brain."[6] As Graph 14 below shows, numbers of capacity assessments logged on Anglia Ice fluctuated throughout this period.

8.2. Assessments of capacity are often handwritten in the notes, so there is limited and unreliable timely ways to collect this data other than to look at each medical record. A case note audit is planned in conjunction with Haringey SAB to look at assessments of capacity to assist with this.

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



Graph 14

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

8.4. Whittington Health continues to be at the forefront of training delivered across the Camden, Islington and Haringey Community Education Partnership Networks (CEPNs). There have now been over 10 sessions delivered in partnership with Islington Adult Social Care, Haringey Adult social care and Haringey CCG.

8.5. The success of these sessions is such that a further three have been requested, with a guarantee of places for Whittington Health staff to increase Knowledge of this important piece of legislation.

9. PRIORITIES 2019/20 (includes continuation of some priorities from 2018/19)

9.1. Children

- To continue to provide high level safeguarding training packages whilst aiming to achieve compliance across all three levels and to work closely with the Learning & Development department to provide novel ways of delivering training
- To continue to deliver on the safeguarding actions and recommendations emerging from JTAI Inspections in both Haringey and Islington
- To contribute and develop practice across the organisation with regards to emerging themes around contextual safeguarding e.g. Think Family and voice of the child
- Develop health strategies in relation to gangs, adolescent mental health and child sexual exploitation
- To further develop partnership working between midwifery and health visiting services
- To continue to develop further the health pathways within the Borough Multiagency Safeguarding Hubs (MASH) that support the transmission of

proportionate health data across the partnership to help protect children and young people effectively

9.2. **Adults**

- Continue to address develop training around use of the Mental Capacity Act within the Trust for staff
- Continue to deliver face to face training to staff to ensure compliance with levels 1&2 safeguarding adults
- Complete a training needs analysis in line with the Intercollegiate document for safeguarding adult training
- Complete an audit in use of the MCA
- Continue with safeguarding adult supervision for community matrons, and explore if this could be rolled out further in the community.

10. RECOMMENDATIONS

The Trust Board is asked to:-

(i) To receive assurance that there are systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care.

(ii) To be assured that partners have confidence that Whittington Health is fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.

Meeting title	**Trust Board - public**	**Date: 31 July 2019**
Report title	**Progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions**	**Agenda item: 11**
Executive director leads	Dr Clare Dollery, Medical Director and Michelle Johnson, Chief Nurse	
Report authors	Dr Helen Taylor, Clinical Director and Shahida Trayling, Associate Director of Midwifery and Nursing	
Executive summary	The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. There are 10 safety actions required to be met by each Trust these are outlined in paper together with a summary as to whether WH meets the criteria. Trusts need to be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund. For WH the rebate is approximately £500k. The expectation is that through implementing these actions this will improve maternity safety. Evidence to support achievement of these standards is collated for submission. This evidence has been reviewed by the Medical Director, Chief Nurse and Maternity Quadrumvirate and will be reviewed for sign off by the commissioners on the 25th July. The outcome of the meeting with the commissioners will be provided verbally at the Trust Board meeting.	
Purpose:	Approval – the Trust Board to confirm that: • they are satisfied that the maternity services demonstrate compliance with the maternity safety actions and that the self-certification is accurate; and • the content of this report and evidence against each safety action has been shared with the commissioners of the Trust's maternity services.	

Recommendation(s)	The Trust Board is asked to approve the self-certification.
Risk Register or Board Assurance Framework	
Report history	This will be formally signed off by the commissioners on the 25th July ready for presentation to the board.
Appendices	None

Whittington Health's progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Introduction

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. The scheme is discretionary and subject to available funds. Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified in 2016/17, obstetric claims represented 10% of the volume and 50% of the value.

There are 10 safety actions required to be met by each Trust these are outlined in the table below and whether WH meets the criteria. Trusts need to be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia). For WH the rebate is approximately £500k.

The 10 safety actions were agreed by the National Maternity Safety Champions as those that both reflect best practice in maternity safety improvement and can be evidenced to demonstrate progress. The expectation is that through implementing these actions this will improve maternity safety.

Evidence to support achievement of these standards is uploaded for submission. This evidence has been reviewed by the Medical Director, Chief Nurse and Maternity Quadrumvirate and will be reviewed for sign off by the commissioners on the 25th July. The outcome of the meeting with the commissioners will be provided verbally at Trust Board.

Safety action – please see the guidance for the detail required for each action	Standard	Standard met (Y/N)	Comments
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed a	Y Y Y Y	We meet this standard. This activity is overseen and managed by the Whittington Health Bereavement Midwives who maintain a log showing all cases requiring a review. Quarter 4 (2018/9) compliance for standard a was 100%, standard b was 50% and standard was100%. The Local Maternity System has also helped facilitate external representation at reviews across North Central London. Maternity service is currently working with service users to develop a leaflet to help define the terms of reference of Serious Incidents. This is currently being reviewed by the local Maternity Voices Partnership. We also meet this standard. All stillbirths and neonatal deaths are reviewed and reported as part of the quarterly "Learning from Death" board report.

2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2)	Y	We meet this standard. This has been confirmed by the Information Team. The score card is discussed at the ICSU board, Quality Committee, and Commissioner Quality Review Group meetings.
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN	y	We meet this standard. Transitional Care (TC) is provided at Whittington Health within the postnatal ward. In January 2018, a review of the admission to NICU for RDS was undertaken as part of the ATAIN programme This demonstrated that the service was meeting the needs of the mothers and babies requiring TC and mothers and babies were re-united as quickly as possible. (80% within 48hrs). The team actively share the learning and good practice identified from this work. ATAIN action plan was presented to the ODN board and a further update has also been provided to show progress.
4). Can you demonstrate an effective system of medical workforce planning?	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.	Y	This is formally recorded both through the General Medical Council Survey and the Royal College of Obstetricians and Gynaecologists Survey. In 2018 the junior doctor workforce identified, that due to gaps in rotas, they have been unable to attend some training locally and at

	b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.		regional level. From October 2019 this should be improved as WH has created two Clinical Fellow roles which we have successfully recruited to, we have two MIT doctors. We are hopeful that the GP trainee roles will be at full complement of 3 this year too. The Trust has not undertaken the Anaesthesia Clinical Services Accreditation (ACSA). However, it has undertaken a review against these standards which it meets. This will be formally ratified at the Cancer and Surgery ICSU board on 25th July 2019. On this basis the Trust meets the standard.
5). Can you demonstrate an effective system of midwifery workforce planning?	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board	Y	This is evidenced through the Chief Nurse Safer Staffing reports presented at the Trust Board. BirthRate Plus tool was undertaken in late 2018 and this has been used to calculate the midwifery staffing ratios. This is presented biannually. The maternity dashboard is used to monitor1:1 care in labour (on labour ward and the birth centre) and presented at the ICSU board, governance meetings and at the Local Maternity System board. A review of maternity staffing was undertaken in June 2019 and a Quality Impact Assessment of reductions in numbers was presented to the Chief Nurse and Medical Director for review. Maintaining the current level of

			staffing was agreed. As required the obstetric unit midwifery labour coordinator has supernumerary status.
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Y	Version 1: as required by these standards - WH is fully compliant. The newly introduced Version 2: WH is compliant for two out of the five actions but has agreed actions plans with NCL for the remaining three. Each month this is discussed at the governance meeting which has midwifery, obstetric, neonatal and anaesthetic representation. From August 2019 either the Medical Director or Chief Nurse will also attend these meetings to further improve board to ward visibility re maternity services.
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	User involvement has an impact on the development and/or improvement of maternity services.	Y	The complaints and PALs reports are reviewed at the ICSU board and the service is able to demonstrate that it has acted on patient feedback. We also have a very active Maternity Voices Partnership. An example of their involvement includes their work as part of the Quality Improvement Project to improve Induction of Labour for women. The NHS Maternity Survey 2018 results were: 100% of women felt they were treated with respect and dignity, 98% had confidence in the

			Trust staff and 96% felt they were involved enough in their care.
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.	Y	The practice development team have been very active and we meet this standard. The training includes theatre nurses and ODPs. For ODPs it has been particularly challenging for them to be released to access the training. One factor is that as support services for a wider range of specialities they are required to be trained in an increasing number of areas and this is having a real impact on capacity and should be noted by the board.
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	Y	Yes and these are in place going forward with the Medical Director and Chief Nurse. The Associate Director of Midwifery and Nursing attends the NCL Local Maternity System Board as well as the NCL LMS Quality and Safety meetings where safety and learning is shared. The monthly Governance meeting in maternity includes anaesthetics and neonatology representation. The plan is to widen the membership to the Medical Director and Chief nurse to provide further visibility to the Board. Safety initiatives are shared through a number of means including the weekly newsletter and ‘message of the week’.

			The executive are also aware of the National MatNeo Improvement work of which the trust is in wave three. Progress reports will be presented to the executive every quarter as part of the Quarterly Performance Reviews.
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.	Y	We meet this standard. The legal team has confirmed that all qualifying incidents have been reported.

The Board of Whittington Health confirms that:

- **The Board are satisfied that the maternity services demonstrate compliance with the maternity safety actions and that the self-certification is accurate.**

- **The content of this report and evidence against each safety action has been shared with the commissioners of the Trust's maternity services**

Meeting title	**Trust Board – public**	**Date: 31 July 2019**
Report title	**Guardian for Safe Working Hours report Q1 2019-20**	**Agenda item: 12**
Executive director lead	Dr Clare Dollery, Medical Director	
Report author	Dr Rebecca Sullivan, Guardian of Safe Working Hours (GoSW)	
Executive summary	There is an overall steady increase in exception reporting in keeping with national findings (164 this quarter) Most exception reports are occurring within the Emergency and Integrated Medicine ICSU. This is as expected as it has the highest number of trainees and the largest proportion of inpatient work. Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against. The GoSW hours is taking a number of steps outlined above to support ICSUs to address the underlying reasons for exception reports being required.	
Purpose:	To provide assurance to the board that junior doctors are working safe hours in accordance with the 2016Terms and Conditions of Service for NHS Doctors and Dentists in Training.	
Recommendation(s)	The Board is asked to review this report	
Risk Register or Board Assurance Framework	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 of income, an adverse impact upon staff retention and damage to organisational reputation	
Report history	Quarterly report to the Board	
Appendices	None	

Guardian for Safe Working Hours report Q1 2019-20

1 Introduction

- This report is presented to the Board with the aim of providing context and assurance around safe working hours for Whittington Health Junior Doctors.
- In August 2016 the new Terms & Conditions (TCS) were introduced for doctors in training. There are clear guidelines of safe working hours and adequate supervision. Trainees submit 'exception report' if these conditions are breached.
- Exception reports (ER) are raised by junior doctors where day to day work varies significantly and/or routinely from their agreed working schedule. Reports are raised electronically through the Allocate's E-Rota system. The Clinical Supervisor for the individual doctor and the Guardian of Safe Working Hours (GoSW) receive an alert which prompts a review the ER and requires the supervisor to meet with the trainee to discuss the events leading to the ER and to take appropriate action to rectify. Such action may include time off in lieu or payment for additional hours worked. They are also asked to review the likelihood of a further exception recurring and address this with the trainee also. Where issues are not resolved or a significant concern is raised the guardian may request a review of the doctors work schedule. The guardian of safe working hours in conjunction with the Medical Workforce team will review all exception reports to identify whether a breach has occurred which incurs a financial penalty. The Guardian for Safe Working will levy a fine to the department employing the doctor for those additional hours worked.
- In line with the 2016 TCS a Junior Doctors Forum has been jointed established with the Guardian of Safe Working and the Director of Medical Education. It is chaired by the Guardian for Safe working. We meet on an alternate monthly basis.

2 High level data

Number of doctors / dentists in training (total):	236
Number of doctors / dentists in training on 2016 TCS (total):	236
Job planned time for guardian:	1 PA
Admin support provided to the guardian (if any):	None *
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

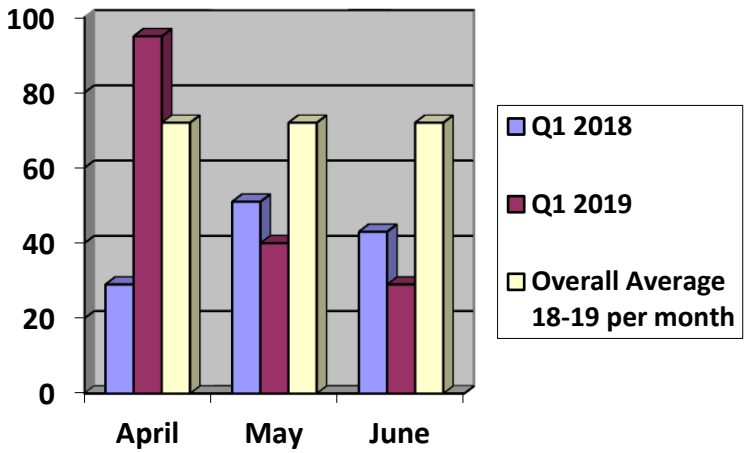
*To be discussed with the new Medical Director

3 Exception reports (with regard to working hours)

Between 1 April 2019 and 30 June 2019, a total of 164 exception reports have been raised. The tables below give detail on where exceptions have been raised and the response times to deal with the issue raised.

		Apr	May	June	Total
Reports	Grand Total	95	40	29	164
	Closed	88	38	24	150
	Open	7	2	5	14
Individual doctors / specialties reporting	Doctors	16	19	17	-
	Specialties	4	5	4	-
Immediate concern		1	1	0	2
Nature of exception	Hours & Rest	94	37	25	156
	Education	1	3	4	8
Additional hours	Total hours	-	-	-	147.5
Response	Agreed	88	38	24	150
	Not Agreed	0	0	0	0
Agreed Action *('No action required' is the only response available for 'education' exception reports)*	Time off in lieu	2	6	2	10
	Payment for additional hours	78	27	13	118
	No action required	1	3	4	8
	NA	7	2	5	14
Grade	Foundation year 1	90	31	21	142
	Foundation year 2	0	0	0	0
	Specialty registrar	0	0	0	0
	General practice specialty registrar	0	0	0	0
	Core medical training	5	9	8	22
Exception type *(more than one type of exception can be submitted per exception report)*	Acute medical event	6	5	6	17
	Pt/Dr ratio too high	83	28	18	129
	Prolonged ward round	4	3	1	8
	Other e.g.IT issues	1	1	0	2
	Educational	1	3	4	8
Specialty	General Medicine	83	27	20	130
	General Surgery	10	1	2	13
	Paediatrics	1	2	0	3
	Anaesthetics	0	0	0	0
	Radiology	0	0	0	0
	Psychiatry	0	5	3	8
	Obstetrics and gynaecology	1	5	4	10
	Accident and emergency	0	0	0	0
	Histopathology and micro	0	0	0	0
	Ophthalmology	0	0	0	0

Exceptions by month



The number of exception reports submitted per month is very variable throughout the year. As might be expected there are more reports in the winter months and less in the summer months when the wards are slightly less busy. The numbers vary between 22 in July 2018 and 175 in October 2018. When reviewed year on year there are increasing numbers of exception reports. This in keeping with an increasingly supportive culture with regards to exception reporting. Junior doctors have recently reported that they had previously felt that the reports went unread and un-actioned but since payments have started to be processed that they now feel that this is an increasingly robust process by which to report exceptions to their contracted working hours.

There are a number of caveats to this quarters reporting. Q1 covers the period including the Easter bank holiday weekend along with the May bank holidays. This lead to a number of exception reports on the days prior to the bank holidays when teams were trying to prepare discharges whilst also ensuring good and accurate handover for the long weekends.

One further anomaly occurred during the month of April where was retrospective bulk reporting by 2 trainees within the gastroenterology department. Victoria ward, at the time, was a well-recognised area of concern with regards to the working hours of the junior doctors. There was a very high patient to doctor ratio leading to the relevant trainees staying late on a daily basis. The reporting reflected hours worked throughout the placement (Jan-Apr) and not only in the months of April. In total this made up for almost a half of the exception reports entered in April. Since the reduction of beds in this area there has been a dramatic reduction in exception reports from this team.

Immediate safety concerns

There have been two immediate safety concerns raised in the last quarter. On both occasions these were raised due to concerns over lack of senior support. Both exceptions occurred in the context of unfilled on-call medical SHO shifts covering the 5pm-9pm slot. These were both due to sick leave taken on the day. Despite efforts being made it was not possible to fill these shifts. On both occasions the junior doctors were able to access senior support from the on-call medical team to keep patients safe. The safety concerns where not related to unsafe working hours.

Work Schedule reviews

No Formal Work Schedule Reviews took place during this period. The GoSW has however met to discuss the CAMHS rota and the number of ERs in this area. This is a complex shared rota that is contributed to by 4 different trusts. Trainees on the rota contribute to a shared on-call rota which routinely involves out of ours calls and frequently involves significant travel.

4 Establishment and vacancy data:

4.1 Agency usage

The table below shows the agency usage across specialities for the period of April-June 2019.

Speciality	Current Agency use – shifts put out to locum agency. April-June
General Medicine	100 shifts put out to agency • 40% filled as internal bank • 44% filled by agency • 16% filled by external bank
General Surgery	59 shifts put out to agency • 83% covered by internal bank • 17% covered by agency
Obstetrics and Gynaecology	173 shifts put out to agency • 49% covered by internal bank • 51 % covered by agency
Paediatrics	43 shifts put out to agency • 88% covered by internal bank • 12% covered by agency

4.2 Locum work carried out by trainees

The table below shows the current vacancy rates across specialists for the period of April to June 2019.

Speciality	Additional shifts worked by trainees
General Medicine	40 additional shifts 312 additional hours worked
General Surgery	110 additional shifts Total hours unknown
Obstetrics and Gynaecology	84 additional shifts 889 additional hours worked
Paediatrics	36 additional shifts 367 ditional hours worked

4.3 Vacancies

The table below shows the current vacancy rates across specialists for the period of April to June 2019.

Speciality	Current vacancies
General Medicine	1 Full time ACCS post vacant 1 Full time SpR vacant 1 Full time CMT vacant 0.6 WTE GPVTS post vacant 0.4 WTE FY1 post vacant
General Surgery	1Full time SpR 2 Full time SHO's 1 Long term sickness FY1 1 Mat leave FY1
Obstetrics and Gynaecology	2.8 WTE SpR vacant

Speciality	Current vacancies
Paediatrics	1 SpR not currently working nights 0.6 WTE SpR vacant

5 Fines and payment

For this quarter 147.5 hours are to be re-paid either in time off in lieu (TOIL) or if this is not possible as pay for additional hours worked. It would not be appropriate for TOIL accrued in one specialty to be rolled over to another specialty.

Currently, these hours equate to a total of approximately £1,972 of which £1,381 has been paid to the junior doctors directly (April & May). Due to procedural difficulties there have been delays in trainees receiving payment and a plan is now in place for payment in the August 2019 payroll.

£2,729.28 has been issued in fines to the Trust in accordance with the terms and conditions laid out in the contract. Work is ongoing to ensure timely payment of fines and ring-fencing into the junior doctor's fund.

Breakdown of fines by ICSU

ICSU	Amount of Fine to Doctor	Amount of Fine to Guardian
Emergency & Integrated Medicine	£1,153.71	£1,367.29
Surgery & Cancer	£77.45	£91.78
Children & Young People	£17.87	£21.18

Fines to the Guardian go into the junior doctor's fund.

6 Next steps

- GoSW to ensure all unclosed ER's are signed off in a timely fashion.
- GoSW to work with ES's/CS's to minimise delays in signing off ER's
- GoSW and HR teams to produce SOP for junior doctors working hours and exception reporting.
- GoSW to work with the next intake of trainees to ensure exception reporting guidance is adhered to in order to try to avoid further bulk reporting.
- GoSW and HR to work with finance team to ensure junior doctors' forum fund is active and ring-fenced as per the TCS.
- Continue to work with ICSU leadership teams, rota coordinators and the bank office to try to reduce the need for exception reporting by working to fill rota gaps whenever possible.
- GoSW will work with relevant sub-specialities in order to try to address the issues relating to over-running/prolonged ward rounds.

7 Conclusions / recommendations

- There is an overall steady increase in exception reporting in keeping with national findings
- Most exception reports are occurring within the Emergency and integrated Medicine ICSU. This is as expected as it has the highest number of trainees and the largest proportion of inpatient work.

- Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against.
- Missed education and training opportunities which have been highlighted via the ER mechanism have been addressed by the DME. The DME will continue to work with the Obstetrics and Gynaecology department during this period of high vacancy to try to minimise the impact on education and training.
- There are still very low levels of reporting in certain specialities, e.g. anaesthetics, radiology etc. and at higher grades. Attempts are being made to increase engagement. This is a well-recognised issue nationally.
- The GoSW hours is taking a number of steps outlined above to support ICSUs to address the underlying reasons for exception reports being required.

Meeting title	**Trust Board – Meeting in Public**	**Date: 31 July 2019**
Report title	**Quality and Safety risk register summary report**	**Agenda item: 13**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report authors	Gillian Lewis, Head of Quality Governance, and 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 July 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. **a. There have been the following changes:-** **1. Risk closures** - No risks were closed in the last period. **2. Downgraded risks:** 970 – Booking team staff vacancies Staffing of Booking team – all band 3 posts recruited to. Awaiting recruitment to band 4; new staff trained by assistant service manager. Risk downgraded from 20 to 12 913 – No consultant cover for on call rotas in some surgical areas Internal staff encouraged to cover gaps in rotas; use of bank & agency staff limited to a number of staff. Risk downgraded from 16 to 8. 950 – Lack of middle grade doctors on rota for CCU Recruitment ongoing for permanent staff & change to rota i.e. 1 in 6 rather than 1 in 7; cover from junior staff and consultants also in place. Risk downgraded from 16 to 12 945 – Coverage issues for Multitone paging signal in theatres Multitone engineer has been to site and has serviced the transmitters and carried out testing in theatres. Confirmed coverage issues in isolated areas	

	– engineer to return for further testing & risk escalated to IT Director. Risk downgraded from 16 to 8. **3. Risk increases** - There have been no existing risks escalated to ≥16 in this quarter **4. New risks** - The following risk has been recently added to the risk register: 988 Increased clinical demand in haematology The Haematology department has had an increase in clinical demand requiring additional capacity to help reduce both 18 week and cancer access outpatient targets; Whittington Health has also been approved as a specialist Haemoglobinopathy Centre (SHT) however retention of this designation and the financial benefits is reliant on meeting set criteria.
Purpose:	Review
Recommendation(s)	The Trust Board is asked to: (i) review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks; and (ii) consider if any ≥16 risks not currently on the Board Assurance Framework (BAF) should be added.
Risk Register or Board Assurance Framework (BAF)	All BAF entries and linked entries on the corporate risk register
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

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 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 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 ≥16 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 risk register and 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: July 2019

5.1 As at 10 July 2019, the Trust currently has four risks graded as ≥20 and fourteen risks/graded as 16. There are eighteen risks graded as 15 which are monitored at Board Committee level.

5.2 There are two key themes from the current high level risks on the risk register.

- Facilities and estates
- Financial

5.3 Due to mitigating actions taken Workforce and Recruitment has not been highlighted as a theme this quarter, however a brief update is given below on progress.

5.4 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.

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

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
750	Facilities and Estates	Patient Safety and Quality	Mental Health Patient Secure Vehicle requires a replacement to meet government standards	16
817	Facilities and Estates	Estates or Infrastructure	Building environmental planned preventative regime for heating,	16

DATIX ID	ICSU/Directorate	Category	Title	Current risk grade
			ventilation and air conditioning systems. Reviewed 10.04.2019; report received & works being considered by Capital works	
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 commenced.	16
907	Trust wide	Estates or Infrastructure	High ambient temperatures of ward/treatment rooms affecting quality of medicines. Reviewed 10.04.2019 – risk increased	16

5.6 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' (**Sustainable 2: 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

5.7 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.' (**Sustainable 2: Failure to deliver cost improvement plan and transformation savings**) which is monitored through this assurance process.

Workforce and recruitment

5.8 The Board should note the mitigating actions taken in workforce and recruitment, outlined in the executive summary, which have reduced three risks since last quarter's report. Workforce and recruitment has consequently not been highlighted as a theme this quarter. These risks continue to be managed at ICSU level. One risk remains at over 16.

DATIX	ICSU/Directorate	Category	Title	Current risk grading
951	Acute Patient Access Clinical Support Services and Women's Health	HR and Workforce	Lack of psychologists to cover maternity clients with perinatal psychology needs. Reviewed 19.02.2019; no change	16

5.9 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: People 1 - Inability to increase substantive workforce capacity***).*

5.10 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.

6. ≥16 Risks not currently on the Board Assurance Framework

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. Replacement equipment ordered and awaiting installation. Risk will be closed once equipment full installed and in use.
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
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

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and Key actions
					cancer targets without significant costs incurred. Reviewed 10.01.2019 – no change
903	ACW	Diagnostics	Ineffective communication 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
988	EIM	Patient Safety & Quality	Increased clinical demand in haematology	16	Controls currently in place to manage increased demand with one extra locum clinic per week, and overbooking existing clinics to see extra patients in the office. Demand and capacity model underway to review next steps and develop business case as required.

7. Recommendations

The Trust Board is asked to:

(i) review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks; and

(ii) consider if any ≥16 risks not currently on the Board Assurance Framework should be added.

Meeting title	**Trust Board – public**	**Date: 31.7.2019**
Report title	**Workforce Race and Disabilities Equality Standards outcomes and Equality Delivery System progress**	**Agenda item: 14**
Executive director lead	Norma French, Director of Workforce	
Report authors	Helen Kent, Assistant Director, Organisational Development, and Eleanor Clarke, Head of Organisational Development	
Executive summary	Since 2016 NHS trusts have been required to report performance on the nine indicators of the Workforce Race Equality Standard (WRES). This year is the first requirement to submit similar data on the Workforce Disability Equality Standard (WDES). The WDES is measured on ten indicators similar, but not identical to, the WRES indicators. This report is written in three parts, to provide this year's WRES results in part one, our first year of WDES results in part two, and an update on work currently undertaken on the Equality Delivery System (second version known as EDS2) in part three. The WRES and WDES data must be published publically, and are provided to the Board in advance of publication. Our **WRES** results this year are mixed with a notable improvement in some areas and a decline in results in others. Indicator two (likelihood of being appointed) shows a higher improvement than in previous years reducing the gap between BME and White staff. Indicator six (relative likelihood of experiencing bullying from colleagues). Another positive score is indicator four which for the first year of reporting shows a balance of take-up of non-mandatory training. Our first **WDES** results show that there is a very low level of disclosure of disabilities in our electronic staff record (ESR) system. What results we have over the ten indicators show that staff with a disability tend to fare less well in comparison with staff with none. The revised 'equality delivery system' (**EDS2**) provides a process to help organisations improve their equality performance by grading current performance in different areas to establish equality objectives. The EDS2 framework identifies two goals relating to patients, one relating to staff and one relating to leadership. For the patient-focused goals, the Trust is collaborating with other trusts in north central London (NCL) sustainable transformation partnership (STP) to ensure we can collaborate with the greatest cross section of partners, patients and the public. For the staff and leadership goals, focus groups are underway to begin grading.	

Purpose:	This paper is for approval, discussion, comment and update.
Recommendation(s)	The Board is asked to: 1. approve submission of the WRES and WDES outcome data to NHS England; 2. note the trends for the WRES outcomes, and the work undertaken to improve WRES performance; 3. note the first year's performance on the WDES outcomes; and 4. note the work to implement EDS2.
Risk Register or Board Assurance Framework	People 1 and People 2
Report history	The Trust Board approved the WRES Improvement Plan on 19 December 2018. An update report was provided in April 2019.
Appendices	Appendix1: Trust WRES Indicator One – Profile of White and BME staff and different bands Appendix 2: RAG-Rated summary of progress with the improvement plan Appendix 3: Trust WDES Indicator One – Profile of staff with and without disabilities at different bands Appendix 4: Suggested WDES priorities Appendix 5: London WRES Strategy

Workforce Race and Disabilities Equalities Standards; & Equality Delivery System Progress

PART ONE – WRES Performance

1.0 Introduction

1.1 The reporting of organisational performance on the nine WRES indicators has been required since 2016. Table one provides a summary of 2019 results and a comparison with 2018 results in the commentary column.

Table 1: Summary of Indicators this and previous years

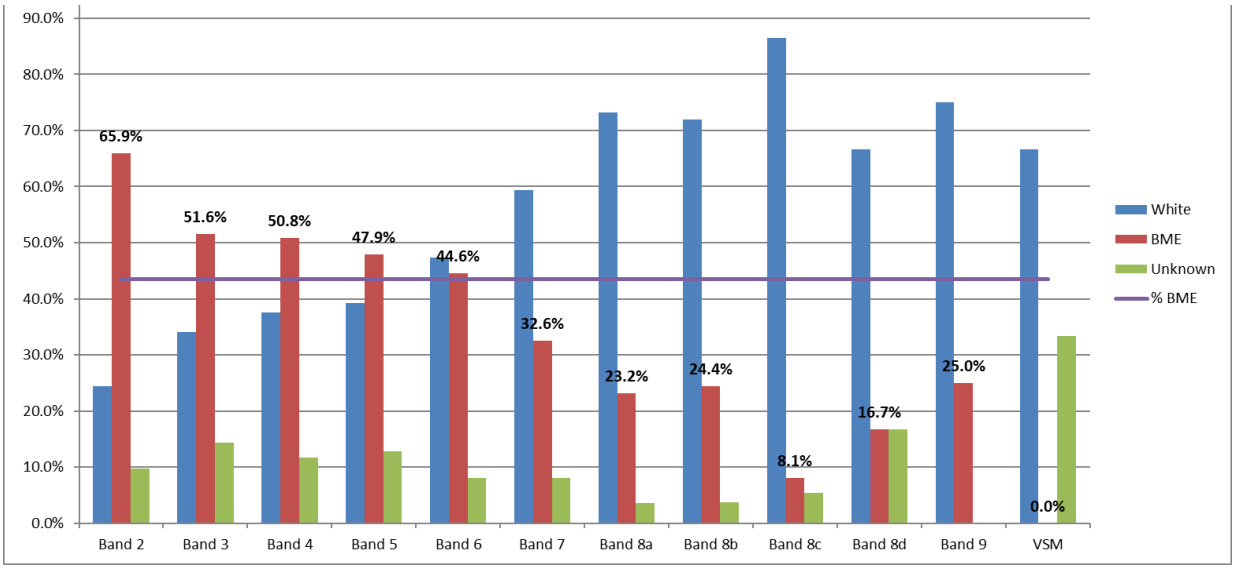
Indicator	2018 Report		2019 Report		Commentary
	White	BME	White	BME	
1. Profile – BAME at different bands	Please see paragraphs 1.3 and 1.4 and Appendix 1 for the organisational profile. There is an improvement in BME representation at the more senior Bands.				
2. Relative likelihood of being appointed	2.14		1.65		Better - the improving trend continues from previous years (2.28, 2.17, 2.14 and 1.65), and is a greater increase than previous years. There us more work to achieve a score of 1.
3. Relative likelihood of entering disciplinary process	1.18		1.44		Worse - the likelihood of entering into a formal disciplinary process has increased slightly showing that BME staff are 0.28 times more likely to enter into the process, than last year.
4. Relative take-up of non-mandatory training	-		0.94		It was not possible to report on indicator 4 in previous years. This first result suggests that there is close to equal access for BME and White staff accessing non-mandatory training, with BME staff accessing very slightly more.
5. Relative likelihood of experiencing harassment and bullying from the public	28%	29%	31%	36%	Worse – the scores overall by 3% for White staff and 7% for BME staff Worse – the gap between BME and White staff has increased from 1% to 5%
6. Relative likelihood of experiencing harassment and bullying from colleagues	27%	33%	31%	36%	Worse – the scores overall by 4% for White staff and 3% for BME staff Better – the gap between BME and White staff has decreased slightly from 6% to 5%
7. Relative opportunities for career development	85%	61%	83%	58%	Worse – the scores overall have reduced by 2% for White staff and 3% for BME staff Worse – the gap between BME and White staff has increased by 1% from 24% to 25%
8. Relative experience of discrimination	8%	17%	9%	20%	Worse – the scores overall have increased by 1% for White staff and 3% for BME staff Worse – the gap between BME and White staff has increased by 2% from 9% to 11%
9. Relative level of Board representation	33% over	-23% under	37.8% over	-21.8% under	Whilst the Board makeup has not changed, the level of over and under representation has changed because it is compared with the total workforce profile for the year: there is a small 5% increase in White representation to 38% over represented; and 1% reduction in under-representation of BME members to -22%.

1.2 Commentary on the results and trends follows separately for each of the nine WRES indicators, and reference is made throughout to the work being done to improve the Trust WRES performance, as indicated by the progress with the WRES improvement plan, summarised in Appendix 2.

Indicator 1 – Profile – BME staff at different pay-bands

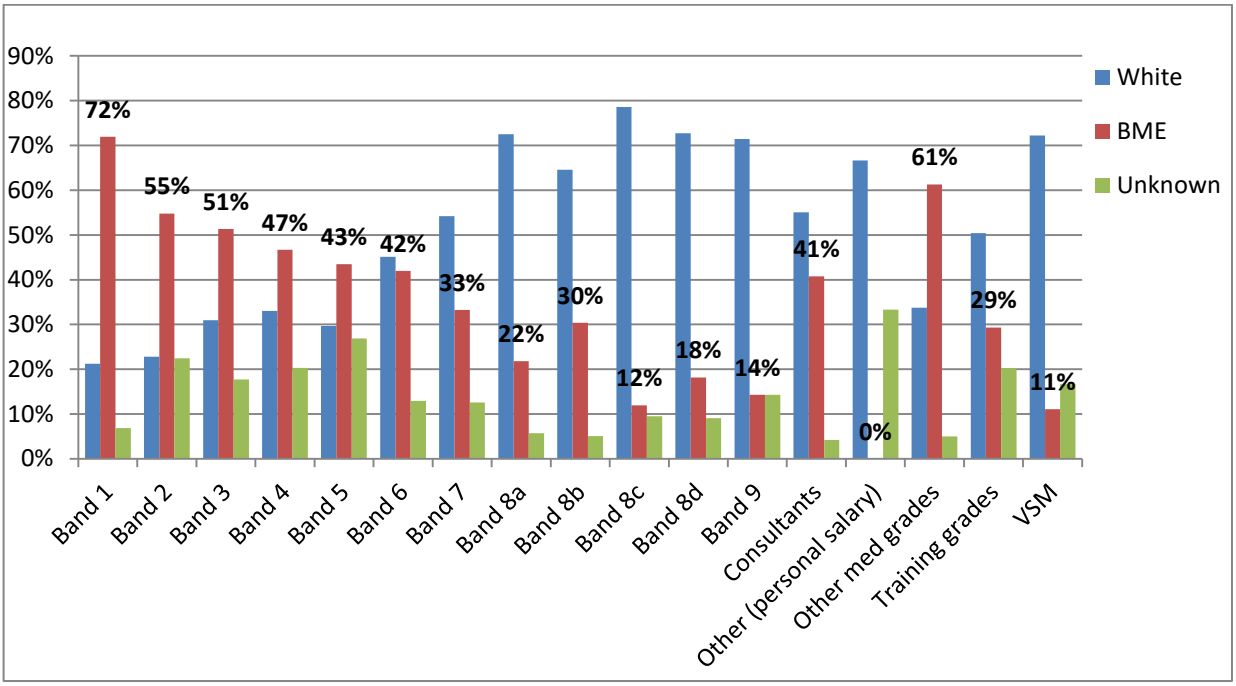
1.3 Appendix 1 shows the profile of White and BME staff at different bands. In many NHS trusts, including Whittington Health in previous years, this is a typical $\mathcal{X}$– shape with White staff increasing with the band, and BME staff decreasing with the bands. Table 2 shows a slight improvement in the representation of BME staff in more senior roles in 2018.

Table 2: 2018 Data for BME and White Staff Distribution Across the Pay-Bands



1.4 Table 3, below, shows the comparison for 2019 data; representation of BME from Band 8B to 8C and VSM has increased further, although performance has dropped slightly for Bands 8A and 9.

Table 3: 2019 Data for BME and White Staff Distribution Across the Pay-Bands



Indicator 2 – Relative likelihood of being appointed

1.5 The improvement in performance for indicator two is greater than in previous years. Previous scores improves performance year on year by 0.11 and 0.03, whilst this year's performance has improved by 0.49: a significant increase. The regime to improve fairness in appointments is described in the improvement plan at Appendix 2 is to ensure that there is BME representation on interview panels, and from August 2019 there will be a reporting process in relation to those BME candidates who came close but were not recruited, which will provide more insight. The intervention is relatively new and the additional reporting on 'close' candidates is yet to start; it is therefore too early to comment on its success. Appropriate in-depth analysis will be undertaken before rolling out to other bands.

Indicator 3 – Relative likelihood of entering disciplinary process

1.6 The results show that BME staff are 1.44 times more likely to enter a formal disciplinary process. The numbers of staff entering into the disciplinary process are low (53 this year and 38 last year) and small differences have a significant impact on the percentages. The Fair Treatment Panel is the intervention used to assess the appropriateness of the action taken and an evaluation of its effectiveness will be undertaken to identify where further improvements can be made.

