Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
30 October 2019

Whittington Education Centre
Room 7

Meeting	**Trust Board – Public meeting**
Date & time	**30 October 2019: From 1400hrs**
Venue	**Whittington Education Centre, Room 7**

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

Attendees:
Councillor Janet Burgess MBE, Islington Council
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Kate Green, Personal Assistant to Director of Workforce
Dr Sarah Humphery, Medical Director, Integrated Care
Swarnjit Singh, Trust Corporate Secretary

Contact for this meeting: jonathan.gardner@nhs.net

AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	1400	**Patient story** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Presentation
2	1420	**Welcome and apologies** *Interim Chair*	Verbal
3	1421	**Declaration of interests** *Interim Chair*	Verbal
4	1422	**25 September 2019 public meeting draft minutes, action log, matters arising** *Interim Chair*	Approve
5	1425	**Chair's report** *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** *Dr Clare Dollery, Medical Director*	Note
8	1450	**Quality Assurance and Compliance summary report** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Note
9	1500	**Quarter 2 Guardian of Safer Working report** *Dr Clare Dollery, Medical Director*	Note
10	1510	**Winter Plan** *Carol Gillen, Chief Operating Officer*	Review
11	1520	**Healthcare worker winter flu vaccination self-assessment** *Norma French, Director of Workforce*	Approve
People			
12	1525	**Learning lessons to improve our people practices** *Norma French, Director of Workforce*	Note
1535-1545: Break			
Performance			
13	1545	**Financial performance and capital expenditure – September 2019** Kevin Curnow, Acting Chief Finance Officer	Review
14	1600	**Integrated performance report – September 2019** *Carol Gillen, Chief Operating Officer*	Review
Governance			
15	1615	**Quality and Safety risk register summary** *Michelle Johnson, Chief Nurse & Director of Allied Health Professionals*	Review
16	1625	**Quarter 2 delivery of strategic objectives** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Review
17	1635	**2018/19 Health and safety annual report** *Adrien Cooper, Director of the Environment*	Approve
18	1645	**Board members' register of interests** *Jonathan Gardner, Director of Strategy,*	Note

Item	Timing	Title and lead	Action
		Development & Corporate Affairs	
Strategy			
19	1650	**EU exit preparations** *Carol Gillen, Chief Operating Officer*	Note
20	1700	**Cyber Security update** *Leon Douglas, Chief Information Officer*	Note
21	1710	**Board forward plan** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Note
22	1710	**Questions to the Board on agenda items** *Interim Chair*	Verbal
23	1715	**Any other business** *Interim Chair*	Verbal

Minutes of the Board of Directors of Whittington Health NHS Trust's meeting held in public on Wednesday, 25 September 2019

Present:

David Holt	Interim Chair
Kevin Curnow	Acting Chief Finance Officer
Dr Clare Dollery	Medical Director
Norma French	Director of Workforce
Professor Naomi Fulop	Non-Executive Director
Jonathan Gardner	Director of Strategy, Development & Corporate Affairs
Carol Gillen	Chief Operating Officer
Siobhan Harrington	Chief Executive
Deborah Harris-Ugbomah	Non-Executive Director
Dr Sarah Humphery	Medical Director, Integrated Care
Michelle Johnson	Chief Nurse and Director of Allied Health Professionals
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:

Janet Burgess CBE	Councillor, London Borough of Islington
James Connell	Patient Experience Manager (item 3)
Casey Galloway	Patient Experience Officer (item 3)
Esme Ingram	Specialty Trainee (item 3)
Helen Kent	Assistant Director, Organisational Development (items 11 and 12)
Kathryn Simpson	Research Portfolio Manager (item 10)
Swarnjit Singh	Trust Corporate Secretary

1.	**Welcome & apologies**
1.1	David Holt welcomed all attendees and reported the very sad news of the unexpected death the previous evening of former Trust Chair, Steve Hitchins. Along with Siobhan Harrington, he paid tribute to the service Steve Hitchins carried out for Whittington Health and his huge presence across Trust sites with staff.
1.2	Apologies were noted for Tony Rice, Non-Executive Director.
2.	**Declaration of conflicts of interest**
2.1	No declarations were reported in addition to those previously listed in the register.
3.	**Staff story – Esme Ingram**
3.1	Michelle Johnson introduced the staff story item by saying that Stave Hitchins had embodied support for staff and was known across the trust and left a great legacy. James Connell introduced Esme Ingram who outlined the

	following to Board members: • She was currently a clinical teaching fellow and had worked here for two years as a core medical trainee • Following time at the North West Thames Deanery, she joined Whittington Health in August 2017. She had really enjoyed her time here and, in the second year, took on role of associate college tutor, helping to deliver training and teaching • The team had sought to increase opportunities and doubled the amount of weekly teaching delivered and invited experts, internal and external, such as Dame Jane Dacre, Director of UCL Medical School • Other examples included arranging for live streaming of teaching by the Royal College of Physicians and relaunching the Whittington Wine Clubs' monthly teaching evenings which included a group encompassing doctors, pharmacists, students and biochemists • Following the sad death of a homeless patient during core medical training, a number of staff developed a project for local homeless people to help signpost them to local services. Steve Hitchins had been involved in this project along with Beauty Bank, a charity which had been overwhelmed with staff donations • At the end of her core medical training, Esme said she loved Whittington Health and did not want to leave. She was successful in securing an opportunity to work for three days a week in ambulatory care focussing on care of elderly, one day a week devoted to teaching medical students and the other day spent in integrated care with the integrated clinical assessment team and had really enjoyed the difference of going into people's homes to carry out assessments
3.2	During discussion, the following points were raised: • There was a real interest in staff wellbeing, particularly after events, such as the death of a patient. Over the past 12 months, a series of supervision sessions with a clinical psychotherapist had been piloted for junior doctors. Unfortunately, this was not sustainable in the psychologist's own time and a survey of incoming junior doctors had overwhelmingly asked for its continuation. Norma French and Clare Dollery would liaise to see what could be done to take the supervision sessions forward • The Trust's charitable funds had invested in an away day for core medical trainees. This was really welcomed and was something unique to Whittington Health • Janet Burgess noted the Mayor of Islington had said that the homeless shelters would be open longer this year, until February 2020 • Siobhan Harrington commented on how Esme epitomised Whittington Health's values and the flexibility of job roles that the trust offered • Deborah Harris-Ugbomah said she would pass on details to Esme of a charity which carried out eye tests for homeless people
3.3	**On behalf of the Board, David Holt thanked Esme Ingram for sharing her staff story and experience.**

4.	**31 July 2019 draft minutes, action log, matters arising**
4.1	The minutes of the previous meeting were agreed as a correct record, subject to the following amendments: • section 7.4 – Naomi Fulop had sought examples of improvements made on wards "in response to identified learning"; and • section 14 – David Holt suggested a need to better reflect the Board's desire to see tangible improvements made over the next 12 months on the workforce race equality standard outcomes and proposed that any drafting amendments be sent to Jonathan Gardner.
4.2	David Holt noted that all action log items were either completed or on target to for completion.
5.	**Chair's report**
5.1	David Holt highlighted the annual general meeting taking place later from 5.30pm in the lecture theatre which would be followed by long service awards for staff. Deborah Harris-Ugbomah reported that the annual staff awards event had been a fantastic and positive celebration of staff and their achievements.
5.2	**The verbal report was noted.**
6.	**Chief Executive's report**
6.1	Siobhan Harrington reported how shocked and saddened staff had been upon hearing the news about Steve's Hitchins who would be missed. She explained that condolences had been sent to his wife, Sarah. Siobhan explained that she had, the previous Friday, given Steve a book signed by staff following his resignation. A book of condolence was now being arranged for staff to sign. Janet Burgess commented on how important Steve Hitchins had been to Islington Council.
6.2	Siobhan Harrington went on to highlight the following points: • An inspection visit by the Care Quality Commission (CQC) was likely by end of the year. It would be accompanied by an assessment of the use of resources and the requirements of the well led framework. The main message to all staff was to be proud of what they and Whittington Health did, be clear on what we are trying to improve and welcome the CQC • August had been a challenging month in terms of operational performance in the emergency department, with attendances 7% up on previous year. A deep dive report was included with this month's performance scorecard showing the work going on to help improve • This year's flu vaccination campaign was underway and, while Whittington Health had a good track record, it needed to be even better this winter, in view of learning from Australia which had had a higher level of flu virus outbreaks this year. A local charity for people with dementia would be the recipient charity this year. Vaccines would be available at the 11 October Board seminar • There was an improvement in the financial position over the last month, however, there was a need to improve the delivery of recurrent savings and there was a real focus on that

	• In terms of senior staffing changes, Kevin Curnow was Acting Chief Finance Officer and the Chief Executive would line manage the Director of Environment and the Chief Information Officer. Michelle Johnson's new job title as Chief Nurse and Director of Allied Health Professionals reflected recognition for the second largest staffing group of over 800 people in Whittington Health's workforce • Additional resources had been invested in organisational development and culture and the trust's new equality, diversity and inclusion lead had a clear plan of actions going forward In discussion, the following points arose:
6.3	• Yua Haw Yoe asked whether the equality lead would have any link to the Freedom to Speak Up Guardian. In reply, Norma French said there was no formal line between both posts; however, the Guardian's role transcended all roles, and linked in with everyone. • Siobhan Harrington reported that there was an aim to also produce a cultural dashboard which included workforce equality and allowed the Board to focus on outcomes
6.4	**Board members noted the report.**
7.	**Serious incidents**
7.1	The report was taken as read and Clare Dollery drew attention to the following important areas: • The importance of learning lessons from two different never events and the need for a system of constant vigilance. Assurance was provided that the Associate Medical Director was leading a review to ensure that all policies were in place in response to each of the never events and to complete a gap analysis to help ensure a standardised way of acting • Changes had been made to communication with the London Ambulance Service following the maternal death of an 18 weeks' pregnant patient who was brought to the emergency department in cardio-respiratory arrest • The importance of community services staff having sepsis training
7.2	During discussion, the following points arose: • Anu Singh asked whether continuous improvement was being achieved in pressure ulcer work. In response, Michelle Johnson confirmed that a report was being prepared for the Quality Committee on this and she would share it beforehand • Yua Haw Yoe highlighted the three issues in the report which related to screening and asked for further details how they arose. Clare Dollery explained that, without prejudging the outcome of the investigation, it appeared there was an appointment on the choose and book system that referred a patient from the GP practice directly to endoscopy services. The trust had an internal triage service to check, by gastroenterologist, that each referral and test was appropriate, however, in some instances; it appeared that patients were booked into a wrong appointment. Whittington Health was working with commissioners and

	primary care to resolve this. Sarah Humphery provided assurance that the last edition of the GP Connect publication contained a message to GPs on this issue, emphasising the need for a letter containing reasons for the test. Siobhan Harrington highlighted the human factors training being planned for staff.
7.3	**The Board noted the report and agreed that the report on pressure ulcers for the November Quality Committee be circulated to Board members.**
8.	**2018/19 Infection Prevention & Control annual report**
8.1	The report was taken as read. Michelle Johnson gave assurance that all key performance indicators had been met and drew attention to the 2019/20 work plan which included additional hand hygiene awareness training and audits of practice.
8.2	David Holt welcomed the clear report and suggested Board members should receive hand hygiene training. Carol Gillen noted the 80% training compliance level and said it would be helpful to identify any areas of focus as part of winter planning. Naomi Fulop noted that Whittington Health performed very well on infection control.
8.3	**The Board noted the 2018/19 annual report, approved the 2019/20 work plan and agreed that hand hygiene training for Board members be arranged this Autumn.**
9.	**Freedom To Speak Up Guardian six monthly report**
9.1	Michelle Johnson presented the report, highlighting the following: • Normally, the Guardian would be here to present and discuss the report, however today, the unique circumstances meant this did not happen • She was proud of the work of the Guardian who had now been in post for ten months. There was an error in section 5.2 where the numbers did not quite add up • In comparison to other trusts, Whittington Health wanted to have a higher level of reporting which was less anonymised • In line with guidance from NHS England and Improvement, the Guardian met regularly with the non-executive lead for speaking up and received other assistance, including formal psychological support
9.2	In discussion, Board members raised the following: • Yua Haw Yoe explained that the most significant issues were attitudes and behaviours and knowing the impact and effectiveness of this work. Norma French provided assurance that a number of activities were being rolled out under the #Caringforthosewhocare, including mandatory training on bullying and harassment for 600 managers. She confirmed that evaluation was taking place through monitoring the outcomes of quarterly pulse surveys and family and friends tests results and also through employee relations information seen by the Workforce Assurance Committee • David Holt suggested gathering a cohort of people to receive feedback

	on the impact of the training on performance within a team. Clare Dollery reported the General Medical Council had agreed to run sessions with groups of clinicians on hierarchical behaviours and patient safety • In reply to a question from David Holt, Michelle Johnson said the next six monthly Guardian's report would outline self-assessment against NHS Improvement guidance • Yua Haw Yoe provided assurance to David Holt that the work priorities outlined in the report were correct
9.3	**The Board noted the report and agreed these actions:** **i. bring back a report on the Freedom To Speak Up Guardian self-assessment to the Board in the next two months;** **ii. review progress with the development of an organisational culture dashboard; and** **iii. bring an update to the Board on the Trust's response to the letter from Dido Harding regarding additional guidance relating to the management and oversight of local investigation and disciplinary procedures.**
10.	**2018/19 Research and development annual report**
10.1	Clare Dollery confirmed that the annual report had been considered by the Quality Committee and was very positive. She thanked the Kathryn Simpson for her leadership and explained that a new research and development strategy was being developed and would be brought back in the New Year.
10.2	Kathryn Simpson outlined the funding of priority one activity in relation to recruited patients to Kevin Curnow who gave assurance that budget plans were as outlined in the report. Siobhan Harrington encouraged the development of an ambitious strategy to help raise of the profile of research and development opportunities taking place. Deborah Harris-Ugbomah encouraged diversification of the research portfolio into areas such as Allied Health Professionals and integrated care and links to research by University College London Providers Academic Health Science Centre. Naomi Fulop highlighted good evidence showing that patients involved in research studies had better outcomes and care and emphasised opportunities in health services and population health research.
10.3	**Board members noted the 2018/19 Research and development annual report.**
11.	**Local staff survey action plans**
11.1	Helen Kent highlighted the following to Board members**:** • Work was taking place with team leaders in two integrated clinical service units with health and wellbeing, morale and quality appraisals as the predominant themes • This year's NHS staff survey would be issued in October with results available in March 2020. It was expected that analysis of team results would be provided earlier following feedback to the supplier • Anu Singh proposed that, in addition to pulse survey and family and friend's test results, other proxy measures for engagement, be identified.

	Siobhan Harrington suggested the following areas as proxies for staff engagement: team time and away days; survey response rates; flu vaccination levels; and, staff awards nominations. Norma French clarified that that pulse surveys were now asking specific additional questions and reported that a staff app was being introduced to help two-way communication
11.2	**The Board:** **i. noted the progress with integrated clinical service unit and directorate action plans following receipt of the 2018 annual NHS staff survey results; and** **ii. agreed that proxy measures for staff engagement be identified and considered at the next meeting of the Workforce Assurance Committee, prior to the Board.**
12.	**2018/19 Public sector equality duty annual report**
12.1	Norma French presented the statutory report and welcomed the inclusion of patient equality information. Michelle Johnson reported on key actions taken since the data was collected and analysed: • Implementation of the frailty pathway for patients aged over 75 years • Having designated waiting areas for under ten year old patients • Providing more personalised care experience by allowing carers to stay on wards • Work taking place with the chaplaincy and pastoral care team to help provide spiritual care needs for Jewish patients
12.2	Michelle Johnson also updated Board members on the approach being taken in the NHS North Central London where Whittington Health would join with partner providers (Camden & Islington Foundation Trust, Barnet, Enfield and Haringey Mental Health Trust and North Middlesex University Hospital Trust) to hold focus groups with patients and Healthwatch representatives to review performance on the two patient domains of the NHS Equality Delivery System (EDS) framework.
12.3	In discussion, the following points arose: • Replying, to David Holt's comments on gaps in patient monitoring against the nine areas (protected characteristics) required, Michelle Johnson provided assurance that a number of actions were being taken at a whole system level including strengthening patient monitoring in primary, community and acute care settings and providing training and support for reception staff in dealing with sensitive areas of monitoring • Deborah Harris-Ugbomah noted that the workforce profile did not represent the patients being served; she also highlighted staff over retirement working at band 1-2 level. In response, Michelle Johnson assured Board members that staff welcomed the flexible retirement opportunities available and agreed there was a need to look more at the local population profile with access to healthcare services • Deborah Harris-Ugbomah and Michelle Johnson concurred on the need to ensure that the compliments and complaints process was accessible to all patient groups

	• Anu Singh welcomed the detailed data provided and highlighted the importance of the outcome of performance against the two EDS patient domains to feed into areas for action for Whittington Health
12.4	**The Board approved the 2018/19 statutory public sector equality duty report for publication on the Trust website.**
13.	**2019/21 Volunteering strategy**
13.1	Michelle Johnson presented the report and drew attention to the Whittington Health Voluntary Services logo which had been designed by a volunteer. She explained that the strategy had been developed using the same template as the Patient Experience strategy and also contained three goals, aligned to the trust's strategic objectives, which sought to make available a wide range of volunteering opportunities across the organisation, especially within community services. Delivery of the strategy's first year action plan would be monitored by the Quality Committee.
13.2	Anu Singh commended the team for a very good and clear strategy. She recognised Steve Hitchins's impetus behind this work and suggested including a link to social prescribing. Sarah Humphery commented on the link to Primary Care Networks. Carol Gillen noted that acute services had done a lot of work on volunteering and the next stage was to see examples from across Whittington Health which helped integrated clinical service units meet the strategy's ambitions.
13.3	**The Board approved the 2019/21 Volunteering strategy and agreed that social prescribing should be reflected within ambition one of the strategy.**
14.	**Finance report**
14.1	Kevin Curnow took the report as read and focussed on key points, as follows: • Performance at the end of month five was £3.7m behind plan, adjusted to £2.4m away from plan, should provider sustainability funding be received at year-end for achievement of the control total • Meetings were scheduled for next week with integrated clinical service units and corporate directorates to identify further savings schemes. The financial recovery plan sought to be £2m behind plan at the end of September. This required the identification of c. £400k savings in-month • There was improved spend on agency staffing expenditure as the trust was below its agency ceiling cap for the second consecutive month • Delivery of the 2019/20 cost improvement programme was disappointing with £1.6m of savings delivered for the year-to-date against a target of £5m for this stage in the year. £12.3m of recurrent savings remained the target for the year, however, achieving this would be very difficult • Approval had been received to spend the 2019/20 capital expenditure allocation of £18.3m. The trust was currently c. £500k behind its capital expenditure plan and assurance was provided that its full capital allocation would be used this financial year
14.2	In discussion, these points arose:

	• Michelle Johnson proposed communicating the message to staff about this year's capital expenditure plans • Kevin Curnow emphasised the need to continue to focus on reducing the run rate
14.3	**Board members:** **i. noted the financial results during August 2019 and recognised the need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing cost improvement programme plans; and** **ii. agreed that the cost improvement programme delivery trajectory for the remainder of the financial year with a forecast outturn be included in next month's report.**
15.	**Integrated performance scorecard**
15.1	In reply to a query from David Holt on any areas of concern, Carol Gillen highlighted emergency department performance in August for which a deep dive review had been carried out. She also explained that the Community Services Improvement Group recognised the progress achieved during the past few months and had decided that reviews of adult community services would continue as business as usual and that children and young people's community services would be reviewed in specific borough partnerships.
15.2	In discussion, Board members raised the following: • Carol Gillen confirmed to Naomi Fulop that the rise in cancelled operations was related to environmental factors in some theatres • Siobhan Harrington noted plans to include accompanying commentary for never events in the scorecard report
15.3	**The Board noted the integrated performance scorecard report.**
16.	**Quality Committee – minutes of the July and September meetings**
16.1	Naomi Fulop provided feedback on the September meeting which had considered a presentation from an integrated clinical service unit on the actions taken to improve teamwork and communication and have better handovers. She also welcomed moves to relaunch the "Hello my name is" campaign across Whittington Health. Michelle Johnson highlighted the July Committee meeting minutes which detailed the progress achieved in nursing and midwifery recruitment campaigns this year.
16.2	**Board members noted the minutes of the July and September meetings of the Quality Committee.**
17.	**Workforce Assurance Committee – September meeting**
17.1	Anu Singh reported that the Committee had considered reports and updates on the following: • Recruitment outcomes and improvements in training compliance • The various activities taking place under the #Caringforthosewhocare brand

17.2	**The Board noted the minutes of the Workforce Assurance Committee meeting held in September.**
18. 18.1 18.2	**Questions from the public** Mr Richards asked the following questions: i. How many beds were closed as part of the Perfect Week? ii. Would this impact on mixed sex wards in winter? iii. Would monitoring data for patient complaints about the non-emergency patient transport services be forwarded to the North Central London team? iv. Could the answers to his questions be appended to the minutes of the meeting? Replies were provided, as follows: • Carol Gillen explained that the trust usually opened up to c. 15 extra beds on the elderly care unit and on wards to tackle additional winter pressures. She also confirmed the trust would plan carefully to ensure it remained compliant with mixed sex/gender accommodation requirements • Jonathan Gardner agreed that data on patient transport service complaints would be shared with North Central London colleagues and reported that no Whittington Health-specific complaints were received during the first two and a half weeks of the new arrangements • Michelle Johnson noted that patients had a right of appeal against initial assessments made by the transport provider, DHL, and provided assurance that the trust monitored both complaints and contact with the Patient Advice & Liaison Service on this issue • David Holt confirmed that answers to the specific questions had been included on the webpages in a separate pdf document
19. 19.1	**Any other business** David Holt thanked all Board members for their commitment and success in getting through a difficult day.

Action log, 25 September 2019 Public Board meeting

Item	Action	Lead(s)	Progress
Draft minutes, 31 July meeting	Provide drafting amendments for the second sentence in section 7.4 for the quarterly Quality & Patient Safety report item	Naomi Fulop	Completed
	Provide drafting amendments for section 14 on the report for Workforce Race & Disabilities Equality Standards Outcomes and Equality Delivery System	All	Completed
Serious Incidents	Circulate the report on pressure ulcers for the November Quality Committee to Board members	Michelle Johnson	Early November
2018/19 Infection Prevention & Control annual report	Arrange hand hygiene training for Board members this Autumn	Michelle Johnson	The Lead Nurse for Infection Prevention & Control is arranging a training slot
Freedom to Speak up Guardian report	Bring back a report on the Freedom To Speak Guardian self-assessment in the next two months	Michelle Johnson	November 2019 meeting
	Review progress with the development of an organisational culture dashboard	Siobhan Harrington	In development
	Bring an update to the Board on the Trust's response to the letter from Dido Harding regarding additional guidance relating to the management and oversight of local investigation and disciplinary procedures	Norma French	Completed - October Trust Board meeting
Staff survey	Identify proxy measures for engagement that can be included in the 2019/20 annual report and consider these at the next meeting of the Workforce Assurance Committee, prior to the Board	Norma French	December meeting of the Workforce Assurance Committee
Whittington Health Volunteer strategy 2019-21	Reflect social prescribing within ambition 1 of the strategy	Michelle Johnson	Completed
Month five Finance report	At October's Board meeting present the cost improvement programme delivery trajectory for the remainder of the financial year with a forecast outturn	Kevin Curnow	Completed

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
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 a monthly update from the Chief Executive 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	1: The London Vision	

Chief Executive's report
This report provides Board directors with highlights of key developments within the health and social care sector at a national and local level:

1. National news

NHS recommendations to Government

1.1 NHS England and NHS Improvement published their response to the consultation feedback on proposals for NHS primary legislation, building on the proposals for implementation of the Long Term Plan. The report[1] outlined a number of areas such as getting better value for money, increasing the flexibility of national NHS payment systems and integrated service provisions. It also recommends an NHS Bill should be introduced in the next session of Parliament to enable different parts of the NHS to work together and with partners more easily to speed implementation of the 10-year NHS Long Term Plan. In summary, the proposals included:

- Repeal of the Competition and Markets Authority's roles in the NHS, as provided for by the Health and Social Care Act 2012
- Removal of the presumption of automatic tendering of NHS healthcare services over £615k and the abolition of Monitor's specific focus and functions in relation to enforcing competition law
- Embedding the principles of community co-production more clearly within the NHS Constitution
- Enabling closer collaboration and decision making between separate providers to assist and further the work of Integrated Care Systems (ICS) which will cover the whole of England
- Managing any increased risks of conflicts of interest from closer collaboration and decision making between NHS commissioners and providers through updated NHS England and NHS Improvement statutory guidance
- Health and Wellbeing Boards continuing to have an important role in assessing local needs and developing joint health and wellbeing strategies
- Actively encouraging local authorities to join ICS joint committees

EU exit

1.2 Whittington Health continues to follow national guidance in its preparations for an EU exit on 31 October and there is a separate item on the Board's agenda which provides more detail of the preparatory work.

The London Vision

1.3 On 1 October, the ambition for healthcare services in London[2] was launched by the Mayor of London, NHS London, Public Health England and London's Councils as a shared aim to make London the world's healthiest global city,

[1] https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf
[2] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/10/London-Vision-2019-FULL-VERSION-1.pdf

and the best global city in which to receive health and care services. A summary of the ten identified areas of focus is shown as appendix to this report.

North Central London Clinical Commissioning Groups

1.4 NHS England and Improvement London has approved an application from local clinical commissioning groups to merge. In line with the NHS Long Term Plan ambitions, forming one clinical commissioning group for North Central London will support the development of an Integrated Care System in this area from April 2020.

2. Local news

Quality and safety operational performance

2.1 In September, performance against the 95% four hour standard was 87.7% (7.3% below NHS Improvement standard of 92%). Patient attendances in the emergency department reduced from 8,778 in August 2019 to 8,658 in September 2019. This can be compared to September 2018 where the attendance was 8,899. There were eight mental health patients who waited in excess of 12 hours following a decision to admit them.

2.2 The Haringey health visiting service achieved the 95% new birth visit target. The teams delivered 95.12% of visits within 14 days (312 visits out of total 328 due).

2.3 The Trust achieved a 92.1% outcome for patients waiting 18 weeks for treatment against a target of 92%. There were also significant improvements in performance on waiting times in key adult community services notably podiatry, cardiology, spirometry, community rehabilitation, stroke and neuro and musculoskeletal services, with overall performance showing an overall upward trend.

2.4 During August, the trust experienced some challenges with cancer performance and marginally missed the 14 day target for suspected cancer patients (92% against a 93% target). Performance against the 62 day cancer target was 78.2% against the 85% target and this reflected pressures in the urology pathway as well as gynaecology and breast pathways. The trust is working closely with tertiary providers to review the pathways to ensure that waiting times for treatment are reduced and also increasing biopsy and hysteroscopy clinic slots to increase capacity for cancer patients.

2.5 In terms of workforce indicators, the trust achieved 80.7% mandatory training compliance rate in September, below the target of 90%. Staff appraisals reached 75.5% last month against a target of 90% and staff sickness absence was 3.35%, below the target of 3.5%.

Flu vaccination campaign

2.6 The Trust has begun to ramp up its preparation for winter flu vaccination through a campaign to ensure that as many of our frontline staff are vaccinated as possible against winter flu.

Financial performance

2.7 At the end of September, the Trust is reporting a year to date deficit of £3.9m (£2.3m after adjusting for the impact of not achieving any Provider and Sustainability Funding). The prime factor for the adverse variance remains the delivery of less cost improvement programme schemes than envisaged with £3m delivered so far this year against a target of £6.2m at this stage in the year.

2.8 Year-to-date pay costs exceeded budget by £2.2m. Bank staffing expenditure was less than in the previous month at £1.76m. Agency staffing costs of £0.6m were below the agency cap for the second consecutive month. The combined expenditure on temporary staffing for the year to date is £2.69m compared with £2.77m at this time last year. At month five, the Trust had spent £6.1m on capital expenditure against a plan of £7m.

Use of resources

2.9 Whittington Health will be having a use of resources assessment with NHS Improvement colleagues in mid-November.

Our people

Organisational culture and development

2.10 Under the umbrella of the #CaringforThoseThatCare programme of work activities, there has been an overwhelmingly positive feedback from the 600 line managers who attended bullying and harassment training which used actors to role play scenarios. Consideration is now being given to rolling this training out to all Whittington Health staff.

NHS staff survey

2.11 This year's NHS staff survey has been sent to all Whittington Health staff and the outcomes will provide the trust with areas to take action in response.

Black History month

2.12 October is Black History Month, a national celebration which aims to promote and celebrate the contribution of black people to British society and to foster an understanding of Black history in general. Whittington Health values inclusion and all staff are encouraged to get involved in at least one of the activities to mark this month.

Freedom to speak up month

2.13 Whittington Health is committed to create a safe and confidential environment where 'Speaking Up' is business as usual for all staff and about any concern which is vitally important to improve patient care and staff experience. The trust supported Speak Up Month this October: a national campaign by the National Guardian's Office, which calls on NHS organisations to increase awareness of how staff can raise concerns at work. The trust's Freedom to Speak Up Guardian is supported by a network of Advocates in different services, wards and sites across the hospital and community.

World Mental Health Day

2.14 On 10 October, Whittington Health demonstrated its commitment to promoting and protecting and enhancing the mental wellbeing of all of our colleagues through a number of ways that addressed mental health and wellbeing. In particular, the trust signed up to the mental health workplace manifesto where everyone's mental health and wellbeing is supported and people can talk about what they are struggling with without fear of stigma or discrimination.

Hello, My Name Is: a simple way to improve patient experience

2.15 From the end of this month, Whittington Health will launch a new campaign to remind all staff, clinical and non-clinical of the importance of the simple phrase – "hello, my name is…" as there are real tangible benefits to be gained both in terms of patient experience and patient safety from all of our staff introducing themselves whenever they meet a patient before they begin any consultation or conversation. The badges will also feature a clearer, larger print, a simpler design and a yellow background to cater to the specific needs of people living with dementia or sight impairments.

Whittington Health environment

2.16 The following updates can be provided:

- Work on a new obstetrics theatre and recovery area have been completed and staff are familiarising themselves with the new area which will be operational in November
- Demolition work continues on the derelict Waterlow building and the trust's planning application for a new education centre facilities was approved by Islington council last week
- Since the last Board meeting, the patient dining service has now come in house and Whittington Health will shortly be tendering for a retail dining provider
- The trust has signed up to a pledge to remove single use plastic items in dining areas as part of its contribution to environmental sustainability

Annual General Meeting

2.17 The Trust held its Annual General Meeting on 25 September. The meeting was attended by staff, patients and stakeholders from the local community and presentations were delivered on a patient story and on Whittington Health's 2018/19 Annual Report and Accounts. In addition, long service awards were presented to eligible staff.

Monthly staff excellence award - Elaine Cronin, Lead Stoma Care Nurse

2.18 This month's staff excellence award goes to Elaine Cronin who was nominated by five patients earlier this year. They all commented on how compassionate she was, holding their hands though an incredibly difficult time, preparing them for a life-changing operation and making them feel as though they could ask her anything. As well as her compassion, her patients commented on her clarity and her humour when communicating with them, answering questions and helping them with any problems or concerns – this was particularly important for these patients, who felt that she recognised the psychological aspects of their care as well as the physical aspects. One of her nominators said that they found her help and advice both motivating and

inspiring. A number of the nominations mentioned how supportive Elaine was, especially when visiting them at home as part of a community visit, and commented on her holistic approach. They found her perceptive, personable and responsive and valued the advice and support she gave beyond stoma care, for example complications with other conditions or treatment. One person said “It was a pleasure to meet Elaine – I can honestly say that she is a person that will always stand out in my mind as an important guide in what has now become a new normal for me as a cancer survivor”.

The London Vision

We have a shared ambition to make London the world's healthiest global city, and the best global city in which to receive health and care services.

We know we need to work together across public services and wider society, both to make the most of opportunities for good health and tackle issues that cause poor health and health inequalities. The London Vision sets out our shared priorities as a partnership and will guide us as we design London-wide and local action together with Londoners.

The Vision represents a major milestone in our partnership. It builds on significant collaborative work over several years through which we have achieved things like a new social movement for better mental health (Thrive LDN), the first London Estates Strategy, and much more. It is the beginning of a conversation about the next phase of this collaborative work, and an important invitation to you – professionals, partner organisations, the community and voluntary sector and members of the public – to discuss and debate it with us.

What is the partnership?

The partnership is made up of:

Public Health England

NHS

MAYOR OF LONDON

LONDON COUNCILS

What health challenges does London face?

Like many big cities, London offers a wealth of opportunities for people to lead healthy and happy lives, but it also presents issues and challenges to health. People are living longer but many are living in poor health, and significant health inequalities persist. No one's health should suffer because of who they are or where they live.

2 million

Londoners experience mental ill health every year

400,000

Children under 18 live in areas that exceed legal limits for air pollution

12

Londoners die each week from suicide

8,000

Smoking remains London's leading cause of premature death, killing 8,000 people per year

200,000

offences of violence including 120 homicides were recorded in London in the 12 months to March 2019

The number of rough sleepers in London has more than doubled in the last 10 years

Despite considerable progress, HIV is twice as common in London as it is in England

Almost 40%

of children in Year 6 are overweight or obese

2x

People with dementia stay in hospital twice a long as other older people

What is our approach?

We cannot rely only on treating people when they become ill. We need a shift in emphasis and resources towards understanding and preventing the root causes of ill-health and tackling health inequalities. This means thinking about the places where people are born, live, work and age; how we value diversity and difference in our communities; and the roles that friends, families and communities play.

We are taking a life course approach, which means we are looking at what support people need to be well throughout their lives – to start well, live well and age well. The city as a human-made environment provides a unique opportunity to shape our own future by designing and building places that enable all Londoners to thrive throughout their lives.

To achieve this, we are developing new, joined-up approaches to health and care, including shared decision-making and joint service provision. We will also work together to: make sure we have the workforce to provide the care Londoners need; harness the power of digital innovation to proactively predict, manage and prevent poor health; and transform London's health and care buildings and land. In the face of significant funding pressures in local government, and increasing demographic challenges, we are coming together to find new ways of working that make best use of our resources.

What are our areas of focus?

