Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
25 September 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**25 September 2019: From 1400hrs**
Venue	**Whittington Education Centre, Room 7**

Non-Executive Director members:	**Executive Director members:**
David Holt, Interim Chair Deborah Harris-Ugbomah Professor Naomi Fulop Tony Rice Anu Singh Yua Haw Yoe	Siobhan Harrington, Chief Executive Clare Dollery, Medical Director Kevin Curnow, Acting Finance Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse & Director of Allied Health Professionals

Attendees:
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

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AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	1400	**Staff story** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Presentation
2	1420	**Welcome and apologies** *David Holt, Interim Chair*	Verbal
3	1421	**Declaration of interests** *David Holt, Interim Chair*	Verbal
4	1422	**31 July 2019 public meeting draft minutes, action log, matters arising** *David Holt, Interim Chair*	Approve
5	1425	**Chair's report** *David Holt, Interim Chair*	Verbal
6	1430	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Note

Item	Timing	Title and lead	Action
Quality & patient safety			
7	1440	**Serious incidents – July and August 2019** *Dr Clare Dollery, Medical Director*	Note
8	1450	**2018/19 Infection Prevention & Control annual report** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Approve
9	1500	**Freedom To Speak Up Guardian six monthly report** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Review
10	1515	**2018/19 Research and development annual report** *Dr Clare Dollery, Medical Director*	Note
	1520	**Break**	
People			
11	1530	**Staff survey – local action plans** *Norma French, Director of Workforce*	Note
12	1540	**2018/19 Public sector equality duty annual report** *Norma French, Director of Workforce and Michelle Johnson, Chief Nurse and Director of Allied Health Professionals*	Approve
13	1555	**Volunteering strategy** *Michelle Johnson, Chief Nurse, Director of Allied Health Professionals*	Approve
Performance			
14	1605	**Financial performance and capital expenditure – August 2019** Kevin Curnow, Acting Finance Director	Review
15	1620	**Performance dashboard – August 2019** *Carol Gillen, Chief Operating Officer*	Review
Governance			
16	1635	**Minutes of the Quality Committee's July and September 2019 meetings** *Professor Naomi Fulop, Committee Chair*	Note

Item	Timing	Title and lead	Action
17	1640	**Minutes of the Workforce Assurance Committee's September 2019 meeting** *Anu Singh, Committee Chair*	Note
18	1645	**Questions from the public on agenda items** *David Holt, Interim Chair*	Verbal
19	1650	**Any other business** *David Holt, Interim Chair*	Verbal

Minutes of the meeting of the Trust Board of Whittington Health held in public on Wednesday, 31 July 2019

Present:

David Holt	Non-Executive Director & Interim Chair
Stephen Bloomer	Chief Finance Officer
Dr Clare Dollery	Medical Director
Naomi Fulop	Non-Executive Director
Jonathan Gardner	Director of Strategy, Development & Corporate Affairs
Siobhan Harrington	Chief Executive
Deborah Harris-Ugbomah	Non-Executive Director
Sarah Humphery	Medical Director, Integrated Care
Michelle Johnson	Chief Nurse & Director of Patient Experience
Tony Rice	Non-Executive Director

In attendance:

Councillor Janet Burgess	London Borough of Islington
James Connell	Patient Experience Manager (item 1)
Kate Green	Personal Assistant to Director of Workforce
Laura Hayward	Acute Liaison Learning Disabilities Nurse (item 1)
Helen Kent	Deputy Director Organisational Development
Swarnjit Singh	Trust Corporate Secretary
Aisling Thompson	Director of Operations, Adult Community Services and Deputy Chief Operating Officer
Kate Wilson	Deputy Director of Workforce
Emma Winn	Speech and Language Therapy Clinical Manager (item 1)

1.	**Patient story**
1.1	David Holt, Interim Chair, invited Michelle Johnson to introduce this month's patient story. Michelle introduced patient, Rodney, to recount his experience of treatment at the hospital. Patient Experience Manager James Connell introduced Marcus, accompanying Rodney, plus members of staff Laura Hayward and Emma Winn. Rodney explained that he was being treated by the hospital for a number of medical conditions and had a mild learning disability.
1.2	Rodney's account of his treatment by the hospital centred around the need for people with learning disability to be given sufficient time by doctors to fully explain their symptoms and difficulties. He gave an example of an occasion when he was in pain and his leg was swollen where it was later discovered that he was suffering from a deep vein thrombosis. He stressed the importance of having learning disability nurses like Laura, without whom he and patients like him would be unable to manage their appointments and care, as she fully understood what the doctors talked about and recommended in terms of treatment. He was concerned, however, that Laura was the only specialist nurse, so if she is absent

	for any reason whether it be annual leave or illness, there was no-one to cover.
1.3	He went on to speak about other aspects of his treatment. Rodney has a very good relationship with his respiratory consultant, saying that when he had mould in his flat (a serious problem because of his respiratory problem), the consultant helped him move to alternative accommodation where he was now much happier. There were less positive aspects of his treatment, however, one example being the way he had been spoken to by a nurse on the ward which compromised his privacy and dignity. He had also taken a tablet not meant to be swallowed before dissolving due to having been given insufficient instructions.
1.4	Siobhan Harrington asked Rodney whether he would like to highlight some specific examples of improvements that might be made to improve care for patients with learning disabilities. In addition to employing more specialist nurses, Rodney said that people needed to be given more time, in particular the opportunity to foster relationships of mutual trust and respect. Thanking him, Siobhan Harrington thanked Rodney for his suggestions and said she hoped he would remain involved and join the Trust's learning disability steering group.
1.5	Emma Winn demonstrated the Makaton signing technique and explained, saying that if health professionals got communications right for people with learning disabilities then they could help improve things for all vulnerable patients. Councillor Janet Burgess said that the Islington Learning Disabilities Partnership would be happy to support the steering group.
1.7	Siobhan Harrington reminded the Board that it was important to hear stories from both patients and staff, and to this end she had asked for a staff story to be brought to the Board in September.
1.8	**The Board:** **i. thanked Rodney for sharing his patient experience;** **ii. agreed the Trust would respond formally to Rodney about actions being taken; and** **iii. agreed that Rodney be invited to participate in the Trust's steering group.**
2.	**Welcome and apologies**
2.1	David Holt welcomed everyone to the meeting, and thanked Aisling Thompson and Kate Wilson for covering for Carol Gillen and Norma French respectively.
2.2	Apologies for absence were received from Norma French, Director of Workforce, Carol Gillen, Chief Operating Officer, Anu Singh, Non-Executive Director, and Yua Haw Yoe, Non-Executive Director.
3.	**Declaration of conflicts of interest**
3.1	Siobhan Harrington informed the Board that her son had recently secured a position with the re-ablement service in Islington and this would be added to the register.
3.2	**Board members noted the declaration and agreed that it did not conflict with agenda items to be discussed at the meeting.**

4.	**Minutes of the meeting held on 26 June 2019, matters arising & actions**
4.1	The minutes of the Trust Board meeting held on 26 June were approved as a correct record.
4.2	It was noted that all items recorded on the action log had either been completed or were on track to complete.
4.3	Councillor Janet Burgess raised one additional matter referring to the non-emergency patient transport service which had been raised by Mr Richards at the previous meeting and assured the Board this was something she had made enquiries about and would continue to keep a watching brief.
5.	**Chairman's report**
5.1	Swarnjit Singh reported that following NHS England and Improvement's appointment of David Holt as Interim Chair of Whittington Health while a substantive new Chair was recruited, a number of governance changes were needed, in line with good practice. Professor Naomi Fulop, Non-Executive Director, was proposed as David Holt's replacement as Senior Independent Director of the Trust. In addition, Deborah Harris-Ugbomah, Non-Executive Director, would become Chair of the Trust's Audit and Risk Committee.
5.2	David Holt thanked both Naomi Fulop and Deborah Harris-Ugbomah for stepping into these roles.
5.3	**The Board:** **i. agreed the appointment of Professor Naomi Fulop as Senior Independent Director; and** **ii. noted that Deborah Harris-Ugbomah was the new Chair of the Audit and Risk Committee**.
6.	**Chief Executive's report**
6.1	Siobhan Harrington informed the Board that the national Long Term Plan implementation framework was now published, and the Trust would be submitting a response during the autumn, with a discussion also being held at a Board seminar. She also reported that Local Primary Care Networks had now been established; four in Islington and eight in Haringey, each headed by a GP clinical director.
6.2	A new national Patient Safety Strategy had been published which Clare Dollery would be looking at in detail. Clare Dollery had now been in post for eight weeks, and Siobhan Harrington commented on how good it was to have her input into this agenda.
6.3	In terms of quality and safety, Siobhan Harrington reported that emergency department (ED) performance in June reached 90.1%, an improvement from May's performance of 88.4%, but still not reaching the planned trajectory of 92%. She explained that the ED continued to strive to achieve this, but remained hamstrung by the ever-increasing attendance (including mental health patients). Siobhan Harrington highlighted a range of improvements within children's community services, with the aim being to focus reporting in future more on outcomes rather than solely numbers.

6.4	Siobhan Harrington briefed Board members on the mental health compact, which had been in place since June, and aimed to ensure that mental health patients gained faster and smoother access to beds where required. This had changed the method of reporting mental health waits, and seven 12 hour trolley breaches had been declared in the ED in June.
6.5	Siobhan Harrington also drew Board members' attention to financial headlines which would be covered in detail later on the agenda by Stephen Bloomer. She reported that whilst income had remained stable, the Trust had declared a year to date deficit of £2.5m at the end of month 3, largely due to delivery of the cost improvement programme (CIP) being behind plan. The executive team and performance management office were working closely with integrated clinical service units (ICSUs) on respective recovery plans.
6.6	There continued to be a major focus on culture within the Trust. Appraisal and mandatory training had been discussed at the most recent round of the ICSU quarterly performance reviews, and new paperwork for appraisals was currently being piloted. The Trust's collaboration with Bank Partners was contributing to efficiency due to reduction of agency expenditure, however, it was also increasing the bank fill rate and therefore cost was not decreasing fast enough. In the autumn there was to be a training programme for some 330 staff to look at how to tackle bullying and harassment within the organisation. NHS values week had recently taken place, and Siobhan Harrington had produced a daily blog which had generated much positive feedback – she cited the example of a consultant who had replied saying how touched they had been by her piece on respect.
6.7	The report contained details of progress with the Trust's estate transformation work, from which Siobhan highlighted the ongoing work to demolish the Waterlow Building. Finally, she spoke about that month's excellence awards, which had gone to the Trust's 'amazing' security team, and in particular security advisor Jason Woodbyrne. The Board commended the team for their work, with some Board members saying that they had personally seen examples of how sensitively the team tackled difficult situations.
6.8	Deborah Harris-Ugbomah asked how the Trust had managed during the recent heatwave. Clare Dollery reported that she had visited the postnatal ward, and witnessed how hard midwifery staff had worked to keep patients as comfortable as possible. David Holt said that such conditions served to reinforce the aspirations the Trust had for its estate. Sarah Humphery stressed the importance of drinking regularly, particularly for renal patients, whose test results could otherwise become inconclusive due to dehydration.
6.9	**Board members noted the Chief Executive's update on national and local developments.**
7.	**Quarterly quality and patient safety report**
7.1	Clare Dollery informed the Board that she and Michelle Johnson were working on making changes to this report for the next quarter. Key mortality indicators had remained stable and were lower than expected, and a crude mortality indicator had also been included which could be captured each month. Data showed that

	fewer people had died this winter compared with 2017/18. Plans were being put in place to reduce the number of E.coli bacteraemia and included some outreach work into the community.
7.2	Clare Dollery drew attention to the recent Quality Improvement event chaired by Julie Andrews, Consultant and Associate Medical Director, and commended Julie for all the work she had undertaken during 2018.
7.3	David Holt enquired about the reporting of medication errors, noting the new system in place. He asked how the Trust measured improvement, whether benchmarking was undertaken, and what the Trust's ambitions for improvement. Clare Dollery replied that the Trust was keen to see incidents reported, and in summary, would like to see the number reported increase but the level of harm caused to reduce. There was no national benchmarking for medication incidents. Michelle Johnson felt it important that reporting came from a wide cross-section of staff – prescribers, dispensers and administrators, and she was pleased to see this was reflected in the report.
7.4	It was noted that, in general, summary hospital level mortality indicator results in London were better than elsewhere in the country, and there was a need to focus on the underlying drivers. Naomi Fulop asked whether in future the Board could be provided with examples of not just process but also improved outcomes implemented on wards, and David Holt reminded the Board of the presentation that had been given by two junior doctors eighteen months ago, and wondered whether this might be repeated at a future meeting.
7.5	**The Board:** **i. noted the report; and** **ii. agreed that learning from incidents be an item on the 2019/20 Board seminar programme.**
8.	**Serious Incident (SI) report**
8.1	Clare Dollery explained that a significant part of the report related to incidents which declared at the June Board meeting, i.e. the two never events declared as a result of the national 'look back' exercise into the misuse of reconstruction plates. She was pleased that the look back had been proven to be so rigorous, and assured the Board that both patients had been made aware and involved in the investigation, and their fractures had healed well. Improved processes had been put into place regarding storage and labelling, and ongoing discussions were taking place with the orthopaedic team.
8.2	Referring to the wrong site block incident, Clare Dollery said that a task and finish group had been convened and a meeting had been attended by all of the Trust's consultant anaesthetists.
8.3	The other SI declared in June related to an intra-uterine death, where there had been a possible lost opportunity to measure a heartbeat two days earlier. Given the gestation period of 30 weeks, the team was uncertain whether the death could have been avoided, but a range of actions had been set in train to minimise the possibility of such an event recurring. Siobhan Harrington provided assurance that the Trust's Management Group had discussed how learning was

	disseminated following the results of SI investigations, not just within individual ICSUs but from learning from across ICSUs and other organisational areas.
8.4	David Holt commented on the apparent decline in the number of SIs declared over the previous two years. Michelle Johnson replied that the overall level of reporting was increasing, which she felt to be a good sign. David Holt suggested that the reduction in numbers might be due to the fact that staff were learning from SIs, a positive message.
8.5	**The Board noted the serious incident report.**
9.	**Quarterly learning from deaths report**
9.1	Clare Dollery introduced the report covering the period 1 October to 31 December 2018 and explained that a new mortality review group had been convened which ran concurrently with the end of life care group. She clarified that 97% of Category A deaths had been reviewed using a structured judgement review process and provided assurance that part of this process involved a rigorous search for any deaths involving patients with learning disabilities.
9.2	The review had identified that there was one potentially avoidable death from the category B deaths scrutinised. This had been that of an intra-uterine death of a 37 week-old foetus, where signs of abnormality were detected earlier; there was a possibility that increased monitoring and early delivery might have resulted in a different outcome. The team had felt that due to the almost complete gestation period the death might have been avoidable. NHS Resolution had been fully briefed. In answer to a question from David Holt about when the incident had been declared, Clare Dollery confirmed replied that this had been declared as a serious incident at the time of occurrence.
9.3	**The Board noted the quarterly learning from deaths report.**
10.	**Integrated safeguarding report**
10.1	Michelle Johnson introduced the six-monthly integrated safeguarding report covering the period October 2018 to March 2019. She highlighted the continued increase in adult cases which was felt to be positive as it reflected increased staff training and more concerns being raised. The number of cases involving a Declaration of Liberty (DOLS) had also increased, and Michelle Johnson explained that changes in legislation were likely to result in increased responsibility being placed on Trusts, in the future. Noting the reduction of assessments logged for this same period, Michelle Johnson explained that, whilst staff had become better and more proactive in reporting, some needed to improve their formal recording. She also highlighted good progress had been made on the delivery of training designed as part of the Government's strategy to prevent the radicalisation of vulnerable adults.
10.2	Moving to children's safeguarding, Michelle Johnson reported on the Joint Area Targeted Inspection in Islington which took place in December 2018 and clarified that the preparation for it had been exemplary, and this was reflected in the very positive letter received following the inspection. She had also reviewed the training figures, saying that the Trust was keen to maintain face-to-face training, although there was a need to balance this with ensuring as many staff as

	possible were up to date with their training even if this had to be conducted on-line.
10.3	The report had been discussed in detail by both the Quality Committee and the Integrated Safeguarding Board. Commenting on paragraph.3.2, David Holt enquired about how the team was coping with the increased numbers of concerns raised. Michelle Johnson provided assurance that the process was robustly monitored by the Head of Adult Safeguarding, who had a very good relationship with the local boroughs, and she was confident that accurate and timely feedback was provided to staff. In answer to a question about the speed of assessment, Michelle Johnson reminded the Board that the Trust was responsible for alerting and working in partnership with local health and care partners, rather than investigating. She also acknowledged that there were some complex cases which took longer to resolve.
10.4	The Board discussed the issue of homeless patients, and Clare Dollery reported on a two-day audit that had been carried out by junior doctors earlier in the month, led by a respiratory consultant, where around 200 in-patients were interviewed about whether they had a safe place to go following their discharge from hospital. The fifteen patients identified as homeless had been followed up by local authority colleagues who could support them in finding accommodation. Michelle Johnson added that changes in legislation had been put in place which put more of an onus on Trusts to support homeless patients via referral to the local authority.
10.5	**The Board:** **i. noted the six monthly safeguarding report;** **ii. received assurance that there were systems in place to protect children and vulnerable adults from abuse and neglect whilst in our care; and** **iii. took assurance that partners had confidence that Whittington Health was fulfilling its role as a statutory partner in safeguarding children and adults at risk in the wider community and health and care economy.**
11.	**Clinical negligence scheme declaration**
11.1	Clare Dollery explained that this declaration related to the Department of Health and Social Care's wish to encourage action to improve safety in maternity services. Earlier reports had already covered assurance processes including mandatory training, and the paper set out in detail progress made against each of the ten safety actions required to be met by all Trusts providing maternity services.
11.2	There was clinical commissioning group oversight of this process, and Clare Dollery was pleased to report that feedback received had been extremely positive, mentioning the amount of work that had obviously been carried out and commending the team for their efforts. On behalf of the Board, David Holt praised the quality of the report, and Board colleagues expressed their congratulations on this achievement.
11.3	**The Board:**

	i. approved the declaration for submission; **ii. confirmed that they were satisfied that maternity services demonstrated compliance with the maternity safety actions and that the self-certification was accurate; and** **iii. noted the content of this report and evidence against each safety action had been shared with the commissioners of the Trust's maternity services.**
12.	**Quarterly report from Guardian of safe working**
12.1	Clare Dollery said that Whittington Health was a high exception reporter, with 164 reports having been received during this quarter (April – June 2019). She explained that the Trust had put considerable effort into ensuring that exception reporting was seen as a neutral act. Locum work and agency use was included in this report for the first time. Clare Dollery added that there were some anomalies in the report due to the fact that one team had collected all reports made during the quarter and declared them in the same month. It was noted there had been no patient safety issues as there had always been an appropriate colleague to escalate issues to.
12.2	Clare Dollery reminded the Board that there were penalties associated with exception reports, and fines could be awarded either to individuals or to the junior doctors' fund. She reported that the team was looking at shift patterns in order to gauge trends – for example, days immediately prior to Bank Holidays were identified as an issue. Clare Dollery emphasised that the Trust was hugely grateful to the junior doctors for the hours they put in, and she was equally aware that nurses also regularly worked over and above the hours for which they were scheduled on the rota. Asked about morale by Deborah Harris-Ugbomah, Clare Dollery said she was aware of some areas where this was affected, for example on Victoria Ward when the bed base had been expanded.
12.3	In answer to a question from David Holt about junior doctors taking time off in lieu, Clare Dollery explained that it was sometimes hard to strike an appropriate balance due to rotation. Naomi Fulop spoke about a report received by the Workforce Assurance Committee which gave more detail about conditions for doctors in training and the environment in which they worked; she had been pleased to note the positive feedback given by the doctors. It was noted that the annual changeover of junior doctors had taken place earlier in the week.
12.4	Clare Dollery briefed the Board on the Trust's planned implementation of recommendations set out in the British Medical Association's Fatigue & Facilities Charter. The Trust had been awarded the maximum level of funding, which had been ring-fenced and which was to be overseen by the postgraduate medical education team. The funding was to be spent on improving conditions for junior doctors working at night, and all proposals would be scrutinised and agreed by the junior doctors' forum and would need to be spent during the 2019/20 financial year.
12.5	**The Board noted the quarter one 2019/20 report from the Guardian of safer working hours and took assurance that junior doctors were working safe hours in accordance with the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.**

13.	**Quality & Safety Risk Register**
13.1	Michelle Johnson presented the Quality & Safety Risk Register. She alerted Board members to risk entries graded 16 or above. Four risks had been downgraded since the last report to the Board, and none escalated. Michelle Johnson invited Board colleagues to consider whether any risks not currently on the Board Assurance Framework (BAF) should be added.
13.2	David Holt felt that reference to the Board's 2019/20 risk appetite statement should be added to individual risk register entries, and Jonathan Gardner replied that, following discussion at a Board seminar, it had been agreed the team needed to work with the ICSUs on actions to be taken forward. The BAF was scheduled to be discussed at the October 2019 Board. Deborah Harris-Ugbomah suggested this be postponed until after the Audit & Risk Committee had met in late October so that that committee could provide appropriate assurances to the Board.
13.3	**The Board agreed:** **i. that none of the risk entries scored at 16 or more needed to be added to the BAF currently;** **ii. that 2019/20 Board Risk Appetite Statement scores be included for each corporate risk register entry; and** **iii. the Board Assurance Framework be reviewed at October's Audit and Risk Committee meeting prior to consideration by the Trust Board.**
14.	**Workforce Race & Disabilities Equality Standards Outcomes and Equality Delivery System progress**
14.1	Siobhan Harrington acknowledged that the report showed that the Trust had some distance to go in achieving its aims in this area, and urged Board members to consider how best to issue challenge and take the agenda forward. Kate Wilson explained that the report, which had to be published, came in three distinct parts: first, this year's workforce race equality standard (WRES) outcome; performance against the workforce disability equality standard (WDES); and, progress with the Equality Delivery System (EDS2).
14.2	Although the results were in some part disappointing, Kate Wilson felt they did illustrate the importance of high-quality data to inform and where necessary change future workforce plans. Helen Kent pointed out that there had been a notable improvement in some areas. She informed the Board that the data supporting indicators 1-4 and 9 had come from the electronic staff record (ESR) whilst 5-8 were taken from the NHS staff survey results.
14.3	Michelle Johnson drew attention to the part of the EDS2 covering patients, saying that the Trust was participating in a focused piece of work with patients and patient groups across the NHS North Central London sector, the results of which would be brought to the Board in due course.
14.4	Siobhan Harrington said that Whittington Health was by no means an outlier; results across London were generally below par, and she was pleased to inform the Board that it had been agreed to commit further investment over the coming months. She drew attention to the London report on tackling race inequality which

	set out clearly those areas requiring priority attention. Deborah Harris-Ugbomah reminded colleagues of unconscious bias in selection decisions.
14.5	Board members discussed some of the Trust's achievements over the past year, starting with the noteworthy improvement in the collection of data. There were three staff equality networks in place, and a very successful workshop had been led by Yvonne Coghill of the national WRES team. Siobhan Harrington emphasised that Trusts had been given aspirational goals to achieve over the next ten years and there was a need to allocate some time for discussion at a future Board seminar. She said it was hugely important to stress that whatever actions and positive changes were made were viewed as business as usual. Siobhan Harrington cited as an example of good practice the work carried out by John Brouder, formerly Chief Executive at North East London Foundation Trust (and now the WRES lead for NHS England and Improvement in London). Clare Dollery proposed that the invitation to John Brouder to come to speak to the executive team be extended to the wider Trust Management Group. Aisling Thompson said that good progress had been made within the Adult Community ICSU.
14.6	**The Board:** **i. agreed the submission of the WRES and WDES outcome data to NHS England;** **ii. noted the work to implement EDS2 and the continuing work with patients across the north central London sector; and** **iii. agreed that the invitation to John Brouder be extended to Trust Management Group members.**
15.	**Performance scorecard**
15.1	Aisling Thompson reported that, in June, emergency department (ED) performance reached 90.1%, with pressures continuing around mental health patients (including twelve hour trolley waits) and delayed transfers of care in Haringey. In terms of cancer targets, there was a dip in the 62 day performance particularly affecting those patients with more complex care pathways. Performance against referral to treatment targets was broadly on track. A significant amount of work had been carried out on theatre utilisation, with targets now being met. Aisling Thompson was also pleased to report there had been a decrease in falls. An overarching steering group had been established to look at grade 3 and 4 pressure ulcers. The Community Services Improvement Group had expressed a wish to see reports focusing on outcomes.
15.2	More work was still required to improve the Trust's compliance with appraisal and mandatory training. Kate Wilson was pleased to report, however, that that there had been a significant improvement in time taken to hire, which exceeded its target last month. She was confident this would continue to improve and reported that monitoring reports also showed clearly where delays were occurring in some cases. The Board discussed the number and range of targets contained within the report, stressing the importance of ensuring that commitments made would be deliverable. Naomi Fulop highlighted the importance of the work on serious pressure ulcers, which had such huge consequences for patients affected and raised the need for assurance that this was a key priority.

15.3	**The Board:** **i. noted the performance scorecard report and took assurance the Trust was managing performance compliance and is putting into place remedial actions for areas off plan; and** **ii. agreed a more detailed exception report be provided for the pressure ulcer key performance indicator at its September meeting which showed the actions being taken to improve performance.**
16.	**Emergency Department Performance Trajectory 2019/20**
16.1	Aisling Thompson reported that the ED improvement programme was divided into three areas: inflow, throughflow and outflow. She reminded Board members that the plan was discussed at June Board meeting and sight of the trajectory was sought in order to be able to measure how well the Trust was performing against it, as well as to understand any potential blockers are and what could be done to resolve them. Performance was benchmarked, and the Trust tended to come in among the top seven NHS providers in London. The main difficulties at present were mental health patients and delayed transfer of care, particularly in Haringey.
16.2	Siobhan Harrington reported that she chaired the local A&E Delivery Board, and it was clear the Trust aspired to achieving performance over 90% every week, but some problem always occurred which prevented this. At present, there was a slight challenge with the multi-agency aspect of care. Naomi Fulop commended staff for all that they had achieved despite the many pressures on the system. Siobhan Harrington added that some Trusts had begun to pilot a different method of recording ED performance.
16.3	**The Board noted the 2019/20 Emergency Department performance trajectory and the improvement plan in place.**
17.	**Financial report**
17.1	Stephen Bloomer informed the Board that the Trust had reported a deficit of £2.5m at the end of month three, £2.7m behind plan. Due to not having achieved the first quarter financial target, the Trust would not receive Provider & Sustainability Funding. The key drivers remained the failure to achieve the cost improvement programme (CIP) and overspend on pay. He confirmed that a number of measures had been put in place around staffing, and additional support was being provided to help both the Programme Management Office (PMO) and the Emergency & Integrated Medicine ICSU. In answer to a question from Deborah Harris-Ugbomah about whether the PMO was functioning well, Siobhan Harrington replied that the team was taking a detailed look-back at what had been successful and what less so. It was stressed however that the role of the PMO was to support the ICSUs in their delivery of CIPs not to carry out the actual delivery.
17.2	Jonathan Gardner asked for the minutes to record that a detailed discussion on finance had taken place at the private Board meeting immediately prior to the public Board meeting.
17.3	**The Board noted the financial results relating to performance during June 2019 and recognised the actions being put in place to improve income**

	delivery, reduce agency spend and improve the delivery of run rate and delivery of CIP plans.
18.	**National patient experience surveys**
18.1	Michelle Johnson reported that three national patient experience surveys had taken place over the past twelve months: maternity, in-patients, and cancer. Results from all three had now been received but this had taken some time. Two further surveys had also been completed - Emergency Department and Children and Young People's, and the 2019 Cancer survey was ongoing.
18.1	Drawing attention to the national inpatient patient survey 2018, Michelle Johnson was pleased to report that there had been some extremely positive results, with eight out of ten respondents reporting a very good experience of being an in-patient in hospital, and a number of areas having been rated better than the national average. There were, however, some areas where the Trust had performed less well, for example on ensuring patients had a restful night. The quality of food for in-patients was also criticised. She explained that an improvement plan would be taken to Patient Experience Committee and then to the Quality Committee.
18.2	There were also some very good results from the maternity survey, where 100% of patients reported they felt they had been treated with dignity and respect. Given the shortcomings of the environment this was felt to have been a particularly praiseworthy achievement. Results were also good from the cancer survey, although one important area needing improvement was access to timely advice and support on first diagnosis. As some patients were diagnosed in ED, when very poorly, it can make this hard to achieve.
18.3	Tony Rice and David Holt both expressed their congratulations to all the staff, saying this was a significant achievement given the pressures everyone was under, and felt the reports to be extremely motivating. Naomi Fulop suggested the results be triangulated with contacts with the Patient Advice and Liaison service and family, complaints received and patient Family and Friends Test outcomes for the next report.
18.4	**The Board noted:** **i. the outcomes from the maternity survey, inpatients survey and the national cancer patient experience survey which took place in 2018; and** **ii. that, once survey results were released, the Board would be apprised of the outcomes for the 2018 emergency department survey, the 2018 children and young people's survey 2018 and the 2019 national cancer patient experience survey 2019.**
19.	**Annual Compliments, Complaints and Patient Advice & Liaison Service (PALs) report**
19.1	Michelle Johnson spoke about the learning that came from good feedback, and commented that, during 2018/19, the Trust had received more compliments than complaints. She explained that the focus for 2019/20 was on improving the quality of complaints responses, with an emphasis that responding in a timely fashion should be business as usual. Michelle Johnson also informed Board

	members the Trust would be signing up to the 'Ask, Listen, Do' initiative led by NHS England which supported organisations to learn from the experiences of people with learning difficulties.
19.2	In answer to a question from Tony Rice about complaints made to GP practices, Sarah Humphery said that there were standards set by NHS England, however, they were not formally required to report clinical commissioning groups (CCGs). For complaints made by GPs about Trust services, Michelle Johnson clarified that these went through the same PALS processes as those received from patients, MPs and local Councillors. Clare Dollery asked whether, when complaints were upheld, any particular themes had been identified, and Michelle Johnson confirmed that communications tended to be a common theme, seen even during the investigation period. Deborah Harris-Ugbomah hoped that the cultural work on attitude and behaviour would help to address this.
19.3	Jonathan Gardner referred back to the conversation held at the previous Board meeting about the new non-emergency patient transport contract, and assured the Board that the progress of this would be closely tracked and monitored.
19.4	**The Trust Board:** **i. received and reviewed the 2018/19 Compliments, Complaints and Patient Advice & Liaison Service annual report; and** **ii. agreed that from September 2019 onwards, patient complaints would be tracked to identify any themes arising from changes to non-emergency patient transport services in north central London.**
20.	**Six monthly safe nursing and midwifery establishment review**
20.1	Michelle Johnson began her report by informing Board colleagues that her intention going forward was to review and report on all areas, rather than just in-patients. The data contained in the report was taken from the position in April, and Michelle Johnson assured the Board that all areas had been classified as safe, although there remained some challenges around temporary staffing.
20.2	Moving to section 7 of the report, Michelle Johnson informed the Board that although the re-modelling carried out in the Emergency & Integrated Medicine ICSU had been largely cost-neutral; one post was unfunded - that of a ward manager on Cavell ward whose role would be 60% clinical and 40% supervisory. She explained that ward managers could sometimes be managing up to 50 staff.
20.3	Michelle Johnson also provided assurance that the District Nursing service was rated safe in terms of staffing levels, however, there were challenges to support periods of annual leave. The paper had already been reviewed by the individual ICSUs, the Executive Team and Trust Management Group, and would also be considered by the Quality Committee.
20.4	**The Board:** **i. reviewed the six monthly safe nursing and midwifery establishment report and agreed that the appropriate level of detail and assessment had been undertaken to provide assurance that the clinical areas considered continued to be safely staffed;**

	and **ii. agreed the recommendation by the Chief Nurse to approve the skill mix and registered nurse reduction as presented in appendix 2 of the report.**
21.	**Medical Appraisal and Revalidation: Annual Board Report**
21.1	Clare Dollery explained that the report presented provided the Board with assurance on medical appraisal and revalidation for 2018/19, and also included the statutory submission to NHS England. Compliance overall was higher than for some other staff groups in the Trust, but was not yet at 100%, which was where she would like it to be. Feedback on appraisals had been good, and there had been no late revalidation recommendations.
21.2	Clare Dollery added that, any decline in compliance might be attributable to the fact that the Associate Medical Director for Revalidation had gone on a sabbatical late in 2018 and the post had remained vacant since then. She would be advertising this post in September which would help to ensure that the Trust had a robust process in place, and this would include the formation of an appraisers' network. David Holt thanked Clare for this extremely comprehensive report.
21.3	**The Board:** **i. received and agreed the report;** **ii. noted the Trust had submitted a separate Annual Organisational Audit to the higher-level Responsible Officer for NHS England, London Region;** **iii. noted the actions being taken to further strengthen the appraisal process for doctors, and the confidence of our stakeholders and public in this process; and** **iv. agreed the Chief Executive 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.**
22.	**Quarter one delivery of 2019/20 strategic objectives**
22.1	Jonathan Gardner reported that a high level dashboard of key metrics had been created in order to measure progress on the four agreed Trust strategic objectives. He thanked everyone who had contributed to this piece of work.
22.2	Jonathan Gardner acknowledged that there was a key gap around engagement with patients, relatives and carers. He explained that the section on integrating care with partners had been rated green due to the quantity of projects proceeding well. Transforming and developing financially sustainable services contained an element of amber rating due to progress on the estates and fast follower projects.
22.3	In discussion, the following points were made: • Deborah Harris-Ugbomah fed back that the report was very helpful, particularly the dashboard format reporting against key metrics • David Holt suggested that an end-year RAG rating be included in future

22.4	quarterly reports. Jonathan Gardner proposed including a RAG for each quarter and also one for the forecast year-end position • Siobhan Harrington commended Jonathan for his work in getting these objectives embedded throughout the organisation. Jonathan Gardner added that he had attended an extremely positive meeting earlier that day with pharmacy colleagues which had served to illustrate the degree to which they had been taken on board • Naomi Fulop also praised the quality of the report. **The Board:** **i. received and welcomed the helpful report and high-level metrics for the delivery of the Trust's strategic objectives; and** **ii. agreed that future reports included each quarter's RAG assessment including one for a year-end forecast**
23 23.1	**Questions from the public** Mr Richards asked who would be accountable for implementing the criteria for non-emergency patient transport arrangements in north central London from September. Stephen Bloomer provided assurance that national criteria would be followed and agreed to formally respond to Mr Richards on this point.
24. 24.1	**Any other business** There were no items reported.

Public Trust Board meeting, 31 July 2019, action log

Item	Action	Lead(s)	Progress
Patient story	1. Respond formally to patient Rodney about actions the Trust is taking.	Michelle Johnson	Completed
	2. Include Rodney on the Trust steering group	Michelle Johnson	Completed
Quarterly Quality and Patient Safety report	Add learning from incidents as an item on the 2019/20 Board seminar programme	Clare Dollery	Completed – included on 11 October Board seminar agenda
Quality and Safety risk register	1. Include 2019/20 Board Risk Appetite Statement scores for each corporate risk register entry	Michelle Johnson	This will be completed for the Board's review of the risk register at its October meeting
	2. Bring the Board Assurance Framework to the next meeting of the Audit and Risk Committee meeting and the Board afterwards	Jonathan Gardner	In hand for the October meeting of the Audit & Risk Committee
Integrated performance report	Provide a more detailed exception report for the pressure ulcer's key performance indicator at the September meeting which shows the actions being taken to improve performance	Carol Gillen	This report is completed and will be considered at the next meeting of the Quality Committee
2018/19 Compliments and complaints annual report	Track patient complaints from September for any themes arising from changes to non-emergency patient transport services in north central London	Michelle Johnson	Transport related feedback (compliments, complaints and PALS) are being picked up by complaints team and each one will be flagged to Chief Nurse and Director of Environment

Item	Action	Lead(s)	Progress
Q1 delivery of 2019/20 strategic objectives	For the next quarterly report include each quarter's RAG outcome, including a year-end forecast	Jonathan Gardner	In hand for the Q2 report at October's Board meeting
Questions from the public	Respond formally to Mr Richards to answer the query as to who will be responsible (Whittington Health, Royal Free or DHL) from September for enforcing the criteria to be applied to requests	Stephen Bloomer	Completed

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
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 provides Board members with updates on 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

DHSC Ministerial changes

1.1 Following the cabinet changes after the appointment of Boris Johnson as Prime Minister, Matt Hancock remained as Secretary of State for Health and Social Care, remained in post and Caroline Dineage and Baronness Blackwood also continued in the Department of Health and Social Care's (DHSC) Ministerial team. They have been joined by the following MPS: Chris Skidmore, Jo Churchill and Nadine Dorries.

Hospital food review

1.2 On 23 August, the government has announced a review of hospital food, working with the NHS to set new quality standards for the 140 million meals served annually to make them safer, healthier and more sustainable. Philip Shelley, former head of the Hospital Caterers Association will chair the "root and branch" review, restaurateur and celebrity chef, Prue Leith, will act as an adviser.

Brexit

1.3 The Trust already has robust plans for a no-deal departure from the European Union focused on working with the national team to ensure essential supplies of drugs and consumables remains and these plans will be reviewed to ensure they are as good as they can be.

NHS Outcomes Framework

1.4 The NHS Oversight Framework for 2019/20 has replaced the provider Single Oversight Framework for NHS providers and the clinical commissioning group (CCG) Improvement and Assessment Framework, and will inform assessment of providers in 2019/20.It is intended as a focal point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and sustainability and transformation partnerships, and integrated care systems.

2. Local news

Care Quality Commission

2.1 The Trust has received a provider information request from the Care Quality Commission in advance of its inspection of Trust services. This inspection will provide an opportunity for Whittington Health's staff to describe what they are proud of and where they are making improvements.

Quality and safety operational performance

2.2 During August, overall performance against the 95% four hour standard was 82.8%. The number of Emergency Department (ED) attendances dropped by 7.7% compared to the previous month, to 8,778. By comparison, in August

2018, ED attendances were 8,164 with a 90.0% performance achieved against the standard. A deep dive review of ED performance during the period 1 July to 31 August has taken place and is presented as a separate appendix to the Board's performance scorecard report on this agenda.

2.3 The trust held a 'Perfect Week' on 19-23 August, which aimed to close unfunded additional beds, put us in a good position going into the bank holiday and establish a sustainable process owned by Ward Managers. Over the week, there was steady progress on discharges and a reduction in the number of patients with a length of stay of over 7 days and over 21 days. However, more progress was needed on delayed transfers of care. ED performance also improved overall by the end of the week. As a result of what we learned during the week, a new Whittington weekly patient flow pattern is being established.

2.4 There were 10 mental health patient 12 hour trolley breaches in the emergency department in August and the Trust continues to work with partners in North Central London to improve pathways for patients with mental health care needs.

Reducing length of stay

2.5 Evidence shows that it is much better for a patient's physical and mental wellbeing to leave hospital as soon as they are medically optimised for discharge. This helps them avoid some of the risks associated with longer hospital stays, such as infections and the loss of independence and mobility. To help support patients to leave hospital as soon as possible, the Emergency and Integrated Medicine Integrated Clinical Service Unit is rolling out the 'Where Best Next?' campaign, focussed on patients leaving hospital for a more suitable location, such as their own home or another care location best suited to their needs, as soon as they are medically optimised for discharge.

Flu vaccination campaign

2.6 The Trust has started to plan its 2019/20 flu vaccination campaign to keep patients and staff well over the winter months. The importance of flu vaccination cannot be underestimated and the campaign will include all staff with the aims of decreasing sickness absence related to flu, reducing the risks of cross-infection and having a positive impact on the delivery of high quality care. Last year the Trust vaccinated 83% of its frontline staff and the aim is to exceed that as part of preparations for this winter.

Financial performance

2.7 At the end of August, the Trust is reporting a year to date deficit of £3.6m (£2.4m after adjusting for the impact of not achieving any Provider and Sustainability Funding), which although £3.7m behind plan, is in line with the recovery plan trajectory. The main reason for the adverse variance is the delivery of less cost improvement programme schemes than expected. However, the Trust forecasts that it will achieve its control total at the end of this financial year.

2.8 Year-to-date pay costs are in excess of budget by £2m. Bank staffing expenditure was less than in the previous month at £1.98m. Agency staffing costs of £0.7m were below the agency cap for the second consecutive month. The combined expenditure on temporary staffing for the year to date was £2.67m compared with £2.77m at this time last year. At month five, the Trust had spent £5.3m on capital expenditure, £0.5m below plan.

Our people

Senior staff changes

2.9 From 9 September, Stephen Bloomer, Chief Finance Officer, has been seconded for one year from Whittington Health to the role of Chief Finance Officer at North West London Sustainability & Transformation Partnership. During the secondment period, Kevin Curnow, previously Operational Director of Finance, will become the Acting Finance Director. In addition, Adrien Cooper, Director of Environment, and Leon Douglas, Chief Information Officer, will report to the Chief Executive.

2.10 Michelle Johnson's new title has been changed to Chief Nurse and Director of Allied Health Professionals (AHPs). This will reflect executive responsibility at the Board for the second largest group of clinical staff and come from a large number of health care professions e.g. physiotherapists, occupational therapists and speech and language therapists amongst others.

Staff focus September

2.11 During each week this month, there has been a range of activities taking place which looked at the importance of supporting each other, celebrating achievements, include talking more. The Trust also launched a new behaviour framework, promoted opportunities for staff to receive free management and leadership qualifications and promoted the ways that diversity is supported and encouraged across the organisation. In addition, lots of opportunities were provided for staff to improve their health and wellbeing including being able to book free eye tests, having access to mental health first aid and new support for colleagues going through the menopause.

2.12 In comparison with July's outcomes, during August, completed staff appraisals rose to 72.7%, however, compliance with mandatory training requirements reduced slightly to 80.8%. The Trust has in place plans to recover performance for both of these important indicators in line with their targets. Staff turnover continued to fall for the third consecutive month and was 10.7% at the end of August.

Organisational culture and development

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

- the new Trust programme on challenging bullying and harassment training has been extended to include senior medical staff and members of the Executive team
- a talent management pilot is in progress, using a 'nine-box grid' tool on which behaviour and performance (from appraisal data) is plotted against five

indicators of 'potential' (such as ability to thrive in ambiguity, ambition, level of self-awareness) to identify direction of exposure to different experiences and development

- reverse mentoring - evaluation work has been carried out with mentors and will be extended to include the senior mentees; anecdotal feedback indicated it would be beneficial to proceed to the second cohort
- Charles Rukwengye, the new organisational lead for equality, diversity and inclusion toured community sites to introduce himself and listen to staff experiences
- Affina project - teams are working through the journey and new teams have joined the original 18; one Affina coach has been accredited and others are working towards accreditation
- Diagnostics provided by the Culture Collaborative were implemented during Staff Focus September such as the culture focus groups and targeted interviews. The second part of the programme has been designed and will include:
  - Liberating Structures - engaging people in shaping their own future
  - Behavioural profiling - understanding oneself and others in the workplace
  - Appreciative Inquiry - what is working well now that we can do more of?
  - Tailored Human Factors training - optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment

Imaging department open evening

2.14 Whittington Health recently invested over £4m in Imaging Equipment upgrades and works which were showcased through an open evening held on 6 September, with tours of the department.

Whittington Health environment

2.15 The following updates are available:

- Work to strip the inside of the derelict Waterlow Building has been taking place over recent months and demolition is expected to start shortly. This is to clear space for the new education centre.
- The standardised contract for non-emergency patient transport across the north central London sector went live in early September with Whittington Health going live on Monday, 9 September. Transition over to the new provider DHL went well and they are now providing services trust wide.
- The patient dining contract currently provided by Sodexo will be coming in house on 30 September and plans are well underway to for the transfer of this service. By moving this service in house, the Trust will have far greater control over the service provided to our patients
- Construction works have been completed for the new Cearns Operating Theatre and the new maternity recovery area; work to refurbish the post-natal ward is expected to be complete later this year

Bright Start Islington reaccreditation

2.16 This initiative is our name for services in Islington for families with children under five which have been reaccredited at the highest level, an excellent achievement. The United Nation's International Children's Emergency Fund

(UNICEF) commented in their re-assessment report that "The staff at Bright Start Islington are commended for their hard work in continuing to support mothers. It was clear to the assessor that, in most areas, pregnant women and new mothers received a high standard of care. Mothers spoke highly of the support they received in the breastfeeding support groups".

Junior doctor wins gold in Tokyo

2.17 Congratulations go to Dr Kim Daybell, foundation doctor at Whittington Hospital, who is a Paralympic table tennis player. He has just returned from the Japan Open where he won a gold medal and the Thailand Open where he won a silver medal. He is hoping to qualify for the 2020 summer Paralympic games in Tokyo.

Internships for people with autism/learning difficulties

2.18 Whittington Health is working in partnership with Ambitious College and Springboard to offer job rotations for young people with autism/learning difficulties. This initiative provides a great opportunity for people with learning difficulties to have work experience at the Trust and the ability to identify permanent roles, particular as apprentices within either Whittington Health or the wider NHS.

Staff awards 2019

2.19 On 12 September, the Trust held its annual staff awards at the Royal College of Physicians. It was a fantastic and very well-attended event with so many staff from different parts of the organisation represented. There was a particularly special moment when Whittington Health's Front of House Porter, JJ McConnell, who is retiring at the end of this month after many years' service, received the Chair's Award and a standing ovation from everyone in the room.

2.20 The judges had a very tough time shortlisting and choosing winners from 450 nominations for staff right across the trust. From a very competitive field, the winners were:

Category	Winner
Chair's Award	JJ McConnell, Front of House Porter
Bank Staff Member of the Year, Sponsored by Bank Partners	Blondell Taylor, Medical Secretary
Non-Clinical Team of the Year Award	The Whittington Education Centre team
Clinical Team of the Year Award	The Community Nutrition and Dietetics team
The Caring for Those who Care Award	Heidi Edmundson, Emergency Department Consultant
The Improving Patient Experience Award	Paula Almeida, Community Nurse
Person of the Year in a Clinical Role Award	Nicole Callender, Matron
Person of the Year in a Non-Clinical Role Award	Petra Prazakova, Medical Education Co-ordinator
Paula Mattin – Emerging Leader Award	Michelle Scully, Acting General Manager,

Category	Winner
	Emergency Department
Improving Patient Safety Award	Ku Shah, Consultant
Research and Innovation Award	Julie Andrews, Consultant & Associate Medical Director
Unsung Hero Award	Duncan Riley, Team Manager, Simmons House Adolescent Unit
Volunteer of the Year	Ivy Steggles
Patient Choice Award	The Neonatal Intensive Care Unit team

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	**Serious Incidents update**	**Agenda item: 7**
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 July and August 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: September 2019 Board report

1. Introduction

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

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 NHS England Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared four Serious Incidents in July and four in August 2019. One of which was declared as a Never Event. This brings the total number of reportable serious incidents to fifteen since 1st April 2019 (see section 4.4).

Table 1: Serious Incidents declared since the last report

Category	Month declared	Summary
Delayed Diagnosis Ref:18666	Aug 19	There was a significant delay in establishing the diagnosis of ovarian torsion, which may have contributed to loss of an ovary.
Medical Device Incident – Never Event Ref:18525	Aug 19	Unintentional connection of a patient requiring oxygen to an air flowmeter. This is a Never Event.
Screening Ref:16966	Aug 19	A patient was twice incorrectly referred by the GP for an endoscopy and not to the liver clinic. The patient had an endoscopy that was not required in November 2018.
Screening Ref:16953	Aug 19	A patient was referred via Choose and book into an upper GI slot but had suspected Liver cancer. They were booked for an endoscopy in error. The patient attended for an endoscopy that was not required in November 2018.
Still Birth Ref:16211	July 19	Intrauterine death at 37+6/40. A woman attended triage with reduced fetal movements and an Intrauterine death was confirmed by scan.

Category	Month declared	Summary
Screening Ref:15565	July 19	A patient was booked incorrectly for a gastroscopy by their GP, but was being initially referred for a colonoscopy.
Screening Ref:15570	July 19	A pregnant woman underwent screening for sickle cell and thalassemia and was identified to have a genetic condition and referred for screening and counselling. Both parents attended an appointment for blood tests. The Woman for ferritin levels and partner for screening for the genetic condition during which the vials were inadvertently mislabelled. (Woman's label placed on both vials).
Delayed Diagnosis -Return to Theatre Ref:14937	July 19	A patient was admitted for an elective procedure, due to deterioration the patient was returned to theatre for abdominal surgery. It was later identified that the patient had developed blindness.

4. Never Events

4.1. 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."

4.2. 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).

4.3. The Trust has declared four Never Events this financial year all of which are under investigation. Immediate actions have been taken to prevent repetition.

4.4 Declared Never Event - Unintentional connection of a patient requiring oxygen to an air flowmeter.

This Never Event was identified following discontinued of resuscitation of an elderly patient who had an out of hospital cardiac arrest – it was found that the water circuit being used to provide positive pressure ventilation was connected to the medical air wall outlet rather than oxygen.

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

- The Patient Safety Alert issued by NHS Improvement in October 2016 'Reducing the risk of oxygen tubing being connected to air flowmeters' (NHS/PSA/D/2016/009) was reviewed.
- The medical air ports in the department were reviewed to ensure compliance with Patient Safety Alert. Six were identified without a labelled flap and were sent to the Medical Physics for replacement. As part of the improvement work

following the alert, air flowmeters in the department were fitted with a labelled, movable flap to mitigate the risk of error.

- All medical air ports not in current use, were removed from the wall and placed in a drawer in the clinical space, in line with the patient safety guidance.
- Staff in the department were all made aware of the incident and the safety actions required. An alert has gone out to all hospital areas to review their air outlets and flaps on the air taps. A systematic review of the need for air outlets will be carried out across the Trust.
- The incident was declared as a Never Event.

Learning from Never Event Investigations

A patient received a paravertebral analgesic nerve block on the unintended side in May 2019.

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

- Local adoption (LocSSIP) of National Safety Standards for Invasive Procedures. This must include the organisational elements of the theatre booking process, staffing and handover; and the sequential elements of written consent for all invasive procedures, marking of all cases with laterality and appropriate safety checks including Stop Before You Block for both stand-alone nerve blocks as well as those associated with surgery. Further training sessions have been arranged for multi-disciplinary anaesthetic team around Stop Before You Block.
- Ensure the paravertebral block guidelines are current and widely accessible to relevant staff. Guidelines are currently being reviewed and refresher teaching sessions for Anaesthetists, Pain Nurses, operating department practitioners (ODPs) and Recovery staff will be arranged on completion to increase familiarity with procedure and infusion with the updated guidelines.

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).
Assault on staff Ref:8646	April 19	A mental health patient became agitated and proceeded to randomly attack staff in the ED department.

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

SI 2019-20 Category	2016/17 Total	2017/18 Total	2018/19 Total		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Total 19/20 YTD
Safeguarding	5	1	1		0	0	0	0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI	1	0	0		0	0	0	0	0	0

Confidential information leak/information governance breach	6	3	4		0	0	0	0	0	0
SI 2019-20 Category	**2016/ 17 Total**	**2017/ 18 Total**	**2018/ 19 Total**		**Apr 19**	**May 19**	**Jun 19**	**Jul 19**	**Aug 19**	**Total 19/20 YTD**
Diagnostic Incident including delay	8	7	7		1	0	0	1	1	3
Disruptive/ aggressive/violent behaviour	0	1	1		1	0	0	0	0	1
Environment Incident meeting SI criteria	0	1	0		0	0	0	0	0	0
Failure to source a tier 4 bed for a child	1	0	0		0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0	0		0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	3	0		0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus	7	2	8		0	0	0	1	1	2
Maternity/Obstetric incident mother only	2	1	0		0	0	0	0	0	0
Medical equipment/devices/ disposables incident meeting SI	1	0	0		0	0	0	0	1	1
Medication Incident	0	1	1		0	0	0	0	0	0
Nasogastric tube	1	0	0		0	0	0	0	0	0
Pressure ulcer meeting SI criteria	0	0	1		2	0	0	0	0	2
Screening Incident meeting SI criteria	0	0	0		0	0	0	2	1	3
Slip/Trips/Falls	7	6	2		0	0	0	0	0	0
Sub Optimal Care	4	2	1		0	0	0	0	0	0
Surgical/invasive procedure incident meeting SI criteria	0	0	2		0	1	2	0	0	3
Treatment Delay	3	4	2		0	0	0	0	0	0
Unexpected death	10	4	2		0	0	0	0	0	0
Retained foreign object	1	1	0		0	0	0	0	0	0
HCAI\Infection Control Incident	0	1	0		0	0	0	0	0	0
Total	**58**	**38**	**32**		**4**	**1**	**2**	**4**	**4**	**15**

5. Submission of Serious Incident reports

5.1 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. The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm. On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

5.2 The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in July and August 2019.

5.4 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.

6. Shared learning from reports submitted to NELCSU during July and August 2019.

6.1 A community patient developed two grade three pressure ulcers which became infected resulting in the patient having to be admitted to hospital for further treatment.

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

- Community sepsis training has been prioritised for district nurses and tissue viability nurses and a system is now in place to ensure regular updates and refresher training is undertaken. In addition the Sepsis eLearning module has been added to each district nurse staff member's profile.
- Co-creating care is being prioritised for frontline staff, and it is expected that the majority would have attended the advanced development programme by June 2020.
- Community and hospital teams to work together with the IT department to look for technical solutions to sharing information across systems.
- All patients who need a full assessment to be seen within 48 hours (priority 1). All Priority 1 patients will be discussed at teleconference and escalated to the Team manager / Lead Nurse to increase senior oversight of the patients at risk of pressure ulcers. This is now being implemented by the On Duty Triage Manager.
- The report and findings has been shared with the Tottenham Hale Renal Dialysis Centre, ICSU Executive team, the District Nursing service and the Acute Community Health Services (ACS) Clinical Leads Meeting where an action plan for further dissemination was agreed.

6.2 A community patient developed multiple pressure ulcers and sepsis resulting in patient having to be admitted to hospital.