Indicator 4 – Relative take-up of non-mandatory training

1.7 The data shows almost equal access to non-mandatory training with BME staff very slightly ahead. Competition to enrol in leadership programmes is monitored and managed to ensure equal participation, and appears to be working well.

Indicator 5 – Relative likelihood of experiencing harassment and bullying form the public

1.8 White staff report a 3% increase and BME staff report a 7% increase in bullying, widening the gap between White and BME staff. A staff charter is being managed and new training for all managers to challenge and manage bullying and ensure they can look after themselves and their staff has been procured. This result comes from the October 2018 staff survey.

Indicator 6 – Relative likelihood of experiencing harassment and bullying from colleagues

1.9 It is important to remember that this indicator is reported from the October 2018 staff survey, and it was expected that there would be a dip in scores once awareness was raised and the subject scrutinised. Considerable work has been undertaken since then, including the 'Affina Team Journey'; Culture and Leadership Collaborative; staff networks; the mediation service; behavioural frameworks; improved and simplified appraisal documents focusing on the conversation rather than completion of forms; staff networks; focus groups to support implementation of the equality delivery system. Work continues under the heading of 'caring for those who care' and includes:

- the commissioning of bespoke training to 327 managers from band 5 upwards
- the comprehensive development of the behavioural framework from band 2 to the top
- publication of unacceptable behaviours
- invitation of staff to participate in developing a 'staff charter'
- continuation of Affina team journey for 20 teams
- creation of more staff networks (LGBTQ, disability)
- continuation of the Culture and Leadership Collaborative work
- monitoring of the effectiveness of the mediation service

Indicator 7 – Relative opportunities for career development

1.10 Again, this score is taken from the October 2018 staff survey. Both White and BME staff groups on average report less satisfaction with the opportunities with career development: a drop of 2% for White staff and 3% for BME staff with an increase of 1% the gap from 24% to 25%. Some work has been undertaken to scrutinise the reasons for band 2 staff remaining at band 2 long term; the departure of equalities staff paused this work, and now that a new equalities lead has been recruited, this work can be reinvigorated. It is also hoped that the staff networks will support discussion on progression. Exploration is underway to provide 'personal presentation' training, to support the building of self-perception, and is dependent on finding a solution to the challenge of releasing staff for training.

Indicator 8 – Relative experience of discrimination

1.11 Indicator 8 as measured in October 2018 demonstrates deterioration in both White and BME staff experience of discrimination: 1% increase for White staff and 3% increase for BME staff, widening the gap by 2% from 9% to 11%. Training in unconscious bias is ongoing and the agenda for this area of work will develop with the new Inclusion Lead joining the team.

Indicator 9 – Relative level of Board representation

1.12 There is no change in the Board make-up, however, the level of over and under representation has changed because the Board representation is compared with the total workforce profile for the year: there is a small 5% increase in White representation on the Board to 38% over represented; and 1% reduction in under-representation of BME members to -22%.

London WRES Strategy

1.13 The London WRES Strategy is provided at appendix 5, and emphasises the imperative to increase the speed of improvement. The work outlined in the Trust WRES improvement plan is a good start in implementing the actions outlined in the London WRES Strategy, in particular the focus on increasing the level of BME representation in higher band staff, for both clinical and non-clinical staff.

PART TWO – WDES Performance

2.0 Introduction

2.1 The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to help improve the experiences of Disabled staff in the NHS. The WDES was piloted by 13 NHS Trusts, with the final Metrics being approved by the Equality and Diversity Council (EDC). The first report must be published by 1 August 2019 and based on the data from the 2018/19 financial year.

2.2 The ten evidence-based Metrics will enable NHS organisations to compare the reported outcomes and experiences of Disabled with non-disabled staff and is mandated by the NHS Standard Contract. NHS Trusts and Foundation Trusts will be required to publish their results and develop action plans to address the differences highlighted by the Metrics with the aim of improving workforce disability equality. The metrics used are similar, but not identical to, the metrics used for the WRES. Table 2 below shows a comparison of similarities and differences between the WRES and WDES.

Table 2: Comparison of WRES and WDES Metrics

WRES	From: **ESR/** Staff Survey		**WDES**
Profile – BAME at different bands	**1**		Profile – disability at different bands
Relative likelihood of being appointed	**2**		Relative likelihood of being appointed
Relative likelihood of entering formal disciplinary	**3**		Relative likelihood of entering formal disciplinary
Relative take-up of non-mandatory training (no data)	**4**	4	Relative percentage of staff experiencing harassment, bullying or abuse from: - Patients and public - Managers - Colleagues
Relative level of HBA from public	5	5	Equal opportunities for career development
Relative level HBA from colleagues	6	6	Relative experience feeling pressure from manager to come to work when not well
Relative opportunities for career development	7	7	Relative percentage saying they are satisfied with WH as a place to work
Relative experience of discrimination	8		Percentage saying employer made reasonable adjustments
Relative level of board representation	**9**	9	Relative engagement scores
		10	Relative level of board representation

2.3 One of the reasons behind the development of the WDES comes from the results of the annual NHS staff survey, which nationally show, that Disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities.

2.4 The purpose of the WDES is to improve the experience of Disabled staff working, and seeking employment in, the NHS. The WDES mandates all NHS Trusts and Foundation Trusts to publish the results of their Metrics, together with an action plan, outlining the steps the organisation will take to improve the experiences of Disabled staff.

Outcome for 2019 Reports

2.5 There is a limit to how meaningful and transferable the outcomes of the WDES data can be when the NHS National Staff Survey indicates that there are at least 12% of staff who have a disability, and ESR indicates that only 2% of staff have disclosed their disability. This indicates that the main priority is to increase the disclosure of disability (and all protected characteristics where ESR has the fields; and to campaign alongside other NHS trusts for ESR to be modified to drive appropriate and meaningful development of the ESR system to enable the recording of all data).

2.6 Table 3 below, shows the 31 March 2019 snapshot results for each of the ten WDES indicators.

Development of WDES Action Plan

2.7 As part of the reporting requirement, the Trust must develop an action plan to support improvement of the results. This will need to be developed in collaboration with ICSUs and Directorates, and is likely to include activities already undertaken such as the following

- Maintenance of policies that build on the Equalities Act 2010 to ensure that reasonable adjustments are made to enable people to work
- The improvement of staff disclosure through communications campaign to engage staff on the benefits of uploading ESR with disability data so that we can target resources needed
- The development of a disability staff network which is likely to be known as the “Whitability Network”
- The continuation and wider engagement of managers in two programmes providing employment skills development for autistic students through work placements
- The maintenance of skills of three cohorts of trained mental health firsts aiders (MHFA) to support and raise alerts for those with mental health issues at work

Table 3: Summary of Performance on each Indicator

	Indicator	Result
1	Profile – disability at different bands	Refer to Appendix 3 for information about disability at different levels of seniority. With only 2% of staff disclosing a disability on ESR, and 12% of respondents to the annual NHS staff survey declaring a disability, there is an imperative to encourage those with a disability to disclose data on ESR.
2	Relative likelihood of being appointed	Non-disabled staff are 1.24 times more likely to be appointed than staff with a disability
3	Relative likelihood of entering formal disciplinary	Staff with a disability are 1.74 times more likely to enter into a formal disciplinary process than non-disabled staff
4	Relative percentage of staff experiencing harassment and bullying from - Patients and public - Managers - Colleagues	Staff with Disability / Staff without Patients and Public 40.3% / 32% Managers 27.3% / 19.3% Colleagues 27.5% / 24.5%
5	Percentage of staff believing there are equal opportunities for career development	Staff with Disability 63.3% Staff without Disability 74.1%
6	Relative experience of feeling pressure from manager to work when not well	Staff with Disability 32% Staff without Disability 23.7%
7	Relative percentage saying they are satisfied with WH as a place to work	Staff with Disability 36.8% Staff without Disability 48.4%
8	Percentage saying employer made reasonable adjustments	62.5%
9	(9a) Relative engagement scores	Staff with Disability 6.6 Staff without Disability 7.1
	(9b) At the time the results were collated, the response to the question 'has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?' was 'No'. Since this, a member of staff has expressed interest in creating a network for disabled staff.	
10	Relative level of board representation	11% over-representation of non-disabled - 2% under-representation of disabled Given the level of disclosure across the Trust, this data has limited meaning.)

2.8 Two per cent of staff represented in the result is 83 people, and 10% less that indicated by the 48.5% of the staff who responded to the staff survey. It is therefore a key priority that we engage staff in the benefits of uploading demographic data into ESR to enable the Trust to target resources and activity in support of those with disabilities.

2.9 The action plan needs to be published by 30 September 2019 and this work will be undertaken in collaboration with ICSUs and Directorates.

PART THREE – Progress with the Equality Delivery System (EDS2)

3.1 The EDS2 is a refreshed equality delivery system to help NHS organisations in discussion with local partners and people review, grade and improve their performance for people with protected characteristics. The protected characteristics are –

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership
v. Pregnancy and maternity
vi. Race (including nationality and ethnic origin)
vii. Religion or belief (or absence of)
viii. Sex (gender)
ix. Sexual Orientation

3.2 In total, there are 18 desired outcomes, grouped under four goals, which are:
Goal 1 - Better health outcomes
Goal 2 - Improved patient access and experience
Goal 3 - Representative and supported workforce
Goal 4 - Inclusive Leadership

3.3 There are nine steps to implementing EDS2 as follows:
Step 1. Confirm governance arrangements and leadership commitment – Good governance is typified by two key attributes: (1) the inclusion of members of the public, patients, carers, governors and members where relevant, communities, staff networks, staff-side organisations and local authority partners in governance structures; and (2) by locating EDS2 governance within existing mainstream governance structures. At Whittington Health, the equalities agenda has identified a Board lead, the CEO as Executive lead and the Director of Workforce and Chief Nurse as staff and patient leads respectively.

Step 2. Identify local stakeholders – For goals 1 and 2 in particular, local stakeholders should include patients, carers, members of community groups, other members of the public, representatives of voluntary and community organisations. For goals 3 and 4, any activity should also include staff and representatives of staff-side organisations, and encompass all protected groups. So far, dates have been agreed to meet with groups of staff, unions and partners, as well as staff networks, to discuss the inclusion agenda and specifically to work through the EDS2 steps.

Step 3. Assemble evidence – Evidence of the ways the Trust supports those with protected characteristics has been collated and a slide deck created to present to focus groups to enable the analysis of our equality performance. It is hoped that once the focus groups begin to feed-back and discuss the strategies we employ to support staff with protected characteristics, knowledge of the evidence will grow. The evidence cites a number of policies and processes designed to improve fairness and equity of opportunities, development, and access including reasonable adjustments.

Step 4. Agree roles with the local authority – NHS organisations should agree the part that local Healthwatch organisations, health and wellbeing boards, and public health and other parts of the local authority will play in EDS2 use. The role of local Healthwatch organisations can be pivotal in making EDS2 work well. (This is particularly in relation to goals one and two.)

Step 5. Analyse performance – By sharing the evidence collated at (iii) above, in accessible formats, we can collaboratively analyse performance on each or most EDS2 outcomes.

Step 6. Agree grades – Based on these analyses, we should agree a grade for each assessed outcome. Scoring sheets based on the templates provided in the EDS2 guidance have been created to enable participation of stakeholders at the focus groups. The grading levels are:
Undeveloped - Staff members from all protected groups fare poorly compared with their numbers in the local population and/or the overall workforce OR evidence is not available
Developing - Staff members from only some protected groups fare well compared with their numbers in the local population and/or the overall workforce
Achieving - Staff members from most protected groups fare well compared with their numbers in the local population and / or the overall workforce
Excelling - Staff members from all protected groups fare well compared with their numbers in the local population and/or the overall workforce

Step 7. Prepare equality objectives and plans – Using the grades across the assessed EDS2 outcomes as a starting point, we can then collaboratively set our equality objectives. It is important not to select more than four or five objectives for the coming business planning period, and that at least one equality objective per EDS goal is chosen.

Step 8. Integrate equality work into mainstream business planning – The EDS2 guidance recommends that work arising from setting equality objectives and plans should be integrated within the Trust's mainstream business planning processes, including reporting on the work in Integrated Plans, and stating how the Trust will respond to QIPP challenges.

Step 9. Publish grades, equality objectives and plans – on the website. Progress on plans should also be published, on the website, in the Annual Report, and any other channels. They should be shared with health and wellbeing boards for comment and possible action.

3.4 For goals one and two, there are plans relating to step four to join with other trusts, local authority and partners across the STP to hold joint focus groups across the area to collect patient and service user-related information.

3.5 For goals three and four, focus groups have started (step three) and more are scheduled. Staff and Partners across the organisation have been invited to participate. The evidence used to draw on is growing as data is collected. Preparations are being made to take further steps with dates scheduled to begin step 5. Further information on the progress of implementing EDS2 will be provided in the report to the Board in September 2019, in relation to the report on our public sector equalities duties.

APPENDIX 1 – Organisational Profile – WRES Indicator One

Non-Clinical Workforce

WHITE	2018	2019	% Total	BME	2018	2019	% Total
Band 1	35	31	23%	Band 1	107	102	77%
Band 2	40	38	38%	Band 2	67	62	62%
Band 3	68	67	40%	Band 3	105	101	60%
Band 4	59	57	33%	Band 4	110	118	67%
Band 5	46	43	45%	Band 5	54	52	55%
Band 6	39	41	45%	Band 6	41	51	55%
Band 7	27	28	62%	Band 7	14	17	38%
Band 8A	35	35	78%	Band 8A	9	10	22%
Band 8B	13	7	58%	Band 8B	4	5	42%
Band 8C	18	16	84%	Band 8C	1	3	16%
Band 8D	5	5	71%	Band 8D	2	2	29%
Band 9	3	3	75%	Band 9	1	1	25%
VSM	4	5	100%	VSM	0	0	0%

Clinical Workforce

WHITE	2018	2019	% Total	BME	2018	2019	% Total
Band 2	23	23	22%	Band 2	103	81	78%
Band 3	83	72	36%	Band 3	124	130	64%
Band 4	88	88	50%	Band 4	89	88	50%
Band 5	204	144	39%	Band 5	251	224	61%
Band 6	324	308	52%	Band 6	301	279	48%
Band 7	358	330	62%	Band 7	197	200	38%
Band 8A	148	148	76%	Band 8A	49	46	24%
Band 8B	46	39	70%	Band 8B	16	17	30%
Band 8C	14	14	88%	Band 8C	2	2	13%
Band 8D	3	3	100%	Band 8D	0	0	0%
Band 9	0	1	100%	Band 9	0	0	0%
VSM	2	2	100%	VSM	0	0	0%
Consultants	129	116	59%	Consultants	73	81	41%
Career Grade	21	22	31%	Career Grade	36	48	69%
Trainee Grade	142	113	63%	Trainee Grade	70	67	37%
Other	0	0	0%	Other	0	4	100%

APPENDIX 2 - Progress with the WRES Improvement Plan

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 1 – Profile (2019) **Non-Clinical AfC % BAME 2019** Band 1 – 77% Band 2 – 62% Band 3 – 60% Band 4 – 67% Band 5 – 55% Band 6 – 55% Band 7 – 38% Band 8A – 22% Band 8B – 42% Band 8C – 16% Band 8D – 29% Band 9 – 25% VSM – 0% **Clinical AfC % BAME 2019** Band 1 – 0% Band 2 – 78% Band 3 – 64% Band 4 – 50% Band 5 – 61% Band 6 – 48% Band 7 – 38% Band 8A – 24% Band 8B – 30% Band 8C – 13% Band 8D – 0% Band 9 – 0% VSM – 0% DiT – 37% Career Grade – 69% Consultants – 41%	Conduct analysis of data by department, profession to assist in identifying specific areas of concern and barriers to career progression.	A huge amount of work has been undertaken and a comprehensive spreadsheet exists developed through the collaboration of Workforce Information and Inclusion. The detailed analysis can be undertaken using this but has not yet been completed. This is high priority. After the sudden loss of EDI staff, a new highly qualified team member joining soon means this can be re-started.	Feb-19 now Dec-19
	Measures agreed for addressing the over representation of BME staff at lower bands	Several initiatives being delivered or researched (for example, Hd OD and Inclusion Lead looking at Band2 data) but no definitive agreement made on actions to be taken. With new EDI team in place this work can be re-energised	Mar-19 now Dec-19
	Incorporate unconscious bias dimensions into HR core skills training to influence recruitment and people management practices.	The newly recruited EDI Lead will reinvigorate this work when he joins in September	Mar-19 now Oct-19
	Continue to deliver unconscious bias training to all staff	This is delivered by BRAP experts and is available for booking onto: 32 are booked onto the next course. The next session is 24-Jul-19 and there is another in September.	Ongoing
	Identify positive role models to promote across the Trust Work with Staff Inclusion Network to develop and showcase case studies of BME staff to profile career progression successes and encourage managers and individuals to raise aspirations in career pathways	Several people have been identified for case studies, however their stories have not yet been written With new EDI team in place this work can be re-energised	Apr-19 now Dec-19
	Continue to take a targeted approach to key leadership programmes, proactively encouraging BAME candidates	Complete – standard process in place to ensure high level of BAME participation. Review booked for Jun-19	Feb-19
	Reverse mentoring to be in place, audited + rolled out	Next cohort ready. New dates being sought from Stacy Johnson.	Nov-18
	Target development programmes at lower banded roles	Last cohort of Stepping Stones offered follow-on development and support such as shadowing and coaching. Setting up focus groups with Band 2 staff on developmental opportunities required for career development	Dec-19
	Continue the work to include sessions on diversity, culture and race and extend	Continuing in B6&7 clinical leadership and ICARE Leadership programmes and to be extended to new Compassionate & Inclusive	Dec-19

	to all ICARE Leadership programmes	leadership programme for 8A and above	
	WRES Workshop led by NHS National WRES team targeting at least 100 staff across the Trust; a cross section of bands, staff groups, professions and roles such as Speak Up Inclusion Champions plus participants of I.CARE Leadership programmes	Completed with 90 diverse members of staff attending	Feb-19
	3 x follow up sessions - "Teach & Learn" led by Yvonne Coghill – NHS National WRES team	The March date for a follow-up was cancelled owing to sudden changes in personnel New dates are being organised. With new EDI team in place this work can be re-energised	Apr-19 Dec-19
	Interventions to include the "Thinking Environment" methodology offered by LLA. Inclusion Labs pilot – creating a more inclusive environment to facilitate EDI becoming a "golden thread" in everything the Trust does in delivering good patient care	Led by Mitzi Wyman, several dates were delivered for exploration and specific workshops New dates are being organised	Ongoing
	Part of WRES NCL CCGS & Providers Group – working collaboratively across the sector e.g. Equality & Diversity Week in May 2019 (to be confirmed)	Data being prepared for first submission in April 2019 as requested by the project	Apr-19 + ongoing

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 2 – Appointed from shortlisting The indicator shows a significant gap in the likelihood of White and BAME staff being appointed from shortlisting.	Investigate this trend further and consider if there are differences between professions, departments and pay bands both from application to shortlisting stage. Narrow the gap in relative likelihood of white staff being appointed compared to BME staff by 0.25	This analysis is due in the Autumn 2019	Autumn 2019
	Ensure that all Band 8A and above panels have a BAME representative	This was implemented and in place. Inclusion Lead working with Comms to change messaging to encourage participation (previously 'we have this new rule' to 'this is not balanced and we want to improve fairness and this is one of the methods we are trying – come and help us' etc. Inclusion Lead working on narrative for Bulletin, CEO Blog and	Dec-18

The data shows that White staff are 2.04 times more likely to be appointed from shortlisting than BAME staff across all posts		Screensavers.	
	Director of Workforce to oversee all 8A and above appointments and to personally check the shortlist, panel and who is appointed	The scheme to ensure BAME representation on interview panels has been in place since December 2018. The scoring and outcomes reporting has been devised and results from April to June will be reported at the next update.	Apr-19
	Increase % of panel members who have attended unconscious bias training to 70% in addition to 95% having completed equality and inclusion training	Face to Face sessions are booked; currently exploring how it can deliver remotely eg e-learning	Apr-19 now Dec-19
	Develop a statement to be included in job adverts about the Trust taking Positive Action	All job advertisements include a positive action statement as part of the standard text	Jan-19
	Complete an audit of a sample of interview scoring sheets for BAME and with candidates. Question included in quarterly applicant survey around impact.	The scoring sheet has been designed and the first quarter results (Apr-19 to Jun-19) can be reported in the next update	Mar-19
	Continue to deliver recruitment and selection training including impact of unconscious bias. Ensure this is a pre-requisite for those taking part in the process	This training has been offered and is due for re-booking for the new financial year	Ongoing
	Where a BME candidate has not been appointed following interview, the recruiting manager to write to Director of Workforce setting out reasons why?	Implementation of this was delayed and is now in place. A communications plan will be disseminated from 01 August 2019	Jan-19 Now Aug-19
	A record kept of all interviewers undertaking training Minimum of one panel member to have unconscious bias training	It is known that one member of the 15 volunteers for BAME representation on interview panels has undertaken unconscious bias training. It is offered freely throughout the organisation on an ongoing basis.	Jan-19
	Quarterly workforce assurance reports	This is second quarter since improvement plan	Apr-19 Jul-19

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 3 – Disciplinary There appears to be a significant change, however, the data is not directly comparable. In 2016-17 all formal cases were included (grievance, disciplinary, probation, performance), while the data for 2017-18 includes disciplinary only. The 2017-18 data shows BAME staff are 0.75 times less likely to enter formal disciplinary processes than White staff	Analyse the disciplinary data to understand whether the likelihood of BAME staff exiting the formal disciplinary process with a sanction is greater than for white staff. Reduce overall representation of BAME staff in formal disciplinary processes by 25%	ER Team have liaised with the Lead for this within Equality, Diversity and Inclusion, TJ, and clarified required information for the National WRES Reporting. All required data has been clarified and can be obtained from the system. To be provided by the end of the first week of April once the 19/20 leave has ended.	Dec-19
	Evaluate the outcome of the Fair Treatment Panels	The WRES action plan outlines that the Panels are to be revised at the end of March 2019. It has been agreed with Carol Gillen and Kate Wilson that a full analysis will highlight the numbers of cases and assessment against the original aims of the process. Informally, it is felt there have been some positives, i.e. 3 cases being managed in an alternative way to a formal hearing. At the same time, there is the question of whether the panel is too late in the process as they follow formal investigations. The question that will be included as part of the analysis and apply learning to reduce the number of formal investigations, including for BME staff. To be reinvigorated in September.	Mar-19 now Sep-19
	Analyse disciplinary offence by ethnicity to consider if there are specific issues relating to particular groups, departments or pay bands	This is part of the quarterly workforce ER reports for which there has been no lead since January. This also feeds into the Pan London Data project. To be completed September 2019 by the newly appointed Head of Employee Relations.	Quarterly from Sep
	Ensure that panel members have had unconscious bias training (min 1 per panel)	All HRBPs and ER Advisers have undertaken Unconscious Bias Training, therefore there will always be one panel member who has undertaken the training. All HR staff are booked on refresher training. We have a list of managers who have undertaken training, and will do a further communications push on this.	Jan-19 Now Jul-19 and Sep-19
	Promote the role of facilitated conversations and mediation in the earlier stages of resolution of conflict that can lead to formal processes	Managers handbook with support on how to facilitate conversations published and webpage with the promotion of facilitated conversations as a means to tackle some bullying and harassment issues drafted	Mar-19
	Participant of Pan-London WRES Project 3 – improving equalities outcomes through better practices. Bench mark progress against other participating Trusts, including the academic research findings	The required data has been fully reviewed and the first submission is due for 12th May 2019 which cover April activity. This data is for the month of April and would represent any cases closed in April. (NB: This is different for the National WRES submission which is cases *open* within 18/19 financial year). Significantly more data is required for the Pan London Project. A trial report has been run and all the data required is available	Apr-19

		from Selenity, the ER system and core workforce data on ESR. There is one area of information we do not have on the system, relating to the characteristics of the commissioning manager. However, this can be obtained without too much difficulty. Deputy ER Manager in agreement that can provide this information to the E&I team on a monthly basis as requested by the Project.	
	Increase capacity of mediation by working with other organisations who are similarly trained and share the resource whilst developing the internal team to manage issues relating specifically to diversity and race	Met and designed pilot with 9 other interested trusts. WH mediated for two other trusts in Apr-19 Head OD (a mediator) completed 2 day EDI in OD training, shared learning with mediators in Mar-19 Offer of mediation in relation to bullying & harassment issues for staff drafted and ready to go onto intranet	Apr-19
	Increase OD offer to facilitate staff disputes (before reaching mediation/disciplinary) by developing internal staff facilitation experts, representative of the diverse workforce and able to use the principles of mediation in a less formal and time intensive setting	FSUG is a trained mediator and agreed he as well as OD team can offer facilitation for disputes. He to signpost staff to OD offer. Support for managers to facilitate disputes drafted and to go onto intranet in April. Training to be offered to coaches to be able to facilitate staff disputes. The commissioning of some training was postponed following the departure of EDI staff and can be restarted on arrival of the new team	Jun-19 now starting Sep-19

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 4 – Training There is currently no data to report. A review to improve collection of data commenced in April 2018 working with Clinical Education/Professional Development Nurses (PDNs) to identify gaps and report as of April 2019 on available data for 2018-2019	Hold a workshop with Staff Inclusion Network to identify opportunities to promote fairness to career progression or promotion as the staff survey results (KF21) reveal that 85% of white staff stated that they believe the Trust provides equal opportunities for career progression. The figure for BAME staff was 61%, a drop from 70% in 2016	Joan Saddler delivered presentation to well attended staff network	Mar-19
	Increase recording of CPD and development opportunities or qualifications on ESR by Professional Development Nurses (PDNs)/Educational/Training Leads	Work has been ongoing with Clinical Education: the Inclusion Lead has collated the data in a comprehensive spreadsheet to enable reporting. This project was successful and for the first year the Trust has been able to report on indicator 4. The results show a balance of White and BME staff accessing non-mandatory training.	Mar-19
	Explicit/focussed attention to the PDP part of annual appraisal with outcomes	The new appraisal paperwork includes a section on development and career aspirations. This will be promoted through a Communications Campaign once the pilot evaluations are complete.	Mar-19 Now Aug-19
	Annual reports sent to ICSUs/directorates as part of KPI & Training Needs Analysis (TNA) planning	It has not yet been possible to report on WRES indicator 4. Data is collated for August reporting, and therefore this has not been split into ICSU TNA data and shared with ICSUs. The data being collated now will later be cross-referenced with data in ESR and from the Staff Survey to enable WRES reporting for ICSUs and Directorates. This reporting is annual.	Aug-19 Dec-19

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 5 – Bullying from Patients The data shows that the percentage of White staff experiencing harassment, bullying or abuse from patients, relatives or the	Continue to monitor annual Staff Survey responses against workforce data (e.g recorded harassment, bullying or abuse from patients, relatives and the public in the last 12 months) and work with the Staff Inclusion Network to understand any discrepancies	A comprehensive template has been developed through collaboration between OD and HRBPs to enable ICSUs to develop action plans following receipt of local staff survey results. The group identified three key focus areas for each ICSU and agreed on final amendments to the Head of OD's template presentation for the ICSUs to use. Wellbeing, morale, safety, quality of appraisals and line managers are the most frequently appearing priorities	Mar-19 to Jul-19
	Offer staff training on personal	Winter resilience workshops delivered to service managers , ops	Mar-19 to

public in the last 12 months is 28%, while for BME staff it is 29%	resilience and management of conflict (including harassment, bullying or abuse) specifically to staff who may receive abuse from patients, relatives or the public	directors and overseas nurses, to be reviewed + relaunched Nov-19 Workplace conflict + resilience modules delivered in I.CARE Leadership, B6/B7 clinical leadership, TKI assessments for conflict resolution styles offered to internal Coachees Workplace bullying (firm but fair framework) covered in I.CARE Team Player Development of Whittington unacceptable behaviours re: bullying & harassment Development of intranet page for support for all staff re: bullying & harassment Toolkit for managers/leaders on managing bullying + harassment complaints with conflict styles guide for managers/leaders in the toolkit	Jul-19
	Analyse data by department, pay band and profession – KF 21 and Q17Collate information regarding "hot spots", bands, roles, etc and produce targeted interventions as part of staff survey action plans	*Picker dartboards delayed until April.* Draft action plans for ICSU leads ready to be published with suggested focus areas HRBPs and OD team agreed areas of focus: EDI, b&h and health and wellbeing	Jun-19
	Promote methods for ensuring personal safety and security – 4 sessions	Training using actors and role play devised for 327 managers plus VSMs commissions and being rolled out	Jul-19 to Dec-19

Indicator data	Actions and outcomes	Progress and commentary	RAG
Indicator 6 – Bullying form Staff The data shows that the percentage of White staff experiencing harassment, bullying or abuse from staff in the last 12 months is 27%, while for BAME staff it is 33%	Promote methods for ensuring personal safety and security – 4 sessions	Training using actors and role play devised for 327 managers plus VSMs commissions and being rolled out	Jul-19 to Dec-19
	Develop managers to be confident in approaching staff to resolve issues sooner rather than later - Four sessions of critical conversation training delivered	The intranet page for support for all staff re: bullying and harassment drafted and with Communications team. Whittington unacceptable behaviours re: bullying and harassment signed off at TMG and is now available on the intranet. The Toolkit for Managers published	End Dec-19
	Training in holding difficult conversations, 4 sessions	WH took up offer to use ActEd for a team re: difficult conversations. ActEd offering a session to leaders 8A & above in April. NHS Elect signed up to offer coaching & facilitation skills for leaders 8A and above (clinical & operational) in 2019	End Dec-19
	Run stress management courses	Stress management courses ready for delivery (piloted in 2017-18). Four	End

	and well-being sessions for all staff	session to be run	Dec-19

Indicators, Trust data	Actions and outcomes	Progress and commentary	RAG
Indicator 7 – Career Data shows % of staff who believe the Trust provides = opportunities for promotion/career progression: 85% White staff + 61% BAME staff	Hold a workshop with the Staff Inclusion Network and staff side to understand the staff survey data, to identify root causes and potential solutions to address the less positive results – 4 sessions	One session has already been delivered and is to be continued	End Dec-19

Indicators, Trust data	Actions and outcomes	Progress and commentary	RAG
Indicator 8 – Discrimination Not only is there a fall when looking at the 2017 (White 87% and BAME 70%) data for White and BAME staff in believing there are career opportunities, there is a widening gap between White and BAME staff. The data shows in White staff it is 8% while in BAME staff it is 17%. When looking at 2017 data (White 7% and BAME 17%) there is a closing gap moving in the right direction, but the gap remains large and the experience of discrimination is too high for both White but especially BAME staff	Train managers in career development /management	As part of appraisal redesign there is a guide for managers, staff, and evaluation sheets to say how useful it is. Personal career development training is being offered in the bespoke programme of sessions for WH managers/leaders between 8A – 8D	Jan-19 start
	Scope requirements for running internal development centres. Introduce development centres to support career and role development	Initial discussions have started related to the appraisal update work Open invitation to pilot and evaluate for amendment before finalising. All-level behavioural framework designed to support assessment centre scoring.	Jan-19 start to Dec-19
	Continue to support the Staff Inclusion Network to provide opportunities for sharing experiences	Continuing with dates booked	Jan-19 start
	Continue conflict resolution training and enhance mindfulness	Conflict resolution is part of mandatory training suite and more bespoke offers are provided by the OD team, including training for the internal coaches, mediators and leaders between 8A-8D. It is also part of the ICARE Leadership programmes.	Mar-19
	Review the role of anti-bullying and harassment advisers. Consider re-branding the role to reflect a range of support, and relaunch communications package. Full evaluation of role, impact and re launch	OD and Inclusion teams have been working with the Freedom to Speak Up Guardian. The role of the Speak-Up Inclusion Champions have now been rebranded as Speak Up Advocates.	Mar-19
	Publicise the wide range of bullying and harassment tools and pathways to staff using a range of media. Directory available on intranet	Intranet page on B&H drafted and with Communications team. Links to other Trust offers of support. Managers Toolkit published – including section on B&H and other support. Highlighted in ICARE programmes	Mar-19
	Develop managers' handbook or Toolkit. Create	Managers Toolkit published on the intranet. Culture	May-19 ongoing

	managers network: all managers invited to find a monthly 30/60min slot to meet a colleague from another part of Trust, discuss cultural issues. Pilot with B7s. Handbook/mngrs' passport in place	Collaborative work continues with Change Team and Reference Group Managers' network to be developed The Managers' Passport has launched as is being delivered in modules.	to Dec-19

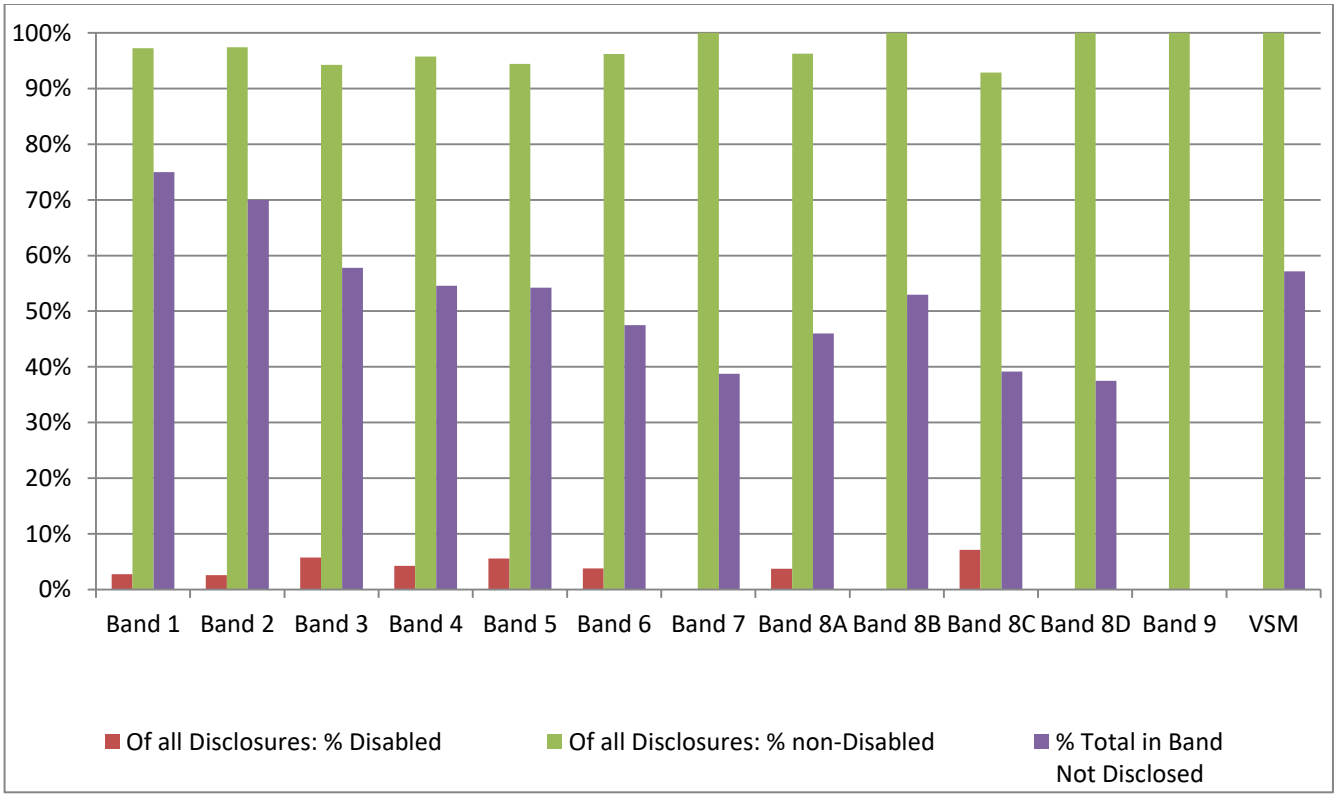
Indicators, Trust data	Actions and outcomes	Progress and commentary	RAG
Indicator 9 – Exec/Board By the voting membership of the board: the data shows that 25% of the Trust board voting members are BAME compared to 43% BAME workforce. The percentage difference is therefore -18% (i.e. 25% - 43%) By executive membership of the board: the data shows that there are no BAME Executive members and the percentage difference is - 43% (i.e.0% - 43%= - 43%)	Board development Programme commissioned	Commissioning completed and ongoing	Feb-19
	Encourage Board members to update protected characteristic information. ESR information update to accurately reflect Board membership.	A previous problem with ESR has been resolved. Campaign and support to begin from Jul-19 onwards	Jan-19 now from Jul-19 onwards
	Ensure that positive action statements are included in recruitment processes. All external recruitment for senior posts to include positive action statement	All job advertisements include a positive action statement as part of the standard text	Dec-18
	Specify to recruitment agencies working with the trust that candidate lists are expected to be of a diverse background. Internal checklist for instructions to external agencies to include information of expectation of diverse candidate lists	Temporary Staffing has transferred to Bank Partners, and therefore this action will be communicated to them.	Apr-19 now Jul-19