We recognise that no single organisation can achieve this alone, and that shared action makes us greater than the sum of our parts. We have identified 10 areas of focus where we believe partnership action is needed at a pan-London level.

Reduce childhood obesity

Improve the emotional wellbeing of children and young Londoners

Improve mental health and progress towards zero suicides

Improve air quality

Improve tobacco control and reduce smoking

Reduce the prevalence and impact of violence

Improve the health of homeless people

Improve services and prevention for HIV and other STIs

Support Londoners with dementia to live well

Improve care and support at the end of life

What happens next?

- We are publishing the vision now as an important invitation to you. We want to continue to talk to you and all our partners about how we collectively take forward its ambitions and objectives.
- We want you to tell us how we can refine, develop and strengthen our proposals, and we need you to help us deliver action on the ground in communities. Together we can work towards ensuring a healthy future for all Londoners.
- We invite your specific reflections and comments on any aspect of the Vision, which can be sent to us at the following email address: england.healthylondon@nhs.net

Meeting title	**Trust Board – public meeting**	Date: **30.10.2019**
Report title	**Serious Incidents update – October 2019**	**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 September 2019. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis. One serious incident has been declared in September and three serious incident investigations have been completed. This report includes the learning from two Never Events which occurred in 2018/19 and 2017/18 respectively and were identified as part of a national look back exercise.	
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: October 2019 Board report

1. Introduction

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

2. Background

2.1 The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director, Chief Nurse and Director of Allied Health Professionals, 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 one Serious Incident in September 2019 which brings the total number of reportable serious incidents to 16 since 1st April 2019.

SI Ref:	ICSU	Description	Incident Date	Datix Date	Incident Datix Interval	Steis Date	Datix-STEIS Interval
19256	EIM	A non-standard technique was used for a chest drain insertion resulting in the retention of a small piece of equipment. Immediate actions taken: • Patient informed of incident • Teaching session on chest drain insertion for ED registrars • Consultant/senior decision maker to be informed of all procedures in ED	21/08/19	28/08/19	5	02/09/19	**3**

Table 1: All serious incidents declared to NHS England externally via the Strategic Executive Information System (StEIS) in September 2019.

3.2 Serious incidents declared and investigations completed in this financial YTD.

Chart 1 below indicates the number of serious incidents declared by the Trust between 1st April 2019 and 30th September 2019 as well as the number of investigation reports which were submitted to the North East London Commissioning Support Unit (NELCSU).

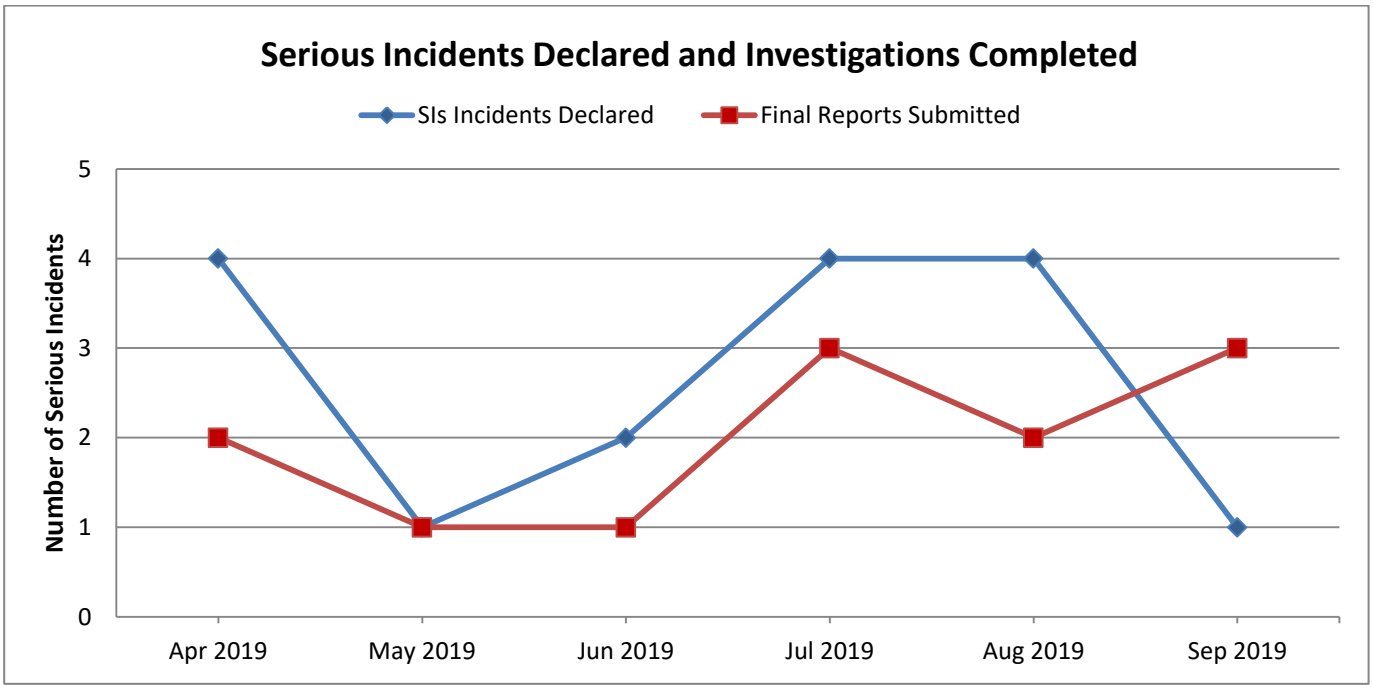


Chart 1: Serious incidents declared and investigations completed

3.3 The chart below shows the number of serious incidents declared by ICSU each month between 1st April 2019 and 30th September 2019.

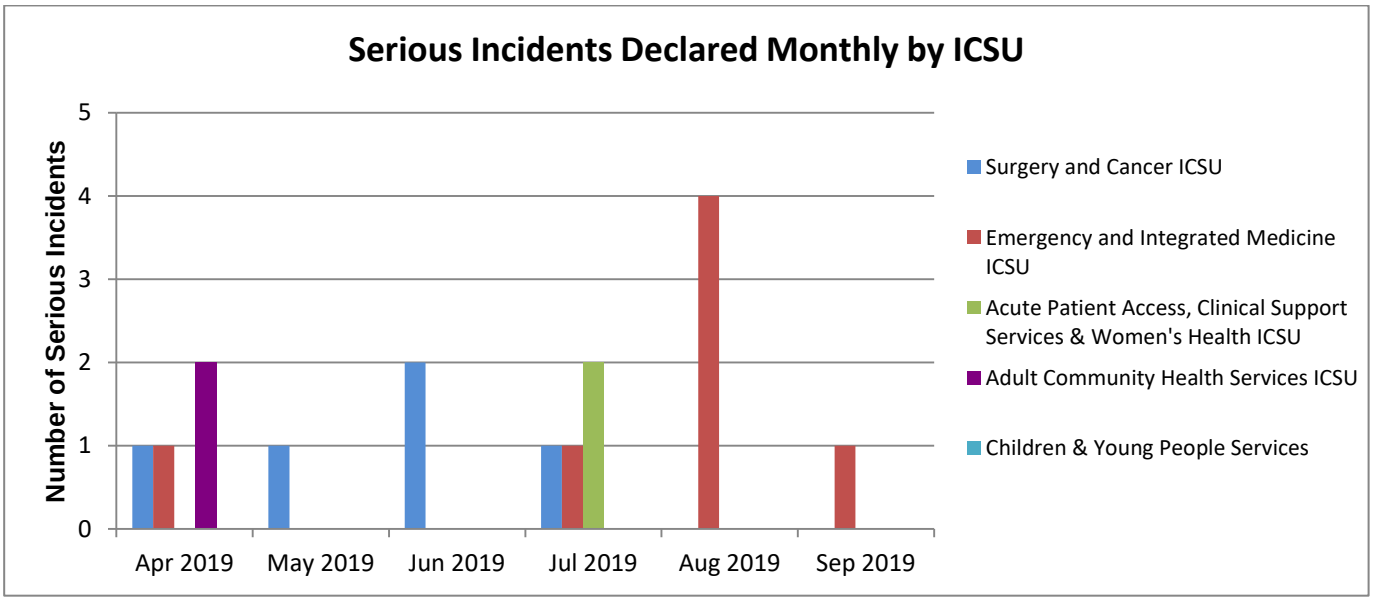


Chart 2: Serious incidents declared by ICSU

3.4 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) Associate Directors of Nursing or representatives 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.

4. Duty of Candour

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

5. Shared learning from reports submitted to NELCSU during September 2019.

5.1 Lessons learnt following the investigation are shared with all staff and departments involved in the patient's care through various means including the trust wide Spotlight on Safety Newsletter, 'Big 4' in theatres, 'message of the week' in Maternity and EIM, and '10@10' in the Emergency Department. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

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

5.3 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.

5.4 Learning from Never Events: 2019.12735 and 2019.12724 (Wrong implant/ prosthesis)

This incident was identified as part of a systematic review following the National Patient Safety Alert NHS/PSA/D/2019/001. A review was carried out of all diaphyseal fractures carried out at Whittington Health where fixation plates had been used. This involved reviewing over 1,000 x-rays relating to over 287 cases. As a result of this review two cases were noted where unintended fixation plates were used. No additional procedures were required in either of the instances identified, and both patients' injuries healed successfully.

- Case 1. A patient had a reconstruction plate fitted instead of a dynamic compression plate (DCP) whilst undergoing surgery in January 2019 for a forearm fracture following a traumatic injury. Healing has been good and no further intervention is required.
- Case 2. A patient underwent surgery in March 2018 after a fall at home causing a forearm fracture. A reconstruction plate was fitted instead of a DCP. Healing has been good and no further intervention is needed.

The investigation identified visual similarity between dynamic compression plates and a reconstruction plate. Trust and National practice at the time was to use an instrument set tray where multiple plates and screws are contained on the same tray, this carries an inherent risk of human error in using an unintended fixation plate. The findings were in keeping with the risks identified by the Patient Safety Alert and the Trust has implemented the recommendation changes accordingly. Learning from this incident has been shared across the Trust.

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

- The instrument trays used at the time of the incident included 8 different types of fixation plates. Reconstruction plates have now been removed from the trays where dynamic compression plates and other implants are included. They are now stored separately and are clearly labelled to mitigate the risk of unintentional use.
- A prosthesis verification policy is being updated as part of the trustwide LocSSIP review.
- Training on fixation plates has been re-established for all doctors in training. Knowledge of the plates is being extended to the wider orthopaedics theatre team, to allow team members to identify the equipment used effectively. Theatre staff have attended refresher training which was provided by the supplier of the fixation plates.
- The Trust Local Safety Standards for Invasive Procedures (LocSSIPs), the templates used as guidance by staff to improve patient safety during interventional procedures, are being reviewed and updated, including the orthopaedic checklists to ensure that future risks regarding the use of equipment in surgical procedures is mitigated.
- Patient prosthesis review meetings are now being held on a weekly basis to review all postsurgical x-rays to ensure the intended and actual use of equipment/hardware has been used during surgery.

5.4 Learning from SI 2019.8646 - A patient attended the Emergency Department presenting with mental health problems, the patient became agitated and assaulted a number of staff.

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

- The Nurse in Charge has been provided with a panic button and will carry this on their person at all times, this will assist in alerting security as soon as an incident occurs.
- A reception standard operating procedure has been developed and shared with reception staff which includes instructions on how to search to ensure a patient does not have a duplicate record on Medway (*the Trust patient electronic information system).*
- A radio connected to security has been placed in the major's areas for extra safety and all staff have been trained on the radio usage.
- A review of material provided in induction for all new doctors and temporary nursing staff which includes presentations that would require referral to security and the method of how to contact them.
- A sign STAFF ONLY has now been placed at the staff station with barn doors so that it is highly visible.

6. Recommendation

6.1 The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.

Meeting title	Trust Board – public meeting	**Date: 30.10.2019**
Report title	Quality Assurance and Compliance summary report	**Agenda item: 8**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals	
Report author	Kat Nolan-Cullen, Compliance and Quality Improvement Manager	
Executive summary	The Trust Board is presented with an update covering: • Compliance with Care Quality Commission (CWC) inspection 2017 recommendations • An update on CQC inspection 2019/20 Good to Outstanding progress and preparation meetings and activity • Quality Account priority updates • Other assurance / external peer reviews	
Purpose:	This paper is to provide the Board with: • an update on actions taken following recommendations made from previous CQC inspections; and • assurance that there is appropriate attention and preparation ahead of any announced inspection.	
Recommendation(s)	Board members are asked to review the work undertaken to monitor areas of actions identified in previous inspections and external reviews.	
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	Report presented to Quality Committee 11/09/2019	
Appendices	None	

Quality assurance and compliance summary report

1 Introduction

1.1 This report provides a summary of regulatory assurance the Trust provides to Care Quality Commission (CQC) and other regulatory bodies. The report gives a summary of updates following the last inspection and preparation for the forthcoming inspection (to take place over the next two to three months).

1.2 The Trust is registered with the CQC without any conditions. The CQC's last targeted inspection of the organisation took place in October 2017 and was published in February 2018. The overall rating for the organisation is 'Good' with outstanding rating for caring. The trust is taking steps to prepare for the next targeted inspection which we expect to be undertaken in 2019 to ensure a 'business as usual' approach, and minimise disruption to services.

1.3 This report is divided into five sections which provide updates in relation to the following areas:

- Compliance with Care Quality Commission inspection 2017 recommendations
- Update on CQC inspection 2019/20
- Good to Outstanding progress and preparation meetings and activity
- Quality Account priority updates
- Other assurance / external peer reviews

2 CQC improvement plan 2017/18

2.1 There were 34 recommended improvement actions from the CQC following the last inspection (published in February 2018). There are four actions which are currently monitored to ensure sustainability and the rest are closed. It is important to note that the immediate concerns raised by the inspection team have been responded to and addressed within the required timeframe.

2.2 The actions that are monitored relate to the following:

- The trust should ensure staff meet the trust's target for staff completing mandatory and safeguarding training
- The trust should ensure staff meet the trust's target for staff appraisals
- The trust should ensure that the national referral to treatment times are met for children and young people community health services

2.3 Following internal self-assessments against the CQC key lines of enquiry and service peer reviews there are a number of actions identified of emerging issues and these are being addressed accordingly and reviewed at the Trust's CQC steering group meetings.

3 Next inspection

3.1 The Trust's CQC relationship manager met with the Chief Nurse in October 2019 and outlined the CQC's risk-based methodology for inspections. The Trust can expect an inspection within the next three months and it is likely to be a targeted inspection, similar to that of 2017 rather than the full inspection of

2015. If the CQC inspect four or less core services the visit will be unannounced, but if the CQC plan to inspect five or more core services then we will be notified approximately 4-5 weeks in advance.

3.2 As part of the CQC inspection process, every trust is asked to complete a Provider Information Request (PIR), which is usually received twelve weeks ahead of the inspection. The Trust received the PIR on 6 September and returned the information by the deadline of 27 September.

3.3 We have been notified by NHS Improvement that our use of resources inspection will be undertaken the week commencing 11 November 2019. The CQC have indicated that the well-led element of our core service inspection will take place after the core service inspection, most likely in early 2020.

4 Improvement work – CQC 'Good to Outstanding' preparation

4.1 The trust wide CQC steering group meets monthly with representation from each Integrated Care Service Unit (ICSU), estates, finance, human resources, corporate and communications teams.

4.2 All 'core services', as defined by the CQC, have completed self-assessments of their services as part of the PIR process which are being used as a baseline for improvement work. This is led and monitored by the ICSU senior management teams. Action plans developed to address areas of concern highlighted. The self-assessments and supporting action plans are reviewed at ICSU quality boards and the steering group to help form the well-led evidence base, as well as support ICSUs with preparation. Revised self-assessments are expected by the end of the month.

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

4.4 A Chief Executive briefing was circulated to staff via email in September 2019. The CQC handy booklet for staff has also been agreed and is in the process of printing. This will be distributed across the Trust to all staff with the October payslips; it includes key information for staff to help prepare for an inspection. There will also be a focus on driving a culture of ownership, and what 'you' as an individual can do to improve care for the patient rather than 'the trust'.

4.5 Our Quality Assurance service peer reviews entitled '**Next Steps to Outstanding'** continue across the Trust. The quality governance team have developed a suite of reports to streamline the process and, ensure we are reviewing the all areas against the 5 Key domains of the CQC. Safe, Effective, Caring and Well Led. Following the peer review, ward managers, matrons and associate directors of Nursing/Midwifery (ADONs) are provided with feedback and targeted improvement actions that will help to bring the ward or department up to outstanding when addressed. The trust quality governance team are providing support required in order to overcome barriers the may prevent the action from being completed.

4.6 The trust runs a peer review programme, led by the Compliance and Quality Improvement manager. Peer reviews are based on the CQC Key Lines of Enquiry but do not include a grading, focusing instead on the steps to take to become outstanding. Peer review teams are made up of staff, as well as patient representatives, Health Watch and our commissioner colleagues. On the 11th October 2019 we conducted our Trust wide Quality Review Day with representatives from the Trust, NMUH, and Islington CCG. On the day, we reviewed 16 areas across the hospital and community sites. A thematic analysis of the findings is being undertaken and targeted feedback will be provided to the service areas reviewed.

4.7 Targeted walk rounds with Estates and Facilities have continued to look at the décor and general upkeep of the Trust remedial or urgent maintenance work. Prioritisation of this work is through agreement with the ICSU and quality governance team on whether the work is overdue maintenance work or specifically considered as CQC improvement work. All CQC related works are reported to the Estates and Facilities helpdesk with the prefix of CQC so that these works are prioritised as urgent.

4.8 A 'Dump the Junk' week is held at regular intervals across the community and hospital to clear clinical and office areas of broken furniture and equipment.

5 Quality Account priorities 2019/20

5.1 The Trust has set thirty nine quality account priorities (three domains Patient Safety, Patient Experience and Clinical Effectiveness).

5.2 Quarter one feedback has been positive with twenty five of the priorities achieved. Monitoring of performance takes place at the Quality Committee.

5.3 *Successes include:*

- Reducing readmissions within 28 days (recognised as 2nd best Trust in the London region)
- Raising the profile of clinical research
- All of the Stepping Stones graduates from last year have been offered follow-on support in regards to coaching or shadowing opportunities. This offer was in direct response to last year's staff survey question relating to white and BME confidence in career development opportunities. In quarter one seven of the cohort are receiving coaching support and six staff have been offered shadowing opportunities in finance, patient access, research, programme management office and patient experience teams.
- The reverse mentoring program has a new cohort booked to start and a waiting list of staff who want to participate
- There has been an increase in the Friends and Family Test (FFT) patient feedback completion rate in the Emergency Department (ED)
- The Volunteer Strategy approved at Trust Board in September 19 and progress already seen in developing volunteer roles, as per the year one action plan

5.4 *Concerns Include:*

- Whilst there is good progress in patients giving feedback on their care received in ED, the rate of patients recommending treatment in ED has fallen
- There is ongoing work to sustain the compliance with the STOPfalls assessment bundle in the hospital with some wards achieving consistently high compliance and other areas requiring more focused work to improve. Training and compliance is being assessed monthly by the falls and quality governance teams. Problem areas and successes are highlighted to matrons and ward managers post audit, so that compliance can be improved.

6 Other assurance/external peer reviews

6.1 An assurance peer review visit of the Children and Young People Haemoglobinopathy service took place in July 2019. Feedback from the review is awaited from the Haemoglobinopathy service and further information will be provided in the next report.

6.2 The Joint Advisory Group on Gastroenterology Endoscopy (JAG) Accreditation Assessment Review was undertaken on 29/08/2019. Formal reaccreditation was deferred for six months with feedback received on key recommendations for the Trust to complete. The Trust is confident that the keys issues will be addressed in this time and accreditation will be awarded.

7 Recommendations

7.1 Board members are asked to review the work undertaken to monitor areas of actions identified in previous inspections and external reviews.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Guardian of Safe Working Hours Report Q2 2019/20**	**Agenda item: 9**
Executive director lead	Dr Clare Dollery, Medical Director	
Report author	Dr Rebecca Sullivan, Guardian of Safe Working Hours (GoSW)	
Executive summary	Nationally there is a steady increase in exception reporting the number at Whittington Health has reduced to 52 this quarter which is significantly down this quarter compared to Q2 2018/19 (106 reports) and the prior quarter of 2019/20(164).The possible reasons for this are discussed. Most exception reports continue to occurring within the Emergency and Integrated Medicine ICSU. This is as expected as it has the highest number of trainees and the largest proportion of inpatient work. Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against. The GoSW hours is taking a number of steps outlined below to support integrated clinical service units to address the underlying reasons for exception reports being required.	
Purpose:	To provide assurance to the board that junior doctors are working safe hours in accordance with the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.	
Recommendation(s)	The Board is asked to review the quarter two report from the Guardian of Safer Working Hours.	
Risk Register or Board Assurance Framework	Quality 1 and People 1	
Report history	Not applicable	
Appendices	None	

Guardian of Safe Working Hours Report Q2 2019-20

1 Introduction

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

2 High level data

Number of doctors / dentists in training (total):	221
Number of doctors / dentists in training on 2016 TCS (total):	221
Job planned time for guardian:	1 PA
Admin support provided to the guardian (if any):	None *
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

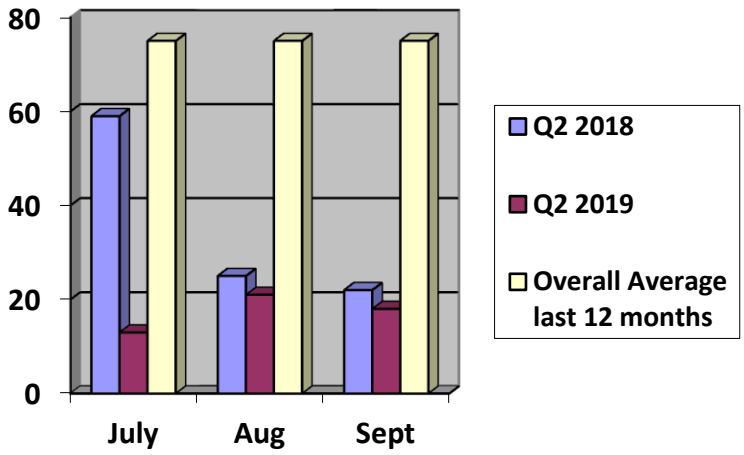
*To be discussed with the Medical Director

3 Exception reports (with regard to working hours)

Between 1st July 2019 and 30th Sept 2019 a total of 52 exception reports have been raised. The tables below give detail on where exceptions have been raised and the response times to deal with the issue raised.

		July	Aug	Sept	Total
Reports	Grand Total	13	21	18	52
	Closed	12	17	15	44
	Open	1	4	3	8
Individual doctors / specialties reporting	Doctors	6	12	12	-
	Specialties	2	2	3	-
Immediate concern		2	1	0	3
Nature of exception	Hours & Rest	12	21	18	51
	Education/Training	1	0	0	1
Additional hours	Total hours	18.75	28.5	43.5	90.75
Response	Agreed	12	17	15	44
	Not Agreed	0	0	0	0
Agreed Action *('No action required' is the only response available for 'education' exception reports)*	Time off in lieu	2	2	4	8
	Payment for additional hours	10	13	10	33
	No action required	0	2	1	4
	Other/Pending	1	4	3	3
Grade	Foundation year 1	10	14	15	39
	Foundation year 2	0	0	0	0
	Specialty registrar	1	1	0	2
	General practice specialty registrar	0	0	0	0
	Core medical training	2	6	3	11
Exception type *(more than one type of exception can be submitted per exception report)*	Acute medical event	4	12	5	21
	Pt/Dr ratio too high	9	7	9	25
	Prolonged ward round	0	2	1	3
	Other e.g.IT issues or unclear	0	2	3	5
	Educational	1	0	0	1
Specialty	General Medicine	12	17	14	43
	General Surgery	0	4	3	7
	Paediatrics	0	0	1	1
	Anaesthetics/ITU	1	0	0	1
	Radiology	0	0	0	0
	Psychiatry	0	0	0	0
	Obstetrics and gynaecology	0	0	0	0
	Accident and emergency	0	0	0	0
	Histopathology and micro	0	0	0	0
	Ophthalmology	0	0	0	0

Exceptions by Months



The number of exception reports submitted per month is very variable throughout the year. As might be expected there are more reports in the winter months and less in the summer months when the wards are slightly less busy. When reviewed year on year there are increasing numbers of exception reports although this quarter there have been fewer that might have been predicted. This in keeping with an increasingly supportive culture with regards to exception reporting alongside the ongoing work of the GoSW and ES in trying to encourage trainee doctors to handover work at the end of the shift and to work to their scheduled hours. Junior doctors have recently reported that they had previously felt that the reports went unread and un-actioned but since payments have started to be processed that they now feel that this is an increasingly robust process by which to report exceptions to their contracted working hours. This has led to much richer information being entered onto the system which also helps in reviewing the underlying issues within different areas.

Given that the vast majority of exception reporting is still undertaken by FY1's Q2 reflects the months at the end of their first year of training. It is therefore unsurprising that there was less reporting in July when they are at their most efficient. It is unclear why there was such a high level of reporting in July 2018. This quarter also co-insides with a slight reduction in inpatient work that is seen in summer. It is also to be expected that when the new trainees start in August that they would not usually report in their first couple of weeks as they are finding their feet. This may explain why reporting in quarter 2 is markedly lower than the average across the year.

Immediate safety concerns

There have been 3 immediate safety concerns raised in Q2. One was accidentally recorded. One was raised due to concerns over lack of senior support in the intensive care unit. This was raised as a training issue and continues to be reviewed by the DME. This occurred due to gaps in the ITU rota which meant that the Consultant was acting down. The remaining incident related to a trainee who was working the last weekday of his rotation with a lot of work that needed to be finished before he rotated on. This co-insided with the need to place a number of medical patients as outliers on a surgical ward. There is no "outlier" medical team for 6 months of the year and therefore a team has to be allocated to care for those patients as the situation arises. This has been widely discussed in the ICSU and an interim agreement was made with the respiratory team but a more permanent arrangement is needed. This led to the junior staying late for a number of hours. He was also working the weekend on-call. Although this was not an "immediate safety concern" relating to his working hours it was addressed immediately to ensure he was safe to

continue to work the rest of the weekend. In the longer term work needs to continue to address the issue of lack of medical cover for medical outlying patients.

Work schedule reviews
No Formal Work Schedule Reviews took place during this period. The GoSW is however continuing to work with the acute medical teams to try to address the rota issues occurring with the psychiatry juniors who work one day a week to cover the medical admissions units. Due to variation between the working hours of the psychiatry FY and the other FY1's on the medical admissions unit it frequently leads to the psychiatry junior staying late with the rest of the team to finish the work on a Friday afternoon in preparation for the weekend. We are looking at ways to address this.

4 Establishment and Vacancy data:

I. Bank and Agency usage

The table below shows the agency usage across specialities for the period of July-September 2019.

Speciality	Current Agency use – shifts put out to locum agency. July-Sept 2019
General Medicine	185 shifts put out to agency • 80 % filled as internal bank • 17 % filled by agency • 3 % filled by external bank
General Surgery	Gen Surgery 137 shifts put out to agency • 72% Covered by bank • 28% covered by agency Trauma and orthopaedics (T&O) 34 shifts put out to agency • 100% covered by bank Urology 39 shifts put out to agency • 100 % covered by bank
Obstetrics and Gynaecology	64 shifts put out to agency • 61% covered by bank • 39% covered by agency
Paediatrics	63 shifts put out to agency • Covered by external bank or agency

II. Locum work carried out by trainees

The table below shows the Additional work carried out by our own trainees across specialists for the period of July -September 2019.

Speciality	Additional shifts worked by trainees
General Medicine	148 additional shifts 898.5 additional hours worked
General Surgery	Gen Surgery

Speciality	Additional shifts worked by trainees
	137 additional shifts 1346 additional hours worked T&O 34 additional shifts 280 additional hours worked Urology 39 additional shifts 659 additional hours worked
Obstetrics and Gynaecology	39 additional shifts 373 additional hours worked
Paediatrics	63 additional shifts 683.5 additional hours worked

III. Vacancies

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

Speciality	Current vacancies
General Medicine	2 SHO vacant (WTE) 1 SHO vacant (WTE) 15/07/19-06/08/19 1 Less than full time 0.8 – 20% vacancy
General Surgery	1 FY1 vacant due to maternity leave 1 SpR vacant – unfilled (WTE) 1 SpR vacant due to sick leave
Obstetrics and Gynaecology	4 trainees are Less than full time (LTFT) at SpR grade Less than full time 0.8 – 20% vacancy Less than full time 0.6 – 40% vacancy Less than full time 0.8 – 20% vacancy Less than full time 0.6 – 40% vacancy 2 Early terminations of contract end 31st Aug – one month's vacancy unfilled until Oct 2x SHO vacant (WTE) 1 Less than full time 0.7 – 30% vacancy (also not covering any on-calls)
Paediatrics	1 SpR WTE vacant due to long term sick 1 SpR less than full time 0.6 – 40% vacancy 1 SHO less than full time 0.6 – 40% vacancy

5 Fines and payment

For this quarter a total of 97.25hours are to be re-paid either in TOIL or if this is not possible as pay for additional hours worked. It would not be appropriate for TOIL accrued in one specialty to be rolled over to another specialty.

Currently, these hours equate to a total of approximately £1,602.71 of which £325.73 has so far been paid to the junior doctors directly (July).

£926.46 has been issued in fines to the Trust in accordance with the terms and conditions laid out in the contract. This is to be added to pre-existing fines that have been accrued and is to be kept in a spate fund for the junior doctors. There are currently still issues with ensuring that these fines have been paid and the money is ring-fenced for the JDF.

Due to backlog payment for August and September's hours have not yet been paid to the trainees. The hours have now been put forward to payroll

Breakdown of fines by ICSU

ICSU	Amount of Fine to Doctor	Amount of Fine to Guardian
Emergency & Integrated Medicine	£401.31	£525.15
Surgery & Cancer	NIL	NIL
Children & Young People	NIL	NIL

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

6 Next steps

- GoSW to ensure all unclosed ER's are signed off in a timely fashion. Ongoing work especially with surgical specialities.
- GoSW and HR teams to distribute SOP for junior doctors working hours and exception reporting.
- GoSW and HR to work with finance team to ensure junior doctors' forum fund is active and ring-fenced as per the TCS.
- Continue to work with ICSU leadership teams, rota coordinators and the bank office to try to reduce the need for exception reporting by working to fill rota gaps whenever possible.
- GoSW will work with relevant sub-specialities in order to try to address the issues relating to over-running/prolonged ward rounds.

5 Conclusions / recommendations

- Levels of reporting need to continue to be reviewed regularly to ensure the Trust does not become an outlier. The majority of exception reporting continues to be done by the more junior trainees e.g. FY1 and 2. Ongoing effort is required to promote engagement from more senior trainees.

- Most exception reports are occurring within the Emergency and integrated Medicine ICSU. This is as expected as it has the highest number of trainees and the largest proportion of inpatient work.
- Primary events leading up to exceptions are issues due to workload and times when there in very minimal staffing on the wards due to rota gaps, on-call commitments and sickness. This is very hard to mitigate against.
- Ongoing work to review how the additional anticipated work seen in the winter months can be managed. Additional staffing to be considered as in previous years.
- Concerns relating to training issues which have been highlighted via the ER mechanism continue to be addressed by the DME.
- There are still very low levels of reporting in certain specialities, e.g. anaesthetics, radiology etc. and at higher grades. Attempts are being made to increase engagement. This is a well-recognised issue nationally. GoSW continues to promote ER in these areas.
- The GoSW hours is taking a number of steps outlined above to support ICSUs to address the underlying reasons for exception reports being required.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**2019/20 Winter Plan**	**Agenda item: 10**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Emergency Planning Officer, Directors of Operations, Associate Directors of Nursing, Communications Team, Deputy Chief Operating Officer and Chief Operating Officer	
Executive summary	This paper *presents the* annual review of the Whittington Health Winter Plan in readiness for winter 2019/2020. This plan has been reviewed and approved by the Trust Management Group on 15 October.	
Purpose:	The key changes made to the existing plan are contained in all sections in relation to new information and initiatives for 2019/2020.	
Recommendation(s)	Board members are asked to review and approve the Winter Plan.	
Risk Register or Board Assurance Framework	Risk assessment seen in Appendix 1 Pg. 28	
Report history	Annual report to Trust Board and Trust Management Group	
Appendices	Winter Plan 2019/2020	

Whittington Health
NHS Trust

Winter Plan 2019/2020

Version Control	
Version 1	Trust Operations Meeting 10th October 2019
Version 2	Trust Management Group 15th October 2019
Final version	Trust Board 30th October 2019

Carol Gillen, Chief Operating Officer - October 2019

Contents

1.0 Introduction

This Winter Plan describes Whittington Health's preparedness for the winter season. Winter presents a variety of challenges that require additional consideration and planning to maintain flow and keep patients safe. This plan has been developed by engaging with the Associate Directors of Nursing, Clinical Directors, Operational Directors and the Emergency Planning Officer. The Winter Plan is a system wide approach and is focused on ensuring that internal operational functions are coordinated with support from external partners. The Winter Plan's elements include monitoring and managing patient surge; protocols for opening emergency capacity; operational initiatives; service improvement innovation; digital technology and monitoring; command and control mechanisms; integrated communication groups and work force planning.

1.1 Aims

Keep patients safe and provide high quality care during the winter months within Whittington Health. Ensure that patients are cared for by the right team in the right place.
Minimise any disruption to operational delivery.

1.2 Scope

The scope of this plan is focused on Winter Planning within Whittington Health and partner agencies. The Winter Plan will include aspects such as leadership and surge management, coordination with the A+E Delivery Board (AEDB), the improvement plan, Haringey and Islington after action review, winter capacity, key system enablers, and risks.

1.3 Objectives

- Avoid unnecessary admissions during the winter months by providing care pathways that deliver safe and efficient care
- Ensure appropriate capacity is available during the winter months
- Monitor and regularly engage with the CCGs, Islington A+E Delivery Group and NHS to provide information, identify risks, communicate plans, monitor sector wide pressures, escalate issues, and challenges to performance and operational delivery.
- Support and focus on performance management of the system to sustain, quality, delivery against plan and good patient experience.
- To clearly identify and direct resources to respond to surges and peaks in demand for services 24/7.
- Coordinate operations efficiently and effectively within and between ICSU teams.
- To maintain flow and optimise safe discharge within the ICO.
- Provide timely communication to all stakeholders.