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

- All staff in this team to attend the Tissue Viability study day. Pressure ulcer training is being provided by the tissue viability nurse three times a year which includes pressure ulcer identification and management.
- Teaching session for staff on how and when to escalate concerns to senior staff, including reporting on DATIX. Discussions regarding escalation were held with staff at the Team meeting and the DN forum.
- All messages received by the District Nursing Messaging Service to be recorded on RiO and E-Community and will include the name of the person taking the message and what action was taken.
- To work with London Ambulance Service (LAS) to create a protocol on transferring patients at home.

6.3 A patient who had recurrent breast cancer after two breast conserving operations and radiotherapy treatments was offered and agreed to an alternative surgical approach, which had not been recommended by the Multi-Disciplinary Team (MDT).

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

- The process for divergence from the Breast MDT recommendations for a patient's pathway is to be written in the MDT Terms of Reference/ standard operating procedure (SOP). This should include a second opinion to be sought externally.
- The management of a haematoma/seromas for patients needing post-operative adjuvant treatment is to be included in the Breast MDT SOP.

6.4 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.

6.5 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.

6.6 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.

7. Learning from a maternal death and prevention of future deaths notice

7.1 HSIB investigation into a maternal death at Whittington Hospital in February 2019.

- 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.
- A uterine rupture in mid-pregnancy in an unscarred uterus is an extremely rare pregnancy complication. The event led to catastrophic internal bleeding that is associated with a significant mortality rate.
- The findings of the HSIB investigation were that all appropriate care was provided and no safety recommendations were made as part of the report findings.

7.2 However, during the inquest the coroner highlighted the potential for better practice around the communication process between the London Ambulance Service (LAS) and the Trust and issued a Prevention of Future Death (PFD) Order. In response to this PFD report the Trust has worked with LAS and put in place the following actions as a result:

- The Trust has modified the Emergency Department 'Priority call information sheet' which is used when recording call details received from London Ambulance Service red phone. The sheet now includes a prompt for Whittington Health staff to ask if the patient is pregnant, where relevant. This new sheet replaced the original form in the Emergency Department in August 2019.
- A set of criteria has been developed to determine if an obstetric call needs to be initiated prior to patient arrival. The Trust already has a process in place for trauma calls, which has now been expanded to cover obstetric callout criteria. In agreeing the criteria, advice was sought from Emergency Department colleagues in other trusts to see if similar systems were already

in place and the final criteria were agreed jointly with our obstetrics and emergency teams. The new criterion has been launched in the Emergency Department.

- The Trust is arranging a simulation exercise with London Ambulance Service to prepare staff on how to receive a critically unwell obstetric patient. The details of this are being planned but we aim to run the drill in September. This will build on lessons from sessions London Ambulance service has run with other acute Trusts. Following the first simulation, a programme will be established for future drills to ensure continuous ongoing shared learning.
- Further work is being undertaken across the Trust in order to standardise handover between clinicians by using the "SBAR" format (Situation, Background, Assessment, Recommendation). This is included in the new junior doctor's induction to the Emergency Department and is being designed into the electronic clinical notes that are used to hand over a patient at any point from presentation to discharge.

8. Recommendation

8.1 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: 25.9.2019**
Report title	2018/19 Infection Prevention & Control annual report	**Agenda item: 8**
Executive director lead	Michelle Johnson, Chief Nurse, Director of Patient Experience and Director of Infection Prevention and Control (DIPC)	
Report author	Julie Singleton Infection and Prevention Control Lead Nurse	
Executive summary	The Trust has maintained robust governance monitoring of infection prevention and control and has worked closely with clinical teams and Public Health England to maintain safe standards around infection risks and prevention. The following information provides the Board with the number of healthcare acquired infections reported over 2018-19. Where there are Nationally or local commissioner targets this is referenced • There was one case of Trust-attributed MRSA bacteraemia during 2018/19 (Q1) • There were 13 cases of Trust-attributed Clostridium Difficile Infection (CDI) with a target of 16 (the reporting for CDI objectives for 2019/20 are slightly different and therefore the target has been set for 19 cases). • There have been eight Trust-attributed MSSA bacteraemia. There are no set national or local thresholds for MSSA bacteraemia. There have been eight Trust-attributed Escheria Coli (E.coli) bacteraemia and the Trust is on target for a 20% reduction in healthcare-associated E.coli bacteraemia in 2019-20 in line with the national objective (halving healthcare-associated Gram-negative BSIs by 2021). The Trust undertakes regular nationally reported audits of surgical site infections in four orthopaedic categories. There were no infections reported. Area of focus in 19-20 was the staff exposure contacts of patients who have infectious diseases e.g. TB and measles this has required significant development and involvement of the Trust DIPC. Please to report that this position has improved, will be closely monitored in 2019-20. The total of positive specimens for 2018-19 flu season was 246 with 3 non-Trust related deaths. Previously reported to the Board, the Trust staff flu campagna successfully vaccinated over 83% of the workforce.	

	Mandatory training at the end of 2018/19 was 80% and the Trust focus on improving this rate is underway with Integrated Clinical Support Units (ICSU) with clear improvement trajectories.
Purpose:	This paper is to provide the Board with a summary of cases of Healthcare associated infections (HCAI), alert organisms, infection related incidences and the yearly surgical site infection data.
Recommendation(s)	Board members are asked to: i. review the summary of the results provided; and ii. approve the actions developed in the 2019/20 work plan to maintain safe IPC practice as well as for continuous improvement.
Risk Register or Board Assurance Framework	Board Assurance Framework risk entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation
Report history	Quality Committee, July 2019
Appendices	None

1. INTRODUCTION

1.1. Whittington Health NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections and related guidance.

1.2. **DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS**

Director of Infection Prevention and Control (DIPC) and Executive lead for IPC - Chief Nurse, Michelle Johnson
Consultant microbiologists – Dr Julie Andrews, Dr Michael Kelsey and Dr Trupti Patel
Lead Nurse for Infection Prevention and Control – Julie Singleton
Antimicrobial stewardship – Ai Nee Lim Pharmacist
Sepsis Programme – CNS and pharmacist support

1.3 Each of the Trust's Integrated Clinical Service Units (ICSU) has responsibility to drive local planning and implementation of IPC actions.

1.4 The Infection Prevention and Control Committee (IPCC) meets quarterly and reports to the Patient Safety Committee and then to the Trust Quality Committee.

1.5 Antimicrobial stewardship and Sepsis is monitored through the infection prevention and control committee and is considered an essential part of normal trust business with additional focus around the Commissioning for Quality and Innovation (CQUIN) framework.

1.6 IPC advice and On-call service. Continuous advice service provided by IPC Team / Consultant Microbiologists (

1.7 Outbreak Reports, Serious incidents and investigations **-** Contemporaneous outbreak reports are written by the IPCT and fed back to clinicians and managers and disseminated through the IPC Committee.

2. HEALTHCARE ASSOCIATED INFECTION MANDATORY REPORTING SUMMARY

2.1. Whittington Health has been compliant over 2018-19 with its reporting arrangements to Public Health England (PHE) and the Clinical Commissioning Group (Islington CCG) on Health care associated infections.

2.2. The Trust is required to report on cases that are '*defined epidemiologically as being most likely ben acquired in hospital. Currently, for MRSA, MSSA and E.coli blood stream infection, Trust cases are those that are identified after two days of hospitalisation: for Clostridium difficile infection (CDI), Trust cases are those that are identified after three days of hospitalisation.* Changes will come into effect to the CDI reporting algorithm, for financial year 2019/20. The following table numbers the reported infections over the reporting period.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD	Ceiling
Trust MRSA BSI	0	0	1	0	0	0	0	0	0	0	0	0	1	0
Non-Trust MRSA BSI	0	0	0	2	0	0	0	1	0	0	0	1	4	
Trust C.difficile	1	2	0	0	2	2	1	1	3	1	0	0	13	16
Non-Trust C.difficile	1	0	2	4	0	3	2	1	0	2	0	2	17	
Trust E.Coli BSI	1	1	1	0	1	1	0	1	1	0	1	0	8	..
Non-Trust E.Coli BSI	8	7	16	6	13	9	14	9	12	13	9	11	94	
Trust MSSA BSI	2	0	0	0	2	1	0	2	0	0	1	0	8	..
Non-Trust MSSA BSI	1	0	2	4	1	0	3	3	8	2	0	4	22	
Trust Pseudomonas aer.	0	0	0	0	0	0	0	0	0	0	1	0	0	
Non-Trust Pseudomonas	1	2	1	1	1	2	2	0	1	0	0	1	11	
Trust Klebsiella	2	0	1	0	1	2	0	0	0	0	1	0	6	
Non-Trust Klebsiella	2	4	3	5	0	3	1	1	4	0	5	3	23	

Table one: **Summary of Public Health England's HCAI mandatory reporting, showing the number of cases by month**

3. SURGICAL SITE INFECTION SURVEILLANCE SCHEME (SSISS)

3.1. Whittington Health participates in the SSISS reporting directly into the PHE SSI surveillance database. Mandatory reporting is for 'at least 1 orthopaedic category for 1 period (quarter) in the financial year'. Whittington Health opted to report two quarters for 2018/19 in four orthopaedic categories.

Surgical Site Surveillance	Q1		Q2	
	Surgical site infection	Number of Operations	Surgical site infection	Number of Operations
Hip replacement	0	37	0	48
Knee replacement	0	40	0	47
Fractured neck of femur	0	20	0	8
Large bowel	0	20		

Table 6 **Whittington Health SSI by quarter – audit of cases**

4. COMMUNICABLE DISEASES

4.1 **Measles and Mumps** There were on-going outbreaks of Measles across Haringey and Islington over the reporting period therefore information and communications (banners and posters) were designed for raising awareness within the hospital and community sites supporting staff and visiting public

awareness. Further communications educating staff on their responsibilities and how to recognise measles was disseminated via the Trusts' April 18 Noticeboard as well as a clinical alert notification to affected clinical areas where these cases were recognised.

4.2 2018-19 reported number of cases at Whittington Health for both Measles and Mumps are not unusual against the heightened activity seen in the rest of London.

5. INFLUENZA

5.1 Over the 2018-19 winter period investigations were undertaken into the care of any patients who died of influenza whilst an inpatient in the hospital. There were three deaths where influenza was part 1a of the death certificate; however, none were acquired in hospital. Therefore there were zero serious incidents declared of any deaths of patients with influenza acquired during a hospital admission. For 2017-18 there were three cases.

5.2 The total of positive specimens for 2018-19 flu season was 246 primarily being influenza type A with 242 cases. 39 cases were noted as being acquired in the hospital and although it has not been determined how, none of these were associated with a previously positive case.

5.3 On the 21st March 2019, the stepping down of routine testing was initiated throughout the Trust. The last positive case was seen on the 29th April 2019.

6. TUBERCULOSIS (TB)

6.1 At the end of 2018-19, one active TB case was being investigated in collaboration with the clinical areas (Emergency Department, Day Treatment Centre, and Clinical Decision Unit, Mercers ward, Mary Seacole South and Montuschi ward), Occupational Health, Infection Prevention, Microbiology and the TB service.

This was a complex investigation as the NCL TB Network Screening Lead had reported a significant history over the previous six months including dry cough, night sweats and weight loss, from a patient known to Whittington Health who collapsed during an emergency outpatient's appointment.

6.2 The investigation remains on the agenda of PHE colleagues, NCL TB Network and Whittington Health as necessary learning for improving future investigations is essential. A robust screening programme for exposed staff is necessary.

6.3 There have been further investigations, where 'Inform and advice' letters were sent to all contacts identified with low risk of infection. Few patients have been identified requiring follow up.

7. INFECTION PREVENTION AND CONTROL TRAINING

7.1 Mandatory Training Compliance by team on 30/04/2019 was 80%.

7.2 Increased efforts have been made to improve compliance on IPC mandatory training with some new initiatives e.g. 'Mandatory May' sessions in the hospital clinical areas weekly through May 18. Other training will continue in this way with a monthly focus held frequently across the trust.

7.3 There is an IPC Link Practitioner for each clinical service and study days are held twice a year to support their learning as well as the cascade of IPC information to point of care staff across the Trust.

8. INFECTION PREVENTION AND CONTROL WORK PRIORITIES AND PLAN 2019/20

8.1. This year IPC have undergone many changes within the executive lead and team structure. There has been staff changes and the introduction of new roles e.g. IPC data information lead. This has meant that a renewed focus on the work of the IPC team has taken place and this report will continue to improve and reflect the new ways of working.

8.2. The key areas for 2019/20 are summarised below:

- Improving hand hygiene awareness within the Trust. Proposed is a hand hygiene programme which will be a tailored plan of activity following a baseline assessment of hospital and community needs. This will include working in partnership with North London Partners IPC leads to build an annual activity training plan; interactive training sessions; quarterly campaigns; a Hand Hygiene message fresh across the Trusts.

- Perfecting environmental IPC auditing. A revised reporting tool is in development and will be implemented in 2019/20 to support the clinical areas towards maintaining a safe and clean place for patients and staff to work.

    - Revision to the reporting methodology as most of it is manual inputting of data, improvement and implementation of electronic platform that enable the upload quality indicators such as hand hygiene compliance immediately with the advantage of having usable data at the fingertips.

    - Setting up semi-automated surveillance and HCAI Digital Capturing System submission system with an enriched process where the data is monitored and analysed with trends quickly identified, real time results given, human error reduced, not to mention precious time saved.

9. RECOMMENDATIONS FOR THE TRUST BOARD

9.1 Board members are asked to

i. review the summary of the results provided; and
ii. approve the actions developed in the 2019/20 work plan to maintain safe IPC practice as well as for continuous improvement.

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	**Freedom To Speak Up Guardian Report (March 2019 - August 2019)**	**Agenda item: 9**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Allied Health Professionals	
Report author	Ruben Ferreira, Freedom to Speak Up Guardian	
Executive summary	The report provides information about Freedom to Speak Up across Whittington Health with information covering the period March 2019 to August 2019. It highlights: • a brief overview of the work of the Freedom To Speak Up Guardian (FTSUG) from March 2019 to August 2019 • learning from the National Guardian Quarter 4 (2019) data • an update on the implementation of the Speak Up Advocates role	
Purpose:	Noting	
Recommendation(s)	The Trust Board is asked to: i. support the recruitment of Speak Up Advocates and acknowledging the importance of providing protected time (within job roles) for the Advocates to support their colleagues; ii. encourage and promote with managers and senior leaders to engage with Freedom to Speak Up; and iii. note the implementation of Freedom to Speak Up training to all members of staff.	
Risk Register or Board Assurance Framework	BAF entry 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	Trust Board March 2019	
Appendices	1: National guidelines on Freedom to Speak Up training in the Health Sector in England: https://www.cqc.org.uk/sites/default/files/20190812%20-%20National%20guidelines%20on%20Freedom%20to%20Speak%20Up%20training%20in%20the%20health%20sector%20in%20England.pdf 2: Guidance for NHS trust and NHS foundation trust boards on Freedom to Speak Up: https://improvement.nhs.uk/documents/2468/FTSU_guidance.pdf	

1. INTRODUCTION

1.1. The role of the Freedom to Speak Up Guardian was created as a result of recommendations from Sir Robert Francis' Freedom to Speak Up review, published in February 2015. Freedom to Speak Up Guardians (FTSUG) are expected to work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

2. BRIEF OVERVIEW – WHITTINGTON HEALTH FREEDOM TO SPEAK UP GUARDIAN

2.1 A key priority for the Guardian has been to extensively engage with teams and services across Community and Hospital departments. The Guardian has connected with several community services, including:

- Haringey Improving Access to Psychological Therapies (IAPT)
- Podiatry
- Smoking Cessation
- District Nursing
- Nutrition and Dietetics
- Musculoskeletal physiotherapy
- Health Visiting services
- Tissue viability
- Islington Community Therapy

2.2 Across the hospital and trust corporate areas the Guardian has met with teams within clinical areas and across Housekeeping, eProcurement, Clinical Coding, Information Management and Decontamination. The FTSUG informally visits different services at the Hospital as well.

2.3 Communication and visibility are two key points for the success of engaging with staff who may wish to raise concerns. The FTSUG has continued to distribute and promote leaflets and posters explaining how to raise concerns in a safe and confidential way. With the collaboration of the Practice Development Nurses in the Hospital, the Guardian is reaching more clinical and operational staff.

2.3 As reported in the last six month report the Guardian has developed and trained a network of Speak Up Advocates. There are nineteen Advocates, across all groups of staff and across different services across the trust. They have received formal training and supervision to actively listen to colleagues raising concerns. They support, encourage and promote the Speak Up voice across the Trust and support and sign post staff when required.

2.4 The role of the Freedom to Speak Up Guardian includes support to staff and managers to de-escalate conflict within a team or between two staff members and over this last period there are have a number of facilitated conversations which have resolved the issue with staff able to successfully move forward with an improved relationship between them. The Guardian will also refer cases as required for formal medication if required. This is demonstrating a pattern of

staff taking an alternative route to resolution than taking a more formal grievance or disciplinary path.

2.5 The Trust has now introduced an introduction to the Freedom to speak up roles to all new starters at the Trust Induction. This includes an explanation of the role and also information on ways to contact them.

3. NATIONAL GUIDANCE

3.1. In August 2019 the National Guardian Office formulated national guidelines on Freedom to Speak Up training in the health sector in England. They are working to support cultural change in the NHS so that speaking up becomes business as usual.

The Office observed on Freedom to Speak Up had not kept pace with developments in the field and did not fully reflect the NHS's approach to speaking up. They have therefore developed and issued national guidelines. These guidelines are set out for all members of staff. Please see **Appendix 1** for more details. Implementation of the training will form the ongoing work for the Trust Guardian working together with the Organisational Development Team.

3.2. In June 2019, the Trust complied with a request from the National Guardian Office to reconcile the data they supplied quarterly about the speaking up cases raised to them during 2018/19.

3.3 August 2019 the National Guardian Office launched the annual survey to seek the views of the Guardians across NHS Trusts. In previous years this led to the development of principles for the Freedom to Speak Up Guardian role and the universal job description.

3.4 NHS Improvement has revised their guidance, which sets out expectations of boards and board members in relation to Freedom to Speak Up. The guidance is now accompanied by a number of supplementary resources, a streamlined toolkit and contains some practical 'how to' information that hopefully you will find helpful. The Trust Management Group will review a self-assessment of these standards in October 2019 and the findings reported in the next Board report.

3.3. The NGO launched the 100 Voices campaign. The100 Voices campaign aims to gather together as many case studies as possible to use in conjunction with their Annual Report and to promote during Speak Up Month in October. The Trust has submitted cases to include in the national report as well reporting to the next trust Board report.

3.4. In July, Henrietta Hughes, National Guardian for the NHS, wrote a letter to all Chief Executives of NHS and Foundation Trusts about the support to be provided to the Speak Up Guardians. In this letter, Attention was drawn to the isolation, responsibility and the burden of holding difficult and challenging information, in confidence, are some of the main challenges. The support and supervision of Whittington Health Guardian was reviewed and the Board can be

reassured that the Freedom to Speak Up Guardian is receiving clinical supervision and psychologist support as well as facilitated access to key members of staff whenever required. As the post sits alongside teams rather than within a team the FTSUG has reached out for other local Guardians (North Middlesex Hospital, UCLH and Royal Free Hospital) to create a network of peer support. The Trust will be hosting the first meeting later in September 19.

4. SPEAK UP ADVOCATES ROLE

4.1 Since the last report the role of the Trust Speak Up Inclusion Champions and Anti-Bullying and Harassment Advisors have been withdrawn as the new Speak Up Advocates network has been established.

4.2 The Speak Up Advocates are raising the profile of Freedom to Speak Up, helping staff to safely raise concerns. At the time of the report the trust has successfully recruited and trained a network of nineteen Speak Up Advocates across different hospital services and community bases, such as: District Nurses, Podiatrists, Health Visitors, Dental services, Housekeeping, Pathology, Women's Health, Pharmacy, Decontamination and Speech and Language. They represent diversity, equality and inclusion across the Trust.

4.3 Moving forward, the focus is the recruitment of new Advocates in departments such as IT and Finances and also different wards. This is done with the collaboration from the directors of the trust.

4.4 The Speak Up Advocates receive supervision and support when required. Since the introduction of the roles there have been five concerns raised directly to the Speak Up Advocates.

4.5 An example of this was two members of staff requested support for a meeting where they were witnesses for an investigation. They were very nervous about this and asked an Advocate to join them in the meeting. The outcome was the staff felt more comfortable during the process (with their silent emotional support) and could speak more confidently on their experience.

4.6 Their information, photos and contact details can be seen on the intranet. Information about the nearest Speak Up Advocate is also displayed in staff areas.

5. LOCAL CONCERNS RAISED (MARCH 2019 to August 219)

5.1 This reporting period the FTSUG received twenty 35 initial concerns. One of the contacts was anonymous and has been reported internally. From the last report we can see a considerable decrease of anonymous concerns from 6 to 1.

5.2 Nineteen have been reported to the National Guardian's Office (Q4). One case reported involved an element of patient safety and 12 and element of bullying and harassment.

5.3 Seventeen of the cases have been closed with satisfactory outcome for reporter. Eighteen cases remain open to the Guardian. The table overleaf shows cases received by month for the reporting period.

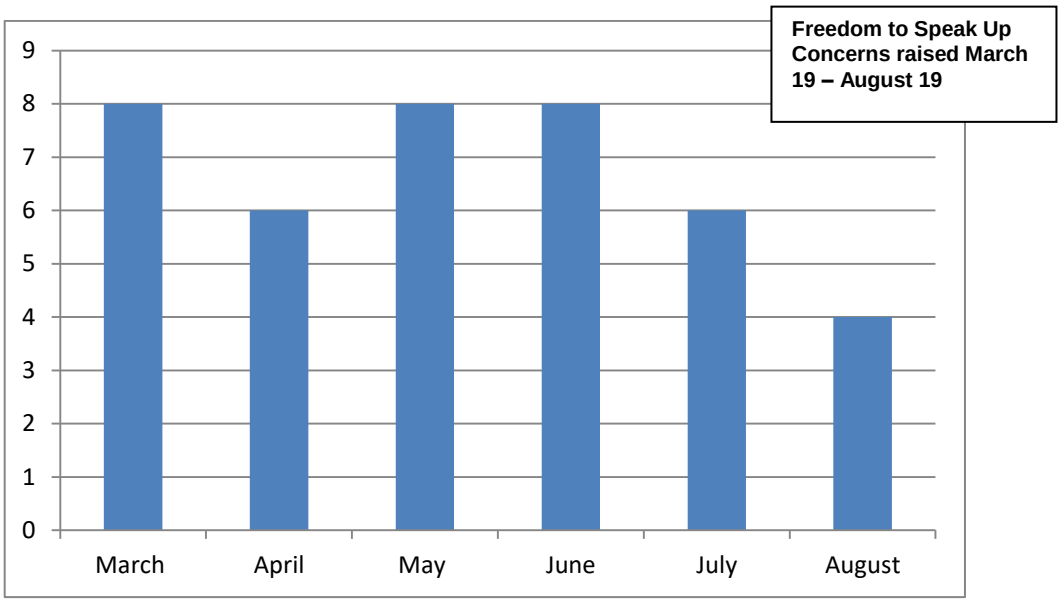


Table one: Freedom to Speak Up Concerns raised March 19 – August 19

5.4 Table two describes the themes raised for the same period.

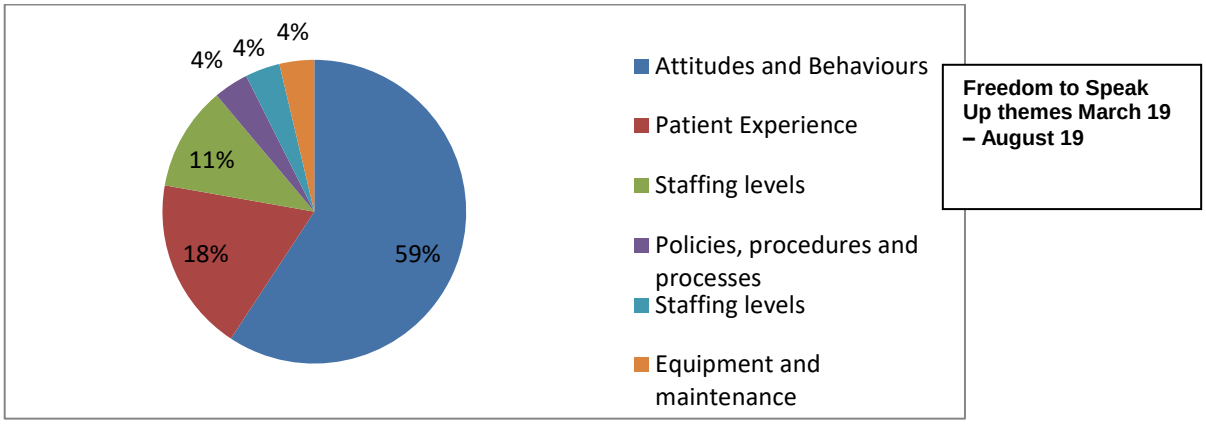


Table two: Freedom to Speak Up themes March 19 – August 19

6. LEARNING FROM NATIONAL GUARDIAN QUARTER FOUR (2018-19) DATA

6.1 The latest reporting period is quarter four 2018/19. The latest results are set out in the below table and reveal that 97% of NHS trusts now provide.

6.2 The following learning from National figures:

- 3,406 cases were raised to Freedom to Speak Up Guardians/ambassadors/Advocates
- 928 of cases included an element of patient safety/quality of care
- 1,312 included elements of bullying and harassment
- 122 related to incidents where the person speaking up may have suffered some form of detriment
- 506 anonymous cases were received
- 5 trusts did not receive any cases through their Freedom to Speak Up Guardian

6.3 Data for Q4 in 2018-19 is represented in Table three and that shows that the rate of referral ranked Whittington Health 62nd out of 228 Trusts.

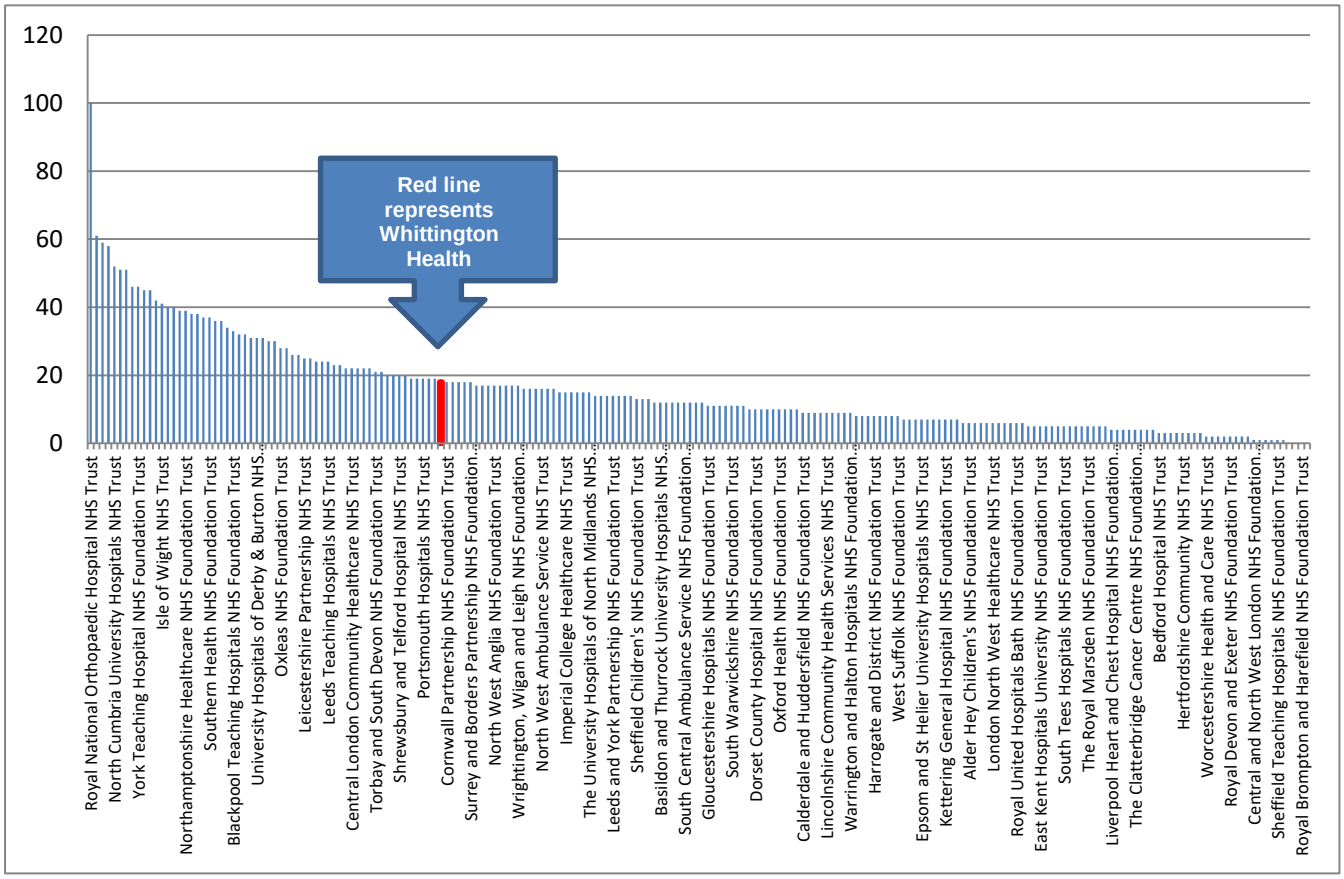


Table three: National NHS Trusts benchmarking quarter four Freedom to Speak Up Referral Rates

6.4 For cases raised in Q4 2018-19, Whittington Health ranked 62nd out of 228 Trusts. Comparing with the last Q3 2018-19 Whittington Health NHS Trust has reported more concerns moving from 131st (out of 221 Trusts) to 62nd (out of 228 Trusts). Only one case reported was concerning patient safety.

6.5 For cases raised in the Q4 2018-19 concerning bullying, Whittington Health ranked 35th with 12 cases.

7. WHITTINGTON HEALTH STAFF FEEDBACK

7.1 The Guardian has been collecting feedback since starting in the post and reports a positive response. Staff members say that they feel that the Guardian is approachable, engaging and that they have gained confidence in raising concerns. This is also reflected by the increment of applications to the Speak Up Advocates role.

7.2 Some examples of feedback include:-

"*Thank you so much for your time and compassionate support the other day. I felt so much better having talked to you and am very grateful*";

"*I just wanted to say thanks so much for all your support. It has transformed my working life, my stress levels and has enabled me to continue to work here when I was at the point of leaving. You provide a fantastic service, particularly at a time when things were very challenging"*

7.3 Data from Surveys regarding the experience of using the Freedom to Speak Up Guardian is included in the table below.

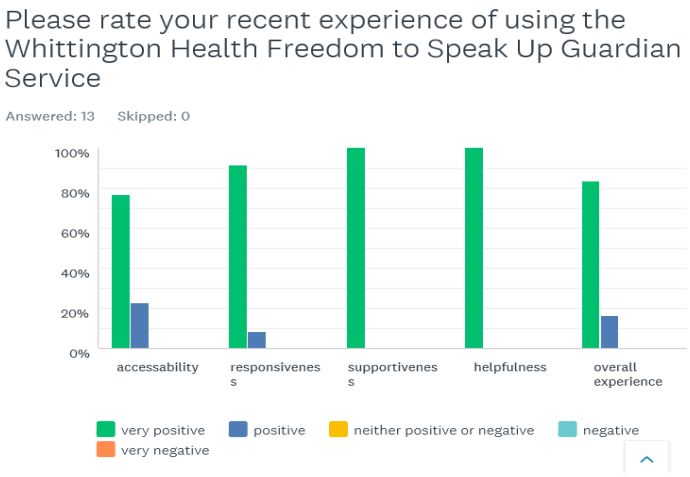


Table four: Rate of experience of using the Whittington NHS Trust FTSU Guardian (March 2019 – August 2019)

8. PRIORITIES NEXT SIX MONTHS

8.1 The Guardian has set out priority for the next 6 months and include;

- Visit all remaining Health Centres and services throughout the Hospital
- Keep the distribution of posters and leaflets to reach as many members of staff as possible
- Raising the profile and create more awareness of Freedom to Speak Up during October – the Speak Up month.
- Support and supervise the Speak Up Advocates, recruiting and train new ones as necessary.
- Work with the leadership teams to create safe forums where staff can attend for an informal conversation or to raise any concerns
- Provide support in the BME Staff Inclusion Group
- Further develop the information intranet page on how to raise concerns and link with support tools

9. RECOMMENDATIONS FOR THE BOARD

i) Support the recruitment of Speak Up Advocates and acknowledging the importance of providing protected time (within job roles) for the Advocates to support their colleagues;

ii) Encourage and promote with managers and senior leaders to engage with Freedom to Speak Up; and

iii) Note the Implementation of Freedom to Speak Up training to all members of staff.

Whittington Health
NHS Trust

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	**2018/19 Research & Development Annual Report**	**Agenda Item: 10**
Executive director lead	Dr Clare Dollery, Medical Director	
Report author	Kathryn Simpson, Research Portfolio Manager	
Executive summary	The Research & Development team along with the Principal Investigators within Whittington Health continued to recruit patients into NIHR portfolio studies. The number of patients recruited was in excess of the target set by the NIHR and the number of patients recruited increased in year to 1077 to 49 studies. This demonstrates our ability to deliver on research aims increasing the number of patients involved in trials and the number of trials gives us increased opportunities to learn and to contribute to wider scientific knowledge and therefore more innovative patient care. There was a cut in funding to the North Thames Clinical Research Network (CRN) of 10%. Whittington Health secured additional funding for research delivery staff in 2018-19 despite other Trusts in the region having funding reduction of circa 5%. Whittington Health has a good value for money (VFM) analysis for the average cost per recruitment unit of £56 which is down from the previous year (£64 VFM). Whittington Health is currently second in 'best value recruitment acute trust' comparisons behind Homerton, within the CRN. Progress was made with commercial studies, as in 2018-19 three further commercial trials were opened. These are within previously successful areas of dermatology and haematology. Gynaecology also has active commercial studies. There remains scope for further development. A new Director of Research and Innovation was appointed in June and takes up the post in September 201 (Professor Hugh Montgomery). The research strategy will be refreshed.	
Purpose:	Review	
Recommendation(s)	The Trust Board is asked to review the 2018/19 research and development annual report.	
Risk Register or Board Assurance Framework	Quality 1	
Report history	Quality Committee, 11 September 2019	
Appendices	None	

Research & Development Annual Report 2018/19

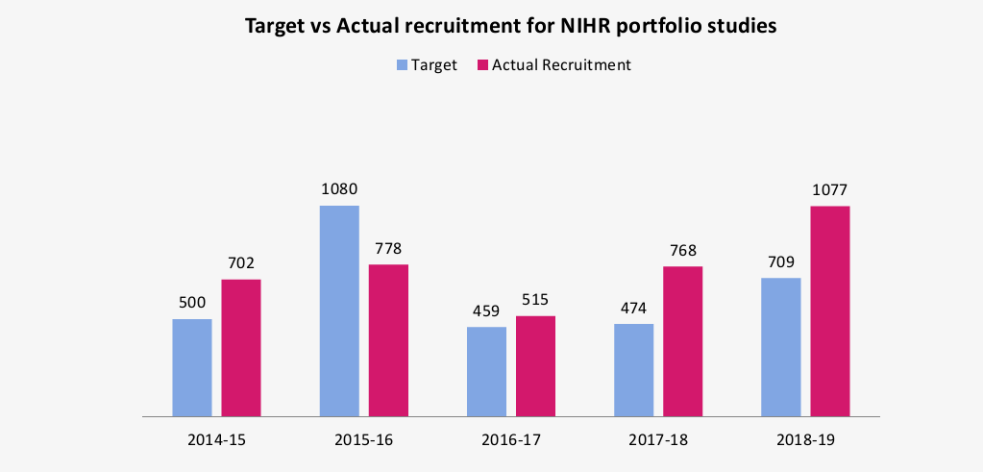
1. Introduction

- Whittington Health is a research active organisation and is committed to research as we believe it improves the care of our patients. Our research strategy outlines our research objectives as:
    - Increasing research in clinical areas where we have a research track record.
    - Developing research in integrated clinical care.
    - Increasing income from commercial research studies.
    - Increasing the culture of research within Whittington Health.
- Research supports our objectives of delivering outstanding, safe, compassionate care and transforming and delivering innovative services.

2. Review of Recruitment into NIHR Studies 2018/19

- Patients were successfully recruited into National Institute of Health Research (NIHR) portfolio studies. These are studies that are recognised as nationally important by the NIHR, where the funding for the studies has been awarded in open competition e.g. from the Medical Research Council (MRC).
- In 2018-19 the Trust exceeded the recruitment target, which was set by the North Thames Clinical Research Network (CRN); see graph 1 below. The recruitment target is agreed annually between the Trust and the North Thames CRN. The target was created by taking the previous five years recruitment and calculating the average.
- The recruitment target does not reflect the complexity of studies e.g. simple observational studies compared to complex interventional drug trials. Whittington Health has a track record of recruiting patients into complex interventional studies, which was again the case this year.

Graph 1 Whittington Health recruitment into NIHR portfolio studies 2014 to 2019



An increase in target from 2017-18 to 2018-19 was reflective of the previous successes and increased recruitment the previous year. However, carefully selected additions to the portfolio ensured that the target was met within the third quarter of the year and then continued to recruit well in the final quarter which contributed to exceeding the target. The highest recruiting studies for the year are shown in Table 1. The clinical areas in which these patients were recruited were not solely from those areas that have historically been areas of research strength at Whittington Health, continuing to build on high recruiting reproductive health. Thus our research strategy of building on research in clinical areas where we have a research track record as well as expanding research capability within women's health and paediatric services has been effective as evidenced by recruitment.

Top 5 Recruiting Adopted Studies during FY 2018/19

Jonathan Wilson	The qFIT Pilot	230
Chandrima Biswas	EQUIPTT (Evaluation of QUIPP app for Triage and Transfer)	142
Denise Lim	Drug Allergy Labels in the Elective Surgical Population	111
Logan Van Lessen	REACH Pregnancy Circles Trial ; Version 1.0	101
Clarissa Murdoch	High-Intensity Specialist-Led Acute Care (HiSLAC)project	40
Kayleigh Gilbert	A public survey of mobile mental health technologies (V 1.0)	40

Adopted Study Recruitment in 2018/19 Per ICSU

ICSU	No. of Studies	Recruitment during 2018/19
Adult Community Health Services	2	29
Children & Young People Services	7	41
Emergency & Integrated Medicine	13	183
Surgery & Cancer	15	461
Women's Health, Acute Patient Access & Clinical Support Services	10	363

Table 1 (Left): Top 5 recruiting studies in 2018-19

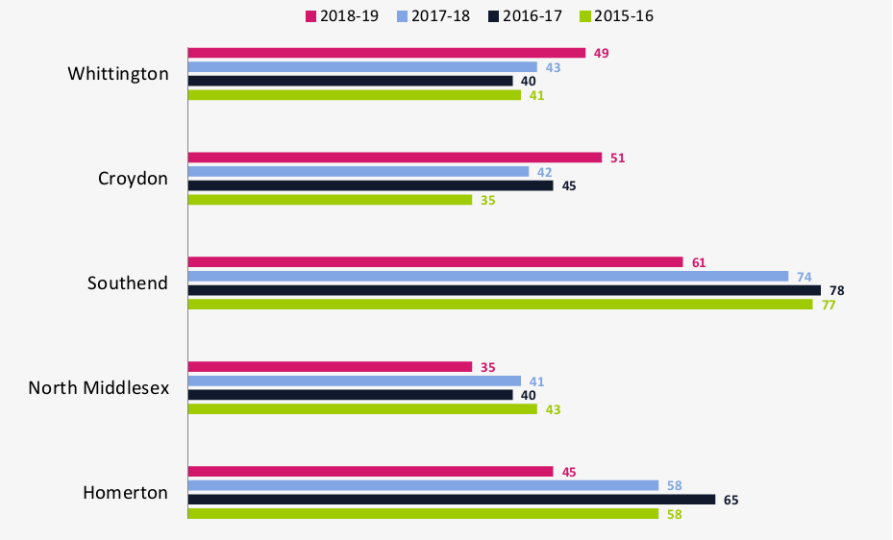
Table 2 (Above): Breakdown of studies and recruitment per ICSU

Surgery and Cancer has the highest number of studies and has also recruited the highest number of patients.

3. Benchmarking of recruitment into NIHR portfolio studies

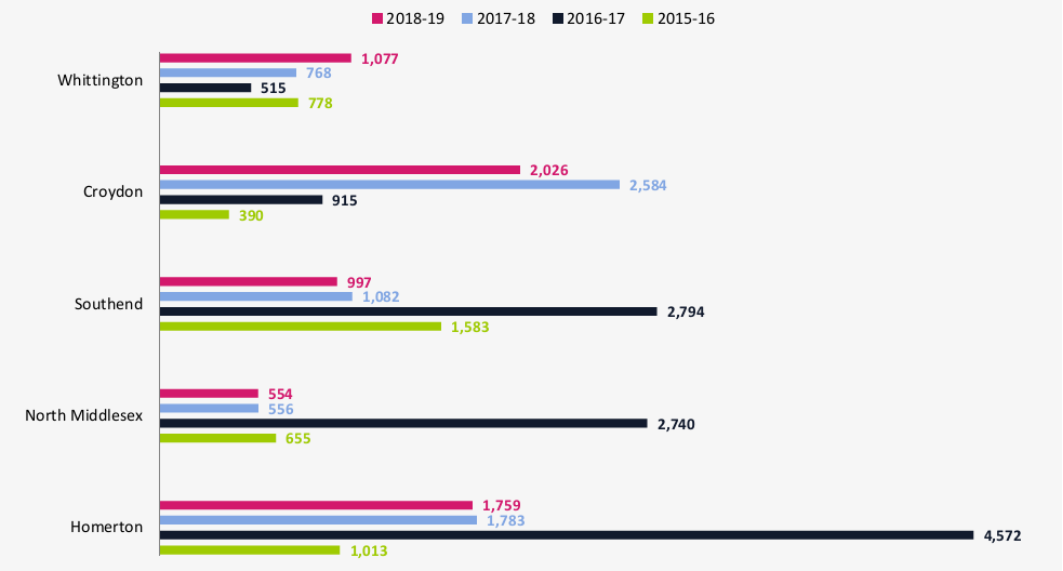
- When compared to other similar size acute trusts, the number of studies that are open and recruiting at Whittington Health is similar to Croydon and higher than the North Middlesex Hospital, but significantly less than the Homerton and Southend Hospitals; see graph 2.

Graph 2 Number of NIHR portfolio studies open in benchmarked acute trusts within the North Thames CRN (2014 to 2018)



- Among the comparator Trusts below Whittington Health was the only Trust to increase the number of recruits from 2017-18, each of the other trusts shown had less recruits in 2018-19 compared to 2017-18, the increase was significant this year and reflective of the continuing development of the portfolio at Whittington Health.

Graph 3: Recruitment of patients into NIHR portfolio studies in benchmarked trusts within the North Thames CRN (2015-19)



- Whittington Health did recruit fewer patients into NIHR portfolio studies in 2018-19 than some but not all comparator Trusts. Of note the qFIT study in 2018-19 recruited the highest number of patients (recruiting 230) - Homerton also participated (recruiting 112).

4. Financial Support to R&D from the North Thames CRN 2018/19

- When compared to other similar size trusts in North Thames CRN, the allocated financial support to Whittington Health, in 2018-19 was significantly less. This is then reflected in the number of research nurses and support workers that are employed within Whittington Health compared to other trusts. The income received from the CRN is pre-allocated for specific research delivery posts or for recharge to clinical support services.

Table 3 CRN funding provided for employment of research delivery staff & clinical support services

	2018/19 CRN Total Support	2019/20 CRN Total Support *indicative figure	2019/20 Clinical Services Support	2019/20 Research Delivery staff
Homerton	£561,060	£556,419	£70,605	£485,814
North Middlesex	£305,267	£406,366	£83,635	£322,731
Southend	£820,487	£944,113	£112,605	£831,508
Whittington	£383,232	£397,209	£56,820	£340,389

- There was a cut in funding from the NIHR to CRN North Thames of almost 10% for 2018-19 (compared to a cut of 5.5% in 2017-18) due to both reduced Department of Health expenditure and performance of North Thames CRN in comparison to other LCRNs in the UK who had a better performance in both recruitment and Recruitment Time to Target (RTT).

Table 4 CRN Value for money (VFM) - value for money analysis Q4 2018-19

Trust name	No. of recruits	IV/Obs/LSS %*	Weighted recruitment (11:3.5:1)	Spend	VFM – cost per recruitment unit	Previous year VFM
Homerton	1759	61/19/20	11,882	£489,867	£41	£62
North Middlesex	554	35/50/15	2,933	£313,460	£107	£201
Southend	997	25/47/28	4,420	£836,857	£189	£256
Whittington	1077	39/45/16	6,263	£353,121	£56	£64

*IV – Interventional studies, Obs – Observational studies, LSS – Large Sample Size studies (those that have a UK target of 10,000 or more).

- Just 16% of the studies Whittington Health hosts are Large Sample Size Studies (LSS) which contributes to the fact that overall recruitment is lower than Homerton and Southend (28% of Southend's studies are LSS). Whittington Health has an impressive VFM analysis of the average cost per recruitment unit of £56 which is down from the previous year (£64 VFM).

- Whittington Health is currently second in 'best value recruitment acute trust' comparisons behind Homerton, within the CRN NT. Within 'best value large academic trust' across the same CRN geography, Moorfields leads with a cost of £50 per recruitment unit in comparison to Royal Free with a cost of £159 per patient.

5. Grant applications submitted within 2018-19

- A number of high financial value grant applications have been made over the year by some key researchers associated with the Trust (Table 5).

Table 5. – Grant applications submitted during 2018/19

Applicant	Study Title	Funding Competition	Costing Status	Grant Outcome
Dr Rishi Gupta	Developing new tools to facilitate a targeted approach to testing and treatment for latent tuberculosis infection	NIHR The Doctoral Research Fellowship 2018 (DRF) Stage 2 - Full Grant	In progress	Awaiting decision
Dr Rajvinder Khasriya	An open label trial of Intravesical Nitrofurantoin (CapFuran) Infusion for the treatment of acute or recurrent, uncomplicated lower urinary tract infection in patients	To Be Confirmed Stage 2 - Full Grant	Completed	Awaiting decision
Dr Emma Drasar	Prospective assessment of non-invasive methods of assessing liver stiffness in iron-loading disorders	NIHR (HTA) 18/65 Researcher-led (Evidence synthesis) Stage 1 - Outline	Submitted	Identifying alternative funding stream

6. Research Infrastructure in 2018-19

- Whittington Health secured additional funding for research delivery staff in 2018-19 despite other Trusts in the region having funding reduction of circa 5%. The team has continued to thrive and grow, however collaboration with the North Thames CRN has been hampered by national funding cuts limiting our ability to maintain existing posts and establish new ones. Strategies to secure other funding streams will need to be put in place to ensure a continuation of capacity and capability to deliver research within the trust.

- Work supporting the ICSUs to engage in research has been underpinned in the last year, Surgery & Cancer (contributing 49% of the total recruitment) and Women's Health (contributing 39% of the total recruitment) in particular have engaged with the research team to develop the portfolio as is evident by their contribution to the total recruitment for the trust (as visible in Table 2). Work across the ICSUs continues to take place and increased engagement through greater reporting of research performance at director level, which was implemented in 2018-19.

7. Commercial Research

- Progress has been made with commercial studies, in 2018-19 three further commercial trials were opened. These are within previously successful commercial specialties of dermatology and haematology. Gynaecology continued to have commercial studies active and the success of ASTEROID 3 and ASTEROID 5 has led to our being selected for ASTEROID 7 and having been approached for a forthcoming endometriosis trial with the same sponsor.

Table 6. – Commercial studies which opened during 2018-19

IRAS ID	Study Name	Whittington ICSU	Local Investigator	Target recruitment	Present Recruitment
232937	LJPC-401 for iron overload in adults with TDT	Emergency & Integrated Medicine	Farrukh Shah	3	3
238480	Study to evaluate the management of patients with ?-thalassaemia	Emergency & Integrated Medicine	Farrukh Shah	30	38
251974	Long-term extension trial in subjects with atopic dermatitis who participated in previous tralokinumab trials – ECZTEND Tralokinumab in moderate-severe AD extension trial 1337	Surgery & Cancer	Ben Esdaile	1	1

8. Raising the Profile of Research

- An annual event for the team that improves the visibility of research within the Trust is International Clinical Trials Day, held in May each year. This again proved a good forum to engage both staff and patients and to inform them of the research activity ongoing within the trust and also with the NIHR 'Be Part of Research' campaign. The research delivery team ran the treat you trial: a mock research study that demonstrated the randomisation process and ran a poll to see whether staff and patients are open to participating in research – the result being a strong yes.

- The trust introduced a staff award ceremony during 2018-19 which included a Research and Innovation category which was won by Kayleigh Gilbert, the research team lead. The research delivery team was also shortlisted in the category of Non-Clinical Team of the Year. Two members of the team were also recognsied in the trusts 70@70 Whittington Health Heroes.

9. Next Steps

- Professor Hugh Montgomery (UCL Professor of Intensive Care Medicine, and consultant intensivist at Whittington Health) has been appointed Director of Research & Innovation taking up post in September 2019. He is working closely with the Research Portfolio Manager and the Medical Director to shape a new research strategy for launch autumn 2019.

  This will include a number of key elements:

  - Scoping research interest across Whittington Health
  - Improving visibility of research activity
  - Facilitating research engagement
  - Forming a new Research Oversight Forum
  - Elevating and maintaining the research reputation of Whittington Health to impact staff recruitment and retention

10. Summary and Conclusion

- In 2018-19, the R&D team along with the Principal Investigators within Whittington Health continued to recruit patients into NIHR portfolio studies. The recruitment number was in excess of the target set by the NIHR which is important in demonstrating our research reputation as increasing the number of patients involved in trials and the number of trials gives us increased opportunities to learn and to contribute to wider scientific knowledge.

- In addition, a number of grant applications were submitted by researchers at Whittington Health; the results of these are awaited. The number of commercial studies that are open at the trust has increased and previous successful recruitment has resulted in pharmaceutical companies approaching the Trust for follow-up studies. There is however still scope for further development. The ambition of creating a commercial income stream to support a clinical researcher who specialises in studies of integrated clinical care has not yet been realised and may be revisited.

- The research strategy will be refreshed in the coming months including defining the scope of our research ambition as a trust and how best to achieve a critical mass of researchers and support staff to make this sustainable.

References

1. Boaz A, Hanney S, Jones T, et al. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015; 5

2. Whittington Health Research Strategy

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	**Progress with action plans following 2018 annual NHS Staff Survey results**	**Agenda item: 11**
Executive director lead	Norma French, Director of Workforce	
Report author	Helen Kent, Assistant Director, Organisational Development Eleanor Clarke, Head of Organisational Development	
Executive summary	Each year, NHS England commission a national staff survey which NHS organisations are required to run, for one month around October or November, using an external supplier to manage the whole process from sending the survey to eligible recipients, to the design of the analysis and reports. The intention behind the use of external suppliers was to increase trust in the process, however, staff remain sceptical that the Trust remains ignorant of individuals' responses. In spite of this, the Trust achieved a response rate of 48.5%, 7.5% higher than average for our type of trust. The results for the 2018 survey were received in March 2019. They are sorted into ten 'themes' instead of thirty-two 'key findings' reported in previous years. Performance on these themes was used to suggest priorities for action for Integrated Clinical Service Units (ICSUs) and Directorates, although these were not mandated and ICSUs and Directorates were free to choose other priorities. On receipt of the results in March 2019, the Workforce Directorate supported ICSUs and Directorates to create action plans based on the results by providing a template and suggesting three priorities. This report provides an update of ICSU and Directorate progress with their plans. The templates provided to ICSUs and Directorates are provided in appendices A to D, and individual team progress is recorded in appendix E	
Purpose:	The paper provides an update on the planned activities following receipt of the annual NHS Staff Survey results	
Recommendation(s)	The Board is asked to note the progress with ICSU and Directorate action plans following receipt of the 2018 annual Staff Survey results	
Risk Register or Board Assurance Framework	BAF entry People 2	
Report history	A verbal update was given at the Workforce Assurance Committee	

Appendices	Appendix A - Summary Results for ICSUs and Directorates Appendix B - Suggested focus areas for each ICSU and Directorate Appendix C - Template action plan for ICSU and Directorate level Appendix D - Team “We said, We did” action plan template Appendix E - ICSU and Directorate Updates Appendix F - Team Updates

Progress with action plans following receipt of the annual NHS Staff Survey results

1. Introduction

1.1 Every year, NHS England commission a national staff survey, and all NHS organisations are required to run the survey for its staff. NHS England provide funding, and the coordination centre which manages the questions and analysis design. This is done in collaboration with unions. This year the thirty-two 'key findings' which were reported in previous years, were replaced by ten 'themes' as follows:

(i) Equality, diversity, inclusion
(ii) Health and wellbeing
(iii) Immediate managers
(iv) Morale
(v) Quality of appraisals
(vi) Quality of care
(vii) Safe environment; bullying and harassment
(viii) Safe environment; violence
(ix) Safety culture
(x) Staff engagement

1.2 All NHS organisations are required to commission one of the approved external suppliers to manage the process – it cannot be run in-house – including the delivery of the surveys to people's workplace or homes, or an online link. The use of an external supplier is designed to ensure, and help manage the perception of complete confidentiality.

1.3 Confidentiality is also protected through the 'rules' governing the release of data. All responses are aggregated into the overall Trust results. More granular local results are provided for teams, providing there are eleven or more responses. This reduces the likelihood of specific individuals' responses being identified.

1.4 In spite of these precautions, staff remain generally distrustful that the survey is confidential, because the external supplier knows who has, and who has not responded to the survey, and sends the latter group a reminder. This presents a challenge to increasing the response rate. In 2018, the response rate was 48.5 per cent, which was 7.5 per cent above the average for our organisation type as well as being an increase on 2017. However, the higher the response rate, the more representative of our staff and the organisation the results can be, and therefore increasing the response rate remains a key goal.

2. Activity on Receipt of Results

2.1 Following receipt of the Trust's results, the Workforce Directorate provided summary of ICSU and Directorate results (at Appendix A) with three suggested focus areas for each ICSU and Directorate (at Appendix B) a high level action plan template (at Appendix C).