APPENDIX 3 – Organisational profile – WDES Indicator One

Non-Clinical Workforce

Disabled by Band	% Disabled Total Disclosed	Non-Disabled by Band	% Total non-Disabled Disclosed	Not Disclosed	% Total Band Not Disclosed
Band 1	3%	Band 1	97%	Band 1	75%
Band 2	3%	Band 2	97%	Band 2	70%
Band 3	6%	Band 3	94%	Band 3	58%
Band 4	4%	Band 4	96%	Band 4	55%
Band 5	6%	Band 5	94%	Band 5	54%
Band 6	4%	Band 6	96%	Band 6	48%
Band 7	0%	Band 7	100%	Band 7	39%
Band 8A	4%	Band 8A	96%	Band 8A	46%
Band 8B	0%	Band 8B	100%	Band 8B	53%
Band 8C	7%	Band 8C	93%	Band 8C	39%
Band 8D	0%	Band 8D	100%	Band 8D	38%
Band 9	0%	Band 9	100%	Band 9	0%
VSM	0%	VSM	100%	VSM	57%

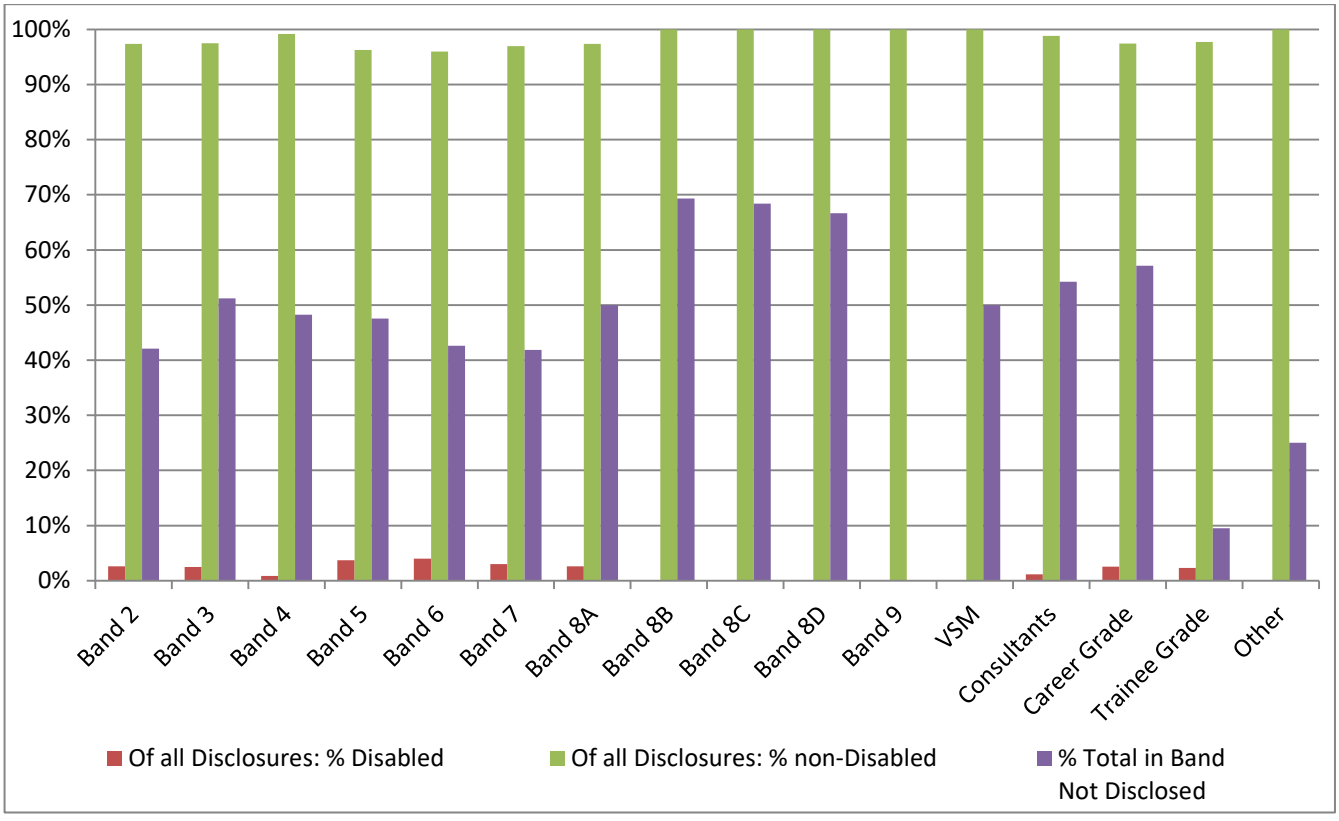
Graphic Representation of the Data Above – Non-Clinical Workforce Disability Disclosure



Clinical Workforce

Disabled by Band	% Disabled Total Disclosed	Non-Disabled by Band	% Total non-Disabled Disclosed	Not Disclosed	% Total Band Not Disclosed
Band 2	3%	Band 2	97%	Band 1	42%
Band 3	3%	Band 3	98%	Band 2	51%
Band 4	1%	Band 4	99%	Band 3	48%
Band 5	4%	Band 5	96%	Band 4	48%
Band 6	4%	Band 6	96%	Band 5	43%
Band 7	3%	Band 7	97%	Band 6	42%
Band 8A	3%	Band 8A	97%	Band 7	50%
Band 8B	0%	Band 8B	100%	Band 8A	69%
Band 8C	0%	Band 8C	100%	Band 8B	68%
Band 8D	0%	Band 8D	100%	Band 8C	67%
Band 9	0%	Band 9	100%	Band 8D	0%
VSM	0%	VSM	100%	Band 9	50%
Consultants	1%	Consultants	99%	VSM	54%
Career Grade	3%	Career Grade	97%	Career Grade	57%
Trainee Grade	2%	Trainee Grade	98%	Trainee Grade	10%
Other	0%	Other	100%	Other	25%

Graphic Representation of the Data Above – Clinical Workforce Disability Disclosure



APPENDIX 4 – Suggested areas for improvement for WDES

Indicators, Trust Data	Actions and Outcomes	Projected Timescales	RAG
Indicator 1 - Profile	The improvement of staff disclosure through communications campaign to engage staff on the benefits of uploading ESR with disability data so that we can target resources needed. The aim to start with should be that the disclosure of disability on ESR (currently at 2%) matches disclosure on national NHS Staff Survey levels (previously at 12%)	This is a long term project likely to be in excess of 12 months and dependent on engaging staff through a communications campaign	Jun-20
Indicator 2 – Appointed from shortlisting	Formal record keeping of disability disclosed at shortlisting and interviews and monitoring of data resulting from the process of making appointment	New monitoring needs to be devised and staff trained by the end of the year to start in the new year.	Dec-19 - Jan-20
Indicator 3 - Disciplinary	Formal record keeping of disability disclosed at the Fair Treatment Panel and data resulting from the disciplinary process	Aligned to indicator 1 and dependent on engaging staff in disclosing disability	Mar-20
Indicator 4 - Bullying from: Patients and public; Managers; and Colleagues	In-depth analysis of national staff survey data Listening to messages from the staff disability network	Four months	Dec-19
Indicator 5 – Career	The development of a disability staff network which is likely to be known as the “Whitability Network” supported by corporate events to support career development, benefits of networking for career advancement etc	Three months	Nov-19
Indicator 6 – Pressure to work when not well	Ensure the inclusion of understanding in different contexts of the Equalities Act 2010 and the range of ‘reasonable adjustments’ that can be made, in the Managers’ Passport (management development)	Six months	Feb-20
Indicator 7 – Work advocacy	The continuation and wider engagement of managers in two programmes providing employment skills development for autistic students through work placements.	Ongoing: two projects have already started	Started
Indicator 8 – Reasonable adjustments	Maintenance and development of policies that build on the Equalities Act 2010 to ensure that reasonable adjustments are made to enable people to work	Ongoing: there is a rolling programme of policy review with staff, Partnership Group	Continuous
Indicator 9 - Engagement	The maintenance of skills of three cohorts of trained mental health firsts aiders (MHFA) to support and raise alerts for those with mental health issues at work	Started and ongoing	Started
Indicator 10 - Board representation	Increase disclosure of disability and encouragement of non-executive directors with disabilities when vacancies arise.	Immediately and ongoing	Jul-19 onwards

Tackling workforce race inequality across London NHS trusts: a strategic approach (2019 – 2022)

July 2019

NHS England and NHS Improvement

Contents

1 Purpose

This paper outlines the proposed strategic approach to reducing the gap in workforce race inequality across NHS trusts in the London region, during 2019/20 to 2021/22. It is a regional strategy designed to support local NHS trusts in their implementation of the Workforce Race Equality Standard (WRES), and to meet the aspirations of increasing black and minority ethnic (BME) representation at senior levels across the NHS.

This strategy will support local NHS trusts to develop and refine their existing WRES action plans. It is **not** intended to undermine local creativity and/or initiatives that are already underway and having a positive impact on this agenda.

2 The strategic approach

The WRES was introduced in April 2015 – to help support NHS organisations make the necessary operational and cultural changes needed to advance workforce race equality. It enables them to then make fundamental improvements in their organisations that will ultimately improve the quality of care for all patients.

To date, good progress has been made in helping NHS trusts to establish the reporting architecture and baseline data against the nine WRES indicators that focus upon workforce representation and staff experience. Evidence based interventions are beginning to close the gaps in workplace race inequality, but more needs to be done.

We know that workforce race equality, and equality in general, is a challenge that requires organisations to go beyond operational change because of data, compliance and regulation. The parallel challenge to conquer here, and possibly the most difficult one, is that of cultural and transformational change on the workforce race equality agenda.

To realise the system-wide change we want to see on this agenda, the WRES programme focuses upon four key strategic areas:

(i) ***Enabling people***: meaningful engagement, focused improvement, communications.
(ii) ***Embedding accountability***: system alignment, regulation, new healthcare architecture.
(iii) ***Encouraging transformation***: embedding learning and compassionate cultures at all levels of the organisation
(iv) ***Evidencing outcomes***: data and intelligence, replicable good practice, evaluation.

This strategic approach will help NHS trusts to meet the workforce race equality commitments set out in the NHS Long Term Plan, the Interim NHS People Plan, and as outlined in the national WRES Model Employer strategy.

It is underpinned by international evidence from major change programmes on workforce equality, and in particular, on what works: demonstrable leadership, data-

driven accountability, metrics and transparency – underpinned by a convincing narrative; as outlined in the 2015 *BMJ* paper by Priest et al[1].

This strategy is intentionally focused upon NHS trusts in the first instance. Over time, it is expected to widen its scope to take into account other NHS organisations within the Integrated Care System.

3 Operational expression of the strategy

Tackling workforce race inequality across the NHS in London is an important priority. A plethora of research and evidence highlights the links between staff engagement and patient safety, quality of care, and overall organisational performance.

The WRES data show that, whilst there may be some improvement over time, London NHS trusts collectively are consistently behind other parts of the country with regard to a range of indictors relating to workplace experiences and opportunities for our BME staff (see Annex).

In autumn 2018, the chief executive officers of London NHS trusts were invited to a meeting on this subject with the national WRES team. It was clear that whilst work in this area was underway within individual trusts, a more joined-up leadership approach was also needed to provide a collaborative focus on the key issues.

Key actions agreed by this senior guiding coalition were to:

Embedding accountability:

- Develop a specific programme for all middle management (line managers and supervisors) within NHS trusts – with a focus on learning and accountability on this agenda.

Encouraging transformation:

- Focus on transforming deep-rooted cultures within organisations – creating compassionate learning environments through implementation of interventions such as (but not restricted to) the NHS Improvement Leadership & Culture Programme, or similar. Indeed, trusts may well want to use fit-for-purpose and effective development programmes that are already currently in place.

- Develop an aspiring leadership programme for BME staff in the NHS across London – with a focus on staff development and progression through the workforce pipeline, and with input and contribution from London chief executive officers.

Evidencing outcomes:

- Monitor progress against the WRES indicators, and with regard to the aspirational targets for BME representation across the workforce pipeline and at leadership positions within each NHS trust. Local systems to set themselves an improvement trajectory that will monitor progress at local and regional levels.

[1] 2015 *BMJ* paper by Priest et al

- Bring together replicable good practice on this agenda in one place – as a toolkit for use by London trusts, and beyond. This may include explicit guidance for appointment/recruitment to Boards and Governing Bodies.

The following were viewed as key enablers to help achieve the above:

Enabling people:

- Share experiences and learning via a 'WRES action learning set' for London chief executive officers – to meet quarterly under the leadership of the regional director.

- Pool together meaningful and sustained resource for this agenda that would benefit the strategic approach and its operational expression across the region.

- Individual NHS trusts will have access to the national WRES team and experts that will help with WRES action planning.

4 Governance and resources

Individual NHS organisations within the London region will have responsibility to working collaboratively and for implementing the actions agreed by the London NHS Top Leaders Group and as set-out in this paper. Progress will be supported by the national WRES team and monitored by the Regional Talent Board. This work also receives overview from the national WRES Strategic Advisory Group.

Strategic theme	Deliverable	March 2020	March 2021	March 2022	Risk(s)
Embedding accountability	Develop and roll-out a programme for line managers and supervisors – with a focus on learning and accountability on workforce race equality	Programme developed, validated and initial roll-out to 20% of all trusts in London	Programme roll-out to 50% of all trusts in London	Programme roll-out to 100% of all trusts in London	Programme not validated, accepted and/or implemented as a strategic priority
Encouraging transformation	Adoption and implementation of the NHS Improvement Leadership & Culture Programme	Programme roll-out to 30% of all trusts in London	Programme roll-out to 50% of all trusts in London	Programme roll-out to 100% of all trusts in London	Programme not accepted and/or implemented as a strategic priority
	Develop and roll-out an aspiring leadership programme for BME staff in the NHS across London	Programme developed, validated and initial roll-out to 20% of all trusts in London	Programme roll-out to 50% of all trusts in London	Programme roll-out to 100% of all trusts in London	Programme not validated, accepted and/or implemented as a strategic priority
Evidencing outcomes	Monitor progress against the WRES indicators, and aspirational targets for BME representation by 2028	All trusts implement WRES; and commence work on aspirational targets	All trusts implement WRES; and are on course to meet aspirational targets	All trusts implement WRES; and are on course to meet aspirational targets	Progress too slow on WRES indicators – falling behind on meeting aspirational targets
	Bring together and share a replicable good practice toolkit on this agenda	Case studies of good practice brought together	Good practice disseminated routinely	Development of a good practice observatory	Replicable good practice is not validated, accepted and/or implemented as a strategic priority
Enabling people	‘WRES action learning set’ for London chief executive officers – to meet quarterly				Chief executives not attending and/or not viewing this agenda as a strategic priority
	Pool together meaningful and sustained resource for this agenda				Chief executives not willing to provide resource to this agenda

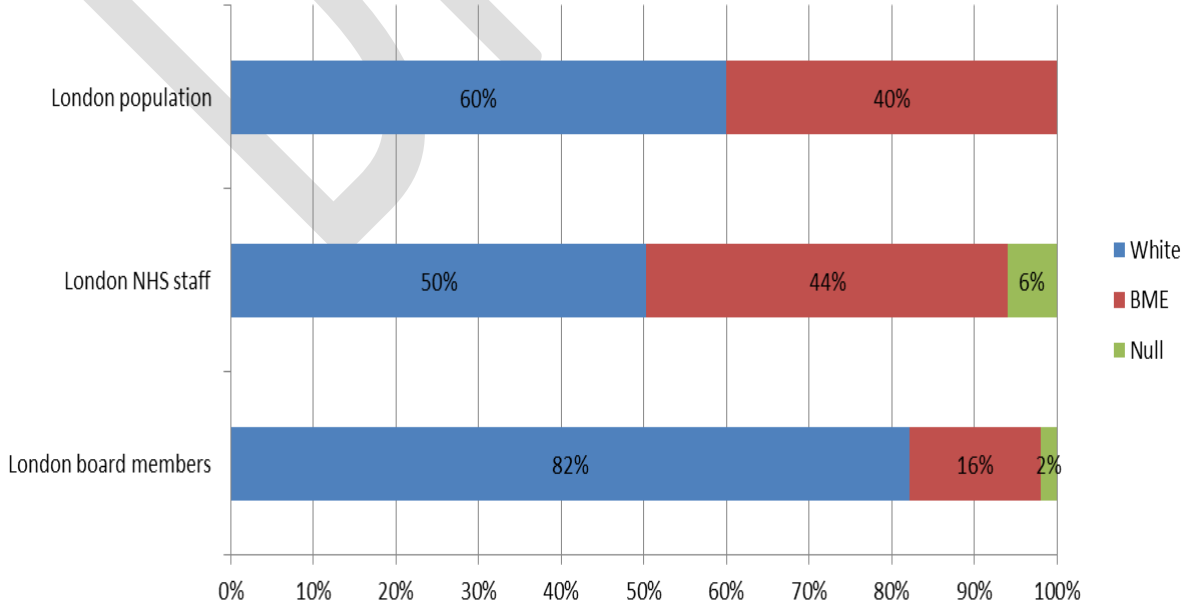
5 Annex – WRES summary data for NHS trusts in London

Indicator Type	WRES Indicator	Metric Description	2017	2018	Direction	2017 National
WORKFORCE	2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts	1.81	1.63	▼	1.6
	3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	1.80	1.77	▼	1.37
	4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff	1.13	1.02	▼	1.22

Indicator Type	WRES Indicator	Metric Description	2016	2017	Direction	2017 National
STAFF SURVEY	5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	30.0%	30.4%	▲	28.7%
	6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	29.0%	29.9%	▲	27.8%
	7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	69.7%	67.6%	▼	71.5%
	8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?b) Manager/team	14.9%	16.3%	▲	15.0%

Indicator Type	WRES Indicator	Metric Description	2017	2018	Direction	2017 National
BOARD	9	Percentage of BME Board membership	14.0%	15.6%	▲	7.0%

Ethnic make-up of London population, NHS trust staff and board membership – 2018



Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Integrated performance report**	**Agenda Item: 15**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Paul Attwal, Head of Performance, Operations	
Executive summary	**Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait:** Overall performance against the national 95% 4 hour standard for May 2019 was 90.1% (1.8% below NHS Improvement standard of 92%). **ED – 12 Hour Trolley Waits – Mental Health** There were 7 patients waiting in excess of 12 hours in ED following a decision to admit for June 2019 with a mental health diagnosis. **Cancer Inter Trust Transfer (ITT) - The percentage of patients sent to subsequent Trust for cancer treatment within 38 days of referral**. The percentage of ITT delays has increased predominately due to urology cancer pathways. This is being reviewed at a local and regional level. **Average Time to Hire:** Average Time to Hire has exceeded target in June 2019	
Purpose:	Review and assurance of Trust performance compliance	
Recommendation(s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan	
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2.	
Report history	Trust Management Group	
Appendices	None	

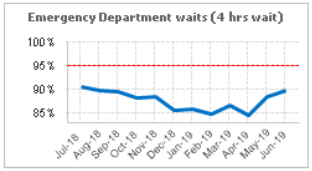
Performance Report

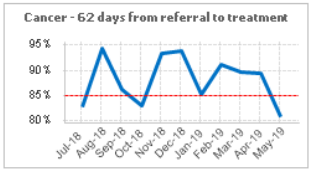
July 2019

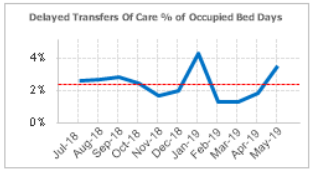
Month 3 (2019 – 2020)

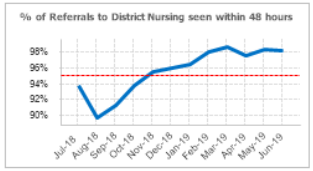
Summary

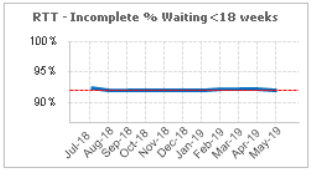
Category	Indicator	17_18 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	
ED	Emergency Department waits (4 hrs wait)	>95%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	87.7%	!
Cancer	Cancer - 14 days to first seen	>93%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%		96.4%	
Cancer	Cancer - 62 days from referral to treatment	>85%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%	89.5%	81.0%		85.0%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.39%	6.36%	5.23%	4.28%	5.30%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%		2.8%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.1%	
Outpatients	Outpatients - FFT % Positive	>90%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	91.0%	
Community	Community - FFT % Positive	>90%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	97.5%	
Staff	Staff - FFT % Recommend Care	>70%			77.4%			65.9%			74.0%			75.9%	75.9%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	95.9%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	93.8%	89.7%	91.3%	93.8%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	98.1%	98.1%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	89.0%	91.1%	91.1%	90.4%	90.5%	90.1%	91.9%	95.2%	94.6%	93.3%	89.8%		91.4%	!
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	98.8%	95.3%	95.6%	93.1%	93.4%	92.4%	95.4%	91.6%	95.0%	95.7%	88.2%		91.8%	

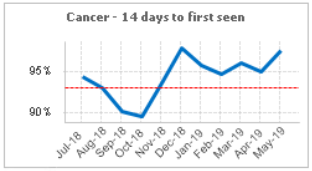


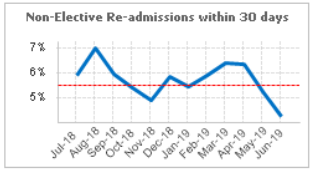


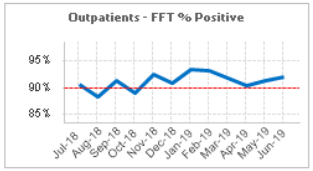












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Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	**<16**	0	2	2	1	1	3	1	0	0	0	0	0	0	
Actual Falls	**400**	33	26	28	36	31	35	44	43	34	42	38	35	115	
Category 3 or 4 Pressure Ulcers	**0**										7	16	12	35	
Harm Free Care %	**>95%**	92.62%	92.25%	93.17%	94.47%	92.25%	93.50%	90.08%	91.22%	94.21%	93.55%	89.58%	94.96%	92.32%	
Non Elective C-Section % Rate	**<19%**	25.9%	19.9%	19.2%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	24.0%	22.5%	19.2%	22.0%	
Medication Errors causing serious harm	**0**	0	0	0	0	0	0	0	0	0	1	0	0	1	
MRSA Bacteraemia Incidences	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	
Never Events	**0**	0				1						3		3	
Proportion of reported Patient Safety Incidents Causing Harm	**N/A**	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.8%	26.0%	21.4%	22.1%	
Serious Incidents	**0**	1	1	2	2	4	2	1	1	1	4	1	2	7	
VTE Risk Assessment %	**>95%**	97.2%	96.1%	96.7%	95.2%	96.9%	95.3%	95.3%	95.2%	95.9%	95.3%	95.2%		95.3%	
Mixed Sex Accomodation Breaches	**0**	0	0	0	1	0	0	2	2	0	0	0	0	0	
Hospital Standardised Mortality Ratio (HSMR)	**100**	102.5	86.0	92.0	68.8	90.8	85.3	79.8	70.3						
Summary Hospital Level Mortality Indicator (SHMI)	**1.14**			0.77			0.78								

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Harm Free Care %: Percentage of patient with no harm on the Safety Thermometer (this includes old and new harm) **Standard:** 95%	**Variance against Plan:** 94.96% achieved - 0.04% from standard **Action to Recover:** 1. New Falls Mandatory training for both corporate induction and mandatory updates has been rolled out in May 2019 and is delivered jointly with Moving and Handling training. A falls awareness day, relaunch of Baywatch and focused training on lying and Standing Blood pressure took place on in June 2019. Monthly audits of compliance to STOPFALLS bundle of all wards are in progress. A falls awareness Day will be held in conjunction with the national falls week in September 2019. 2. There is currently as project reviewing our enhanced care policy and process which will mitigate our high risk of falls 3. The tissue viability team continue to provide pressure ulcer prevention education and awareness across Whittington health. The pressure ulcer prevention and management policy is being reviewed and finalised incorporating the NHSI recommendations. We have introduced a leaflet '5 key tips' for nutrition and pressure ulcer prevention', new categorisation posters and reporting process and will be reviewing our carer/patients package in the next 3 months. The District nursing teams have introduced a "Day of the week" focus on PUs**.** 4. The Trust is also establishing a new Pan Trust Pressure Ulcer Prevention and Management group in July 2019 with the remit to oversee, agree and review pressure ulcer prevention work, policy, planning and performance	**Named Person:** Deputy Chief Nurse & Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** 1. August 2019 2. October 2019
Category 3 or 4 Pressure Ulcers attributed to Whittington health: Total number recorded. Category 3 = 10	**Variance against Plan:** Of the pressure ulcer attributed to Whittington Health one Category 4 pressure ulcer within the DNS had service and care delivery issues identified. The pressure ulcer deteriorated from a category 3 to category 4 whilst on the DNS	**Named Person:** Lead Nurse Tissue Viability Service

Category 4 = 2 **Standard:** 10% reduction in the total number of attributable PUs during 2019/20 compared to 2018/19 including a breakdown of Pressure Ulcers by category	caseload. A full assessment was not completed by the DNS on readmission to the caseload, no escalation of deterioration and no referral to TVS. Patient required readmission due to sepsis associated with the pressure ulcer. **Action to Recover:** Trust wide Pressure ulcer governance and monitoring panel will be implemented chaired by Deputy Chief Nurse. To review incidents and ensure actions are taken forward. Review and understanding of the NHSI recommendation for reporting so consistency in reporting across the organisation.	**Time Scale to Recover Performance:** Work on the trajectory is not yet completed and is expected to be finalised in July 2019
Non Elective C-Section Rates: % of all deliveries where the method of delivery is a non - elective (unplanned) caesarean section **Standard:** Less than 19%	**Variance against Plan:** 0.2% from standard for June 2019 **Action to Recover:** In June, emergency/unplanned C Sections have fallen by over 3%. Twice weekly Multi-Disciplinary C Section Review Meeting is now in place with standard operating procedures and a review pro forma produced.	**Named Person:** Consultant in Obstetrics and Fetal Medicine **Time Scale to inform Performance:** Governance mechanism now in place
Never Events: The number of Never Events declared by the Trust this month.	We have had three Never Events this year. one - Wrong side surgery and two – Wrong implant/prosthesis	**Named Person:** Quality Assurance & Serious Incident Officer
Serious Incidents: The number of Serious Incidents declared by the Trust this month.	Two SIs were declared in June 2019, both are Never Events**.** 2019.12724 [Surgery & Cancer ICSU] Wrong implant/prosthesis 20191.12735 [Surgery & Cancer ICSU] Wrong implant/prosthesis	**Named Person:** Quality Assurance & Serious Incident Officer

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Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
ED - FFT % Positive	>90%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	78.6%	78.6%	81.9%	79.8%	
ED - FFT Response Rate	>15%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	10.3%	12.6%	13.0%	12.0%	
Inpatients - FFT % Positive	>90%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	96.6%	97.4%	98.2%	97.5%	
Inpatients - FFT Response Rate	>25%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	15.1%	23.3%	21.0%	19.8%	
Maternity - FFT % Positive	>90%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	95.1%	93.9%	94.1%	94.3%	
Maternity - FFT Response Rate	>15%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	31.1%	41.3%	52.2%	41.2%	
Outpatients - FFT % Positive	>90%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	91.0%	
Outpatients - FFT Responses	400	310	223	138	328	484	233	423	389	421	419	233	126	778	
Community - FFT % Positive	>90%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	97.5%	
Community - FFT Responses	1500	869	890	1122	1159	998	622	1014	1028	953	842	909	799	2550	
Staff - FFT % Recommend Care	>70%			77.4%			65.9%			74.0%			75.9%	75.9%	
Complaints responded to within 25 or 40 working days	>80%										75.0%	92.9%	84.2%	85.1%	
Complaints (including complaints against Corporate division)	N/A	0	0	0	0	0	0	0	0	0	20	28	19	67	

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate : number of responses and satisfactory/ positive responses achieved for ED. **Standard:** 15% of responses and 90% satisfactory/ positive responses	**Variance against Plan:** Though there was an increase in both recommend rate (82% for June) and response rate (13% for June), ED are still not meeting their KPIs. It is worth noting that, across both measures, this has been the best performance in the area since January 2019. **Action to Recover:** An MDT working group has been developed in the area to work on patient experience initiatives, including improving the uptake and recommend rates for FFT.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2020 Improving the response and recommend rate for ED has been included as a Quality Account priority for 2019/20.
Inpatients FFT Response Rate: number of responses achieved for Inpatients. **Standard:** 25%	**Variance against Plan:** The recommend rate KPI has been exceeded again, with 98% for June. Unfortunately the response rate was still shy of the KPI, with 21% in June 2019. **Action to Recover:** Welcome Packs have been launched across half of the inpatient wards, with the second half to be delivered throughout July. The FFT survey is signposted inside the Welcome Packs. The patient experience team is meeting with IQVIA, who provide the Trust's Meridian service, and will be discussing the process for introducing SMS FFT alerts for patients discharged from DTC.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** September 2019
Community FFT Responses: number of responses a month for Community. **Standard:** 1500	**Variance against Plan:** There was a decrease in FFT collected in the area, with 799 for June against the 1,500 monthly KPI. **Action to Recover:** The cause of the decrease over the past few months has been identified: due to a fault with the link sent to patients via SMS to podiatry and MSK patients, responses from podiatry in particular have declined.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** November 2019

	The link has been updated and is now functioning. The MSK and Podiatry teams have been provided with this link. The patient experience team has been working with adult community dietetics to launch SMS FFT links in this area also. The information team are supporting with creating a Qlikview report.	

Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance	
Hospital Cancelled Operations	0	4	1	2	8	10	4	5	14	7	10	3		13		!
Cancelled ops not rebooked < 28 days	0	0	0	0	1	2	0	0	1	0	0	0		0		
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0		
Theatre Utilisation	>85%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	80.4%	78.5%	77.5%	81.5%	85.3%	83.9%	83.5%		
Breastfeeding Initiated	>90%	91.2%	91.5%	91.7%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	91.7%	89.9%	89.5%	90.4%		
Mortality rate per 1000 admissions in-months	14.4	5.3	4.7	5.0	5.5	6.6	8.4	7.7	6.0	9.2	8.1	7.4	7.4	7.6		
Community DNA % Rate	<10%	8.5%	8.1%	7.7%	7.8%	7.5%	8.0%	7.5%	7.3%	6.7%	7.6%	7.0%	7.0%	7.2%		
Community Services - Provider Cancellations	<8%	6.3%	6.3%	5.9%	6.1%	6.6%	7.4%	6.3%	6.0%	6.3%	6.3%	6.3%	5.9%	6.1%		
Acute DNA % Rate	<10%	10.4%	10.8%	10.6%	10.5%	10.5%	10.2%	10.0%	10.6%	9.7%	10.5%	11.4%	13.5%	11.8%		!
% of GP Referrals that were completed via ERS		82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.4%	88.1%	89.1%	88.5%		
Outpatients New:FUp Ratio	2.3	1.94	1.98	1.93	1.92	1.88	1.94	1.97	1.86	1.92	1.94	1.92	1.91	1.92		
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.6%	2.7%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%		2.8%		
Non Elective Re-admissions within 30 days	<5.5%	5.89%	6.97%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.39%	6.36%	5.23%	4.29%	5.30%		
Rapid Response - % of referrals with an improvement in care					18.0%	92.4%	89.4%	84.1%	90.2%	80.8%	89.7%	100.0%	78.7%	89.5%		

! **Target has not been achieved for the past three months

Date & time of production: 16/07/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Hospital Cancellations Operations : The number of patients operation cancelled on the day **Target:** 0	**Variance against Plan:** There was 3 operations cancelled in May 2019 due to overrunning lists. 2 x General Surgery cases and 1 x Orthopaedics case. **Action to Recover:** Theatre Improvement programme in place which is driven by improvements in pre-operative assessment and booking office issues. Theatre lists are signed off in advance by clinicians however timing of lists can be improved with guide standard times, booking team has been completely reviewed with new staff and significantly increased training and this should eradicate the administrative errors. Demand and capacity work undertaken to confirm anaesthetic required resources to meet business plan.	**Named Person:** General Manager Theatres, ITU, POA & Admissions **Time Scale to Recover Performance:** This is reviewed on a daily basis. Part of KPI for Theatre Productivity. Priority to reduce theatre list overrun to only 1 per month by end of July 2019.
Acute DNA % Rate: Percentage of patients who did not attend their outpatients appointment **Standard:** <10%	**Variance against Plan: 3.5% over standard** **Action to Recover:** Mitigation plan has been approved by the Trust Management Group to bring DNA rate down to 10% in the specialities that currently Exceed. Key Enablers are to use smart overbooking processes to optimise outpatient lists. Remind Plus, a text reminder service, has been live since April 2019, with an extension of text message to communicate to patients the NHS costs incurred of missing an appointment, this is to go live in August 2019.	**Named Person:** Outpatient Programme Lead **Time Scale to Recover Performance:** August 2019

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Indicator	18_19 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
Emergency Department waits (4 hrs wait)	>95%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	87.7%	
ED Indicator - median wait for treatment (minutes)	<60 mins	74	63	75	79	88	90	85	92	97	91	76	67	78	
Ambulance handovers waiting more than 30 mins	0	18	9	12	18	15	23	18	53	28	56	35		91	
Ambulance handovers waiting more than 60 mins	0	0	10	2	0	0	2	2	14	7	5	4		9	
12 hour trolley waits in A&E - Non Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
12 hour trolley waits in A&E - Mental Health	0	2	0	0	0	0	1	0	1	0	1	0	7	8	
Cancer - 14 days to first seen	>93%	94.4%	93.1%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%		96.4%	
Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	97.4%		97.7%	
Cancer - 62 days from referral to treatment	>85%	82.9%	94.2%	86.2%	83.1%	93.3%	93.8%	85.2%	91.1%	89.6%	89.5%	81.0%		85.0%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%			89.5%	81.4%	93.3%	90.6%	88.9%	90.2%	89.6%	89.2%	81.0%		84.8%	
Cancer ITT - % of Pathways sent before 38 Days	>85%			62.5%	60.0%	81.8%	50.0%	100.0%	40.0%	75.0%	71.4%	25.0%		46.7%	
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		93.0%	93.0%	80.4%	83.6%	86.1%	93.9%	88.3%	88.2%	83.3%	89.9%	94.9%		92.2%	
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 - 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%	
Cancer - 62 Day Screening	>90%	100.0%	100.0%		100.0%	75.0%	60.0%				100.0%	100.0%		100.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	99.2%	99.2%	99.1%	99.1%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	1	1	0	0	0	0	0	0	0	0	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	95.9%	
% seen <=48 hours of Referral to District Nursing Service	>95%	93.8%	89.7%	91.3%	93.8%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	98.1%	98.1%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	89.0%	91.1%	91.1%	90.4%	90.5%	90.1%	91.9%	95.2%	94.6%	93.3%	89.8%		91.4%	
Islington New Birth Visits - % seen within 2 weeks	>95%	98.8%	95.3%	95.6%	93.1%	93.4%	92.4%	95.4%	91.6%	95.0%	95.7%	88.2%		91.8%	

Date & time of production: 16/07/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Waits: Percentage of A&E Attendances seen within 4 hours **National standard:** 95% **NHSI Standard:** 92%	**Variance against Plan:** 90.1% (1.9% below NHSI standard) **Action to Recover:** • Relaunch of the first 60 minutes imitative • Implementation of the revised front of house model i.e. streaming, redirection, triage & RAT. • Extending the streaming model to weekends • Reviewing the current structure of CDU and restructuring CDU pathways to include direct access to CDU • Review and implement the internal professional standards in relation to speciality responses • Increase direct patient pathways to AEC to fully optimise AEC capacity • LAS conveyances and alternative care pathways i.e pilot LAS direct access to AEC for appropriate patients • Weekend shifts with enhanced consultant and junior doctor cover	**Named Person:** Acting ED General Manager **Time Scale to Recover Performance:** We expect to see recovery to start by the end August 2019 once processes are embedded
ED – median wait for treatment: The median wait for the number of patients waiting for more than 60 minutes to be seen. **Standard:** 60 minutes	**Variance against Plan:** Improved by 9 minutes (median wait in June is 67 minutes) **Action to Recover:** • Implementation of the revised front of house model i.e. streaming, redirection, triage & RAT. • Dedicated RAT registrar and EDA at the front of house 7 days per week • 50% of patients seen by a clinician/senior decision marker within 60 mins of registration • 90% of the RAT shifts filled with a registrar or equivalent • 40% of patients seen and discharged within 2 hours of arrival – June noted 32% (8% variance against the plan)	**Named Person:** Acting ED General Manager **Time Scale to Recover Performance:** Expect to see recovery to start by the end of August 2019, once improved processes are embedded.