2.0 Review of Winter 2018/19

2.1 Stakeholders After Action Review for Haringey and Islington

On the 6th of June 2019, the Islington CCG conducted an after actions review with key stakeholders which were engaged in winter planning for 2018/2019. Whittington Health NHS Trust has been working closely in strong partnership with Islington A+ E delivery board in the planning, preparation and delivery of winter initiatives. There is evidence to suggest that the A+E Delivery Board partners have worked side by side to deliver the 2018/2019 Winter Plan. There is an opportunity to enhance integrated working by shadowing across the system, sharing knowledge on pressure points and further developing the coordination between A+E front of house and social care. Winter planning for 2018/2019 saw increased cooperation with Barnet, Enfield and Haringey.

In the review there was evidence of plan co-production within the Outflow Group. In 2019/2020 there will be further development of ways to improve communication of key messages across the sector in a simple understandable language.

There has been continued effort to improve the coordination and integration with the acute and social services sectors. Last winter there were regular teleconferences to coordinate the care of patients. The A+E delivery board will continue to improve integration with social services by delivering on the next step actions.

Systems intelligence will continue to improve with shared information across the sector in relation to capacity, nursing home placement, care home transfers and close working with sector partnerships.

2.2 Review of Winter Performance 2018/2019

Over the last year there has been an increase in presentations to hospitals within the North Central sector, however there has been increased efficiency for unloading patients from London Ambulance and reducing delays in transfers of care at Whittington Health NHS Trust.

- Attendances rose by 6.3% when comparing October to March 2018 with October to March 2019 total Emergency Department.

- Most hospitals in North Central London have seen an increase >5% in presentations when comparing 2018 to 2019.

- The number of patients triaged for ED (Majors) rose by 9.6% in 2018/2019

- Ambulance activity has remained steady increasing by 0.6%, Urgent Care Centre activity increased by 4.0% in 2019.

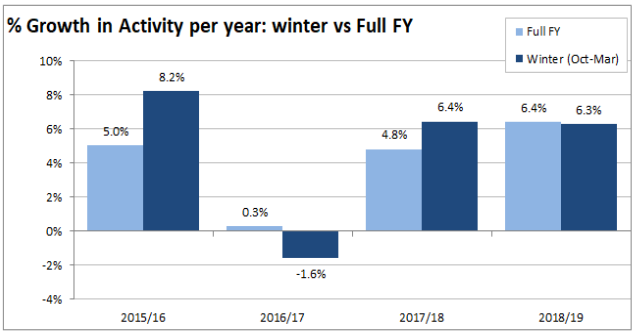
- Bed days lost to Delayed Transfers of Care decreased by 28.7% in the 2018/2019 winter period when compared to the previous year.

- Year-end performance for 4-hour wait showed decrease of 1.3% with an average of 86.7**%** during 2018/2019 winter when compared to the previous year**.**

2.3 Emergency Department Activity/4hr Target

Since 2015 there has been a 17% increase in presentations to the Emergency Department. There has been an overall increase in winter presentations to the EUC of 20% since 2015. Since 2018 to winter 2019 there has been a 6.3% increase in presentations to the Emergency Department.

Fig 1

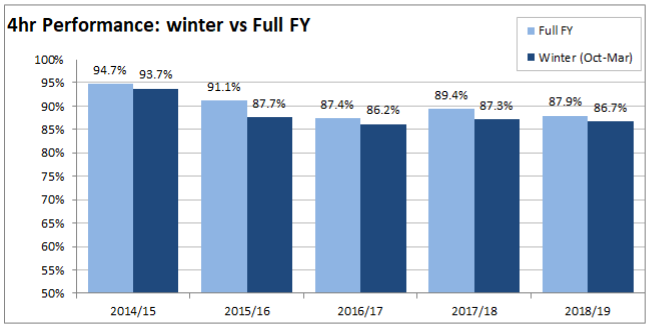


Activity		Full FY	Winter (Oct-Mar)
Activity	2014/15	92203	45997
	2015/16	96837	49766
	2016/17	97134	48987
	2017/18	101812	52143
	2018/19	108336	55415
% Change	2015/16	5.0%	8.2%
	2016/17	0.3%	-1.6%
	2017/18	4.8%	6.4%
	2018/19	6.4%	6.3%
	since 14/15	17%	20%

2.4 4hr Performance: Winter vs Full FY

The average of the 4hr target to be seen and discharged from the Emergency department has decreased by 6.8% since 2015. Last winter 2018/2019 there was a 0.6% decrease in performance of 86.7% when compared against 2017/2018.

Fig 2



4hr Performance		Full FY	Winter (Oct-Mar)
4hr %	2014/15	94.7%	93.7%
	2015/16	91.1%	87.7%
	2016/17	87.4%	86.2%
	2017/18	89.4%	87.3%
	2018/19	87.9%	86.7%
change	2015/16	-3.6%	-6.1%
	2016/17	-3.8%	-1.5%
	2017/18	2.1%	1.1%
	2018/19	-1.5%	-0.6%
	since 14/15	-6.8%	-7.0%

2.5 North London Trusts – Winter activity & Performance

All North London hospitals saw growth in attendance during last year's winter. The Homerton Hospital saw growth of 1.7%, the remaining hospitals in the sector had growth of over 5%. There was a decrease of 0.5% in performance against the 4 hour target for the Whittington Hospital. In comparison UCLH performance decreased by 3.2% against the 4hrs target.

Fig 3

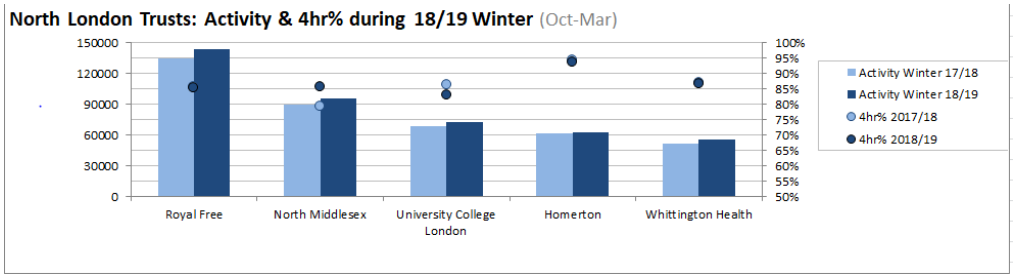
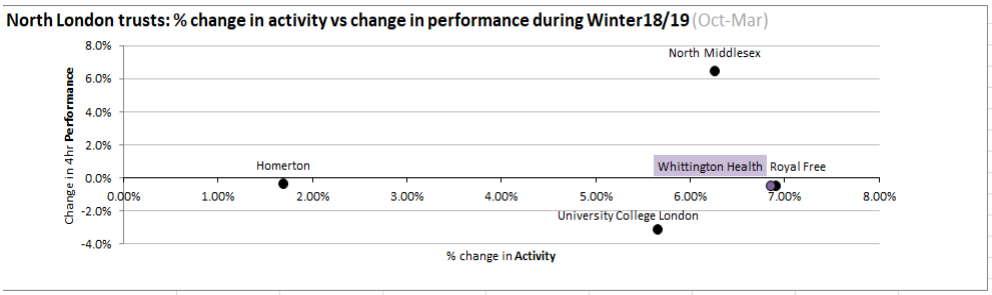


Fig 4



	2017/18			2018/19			% Change in	Change in 4hr
Name	Attendances	Breaches	4hr%	Attendances	Breaches	4hr%	Attendances	Performance
Royal Free	134835	19090	85.8%	144157	21198	85.3%	6.91%	-0.5%
North Middlesex	90069	18671	79.3%	95714	13668	85.7%	6.27%	6.4%
University College London	68927	9379	86.4%	72830	12231	83.2%	5.66%	-3.2%
Homerton	62142	3554	94.3%	63194	3851	93.9%	1.69%	-0.4%
Whittington Health	52151	6650	87.2%	55728	7439	86.7%	6.86%	-0.5%
North London Total	**408124**	**57344**	**85.95%**	**431623**	**58387**	**100.00%**	5.76%	14.0%

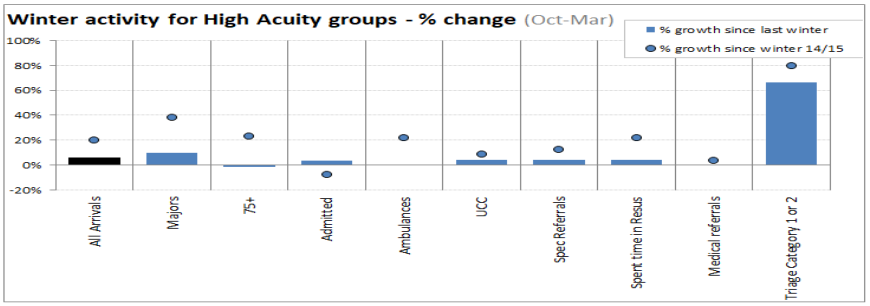
2.6 Attendance by High Acuity Patient Groups

Overall growth in activity was 6.3% in comparison to last winter.There was a 9.6% increase in patients streamed to Majors 9.6%. There was an increase of 66.5% in Triage category 1 or 2 patients in comparison with the previous winter. This may suggest an increase in the acuity of presentation.

Fig 5

Attendances by High-Acuity patient groups in Winter (Oct to Mar)

	Activity					% change				
	2014/15	2015/16	2016/17	2017/18	2018/19	2015/16	2016/17	2017/18	**2018/19**	**since 14/15**
All Arrivals	45997	49766	48987	52143	55415	8.2%	-1.6%	6.4%	**6.3%**	**20%**
Majors	18784	19710	21579	23685	25970	4.9%	9.5%	9.8%	**9.6%**	**38%**
75+	3817	4060	4406	4788	4707	6.4%	8.5%	8.7%	**-1.7%**	**23%**
Admitted	9097	7568	7651	8159	8437	-16.8%	1.1%	6.6%	**3.4%**	**-7%**
Ambulances	8870	9406	9879	10770	10831	6.0%	5.0%	9.0%	**0.6%**	**22%**
UCC	26835	29576	26774	28065	29196	10.2%	-9.5%	4.8%	**4.0%**	**9%**
Spec Referrals	9650	9894	10111	10420	10855	2.5%	2.2%	3.1%	**4.2%**	**12%**
Spent time in Resus	2299	2313	2595	2688	2803	0.6%	12.2%	3.6%	**4.3%**	**22%**
Medical referrals	3705	3778	3717	3832	3839	2.0%	-1.6%	3.1%	**0.2%**	**4%**
Triage Category 1 or 2	3528	4041	4343	3817	6357	14.5%	7.5%	-12.1%	**66.5%**	**80%**

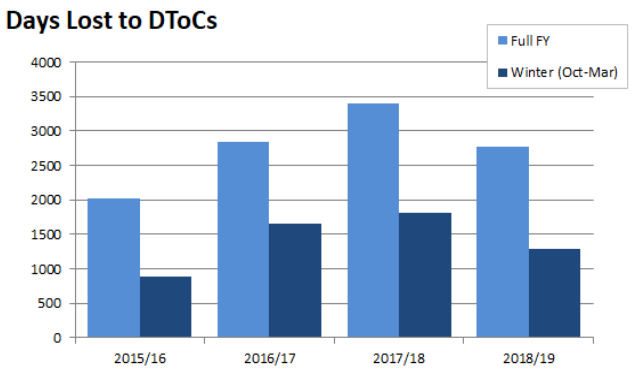


2.7 Days lost to DTOCs

The number of days lost to DTOC's, have decreased in comparison to the previous year. There was an overall reduction of 18% for the year and 28.7% for the winter months.

Fig 6

Inpatient Flow during Winter (Oct-Mar)



Days Lost to Delayed transfers of Care

		Full FY	Winter (Oct-Mar)
Count	2015/16	2021	879
	2016/17	2842	1662
	2017/18	3392	1806
	2018/19	2777	1288
% Change	2016/17	40.6%	89.1%
	2017/18	19.4%	8.7%
	2018/19	-18.1%	-28.7%
	since 15/16	37%	47%

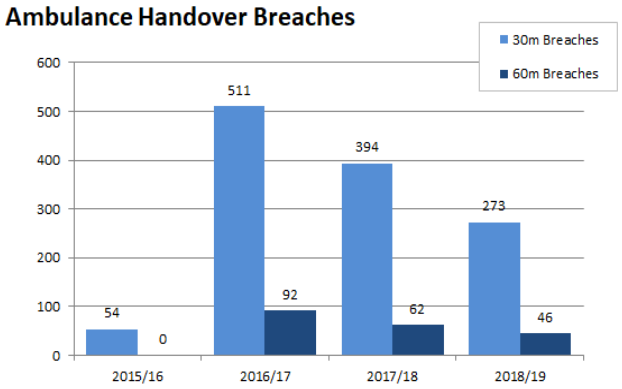
Equivalent beds occupied by DTOCs

	Full FY	Winter (Oct-Mar)
2015/16	5.5	4.8
2016/17	7.8	9.1
2017/18	9.3	9.9
2018/19	7.6	7.1

2.8 Ambulance Handover Performance

There was a significant increase in 30 minute and 60 minute ambulance breaches in 2016/2017. There has been a steady decrease in ambulance breaches, with a reduction of 30 minute breaches in 2018/2019 by 30.7% and 60 minute breaches by 25.8%.

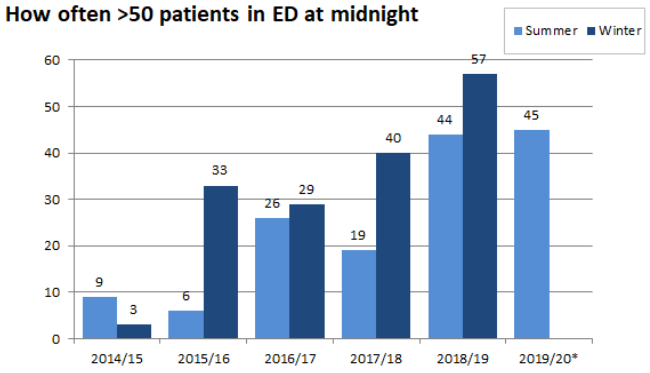
Fig 7



		30m Breaches	60m Breaches
Count	2015/16	54	0
	2016/17	511	92
	2017/18	394	62
	2018/19	273	46
% Change	2016/17	846.3%	-
	2017/18	-22.9%	-32.6%
	2018/19	-30.7%	-25.8%
	since 15/16	406%	-

2.9 Increased Numbers of Patients in the EUC at Midnight

Fig 8



		Summer	Winter
Count	2014/15	9	3
	2015/16	6	33
	2016/17	26	29
	2017/18	19	40
	2018/19	44	57
	2019/20*	45	
% Change	2015/16	-33.3%	1000.0%
	2016/17	333.3%	-12.1%
	2017/18	-26.9%	37.9%
	2018/19	131.6%	42.5%
	18/19 vs 14/15	389%	1800%

*Summer Data is complete to end of August 2019

The frequency of patient numbers greater than (n) 50 has increased from (n) 40 occurrences in 2017/2018 to (n) 57 occurrences in 2018/2019 showing a 42.4% increase. There has been a significant increase of 131.6% in presentations after midnight in summer 2018/2019 compared to the previous year.

3.0 Winter Preparation 19/20

In developing our overarching winter plans, Local A&E Delivery Boards were asked to focus on the following:

- Demand and capacity
- Workforce
- Emergency Department flow, streaming and redirection
- LAS Handover
- Same Day Emergency Care (SDEC) and frailty
- Mental health improvements and reduction in breaches
- Effective discharge processes

3.1 Capacity

The trust bed capacity for Winter 2019/20

Fig 9

AAU (Mary Seacole N&S)	Acute Medicine	34	Acute Physicians	Dr Ip	Will be managed as an single unit
Nightingale	Respiratory	21	Respiratory Physicians	Dr Lock	
Montuschi	Cardiology	16	Cardiology Physicians	Dr Brull	
Victoria	Haematology Gastroenterology + General Medicine 'Step down'	16	Haematologists Gastroenterology	Dr Davis Dr Lerman	
COOP unit (Incorporating Cloudsley, Meyrick, and Cavell)	Care of Older People	6 with flex capacity to 74	COOP Physicians	Dr Law	Will be managed as an integrated unit
Coyle	Surgery	24			Medical outliers will be managed by the Endocrine team
Mercers	Surgery	16			Medical outliers will be managed by the Respiratory team
Thorogood	Surgery	10			

In order to manage within the core bed capacity during the winter period of 2019 / 2020 the Trust aims to support a rotating discharge team made up of appropriate and relevant professionals including Medical, Therapy and Pharmacy staff. The aim of this is to target support to identified patients in order to facilitate flow and discharge.

3.2 Full Capacity Protocol Update (EMERGO)

Training sessions started in October and will be continuing in November.

Number	Exercise Type	Date, Time and Venue
1	Winter Pressures Exercise	1st October, 9-11am, Library Room
2	Winter Pressures Exercise	16th October, 3-5pm, WEC 13
3	Winter Pressures Exercise	6th November, 9-10:45am, WEC 12
4	Winter Pressures Exercise	11th November, 1-3pm, WEC12

The Escalation and Full Capacity Protocol is designed to facilitate command and control functions within the Emergency Department and Urgent Care Centre (EUC) to ensure delivery of high quality care in a safe environment for all patients. It stipulates the process for monitoring operational performance within the EUC. The monitoring of operations by key personnel within a command structure will trigger actions to be considered and applied when there is increased service demand that is over and above that expected *(i.e. crowding in the department).*This may be driven by patient number or acuity or a mixture of both.

The demand for service will be quantified within specific escalation ranges. The escalation ranges are Green, Amber, Red and Black. In the event of overcrowding in ED there are **11 Plus One Beds** that can be opened under exceptional circumstances, to maintain patient safety. The process for using the 11 Plus One Beds is outlined within the Full Capacity Protocol. The process for triggering the additional 15 beds in the Care of Older Persons wards will communicated and tested in the training session.

In the event of a significant patient surge in winter triggering OPEL Level 3, Associate Directors of Nursing will be able to open 11 Plus One Beds to reduce overcrowding in the ED

The Plus One beds are located in the following areas:

Location	Number of Beds
Mary Seacole North	1 Bed
Mercers and Nightingale**	(1 Bed each bay = 4 Beds) HDU excluded opening
Meyrick staff room	1 Bed
Cavell day room	1 Bed
Coyle staff room	1 Bed
Monthuschi day room	1 Bed
Victoria	1 Bed
Cloudesley	1 Bed

In the event of ED triggering RED in the operational escalation levels, staffs have been trained to establish an Incident Coordination Team in hours, with the aim of system wide response to reducing overcrowding within the EUC. The Director of Operations for EIM will task Associate Directors of Nursing, Directors of Operations and Clinical Directors to lead the response and implement actions from the Full Capacity Protocol in their respective areas.

3.3 Community Winter Resilience Response

During this winter there will be additional contingency in place for community providers to enhance flow throughout the system. The community and system will have Operational Pressure Escalation Levels in place. Within the system and community there will be triggers for OPELs (Operational Escalation Levels 1-4). OPEL levels will specify what actions are required to focus on delivering safe and timely dis charge into the community. Key community members will be integrated into the winter escalation communication system, which will provide contemporaneous alerts. The alerts will notify community staff of OPEL Levels which will be the impetus to initialise the actions required on each level. There will continue to be resilience workshops and simulation exercises to test Operational Escalation in the lead up to winter for community providers.

3.4 Front door improvements – (Emergency Department Streaming and Rapid Assessment and Treatment Model (RAT)

An enhanced streaming model is in place led by the lead ENPs. The pathway allows for a quick assessment of every patient (0800 – 2000) by a senior nurse with the aim to ensure they are streamed to the most appropriate treatment area (UCC, AEC, Primary Care, RAT). This creates flow within the department allowing for the timely treatment of patients and an enhanced patient experience.

Medical led RAT – Patients who arrive by ambulance have access to a Doctor on arrival between the hours of 1100 and 1700. This allows for increased streaming to Ambulatory care, timely initiation of the frailty pathway and timely initiation of any necessary diagnostic tests and treatments. An occupational therapist is part of this MDT to provide holistic care at the front door.

There is increased capacity of GPs in the UCC in the evenings in order to meet the demand on primary care services.

Increased capacity in the Ambulatory Care unit at a weekend has been identified for the winter period. This is to allow for increased streaming to AEC over the weekends creating more flow throughout the department.

Plans to reduce barriers and differences in service provision in the Virtual Ward and rapid Response teams across Islington and Haringey are in place to maximise attendance and admission avoidance and facilitated discharge meaning patients can remain in their own home and receive the necessary treatment, where clinically appropriate.

3.5 Emergency Medical Unit (EMU)

In order to reflect the new role of CDU the new name is EMU (Emergency Medical Unit).

The Emergency Medical Unit (EMU) is a short stay ambulatory majors unit located in the Emergency Department (ED) at Whittington Health. It consists of 12 chairs and one assessment room. The EMU is open 24 hours a day, 365 days a year. The purpose of the EMU is to provide better continuity of care for medically appropriate adult patients attending the Emergency Department who need a period of observation, further investigation or treatment, but who are likely to go home within 8 hours.

The unit is staffed by a multidisciplinary team (MDT) consisting of a supervising Consultant in Emergency Medicine (EM), an EM registrar (ST4 and above), an EM junior doctor (Foundation year 2-3) or Advanced Nurse Practitioner, two ED nurses (band 5 and 6) or one band 6 nurse and an Emergency Department Assistant (EDA) or Nursing Associate (NA). Staffing will vary based on the time of day and on the demand in the EMU and in other areas of the ED.

The aim is to provide high quality, evidence-based care for this group of short stay patients, and complement both the ED and Ambulatory Care (AEC) to deliver same day emergency care to our patients.

Changes have been made to the CDU in order to make it a more functional and useful space to care for patients who are likely to go home but who need a short period (up to 8 hours) of observation, investigation or treatment. The patients using the EMU will be identified at the front door. Use of this space will also be for an **additional area for assessment**. This will help improve flow and reduce overcrowding in non-clinical spaces around the desk in Majors. This area will be a new area for patients who are "**fit to sit**".

Beds have been replaced with reclining chairs and updated pathways to a **shorter maximum length of stay of 8 hours.** This area will be ring-fenced for appropriate patients to ensure that there is space to see these patients. The Trust are in the process of ensuring there are alternative plans for patients for whom this area is no longer suitable - as there are no longer beds in this space. For those patient requiring in-patient care will need to be referred on to specialty teams for admission to the wards.

3.6 Acute Frailty

The Acute frailty pathway is in place and is currently being embedded into normal practice. The pathway consists of patients being given a Rockwood score at Triage, being assessed with a 'home first' approach and then moved to Ambulatory Care (AEC) if not for clear admission. In AEC the patients are reviewed by a MDT with the aim to avoid an admission and put in place appropriate care plans for the patient to remain at home where clinically appropriate. The frailty consultant started on the 6th October 2019 which will enhance the support for frailty at the front of house.

3.7 Occupational therapy at front of house

ED has access to the START team who assess patients with frailty and other therapy needs in the department with a '**Home First'** attitude with the aim to avoid admission.

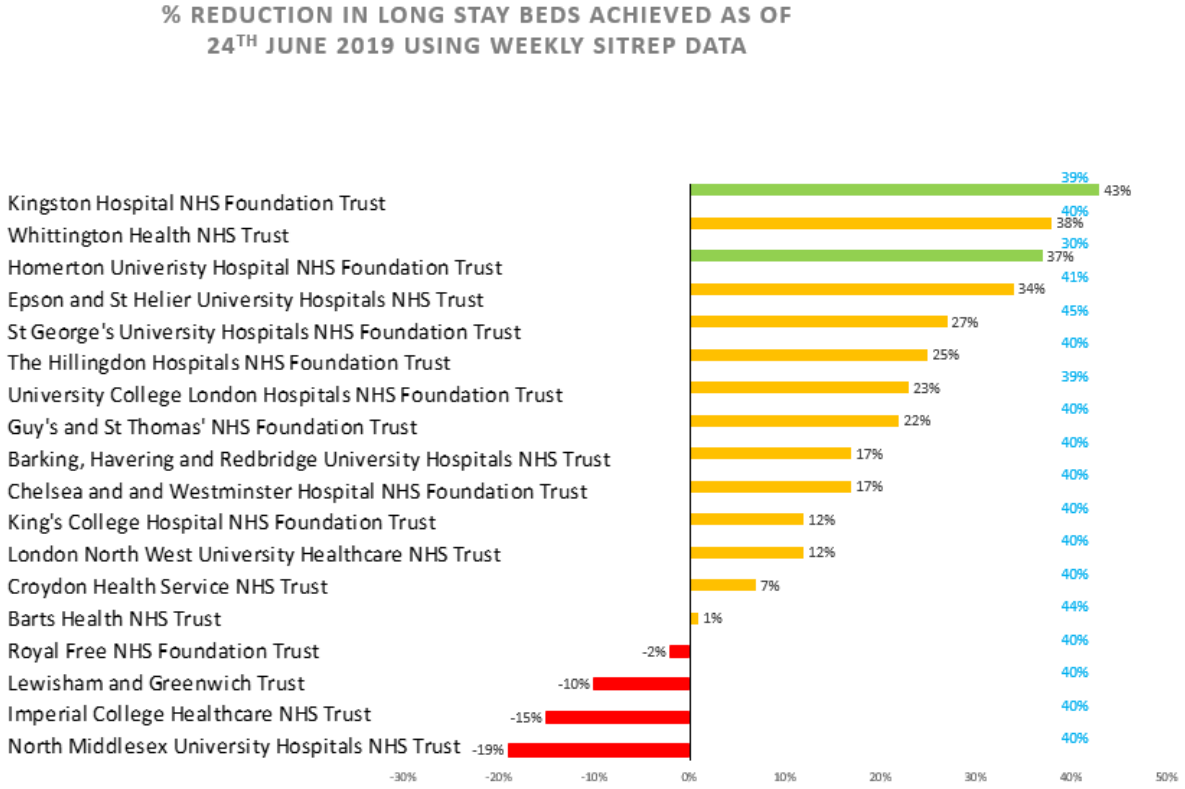
3.8 MADE and Whittington Flow

The Trust has been using Multi Agency Discharge Events (MADE) since December 2017. The aim of the MADE is to review “Stranded patients” (including delayed transfers of care (DTOC) to understand what the plan is and “what is the next thing that these patients are waiting for on the day of review”. The review captures both qualitative and quantitative information on the reasons for the wait, with a report compiled from all the material gathered, and should aim to:

- Understand why patients are in hospital for seven days or more
- Identify themes, where possible
- Identify patient characteristics so patient groups can be identified early
- Identify areas of good practice
- Identify areas requiring focus where there is the opportunity for improvement
- Meeting-less Mondays, No tolerance for delays, enhanced escalation
- Long Stay Tuesdays, 14+ ward based length of stay reviews
- Ward Focus Wednesdays, Progress reviews on wards
- Follow up Thursdays, Update Long Stay Tuesday patient cases
- Friday Forecasts, Planning weekend discharge picture
- Weekend Grip, Continue flow over weekend

3.9 Length of Stay Reduction

The Trust has an ambition to reduce the number of beds occupied by patients in hospital for 21 days or more. Last validated data (June 2019) shows that the trust is 2% away from achieving its required standard of 40%. The Trust is progressing at a relatively fast pace towards the ambition compared to other trusts in London.



3.10 Flow Co-ordinators

Using best practice the Trust has now fully embedded a team of Flow Co-coordinators (FLOW)s to work between key wards and the clinical site team using NHSI methodology for managing flow by identifying delays using fit and not fit codes. This approach helps the FLO(W) team identify factors contributing to reduced movement; proactively troubleshoot and remove blockages; and to provide appropriate information and escalation to enable clinical and operational teams to deliver safe and timely discharge and admissions. These posts are the main part of the discharge planning team and support the overall patient flow function. The Flow Co-ordinators have a discharge checklist for each patient that is used to

identify any barriers that may impede flow. Daily reviews of patients are carried out using MADE principles and national codes to identify delays. (Appendix 4 - EDD).

The role of the Flow Co-ordinator is to:-

- Escalate delays with DTOC's and MO's to key stakeholders.
- Escalate delay issues and actions to partners internal and external to Whittington Health.
- Participate and support discharge planning processes.
- Establish daily and next day lists of patients to be discharged.
- Communicate with Site Practitioners when beds become available in wards.
- Highlight patients whom have a length of stay over 7 days
- Highlight patients whom have a length of stay over 2 days on the seacole wards.
- Prepare the whiteboard and attend the board round
- Establish situation reports and continually update Medway
- Complete any urgent actions from the access sitreps meeting.

The Emergency Department (ED) are currently trailing Flow Coordinators based on the same NHSI methodology, which has been adapted to fit the needs of the ED. The focus on this work is to maintain flow throughout the department, to SDEC services, the new Emergency Medicine Unit and onto the wards where appropriate, in order to meet the 4 hour national standard. The role of the ED Flow Coordinator is:

- Monitor ED KPIs in real time
- Highlight patients where focus is needed (ie >60 minute wait for 1st assessment)
- Escalate delays early in the patients journey
- Facilitate early investigation
- Liaise with speciality teams to ensure timely specialty review
- Ensure sitreps are completed at regular times throughout the day
- Complete any urgent actions identified in the sitreps / board rounds
- Facilitate timely validation of performance
- Work with the Mental Health Team to ensure timely review of patients
- Monitor LAS handover times

3.11

(NHSI Emergency 4 hour trajectory and (STF)requirements)

In March 2019 the organisation agreed monthly trajectories for the four hour wait target with NHSI in line with the national communications from NHSE/I as below:

Month	Apr - 19	May - 19	Jun - 19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Target	90.0%	91.0%	92.0%	92.0%	93.0%	92.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Actual	84.6%	88.6%	90.1%	84.8%	82.8%	87.7%						

4.0 Adopting Best Practice

The Trust continues to use the NHS Improvement Guide to Reducing Long Hospital Stays to examine and facilitate its performance for flow.

Key areas of improvement suggested by NHS Improvement are:

- Focus on the admission pathway (assess early and short stay)
- Maximise same day emergency care
- Assertively manage frailty and tackle deconditioning
- Focus on down-stream flow
- Have processes to reduce delays
- Focus on simple discharge case manage and not over assess in hospital *(think #homefirst)*
- Work as a system – as a team of teams

The Trust continues to work on the delivery of these key areas. The Trust has implemented the Long Length of Stay Patient Tracking List (LLOS DPTL)

The DPTL gives the Trust visibility of the constraints that may be producing discharge delays and to support escalation. It is an essential building block to support delivery of the ambition in the Long-Term Plan of a 40% reduction in the number of patients in hospital for 21 days and over LOS.

4.1 Intermediate Care

Improvements in discharge planning

Refresher training including CRIB sheets will be provided to all wards over the next four weeks given the many improvements that have been progressed through the pan sector Simplified Discharge working group. This includes Discharge to Assess (D2A), Single point of access (SPA) and the Choice policy.

Information will also be refreshed on the Whittington Health intranet discharge planning page http://whittnet.whittington.nhs.uk/default.asp?c=6874 by mid/end of October and also cascaded to staff groups involved the discharge process.

Communication for patients will also be provided reflecting the above improvements and including changes to the STP agreed Choice Policy.

The available intermediate care beds for the 6 months winter period in both Haringey and Islington are outlined in this table. There are additional four convalescing beds this year for patients who need this before going home. The bed sharing agreement between Haringey and Islington will continue over the winter which ensures full utilisation of the intermediate care beds

Islington	**Beds**	**Haringey**	**Beds**
St Pancras	**21**	Bridges	**14**
St Anne's	**5**	Priscilla Wakefield (PWH)	**14**
Mildmay	**12**	Protheroe	**10**

5.0 Cold weather plan

This winter the Cold Weather Plan will be insitu. This will instruct the acute and community teams within Whittington Health NHS Trust on how to prepare, respond and recover from Cold Weather. The Cold Weather Plan identifies how the trust will escalate, communicate and coordinate mitigations during any prolonged cold weather conditions. When the Cold Weather Plan is activated it enables staff to activate business continuity arrangements, receive and cascade Met Office Notifications, comply with external reporting requirements, identify and respond to vulnerable patients and support staff to access and deliver safe quality care.

As in previous years, the Cold Weather Plan for England is also supported by a series of Information Guides published online which aim to provide an authoritative source of additional information about the effects of severe cold weather on health for:

* Making the case: why long term strategic planning for cold weather is essential to health & well being
* GP in hours bulletin
* Action Card for provider organisations
* Keep warm keep well booklet

These can be found at:

https://www.metoffice.gov.uk/public/weather/cold-weather-alert/?tab=coldWeatherAlert&season=normal#?tab=coldWeatherAlert

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561101/Keep_warm_keep_well_leaflet_2016.pdf

https://www.gov.uk/government/publications/gp-in-hours-bulletin

https://www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465111/Top_tips_to_keep_warm_keep_well.pdf

www.nice.org.uk/guidance/ng6

http://whittnet.whittington.nhs.uk/default.asp?c=6988

6.0 Workforce

6.1 District Nursing

Vacancy rates - September 2019

The District Nursing service has a rolling recruiting programme and has successfully managed to reduce their vacancy rate down to approximately 8%. The vacancy profile at team leave is shown below. The service continues to successfully recruit overseas nurses

District nursing team	Sum of establishment	Sum of vacant posts	Sum of % vacancy
Haringey Central	11.9	-1.9	-16.1%
Haringey North East	18.3	1.3	7.1%
Haringey South East	17.3	1.4	8.1%
Haringey West	25.1	0.3	1.0%
Haringey Twilight	13.5	6.1	45.4%
Islington Central	18.9	-1.3	-7.0%
Islington North	23.8	3.9	16.4%
Islington South East	16.6	0.3	1.6%
Islington South West	16.6	0.4	2.4%
Islington Twilight	17.0	7.3	42.7%
Leg Ulcer Clinic	15.9	-1.7	-10.5%
Total	**210.7**	**16.0**	**7.6%**

6.2 Emergency and Integrated Medicine

Cost Centre Description	Budgeted Wte	SIP Wte	Vacany Wte	Vacancy %
Aau	66.24	52.27	13.97	21.10
Accident & Emergency	142.44	102.66	39.78	27.93
Total	**208.68**	**154.93**	**53.75**	**25.76**

Nursing

There has been is a plan in place to interview 28 Nurses in the week of the 14th of October. Newly appointed staff could potentially start in January.