2.2 In addition, teams large enough to be provided with their own results (teams with more than eleven responses) were provided with an action plan outlining three main actions or focus areas. This is shown in Appendix D.

2.3 Whilst the Trust, and high level ICSU and Directorate results were received when expected, the local teams results were not delivered until July 2019, some four months later than expected, limiting the time available for teams to take action based on their specific results before the next survey is due to start.

3. Progress with Activity Plans

3.1 Appendices E and F show the progress on activities for the three main priorities for each ICSU and Directorate; and Teams respectively

3.2 The action plans demonstrate the importance of focusing on a small number of key areas to ensure progress can be made and felt by staff before the onset of the following year's

survey. Whilst some plans are very ambitious and others are more realistic, significant progress has been made in many ICSUs and Directorates with making improvements to the working environment and staff experience.

3.3 The full impact of the activity undertaken during 2019 will be measured in the 2019 staff survey (as well as the quarterly Pulse Point and staff 'friends and family test').

4. Next Steps

4.1 The 2019 national staff survey is being prepared now, and work is being undertaken in liaison with Whittington Health's external contractor, Picker. To date the staffing data of eligible staff as at 01 September 2019 has been sent to Picker with information about how and where they can be contacted to be sent a link or a hard copy of the 2019 questionnaire.

4.2 The survey is open for thirty days during which the Trust is provided with updates on response rates. For the 2018 staff survey, members of the Executive Team actively walked wards and Directorates, particularly of those areas with lower response rates that average for the Trust.

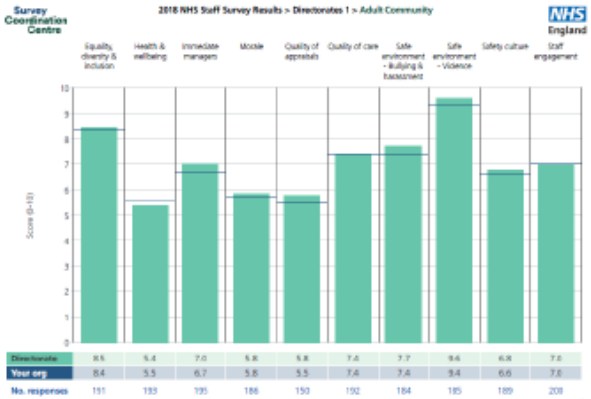
4.3 As well as creating action plans in relation to the ten themes or as a direct result of commentary made following the 2018 staff survey; and with the evidential activity working through them; it is hoped that the 'Caring for Those Who Care' activities of the last year, will also help to persuade staff that the cascade of managers throughout the Trust want to hear how we can improve staff experience.

4.4 The survey will be held in October to November 2019, and the results are expected in March 2020. A commitment to provide the local team results in March 2020 has also be made by the contractor (to improve on the 2018-19 performance in which team results were not released until August 2019).

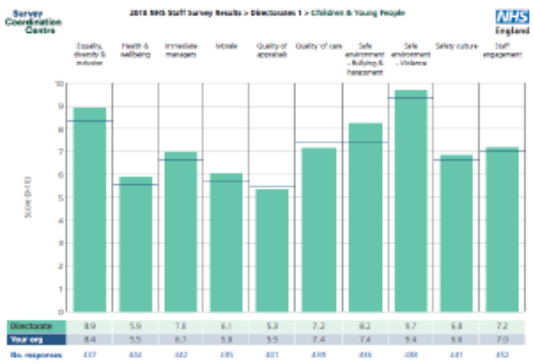
APPENDIX A – Overall Theme Results for Localities (1)

(The columns are, in order from left to right for each locality: Equality, diversity & inclusion; Health & wellbeing; Immediate managers; Morale; Quality of appraisals; Quality of care; Safe environment (bullying); Safe environment (violence); Safety culture; Staff engagement.)

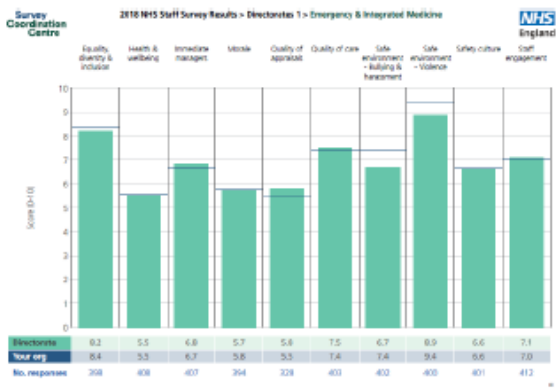
Adult Community



CYPS

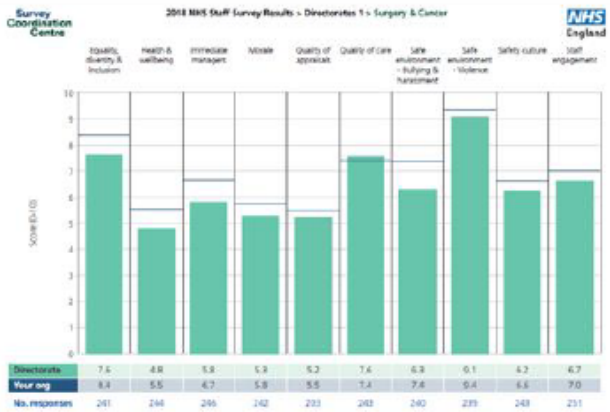


E&IM

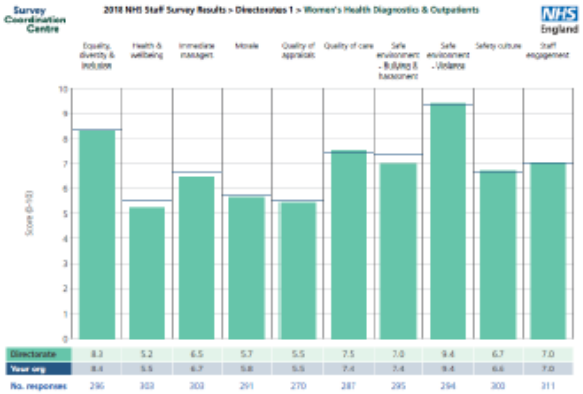


Nursing & Patient Experience

Surgery & Cancer



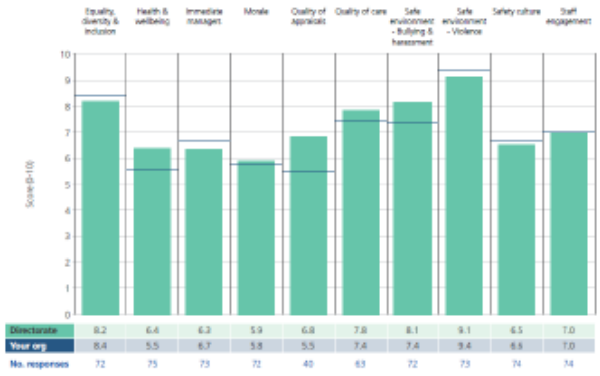
Women's Health



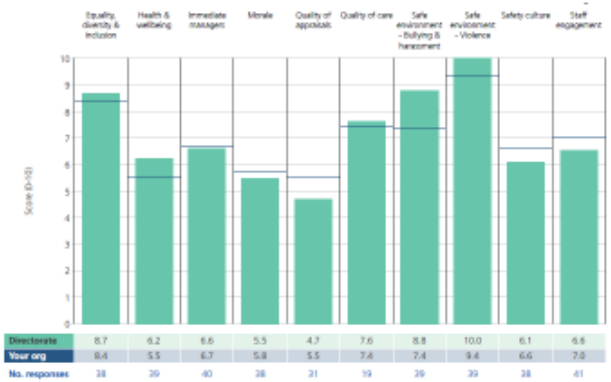
APPENDIX A Continued – Overall Theme Results for Localities (2)

(The columns are, in order from left to right for each locality: Equality, diversity & inclusion; Health & wellbeing; Immediate managers; Morale; Quality of appraisals; Quality of care; Safe environment (bullying); Safe environment (violence); Safety culture; Staff engagement.)

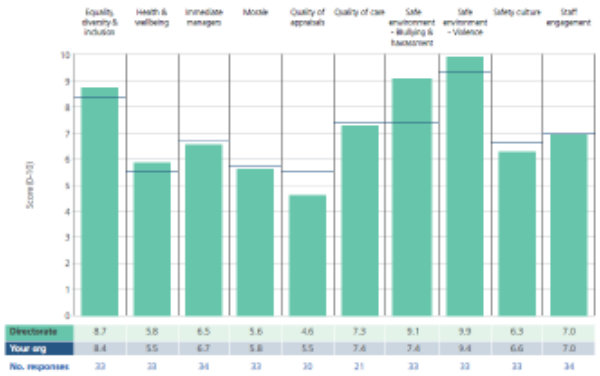
Facilities



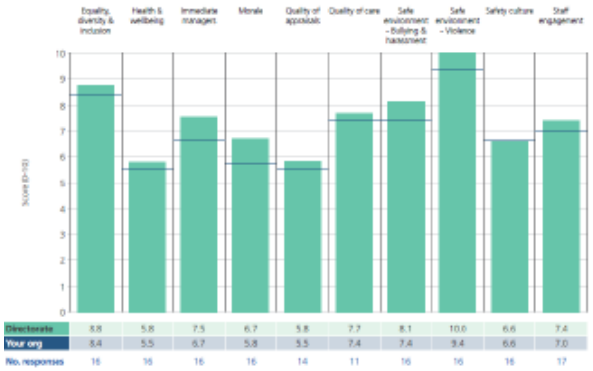
Finance



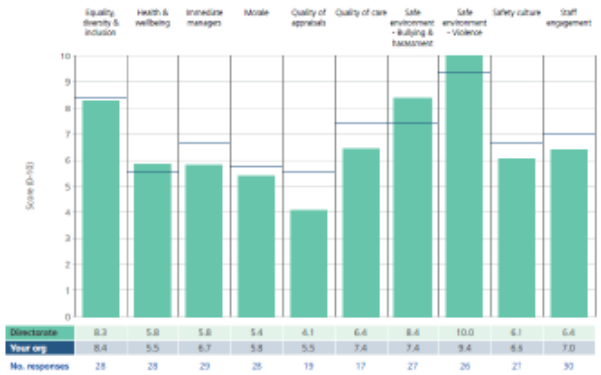
IT



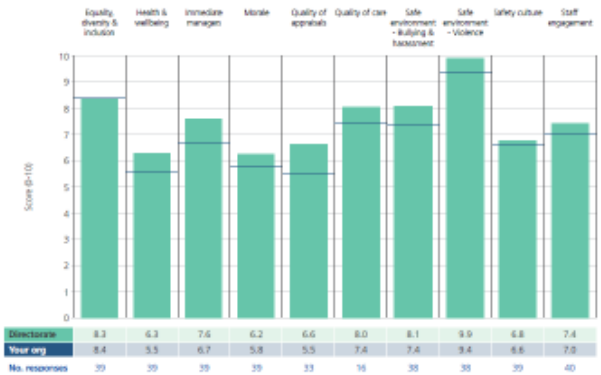
Medical Director



Procurement



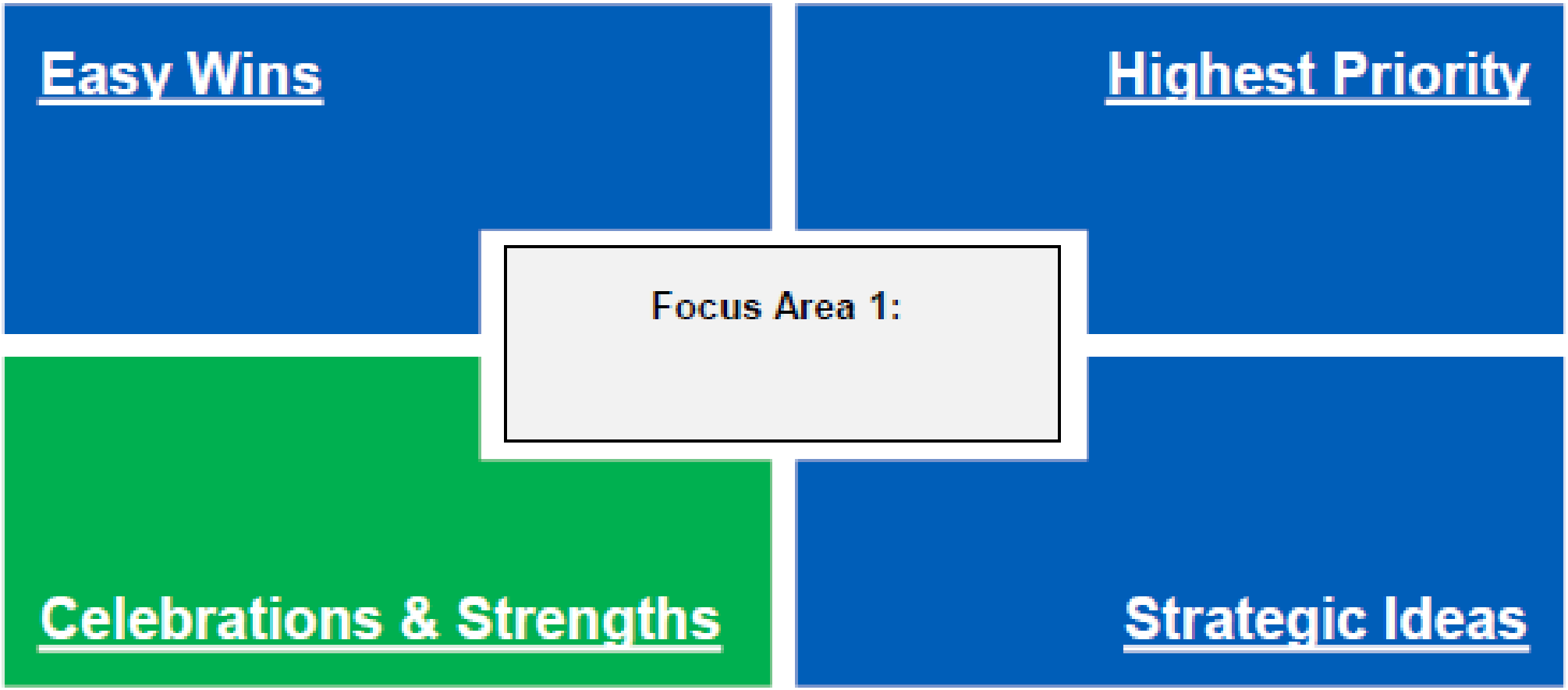
Workforce



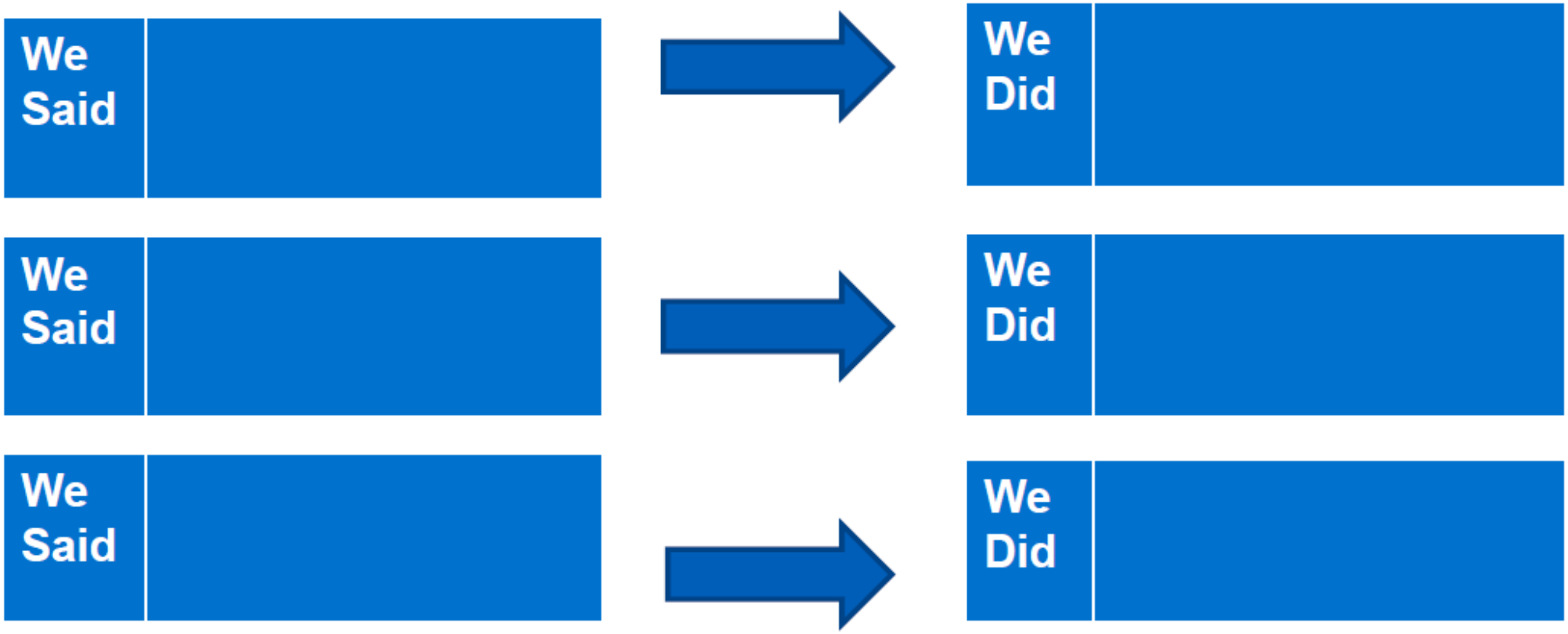
APPENDIX B – Suggested Focus Areas for Each ICSU and Directorate Based on Results

Adult Community	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
CYPS	1. Morale 2. Quality of Appraisals 3. Quality of Care
E&IM	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Facilities	1. Health & Wellbeing 2. Immediate Managers 3. Morale
Finance	1. Morale 2. Safety Culture 3. Quality of Appraisals
IT	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Medical Director	1. Health & Wellbeing 2. Safety Culture 3. Quality of Appraisals
Nursing & Patient Experience	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Procurement	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Surgery & Cancer	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Womens Health	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals
Workforce	1. Health & Wellbeing 2. Morale 3. Quality of Appraisals

APPENDIX C – Template for High Level ICSU and Directorate Action Plan



APPENDIX D – Team Based Action Plan Template



APPENDIX E – ICSU and Directorate Action Plans

Adult Community

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Promote positive mental health guidance Shared breakfasts /lunches Start meetings with 'How are are you feeling…' Embedding ICARE values	Shared with all teams Shared leaving and welcome breakfast at July ACS board Using ICARE values in appraisals Leaders modelling values	Test awareness with community staff List services having shared lunch /b'fast Reduction in grievances within ICSU Achieve more positive scores under Health & Wellbeing domain in next staff survey
Highest Priority	Supporting European colleagues Use of mental health first aiders Base/environmental improvements	Shared Brexit docs: leaders discussion /cascade Shared list of mental health first aiders Director involvement in community estates planning	European staff remain working for WH Improvement in 2019 staff wellbeing score of 1 point
Celebrations and Strengths	RSI breaks Staff awards/ heroes Discounts	8 ACS staff/teams shortlisted for WH staff awards	Shortlisted teams for staff awards
Strategic Ideas	Localities culture- 'Sense of influence' Applying flexible working requests consistently Realignment of ICSU teams, 'Parity of esteem'	ACS staff involved in groundwork groups for localities development	Localities developed with ACS staff ownership

Continued

Adult Community continued

Focus: ***Morale***			
Easy Wins	Extend local induction / leavers checklist Staff training ESR, qlickview etc 1:1 monthly mgr/supervision support Leavers/starters breakfast Board invites	Starters and leavers breakfast for senior team achieved Staff training on ESR at board meeting	All new starters report welcoming and well nised induction Continued improvement in turnover and retention rates
Highest Priority	Improve internal processes: ESR, Trac Standard email signature include contact Running shared service courses	Standard email signature in use MSK and DNs running courses with free places for WH staff	1 point improvement in 'morale' 2019 staff survey Improved access to training/development
Celebrations and Strengths	Regular away days, Happy Friday (ICTT), Regular Newsletter, Director's visibility, team meetings booked through 2019, Compliments shared	ACS quarterly away days for senior leaders we attended Compliments shared and Directors provide personal response to staff member Director visibility schedule in place	Better staff engagement score - 2019 staff survey results
Strategic Ideas	Understanding of recruitment improvement plans Admin support for clinical staff Development programme for admin staff	Improved understanding of recruitment improvement plans across ICSU Admin training programme underway in CBS	Reduction in vacancy rates
Focus: ***Quality of Appraisals***			
Easy Wins	Share ESR guides; pay progression criteria Services to email with key appraisal points Dates in diaries; plan, commit, prioritise	Reiterating this message to staff Share pay progression dates to support completion Piloted/rolled out new appraisal papers to support	Improved quality of ESR inputting Increase in numbers of staff receiving annual incremental progression
Highest Priority	Quality embed values – discussion to link individual objectives – Trust target 90% compliance	Snr team agreed ICSU objectives aligned to Trust's Teams setting their own objectives in line with ICSU Rate increased: 61% Dec-18-76% Aug-19	Achieve 90% target All appraisals clearly aligned to trust and ICSU objectives
Celebrations and Strengths	Recognise staff achievements; value their work Acknowledge gains made towards compliance	Teams setting their objectives – to review together regularly	Improved staff results under 'Your Personal Development' domain
Strategic Ideas	Collect staff feedback on benefits/experience Implement Managers' Passport to inc appraisal 6-month check-in with staff	Feedback +ve on new paperwork & ICSU objs Central appraisal records underway in many services	New B6 + managers receive management framework to support dealing with ER issues – improved time to resolve on ER cases

Emergency and Integrated Medicine

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Team nights/ICSU events; Breakfast clubs ED night shift- bake a dish Ward level induction: capital nurse programme Promote mental health guidance Encourage staff to take breaks	Shared with all teams EIMI breakfast club commencing September 2019	To have regular attendance of breakfast club Reduction in grievances within ICSU Achieve more positive scores under Health & Wellbeing domain in next staff survey results
Highest Priority	Environment Shared space		To create space for staff to have breakout areas
Celebrations and Strengths	Increase in nursing staff Archies – 15% discount; Staff awards	EIM staff/teams nominated and shortlisted for WH staff awards	Shortlisted teams for staff awards
Strategic Ideas	EIM Away Day; Wellbeing initiatives Service leads – facilitation skills Empower team lead to take on Health and	Away Day booked for 10 October Services are booking in Away Days post ICSU Away Day	Each service to have developed team objectives
Focus: ***Morale***			
Easy Wins	Staff having access to essential stationary Consultant photos – who's who Taking time to stop and talk to people EIM Staff awards; Leadership visibility	Staff are able to order stationary to do roles EIM weekly staff awards commencing Sep-19 Plan for Director to attend team meetings	All staff to feel they engaged Mgt team to have attended team meetings
Highest Priority	Away Days	Booked for October 2019	To have agreed objectives for next 12m
Celebrations and Strengths	Admin staff feeling connected with teams Get to know you huddle; Chocolate Tree Senior nurses forum – highlight of the week Microwaves for staff		
Strategic Ideas	Regular Away Days Roll out wellness initiatives across EIM Ask staff what staff engagement looks like Embedding values- culture shift	Away Day booked for 10 October Services booking Away Days post ICSU OD to support facilitating frontline staff Away Day to establish what priorities for engagement are	Each service to have team objectives Frontline staff to have developed priorities for staff engagement to be acted on

Continued

Emergency and Integrated Medicine continued

Focus: ***Quality of Appraisals***			
Easy Wins	Hierarchy of appraisers: get right on the system Commit to appraisal date; Share ESR guidance Encourage clinical supervision and mentoring Appraisals held away from the department	Shared with service leads ICARE leadership has been shared Training dates shared ESR guidance shared	Improve quality of ESR data Increase in appraisals completed on time
Highest Priority	Appraiser training; Objectives set aligned to Trust's Better data to avoid rush for pay progression Report to show no.appraisals needed for 90%	Senior staff have Trust objectives that filter down to all staff HR asked for improved pay progression report for managers to be pro-active rather than re-active	Achieve 90% target
Strategic Ideas	Appraisal feedback similar to medical staff Embed new simplified appraisal system 360 appraisals; mid-year review of appraisals Change focus from 90% target to quality	Have embedded new appraisal tool Shared with staff how to access 360 tools	To have report on quality of appraisals set up

Surgery and Cancer

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Engagement***			
Easy Wins	Clinical Wednesdays ICSU and Dental Newsletters		
Highest Priority	Team-building (Dental) Completion of investigations		
Celebrations and Strengths	Mannequins IP Nursing Rates reducing	Mannequins have arrived	
Strategic Ideas	Implementing Governance changes BMA Charter for Wellbeing	Orthohub	
Focus: ***Visibility***			
Easy Wins	Frog awards Drop-ins with ICSU Directors	Coyle Team Winner of the year Lianta Downes Florence Nightingale Scholarship	
Highest Priority	Challenging inappropriate behaviour		
Celebrations and Strengths			
Strategic Ideas			
Focus: ***Leadership***			
Easy Wins			
Highest Priority	Job planning Middle manager development		
Celebrations and Strengths			
Strategic Ideas	Clinical Leadership Leadership away day		

Acute, Clinical Support and Women's Health: **Patient Access**

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Regular 1:1 meetings for all staff with line manager	In progress	every staff member gets allotted time with line manager
Highest Priority	Ensure staff know what services & support available to them	In progress	Invite speakers (OD, Speak up guardian) to team meetings.
Celebrations and Strengths	Identify strengths in team and acknowledge achievement	In progress	Nominate for staff awards.
Strategic Ideas	Understand local turn over and work towards making improvements in roles to ensure retention	In progress	Staff are retained and an issues are raised, discussed and resolved
Focus: ***Morale***			
Easy Wins	Bi Monthly team meeting with open floor for staff to fed back issues	Date sets for next year with rolling agenda	Improved feedback from staff survey
Highest Priority	Feeding back to staff and reviewing work what when well, areas for improvement	In progress	Staff will feel more supported and can identify any issues as they occur.
Celebrations and Strengths	Recognition for a job a Well Done – ICSU level staff wards Monthly	In progress	Nomination of staff for Trust awards
Strategic Ideas	Develop internal training programme to enable staff to progress.	In progress	New starters will be able to be inducted easier and current staff will have clear documentation to refer to.
Focus: ***Quality of Appraisals***			
Easy Wins	Staff given dedicated time to ensure they complete objectives	In progress	All Objectives completed within shorter timeframe.
Highest Priority	100% annual appraisal and 3 monthly reviews with all staff	In progress	Trust appraisal data
Celebrations and Strengths	Recognition at team meeting when objectives complete	In progress	
Strategic Ideas	Develop internal training programme to enable staff to progress.	In progress	New starters will be able to be inducted easier and current staff will have clear documentation to refer to.

Acute, Clinical Support and Women's Health: **Imaging**

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Staff feedback box	Box in staffroom 09-Sep-19	Regular staff feedback: 5 responses per month
Highest Priority	Understanding bullying and harassment scores via Survey Monkey	Survey still open	Examples of behaviours (identifying whether Imaging or other Trust staff)
Celebrations and Strengths	Imaging open evening to thank Imaging staff for work making equipment replacement possible	Open evening 06-Sep-19	Successful evening
Strategic Ideas	Deep-dive into areas of high staff turnover	Information gathers has started	Real cost attributed to staff turnover with suggestion to improve

Acute, Clinical Support and Women's Health: **Nursing and Midwifery**

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Tea trolley rounds Regular team/dept/unit meetings	Meeting dates agreed for all 2019	Improved feedback from annual staff surveys
Highest Priority	Changing departmental culture	Professional midwifery advocates to support staff	As above
Celebrations and Strengths	Acknowledgement of staff and department successes	Weekly staff newsletter highlights this	Nomination of staff for Trust and national awards
Strategic Ideas	Capital midwife involvement	CM tea morning event 01-Nov-19	Relaunch of RCM 'Caring for You' campaign
Focus: ***Morale***			
Easy Wins	Encourage and seek staff input	Suggestion boxes 'we said, we did' Newsletter updates	Staff survey working group Door signs showing senior team managers' availability
Highest Priority	Cohesive multi-disciplinary working	Clarity regarding roles and responsibilities	Forums for all staff to meet
Celebrations and Strengths	Acknowledgement of staff and service users compliments and thanks	Sharing of compliments with relevant staff and teams	Staff theatre-hats / lanyards / IDM/N celebrations, regular staff tea trolley
Strategic Ideas	Environmental improvements	Labour ward refurbishment urgently needed	Improved staff morale reported via staff survey
Focus: ***Quality of Appraisals***			
Easy Wins	Improve quality of appraisals	Themes from appraisals shared with relevant managers	All appraisers have had appraisal training
Highest Priority	Time for appraisals		Protected time for appraisals
Celebrations and Strengths	Full compliance	Monthly updates	100% undertaken appraisals
Strategic Ideas	Central Trust recording of appraisal data	Appropriate ESR access including hierarchy	Timely accurate recording of appraisals

Acute, Clinical Support and Women's Health: **Pharmacy**

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Quality of care / patient experience***			
Easy Wins	Report back findings of patient experience pilot on Montushi to Dept. Engage with PE team to advise on findings and support iteration.	In progress	Findings presented. Feedback received from PE team.
Highest Priority	Update process based on findings and roll out. Plan for implementation across ICSUs	In progress	Patient Survey conducted in all ICSUs at least quarterly
Celebrations and Strengths	Positive feedback received. Implementation of pilot.	In progress	Publication of feedback
Strategic Ideas	Patient experience data gathering via social media, internet, reaching out to patients through an app?	In progress	IT related mechanism in place to gather PE.
Focus: ***Department and Team Objectives and Goals***			
Easy Wins	Use new appraisal paperwork and importance of development as feature Use new department priorities to inform objective setting	In progress	95% Appraisal rate All appraisals in new paperwork New priorities used to craft all staff objectives.
Highest Priority	Implement local Study Leave Policy Create Education and training Lead Pharmacist and Pharmacy tech post Upskill tech staff to support & increase provision of patient facing care	In progress	Study Leave Policy published. Pharmacist / pharmacy tech in post. Workforce Strategy drafted includiing L&D. Workforce review complete and staff working to top of licence
Celebrations and Strengths	Strong interest in E&D within department Recruitment and retention working group in place	In progress	Formal E&T structure in place with relevant governance arrangements. HEE approval of interventions and actions.
Strategic Ideas	Innovative roles across boundaries – supporting PCNs. Development of a Education Hub for Medicines Optimisation to support ICS.	In progress	Draft proposal for MO education Hub. New roles in place, or in development across boundaries of care.

Continued

Acute, Clinical Support and Women's Health: **Pharmacy** continued

Focus: ***Quality of Appraisals – Learning and Development of staff***			
Easy Wins	Utilise new appraisal paperwork. Increase uptake of appraisal training	In progress	More staff trained on meaningful appraisals and objective setting
Highest Priority	Co-develop with pharmacy team departmental priorities and objectives to align with trust.	In progress	Staff engaged and aware of priorities. Alignment of staff objectives with Trust objectives
Celebrations and Strengths	High appraisal rate (90%) currently Engagement in vision for pharmacy services	In progress	Appraisal rate over 95% Agreed vision
Strategic Ideas	Linking local pharmacy priorities into Medicines optimisation priorities across ICS	NCL ICS Chief Pharmacist meetings taking place to review cross ICS working.	Joint working on MO priorities across interface

Nursing and Patient Experience

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Promote realistic time frames on work returns	Team now discuss expected timelines for returns so staff have adequate time to deliver	Positive feedback from within the team Staff Survey results
Highest Priority	Ensure all staff have the resources to do their jobs	Staff aware how to escalate if unable to source non-pay items	Staff Survey results Monitoring of budget expenditure
Celebrations and Strengths	Celebrate staff achievements	Monthly Nursing Letter highlights achievements within the nursing directorate Staff nominated for Staff awards	Staff award & nominations
Strategic Ideas	Social events for all teams every 6 months	Christmas Quiz in planning Education Team lunchtime walks and weekly lunch	Quiz Master & date identified Walks occur weekly
Focus: ***Morale***			
Easy Wins	Support and share learning	Increased meetings to bi-monthly Meeting topics to help share innovative projects	Meetings take place Off site away day booked.
Highest Priority	Staff know who to escalate issues and concerns within the team	Staff booked on “Caring for those who Care” sessions Staff to Call out poor behaviour when identified	Staff report confidence in dealing with difficult situations
Celebrations and Strengths	Support staff member of the month	Not yet initiated	
Strategic Ideas	Celebrate teams and their achievements on Twitter/Trust newsletter	A high % of staff already tweet – this is an ongoing project	
Focus: ***Quality of Appraisals***			
Easy Wins	Support and share learning	Increased meetings to bi-monthly Meeting topics to help share innovative projects	Meetings take place Off site away day booked.
Highest Priority	Staff know who to escalate issues and concerns within the team	Staff booked on “Caring for those who Care” sessions Staff to Call out poor behaviour when identified	Staff report confidence in dealing with difficult situations
Celebrations and Strengths	Support staff member of the month	Not yet initiated	
Strategic Ideas	Celebrate teams and their achievements on Twitter/Trust newsletter	A high % of staff already tweet – this is an ongoing project	

Finance

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Morale***			
Easy Wins	Regular team meetings Social events Bitesize learning sessions	Team meetings booked Progress needed on social events and bitesize learning sessions	Continued attendance at sessions
Highest Priority	Directorate Away day to develop team mission statement	To be planned and organised	Attendance and outputs
Celebrations and Strengths	Monthly Awards/recognition nominated by colleagues	Comms to be developed to inform	Continuing pool of nominations made
Strategic Ideas	Greater visibility of training opportunities and career progression evidenced	Training communications and availability	Better engagement scores in next staff survey
Focus: ***Quality of Appraisals***			
Easy Wins	Simplify appraisal documents to focus on the conversation, and pilot with end users	Pilot complete with positive responses. Roll out continues in September	Quality of appraisals scores increasing.
Highest Priority	Appraisal compliance to target of 90%	Managers reminded to check data and undertake outstanding appraisals	Regular reporting of compliance shows 90% achieved
Celebrations and Strengths	Celebrate individual team performance and communicate – league table	Communications to be included on monthly emails/newsletter	Quality of appraisals scores increasing.
Strategic Ideas	Visibility of tangible links between appraisals and progression/developments	Need to develop a way of providing visibility of linkages	Quality of appraisals scores increasing.

Workforce

Category	Plan	Update + Impact (if known)	Indicators of goal met
Focus: ***Health and Wellbeing***			
Easy Wins	Tea Trolley rounds to staff	Workforce team have offered staff tea and coffee in a number of wards and areas such as pharmacy	Provided uplift for Workforce staff.
Highest Priority	'Challenging bullying' for 600+ staff	Nelson to deliver training to 600+ staff	Good evaluations & survey scores
Celebrations and Strengths	Colleagues / teams support each other	EG Project to reduce L&D emails	Emails reduced from 1,700 to below 100
Strategic Ideas	Train more coaches to grow capacity Train Affina Team Journey coaches to improve Trust wellbeing	4 new coaches accredited, more to come 1 Affina coach accredited and 17 others are working on their accreditation	Coached 55 staff members in the Trust Over 18 teams have begun the journey
Focus: ***Morale***			
Easy Wins	Book 'Lunch & Learn' sessions in which we eat, share knowledge, discuss	Regular sessions booked and attended	Continued attendance at sessions
Highest Priority	First Directorate Away day held in November 2018	Activities committed to during the workshop undertaken eg 'In Your Shoes'; Coffee Connect. Next event Nov-19	In Your Shoes taken up by several members; Coffee Connect a popular idea though less active
Celebrations and Strengths	Monthly Workforce Star Awards nominated by colleagues	A Star is Awarded every month and news shared with all Directorate staff	Continuing pool of nominations made
Strategic Ideas	Support London Pride; badges acquired Support wellbeing events run by colleagues for colleagues	Whittington Health at London Pride Wellbeing events celebrated at Culture Fair and attended	Better engagement scores in next staff survey
Focus: ***Quality of Appraisals***			
Easy Wins	Simplify appraisal documents to focus on the conversation, and pilot with end users	Pilot complete, +ve responses, comments used in revised document published on intranet. (Still to do: medics)	New documentation well received; used. Scores on next survey for quality of appraisals should increase.
Highest Priority	Drive to improve appraisal compliance to target of 90%	Active cascade of instruction from managers to check data and undertake outstanding appraisals	Regular reporting of compliance shows 90% achieved – still to do
Celebrations and Strengths	Monitor feedback on use of new document	New form being used and early local feedback is positive	Scores on next survey for quality of appraisals should increase.
Strategic Ideas	Collaboration on design and pilot to maximise buy-in	Design largely approved with minor requests from those piloting documents	Simpler paperwork used throughout the Trust with more person focus

We Said We Did

NHS Whittington Health NHS Trust

Team name: District Nursing June 2019

We Said

- Time to do the job
- Unrealistic time pressures
- Unpaid overtime
- Enough staff to do the job properly

We did

Improve staffing levels with recruitment
Skill Mix review with increased PDN's and training roles.
Request for 15% uplift for DN service
Moving meds admin over to Social care
Phlebotomy

We Said

- Adequate materials to me the job

We did

- Providing Ipads for agency staff, also trialling better approach with range of IT solutions
- Every staff has a blood glucose machine (Incl 2 for agency
- Extra ear irrigation , Checking
- New starters have BP machine

We Said

We did

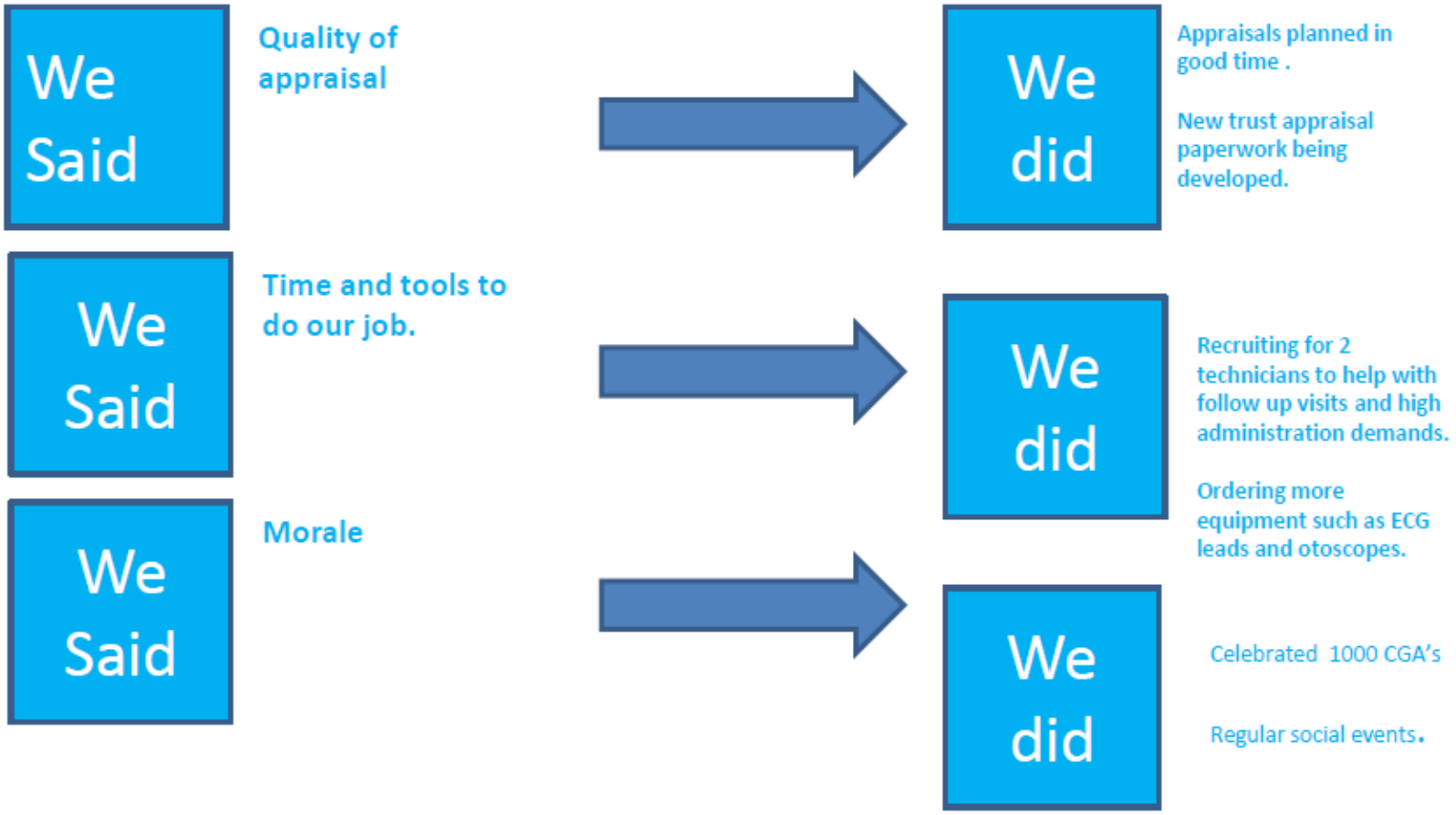
Using our ICARE Values - The more you tell us the more we can do

APPENDIX F (ii) ICAT/NIFT

We Said We Did

NHS Whittington Health NHS Trust

Team name: ICAT/NIFT



Using our ICARE Values - The more you tell us the more we can do

APPENDIX F (iii) MSK/PHYSIO

We Said We Did

NHS Whittington Health NHS Trust

Team name: MSK Physiotherapy and MSK CATS April 2019

We Said	Time to do the job 23-33% Unrealistic time pressures 15-23% Unpaid overtime 0-7%	→ We did	Improve staffing levels with recruitment Demand and capacity review Skill mix with increased admin support
We Said	Adequate materials to me the job 15-23%	→ We did	Ordered new weights with student money last year Looking as buying more this year
We Said	Enough staff to do the job properly 38%	→ We did	Improving recruitment time Regular meeting with HR and prompt VSP submission Skill mix review with more admin support

Using our ICARE Values - The more you tell us the more we can do

NHS
Whittington Health
NHS Trust

We Said We Did

Team name: Nutrition and Dietetics (2019). *Note there is no team specific breakdown*

We Said	Time to do my job	We did	CBS to begin to book DOM visits Review job templates to allow more time to do paperwork? More time for DOMS
We Said	Clinical Supervision – would like more	We did	Joint CPD sessions with Acute Dietitians being arranged Annual Clinical Observation (peer to peer) rota created
We Said	Inter team working – would like to work better with other teams	We did	Quarterly meetings with Acute Dietitians team Use CareFlow to communicate more effectively

Using our ICARE Values - The more you tell us the more we can do

APPENDIX F (v) CENTRAL BOOKING TEAM

We Said We Did

Whittington Health NHS Trust

Team name: CBS

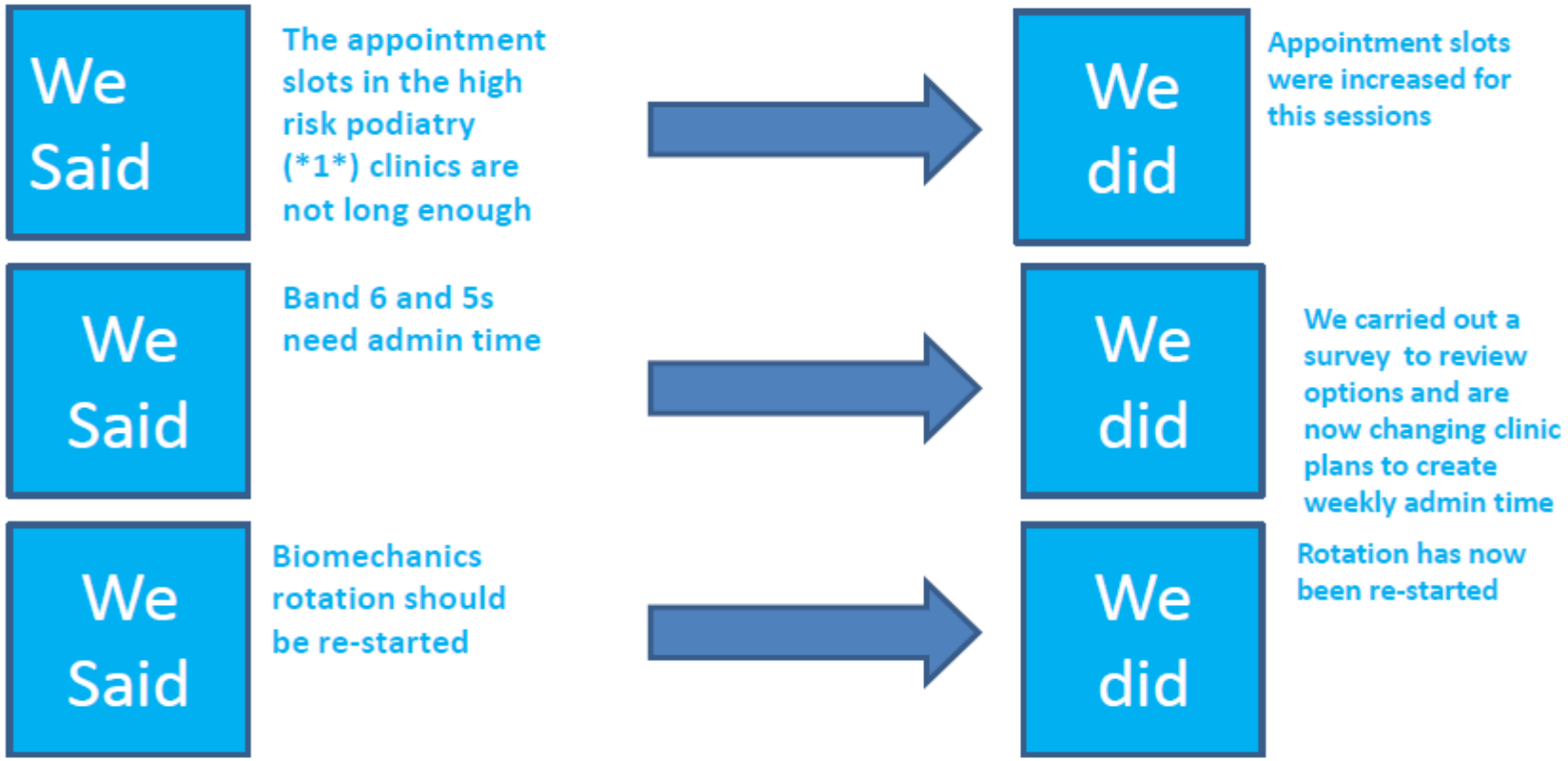
We Said	We did
Listening and involving: Needs to be better staff need to be heard more Management should be more approachable. Happier staff better workers Staff sometimes feel secluded. This should be recognised and stopped Staff morale We should have a team building day for everyone to come together and build a happier bond and see staff personalities out of the office.	Confidential box provided. Team leads have met and now ensure they give proper attention to staff more responsive to staff needs when they are approached. No staff is in seclusion as all staff are on the general floor. Team away day being planned
Time to do Job All Hubs should have regular training	Training has been arranged for staff which has covered: RIO, Medway, General appointment booking. Staff have all been encouraged to register and complete several modules for Microsoft Office
Motivation from employer, appreciation, work life balance	More staff have been recruited and have started Arrangements have been made for Service leads to come to Team meetings and the ICSU leadership team would also be attending from time to time and express appreciation to the team.

Using our ICARE Values - The more you tell us the more we can do

NHS
Whittington Health
NHS Trust

We Said We Did

Team name: Podiatry



Using our ICARE Values - The more you tell us the more we can do

APPENDIX F (vii) REACH

We Said We Did

NHS Whittington Health NHS Trust

Team name: REACH

We Said	Health & Wellbeing	We did	• Opening pleasantries for all meetings • No pressure Sick Leave • Mental Health training • Comprehensive risk assessments
We Said	Morale	We did	• Comprehensive and tailored induction to team • Visible Leadership presence • Team Huddle • Welcome Breakfast
We Said	Quality of Appraisal	We did	• All to attend Appraiser and appraisee training • Advanced dates in the diary • TNA completed during S/V • No surprises during appraisal

Using our ICARE Values - The more you tell us the more we can do

APPENDIX F (viii) PHARMACY

Team: Pharmacy
Theme:

We Said	We would co-develop department wide priorities aligned with Trust's Objectives		We Did	Develop an agreed vision and set of priorities for Pharmacy and Medicines Optimisation
We Said	We would implement new posts to specifically support workforce development		We Did	Developed a Pharmacist and Pharmacy technician Lead role For E&T and Workforce.
We Said	We would improve our understanding of patients' experiences of our service		We Did	Piloted and implemented patient surveys and feedback from these to inform service provision

APPENDIX F (ix) Nursing Directorate

We said	We need to improve communication within the team/directorate	→	We did	Introduced team huddles, have monthly team meetings, share calendars
We said	We need to support a positive and supportive culture at work	→	We did	We request everyone to ensure correct email etiquette, call out poor behaviour, ensure people have access to FSUG
We said	Improve communication from Board down	→	We did	Increase to Directorate bi-monthly meetings to help with information sharing

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2.019**
Report title	**2018/19 Public Sector Equality Duty Annual Report**	**Agenda item: 12**
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	All public sector organisations are required to undertake a review of their equality and diversity data and the organisation's activities to improve equalities and inclusion under their public sector equality duty. The draft report provides information on the Equalities Act 2010 which came into force in April 2011, and explains the purpose of our duty and requirement to scrutinise the impact of our actions on our service users and staff in relation to the nine 'protected characteristics' created by the 2010 Act. The report also provides information on the Trust, our service-users, our purpose and corporate objectives. Information is presented in graph and table form on the patient profile, followed by a section with data on staff profile, according to the protected characteristics. The final section of the report discusses Trust 'equality delivery system' (EDS2) activity and explains the goals and outcomes supported by the tool. In relation to the two goals relating to patient care, Whittington Health is collaborating with other trusts to maximise the range of patients and services included in the grading of Trust performance with respect to equality of access and care. In relation to the two goals relating to staff and leadership, focus groups have been undertaken to grade our performance collaboratively with staff, partners and unions, staff networks, leaders and managers, with the predominate grade being 'developing' which means that some progress has been made and there is more work to be done.	
Purpose:	This paper presents the proposed draft for the 'public sector equality duty report' to be made available to the public, and provides equality and diversity information on our patients and staff.	
Recommendation(s)	The Board is asked to note approve the draft report for publication on the Trust website.	
Risk Register or Board Assurance Framework	BAF entry - People 2	
Report history	None	
Appendices	Draft 2018/19 Public Sector Equality Duty annual report	

NHS
Whittington Health
NHS Trust

Whittington Health

2018/2019 Statutory Public Sector Equality Duty Annual Report

I INNOVATION
C COMPASSION
A ACCOUNTABILITY
R RESPECT
E EXCELLENCE

CONTENTS

1 Purpose of the Report

1.1 This report presents equality information about the Trust's service user population and workforce with reference to the protected characteristics identified in the Equality Act 2010.

1.2 The report is split into two main Sections: 'A. patients and service users'; and 'B. workforce'. Information in each section is largely presented in section headings which relate to the nine protected characteristics. Some sections are likely to contain significantly less information than others which is reflective of the challenges and limitations of collecting information, and individual personal rights to choose what to disclose. Where there is limited information, these come with the caveat that it is hard to draw conclusions except give opinion in places.

1.3 The Equality Act 2010 (the Act) replaced previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies to make it easier for people to understand and comply with. The public sector Equality Duty (section 149 of the Act) came into force on 5 April 2011.

1.4 The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services which are efficient and effective; accessible to all; and which meet different people's needs.

1.5 The Equality Duty is supported by specific duties, set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives.

1.6 The information published is expected to demonstrate the Trust's regard and support for achievement of the three aims of the Equality Duty:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it.

1.7 The nine protected characteristics covered by the Equality Duty are:

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership (only with respect to eliminating unlawful discrimination)
v. Pregnancy and maternity
vi. Race (this includes ethnic or national origins, colour or nationality)
vii. Religion or belief (this includes lack of belief)
viii. Sex (gender)
ix. Sexual orientation

2 The Protected Characteristics Defined by the Equality Act

2.1 **Age** – This refers to a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. Where people fall into the same age group they share the protected characteristic of age.

2.2 **Disability** – In the Act, a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. For the purposes of the Act, these words have the following meanings:

- 'substantial' means more than minor or trivial
- 'long-term' means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions)
- 'normal day-to-day activities' includes everyday things like eating, washing, walking and going shopping
- There are additional provisions relating to people with progressive conditions. People with HIV, cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairment are automatically deemed to be disabled. Where people have the same disability, they share the protected characteristic of disability.

2.3 **Gender reassignment** – This is defined for the purpose of the Act as where a person has proposed, started or completed a process to change his or her sex. A transsexual person has the protected characteristic of gender reassignment. A person who has only just started out on the process of changing his or her sex, and a person who has completed the process, share the characteristic of gender reassignment.

2.4 **Marriage and Civil Partnership** – This refers to people who have the common protected characteristic of being married or of being civil partners. A person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic.

2.5 **Pregnancy and maternity** – A woman remains protected in her employment during the period of her pregnancy and any statutory maternity leave to which she is entitled. This is now separate from protection on grounds of sex, which is not available to a woman during pregnancy and maternity. It is unlawful to take into account an employee’s period of absence due to pregnancy related illness when taking a decision about her employment.

2.6 **Race** – For the purposes of the Act, 'race' includes colour, nationality and ethnic or national origins. People who have or share characteristics of colour, nationality or ethnic or national origins can be described as belonging to a particular racial group. Examples: Colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be 'black Britons' which would encompass those people who are both black and who are British citizens.

2.7 **Religion or Belief** – This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system. The Act includes the following examples: The Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism. To be considered a philosophical belief for the purposes of the Act, it must be:

- genuinely held
- be a belief and not an opinion or viewpoint
- be a belief as to a weighty and substantial aspect of human life and behaviour
- attain a certain level of cogency, seriousness, cohesion and importance
- be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others
- The Act cites as examples of philosophical beliefs, Humanism and Atheism. Adherence to a particular football team would not be a religion or belief. A cult involved in illegal activities would not satisfy these criteria. People who are of the same or different religions or beliefs share the protected characteristic of religion or belief.