ED – 12 Hour Trolley Waits – Mental Health: Patients that have a decision to admit and waited on a trolley for more than 12 hours with Mental Health diagnosis. **Standard:** 0	**Variance against Plan:** There were 7 patients waiting in excess of 12 hours in ED following a decision to admit for June 2019 with a mental health diagnosis. **Action to Recover:** • Review with the aim implement the recommendations from the ECIST mental health audit on the 17th June in relation to our current escalation, breach reasons, common presenting themes and internal and external mental health response times • Pilot a MH nurse to work alongside the ED streamer the front of house to identify low risk/suitable patients that can go directly to the suite without being taken to majors pending referral to the MH team. • Optimise utilisation of the mental health suite for lower acuity of non-admitted patients. Target 50%. • All Mental Health patients in ED referred to MHLT assessed within 60 minutes of arrival. Target 90% • The expected increase in Mental Health breaches is being addressed at Sector and London level, as it has highlighted the lack of existing AMPs and Mental Health bed capacity in London.	**Named Person:** Acting ED General Manager **Time Scale to Recover Performance:** End August/September 2019
Ambulance Hand Overs more than 30 minutes and more than 60 minutes: There should be zero patients waiting for more than 30 and 60 for ambulance handover to ED. **Standard:** 0	**Variance against Plan:** 35 waiting more than 30 minutes and 4 more than 60 minutes (May data only) **Action to Recover:** • LAS direct access to AEC for medically appropriate patients in place from July 2019. • Direct access to UTC for patients with minor illness that come via LAS • To reduce the percentage of ambulance handovers that exceeds 15 minutes to achieve compliance by September 2019	**Named Person:** Interim ED General Manager **Time Scale to Recover Performance:** End of September to have 0 x 30 mins & 60 mins Ambulance breaches
Cancer ITT - % of patients sent before 38 days The percentage of patients sent to subsequent Trust for cancer treatment within 38 days of referral.	**Variance against Plan:** 25% **Action to Recover:** • The number of ITT delays is predominately due to urology cancer pathways. This is being reviewed at a local and	**Named Person:** Service Manager **Time Scale to Recover Performance:** Expected to see recovery by

Standard: >85%	regional level. There is a local service review meeting on 18th July 2019 to address patient pathway monitoring for urology.	end of October 2019
New birth visits seen within 2 weeks: 95 % of New Birth Visits should be carried out within 14 days of birth. **Target:** 95%	**Variance against Plan:** Haringey health visiting – in May 92.42% new birth visits were carried out within 14 days**.** **Action to Recover:** Health visiting teams continue to work to achieve the 95% target. In May 293 out of 317 visits happened within timeframe. Of the 24 remaining: • 14 (4.41%) were seen but out of timeframe (i.e. after 14 days). • 10 were not seen: - 8 x are in SCBU - 1 x administrative issue using incorrect template - 1 was wrongly allocated within the team	**Named Person:** Head of Haringey Children and Young People's Services **Time Scale to Recover Performance:** July 2019

Safe | Caring | Effective | Responsive | **Well Led**

Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance	
Appraisals % Rate	>90%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	71.3%	69.8%	71.4%	70.8%		!
Mandatory Training % Rate	>90%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%	80.8%	80.8%	80.8%	80.2%	80.1%	79.9%	80.0%		!
Permanent Staffing WTEs Utilised	>90%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.3%	86.9%	87.2%	87.1%		!
Staff FFT % recommended work	>50%			64.4%			57.4%			61.8%			59.9%	59.9%		
Staff FFT response rate	>20%			8.0%			47.8%			16.2%			22.6%	22.6%		
Staff sickness absence %	<3.5%	3.52%	3.10%	3.52%	3.92%	3.81%	3.35%	3.71%	3.69%	3.49%	3.27%	3.13%		3.20%		
Staff turnover %	<10%	13.5%	13.1%	12.8%	12.7%	12.7%	12.0%	11.7%	11.4%	10.8%	10.6%	10.9%	10.9%	10.8%		!
Vacancy % Rate against Establishment	<10%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.7%	13.1%	12.8%	12.9%		!
Average Time to Hire (Days)	<61 Days									63	65	69	60	65		
Nursing Staff Average % Day Fill Rate - Nurses		82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	89.3%	87.4%	86.1%	86.7%	86.2%	89.8%	87.5%		
Nursing Staff Average % Day Fill Rate - HCAs		120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	112.6%	117.1%	112.6%	109.1%	115.0%	113.8%	112.6%		
Nursing Staff Average % Night Fill Rate - Nurses		86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	92.2%	90.8%	88.6%	88.4%	87.2%	92.1%	89.2%		
Nursing Staff Average % Night Fill Rate - HCAs		114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	134.5%	124.4%	115.7%	109.3%	114.6%	113.2%	112.4%		
Safe Staffing Alerts - Number of Red Shifts		1	1	2	0	0	0	0	2	1	0	0	3	3		
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		10.0	9.0	8.8	9.2	8.8	10.2	9.0	9.0	9.1	9.0	9.1	9.7	9.2		

! **Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate: 90% of appraisals should be in date. **Standard:** 90%	**Variance against Plan:** -17% **Action to Recover:** Simplified 2-page appraisal to support better conversations Simplified 2-page guidance for appraises and managers Shorter, clearer screenshot guidance on loading to ESR	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** 3 months (September 2019)
Mandatory Training % Rate: 90% of members of staff should have completed their mandatory training. **Standard:** 90%	**Variance against Plan:** -8% **Action to Recover:** Participating in Stainability and Transformation Partnerships (STP) alliance to transfer compliance data Working with internal and external partners to improve access to ESR and use of wider functionality Advertising e-learning supported sessions at Crouch End E-learning suite Improving communications and 'how to' guides for staff Creating new drop-in sessions at Archway site Involving ESR account manager in complex queries Improving reporting	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** 6 months (December 2019)
Permanent Staffing WTEs Utilised: 90% of post should be filled. **Standard:** 90%	**Variance against Plan:** 2.81% **Action to Recover:** There has been a slight increase in permanent staffing WTE's utilised which is reflective of the on-going recruitment and retention work. This continues to be reviewed in line with vacancy rate reviews, staff turnover and recruitment and retention planning.	**Named Person:**, Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019

Staff Turnover %: The Trust should have less than 10% of staff who have left the Trust within the last 12 months. **Standard:** 10%	**Variance against Plan:** .6% **Action to Recover:** There has been a marginal increase in turnover rates (0.2%). Work is ongoing with NHSI to improve retention, and results are being seen with the reduction in turnover.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Vacancy % Rate against Establishment: The Trust should have less than 10% unfilled posts. **Standard:** 10%	**Variance against Plan:** 2.81% **Action to Recover:** The vacancy rate has decreased for June, while still above target, which is reflective of the ongoing work in recruitment and retention. A new recruitment dashboard has been in place since April, which provides the ICSU's and Corporate services with information regarding recruitment, to identify any blockers to recruitment and to take appropriate action. The nurse recruitment has been expanded on a temporary basis to look at HCA recruitment. We are partnering with local borough networks to provide outplacements for school leavers and those with disabilities.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Time to hire: Time taken from resignation/creation of new post to confirmed start date **Standard:** 8 weeks	**Variance against Plan:** 0.6 weeks **Action to Recover:** The time to hire has decreased from 9.9 weeks to 8.6 weeks. HR Business Partners and Recruitment Advisers meet monthly with ICSU's/Corporate Services to review the dashboard and take appropriate action.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** September 2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children's community waiting times Services under Children, Young People (CYP) operate on different waiting time a target, performance is monitored monthly in the Community Service Improvement Group (CSIG); services are divided into 3 categories: Phase 1, Monitored Services and Light Touch Services. • Phase 1 – Overall, services are delivering progress against 95% target apart from Occupational Therapy (OT) Haringey due to historic clinical backlog but their average waiting time has improved since October 2018. • Monitored Services – Improvement noted in Community Paeds, School Nursing and Family Nurse Partnership (FNP). CAMHS still an area where focus is needed. Service improvement now in progress which aims to change management structure and improve patient waiting times. Improvement work around Therapy in Haringey also in progress. • Light Touch – services such as Community Paeds (CP), Parent Infant Psychology Service (PIPS), Haematology and PIPS consistently delivering 95-100% target.	**Overall summary:** CAMHS anticipates an overall improvement in waiting times in Q2 now additional waiting list initiative capacity in place, soft launch of single point of access and new team structure finalised. Therapy Review, further update on the impact will be reported in Q2. Community Paediatrics – NDC, CP and Com Paeds Islington show good improvement, except SCC. CYP ICSU continues to focus on reducing waiting times, a few services in CYP such as Looked After Children and FNP will continue to experience challenges which invariably can be out of the control of the services. **Action to Recover:** Revised waiting times target proposal currently under with CCG for approval – this will give services to work to realistic waiting times. Services to continue to address data quality and ensure that Borough Leads consistently review and monitor this.	**Named Person:** Director of Operation CYP **Time Scale to Recover Performance:** Consistent performance for light touch services; Speech and Language Therapy Michael Palin Centre will move to light touch services. Expect improvement in waiting times for CAMHS in the next quarter. Director of CYP will continue to challenge service managers to ensure data are entered correctly and services have robust grip on Patient Tracking List (PTL).

Adults community waiting times Adult Community Services (ACS) operate on different waiting time targets, performance is monitored monthly in the Community Service Improvement Group (CSIG)	**Overall Summary:** Adult Community Services have experienced pressures in relation to waiting times in June 2019 in Bladder and Bowel, Community Rehabilitation, ICTT, Intermediate Care, Musculoskeletal Services (MSK), Podiatry, Tissue Viability and Spirometry Services **Action to Recover:** There are a number of work streams underway that are being monitored through the Adult Community Service Improvement Group (CSIG). For Bladder and Bowel, the service is working closely with clinicians and commissioners to develop a Single Point of Access and streamline referral pathways to improve efficiency and signpost patients to the most appropriate service. In Community Rehabilitation, Integrated Care Therapy Team (ICTT) and Intermediate Care there is ongoing work through CSIG to reduce inappropriate referrals and maximise existing capacity. In Podiatry there have been some issues with the booking of new appointments and this is being addressed through a Central Booking Service improvement plan. In MSK there has been an increase in demand that is being addressed through additional capacity and ongoing monitoring at CSIG on monthly basis. The Spirometry Service has started an improvement project which included the recruiting to band technician post, Improving patient pathways to ensure they are aware of what to bring with them to the appointment (IE Spacer and inhaler) as these are often not brought with the patient, contacting patients prior to appointments to reduce DNA or cancellation of appointments and closer support for the admin to familiarise processes.	**Named Person:** Director of Operations ACS **Time Scale to Recover Performance:** The timescale for recovery for services is 3-6 months.

Appendix 1. Community Performance Dashboard

Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
IAPT Moving to Recovery	>50%	52.4%	55.7%	57.0%	62.5%	57.4%	58.2%	62.3%	65.1%	59.1%	62.2%	54.2%		58.5%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	82.0%	82.0%	80.2%	89.1%	86.2%	92.1%	84.1%	91.9%	88.1%	90.8%	90.3%		90.5%	
Haringey - HR1 % carried out before child aged 15 months	N/A	70.4%	62.5%	70.5%	70.6%	72.0%	74.1%	77.0%	77.4%	80.6%	81.8%	79.9%		81.0%	
Haringey - HR2 % carried out before child aged 30 months	N/A	65.1%	66.7%	63.8%	60.8%	60.5%	62.3%	67.9%	70.3%	71.7%	70.9%	72.5%		71.6%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	91.8%	95.1%	96.5%	96.7%	92.5%	90.7%	86.5%	90.3%	91.7%	93.0%	94.9%		93.9%	
Islington - HR1 % carried out before child aged 15 mths	N/A	82.4%	80.2%	87.9%	77.3%	80.8%	82.4%	74.1%	73.7%	83.3%	80.5%	80.3%		80.4%	
Islington - HR2 % carried out before child aged 30 mths	N/A	79.1%	78.8%	81.0%	80.2%	82.0%	85.9%	76.8%	75.5%	72.4%	78.2%	76.8%		77.5%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	89.3%	96.2%	95.5%	93.0%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	84.8%	90.0%	77.8%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	78.8%	87.1%	96.2%	86.7%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	80.6%	74.3%	84.8%	80.4%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	98.7%	96.2%	91.0%	95.1%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	57.1%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	100.0%	60.0%	66.7%	66.7%	83.3%	71.4%	42.9%	76.9%	100.0%	81.8%	75.0%	71.4%	77.3%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	88.9%	78.6%	80.0%	91.7%	94.1%	72.7%	77.8%	100.0%	90.0%	100.0%	100.0%	85.7%	95.5%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%			47.9%			47.8%			42.3%					
Islington Self-Management - Average Increase in PAM Score	>=9						11			18					
Haringey Self-Management - Average Increase in PAM Score	>=9						13			15					

Appendix 2. Community Waiting Times Dashboard

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	66.70%	81.00%	88.90%	7.5	18	>95%						0
Community Matron	>95%	6	98.00%	97.60%	100.00%	0.7	38	>95%	2	0.00%		100.00%	0.1	1
Adult Wheelchair Service	>95%	8	100.00%	92.70%	97.00%	8.2	33	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	89.70%	81.50%	90.30%	4.9	124	>95%	2	57.60%	78.80%	63.60%	2.5	33
ICTT - Other	>95%	12	92.40%	96.10%	96.60%	4.2	261	>95%	2	48.30%	75.00%	66.70%	2.3	75
ICTT - Stroke and Neuro	>95%	12	70.60%	65.30%	69.10%	9.3	55	>95%	2	47.80%	58.10%	37.00%	2.9	27
Intermediate Care (REACH)	>95%	6	94.70%	84.00%	92.90%	2.8	140	>95%	2	84.60%	83.60%	90.00%	1.1	50
Paediatric Wheelchair Service	>95%	8	92.30%	100.00%	100.00%	2.4	2	>95%						0
Bladder and Bowel - Adult	>95%	12	46.40%	49.40%	49.60%	13.6	115	>95%						0
Musculoskeletal Service - CATS	>95%	6	72.60%	57.70%	47.50%	6.1	550	>95%		100.00%				0
Musculoskeletal Service - Routine	>95%	6	70.50%	67.60%	67.60%	4.8	1465	>95%	2		100.00%			0
Nutrition and Dietetics	>95%	6	98.20%	98.20%	97.80%	2.7	179	>95%	2		100.00%			0
Podiatry (Foot Health)	>95%	6	78.40%	74.40%	84.80%	4.4	697	>95%	2	100.00%				0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.4	24	>95%						0
Tissue Viability	>95%	6	88.20%	83.60%	87.90%	2.5	66	>95%						0
Cardiology Service	>95%	6	96.60%	94.70%	100.00%	2.7	25	>95%	2	100.00%	88.90%	80.00%	1.7	5
Diabetes Service	>95%	6	100.00%	98.10%	100.00%	2.1	80	>95%	2		0.00%			0
Respiratory Service	>95%	6	94.00%	98.30%	97.10%	2.4	69	>95%	2	100.00%	100.00%	100.00%	0.6	3
Spirometry Service	>95%	6	15.40%	37.00%	36.40%	6.3	44	>95%	2					0

Date & time of production: 16/07/2019

Appendix 2. Community Waiting Times Dashboard

Haringey

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12					0	>95%						0
Community Matron	>95%	6	93.80%	90.90%	100.00%	1.6	6	>95%	2			100.00%	0.1	1
Adult Wheelchair Service	>95%	8	100.00%	92.50%	100.00%	3.6	30	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	100.00%	66.70%	100.00%	3.6	2	>95%	2					0
ICTT - Other	>95%	12	93.10%	96.20%	96.20%	4.2	238	>95%	2	47.50%	70.30%	64.80%	2.4	71
ICTT - Stroke and Neuro	>95%	12	66.70%	66.00%	69.20%	9.4	52	>95%	2	47.10%	60.00%	37.50%	2.9	24
Intermediate Care (REACH)	>95%	6		80.00%			0	>95%	2	100.00%	100.00%			0
Paediatric Wheelchair Service	>95%	8	92.30%	100.00%	100.00%	2.4	2	>95%						0
Bladder and Bowel - Adult	>95%	12	51.20%	46.50%	52.50%	12.9	40	>95%						0
Musculoskeletal Service - CATS	>95%	6	83.80%	65.90%	49.80%	5.7	265	>95%		100.00%				0
Musculoskeletal Service - Routine	>95%	6	68.90%	68.50%	68.70%	4.7	802	>95%	2					0
Nutrition and Dietetics	>95%	6	100.00%	100.00%	96.40%	2.9	110	>95%	2		100.00%			0
Podiatry (Foot Health)	>95%	6	81.20%	66.00%	85.30%	4.4	361	>95%	2	100.00%				0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3.1	12	>95%						0
Tissue Viability	>95%	6	96.20%	100.00%	90.90%	2	11	>95%						0
Cardiology Service	>95%	6	94.10%	88.90%	100.00%	3	11	>95%	2	100.00%	100.00%	100.00%	0	1
Diabetes Service	>95%	6	100.00%	97.70%	100.00%	2.2	67	>95%	2		0.00%			0
Respiratory Service	>95%	6	95.50%	95.70%	100.00%	2.2	32	>95%	2			100.00%	0.4	1
Spirometry Service	>95%	6	15.40%	35.60%	36.40%	6.3	44	>95%	2					0

Date & time of production: 16/07/2019

Appendix 2. Community Waiting Times Dashboard

Islington

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (June-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	37.50%	75.00%	100.00%	6	9	>95%						0
Community Matron	>95%	6	100.00%	100.00%	100.00%	0.4	28	>95%	2	0.00%				0
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	89.90%	82.30%	89.70%	5	117	>95%	2	57.60%	78.80%	63.60%	2.5	33
ICTT - Other	>95%	12	50.00%	100.00%	100.00%	1.3	6	>95%	2	100.00%	100.00%	100.00%	1.9	2
ICTT - Stroke and Neuro	>95%	12	100.00%				0	>95%	2					0
Intermediate Care (REACH)	>95%	6	94.30%	83.60%	92.60%	2.8	135	>95%	2	83.90%	84.40%	89.60%	1.1	48
Paediatric Wheelchair Service	>95%	8					0	>95%						0
Bladder and Bowel - Adult	>95%	12	35.00%	43.10%	28.20%	17.1	39	>95%						0
Musculoskeletal Service - CATS	>95%	6	59.90%	47.70%	44.40%	6.4	270	>95%						0
Musculoskeletal Service - Routine	>95%	6	73.50%	66.80%	68.70%	4.8	540	>95%	2					0
Nutrition and Dietetics	>95%	6	96.70%	98.60%	100.00%	2.4	65	>95%	2					0
Podiatry (Foot Health)	>95%	6	76.20%	81.50%	84.40%	4.4	326	>95%	2	100.00%				0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.7	12	>95%						0
Tissue Viability	>95%	6	91.70%	94.10%	95.80%	1.7	24	>95%						0
Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.4	13	>95%	2	100.00%	83.30%	75.00%	2.1	4
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.6	13	>95%	2					0
Respiratory Service	>95%	6	93.30%	100.00%	94.60%	2.6	37	>95%	2	100.00%	100.00%	100.00%	0.6	2
Spirometry Service	>95%	6					0	>95%	2					0

Children's Community Waits Performance

Date & time of production: 16/07/2019

		Routine Referral Urgency							Urgent Referral Urgency						
Service	Team Group	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (Jun-19)	No of Pts First Seen	% Target	Target Weeks	Apr-19	May-19	Jun-19	Avg Wait (Jun-19)	No of Pts First Seen
CAMHS	CAMHS Core - Islington	>95%	4	36.70%	31.30%	27.60%	9.3	116	>95%	2	75.00%	77.80%	88.90%	1.3	9
	CAMHS NDT / ADHD - Islington	>95%	8	42.10%	45.50%	0.00%	34.4	16	>95%	2					0
	CAMHS Schools - Islington	>95%	8	72.70%	54.20%	74.10%	6.3	27	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	0.00%	66.70%	100.00%	0.9	2	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	85.30%	80.20%	83.10%	0.9	83	>95%	1	100.00%	100.00%	100.00%	0.1	10
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	11.10%	25.00%	16.70%	51.6	18	>95%	1	0.00%	0.00%	0.00%	23.7	2
	Community Paediatrics - Haringey (NDC)	>95%	12	93.30%	91.40%	95.50%	10.8	22	>95%	1		0.00%			0
	Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	100.00%	100.00%	0.5	30	>95%	1					0
	Community Paediatrics - Haringey (Other)	>95%	12	100.00%	100.00%	75.00%	6	4	>95%	1					0
	Community Paediatrics - Islington	>95%	12	33.30%	63.00%	62.50%	8.4	32	>95%	1					0
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	90.00%	100.00%	100.00%	1.3	9	>95%						0
	Family Nurse Partnership - Islington	>95%	12	80.00%	100.00%	100.00%	2.4	7	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	1.2	12	>95%						0
IANDS	IANDS	>95%	14	50.00%	50.00%	62.50%	6.5	8	>95%						0
	IANDS - SCT	>95%	20	8.30%	13.30%	9.10%	28.5	22	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	60.00%	78.90%	80.00%	2.3	10	>95%						0
	Looked After Children - Islington	>95%	4	100.00%	88.90%	62.50%	6.4	8	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	31.60%	42.90%	56.50%	7.7	23	>95%	2	0.00%				0
	Occupational Therapy - Islington	>95%	8	30.00%	26.10%	14.30%	18.1	7	>95%	2					0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	100.00%	100.00%	90.00%	2.3	10	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	72.70%	85.70%	92.30%	4.1	13	>95%		0.00%				0
Physiotherapy	Physiotherapy - Haringey	>95%	8	86.70%	70.30%	85.70%	5.4	49	>95%						0
	Physiotherapy - Islington	>95%	8	93.00%	87.70%	89.00%	4.8	82	>95%						0
PIPS	PIPS	>95%	12	100.00%	87.50%	93.30%	3.6	15	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	8	42.50%	31.30%	61.00%	7.9	41	>95%	2	0.00%	100.00%			0
	SALT - Islington	>95%	8	54.30%	26.80%	34.30%	9.7	70	>95%	2					0
	SALT - MPC	>95%	18	100.00%	100.00%	98.80%	5.9	84	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	87.70%	94.50%	92.60%	3.3	135	>95%						0
	School Nursing - Islington	>95%	12	97.10%	100.00%	96.80%	2.5	62	>95%						0

Appendix 3. Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
Breast	>85%	90.5%	100.0%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>85%		100.0%	66.7%	100.0%	66.7%	100.0%	66.7%	0.0%	100.0%	50.0%	50.0%		50.0%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%		100.0%	0.0%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>85%	71.4%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%		66.7%	
Lung	>85%	100.0%	100.0%	0.0%	100.0%	100.0%		100.0%	85.7%	100.0%	100.0%	50.0%		80.0%	
Other	>85%	100.0%						100.0%		100.0%	100.0%			100.0%	
Skin	>85%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%		100.0%	
Testicular	>85%		100.0%						100.0%		100.0%			100.0%	
Upper Gastrointestinal	>85%	0.0%	0.0%	100.0%	100.0%		75.0%	100.0%		100.0%	50.0%	100.0%		66.7%	
Urological (Excluding Testicular)	>85%	68.4%	77.8%	100.0%	44.4%	100.0%	66.7%	64.7%	80.0%	76.9%	88.9%	70.6%		76.9%	

Cancer - 2WW Performance by Tumour Group

Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2019-2020	Performance
Breast	>93%	98.2%	97.5%	96.4%	94.0%	97.3%	98.6%	98.5%	93.7%	96.0%	93.9%	99.0%		96.3%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	100.0%	98.0%	97.4%	95.6%	96.4%	97.8%	97.1%	91.8%	96.6%	94.5%	96.0%		95.3%	
Haematological	>93%	11.1%	37.5%	62.5%	92.9%	91.7%	95.0%	100.0%	91.7%	100.0%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>93%	87.2%	88.2%	82.4%	73.0%	87.3%	98.3%	92.8%	94.2%	95.8%	91.2%	96.7%		94.3%	
Lung	>93%	92.0%	100.0%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%		90.0%	
Skin	>93%	99.5%	98.8%	97.4%	98.0%	97.5%	98.6%	97.6%	99.3%	96.2%	98.0%	98.8%		98.3%	
Upper Gastrointestinal	>93%	72.4%	55.0%	20.6%	59.6%	89.2%	98.0%	87.2%	98.2%	98.9%	91.4%	96.6%		94.0%	
Urological	>93%	89.8%	94.7%	97.4%	97.9%	86.4%	94.9%	91.8%	92.4%	92.1%	98.8%	98.4%		98.6%	

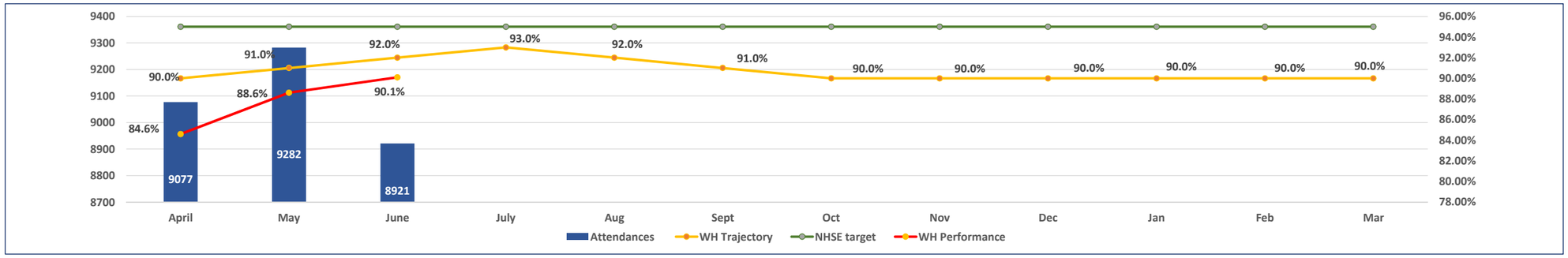
Appendix 4. Trust Level Activity

Category	Indicator	19_20 Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Activity
ED	ED Attendances	8285	9660	8464	9225	9425	9604	9594	9961	9245	10113	9477	9624	9330	
ED	ED Admission Rate %		15.6%	15.6%	15.5%	15.3%	16.4%	16.2%	15.2%	14.7%	15.3%	15.3%	14.3%	15.2%	
Community	Community Face to Face Contacts		61501	54970	57975	64105	63985	51479	62529	56314	60404	55739	59855	59416	
Admissions	Elective and Daycase		1763	1821	1923	2267	2221	1813	2149	1989	2132	2120	2071	2152	
Admissions	Emergency Inpatients		2218	2193	2164	2185	2289	2230	2268	2036	2297	2223	2217	2077	
Referrals	GP Referrals to an Acute Service		7563	7054	6883	8283	7963	6683	8149	7913	8639	8467	8938	7907	
Referrals	% of GP Referrals that were completed via ERS		82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.4%	88.1%	89.1%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	8.8%	10.5%	11.9%	13.0%	12.7%	10.7%	7.6%	7.1%	10.3%	12.7%	12.0%	11.5%	
Maternity	Maternity Births	320	297	321	312	296	299	281	295	246	300	306	312	283	
Maternity	Maternity Bookings	377	376	330	334	398	363	327	420	379	419	367	390	342	
Outpatients	Outpatient DNA Rate % - New	<10%	10.6%	11.2%	11.3%	10.7%	10.7%	10.5%	10.5%	10.5%	9.8%	10.7%	11.4%	13.2%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.3%	10.6%	10.2%	10.4%	10.3%	10.1%	9.6%	10.6%	9.7%	10.3%	11.5%	13.7%	
Outpatients	Outpatient New Attendances		9692	9134	8928	10515	10217	8502	10169	9376	9387	9442	9655	8760	
Outpatients	Outpatient FUp Attendances		18782	18094	17266	20230	19175	16467	20004	17439	18014	18339	18529	16694	
Outpatients	Outpatient Procedures		7608	6903	7360	8166	7969	7106	8390	7533	7961	7435	7444	7106	

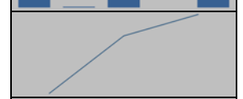
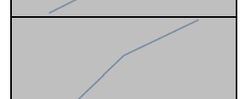
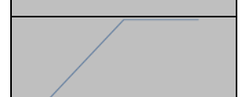
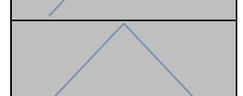
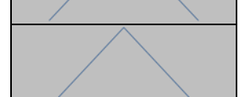
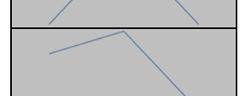
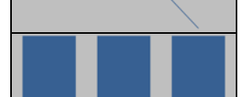
Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Emergency Department performance trajectory 2019/20**	**Agenda Item: 16**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Paul Attwal, Head of Performance, Operations	
Executive summary	**Areas to draw to Board members' attention are:** **Improvement Programme – The** Improvement Programme is split up into 3 key areas: • Inflow • Throughflow • Outflow **Inflow - Reduction in avoidable A&E attendances** Progress made in increased extended access to Primary Care after hours. **Throughflow - Improvement of the internal flow of patients by developing and embedding processes that enable staff to deliver the highest quality of care in a timely way.** Progress being made in each of the key impacts areas. On track for patients to be handed over by LAS with 100% of patients handed over by 30 mins by September 2019 **Outflow - Effective transfer and discharge of patients from the Emergency Department and wards by embedding clear transfer processes with partners in the systems and maximising the impact of existing integrated care initiatives.** Good improvement reduction of the percentage of patients who are long stayers in hospital (length of stay greater than 7 days and greater than 21 days). Delayed transfers of care (DTOCs) have had specific delays in May and June relating to higher than expected numbers in Haringey and CHC delays. There will be a focus in August to address the DTOCs by running a large MADE DTOC event supported by the Emergency Care Intensive Support Team which will involve senior leads from local authorities, clinical; commissioning groups and Whittington Health.	

Purpose:	Review and assurance of Trust performance compliance
Recommendation(s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1; Quality 2; Quality 3; People 1; and, People 2.
Report history	Trust Management Group
Appendices	None

Islington A&E Delivery Board - Improvement Programme 2019/20



Inflow	Key action	Expected impact	Target	Apr-19	May-19	Jun-19	Q1	Trend
Reduction in avoidable A&E attendances	Extended access to primary care in evening (6.30-8pm) and weekends (8-8)	Reduce daily attendances (TBC)	TBC	302	299	280	294	
	Direct support for GP practices with high A&E att. rates /avoidable A&E referrals	Reduction in LAS conveyances to A&E	TBC					
	Attendance and admission avoidance scheme – Rapid response service	Reduction in GP referrals requiring no significant investigation or treatment	5%	6.0%	6.0%	6.0%	6.0%	
	Integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call-handling and GP out-of-hours services	Reduction in Low acuity attendances	5%	6.0%	7.0%	6.0%	6.3%	
	Assertive Alcohol Outreach Team and Alcohol Liaison working with high risk and dependent drinkers in order to reduce their utilisation of A&E and reduce the rate of alcohol specific admissions	Integrated Urgent Care 111 - % of calls referred to A&E (NCL)	England Avg	8.6%	9.2%	9.4%	9.1%	
	Direct conveyances to Whittington's AEC and UTC and other alternative pathways	Increase in extended access to primary care after hours (i-Hub) utilization	85%	82.0%	83.0%	93.0%	86.0%	
	Health Based Place of safety enabling direct police conveyances of MH patients	Reduction in MH conveyances	TBC					
Through flow	**Key actions**	**Expected impact**	**Target**	**Apr-19**	**May-19**	**Jun-19**	**Q1**	**Trend**
	Develop a staffing structure model with the right skills set that ensures the Emergency Department is more adaptable and resilient to pressures at different times of the day	Weekend shifts with enhanced consultant cover	100%	50%	75%	90%	72%	

Outflow	Key actions	Expected impact	Target	Apr-19	May-19	Jun-19	Q1	Trend
Improvement of the internal flow of patients by developing and embedding processes that enable staff to deliver the highest quality of care in a timely way.	Redesign of FoH pathways to support streaming, redirection, triage and LAS handover	Weekend shifts with enhanced doctor cover (exact shifts to be defined)	100%	88%	90%	90%	89%	
	Improve Emergency Department flow through effective and timely LAS handover of patients	% of middle grades posts filled	100%	99%	91%	98%	96%	
	Increase use of ambulatory care across all specialities as an appropriate alternative to hospital admission for the diagnosis, management & treatment of patients	95% of patients are seen, treated and admitted/discharged within 4 hours	95%	84.6%	88.6%	90.1%	88%	
	Medically enhanced RAT_ providing early senior assessment and treatment patients.	100% of patients handed over within 30 minutes	100%	94.0%	98.0%	98.0%	96.7%	
	improve patient flow away from the ED department streaming to onsite services and redirection to offsite services (such as GP or Pharmacy).	100% of patients have an initial assessment within 15 minutes	100%	70.0%	78.0%	82.0%	76.7%	
	Increasing the utilisation of the Clinical Decision Unit. (20 patients per day)	50% of patients are seen by a clinician/decision maker within 60 minutes	50%	32.1%	38.7%	46.1%	39.0%	
	Improve the experience of mental health patients by optimising existing Mental Health pathways, increasing the use of Mental Health Recovery Suite, reducing the number of Mental Health breaches and reducing the length of stay in Emergency Department	40% of patients discharged within 2 hours of arrival	40%	23.0%	29.0%	32.0%	28.0%	
		Mental health patients spend under 4hrs in ED (mins)	239	535	510	478	507	
		Mental Health Transfers - 48 hour from Medically Fit For Discharge on ward to Mental Health bed	100%	0%	67%	50%	39%	
Effective transfer and discharge of patients from both the Emergency Department and wards by embedding clear transfer processes with partners in the systems and maximising the impact of existing integrated care initiatives.	Agree and embed transfer processes from ED to other organisations to minimise delay	Increase in the percentage of patients with early EDD (early discharge date)	TBC					
	Optimise existing models - Discharge to Assess (D2A), Rapid response and virtual ward, Reablement	Reduction in the % of DToC against bedbase	3%	3%	4%	4%	4%	
	Weekly reviews of Long length of stay patients	Reduction in the % of Medically optimised patients ready for discharge	4%	5%	8%	5%	6%	
	Weekly reviews of medically optimised patients	Reduction in % of stranded patients (Length of stay greater than 7 days)	18%	14%	18%	14%	15%	
	Senior MDT review of complex patients	Reduction in % of super stranded patients (Length of stay greater than 21 days)	40%	40%	42%	35%	39%	
	Bi-weekly MADE meetings with system partners to discuss delayed transfers	Increase in number of patients active on the virtual ward per day	10	10	10	10	10	
	Embed choice policy across all wards	Increase in bed days saved through Rapid Response, Virtual Ward and Discharge to Assess	TBC					

Meeting title	**Trust Board - Public**	**Date: 31 July 2019**
Report title	**June (Month 3) 2019/20 – Financial Performance**	**Agenda item: 17**
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a year to date deficit of £2.5m which is £2.7m behind plan. The Trust has not achieved the Q1 financial target and therefore has not assumed any Provider & Sustainability Funding relating to its financial performance resulting in a negative variance of £0.7m. Should the Trust improve and achieve the Control Total this can be regained but given the material variance and confidence levels a prudent view has been taken in reporting. The primary driver for the adverse variance remains the failure to achieve the Cost Improvement Programme (CIP) with delivery of £0.3m in month being £0.7m year to date against a £3.1m target. The CIP variance broadly equal within both pay and non-pay. It is important that the Trust delivers on existing plans and investigates other productivity opportunities to meet financial balance. The year to date pay costs are in excess of budget by £1.4m. Bank spend is broadly consistent each month with £1.9m in June, agency spend is almost £0.9m a decrease of £35k on May. Agency staffing costs at the end of Month 3 amount to £2.9m and therefore need to be tightly managed to ensure the Trust remains within the NHS Improvement annual agency ceiling of £8.8m. Non pay expenditure is £0.1m overspent in month and £1.2m year to date. The Trust has spent £2.3m on capital expenditure as at month 3. The planned spend is £3.3m. The Trust is currently liaising with NHS Improvement to confirm its capital allocation for the financial year but it is anticipated that there will be a £3m reduction.	
Purpose:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends	
Recommendation(s)	To note the financial results relating to performance during June 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 – People 1, Integration 1 and Sustainable 1	
Report history	July 2019 meetings of the Trust Management Group and Finance & Business Development Committee	
Appendices	None	

June (Month 3) 2019/20 – Financial Performance

Financial Overview

The Trust is reporting a year to date deficit of £2.5m deficit in June, which is a negative variance to plan of £2.7m. The Trust is failing a number of the key measures it has previously identified and as predicted has not met its financial target at the end of quarter 1.

MEASURE	TARGET	ACTUAL	Prev month	RAG	RESPONSIBLE OFFICERS
Beds at funded establishment	197	206	226		DOO - Surgery & Cancer & EIM
CIP schemes identified (of £12.3m original target)	100%	100%	76%		Head of PMO
CIP schemes delivery	100%	22%	19%		Head of PMO
Emergency Length of stay	TBC	7.4	8.1		DOO - EIM
Elective Activity planned delivered (DC & Elective)	100%	99%	102%		DOO - Surgery & Cancer
Trust wide agency spend (per month)	£0.7m	£0.9m	£1.0m		DOOs

The Trust is still forecasting to meet its control total for the full year and is developing a recovery plan. Recovery actions include:

- Third party assurance on Cost Improvement Programme including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case advise on the steps required.
- Ensure all escalation beds are closed and the Trust delivers planned activity with the funded bed capacity reducing Average Length of Stay, Delayed Transfers of Care and the number of Medically Optimised patients in beds.
- Ensure all Average Length of Stay targets and metrics signed off by specialty with a clinical lead working with the Performance Director on delivery
- Ensure all ICSUs deliver to funded establishments with Executive sign off for over establishments
- Whilst income is broadly to plan there are areas with shortfalls. Each of these areas to complete an actions plan to address shortfalls and ensure waiting lists do not grow
- Review of Trust capacity to identify opportunities to repatriate work from private providers or assist with other capacity concerns at other NCL organisations
- To increase the financial improvement capacity in the short term to support areas failing

The financial position is largely driven by failed CIP of £2.4m year to date.