Retention is a top priority for the trust, recruitment must be partnered with retention. We have many recruitment strategies including:-

- *career clinics*
- *focus groups*
- *health and wellbeing approaches*
- *length of service recognition*

Additionally we offer flexible working approaches and rotation and transfer schemes.
The trust continually acts on service needs running targeted adverts and recruitment events.

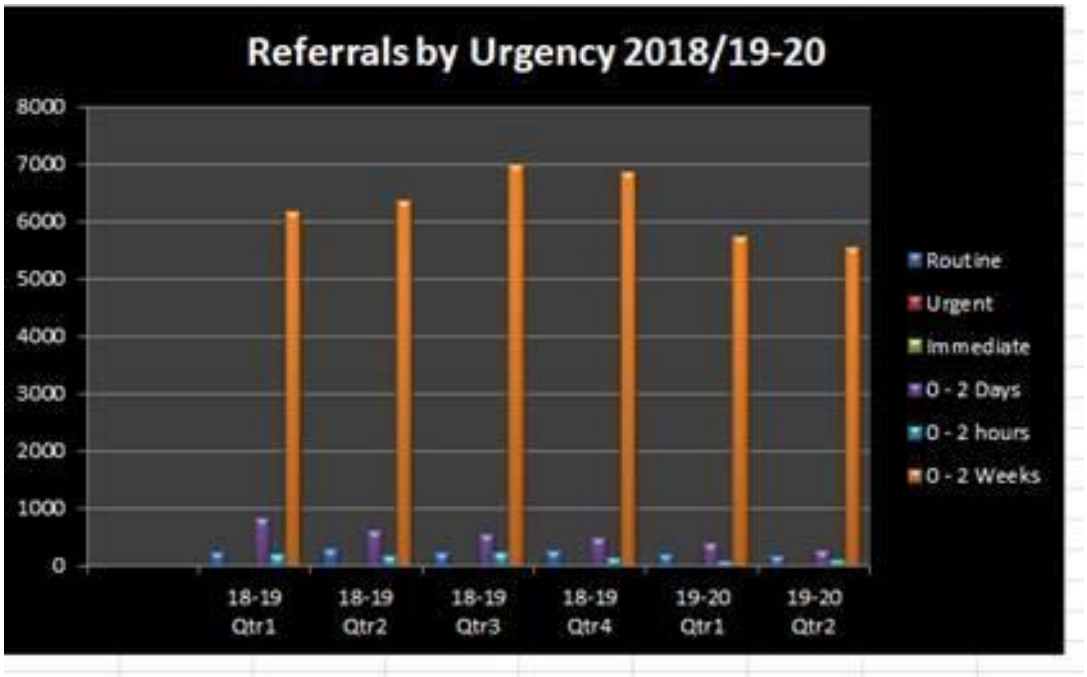
ED Middle Grade
The senior clinical and operational leads are working with medical staffing in exploring further options for fixed term middle grades to provide further resilience in middle grade rotas.

7.0 Community District Nursing Services

Both Whittington Health District Nursing services (covering both Haringey and Islington) are working with the GP federations in both boroughs to ensure that the flu vaccination is given to their most vulnerable, housebound patients. The service is reviewing their out of hours services and how those might best be provided to ensure patients receive the care they need as close to home as possible and to remain at home if that is their wish for palliative care. Staff are being encouraged to take up the flu vaccination themselves so as to avoid passing on flu to our most vulnerable patients.

Whittington Health District nursing services are imminently reviewing their business continuity plans in order to ensure continuation of service provision despite the weather.

Fig 1



As can be seen by the above graph, urgent referrals that require a visit within 2 hours remain low in number.

Fig 2

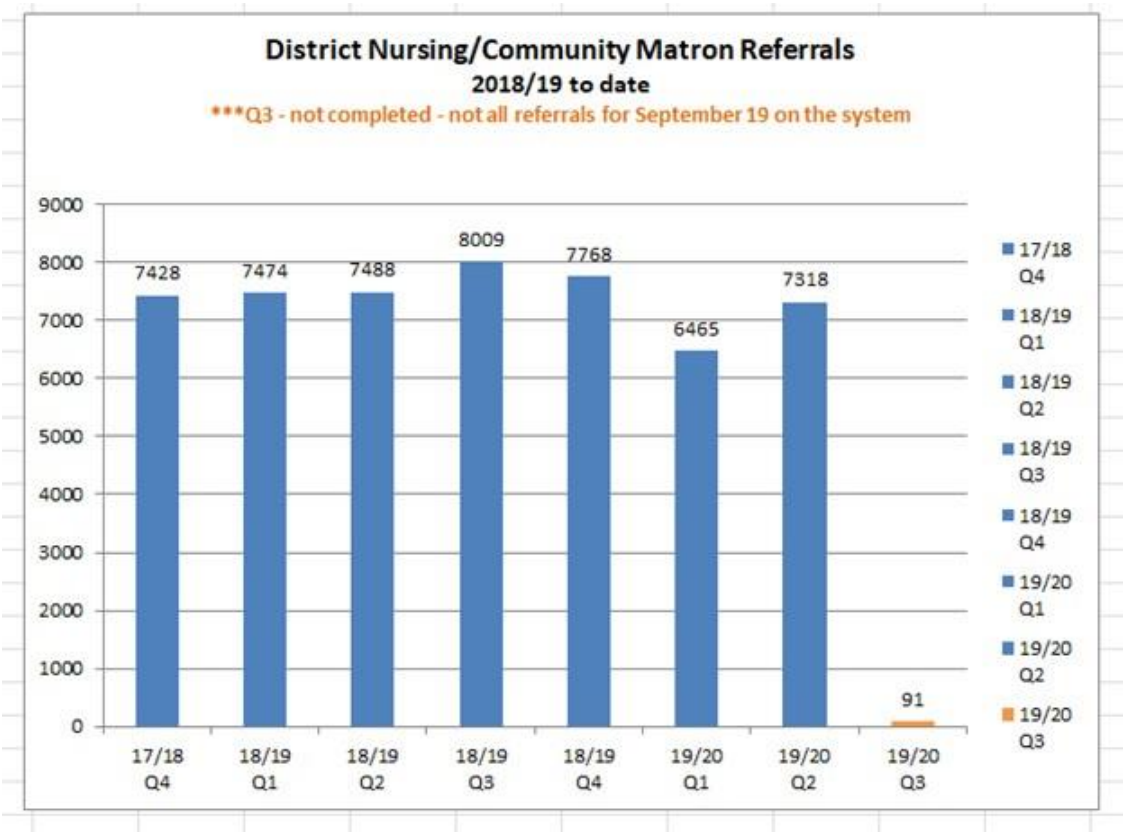
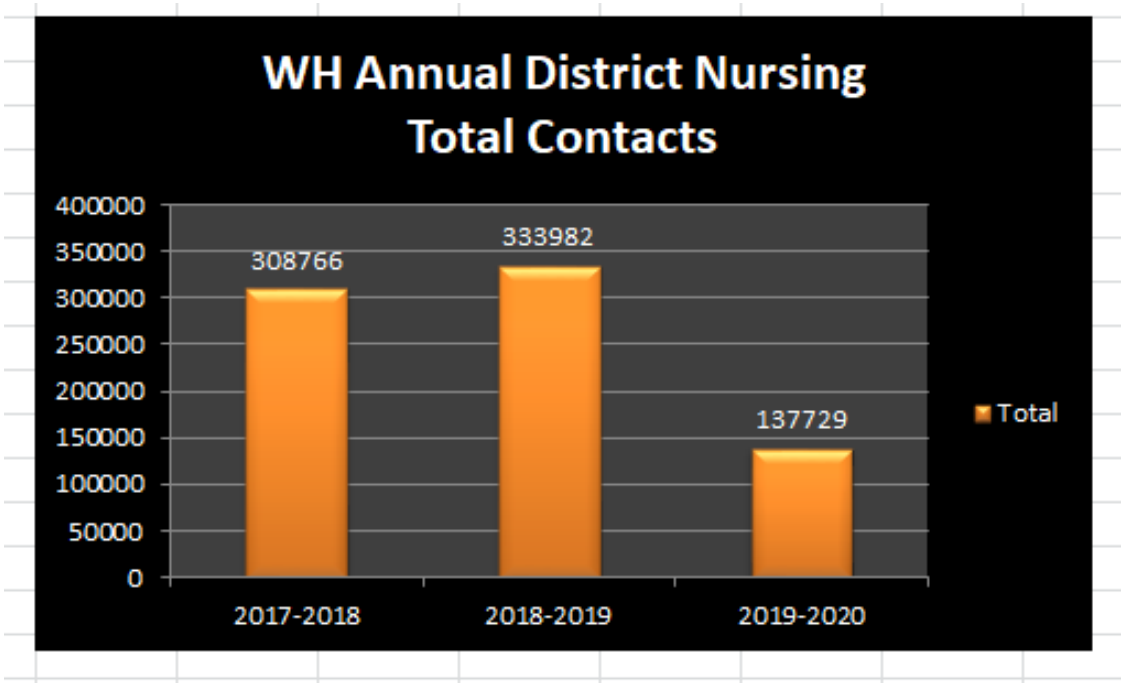

District Nursing/Community Matron Referrals
2018/19 to date
***Q3 - not completed - not all referrals for September 19 on the system
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
7428
7474
7488
8009
7768
6465
7318
91
17/18 Q4
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
19/20 Q1
19/20 Q2
19/20 Q3
17/18 Q4
18/19 Q1
18/19 Q2
18/19 Q3
18/19 Q4
19/20 Q1
19/20 Q2
19/20 Q3

Fig 3


WH Annual District Nursing
Total Contacts
400000
350000
300000
250000
200000
150000
100000
50000
0
308766
333982
137729
2017-2018
2018-2019
2019-2020
Total

8.0 Community Rehabilitation Services

Community health services are working closely with partners to minimise duplication of resources. Locality working is focused on reducing risk and addressing issues to prevent admissions where possible and support earlier discharge from hospital. There is a focus on maintaining a low vacancy rate and maximising efficiency of teams.

8.1 Care Closer to Home

Discharge to Assess (D2A) is operating as a standard referral pathway for people who are medically optimised and ready to be discharged from hospital, to have their social care and therapy needs assessed at home or other community setting rather than on the ward. This approach to discharge has helped improve patient flow through the hospital, ease demand on hospital beds and staff, make better use of our community services and deliver better overall outcomes for patients.

The Community Rehabilitation teams have plans in place to ensure that a resilient service is maintained in response to emergency pressures. This includes close management of annual leave and proactive recruitment. Within Haringey there has been investment in additional community rehabilitation capacity through resilience funding. The additional capacity will be utilised to support weekend and 24 hour response times.

8.2 Admissions avoidance

There is a comprehensive range of services to support admissions avoidance for Haringey and Islington residents. These services work closely with the Emergency Department and Ambulatory Care staff to ensure that support is provided appropriately to patients to support them to remain at home and avoid unnecessary hospital admissions.

These services include:

- Rapid Response Team
- Virtual Ward
- Care of the Elderly consultant and community team support to care homes to prevent admissions
- Integrated multi-agency and multi-disciplinary approach to review patients with increasing or high intensity needs (INC in Islington and Frailty Integrated Network in Haringey)

9.0 Elective Plan

The plan for elective surgery has been organised as follows over the Christmas and New Year period.

Monday 16th December – 20th December	Normal working hours
Saturday 21st and Sunday 22rd December	Normal weekend working hours
Monday 23rd December Tuesday 24th December	Daycase lists Emergency/trauma/flexis/maternity as normal Emergency/trauma/maternity emergencies and any urgent cases
Wednesday 25th December	Public Holiday
Thursday 26th December	Public Holiday
Friday 27th December	Emergency/trauma/maternity emergencies and any urgent cases
Saturday 28th and Sunday 29th December	Normal weekend working hours
Monday 30th December	Daycase lists Emergency/trauma/flexis/maternity as normal
Tuesday 31st December	Emergency/trauma/flexis/maternity as normal Any urgent cancers as needed
Wednesday 1st January 2020	Public Holiday
Thursday 2nd and Friday 3rd January 2020	Business as usual.
Saturday 4th and Sunday 5th January 2020	Normal weekend working
Monday 6th January 2020 onwards	Business as usual

In the event of having to cancel surgical inpatients the following protocol will be adhered to:-

All potential cancellation of surgical elective inpatients will be reviewed by a Senior Clinician, and Director of Operations/and or Associate Director of Nursing for Surgery and Cancer. This is to ensure that no patient who has already been cancelled is cancelled again, that no cancer patient is cancelled, no patient who has an extended wait for surgery, i.e.long waiter, or a patient who is at risk of breaching 52 weeks is cancelled. Before any patient is cancelled the consultant in charge of the patient will be contacted to ensure that all information in regards to the patient is known and understood so that the cancellation while although not ideal, is undertaken in a safe manner. All patients will be telephoned in advance of their surgery date and given a date as soon as possible afterwards, unless there is a problem on the day of surgery and patients have to be cancelled on the day, where normal processes for rebooking will be maintained.

10.0 Building Resilience

10.1 Leading a Resilient Team Workshop

In preparation for the winter pressure, the Organisational Development Team were asked to put on a series of six resilience workshops. These workshops allowed staff members to explore their inner resilience and values, develop tools and techniques to support themselves and understand how to lead a psychologically healthy team.

	Session	Date, Time and Location
1	Understanding Resilience and Business Continuity	Tuesday 13th Nov, 12-2pm, WEC Room 6
2	Self-resilience and harnessing your energy and Business Continuity	Monday 19th Nov, 12-2pm, WEC Room 13
3	Knowing and using your strengths and Business Continuity	Tuesday 27th Nov, 1-3pm, WEC Room 11
4	Promoting team resilience and a positive mind set and Business Continuity	Wednesday 5th Dec, 1-3pm, WEC Room 1
5	Analysing emotions and Business Continuity	Monday 10th Dec, 11:30am – 1:30pm, WEC Room 4
6	Being valued for your contribution and Business Continuity	Wednesday 19th Dec, 12 – 2pm, WEC Room 4

11.0 Staff Flu vaccination programme 2019/20

This year's flu programme was launched on the 1st October and will run until Feb 2020. The Trust is are planning to achieve a universal uptake of 100% unless an individual is clinically exempt. The CQUIN for this year is 80%. The Chief Nurse has agreed to be our board champion.

During the 2018/19 campaign the Trust supported two local homeless charities in Haringey and Islington. We donated £2,398 towards providing hot food and shelter for some of our local homeless people.

This year the Trust plan to support Dementia UK.

The Trust has 70 flu champions spread across our hospital and community sites.
There are 50 booked flu clinics on site at the Whittington hospital site and several more across the community sites, the plan is to offer more night and roving clinics, as these proved very successful last year. The intention is to also attend any large events where staff plan to gather for conferences/forums/executive meetings etc.

Patient Group Directives have been replaced with *written instructions* for the quadrivalent (QIV) vaccine and consent forms (aligned to the new ICSUs) have been finalised and will be circulated to champions on the 1st October. Training is available for new champions or for those wanting a refresher.

Staff over 65 years will be offered the Influenza (adjuvanted trivalent) inactivated 65 years & over vaccine.

The plan also includes introducing some healthy competition between the ICSUs and with the help of our communications team we be using the jab-o-meters, featuring syringes (one per ICSU) with numbers on to denote uptake. All information will be displayed on a screen saver and counted and updated weekly.

Champions will receive a £25 M&S voucher when they have administered the targeted number of jabs and everyone who has a vaccine will be entered into 2 separate draws to get a chance to win £250 worth of M&S vouchers.

The volunteers have kindly offered to help support the counting and data entry.

The District Nursing Service is jointly working with both GP Federations to deliver flu vaccinations to housebound patients.

12.0 Escalation with External Partners

The NHS Improvement Team and NHS England have provided clear guidance in relation to the daily Winter Rhythm, Data Information & Intelligence, Bank Holiday/Weekend Assurance and Escalations.

Winter Rhythm	• Day to day management of local U & EC systems • Daily system surge calls that inform the national command and control centre.
Data, Information and Intelligence	• Daily Sitrep collected and distributed by NHS Improvement • Weekend Plans • LASD/111 data sources • Winter Intelligence bulletin
Bank Holiday/Weekend Assurance	• Assurance of Acute, Primary Care, LAS, 111, CAMHS in advance of Christmas/New Year period • Intermittent assurance of acute systems
Escalations	• 12 hour breaches • ED redirects in exceptional cases only • Beds lost to infection control • Workforce update and early recognition of rising tide • Performance against ED trajectory • Beds occupied by DTOC's /MO/Stranded patients • Ambulance handover delays • LAS Resource Escalation Action Plan (REAP) levels • Bespoke plans for weekends +BH • Primary care and out of hospital capacity • Availability and responsiveness of community services.

External monitoring is part of a pan North Central London resilience system known as Surge Management & Resilience Toolset SMART

13.0 Communications Plan

The communications leads will be using all the key messaging and resources from the National Campaign.

This year's theme: ***'Help us help you'*** the other themes include:-

- Self Help Winter Preparation
- Vaccination Campaign
- Resilience Work Shops.
- Owners, Senior Clinicians
- Continuing our #Caring For Those Who Care campaign to promote ways in which the trust supports its people's physical and mental wellbeing during our busiest time.

The key messages will be developed to deliver the priorities for the winter plan.

These messages will be used across various materials and channels, to ensure consistency of messaging.

As winter progresses, the plan will be revised and updated to react to any current or predicted issues, such as the weather conditions, health outbreaks, or pressures on services.

Current communications materials and channels:

- Posters, flyers, screensavers
- Hand-outs at key events and meetings
- Social media - Facebook and Twitter
- Noticeboard (staff and GP newsletter), intranet updates

Activity	Timing	Audience
Content included on staff intranet: Flu campaign: **Protect Yourself, Protect your Patients, Protect your Colleagues**. How many staff vaccinated, photos of senior management getting vaccinated. Flu Jab clinics timetable – on intranet	1/10/19	All staff
Content included on staff intranet: lessons learned from last winter, severe weather, flexible working for staff – staffing resilience	18/10	All staff
Screensavers	1/10/19	Staff
Posters - avoidance of A&E attendance/admission messages on social media and in our communications to patients.	Weather Dependant	Patients, Potential Patients, visitors, stakeholders our

	At peak times around Christmas	community.
Noticeboard content letting people know about winter plans campaign	Updates monthly until winter completion	All Staff
Social Media posts with flu messages and how many staff vaccinated using **#Jabathon**	From 01/10/19	Patients, Staff, stakeholders our community

Appendix 1

Winter Risk Assessment 2019/2020

Number	Risk	Initial Risk Rating	Actions	Post Intervention Risk Rating
1	System wide interventions do not have the anticipated impact on hospital flow	**3 X 4 = 12**	• Regular SitRep and robust monitoring of the outcomes • System wide interventions at weekly AEDB teleconference • MADE meetings twice a week • Robust escalation to surge	**3x2=6**
2	Insufficient resources available to maintain resilient services during peaks in demand	**4x4=16**	• Key enablers • Operational escalation (OPEL 1-4) • Discharge to Assess • Escalation Externally (surge) • EUC/System Wide Escalation Actions	**3x2=6**
3	Insufficient workforce on wards and community	**4x4=16**	• Agreed plan sign off by ADON Nursing for Escalation Beds • Daily review of staff for unfilled shifts Retaining effective and regular locum staff (ED) • Flu Vaccination of Staff and Community • Staff escalation as per SOP • Red Hit list	**3x2=6**
4	Refer to EU Exit Plan	**3 X 4 = 12**	• EU Exit Team, Regular meetings, Exercising • EU assurance and escalation	**3x 2=6**
5	Maintaining patient safety in ED	**3X4 = 12**	• Safer staffing • Escalation • Ten at ten (clinical education) • Full Capacity Protocol	**3x2 = 6**

Appendix 2: Emergency Department Situation Report 2019

EMERGENCY DEPARTMENT SITREP: Assessor : Date : Circle 0900, 1200, 1500, 1800, 2200. Repeat 1hr later if triggers Red or Black with Site Manger

	INDICATORS	GREEN OPEL 1	AMBER OPEL 2	RED OPEL 3	BLACK OPEL 4
CAPACITY	Capacity	<50 Patients	50-70 Patients	71-90 – D/C FFD's Patients	>90 – D/C FFD'S Patients
	Resus/Majors Capacity	<20 Patients	20-25 Patients	26-30 Patients	>30 Patients
ARRIVALS	LAS handover	<20 Minutes	20-30 Minutes	31-45 Minutes	>45 Minutes
	Time to Triage	<15 Minutes	15-20 Minutes	21-40 Minutes	>40 Minutes
	Number of Arrivals in last hour	<15 Day <6 Night	15-18 Day 6-7 Night	19-25 Day 8-10 Night	>25 Day >10 Night
ASSESSMENT	Number of Patients to be seen	<20 Patients	20-30 Patients	31-40 Patients	>40 Patients
	ED waiting Times	<60 Minutes	60-100 Minutes	101-180 Minutes	>180 Minutes
REFERRALS	Speciality Referral/ Number to be seen	<30 Minutes	30-60 Minutes	61-90 Minutes	>90 Minutes
		< 5 patients waiting	5-8 patients waiting	9 patients waiting	10+ waiting
	Imaging Time: from order to completion	<30 Minutes	30-60 Minutes	61-90 Minutes	>90 Minutes
	General Blood Results	<45 Minutes	45-60 Minutes	61-90 Minutes	>90 Minutes
	Mental Health Patients in ED/ Moderate to High Risk patients in ED	<60 Minutes	60-120 Minutes	121-180 Minutes	>180 Minutes
		1 Moderate risk patient	2 Moderate risk patients	2 high risk / sectioned patients	4+ high risk / sectioned patients
ADMISSION	DTAs	<4 Patients	4-8 Patients	9-14 Patients	>14 Patients
	CDU 8 beds 4 chairs	<6 Patients	6-9 Patients	10 Total/ 8 Bedded Patients	10 Patients under other teams
TOTALS					
ED STATUS IS		GREEN Business as usual	AMBER if ≥4 TRIGGERS	RED if ≥5 or ≥2 FULL CAPACITY TRIGGERS	BLACK if ≥5 or ≥2 FULL CAPACITY TRIGGERS

SERVICE RESPONSE STANDARDS FOR ACUTE INPATIENT WARDS

Appendix 3

Please consider whether investigations are discharge dependent or could be done in an outpatient setting at a later date

General rule of thumb if no agreed standard below a wait of 6 hours is red on main wards and 4 hours on AAU

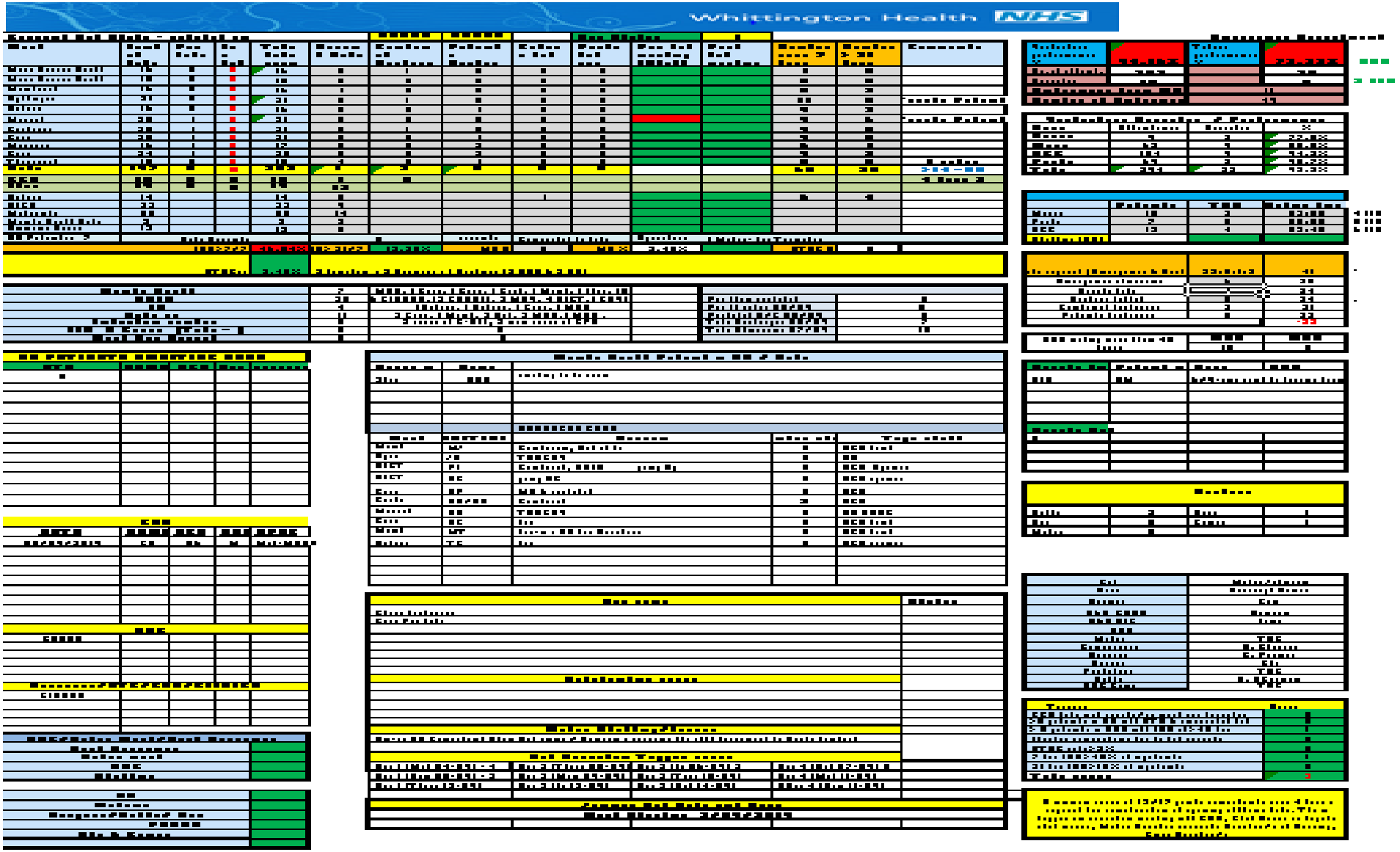
SERVICE	THEME	WHAT WOULD BE GREEN?	WHAT WOULD BE RED?	Escalation
Ward	Senior Review	Review before 12 noon (Board Round/ Face to Face)	Review post noon/ no review	Contact Lead Consultant responsible for Ward at noon Further escalation to CD if no response 12.30pm
	EDD	Set on admission to the ward* Based on ideal recovery and timely processes * EDD should be updated/ confirmed following daily Senior Clinician Review and Core Criteria for discharge documented in the notes	Not set on admission to the ward Based on probable delays e.g. can only get a renal ultrasound on a Thursday	Contact Ward Manager/Charge Nurse to confirm with local medical team and confirm EDD within 14 hours of admission.
	TTAs Request Please Note: Ward staff should notify pharmacy via telephone if pharmacist not on the ward; and should check the pharmacy tracker rather than phoning the pharmacy department for status update	Prescribed 24 hours in advance* of planned discharge (48 hours in advance for blister packs) where EDD is expected the next day Written by 4p.m. for planned next day discharges based on current EDD Written by 12 noon for evening discharge * In exceptional prescribing circumstances 80% of same day discharge requests should be in pharmacy by 9a.m.	Prescribed less than 24 hours prior to discharge where EDD is expected the next day Written after 4p.m. for planned next day discharges based on current EDD Written after 12 noon for same day discharge	
	Transport Booking	Where transport is required, where possible it should be booked 24 hours ahead of planned discharge time – stipulating any specialist requirements and collection no later than 11a.m.* * Other than by exception for clinical reasons/ patient safety	Booked post 11a.m. based on potential delays such as TTAs* * Where safe patients can be seated in day room	
	Completion of D/C paperwork Please Note: Paperwork completion should commence at earliest opportunity and where possible in tandem with treatment phase	For non-complex patients paperwork to be turned around within 24 hours More complex patients requiring significantly more attention e.g. CHC requirements paperwork to be turned around within 4 working days	For non-complex patients paperwork not turned around within 24 hours More complex patients requiring significantly more attention e.g. CHC requirements paperwork not turned around within 4 working days	
Therapies	Routine Patients Urgent Patients	Patients are reviewed and where required have a treatment plan in place within 24 working hours from referral; with delivery of treatment as per plan Patients are reviewed with a treatment plan in place within 4 working hours from referral; with delivery of treatment as per plan	Patients are not reviewed and where required do not have a treatment plan in place within 24 working hours from referral or treatment plan not delivered Patients not reviewed with a treatment plan in place within 4 working hours from referral or treatment plan not delivered	
Cardiology	Non-Emergency Echo Emergency Echo	Undertaken and reported within 48 hours Undertaken and reported same day if request	Not undertaken and reported within 48 hours Not undertaken and reported same day if request	

4.1 dated 13th August 2018

		received before noon. Otherwise undertaken and reported before noon the following day	received before noon/ otherwise undertaken and reported before noon the following day	
	Treadmill Test	Undertaken and reported within 48 hours	Not undertaken and reported within 48 hours	
	Non-Emergency In-patient Angiography	Patient transferred within 72 Hours of request	Patient not transferred within 72 Hours of request	
Diagnostic Imaging	Urgent X-RAY	Response within 2 hours and report within 4 hours	Response more than 2 hours/ report not available within 4 hours	
	Urgent Scan	Response within 4 hours and report within 2 hours	Response more than 4 hours/ report not available within 2 hours	
	Routine work	Same day response and report within 24 hours	Next day response/ report not available within 24 hours	
Pathology	Discharge Bloods	If clearly identified as 'urgent D/C' bloods and dropped to the lab by 7a.m. tests reported by 10a.m.	Tests not reported by 10a.m. if bloods clearly labelled as 'urgent D/C' and dropped to the lab by 7a.m.	
Pharmacy	TTA Turnaround	TTAs on the ward to facilitate pre 11a.m. discharge if the request has been made by the ward before 4p.m. for planned next day discharges	TTAs not available on the ward to facilitate pre 11a.m. discharge if the request has been made by the ward before 4p.m. for planned next day discharges	
		TTAs available on the ward (> 6pm) to support same day discharge if the request has been made by the ward before noon	TTAs not available on the ward (> 6pm) to support same day discharge if the request has been made by the ward before noon	
		Blister packs available if 48 hours' notice provided by the ward	Blister packs not available if 48 hours' notice provided by the ward	

Data improvement

Over 90% of Whittington Health patients now have an Estimated Date of Discharge (EDD)



Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Healthcare Worker 'Flu Vaccination**	**Agenda item: 11**
Executive director lead	Norma French, Director of Workforce	
Report author	Catherine Ferguson, Occupational Health & Wellbeing	
	Background Each NHS Trust in England has received a communication from the National Medical Director, Chief Nursing Officer and National Director of Emergency & Elective Care of NHS England and NHS Improvement (NHSE/I). This communication reiterates the importance of ensuring frontline staff receive the flu vaccination. The national uptake for 2018/19 was 70.3%. Whittington Health had an uptake of 83.4%. NHSE/I have requested that each organisation completes a best practice management checklist and publishes this self-assessment against these measures in Trust Board papers before the end of December 2019. **Whittington Health Checklist** This paper shows the completed checklist for the Trust. All aspects of the four criteria shown below: a) Committed leadership b) Communications plan c) Flexible accessibility d) Incentives have been achieved and the Trust is able to report, in line with the best practice guidance, that it is in a good position to roll out our 'flu campaign' and achieve our uptake in line with previous years.	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to: i. note this paper and the assurance it provides on successful compliance with the best practice	

	management checklist issued by NHSE/I; and ii. agree the proposed incentives outlined in section D1 of the self-assessment of the checklist.
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.
Report history	None
Appendices	1: Healthcare worker 'flu vaccination best practice management checklist

Appendix 1: **Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019**

A. Committed leadership

- **A1 - Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.** The Trust's 2019/20 winter flu plan commits to planning to achieve a universal uptake of 100% of relevant staff, unless an individual is clinically exempt.
- As part of the winter flu plan, the Trust will be using a decliner's form for staff who decline the vaccine to complete.

A2 - Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers

- The Trust is able to confirm that 3,300 influenza (quadrivalent) inactivated vaccines and 10 influenza (cell-grown quadrivalent) inactivated 65 years+ vaccines were ordered and have been successfully received by the Trust's Pharmacy services.

A3 - Board received an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt

- A report on the 2018/19 campaign was considered by the Infection Prevention and Control Committee in March 2019 and was also reported to the Board's Quality Committee. The Trust Board will receive regular updates from the occupational health team throughout the 2019/20 campaign.

A4 - Agree on a board champion for flu campaign

- The Trust board's flu campaign champion is the Chief Nurse & Director of Allied Health Professionals.

A5 - All board members receive flu vaccination and publicise this

- Dates have been agreed for the flu vaccination campaign. Photographs will be taken of board members receiving their vaccinations and will be used on publications across the trust.

A6 - Flu team formed with representatives from all directorates, staff groups and trade union representatives

- The Trust's flu planning group meets regularly and is drawn from across all directorates and staff groups and includes staff side representatives.

A7 - Flu team to meet regularly from September 2019

- A number of meetings of the flu campaign team were set up for June and July 2019 and they continue to meet regularly each month across trust locations to progress this year's flu campaign and arrange further meeting dates.

B Communications plan

B1- Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions

- The Trust's all staff 'NoticeBoard' email will carry a headline around the launch date of the vaccinations with a flu story. This will indicate that vaccinations are now available, the importance of protecting yourself, your patients and your colleagues by getting the vaccine.
- Later in the flu season, the Trust will look to send a dedicated all staff email from the Chief Nurse encouraging those who have not yet done so to get their vaccination.
- Flu will also be one of the main headline news tabs on our staff intranet with links to dedicated pages with persuasive rationale for getting your jab and details of where you can be vaccinated.

B2 - Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper

- Vaccination clinics will be published on our intranet, screensavers, Notice Board emails and posters. Night clinics will be advertised on our social media channels.