2.8 **Sex (gender)** – For the purposes of the Act, sex means being a man or a woman. Men share the sex characteristic with other men and women with other women. There is no reference in the Act to non-binary gender (those who do not identify themselves as exclusively a man or a woman).

2.9 **Sexual Orientation** – This is defined in the Act as a person's sexual orientation towards:

- People of the same sex as him or her (in other words the person is a gay man or a lesbian).
- People of the opposite sex from him or her (the person is heterosexual).
- People of both sexes (the person is bisexual).
- People sharing a sexual orientation mean that they are of the same sexual orientation and therefore share the characteristic of sexual orientation.

3 About Whittington Health

3.1 Whittington Health aims to help local people live longer and healthier lives by providing safe, personal, coordinated care for the community we serve.

3.2 As an 'integrated care organisation' (ICO), both hospital and community care services are provided to over 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

3.3 Whittington Health also provides several specialist services to broader geographies such as our community dentistry services in ten London boroughs and its internationally recognised Michael Palin Centre - a specialist speech and language service which receives referrals from around the world.

3.4 The Trust aims to create innovative ways to integrate teams across the organisation and with partners in the council, primary care, mental health and the voluntary sector.

3.5 Our priority is to provide the right care, at the right time and in the right place for our patients. We provide a large range of services from the hospital, including accident and emergency, maternity, diagnostic, therapy and elderly care. We also run services from 30 community locations in Islington and Haringey, and dental services across north, central and west London. Over the past year we have reviewed and developed services to make them stronger and better support the needs of patients.

3.6 As an integrated care organisation we bring high quality services closer to home and speed up communication between community and hospital services, improving our patients' experience. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

3.7 Our organisation has a highly-regarded educational role. We teach undergraduate medical students (as part of University College London (UCL) Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals.

3.8 The Trust has recently refreshed its corporate objectives, which are:

i. Deliver outstanding, safe and compassionate care
ii. Empower, support and develop staff
iii. Integrate care with partners and promote health and wellbeing
iv. Transform and deliver innovative, financially sustainable services

3.9 The Trust recently developed staff networks including a general staff inclusion network, a black and minority ethnic (BME) network, and is currently supporting the creation of a diverse ability network.

3.10 There is more information about the Trust on its website at https://www.whittington.nhs.uk/

4 Patient Equality Information

4.1 There are two sets of patient equality information that are available. Firstly data which analyses data that relates to who is using our services and secondly data that relates to the patient experience while they are under our care. Some data is not able to be analysed as it is not routinely collected via Medway or Rio our patient management systems. This information may be held in the written medical or nursing notes for patients. This has been reported to the Chief Nursing Information Officer who will action this as part of our ongoing work to digitalise patient records

4.1.1 Age

Charts 1 to 4 below show the age profile of patients who have attended ED last year, were inpatients, outpatients or cared for in the community. The figures indicated that the age profile for those attending ED peaks at 20-30 years, closely followed by 30-40 years. For inpatients and outpatients, the peak is it 30-40 years and for community it is 80-90 years.

Chart 1

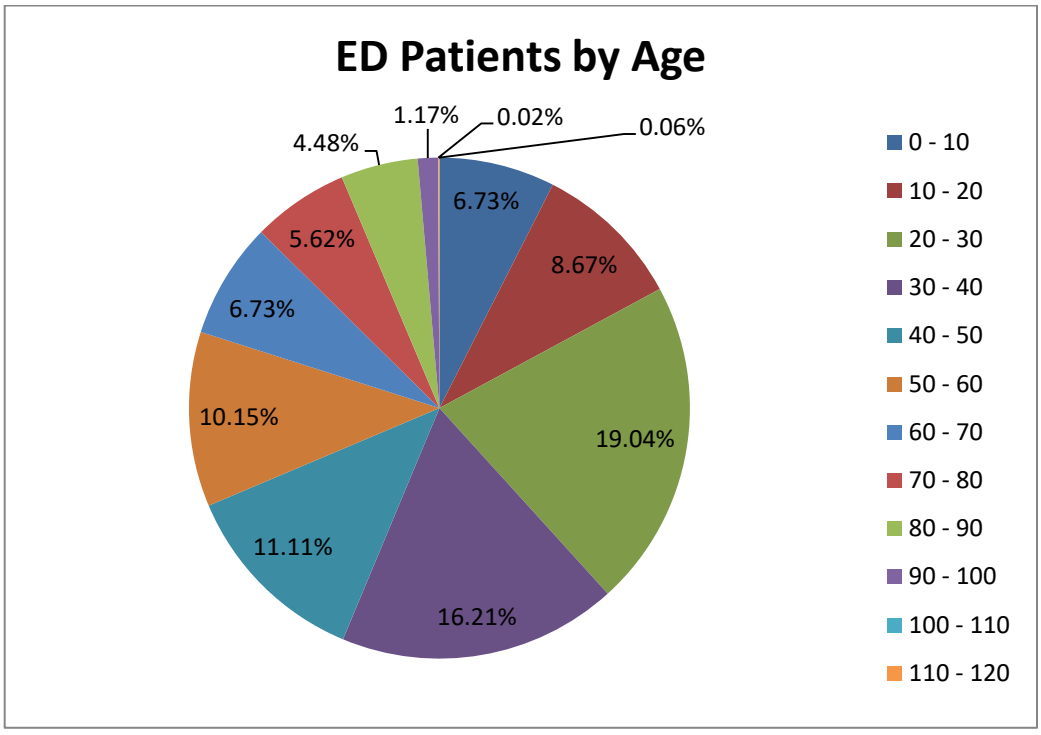


Chart 2

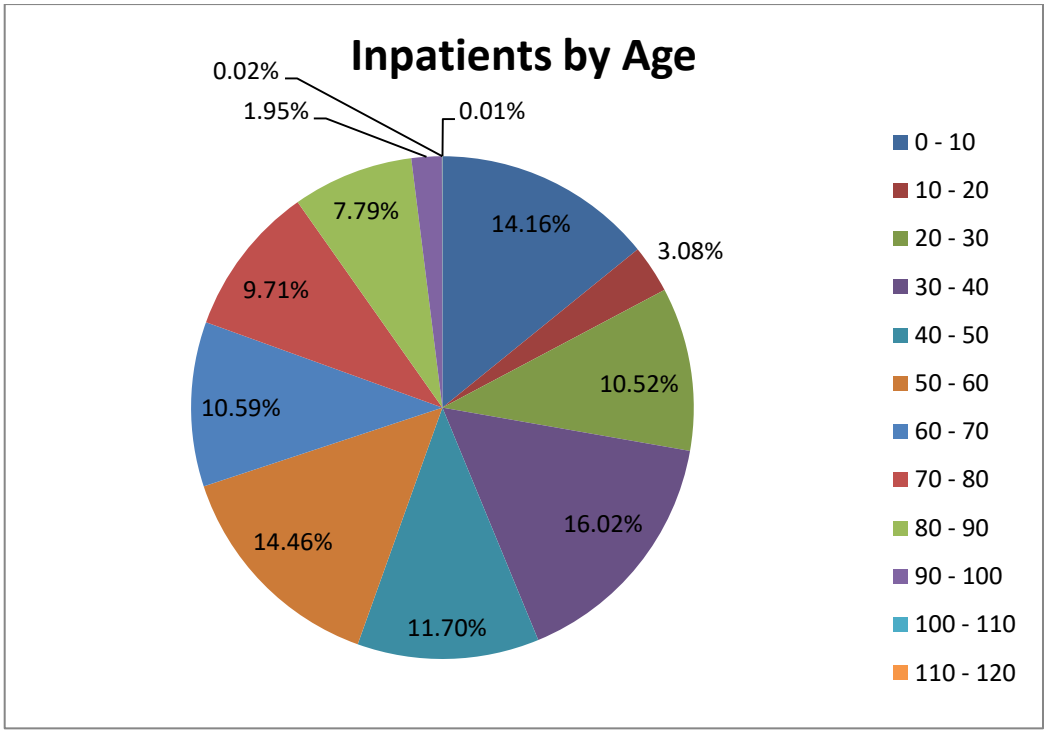


Chart 3

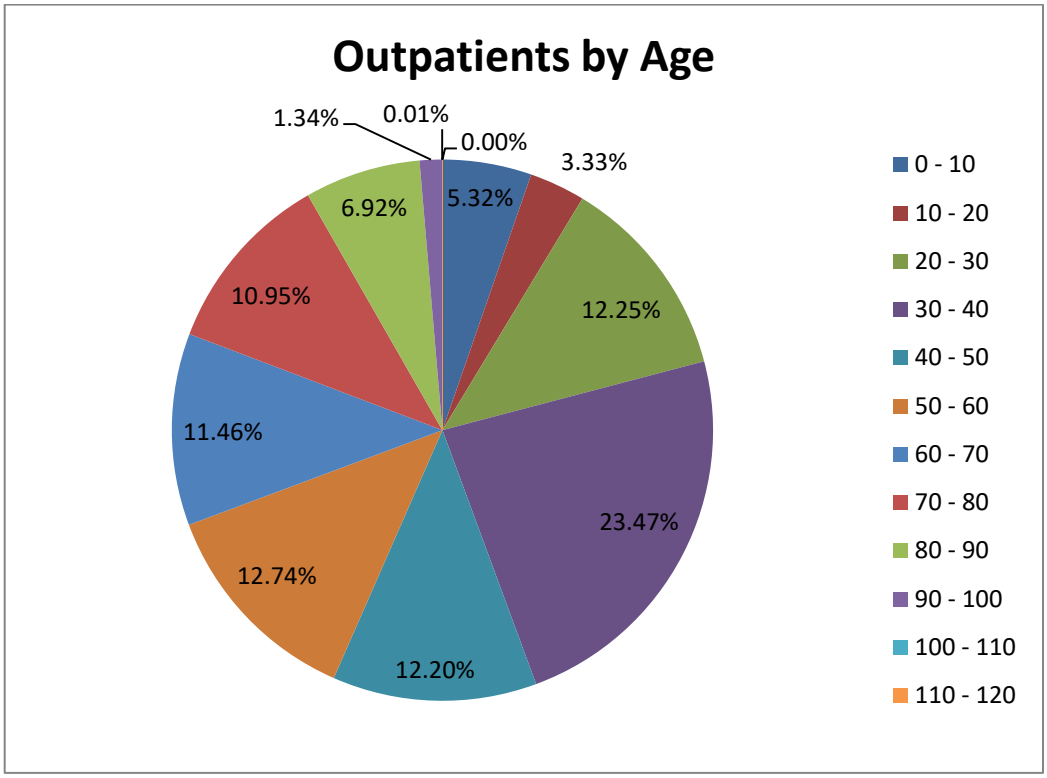
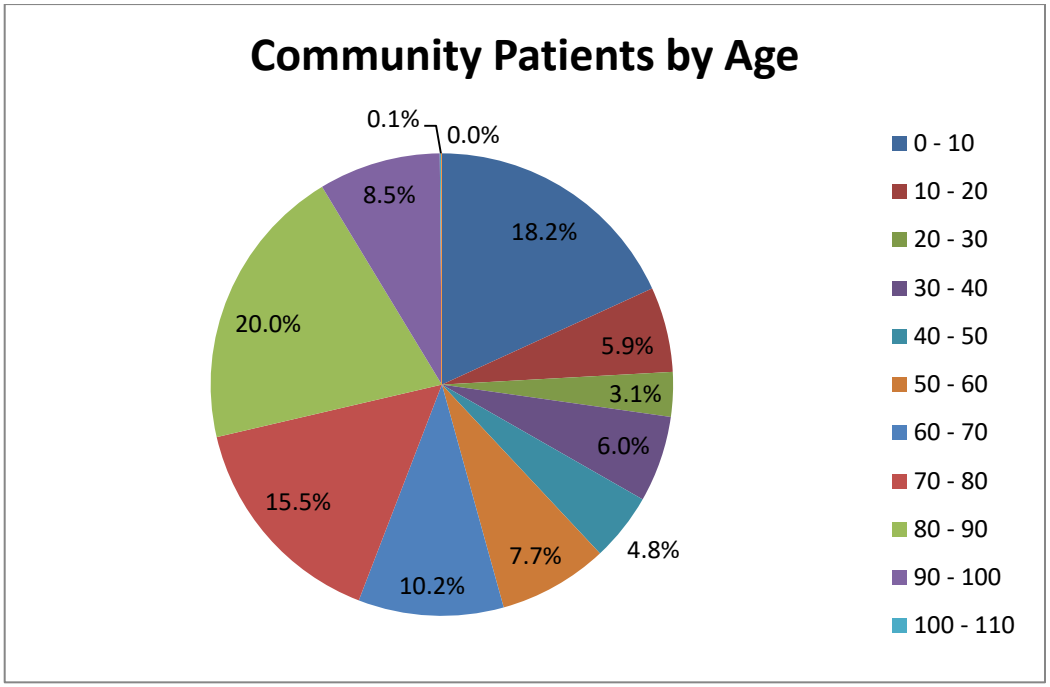


Chart 4



4.1.2 Disability

This information isn't routinely collected through Medway or Rio our patient information management systems.

4.1.3 Gender Reassignment

This information isn't routinely collected through Medway or Rio our patient information management systems.

4.1.4 Marriage and Civil Partnership

Charts 5 to 7 below show the marital status declared by patients who attended ED, inpatient and outpatients. The majority of patients are registered as single, however for a considerable number, their status is unknown. This information is not available for community patients as it isn't routinely collected on Rio.

Chart 5

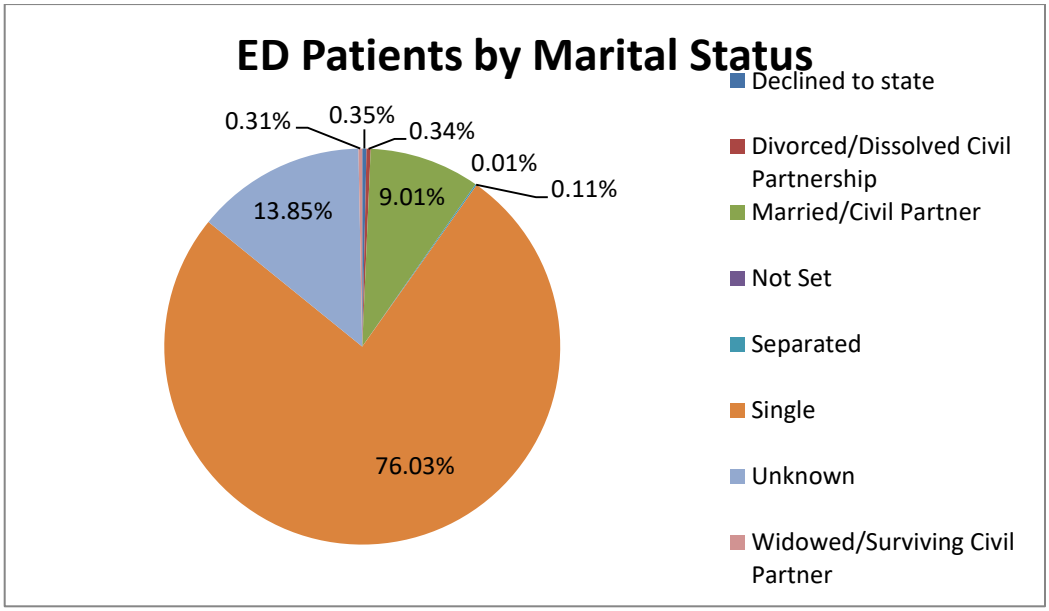


Chart 6

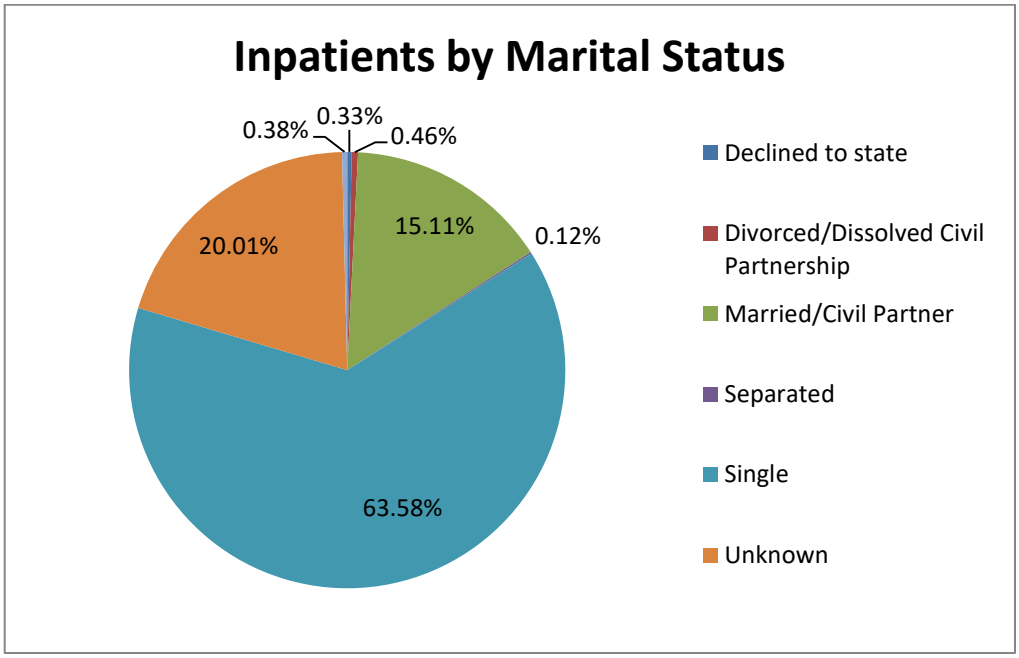
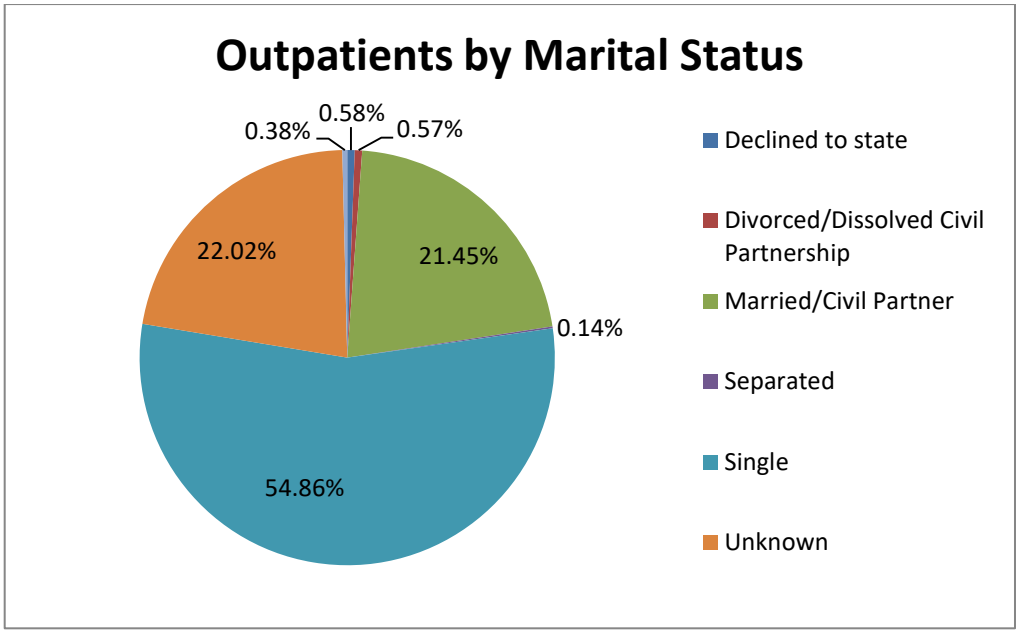


Chart 7



4.1.5 Pregnancy and Maternity

This information isn't routinely collected through Medway or Rio our patient information management systems.

4.1.6 Race (this includes ethnic or national origins, colour or nationality)

Charts 8 to 10 below shoe a breakdown of race of patients. For all areas, the predominant race is White British. The proportion of white patients is lower than the proportion in the local population (see section 5). The data for community patients is incomplete and 28.3% of patients are allocated codes that are no longer used, or it is recorded as not stated. Of the data that is available, the predominant race is British at 23.7%, with the next highest percentage being Black or Black British – Caribbean.

Chart 8

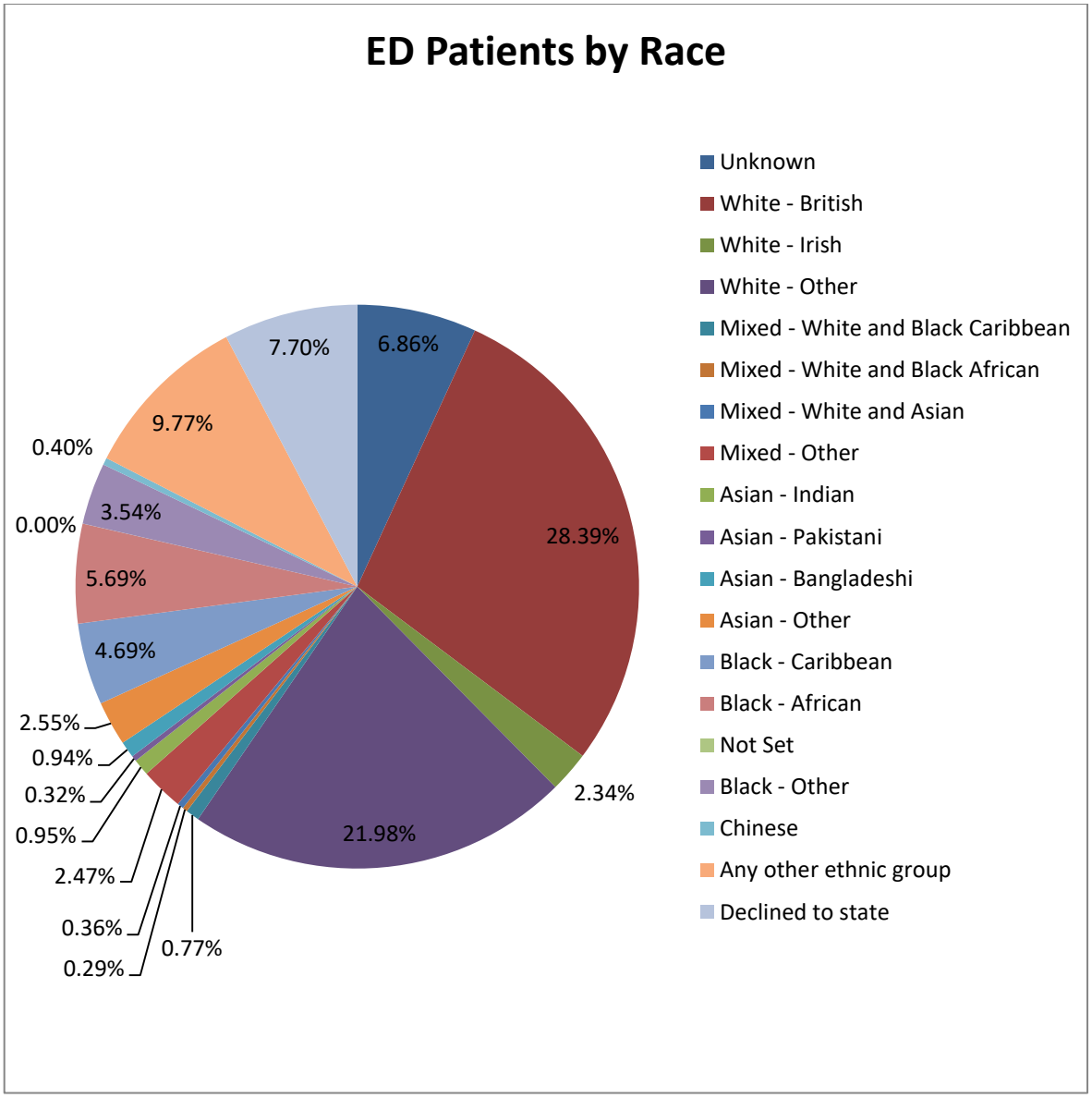

ED Patients by Race
6.86%
28.39%
2.34%
21.98%
0.77%
0.29%
0.36%
2.47%
0.95%
0.32%
0.94%
2.55%
4.69%
5.69%
0.00%
3.54%
0.40%
9.77%
7.70%
Unknown
White - British
White - Irish
White - Other
Mixed - White and Black Caribbean
Mixed - White and Black African
Mixed - White and Asian
Mixed - Other
Asian - Indian
Asian - Pakistani
Asian - Bangladeshi
Asian - Other
Black - Caribbean
Black - African
Not Set
Black - Other
Chinese
Any other ethnic group
Declined to state

Chart 9

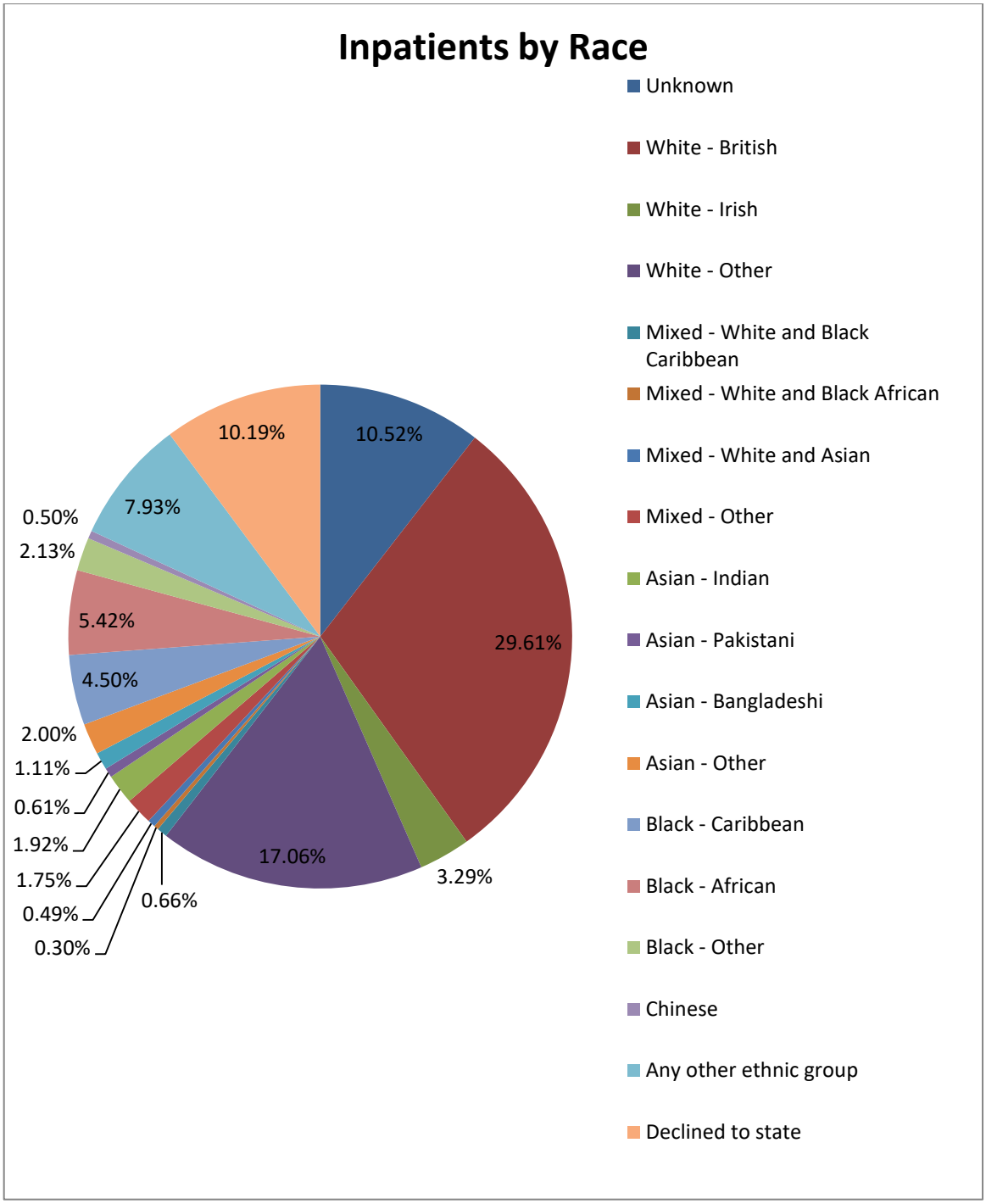
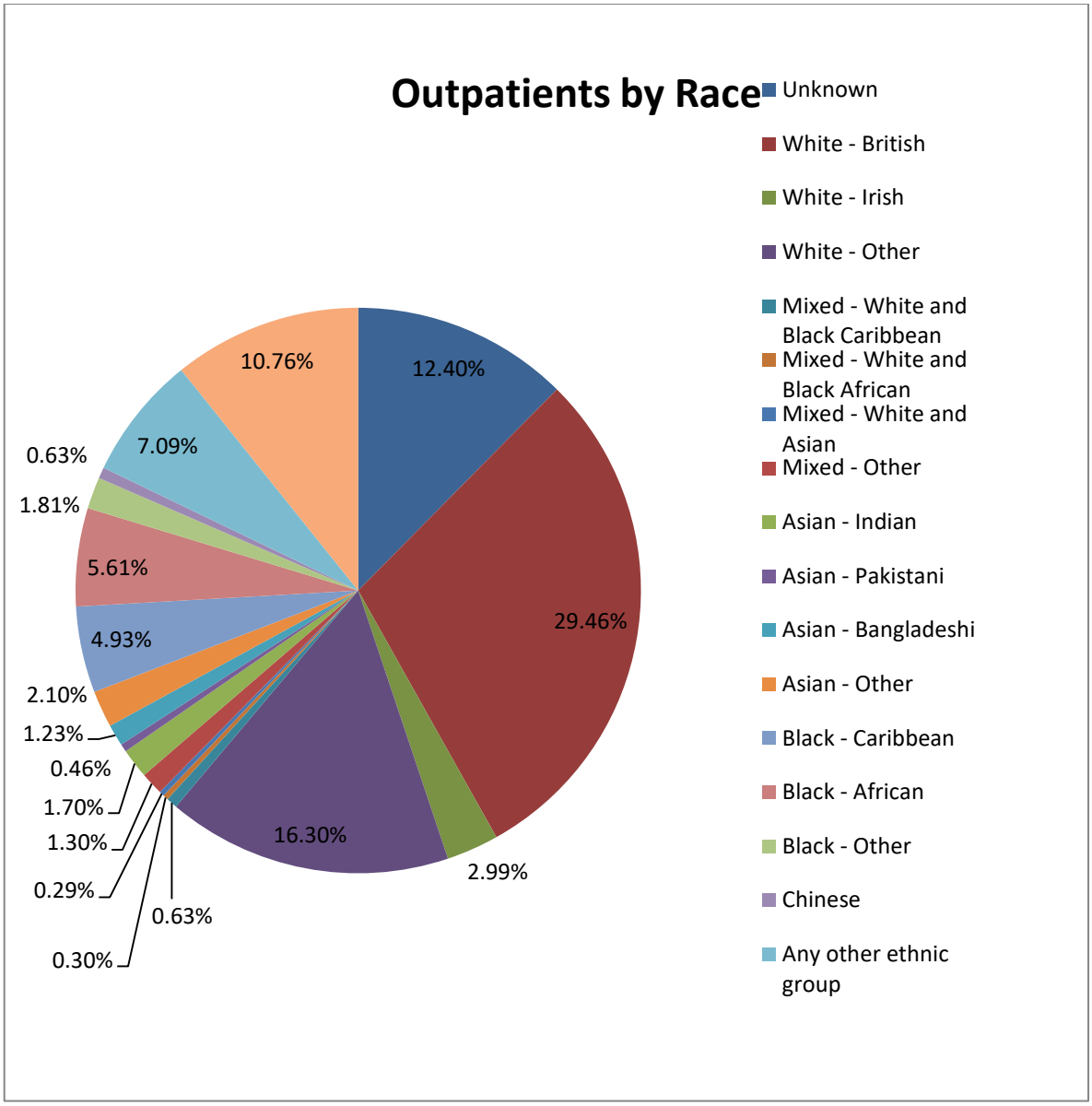

Inpatients by Race
Unknown
White - British
White - Irish
White - Other
Mixed - White and Black Caribbean
Mixed - White and Black African
Mixed - White and Asian
Mixed - Other
Asian - Indian
Asian - Pakistani
Asian - Bangladeshi
Asian - Other
Black - Caribbean
Black - African
Black - Other
Chinese
Any other ethnic group
Declined to state
10.52%
29.61%
3.29%
17.06%
0.66%
0.30%
0.49%
1.75%
1.92%
0.61%
1.11%
2.00%
4.50%
5.42%
2.13%
0.50%
7.93%
10.19%

Chart 10



4.1.7 Religion or belief

It is difficult to comment accurately on the religion of patients as over 50% in all categories is unknown. Where religion or belief is known, 10-13% are registered as having no religion, and 11-15% are Christian or Roman Catholic. Overall, patients with 50 different religions or beliefs attended Whittington Health last year. This information is not routinely collected on Rio and so it is not possible to comment about community patients.

4.1.8 Sex (gender)

Of all patients seen in ED or who are inpatients, outpatients or those who are cared for in the community, over 50% identify as female. (Please see Charts 11 to 14 below)

Chart 11

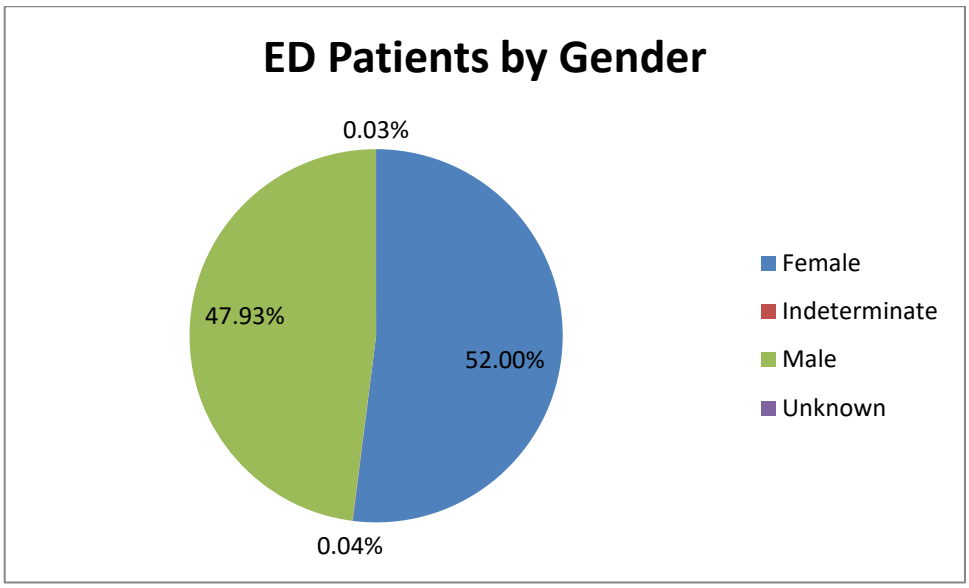


Chart 12

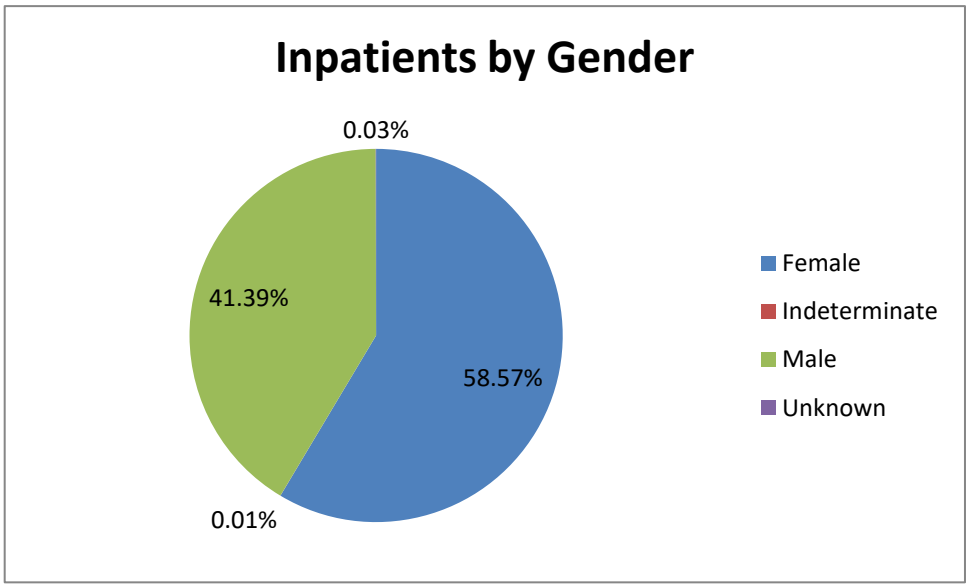


Chart 13

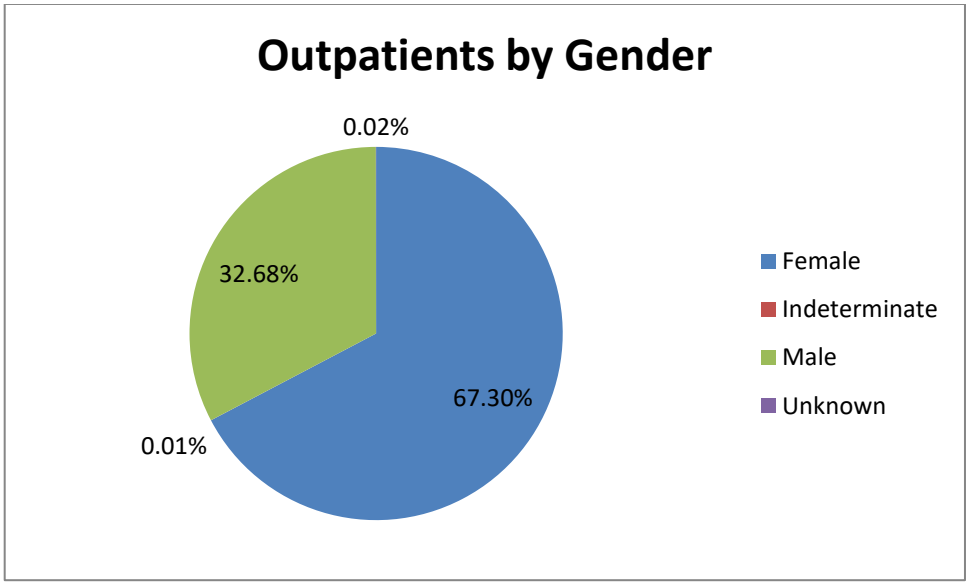
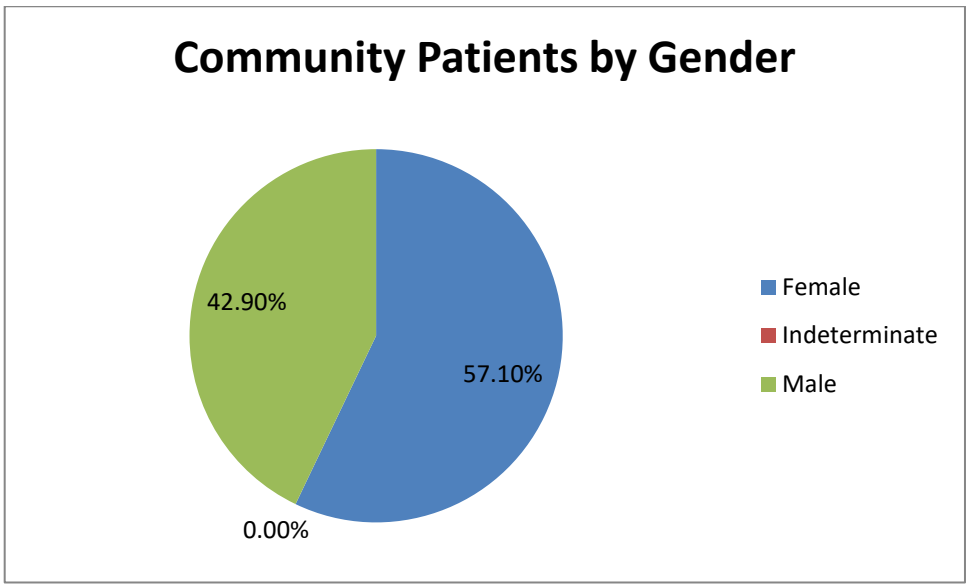


Chart 14



4.1.9 Sexual orientation

This information isn't routinely collected through Medway or Rio our patient information management systems.

4.2.4 Serious incidents

A total of 30 Serious Incidents (Sis) were reported in 2018-19. A breakdown by gender (Chart 15), age (chart 16), ethnicity (chart 17) and disability (chart 18) are displayed below.

Chart 15

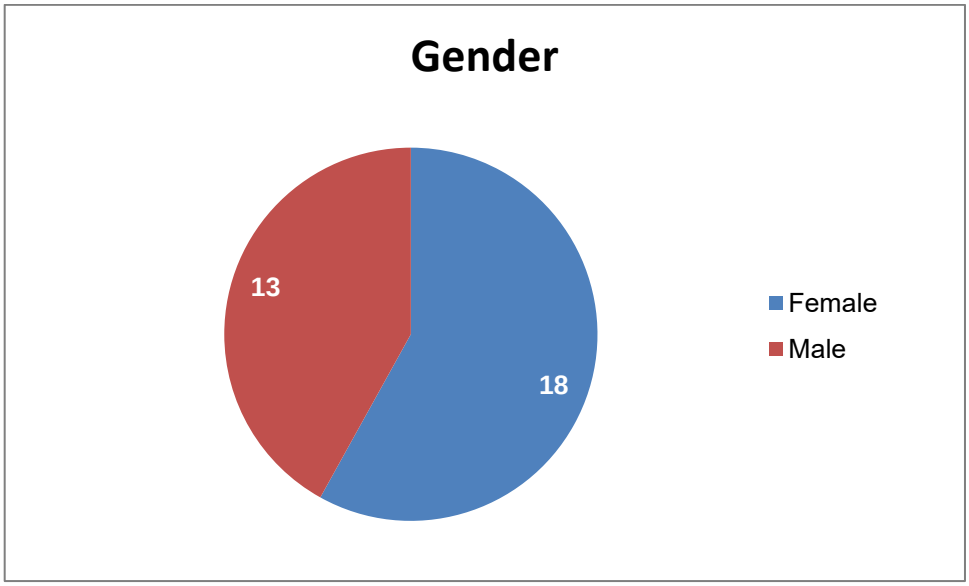


Chart 16

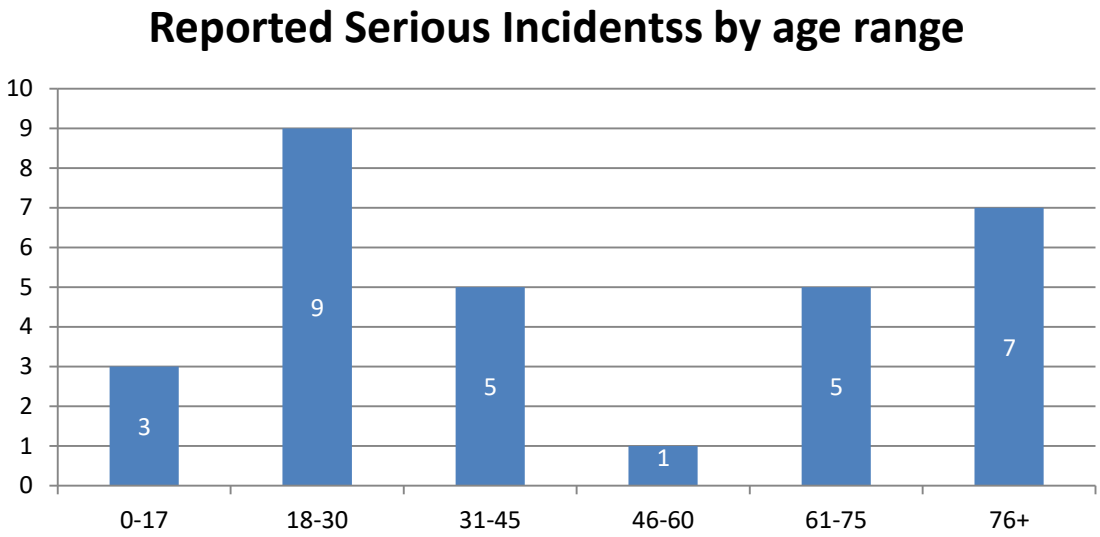


Chart 17

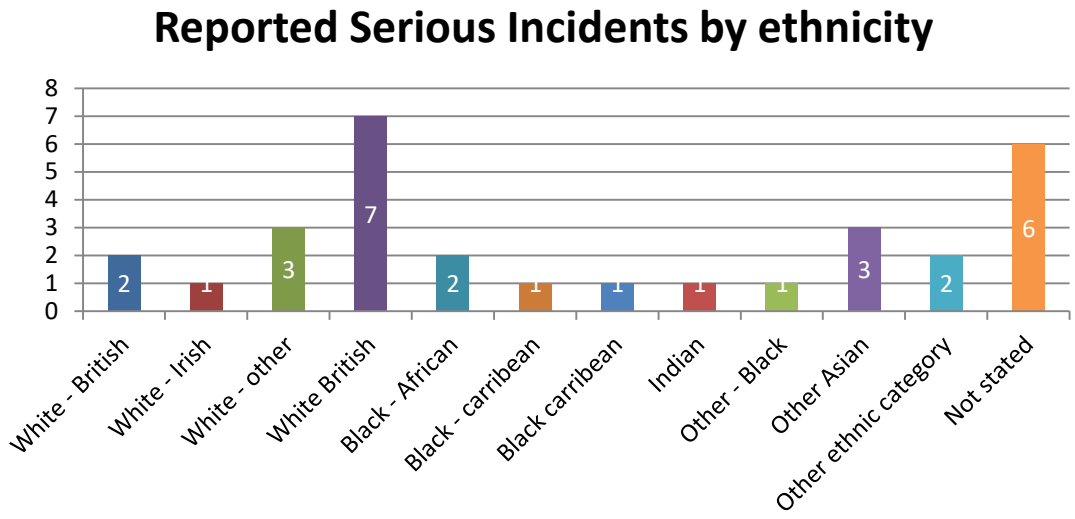
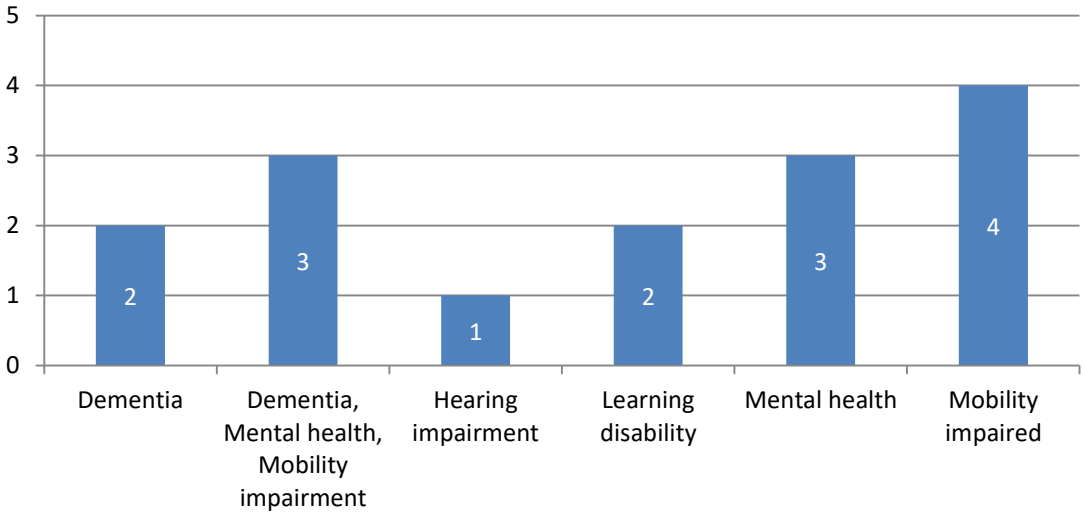


Chart 18



This shows that 58% of those who were involved in an SI were female, which is consistent with the percentage users of our service. Reports by ethnicity are appear to be broadly representative. It is interesting to note that the predominant age range of 18-30 is lower than we would expect from the local service users. Of the SIs reported, there were 8 patients with multiple disabilities and most of those comprised patients with mobility issues.

4.2.5 Complaints

There were 324 complaints last year. The data broken down by gender, age, ethnicity and disability is displayed below (Charts 19 to 22 respectively).

Chart 19

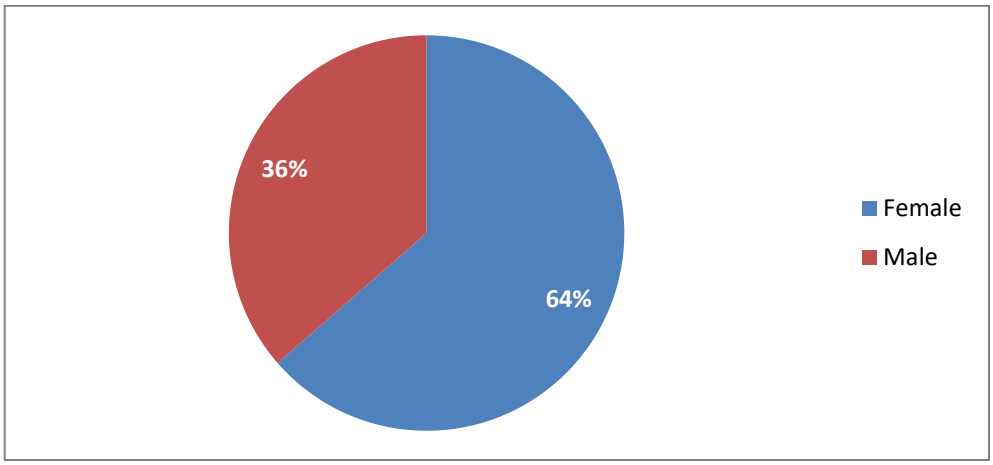


Chart 20

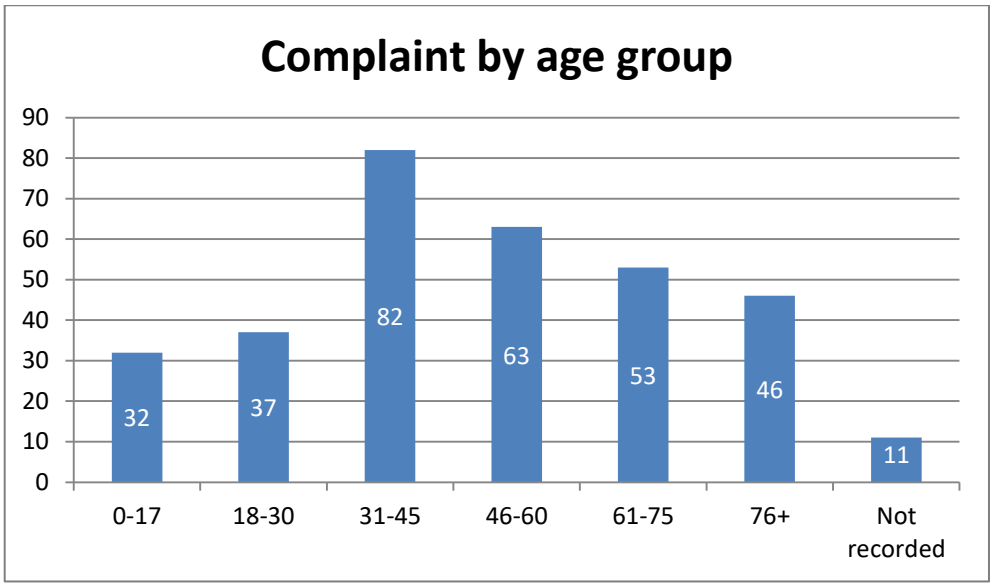


Chart 21

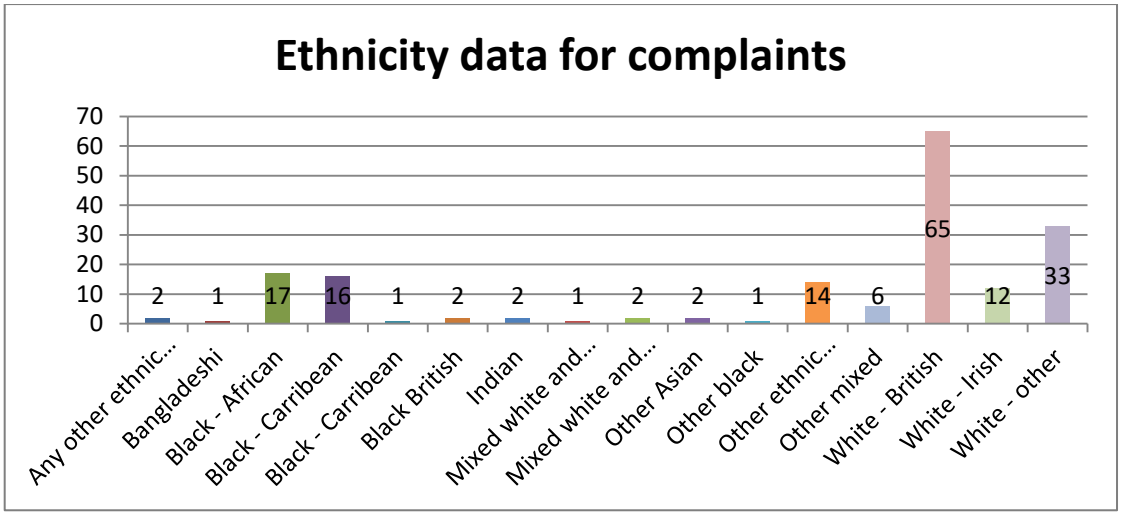
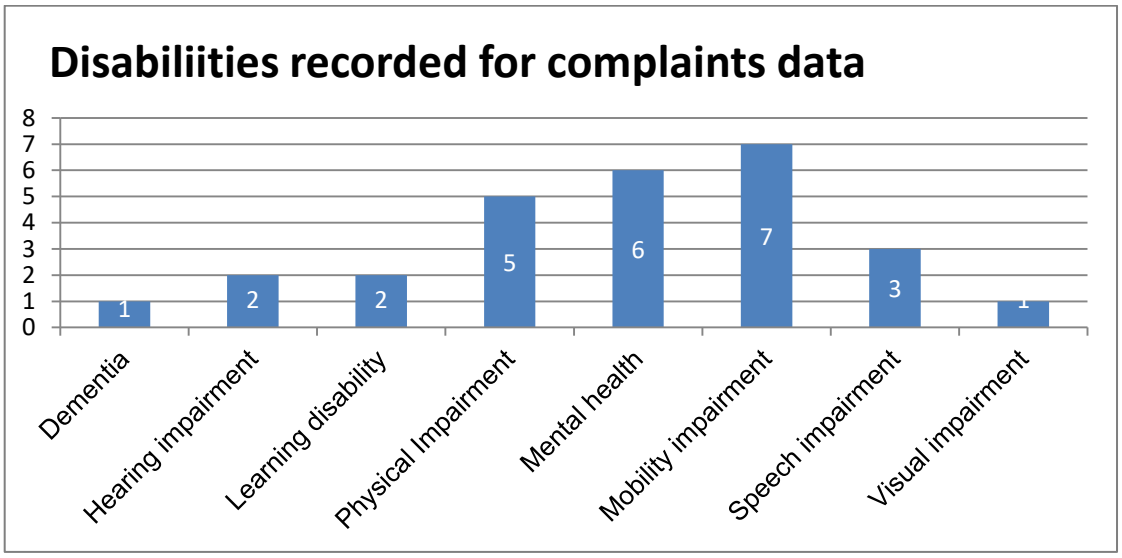


Chart 22



The data for age is broadly representative of what we would expect, however for gender there was a slightly higher proportion of complaints than expected from females than males. It is difficult to comment on the ethnicity data as in the case of 147 complaints, the ethnicity was either not stated or unknown and this is not included within the chart. It is also difficult to comment on disabilities as for the majority of complaints (225) “unknown” was recorded for disability. Please note that there were 17 patients reported to have a disability, and if more than one disability was recorded that is displayed in the graph.