The table below shows the summary position for the June.

Statement of comprehensive income

2019/20, Month 3 (June 2019)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	YTD Variance (£000s)	FULL YEAR BUDGET (£000s)
Clinical Income	24,221	24,380	159	73,116	73,920	804	290,479
Other Non-Patient Income	1,946	1,900	(46)	6,098	5,712	(386)	24,921
High Cost Drugs	665	653	(12)	1,996	2,059	64	7,984
Pay Award Funding	0	0	0	0	0	0	0
Total Income	**26,832**	**26,933**	**101**	**81,210**	**81,692**	**482**	**323,384**
Pay	(19,128)	(19,665)	(537)	(57,754)	(59,165)	(1,411)	(232,207)
Non-Pay (excl HCD)	(6,039)	(6,198)	(158)	(18,094)	(19,341)	(1,247)	(72,407)
High Cost Drugs	(668)	(611)	57	(2,003)	(1,973)	30	(8,011)
Total Operating Expenditure	**(25,835)**	**(26,473)**	**(638)**	**(77,851)**	**(80,479)**	**(2,628)**	**(312,625)**
	997	**460**	**(537)**	**3,359**	**1,213**	**(2,146)**	**10,759**
Depreciation	(622)	(588)	34	(1,863)	(1,758)	105	(7,481)
Dividends Payable	(432)	(432)	0	(1,296)	(1,296)	0	(5,187)
Interest Payable	(271)	(270)	1	(812)	(817)	(5)	(3,238)
Interest Receivable	9	18	9	27	58	31	156
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,316)**	**(1,272)**	**44**	**(3,944)**	**(3,813)**	**131**	**(15,750)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(319)**	**(812)**	**(493)**	**(585)**	**(2,600)**	**(2,015)**	**(4,991)**
Provider Sustainability Fund (PSF) (including FRF & MRET)	260	(151)	(411)	778	91	*(687)*	*4,946*
Net Surplus / (Deficit) - before IFRIC 12	**(59)**	**(963)**	**(904)**	**193**	**(2,509)**	**(2,702)**	**(45)**
Add back							
Impairments	0	0	0	0	0	*0*	0
IFRS & Donate	4	6	2	9	19	*10*	45
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(55)**	**(957)**	**(902)**	**202**	**(2,490)**	**(2,692)**	**0**

Income and activity

The comments and table below refer to the Trust's performance against its overall operating plan. The Trust is performing (before the application of PSF) £0.5m (0.6%) ahead of plan but this is offset by a reduction to PSF (£0.7m) as the Trust's control total has not been met. The revised income position after this reduction is £0.2m (0.3%) adverse to plan.

The main areas of material variance are within controllable planned care. Elective admissions and day cases are £0.6m (11%) favourable year to date (YTD) compared to the operating plan submission. Outpatients are £0.4m (7%) YTD adverse to plan with continued adverse performance in M3 by £0.2m (8%).

The Trust has not assumed any income relating to the Provider Sustainability/Financial Recovery Fund as the Trust is not currently meeting its planned financial position.

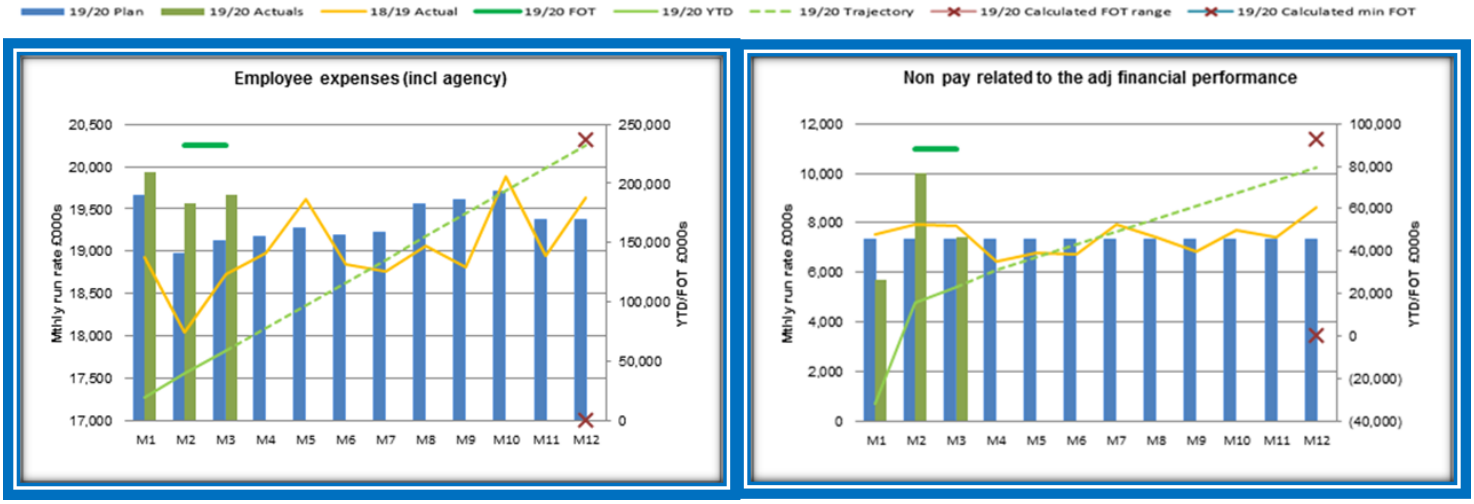
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
Elective and Day Case	1,819	2,039	220	5,544	6,139	595
Non Elective 0 LOS	1,023	1,017	(6)	3,103	3,161	58
Non Elective LOS I Day or Greater	3,601	3,582	(19)	10,925	11,131	206
OP Attendances - 1st	997	947	(50)	3,038	2,872	(166)
OP Attendances - follow up	898	797	(101)	2,737	2,487	(250)
A&E Attendances	1,387	1,390	3	4,207	4,194	(13)
High Cost Drugs	650	624	(26)	1,950	2,006	56
Community	6,160	6,160	0	18,480	18,480	0
Other Clinical income NHS	5,180	5,130	(50)	15,787	15,852	65
Other Clinical Income Non NHS	3,041	3,348	307	9,211	9,657	446
Total Income From Patient Care Activities	**24,756**	**25,035**	**279**	**74,982**	**75,980**	**998**
Other Operating Income Excluding PSF	**2,076**	**1,898**	**(178)**	**6,228**	**5,712**	**(516)**
Total	**26,832**	**26,933**	**101**	**81,210**	**81,692**	**482**
PSF/FRF/MRET	260	(151)	(411)	778	91	(687)
Revised Total	**27,092**	**26,782**	**(310)**	**81,988**	**81,783**	**(205)**

Monthly run rates – expenditure

The in month combined expenditure position is £0.6m adverse to plan (£2.6m adverse YTD). Key points to note include:

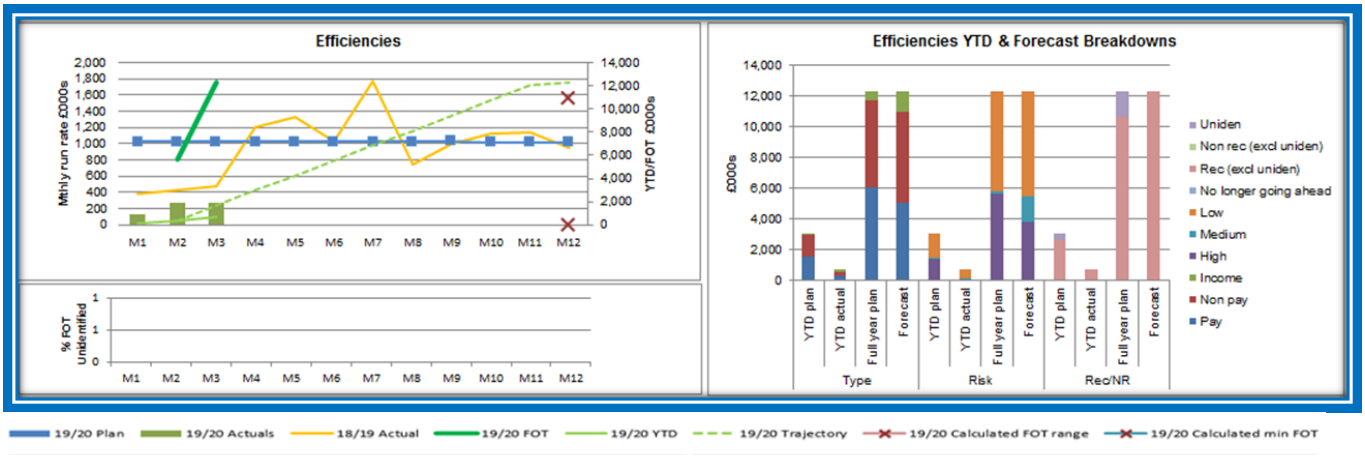
- **Pay and Activity Correlation**
  - Total pay expenditure for June was £19.7m, £0.5m adverse to budget, (£1.4m adverse) YTD.
  - The majority of the pressures are within Emergency Integrated Medicine where there continues to be a high level of over establishment. This sits within the ward areas (£0.6m) as there are a higher than planned number of beds open combined with a pressure on one to one care and within the Emergency areas (£0.5m) where there is a mix of over establishment in nursing (£0.3m) and premium rate staffing pressures due to vacancies particularly within middle grade doctors (£0.2m).
  - Other ICSUs are experiencing pay pressure including Surgery where excess beds are also an issue.
  - Within total pay expenditure, agency costs were £0.9m in month, £2.9m year to date with Bank spend at £1.9m which is consistent with previous months. Total temporary spend for the year is £8.4m.

- **Non Pay**
  - Non pay expenditure for June was £6.8m, including High Cost Drugs.
  - The non-pay variance in month 3 is an adverse variance of £0.1m. This brings the year to date overspend of £1.2m, pressures within clinical supplies for theatres, endoscopy insourcing and utilities and unachieved CIP.



Cost Improvement Programme (CIP)

The Trust has planned CIP delivery just in excess of £1m each month, with the year to date target being £3.1m. The Trust has delivered £0.7m. This is an adverse variance of £2.4m.



Next Steps

The Trust is already taking action to address the gaps identified. These actions include:

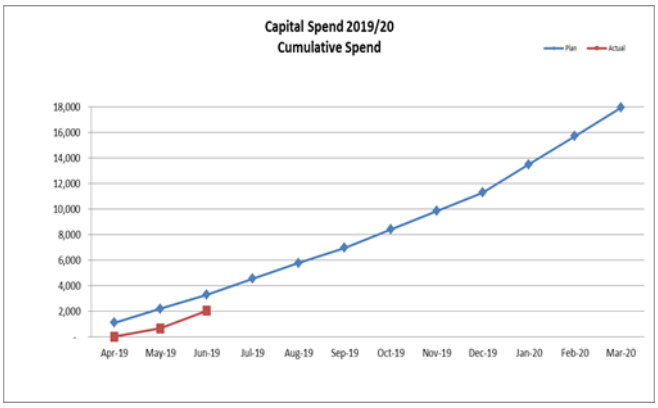
- Third party assurance on Cost Improvement Programme including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case advise on the steps required.
- Changes to the PMO structure to provide greater support to ICSUs to assist with the development and delivery of CIP
- Additional support to ICSUs including operational, financial and quality, providing greater capacity and increased scrutiny
- Weekly reporting and reviews at Executive Team Meetings

Statement of Financial Position

THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 30 June 2019 £000	Plan 30 June 2019 £000	Year to Date Plan variance 30 June 2019 £000
Property, plant and equipment and intangibles	218,861	224,698	(5,837)
Trade and other receivables	738	1,400	(662)
Total Non Current Assets	**219,599**	**226,098**	**(6,499)**
Inventories	1,291	1,355	(64)
Trade and other receivables	49,537	37,018	12,519
Cash and cash equivalents	20,496	17,656	2,840
Total Current Assets	**71,324**	**56,029**	**15,295**
Total Assets	**290,923**	**282,127**	**8,796**
Trade and other payables	48,167	44,146	4,021
Borrowings	28,309	29,124	(815)
Provisions	1,032	1,391	(359)
Total Current Liabilities	**77,508**	**74,661**	**2,847**
Net Current Assets (Liabilities)	**(6,184)**	**(18,632)**	**12,448**
Total Assets less Current Liabilities	**213,415**	**207,466**	**5,949**
Borrowings	28,830	31,808	(2,978)
Provisions	839	842	(3)
Total Non Current Liabilities	**29,669**	**32,650**	**(2,981)**
Total Assets Employed	**183,746**	**174,816**	**8,930**
Public dividend capital	66,691	67,941	(1,250)
Retained earnings	22,135	4,304	17,831
Revaluation reserve	94,920	102,571	(7,651)
Total Taxpayers' Equity	**183,746**	**174,816**	**8,930**



There are some significant variances in the balance sheet against plan. Overall, the value of the balance sheet is £8.9m higher than plan. The taxpayers' equity section is signifcantly more than plan; 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 (information available after the submission of the 2019-20 operating plan), which indicated an average decrease of approximately 2%.

Property, Plant & Equipment (PPE) and intangible assets are £6.6m lower than plan. This variance against plan largely arises from the revaluation decreases mentioned above, but also that capital spend is behind draft plan numbers issued to NHSI. Spend is £2.1m against planned spend of £3.3m. Original forecast outturn of £18m is likely to reduce to £15m, subject to NHS Improvement approval.

Cash and cash flow: the Trust has £20.5m in cash at the end of June 2019. This reflects the completion of the land sale transaction to Camden and Islington NHS FT in March 2019, and forms part of a significant level of cash that will fund a transformative Estates Strategy in future years. £15m of the balance is invested with the National Loans Fund.

The Trust is unlikely to require any cash support during 2019/20. The Trust expects that its most significant debtor, for approximately £22m with NHS England for Provider Sustainability Funding (PSF) will be settled in July or August 2019.

Receivables (Debtors) are £11.8m higher than plan. This increase is primarily driven by the £6.8m additional PSF awarded to the Trust by NHSI as a reward for meeting its financial targets in 2018-19, and by the raising in advance of the £4.0m Q2 Health Education England invoice. The Trust expects both of these to be settled in July or August 2019, and we would anticipate that this balance should return to plan after this time.

Meeting title	**Trust Board –Public**	**Date: 31 July 2019**
Report title	**National Patient experience surveys - results and learning**	**Agenda item: 18**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	Breeda McManus, Deputy Chief Nurse	
Executive summary	Over the last twelve months the Trust has received results and feedback on a number of nationally coordinated patient experience surveys. This report provides a summary of the results and the work being undertaken to improve patient experience as required. The report also provides an overview of the positive feedback received from the results and recognises the compassion and care that Whittington Health staff provides to its patients and public. Monitoring of improvements is through the Trust Patient Experience Committee and Quality Committee. The reports included in this report are: • **Maternity Survey 2018** • **Inpatients Survey 2018** • **National Cancer Patient Experience Survey 2018** The next report will provide an update on the following survey results which have not been released to date: • **Emergency Department Survey 2018** • **Children and Young People's Survey 2018** • **National Cancer Patient Experience Survey 2019** (April 2019, the fieldwork period is ongoing for this survey)	
Purpose:	Review	
Recommendation(s)	Board members are asked to review the summary of the results provided.	
Risk Register or Board Assurance Framework	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 of income, an adverse impact upon staff retention and damage to organisational reputation	
Report history	Relevant Integrated Clinical Service Unit Quality Board Patient Experience Committee May 2019 Quality Committee July 2019	
Appendices	None	

National Patient experience surveys - results and learning

1. Introduction

1.2 Patient experience and feedback is well established as a measure of quality and referred to by the CQC as an indicator of a well led organisation. This paper summarises the key findings in the Trust's national patient experience survey results for 2018 and outlines the actions planned or underway to improve the patient experience. These actions outline key areas of focus for patient experience and must be considered in the wider context of other programmes of work, including ongoing Quality Improvement programmes.

2. Patient experience survey

2.1 The Trust contributed to a number of patient surveys during 2018 -19. These included:-

- **Maternity Survey 2018**
- **Inpatients Survey 2018**
- **National Cancer Patient Experience Survey 2018**

2.2 The Trust also took part in patient surveys for the following clinical areas but the results are not yet published:-

- **Emergency Department Survey 2018**
- **Children and Young People's Survey 2018**
- **National Cancer Patient Experience Survey 2019** (April 2019, the fieldwork period is ongoing for this survey)

3. National inpatient patient survey 2018

3.1 This survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between August 2018 and January 2018, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 389 patients at Whittington Health NHS Trust.

3.2 The Whittington Health response rate was 32% (n=389) compared to 45% nationally and included patients discharged during July 2018.

3.3 The CQC published the 2018 Inpatient Survey results in June 2019. The survey contains 63 questions. The Picker Institute conducted the survey on behalf of Whittington Health. The CQC presents the results each year, benchmarking Trusts nationally. The CQC weights the scores of each participating Trust by age, gender and route of admission (emergency or elective). By doing this each Trust, in effect, has the same age, gender and route of admission profile and it means that scores are then comparable across Trusts with different profiles. The CQC does not compare, or recommend comparing Trusts' overall performance.

3.4 **Whittington Health NHS Trust Results**

- This survey has highlighted many positive aspects of the patient experience, 8 out of 10 of our hospital patients say that overall they had a very good experience as an inpatient at Whittington Health.
- The Trust scored better on a number of areas, 90% reported being given enough information on treatment in the Emergency Department and on medication side effects on discharge, 55% reported the information given on medication side effects on discharge was adequate and 70% reported the information given to family / carers on how to care for them on discharge, if needed, was sufficient.
- While most patients are highly appreciative of the care they received, there is always room for improving the patient experience. The areas where we scored worse were in relation to the cleanliness of the ward/room, the quality of the food, noise levels at night and movement of patients overnight.
- Whittington Health performed about the same as most other trusts that took part in the survey in the following areas:
  - There was good evidence of teamwork and patient felt respected and dignified
  - Patients feel they wait the right amount of time on the waiting list
  - Patients felt that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them, they also felt they received good information on what to expect from surgery and how the surgery went.
  - Patients felt they had trust in both the nursing and medical team and were given information in a way they understood, they felt looked after by non-clinical staff
  - They did not have to wait a long time to get to a bed on a ward

3.5 **Improvement Plan**. This year's action plan continues to focus on top key areas identified such as improving the cleanliness of the wards, improving food quality and providing a restful night. Ensuring patients are made aware of whom to approach with queries and ensuring that we continue to improve the patient experience of discharge planning and discharge.

3.6 Patients would like to feel more involved in decisions about their care, especially around discharge; work is underway to improve the written patient information provided to patients and their families. Discharge planning needs to ensure that patients are kept informed and that information is improved to patients.

3.7 Progress with the inpatient experience action plan will be monitored through the Patient Experience Committee, and progress reported to Quality Committee.

4. Experiences of women receiving maternity services 2018

4.1 The 2018 NHS Maternity Service is carried out annually by the Care Quality Commission as the independent regulator of all health and social care

services in England. This year's survey results were published in January 2019. Whittington Health had a response rate of 37%.

4.2 The report finds that new families report that they were treated with dignity and respect 100% of the time, with more than 95% reporting that they had confidence in staff at Whittington Health NHS Trust and that they felt involved in decisions about their care.

4.3 The results of the survey place Whittington Health NHS Trust, which delivers around 3,700 babies each year, as the 12th most improved service amongst the 129 units across the country. In particular, significant improvement was reported in the number of new parents who said midwives asked about how mothers were feeling emotionally and they were given advice about where to seek support if they experienced changes in their emotional wellbeing.

4.4 Mothers said that being able to have their partner stay with them as long as they wanted was a strength of Whittington Health's Maternity Service and that they were not left alone when worried.

4.5 The findings of this year's survey show that many women are experiencing high quality care and treatment during pregnancy and birth. Whilst there is always room for improvement 88% of respondents say that when they did raise issues that they were taken seriously. This is a testament to efforts and dedication of staff working hard to provide care for pregnant women and new mothers attending Whittington Health.

4.6 **Improvement Plan**. This year's action plan will focus on key areas identified such as improving the cleanliness of the wards, improving the environment and reducing delays on discharge.

4.7 We have a number of projects taking place in women's services to improve the environment for parents and staff. The second obstetric theatre is nearly complete and will be ready for patients in summer 2019 Work has started to refurbish our postnatal ward and we will also be extending the neo-natal intensive care unit (NICU).

5. National cancer patient experience survey 2018

5.1 The 2017 results for the National Cancer Patient Experience Survey (NCPES) are positive for Whittington Health NHS Trust with approximately 50% of feedback being above the national average.

5.2 According to patient feedback, things that we do particularly well at the Trust include; involving patients in their care and treatment decisions, providing a named Clinical Nurse Specialist, who is easy to contact when needed, ensuring that patients understand who to contact if worried about their condition or treatment after discharge and importantly, treating people with dignity and respect whilst they are cared for within the hospital.

5.3 **Improvement Plan** These are predominantly grouped in to three main areas; communication, in patient care on medical or surgical wards and the provision of seamless care and support which continues from hospital to home.

5.4 Overall and alongside nationally recognised areas for development; patient feedback in 2017 suggests that Whittington Health needs to focus on improving access to good quality advice and support around the immediate and longer-term impact a diagnosis of cancer can have on the individual and their family. Further, improvements are to be made within Multidisciplinary working which ensures a smooth transition of care and support form hospital to home.

5.5 Pivotal to these suggested improvements will be the recruitment of a Recovery Package Manager and the implementation of the Personalised Care Agenda objectives for Whittington Health patients, which aligns to Pan London and National strategies to improve the overall experience of the individual diagnosed with cancer.

5.6 A comprehensive action plan has been developed in response to the survey results, which is currently being implemented. Impact from these actions will not be measurable within the 2018/19 NCPES results, as the annual collection of feedback has already taken place.

5.7 **Key things from the action plan we have already achieved**

- Review and update of all cancer related leaflets.
- Review of website information for breast cancer patients
- Standardisation of information for all cancer patients given at diagnosis
- Follow up calls to patients within a week of diagnosis to check in.
- Gathered patient feedback to feed in to the development of a new diagnosis support group.
- CNS team have begun 360 degree feedback process
- All CNS team members have now been adopted by Macmillan

5.8 **Key items in progress**

- Sage and Thyme training has been relaunched and is accessible to all Macmillan adopted professionals
- Accessible information Quality Improvement project – working closely with the patient experience team to translate key information and Friends and Family Test cards in to our top 10 languages. Plan to trial use in outpatients, with the interpreter team and on chemotherapy unit and then share the translated information trust wide. Costs have been minimal so far.
- There is an available and tested training package which the trust can access for free to upskill ward based nurses around cancer care. This is not exhaustive or overly time restricted and is going to be used across the hospital.

6. Recommendations

6.1 Trust Board is asked to discuss and note the survey results for the:

- Maternity Survey 2018
- Inpatients Survey 2018
- National Cancer Patient Experience Survey 2017

Meeting title	**Trust Board – Public**	**Date: 31 July 2019**
Report title	**2018-2019 Annual Compliments, Complaints & PALS report**	**Agenda item: 19**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Patient Experience	
Report authors	Kat Nolan-Cullen, Compliance and Quality Improvement Manager, and Paul Macpherson, Patient Advice & Liaison Service (PALS) & Complaints Manager	
Executive summary	This report provides an annual overview of compliments, complaints, PALS and quality alerts received during the period 1 April 2018 – 31 March 2019. In summary there were: **Compliments** • During 2018-2019, the Trust received 384 compliments compared to 347 compliments during 2017-2018 • The Trust received more compliments than formal complaints during 2018-2019 **Complaints** • 315 complaints, 100 in Quarter 1, 62 in Quarter 2, 78 in Quarter 3 and 75 in Quarter 4 • All complaints were acknowledged within the stipulated 3 working day target • 384 compliments received compared with 315 complaints • 81% of complaints were responded to within 25 day working days; the target is 80%. (This compares to 83% in 2017-18) • 2.8% (9) of complaints were referred to Parliamentary Health Service Ombudsman **PALS** • During 2018-2019, a total of 2235 PALS contacts were received compared to the 2246 contacts during 2017-2018 • 1704 (76%) queries related to concerns and 531 (23%) related to requests for information	

	Quality Alerts • During 2017-2018, 37 quality alerts were received compared to 52 during 2016-2017 • During 2018-2019 the Trust received 9. This is a significant drop when compared with previous years; the significant drop is due to a change in process; whereby concerns about an individual patient received via a GP are now logged as a 'GP Concern' as opposed to a 'Quality Alert'.
Purpose:	Review
Recommendation(s)	The Trust Board is asked to: i. review the 2018/19 annual report; and ii. be aware and understand the trust's learning and management of feedback received from people who use our services;
Risk Register or Board Assurance Framework	This links to BAF 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 of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	Quality Committee, 10 July 2019

2018-2019 Annual Compliments, Complaints & PALS report

1. INTRODUCTION

1.1. This is the Complaints & PALS annual report for Whittington Health NHS Trust for 2018 – 2019. The Trust provides services for a population 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

1.2. The report provides a summary of patient complaints due to be closed in 2018-19. It includes details of numbers of complaints received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman investigations, and action taken by the Trust in response to complaints.

1.3. The report also includes details of the PALS concerns and enquiries and compliments received during 2018-19. Of note is that the Trust receives more compliments centrally through the PALS & Complaints team than complaints. There are also a significant number of complaints and compliments that are received at ICSU level.

1.4. Delivering a quality service to our patients and being accountable is one of the Trust's core ICARE values. Key national programmes to drive improvement in the patient experience include annual Quality Account and the Care Quality Commission national patient survey programme.

1.5. Whittington Health NHS Trust has a strong focus on improving patient experience and this continues to develop and evolve. There are both well established, and some newer mechanisms to capture the experience of patients and drive ongoing improvement. These include the Friends & Family survey and use of information gathered through complaints and PALS, listening to patients, our excellent volunteering programme and in addition each Trust Board meeting starts with a patient story.

1.6. A tracker of the 'live' complaints is kept and shared with the Integrated Clinical Service Units (ICSU) and Corporate departments on a weekly basis and discussed at regular meetings with lead investigators to ensure complaint investigations are on track and any barriers to timely completion identified.

1.7. Patient complaints are reported to the Board on a quarterly basis, which in addition forms part of the Patient Experience report which integrates complaints data with patient feedback from the Patient Advice and Liaison Service (PALS), the inpatient survey and patient comments.

1.8. From April 2019 the 40 working day target used for complex complaints will be included in the performance measure along with the established reporting of the 25 day target.

1.9. In summary during 2018/2019 there were:

- 384 compliments received compared with 315 complaints
- 315 complaints, 100 in Quarter 1, 62 in Quarter 2, 78 in Quarter 3 and 75 in Quarter 4
- All complaints were acknowledged within the stipulated 3 working day target.
- 81% of complaints were responded to within 25 day working days; the target is 80%. (This compares to 83% in 2017-18)
- 2.8% (9) of complaints were referred to Parliamentary Health Service Ombudsman

2. COMPLIMENTS

2.1. During 2018-2019, the Trust received 384 compliments compared to 347 compliments during 2017-2018. The Trust received more compliments than formal complaints during 2018-2019. A few examples of the comments received are shown below.

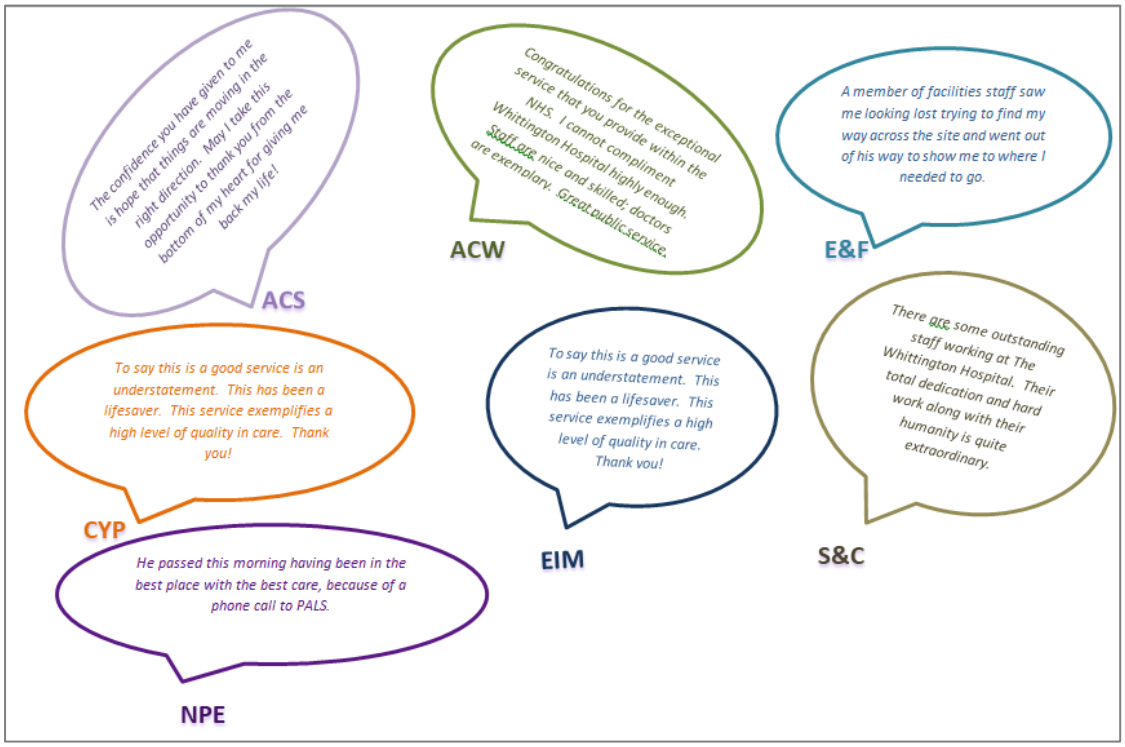


Table 12: Compliments by ICSU pre-July 2018

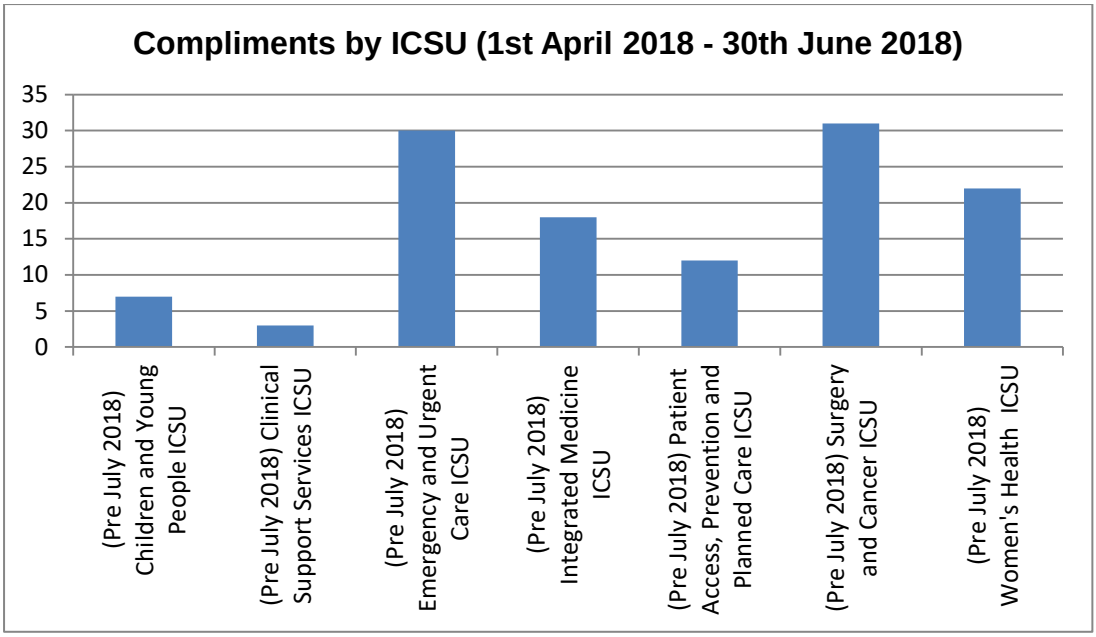


Table 13: Compliments by ICSU following ICSU re-configuration July 2018-March 2019

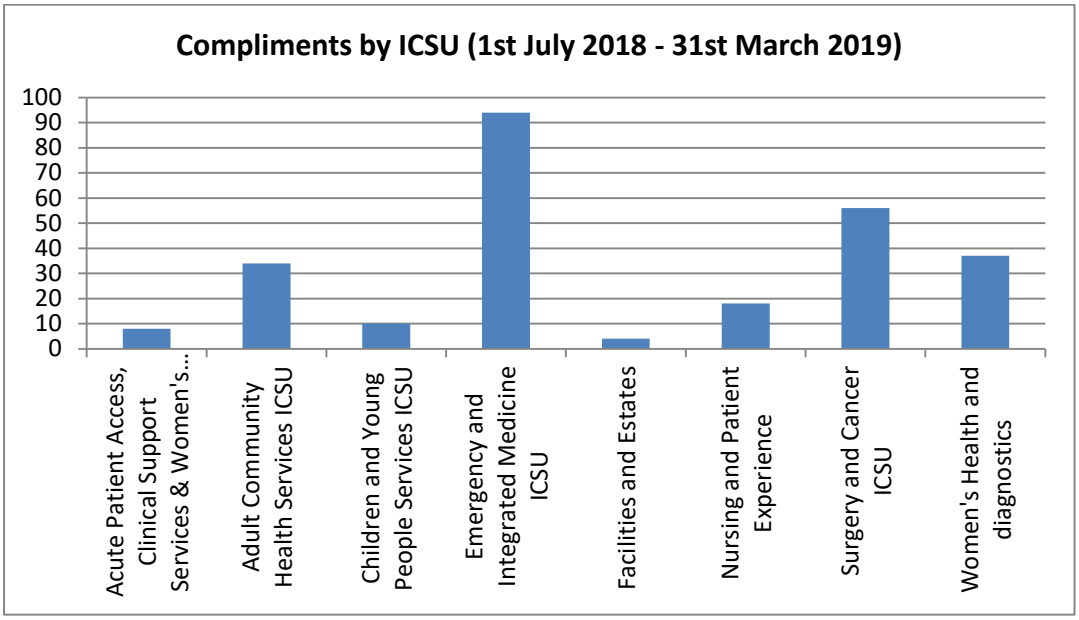


Table 14: Compliments by ICSU (1st July 2018 - 31st March 2019)

3. COMPLAINTS

3.1. During 2018-2019 a total of 315 complaints were received and closed which is a decrease of approximately 1% on the previous year 2017-2018 when 319 complaints were closed. But 4% when compared with 2016-2017 when 326 complaints were closed.

3.2. The charts below show the breakdown of complaints across the ICSUs. It is worth noting, that the arrangement of the ICSU's changed significantly in 2017-18 as the Trust reduced its operational ICSU's from 7 to 5 from 1st July 2018.