B3 - Board and senior managers having their vaccinations to be publicised

- Pictures of board members and senior staff being vaccinated will be shared on our social media, screensavers and Notice Board emails. We may also drop them into the Public Health England poster templates.

B4 - Flu vaccination programme and access to vaccination on induction programmes

- A dedicated flu vaccinator will attends Trust induction training session scheduled for 7 October, 4 November and 2 December.

B5 - Programme to be publicised on screensavers, posters and social media

- The Trust will publicise the flu vaccination programme prominently across all of our channels, including screensavers (with a "take up challenge" showing take up by Integrated Clinical Service Unit), intranet, posters available for all wards and services and on our social media channels (Twitter and Facebook).

B6 - Weekly feedback on percentage uptake for directorates, teams and professional groups

See above – "Take up Challenge" across our Integrated Clinical Service Units (ICSUs). The jab-o-meter will be updated weekly and circulated on a screen saver

C. Flexible accessibility

C1 - Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered

- The Trust has 50 hospital-based and 20 community-based flu champions signed up. These include the Chief Nurse and Assistant Chief Nurse and all of the five ICSUs are represented. The Communications team will promote local champions using promotional material from NHS England.

C2 - Schedule for easy access drop in clinics agreed

- A schedule of planned clinics with easy drop in access for staff will be included as was the case in the successful 2018/19 flu vaccination campaign In addition, the Trust will also have planned multiple roving clinics which include late event and night clinics.

C3 - Schedule for 24 hour mobile vaccinations to be agreed

- Occupational Health nurses will cover clinics from 5pm to midnight. Champions on night shifts will be encouraged to vaccinate colleagues.

D Incentives

D1 - Board to agree on incentives and how to publicise this

- To incentivise staff, the Trust has collaborated with a charity – this year's chosen charity is Dementia UK.
- Funding from the Trust's Charitable Funds Committee for flu champions to receive a £25 voucher from Marks & Spencer when they have vaccinated 30 colleagues (approx. 1%).
- There will also be two separate raffles open to everyone who has received a flu jab with the winners receiving a £250 Marks & Spencer voucher.

D2 - Success to be celebrated weekly

- The Communications team will publicise the jab-o-meter which records the flu uptake across the orgsanisation.
- Details of all staff vaccinated in each of the five ICSUs will be updated weekly.
- In addition, vaccination records will be input onto the Electronic Staff Record in order to encourage some healthy completion by wards/departments/ICSU.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Learning Lessons to improve our people practices**	**Agenda item: 12**
Executive director lead	Norma French, Executive Director of Workforce	
Report author	Kate Wilson, Deputy Director of Workforce	
Executive summary	This paper is a response to the letter of from Baroness Dido Harding to NHS Trust Chairs and Chief Executives entitled 'Learning Lessons to improve our people practices' to give assurance to the Board around the recommendations made. Whilst this paper identifies satisfactory compliance against the majority of recommendations, there are a number of areas where further improvement is being explored, detailed in section 4, "next steps".	
Purpose:	Noting	
Recommendation(s)	Board members are asked to review the paper and to take assurance on the actions highlighted in response to the letter from Baroness Dido Harding on improving people practices in the NHS	
Risk Register or Board Assurance Framework	People 2	
Report history	Trust Management Group, 29 October 2019	
Appendices	Appendix 1: Copy of letter sent by Baroness Harding	

Learning Lessons to Improve our People Practices

1 Introduction

Following an independent report into a tragic event involving a staff member at a London NHS Trust, Baroness Harding wrote to Trust Chairs and Chief Executives on 24th May 2019 (see Appendix 1) to set out guidance relating to management and oversight of local investigation and disciplinary procedures.

This report outlines for the Board where the Whittington Health's procedures and processes are already in line with the guidance and also sets out work ongoing to further improve our people practices.

2 Description of the Guidance

The letter gave seven areas of focus for Trusts to consider and benchmark their practice against, and to ensure there is Board level oversight of the response to the recommendations. The seven areas of focus are as follows:

- Adhering to best practice
- Applying a rigorous decision-making methodology
- Ensuring people are fully trained and competent to carry out their role
- Assigning sufficient resources
- Decisions relating to the implementation of suspensions/exclusions
- Safeguarding people's health and wellbeing
- Board level Oversight

Section 3 outlines the Trust's current position against these areas.

3 Impact on the work of Whittington Health

3.1 Adhering to Best practice

- Trust Disciplinary policy was reviewed and approved in July 2019, in line with ACAS code of practice
- Conduct. Performance and Ill Health Procedures for Medical and Dental Staff reviewed and approved in July 2019, in line with Maintaining High Professional Standards in the Modern NHS, and the GMC Principles of a Good Investigation.
- All Investigating Officers, Case Managers, and Panel members have no previous involvement in the case previously.
- External Investigators appointed where appropriate.
- Fair Treatment Panel implemented in August 2018. All conduct cases are anonymised and considered by this panel prior to going to a formal hearing.
- Medical employee relations (ER) cases are reviewed monthly by the Medical Director and the Deputy Director of Workforce to ensure adherence to timescales in policies.
- ER case review meeting in place within the Workforce Directorate to ensure adherence to key performance indicators.

- All cases with a time to resolve of over 90 days are reviewed weekly by the Deputy Director of Workforce.

3.2 Applying a Rigorous decision making methodology

- The new Disciplinary Policy places a higher emphasis on the informal stages of the policy.
- All cases are reviewed in conjunction with the ER team to ensure that informal stages are followed
- All formal cases are further reviewed via the Fair Treatment panel
- Terms of reference training in place

3.3 Ensuring people are fully trained and competent to carry out their role

- Human resources (HR) Investigation skills training in place
- Terms of reference training in place
- All Case Investigators, Case Managers and Panel members are supported by an HR Representative.
- At least one panel member must be unconscious bias trained.

3.4 Assigning Sufficient Resources

- Appointment of an Investigating Officer, Case Manager and Panel member is undertaken with a review of workload
- An HR Representative is assigned at all levels to provide advice and support.

3.5 Decisions relating to the Implementation of Suspensions/Exclusions

- Decisions relating to the exclusion of medical and dental staff are taken by the Medical Director in conjunction with the Executive Director of Workforce
- Decisions relating to the exclusion of other staff groups are taken by the Most Senior Manager in conjunction with the appropriate Executive Director, and senior Human Resources advice
- Suspensions/exclusions are always a last resort
- An expanded checklist was introduced in March 2019 that all suspension/exclusion decision makers must complete. This includes an emphasis on the fair reasons for exclusion, and due consideration to relocation to other areas
- Suspensions are reviewed fortnightly through Case Review sessions and reported to the Workforce Assurance Committee

3.6 Safeguarding Peoples Health and Well Being

- From August 2019 a ‘critical friend’ is appointed for all staff undergoing a conduct investigation, not connected with the investigation to ensure the ongoing health and well-being of the staff member.
- Cases are reviewed fortnightly to ensure that they are progressing in line with key performance indicators (KPIs);
- Staff are referred to Occupational Health to access the Employee Assistance Programme
- Where staff are not part of a Trade Union, every effort is made to recommend a suitable person to accompany them to meetings
- All allegations and terms of reference are given to the staff member in person prior to in writing.

3.7 Board Level Oversight

- The Workforce Assurance Committee meets quarterly and reviews all ER related cases and associated KPI's.

4 Next steps

Over the past 12 months the Workforce Directorate has implemented a substantial amount of actions to improve the process of investigations within the Trust. Work is ongoing in this area, and it is clear that more can be done to improve our people practices. As such, the following are steps that are currently being undertaken or will be undertake in the next six months

Action	Timescale	By whom
Develop an ER Dashboard to be reviewed through ICSU Boards and Quarterly Performance Reviews	1 November 2019	Head of Employee Relations
Full review of the investigation process including the impact of the Fair Treatment panel	29 November 2019	Head of Employee Relations
ER Function review	19 October 2019	Deputy Director of Workforce
Launch of 'sprit of enquiry not blame' project	1 January 2020	Deputy Director of Workforce
Expand the number of Investigators within the trust	April 2020	Employee Relations
Incorporate Unconscious Bias into Investigator Training	April 2020	Deputy Director of Workforce

5 Conclusion / recommendation

It is recommended that the Trust Board receive assurance against the work previously undertaken in relation to the seven key areas and support the next steps.

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**September (Month 6) 2019/20 – Financial Performance**	**Agenda item: 13**
Executive director lead	Kevin Curnow, Chief Finance Officer (Acting)	
Report authors	Finance Team	
Executive summary	The Trust is reporting a year to date deficit of £3.9m which is £3.9m behind plan, £2.3m adverse after adjusting for Provider & Sustainability Funding (PSF). As with prior periods the Trust has not achieved the financial target and therefore has not assumed any PSF resulting in a negative variance of £1.6m. Should the Trust achieve the Control Total this can be recovered in future periods. The adverse variance is still mainly driven by the failure to achieve the Cost Improvement Programme (CIP), however £1.3m was delivered this month. CIP achievement year to date amounts to £3.0m against a £6.2m target. The year to date pay costs are in excess of budget by £2.2m. Bank spend is less than the previous month at £1.76m with agency spend at £0.6m, this is the second month in a row being beneath the agency cap. Combined temporary spend is £2.69m down on the previous year to date average of £2.77m. Non pay expenditure is £0.3m overspent in month and £2.3m year to date. The variances predominately driven by underachieved CIP. The Trust has spent £6.1m on capital expenditure at month 6. The planned spend is £7.0m.	
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 September 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, October 2019	
Appendices	None	

September (Month 6) 2019/20 – Financial Performance

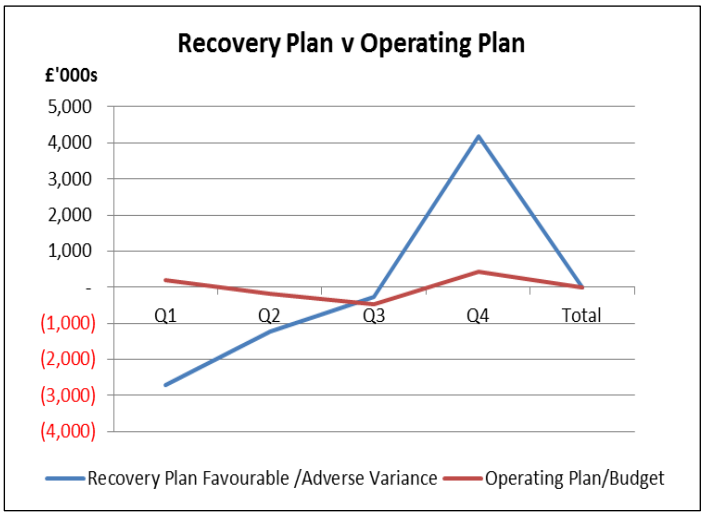
Financial Overview

The Trust is reporting a year to date deficit of £3.9m deficit, which is a negative variance to plan of £3.9m. The performance has improved from the previous month on a number of indicators including CIP delivery and agency spend. However, the number of open beds and the underperformance relating to CIP delivery remain of concern.

MEASURE	TARGET	ACTUAL	Prev month	RAG	RESPONSIBLE OFFICERS
Beds at funded establishment	197	212	211		DOO - Surgery & Cancer & EIM
CIP Forecast	£12.3m	£7.7m	£7.7m		Head of PMO
CIP schemes delivery	100%	39%	32%		Head of PMO
Emergency Length of stay	TBC	4.2	4.3		DOO - EIM
Elective Activity planned delivered (DC & Elective)	100%	98%	98%		DOO - Surgery & Cancer
Trust wide agency spend (per month)	£0.7m	£0.6m	£0.6m		DOOs

The Trust continues to closely scrutinise any additional bed capacity and ensures appropriate escalation procedures when above target. The CIP forecast and delivery remains a significant issue and the Executive Team are currently reviewing options to provide assurance on likely delivery. In September, 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 all temporary staffing groups including medical staff.

The Trust is still forecasting to meet its control total for the year and has produced a revised recovery plan which is undergoing review for further improvements and sign off at ICSU level. The identification of future non-recurrent recovery actions have been incorporated as well as finance scrutiny of the previously planned CIPs. The approach is a 'most likely' as at month 6 and is built up at cost centre level and includes some areas of adverse run rate.



	Forecast Variance £'000s				
	Q1	Q2	Q3	Q4	Total
EIM	(2,725)	(2,274)	(2,052)	(1,624)	(8,675)
S&C	(1,063)	(1,136)	(787)	(574)	(3,560)
ACS	(206)	(117)	(0)	(15)	(339)
ACW	(847)	(262)	(725)	(485)	(2,320)
CYP	(6)	206	61	11	272
	(4,848)	**(3,584)**	**(3,502)**	**(2,688)**	(14,621)
Corp / Central	2,139	2,361	3,242	2,380	10,122
	(2,709)	**(1,223)**	**(259)**	**(308)**	(4,500)
PSF Adj				4,500	4,500
Recovery Plan Favourable /Adverse	(2,709)	(1,223)	(259)	4,192	0
Operating Plan/Budget	201	(174)	(463)	436	0

The recovery plan, excluding Provider Sustainability Fund (PSF), targeted a £2m negative variance at the end of quarter 2. The Trust is reporting a £2.3m variance at the end of month 6, excluding PSF. The Trust continues to develop and refine the forecasting of its financial position and include monthly details to provide a more granular view.

The table below shows the summary position for September.

Statement of comprehensive income

2019/20, Month 6 (September 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	23,869	24,210	341	145,211	146,709	1,498	290,256
Other Non-Patient Income	2,185	2,503	318	12,370	12,600	230	24,921
High Cost Drugs	777	662	(115)	4,103	4,244	141	8,207
Total Income	**26,832**	**27,376**	**544**	**161,685**	**163,553**	**1,869**	**323,384**
Pay	(19,188)	(19,379)	(191)	(115,376)	(117,567)	(2,191)	(232,207)
Non-Pay (excl HCD)	(6,024)	(6,400)	(376)	(36,206)	(38,478)	(2,272)	(72,407)
High Cost Drugs	(668)	(626)	41	(4,006)	(4,019)	(13)	(8,011)
Total Operating Expenditure	**(25,880)**	**(26,405)**	**(525)**	**(155,588)**	**(160,064)**	**(4,476)**	**(312,625)**
	952	**971**	**19**	**6,097**	**3,489**	**(2,607)**	**10,759**
Depreciation	(622)	(571)	51	(3,729)	(3,478)	251	(7,481)
Dividends Payable	(432)	(432)	0	(2,592)	(2,592)	0	(5,187)
Interest Payable	(268)	(270)	(2)	(1,621)	(1,647)	(26)	(3,238)
Interest Receivable	15	9	(6)	66	118	52	156
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,307)**	**(1,264)**	**43**	**(7,876)**	**(7,598)**	**278**	**(15,750)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(355)**	**(294)**	**61**	**(1,779)**	**(4,109)**	**(2,329)**	**(4,991)**
Provider Sustainability Fund (PSF) (including FRF & MRET)	335	30	(305)	1,785	182	(1,603)	4,946
Net Surplus / (Deficit) - before IFRIC 12	**(20)**	**(263)**	**(243)**	**6**	**(3,927)**	**(3,932)**	**(45)**
Add back							
Impairments	0	0	0	0	0	0	0
IFRS & Donate	4	6	2	21	39	18	45
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(16)**	**(257)**	**(241)**	**27**	**(3,888)**	**(3,914)**	**0**

Income and activity

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

The Trust is performing (before the application of PSF) £1.9m (1.1%) ahead of plan but this is offset by a reduction to PSF (£1.6m) as the Trust's control total has not been met. The revised income position after this reduction is £0.3m (0.2%) equal to plan.

The main areas of material activity variance are within controllable planned care. Elective admissions and day cases are £0.7m (6%) favourable year to date (YTD), – a small decrease. There has also been a small decrease in Outpatients performance of £0.7m (6%) YTD adverse to plan.

There are two risks to income from North Central London CCGs that are not currently reflected in the reported position, closure of 18/19 and an activity query notice for increased reported casemix (particularly impacting on emergency admissions). Either or both could impact on the future reported income dependent on final settlement. The Trust is working to mitigate these risks.

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

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Elective and Day Case	1,811	1,742	(69)	10,914	11,620	706
Non Elective 0 LOS	1,023	1,054	31	6,240	6,349	109
Non Elective LOS I Day or Greater	3,601	3,713	112	21,972	22,360	388
OP Attendances - 1st	997	936	(61)	5,981	5,771	(208)
OP Attendances - follow up	898	772	(126)	5,388	4,921	(467)
A&E Attendances	1,387	1,355	(32)	8,460	8,368	(92)
High Cost Drugs	650	603	(47)	3,900	4,244	344
Community	6,160	6,160	0	36,960	36,960	0
Other Clinical income NHS	5,180	4,753	(427)	31,080	32,447	1,367
Other Clinical Income Non NHS	3,049	3,786	737	18,334	17,913	(421)
Total Income From Patient Care Activities	**24,756**	**24,874**	**118**	**149,229**	**150,953**	**1,726**
Other Operating Income Excluding PSF	**2,075**	**2,503**	**428**	**12,456**	**12,600**	**143**
Total	**26,831**	**27,377**	**546**	**161,685**	**163,553**	**1,869**
PSF/FRF/MRET	336	30	(306)	1,785	182	(1,603)
Revised Total	**27,167**	**27,407**	**240**	**163,470**	**163,735**	**266**

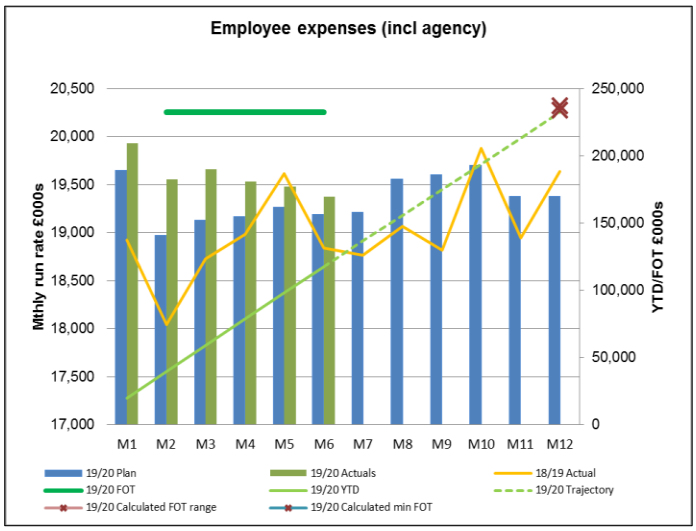
Monthly run rates – expenditure

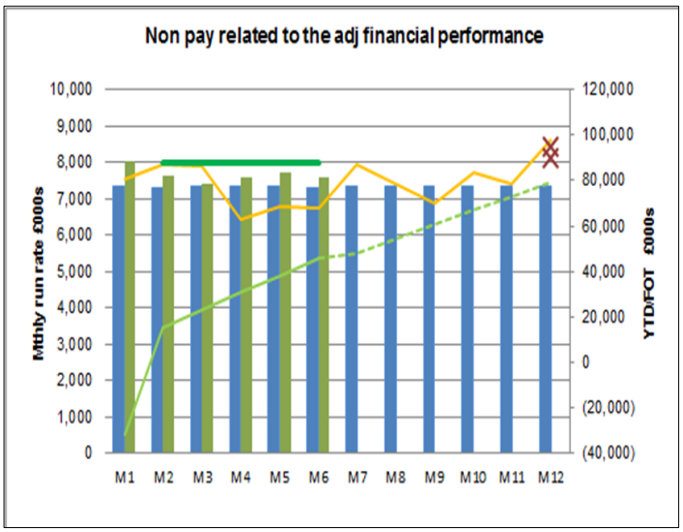
The in month combined expenditure position is £0.5m adverse to plan (£4.5m adverse YTD). Key points to note include:

- **Pay**
  - Total pay expenditure for September was £19.3m, £0.2m adverse to budget, (£2.2m 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 (£1.1m) 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 £0.6m in month, £4.9m year to date. Bank spend is at £1.8m which is marginally higher than previous months. Total temporary spend for the year is £16.1m.

- **Non Pay**
  - Non pay expenditure for September was £7.0m compared to £7.1m for the previous month
  - The non-pay variance in month 6 is an adverse variance of £0.3m. This brings the year to date overspend to £1.9m, pressures within clinical supplies for theatres, endoscopy insourcing and utilities and unachieved CIP.

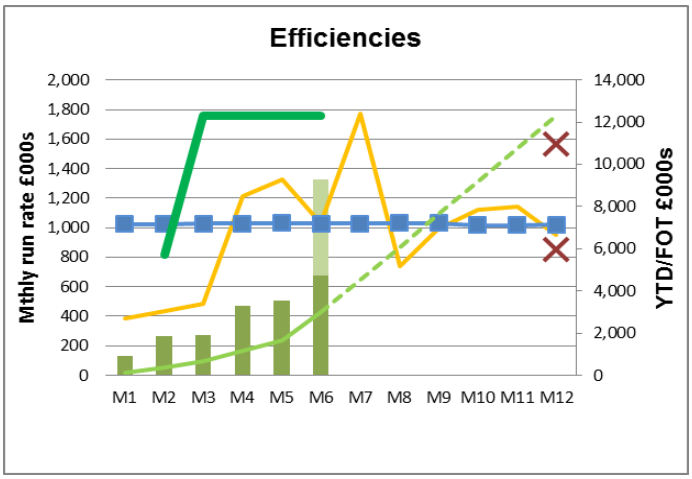
    .

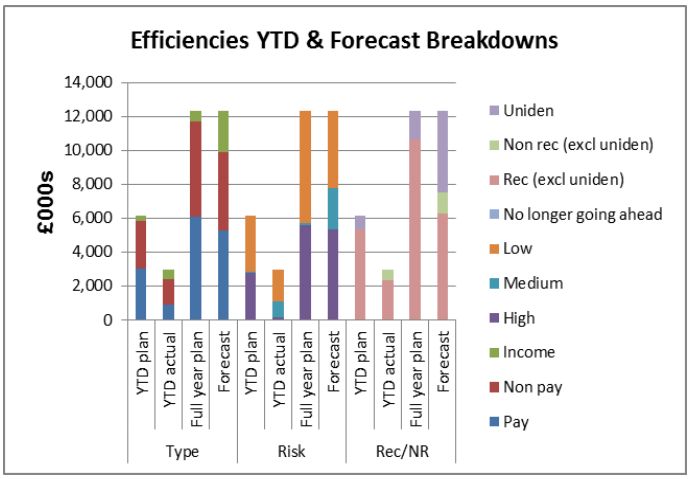




Cost Improvement Programme (CIP)

The Trust has planned CIP delivery just in excess of £1m each month, with the year to date target being £6.2m. The Trust has delivered £3m. This is an adverse variance of £3.2m.





Next Steps for this Quarter:

The Trust is already taking action to address the gaps identified; these actions include:

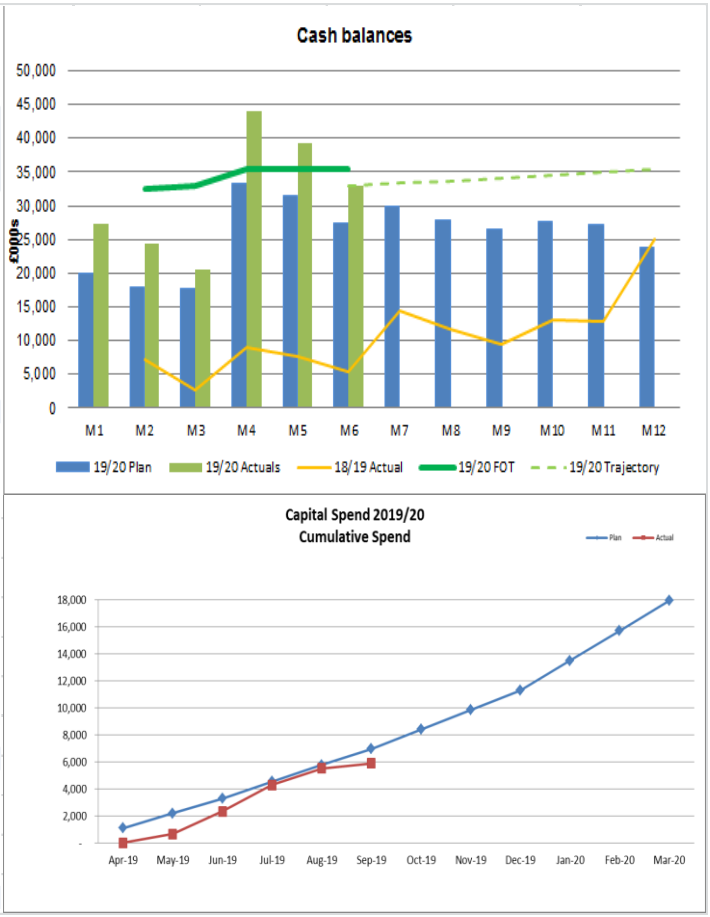
- Third party assurance on CIP including reviews of specific schemes identifying to give assurance that the details within key schemes are adequate to deliver the target value and where this is not the case, advise on the steps required
- Changes to the PMO structure to provide greater support to ICSUs 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 £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

	As at 30 Sep 2019 £000	Plan 30 Sep 2019 £000	Year to Date Plan variance 30 Sep 2019 £000
Property, plant and equipment and intangibles	220,722	226,470	(5,748)
Trade and other receivables	965	1,400	(435)
Total Non Current Assets	**221,687**	**227,870**	**(6,183)**
Inventories	1,776	1,355	421
Trade and other receivables	30,936	25,541	5,395
Cash and cash equivalents	32,881	27,387	5,494
Total Current Assets	**65,593**	**54,283**	**11,310**
Total Assets	**287,280**	**282,153**	**5,127**
Trade and other payables	46,755	41,719	5,036
Borrowings	27,848	29,057	(1,209)
Provisions	973	1,391	(418)
Total Current Liabilities	**75,576**	**72,167**	**3,409**
Net Current Assets (Liabilities)	**(9,983)**	**(17,884)**	**7,901**
Total Assets less Current Liabilities	**211,704**	**209,986**	**1,718**
Borrowings	28,313	31,252	(2,939)
Provisions	839	842	(3)
Total Non Current Liabilities	**29,152**	**32,094**	**(2,942)**
Total Assets Employed	**182,552**	**177,892**	**4,660**
Public dividend capital	66,691	69,191	(2,500)
Retained earnings	21,074	4,130	16,944
Revaluation reserve	94,787	104,571	(9,784)
Total Taxpayers' Equity	**182,552**	**177,892**	**4,660**



There are some significant variances in the balance sheet against plan. Overall, the value of the balance sheet is £4.7m 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 £5.8m lower than plan. This variance against plan largely arises from the revaluation decreases mentioned above. The gap between capital plans and actual capital spend is £0.9m at the end of month 6. The Trust remains confident that it will be able to spend capital allocations in year.

Cash and cash flow: the Trust has £32.9m in cash at the end of September 2019. This is £5.5m ahead of plan, and 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. The Trust will not require any cash support during 2019/20.

Receivables (Debtors) are at £31.9m at the end of September. This is £4.9m greater than plan, and the variance largely relates to an outstanding quarterly invoice from Health Education England for £4m. A significant proportion of old NHS debt was settled in September.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Integrated performance report**	**Agenda Item: 14**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Aisling Thompson, Deputy Chief Operating Officer and Director of Operations for Adult Community Services	
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 September 2019 was 87.7% (7.3% below NHS Improvement standard of 92%). Attendance in the ED was reduced from 8778 in August 2019 to 8658 in September 2019. This can be compared to September 2018 where the attendance was 8899. **ED – 12 Hour Trolley Waits – Mental Health** There were 8 patients waiting in excess of 12 hours in ED following a decision to admit for September 2019 with a mental health diagnosis. **Haringey New Birth Visits** The Haringey health visiting service achieved the 95% new birth visit target. The teams delivered 95.12% of visits within 14 days (312 visits out of total 328 due).	
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, October 2019	
Appendices	1. Community Performance Dashboard 2. Community Waiting Times Dashboard 3. Cancer Performance- 62D and 2WW by Tumour Group 4. Trust Level Activity	

Whittington Health
NHS Trust

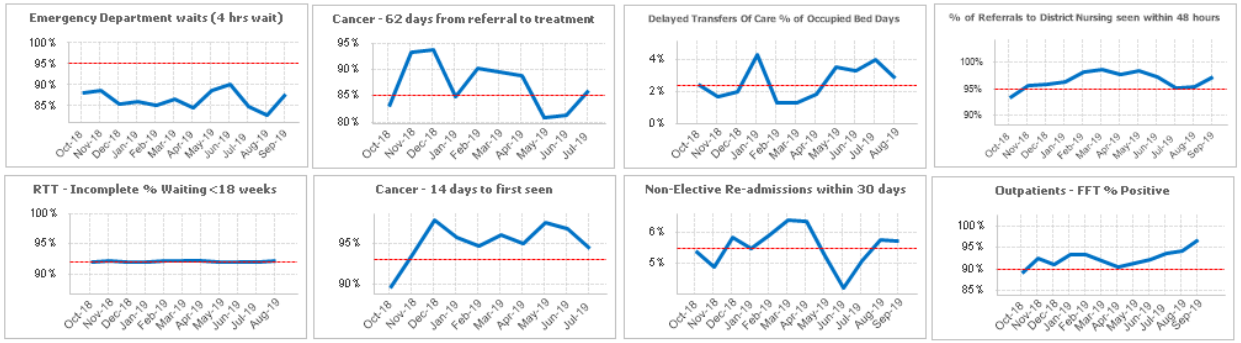
Performance Report
October 2019

Month 6 (2019 – 2020)

Date & time of production: 16/07/2019

Summary

Category	Indicator	17_18 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	
ED	Emergency Department waits (4 hrs wait)	>95%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	84.8%	82.8%	87.7%	86.4%	!
Cancer	Cancer - 14 days to first seen	>93%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%	97.0%	94.4%	92.0%		95.3%	
Cancer	Cancer - 62 days from referral to treatment	>85%	83.1%	93.3%	93.8%	84.9%	90.2%	89.6%	88.9%	81.0%	81.3%	85.9%	78.2%		82.9%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.42%	4.91%	5.86%	5.48%	5.92%	6.38%	6.36%	5.26%	4.24%	5.07%	5.75%	5.66%	5.38%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%	3.3%	4.0%	2.8%		3.1%	!
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.0%	92.2%	92.1%	92.1%	
Outpatients	Outpatients - FFT % Positive	>90%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	93.8%	94.3%	96.9%	93.8%	
Community	Community - FFT % Positive	>90%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	92.7%	95.0%	94.6%	95.8%	
Staff	Staff - FFT % Recommend Care	>70%			65.9%			74.0%			75.9%			77.1%	76.4%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	100.0%	92.5%	100.0%	96.6%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	93.3%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	97.2%	95.1%	95.4%	96.3%	96.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	90.9%	92.3%	90.7%	92.4%	95.5%	94.9%	94.0%	91.6%	93.0%	91.1%	95.1%		93.0%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	93.5%	93.8%	93.3%	95.4%	92.1%	95.4%	97.0%	90.4%	94.2%	92.9%	96.2%		94.1%	



Date & time of production: 16/07/2019

Safe | Caring | Effective | Responsive | Well Led

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	8	7	9	7	10	8	49	
HCAI C Difficile	<16	1	1	3	1	0	0	0	0	0	2	1	1	4	
Actual Falls	400	36	31	35	44	43	34	42	38	35	32	38	32	217	
Category 3 or 4 Pressure Ulcers	0							5	13	3	8	4	2	35	
Harm Free Care %	>95%	94.47%	92.25%	93.50%	90.08%	91.22%	94.21%	93.55%	89.58%	94.96%	90.70%	93.04%	93.90%	92.46%	
Non Elective C-Section % Rate	<19%	18.8%	21.5%	25.4%	20.1%	22.3%	24.7%	24.0%	22.5%	19.2%	21.1%	22.8%	23.4%	22.2%	
Medication Errors causing serious harm	0	0	0	0	0	0	0	1	0	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	0	1	0	0	0	0	0	1	2	0	1	0	4	
Proportion of reported Patient Safety Incidents Causing Harm	N/A	19.1%	16.7%	21.0%	20.9%	18.4%	22.4%	18.8%	26.0%	21.4%	21.4%	20.1%	21.7%	21.6%	
Serious Incidents	0	2	4	2	1	1	1	4	1	2	4	4	1	16	
VTE Risk Assessment %	>95%	95.2%	96.9%	95.3%	95.3%	95.2%	95.9%	95.3%	95.2%	96.4%	95.4%	95.3%		95.5%	
Mixed Sex Accomodation Breaches	0	1	0	0	2	2	0	0	0	0	0	8	1	9	
Hospital Standardised Mortality Ratio (HSMR)	100	69.0	92.1	87.3	79.9	75.0	94.7	79.9	95.6					87.4	
Summary Hospital Level Mortality Indicator (SHMI)	1.14			0.78			0.77								

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

Date & time of production: 16/07/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Harm Free Care %: Percentage of patients with no harm on the Safety Thermometer (includes old and new harm) **Standard:** ***95%***	**Variance against Plan: 93.9% - 2.1 from standard** **Action to Recover:** 1. The number of falls for the month reduced further to 32, but four of the falls this month resulted in harm. A deep dive to establish trends has been requested. A new initiative "What will prevent your patient from Falling today" has been introduced to generate discussion at board rounds and handovers to help continue to raise awareness. Bay watch and our enhanced care programme continue to help prevent high risk patients from falling. The monthly fall audits continue. 2. Our number of Category 3 / 4 pressure ulcers reduced to 2 this month. We are continuing to focus learning from the NHSI Improvement programme in the community and Critical Care unit. 3. Our safer staffing this month the % DAY fill rate for registered nurses for all wards apart from 3 received adequate staffing levels during September 2019. There were 3 reds shifts during this month. Our % Day fill rate for HCAs showed there has been significant increase in enhanced care for patients under Mental Health and falls risk. The appropriate decision making process (including assessment, and evaluation of care) is being followed and enhanced care shifts are scrutinised and authorised by the Associate Directors of Nursing. Safety was maintained through senior nurse oversight at all times. The review of all HealthRoster and safe care templates against the staffing ratios recommended in the last establishment review is in progress.	**Named Person:** Deputy Chief Nurse & Lead Nurse for Safer Staffing **Time Scale to Recover Performance:** November 2019