5 Workforce Equality Information

The following information details the workforce equalities information by protected characteristic.

5.1 Age

Chart 23 below show the age profile of Whittington Health staff. The figures indicate that the age profile peaks between ages 26-30, closely followed by those between 31-35 and 36-40.

Chart 23 – Age Profile of Whittington Health Staff

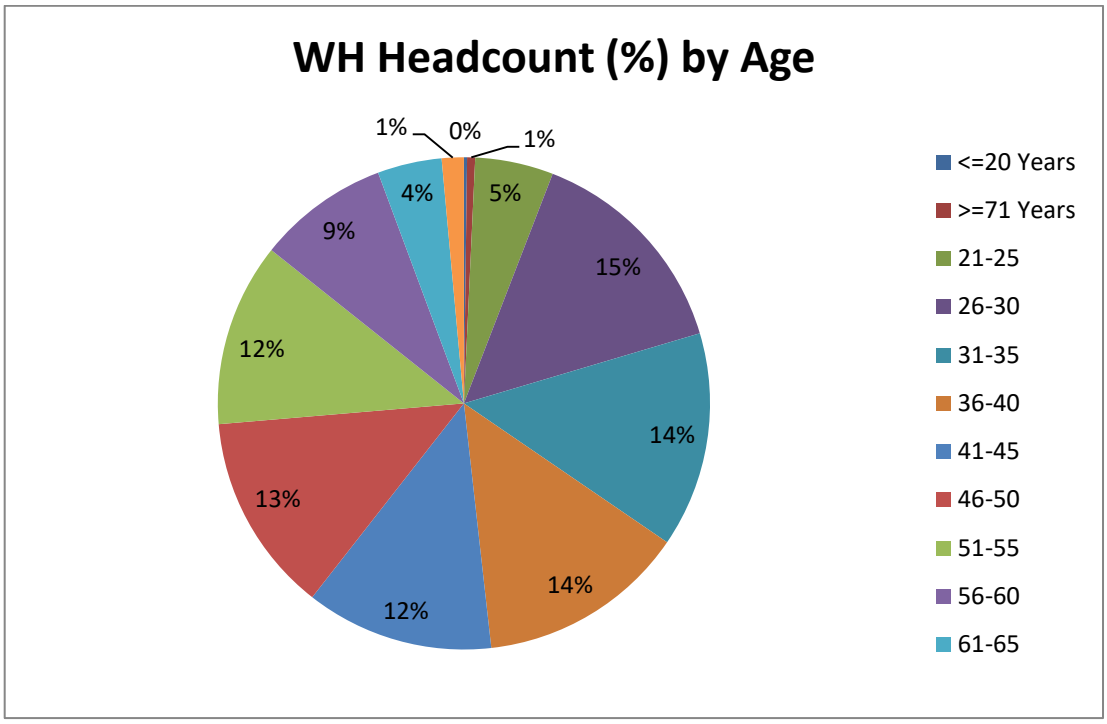
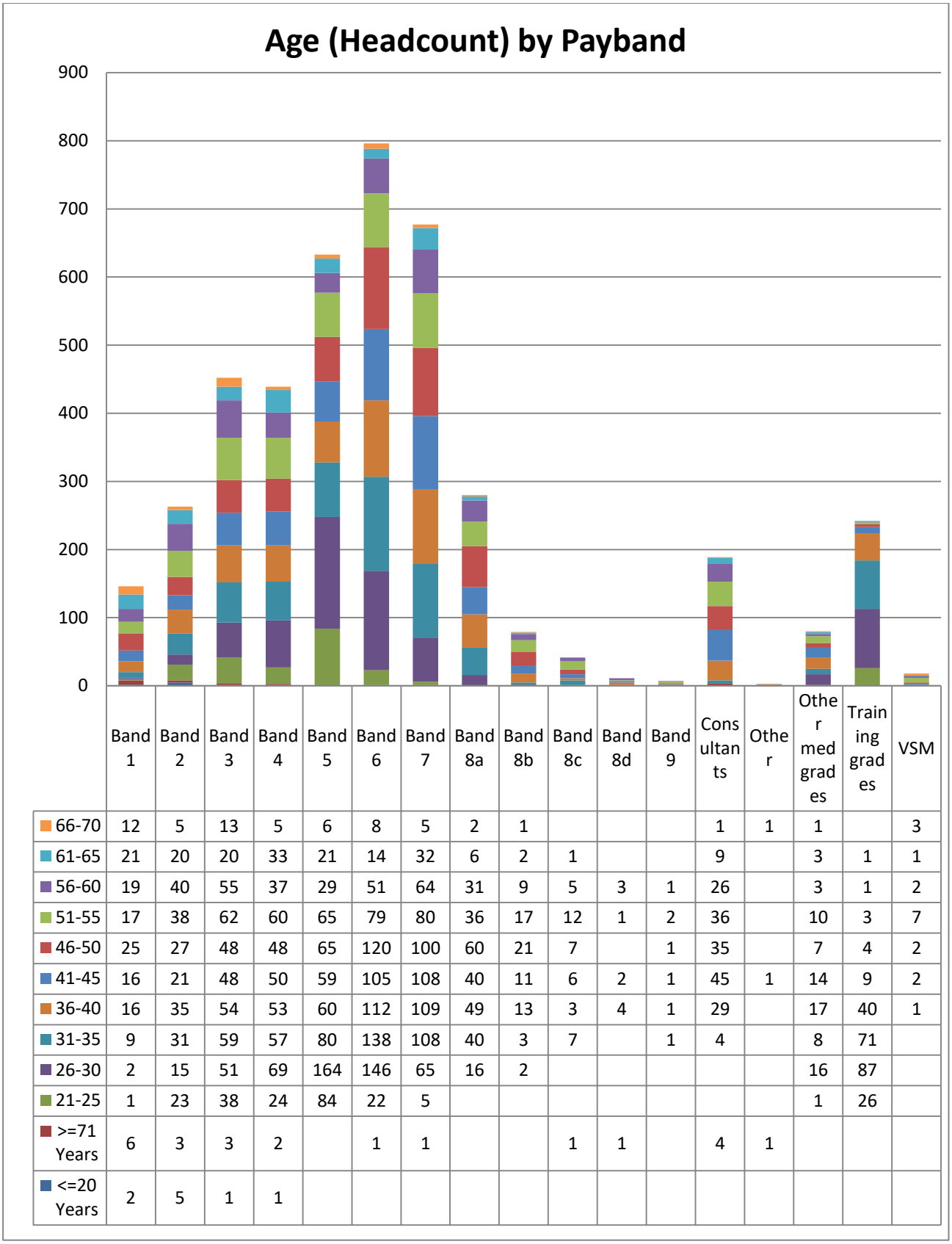


Chart 24 – comparison of age by pay-band by age as at 31 March 2019



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultants	Other	Other med grades	Training grades	VSM
66-70	12	5	13	5	6	8	5	2	1				1	1	1		3
61-65	21	20	20	33	21	14	32	6	2	1			9		3	1	1
56-60	19	40	55	37	29	51	64	31	9	5	3	1	26		3	1	2
51-55	17	38	62	60	65	79	80	36	17	12	1	2	36		10	3	7
46-50	25	27	48	48	65	120	100	60	21	7		1	35		7	4	2
41-45	16	21	48	50	59	105	108	40	11	6	2	1	45	1	14	9	2
36-40	16	35	54	53	60	112	109	49	13	3	4	1	29		17	40	1
31-35	9	31	59	57	80	138	108	40	3	7		1	4		8	71	
26-30	2	15	51	69	164	146	65	16	2						16	87	
21-25	1	23	38	24	84	22	5								1	26	
>=71 Years	6	3	3	2		1	1			1	1		4	1			
<=20 Years	2	5	1	1													

Chart 24 shows the breakdown by pay-band of the Trust's workforce by age. There appears to be an even distribution of ages throughout the bands with no particular trends in favour or against any specific age group.

5.2 Disability

Chart 25 shows the composition of the trust's workforce by disability and chart 2 shows the distribution by pay bands. WH has 2% of its workforce with a declared disability on the Electronic Staff Record (ESR) an increase from 1% in 2018. However it is likely that a truer reflection of the current staff profile is the 2018 staff survey where 12.4% of WH staff declared that they had a physical or mental health condition, disability or illness that has lasted or is expected to last for 12mths or more. It is important that the Trust continues to encourage disclosure of disability to enable support to be targeted to those who need it.

Chart 25 – Headcount (%) by disability in ESR

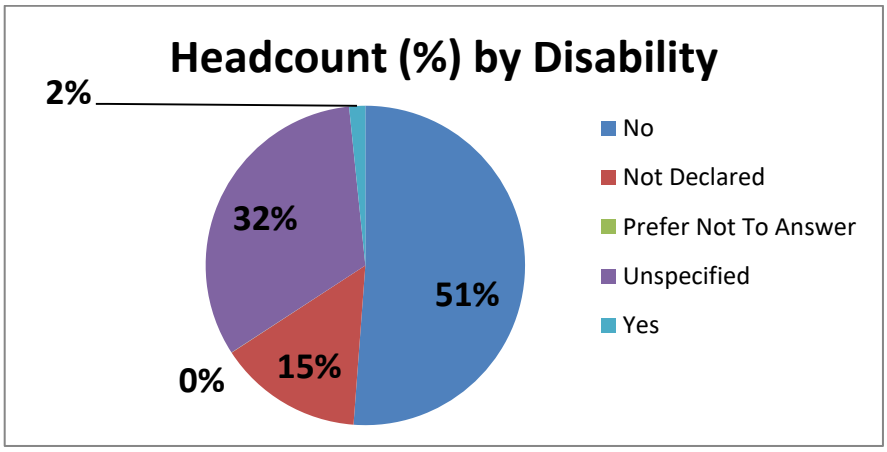
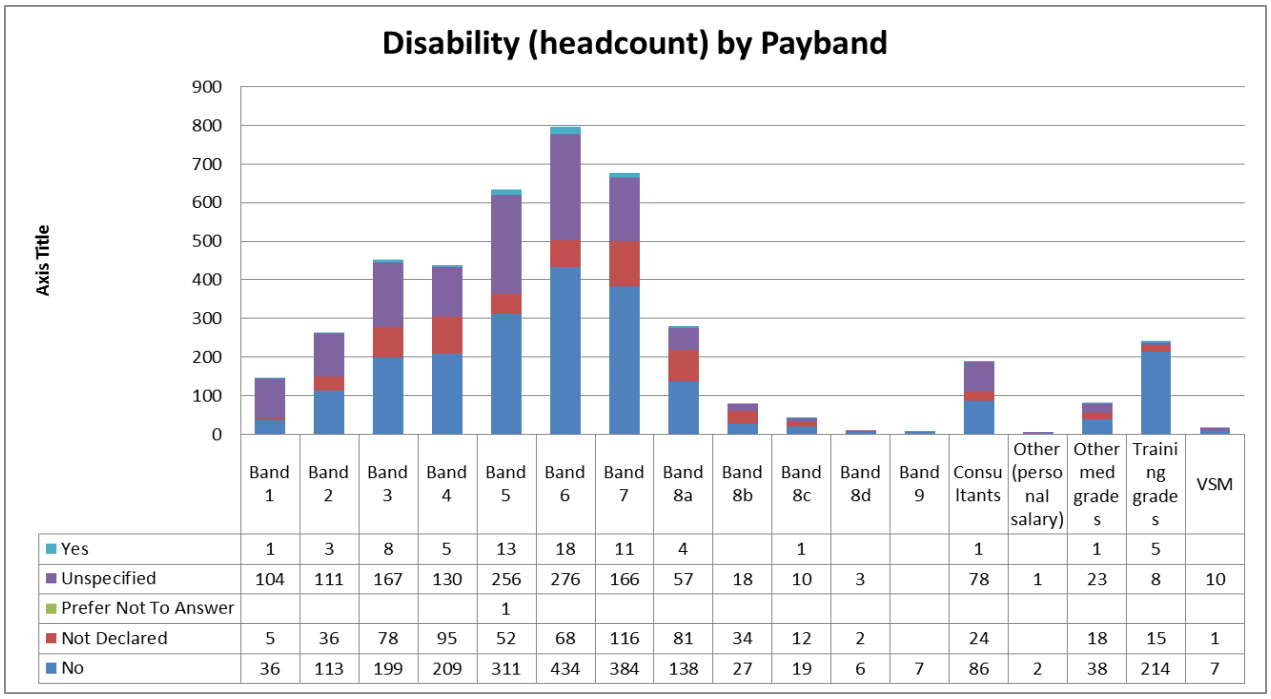


Chart 26 – Disability (headcount) by payband



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultants	Other (personal salary)	Other med grades	Training grades	VSM
Yes	1	3	8	5	13	18	11	4		1			1		1	5	
Unspecified	104	111	167	130	256	276	166	57	18	10	3		78	1	23	8	10
Prefer Not To Answer					1												
Not Declared	5	36	78	95	52	68	116	81	34	12	2		24		18	15	1
No	36	113	199	209	311	434	384	138	27	19	6	7	86	2	38	214	7

There is insufficient data to comment on the distribution of those with disability, however, chart 26 shows that they are represented at all bands except 8B, 8D, 9 and very senior managers (VSM).

Staff at the Trust plan to start a disability network to be known as ‘Whitability’ with an accompanying Facebook Group, as a resource for support for staff with disabilities. This is being featured during ‘Staff Focus September’ activities around the Trust.

5.3 Gender reassignment

ESR does not have an option to record this which has been flagged nationally with the providers of this system widely used in the NHS. Therefore no comment can be made.

5.4 Marriage and civil partnership

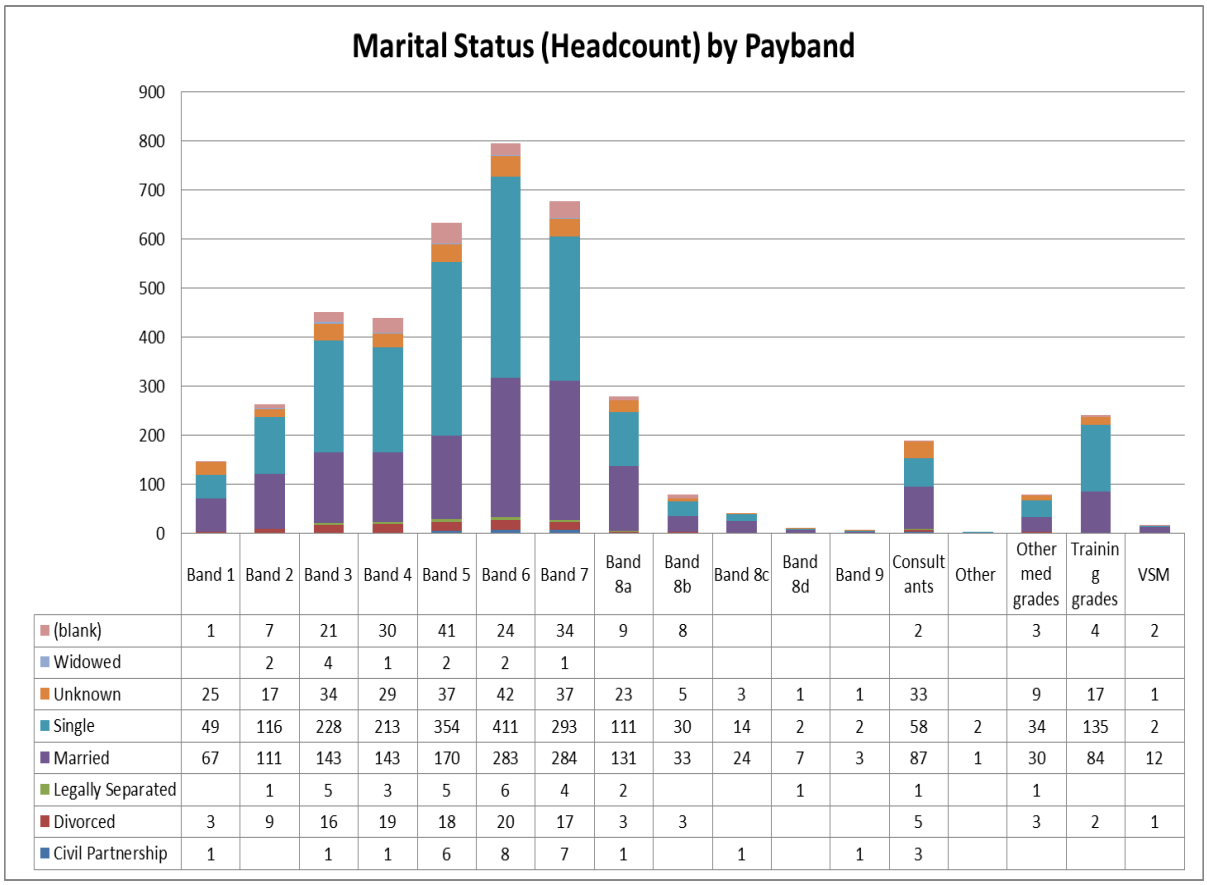
Table 1 shows as at 31st March 2019, the trust held the following information of its employees’ declared marriage or civil partnership status

Table 1

Marital Status	Headcount	Percentages
Civil Partnership	30	0.7
Divorced	119	2.7
Legally Separated	29	0.7
Married	1613	37.0
Single	2054	47.1
Unknown	314	7.2
Widowed	12	0.3
(blank)	186	4.3
Grand Total	**4357**	**100%**

Chart 27 shows the breakdown of staff by marital status and payband.

Table 27



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultants	Other	Other med grades	Training grades	VSM
(blank)	1	7	21	30	41	24	34	9	8				2		3	4	2
Widowed		2	4	1	2	2	1										
Unknown	25	17	34	29	37	42	37	23	5	3	1	1	33		9	17	1
Single	49	116	228	213	354	411	293	111	30	14	2	2	58	2	34	135	2
Married	67	111	143	143	170	283	284	131	33	24	7	3	87	1	30	84	12
Legally Separated		1	5	3	5	6	4	2			1		1		1		
Divorced	3	9	16	19	18	20	17	3	3				5		3	2	1
Civil Partnership	1		1	1	6	8	7	1		1		1	3				

5.5 Pregnancy and maternity

In the last year, 156 women were recorded on ESR as pregnant, which is 4% of the organisation. It is not possible to know the number of all women in the Trust who are pregnant because there is no requirement to record it until the Maternity Certificate can be issued after 20 weeks of pregnancy: ESR will only record those who have completed and submitted their Maternity Certificates.

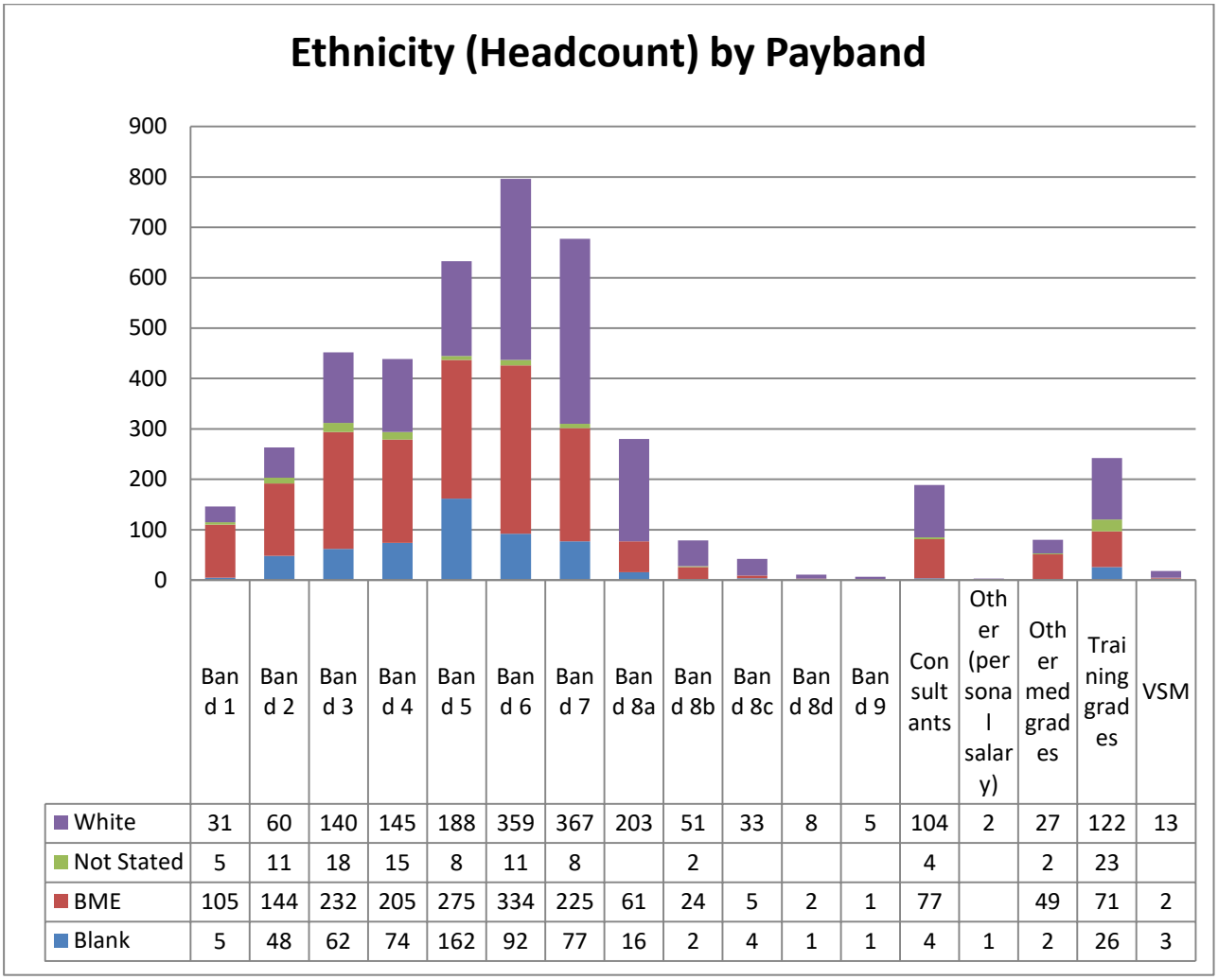
5.6 Race (this includes ethnic or national origins, colour or nationality)

As can be seen in table 2 below, the workforce of Whittington Health is not proportionate to the Haringey and Islington Census 2011 figures, as the trust employs a greater proportion of BME staff relative to the local populations

Table 2

Ethnicity	Haringey population aged 16-64	Islington population aged 16 to 64	Whittington Health
White	60.5%	68%	42.6%
BME	39.5%	32%	41.6%
Not stated			15.8%

Chart 28



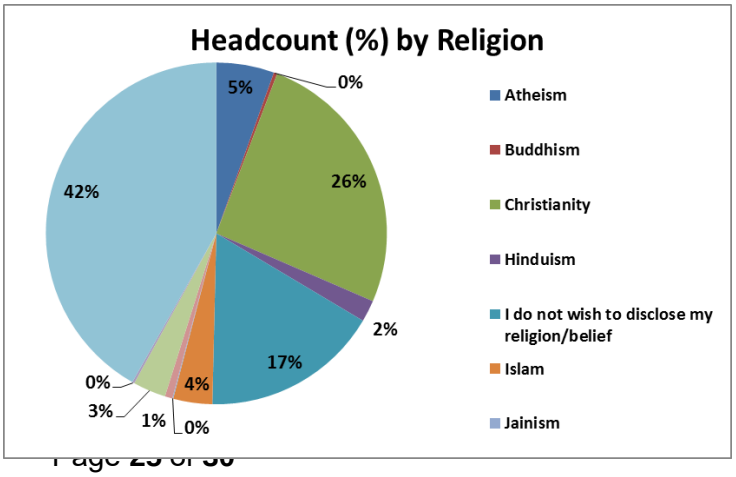
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultants	Other (personal salary)	Other medgrades	Training grades	VSM
White	31	60	140	145	188	359	367	203	51	33	8	5	104	2	27	122	13
Not Stated	5	11	18	15	8	11	8		2				4		2	23	
BME	105	144	232	205	275	334	225	61	24	5	2	1	77		49	71	2
Blank	5	48	62	74	162	92	77	16	2	4	1	1	4	1	2	26	3

Chart 28 above, shows the breakdown by pay-band of the Trust's workforce by ethnicity; the numbers of BME and white staff by pay-band. Although there is a 1% difference in the number of BME to white staff, it shows that the career path is notably different, with BME in the majority of staff up to Band 5 and from and White staff in the majority from Band 6. However, in the last year there has been a 4% increase in BME staff across Bands 8a to VSM.

5.7 Religion or belief

Chart 29 below below show the composition of the trust's workforce by religion or belief. The trust has 1821 (42%) of staff who have not specified a religion and 734 (17%) who stated they did not wish to disclose their religious belief

Chart 29



When we look at the 2018 Staff Survey it is staff who specify their religion as Muslim who report the worst discrimination levels in regards to other staff, managers and patients/service users.

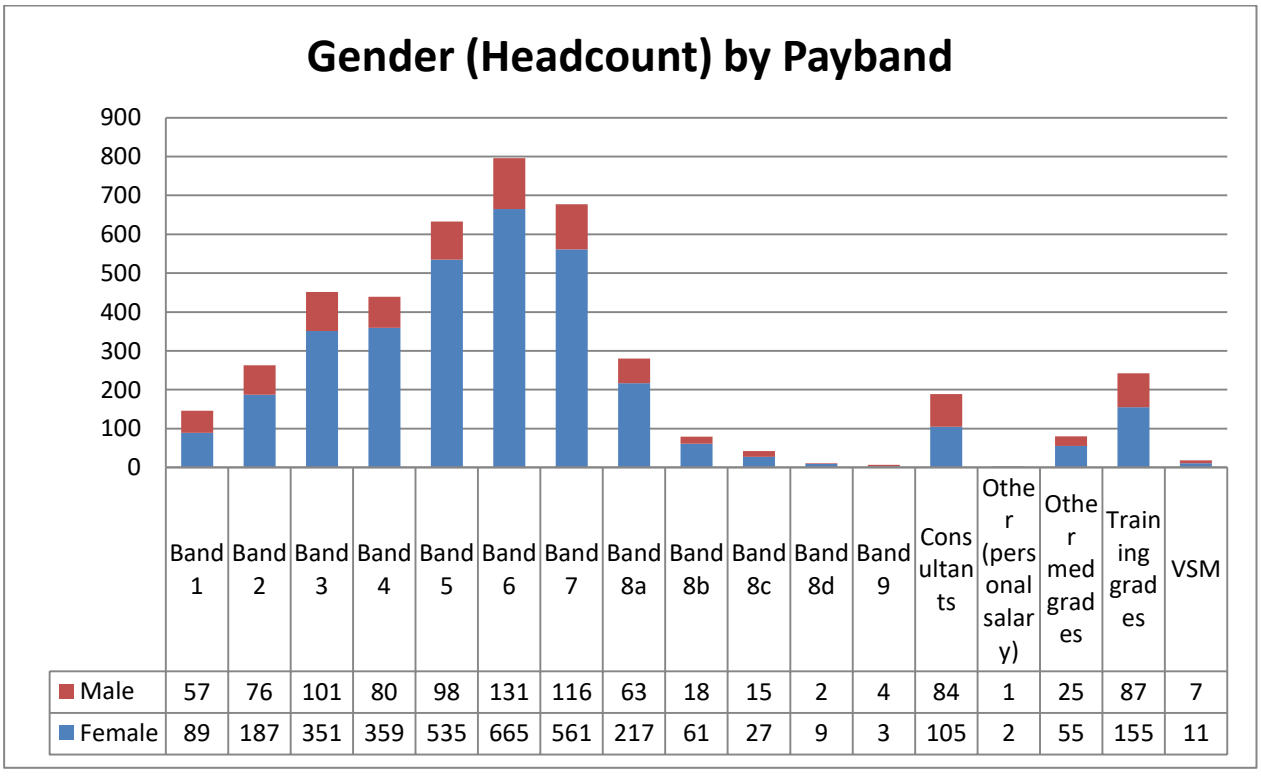
Table 3 below shows staff survey responses on discrimination by religion

Table 3

Question	Trust Overall	No religion	Christian	Buddhist	Hindu	Jewish	Muslim
Not experienced discrimination from patients/service users, their relatives or other members of the public	87.7%	93.4%	84.8%	95.0%	87.8%	92.5%	80.4%
Not experienced discrimination from manager/team leader or other colleagues	85.9%	92.5%	85.6%	85.0%	83.8%	85.0%	80.4%

5.8 **Sex (gender)** Chart 30 below shows how female and males are represented across pay bands.

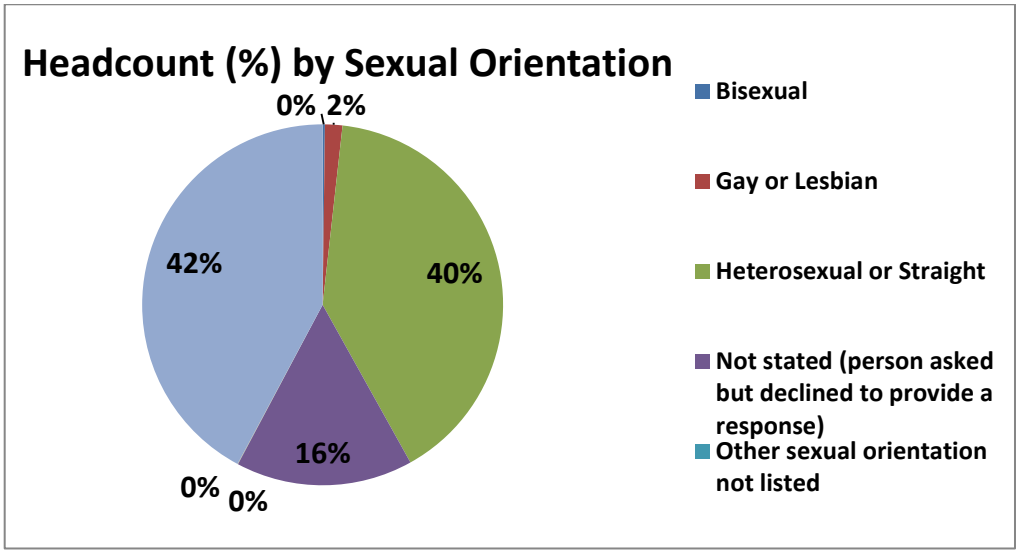
Chart 30



5.9 **Sexual orientation**

Chart 31 shows the breakdown of staff by sexual orientation

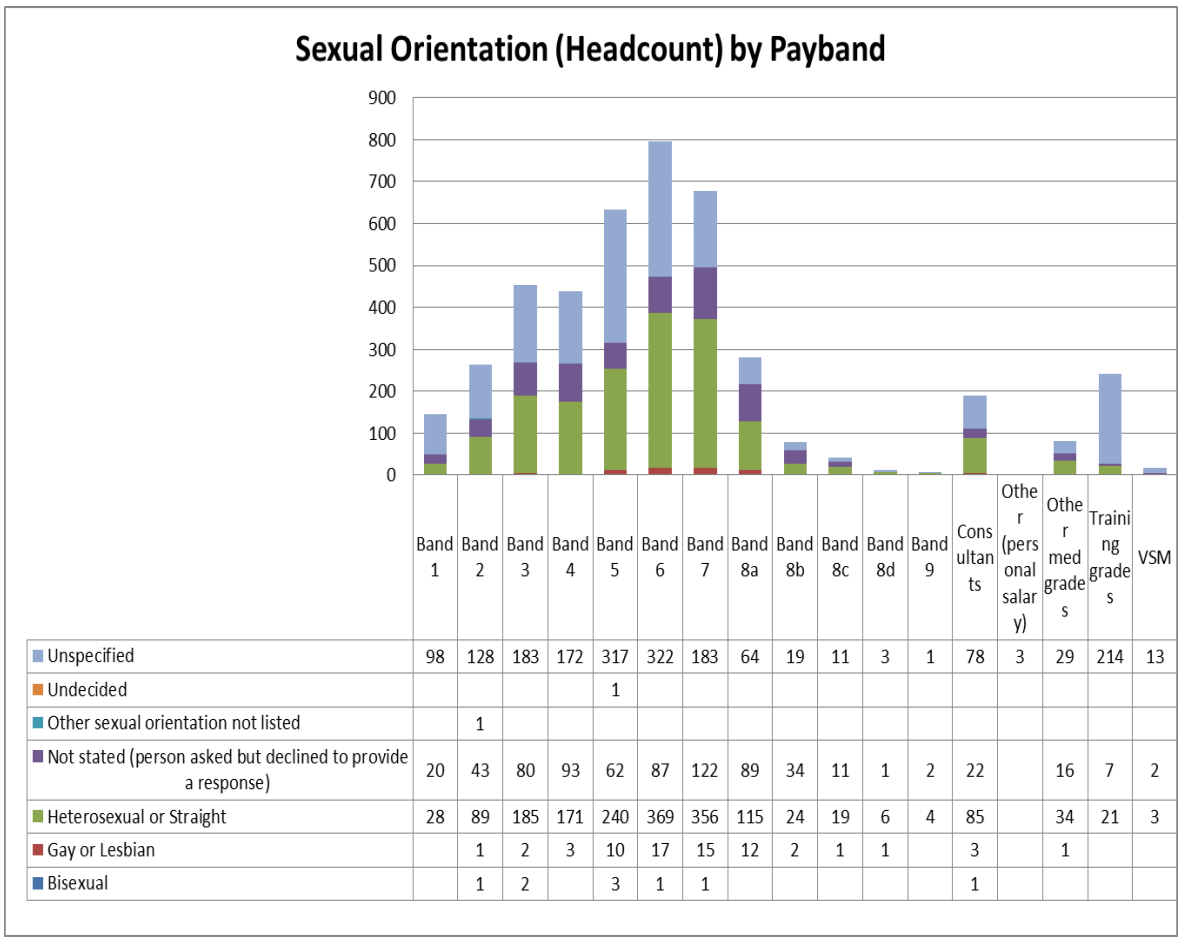
Chart 31



5.9.1 Whilst 40% of staff describe themselves as heterosexual another 58% chose to either ignore the question or declined to provide a response with only 2% describing themselves as gay, lesbian or bisexual. Whilst we are unable to confirm why so many members of staff are unwilling to answer the question, we hope that the recent development of a staff LGBT network, the celebrated Whittington participation at Pride in 2019 and 2018 as well as the launch of Rainbow Badges may prove to improve future declaration of sexual orientation

5.9.2 Chart 32 below shows staff by pay-band and sexual orientation

Chart 32



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Consultants	Other (personal salary)	Other med grades	Training grades	VSM
Unspecified	98	128	183	172	317	322	183	64	19	11	3	1	78	3	29	214	13
Undecided					1												
Other sexual orientation not listed		1															
Not stated (person asked but declined to provide a response)	20	43	80	93	62	87	122	89	34	11	1	2	22		16	7	2
Heterosexual or Straight	28	89	185	171	240	369	356	115	24	19	6	4	85		34	21	3
Gay or Lesbian		1	2	3	10	17	15	12	2	1	1		3		1		
Bisexual		1	2		3	1	1						1				

6 Equality Delivery System (EDS2) Activities

6.1 The EDS2 is the second version 'slimmer and more flexible version' of this tool to help NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. It aims to support four goals:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

6.2 The goals have specific elements to consider when grading performance:

6.2.1 Goal 1: **Better health outcomes** considers whether:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
- When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
- Screening, vaccination and other health promotion services reach and benefit all local communities

6.2.2 Goal 2: **Improved patient access and experience** considers whether:

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences of the NHS
- People's complaints about services are handled respectfully and efficiently

6.2.3 Goal 3: **A representative and supported workforce** considers whether:

- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
- Training / development opportunities are taken up and positively evaluated
- When at work, staff are free from abuse, harassment, bullying and violence from any source
- Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
- Staff report positive experiences of their membership of the workforce

6.2.4 Goal 4: **Inclusive leadership** considers whether:

- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
- Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

6.3 The EDS2 tool requires organisations to grade performance on each of the goals and outcomes collaboratively with staff, patients and partners. The grading system provides four levels of performance as follows:

- **Undeveloped** if there is no evidence one way or another for any protected group of how people fare or if evidence shows that the majority of people in only two or less protected groups fare well
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well
- **Achieving** if evidence shows that the majority of people in six to eight protected groups fare well
- **Excelling** if evidence shows that the majority of people in all nine protected groups fare well

6.4 The Trust has partnered with others in the North London Alliance in order to coordinate a joint grading exercise for the patient focussed goals 1 and 2 in Haringey and Islington. This will allow an overall view of grading in the boroughs and also minimise the need for patients to attend a number of separate grading events. It is anticipated that this will take place in November 2019. In preparation for this, the Trust is currently in a data and evidence collection phase.

6.5 In relation to staff and leadership related goals 3 and 4, a number of focus groups have been held to enable a cross-section of staff, partners, unions and staff networks participate in grading the Trust performance.

6.6 Tables 4 and 5 below shows the grading for goals three and four

Table 4 - Goal 3 – A Representative and Supported Workforce

Outcome	Grading
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3 Training and development opportunities are taken up and positively evaluated by all staff	Developing

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
3.6 Staff report positive experiences of their membership of the workforce	Developing

Table 5 - Goal 4 – Inclusive Leadership

Outcome	Grading
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

6.7 The focus groups discussions and results indicate that the policies and procedures in place underpin good practice in supporting equality and inclusion in the workplace. Improvements in some of our statistical data (such as the increase in BME staff at higher pay-bands) demonstrates that our activities are appropriately designed to improve specific areas of performance. There is more work to be done, and our Trust objectives, values and improvement plans demonstrate our commitment to continuing efforts on the equalities and inclusion agenda.

7 Equality objectives

7.1 The Trust's equality objectives are driven by the results of the grading outcomes following discussion with all the stakeholders attending the focus groups using the EDS2.

7.2 Whilst it is too early to set equality objectives, it is clear from the evidence and statistics gathered so far, that work will need to be done on our data systems in order to maximise the data accuracy and availability. For example, the data descriptions need to be aligned, systems must be amended to ensure it is possible to hold data not currently held, and it is important to continue with digitalisation of paper-based records.

8 Next steps

8.1 Work will continue collaboratively to grade performance for goals 1 and 2 to enable the Trust to have a comprehensive understanding of its priorities in creating an improvement plan with realistic goals and timeframes.

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	Volunteer Strategy 2019-21	**Agenda item: 13**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patient Experience	
Report author	James Connell, Patient Experience Manager	
Executive summary	The Trust is very pleased to present its first Volunteer Strategy. The strategy is building on the fantastic work of a growing group of dedicated volunteers. The focus is on growing, supporting Whittington Health clinical and support staff and that we support the Volunteers to develop their learning and experience. This fits with our Trust objective to empower, support and develop engaged staff. The Volunteer Strategy was presented at the Patient Experience Committee on 5th July 2019 and at Quality Committee on 10th July 2019, it was well received with a healthy discussion on the key ambitions. Comments and suggested changes were considered and agreed with agreement that it was recommended for approval by the Trust Board. The three ambitions for the Strategy are as follows: **Ambition 1**: We will have developed a network of relationships with our local public community to support the recruitment and retention of volunteers **Ambition 2:** We will have volunteers supporting staff in specialised, developed roles increasing the scope and range of volunteering for the Trust **Ambition 3:** We will have Whittington Health volunteers supporting throughout our community services and in patient homes Achievement of the ambitions will be monitored through the Trust Patient Experience Committee reporting to the Trust Board Quality Committee. A year one implementation plan has been developed and shared with the Quality Committee at its September meeting.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to approve the Volunteer Strategy 2019-21	
Risk Register or Board Assurance Framework	There are no BAF entries that specifically relate to patient experience however the strategy provides evidence that the Trust is maintaining a focus on delivering high quality, safe and compassionate care for our patients (BAF Quality One).	
Report history	Patient Experience Committee (including Health Watch partners) Quality Committee, July 2019	
Appendices	1: 2019-21 Volunteer Strategy	

NHS
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NHS Trust

Whittington Health Volunteer Strategy

2019-2021

From our local community, for our local community

@WhittHealthVols #whittingtonvolunteers WhittHospVols

Whittington Health
Voluntary Services

Introduction

NHS
Whittington Health
NHS Trust

- This strategy has been developed in order to support the Trust's mission statement: *helping local people to live longer healthier lives*. The volunteer strategy has been written to support the Trust's overall strategic objectives, and to support and complement the Patient Experience Strategy, which will be launched in October 2019 and will also cover the same three year period (2019-2021).
- Whittington Health was one of the first in the country to be established as an Integrated Care Organisation, joining community services with hospital care. The ambitions of this strategy apply to all services across the hospital and all of our community services.
- Each of the three ambitions outlined in the strategy have been written to reflect the aspirational nature of where we want to be and what we seek to achieve, and how we will measure our success in reaching each ambition. Our strategy key statement: *from our local community, for our local community*, reflects the core aims within each of our ambitions. We want to better engage and represent our community through our volunteer team, and enable our volunteers to support our local community in return.
- This strategy was written in response to feedback, and with feedback from patients, staff colleagues, volunteers and Healthwatch Islington and Haringey.
- The progress on achieving each of these ambitions will be tracked through an annual implementation plan and monitored through, the patient experience committee. Updates will be provided to the Trust Quality Committee.

Volunteer Strategy

NHS
Whittington Health
NHS Trust

Volunteer Service Strategy

From our local community, for our local community

Our ambitions:

Below are the three ambitions we have set that we want to achieve by 2021. The following slides detail, for each of these ambitions, the actions we will take to meet these ambitions, and the outcomes we will need to attain to show that we have met these ambitions:

Ambition 1
We will have developed a network of relationships with our local public community to support the recruitment and retention of volunteers

Ambition 2
We will have volunteers supporting staff in specialised, developed roles increasing the scope and range of volunteering for The Trust

Ambition 3
We will have Whittington Health volunteers supporting throughout our community services and in patient homes

Ambition One

Whittington Health NHS Trust

We will have developed a network of relationships with our local public community to support the recruitment and retention of volunteers

What does this mean?

As an integrated care organisation providing care for local people across Haringey and Islington (and wider afield) we believe it is important that we are outward looking as a service and NHS Trust.

We know that in order to serve and represent our diverse local population, we need to engage and work with our whole community. We want to recruit volunteers from our community in order to represent and best support the health and well-being needs of those in the community.

In order to achieve this, we need to develop strong working relationships, and maintain on-going links, with our local voluntary community sector (VCS). In addition, we need to work with local colleges, universities, community groups and faith groups in order to promote volunteering in The Trust as a means to fostering social engagement and community cohesion.

Ambition 1

We will have developed a network of relationships with our local public community to support the recruitment and retention of volunteers

What will success look like?

We will know that we have accomplished our aims if we have achieved the following:

- Launched a comprehensive and wide reaching advertising programme
- Re-launch an updated version of the volunteer webpage
- Developed formal relationships with local sixth forms, colleges and universities
- Ongoing engagement with Healthwatch Islington and Haringey volunteer work
- **Involve service user groups and the Trust's inclusion network in volunteer role development**
- Developed volunteering in collaboration with the Whittington Health community forum
- Co-working with other volunteer teams, across NHS trusts and the voluntary community sector (VCS)
- Developed volunteer peer mentoring roles, to support with recruitment and development
- Developed forms of accredited volunteer training and qualifications
- Reported on volunteer recruitment and retention at the patient experience committee

Ambition Two

NHS
Whittington Health
NHS Trust

We will have volunteers supporting staff in specialised, developed roles increasing the scope and range of volunteering for The Trust

What does this mean?

We recognise that our volunteers are not *just* volunteers; our volunteers are not limited to the roles they undertake. Our volunteers are rounded individuals who bring their own varied life experiences and acquired expertise to volunteering. We want this understanding to be central to how Whittington Health recruits and develops volunteers.

This ambition has been established to ensure that as a service and Trust, we are committed to the individual development of each of our volunteers. The more specialised and enhanced we can make our volunteer roles, the more likely we are to retain volunteers, and the better placed our volunteer team will be to support our patients and services. Importantly, we, as a Trust, will be able to offer interesting, rewarding voluntary roles to our local public,

Developing enhanced roles will be beneficial to our clinical and non-clinical teams, as they will benefit from this added element of expertise in their teams. Developing enhanced roles will benefit our patients and service users, as they will be able to access an additional resource towards improving their experience and quality of care.

Ambition 2

We will have a larger volunteer team supporting staff in specialised, developed roles increasing the scope and range of volunteering for The Trust

What will success look like?

We will know that we have accomplished our aims if we have achieved the following:

- Updated our role descriptions in partnership with key healthcare staff
- Developed a catalogue of specialised volunteer roles
- Created role-and-location specific inductions for new volunteers
- Created staff 'volunteer champions' to promote and develop volunteers
- By 2021, we will have doubled the size of our team, to over 300 active volunteers
- Worked with local groups, schools, colleges and universities to develop pathways into volunteering
- Introduced formal volunteer 1-1 support and development meetings
- Provided volunteers with access to Trust training modules.
- Have 30 volunteers actively supporting across our community teams

Ambition Three

NHS
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NHS Trust

We will have Whittington Health volunteers supporting throughout our community services and in patient homes

What does this mean?

As an integrated care organisation, Whittington Health provides care for our local community from over 40 sites situated primarily in Haringey and Islington, as well as from the homes of our patients and service users.

As of May 2019, the majority of our volunteers support is at the Whittington Hospital site. Though the hospital is our largest individual, we believe that, in order to match the needs of our clinical services across the Trust, and to support our entire patient base, we must imbed our volunteers throughout our community teams.

Our aim is also to be able to provide a broader and more flexible approach to volunteering. We aim to be able to offer our volunteers opportunities that fit in with their lives and grow and develop as they do, as well as meeting the changing needs of our patients.

NHS
Whittington Health
NHS Trust

Ambition 3

We will have Whittington Health volunteers supporting throughout our community services and in patient homes

What will success look like?

We will know that we have accomplished our aims if we have achieved the following:

- Identified community teams to pilot community volunteering
- Developed specialised roles for volunteers in our community
- Comprehensive risk assessments in place for community volunteers
- Created a 'community volunteer' specific induction programme
- Formalised the management of community volunteers to local community teams
- Formalised recruitment links with local state colleges and schools
- Developed, reciprocal relationships with local volunteer organisations
- On-going engagement with the national Helpforce initiative and its learning network
- 10% of our volunteer team providing support in patient homes and at community sites

What happens next?

- Volunteer strategy will go to Trust Board in July 19 for approval
- Volunteer strategy will be publicly launched in August/September 19
- Year one implementation plan will be created, breaking down the actions required for the first year of the strategy
- Implementation plan tracked through each patient experience committee.

Meeting title	**Trust Board – public meeting**	**Date: 25.9.2019**
Report title	**August (Month 5) 2019/20 – Financial Performance**	**Agenda item: 14**
Executive director lead	Kevin Curnow, Chief Finance Officer (Acting)	
Report author	Finance Team	
Executive summary	The Trust is reporting a year to date deficit of £3.6m which is £3.7m behind plan, £2.4m after adjusting for the impact of not achieving any Provider & Sustainability Funding. This is position is in line with the recovery plan trajectory. Should the Trust achieve the Control Total, PSF can be recovered in future periods. The Trust is forecasting achievement of its control total. The adverse variance is still mainly driven by the failure to achieve the Cost Improvement Programme (CIP); £0.4m was delivered this month. The recurrent year to date CIP achievement amounts to £1.6m against a £5.1m target. The Trust is currently delivering non-recurrent schemes to mitigate some of this variance which will be included in future reporting periods. The year to date pay costs are in excess of budget by £2m. Bank spend is less than the previous month at £1.98m with agency spend at £0.7m, the second month in a row being beneath the agency cap. Combined temporary spend is £2.67m down on the previous year to date average of £2.77m. Non pay expenditure is £0.4m overspent in month and £1.9m year to date. The variances predominately driven by underachieved CIP. The Trust has spent £5.3m on capital expenditure as at month 5. The planned spend is £5.8m. The Trust is still awaiting confirmation of its total capital allocation for the year following the recent request to reduce limits.	
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 August 2019 recognising the need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans	
Risk Register or Board Assurance Framework	Sustainability 1	
Report history	Trust Management Group, 25 September	
Appendices	None	

August (Month 5) 2019/20 – Financial Performance

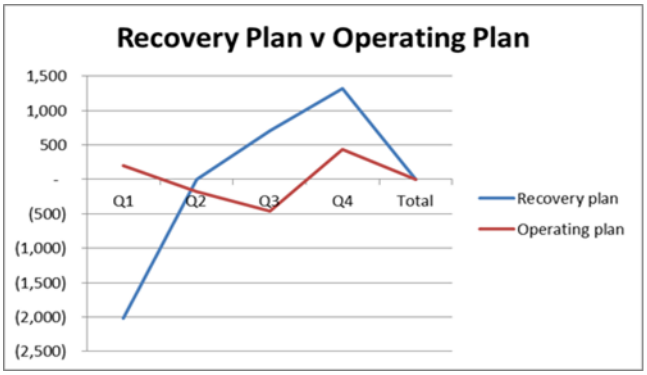
Financial Overview

The Trust is reporting a year to date deficit of £3.6m deficit, which is a negative variance to plan of £3.7m. The performance has improved from the previous month on a number of indicators including CIP delivery and agency spends. However, the number of open beds and the underperformance relating to CIP delivery are significant concerns.

MEASURE	TARGET	ACTUAL	Prev month	RAG	RESPONSIBLE OFFICERS
Beds at funded establishment	197	211	209		DOO - Surgery & Cancer & EIM
CIP Forecast	£12.3m	£7.7m	£7.7m		Head of PMO
CIP schemes delivery	100%	32%	27%		Head of PMO
Emergency Length of stay	TBC	4.3	4.3		DOO - EIM
Elective Activity planned delivered (DC & Elective)	100%	98%	98%		DOO - Surgery & Cancer
Trust wide agency spend (per month)	£0.7m	£0.7m	£0.6m		DOOs

The Trust continues to closely scrutinise any additional bed capacity and ensures appropriate escalation procedures when above target. The Cost Improvement Programme forecast and delivery remains a significant issue and the Executive Team are currently reviewing options to provide assurance on likely delivery. In August, the Trust has seen a consolidation in its level of agency spend, with spend being below the agency cap for the second month in a row. Review meetings have been expanded to provide greater assurance on the use of temporary staffing.

The Trust is still forecasting to meet its control total for the year and has produced a recovery plan which has been presented and accepted by the Trust Board.



	Q1	Q2	Q3	Q4	Total
EIM	(2,725)	(2,366)	(1,952)	(1,477)	(8,521)
S&C	(1,064)	(905)	(650)	(597)	(3,215)
ACS	(25)	90	45	83	193
ACW	(850)	(449)	(428)	(428)	(2,155)
CYP	(199)	(94)	(27)	19	(300)
	(4,862)	**(3,723)**	**(3,013)**	**(2,400)**	**(13,998)**
Corporate	2,160	3,093	3,093	3,093	11,440
	(2,702)	**(630)**	**80**	**694**	**(2,558)**
PSF Adj	687	271	271	271	1,500
Additional CIPS		352	352	353	1,058
Recovery plan	**(2,015)**	**(7)**	**703**	**1,318**	**0**
Favourable/(adverse) variance					
Operating plan	**201**	**(174)**	**(463)**	**436**	-

The recovery plan, excluding PSF, targets a £2m negative variance at the end of quarter 2.The Trust is currently reporting a £2.4m variance at the end of month 5, excluding PSF. The Trust continues to develop and refine the forecasting of the financial position and include detail by month to provide a more granular view.

The table below shows the summary position for the August.