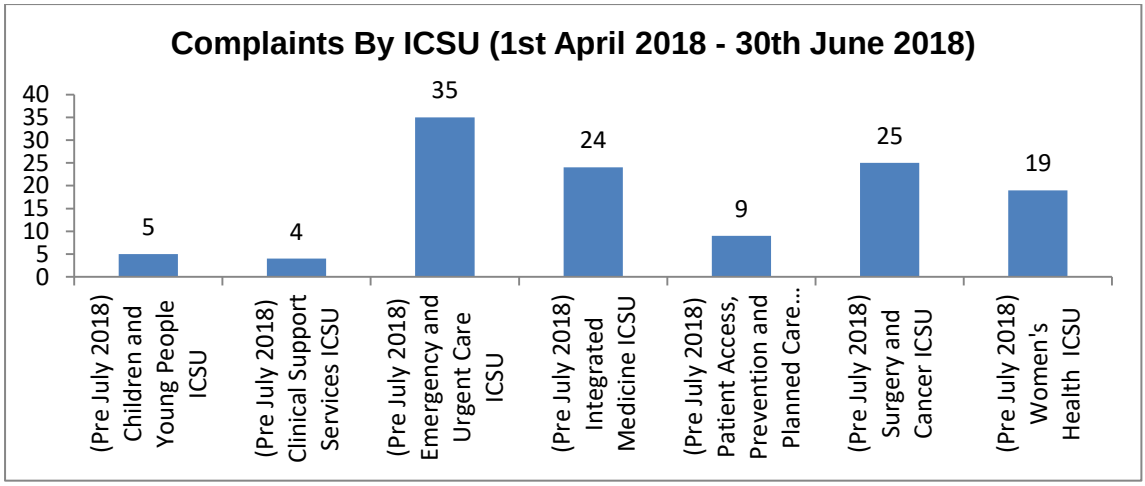


Table 1: Formal Complaints by ICSU pre-July 2018

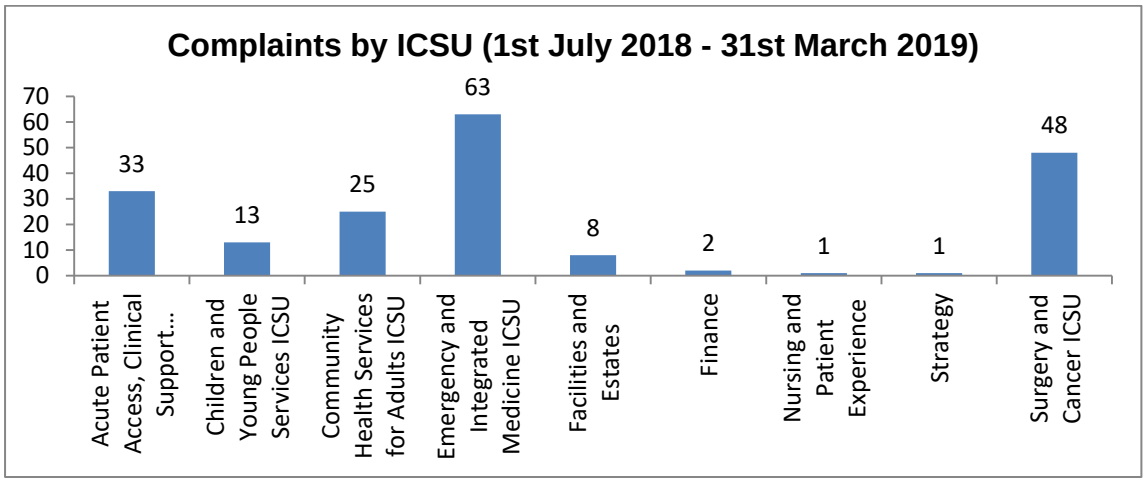


Table 2: Formal Complaints following ICSU re-configuration July 2018 – March 2019

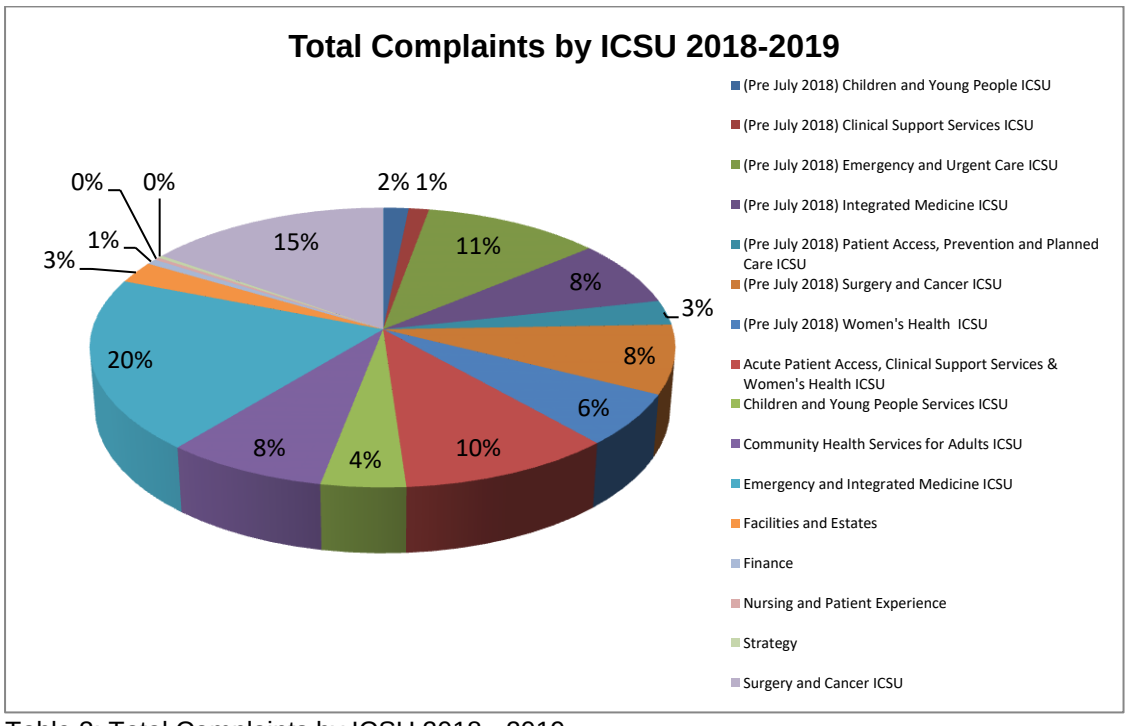


Table 3: Total Complaints by ICSU 2018 - 2019

3.3. **Complaints across the Trust by subject area**

Table 4 below shows the top 5 subject areas cited in the complaints received during 2018-2019.

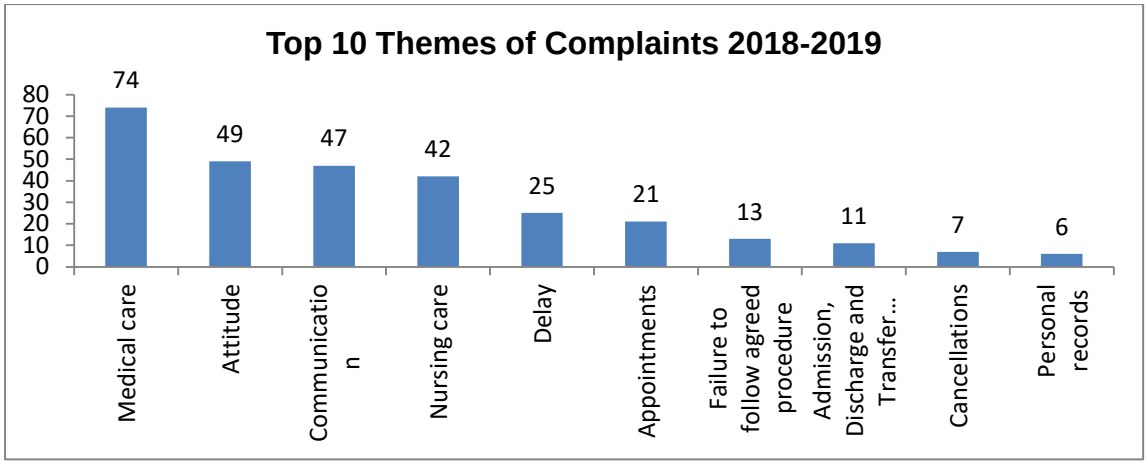


Table 4: Top 10 themes of Complaints 2018-19

3.4. **Complaints across the Trust by risk rating**

During 2018-2019, 20 (6%) complaints were designated 'high' risk compared to 7 (3%) in 2017-2018; the majority of complaints closed 157 (50%) were designated 'low' risk. 138 complaints (44%) were designated 'moderate' risk. All complaints are risk assessed by the PALS & Complaints team upon receipt and are required to be risk-assessed again by the lead investigator following completion of the investigation.

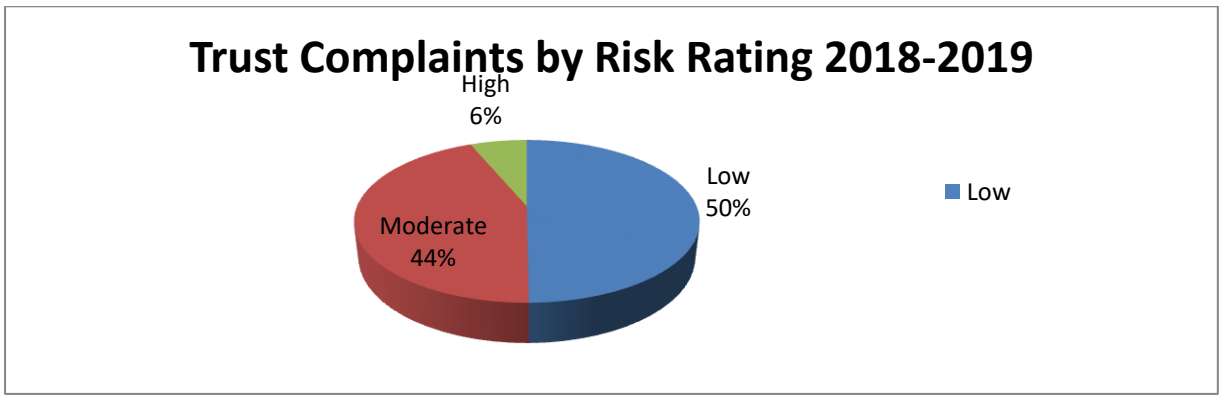


Table 5: Trust Complaints by risk rating 2018-19

3.5. **Complaints across the Trust by Upheld Status**

During 2018-2019, of the 315 complaints that have closed, 105 (34%) were fully upheld and 138 (44%) were partially upheld meaning that 243 (78%) complaints were upheld in one form or another, compared to 2017-2018 when 228 (72%) complaints were upheld in one form or another.

3.6. Two complaints were closed but under investigation as serious incidents at the time of compiling this report.

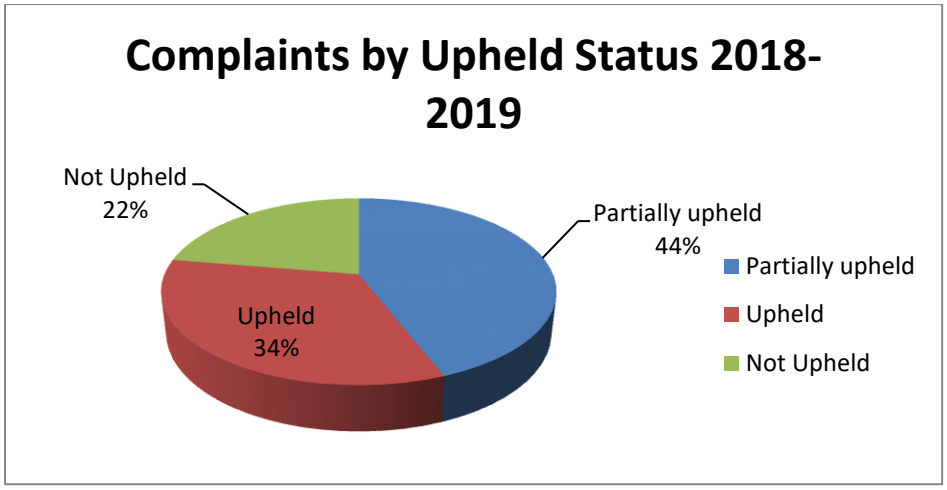


Table 6: Complaints by Upheld Status 2018-19

3.7. **Response Timescales**

The Trust target is for 80% of complaints to have a response within 25 working days. During 2018-2019, 81% of complaints were responded to within the required timeframe, compared to 83% during 2017-2018. It should be noted that complex complaints which fall within the 40 day timescale for investigation are now being monitored by the Trust with effect from April 2019 and will be included in the overall numbers for data reporting purposes.

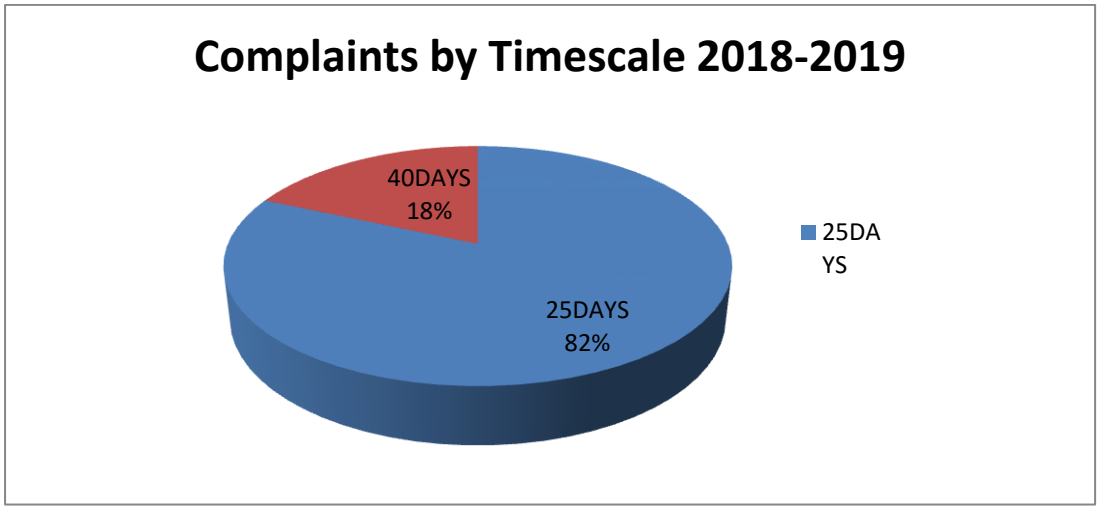


Table 7: Complaints by Timescale 2018-19

3.8. **Quality Alerts**

During 2017-2018, 37 quality alerts were received as shown below, compared to 52 during 2016-2017. During 2018-2019 the Trust received 9. This is a significant drop when compared with previous years. The significant drop is due to a change in process; whereby concerns about an individual patient received via a GP are now logged as a 'GP Concern' as opposed to a 'Quality Alert'.

ICSU	2016-2017	2017-2018
CSS	3	5
CYPS	3	1
EUC	8	3
IM	5	9
PPP	15	10
S&C	11	4
WH	6	1
IMT	1	3
Trust	**52**	**37**

ICSU	2018-2019
ACW	1
ACS	2
EIM	2
S&C	4
Trust	**9**

Table 8: Quality Alerts by ICSU 2018-19

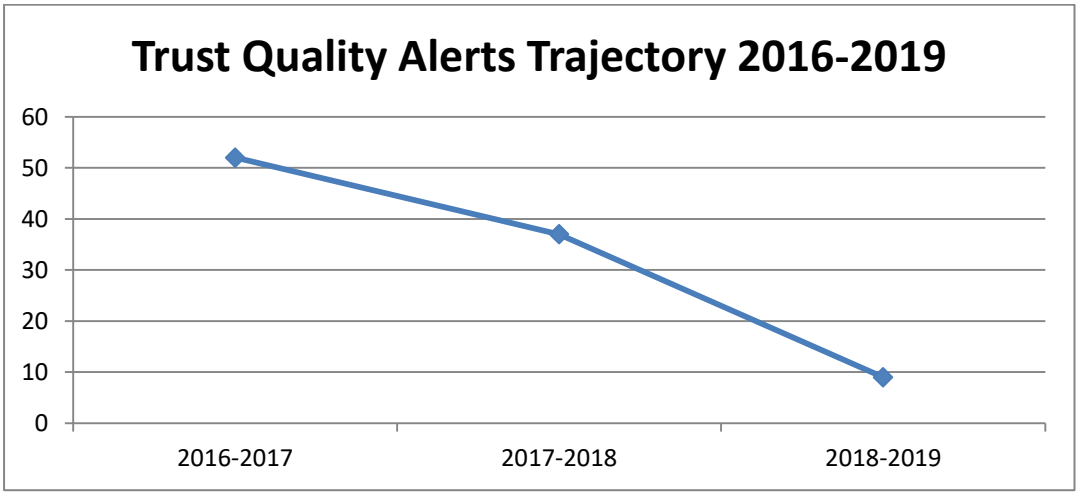


Table 9: Quality Alerts Trajectory 2016-19

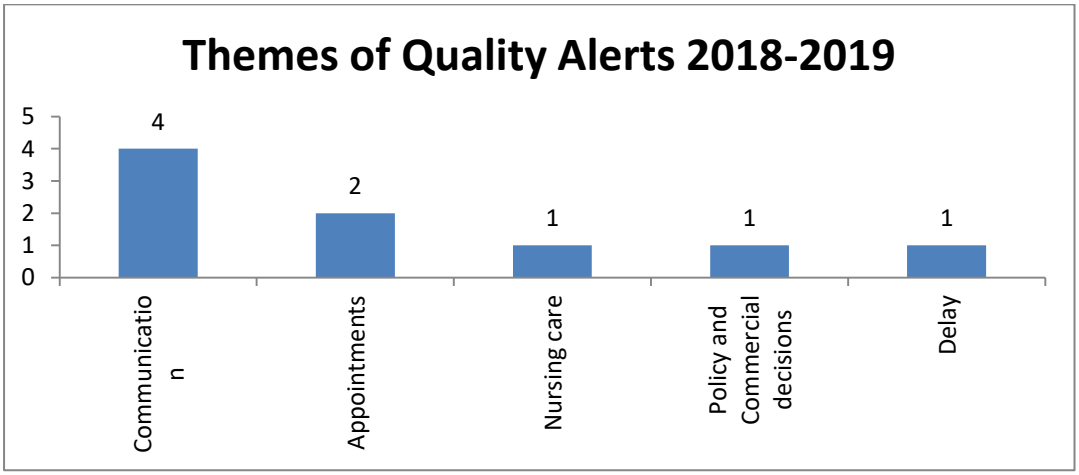


Table 10: Quality Alert Themes 2018-19

3.9. Dissatisfied complaints

Table 11 below shows the number of complainants returning dissatisfied or requiring further clarification (by ICSU). During 2018-2019, 41 complainants returned as dissatisfied (or asking for clarification) compared to 46 during 2017-2018.

ICSU	Total
Surgery and Cancer ICSU	11
Community Health Services for Adults ICSU	5
(Pre July 2018) Emergency and Urgent Care ICSU	5
(Pre July 2018) Patient Access, Prevention and Planned Care ICSU	4
Emergency and Integrated Medicine ICSU	3
Acute Patient Access, Clinical Support Services & Women's Health ICSU	3
(Pre July 2018) Surgery and Cancer ICSU	3
Children and Young People Services ICSU	2
(Pre July 2018) Integrated Medicine ICSU	2
(Pre July 2018) Women's Health ICSU	2
(Pre July 2018) Clinical Support Services ICSU	1
Trust	**41**

Table 11: Dissatisfied Complaints by ICSU 2018-19

3.10. **Parliamentary Health Service Ombudsman (PHSO) Cases**

The PHSO makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other UK public organisations. It looks into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right.

3.11. During 2018-2019 the Trust received nine requests from the PHSO to provide our complaint file and associated records in order that the PHSO could review and consider whether to undertake an independent review compared to four in 2017-2018.

Case Number	ICSU	PHSO Investigation Yes/No	Complaint Upheld
34882	CYP	Full Investigation	Upheld
33886	S&C	Full Investigation	Upheld
28644	ACW	No Investigation	-
33223	EIM	Full Investigation	Partially Upheld
35159	ACW	No Investigation	-
32819	EIM	Full Investigation	No outcome to date
34578	EIM	Pending – awaiting PHSO decision	
35707	EIM	Pending – awaiting PHSO decision	
36601	ACS	Pending – awaiting PHSO decision	

4. PALS

4.1. **Trust PALS Contacts (concerns & information requests) by ICSU**

During 2018-2019, a total of 2235 PALS contacts were received compared to the 2246 contacts during 2017-2018; 1704 (76%) related to concerns and 531 (23%) related to requests for information.

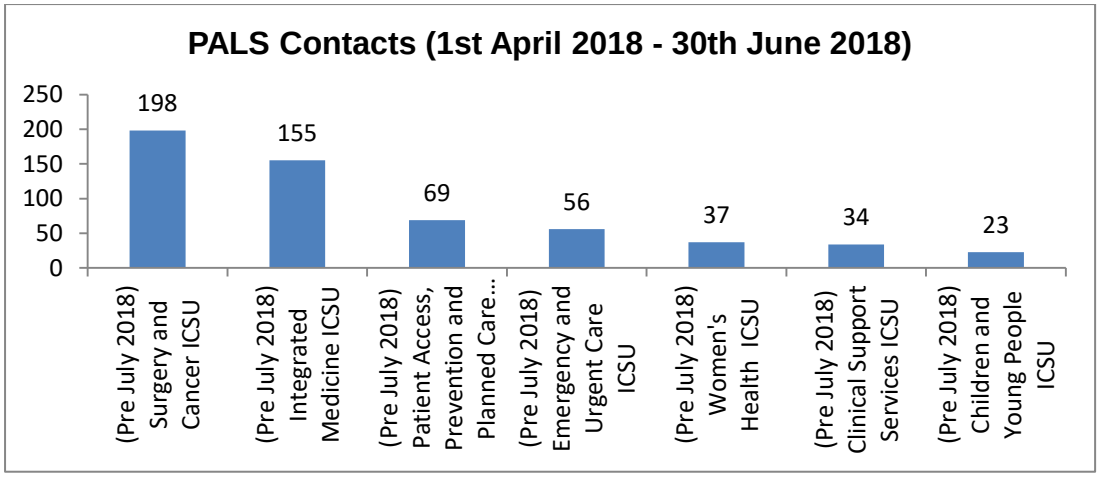


Table 14: PALS Contacts pre July 2018

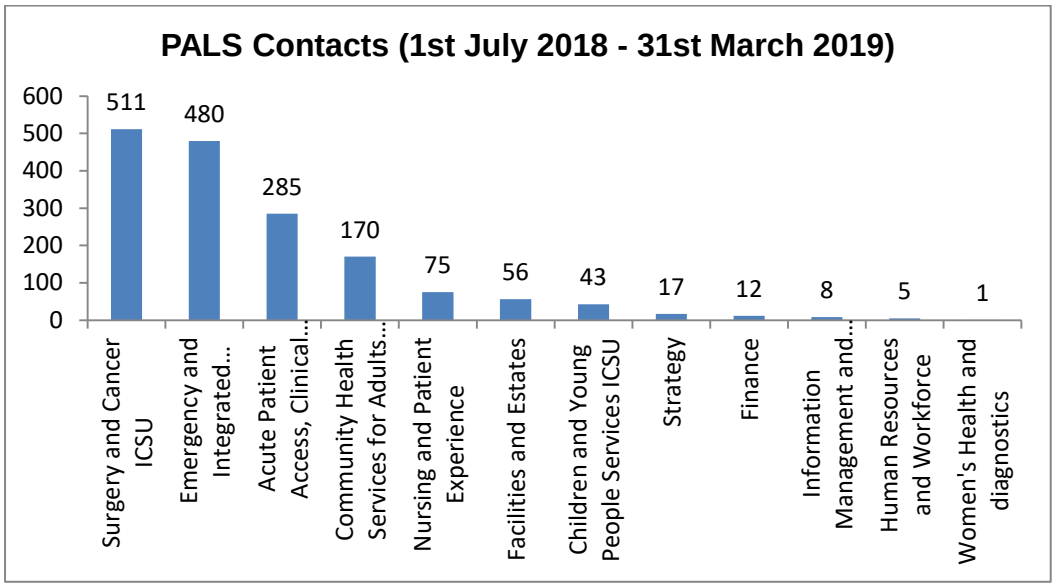


Table 15: PALS Contacts following ICSU re-configuration July 2018 – March 2019

4.2. Trust PALS Contacts by subject area

The chart below shows the top 10 subject areas cited in PALS contacts received during 2018-2019.

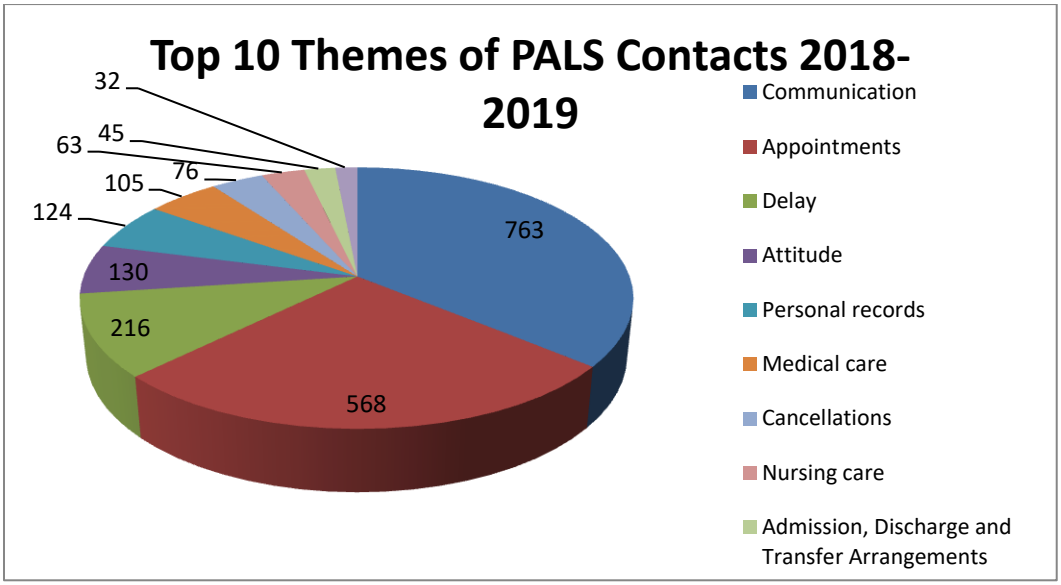


Table 16: Top 10 Themes for PALS Contacts 2018-19

5. EQUALITY AND DIVERSITY DATA

5.1. The PALS & Complaints team continues to reference equality information through Medway and RiO (electronic patient records) although the information is also requested through the PALS & Complaints leaflet. The PALS & Complaints team have recently been given access to the community electronic patient record system (RiO) enabling the team to cross-check information from 2019-20.

6. GP CONCERNS

6.1. During 2018-2019 the Trust received 164 GP Concerns. The main themes of the GP concerns are shown in the graph below.

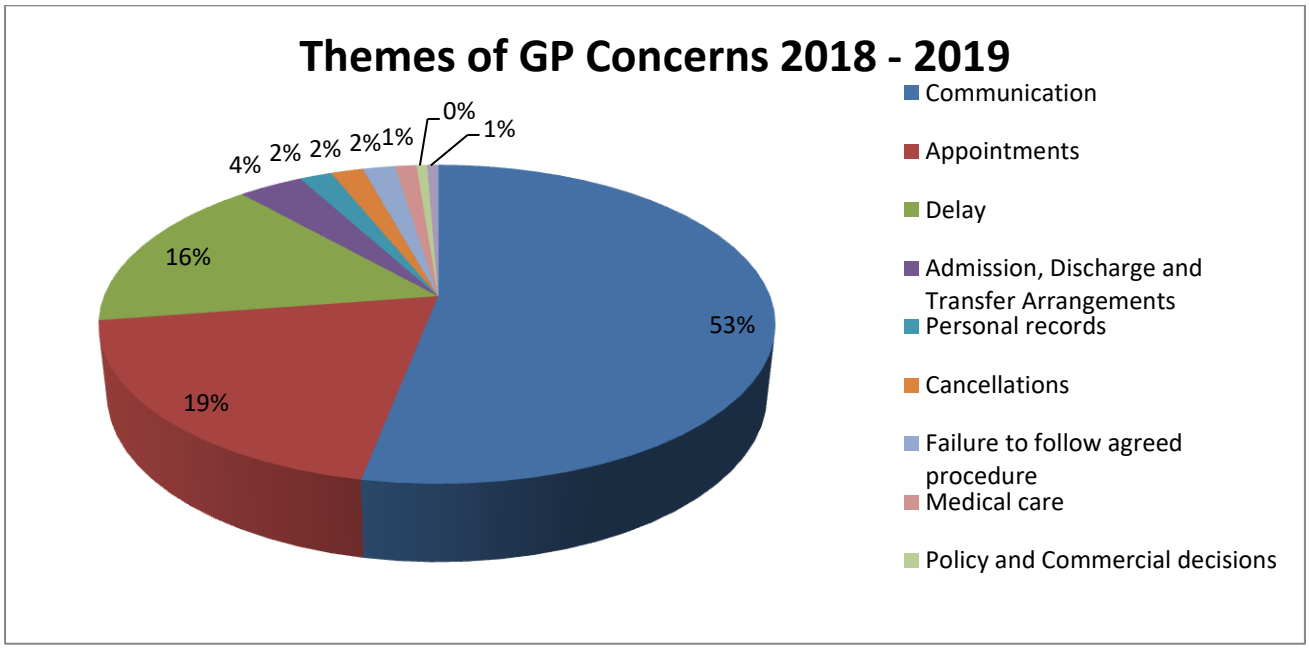


Table 17: GP Concerns by Theme 2018-19

7. NHS CHOICES

7.1. 16 NHS Choices comments were received by the Trust in 2018-2019. 8 were compliments from patients on the treatment and care they received. 6 were concerns raised by patients. 2 were a mixture of compliments and concerns. These have all been responded to within the required timeframe.

8. SUPPORT & TRAINING

8.1. The PALS & Complaints team provides ongoing support to the ICSUs by ensuring the availability of a regular programme of training sessions, delivered across a number of sites. The team also provides a complaints introductory session as part of Trust Induction and ad hoc complaints management training for relevant new employees. The team will continue to work closely with the ICSUs to identify further ways in which it can be supportive and facilitate continuous learning and improvement.

8.2. During 2018-19 the PALS & Complaints team delivered training sessions to around 50 colleagues across the organisation. Each session was introduced by Steve Hitchins, Trust Chairman, and included a section on the importance of 'Saying Sorry'. In addition, a bespoke training session was also delivered to the expanded Community Dental Service, attended by around 80 colleagues.

8.3. Further training has been and will continue to be delivered during 2019-20.

8.4. **Learning from incidents, complaints and claims** A collaborative project is to be undertaken by the Complaints and Legal Services Team to improve safety and learning through the triangulation of data by investigating and monitoring the percentage of complaints that become claims. A data set has been identified and collated which will be reviewed to identify whether any common themes exist with the aim to reduce claims, legal costs and improve patient experience.

8.5. During 2019-20 the trust will be signing up to the NHS England 'Ask Listen Do' Campaign (https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/) to improve our approach to support people with learning disabilities and/or autism can give feedback on our services.

9. The Trust Board is asked to:

- review the Annual Report;
- be aware and understand the trust's learning and management of feedback received from people who use our services;

Meeting title	**Trust Board – Public**	**Date: 31 July 2019**
Report title	**Six monthly safer staffing review of nursing and midwifery establishments (April 2019 data)**	**Agenda item: 20**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Patient Experience	
Report author	Maria Lygoura, Lead Nurse for Safer Staffing	
	• In line with National Quality Board guidance this report provides an update to the Executive Team Meeting (ahead of NMEC and TMG) on the latest safe nursing and midwifery staffing position. • The review was undertaken using April 2019 data in line with the recommended six month review. • This review includes a nurse/midwife establishment review of the Emergency Department (ED), Maternity Unit, Inpatient Wards, District Nursing, Critical Care Unit (CCU), Endoscopy Unit and Day Treatment Centre ward (DTC). • The report includes the findings of a review of the supervisory status of ward managers in the hospital and recommends standardisation across the hospital • The review makes recommendation for a small number of changes to budgeted establishments where there has been bed modelling (Emergency and Integrated Medicine)	
Purpose:	1. For approval, review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure wards, ED, Maternity Unit, District Nursing, CCU, Endoscopy Unit and Day DTC. 2. To discuss the potential future workforce challenges	
Recommendation	The Trust Board is asked to: • review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed; and • agree the recommendation by the Chief Nurse to approve the skill mix and Registered Nurse reduction as presented in Appendix 2.	
Risk Register or Board Assurance Framework	People 1 - Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs	

Report history	1. Nursing and Midwifery Confirm and Challenge Session 31st May 2019 2. Nursing and Midwifery Executive Committee 24th June 2019 3. Executive Team Meeting 15th July 2019 4. Trust Management Group 16th July 2019
Consultation process	1. Challenge session with the Associate Directors of Nursing & Midwifery (ADON/Ms) & Finance Manager 2. Nursing & Midwifery Executive Committee (NMEC) 3. Chief Finance Officer and Executive Team
Appendices	1. Model Hospital Data 2. Summary Table

Six monthly safer staffing review of nursing and midwifery establishments (April 2019 data)

1. Introduction

1.1 This paper provides an update on the current nursing and midwifery staffing levels following a review of the establishments undertaken in April 2019. This paper should be considered alongside the information provided each month at the performance indicators dashboard.

1.2 Currently there is national requirement to provide annual governance statement, in which the trust will confirm the staffing governance processes are safe and sustainable.

1.3 As an integrated care organisation Whittington Health is keen to ensure that community and hospital nursing and Health Visiting staffing levels are reviewed periodically.

1.4 Future reviews will include increasingly comprehensive reviews of Health Visiting, school nursing and community children's nursing.

1.5 Safer staffing and skill mix reviews were undertaken in April 2019 for the following clinical areas

- Adult inpatient
- Critical Care Unit (CCU)
- Emergency Department
- Day Treatment Centre Ward – first time reported
- Endoscopy Unit – first time reported
- CYP inpatient – IFOR ward & Neonatal Unit (NNU)
- Midwifery – BirthRate Plus © - assessed and reported in October 2018
- District Nursing – separate establishment paper

2. Our approach to ensure safe staffing levels

2.1 Nursing & Midwifery staff establishments are formally reviewed biannually or annually for a number of areas, to ensure that the Nursing & Midwifery workforce meets the demands of clinical care provision, deliver safe care with a positive patient experience and fits within the financial strategic objectives of the organisation.

2.2 The calculation for the recommended establishment is based on the Safer Nursing Care Tool (SNCT) for the adult and children wards and on NICE guidance for the CCU. A systematic staffing assessment with BirthRate Plus is used for the maternity services and the recommendations of the British Association of Perinatal Medicine (BAPM) for the establishment assessment in NNU. There are no nationally validated tools currently available to review safer staffing in District Nursing (DN), Day treatment Centre (DTC) ward and Emergency Department (ED). The Whittington Health District Nursing Service has developed and tested its own skill mix tool. The ED department adopted

the SNCT and amended the multipliers to reflect more accurately the care hours required for the patients. For DTC ward the SNCT was amended in order to take into consideration the hours it operates.

2.3 The Acuity and Dependency level of each inpatient is assessed and recorded on SafeCare® three times daily. The validity of data entered onto SafeCare® is checked by the matrons and verified by the Lead Nurse for safer staffing. The afternoon patient's census is utilised to apply the SNCT multipliers and generate the SNCT recommended establishment. For the purpose of this review, data was collected for April 2019 through ESR, QlikView®, HealthRoster® and SafeCare®. The nurse to patient ratios as recommended by NICE was applied where appropriate. Professional judgement was applied having taken into account performance on risk and quality indicators. Information regarding care hours per patient per day is also reviewed. Challenge sessions took place with the ADONs across all ICSUs and the details of the recommended establishment were discussed and approved.

2.4 **Supervisory status of the ward managers**

- In 2011, the RCN recommended that the ward sister role should be made supervisory and developed a framework for the supervisory role. In 2012, the Department of Health published Compassion in Practice and recommended that ward managers and leaders should be supervisory and not included in ward staff numbers. This reflects the time required to effectively lead a team; with more time for activities such as leadership, education, management, interdisciplinary work, patient safety, coordination and planning of care.
- The supervisory status of the ward managers across the adult and children wards was reviewed and the recommendations are included in Appendix 2
- There was a variety of arrangements in place with some clinical areas with ward managers who had 100% supervisory status and other who were 0%
- The senior nursing and midwifery executive committee has agreed the following
    - Ward managers who lead 2 wards e.g. Thorogood/Coyle and AAU (Mary Seacole North and South) require 100% supervisory capacity
    - Wards ≥ 20 beds to have 40% supervisory status for the ward manager e.g. COOP Unit wards
    - Wards <20 beds to have 20% supervisory status (exception- duration of the shift in endoscopy the ward manager will require 25% supervisory capacity) e.g. Victoria and Mercers

3. Vacancy levels

ICSU	March 2018 (%)	October 2018 (%)	April 2019 %	Trend
CYP	14.09	11.5	**14.70**	↑
ACS	33.33	17.4	**13.40**	↓
EIM	22.37	25.9	**16.85**	↓
S&C	28.2	24.5	**19.32**	↓
ACW	8.02	4	**9.03**	↑
Total	**21.2**	**16.6**	**15.10**	↓

3.1 There has been a noticeable reduction of the vacancy level in some integrated clinical service units (ICSUs) for registered nurses & midwives and the overall vacancy level across the trust is reduced by 1.5% between October 2018 and April 2019.

3.2 WH continues to implement a number of creative recruitment and retention strategies. A new Nurse Recruitment microsite was launched in February 2019 which showcases and promotes the opportunities and skills training our integrated care organisation offers. The Nurse Recruitment Team is working hard to attract staff from the UK and internationally to the organisation. They continue to actively pursue all avenues for Band 5 recruitment and pilot skype interviews as a method to recruit international nurses. They also support all routes into nursing processes such as the return to practice, Trainee Nurse Associate (TNA) and local international recruitment.

3.3 In Surgery and Cancer ICSU (S&C), CCU plan to recruit overseas and newly graduate nurses for the first time while DTC and Theatres will explore skill mix adjustments using Band 4 Nursing Associates (NAs). Maternity servicers are organising recruitment open days and planning to recruit their students who are due to qualify. The majority of vacancies in CYP are in Simmons House where the Nursing Recruitment Team plans to concentrate its efforts. The District Nursing (DN) teams are looking to introduce joined roles with primary care and introduce rotational DN posts with hospital settings within Whittington Health as well as externally. Emergency and Integrated Medicine ICSU (EIM) is leading in local Band 3 & 4 recruitment with good success rate and have increased the uptake of return to practice nurses and TNAs.

3.4 Turnover of registered nurses and midwives was **10.07%** across ICSUs for May 2018/19. This represents an improvement from March 2018 (12.7%). Work is ongoing with NHSI to improve retention, and results are being seen with the reduction in turnover. The preceptorship programme received additional investment from Health Education England (HEE) and North Central East London (NCEL) that will enable the team to increase the support of the new nursing staff, the preceptors and ward managers.