	The % night fill rate-nurses showed all wards apart from 2 received adequate staffing levels during September 2019, we had two Red shifts reported. Nightingale had had an increase in levels overnight due to caring for Tracheostomy patients. The % night fill rate for HCAs showed there has been significant increase in enhanced care in Acute Assessment Unit and the COOP Wards for patients under Mental Health and falls risk.	
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:** 23.4% - 4.4% from standard for September 2019 **Action to Recover:** 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 = 1 Category 4 = 1 Unstageable = 5 Deep Tissue Injury = 1 **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:** One Category 3 attributed to Whittington Hospital with all other pressure ulcers Category 3 and above attributed to District nursing service. Of the attributed pressure ulcers, 3 patients with unstageable pressure ulcers had service delivery identified which incorporated lack of assessment, no early provision of heel protectors. **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. The targets set within the board report require reviewing with the changes in measuring following the recommendations from NHSI/E April 2019.	**Named Person:** Lead Nurse Tissue Viability Service **Time Scale to Recover Performance:** Work on the trajectory was expected to be finalised in August 2019 but took longer than anticipated. New trajectory aims for November 2019

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

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
ED - FFT % Positive	>90%	80.9%	82.3%	81.0%	82.8%	78.3%	75.6%	78.6%	78.6%	81.9%	78.4%	81.7%	84.9%	80.9%	
ED - FFT Response Rate	>15%	13.1%	11.9%	12.0%	13.2%	11.9%	11.7%	10.3%	12.6%	13.0%	13.3%	15.1%	15.3%	13.3%	
Inpatients - FFT % Positive	>90%	96.8%	97.8%	98.1%	95.5%	96.3%	98.4%	96.6%	97.4%	98.2%	97.6%	98.0%	96.7%	97.5%	
Inpatients - FFT Response Rate	>25%	12.4%	20.5%	18.1%	14.1%	21.7%	23.5%	15.1%	23.3%	21.0%	19.9%	26.4%	18.1%	20.6%	
Maternity - FFT % Positive	>90%	95.3%	92.8%	92.9%	95.6%	96.5%	94.0%	95.1%	93.9%	94.1%	93.8%	94.0%	92.8%	93.9%	
Maternity - FFT Response Rate	>15%	40.0%	42.9%	48.9%	53.1%	50.7%	52.4%	31.1%	41.3%	52.2%	34.1%	48.1%	45.8%	41.9%	
Outpatients - FFT % Positive	>90%	89.0%	92.6%	91.0%	93.4%	93.3%	91.9%	90.5%	91.4%	92.1%	93.8%	94.3%	96.9%	93.8%	
Outpatients - FFT Responses	400	328	484	233	423	389	421	419	233	126	273	690	586	2327	
Community - FFT % Positive	>90%	95.5%	97.1%	97.9%	96.7%	97.7%	97.6%	96.8%	97.7%	98.0%	92.7%	95.0%	94.6%	95.8%	
Community - FFT Responses	1500	1159	998	622	1014	1028	953	842	909	799	832	762	792	4936	
Staff - FFT % Recommend Care	>70%			65.9%			74.0%			75.9%			77.1%	76.4%	
Complaints responded to within 25 or 40 working days	>80%							75.0%	92.9%	84.2%	88.9%	82.1%	81.8%	84.7%	
Complaints (including complaints against Corporate division)	N/A	0	0	0	0	0	0	20	28	19	27	28	22	144	

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

Date & time of production: 16/07/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate : September – positive response rate 85%; response rate 15.3% **Standard:** Positive Response >90% Response Rate >15%	**Variance against Plan:** ED's FFT positive response rate for September (85%) was below the positive responses KPI (90%). It is worth noting however that 85% for September 2019 represents the highest individual monthly response rate since July 2017 (85% also). **Action to Recover:** Actions undertaken by the patient experience working group, led by the Lead Nurse for CDU, Patient Experience, Trauma and Practice Development in ED, have resulted in a sustained improvement in the response rate (exceeding the Trust set KPI across the past two months). The group continue to meet monthly to ensure improvement is sustained and developed.	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** March 2020
Inpatients FFT Response Rate : September – 97% positive responses; 18% response rate **Standard:** Positive Response >90% Response Rate >25%	**Variance against Plan:** Response rate for September (18%) dropped below the KPI (25%). This result does buck the trend of improvement in this area, where the response rate had exceeded 20% since May 2019. **Action to Recover:** Patient experience manager will address this with the ward managers and matrons.	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** November 2019
Community FFT Responses: September – 95% positive responses; 792 responses **Standard:** Positive Response >90% Response Rate 1500	**Variance against Plan:** Community reporting continues to exceed the 90% KPI (41 months in succession) for positive responses, but did not meet the Trust set KPI of 1,500 responses per month. **Action to Recover:** Work continues to optimise the email to sms service employed within podiatry, MSK and adult community dietetics. The patient experience manager will be working with MSK team leaders through October to enhance awareness among their teams around collecting and reporting on FFT.	**Named Person:** James Connell, Patient Experience Manager **Time Scale to Recover Performance:** January 2020

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

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance	
Hospital Cancelled Operations	0	8	10	4	5	14	7	10	3	10	18	4		45		!
Cancelled ops not rebooked < 28 days	0	1	2	0	0	1	0	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%	80.69%	79.61%	80.85%	80.42%	78.49%	77.53%	81.47%	85.32%	83.92%	84.97%	85.71%	85.11%	84.35%		
Breastfeeding Initiated	>90%	93.2%	93.2%	89.2%	91.3%	92.4%	93.9%	91.7%	89.9%	89.9%	91.9%	91.1%	88.1%	90.4%		
Mortality rate per 1000 admissions in-months	14.4	5.5	6.6	8.4	7.7	6.0	9.2	8.1	7.4	7.3	7.4	7.1	7.0	7.4		
Community DNA % Rate	<10%	7.8%	7.5%	8.0%	7.5%	7.4%	6.7%	7.6%	7.0%	7.1%	7.8%	8.1%	7.6%	7.5%		
Community Services - Provider Cancellations	<8%	6.1%	6.6%	7.4%	6.3%	6.0%	6.3%	6.3%	6.3%	5.9%	6.3%	6.8%	6.5%	6.3%		
Acute DNA % Rate	<10%	10.5%	10.5%	10.3%	10.0%	10.6%	9.7%	10.5%	11.5%	13.3%	12.6%	12.3%	12.0%	12.0%		!
% of GP Referrals that were completed via ERS		87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.3%	88.1%	89.0%	88.6%	86.8%	87.7%	88.1%		
Outpatients New:FUp Ratio	2.3	1.92	1.87	1.94	1.96	1.86	1.92	1.94	1.92	1.87	1.83	1.83	1.80	1.86		
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.5%	1.7%	2.0%	4.3%	1.3%	1.3%	1.8%	3.6%	3.3%	4.0%	2.8%		3.1%		!
Non Elective Re-admissions within 30 days	<5.5%	5.42%	4.91%	5.86%	5.48%	5.92%	6.38%	6.36%	5.26%	4.24%	5.07%	5.75%	5.71%	5.39%		

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

Date & time of production: 16/07/2019

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Theatre Cancellations On The Day : 4	**Variance against Plan:** 4 cases cancelled on the day 2 x urology cases due to unavailability of equipment 2 x T&O cases cancelled due clinical complications during earlier cases. **Action to Recover:** All cases were rebooked within 28 days The team is working with Medical Physics in order to purchase the appropriate urology equipment within the budget available.	**Named Person:** Otilia Beres **Time Scale to Recover Performance:** 1 month
Delayed Transfers of Care % of Occupied Bed Days: **Standard:** <2.4%	**Variance against Plan:** 0.4% adverse variance against plan in September 2019. **Action to Recover:** There is continued focus on reducing delayed transfer of care through proactive discharge planning and appropriate & timely escalation of delays. Much of the improvement work is overseen within the Outflow group (part of the AEDB improvement plan), including optimising community pathways. There is also additional operational capacity within the COOP speciality	**Named Person:** Nicola Stephenson **Time Scale to Recover Performance:** March 2020

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

Indicator	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
Emergency Department waits (4 hrs wait)	>95%	88.2%	88.5%	85.5%	86.0%	85.1%	86.6%	84.6%	88.6%	90.1%	84.8%	82.8%	87.7%	86.4%	
ED Indicator - median wait for treatment (minutes)	<60 mins	79	88	90	85	92	97	91	76	67	84	72	65	76	
Ambulance handovers waiting more than 30 mins	0	18	15	23	18	53	28	56	35	28	30	41		190	
Ambulance handovers waiting more than 60 mins	0	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	1	0	1	0	1	0	7	12	10	8	38	
Cancer - 14 days to first seen	>93%	89.6%	93.7%	97.9%	95.9%	94.8%	96.2%	95.0%	97.7%	97.0%	94.4%	92.0%		95.3%	
Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	97.4%	97.7%	95.5%	100.0%		97.4%	
Cancer - 62 days from referral to treatment	>85%	83.1%	93.3%	93.8%	84.9%	90.2%	89.6%	88.9%	81.0%	81.3%	85.9%	78.2%		82.9%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%				83.0%	90.0%	89.6%	88.2%	76.7%	82.6%	80.6%	78.2%		80.8%	
Cancer ITT - % of Pathways sent before 38 Days	>85%				100.0%	40.0%	75.0%	62.5%	25.0%	100.0%	33.3%	45.5%		45.2%	
Cancer - % Pathways received a Diagnosis within 28 Days of Refer...		83.6%	86.1%	93.9%	88.3%	88.2%	83.3%	89.9%	94.9%	96.4%	94.5%	92.8%		93.7%	
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%	0.0%		75.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.1%	99.0%	99.0%	99.0%	99.0%	99.2%	99.2%	99.1%	99.4%	99.3%	99.5%	99.3%	
RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.1%	92.1%	92.1%	92.3%	92.2%	92.1%	92.1%	92.0%	92.0%	92.2%	92.1%	92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	1	1	0	0	0	0	0	0	0	0	0	0	0	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	89.2%	82.5%	95.8%	84.1%	89.7%	90.3%	94.1%	100.0%	96.0%	100.0%	92.5%	100.0%	96.6%	
% seen <=48 hours of Referral to District Nursing Service	>95%	93.3%	95.6%	95.9%	96.4%	98.1%	98.7%	97.6%	98.4%	97.2%	95.1%	95.4%	96.3%	96.8%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	90.9%	92.3%	90.7%	92.4%	95.5%	94.9%	94.0%	91.6%	93.0%	91.1%	95.1%		93.0%	
Islington New Birth Visits - % seen within 2 weeks	>95%	93.5%	93.8%	93.3%	95.4%	92.1%	95.4%	97.0%	90.4%	94.2%	92.9%	96.2%		94.1%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Wait Performance: 95%	**Variance against Plan: 7.35%** September – 87.65% **Action to Recover:** • Embedded importance of first 60 minutes initiative which noted an improvement in the medium time to treatment • Front of House model for i.e. streaming, redirection, triage & RAT has noted an improvement on the % departed within 2 hours. • Launch of the Emergency Medical Unit (EMU) in October 2019 to improve flow and reduce overcrowding in the ED. • Submission for signoff on the internal professional standards in relation to speciality responses • Increase direct patient pathways to AEC to fully optimise AEC capacity • LAS conveyances and alternative care pathways i.e LAS direct access to AEC and UTC waiting room for appropriate patients • Weekend shifts with enhanced consultant and junior doctor cover • Revised admission pathways for the Clinical Decision Unit (CDU)	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** During September the ED did not see the expected recover in 4hr performance and throughout October we are concentrating on implementing the revised CDU and front of house (FoH) work. During the winter period the ED will regularly review the medical decision making capacity patient pathways in line with the A&E improvement and ECIST corridor care reports and action plan to maintain safety within the department.
ED – 12 Hour Trolley Waits : **September 2019** 8x 12 hr trolley breaches for patients awaiting a mental health admissions.	**Variance against Plan: 8** **Action to Recover:** • Exploring 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	**Named Person:** Acting General Manager **Time Scale to Recover Performance:**

Zero x 12 hr trolley breaches for acute admission	team • Aim for 50% utilisation of the mental health suite for lower acuity of non-admitted patients • Ensure that 90% of patients in ED are referred to MHLT assessed within 60 minutes of arrival. • Adhering to agreed escalation processes	End November/December 2019
Ambulance Hand Overs more than 30 and 60 minutes: September - LAS 16 x 30 mins breaches 0x 60 mins breaches	**Variance against Plan: 0** **Action to Recover:** • Established LAS direct access to AEC for medically appropriate patients • Re-establish LAS direct access to UTC waiting room for patients with minor illness and or injuries • To reduce the percentage of ambulance handovers that exceeds 15 minutes as per agreed trajectory (AEDB improvement plan)	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** End of September to have 0 x 30 mins & 60 mins LAS breaches
ED – median wait for treatment: . **Target:** 60 minutes	**Variance against Plan: 5 minutes** **September 2019 – 65 mins** **Action to Recover:** • Implementation of the revised front of house model i.e. streaming, redirection, triage & RAT. • Dedicated RAT registrar and EDA (emergency department assistant) at the front of house 7 days per week • Achieve 50% of patients seen by a clinician/senior decision marker within 60 mins of registration • Achieve 90% of the RAT shifts filled with a registrar or equivalent • Achieve 40% of patients seen and discharged within 2 hours of arrival – September noted 31% (9% variance against the plan) (as part of AEDB improvement plan)	**Named Person:** Acting General Manager **Time Scale to Recover Performance:** We expect to see recovery to start by the end November 2019 once processes are embedded

Cancer – 14 day performance	**Variance against Plan:** 92% against 93% target The Trust demonstrates compliance against this metric in previous months however there has been a minor deterioration in August. It is anticipated that our position will recover by October 2019.	**Named Person:** Prabha Greedhun
Cancer – 62 day performance	**Variance against Plan:** 78.2% against 85% target The Trust did not meet 62 day performance in August. This reflected pressures in the Urology pathway as well as Gynaecology and Breast. Inter-Trust Transfer (ITT) performance was low with 45.5% of patients referred to tertiary providers within the 38 day timescale. **Action to Recover:** Gynaecology: To increase number of hysteroscopy clinics by end of November. Urology: To implement biopsy clinic on Friday to ensure that patients are booked in the results clinic in a timely manner. Ongoing dialogue with tertiary providers to reduce waiting times for treatment. Inter-Trust Transfers (ITT): To reinforce the ITT policy to all MDT members across all tumour groups. All relevant information including imaging and pathology reports to be included in the ITR (inter trust referral) pack.	**Time Scale to Recover Performance:** Urology - end of November 2019 Gynaecology – end of December 2019

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

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
Appraisals % Rate	>90%	77.0%	76.0%	73.2%	72.7%	72.4%	72.6%	71.3%	69.8%	71.4%	72.4%	74.2%	75.5%	72.5%	
Mandatory Training % Rate	>90%	82.4%	81.1%	80.7%	80.8%	80.8%	80.8%	80.2%	80.1%	79.9%	82.2%	80.8%	81.1%	80.7%	
Permanent Staffing WTEs Utilised	>90%	87.3%	87.2%	88.0%	88.1%	88.0%	88.0%	87.3%	86.9%	87.2%	88.9%	86.8%	87.9%	87.5%	
Staff FFT % recommended work	>50%			57.4%			61.8%			59.9%			59.6%	59.8%	
Staff FFT response rate	>20%			47.8%			16.2%			22.3%			16.3%	19.3%	
Staff sickness absence %	<3.5%	3.92%	3.81%	3.35%	3.71%	3.69%	3.49%	3.27%	3.13%	3.62%	3.57%	3.19%		3.35%	
Staff turnover %	<10%	12.7%	12.7%	12.0%	11.7%	11.4%	10.8%	10.6%	10.9%	10.9%	10.8%	10.7%	10.6%	10.7%	
Vacancy % Rate against Establishment	<10%	12.7%	12.8%	12.0%	11.9%	12.0%	12.0%	12.7%	13.1%	12.8%	11.1%	13.2%	12.1%	12.5%	
Average Time to Hire (Days)	<61 Days						63	65	69	60	61	62	59	63	
Nursing Staff Average % Day Fill Rate - Nurses		76.8%	76.7%	74.9%	89.3%	87.4%	86.1%	86.7%	86.2%	89.8%	93.2%	87.4%	89.3%	88.7%	
Nursing Staff Average % Day Fill Rate - HCAs		130.4%	130.4%	125.3%	112.6%	117.1%	112.6%	109.1%	115.0%	113.8%	115.6%	127.8%	125.9%	117.6%	
Nursing Staff Average % Night Fill Rate - Nurses		85.3%	85.3%	79.2%	92.2%	90.8%	88.6%	88.4%	87.2%	92.1%	92.9%	91.8%	90.4%	90.4%	
Nursing Staff Average % Night Fill Rate - HCAs		79.6%	83.0%	131.1%	134.5%	124.4%	115.7%	109.3%	114.6%	113.2%	131.1%	126.2%	134.7%	120.5%	
Safe Staffing Alerts - Number of Red Shifts		0	0	0	0	2	1	0	0	3	2	3	5	13	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		9.2	8.8	10.2	9.0	9.0	9.1	9.0	9.1	9.7	9.3	9.2	8.8	9.2	

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

Safe | Caring | Effective | Responsive | Well Led

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate : 75.5% **Standard:** 90% of staff members should have an appraisal in each 12 month period.	**Variance against Plan: -15%** **Action to Recover:** Simplified documents are currently in place Guidance for managers and appraisees has been merged into one guide now available on intranet and are live. Appraisal training continues to confirm 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 in the e-learning suite (ground floor) Mon-Fri 09:00–17:00 (booking advised) and new sessions in Archway for mandatory training support, in the Social Club computer suite Tue, Wed and Fri 09:30-14:30, can also be used to get help loading appraisal dates into ESR. L&D team supporting managers to input appraisal dates on ESR	**Named Person:** Helen Kent, Assistant Director L&OD **Time Scale to Recover Performance:** September has shown a small increase in appraisal rate performance ahead of the expected October 2019 improvements.
Mandatory Training % Rate : 81.1% **Standard:** 90% compliance across staff reported monthly	**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	**Named Person:** Helen Kent, Assistant Director L&OD **Time Scale to Recover Performance:** Milestones: Auditor observations expected end of October 2019 QI project results and actions to recover errors expected to end at the end of December 2019

	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 Restructure resulting in new larger L&D team being recruited to	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: 87.9 **Standard:** 90%	**Variance against Plan:** 2.1% **Action to Recover:** There has been a slight improvement from September 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: 10.6% The Trust should have less than 10% of staff who have left the Trust within the last 12 months **Standard:** 10%	**Variance against Plan:** 0.6% **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: 12.1% The Trust should have less than 10% unfilled posts **Standard:** 10%	**Variance against Plan:** 2.1% **Action to Recover:** There has been a slight decrease 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: 8.4 Time taken from resignation/creation of new post to confirmed start date **Standard:** 8 weeks	**Variance against Plan:** 0.4 weeks **Action to Recover:** The time to hire has decreased to a variation of 0.4%. 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: November 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 and actions to recover:** Haringey New birth visits– the Haringey health visiting service achieved the 95% new birth visit target. The teams delivered 95.12% of visits within 14 days (312 visits out of total 328 due). Haringey Community Paediatrics – SCC We have introduced changes to the autism diagnosis pathway and we are monitoring the impact of this change over the autumn. We are also putting in place additional clinics run by SLTs to reduce the backlog of patients. Islington Community Paediatrics Capacity does not meet demand, recruitment underway to fill vacant medical positons. A re-structure across both Haringey and Islington Community Paediatric Teams is underway with a view to making better use of available capacity. Islington and Haringey OT Staff vacancies within the service are behind the longer waits. The lead for the service is recruiting to vacancies and we expect an improvement over the coming months School nursing Haringey The average waits for the service are good. The waits are skewed by the	**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).

	Enuresis clinic which is provided by the school nursing team. This capacity issue is known and there are ongoing discussions with commissioners regarding funding toward existing and increased capacity. Islington and Haringey SALT High vacancy rates and maternity leave within mainstream SALT service is contributing to challenged performance. Recruitment underway and improvement expected over the coming months. CAMHS On line with agreed trajectory- on track for meeting average RTT of 9 weeks by December Single point of access launched Services to continue to address data quality and ensure that Borough Leads consistently review and monitor this.	
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:** Significant improvements in performance are apparent in key services notably Podiatry, Cardiology, Spirometry, Community Rehabilitation, ICTT - Stroke and Neuro and Musculoskeletal services. Overall performance is showing an overall upward trend. **Action to recover:** In Community Rehabilitation, Integrated Care Therapy Team (ICTT) and Intermediate Care, there is ongoing work being monitored through the ICSU Board and Community PTL meetings to maximise existing capacity. This has demonstrated improvements in Stroke and Neuro performance. Community Matron performance dipped in Islington in September due to vacancies and sickness absence however it is anticipated that performance targets will be met in October. Musculoskeletal services have experienced referrals above expected levels and have also successfully implemented a roll -out of the Single Point of Access. Despite pressures, waiting times are improving month on month and are at their highest levels this year. Ongoing recruitment will enable the service to continue to improve waiting times. The ICSU is working closely with EIM colleagues to develop an	**Named Person:** Director of Operations ACS **Time Scale to Recover Performance:** The timescale for recovery for services is 3 months.

	integrated continence service that wisely result in streamlined referral pathways for Bladder and Bowel services. This will improve efficiency and support achievement of waiting times.	

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
IAPT Moving to Recovery	>50%	62.5%	57.4%	58.2%	62.3%	65.1%	59.1%	62.2%	54.2%	60.8%	60.5%	56.6%		59.1%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	96.8%	95.8%	96.6%	95.6%	95.4%	94.3%	96.9%	95.0%	97.4%	97.8%	94.0%		96.4%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	88.9%	85.8%	91.9%	83.7%	91.8%	88.1%	90.4%	89.4%	87.2%	91.1%	88.8%		89.4%	
Haringey - HR1 % carried out before child aged 15 months	N/A	69.9%	72.0%	73.1%	77.9%	77.0%	79.6%	81.3%	80.8%	80.6%	87.9%	81.0%		82.2%	
Haringey - HR2 % carried out before child aged 30 months	N/A	60.6%	60.4%	61.7%	67.6%	70.4%	71.0%	70.2%	71.8%	70.6%	74.4%	75.9%		72.4%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	96.7%	92.4%	90.6%	86.5%	90.3%	91.7%	92.9%	95.4%	90.8%	90.8%	94.3%		92.8%	
Islington - HR1 % carried out before child aged 15 mths	N/A	76.5%	80.6%	82.0%	74.4%	73.7%	83.0%	80.2%	79.5%	83.0%	86.1%	78.8%		81.6%	
Islington - HR2 % carried out before child aged 30 mths	N/A	80.3%	82.0%	85.0%	77.2%	75.1%	72.4%	78.1%	76.5%	79.4%	81.8%	77.7%		78.8%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	83.0%	82.6%	75.7%	85.1%	92.9%	92.9%	89.3%	96.2%	95.5%	92.1%	94.3%	92.0%	92.9%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	83.7%	95.1%	81.5%	89.7%	90.0%	86.2%	78.8%	87.1%	96.2%	95.8%	84.6%	86.2%	88.6%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	71.2%	80.0%	75.3%	73.8%	71.9%	78.5%	80.6%	74.3%	84.8%	88.1%	70.2%	71.2%	79.1%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	89.4%	96.9%	95.3%	93.3%	95.7%	93.5%	98.7%	96.2%	91.0%	87.6%	96.6%	95.7%	93.8%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	100.0%	100.0%	88.9%	100.0%	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%	70.0%	83.3%	73.3%	42.9%	78.6%	100.0%	81.8%	75.0%	71.4%	60.0%	75.0%	40.0%	68.3%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	91.7%	90.0%	72.7%	77.8%	100.0%	90.0%	100.0%	100.0%	85.7%	88.9%	93.3%	88.9%	92.7%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%			47.8%			42.3%			59.8%				59.8%	
Islington Self-Management - Average Increase in PAM Score	>=9			11			18			8				8	
Haringey Self-Management - Average Increase in PAM Score	>=9			13			15			9				9	

Appendix 2. Community Waiting Times Dashboard

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	87.50%	87.50%	60.00%	5	5	>95%						0
ACS	Community Matron	>95%	6	100.00%	96.80%	91.20%	34	34	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	98.10%	100.00%	98.10%	52	52	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	86.90%	90.90%	93.70%	111	111	>95%	2	80.00%	75.00%	85.70%	1.3	21
ACS	ICTT - Other	>95%	12	95.90%	93.00%	92.30%	299	299	>95%	2	75.50%	61.70%	40.00%	3.2	50
ACS	ICTT - Stroke and Neuro	>95%	12	51.30%	73.70%	87.10%	31	31	>95%	2	50.00%	68.00%	73.50%	1.5	34
ACS	Intermediate Care (REACH)	>95%	6	89.80%	95.30%	84.10%	138	138	>95%	2	87.00%	85.20%	84.70%	0.9	111
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	5	5	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	69.40%	72.60%	78.00%	91	91	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	47.00%	61.80%	71.00%	613	613	>95%		0.00%	33.30%	33.30%	3.5	15
ACS	Musculoskeletal Service - Routine	>95%	6	70.70%	82.20%	83.20%	1593	1593	>95%	2		100.00%	60.00%	2.1	15
ACS	Nutrition and Dietetics	>95%	6	100.00%	100.00%	100.00%	194	194	>95%	2		100.00%			0
ACS	Podiatry (Foot Health)	>95%	6	90.00%	95.70%	95.90%	604	604	>95%	2			100.00%	1.1	1
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	17	17	>95%						0
ACS	Tissue Viability	>95%	6	95.20%	95.80%	100.00%	39	39	>95%						0
ACS	Cardiology Service	>95%	6	95.70%	84.20%	96.80%	31	31	>95%	2		100.00%	100.00%	1	3
ACS	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	67	67	>95%	2					0
ACS	Respiratory Service	>95%	6	100.00%	100.00%	100.00%	59	59	>95%	2	100.00%	100.00%	100.00%	2	1
ACS	Spirometry Service	>95%	6	66.20%	92.40%	96.00%	50	50	>95%	2					0

Appendix 2. Community Waiting Times Dashboard

Haringey

Service	Routine Referral Urgency							Urgent Referral Urgency						
	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-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%	0.9	10	>95%	2					0
Adult Wheelchair Service	>95%	8	98.00%	100.00%	100.00%	2.5	38	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	100.00%	0.00%	100.00%	3	6	>95%	2	100.00%				0
ICTT - Other	>95%	12	96.10%	93.00%	91.90%	4.5	234	>95%	2	75.30%	63.50%	43.60%	2.9	39
ICTT - Stroke and Neuro	>95%	12	50.00%	80.00%	84.20%	7.1	19	>95%	2	46.70%	66.70%	66.70%	2	15
Intermediate Care (REACH)	>95%	6	100.00%				0	>95%	2	100.00%		100.00%	1.3	2
Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	5.4	5	>95%						0
Bladder and Bowel - Adult	>95%	12	69.00%	67.40%	86.20%	7.5	29	>95%						0
Musculoskeletal Service - CATS	>95%	6	49.70%	64.30%	77.10%	4.9	214	>95%		0.00%	100.00%	0.00%	4.8	4
Musculoskeletal Service - Routine	>95%	6	70.40%	81.30%	82.40%	4.2	680	>95%	2			75.00%	1.8	4
Nutrition and Dietetics	>95%	6	100.00%	100.00%	100.00%	2.6	98	>95%	2		100.00%			0
Podiatry (Foot Health)	>95%	6	87.70%	94.20%	93.90%	3.8	244	>95%	2					0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.9	6	>95%						0
Tissue Viability	>95%	6	90.90%	88.90%	100.00%	0.8	19	>95%						0
Cardiology Service	>95%	6	100.00%	88.90%	100.00%	2	12	>95%	2		100.00%			0
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.6	40	>95%	2					0
Respiratory Service	>95%	6	100.00%	100.00%	100.00%	3.3	20	>95%	2					0
Spirometry Service	>95%	6	65.60%	92.40%	97.40%	3.2	39	>95%	2					0

Appendix 2. Community Waiting Times Dashboard

Islington

Date & time of production: 16/07/2019

	Routine Referral Urgency							Urgent Referral Urgency						
Service	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen	% Target	Target Weeks	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen
Bladder and Bowel - Children	>95%	12	87.50%	87.50%			0	>95%						0
Community Matron	>95%	6	100.00%	95.20%	81.30%	1.8	16	>95%	2					0
Adult Wheelchair Service	>95%	8					0	>95%	2					0
Community Rehabilitation (CRT)	>95%	12	85.80%	92.20%	93.80%	4.9	80	>95%	2	80.50%	75.00%	80.00%	1.6	15
ICTT - Other	>95%	12	50.00%	75.00%	100.00%	5.1	3	>95%	2	0.00%	0.00%			0
ICTT - Stroke and Neuro	>95%	12			100.00%	0.9	1	>95%	2	100.00%		100.00%	1	2
Intermediate Care (REACH)	>95%	6	89.50%	95.20%	85.60%	3.2	97	>95%	2	85.90%	84.20%	83.30%	0.9	72
Paediatric Wheelchair Service	>95%	8					0	>95%						0
Bladder and Bowel - Adult	>95%	12	68.30%	81.60%	77.40%	7.9	31	>95%						0
Musculoskeletal Service - CATS	>95%	6	43.80%	58.60%	66.90%	5.7	239	>95%			0.00%	42.90%	3.7	7
Musculoskeletal Service - Routine	>95%	6	71.60%	84.70%	83.80%	4.2	536	>95%	2		100.00%	55.60%	2.2	9
Nutrition and Dietetics	>95%	6	100.00%	100.00%	100.00%	2.3	55	>95%	2					0
Podiatry (Foot Health)	>95%	6	92.40%	97.00%	97.40%	3.4	232	>95%	2					0
Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	2	11	>95%						0
Tissue Viability	>95%	6	100.00%	100.00%	100.00%	0.8	9	>95%						0
Cardiology Service	>95%	6	92.30%	80.00%	91.70%	2.6	12	>95%	2		100.00%	100.00%	1.1	2
Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.8	19	>95%	2					0
Respiratory Service	>95%	6	100.00%	100.00%	100.00%	2.7	26	>95%	2	100.00%	100.00%			0
Spirometry Service	>95%	6					0	>95%	2					0

Children's Community Waits Performance

	Routine Referral Urgency							Urgent Referral Urgency						
Team Group	% Target	Target	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen	% Target	Target	Jul-19	Aug-19	Sep-19	Avg Wait (Sep-19)	No of Pts First Seen
CAMHS	>95%	8	60.00%	65.80%	54.20%	12.3	142	>95%	2	72.70%	100.00%	83.30%	1.7	6
Community Children's Nursing - Haringey	>95%	2	100.00%	66.70%	0.00%	7.9	1	>95%	1					0
Community Children's Nursing - Islington	>95%	2	83.20%	86.90%	92.10%	0.5	114	>95%	1	100.00%	100.00%	100.00%	0	13
Community Paediatrics - Haringey (SCC)	>95%	18	20.80%	61.50%	31.80%	55.2	22	>95%	1		0.00%	0.00%	64.1	2
Community Paediatrics - Haringey (NDC)	>95%	18	100.00%	100.00%	97.00%	9.5	33	>95%	1	0.00%				0
Community Paediatrics - Haringey (Child Protection)	>95%	18	100.00%	100.00%	100.00%	0.7	12	>95%	1					0
Community Paediatrics - Haringey (Other)	>95%	18	0.00%		100.00%	3.7	9	>95%	1					0
Community Paediatrics - Islington	>95%	18	80.00%	69.20%	96.00%	7.7	25	>95%	1					0
Family Nurse Partnership - Haringey	>95%	12	92.90%	80.00%	77.80%	6	9	>95%						0
Family Nurse Partnership - Islington	>95%	12	100.00%	100.00%	100.00%	4	1	>95%						0
Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.4	7	>95%						0
IANDS	>95%	18	80.00%	100.00%	87.10%	7.7	31	>95%						0
IANDS - SCT	>95%	20	0.00%	16.70%	50.00%	23.1	2	>95%						0
Looked After Children - Haringey	>95%	4	93.30%	100.00%	69.20%	3.3	13	>95%						0
Looked After Children - Islington	>95%	4	70.00%	91.70%	84.60%	3.2	13	>95%						0
Occupational Therapy - Haringey	>95%	18	82.40%	50.00%	76.20%	7.5	42	>95%	2			100.00%	0.1	1
Occupational Therapy - Islington	>95%	18	71.40%	66.70%	64.30%	14	14	>95%	2					0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12	100.00%	100.00%	100.00%	3	3	>95%						0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	95.50%	100.00%	100.00%	4.1	25	>95%						0
Physiotherapy - Haringey	>95%	18	97.10%	94.60%	98.30%	6.2	59	>95%						0
Physiotherapy - Islington	>95%	18	100.00%	100.00%	100.00%	4.3	85	>95%						0
PIPS	>95%	12	90.50%	100.00%	100.00%	2.3	13	>95%						0
SALT - Haringey	>95%	15	37.80%	50.00%	62.80%	11.3	113	>95%	2	33.30%	33.30%	40.00%	2.1	5
SALT - Islington	>95%	15	95.40%	100.00%	90.20%	7.7	61	>95%	2					0
SALT - MPC	>95%	18	97.70%	96.70%	98.50%	4.6	68	>95%	2					0
School Nursing - Haringey	>95%	12	86.30%	94.70%	85.70%	4.5	77	>95%						0
School Nursing - Islington	>95%	12	97.00%	100.00%	93.60%	3.1	47	>95%						0

Date & time of production: 16/07/2019

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

Cancer - 62D Performance by Tumour Group

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
Breast	>85%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.6%	100.0%	83.3%			
Gynaecological	>85%	100.0%	66.7%	100.0%	66.7%	0.0%	100.0%	50.0%	50.0%		0.0%	44.4%			
Haematological (Excluding Acute Leukaemia)	>85%	100.0%	100.0%	100.0%		100.0%	0.0%	100.0%	100.0%			100.0%			
Lower Gastrointestinal	>85%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	83.3%			
Lung	>85%	100.0%	100.0%		100.0%	85.7%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%			
Other	>85%				100.0%		100.0%	100.0%							
Skin	>85%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%			
Testicular	>85%					100.0%		100.0%		0.0%		100.0%			
Upper Gastrointestinal	>85%	100.0%		75.0%	100.0%		100.0%	50.0%	100.0%	66.7%	0.0%				
Urological (Excluding Testicular)	>85%	44.4%	100.0%	66.7%	64.7%	80.0%	76.9%	88.9%	70.6%	71.4%	62.5%	80.0%			