Statement of comprehensive income

2019/20, Month 5 (August 2019)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	YTD Variance (£000s)	TFMS FULL YEAR BUDGET (£000s)
Clinical Income	22,902	23,158	256	121,341	122,499	1,158	290,479
Other Non-Patient Income	2,044	2,297	254	10,185	10,097	(88)	24,921
High Cost Drugs	665	745	80	3,326	3,582	255	7,984
Total Income	**25,611**	**26,200**	**589**	**134,853**	**136,177**	**1,324**	**323,384**
Pay	(19,265)	(19,487)	(222)	(96,188)	(98,188)	(2,000)	(232,207)
Non-Pay (excl HCD)	(6,042)	(6,432)	(389)	(30,182)	(32,078)	(1,896)	(72,407)
High Cost Drugs	(668)	(697)	(29)	(3,338)	(3,392)	(54)	(8,011)
Total Operating Expenditure	**(25,975)**	**(26,616)**	**(641)**	**(129,708)**	**(133,658)**	**(3,950)**	**(312,625)**
	(364)	**(416)**	**(52)**	**5,145**	**2,519**	**(2,626)**	**10,759**
Depreciation	(622)	(574)	48	(3,107)	(2,907)	200	(7,481)
Dividends Payable	(432)	(432)	0	(2,160)	(2,160)	0	(5,187)
Interest Payable	(271)	(281)	(10)	(1,353)	(1,377)	(24)	(3,238)
Interest Receivable	15	35	20	51	109	58	156
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,310)**	**(1,252)**	**58**	**(6,569)**	**(6,334)**	**235**	**(15,750)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(1,674)**	**(1,668)**	**6**	**(1,424)**	**(3,816)**	**(2,392)**	**(4,991)**
Provider Sustainability Fund (PSF) (including FRF & MRET)	336	30	(306)	1,450	152	*(1,298)*	*4,946*
Net Surplus / (Deficit) - before IFRIC 12	**(1,338)**	**(1,638)**	**(300)**	**26**	**(3,664)**	**(3,690)**	**(45)**
Add back							
Impairments	0	0	0	0	0	*0*	0
IFRS & Donate	4	6	2	17	32	*15*	45
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(1,334)**	**(1,631)**	**(297)**	**43**	**(3,632)**	**(3,675)**	**0**

Income and activity

The comments and table below refer to the Trust's performance against its overall operating plan. Month five is following a very similar trend to month four.

The Trust is performing (before the application of PSF) £1.3m (1%) ahead of plan but this is offset by a reduction to PSF (£1.3m) as the Trust's control total has not been met. The revised income position after this reduction is equal to plan.

The main areas of material activity variance are within controllable planned care. Elective admissions and day cases are £0.8m (9%) favourable year to date (YTD), – a small improvement. There has been a small improvement in Outpatients performance, £0.5m (5%) YTD adverse to plan.

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.

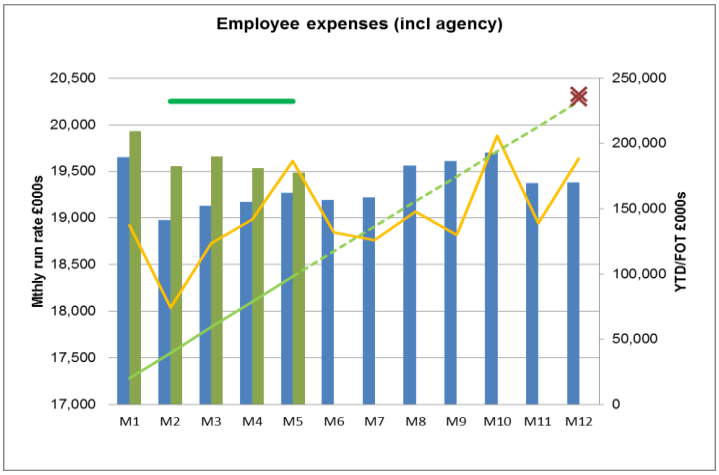
Category	In Month Income Plan £000's	In Month Income Actual £000's	In Month Variance £000's	YTD Income Plan £000's	YTD Income Actual £000's	YTD Variance £000's
Elective and Day Case	1,559	1,678	119	9,095	9,888	793
Non Elective 0 LOS	1,057	1,059	2	5,217	5,295	78
Non Elective LOS I Day or Greater	3,723	3,731	8	18,371	18,647	276
OP Attendances - 1st	854	910	56	4,984	4,837	(147)
OP Attendances - follow up	770	770	0	4,490	4,149	(341)
A&E Attendances	1,433	1,364	(69)	7,073	7,013	(60)
High Cost Drugs	665	745	80	3,326	3,581	255
Community	6,160	6,160	0	30,800	30,800	0
Other Clinical income NHS	4,453	5,433	980	26,021	27,454	1,433
Other Clinical Income Non NHS	2,893	2,053	(840)	15,293	14,418	(875)
Total Income From Patient Care Activities	**23,567**	**23,903**	**336**	**124,670**	**126,082**	**1,412**
Other Operating Income Excluding PSF	**2,044**	**2,297**	**253**	**10,185**	**10,097**	**(88)**
Total	**25,611**	**26,200**	**589**	**134,855**	**136,179**	**1,324**
PSF/FRF/MRET	336	30	(306)	1,450	152	(1,298)
Revised Total	**25,947**	**26,230**	**283**	**136,305**	**136,331**	**26**

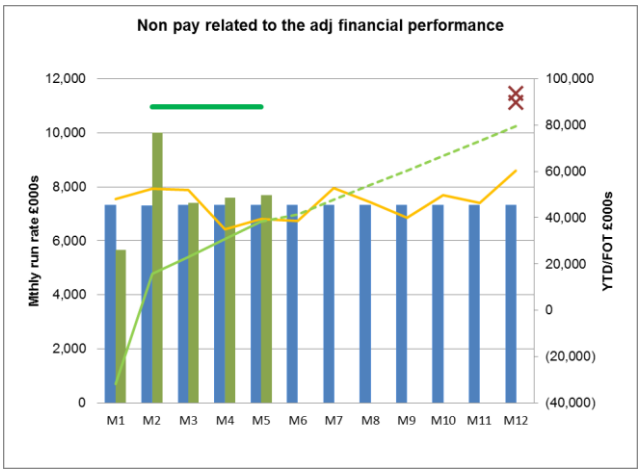
Monthly run rates – expenditure

The in month combined expenditure position is £0.6m adverse to plan (£4m adverse YTD). Key points to note include:

- **Pay**
  - Total pay expenditure for August was £19.5m, £0.2m adverse to budget, (£2m adverse) YTD.
  - The majority of the pressures remain within Emergency Integrated Medicine where over established post were almost 100 WTEs. Significant overspends relate to ward areas (£0.8m) even though there is a significant drop in reported bed capacity.
  - Surgery is the other ICSU experiencing significant pay spends pressures where several factors contribute. Including premium rate theatre staffing, non-delivery of CIP plans and medical staff over establishments
  - Within total pay expenditure, agency costs were £0.7m in month, £4.1m year to date. Bank spends at £2m which is marginally higher than previous months. Total temporary spend for the year is £13.7m.

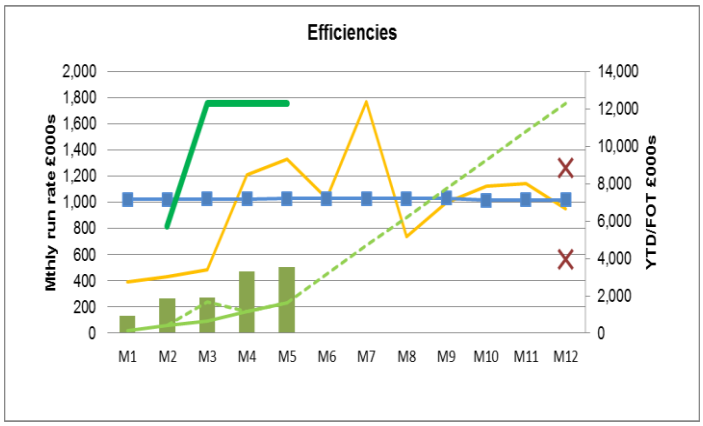
- **Non Pay**
  - Non pay expenditure for August was £7.1m compared to £7m for the previous month
  - The non-pay variance in month 5 is an adverse variance of £0.4m. This brings the year to date overspend to £1.9m, pressures within clinical supplies for theatres, endoscopy insourcing and utilities and unachieved CIP.
  - The 'insourcing' of endoscopy has had notice served with an internal solution in place to deliver the service. This should result in a significant reduction to spend from month 6.

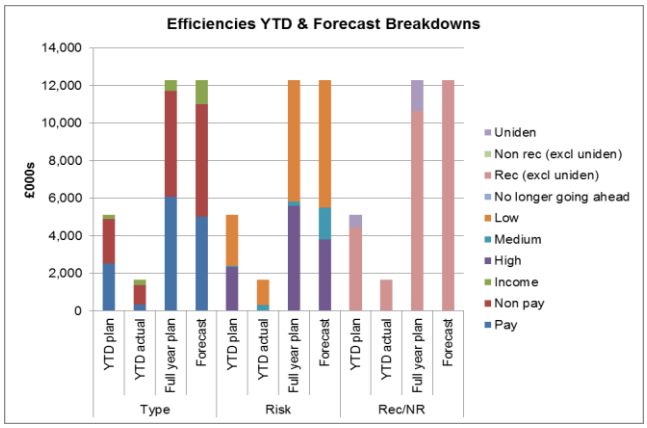




Cost Improvement Programme (CIP)

The Trust has planned CIP delivery just in excess of £1m each month, with the year to date target being £5.1m. The Trust has delivered £1.6m. This is an adverse variance of £3.5m.





Next Steps for this Quarter

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

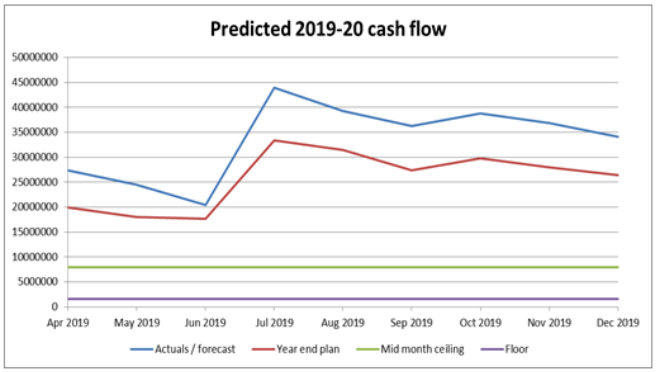
- Third party assurance on Cost Improvement Programme including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case, advise on the steps required.
- Changes to the PMO structure to provide greater support to ICSUs to assist with the development and delivery of CIP
- Additional support in place for ICSUs including operational, financial and quality, providing greater capacity and increased scrutiny
- Weekly reporting and reviews at Executive Team Meetings
- CIP Delivery Board now chaired by Chief Executive Officer
- Nurse booking oversight meeting to provide greater scrutiny and assurance on the appropriateness of shifts requested
- With temporary staffing spend at c£750k each week, an enhanced Vacancy Scrutiny Panel (VSP) will be adopted along with potential restrictions on agency spend
- VSP to receive more detailed information of consequences should non-urgent posts be left vacant and options of different staff groups undertaking the role

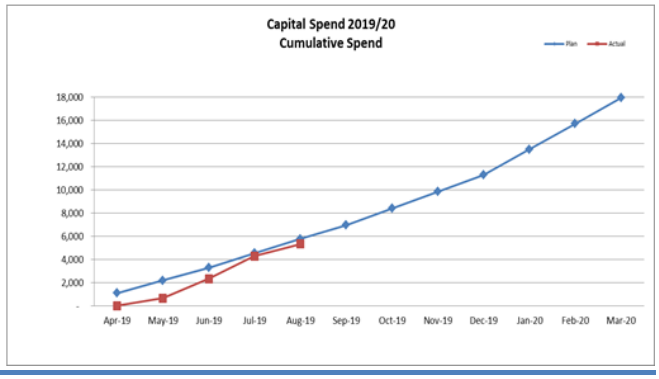
Statement of Financial Position

THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

			Year to Date
	As at 31 August 2019 £000	Plan 31 August 2019 £000	Plan variance 31 August 2019 £000
Property, plant and equipment and intangibles	220,802	225,879	(5,077)
Trade and other receivables	823	1,400	(577)
Total Non Current Assets	**221,625**	**227,279**	**(5,654)**
Inventories	1,776	1,355	421
Trade and other receivables	26,437	22,416	4,021
Cash and cash equivalents	39,311	31,510	7,801
Total Current Assets	**67,524**	**55,281**	**12,243**
Total Assets	**289,149**	**282,560**	**6,589**
Trade and other payables	48,103	45,098	3,005
Borrowings	27,944	29,079	(1,135)
Provisions	979	1,391	(412)
Total Current Liabilities	**77,026**	**75,568**	**1,458**
Net Current Assets (Liabilities)	**(9,502)**	**(20,287)**	**10,785**
Total Assets less Current Liabilities	**212,123**	**206,992**	**5,131**
Borrowings	28,468	31,492	(3,024)
Provisions	839	842	(3)
Total Non Current Liabilities	**29,307**	**32,334**	**(3,027)**
Total Assets Employed	**182,816**	**174,658**	**8,158**
Public dividend capital	66,691	67,941	(1,250)
Retained earnings	21,294	4,146	17,148
Revaluation reserve	94,831	102,571	(7,740)
Total Taxpayers' Equity	**182,816**	**174,658**	**8,158**





There are some significant variances in the balance sheet against plan. Overall, the value of the balance sheet is £8.2m higher than plan. The taxpayers' equity section is significantly 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 £5.1m lower than plan. This variance against plan largely arises from the revaluation decreases mentioned above. The gap between capital plans and actual capital spend shrank significantly in month 4 from £1.1m to £0.5m, and has remained steady in month 5. As such, the Trust is confident that it will be able to spend capital allocations in year.

Cash and cash flow: the Trust has £39.3m in cash at the end of August 2019. This reflects the completion of the land sale transaction to Camden and Islington NHS FT in March 2019 and the receipt of £22m in Provider Sustainability Funding (PSF) from NHS England in July. £33m of the balance is invested with the National Loans Fund. The Trust is unlikely to require any cash support during 2019/20.

Receivables (Debtors) are at £27.3m at the end of August. This is £3.5m ahead of plan, but £23m lower than in June following the receipt of PSF mentioned above. The variance against plan relates primarily to longstanding debts in intra-NHS relationships, a significant proportion of which will be cleared in September.

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Meeting title	**Trust Board – public meeting**	**Date: 25 Sept 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 August 2019 was 82.8% (9.2% below NHS Improvement standard of 92%). A deep dive in to August's position is included as an appendix to this report which presents a review of August's position, the key reasons for non-compliance and specific areas contributing to delivery. **ED – 12 Hour Trolley Waits – Mental Health** There were 10 patients waiting in excess of 12 hours in ED following a decision to admit for August 2019 with a mental health diagnosis. **Cancer Inter Trust Transfers – Reallocated Breach Performance for 62 days performance** There have been data issues between the Trust and University College London Hospitals (UCLH) NHS Foundation Trust around confirming onward treatment for patients. The data return is negatively affecting the Trust position. This could be due to UCLH's new patient information system upgrade. This has been escalated to UCLH and to NHSE for further investigation.	
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, September 2019	
Appendices	1: Performance scorecard 2: ED deep dive	

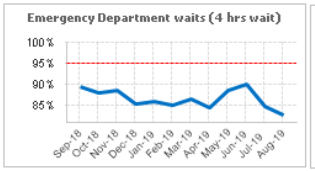
Performance Report
September 2019

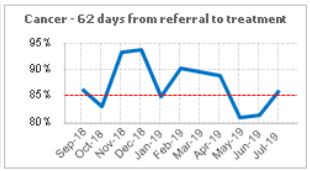
Month 5 (2019 – 2020)

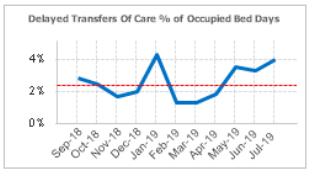
Date & time of production: 16/09/2019

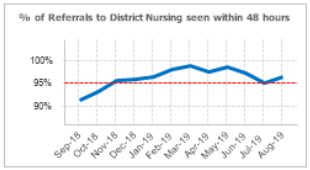
Summary

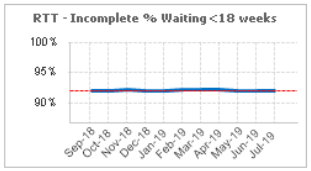
Category	Indicator	17_18 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	
ED	Emergency Department waits (4 hrs wait)	>95%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	84.8%	82.8%	86.2%	!
Cancer	Cancer - 14 days to first seen	>93%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%	97.0%	94.4%		96.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	86.2%	83.1%	93.3%	93.8%	84.9%	90.2%	89.6%	88.9%	81.0%	81.3%	85.9%		84.2%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.39%	6.36%	5.26%	4.24%	5.12%	5.81%	5.35%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%	3.3%	4.0%		3.2%	!
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.0%		92.1%	
Outpatients	Outpatients - FFT % Positive	>90%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	93.8%	94.3%	92.8%	
Community	Community - FFT % Positive	>90%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	92.7%	95.0%	96.1%	
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%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	100.0%	92.5%	95.6%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	91.3%	93.3%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	97.2%	95.1%	96.5%	97.1%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	90.9%	90.3%	90.5%	90.1%	91.9%	95.2%	94.6%	93.7%	89.8%	91.7%	88.9%		90.9%	!
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	95.6%	93.1%	93.4%	92.4%	95.4%	91.6%	94.5%	96.1%	89.6%	94.3%	92.4%		93.0%	!

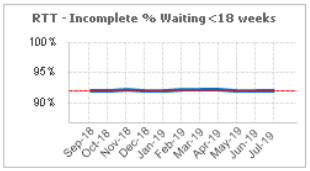


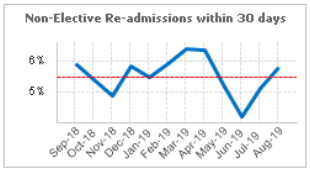


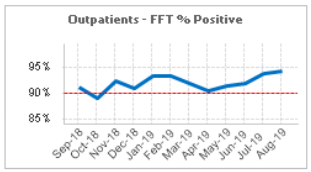












Date & time of production: 16/09/2019

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Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-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**	2	1	1	3	1	0	0	0	0	0	2	1	3	
Actual Falls	**400**	28	36	31	35	44	43	34	42	38	35	32	38	185	
Category 3 or 4 Pressure Ulcers	**0**								5	13	3	8		29	
Harm Free Care %	**>95%**	93.17%	94.47%	92.25%	93.50%	90.08%	91.22%	94.21%	93.55%	89.58%	94.96%	90.70%	93.04%	92.19%	
Non Elective C-Section % Rate	**<19%**	19.2%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	24.0%	22.5%	19.2%	21.1%	22.8%	22.0%	
Medication Errors causing serious harm	**0**	0	0	0	0	0	0	0	1	0	0	0	0	1	
MRSA Bacteraemia Incidences	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	
Never Events	**0**			1		0	0	0	0	3	0	0	1	4	
Proportion of reported Patient Safety Incidents Causing Harm	**N/A**	17.0%	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.8%	26.0%	21.4%	21.4%	20.1%	21.6%	
Serious Incidents	**0**	2	2	4	2	1	1	1	4	1	2	4	4	15	
VTE Risk Assessment %	**>95%**	96.7%	95.2%	96.9%	95.3%	95.3%	95.2%	95.9%	95.3%	95.2%	96.4%	95.4%		95.6%	
Mixed Sex Accomodation Breaches	**0**	0	1	0	0	2	2	0	0	0	0	0	0	0	
Hospital Standardised Mortality Ratio (HSMR)	**100**	92.0	68.8	90.8	85.3	79.8	70.3								
Summary Hospital Level Mortality Indicator (SHMI)	**1.14**	0.77			0.78			0.77							

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

Date & time of production: 16/09/2019

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:** 92.4% achieved – 2.6% from standard **Action to Recover:** • New Falls Mandatory training for both corporate induction and mandatory updates are ongoing. Monthly audits of compliance to STOPFALLS bundle of all wards are in progress, feedback and actions from audit feedback to all areas to help improve compliance. A falls awareness Day will be held in conjunction with the national falls week in September. • There is currently a business case to support our enhanced care programme which will support a sustainable process which will mitigate our high risk of falls. A pilot programme rolling out the concept of an Enhanced Care Team has started on all ward areas, the team have had bespoke training to help with the management and prevention of falls. • The tissue viability team continue to provide pressure ulcer prevention education and awareness across Whittington health. • We have been accepted on to the NHSI Pressure Ulcer Collaborative Improvement Programme and attended the first event; we have identified key areas / wards where we will focus this improvement programme on. • 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. The TVN team have developed a new pressure ulcer investigation tool to aid a comprehensive investigation. • 5. The Pan Trust Pressure Ulcer Prevention and Management group continues to meet 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. September 2019 2. October 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:** 22.8% - 3.9% from standard for August 2019 **Action to Recover:** In August, emergency/unplanned C Sections have increased by 1.7% compared to July (4 patients). Twice weekly Multi-Disciplinary C Section Review Meeting 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 for continuous monitoring
Category 3 or 4 Pressure Ulcers attributed to Whittington health: Total number recorded. Category 3 = 3 Category 4 = 1 Unstageable = 7 **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	**Variance against Plan:** Of the pressure ulcer attributed to Whittington Health one Category 3 pressure ulcer and two unstageable pressure ulcer had service delivery issues identified. The two unstageable pressure ulcers occurred within the Hospital, one of which was devise related. The device related pressure ulcer occurred as the bandage applied to the patient foot did not have any padding and was applied too tightly causing pressure damage. The second unstageable was on the heel and resulted from not offloading the heel sufficiently, however the patient did have significant co-morbidity and risk factors. The Category 3 pressure ulcer was attributed to DNS and a full assessment was not carried out on referral and first visit. **Action to Recover:** Trust wide Pressure ulcer governance and monitoring panel implemented chaired by Deputy Chief Nurse, to review incidents and ensure actions are taken forward and review the target of the quality indicator to reflect the changes in reporting.	**Named Person:** Lead Nurse Tissue Viability Service **Time Scale to Recover Performance:** Work on the trajectory is not yet completed and is expected to be finalised in September 2019
Serious Incidents: The number of Serious Incidents declared by the Trust this month.	**Aug 2019 to date - One Never Event** 4 Sis were declared to date in Aug 2019 2019.16953 - [EIM] Screening issues, endoscopy Cluster SI investigation 2019.16966 - [EIM] Screening issues, endoscopy Cluster SI investigation. 2019.18525 [EIM] Unintentional connection of a patient requiring oxygen to an air flowmeter-**Never Event** 2019.18666 - [EIM] Delayed Diagnosis, Ovarian Torsian	**Named Person:** Quality Assurance & Serious Incident Officer

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Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
ED - FFT % Positive	>90%	82.8%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	78.6%	78.6%	81.9%	78.4%	81.7%	79.9%	
ED - FFT Response Rate	>15%	12.8%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	10.3%	12.6%	13.0%	13.3%	15.1%	12.9%	
Inpatients - FFT % Positive	>90%	97.0%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	96.6%	97.4%	98.2%	97.6%	98.0%	97.6%	
Inpatients - FFT Response Rate	>25%	13.6%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	15.1%	23.3%	21.0%	19.9%	26.4%	21.0%	
Maternity - FFT % Positive	>90%	95.5%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	95.1%	93.9%	94.1%	93.8%	94.0%	94.1%	
Maternity - FFT Response Rate	>15%	49.3%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	31.1%	41.3%	52.2%	34.1%	48.1%	41.2%	
Outpatients - FFT % Positive	>90%	91.3%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	93.8%	94.3%	92.8%	
Outpatients - FFT Responses	400	138	328	484	233	423	389	421	419	233	126	273	690	1741	
Community - FFT % Positive	>90%	95.7%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	92.7%	95.0%	96.1%	
Community - FFT Responses	1500	1122	1159	998	622	1014	1028	953	842	909	799	832	762	4144	
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%	88.9%	75.0%	84.2%	
Complaints (including complaints against Corporate division)	N/A	0	0	0	0	0	0	0	20	28	19	27	20	114	

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

Date & time of production: 16/09/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate : August - 82% positive responses; 15.1% response rate	**Variance against Plan:** ED's FFT results for August were below the positive responses KPI (90%) **Action to Recover:** A local working group to improve patient experience has been established in the Accident and Emergency department. There has been very positive progress in this regards, with the response rate target of 15% being met for the first time since April 2018. One of the key drivers behind this positive improvement has been including FFT cards with patient prescriptions. An additional 115 FFTs were collected through this method.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2020
Community FFT Responses: August – 93% positive responses; 762 responses	**Variance against Plan:** Community reporting exceeds the 90% KPI for positive responses, but did not meet the Trust set KPI of 1,500 responses per month. **Action to Recover:** The patient experience manager has agreed a new process with IT for requesting iPads for FFT and patient experience feedback collection. A new process map will be hosted on the intranet (September 19), and a SOP for FFT and patient experience collection is being written (expected for November 19 once approved at November's patient experience committee). MSK Physiotherapy had been having issues with the url link they use to email patients for FFT collection. This has been corrected and is now operational again. In addition to this, the 'email2sms' service has been established in adult community dietetics. The plan is to hopefully spread this method of collection across the ACS teams, if successful with the adult community dietetics service.	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** January 2019

Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance	
Hospital Cancelled Operations	0	2	8	10	4	5	14	7	10	3	10	18		41		!
Cancelled ops not rebooked < 28 days	0	0	1	2	0	0	1	0	0	0	0	0		0		
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0		
Theatre Utilisation	>85%	82.1%	80.7%	79.6%	80.9%	80.4%	78.5%	77.5%	81.5%	85.3%	83.9%	85.0%	85.7%	84.2%		
Breastfeeding Initiated	>90%	91.7%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	91.7%	89.9%	89.9%	91.9%	91.7%	91.0%		
Mortality rate per 1000 admissions in-months	14.4	5.0	5.5	6.6	8.4	7.7	6.0	9.2	8.1	7.4	7.3	7.4	7.2	7.5		
Community DNA % Rate	<10%	7.7%	7.8%	7.5%	8.0%	7.5%	7.4%	6.7%	7.6%	7.0%	7.1%	7.8%	8.1%	7.5%		
Community Services - Provider Cancellations	<8%	5.9%	6.1%	6.6%	7.4%	6.3%	6.0%	6.3%	6.3%	6.3%	5.9%	6.3%	6.8%	6.3%		
Acute DNA % Rate	<10%	10.7%	10.5%	10.5%	10.3%	10.0%	10.6%	9.7%	10.5%	11.5%	13.3%	12.6%	12.2%	12.0%		!
% of GP Referrals that were completed via ERS		84.8%	87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.3%	88.1%	89.0%	88.7%	86.6%	88.2%		
Outpatients New:FUp Ratio	2.3	1.93	1.92	1.87	1.94	1.96	1.86	1.92	1.94	1.92	1.87	1.83	1.84	1.88		
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.8%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%	3.3%	4.0%		3.2%		!
Non Elective Re-admissions within 30 days	<5.5%	5.93%	5.42%	4.91%	5.86%	5.48%	5.92%	6.39%	6.36%	5.26%	4.24%	5.07%	5.81%	5.34%		
Rapid Response - % of referrals with an improvement in care			18.0%	92.4%	89.4%	84.1%	90.2%	84.9%	89.7%	100.0%	78.7%	81.8%	98.4%	89.8%		

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

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatre Cancellations On The Day :	**Variance against Plan:** 18 patients cancelled on the day 5 cases were cancelled due to environment issues. 8 cases were cancelled due to list-overrun 5 cases cancelled due to anaesthetist unavailability **Action to Recover:** Environment issues – due to an increase in theatre temperature 5 cases were cancelled. This has now been resolved with additional steps in place to reduce risk. Lists overrunning – A mitigation plan map has been agreed in Theatre Improvement forum. The service will use standard procedure timing at the time of booking of the surgical procedure in order to optimise theatre session utilisation and reduce the risk of cancellation. Anaesthetist unavailability – A recruitment plan is in place to manage required establishment.	**Named Person:** General Manager Theatres, ITU, POA & Admissions **Time Scale to Recover Performance:** October 2019
Delayed Transfers of Care % of Occupied Bed Days: The percentage of patients who are ready to leave hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.	**Variance against Plan:** 4.0% for July 2019 – 1.6% above target **Action to Recover:** A Super MADE (Multi Agency Discharge Event), with a focus on DTOCs took place on 14th August 2019. A number of key themes were identified to improve learning and reduce actual number of delays. Additional actions to be picked up by the Accident and Emergency Delivery Board. Once a week senior teleconference has also been established to manage escalated delays.	**Named Person:** Head of Performance, Operations **Time Scale to Recover Performance:** September 2019
Acute DNA % Rate: Percentage of patients who did not attend their outpatients appointment **Standard:** <10%	**Variance against Plan:** 2.2% over standard. Improvement by 0.4% from July to August. **Action to Recover:** As part of the Outpatient transformation programme there is a targeted action plan looking at any specialities that are not achieving the 10%	**Named Person:** Outpatient Programme Lead **Time Scale to Recover Performance:** September 2019

	target on both new and follow up appointments. This is being monitored through the operational working group with an aim to improve performance from September 2019 onwards.	

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Indicator	18_19 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
Emergency Department waits (4 hrs wait)	>95%	89.6%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	84.8%	82.8%	86.2%	
ED Indicator - median wait for treatment (minutes)	<60 mins	75	79	88	90	85	92	97	91	76	67	84	72	78	
Ambulance handovers waiting more than 30 mins	0	12	18	15	23	18	53	28	56	35	28	30	41	190	
Ambulance handovers waiting more than 60 mins	0	2	0	0	2	2	14	7	5	4	1	3	5	18	
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	0	0	0	1	0	1	0	1	0	7	12	10	30	
Cancer - 14 days to first seen	>93%	90.1%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%	97.0%	94.4%		96.0%	
Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	97.4%	97.7%	95.5%		96.9%	
Cancer - 62 days from referral to treatment	>85%	86.2%	83.1%	93.3%	93.8%	84.9%	90.2%	89.6%	88.9%	81.0%	81.3%	85.9%		84.2%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%					83.0%	90.0%	89.6%	88.2%	76.7%	82.6%	80.6%		81.6%	
Cancer ITT - % of Pathways sent before 38 Days	>85%					100.0%	40.0%	75.0%	62.5%	25.0%	100.0%	33.3%		45.2%	
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		80.4%	83.6%	86.1%	93.9%	88.3%	88.2%	83.3%	89.9%	94.9%	96.4%	94.5%		93.8%	
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%	75.0%	60.0%				100.0%	100.0%	100.0%	0.0%		77.8%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.0%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	99.2%	99.2%	99.1%	99.4%	99.3%	99.2%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.0%		92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	1	1	0	0	0	0	0	0	0	0		0	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	90.9%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	100.0%	92.5%	95.6%	
% seen <=48 hours of Referral to District Nursing Service	>95%	91.3%	93.3%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	97.2%	95.1%	96.5%	97.1%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	90.9%	90.3%	90.5%	90.1%	91.9%	95.2%	94.6%	93.7%	89.8%	91.7%	88.9%		90.9%	
Islington New Birth Visits - % seen within 2 weeks	>95%	95.6%	93.1%	93.4%	92.4%	95.4%	91.6%	94.5%	96.1%	89.6%	94.3%	92.4%		93.0%	

Date & time of production: 16/09/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Wait Performance: Percentage of A&E Attendances seen within 4 hours **National standard:** 95% **NHSI Standard:** 92%	**Variance against Plan:** August – 82.8%, 12.2% behind target and (8.2% below NHSI standard) **Action to Recover:** • A deep dive into ED performance will be presented separately for the September Trust Board. • There are a number of actions established as part of the ED Improvement plan; these include further development in the Long Length of Stay improvement and Bed Capacity.	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** We are unlikely to see recover until September 2019. The Deep dive into performance will give an indication on the expected improvement in performance.
ED – 12 Hour Trolley Waits : 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:** 10 x 12 hr trolley breaches for patients awaiting a mental health admissions. **Action to Recover:** • 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. • 50% Optimise utilisation of the mental health suite for lower acuity of non-admitted patients • 90% of patients in ED referred to MHLT assessed within 60 minutes of arrival. • Adhere to escalation processes	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** End November/December 2019
Ambulance Hand Overs more than 30 minutes: There should be zero patients waiting for more than 30 and 60 for ambulance handover to ED. **Standard:** 0	**Variance against Plan:** 41 x 30 mins breaches and 5 x 60 mins breaches **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:** Acting General Manager **Time Scale to Recover Performance:** September 2019

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:** August 2019 performance at 72 minutes. 12 minutes behind plan. **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	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** November 2019
Cancer Inter Trust Transfers – Reallocated Breach Performance for 62 days performance **Standard:** 85%	**Variance against Plan:** 80.6% performance in July 2019, 4.4% from target **Action to Recover:** There have been a number of data issues relating to patients being transferred to University College London Hospitals (UCLH) NHS Foundation Trust for their subsequent treatment, this may possibly be due to UCLH's new patient information system upgrade. The data return from UCLH has affected the Trust position; this has been escalated to UCLH and to NHSE. There is an action plan in place to target urology pathways as the majority of patients delays are in this area	**Named Person:** Cancer Service Lead **Time Scale to Recover Performance:** November 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 July 88.9% new birth visits were carried out within 14 days**.** In July 278 out of 306 visits happened within timeframe, the remainder took place but out of timeframe: • 3 were due to late NB notifications received • 14 were on SCBU • 7 were booked late by the HV service • 3 had an appointment booked within timeframe but did not attend • 1 was a transfer within Haringey and was booked after 14 days The Haringey HV teams are working to achieve the target. To improve performance the team have reviewed systems and processes across the service and that will strengthen booking processes.	**Named Person:** Head of Haringey Children and Young People's Services **Time Scale to Recover Performance:** November 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:** Islington health visiting – August 94.2% (5 seen after 14 days) **Action to Recover:** Health visiting teams continue to work to achieve the 95% target and provide exception reports to account for those visits completed after 14 days. Principal reason for delays is babies that are still in hospital. Updated new birth protocol states new birth contact should be made with family in hospital where appropriate. Parental choice is also having an impact – work has been done with teams to address this with a change in the administrative processes to ensure families are contacted earlier to avoid breach.	**Named Person:** Head of Islington Children and Young People's Services **Time Scale to Recover Performance:** Ongoing monitoring

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Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
Appraisals % Rate	>90%	74.7%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	71.3%	69.8%	71.4%	72.4%	72.7%	71.5%	
Mandatory Training % Rate	>90%	82.2%	82.4%	81.1%	80.7%	80.8%	80.8%	80.8%	80.2%	80.1%	79.9%	82.2%	80.8%	80.6%	
Permanent Staffing WTEs Utilised	>90%	86.4%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.3%	86.9%	87.2%	88.9%	86.8%	87.4%	
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%	3.92%	3.81%	3.35%	3.71%	3.69%	3.49%	3.27%	3.13%	3.62%	3.57%		3.40%	
Staff turnover %	<10%	12.8%	12.7%	12.7%	12.0%	11.7%	11.4%	10.8%	10.6%	10.9%	10.9%	10.8%	10.7%	10.8%	
Vacancy % Rate against Establishment	<10%	13.6%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.7%	13.1%	12.8%	11.1%	13.2%	12.6%	
Average Time to Hire (Days)	<61 Days							63	65	69	60	61	62	63	
Nursing Staff Average % Day Fill Rate - Nurses		82.3%	76.8%	76.7%	74.9%	89.3%	87.4%	86.1%	86.7%	86.2%	89.8%	93.2%		88.8%	
Nursing Staff Average % Day Fill Rate - HCAs		139.9%	130.4%	130.4%	125.3%	112.6%	117.1%	112.6%	109.1%	115.0%	113.8%	115.6%		113.4%	
Nursing Staff Average % Night Fill Rate - Nurses		86.6%	85.3%	85.3%	79.2%	92.2%	90.8%	88.6%	88.4%	87.2%	92.1%	92.9%		90.1%	
Nursing Staff Average % Night Fill Rate - HCAs		138.0%	79.6%	83.0%	131.1%	134.5%	124.4%	115.7%	109.3%	114.6%	113.2%	131.1%		116.5%	
Safe Staffing Alerts - Number of Red Shifts		2	0	0	0	0	2	1	0	0	3	2	3	8	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.8	9.2	8.8	10.2	9.0	9.0	9.1	9.0	9.1	9.7	9.3		9.3	

**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 : 73% **Standard:** 90% of members of staff should have undertaken an appraisal.	**Variance against Plan: -17%** **Action to Recover:** Feedback from pilot of simplified appraisal documents collated and new document created based on feedback created – now on intranet and live. Guidance for managers and appraisees being merged into one guide now available on intranet and live. Appraisal training confirms that only the appraisal date needs to be recorded in ESR Shorter simpler guidance on loading dates using screenshots on intranet Existing e-learning sessions at Crouch End and new sessions in Archway for mandatory training support, can be used to get help loading appraisal dates into ESR L&D team supporting managers to input appraisal dates on ESR	**Named Person:** Assistant Director Learning and OD **Time Scale to Recover Performance:** New documents can be published with immediate effect. Appraisal rate improvements expected by the end of October 2019
Mandatory Training % Rate : 81% **Standard:** 90% of members of staff should have completed their mandatory training.	**Variance against Plan: -9%** **Action to Recover:** • Intra-authority transfers (IAT) to transfer compliance data now routine processes in Recruitment and Learning and Development. • 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 • Supported e-learning sessions at Archway started 13-Aug-19 Improving communications and 'how to' guides for staff • L&D team supporting staff to input workbook updates on ESR • Involving ESR account manager in complex queries 'Deep Dive' QI project into one ICSU to investigate issues and gather learning that can be applied to other areas • Improving reporting by consulting with users and report writers	**Named Person:** Assistant Director Learning and OD **Time Scale to Recover Performance:** Milestones: Action plan to any outstanding auditor observations ready by the end of October 2019 Improved reporting by end of October 2019 QI project results and actions to recover errors expected to end at the end of December 2019 Full rollout of deep-dive including checking competency structure and staff profiles, ICSU by ICSU (approximately 2m per ICSU) by the end of August 2020. (With 2nd to 5th

		ICSUs completed end Feb-20, Apr-20, Jun-20, Aug-20)
Permanent Staffing WTEs Utilised: 90% of posts should be filled. **Standard:** 90%	**Variance against Plan:** 3.4% **Action to Recover:** There has been a decrease of 3% from July's figures in permanent staffing WTE's utilised. 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 Rates: The Trust should have less than 10% of staff who have left the Trust within the last 12 months **Standard:** 10%	**Variance against Plan:** 0.3% **Action to Recover:** There has been a marginal decrease in turnover rates (0.2%). Work is ongoing with NHSI to improve retention.	**Named Person:** Deputy Director of Workforce **Time Scale to Recover Performance:** December 2019
Vacancy Rates: The Trust should have less than 10% unfilled posts **Standard:** 10%	**Variance against Plan:** 3.1% **Action to Recover:** There has been an increase in vacancy rates (2.1%). The recruitment dashboard continues to be shared with the ICSU's identifying blockers within the process. Recruitment and selection training including system training is on-going with Managers. There has not been a corresponding increase in agency or bank hours; some of the drop can be attributed to planned gaps in filling vacancies.	**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 increased from slightly by 0.1%, however this is part of a natural fluctuation. HR Business Partners and Recruitment Advisers meet monthly with ICSU's/Corporate Services to review the dashboard and take appropriate action.	**Named Person:** Kate Wilson, Deputy Director of Workforce **Time Scale to Recover Performance: October 2019**

Appendix 1. Community Performance Dashboard

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)	**Overall summary:** RTT waits on improving trajectory, although target still not met and showing as red. Work undertaken to remodel CAMHS teams, and setting up of a multi-agency central point of access for all social, emotional and mental health referrals. CAMHS have been awarded contract to set up school based trailblazer service across Islington, which will mean that all Islington Schools have access to school based CAMHS workers. National Benchmarking data also shows that Islington service contact four times more than the national average Community Paediatrics – There was a reduction in capacity due to annual leave being taken in August but more importantly the junior doctor changeover which affected capacity during the last 2 weeks of August 2019. **Action to Recover:** New access targets have been agreed and will be updated for the October Board report - this will give services waiting time targets in line with clinical evidence and best practice. 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:** 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 demonstrated reductions in waiting times in a number of services, reflecting the transformation work that is being undertaken. Particular improvements to note include Bladder and Bowel - Adult, ICTT- Stroke and Neuro, Intermediate Care, Musculoskeletal Services, Podiatry, Tissue Viability and Spirometry Services, which have all been showing steady month on month improvement. **Action to Recover:** There are a number of work streams underway that are being monitored through the Adult Community Service Improvement Group (CSIG). These are already demonstrating improvements and further improvement is anticipated over the next 3 months	**Named Person:** Director of Operations ACS **Time Scale to Recover Performance:** The timescale for recovery for services is 3 months.

	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. The service has shown a reduction in waiting times in June as compared to previous months. In Community Rehabilitation, Integrated Care Therapy Team (ICTT) and Intermediate Care there is ongoing work being monitored through the local ICSU Board to reduce inappropriate referrals and maximise existing capacity. In MSK there has been an increase in demand that is being addressed through additional capacity. Additional staff have been recruited to support the roll-out of the Single Point of Access in July.	

Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
IAPT Moving to Recovery	>50%	57.0%	62.5%	57.4%	58.2%	62.3%	65.1%	59.1%	62.2%	54.2%	60.8%	60.5%		59.6%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	95.1%	96.8%	95.8%	96.6%	95.6%	95.4%	94.3%	96.9%	95.0%	97.4%	97.8%		96.9%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	80.0%	88.9%	85.8%	92.2%	84.1%	91.9%	88.1%	90.5%	89.8%	87.3%	91.4%		89.8%	
Haringey - HR1 % carried out before child aged 15 months	N/A	69.6%	70.4%	72.0%	73.5%	77.3%	77.0%	80.1%	81.3%	79.5%	79.9%	87.9%		82.1%	
Haringey - HR2 % carried out before child aged 30 months	N/A	63.8%	60.9%	60.4%	62.0%	67.7%	70.4%	71.7%	70.5%	71.9%	71.3%	74.8%		72.1%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	96.5%	96.7%	92.5%	90.7%	86.5%	90.3%	91.7%	93.0%	94.9%	90.8%	90.7%		92.3%	
Islington - HR1 % carried out before child aged 15 mths	N/A	87.5%	76.5%	80.7%	82.0%	74.1%	73.7%	83.3%	80.1%	79.5%	83.0%	86.1%		82.3%	
Islington - HR2 % carried out before child aged 30 mths	N/A	80.8%	80.2%	82.0%	85.0%	77.2%	75.1%	72.4%	78.1%	76.5%	79.4%	82.3%		79.1%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	68.5%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	89.3%	96.2%	95.5%	92.1%	94.3%	93.0%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	77.8%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	78.8%	87.1%	96.2%	95.8%	84.6%	89.0%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	78.0%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	80.6%	74.3%	84.8%	88.1%	70.2%	80.2%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	94.0%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	98.7%	96.2%	91.0%	87.6%	96.6%	93.5%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	66.7%	66.7%	83.3%	71.4%	42.9%	78.6%	100.0%	81.8%	75.0%	71.4%	60.0%	75.0%	72.2%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	80.0%	91.7%	94.4%	72.7%	77.8%	100.0%	90.0%	100.0%	100.0%	85.7%	88.9%	100.0%	95.0%	
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	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	100.00%	87.50%	87.50%	8.1	8	>95%						0
Community Matron	>95%	6	100.00%	100.00%	96.60%	0.9	29	>95%	2	100.00%				0
Adult Wheelchair Service	>95%	8	100.00%	98.10%	100.00%	2.9	42	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	90.30%	88.40%	92.10%	5	114	>95%	2	63.60%	80.00%	75.00%	2	20
ICTT - Other	>95%	12	96.60%	95.90%	92.90%	4.2	224	>95%	2	66.70%	75.50%	60.30%	2.1	78
ICTT - Stroke and Neuro	>95%	12	69.10%	51.30%	73.70%	8.2	38	>95%	2	37.00%	50.00%	68.00%	3.1	25
Intermediate Care (REACH)	>95%	6	92.90%	89.80%	95.30%	3.2	129	>95%	2	88.70%	87.00%	85.20%	1	61
Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	4.3	7	>95%						0
Bladder and Bowel - Adult	>95%	12	52.00%	69.90%	73.50%	8.4	113	>95%						0
Musculoskeletal Service - CATS	>95%	6	47.50%	47.00%	61.80%	5.6	644	>95%			0.00%	33.30%	3.8	3
Musculoskeletal Service - Routine	>95%	6	67.60%	70.70%	82.10%	4.2	1633	>95%	2			100.00%	0.9	1
Nutrition and Dietetics	>95%	6	97.80%	100.00%	100.00%	2.1	195	>95%	2			100.00%	0.9	1
Podiatry (Foot Health)	>95%	6	84.80%	90.00%	95.70%	3.4	648	>95%	2					0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.9	26	>95%						0
Tissue Viability	>95%	6	88.10%	95.20%	95.80%	1.1	48	>95%						0
Cardiology Service	>95%	6	100.00%	95.70%	84.20%	3.1	19	>95%	2	80.00%		100.00%	0.6	3
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.5	60	>95%	2					0
Respiratory Service	>95%	6	97.10%	100.00%	100.00%	2.4	57	>95%	2	100.00%	100.00%	100.00%	0.5	2
Spirometry Service	>95%	6	36.40%	66.20%	92.40%	3.2	66	>95%	2					0

Date & time of production: 16/09/2019

Appendix 2. Community Waiting Times Dashboard

Haringey

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12					0	>95%						0
Community Matron	>95%	6	100.00%	100.00%	100.00%	1.5	8	>95%	2	100.00%				0
Adult Wheelchair Service	>95%	8	100.00%	98.00%	100.00%	3	41	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	100.00%	100.00%	0.00%	13.1	2	>95%	2		100.00%			0
ICTT - Other	>95%	12	96.30%	96.10%	93.00%	4.2	214	>95%	2	64.80%	75.30%	62.00%	2	71
ICTT - Stroke and Neuro	>95%	12	69.20%	50.00%	80.00%	7.7	35	>95%	2	37.50%	46.70%	66.70%	3.4	21
Intermediate Care (REACH)	>95%	6		100.00%			0	>95%	2	0.00%	100.00%			0
Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	4.3	6	>95%						0
Bladder and Bowel - Adult	>95%	12	51.20%	69.00%	67.40%	9.1	46	>95%						0
Musculoskeletal Service - CATS	>95%	6	49.80%	49.70%	64.30%	5.4	325	>95%			0.00%	100.00%	1.4	1
Musculoskeletal Service - Routine	>95%	6	68.80%	70.40%	81.20%	4.3	877	>95%	2					0
Nutrition and Dietetics	>95%	6	96.40%	100.00%	100.00%	2.3	107	>95%	2			100.00%	0.9	1
Podiatry (Foot Health)	>95%	6	85.30%	87.70%	94.20%	3.5	311	>95%	2					0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	3	16	>95%						0
Tissue Viability	>95%	6	91.70%	90.90%	88.90%	1.5	18	>95%						0
Cardiology Service	>95%	6	100.00%	100.00%	88.90%	2.9	9	>95%	2	100.00%		100.00%	0	1
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.3	39	>95%	2					0
Respiratory Service	>95%	6	100.00%	100.00%	100.00%	2.5	29	>95%	2	100.00%				0
Spirometry Service	>95%	6	36.40%	65.60%	92.40%	3.2	66	>95%	2					0

Date & time of production: 16/09/2019

Appendix 2. Community Waiting Times Dashboard

Islington

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	100.00%	87.50%	87.50%	8.1	8	>95%						0
Community Matron	>95%	6	100.00%	100.00%	94.70%	0.7	19	>95%	2					0
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	89.70%	87.50%	93.60%	4.9	109	>95%	2	63.60%	80.50%	75.00%	2	20
ICTT - Other	>95%	12	100.00%	50.00%	66.70%	6.2	3	>95%	2	100.00%	0.00%	0.00%	2.1	1
ICTT - Stroke and Neuro	>95%	12					0	>95%	2		100.00%			0
Intermediate Care (REACH)	>95%	6	92.60%	89.50%	95.20%	3.2	124	>95%	2	90.00%	85.90%	84.20%	1.1	57
Paediatric Wheelchair Service	>95%	8					0	>95%						0
Bladder and Bowel - Adult	>95%	12	30.00%	68.30%	81.30%	7.8	48	>95%						0
Musculoskeletal Service - CATS	>95%	6	44.40%	43.80%	58.60%	5.8	304	>95%				0.00%	4.9	2
Musculoskeletal Service - Routine	>95%	6	68.60%	71.60%	84.70%	4	634	>95%	2			100.00%	0.9	1
Nutrition and Dietetics	>95%	6	100.00%	100.00%	100.00%	1.9	87	>95%	2					0
Podiatry (Foot Health)	>95%	6	84.40%	92.40%	97.00%	3.4	331	>95%	2					0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2.8	10	>95%						0
Tissue Viability	>95%	6	95.80%	100.00%	100.00%	0.8	28	>95%						0
Cardiology Service	>95%	6	100.00%	92.30%	80.00%	3.2	10	>95%	2	75.00%		100.00%	0.9	1
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.9	21	>95%	2					0
Respiratory Service	>95%	6	94.60%	100.00%	100.00%	2.5	26	>95%	2	100.00%	100.00%	100.00%	0.5	2
Spirometry Service	>95%	6					0	>95%	2					0

Date & time of production: 16/09/2019

Children's Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
Service	Team Group	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen	% Target	Target Weeks	Jun-19	Jul-19	Aug-19	Avg Wait (Aug-19)	No of Pts First Seen
CAMHS	CAMHS	>95%	8	45.50%	53.00%	56.10%	10.7	98	>95%	2	87.50%	72.70%	100.00%	1	4
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	100.00%	100.00%	66.70%	1.9	3	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	83.30%	83.80%	86.90%	0.9	84	>95%	1	100.00%	100.00%	100.00%	0.1	8
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	18	16.70%	20.80%	61.50%	29	13	>95%	1	0.00%		0.00%	78.9	2
	Community Paediatrics - Haringey (NDC)	>95%	18	100.00%	100.00%	100.00%	8.7	18	>95%	1		0.00%			0
	Community Paediatrics - Haringey (Child Protection)	>95%	18	100.00%	100.00%	100.00%	0.7	7	>95%	1					0
	Community Paediatrics - Haringey (Other)	>95%	18	80.00%	0.00%			0	>95%	1					0
	Community Paediatrics - Islington	>95%	18	93.90%	80.00%	72.70%	15	11	>95%	1					0
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	100.00%	92.90%	80.00%	4.4	10	>95%						0
	Family Nurse Partnership - Islington	>95%	12	100.00%	100.00%	100.00%	0.4	2	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	1.3	9	>95%						0
IANDS	IANDS	>95%	18	100.00%	80.00%	100.00%	1.5	30	>95%						0
	IANDS - SCT	>95%	20	9.10%	0.00%	16.70%	28.7	12	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	81.80%	93.30%	100.00%	1.1	3	>95%						0
	Looked After Children - Islington	>95%	4	62.50%	70.00%	100.00%	2.5	11	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	18	91.30%	82.40%	46.20%	13.4	13	>95%	2					0
	Occupational Therapy - Islington	>95%	18	50.00%	71.40%	66.70%	15.4	12	>95%	2					0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.00%	100.00%	100.00%	2.9	5	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	12	92.30%	95.50%	100.00%	4.6	16	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	18	100.00%	97.10%	94.60%	7.8	56	>95%						0
	Physiotherapy - Islington	>95%	18	100.00%	100.00%	100.00%	4.5	67	>95%						0
PIPS	PIPS	>95%	12	87.50%	100.00%	100.00%	3.5	12	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	15	77.80%	72.70%	50.00%	12.7	6	>95%	2		0.00%			0
	SALT - Islington	>95%	15	72.90%	73.80%	77.40%	8.1	31	>95%	2					0
	SALT - MPC	>95%	18	100.00%	97.70%	100.00%	4.2	53	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	93.30%	86.30%	91.70%	2.6	12	>95%						0
	School Nursing - Islington	>95%	12	96.80%	97.00%	100.00%	3.9	42	>95%						0

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

Cancer - 62D Performance by Tumour Group

Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
Breast	>85%	86.7%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.6%	100.0%			
Gynaecological	>85%	66.7%	100.0%	66.7%	100.0%	66.7%	0.0%	100.0%	50.0%	50.0%		0.0%			
Haematological (Excluding Acute Leukaemia)	>85%	60.0%	100.0%	100.0%	100.0%		100.0%	0.0%	100.0%	100.0%					
Lower Gastrointestinal	>85%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			
Lung	>85%	0.0%	100.0%	100.0%		100.0%	85.7%	100.0%	100.0%	50.0%	100.0%	100.0%			
Other	>85%					100.0%		100.0%	100.0%						
Skin	>85%	92.3%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Testicular	>85%						100.0%		100.0%		0.0%				
Upper Gastrointestinal	>85%	100.0%	100.0%		75.0%	100.0%		100.0%	50.0%	100.0%	66.7%	0.0%			
Urological (Excluding Testicular)	>85%	100.0%	44.4%	100.0%	66.7%	64.7%	80.0%	76.9%	88.9%	70.6%	71.4%	62.5%			

Cancer - 2WW Performance by Tumour Group

Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	2019-2020	Performance
Breast	>93%	96.4%	94.0%	97.3%	98.6%	98.5%	93.7%	96.0%	93.9%	99.0%	96.8%	98.0%		96.8%	
Childrens	>93%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	97.4%	95.6%	96.4%	97.8%	97.1%	91.8%	96.6%	94.5%	96.0%	96.1%	96.4%		95.8%	
Haematological	>93%	62.5%	92.9%	91.7%	95.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>93%	82.4%	73.0%	87.3%	98.3%	92.8%	94.2%	95.8%	91.2%	96.7%	96.2%	92.8%		94.4%	
Lung	>93%	90.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	83.3%	83.3%		86.4%	
Skin	>93%	97.4%	98.0%	97.5%	98.6%	97.6%	99.3%	96.2%	98.0%	98.8%	97.5%	91.1%		95.8%	
Upper Gastrointestinal	>93%	20.6%	59.6%	89.2%	98.0%	87.2%	98.2%	98.9%	91.4%	96.6%	98.5%	97.9%		96.1%	
Urological	>93%	97.4%	97.9%	86.4%	94.9%	91.8%	92.4%	92.1%	98.8%	98.4%	98.8%	93.8%		97.1%	

Appendix 4. Trust Level Activity

Category	Indicator	19_20 Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Activity
ED	ED Attendances	8285	8897	9082	9245	9219	9595	8868	9720	9077	9281	8921	9458	8778	
ED	ED Admission Rate %		15.2%	15.0%	16.2%	15.9%	14.9%	14.3%	15.1%	15.0%	14.2%	14.8%	13.4%	13.5%	
Community	Community Face to Face Contacts		57986	64105	63988	51480	62549	56387	60488	55825	59991	59699	61357	51151	
Admissions	Elective and Daycase		1923	2267	2221	1813	2149	1989	2132	2121	2072	2153	2238	1948	
Admissions	Emergency Inpatients		2164	2185	2289	2230	2268	2036	2297	2223	2217	2094	2101	2035	
Referrals	GP Referrals to an Acute Service		6881	8283	7962	6682	8149	7913	8635	8457	8927	8210	7925	6612	
Referrals	% of GP Referrals that were completed via ERS		84.8%	87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.3%	88.1%	89.0%	88.7%	86.6%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	11.9%	13.0%	12.7%	10.7%	7.6%	7.1%	10.3%	12.7%	12.0%	11.5%	13.4%		
Maternity	Maternity Births	320	312	296	299	281	295	246	300	306	312	283	315	307	
Maternity	Maternity Bookings	377	334	398	363	327	420	379	419	367	390	342	408	357	
Outpatients	Outpatient DNA Rate % - New	<10%	11.3%	10.7%	10.7%	10.5%	10.5%	10.5%	9.8%	10.7%	11.4%	12.9%	12.9%	12.9%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.2%	10.4%	10.3%	10.1%	9.7%	10.7%	9.7%	10.3%	11.5%	13.6%	12.4%	11.7%	
Outpatients	Outpatient New Attendances		8956	10552	10270	8514	10201	9405	9412	9478	9682	9187	10358	8980	
Outpatients	Outpatient FUp Attendances		17279	20252	19206	16491	20029	17462	18041	18379	18584	17149	18926	16512	
Outpatients	Outpatient Procedures		7375	8178	8003	7121	8410	7549	7978	7494	7497	7492	8270	7177	

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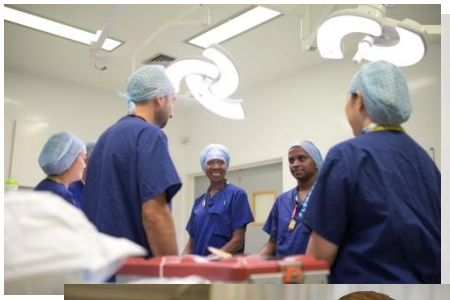
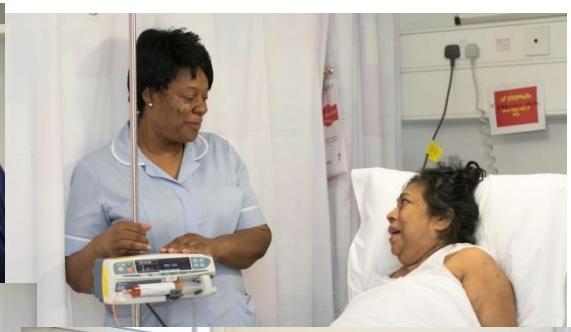
ED Performance Deep Dive Report

1st July 2019 – 31st August 2019



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INNOVATION COMPASSIONATE ACCOUNTABLE RESPECTFUL EXCELLENT

Introduction

Whittington Health NHS Trust

Context and Purpose

- Whittington Health NHS Trust is not achieving it's the 4 hour Accident and Emergency (A&E) waiting time standard trajectory as agreed with NHSI. In August 2019 performance was 9.2% lower then agreed target of 92%.
- The rationale for the deep dive is to review August's position and understand the key reasons of non-compliance and reviewing specific areas contributing to delivery.
- Plans are underway to develop resilient systems to improve overall performance. This report has been designed to inform and support the development of robust action plans, building on work that has already commenced within the Trust, towards providing a sustainable service.
- Performance measures are a proxy for the quality and safety of care delivered by a service and as such aspects of the quality and safety of care delivered in the department were considered in this review.