Staff Turnover - October 2018	**Nursing & Midwifery Registered**		
	Leavers FTE	**Average FTE**	**Turnover %**
Adult Community	10.53	99.98	10.53
Children & Young People	48.52	270.95	17.91
Emergency & Integrated Medicine	16.93	272.82	6.21
Surgery & Cancer	19.41	174.90	11.10
Acute Patient Access Clinical Support Service & Women's Health	8.69	170.78	5.09
Grand Total	**104.08**	**989.42**	**10.52**

4. Findings

4.1 Surgery & Cancer (S&C)

4.1.1 The bed occupancy level on Coyle and Mercers wards was consistently reported at 95% but reduced in Thorogood ward. Escalations beds were open on Coyle ward at the time of the data collation and now are closed.

4.1.2 There was high acuity and dependency level across the wards as well as a high number of patients requiring enhanced care due to very high risk of falls. The number of patients requiring 1b level of care (dependency on staff) continues to have an increasing trend in comparison with previous establishment reviews.

4.1.3 The staffing establishment across the surgical wards (excluding enhanced care) is comparable to the recommended establishment as calculated with the Safer Nursing Care Tool (SNCT).

4.1.4 The review of the establishment in Day Treatment Centre ward (DTC) and benchmarking with peer unit is in progress.

4.1.5 Bed occupancy in CCU during the review period was at 89.5 % (74% in 2018/19). The split between Level 3 and Level 2 patients* was L3: 55% and L2: 45%. The unit implements annualised rostering and are currently in the process of introducing Health Care Assistants (HCAs). It is recommended that the ICSU undertakes a detailed review of the activity in CCU to determine the required establishment in line with bed occupancy and also consider further flexibility in workforce contracts e.g. expansion of annualised hours so that peaks and troughs can be managed efficiency.

**Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs. Level 2: Deteriorating patient with compromised single organ failure*

4.2 Emergency and Integrated Medicine (EIM)

4.2.2 During the review period the bed occupancy levels of the medical wards was consistently reported at 95% and above. Additional escalation beds continued to be open in the Care Of Older People wards (COOP), Victoria and Nightingale wards during the data collection period and are now closed.

4.2.3 There was high acuity and dependency level across the wards as well as a high number of patients requiring enhanced care due to their mental health needs or being at very high risk of falls leading to serious harm. The number of patients requiring 1b level of care (dependency on staff) continues to have an increasing trend in comparison with previous establishment reviews.

4.2.4 Changes to bed configuration in EIM were implemented in June 2019 resulted in increase of beds across the COOP wards and reduction of beds on Victoria ward. There were no implications to staffing to patient ratio resulted from these changes. Since the closure of beds, the acuity and dependency level of patients on Victoria ward has shifted to having more acute (1a) than dependent (1b) but remained the same on the COOP wards.

4.2.5 Patient demand for the Emergency Department (ED) continues to rise significantly at average daily attendances of 313 patients. Approximately 65-75 patients are in ED at any point in day. Attendance and treatment of MH patients has also increased to the average of 231 per month (average around 7 patients each day). Consideration should be given to reflect 10% increase in activity.

4.3 **Maternity**

4.3.1 A systematic staffing assessment was undertaken in October 2018 with the use of BirthRate Plus® (BR+) framework and was reported at the previous review. BirthRate Plus® is a tool endorsed by the Royal College of Midwives and NHSI for determining safe staffing and is a framework which recommends an establishment and skill mix based on the complexity of the mothers that use the service. There is a recommendation that a three yearly BR+ is undertaken.

4.3.2 BirthRate Plus® analysis uses actual activity (actual number of births) rather than planned activity. The ratio of midwife to births during the assessment based on 3,762 births a year was 1:28. BirthRate Plus® deems this ratio as adequate and was in line with the recommended establishment using the North Central London (NCL) calculator. The number of Births in 2018/19 reduced to 3543. The Associate Director of Midwifery is exploring the options to validate the current midwife to births ratio while the NCL tool and its appropriate application is been evaluated.

4.3.3 A proposal to review the midwife to birth ratio was suggested as a cost improvement. This had undergone a quality impact assessment and was not approved. A further review is required however adjustments to midwife to birth ratio should be considered with caution while the “Better Births” paper recommend that trusts should meet new performance indicators relating to improved choice and personalised continuity of care.

4.4 **Children and Young People (CYP)**

4.4.1 **Neonatal Unit (NNU)**

Using The British Association of Perinatal Medicine (BAPM) standards for safe workforce establishments and requirements for NNUs there is a need for an establishment of 61.54 WTE for the number of cots and for the appropriate ratio of neonatal nurses for intensive care, high dependency and special care babies. Current establishment for the reference period was 62.47 WTE. The cot occupancy decreased since the last review from 73% to 68%. The staffing level is reviewed daily to ensure it matches the cot occupancy. It is recommended that the ICSU undertakes a detailed review of the activity in NNU to determine the required establishment and skill mix in line with cot occupancy. Also to recommend that the unit holds a vacancy factor so they do not risk over spend on occupancy levels.

4.5 **IFOR Ward** (Children’s Ward)

4.5.1 A reduction of bed capacity from 23 to 19 beds was implemented in August 2018. Bed occupancy during from August 18 to April 19 as well as during the review period was at 62%. The number of children and young people with

mental health needs has risen. The staffing level is reviewed daily to ensure it matches the bed occupancy. It is recommended that the ICSU undertakes a detailed review of the activity in IFOR ward to determine the required establishment and skill mix in line with bed occupancy. It is also recommended that benchmark with peer units to be undertaken for the next safe staffing review. Also to recommend that the ward holds a vacancy factor so they do not risk over spend on occupancy levels.

4.6 **District Nursing**

4.6.1 Staff remodelling was undertaken in September 2018 which resulted in altering the skill mix by increasing the number of care support workers, Nursing Associates and Assistant Practitioners, whilst decreasing the number of registered nurses and the introduction of a practice development team. The ICSU has requested 15% headroom and funding for the unsociable hours that were not included in the budget.

5. Comparison with peer trusts - model hospital

NB It should be noted that the recommended peer trusts are not all ICOs or of the same size with comparable number of sites. There are also inconsistencies in how trusts are reporting the CHPPD which affects the figures produced.

5.1 Key Model Hospital data is shown in Appendix one.

5.2 The care hours per patient day (CHPPD) and the cost per care hour has improved over the last years and remain marginally above the national median.

5.3 The proportion of harm free care is marginally below the national median. Trusts with significant community services are expected to have a lower performance in the "*harm free care"* indicator as it is taken from the Safety Thermometer which counts old as well as new episodes of harm using a point prevalence method. The relevant service units are working in addressing the issue and to providing more accurate harm free data.

6. Recommendations

6.1 The recommendations for the adult inpatient wards are summarised in Appendix 2.

6.2 **Surgery**

- Review the activity of Thorogood ward in light of reduced bed occupancy (73%) and consider converting to 5-days service with subsequent establishment and skill mix adjustments. This needs to be considered within the operating theatre schedule, theatre productivity and NLP strategic priorities.
- CCU evaluate the pilot allocation of HCAs as floating staff the outcome of which will be analysed in the next safe staffing review
- DTC ward to benchmark with peer units the staffing in relation to activity and complete the safe staffing review. Introduce Band 4 Nursing associates into the nursing establishment

6.3 **Emergency and Integrated Medicine**

- Monitor the CHPPD and Nursing Quality indicators changes in response to the altered bed modelling
- Review the skill mix model and ward manager supervisory status on Bridges ward and undertake benchmarking with peer unit
- Increase the establishment in ED in line with increased and sustained activity till October 2019 whilst work is embedded in the following areas
    - Monitor the activity in ED and nursing quality indicators
    - Frailty pathway is fully implemented seven days a week
    - Front of house/rapid assessment and treatment (RAT) and ECSIT recommendations are implemented
    - Impact of closure of the s136 rooms is completed

6.4. **Midwifery and Children and Young People (CYP)**

- Ifor ward and NNU to consider reduction of bed base and staffing establishment in line with bed occupancy. This needs to be considered from a medical staffing perspective and in line with trust and NLP strategic priorities.
- Ifor ward and NNU to benchmark with peer units the staffing in relation to activity
- Staffing numbers in NNU and Ifor ward to be reviewed on a daily basis using the SafeCare tool in response to flexing of Beds/cots and ensure safe staffing is maintained with no additional staff hours
- NNU and Ifor ward holds a vacancy factor so they do not risk over spends on occupancy levels.

6.5. The ratio in **Midwifery** to be reviewed monthly by the Associate Director of Midwifery using the North Central London calculator with closer monitoring of actual deliveries against plan and staff areas accordingly. This requires further work and alignment across north central London.

6.6. Undertake an activity review in **District Nursing** services and monitor the Nursing Quality indicators

7. Financial implications

7.1. Near cost neutral bed re-modelling in EIM that was facilitated with establishment adjustments and review of ward manager supervisory status across the medical wards. There is one post which is unfunded and that is a Band 7 ward manager on Cavell ward. The post will be 60% clinical (in the ratio of staff to patients) and 40% supervisory.

7.2. Increase of 0.25 WTE Band 7 in Endoscopy to enable one supervisory day

7.3. Six month non-recurrent increase in the staffing establishment in ED of 5.75 WTE – see details in appendix 2

7.4. A separate establishment paper is in the consultation phase for addition of headroom into the District Nursing budget and will be taken forward after the safe staffing review

8. Next steps

8.1 The next establishment review will take place in September 2019,

8.2 Monitor data entries on HealthRoster and SafeCare and validate accuracy at regular intervals. Ward based training and support will be offered where necessary.

8.3 Other areas of the Trust that will be reviewed are:
Outpatients, Ambulatory Care - Health Visiting - School Nursing - Community Children's nursing

8.4 Ward based Allied Health Professionals who are part of the roster will be included as part of the Care Hours per Patient Day (CHPPD) data within the next year and will be considered internally on Bridges ward where there is a dedicated therapy team.

8.5 Work is progress and will continue to align the Health Roster demand templates with the recommended staffing ratio according to the safer staffing paper.

8.6 Further work and analysis of the midwifery to birth ratio within the trust and reviewing the alignment with other units in north central London.

8.7 Review of elective surgery utilisation on Thorogood Ward to consider hours of operation. This needs to be considered within the operating theatre schedule and theatre productivity.

9. The Trust Board is asked to:

- review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed; and

- agree the recommendation by the Chief Nurse to approve the skill mix and Registered Nurse reduction as presented in Appendix 2.

Appendix 1: Model Hospital Data – 2018/19

It should be noted that the recommended peer trusts are not all ICOs or of the same size with comparable number of sites. There are also inconsistencies in how trusts are reporting the CHPPD which affects the figures produced.

	Data period	Trust value	Peer median	National median	Chart
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Mar 2019	9.1	8.3	8.0	
Cost per Care Hour - Total Nursing & Midwifery Staff	Mar 2019	£22.68	£21.96	£23.65	
Cost per Patient Day - Total Nursing & Midwifery Staff	Mar 2019	£210.27	£188.19	£189.65	
Proportion of Patients with Harm Free Care	Feb 2019	91.2%	96.4%	93.8%	
Proportion of Patients with Harm from a Fall	Feb 2019	0.9%	0.0%	0.3%	
Proportion of Patients with New VTE	Feb 2019	0.2%	0.3%	0.4%	
Proportion of Patients with New Pressure Ulcers	Feb 2019	1.2%	0.2%	0.8%	
Proportion of Patients with a UTI and Catheter	Feb 2019	0.8%	0.5%	0.7%	

Sickness Absence Rate - Nursing & Health Visitors	Nov 2018	4.6%	4.2%	4.5%	
Sickness Absence Rate - Midwifery	Nov 2018	4.6%	4.2%	4.7%	
Sickness Absence Rate - Healthcare Support Workers	Nov 2018	6.1%	6.2%	6.4%	
Staff Retention Rate - Nursing & Health Visitors	Dec 2018	80.6%	85.9%	87.4%	
Staff Retention Rate - Midwifery	Dec 2018	91.1%	83.6%	88.7%	
Staff Retention Rate - Healthcare Support Workers	Dec 2018	81.6%	82.1%	83.3%	

		Ward summary	Bed Occupancy April 19 (funded beds)	SNCT April 19 WTE (funded beds)	CHPPD April 19 WTE	Ratio Day RN : Pt Registered : patient	Ratio Night RN : Pt Registered : patient	Staff to Bed Ratio	Recommendations from challenge session (May 19)	Current Funded (WTE) (nursing staff)	WTE May 2019	WTE recommended Following the establishment r/v April 19 & challenge session	Financial impact
Surgery	**Coyle**	24 (+8 escalation) beds Non-elective orthopaedic, trauma, general surgery. Ward manager (W/M) 100% supervisory (SUPV) crossovers Coyle and Thorogood	**101%**	**36.94**	**40.76**	**1:6** **1:5**	**1:8** **1:8**	**1 : 4**	0.4 WTE of Band 2 HCAs was approved on 01/04/19 to move to AAKU to fund the central phlebotomy service	**37.03**	**37.03**	**36.23** Band 7: 1 Band 6: 2 Band 5: 17.03 Band 4: 5 Band 3: 5 Band 2: 6.2	Already removed
	Thorogood	10 Beds (flex to 12) "clean" orthopaedic ward W/M 100% SUPV crossovers Coyle and Thorogood wards. No Band 4 AP/NAs	**73%**	**10.11**	**13.68**	**1:5** **1:5**	**1:5** **1:5**	**1 : 4**	No change Consider introducing Band 4 NAs - Review occupancy & consider converting to 5 - Days ward	**14.00**	**14.00**	**14.00**	
	Mercers	16 (+2 escalation) beds General surgical ward including 4 ICU step down & L2 beds. W/M 40% SUPV. **Band 4 on LD only**	**99%**	**23.97**	**24.42**	**1:4** **1:3**	**1:5** **1:5**	**1:3.5**	No change 0.4 WTE of Band 2 HCAs was approved on 01/04/19 to move to AAKU to fund the central phlebotomy service	**25.20**	**25.20**	**25.20**	Already removed
	CCU (ITU)	10 Beds unit which cares for ventilated and high dependency patients.	**89.5%**	**41.94**	**56.01**	**1:1**	**1:1**		Pilot the allocation of HCAs as floating staff	**59.87**	**59.87**	**65.35** Band 7: 7 Band 6: 21 Band 5: 32 Band 4: 0 Band 3: 2.6 Band 8: 1 Band 8 PDN: 1 Band 7 PDN: 0.75	Identified reductions of WTE from Aug 2018 to April 2019 that the ICSU leads are now investigating
	DTC Ward	39 trolley spaces The Unit is open 5-days per week and specialises in the care of patients undergoing Day Surgery (27 spaces) & Endoscopic procedures 12spaces	**1117** cases per month between Dec18-Feb19	**25.04**		**1:5**	**N/A**	**1:4**	No Change Benchmark with peer Units –review skill mix – consider – introduction of Band 4 NAs – review shift patterns – update Roster demand template- Est r/v in progress	**24.37**	**24.37**	**24.37**	

		Ward summary	Bed Occupancy April 19 (funded beds)	SNCT April 19 WTE (funded beds)	CHPPD April 19 WTE	Ratio Day	Ratio Night	Staff to Bed Ratio	Recommendations from challenge session (May 19)	Current Funded (WTE) (nursing staff)	WTE May 2019	WTE recommended Following the establishment r/v April 19 & challenge session	Financial impact
						RN : Pt							
						Registered : patient							
									aiming to conclude by Aug 19				
EIM	**Cloudesley**	20 (+5 escalation) beds for the care of older people – high No of pts requiring enhanced care – complex discharges - W/M 100 % SUPV – establishment does not include staffing requirements for using the escalation beds	**100%**	**32.75**	**37.81**	**1:7.5** **1:5.5**	**1:10** **1:7**	**1:3.5**	Staffing model is adjusted to match the new bed model of the COOP unit – to review in 3 months – update HRoster demand templates - Reduction of Band 6 from 2 to 1 WTE – Reduction of W/M SUPV from 100% to 40%	**33.28**	**See COOP**	**30.18 wte** 1.00 x Band 7 1.00 x Band 6 10.0 x Band 5 5.19 x Band 4 3.00 x Band 3 9.99 x Band 2	Reduction of Band 6 from 2 to 1 WTE – Reduction of W/M SUPV from 100% to 40%
EIM	**Meyrick**	20 (+5 escalation) beds for the care of older people – high No of pts requiring enhanced care – complex discharges - W/M 100% SUPV – establishment does not include staffing requirements for the escalation beds – designated area for tracheostomy care	**100%**	**31.95**	**37.26**	**1:7.5** **1:5.5**	**1:10** **1:7**	**1:3.5**	Staffing model is adjusted to match the new bed model of the COOP unit – to review in 3 months – update HRoster demand templates - Reduction of Band 6 from 2 to 1 WTE – Reduction of W/M SUPV from 100% to 40%	**32.08**	**See COOP**	**30.18 wte** 1.00 x Band 7 1.00 x Band 6 10.0 x Band 5 5.19 x Band 4 3.00 x Band 3 9.99 x Band 2	Reduction of Band 6 from 2 to 1 WTE – Reduction of W/M SUPV from 100% to 40%
EIM	**Cavell**	20 (+5 escalation) beds for the care of older people- high No of pts requiring enhanced care – complex discharges - W/M 100% SUPV – establishment does not include staffing requirements for using the escalation beds	**100%**	**32.26**	**40.88**	**1:7.5** **1:5.5**	**1:10** **1:7**	**1:3.5**	Staffing model is adjusted to match the new bed model of the COOP unit – to review in 3 months – update HRoster demand templates - Reduction of Band 6 from 2 to 1 WTE – Reduction of W/M SUPV from 100% to 40%	WTE is consisted of wte moves from Vic, N'gale & Mont	**See COOP**	**30.18 wte** 1.00 x Band 7 1.00 x Band 6 10.0 x Band 5 5.19 x Band 4 3.00 x Band 3 9.99 x Band 2	addition of 1 B7 RN not previously funded when Cavell was escalation ward
	COOP wards	Summary of Cloudesley, Meyrick & Cavell. The budget of the three wards	**As above**	**As above**	**As above**	**As above**	**As above**		0.75 WTE of Band 2 HCAs was approved on 01/04/19 to move to AAKU to fund the central	**65.36**	**64.56**	**89.79** 3.00 x Band 7 3.00 x Band 6	See Cavell, Cloudesley, Meyrick -

		Ward summary	Bed Occupancy April 19 (funded beds)	SNCT April 19 WTE (funded beds)	CHPPD April 19 WTE	Ratio Day / Ratio Night RN : Pt Registered : patient		Staff to Bed Ratio	Recommendations from challenge session (May 19)	Current Funded (WTE) (nursing staff)	WTE May 2019	WTE recommended Following the establishment r/v April 19 & challenge session	Financial impact
		is merged into one							phlebotomy service			30.0 x Band 5 15.57 x Band 4 9.00 x Band 3 29.22 x Band 2	0.75 wte of B2 HCA moved to AAKU
	Bridges Rehab Unit	12 (+2 escalation) beds – Rehabilitation unit, high level of dependency - Complex discharges - W/M 100% SUPV	**100%**	**17.2**	**20.5**	**1:6** 	**1:6** 	**1:3.8**	No Change - Review % of SUPV W/M – consider introducing Band 4 – discuss with clinical leads the future staffing model - Benchmark with peer Units – review roster temp	**19.30**	**19.30**	**19.30**	
	Nightingale	21 (+2 escalation) beds - respiratory ward 4 beds of which are L2 – a Band 4 on every shift – W/M 100% SUPV – designated area for tracheostomy care	**104%**	**28.1**	**36.9**	**1:7** **1:5**	**1:10.5** **1:7**	**1:4**	W/M 40% SUPV – 0.60 Band 5 WTE to move to COOP – update HR demand template	**30.57**	**30.57**	**29.97** 1.00 x Band 7 2.00 x Band 6 14.00 x Band 5 4.97 x Band 4 3.00 x Band 3 5.00 x Band 2	0.60 Band 5 WTE moved to COOP
EIM	Montuschi	16 acute assessment unit c– cardiology ward providing 4 x L2 coronary care – W/M 100% SUPV – designated area for tracheostomy care	**98.4%**	**24.5**	**25.8**	**1:5** 	**1:5** 	**1:4**	W/M 20% SUPV – 0.66 Band 5 WTE to move to COOP – update HR demand template – currently piloting Band 4 NA (on TNA phase)	**21.64**	**21.64**	**20.98** 1.00 x Band 7 1.00 x Band 6 12.79 x Band 5 1.00 x Band 4 1.00 x Band 3 4.19 x Band 2	0.66 Band 5 WTE moved to COOP
EIM	**Victoria**	16 (+5 escalation) beds – Mixture of highly acute medical patients with complex needs: Sickle Cell crisis, oncology, gastro, encephalopathy – a Band 4 on every shift – W/M 50% SUPV	**100%**	**23.57**	**30.06**	**1:6** **1:4.5**	**1:8** **1:5**	**1:4**	W/M 20% SUPV – 17.62 WTE of RNs and HCAs will move to COOP – update HR demand template - 0.25 WTE of B2 HCAs was approved on 01/04 to move to AAKU to fund the central phlebotomy service	**38.90**	**38.90**	**21.03** 1.00 x Band 7 1.00 x Band 6 9.80 x Band 5 5.19 x Band 4 2.00 x Band 3 2.29 x Band 2	17.62 wte RN & HCA moved to COOP - 0.25 wte of B2 moved to AAKU
EIM	**Mary Seacole**	16 (+1 escalation) beds – acute assessment unit – High	**94.6%**	**28.3**	**34.1**	**1:5**	**1:5**	**1:1.5**	The budget of the 2 wards merged to 1, see AAU			**See AAUs**	

		Ward summary	Bed Occupancy April 19 (funded beds)	SNCT April 19 WTE (funded beds)	CHPPD April 19 WTE	Ratio Day / Night RN : Pt / Registered : patient		Staff to Bed Ratio	Recommendations from challenge session (May 19)	Current Funded (WTE) (nursing staff)	WTE May 2019	WTE recommended Following the establishment r/v April 19 & challenge session	Financial impact
	North	flow ward – W/M 100% SUPV cross covers both AAUs – Band 4 on LD				**1:4**	**1:5**						
	Mary Seacole South	18 beds – acute assessment unit 6 beds of which are L2 – High flow ward – W/M 100% SUPV cross covers AAUs	**91.1%**	**29.8**	**36.63**	**1:6** **1:4.5**	**1:6** **1:1.6**	**1:1.6**	The budget of the 2 wards merged to 1, see AAU			**See AAUs**	
	AAUs								Converted 1 Band 7 RN to Band 7 dementia RN. This was agreed outside the scope of the safe staffing review	**61.24**	**61.24**	**61.24** 1.00 x Band 7 8.00 x Band 6 23.46 x Band 5 8.00 x Band 4 6.00 x Band 3 14.78 x Band 2	
	Endoscopy Unit	5-days/week service, specialises in the perioperative care of patients undergoing Endoscopic procedures 3 rooms per day - Patients are recovered in DTC	**980 procedures per month**			**2:1**			Add 0.25 WTE of Band 5 RN to enable 25% of W/M SUPV Patients to continue to be recovered in DTC	**12.03**	**12.03**	**12.28** 1.00 x Band 7 3.00 x Band 6 8.28 x Band 5	0.25 WTE of Band 5 RN to be added

EIM	Emergency Department Summary	Average attendance per day	Average No of pts in Ed	SNCT (WTE)	Challenges	Recommendations from challenge session (May 19)	Current Funded (WTE)	WTE May 2019	WTE recommended Following the establishment r/v April 19 & challenge session	Financial impact
ED	ED contains both an adult and a paediatric area. Majors: 13 cubicles +2MH Resus: 4 bed spaces CDU: 8 beds + 2 esc UTC: 6 cubicles + 3 bed spaces RAT & triage: 5 cubicles Streaming: 1 space Paed: 7 cubicles + 1 triage	**313**	**70**	**111.8** **for 70 pts in ED**	Increased number of attendances of MH pts. Average 231 pts per month with average LOS 8 hrs. 50% of the MH pts require 1-1 RMN Increase of average LOS of all pts	10% increase in establishment to match activity. Streaming and Rapid Assessment Treatment (RAT) require funding	**96.55 (AAEQ + AAEP)**	**95.55**	**101.3** **(to enable LD: 17+3, Night: 15+2)** 10.39 x Band 7 25.97 x Band 6 41.56 x Band 5 10.39 x Band 4 12.99 x Band 3	Increase of total establishment by 5.75 WTE in **(AAEQ + AAEP)**

CYP	Ward summary	B/occupancy Activity	RCN - WTE recommended < 2 yrs.: 1:3 > 2 yrs.: 1:4 HDU/L2: 1:2	SNCT WTE	CHPPD WTE	Current Planned Staffing levels	RN:Child Ratio (average)	Current Funded (WTE)	Recommendations from challenge session (May 19)	WTE recommend. following the establishment r/v April 19 & challenge session	Financial impact
Ifor Children's ward	19 beds Paediatric Ward for young people between the ages of 0-16	62% 12 Beds	**21.78** 62 % b/occupancy **32.17** 100% b/occupancy	**28** 62% b/occupancy **45.2** 100% b/occupancy	**28.7** 61% b/occupancy **45.5** 100%b/occupancy	Day: 6+1 Night: 5+1	1:2 – 62% 1:3 – 100%	31.62 **WTE May19** 31.66	Review Shill Mix (No of B6, RN/HCA split) - realign budget - consider reduction of bed base and establishment in line with bed occupancy - benchmark with peer settings	31.62	No change
NNU	23 cots: 6 L3, 6 L2, 11 SCBU. NNU is a level 2 unit and receives acute referrals from local level 1 units	64%	61.54	70%: 43.08 75%: 46.16 80%: 49.23 85%: 52.31	**38.79** 64% B/occupancy **63.74** 100% B/occupancy	Day: 9+1 Night: 9+1	L3: 1:1 L2: 1:2 SC: 1:4	62.47 **WTE May19** 62.68	consider reduction of bed base and establishment in line with bed occupancy - benchmark with peer settings	62.47	No change

	Ward summary	Funded Beds	Births per Year	Funded Establishment Oct '18	Birth Rate + ® Recommends WTE	Current Births per WTE	Recommendations from challenge session (May 19)	WTE recommend. following the establishment r/v April 19 & challenge session	Financial impact
Maternity	Labour Ward, Birth Centre, Postnatal, Antenatal, transitional, inductions of labour, Triage of ante and postnatal mothers & babies	55	3543	180.43 WTE	180.60 WTE 90:10 spilt of RM: Support worker	1:28	Better Births target 35% will require review & possibly increase in core & flexing staff by March 2020	180.43 WTE	No change

Meeting title	**Trust Board - public**	**Date: 31 July 2019**
Report title	**Medical Appraisal and Revalidation: Annual Board report**	**Agenda item: 21**
Executive director lead	Clare Dollery, Executive Medical Director	
Report author	Ashleigh Soan, Medical Director Portfolio Manager	
Executive summary	This is the annual Medical Appraisal Board Report in the format suggested by NHS England as part of the quality assurance process for medical appraisal and revalidation. In 2018-19, 91% of consultants, 83% of SASG doctors, and 84% of Trust grade doctors completed appraisal according to our policy – this includes a small number of late appraisals and those with agreed reasons to postpone their appraisal. This report reviews appraisals completed and revalidation recommendations submitted in the financial year 2018/19. The Board is asked to accept the report. The CEO is asked to approve the 'NHS England Designated Body Annual Board Report' (Appendix 1) confirming that the organisation, as a designated body, is in compliance with the regulations. Once approved this Report will be submitted to the higher-level Responsible Officer for NHS England, London Region.	
Purpose:	Approval	
Recommendation(s)	1. The Board is asked to accept the report. The Trust has submitted a separate Annual Organisational Audit or AOA to the higher-level Responsible Officer for NHS England, London Region. 2. The Board is invited to focus discussion on how we may further strengthen the appraisal process for doctors, and the confidence of our stakeholders and public in this process. 3. The Chief Executive is asked to approve the 'NHS England Designated Body Annual Board Report' (Appendix 1) confirming that the organisation, as a designated body, is in compliance	

	with the regulations. Once approved this Report will be submitted to the higher-level Responsible Officer for NHS England, London Region.
Risk Register or Board Assurance Framework	
Report history	Annual report to Trust Board
Appendices	1. NHS England Designated Body Annual Board Report 2. Terminology 3. Governance arrangements and responsibilities 4. Amended Appraisal Summary and PDP Audit Tool Template (ASPAT) *5.* The Medical Appraisal and Revalidation Decision Group Terms of Reference

Medical Appraisal and Revalidation: Annual Board report

1. Background

Medical revalidation was introduced in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but was designed as a way to ensure that doctors stay up to date and fit to practice.

All provider organisations known as Designated Bodies have a statutory obligation to support their Responsible Officer in fulfilling his or her duties under the Responsible Officer Regulations[1]. For this reason, this report has been designed to ensure that the Board has oversight of the following areas:

- monitoring the frequency and quality of medical appraisals within the Trust;
- checking there are effective systems in place for monitoring the conduct and performance of the Trust's doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for the Trust's doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work that they perform.

Dr Clare Dollery, the Trust's Executive Medical Director, was appointed to the role of Responsible Officer and has been in post since 10th June 2019.

A glossary of terminology related to revalidation is included at Appendix 2 for information.

2. Prescribed connection and appraisal completion rate

2.1 Appraisal Performance Data

Between 1st April 2018 and 31st March 2019 180 medical appraisals (69%) were completed, between 1st April 2019 and 31st May 2019 a further 15 doctors (6%) completed a late 2018/19 medical appraisal.

Agreed and acceptable reasons for not completing an appraisal may include:

- Maternity leave
- Long-term sickness absence
- Having joined the Trust within the previous 6 months
- Absence due to an agreed sabbatical or career break
- The doctor no longer being clinically active and in the process of voluntary self-erasure from the GMC register

Completion of medical appraisals in 2018/19 by grade of doctor (n = 260)
Consultants (n = 172)

- 134 (78%) completed appraisals in line with policy
- 12 (7%) completed appraisals, but were late in doing so
- 10 (6%) did not complete appraisals, but had previously agreed and acceptable reasons for not completing

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

- 16 (9%) did not complete appraisals and did not have previously agreed or acceptable reason for not completing

Specialty Doctors/Associate Specialists (SASG)/Doctors on Performers Lists (n = 19)

- 13 (68%) completed appraisals in line with policy
- 3 (16%) did not complete appraisals, but had previously agreed and acceptable reasons for not completing
- 3 (16%) with no previously agreed or acceptable reason for not completing

Trust grade doctors or doctors on short term contracts (including non-training grade junior doctors) (n= 69)

- 33 (47%) completed appraisals in line with policy
- 3 (4%) completed appraisals, but were late in doing so
- 21(30%) did not complete appraisals, but had previously agreed and acceptable reasons for not completing
- 12 (17%) with no previously agreed or acceptable reason for not completing

Table 1: Appraisals completed and doctors with an agreed and acceptable reason for not completed in 2015/16, 2016/17, 2017/18 and 2018/19 by grade of doctor

Appraisals in-line with policy (%)	Consultants	SASG doctors	Trust grade doctors
2015/16	95	95	86
2016/17	100	100	98
2017/18	97	93	93
2018/19	91	84	83

2.2 Comparison data with other Designated Bodies in England

Following submission of the AOA, the Higher-Level Responsible Officer sends each Designated Body a comparator report. Tables 2 – 4 below highlight relevant information from this comparator report in relation to medical appraisal performance data.

This shows a lower compliance with appraisal than other similar organisations. Reasons for this may include the lack of an Associate Medical Director for appraisal and revalidation since December 2018 and a related administrative vacancy since August 2018.

Table 2: Number of doctors in Whittington Health, other acute Trusts and all other Designated Bodies in England who had a completed appraisal 1 April 2018 – 31 March 2019

		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	146 (84.9%)	94.1%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	13 (68.4%)	85.4%	88.2%
2.1.3	Doctors on Performers Lists	N/A	N/A	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	36 (52.2%)	79.6%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	91.6%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	195 (75.0%)	89.6%	91.5%

Table 3: Number of doctors in Whittington Health, other acute Trusts and all other Designated Bodies in England who had an approved incomplete or missed appraisal 1 April 2018 – 31 March 2019

		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	10 (5.8%)	3.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	3 (15.8%)	9.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	N/A	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	21 (30.4%)	14.2%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	4.9%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	34 (13.1%)	6.7%	6.4%

Table 4: Number of doctors in Whittington Health, other acute Trusts and all other Designated Bodies in England who had an unapproved incomplete or missed appraisal 1 April 2018 – 31 March 2019

		Your organisation's response	Same sector: DBs in sector: 52	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	16 (9.3%)	2.5%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	3 (15.8%)	4.8%	3.2%
2.1.3	Doctors on Performers Lists	N/A	N/A	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	12 (17.4%)	6.3%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	3.5%	1.6%
2.1.7	Total number of doctors who had an unapproved incomplete or missed annual appraisal	31 (11.9%)	3.7%	2.1%

2.3 Appraisers

The Trust had 54 active appraisers for the 2018/19 appraisal period (an active appraiser is defined as having performed at least one appraisal in the year). All appraisers have received revalidation-ready training from approved external providers.

Appraiser feedback 2018/19

Following each completed appraisal doctors are invited to complete a short survey to give feedback to their appraiser. All appraisers are provided with an anonymised copy of their feedback at the end of each appraisal year to include in their own appraisals. Table 5 shows the feedback received for all of our appraisers for the period 1 April 2018 to 30 June 2019 showing an overall positive view of appraisal while Table 6 shows a year on year improvement in appraisal feedback scores.

Table 5: Appraiser feedback 2018/19 (n= 232)

Area	Unable to comment	Poor	Borderline	Satisfactory	Good	Very Good
Establishing rapport	0	0	0	3	30	199
Demonstrating thorough preparation for your appraisal	0	0	0	5	29	198
Listening to you and giving you time to talk	0	0	1	1	32	198
Giving constructive and helpful feedback	0	0	0	5	32	195
Supporting you	1	0	2	4	27	198

Challenging you	1	0	1	9	48	173
Helping you to review your practice	0	0	0	6	42	184
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	1	0	0	9	48	174
Helping you to review your progress against your Personal Development Plan (PDP)	3	0	0	4	42	183
Helping you to produce a new PDP that reflects your development needs	0	0	0	5	39	188

The qualitative feedback received about medical appraisals has been exceedingly positive. This list provides examples of anonymous written feedback received for medical appraisers in 2018/19.

- “This has been the most valuable appraisal I have had so far. I was challenged, listened to, encouraged to improve on what I have already achieved and I am grateful to my appraiser for taking the time to do this.”
- “He was quite supportive in the entire appraisal process and I feel encouraged to take up newer challenges.”
- “It has been a very constructive and supportive session. I have had opportunity to reflect on my performance and role as a consultant and build a future strategy for service development.”
- “I am grateful for the time and thoroughness of this year’s appraisal.”
- “I feel I have been listened to, praised for what I have achieved and given the chance to reflect on my practice as a clinician.”
- “Extremely helpful in guiding me through my first appraisal. Well prepared and excellent advice on setting PDP goals. Always approachable and willing to give time to help.”
- “A very good appraisal experience. Lots brought up for me to reflect on.”
- “She is meticulous in her preparation and always challenges me to think about my roles ‘outside of the box’.”
- “It was a helpful appraisal in terms of thinking of the changes ahead of me and how I am to approach these.”
- “I have found her to be very caring and understanding; she focuses on my needs as a person

Table 6: Appraiser feedback received (%) in 2015/16, 2016/17, 2017/18 and 2018/19

Area	2015/16 (%)			2016/17 (%)			2017/18 (%)			2018/19 (%)		
	Satisfactory	Good	Very Good	Satisfactory	Good	Very Good	Satisfactory	Good	Very Good	Satisfactory	Good	Very Good
Establishing rapport	2	19	79	1	17	82	0	13	86	1	13	86
Demonstrating through preparation for your appraisal	2	23	74	3	13	84	2	11	87	2	13	85
Listening to you and giving you time to talk	2	18	80	3	17	80	0	13	87	0	14	85
Giving constructive and helpful feedback	3	22	74	2	19	79	1	20	79	2	14	84
Supporting you	3	21	74	2	17	80	0	18	82	2	12	85
Challenging you	4	31	64	4	28	68	2	30	68	4	21	75
Helping you to review your practice	3	28	68	2	27	71	2	20	77	3	18	79
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	4	30	64	3	25	71	23	20	77	4	21	75
Helping you to review your progress against your PDP	3	28	68	2	18	80	1	17	82	2	18	79
Helping you to produce a new PDP that reflects your development needs	2	26	71	2	22	75	0	15	84	2	17	81

3. Quality Assurance

3.1 Quality assurance of appraisals

An audit of completed appraisals is conducted by the RO's team following the completion of the appraisal cycle. This audit is conducted using an adapted version of the NHS England Appraisal Summary and PDP Audit Tool Template (ASPAT) (Appendix 4).

The latest review was conducted in July 2019 and looked at 20 appraisal summaries and PDPs of appraisals conducted by 20 different appraisers in 2018/19 appraisal year. The summary results of the audit are encouraging (table 7), but there are specific areas where the Trust will need to develop, including:

- Ensuring that appraisers record discussion around the reasons for a doctor having not been able to complete or make progress with their PDP for the previous year;
- Appraisers should link objective statements to supporting information and describing what this supporting information shows;
- Appraisers should try to make reference to specialty specific guidance for appraisal (e.g. recommendations for CPD);
- Appraiser summaries should also provide evidence that doctor has been involved in sharing learning with colleagues, or that the appraiser has discussed with the doctor ways in which learning could be shared with colleagues.