Cancer - 2WW Performance by Tumour Group

Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019-2020	Performance
Breast	>93%	94.0%	97.3%	98.6%	98.5%	93.7%	96.0%	93.9%	99.0%	96.8%	98.0%	95.5%		96.6%	
Childrens	>93%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	95.6%	96.4%	97.8%	97.1%	91.8%	96.6%	94.5%	96.0%	96.1%	96.4%	94.3%		95.5%	
Haematological	>93%	92.9%	91.7%	95.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Lower Gastrointestinal	>93%	73.0%	87.3%	98.3%	92.8%	94.2%	95.8%	91.2%	96.7%	96.2%	92.8%	95.5%		94.6%	
Lung	>93%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	83.3%	83.3%	100.0%		88.5%	
Skin	>93%	98.0%	97.5%	98.6%	97.6%	99.3%	96.2%	98.0%	98.8%	97.5%	91.1%	82.3%		93.2%	
Upper Gastrointestinal	>93%	59.6%	89.2%	98.0%	87.2%	98.2%	98.9%	91.4%	96.6%	98.5%	97.9%	97.1%		96.2%	
Urological	>93%	97.9%	86.4%	94.9%	91.8%	92.4%	92.1%	98.8%	98.4%	98.8%	93.8%	95.0%		96.6%	

Appendix 4. Trust Level Activity

Category	Indicator	19_20 Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Activity
ED	ED Attendances	8285	9082	9245	9219	9595	8868	9720	9077	9281	8921	9458	8778	8658	
ED	ED Admission Rate %		15.0%	16.2%	15.9%	14.9%	14.3%	15.1%	15.0%	14.2%	14.8%	13.4%	13.5%	13.8%	
Community	Community Face to Face Contacts		64113	63989	51482	62551	56389	60494	55842	59998	59713	61419	51857	54434	
Admissions	Elective and Daycase		2267	2221	1813	2149	1989	2133	2121	2072	2154	2236	1965	1850	
Admissions	Emergency Inpatients		2185	2289	2230	2268	2036	2297	2224	2217	2095	2101	2036	2084	
Referrals	GP Referrals to an Acute Service		8283	7961	6682	8146	7912	8634	8454	8922	8199	7923	6605	7026	
Referrals	% of GP Referrals that were completed via ERS		87.4%	89.0%	85.5%	87.6%	87.5%	88.2%	88.3%	88.1%	89.0%	88.6%	86.8%	87.7%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	13.0%	12.7%	10.7%	7.6%	7.1%	10.3%	12.7%	12.0%	11.5%	13.4%	14.3%	11.0%	
Maternity	Maternity Births	320	296	299	281	295	246	300	306	312	283	315	307	310	
Maternity	Maternity Bookings	377	398	363	327	420	379	419	367	390	342	408	357	314	
Outpatients	Outpatient DNA Rate % - New	<10%	10.7%	10.7%	10.5%	10.5%	10.5%	9.8%	10.7%	11.4%	12.9%	12.9%	13.0%	12.4%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.4%	10.3%	10.1%	9.7%	10.7%	9.7%	10.3%	11.5%	13.6%	12.4%	11.7%	11.6%	
Outpatients	Outpatient New Attendances		10552	10270	8514	10201	9405	9412	9479	9684	9189	10362	9076	9368	
Outpatients	Outpatient FUp Attendances		20252	19206	16491	20029	17462	18047	18380	18590	17156	18941	16649	16871	
Outpatients	Outpatient Procedures		8178	8003	7121	8410	7549	7982	7494	7497	7492	8273	7220	7676	

Meeting title	**Trust Board – meeting in public**	**Date: 30.10.2019**
Report title	**Trust Risk (Quality and Safety) Register summary report – October 2019**	**Agenda item: 15**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals	
Report author	Gillian Lewis, Head of Quality Governance	
Executive summary	This paper provides a brief overview of the risk management structure and a summary of the high level risks (≥16) currently on the Risk Register in October 2019. The report demonstrates that two of the top three risks to the organisation are aligned with the principle Board Assurance Framework (BAF) risks. Which are **failure to deliver savings plan** and **failure to modernise the Trust's estate**. This report does not report the third top risk for the organisation reported in the BAF risks which is of a lack of improvement in the **culture of the organisation**. The Executive Team has requested that this top risk to be assessed against the Trust risk assessment matrix. This will be reported in the next reporting period. The Trust has set a threshold for risks reviewed at Board Committee level (≥15) to ensure Non-Executive Director oversight. The Non-Executive Director who chairs the committee will escalate any ≥15 risks to the Trust Board as required. All risks <15 are managed at an Integrated Clinical Service Unit (ICSU) or corporate directorate level and escalated to the relevant Trust Board Committee if necessary. **There have been the following changes:** **1. Risk closures** 951: Unavailability of perinatal psychology services. Update: Vacancy filled, risk closed 784 Failure to deliver CIPs and savings to £16.5m 2018/19. Update: This is an old risk that a new risk is in place (780) for financial control **2. Downgraded risks** 866: GE holter analysis system (MARS and MUSE) Update: System installed, awaiting one further PC before fully functional expected November 2019. 903: Multiple failures in combined screening tests process Update: New more robust Service Line Agreement (SLA) in place with University College	

	London Hospitals (UCLH) with clear performance indicators agreed. Regular contract management in place. There is a process to review and monitor the SLA arrangement if ongoing failure to meet KPIs. 988: Increased clinical demand in haematology. Update: Extra clinics in place *A number of estates and facilities risks have been downgraded:* 807: Works arising from fixed electrical installation testing. Update: Capital project to address all high risk items was completed in the summer of 2019. A full testing regime is planned and being delivered. 817: Building environmental planned preventative regime for heating, ventilation and air conditioning systems. Update: improved capital investment, management systems and maintenance practice has seen the frequency and consequence of incidents relating to engineering plant failure decrease. 892: The Trust must have an operational fire strategy complying with legislation. Update: Risk reduced following three years of continual improvement evidenced through both the Fire Safety Group and Fire Engineering Group **3. Risk increases** 858: Neonatal Unit environment - including lack of space between cots. Update: Risk increased following review at ICSU quality and safety meeting in September 2019. Risk linked to 697: Maternity and neonatal redevelopment. **4. New risks** The following risks have been recently added to the risk register: • 1002: Inadequate establishment of anaesthetic staff • 1014: Failure of Everlight (Outsource radiology reporting provider) to maintain reporting services within performance indicators • 1017: Existing Visual Re-enforcement Audiometry systems in Paediatric Audiology not compatible with Windows 10 PCs -urgent replacements need to be purchased
Purpose:	Review
Recommendation(s)	The Trust Board is asked to (i) Review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks (ii) Note that the Executive Team has requested that the BAF risk of the failure to change the culture of the organisation will assessed against the Trust risk assessment matrix. This will be reported in the next reporting period. (iii) Consider if any ≥16 risks not currently on the Board Assurance Framework (BAF) should be added
Risk Register or Board Assurance	All BAF entries and linked entries on the corporate risk register

Framework (BAF)	
Report history	The information in this report is presented at the relevant Committee of the Board (Quality, Workforce Assurance, Finance & Business, Audit & Risk)
Appendices	None

Risk register summary report

1. Introduction

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

1.2 The report demonstrates that two of the top three risks to the organisation are aligned with the principle Board Assurance Framework (BAF) risks. Which are **failure to deliver savings plan** and **failure to modernise the Trust's estate**. This report does not report the third top risk for the organisation reported in the BAF risks which is of a lack of improvement in the **culture of the organisation**. The Executive Team has requested that this top risk to be assessed against the Trust risk assessment matrix. This will be reported in the next reporting period.

2. Risk management overview

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

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

3. ≥ 16 Risk register

3.1 The Trust has set a threshold of ≥16 risk grading for review at Board Committees. This is to ensure that there is Non-Executive oversight of these risks and a clear escalation process to Board.

3.2 To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Committees with responsibility for risk. These include Audit and Risk, Quality, Finance and Business Development and Workforce Assurance.

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

4. Relationship between Risk register and Board Assurance Framework

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

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

5. Risk register update: October 2019

5.1 As at 14 October 2019, the Trust currently has three risks graded as ≥20 and eleven risks/graded as 16. There are ten risks graded as 15 which are monitored at Board Committee level.

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

- Facilities and estates
- Financial

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

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

5.2 Facilities and Estates

DATIX ID	ICSU/Directorate	Category	Title	Current risk grade
91	Acute Patient Access Clinical Support Services and Women's Health	Estates or Infrastructure	Labour ward has 1 obstetric theatre. Update: New obstetrics theatre now complete. Grand opening of theatre planned for November 2019.	20
697	Acute Patient Access Clinical Support Services and Women's Health (ACW)	Patient Safety and Quality	Maternity and neonatal redevelopment. Update: As above for obstetrics theatre, further redevelopment to follow.	20
858	Children and Young People's Services	Patient Safety and Quality	Neonatal Unit environment - including lack of space between cots Linked to risk 697	16
750	Facilities and Estates	Patient Safety and Quality	Mental Health Patient Secure Vehicle requires a replacement to meet government standards. Update: Leased solution sought, due to technical specifications of the van, the lead in time is significant, and the new van is expected	16

DATIX ID	ICSU/Directorate	Category	Title	Current risk grade
			for delivery in early 2020	
907	Trust wide	Estates or Infrastructure	High ambient temperatures of ward/treatment rooms affecting quality of medicines. Update: Comprehensive assessment of room temperatures completed. Calibrated thermometers purchased and awaiting installation for accurate recording of temperatures across organisation. Review of SOP relating to the recording of temperatures and handling of medicines outside usual ranges updated. Review of Moorfields Trust use of temperature controlled cabinets for potential implementation.	16

There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our corporate objective to 'deliver quality, patient safety and experience' (*BAF Risk Sustainable 2: Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience*). The Trust Board monitors actions against this risk through the BAF process, including implementation of the Estates Strategy.

5.3 Financial

DATIX	ICSU/Directorate	Category	Title	Current risk grading
723	Emergency Integrated Medicine (EIM)	Financial	Finance deficit in EIM ICSU	16
772	Surgery and Cancer	Financial	Not meeting CIP target and financial balance for 2018/19.	20
780	Finance	Financial	Budget Control	16

Each ICSU and Corporate Department has a specific plan in place to manage their budget and meet the required Cost Improvement Plan savings required for 2019/20. This has been identified as a strategic risk to our corporate objective 'To deliver efficient and financially sustainable services.' *(BAF Risk Sustainable 1: Failure to deliver savings plan year and control in operational budgets leads to adverse underlying financial position that cannot be mitigated by non-recurrent measure. This will lead to not hitting control total, loss of Provider Sustainability Funding, greatly reduced capital resource to address other BAF risks and reputational risk)* which is monitored through this assurance process.

6. Other ≥16 risks reflected on the BAF

6.1 **Workforce and recruitment**
The Board should note the ongoing improvements in workforce and recruitment as reported through workforce reports. It is noted that risk 951 (Unavailability of perinatal psychology services) has been closed this quarter and a new risk 1002 added. However, workforce issues have not been highlighted as a risk theme on ≥16 Risk Register this quarter.

6.2 <15 risks continue to be monitored at ICSU level and the trustwide controls and actions are reflected in the *BAF Risk People 1: Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. nursing, junior doctors, medical posts).*

DATIX	ICSU/Directorate	Category	Title	Current risk grading
1002	Surgery and Cancer	HR and Workforce	Inadequate establishment of anaesthetic staff	16

7. ≥16 Risks not currently on the BAF

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and Key actions
760	ACW	Patient Safety & Quality	Radiology systems interface	16	Radiology works across several systems for which there is a parallel paper system; if paper system does not change unlikely to meet cancer targets without significant costs incurred. Update: Business case presented to the Capital Monitoring Group September 2019
901	Trustwide	Patient Safety and Quality	Lack of equipment for flat-lifting patients (post-falls)	16	When a patient has fallen and if they cannot get up with minimal assistance, current practice is to hoist. This carries a risk to the patient and to staff. Update: Business case presented to the Capital Monitoring Group September 2019
1014	ACW	Patient Safety and Quality	Failure of Everlight (Outsource radiology reporting provider) to maintain reporting	16	The Trust outsources radiology reporting to Everlight but due to summer leave there has been a backlog. Update: Backlog position much improved as of 24.9.19. Position continues to be monitored

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and Key actions
			services within KPIs		closely.
1017	CYP		Existing VRA systems in Paediatric Audiology not compatible with Windows 10 PCs -urgent replacements need to be purchased	16	Visual Reinforcement Audiometry (VRA) is a key behavioural assessment technique used for testing the hearing of younger children, and children and adults with complex needs. The current VRA system is delivered through Windows 7 PCs. WH Trust is currently replacing all Windows 7 PCs with Windows 10 PCs and from January 2020 will no longer be supported. Update: VRA equipment approved for capital replacement funding.

8. Recommendations to the Board

8.1 The Trust Board is asked to:

(i) review all ≥16 risks and agree there is adequate mitigating action and assurance to manage these risks;
(ii) note that the Executive Team has requested that the BAF risk of the failure to change the culture of the organisation will assessed against the Trust risk assessment matrix. This will be reported in the next reporting period; and
(iii) consider if any ≥16 risks not currently on the BAF should be added.

Meeting title	**Trust Board – public meeting**	**Date: 30 October 2019**
Report title	**Quarter two delivery of 2019/20 strategic objectives**	**Agenda Item: 16**
Executive director lead	Jonathan Gardner, Director of Strategy	
Report author	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Executive summary	Board members are presented with a review of quarter two delivery of the Trust's 2019/20 strategic objectives. The purpose of this report is to give the board an overview of progress against our strategic objectives at a high level. A few proxy measures have been highlighted against each of the four objectives to give a sense of progress and achievement. This does not replace the detailed monthly performance report. The board are asked to comment on where they feel more focus should be brought to bear, and to continue to confirm or comment on our priority actions.	
Purpose:	Review and comment on progress.	
Recommendation(s)	Board members are invited to review delivery against the performance metrics outlined for respective strategic objectives.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	None	
Appendices	None	

Quarterly progress report on the strategic objectives

QUARTER 2

October 2019

Deliver outstanding safe and compassionate care in partnership with patients

Exec: Chief Nurse / MD

Committee: Quality

worse
better
Same

Key metrics	Target	Score	RAG
SHMI score		0.77	
Readmission rate	5.5%	5.71%	
Pressure ulcers grd. 4 and 3	Reduce 10%	14 (QTR)	
FFT % satisfaction	90%	IP: 96.7 OP: 96.9%	

Key metrics	Target	Score	RAG
RTT	92%	92.1%	
ED 4hr	95%	87.7%	
Adult community metrics green	↑	10	
Child community	↑	12	

Key metrics	Target	Score	Direction and RAG
PALS response time	80%	84.7%	
No. volunteers	300 by 2021	200	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
Partner with those who use our services to deliver outcomes that matter to them through experience led design and delivery of services and the objectives set out in the quality account	• To move from Good to 'Outstanding' in our CQC rating including moving community children's services from 'Requires Improvement' to Good • Improve feedback numbers and experience of people attending the Emergency department • Improve our clinical effectiveness priorities as outlined in the quality account • Work with patients and people who use our services to develop meaningful clinical outcomes, hear patient stories at Trust Board and embedded at Trust and ICSU committees	• Improvement with ED FFT rates - The average response rate for Q2 was 14.56%, a 2.6% increase on Q1. The recommend rate for Q2 included a 1.6% increase (81.6% for Q2). • The 2018 National UEC Patient Experience Survey was returned to the Trust. The results are embargoed until October 23rd, when they will be publicly published. • The patient experience team across Q2 have been working with clinical teams to catalogue current patient/service user groups . • 'Good to outstanding' peer reviews at the Northern Health Centre, Simmons House, Lordship Lane and school nursing services	• The patient experience manager will attend ED Board to discuss the findings and support action planning from the 2018 Survey • Develop a framework for the creation and facilitation of patient/service user groups, and link this to the new role descriptions for patient representatives • Ongoing peer reviews and targeted support in children's community centres
Ensure timely and responsive care that is seamless between services	• Meet constitutional standards • Improve treatment and waiting time standards for our mental health patients within emergency department • Continue to achieve cancer and referral to treatment national standards • Improve the waiting times for people who need community health services • Deliver the better births action plan	• Cancer targets were not met in September 2019 • 30 mental health 12hr breeches in ED • 2hr and 48hr district nursing targets are being met • New birth visit targets in September at 95% (Haringey) and 96% (Islington) against target of 95%	• Actions through the A&E delivery board • Actions through the community services improvement group
Improve patient experience through delivery of the patient experience strategy ambitions	• We will improve the information we provide to patients and carers to enhance two-way communication • We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement • We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care	• Patient Experience Strategy Launched 23.09.2019 • Continuing to update patient information and leaflets, including ward & ED departments and service specific areas. • 'Hello, my name is…' badges developed and ordered • Welcome Packs distributed on COOP, Surgical & Assessment wards • Two 15 steps challenges facilitated for CYP ICSU	• Review and Improve signage and correspondence (Patient letters) • Patient Notice Boards to be standardised & updated across the Trust • 15 step challenge to be completed across Whittington OPD & St Ann's • Volunteer Strategy presented to Board
Continually learn through our Quality Improvement (QI)strategy building a curious workforce that strives to use evidence	• Embed a QI culture throughout the organisation from Board to ward/team • Offer training to all staff • Increase the number of QI initiatives across the Trust	• 130 active projects, 24 completed. • Projects range from local, to trustwide and include joint working with local GPs and Healthwatch (for example: falls, improved discharge summaries, frailty, hello my name is)	• Share all learning from projects more widely

Empower support and develop engaged staff

Exec: Workforce Director / COO

Committee: WAC

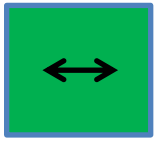
Key metrics	Target	Score	Direction and RAG
Turnover rate	10%	10.6%	
Vacancy rate	10%	12.1%	
Appraisal rate	90%	75.5%	
Mandatory training	90%	84%	

Key metrics	Target	Score	Direction and RAG
# teams doing 'team journey'	Tbc	20	
Likelihood BAME candidate being appointed		1.65	
Staff FFT/Pulse response rate		16%	

Key metrics	Target	Score	Direction and RAG
Relative likelihood of disciplinary for BAME		1.48	
% staff recommending WH as place to work	65%	60%	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
Provide outstanding inter-professional education and inclusive, fair development opportunities	• Roll out diverse interview panels for senior staff roles, consultants and bands 8A and above • Continue to host CEPN and develop educational opportunities • Complete the WRES Improvement Plan (which includes reduction targets)	• Fully Implemented • Fully Implemented • WRES action plan developed • Inclusion Lead Appointed • Inclusion events commenced • Social media presence improved	• Review the impact in line with WRES action plan • Continue to raise profile of all inclusion events • Continue with WRES actions
Focus on the health and wellbeing of staff including improving the environment	• Increase our offer of health and wellbeing to staff and promote well-being • Enhanced staff access to smoking cessation • Create the events calendar to promote to staff on intranet by June 2019 • Develop a staff engagement and wellbeing social media platform	• Health and Well being plan in place • Implemented • Implemented • In progress • Flu vaccination programme launched	• Continue with plan • Project in place for 6 months • H&WB Committee to be reviewed
Be the employer of choice recruiting and retaining and recognising the best	• Continue work with capital nurse • Implementation of the NHSI Retention Plan including Implement Managers Breakfast and 'itchy feet' retention events • Recruitment service Recovery Plan	• Working with Capital Nurse • NHSI retention plan in place • STP Lead on RTP • Improved retention and vacancy rates • In place	• Working with capital Nurse • Continue with plan and reviews • Continue with plan
Create a kind environment of honesty and transparency where all staff are listened to and feel engaged	• Take forward staff survey action plans locally and corporately • Implement the Cultural survey action plan focussing on engagement and bullying and harassment • Audit the Fair Treatment panels for reduction in BME disciplinary cases	• Currently being taken forwards • Cultural Survey plan in place • #CaringForThoseWhoCare Initiative Launched • Resources identified • Staff Survey 2019 launched	• Assurance through WAC • Assurance through WAC • commenced
Promote compassionate leadership, accountability and team working where bullying and harassment is not tolerated	• Implement the Cultural survey action plan • Promote the Leadership Development programme • Development of Managers 'passport'	• Action plan in place • Current promotions in place • Timeline of Inclusion events • Resources identified, positions offered • 600 managers identified to go through Challenging Behaviours Training	• Assurance through WAC • Further developing leadership and focusing on middle managers • In place by October 2019. • Underway

Integrate care with partners and promote health and well-being



Exec: Director of Strategy / COO

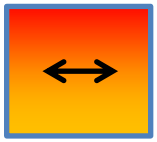
Committee: Board

Key metrics	Target	Score	RAG
DTOC rate	2.5%	2.8%	
Careflow project status	Green	Amber/Green	
NMUH project status	Green	Red	
UCLH project status	Green	Amber	
Locality project status	Green	Green	

Key metrics	Target	Score	RAG
Intermediate care project	Green	Amber	
No. staff completed MECC	All DN by Dec	10+	
Website project status	Green	Green	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
Partner with social, primary, mental health care, and the voluntary sector around localities to make an impact on population health outcomes and reduce inequalities	• Develop and begin to implement a new model of care around localities • Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP • Collaborate with other NHS providers to improve efficiency and resilience)	• Successful Haringey localities design day focussing around 'connected communities' • Islington operating model designed • Successful meeting with GP Clinical Directors of PCNs • Borough partnership boards forming • WH / UCLH ortho hub bid approved • NMUH progress has been slow	• Begin rollout of Islington operating model • Progress next steps with connecting our staff in Haringey • Continue to refine borough partnership boards • Begin implementation of ortho hub • Contract offer for MSK first contact practitioners • Progress NMUH collaboration further
Improve the joining up of teams across and between community and hospital services	• Progress work of the 'integrated forum' • Support roll out of 'careflow connect'	• Integrated forum continues to meet • Good discussion around the role of the specialty services in localities • Community went first so teams setup and users invited. Some teams use it more than others. They can direct message, team message and see current inpatients etc. For teams who span across the ICO they can also contribute to handover	• Define new model of care for specialty services • Roll out careflow as per plans • Clinical teams are adopting the SBAR handover technique across the clinical disciplines utilising the functionality within Careflow to record and review the handover electronically. Clinical teams will be working on embedding the practice and adoption of the tool over the Autumn/early Winter while planning the addition of task management and referral for consult over the final quarter of the year.
By working collaboratively, coordinate care in the community to get people home safely faster and keep people out of hospital where appropriate	• Design and implement new intermediate care pathway • Consider business case for delivering new model at Osborne Grove	• the emphasis has been on refocusing the vision and objectives at borough-level • Osborne Grove no update	• Plan is to prioritise work related to the respective borough Ageing Well strategies. • There is also an internal Whittington IC steering group being set up to drive actions related to implementation of the strategy.
Prevent ill-health and empower self-management by making every contact count and engaging with the community and becoming a source of health advice and education	• Continue to grow the self-management service • Restart 'make every contact count' MECC model • Begin new approach to community engagement and advice and guidance	• Self-management team have been attending community events and signing people up • Good session with ground teams on how to simplify routes into services of a locality. As a result discussions beginning on how the MECC course can be redesigned. • The trust has seen a significant increase in Advice and Guidance referrals above Trust Trajectory	• Revise MECC training • Set up next community event • Send out next community newsletter • Describe better the engagement already going on • Performance continues to be monitored through the Collaborative Outpatient programme Board

Transform and develop financially sustainable innovative services



Exec: Finance Director / COO

Committee: TMG

Key metrics	Target	Score	RAG
% CIP delivery against target	100% £6.2m	48% £3.0m	
Average beds used	197	203	
Financial position	Break-even	-£2.5m	
Capital spend against plan	£3.3m	£2.3m	
% D2A	TBC		
Average LOS Non-elective	4	4	

Key metrics	Target	Score	RAG
% stranded pts	35%	42%	
Elective activity	100% on plan		
Theatre utilisation	>85%	85.1	
Estates project status	Green	Green	
Fast follower project status	Green	Green	
Financial training sessions delivered	>12 per year	4	

Descriptor	Deliverables	Progress last quarter	Actions next quarter
Transform patient flows and models of care (outpatients, same day emergency care, community localities, children's pathways)	• Operate within funded bed base by optimising discharge to assess and reducing length of stay • Develop locality working and create locality leadership team • Improve outpatient productivity, develop new virtual clinic models and increase advice and guidance • Improve emergency care and ambulatory care (adult and children)	• The Trust has achieved core bed base and plus ones during most of Sept and Oct. • Locality working is progressing at pace • AVLOS has remained broadly similar • Outpatient workstream is progressing with CCG / STP input but has not found the realisable saving required	• Continue with bed base • Reduce AVLOS to reduce open beds further creating flexibility in winter • Redesign outpatients to create a full year system saving of £4m so that in year the net saving to WH can still be achieved
Reduce system cost and improve clinical productivity and financial literacy everywhere	• Deliver £12m savings through CIPs and deliver to budgets to deliver the 19/20 control total • Identify alternative pathways to outpatients with primary care • Roll out programme of financial awareness to key staff • Implement new intermediate care pathway • Restructure therapy and autism pathways for children	• 24% of year CIP target achieved (or 48% of 6month target) • Recovery meetings instigated. CT achievement still forecast • All EIM Budget Holders have been trained with awareness sessions. • Intermediate care programme on track • LDP developing Gastro outpatient pathway	• Continue recovery plan and improved delivery on CIP • Further Surgeries to be offered in all ICSUs • By end of December agree Gastro funding mechanism • MSK impact review
Transform our estates and IT to enable new ways of working	• Create the case and plans for a transformed estate and produce various legal documentation • Deliver estates improvement programme • Deliver the fast-follower programme	• Meeting held with CCGs to discuss community estate ideas. • Major improvement on Estate in key areas fire, water, asbestos and third party assurance achieved • Fast Follower remains on track	• Further work to be done on a summary vision for estates prior to revisiting SOC timeline. • As per plans

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**2018/19 Health and Safety annual report**	**Agenda item: 17**
Executive director lead	Adrien Cooper, Director of Environment	
Report author	Adrien Cooper	
Executive summary	The aims of this report are to provide: • Assurance that the Health, Safety and Welfare Committee (**HSWC**) is delivering organisational compliance with regard to the legislative health and safety requirements • Health and safety performance for the period from June 2018 to May 2019. The Board is asked to note the content of this report and to: • Agree on the level of assurance provided by the data presented. • Determine what additional measures if any are required to improve the level of assurance	
Purpose:	Approval	
Recommendation(s)	The Trust Board is asked to approve the 2018/19 annual health and safety report.	
Risk Register or Board Assurance Framework	Compliance with Health and Safety Legislation, (Fire Safety) and the Regulatory Reform (Fire Safety) Order 2005, Health Technical Memoranda (HTM) 05 and NHSI requirements	
Report history	Quality Committee, 11 September 2019	
Appendices	None	

2018/19 Health and Safety annual report

1. Overview

1.1 The Health, Safety and Welfare Committee (HSWC) is responsible to the Quality Committee for the promotion, development and monitoring of health, safety and welfare standards across the organisation.

1.2 The HSWC is part of the Whittington Health Risk Management Strategy organisational structures and the Committee remit is to facilitate consultation on health, safety and welfare issues and to promote a positive Health, Safety and Welfare culture.

1.3 The HSWC Chair is responsible for effectively monitoring and progressing Committee's actions within a reasonable timeframe.

1.4 The HSWC is accountable for:

- Fire Safety Group
- Pathology Safety Group
- Security and Personal Safety Group
- Compliance Group
- Environment and Food Hygiene Group
- Asbestos Group
- Radiation Safety Group (Staff)

1.5 Each Group's Chair is responsible for the administration, the planning and the organising of the Group's work. Each Group operates within a regulatory compliance work-plan and provides an annual exception report to the HSWC on key performance indicators, enforcement agencies activity and significant/intractable issues. Each Chair is required to effectively monitor and progress actions within a reasonable timeframe. Each chair is a member of the Health, Safety and Welfare Committee.

1.6 The HSWC and sub-groups provide forums for management and staff consultation and participation on health, safety and welfare issues. The Trust is able to listen to and act upon staff safety concerns and develop policies and procedures accordingly.

1.7 The Health and Safety Executive (HSE) is the regulatory body with responsibility for enforcing health and safety legislation.

1.8 The Fire Authority is the regulatory body with responsibility for enforcing fire safety legislation; this is discharged in London by the London Fire Brigade (LFB).

1.9 The Local Authority (LA) is the regulatory body with responsibility for enforcing food safety legislation.

2. Introduction

2.1 The annual health and safety report aims to demonstrate the Trust's level of legislative compliance across seven key health and safety metrics.

2.2 These metrics are:

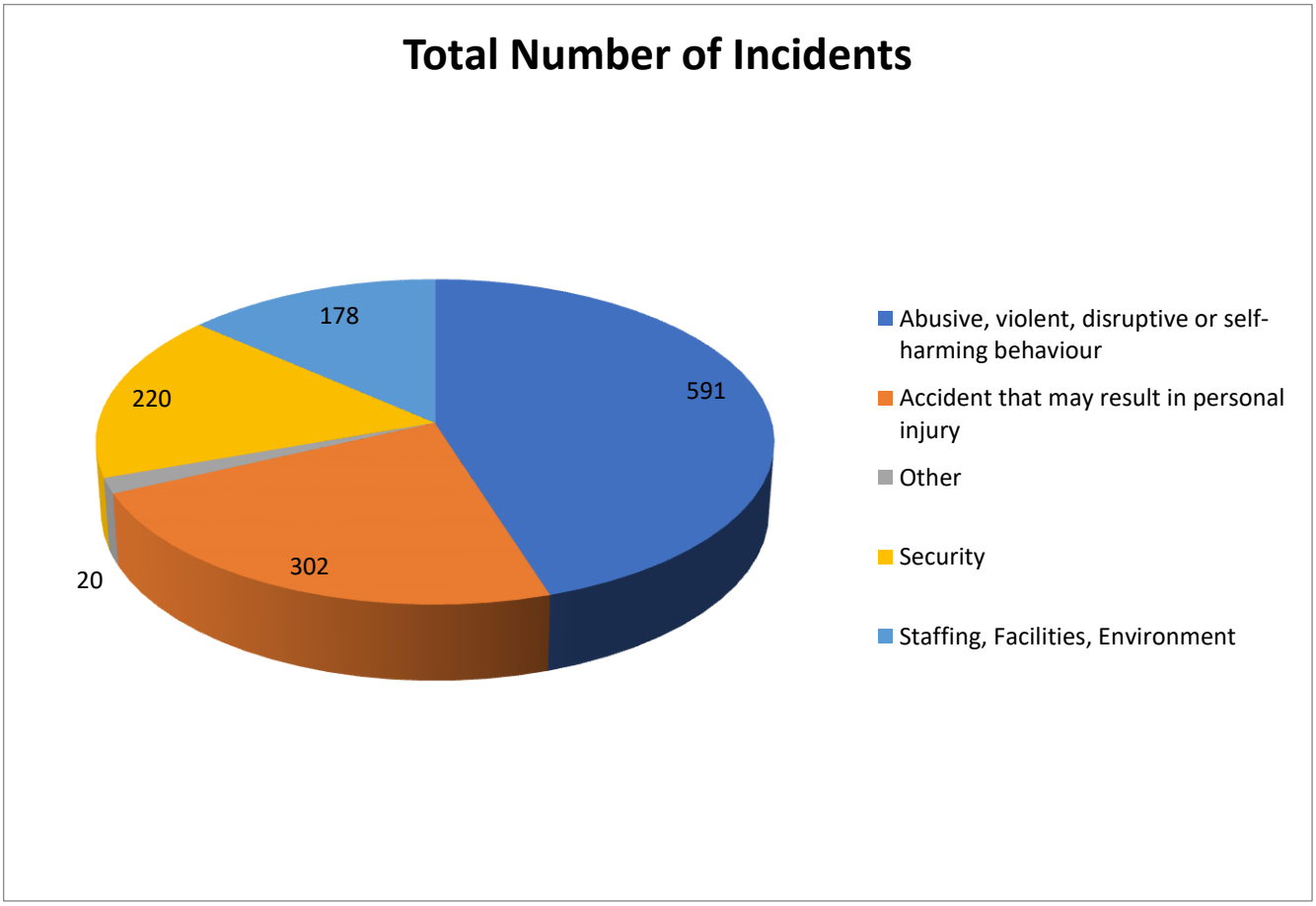
- Incident reporting within seven days
- Incidents and Investigations
- Policy management
- Safety notices
- Mandatory training
- Inspection & Audit
- Fire Safety

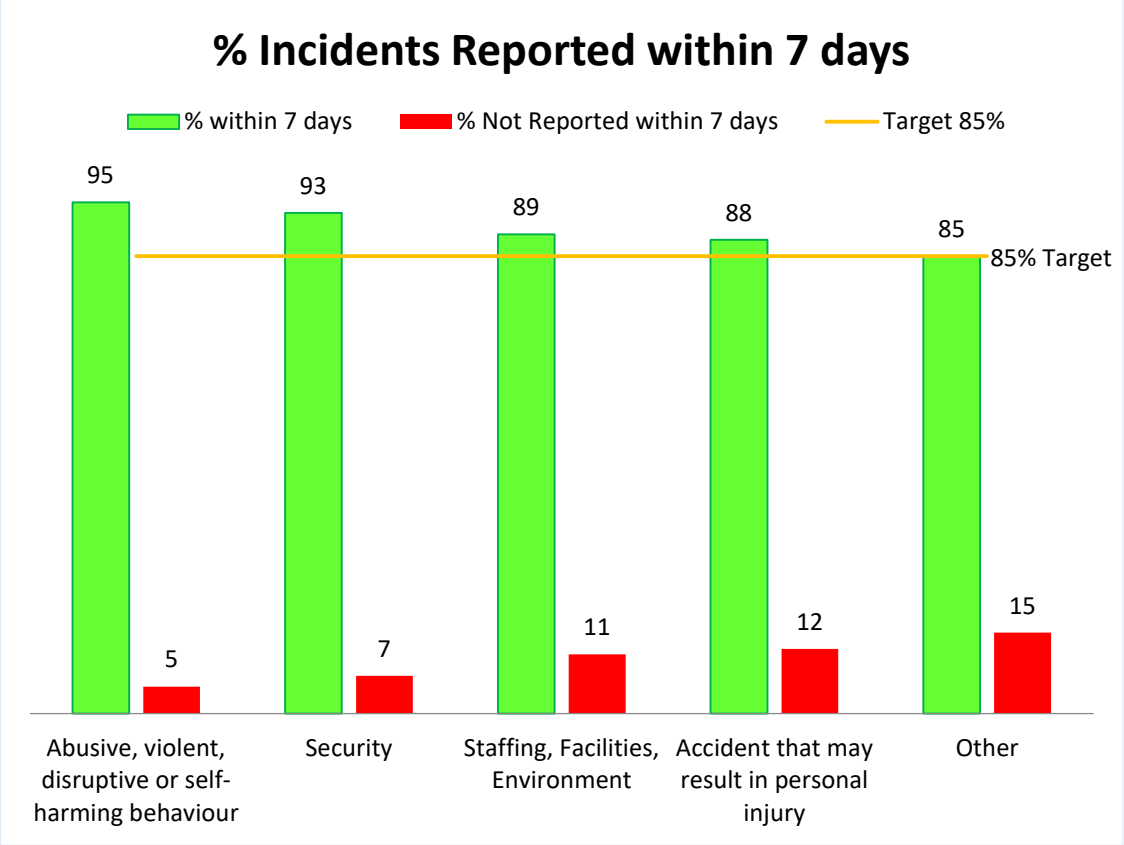
3. Analysis

3.1 Incident reporting within seven-days

This metric assesses the reporting of incidents in accordance with the Trust's Incident Reporting Policy that requires incidents to be reported on the day of or no later than the day after they occurred (or when staff are first made aware of the incident).