Summary

Whittington Health NHS Trust

August 2019 performance

- The data suggests that although ED attendances continue to increase, our number of admissions have remained consistent which although has resulted in a lower conversion rate, assumptions could be made that the patients being admitted or potentially those with a naturally higher LOS. There was an increase in the average length of stay in August contributing in increased bed occupancy in that month.

- We have seen an increase in the percentage of admitted patients over the age of 75 in August. This group of patients tend to have a higher LOS and can been seen as having an impact during this month.

Summary cont.

Whittington Health NHS Trust

August 2019 performance

- Patients physically in ED appears to increase from the morning until 12pm where levels remain high until it begins to decrease at 8pm onwards – this is reflected in our pattern of breaches. Focus on flow to increase timely discharges (pre 11am, pre 3pm, pre 5pm) to break this pattern and reduce overall breaches as a possible intervention.

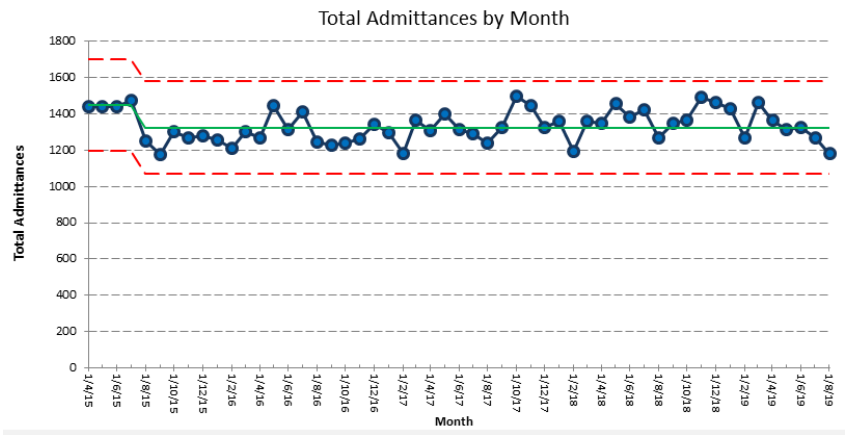
- Higher levels of DTOCs and staffing issues reported between June & August 2019 – DTOC numbers have had an impact on bed availability. DTOCs in August 2019 have been seasonally high and higher than previous years.

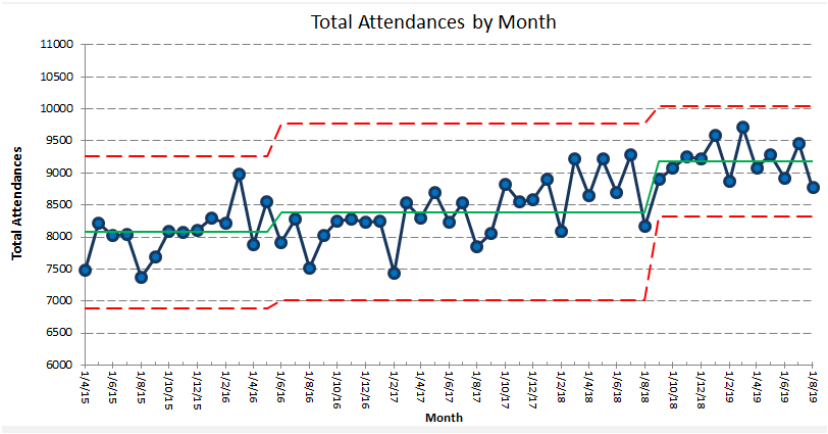
- During August 2019 the impact of the change in junior doctors and annual leave being taken by senior clinicians in ED and EIM are higher than other months could be contributing factor into August's lower performance.

Attendances, Admittances and LoS

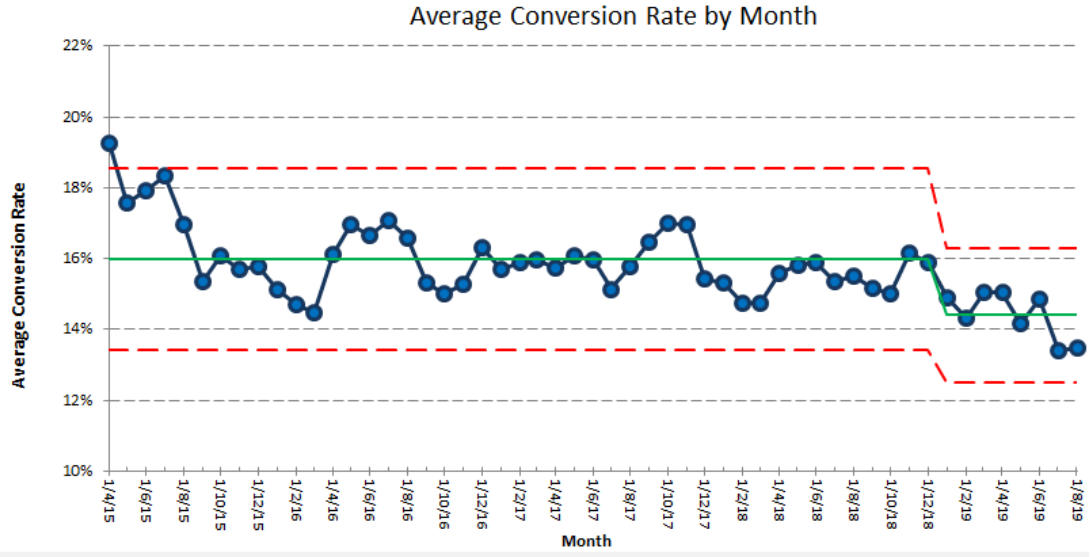
Weekly 4 Hour Performance by W/E

NHS Whittington Health NHS Trust





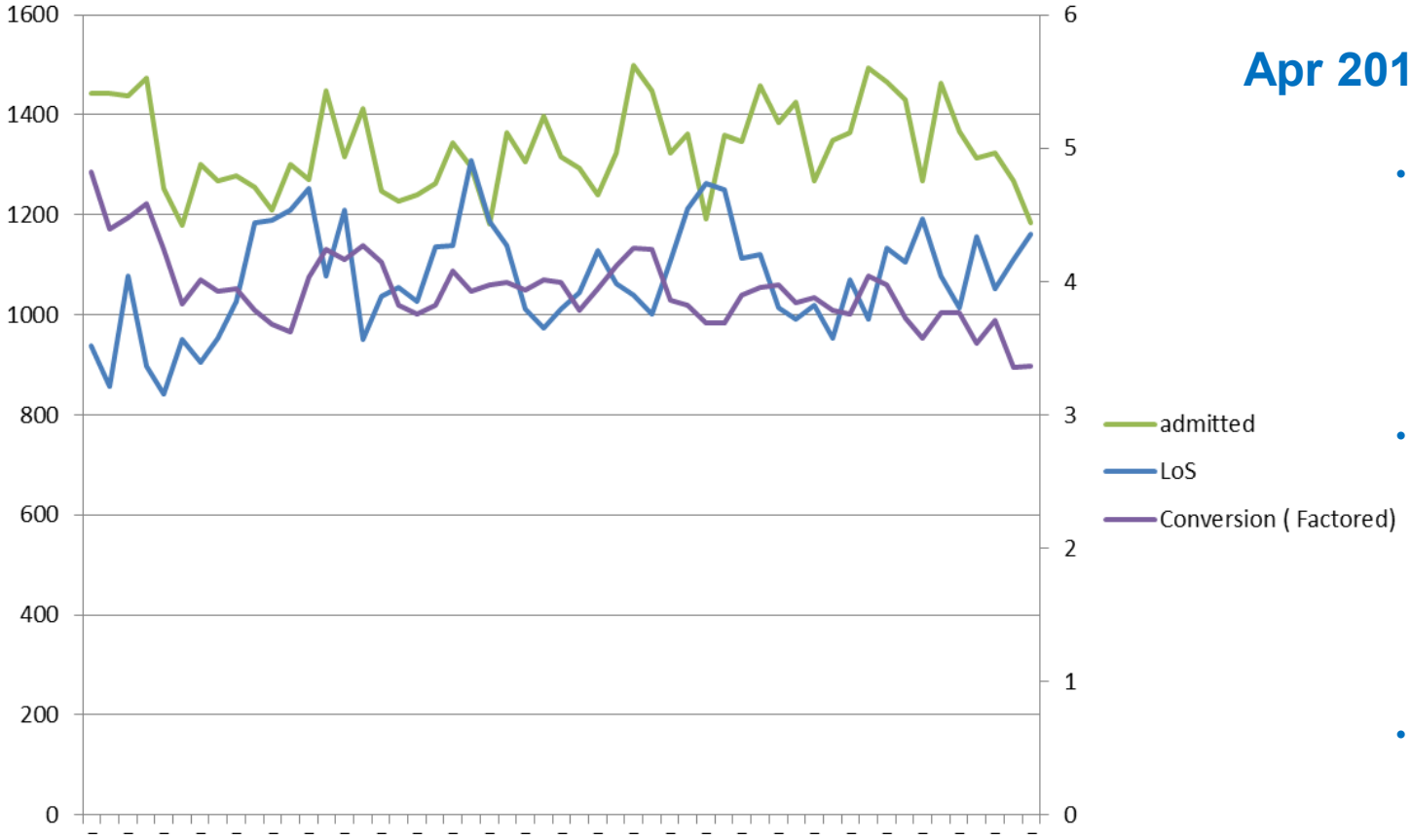
Admittances has remained consistent despite steady increase in average monthly attendances. August 2019 shows a similar pattern



16% average moved to 14.4% from Jan 2019 - **9% reduction. Conversion rates in August 2019 have improved however there was an increase in average LOS**

Admitted/LoS/Conversion Relationship Trends

Whittington Health NHS Trust



Apr 2015 – Aug 2019

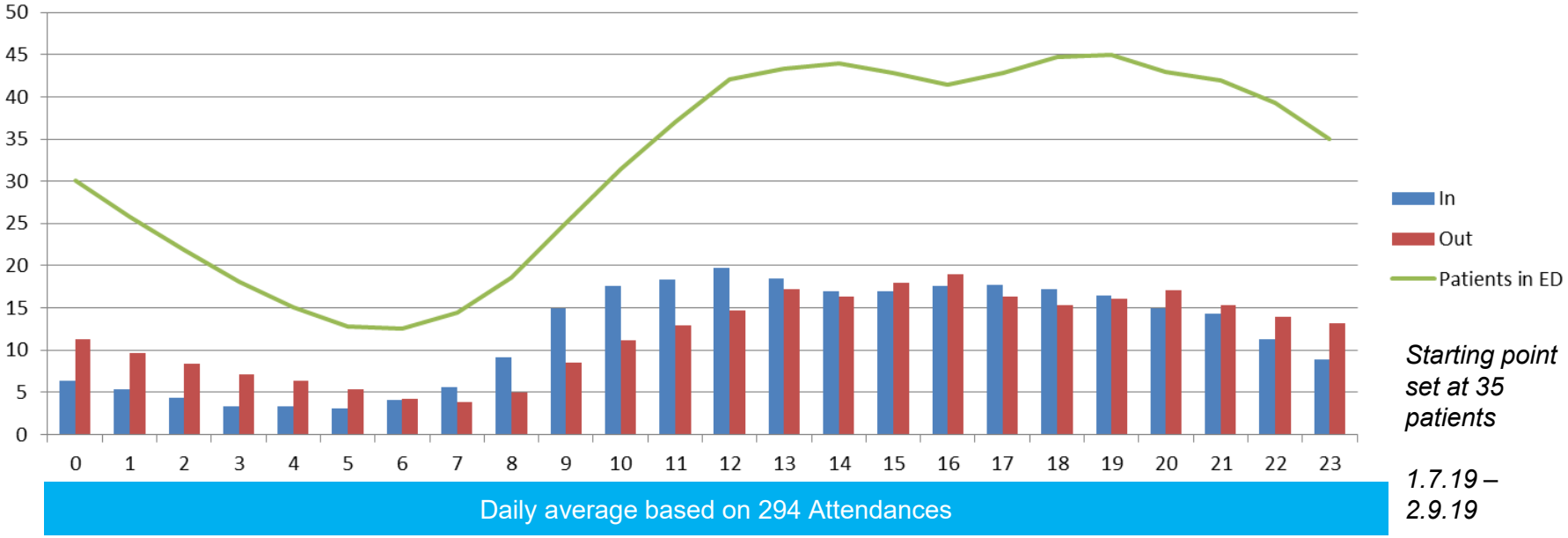
- Average LoS appears to have same trend movements as Admitted whilst conversion has an opposite relationship with LoS
- With growing attendances whilst admittances have remained consistent, data suggests that the type of patients being admitted are those who tend to have a naturally higher LoS
- **August 2019** shows a decrease in admitted patients compared to previous months but an increase in ALOS

By Hour Trends

No. Patients in ED

Whittington Health NHS Trust

Average No. Patients arriving and leaving ED per hour:



Daily average based on 294 Attendances

Starting point set at 35 patients

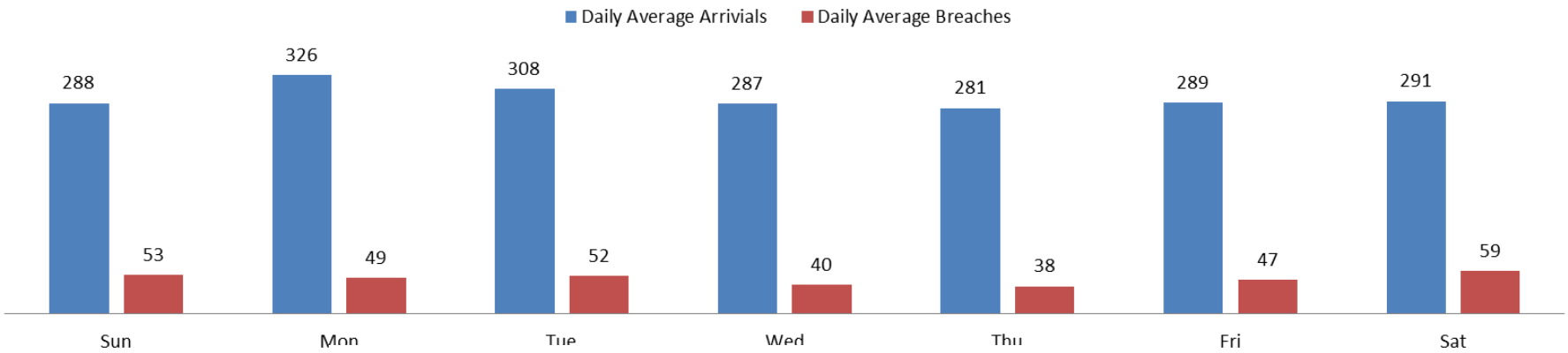
1.7.19 – 2.9.19

- The pattern of patients in the department for **August 2019** is comparable to other months

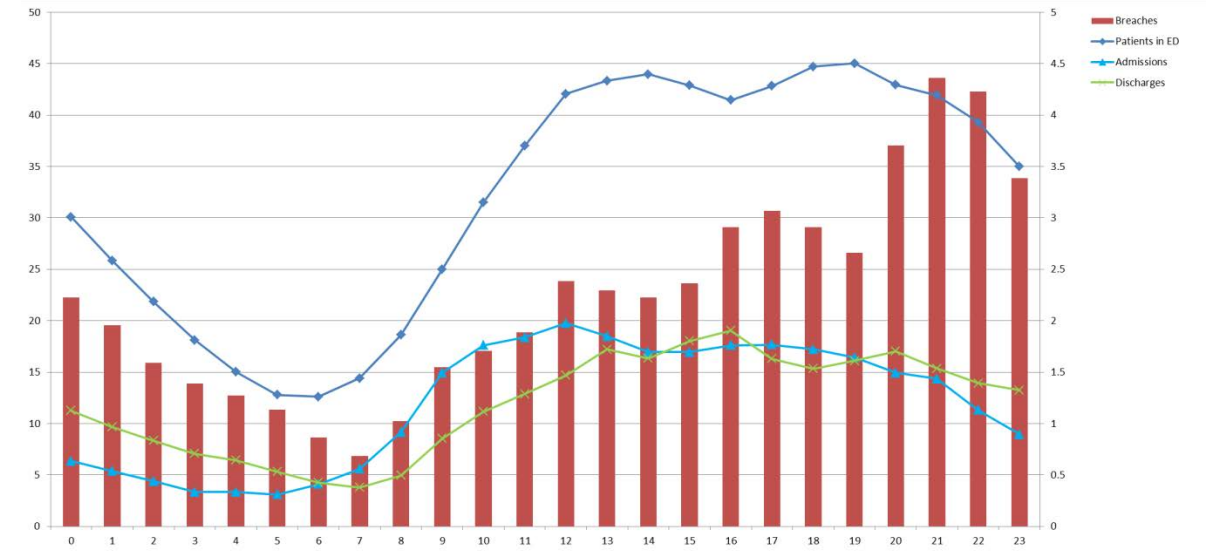
Arrivals/Percentage Breached per day

NHS Whittington Health NHS Trust

Attendances and Breaches by Weekday



Attendances and Breaches by Arrival Hour



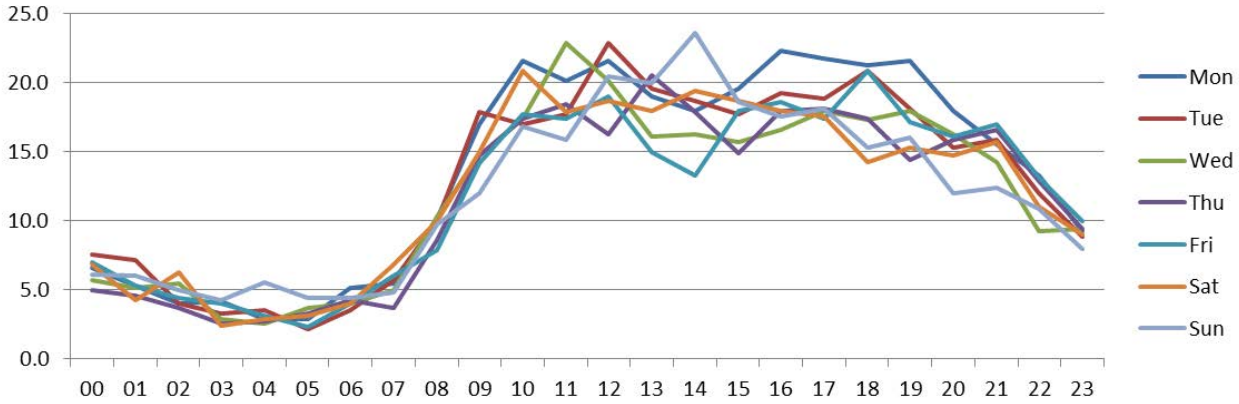
Hourly averages 1.7.19 – 2.9.19

- Breaches more closely follows pattern of patients in ED rather than admission pattern. This consistent compare to previous months for **August 2019**.

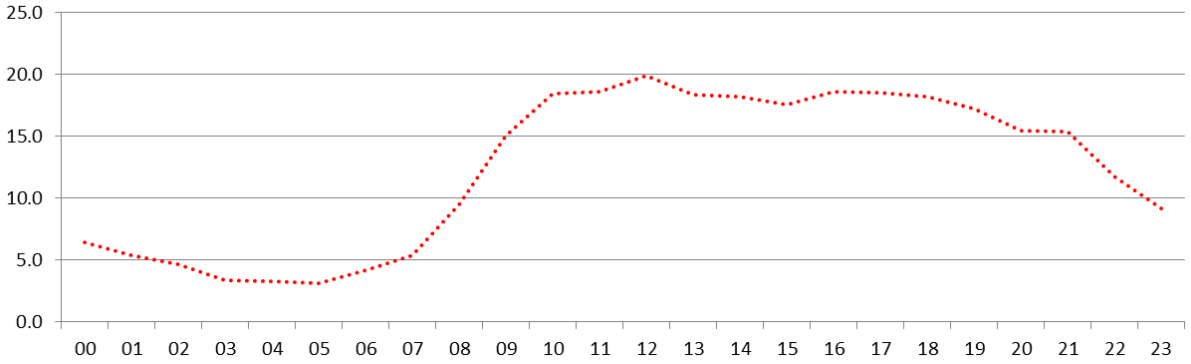
Attendances by Hour – 1st July 2019 – 17th August 2019

Whittington Health NHS Trust

Average Daily Attendances by Weekday & Hour



Average Daily Attendances by Hour

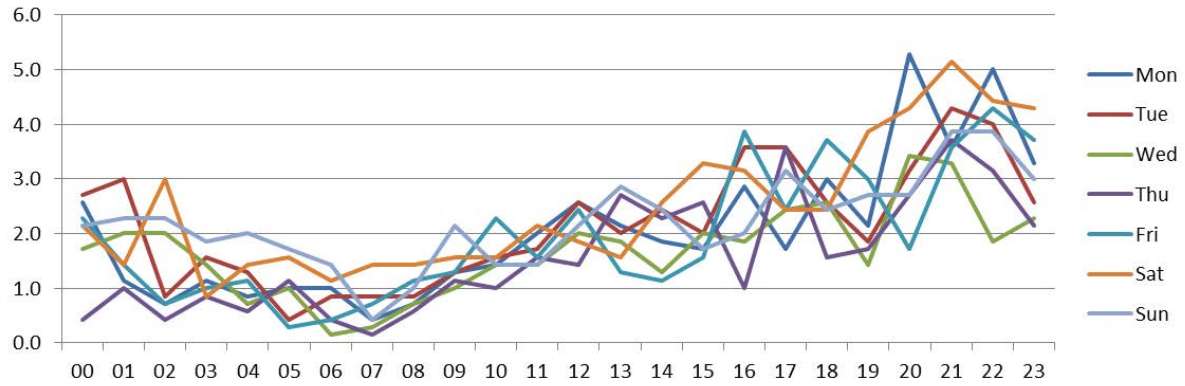


- Further analysis to test daily attendances by hour could confirm if variance in afternoon across days increases or reduces

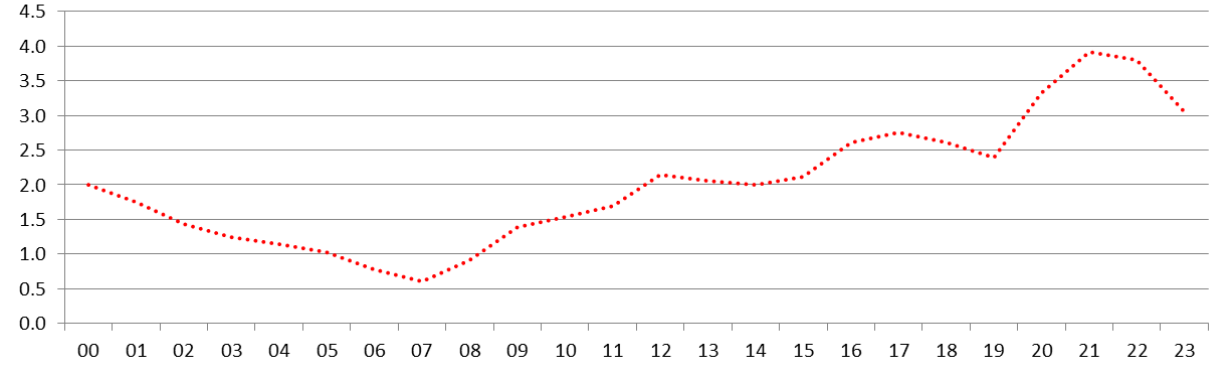
Breaches by Hour – 1st July 2019 – 17th August 2019

Whittington Health NHS Trust

Average Daily Breaches by Weekday & Hour



Avaerage Daily Breaches by Hour

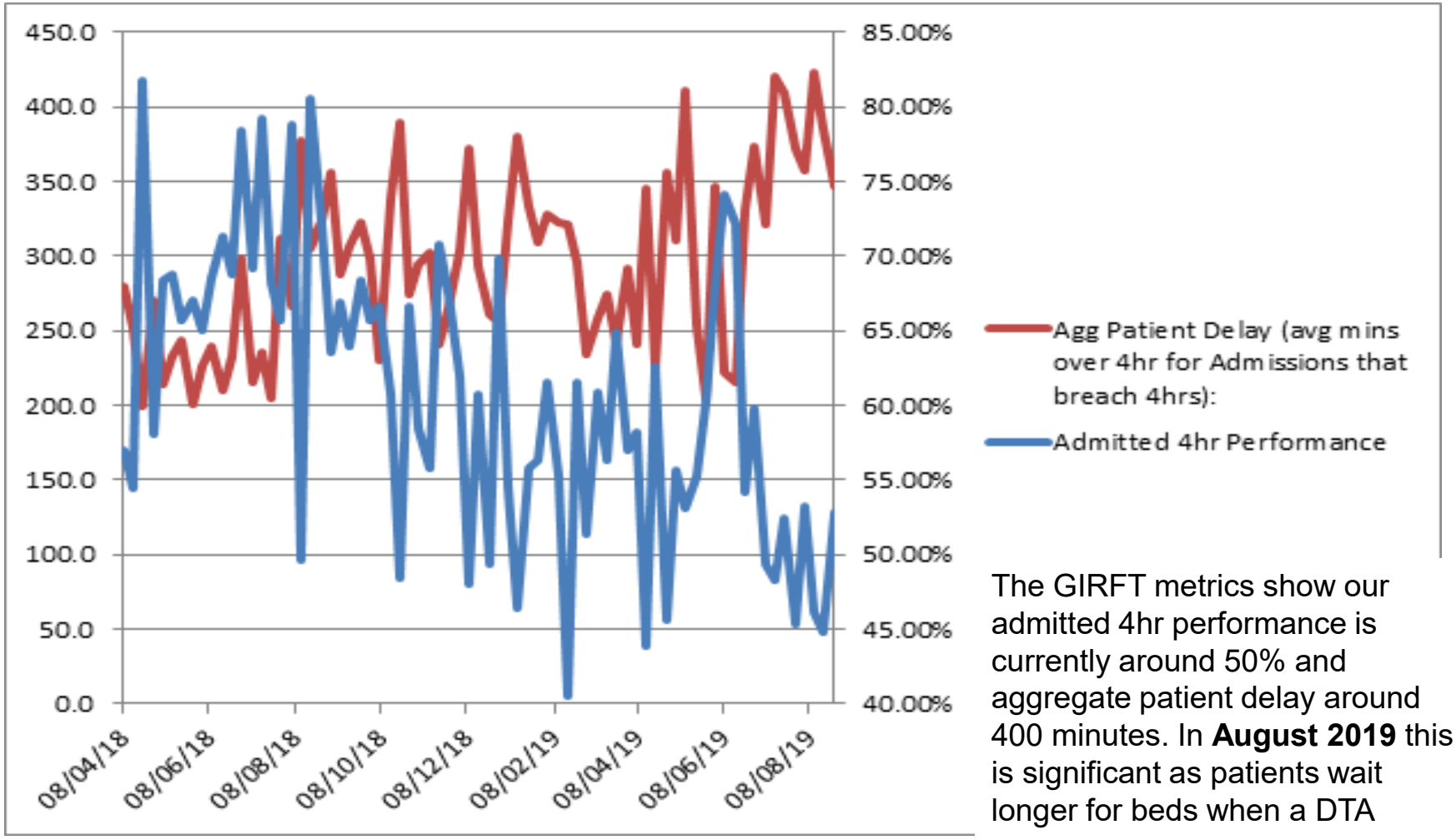


- Data follows same overall pattern but with Wednesday and Saturday having highest peaks

Additional Trends

Admitted Patient Breach rate vs Aggregate Patient Delay

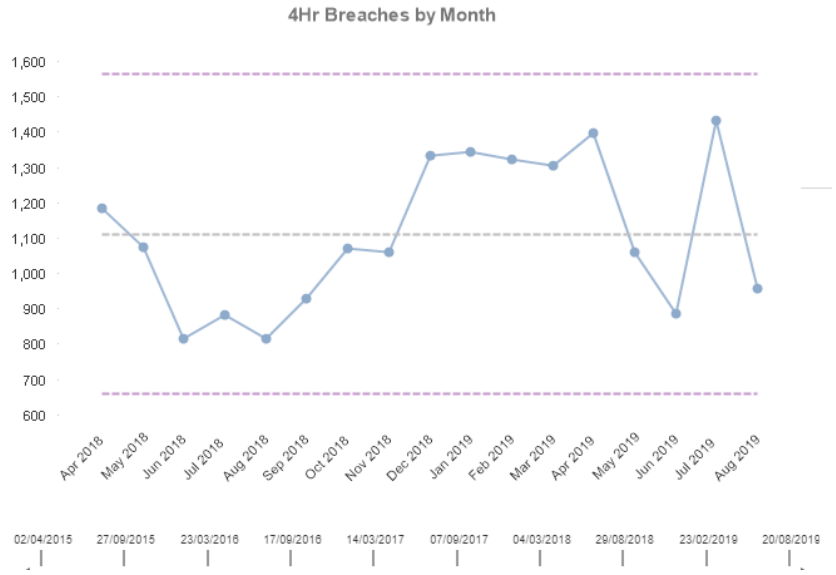
Whittington Health NHS Trust

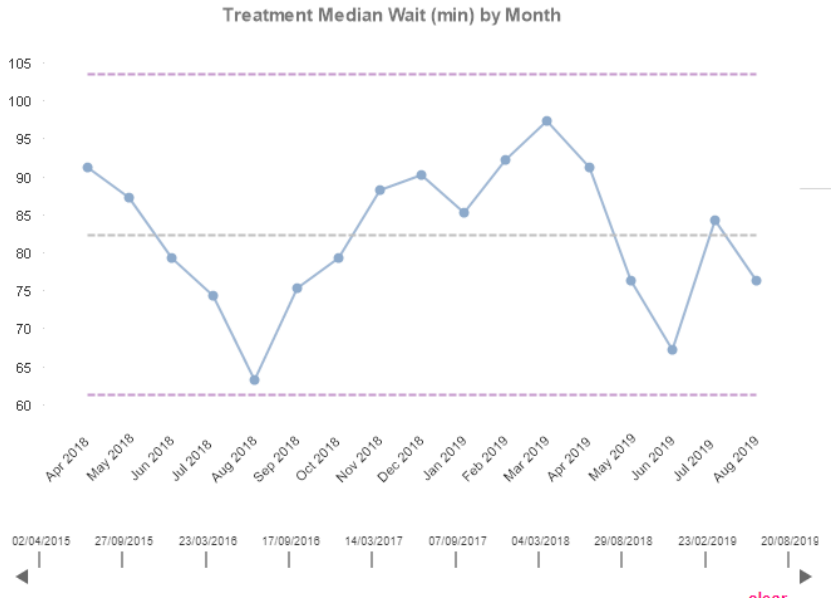


The GIRFT metrics show our admitted 4hr performance is currently around 50% and aggregate patient delay around 400 minutes. In **August 2019** this is significant as patients wait longer for beds when a DTA occurs

Trends

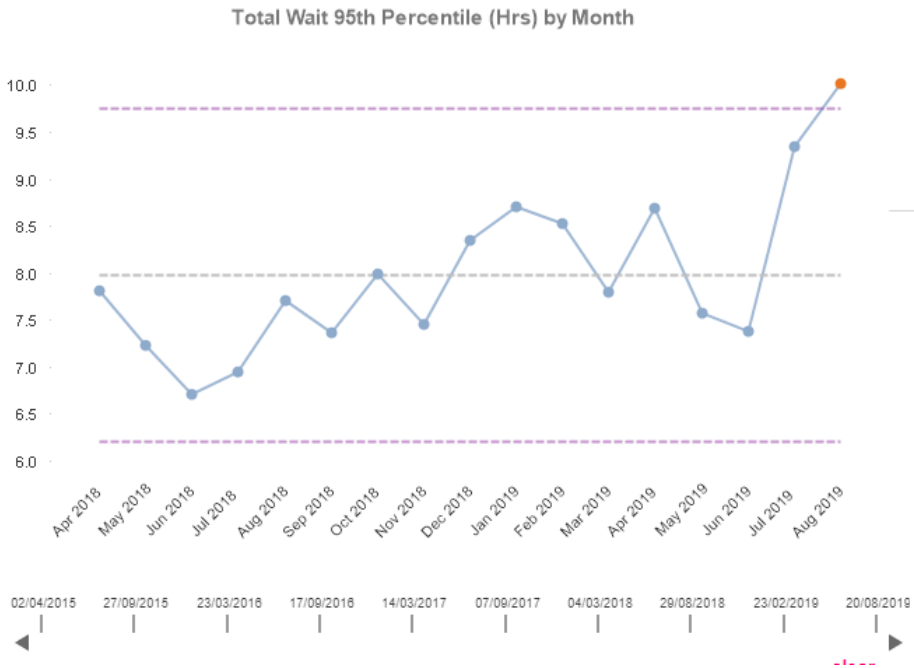
Whittington Health
NHS Trust

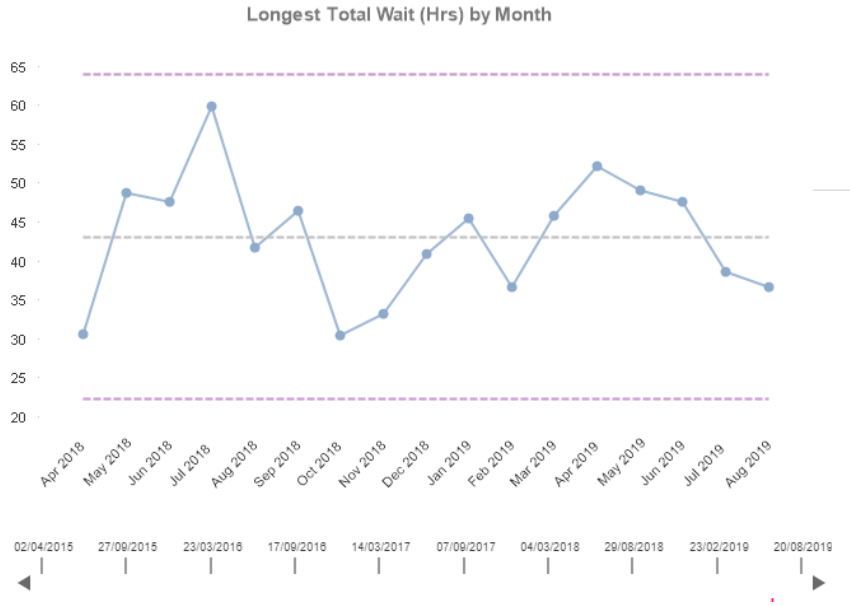




Trends 2

Whittington Health
NHS Trust





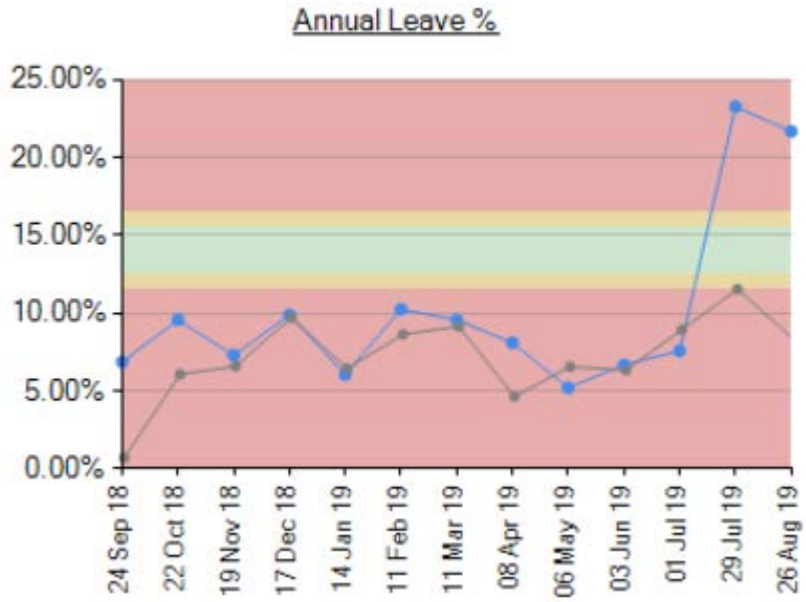
Staffing

Consultant Annual Leave

Whittington Health NHS Trust

ED

EIM



The blue line is this 12 month period compared with the black line (previous year)

- Annual leave in August 2019 increases across both ED and EIM – this could be a contributing factor to ED performance where regular senior decision makers may not be available.
- New junior doctors rotations also occur in August 2019 – this may also have a contributing factor to achieving target.

MADE Analysis

MADE Event Analysis Apr 2019 – July 2019

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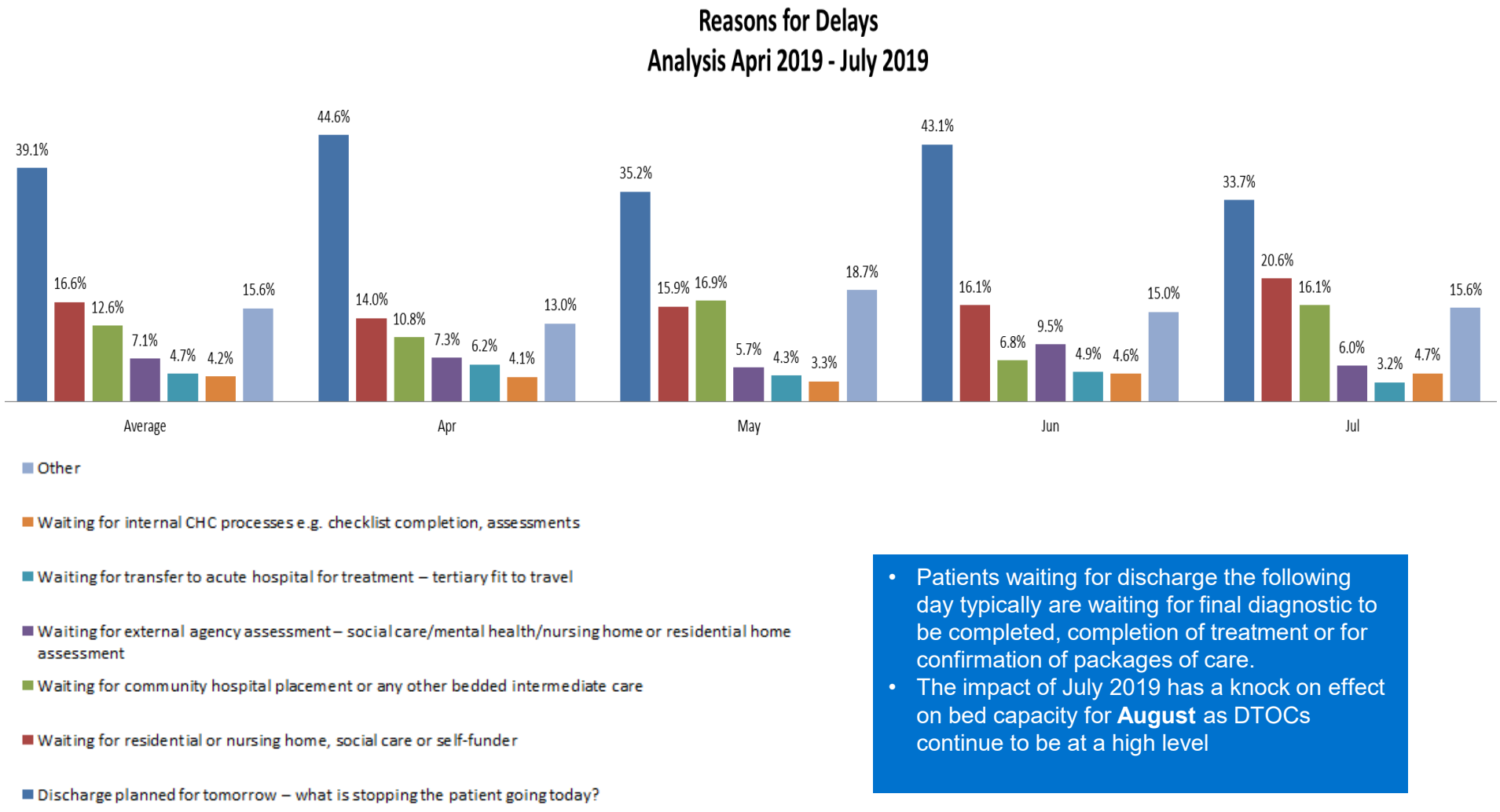

- Patients waiting for discharge the following day typically are waiting for final diagnostic to be completed, completion of treatment or for confirmation of packages of care.
- The impact of July 2019 has a knock on effect on bed capacity for **August** as DTOCs continue to be at a high level

MADE Event Analysis Apr 2019 – July 2019 cont.

Whittington Health NHS Trust

Key areas:

- External bed capacity, including Intermediate Beds (community hospital beds) and residential/nursing homes contributes to have over the last four months contributed to 29.2% of delays, with a spike in July 2019
- Brokerage delays have contributed the high level of patients waiting for external beds.
- Discharges for the following day – performance has significantly dip in July 2019
- External assessment delays continue to be a problem.
- CHC assessment issues continue to cause delays to discharges throughout the four month period.
- Patients waiting for neuro-rehabilitation beds have also contributed to the number delays.
- Increased number of equipment delays in July.
- Increase in delays for patients on a homeless pathway have increased since June 2019.

Delayed Transfer of Care

NHS
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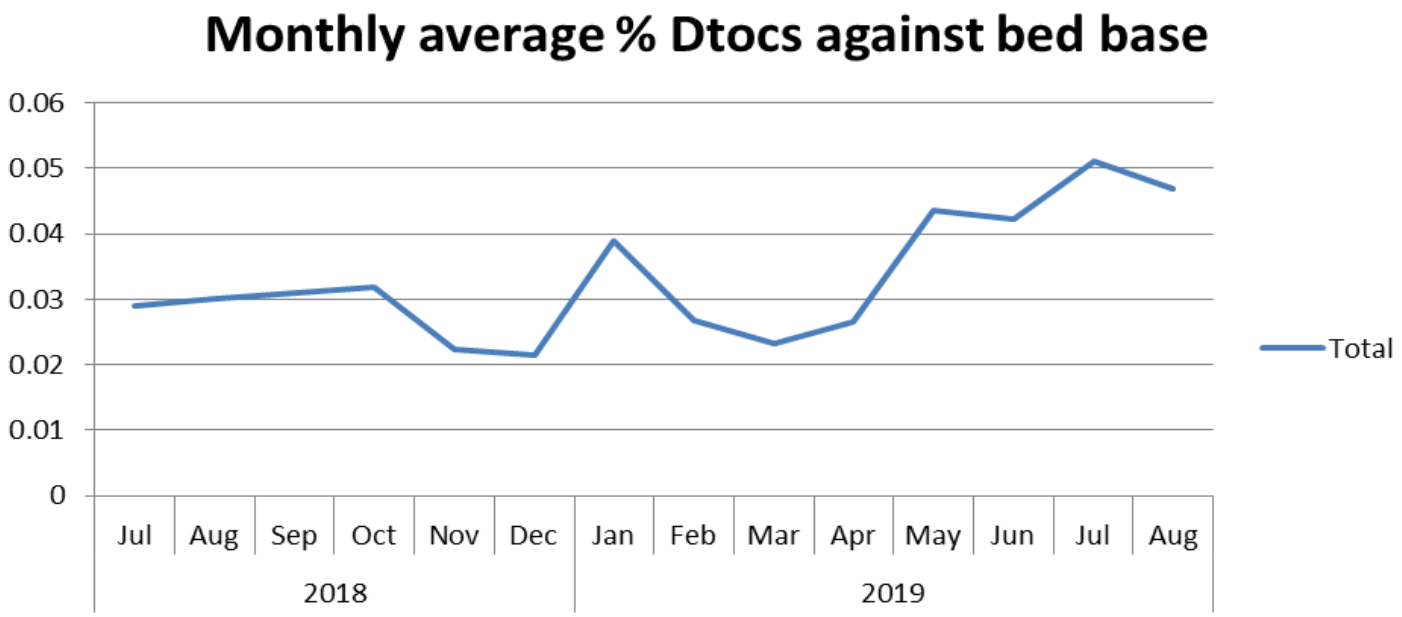
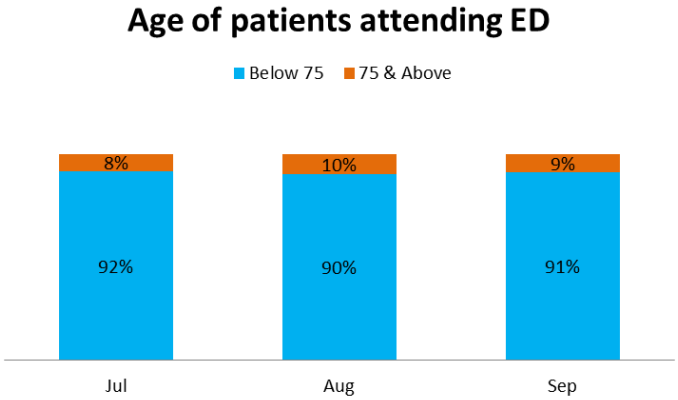


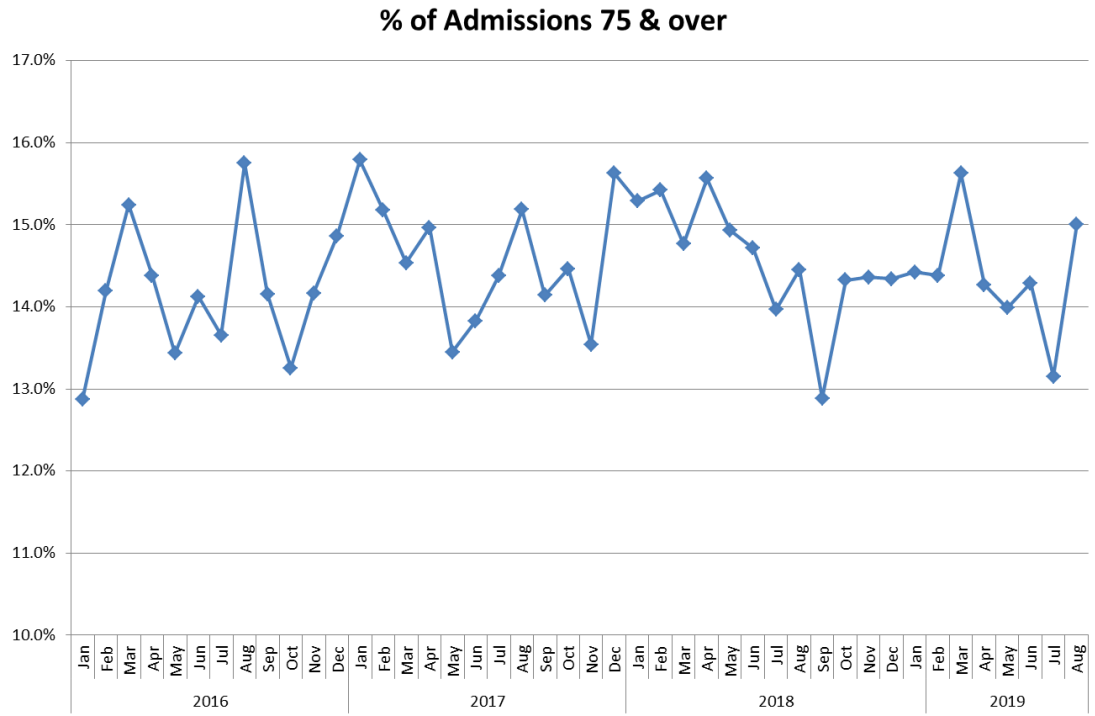
- **DTOCs have increased since May 2019 and have stayed consistently high since this date. The main contributors correlate with the MADE analysis:**
  - Delays from Care home assessments
  - Neuro-rehabilitation capacity
  - Brokerage delays
  - Increase in homeless pathways delays
  - Mental health patients that have a care requirement have also contributed to delays.
- **The impact of high numbers of DTOCs has continued into August 2019 and is significantly higher compared to August 2018**

Patients 75 & Over

Patients 75 & Above

Whittington Health NHS Trust





- Data shows if your over 75 years you are disproportionately likely to be admitted. **August 2019** has shown an increase in percentage of over 75s admitted compared to previous year's data and is comparable to winter periods

Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 10th July 2019
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Naomi Fulop (NF), Non-Executive Director
Members Present:	Clare Dollery (CD) Medical Director Deborah Harris-Ugbomah (DHU) Non-Executive Director Michelle Johnson (MJ) Chief Nurse & Director of Patient Experience Tony Rice (TR) Non-Executive Director
In attendance	Claire Challinor (CC) Sita Chitambo (SC) Associate Director of Nursing EIM Deborah Clatworthy (DC) Associate Director of Nursing Surgery James Connell (JC) Patient Experience Manager Casey Galloway (CGa) Patient Experience Officer Anna Gorringe (AG) Consultant Palliative Care Rose Hensman (RH) Associate Director of Nursing CYP Gillian Lewis (GL) Head of Governance & Risk Paul MacPherson (PM) PALS and Complaints Manager Karen Miller (KM) Children's Safeguarding Lead Louisa Mitchell (LM) Legal Services Manager Kat Nolan-Cullen (KNC) Compliance & QI Manager Louise Roper (LRop) Quality & Risk Manager for Surgery & Cancer Paula Ryeland (PR) – QI Lead Aisling Thompson (AT) Director of Operations ACS Shahida Trayling (ST) Associate Director Nursing & Midwifery Swarnjit Singh (SS) Corporate Secretary Carolyn Stewart (CS) Minute taker

Agenda items

1.1	Welcome & Apologies	Chair
	Naomi Fulop (NF) welcomed everyone to the meeting. Apologies were received and recorded from: Carol Gillen (CG) Chief Operating Officer Helen Taylor (HT) Clinical Director ACW Theresa Renwick (TR) Adult Safeguarding Lead Leanne Rivers (LR) Patient Representative	

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

1.3	Minutes of the previous meeting	Chair
	No amendments were requested to be made to the minutes of the previous meeting held on 8th May 2019. The minutes were approved.	

Action Log – open items	Deadline	Owner
See action tracker		

1.4	Matters Arising	Chair
	There were no matters arising that were not on the agenda	

2.1	Quality Committee Annual Review and TOR
2.1.1	NF thanked everyone for their positive feedback on the annual review. The TOR had previously been to the Quality Committee and had since been to Trust Board. Noted as final. The annual review was approved. MJ mentioned the timeliness of papers for Quality Committee and that we are working hard to get these submitted on time. NF acknowledged that the sequencing regarding quarterly data is challenging and it was agreed to discuss this further outside the meeting. NF agreed with feedback to have more focused and in depth discussion on one or two key issues each meeting as this would enhance the meeting and further enrich learning.