The trust has most recently conducted a peer-review audit in April 2018 and the completion of a further peer-review audit is included as an objective for 2019/20.

Table 7: Average scores received for the Review Audit for appraisals completed in 2018/19

Appraisal number	Section 1: Setting the scene (out of 16)	Section 2: reflection and effective learning (out of 6)	Section 3: The PDP and developmental progress (out of 16)	Section 4: General standards and revalidation readiness (out of 8)	Overall score (out of 46)
1	5	6	11	8	30
2	16	6	16	8	46
3	10	6	3	7	26
4	15	4	13	7	39
5	13	2	16	7	38
6	14	4	16	7	41
7	14	5	16	8	43
8	9	2	12	7	30
9	16	2	13	8	39
10	13	4	15	7	39
11	12	5	14	7	38
12	5	2	11	8	26
13	11	6	16	7	40
14	12	3	14	7	36
15	7	4	14	7	32
16	9	4	14	7	34

17	11	6	11	7	35
18	13	6	10	7	36
19	12	4	16	7	39
20	14	6	13	7	40
Mean scores	**12**	**4**	**13**	**7**	**36**

An individual doctor's appraisal output documents and some key pieces of evidence from the appraisal portfolio are always reviewed by the Responsible Officer and a member of his team and this is used to inform the discussion of the Medical Appraisal and Revalidation Decision Making Group.

3.2 *Quality assurance for appraisers*

Revalidation Management System; this feedback is collated by the RO's team and provided to individual appraisers so that they can reflect on it at their own appraisal. In cases where an appraiser consistently scores very low in a number of areas, where multiple doctors have requested not to be appraised by one individual, or where audits have identified substandard appraisals conducted by one appraiser, the RO's team will escalate this to the RO and this appraiser may be asked to undertake further training. The Trust also keeps records of appraiser attendance at refresher training events which can be used in the appraiser's portfolio as evidence of ongoing professional development.

4. Clinical Governance Data

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and compliments;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audits and contribution to clinical guidelines.

This data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

In 2018/19 we have also been able to provide surgical activity for all operating clinicians.

5. Revalidation Recommendations

Since revalidation was introduced in November 2012 to 18th July 2019, the Trust has made 445 recommendations for doctors with a prescribed connection to the Whittington, of which 296 were positive recommendations, and 147 were requests for deferrals. In 2018/19 the Trust made its first recommendation of non-engagement; the Trust is working with both the individual doctor and the GMC to support the doctor to appropriately engage with appraisal and revalidation.

Table 8: Audit of revalidation recommendations

Revalidation recommendations between 1 April 2018 to 31 March 2019	
Recommendations completed on time (within the GMC recommendation window)	79 (for 75 doctors)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**79**

Between the 1st April 2018 and 31st March 2019 the Trust has made 62 positive recommendations, and 17 doctors had their revalidation dates deferred pending further information, for 4 of these doctors this was due to their being in a formal process under the policy for Maintaining High Professional Standards (MHPS).

In this time period no recommendations were submitted later than the requested submission dates. The ability of the Trust to submit recommendations in a timely manner has been improved through the implementation of the Medical Appraisal and Revalidation Decision Group who review revalidation recommendations up to 4 months in advance of the due date; the terms of reference for this Group are included as Appendix 5 to this report.

6. Recruitment and engagement background checks

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- Criminal records checks and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK, where this is necessary
- Verification of license to practice and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

With regard to doctors working at the Trust via an agency, the Trust has framework agency agreements which are used to secure the majority of agency bookings for medical staff. However,

when the Trust uses non-framework agencies, where there is no such agreement, there is no assurance that the agency is following NHS mandated recruitment standards.

7. Responding to Concerns and Remediation

The Trust has a local policy for '*Conduct, Performance and Ill-Health Procedures for Medical and Dental staff*'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS'[2] and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

8. Action Planning and Next Steps

For 2018/19 we chose to focus on the areas for review identified by the Higher Level Responsible Officer

- "*Ensure that we have a lay or public representation on the Medical Appraisal and Revalidation Decision Making Group.*" This has been acted upon and Non-Executive Director Yua Haw Yoe is now a member of the Medical Appraisal and Revalidation Decision Making Group.

- "*Hold twice yearly Appraiser Forum for our medical appraisers*." This has been acted upon and two forums were held on the 12 October 2018 and 21 January 2019.

- "*Increase appraisal rates for Trust Grade Doctors*". The Medical Directorate Portfolio Manager held meetings with Trust Grade Doctors to assist them in preparing for appraisal and revalidation. 2018/19 saw an increase in the number of Trust grade doctors undertaking appraisal in-line with policy, but this increase has not been sufficient to match the appraisal rates of other groups of doctors.

- "*Publicise Appraisal and Revalidation on the Trust's extranet to increase public awareness of the processes*." We are in the process of discussing the best approach to this with our Communications Department.

- "*Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation*." We are considering approaches to this issue.

For 2019/20 we will focus on the following areas

- Re-advertise and successfully recruit to the post of Associate Medical Director for Revalidation by 1 November 2019.

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[2] Department of Health, *Maintaining High Professional Standards in the Modern NHS*, accessible at http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

- Re-advertise and successfully recruit to the post of Medical Director Project Coordinator including Revalidation by 1 October 2019.

- Develop a Trust-wide medical appraiser network.

- "*Publicise Appraisal and Revalidation on the Trust's extranet to increase public awareness of the processes*." We will ensure that information is published externally by 1 October 2019.

- "*Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation*." We will ensure that this is completed by 1 September 2019.

- Increase the number of medical appraisals undertaken in-line with policy by 31 March 2020. A particular focus will be paid to locum and Trust grade doctors.

- Undertake a peer-review quality assurance process with neighbouring Trusts by 31 March 2020.

9. Recommendations

The Board is asked to accept the report. The CEO is asked to approve the 'NHS England Designated Body Annual Board Report' (Appendix 1) confirming that the organisation, as a designated body, is in compliance with the regulations.

Appendix 1: NHS England Designated Body Annual Board Report

Section 1 – General:

The board of Whittington Health NHS Trust confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 31/05/2019

Action from last year:

Comments:

Action for next year:

Review the comparator report data and focus on improving the number of medical appraisals completed before 1 April 2020.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:

Not applicable.

Comments:

Dr Julie Andrews was Acting Medical Director and Responsible Officer from 19th November 2018 to 9th June 2019.

Dr Clare Dollery has been Responsible Officer and Executive Medical Director since 10th June 2019.

Action for next year:

Not applicable.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:

Not applicable

Comments:

Not applicable

Action for next year:

The Trust needs to re-advertise and make an appointment to the role of Associate Medical Director for Revalidation. This is a key medical leadership role to support the Responsible Officer to discharge her duties.

The Trust needs to re-advertise and make an appointment to the role of Project Support Officer. This is a key administrational role to support the Responsible Officer to discharge her duties.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

Not applicable

Comments:

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports.

Action for next year:

Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

Not applicable

Comments:

The Trust's 'Medical Appraisal and Medical Revalidation Policy' is due for regular review. The policy was discussed at the Trust's Medical Negotiating Sub-Committee on 19th July 2019. Following appropriate consultation the policy will go through the Trust's ratification process.

Action for next year:

The '*Medical Appraisal and Medical Revalidation Policy'* to be reviewed and ratified by 1 October 2019.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

A peer review was last completed in April 2018 with two neighbouring Trusts.

Comments:

On 13 December 2017 the Trust was visited by a team who were acting on behalf of the Higher Level Responsible Officer (HLRO) Dr Vin Diwakar, to provide him with assurance that the RO and designated body has appraisal and revalidation systems and processes in place in keeping with 'The Medical Profession (Responsible Officers) Regulations 2010,

Amendments 2013'. The visit was also to highlight good practice, to identify areas for development and to provide the RO with support and advice on any revalidation issues.

Action for next year:

Complete a further peer-review process, ideally with the same neighbouring Trusts.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

The Medical Directorate Portfolio Manager held meetings with Trust Grade Doctors to assist them in preparing for appraisal and revalidation.

Comments:

2018/19 saw an increase in the number of Trust grade doctors undertaking appraisal in-line with policy, but this increase has not be sufficient to match the appraisal rates of other groups of doctors.

Action for next year:

Focus on the process for Trust-grade and short-term locums, including the regular recording of appraisals conducted at other Trusts.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

An audit was conducted by the RO's team of completed appraisals following the completion of the appraisal cycle.

Comments:

Whether sufficient information has been provided regarding the doctor's full scope of practice to meet the GMC requirements is considered by the Medical Appraisal and Revalidation Decision Making Group ahead of making a revalidation recommendation decision.

Action for next year:

Undertake a peer-review quality assurance process with neighbouring Trusts.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Those doctors with missed 2018/19 appraisals are being asked to under an early 2019/20 appraisal.

Comments:

Not applicable.

Action for next year:

Increase the number of medical appraisals undertaken in-line with policy from 69% to 80% by 31 March 2020.

Focus on the process for Trust-grade and short-term locums, including the regular recording of appraisals conducted at other Trusts

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Not applicable

Comments:

The Trust's 'Medical Appraisal and Medical Revalidation Policy' is due for regular review. The policy will be discussed at the Trust's Medical Negotiating Sub-Committee on 19th July 2019. Following appropriate consultation the policy will go through the Trust's ratification process.

Action for next year:

The 'Medical Appraisal and Medical Revalidation Policy' will be reviewed and ratified by 1 October 2019.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

Four appraisers newly trained appraisers completed their first round of appraisals.

Comments:

The Trust have had a number of senior medical appraisers either retire or undertake career breaks and this has meant that there is not as much flexibility in the appraisal system to allow for other types of leave, or for people needing appraisals at short-notice.

Action for next year:

Five consultants and SASG doctors should be trained as appraisers before April 2020.

The role of the medical appraiser should be included within job plans to ensure that this is a recognised role.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[3] or equivalent).

Action from last year:

Two appraiser forums were held last year, one on the 12 October 2018 and another on 21 January 2019.

Comments:

Not applicable

Action for next year:

Develop a Trust-wide Medical Appraiser Forum. Forums will allow a platform for peer-review, regular training, and development of medical appraisers.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Peer-review audit conducted with two local hospitals and this was included in the Trust Board Report (September 2018).

Comments:

Not applicable

Action for next year:

Undertake a peer-review quality assurance process with neighbouring Trusts. This will then be reported to the Board through this Annual Board Report Template in July 2020.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Not applicable

Comments:

[3] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Between 1st April 2018 and 31st March 2019 180 medical appraisals (69%) were completed, between 1st April 2018 and 31st May 2018 a further 15 doctors (6%) completed a late 2018/19 medical appraisal. 34 doctors (13%) had an agreed postponement of appraisal with the RO. 34 doctors missed an appraisal in 2018/19 and we are now asking them to complete an appraisal in early 2019/20 to include all relevant supporting information since their last appraisal.

Action for next year:

Not applicable

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Comments:

Following discussion at the Medical Appraisal and Revalidation Decision Making Group, positive recommendations are submitted through the GMC portal and confirmations sent to the relevant doctors. If there was a recommendation made for deferral, or if there was insufficient evidence to support revalidation an attempt is always made to try to support the doctor to be able to provide the missing information ahead of the their revalidation date.

Action for next year:

Currently confirmations to doctors are emailed. We would like to develop a letter template to send to doctors following successful revalidation.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

In 2018/19, along with the information noted in the comments section below, we have also been able to provide surgical activity for all operating clinicians.

Comments:

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and compliments;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

This data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

The Trust now also has a Quality Improvement Lead in post and she has supported a number of teams and individual doctors to undertake quality improvement projects and share the learning from these projects.

Action for next year:

Not applicable

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Not applicable

Comments:

The Trust has relevant local policies in place, including 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'

Action for next year:

Not applicable

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Not applicable

Comments:

The Ttust has a local policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS' and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

Action for next year:

Not applicable

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[4].

Action from last year:

Not applicable.

Comments:

The Trust's Private Board receive monthly reports regarding doctor's whose practice has been restricted, or where a doctor has been excluded from the Trust.

Action for next year:

Not applicable.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[5].

Action from last year:

Not applicable.

Comments:

We utilise the MPIT form where appropriate.

Action for next year:

Not applicable.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Not applicable.

Comments:

The Trust has introduced a Fair Treatment Panel that reviews processes conducted under HR policies; this includes any action under the Trust's *Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff*.

The Trust have a Medical Appraisal and Revalidation Decision Making Group to make decisions around revalidation recommendations.

Action for next year:

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[5] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Not applicable.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

Not applicable.

Comments:

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- Criminal records checks and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK, where this is necessary
- Verification of license to practice and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

With regard to doctors working at the Trust via an agency, the Trust has framework agency agreements which are used to secure the majority of agency bookings for medical staff. However, when the Trust uses non-framework agencies, where there is no such agreement, there is no assurance that the agency is following NHS mandated recruitment standards.

Action for next year:

Not applicable.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions**

For 2018/19 we chose to focus on the areas for review identified by the Higher Level Responsible Officer

- "*Ensure that we have a lay or public representation on the Medical Appraisal and Revalidation Decision Making Group.*" This has been acted upon and Non-Executive Director Yua Haw Yoe is now a member of the Medical Appraisal and Revalidation Decision Making Group.

- "*Hold twice yearly Appraiser Forum for our medical appraisers*." This has been acted upon and two forums were held on the 12 October 2018 and 21 January 2019.

- "*Increase appraisal rates for Trust Grade Doctors*". The Medical Directorate Portfolio Manager held meetings with Trust Grade Doctors to assist them in preparing for appraisal and revalidation. 2018/19 saw an increase in the number of Trust grade doctors undertaking appraisal in-line with policy, but this increase has not be sufficient to match the appraisal rates of other groups of doctors.

- "*Publicise Appraisal and Revalidation on the Trust's extranet to increase public awareness of the processes*." We are in the process of discussing the best approach to this with our Communications Department.

- "*Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation*." We are considering approaches to this issue.

- **New Actions:**

For 2019/20 we will focus on the following areas

- Re-advertise and successfully recruit to the post of Associate Medical Director for Revalidation by 1 November 2019.

- Re-advertise and successfully recruit to the post of Associate Medical Director for Revalidation by 1 October 2019.

- Develop a Trust-wide medical appraiser network.

- "*Publicise Appraisal and Revalidation on the Trust's extranet to increase public awareness of the processes*." We will ensure that information is published externally by 1 October 2019.

- "*Hold and maintain a database of all doctors who work at the Trust, or hold honorary contracts with the Trust to ensure that all have been linked appropriately to a designated body and are engaged with appraisal and revalidation*." We will ensure that this is completed by 1 September 2019.

- Increase the number of medical appraisals undertaken in-line with policy from 69% to 80% by 31 March 2020. A particular focus will be paid to locum and Trust grade doctors.

- Undertake a peer-review quality assurance process with neighbouring Trusts by 31 March 2020.

Section 7 – Statement of Compliance:

The Board of Whittington Health NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: Whittington Health NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Appendix 2 – Terminology

'Revalidation': the process whereby the General Medical Council (GMC) renews a doctor's license to practise every five years, based on a recommendation from the doctor's Responsible Officer.

'Designated body': an organisation recognised by the GMC as responsible for submitting revalidation recommendations. Every designated body must have a Responsible Officer.

'Responsible Officer' (RO): a senior doctor, usually the Medical Director, who is responsible for medical appraisal and revalidation within the organisation and who makes recommendations to the GMC about doctors' fitness to practise. The revalidation recommendations submitted by the RO are considered by the GMC when they make the final decision with regards to a doctor's revalidation. The RO's responsibilities are laid out in the Responsible Officer Regulations, and in additional documents provided by the GMC such as the Responsible Officer Framework.

'Prescribed Connection': the term used to indicate the link with a doctor and their designated body. The prescribed connection is determined by law in the Responsible Officer Regulations and cannot be chosen, though it can be altered in exceptional circumstances. For doctors in a formal training programme, their prescribed connection is with the relevant region for Health Education England (HEE) that administrates their course. All GPs on performers' lists have a prescribed connection to their Area Team for NHS England. Doctors who only work privately have a prescribed connection to the private organisation for which they do most work, and doctors employed only by an agency will usually have a prescribed connection to that agency. For all other doctors, including those with honorary contracts or on the bank, their prescribed connection is to the organisation for which they do most work, or, in the case of doctors who do an equal amount of work at two different NHS Trusts, to the organisation which is closest to their GMC registered address.

'Medical Appraisal': the evidence to inform revalidation recommendations is based on annual medical appraisals. Medical appraisals are performed by trained appraisers, and include a process whereby the doctor must provide a portfolio of evidence regarding their practice, including six kinds of information which are considered mandatory by the GMC. These should relate to:

1. Continuing Professional Development
2. Quality improvement activity
3. Significant events (including but not limited to Serious Incidents)
4. Colleague feedback (completed through a formal 360)
5. Patient feedback (completed through a formal 360)
6. Review of complaints and compliments

Revalidation recommendations

Responsible Officers are only able to submit one of three revalidation recommendations about a doctor to the GMC[6]:

1. ***'Positive recommendation':*** a recommendation from the Responsible Officer to the GMC that in his/her opinion a doctor is up to date, fit to practice, and without unaddressed concerns.

[6] Revalidation Statements, accessible at http://www.gmc-uk.org/doctors/revalidation/12394.asp

2. ***'Deferral request':*** a request from the Responsible Officer to the GMC to delay a doctor's revalidation submission date to allow for additional information to be considered (for example, if the doctor has not completed a 360 Multi-Source Feedback exercise, or if they are in a local HR process that has not yet come to a conclusion). Deferral of revalidation is neutral and has no impact on a doctor's practice; however, more than one request for deferral of revalidation date for an individual will lead to the GMC requesting further information as to the reasons for the deferral.

3. ***'Recommendation of non-engagement'***: a recommendation of non-engagement is made by the Responsible Officer to the GMC where a doctor is failing to engage with the processes that support revalidation (for example, where a doctor has repeatedly failed to complete an appraisal). A

Appendix 3 - Governance Arrangements and Responsibilities

The Responsible Officer is supported by the Medical Director Portfolio Manager and the Project Support Officer. The responsibilities of the Medical Director Portfolio Manager and Project Support Officer include:

- Maintaining the Trust's prescribed connection list on GMC Connect;
- Monitoring revalidation submission dates;
- Responding to revalidation information requests from other organisations on behalf of the Responsible Officer;
- Storing information relating to revalidation recommendations;
- Maintaining and monitoring the annual appraisal list, including providing reminders to doctors that their appraisals are due and escalating missed appraisals appropriately to Clinical Directors and the Responsible Officer;
- Supporting the Clinical Directors in allocating appraisers to the Trust's doctors, and keeping records of appraisal pairings in order to ensure that these are in line with the policy;
- Monitoring the Trust's online Revalidation Management System and liaising with the provider on improvements and development;
- Providing training for doctors with regard to using the online system, as well as more generally about the requirements of appraisal and revalidation;
- Providing refresher training to appraisers;
- Ensuring that Trust-held data on complaints, incidents and registered audit is entered onto the Revalidation Management System;
- Monitoring new advice from the GMC and NHS England and providing advice on process to individual doctors and to the Responsible Officer as necessary;
- Reviewing and updating the Medical Appraisal Policy in line with new guidance;
- Managing appraisal reporting, including locally to the Responsible Officer, and the completion of quarterly reports to NHS England;
- Drafting the Annual Organisational Audit (AOA);
- Completing quality assurance audit of annual appraisals.

The Trust will shortly be undertaking a new recruitment process for the post of Associate Medical Director for Revalidation. The responsibilities of the Associate Medical Director for Revalidation include:

- To oversee the medical appraisal process to help ensure that all non-training grade doctors employed by the Trust have an annual appraisal.
- With the day to day support of the Medical Director Portfolio Manager and Project Support Officer, to agree a strategy to ensure improvements in the medical appraisal and medical revalidation processes.
- To develop reviews of medical appraisal outputs to ensure the inclusion of all required documentation and to use regular reviews to set a standard for medical appraisals in the Trust.
- To offer bespoke advice and support to colleagues who have complex issues around evidencing performance and quality.
- To support the Responsible Officer in ensuring the evidencing of recommendations made to the GMC about the fitness to practice of doctors employed by the Trust.

- To oversee the continuous quality review and improvement of training and guidance for Trust medical appraisers.
- To assist the Medical Director in overseeing the Trust's process for responding to correspondence from the GMC.
- To refer concerns about a doctor to the Responsible Officer (Medical Director) for further investigation and support the Responsible Officer in ensuring that appropriate timely action is taken, in accordance with Trust procedures, when a concern is raised about a doctor's performance or conduct.
- To oversee existing processes to ensure that the Trust complies with the external reporting related to medical revalidation and medical appraisals.
- To chair appropriate meetings relating to the role.

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports.

Appendix 4: Amended Appraisal Summary and PDP Audit Tool Template (ASPAT)

Appraiser's name	
Date of appraisal	
Organisation	
Auditor	
Auditor's organisation	
Date of audit	

Scale:
0 – No evidence
1 – Limited evidence / Doesn't meet requirements
2 – Good evidence / Meets requirements

Section 1: Setting the scene		**Score (out of 2)**
1.	There is a **summary** of the doctor's scope of work	
2.	There is documentation of whether or not the supporting information covers the **whole scope of work**	
3.	Specific supporting information is summarised with a description of what it demonstrates	
4.	The appraiser's summary includes **objective statements** about the **quality** of the supporting information provided	
5.	**All** statements made by the appraiser are supported by evidence	
6.	There is **reference to the four GMC domains** as set out in the GMC guidance *Good Medical Practice Framework for Appraisal and Revalidation*	
7.	There is reference to **specialty specific guidance** for appraisal (e.g. college recommendations for CPD).	
8.	There is reference to the doctor's **mandatory training status**	

Section 2: Reflection and effective learning		**Score (out of 2)**
9.	There is evidence that **reflection on learning** has taken place, or that the appraiser has discussed how the doctor should document their reflection	
10.	There is evidence that **learning has been shared with colleagues** or that the appraiser has discussed with the doctor that learning should be shared with colleagues	
11.	There is evidence of the doctor having put measures in place to **improve patient care or of him/her changing his/her clinical practice** to improve patient care, or that the appraiser has discussed this with the doctor	
Section 3: The PDP and developmental progress		**Score (out of 2)**
12.	There is a **summary** of the doctor's achievements over the last	

	year	
13.	There is evidence of **appropriate challenge** from the appraiser in the discussion and formation of the new PDP	
14.	The progress against last year's PDP is **recorded**	
15.	**Reasons for incompletion** are recorded for any PDP points that were not completed	
16.	There are **clear links** between the summary of discussion and the doctor's new PDP	
17.	The PDP has **SMART** objectives	
18.	The **PDP** covers the doctor's **whole scope of work**	
19.	The **PDP** contains between **3-6 items**	

Section 4: General standards and revalidation readiness		
20.	The documentation is typed in **clear and fluent English** and is electronically and retrievably stored	
21.	There is evidence regarding the doctor's **progress towards revalidation** and outstanding supporting information or requirements have been discussed with the doctor	
22.	The appraiser has made **appraisal statement** (including about fitness to practice)	
23.	The appraiser and doctor have both reviewed and agreed to the appraisal summary	

Score out of 46	

Appendix 5: The Medical Appraisal and Revalidation Decision Group Terms of Reference, version 0.4, last updated 9.7.2019

1. Authority and Scope

1.1 The Medical Appraisal and Revalidation Decision Group has been established by the executive authority of the Executive Medical Director.
1.2 The Medical Appraisal and Revalidation Decision Group shall meet no fewer than 6 times per year.
1.3 The Group is authorised by the Executive Medical Director to act within its terms of reference and to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation by the General Medical Council (GMC).
1.4 The revalidation recommendation is made by the Trust's Responsible Officer and the Responsible Officer is not obliged to take the advice of the Medical Appraisal and Revalidation Decision Group.
1.5 The Group is authorised by the Executive Medical Director to obtain such internal information as is necessary to exercise its functions and discharge its duties.

2. Membership

2.1 The Group will be chaired by the Trust's Responsible Officer and administered by the Business Manager for the Medical Directorate or appropriate nominated officer.
2.2 The Group will comprise of the Medical HR Business Partner, Head of Quality Governance, Executive Medical Director, Medical Director Project Officer, Associate Medical Director for Patient Safety, and Non-Executive Director as a lay member.
2.3 If the Medical HR Business Partner and Head of Quality Governance are not able to attend meetings then a summary document detailing the relevant information for each individual doctor may be sent to the Chair in advance of the meeting.
2.4 The Medical Director Project Officer is a member of the Group, but attendance by these members or their nominated officers is not required for the Group to be quorate.

3. Purpose and role

3.1 The purpose of the Group is to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation to the GMC.
3.2 The Group will provide scrutiny of the medical appraisal documentation and information from Trust governance and risk systems to inform the recommendations made to the Responsible Officer.
3.3 The Group will make one of three recommendations to the Responsible Officer for each individual doctor linked to the Trust for the purposes of revalidation. The three recommendations the Group can make are: revalidate, defer, or non-engagement.
3.4 A recommendation by the Group that a doctor should be positively recommended for revalidation will act to provide the Responsible Officer with assurance that all information required by the GMC has been appropriately considered and is deemed by the Group to be sufficient for a positive revalidation recommendation to be made by the Responsible Officer.

4. Duties

4.1 Ahead of the meeting a list of all medical doctors to be considered will be circulated to members. Members of the Group are required to review and interrogate all relevant
4.2 information in their area of expertise for all doctors to be considered at the meeting. Members are required to bring summary information for each doctor to the meetings.

4.3 The Head of Quality Governance is required to review information from the Trust's risk management systems and information highlighted to them through patient safety.
4.4 The Medical HR Business Partner is required to review information all employee relation and human resourcing matters.
4.5 The Associate Medical Director for Patient Safety will bring to the attention of the group patient safety concerns relating to the practice of doctors considered.
4.6 The Associate Medical Director for Revalidation is required to review appraisal output documentation, colleague and patient feedback and external information received or sent by the Trust relating to the doctor (e.g. correspondence with other employers, correspondence from the GMC).
4.7 The Group will decide on the recommendation to make to the Responsible Officer for each doctor considered by the Group. If a consensus between members cannot be reached then the Chair will decide on the recommendation.
4.8 The Group will ensure a completed summary form (Appendix A) is made available to the Responsible Officer in good time to ensure that revalidation recommendations can be submitted to the GMC.

5. Review

5.1 The terms of reference of the Group will be reviewed annually by the Trust's Executive Medical Director.

Appendix A: Revalidation Group Summary Form

Revalidation Group held on XX.XX.XXXX			
Doctors full Name			
GMC Number			
Current role			
Employed from		**Employed to**	
Revalidation Date		**Date last Revalidated**	
Please list all appraisal dates within the last 5 years (starting with the most recent)	1.	**Comments** (e.g. agreed missed appraisals for approved leave):	
	2.		
	3.		
	4.		
	5.		

In relation to this doctor the Revalidation Group are aware of:	**Yes**	**No**	**Comments:**
Any current, unresolved or relevant complaints, claims or inquests	☐	☐	
Any serious or untoward incidents which are current, unresolved or any relevant previous concerns	☐	☐	
Any current disciplinary investigations and/or live action taken	☐	☐	
Any referrals to GMC or NCAS	☐	☐	

5 year appraisal documentation includes appropriate:	Colleague and Patient/ Carer/ Service User feedback (last 5 years)	☐	Evidence of appropriate reflective practice	☐
	Probity and Health Declarations	☐	Evidence from private practice employers (where appropriate)	☐
	SI and complaints declarations or inclusion of relevant documents	☐	No unresolved issues noted by appraiser	☐
	Evidence of appropriate CPD	☐	Previous PDP discussed and new PDP created	☐
	Evidence of quality improvement	☐	**Comments:**	
	Full scope of practice considered	☐		

Recommendation to RO:	Revalidate	☐
	Defer	☐ Reason:
	Non-engagement	☐ Reason:

Meeting title	**Trust Board – public meeting**	**Date: 31 July 2019**
Report title	**Quarter one delivery of 2019/20 strategic objectives**	**Agenda Item: 22**
Executive director lead	Jonathan Gardner, Director of Strategy	
Report author	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Executive summary	Board members are presented with a review of quarter one delivery of the Trust's 2019/20 strategic objectives. The purpose of this report is to give the board an overview of progress against our strategic objectives at a high level. A few proxy measures have been highlighted against each of the four objectives to give a sense of progress and achievement. This does not replace the detailed monthly performance report. The board are asked to comment on where they feel more focus should be brought to bear, and to continue to confirm or comment on our priority actions.	
Purpose:	Review and comment on progress.	
Recommendation(s)	Board members are invited to review delivery against the performance metrics outlined for respective strategic objectives.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	None	
Appendices	None	

Quarterly progress report on the strategic objectives

QUARTER 1

July 2019

Deliver outstanding safe and compassionate care in partnership with patients

RAG

Exec: Chief Nurse / MD

Committee: Quality

worse

better

Same

Key metrics	Target	Score	RAG
SHMI score		0.78	
Readmission rate	5.5%	5.3%	
Pressure ulcers grd. 4 and 3	Reduce 10%	35	
FFT % satisfaction	90%	IP: 97.5 OP: 91%	

Key metrics	Target	Score	RAG
RTT	92%	92.2%	
ED 4hr	95%	87.7%	
Adult community metrics green	↑	9	
Child community	↑	8	

Key metrics	Target	Score	Direction and RAG
PALS response time	80%	85.1%	
QI initiatives	TBC		
No. volunteers	TBC		

Descriptor	Deliverables	Progress last quarter	Actions next quarter
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 CQC rating including moving community children's services from 'Requires Improvement' to Good • Improve feedback numbers and experience of people attending the Emergency department • Improve 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 embedded at Trust and ICSU committees	• More robust therapy pathways, Health Visiting and Scholl Nurse KPI's • Wait times for CAMH's have reduced significantly to 9 wks, a new central point of access for all social/emotional/mental health referrals across Islington is starting. • The patient experience team meet monthly with the ED patient experience lead to forward actions • All Stepping Stones graduates from 2017/18 being offered follow-on support • A new Inclusive leadership programme launched in June	• Exploring research opportunities in haematology and paediatric nephrology; monitoring usage of Learning from Excellence and implementing changes to the Quality Committee reporting structure • ICSU's boards are exploring how they can engage patients in service redesign
Ensure timely and responsive care that is seamless between services	• Meet constitutional standards • Improve treatment and waiting time standards for our mental health patients within emergency department • Continue to achieve cancer and referral to treatment national standards • Improve the waiting times for people who need community health services • Deliver the better births action plan	• RTT and cancer targets are still being hit with A&E improving slightly but still under trajectory • 8 mental health 12hr breeches in ED • 2hr and 48hr district nursing targets are being met • New birth visit targets are at 91% against target of 95%	• Actions through the A&E delivery board • Actions through the community services improvement group
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	• We are currently updating patient information and leaflets. We will also be reviewing signage and correspondence (Patient letters) to ensure that they contain the right information.	
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	• 126 active projects, 24 completed. • 194 staff have attended face to face training • We celebrated work and successes at our annual QI celebration event. • We have created videos sharing advice from staff to others starting projects	• Two more are scheduled to run in 2019 35 staff booked • Some areas devising QI programmes to focus on the common themes in incidents, complaints and patient/ staff experience. MD to do review of QI strategy.

Empower support and develop engaged staff

RAG

Exec: Workforce Director / COO

Committee: WAC

Key metrics	Target	Score	Direction and RAG
Turnover rate	10%	10.8%	
Vacancy rate	10%	12.9%	
Appraisal rate	90%	70.8%	
Mandatory training	90%	80%	

Key metrics	Target	Score	Direction and RAG
# teams doing 'team journey'	Tbc	20	
Likelihood BAME candidate being appointed		1.65	
Staff FFT/Pulse response rate		23%	

Key metrics	Target	Score	Direction and RAG
Relative likelihood of disciplinary for BAME		1.44	
% staff recommending WH as place to work	65%	60%	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
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 CEPN and develop educational opportunities • Complete the WRES Improvement Plan (which includes reduction targets)	• Fully Implemented • Fully Implemented • WRES action plan developed	• Review the impact in line with WRES action plan • Continue to host • Continue with WRES actions
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 • Enhanced staff access to smoking cessation • Create the events calendar to promote to staff on intranet by June 2019 • Develop a staff engagement and wellbeing social media platform	• Health and Well being plan in place • Implemented • Implemented • In progress	• Continue with plan • Project in place for 6 months
Be the employer of choice recruiting and retaining and recognising the best	• Continue work with capital nurse • Implementation of the NHSI Retention Plan including Implement Managers Breakfast and 'itchy feet' retention events • Recruitment service Recovery Plan	• Working with Capital Nurse • NHSI retention plan in place • In place	• Working with capital Nurse • Continue with plan and reviews • Continue with 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 • Implement the Cultural survey action plan focussing on engagement and bullying and harassment • Audit the Fair Treatment panels for reduction in BME disciplinary cases	• Currently being taken forwards • Cultural Survey plan in place • Not due until October 2019	• Assurance through WAC • Assurance through WAC • Due October 2019
Promote compassionate leadership, accountability and team working where bullying and harassment is not tolerated	• Implement the Cultural survey action plan • Promote the Leadership Development programme • Development of Managers 'passport'	• Action plan in place • Current promotions in place • Under development	• Assurance through WAC • Further developing leadership and focusing on middle managers • In place by October 2019.

Integrate care with partners and promote health and well-being

RAG

Exec: Director of Strategy / COO

Committee: Board

Key metrics	Target	Score	RAG
DTOC rate	2.5%	2.8%	
Careflow project status	Green	Green	
NMUH project status	Green	Red	
UCLH project status	Green	Amber	
Locality project status	Green	Green	

Key metrics	Target	Score	RAG
Intermediate care project	Green	Amber	
No. staff completed MECC	All DN by Dec	3	
Website project status	Green	Green	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
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 • Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP • Collaborate with other NHS providers to improve efficiency and resilience)	• New lanyards, staff going on Council making every contact count courses, localities booklet, core team defined, ways of working principles defined • Execs helping to design new borough partnership boards • WH / UCLH ortho hub bid submitted • NMUH progress has been slow	• Confirm operating model • Progress NMUH collaboration further
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'	• Integrated forum met every month and helped design localities operating model • Careflow in place in West Haringey	• Integrated forum considering contractual implications of simplifying referrals • Roll out careflow as per plans
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 business case for delivering new model at Osborne Grove	• Separate project groups established (Haringey and Islington) • Draft SPOA model developed for ISLINGTON • Haringey focus on integrated delivery • Osborne Grove engagement event was positive and the council continue to be keen to work with us	• Test integrated intermediate care pilot in North Tottenham. • Continue to work on workforce model for future building 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' MECC model • Begin new approach to community engagement and advice and guidance	• Self-management team have been attending community events and signing people up • A few staff have gone on Islington MECC • Community newsletter launched • Community event held covering estates, dealing with heat and skin cancer • Adverts in the local paper	• Create roll out plan for MECC • Make the newsletter and events quarterly

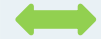
Transform and develop financially sustainable innovative services

RAG

Exec: Finance Director / COO

Committee: TMG

Key metrics	Target	Score	RAG
% CIP delivery against target	100% £3.1m	23% £0.7	
Average beds used	197	203	
Financial position	Break-even	-£2.5m	
Capital spend against plan	£3.3m	£2.3m	
% D2A	TBC		
Average LOS Non-elective	4	4	

Key metrics	Target	Score	RAG
% stranded pts	35%	42%	
Elective activity	100% on plan		
Theatre utilisation	>85%	83.5	
Estates project status	Green	Green	
Fast follower project status	Green	Green	
Financial training sessions delivered	>12 per year	1	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
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 team • Improve outpatient productivity, develop new virtual clinic models and increase advice and guidance • Improve emergency care and ambulatory care (adult and children)	• The Trust has achieved core bed base and plus ones during the last few weeks of June and July • Locality working is progressing at pace • AVLOS has remained broadly similar • Outpatient work stream is progressing with CCG / STP input but has not found the realisable saving required	• Continue with bed base • Reduce AVLOS to reduce open beds further creating flexibility in winter • Redesign outpatients to create a full year system saving of £4m so that in year the net saving to WH can still be achieved
Reduce system cost and improve clinical productivity and financial literacy everywhere	• Deliver £12m savings through CIPs and deliver to budgets to deliver the 19/20 control total • Identify alternative pathways to outpatients with primary care • Roll out programme of financial awareness to key staff • Implement new intermediate care pathway • Restructure therapy and autism pathways for children	• Only 23% CIP achieved • Limited progress • All EIM Budget Holders have been trained with awareness sessions. • Intermediate care programme on track	• Continue recovery plan and improved delivery on CIP • Further Surgeries to be offered in all ICSUs
Transform our estates and IT to enable new ways of working	• Create the case and plans for a transformed estate and produce various legal documentation • Deliver estates improvement programme • Deliver the fast-follower programme	• The design of the estate for the draft SOC is complete and key stakeholders are engaged • Major improvement on Estate in key areas fire, water, asbestos and third party assurance achieved • Fast Follower remains on track	• SOC in July • As per plans