Actions	Deadline	Owner
Quarterly data sequencing for papers discussion	ASAP	GL

2.2	**Volunteer Strategy 2019 - 2022**		
2.2.1	The paper was taken as read. JC advised the Committee that this document will eventually be hosted on the trust website with a more corporate look. It outlines 3 core ambitions and work planned for the next 3 years. The strategy was submitted to the Patient Experience Committee last week and recommended for approval by Quality Committee and Trust Board with a couple of amendments.		
2.2.2	DHU stated that it is helpful to see a strategy in this format; however it must clearly link with other Trust strategies and corporate objectives within the Organisation. DHU also would like to see evidence of where volunteers are being recruited from to ensure that it isn't just through family or friends of existing staff and it is a fair and inclusive process.		
2.2.3	JC advised that a year one implementation plan had also been produced and offered to send it to DHU. JC reminded the committee that this will be a public document. It was also noted that at the recent Patient Experience Committee there had been discussion regarding recruiting volunteers from schools and it was agreed that it should clearly show in the document that volunteers are from across the local population. It was suggested that state schools should be prioritised to maximise opportunities from our diverse population.		
2.2.4	CD asked JC how many volunteers we have now and how many we wish to have by the end of the year and what are our expectations. NF requested for implementation plans to be reviewed at Quality Committee. JC agreed to send the year one implementation plan to QC members.		
2.2.5	TR stated that the Citizen Advice Bureau has the highest volunteer rate and this is due to investment in providing training and qualifications for volunteers. DHUs stressed that volunteering is a great opportunity and that consideration should also be given to older people who may be socially isolated and not just focus on encouraging younger people to volunteer.		
2.2.6	SS queried that if this paper is going to the September Trust Board would it impact on the launch. JC replied that the Patient Experience Strategy will be launched first and the Volunteer Strategy will follow after that.		
2.2.7	NF thanked JC and his team for their efforts in producing the strategy. The committee agreed that the Volunteer Strategy should go to the September Trust Board for approval.		
Actions		**Deadline**	**Owner**
2.2.4 Year One implementation plan to be circulated to the Committee members		31/7/2019	JC
2.2.7 Volunteer Strategy – September Trust Board for approval		11/9/2019	JC

2.3	**Nursing & Midwifery Strategic Priorities**	
2.3.1	MJ advised that this paper is the draft Nursing & Midwifery priorities for Nurses, Midwives and AHPs and is aligned with Trust objectives. It details the progress made over the last 12 months together with a plan for the next 12 months. With two key main priorities	

	to deliver outstanding care and provide assurance that the Trust will be ready for a CQC inspection.
2.3.1	The Trust has recruited 72 graduate nurses this year which is an excellent achievement. There were 43 in the previous year so this is a substantial increase. The turnover was approximately 10% for last year and the Trust is striving to increase retention by focusing on leaders and ensuring that they are visible and supportive to staff to raise awareness of research and this this also fits in with the Corporate objective. MJ advised that Colette Datt is working 2 days a week for 3 years (funded through NIHR, received from DHSC). CD queried whether it is mapped in with our Quality Account priorities. MJ replied that it is currently not aligned directly to the quality account priorities as these are based on patient experience and patient safety but would be happy to discuss further with CD.

Actions	**Deadline**	**Owner**
To review Nursing, Midwifery & Therapy priorities are aligned to Quality Account priorities	31/7/2019	MJ

2.4	**Board Assurance Framework (BAF)**
2.4.1	SS reminded the Committee that at the May Trust Board it was agreed that the BAF would become a standing item on the Quality Committee agenda to review the position regarding mitigating risks. MJ replied that with regard to Q1 on the BAF that this relates to the whole of the Quality committee agenda. She added that what is less obvious is the Trust performance targets and how this is linked to the Quality Committee e.g. Refer To Treatment or Maternity is not focused on at this Committee. It was suggested that the ICSUs align their reports with the BAF risks.
2.4.2	DHU stated that quality equals delivery; outcomes; safety; experience and effectiveness. CD suggested that there should be an annual review for the committee about standardising report templates. GL agreed to ensure that the same dataset is used for consistency and check the balance between the performance and the quality aspect is evident.
2.4.3	DHU referred to Appendix 2 on the BAF and asked if there is a gap in the sources of assurance. SS replied that Q2 required updating to reflect the current position as Quality isn't mentioned. It was agreed that CG would be asked to review Quality 2 and 3 – source of assurances.
2.4.4	NF considered the 4 recommendations in the paper– risks being mitigated and that there is a need to review risk 2 around assurances. All others are currently evident. There will always be uncertainty with regard to the CQC requirements and we are doing all we can regarding mitigation. SS replied that this should be reviewed on a quarterly basis.
2.4.5	DHU added that with regard to legal and claims the 2nd tier assurance could go into quality 1 and that quality 2 requires updating. Q3 needs to be reviewed around mental health patients and the 136 rooms in ED opening in November 2019. These assurances should be added.
2.4.6	PR stated that performance and activity data, provided through the ICSUs and corporate reports, can raise quality issues e.g. where there is delay to treatment which can impact on patient care. A template has been developed to include any quality concerns in the monitoring of performance data and DC confirmed that when it has an impact it is discussed at team/department and ICSU meetings.

	CD suggested a tiered structure for quality 2 BAF entry and that the ICSU board should be the 1st tier then to TMG and finally to Quality Committee.

Actions	Deadline	Owner
2.4.2 GL to review ICSU reporting template to include key performance indicators	11/09/2019	GL
2.4.3 Review BAF Q2 and 3 – sources of assurance to be reviewed	11/09/2019	CG

3.1	Children and Young People Services (CYP)
3.1.1	RH gave a brief synopsis of issues in relation to risks. The lack of laptops for the services in the community was a high risk on the risk register but has now reduced. Two thirds of the laptops have been supplied with the remainder on their way.
3.1.2	All risks are being reviewed. Ones to mention include staffing, specifically with regard to Paediatric Mental Health consultants and nurses in the inpatient ward (IFOR). The Neonatal Unit (NNU) environment is an ongoing consideration as there is insufficient space for each cot based on the national recommendation. This is being managed by estates and the ICSU.
3.1.3	Monthly meetings have been set up to review children being seen in outpatients' clinics in an adult environment and to ensure that children in ED are cared for in a friendly environment. Considering a pager system similar to the one in Imaging.
3.1.4	RH referred to the Quality Improvement projects within CYP, one of which highlighted children being contacted for appointments within 48 hours. As a result the ICSU is now hitting target and preventing children being re-admitted.
3.1.5	MJ asked why the neonatal Friends and Family Test (FFT) response rate and satisfaction had dropped in May in the NNU. RH replied that she believed it could be because the questions are not child friendly and that the questions need to be appropriately worded. MJ requested that the neonatal FFT should return to the next Quality committee with an update. It was suggested that JC should work with RH on the FFT and link up with Maternity Voices. Volunteers should also be linked in and Hospital at Home should also be involved.
3.1.6	CD queried the number of complaints and asked for assurance of response times. RH replied that she meets weekly with the complaints manager and they are up to date with their responses. She added that some of the complaints are extremely complex and still on-going. Most responses are on time and are well managed. MJ commented that we need to focus on the complaints that have been upheld. NF thanked RH for attending.

Actions	Deadline	Owner
3.1.5 - Neonatal FFT update for next Quality Committee	30/9/ 2019	RH
Link up FFT with Maternity Voices, Volunteers and Community Children's Nursing.	30/9/ 2019	RH/ST
3.1.6 Review criteria for categorization of complaints/concerns	31/10/19	GL/PM

3.2	Surgery: Work in Practice

3.2.1	This item was deferred to the September Quality Committee

Actions	Deadline	Owner
For September agenda	September 2019	GL

4.1	Aggregated Learning Quarterly Report
4.1.1	CC advised that some of the data was unavailable at present but offered to return to Quality Committee in September to update on themed learning. She added that there had been an increase in reporting clinical incidents this quarter with 400 relating to patient safety. Rejected incidents had reduced. With regard to Serious Incidents (SIs) there had been a slight increase in April. 7 SIs were reported in quarter 3 of which 3 were never events (noted that only one occurred within the reporting period).
4.1.2	The original high number of complaints regarding the Uro-gynaecological has reduced. NR queried the format of learning element and CC replied that they will be looking this at the Acute Access, Clinical support & Women's Health (ACW) ICSU quality meeting. GL added that a group meeting had been set up with the Head of complaints and Patient experience and all risk managers to discuss key themes. NR stressed that the Quality Committee seeks assurance that improvements are being made and thanked CC for presenting the report.

Actions	Deadline	Owner
None		

4.2	Quality & Safety Quarterly Report
4.2.1	CD advised the Committee that mortality data had been included in this report. She added that there had been a focus from the medicine management safety group learning.
4.2.2	TR asked about the number of cases of measles reported and whether there is anything that can help in terms of education. MJ replied that the increase is due to the number of ED patients presenting with suspected measles. Patients who present to ED with suspected measles are advised to go home with self-management. The bigger challenge is to protect staff from catching measles from infected patients. MJ added that there is also an issue with Tuberculosis. Staff are sent letters to attend occupational health indicating risk but not all of them respond in a timely way. This will be discussed at the Infection and Prevention Control Committee.
4.2.2	CD advised that the recent Quality Improvement Celebration Event had been very successful and thanked Julie Andrews and everyone involved in organising it. MJ suggested that Medicines Matter Work should be used as one of the top 3 learning topics from Quality Committee. NF thanked CD for attending and presenting.

Actions	Deadline	Owner
None		

4.3	Patient Experience Quarterly Report
4.3.1	JC advised the committee that the Patient Experience in patient national survey published by CQC was released a few weeks ago. The results were broadly positive and in line with the improvements the Trust had taken since last year's results. There was significant improvement with regard to Question 67: "Did you feel you were treated with respect and dignity in the hospital?" The Committee asked JC to send the scores to members of the Committee. JC advised that Picker will be facilitating a workshop to present the results to the teams and to devise an action plan.
4.3.2	NF stated that it was good to see such a big improvement in the figures for this year and asked how this is this is communicated throughout the Trust. JC replied that it is included in the Communications Noticeboard and available on the intranet.
4.3.3	CD queried the response regarding Q16 and whether it relates specifically to cleaning or the environment. She added that this needs focusing on and a breakdown of each area should be provided. ST highlighted a problem in maternity in relation to the ward temperatures and this had impacted on the feedback. JC replied that KNC had been carrying out spot checks with estates. Cleaning audits are included in the cleaning contracts and there is also monitoring of ward hygiene. SC confirmed it had improved. DC requested that the action plan session should consist of multi-disciplinary teams to include medical staff instead of just nursing teams.
4.3.4	It was agreed that the report should be aligned with the 3 patient experience ambitions. JC would look at the breakdown figures and will bring the action plan to the next Quality Committee.
4.3.5	JC advised the Committee that National Volunteers' Celebration week held in July received very positive feedback. NF thanked JC for attending

Actions	Deadline	Owner
4.3.1 Patient Experience survey scores to be circulated to the Committee	31/07/ 2019	JC
4.3.4 Action plan to go to Sept Quality Committee	11/9/2019	JC

4.4	End of Life Care (EOLC) Activity & Strategy Update
4.4.1	AG advised the committee that the EOLC report covered the last 12 months and included plans for the year ahead as well as Hospital, Community and Life Force Children & Young People Services with gap analysis. She advised the committee that there was no designated Chair for the EOLC at present and requested another representative to chair the group for its quarterly meetings.
4.4.2	AG advised that the palliative care activity had doubled in the last 2 years. The dashboard displayed results of the national audit for care at the end of life in hospitals which consisted of data from April 2018. AG added that the remarkable scoring on the clinical indicators is a tribute to our staff and the neonatal specialist palliative care team. This is also the first time a bereaved family survey had been used. Clinical indicators of care are good. There are a couple of workforce and governance issues and there isn't currently a formal process for discussing the 5 priorities of care at Trust Board level.

4.4.3	The palliative care team saw 49% of patients who died in hospital. The average percentage seen as reported in the National Audit is 38%. She suggested EOLC training is included either in mandatory training or as a focus for staff training. NR recommended that the relevant areas are targeted.
4.4.4	Recruited two staff to the hospital team recently and a bespoke training programme for medical registrars for 7 day working had been created. Bundles are available on electronic diary prescribing JAC and on the intranet. With regard to the "Co-ordinate My Care" package MJ suggested that further discussion should take place outside the meeting.
4.4.5	With regard to District Nursing services AG reported that the teams are responding to 82% of calls within 2 hours and 100% within 3 hours. Paediatric services are also doing very well but are currently having recruitment problems. MJ mentioned the "Outstanding" CQC rating for EOLC within the community and asked if there are any actions outstanding since last the last CQC inspection. AG replied that there needed to be improvement to syringe driver training across the Trust team and asked that ward managers ensure this is happening and is signed off. TR praised AG and her team for such a superbly clear and concise report.

Actions	**Deadline**	**Owner**
4.4.4/5 AG to meet with MJ to discuss Co-Ordinate My Care and syringe driver training	Asap	MJ/AG

4.5	**Annual Complaints & Compliments Report**
4.5.1	Referring to the report, LM advised the Committee that the number of complaint responses within 25 days was 315 which was similar to last year. Since April 2019 the focus has been on monitoring 40 day complaints and the Complaints team is working with the ICSUs.
4.5.2	The number of upheld complaints increased slightly while the number of dissatisfied complaints has slightly reduced. The quality of reports has helped to bring these down. Currently meeting complaints response target of 80% for 25 days. There is learning shared across the ICSU and Trust.
4.5.3	With regard to Parliamentary Health Service Ombudsman complaints, there are nine open complaints. Two have been upheld and one partially upheld. Quality alerts are now being reported differently, separating GP concerns so there is a downward figure.
4.5.4	There has been a 10% increase in compliments received and these are featured in the weekly Communications bulletin. Complaints' training takes place every month and learning from complaints has improved in particular with understanding the difference between quality alerts and referrals from GPs. MJ recommended the report is renamed the Annual Compliments and Complaints Report. Report recommended to be approved for Trust Board.

Actions	**Deadline**	**Owner**
Rename the report		LM

4.6	CNST & Maternity Standards of Care Bundle
4.6.1	This item was deferred to the September Quality Committee.

Actions	Deadline	Owner
Agenda item	Sept 2019	GL

4.7	Bi-Annual Adult & Children's Safeguarding Report
4.7.1	KM advised that the Children's Safeguarding Training compliance remains static and is just below target but this will be addressed within the next 6 months. On line training for level 2 was not functioning for 3 months but this has now been rectified.
4.7.2	A Joint Targeted Area Inspection (JTAI) for Islington took place in December 2018 focusing on sexual abuse that occurred in the family home and our response. Very positive feedback was received and all actions have been completed or underway.
4.7.3	Discussion took place regarding the statutory changes with regard to homelessness and the requirement to ensure that patients have a safe place to go to after being discharged from hospital. It was noted that not all NHS Trusts record the ethnicity of safeguarding patients and it is notable that we report this.
4.7.4	CD queried whether there are protected characteristics for people involved in Serious Incidents as we are not currently reporting equality EDS2. This is now being taken forward.
4.7.5	Report recommended for approval at Trust board.

Actions	Deadline	Owner
To be presented at Trust Board	31/7/2019	MJ

4.8	Clinical Audit & Effectiveness Annual Report
4.8.1	MJ reported that progress has been made with a need for more evidence on how learning could be improved. CD was impressed with the 100% participation result and offered to share templates from previous Trusts to use as a comparison to how other Trusts share the learning from national audits. DC requested that the ICSUs are shown the summaries before they are incorporated in an annual report. It was agreed that the new Quality & Safety ICSU board should take this up with GL and her team, and they should all be working together.
4.8.2	CD/MJ to review the next stage of development for this report to ensure that the ICSUs receive the information and how it can be linked to Quality Improvement.

Actions	Deadline	Owner
4.8.1 GL to arrange sharing reports with ICSU directors so included in ICSU quality and safety boards.	31/7/2019	GL
4.8.2 CD/MJ to review the next stage of development for this	14/11/2019	MJ/CD

report to ensure that the ICSUs get the information and how it can be linked to Quality Improvement		

4.9	Serious Incident Report
4.9.1	The report was noted as it had been presented to the June Trust Board.

Actions	Deadline	Owner
None		

4.10	Quality Improvement (QI) Update
4.10.1	PR verbally updated on the Quality Improvement programme. Key projects are due to take place with new trainee medical staff in August focusing on different areas. PR referred to the Chest Trauma Project which examines the patient's journey around the hospital starting with ED representation to each ward they are likely to be transferred to. Compiled of 3 Serious Incidents and led by a consultant, with a considerable contribution from MDT to identify the best pathway for patients. The MDT team worked out a pathway with a flowchart resulting in a clear treatment plan for chest trauma patients. The key learning is ensuring everyone who needs to be involved is involved and being aware if anyone is missing when applying methods for other pathways. A follow-up meeting will take place in the next few weeks to identify how many patients have followed this pathway to see the progress or highlight any issues. DC suggested PR should discuss this with Katie Batt. PR also advised the Committee that new appraisal forms are being piloted as a QI project. NF thanked PR for the update and recommended the Chest Trauma pathway Quality Improvement was a key learning message from the Committee.

Actions	Deadline	Owner
PR to contact Katie Batt	30/9/2019	PR

4.11	Quality and Safety Risk Register
4.11.1	MJ advised that a lot of work had been done to update the risk register and ICSU risks are now aligned. There are a few which need to be reviewed.

Actions	Deadline	Owner
Review all risks on register	ASAP	GL

4.12	Trust Policies Report
4.12.1	KNC updated the Committee that 3 new policies have gone through the Policy Approval Group (PAG) since the last Quality Committee. 31 existing policies reviewed and renewed. There are 157 outstanding and PAG are working on these. PAG is now meeting every 2 weeks instead of monthly.
4.12.2	When asked about Standard Operating Procedures (SOPs) being mixed in with policies GL advised that she is meeting with SS with to identify separating Workforce policies and governance policies. This will also include SOPs.
4.12.3	MJ requested that when this has been completed the list should be rag rated and

4.12.4	returned to Quality Committee for assurance. GL advised that when policies have been updated it is circulated to staff via the communications noticeboard. CD asked for a one page update on the Clinical Governance intranet page which is visible to all of the ICSU Governance teams to ensure clarify on which policies should be updated.

Actions	**Deadline**	**Owner**
4.12.3 Rag rate completed policy list to return to the next Quality Committee	11/9/2019	GL
4.12.4 Clinical Governance Intranet page update to be visible to ICSU governance teams	11/9/2019	GL

5.	**Minutes of Reporting Groups for information only**
5.1	ICSU Quality & Safety Meetings – There were no exceptions to report from the ICSU Quality & Safety meetings.
5.2	The minutes from the Patient Safety Committee were taken as read and noted.
5.3	The minutes from the Patient Experience Committee were taken as read and noted.
6.	**Any Other Urgent Business**
6.1	The Infection Prevention & Control Committee (IPCC) new Terms of Reference was circulated to the Quality Committee with a request to change frequency from bi-monthly to quarterly meetings. The Committee approved this request.
6.2	NHSI Patient Safety Strategy Presentation CC asked the ICSU representation to be aware of this document as there would be more leaning to come from this. She added that not all of the areas of the strategy are complete. The Patient Safety committee will be scrutinizing the strategy. CD suggested that this should be included in the Trust Patient Safety Strategy.
6.3	NF recommended that the timing for all future Quality Committee meetings should be extended by 30 minutes, to commence at 2pm and finish at 4.30pm. This was agreed by the Committee. CS will update all invitations.

The meeting closed at 4.35pm

The next Quality Committee is scheduled for **Wednesday 11 September 2019**

Future dates:

- 13th November 2019
- 8th January 2020
- 11th March 2020
- 13th May 2020
- 8th July 2020
- 9th September 2020

Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 11th September 2019
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Naomi Fulop (NF), Non-Executive Director
Members Present:	Carol Gillen (CG) Chief Operating Officer Deborah Harris-Ugbomah (DHU) Non-Executive Director (from 3.10pm) Michelle Johnson (MJ) Chief Nurse & Director of Patient Experience Tony Rice (TR) Non-Executive Director
In attendance	Chetan Bhan (CB) Consultant General Surgery Bessie Bulman (BB) PMO Graduate Trainee Alex Campbell (AC) Graduate Management Trainee EIM Sita Chitambo (SC) Associate Director of Nursing EIM Cecil Douglas (CDo) Assistant Director of Facilities Jonathan Gardner (JG) Director of Strategy, Development & Corporate Affairs Rose Hensman (RH) Associate Director of Nursing CYP Fiona Isacsson (FI) Director of Operations Surgery Alison Kett (AK) Associate Director ACS Gillian Lewis (GL) Head of Governance & Risk Kat Nolan-Cullen (KNC) Compliance & QI Manager Sharon Pilditch (SP) Matron Surgery (attending for Deborah Clatworthy) Leanne Rivers (LR) Patient Representative Claire Rohan (CR) Clinical Director CYP Paula Ryeland (PR) – QI Lead Kathryn Simpson (KS) Research Portfolio Manager Swarnjit Singh (SS) Corporate Secretary Helen Taylor (HT) Clinical Director ACW Aisling Thompson (AT) Director of Operations ACS James Ward (JW) Health & Safety Adviser Carolyn Stewart (CS) Minute taker

Agenda items

1.1	**Welcome & Apologies**	**Chair**
	Naomi Fulop (NF) welcomed everyone to the meeting. Apologies were received and recorded from: Clare Dollery (CD) Medical Director Deborah Clatworthy (DC) Associate Director of Nursing Surgery Julie Andrews (JA) Associate Medical Director Stuart Richardson (SR) Chief Pharmacist	

	Shahida Trayling (ST) Associate Director of Nursing ACW Adrien Cooper (AC) Director of Environment Lesley Platts (LP) Clinical Director CYP Nick Harper (NH) Clinical Director Surgery Rachel Landau (RL) Clinical Director EIM

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

1.3	Minutes of the previous meeting		Chair
	No amendments were requested to be made to the minutes of the previous meeting held on 10th July 2019. The minutes were approved.		
Action Log – open items		**Deadline**	**Owner**
	See action tracker		

1.4	Matters Arising	Chair
	There were no matters arising that were not on the agenda	

2.1	Board Assurance Framework (BAF) – Quality Entries
2.1.1	Entry 1: this had been reviewed and SS referred to the report that is linked to the other BAFS. BAF 2 and 3 - Changes to level of details: Gaps in controls and assurances (appendix 2). Quality 1 BAF - there is still some risk while these remain open. MJ requested that each of the ICSUs and the Corporate Directorate focus on risks identified and review risk harm. It was noted that the Trust is compliant its Duty of Candour responsibilities. GL is working on plan with ICSU leads to reduce the volume of open incidents. All areas of the Trust should look at how many open incidents are on datix. Actions related are being monitored at the CQC preparation meetings with a clear plan for each to previous CQC inspections. The quality governance team will work with the ICSU directors to reduce the number of open risks in time for the next review risk assessment for the next Quality Committee meeting.
2.1.2	CG referred to Quality 2 regarding the failure to hit national and local performance targets which can result in financial penalties and possible decommissioning of services due to a diminishing performance in ED. Progress has been made in the community. The risk has not changed in relation to mitigating actions concerning ED and the actions reflect the work in progress at the A&E Delivery Board.
2.1.3	Q3 – Mental health and ED dept. A considerable amount of these actions are now closed. The current issues in ED relate to waiting times and with mental health patients waiting longer in ED due to shortage of mental health beds.

	A review of the model of the mental health suite is currently being undertaken. There is an increase in12 hour mental health breaches due to change in reporting mechanisms. The current risks remain unchanged but processes are in place to address these.
2.1.4	FI queried the term "target score" on page P3 of Appendix 1 and it was agreed that this should be changed to read "Risk appetite". SS to action.

Actions	Deadline	Owner
"Target score" to be changed to "Risk Appetite" on Page 3 Appendix 1	1/10/19	SS

2.2	Trust Strategy Update 2019-2020
2.2.1	JG advised the committee that this update had already been to the Trust Management Group and the Trust Board as an update on Quarter 1. The purpose of the presentation at Quality Committee is to reiterate how this aligns with the Trust's objectives. JG asked ICSU leads to recognise this link to strategy going forward and added that he will be attending the Surgery Board this month. MJ suggested that JG attends all of the ICSU boards as this will provide good evidence of a link with corporate objectives to the operational and clinical leads of the Trust. JG replied that he would welcome the opportunity to attend any team meetings to work through shared team objectives and requested that he be invited to these meetings.
2.2.2	Tony Rice queried the vacancy rate and JG confirmed this is improving. It was noted that Coyle ward band 5 vacancies, which were at 50% at the same time last year, are now down to zero. Mercers Ward has also achieved the same result. The staff turnover rate has also gone down resulting in fewer staff leaving the Trust. NF thanked JG for attending and updating the Committee.

Actions	Deadline	Owner
ICSU leads to encourage their teams to invite JG to team meetings to share team objectives	Dates set by 1/10/19	ICSU leads

3	ICSU Update
3.1	NF queried when the expected standard template for ICSU reports would be completed. GL replied that it will be ready for the November meeting. It will be a standard report that is simplified for Quality Committee to include Patient Experience, Patient Safety and clinical effectiveness outstanding actions in relation to CQC. NF requested that the correct information is included on the template without having to refer to other documents. MJ suggested further discussion in reviewing this alongside the review of the Trust governance framework which is currently underway.
3.2	NF accepted this on the proviso that it will be available for the November meeting, without delay. GL agreed to discuss further with the ICSU leads.

Actions	Deadline	Owner
3.1 Further discussion and agreement on standard template reporting between governance team and ICSU leads.	Next meeting	GL

3.1	**Emergency & Integrated Medicine (EIM)**
3.1.1	SC apologised for the lateness of the paper, which some of the committee hadn't had a chance to see prior to the meeting. SC went through the summary of key information. Up to July 2019 there was 1 HCAI C-Difficile case reported. There was an increase, as expected, in the number of reported pressure ulcers due to the change in the method of reporting (meeting NHSI standards). Incidents/ investigations reported through datix and completed: Q3 2018/19 (12/12) Q4 2018/19 (4/5) Q1 2019/20 (2/7) Q2 2019/20 (0/8 to 6.9.2019). These figures show an increase in both investigation and reporting.
3.1.2	SC advised that the ICSU is working towards full compliance with Duty of Candour responsibilities. Delays are due to incidents in relation to pressure ulcers. Ward Managers and matrons have worked hard and a large number of incidents were closed in the last quarter.
3.1.3	A review of all moderate and serious incidents had taken place and it had been agreed that the risk managers review each incident. The patient safety trauma pathway had been presented and approved. The Care of Older People (COOP) unit had carried out a lot of work on pressure ulcers; falls and the Dementia Strategy.
3.1.4	Areas to highlight to Quality Committee: • Timely completion of investigations and approving of incidents on datix. • Some datix entries remain incomplete and this is being addressed. • 1:1 teaching to help staff review datix incidents. • Endoscopy issues. MJ advised that the PALS team had received 4 or 5 complaints with regard to endoscopy procedures. As a result the team investigated any possible datix issues. 3 incidents were identified that the information between the initial GP referral through to the triage resulted in the incorrect procedure being carried out. The team is working with CCG colleagues and GPs and Trust representatives to hold a panel investigation to learn from these errors and to ensure that this does not happen again. No harm was reported although 1 extra procedure for a patient was carried out as a result. This is referred to in the SI report. • One Never Event was declared within the last month whereby air was used instead of oxygen. This is being fully investigated and was declared externally.
3.1.5	FI suggested that when the risk managers notice high level incidents on datix they should escalate. MJ advised that with high level datix reports of harm, emails are circulated to all ICSU and Executive directors to ensure that they have sight of every incident reported. NF thanked Sita for attending and reporting to the Quality Committee.

Actions		
None		

3.2	Surgery and Cancer – Surgery : Work in Practice
3.2.1	CB updated the Committee on the background to this work. This included a period of mediation during summer 2018. This work also included a review of patient outcomes, GiRFT findings.
3.2.2	The purpose of the mediation work was also to review the reporting of clinical incidents in particular regard to issues around handover and weekend work. There is now a weekly discussion before the weekend with detailed handover with all the junior doctors. Job descriptions were also re-defined and this helped with the staff relationships within the department and the team is learning from reporting clinical incidents. Ward rounds are completed at weekends with 3 dedicated emergency surgeons. The department is now engaging more with the ICSU leaders resulting in significant progress in dealing with clinical issues.
3.2.3	NF thanked Chetan and his colleagues for the progress in addressing a difficult situation, and for their openness and honesty in sharing this with this committee. LR queried how many areas required help with staff relationships. MJ replied that as a result of the disappointing survey results there has been significant improvement to ensure staff feel engaged and supported and that this is a good example of how it can be improved and that mediation can support team working. There are varied mediators in the Trust, a Speak Up Guardian as well as speak up advocates across the trust to highlight that staff can raise issues. This is proving to be a good format in enabling staff to seek help as needed.
3.2.4	NF asked how CB's team would continue to monitor improvement over the next 12 months. CB replied that it is essential to maintain the weekly meetings where discussion takes place with all of the multi-disciplinary team. Improvement should be seen in the appropriate reporting of incidents. NF thanked CB for attending and presenting.

Actions		
None		

3.3	CNST and Maternity Standards of Care Bundle
3.3.1	HT referred to the 10 standards to support the Maternity Clinical Negligence Scheme. This will improve the quality of maternity services and reduce risks. Self-assessment was carried out together with significant work with Maternity Voices. The team had also met with the Commissioner for maternity services. The standards were signed off by commissioners as well as at Trust Board and have been submitted. The Standards for 2020/21 will be even more stretching.
3.3.2	The bid has been approved from the capital group for CTG monitoring and an acuity tool for staffing for maternity unit will go to the Investment Group. The Trust could qualify for a £500k rebate, and the decision should be made before the end of September. NF thanked the ICSU for the comprehensive and excellent work undertaken and asked HT to pass on thanks and congratulations to the team.

Actions	Deadline	Owner
None		

4.1	Patient Led Assessment of the Care Environment (PLACE) Report
4.1.1	CD highlighted the overview of the previous year's audit and the actions from that audit. The timeline for the 2019/20 audit has now changed due to the NHSE/I review of the PLACE audit. The audit process will commence in September 2019 and the assessment for the hospital will take place in November. We will not be able to compare this year's results with previous years' results as the matrix has changed considerably. We are looking at the potential for improvement where necessary. MJ asked that the assessment is completed as soon as possible once the 10 week window opens during September.
4.1.2	CD advised the Committee that patient meal services will be brought back in house by the end of September. In January 2020 the scores will be revalidated. Then an action plan will be provided to be reported on by August 2020. LR queried how the "in-house cooking" would work and CD replied that it is currently run by Sodexo. The Trust will now operate the service and will use the existing service providers that Sodexo use but will be monitoring and piloting the catering services. Ward staff will also be involved with patients regarding nutrition and dietary requirements.
4.1.3	SS asked how many patients participated in the PLACE assessment. CD advised that the number of patients should not be less than the number of Trust employees. Normally 2 patients participate in the PLACE assessment. It was agreed more patients should be included. MJ requested further information to review representation to ensure that the proportion of patients and staff is correct as the Committee seeks assurance on this. CD replied that the Healthwatch representatives were also patients. MJ asked the ICSU directors to release staff to participate with the PLACE assessments. NF requested an update at Quality Committee in November.
4.1.4	In response to HT's question regarding how dementia friendly the Trust is, CD assured the Committee that this had been reviewed on all of the wards, with the exception of the Children's ward and confirmed the wards are all dementia friendly. He added that they are currently reviewing the contrast of colours and flooring in outpatients and in-patients. CR asked if this would include the community and CD advised that the in-patient and outpatient facilities only included the hospital. NF thanked CD for attending the meeting.

Actions	Deadline	Owner
Update to be presented at the next Quality Committee meeting	Nov 2019	CD

4.2	Annual research report 2018/19
4.2.1	KS advised the Committee that it had been a positive year for Research. Recruitment to projects has increased and is above target. The most suitable studies and investigators had been selected. She added that NIHR will penalize Trusts in future if they do not recruit to target.
4.2.2	Highlights of the report included Bowel Cancer screening test, 230 patients were recruited. There is a mix of studies within the ICSUs, with Surgery and Cancer leading on a number of studies and also Women's Health. 4 more studies are in the pipeline and KS assured the Committee that she is confident that progress is being made.

4.2.3	There had been a significant increase of studies combined with different areas of research to include bariatrics, anaesthetics, paediatrics and patients with Autism. (This will be community based). Funding from the CRN (Clinical Research Network) was previously cut by 5% for each Trust's budget and for 2020/21 it will decrease by around 10%. KS advised that the funding was topped up this year with commercial income and queried whether the Trust will commit to agree funding to compensate for next year's cut in budget.
4.2.4	With regard to the next steps, KS advised that Hugh Montgomery had been appointed as Research Director. MJ commented that the next annual report could be even better if it included nursing and AHP research and multi-disciplinary teams.
4.2.5	KS was pleased to announce that the Trust would start to receive funds from the speech and language £250k grant over the next 2 years via Michael Palin Centre. With regard to SS's query on the 3 applications where funding is being sought, KS replied that she was 100% confident that the first one will be approved. A decision on the second one was imminent and the third one had just been submitted to the NRC. NF thanked KS for updating the Committee.

Actions	**Deadline**	**Owner**
Nursing, AHP and multi-disciplinary teams to be included in annual reports.	ASAP	KS

4.3	**Health & Safety Annual Report**
4.3.1	The report was taken as read. JW advised that the Health & Safety committee meets every 2 months. The focus is on 6 key metrics: • Incidents and investigations (including reporting incidents within 7 days) • Policies • Safety Notices • Training • Inspection and Audit • Fire Safety
4.3.2	JW reported that there had been 14 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which were detailed in the report. The risks are considered low to moderate. No high risk incidents to report and there is one on-going hospital incident being investigated as a Serious Incident (SI). The Health & Safety Committee monitor all incidents.
4.3.3	Fire risk assessments are 100%, meeting the performance target. The risk is considered "moderate". The Fire Safety Group holds monthly meetings with representation from each ISCU as well as the Trust's Emergency Planning Office. The Group monitor the legal requirements of fire safety, carrying out fire risk assessments and all statutory requirements. The group also work with NHSI and the London Fire Brigade. A Trust mitigation strategy has also been implemented. MJ stressed the importance of all staff attending fire training was a priority.
4.3.4	The report was recommended to be presented to the next Trust Board for approval and it was agreed that the appendices should be removed.

	NF thanked JW for attending and presenting.

Actions	Deadline	Owner
The report was recommended to go to Trust Board for approval.	25/9/19	AC

4.4	Quality Assurance Report (CQCD action plan, Peer Review programme etc)
4.4.1	The report was taken as read. KNC reported that there were 4 actions remaining from the previous improvement plan (five new actions identified) and 9 actions are being monitored at the CQC planning meeting. The team had met with the CQC relationship manager in August and the CQC inspection is likely to be similar to the inspection carried out in 2017 rather than the full inspection in 2015. The PIR had now been received and it is anticipated that the inspection will be towards the end of November/first week in December. It could be an announced or unannounced inspection. If the focus is on more than 4 core services it will likely be an announced inspection. If less than 4, it is more likely to be unannounced. KNC requested that all ICSU leads ensure that they are aware of information requested for the PIR as the deadline for submission is 27th September. MJ advised the Committee that the CQC is also keen to look at areas where we believe the Trust can achieve an "Outstanding" rating.
4.4.2	KNC advised the Committee that a Trust wide quality review day is being held on 11th October and support was requested from ICSU leads as well as Executive Directors and Non-Executive Directors. The review will cover both the Trust and the community.
4.4.2	The report showed 39 Quality Assurance priorities, 34 of which are new priorities. This places the Trust as the 2nd best Trust in the London region for Quality Assurance.
4.4.2	NF confirmed the Committee was encouraged by the preparations in hand and noted that a 6 monthly report will be presented to the Trust Board in October. NF thanked KNC for attending and presenting.

Actions	Deadline	Owner
ICSU leads, Exec team and NEDs to be invited to the Quality Review day on 11th October	ASAP	KNC

4.5	**Quality Improvement Update and ICSU Project Presentation**
4.5.1	PR updated the Committee on the "Hello my Name is…" campaign. She had spoken to 100 patients asking them if they knew the name of their clinician/nurse. 45% were aware of their names. The Community result was higher. As a result, all staff will be issued one of the "Hello my Name is…" badges including NEDS. The decision was made to include first name only. There will be Communication notifications circulated to highlight the importance of staff introducing themselves and increasing visibility around the Trust. This is a direct link to patient safety and encourages patients to speak to any staff member. This will be linked to the World Patient Safety Day next week.

Actions	Deadline	Owner
None		

4.6	Serious Incident Review: Learning lessons yearly update report
	This item was deferred to the November Quality Committee

Actions	Deadline	Owner
For November Quality Committee agenda	November 2019	GL/KNC

4.7	SI report (monthly to Trust Board)
4.7.1	GL reported that the Never Event was connected to a patient safety alert. Airflow instead of oxygen was used in resuscitation but resulted in no harm. Actions were taken in line with the patient safety alert and a review of the entire trust took place to ensure that airflow meters are either blocked or moved or placed in separate area to the oxygen. When both may be required, flaps have been incorporated to distinguish the difference between air and oxygen.
4.7.2	GL referred to the Prevention of Future Deaths notice (PFD) issued by the Coroner in relation to a maternal death. The Coroner raised concerns about the London Ambulance Service (LAS) as well as our Emergency Department. The criteria for maternity emergencies is being reviewed. The CQC requested an immediate response and this was actioned swiftly. A simulation exercise is planned with the LAS. MJ asked for the date of this exercise to be circulated.

Actions	Deadline	Owner
Date of simulation exercise to be circulated to staff	Asap	GL

4.8	Quality & Safety Risk Register (risks >15)
4.8.1	GL reported that a new risk management policy has been created to improve the process of how risks are dealt with and added to the risk register. This will focus on the difference between active risks and risks that are tolerated and training to reflect the difference in risks is now in place. In the last 6 months 1 new risk has been added to the risk register. GL will be meeting with the ADoNs and ICSU Risk & Quality Managers to ensure risks are being updated regularly.
4.8.2	The CQC's recommendation to the Trust to acquire a mental health patient vehicle was still open on the risk register. CG advised that this had been discussed at the Capital Monitoring Group. GL to request an update on this from Adrien Cooper and to advise the Trust Board how this will be managed. NF advised that the Committee were assured that the older risks are now being updated and thanked GL for presenting.

Actions	Deadline	Owner
Update on mental health patient vehicle	30/09/19	AC

4.9	Infection Prevention annual Update Report
4.9.1	MJ advised the Committee that this annual report will be submitted to the Trust Board in September and the appendices will not be included. She was pleased to announce that the Trust is within the targets for healthcare associated infections the levels for last year, with only 1 Trust attributable MRSA case in June 2018 and no cases reported so far this year.

	The surgical site surveillance scheme has been reviewed and no evidence of surgical site infections was identified.
4.9.2	With regard to communicable diseases and staff contact, MJ reported significant progress in encouraging staff who may have been in contact with a patient who has a communicable disease to seek help, and all staff are being supported. PHE are aware of the dilemma of staff seeking help.
4.9.3	Infection Prevention & Control (IPC) – mandatory training at 80%. MJ advised the Committee that the infection control team will attend any team meeting to provide IPC training. The report was recommended for presentation and approval at the September Trust Board and NF thanked Julie Singleton and her team for their efforts.

Actions	Deadline	Owner

4.10	Bi-Annual Nursing Establishment Review
4.10.1	The paper was taken as read. MJ advised the committee that this had already been to the previous Trust Board. This 6 monthly Nursing Establishment Review consisted of data from April and July 2019.

Actions	Deadline	Owner
None		

4.11	Trust Policies Report
4.11.1	KNC reported that 3 new policies had been approved since the last Quality Committee. 22 policies have been reviewed and updated with 122 still outstanding. Authors of policies have been contacted. Progress is being made in updating policies. CG suggested escalation to the directorate leads to remove old and out of date policies and the report should show details of who it has been sent to. The Report will be amended to show the current report lead, the Directorate and the rag rating. The new version will be sent out within the next week and it will reviewed at the November Quality Committee agenda. The paper will be circulated to Quality Committee members imminently.

Actions	Deadline	Owner
Trust Policies Report to be circulated to QC members. Updated report to be circulated to QC members	20/09/19 20/09/19	KNC KNC

5.	Minutes of Reporting Groups for information only
5.1	ICSU Quality and Safety Meetings – There were no exceptions to report from the ICSU Quality & Safety meetings. The minutes were taken as read and noted.
5.2	The minutes from the Patient Safety Committee were taken as read and noted.
5.3	The minutes from the Patient Experience Committee were taken as read and noted.

6.	Any Other Urgent Business
6.1	Paula Ryeland advised the committee that she and Dr Ashling Lillis are applying for the Sir Peter Carr Award. This is an award for partnership between clinician and manager with their QI work on discharge summaries. This is exciting innovative work, and good results have already been recorded. This was approved by the Committee.

The meeting closed at 4pm
The next Quality Committee is scheduled for **Wednesday 13 November 2019**

Future dates: 2pm – 4pm

- 8th January 2020
- 11th March 2020
- 13th May 2020
- 8th July 2020
- 9th September 2020

Draft minutes of the Workforce Assurance Committee meeting held on Tuesday, 10th September 2019

Present:

Kevin Curnow	Acting Chief Finance Officer
Norma French	Director of Workforce
Carol Gillen	Chief Operating Officer
Michelle Johnson	Chief Nurse & Director of Patient Experience
Helen Kent	Assistant Director of Learning & OD
Anu Singh	Non-Executive Director (in the Chair)
Kate Wilson	Deputy Director of Workforce

In attendance:

Kate Green	PA to Director of Workforce (Minutes)
Fiona Isacsson	Director of Operations, Surgery & Cancer
Swarnjit Singh	Trust Corporate Secretary
Nicola Stephenson	Acting Director of Operations, Emergency & Integrated Medicine

Apologies:

Clare Dollery	Medical Director
Yua Haw Yoe	Non-Executive Director

19/23 Welcome and Introductions

23.01 Anu Singh welcomed everyone to the meeting. Swarnjit Singh explained that due to having only one Non-Executive Director present the meeting was inquorate, therefore any decisions made would have to be ratified by the next meeting or via e-mail correspondence.

19/24 Minutes of the last meeting

24.01 Reviewing the minutes of the Workforce Assurance Committee held in April, Anu noted that the Medical Director had now been added to the membership, and ICSU representatives invited to attend.

24.02 Referring to minute 19.08 (Cultural Survey action plan), Norma was pleased to announce that some additional resource had been identified to support this work programme. This would take the form of a communications lead who would act as a conduit between the workforce team and the communications team, plus some high-level administrative/project support.

24.03 The minutes of the meeting held on 24th April 2019 were approved.

19/25 Matters arising

25.01 There were no further matters arising other than those scheduled for discussion.

Action Plan

25.02 Item14.02: The rolling action plan, including dates for actions, had now been added to the minutes.
Item 16.04: The briefing on recruitment tracker issues was to be tabled.
Item 16.08: Helen had presented the paper on mandatory training to the Trust Management Group (TMG).
Item 17.05 The report from the Guardian of Safe Working would be come to WAC every six months.
Item 19.08 Norma had reported on the additional support that was to be provided to support the cultural transformation agenda.
Item 19.10 Helen Kent would be providing a verbal report to WAC on the WRES work programme.
Item 20.02 Terms of reference now reflected the addition of the Medical Director to the WAC membership, and ICSU representatives had been invited to attend.
Item 20.03 Swarnjit had brought a copy of the draft committee structure to the meeting.

19/26 Board Assurance Framework (BAF)

26.01 Swarnjit Singh reminded committee members that the Board had agreed all sub-committees would look at key risks on the BAF in their areas and that this should be a standing item on the agenda. The latest version of the BAF had been agreed at the April Board, and two risks came within the remit of WAC:

- People 1- Failure to recruit and retain high quality substantive staff could lead to reduced quality of care and higher costs, and
- People 2 – That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised, staff morale is affected and ultimately patient care suffers as a result.

26.02 Norma felt that the development of the nursing recruitment and retention strategy was key to addressing the first, and the cultural action plan to the second. Anu reminded colleagues that originally Siobhan Harrington had been the Trust Board lead for People 2, which she felt conveyed the right message to staff, and Norma agreed that mitigation of the risk was not entirely within the gift of workforce and said that she would take this back. Anu asked whether WAC members had been provided with sufficient assurances to make them confident that everything possible was being done to mitigate against these risks, and there was agreement that a great deal of work was under way; this would however require regular monitoring.

26.03 Referring to the action plan being developed (page 5) it was noted this was now in place so this section would need to be updated.

19/27 Quarter 1 Workforce Report

27.01 Kate Wilson had produced a cover sheet which set out some of the key points contained in the report. She highlighted the following:

- There had been a slight reduction in sickness, with the only area of concern being within the Children & Young People (CYP) ICSU.
- Turnover had reduced by 1% since Quarter 4, and all areas were now on target save for CYP. There had been a small (0.8%) increase in overall vacancy levels.

- Bank and Agency usage had again decreased since the last report.
- Mandatory Training compliance remained at 80%, and Appraisal rates at 72%.

27.02 Kate Wilson tabled a paper providing an overview of recruitment issues. She was pleased to report that end to end recruitment time now stood at 8.5 weeks, an improvement from 9.1 weeks at the end of Quarter 4. The longest area of delay was that between the resignation of a staff member and financial approval, and Kate informed the meeting that she had seen three examples of this at the previous day's Vacancy Scrutiny Panel (VSP). It was noted that 'financial approval' meant reaching the stage of the post being presented to VSP. This data is also circulated to the ICSUs.

27.03 Training had been organised for staff around recruitment, and further sessions could be carried out in the autumn. Carol added that her team was currently pulling together a comprehensive programme for service managers in which this could also be included. Kate said that there were also 'bite size' training sessions for managers which had proved useful. Michelle pointed out, however, that recruitment was particularly time-consuming in some clinical areas; for example where ward managers were recruiting health care assistants (HCAs) they might receive as many as 200 applicants which would take the best part of two days to shortlist from. Much thought was going into how this was planned for. For some posts filters could be used, but this was difficult when recruiting Band 2 HCAs. Anu suggested clustering between different areas, and Fiona replied that this was already done when recruiting nurses. It was possible to close vacancies early, but this was not a preferred solution. Additional guidance was being produced on references.

27.04 In answer to a question about what was achievable in terms of timescales for end to end recruitment, Kate replied that the national standard was 8 weeks; however she felt that the team could achieve 7.5. Anu asked whether there were concerns about the Children and Young People's ICSU, and Carol replied that there had been some significant changes in the CAMHS team, both service and restructuring, and the consultation had been paused and restarted due to commissioning issues. In addition, because numbers were so small, the turnover appeared deceptively high.

27.05 Fiona made the point that there had been a great deal of focus on nursing, and the same rigour now needed to be applied to medical staffing, particularly given the need for compliant rotas. There was a need to look at what roles crucially needed to be fulfilled by doctors, and Clare Dollery would be progressing this on her return from leave.

19/28 <u>Employee Relations Activity</u>

28.01 Kate began her report by informing the committee that there had been four cases which had exceeded the 90 day completion standard, three disciplinary and one grievance. All these cases had now been resolved, meaning that the only active cases exceeding 90 days were tribunals, which were outside the Trust's control. Anu enquired whether it was possible to report on those cases resolved informally, and Norma replied that data was collected from Fair Treatments Panels and the Freedom To Speak Up Guardian and champions, however the electronic system held by the employee relations team only captured formal cases. It would however be possible to invite the ICSUs to attend to speak about cases in their areas.

28.02 Fiona felt that not all the active cases in her area were visible on the report, and Kate undertook to check this after the meeting. Norma reminded the committee that medical cases fell under the Maintaining High Professional Standards regulations, the processes and timescales for which differed from other formal Trust processes. She added that the

Board received details of such ongoing cases every month, and Kate added that the team held a monthly meeting with the Medical Director to discuss these. Anu asked that a paragraph be added to the report to reflect this.

28.03 Kate reported that at the last Board meeting there had been some discussion about the high number of formal disciplinary cases which had resulted in there being no case to answer, and said that these would be reviewed, the aim being to see an overall reduction.

19/29 Caring for Those Who Care Programme

Mandatory Training and Appraisal Compliance

29.01 Introducing this item, Helen Kent briefed the committee on the ongoing work being undertaken to improve mandatory training compliance. There was an e-learning suite at Crouch End (a resource that had been in place for a considerable time but was not universally known about) plus a new three days per week service on the hospital site. Staff continued to experience difficulties in locating the correct courses, and the deep dive currently being undertaken in adult community services would help to identify and thus rectify some of these difficulties. The discussion at TMG had been positive, and had in fact triggered the deep dive.

29.02 It was noted that the data produced this month would serve to informal the CQC's inspection (to be held late November/early December) and Norma and Helen would be writing to all ICSUs and Directors informing them what actions would be taken in preparation for this. The QI project had also just started. Issues contributing to non-compliance ranged from difficulties in releasing staff to undertake training to IT difficulties. Norma also mention the procurement department, which included some staff based at other hospital sites over whom the Trust had less ability to influence. Anu understood this, but felt the Trust had a strong story to relay about the work that had been carried out.

29.03 Appraisal paperwork had recently been simplified, and Helen stressed that this resource was designed to support appraisal conversations rather than to give staff onerous paperwork to complete. The only thing necessary to record was the date of the appraisal itself. Helen acknowledged that recording appraisal dates was not entirely straightforward, but said that additional help would be provided. She was also pleased to inform the committee that Astrid Von Volckamer had recently returned from maternity leave, and the small team was to be expanded. Norma expressed her confidence in the ability of the team to improve the Trust's position.

NHS Staff Survey

29.04 The data from the 2018 staff survey had been received by the Trust in March, and all areas had identified key areas to focus on. A template had been provided to support this work. The team had recently requested an update, and Helen said that to date four comprehensive responses had been received:

Adult Community – health & wellbeing, morale and quality of appraisals
Surgery & Cancer – engagement, visibility and leadership
Nursing & Patient Experience - health & wellbeing, morale and quality of appraisals
Workforce - health & wellbeing, morale and quality of appraisals.

Helen was expecting further resources imminently, which would serve to inform her paper for the September Board update.

29.05 The 2019 staff survey would be launched soon, and Anu enquired whether any different approaches were being considered. Norma replied that the emphasis remained on encouraging staff to complete the survey, which would be issued via a mixture of electronic and paper questionnaires, the latter of which were to be issued by directors. It was also hoped to repeat the prize draw.

WRES and WDES outcomes

29.06 Helen was pleased to report that there had been an improvement in the likelihood of BME candidates being appointed to posts, adding that trained BME representatives now sat on all interview panels for grades 8A and above. The percentage of BME staff occupying positions graded 8A to VSM had increased by 4%, for which the Trust had been commended by Yvonne Coghill. For the first time the team was able to report on the take-up of non-mandatory training, and from this Helen was able to report there had been a slight increase in the number of BME staff taking up non-mandatory training. There was however still much to do.

29.07 WDES outcomes were not as favourable, however this was in part influenced by staff being unwilling to report disabilities on ESR. Anu said that this was a national rather than a local problem, and Michelle agreed, saying the Trust needed to do far more to reassure people's fear of being stigmatised or discriminated against.

29.08 Newly-appointed Inclusion Lead Charles Rukwengye was now in post, and the hours allocated to that post had been almost doubled. Referring back to ESR data, Helen said that some fields were missing – it was for example not possible to record transgender; again this was a national rather than a local issue. Anu felt that Trusts should be working to get some of these changes made, and suggested the WAC write to STP ESR lead Nicola accordingly. Kate reported on the discussion at the last Board, where the need to change perceptions, receive appropriate assurances and target specific areas had been highlighted as priorities.

29.09 Anu said that the directorate was obviously doing sterling work in this area but was concerned about the degree to which this was being captured, and Norma agreed that there was a need to brand and market achievements. Michelle added that good communications was key to this, and the additional resource to be put in would assist with this. Anu also suggested this centred around the establishment of a social movement, and wondered how best to support staff to achieve this; Norma replied that she had recently linked up with NHS Chief People Officer Prerana Issar on Twitter and had been given some inspiring examples from around the country. In addition Charles Rukwengye was already planning to reinvigorate the Trust's equalities networks.

Manager Training

29.10 Helen informed the committee that invitations to attend the training badged as 'challenging bullying' had initially been sent to around 300 staff – over 600 had now been identified (including senior clinicians) and additional funding had been secured to increase the sessions available. It had been made clear that this training was a mandatory requirement, and attendance would be logged by the team. Eleanor Clarke was reviewing the training, which included working with professional actors, and which Norma felt was extremely positive. The key message which had come from TMG was the importance of consultant medical staff attending.

29.11 Helen also drew attention to other ongoing work being progressed by the team:

- carrying out a pilot run for the 9 box grid
- an extension of the reverse mentoring programme
- the accreditation of two Affina team coaches
- the next phase of the cultural collaboration work
- Norma's successful bid for funding to support the development of a staff app.

Michelle stressed the importance of communications needing to come 'from the bottom up'; there was no 'one size fits all'.

19/30 Committee Terms of Reference and proposed Governance Structure

30.01 Swarnjit Singh confirmed that the terms of reference had been updated in the light of comments made at the previous meeting. The draft governance structure would be discussed at the Executive Management Team and TMG; Swarnjit had included with the WAC meeting papers a diagram showing the current position of the WAC and the draft proposal for which committees might report into it in future. Anu suggested the addition of the Culture Collaborative. Overall, she felt that the proposals were right and proper. Committee members approved the revised Terms of Reference, and noted the governance structure as a work in progress.

19.31 Forward Planner

31.01 Introducing this item, Norma said this was a first draft at a forward planner which might be subject to change, and the immediate key task was to finalise meeting dates for the next year. Items to be added included the Caring for those who Care action plan, and the 6-monthly report from the Freedom to Speak Up Guardian. Anu wished to include a deep dive, and wanted that to be issue (rather than ICSU) focussed; Norma would give further thought to this. Fiona suggested the inclusion of the GMC survey report, and Swarnjit added:

- Gender Pay gap reporting (annual requirement) – March
- Statutory annual public sector equality duty report – July
- Staff FFT and Pulse Surveys.

31.02 The importance of not duplicating reports produced for the Trust Board was emphasised.