- **Performance:** 85% target. The Health and safety, fire and security reporting standard is being met at 90%. Information provided is based on Datix's five incident categories.





- **Risks to the delivery of the target:** This risk of delay in reporting is considered low.
- **Actions to Improve:** Whilst it is acknowledged that the reporting standard target of 85% is being met, line management should ensure that incident reporting is monitored at ICSU and Corporate Directorate level to maintain appropriate governance. The HSWC will continue to monitor compliance.
  In terms of reduction of abusive, violent, disruptive or self-harming behaviour incidents, the Safe Care of Challenging Behaviour Group will look to develop strategies to help the organisation reduce current levels.

3.2 Incidents and investigations

This metric assesses the Trust's management of non-clinical incidents and investigation covering serious incidents, high risk and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). A total of 1311 non-clinical incidents occurred within the reporting period, 14 were RIDDOR reportable, none were categorised as a serious incident by SIEAG.

- **Performance:** All RIDDOR incidents have been fully investigated, reports produced and any resulting actions monitored, managed and closed at the HSWC. The Serious Incident investigation resulting from the fire within the PFI Building that occurred on the 17th January 2018 remains open. The Trust Board is regularly receiving progress updates on this incident.

- **Risks to the delivery of the target:** RIDDOR incidents are reported to the **HSE** who may consider additional action if deemed necessary. The risk is considered moderate.

- **Actions to improve:** The HSWC will continue to review all high-risk and RIDDOR incidents for necessary actions to prevent re-occurrence and confirm staff welfare issues have been fully considered before closing.

- **For information:** Serious Incident Panel reviews, monitors and closes Serious Incidents.

3.3 **Policies**

This metric assesses the compliance position with regard policy review and update that are approved by the HSWC.

- **Performance:** Health and Safety, Fire and Security Policies are mostly up to-date – 97%. Performance target is 100%.

- **Risk to the delivery of the target:** This risk is considered low.

- **Actions to improve:** The HSWC chair will continue to administer a policy register at the meetings.

- **For information:** Each HSWC and sub-Groups have a policy register review as a standing agenda item. The Chair of each Committee/Group is charged with ensuring policies are keep up to-date. Any policy that is out-of-date is required to be added to the Committee/Groups respective action log for action.

3.4 **Safety Alert Notices**

This metric assesses the Trust's response to Health and Safety, Fire and Security Safety Alerts received through the Central Alert System (CAS) covering: NHS Estates, Medicines & Healthcare Products Regulatory Agency (MHRA), NHS England Patient Safety Alerts, the Department of Health and Health and Safety Executive.

- **Performance**: There were four alerts notified during the reporting period. Three alerts have been completed. One safety notice is work in progress: Anti-ligature' type curtain rail systems - Risks from incorrect installation or modification.

  Remedial actions will be concluded within the next three months in Trust owned premises or leased premises where full repairing leases exist.

  Information is awaited from the Trust's landlords where compliance with the alert requirements is included within lease arrangements.

  Actions remain from the previous reporting period with regard anti barricade risks.

- **Risk to the delivery of the target:** This risk is considered moderate.
- **Actions to improve:**
  Work is required to conclude anti-barricade risk assessments across the Trust. This risk is on the Trust's Risk Register 919.

A Safe Care of Challenging Behaviour Group has been set up to lead on alerts that require clinical instruction and direction relating to challenging patient behaviour. The Group terms of reference have been drafted and a chair appointed.

The Quality Committee has supported the formation of this Group.

- **For information:** An Estates and Facility Safety Alert Group meets monthly to discuss new and ongoing safety notices compliance. The HSWC chair will continue to administer a safety notice register at meetings.

3.5 **Mandatory & Statutory Training**

This metric assesses the Trust's performance with regard to mandatory and statutory training; the performance target is 90%.

- **Performance:** Mandatory training for Health and Safety: 86%, Fire: 79% Moving and Handling: 77% and Conflict Avoidance: 76%.
- **Risk to the delivery of the target**: This risk is considered moderate.
- **Actions to improve:** Learning and Development lead on mandatory courses. Compliance is monitored at the Mandatory Training Group. A mandatory training report is issued at each month detailing staff training compliance and displayed on Trust's intranet. Line management should ensure that mandatory training is monitored and managed at ICSU and corporate directorate level to maintain a compliant position.
- **For information:** The HSWC will continue to monitor mandatory training. Course tutors do provide additional courses when requested.

3.6 Inspection and audit

This metric assesses the Trust's performance with regard to arrangements to regularly inspection of key health and safety and fire activities that can have a significant impact on safety.

- **Performance**: Inspections are stable and above target for Community: 92% Health and Safety and Fire. However, Hospital is below target health and safety: 70% and fire: 71%. Performance Target is 85%.
- **Risk to the delivery of the target**: This risk is considered moderate.
- **Actions to improve:** The Hospital Health and Safety team inform staff Leads and managers of non-compliances and where improvement is needed.
- **For information:** The HSWC will continue to monitor inspection performance. The Trust's Local Security Management Specialist is reviewing Security inspection program with the intention of introducing a risk based local inspection program.

3.7 **Fire safety**

This metric assesses the Trust's Fire Risk Assessments performance with Regulatory Reform (Fire Safety) Order 2005 to take all reasonable steps to ensure that fire safety levels are appropriate at all times.

- **Performance:** Fire Risk Assessments are 100%. Performance Target is 100%.
- **Risk to the delivery of the target:** This risk is considered moderate.
- It is acknowledged that following the fire incident on 17th January 2018 within the PFI building, there is a major fire safety remediation project currently in planning. The Trust

has put in place a mitigation strategy that includes increased levels of security guards, fire wardens, additional fire drills and an enhanced fire response team. The number of trained fire wardens is currently circa five hundred (500). The mitigation strategy is reported to both NHSI and London Fire Brigade and is currently acknowledged as robust.

- The Trust has a compliant fire safety management system. The Fire Safety Group meets on a monthly basis. Each ICSU has a named Responsible Person for Fire Safety who attends the meeting, along with the Trust's Emergency Planning Officer. The meeting is chaired by the Director of Environment and is also attended by an external Authorising Engineer who provides subject matter expert advice and auditing. The Group monitor and support the legal requirements of fire safety to carry out fire risk assessments, training needs analysis and delivery, plan and execute fire drills.
- There is also a Fire Engineering Group that meets monthly, monitoring and manages technical compliance. There is also a weekly Fire Safety meeting that monitors fire warden training levels, and deals with fire incident review. The importance of fire safety within the organisation is acknowledged at Board level, with the Director of Environment providing regular update reports to the Trust's Board.

4 Improvement Plan

The Trust aims to establish and maintain sensible and proportionate standards of health and safety management that will ensure the welfare of patients, visitors, employees and others.

The Quality Committee has supported the formation of a Safer Care of Challenging Behaviour Group. The expectation is this Group will deal with management of patients who become agitated and distressed whilst in the care of Whittington Health. The Group chair has been appointed. The Group terms of reference and work plan have been drafted.

The Quality Committee is supporting the need for clinical representation at health and safety governance groups.

For the forthcoming year, health and safety objectives are detailed below.

Objective	Aim	Action To Improve	Target Date
Examination of staff training to deal with challenging patient behaviour at the Safe Care of Challenging Behaviour Group.	Attest staff training and skills met their needs to deal safely with challenging patient behaviour.	Safer Care of Challenging Behaviour Group to recommend actions based upon analysis.	Next Reporting Period
Examination of challenging patient behaviour incidents at the Safe Care of Challenging Behaviour Group.	Scrutinize patient challenging behaviour incidents for any lessons to be learnt.	Safer Care of Challenging Behaviour Group to recommend actions based upon analysis. The HSWC and Personal Safety Group to continue to review high risk and RIDDOR staff physical assaults incidents and provide assurance that staff are supported, the incidents are thoroughly investigated and lessons are learnt.	18 December 2019 Ongoing
Examination of challenging patient behaviour policies, management plans and standard operating procedures at the Safe Care of Challenging Behaviour Group.	Attest existing policies, management plans and standard operating procedures meet the needs of the Trust.	Safer Care of Challenging Behaviour Group to recommend actions based upon analysis.	Next Reporting Period

Objective	Aim	Action To Improve	Target Date
Examination of safety alerts at the Safe Care of Challenging Behaviour Group.	Administer and instruct on safety alerts in the field of patient challenging behaviour.	Safer Care of Challenging Behaviour Group to advise on safety alerts requirements and certify completion. Senior Estate and Facilities managers to support Safe Care of Challenging Behaviour Group by attending meetings and providing technical support as required.	18 December 2019 Ongoing
Increase clinical attendance and participation at Health and Safety governance groups.	Nominated clinicians to attend groups	Each Group to measure clinical attendance. Chairs to directly seek support of Directors to support in ensuring their representation at the Groups.	1st January 2020 1st January 2020
Increase seven-day reporting standard target to 90% for health and safety, fire and security incidents.	Target standard to be increased from 85% to 90%.	The HSWC to continue review incident reporting within seven-day. Chairs to seek support of directors to deal with poor performing area. Risk Management to provide ad hoc training for poor performing areas.	28th February 2020 28th February 2020 28th February 2020

Objective	Aim	Action To Improve	Target Date
Maintain zero serious incidents (non-clinical) reported in the next reporting period.	Aim for zero serious incidents (non-clinical) reported in the next reporting period.	The HSWC to continue to monitor incidents reported.	Next reporting Period
Maintain no high-risk incident (non-clinical) reported in the next reporting period.	Aim for no high-risk incident (non-clinical) reported in the next reporting period.	The HSWC will continue to review all high-risk incidents for necessary actions to prevent re-occurrence and confirm staff welfare issues have been fully considered before closing.	Next reporting Period
Reduce RIDDOR incidents in the next reporting period comparatively to this period.	Aim to reduce RIDDOR incidents in the next reporting period comparatively to this period.	The HSWC will continue to review all RIDDOR incidents for necessary actions to prevent re-occurrence and confirm staff welfare issues have been fully considered before closing.	Next reporting Period
Achieve policies performance target of 100% for Health and Safety, Fire and Security.	Aim for all Health and Safety, Fire and Security Policies to be in date.	Each Group Chair charged with achieving meeting performance target.	Next reporting Period
Examination of the cohort of Health and Safety, Fire and Security policies, management plans and standard operating procedures.	Attest existing policies, management plans and standard operating procedures met the needs of the Trust.	Each Group Chair to recommend actions based upon analysis on removal or additional policies, management plans and standard operating procedures required.	Next reporting Period

Objective	Aim	Action To Improve	Target Date
Maintain Health and Safety, Fire and Security alerts are processed within set deadlines.	Attest Health and Safety, Fire and Security alerts are processed within set deadlines.	Estate and Facilities Alert Group to meet monthly and monitor compliance. Senior Estate and Facilities managers to support Estate and Facilities Alert Group by attending meetings and instruction.	1st January 2020 1st January 2020
Produce Estates and Facility Safety Alert Group Terms of Reference and report to Health, Safety and Welfare Committee.	Ratify Estates and Facility Safety Alert Group Terms of Reference at the Health, Safety and Welfare Committee.	The HSWC will monitor Group compliance by exception reporting.	28th February 2020
Achieve mandatory training performance target of 90% for Health and Safety, Fire, Moving and Handling and Conflict Avoidance.	Aim for mandatory Health and Safety, Fire, Moving and Handling and Conflict Avoidance training target of 90%.	Learning and Development to continue to produce monthly mandatory training report detailing staff training compliance and display information on the Trust's intranet. Directors to ensure staff in their ICSU/directorates are fully trained Health and Safety, Fire, Moving and Handling course tutors will provide ad hoc courses when requested. The HSWC to continue to monitor mandatory training.	Ongoing Ongoing Ongoing Ongoing

Objective	Aim	Action To Improve	Target Date
Migrate the hospital fire inspection form to an electronic quality management system.	Aim for all hospital fire inspection forms to be on electronic based by next reporting period.	The Fire Safety Group monitor to rollout and performance.	28th February 2020
Introduce security risk based local inspection program for Hospital and Community premises.	Local Security Management Specialist to set up inspection program.	Introduce security risk based local inspection program for Hospital and Community premises. The HSWC and Personal Safety Group review performance.	28th February 2020
Achieve 85% inspections performance target for Hospital Health and Safety and Fire.	Improve Hospital Health and Safety and Fire inspections performance target to 85%.	The Hospital Health and Safety Assistant to inform staff leads, managers and Directors of non-compliances and where improvement is needed. The HSWC will continue to monitor inspection performance.	Ongoing Ongoing
Maintain 85% inspections performance target for Community health and safety and fire.	Inspection performance target of 85% to be met.	The HSWC will continue to monitor inspection performance.	Next Reporting Period
Maintain Fire Risk Assessments are 100%.	Aim for performance target of 100%.	The Fire Engineering Group to monitor fire risk assessment technical compliance. The Fire Safety Group to receive exception report from Fire Engineering Group on compliance.	Ongoing 28th February 2020
Implementation of the serious incident PFI Building action plan.	Implementation of action plan.	The Fire Engineering Group to monitor fire risk assessment technical compliance. The Fire Safety Group to receive exception report from Fire Engineering Group on compliance. The Trust Board provided with progress reports. The NHSI and London Fire Brigade provided with progress reports.	Ongoing 28th February 2020 Ongoing Ongoing

Objective	Aim	Action To Improve	Target Date
Implementation of Fire Wardens training program	Implementation of training program	The Fire Safety Group to monitor Fire Warden training program compliance. The Trust Board provided with progress reports. The NHSI and London Fire Brigade provided with progress reports.	Ongoing Ongoing Ongoing
Implementation of monthly fire drills program	Implementation of fire drills program	The weekly Fire Safety meeting to monitor completed fire drills. The monthly Fire Engineering Group to monitor fire drills program, actions and compliance. The Fire Safety Group to monitor performance by exception reporting. The Trust Board provided with progress reports. The NHSI and London Fire Brigade provided with progress reports.	Ongoing 30th January 2020 28th February 2020 Ongoing Ongoing
Planning PFI fire safety remediation project.	Aim for planning PFI fire safety remediation project to be completed by 2022	The Trust Board to approve remediation project. The Trust Board provided with progress reports. The NHSI and London Fire Brigade provided with progress reports. The Fire Engineering Group to monitor progress and compliance The Fire Safety Group to monitor by exception reporting.	Ongoing Ongoing Ongoing 30th January 2020 28th February 2020

5 Conclusion

This report is structured in a new format aimed to clearly demonstrate the mandate of the Health, Safety and Welfare Committee in delivering compliance with regard to the legislative health and safety requirements.
The Improvement plan will be actively monitored at the Health, Safety and Welfare Committee. Future annual Health and Safety reports will be able to bench mark against the previous reporting period, and where relevant, compare against other NHS organisations.

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Trust Board members' declaration of interests**	**Agenda item: 18**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	In line with the Trust Board's forward plan and the Department of Health's Code of Conduct and Code of Accountability which sets out the highest standards of corporate behaviours which all individuals within Whittington Health NHS Trust must have regard to in their work, the updated register of Board members' interests is presented.	
Purpose:	Note	
Recommendation(s)	The Board is asked to receive and note the declared conflicts of interest for Board members as at March 2019, in line with NHS England's guidance on managing conflicts of interest in the NHS	
Risk Register or Board Assurance Framework	BAF entry- Quality 1 – evidence for well led review	
Report history	Six monthly report to Board	
Appendices	1: Register of Board members' declared interests, October 2019	

Appendix 1: Whittington Health NHS Trust Board members' register of interests, October 2019

Non-Executive Directors:	
Name	**Register of interests declared**
David Holt, Interim Chair	‣ Non-Executive Director, Senior Independent Director and Chair of Audit Committee at Tavistock and Portman NHS Foundation Trust ‣ Deputy Chair, Chair of Audit Committee, Ebbsfleet Development Corporation (MCLG) ‣ Non-Executive Director and Chair of Audit Committee, Planning Inspectorate (MCLG) ‣ Non-Executive Director, Department of Work & Pensions Board and Chair of the Departmental Audit, Risk & Assurance Committee ‣ Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> ‣ None
Deborah Harris-Ugbomah	‣ Governor and Audit Committee Chair, Trinity Laban Conservatoire of Music and Dance ‣ Director and Audit Committee Chair, The Shared Learning Trust ‣ Independent Member, Audit Committee and Independent Member , Treasury Committee, Southern Housing Group ‣ Director, Harris Manor Properties Ltd ‣ Director, HMJ Property Solutions Ltd ‣ Co-founder & Consultant, Inspiring Insights ‣ Founder and UK Regional Lead, Lean In (UK Network) ‣ Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> ‣ Nil
Naomi Fulop	‣ Honorary contract, University College London Hospitals NHS Foundation Trust ‣ Professor of Health Care Organisation & Management, Department of Applied Research,

Name	Register of interests declared
	University College London • Trustee, Health Services Research UK (Charitable Incorporated Organisation) • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Tony Rice	• Chair, Halma Plc • Chair, Ultra Electronics • Chair of Trust Hub • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Anu Singh	• Member of HMG's Advisory Committee on Fuel Poverty • Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Yua Haw Yoe	• Trustee, Whittington Health Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Executive Directors:	
Name and job title	**Register of interests declared**
Siobhan Harrington, Chief Executive	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Daughter-in-law employed by the Whittington Health Pharmacy department • Son employed by Islington re-ablement service
Kevin Curnow, Acting Chief Finance Officer	• Chair, Whittington Pharmacy, Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Clare Dollery, Medical Director	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Norma French, Director of Workforce	• Nil <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Husband is consultant physician at Central & North West London NHS Foundation Trust • Son is employed as a Business Analyst in the Procurement department at Whittington Health
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	• Chair of Governors, St James Church of England Primary School, Woodside Avenue, Muswell Hill, Haringey, London, N10 3JA <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Name and job title	Register of interests declared
Carol Gillen, Chief Operating Officer	Non-Executive Director, Whittington Pharmacy Community Interest Company <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Sarah Humphery, Medical Director, Integrated Care	• GP Partner Goodinge Group Practice, Goodinge Health Centre, 20 North Road, London N7 9EW: General Medical Services • The Goodinge Practice is part of WISH, the GP service in the Whittington Health emergency department and also the Islington North Primary Care Network • Named GP Safeguarding, Islington CCG <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil
Michelle Johnson, Chief Nurse & Director of Allied Health Professionals	• Trustee on Board of Roald Dahl Marvellous Children's Charity <u>Conflicts of interests that may arise out of any known immediate family involvement</u> • Nil

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**EU Exit preparation**	**Agenda item: 19**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report authors	Carol Gillen, Chief Operating Officer, and Lee Smith, Emergency Planning Officer	
Executive summary	This slide set represents the latest EU Exit information at a national and local level including Whittington Health NHS Trust.	
Purpose:	To provide an information update to the board.	
Recommendation(s)	Board members are asked to review.	
Risk Register or Board Assurance Framework	Quality 1	
Report history	None	
Appendices	1: EU exit briefing slides	

NHS
Whittington Health
NHS Trust

NHS operational response to EU Exit

Whittington Health

ICO

I·C A R E

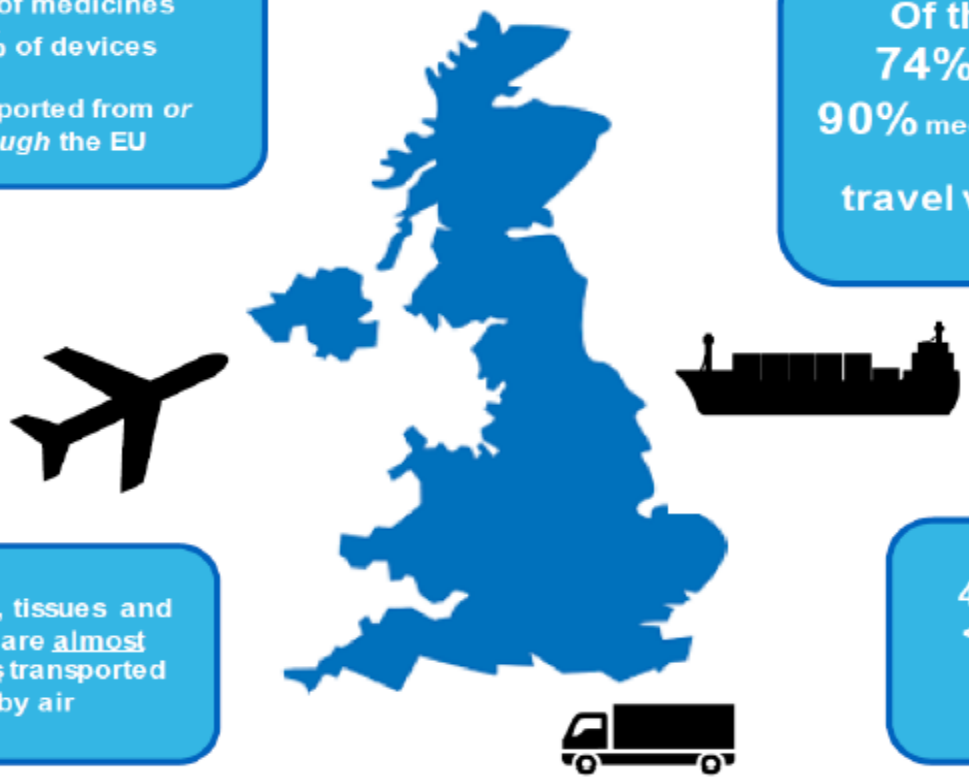
Continuity of supply recap

Whittington Health
NHS Trust

The NHS has goods entering the UK from the EU across all methods of transport

76% of medicines
56% of devices

are imported from *or through* the EU



Of the EU imports:
74% of medicine products
90% medical devices volume

travel via channel ports

Organs, tissues and cells are almost always transported by air

Of the EU imports:
4% medicine products
<1% medical devices volumes

travel via air

Changes in preparation for 31 October

Whittington Health NHS Trust

- **National procurement** preparation for alternative routes and express freight channel are ongoing. All medical good are given the highest priority category 1
- **Engagement with key suppliers** Confirmation of supply at a national an local level
- **Winter pressures –** EU Exit planning will focus on workforce capacity; UEC demand; adverse weather; seasonal flu and changes to supply requirements, increase freight capacity

National and local preparedness

NHS
Whittington Health
NHS Trust

- Put in place and **test business continuity and EPRR plans**
- Ensure **EU Exit SRO and associated SME team** in place
- Make **Board aware** of issues
- **Communication plans / key messages to front-line colleagues**
- **Revisit operational guidance and current information** from each workstream to ensure plans are up-to-date
- Revisit assurance exercises and **address outstanding actions**
- Test and communicate **escalation routes**
- **Engage across system** and **'walk the floor'** to identify any further concerns, interdependencies and vulnerabilities around supply chain
- With partners **ensure integrated system-based approach** to plans
- **Consider differences** - implications of winter, assumptions about port access, vulnerable populations etc.
- Ensure **local risk assessments are up to date**

Medicines: NHS action

Website https://www.whittingtonpharmacy.co.uk/further-advice

NHS
Whittington Health
NHS Trust

Prescribe and dispense as normal: Doctors and pharmacists should continue to prescribe and dispense as normal and reassure patients that extra medication is not required and avoid issuing longer prescriptions

Do not stockpile locally: Buffer stocks and rerouting is being managed upstream with suppliers. Local stockpiling is not appropriate and places risk on the availability of medicines

Incidences involving over-ordering of medicines will be investigated. NHS has enhanced medicines monitoring functionality for primary and secondary care

Report any shortages through usual routes and collaborate locally: Reporting of any shortages should be conducted through usual routes, which will be managed at a national level in line with usual practice. To support this, a national Medicines Shortage Response Group (MSRG) has been established

Ensure that your organisation is familiar with the latest information on supply disruption: Ensure all appropriate staff are able to share the information contained in CAS alerts and other central communications with clinicians.

Pharmacy Information Links
EU Exit

Whittington Health NHS Trust

- Website for Whittington Pharmacy. Linked to NHS Patient information leaflet and FAQs https://www.whittingtonpharmacy.co.uk/further-advice
- Trust intranet with information on EU Exit and FAQs https://whittnet.whittington.nhs.uk/default.asp?c=32007&q=
- Trust internet https://www.whittington.nhs.uk/mini-apps/news/NewsPage.asp?NewsID=2146

Medicines: Key Messages
Patients Staff and the Community

Whittington Health
NHS Trust

For Patients:

- ***Please keep ordering your repeat prescriptions and taking your medicines as normal.*** *It's very important you don't order more medicines than normal. If you do, then it may mean that other people won't be able to get their medicines. Further information is available on NHS.uk*

For Secondary Care:

- **You should continue to manage medicines supply issues as per current processes which have been enhanced**. Any medicines supply issues you are concerned about, or for which you require further assistance, should continue to be reported via your Pharmacy Department to the specialist Regional Procurement Leads.

For Primary Care:

- **Prescribers and community pharmacists should work together as normal to manage medicines shortages**. Where a medicine is not available the prescriber and pharmacist should consider suitable alternatives jointly with the patient.

In general, national clinical guidance will be provided as necessary.

Medical Devices

- **No action needed. CE marks will remain valid in the UK for existing and new devices**
- **From Exit Day, all medical devices and IVDs placed on the UK market must be registered with MHRA**. There is a 4-12 month grace period, depending on risk class.
- **Trusts placing new devices on the UK market post-Exit must use an EU27 Notified Body**, as UK Notifiable Bodies will not be able to issue certificates from 1/11/19.

Medicines Supply, Certification, and Safety

- ~90% of medicines available in the UK already have a UK licence – this will not change.
- ~10% are EU-licenced. None have so far declined conversion to a UK licence.
- **If sourcing medicines from outside the UK, you will need the relevant manufacturer's import licence or wholesale dealers licence, or to import via someone who does.**
- **All human medicines should be obtained from the UK-licensed supply chain.** This will cover authorised medicines, unlicensed medicines, IMPs, and ATMPs.
- Know your suppliers and their capacity, so that you are aware of stock capabilities
- **MHRA will continue medicine/device monitoring and communicate any safety issues**.
- Adverse reaction/incident reporting to the Yellow Card Scheme should continue as now

Health Care Products
Whittington Health and Procurement

NHS
Whittington Health
NHS Trust

- Whittington Health have conducted extensive internal reviews of stock items in 2018/2019
- The Procurement Team have oversight of contacts and services. Plan have put plans into place for a "*No Deal*" scenario.
- The procurement team will closely monitor stock items and respond immediately to an specific issues related to EU Exit.

Workforce

Whittington Health
NHS Trust

- **Provide continued reassurance to EU staff; they are welcome and a vital part of the health and care family.** Letters from the Secretary of State and the senior leadership of NHS England have been issued; use as the basis for your organisation's communications
- **Continue to promote the BENEFITS of Settlement Scheme** to EU staff
- **UK legislation recognising EU nationals qualifications is in place**, but requires individual agreements with member states to recognise UK qualifications across EU respective professional bodies. This cannot happen until the UK leaves the EU.
- If a professional qualification is not automatically recognised under the Directive at exit day, it will be assessed by the relevant UK regulator as now
- **There will be no need for any change to existing employment contracts if the UK leaves the EU without a deal.** There is no question of EU staff needing to reapply for their own jobs because of EU exit
- The Government made an announcement that, if the UK leaves the EU without a deal, there will be a transition period until the UK's new skills-based immigration system is introduced in 2021. **This means NHS organisations can continue to recruit staff from EU countries**

- Work with partners across social care, **continue to assess the number of EU national staff and escalate shortages to regional teams**
- **Develop local contingency plans to mitigate workforce shortages** in conjunction with social care providers and feed these into Local Health Resilience Partnership and Local Resilience Fora
- **Be aware that NHS England and Improvement encourage NHS organisations to allow staff to be 'passported' across different trusts**

Information for patients:

- ***Measures have been put in place to ensure that the NHS is able to maintain staff levels following EU exit***
- ***Under UK legislation, the qualifications of EU staff will continue to be recognised in the UK***

EU Settlement Scheme

Link: https://www.gov.uk/settled-status-eu-citizens-families

Whittington Health NHS Trust

- Tell your EU staff about the EU settlement scheme
- EU nationals can register for settled status if they have been in the UK for 5 or pre-settled status if less than 5 years
- The scheme is free and simple to register
- The deadline for applications is 31st December 2020 if there is a no-deal EU Exit or 30th June 2021 if the UK leaves the EU with a deal.
- Irish citizens are not required to apply, however can if they wish

Professional Qualifications

Whittington Health NHS Trust

- Legislation is in place to ensure that professional qualifications from the EU, Norway, Iceland, Liechtenstein and Switzerland will still be recognised by professional bodies when the UK leaves the EU.
- GMC https://www.gmc-uk.org/news/news-archive/brexit---information-for-doctors
- NMC https://www.nmc.org.uk/registration/what-brexit-means-for-nursing-and-midwifery/
- GPC https://www.pharmacyregulation.org/news/recognition-professional-qualifications-event-no-deal-brexit
- GDC https://www.gdc-uk.org/search?indexCatalogue=search&searchQuery=EU%20Exit&wordsMode=AllWords

Reciprocal healthcare and overseas visitors charging: Overseas visiting Team

Whittington Health NHS Trust

- Trusts must **continue to support current reciprocal healthcare arrangements**
- . (EHIC, PRC, S1, S2) and apply cost recovery regulations until further advice from Government on how the system may change
- **GP Practices must collect the supplementary information on p2 of GMS1** form (or equivalent) until advised otherwise

. Providers need to determine NHS eligibility, and exemption from charging under NHS Charges to Overseas Visitors (incl Amendment) EU Exit Regulations 2019 http://www.legislation.gov.uk/uksi/2019/516/contents/made

- Ensure overseas visitor management team and other staff understand the new regulations and are able to put them into practice. **Increase staffing as necessary**
- Check the NHS visitor and migrant cost recovery page regularly to see the latest guidance, or set up an email alert subscription to receive all the latest updates from the Department of Health and Social Care.
  - https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme
  - https://www.gov.uk/email-signup?link=/government/organisations/department-of-health-and-social-care
- **CCGs ensure risk share arrangements are in place** and being operated correctly
- DHSC, NHS England and Improvement will provide updates and further information once the position on post-EU Exit reciprocal arrangements is agreed

- **Do not stockpile products from NHSBT.** NHSBT is aiming to supply as normal and is stockpiling medical devices and critical consumables from the EU
- **Continue to behave as normal around NHSBT products and services,** unless contacted by NHSBT to change
- **Group O Negative blood** is, as ever, a valuable resource and we thank hospital transfusion departments and users for their work in using this resource to its best effect. We ask that hospitals continue this good work.

Information for patients:

- ***Blood products will continue to be available. The UK is largely self-sufficient. In cases where EU sourced, they are covered by the government's contingency plans and can be quickly imported including air freight for products with a short shelf life***

- ***Blood donors should continue to donate blood as normal.***

Vaccines

- **Vaccines should not be stockpiled beyond business-as-usual levels.** Over-ordering will be investigated
- **Pharmacists and emergency planning staff should meet at a local level** to discuss and agree local contingency and collaboration agreements
- **Local cross-system medicines supply continuity plans should be developed and agreed at trust/CCG board level** – including arrangements for collaboration to ensure shortages of locally-procured vaccines are dealt with promptly
- **There will be a Vaccines Shortage Response Group** for nationally and locally-procured vaccines, coordinated by PHE with NHS E&I and Devolved Administrations

Information for patients:

- ***The government, NHS and PHE have been working together to ensure vaccines will be available as needed after the UK leaves the EU***
- ***Vaccines brought in from the EU are covered by the government's contingency plans; can be imported at short notice including air freight for products with a short shelf life***

Data sharing, processing and access

Whittington Health NHS Trust

- Currently, personal data can be transferred freely between the UK and the EU. The EU describes the UK as having adequate data protection
- Data will continue to flow unaffected
- Check whether your department relies on data transfers of personal data from the EU or other adequate countries to the UK. This has been reviewed by IM+T and the Information Governance Team.
- The transfer of personal data from the EU to the UK may be restricted if the UK leaves the EU without a deal.

Research and Clinical Trials

Whittington Health NHS Trust

- Sponsors of clinical trials or investigations should review their supply chains and put arrangements in place
- Chief investigators of clinical trials should contact trial sponsors to understand their continuity arrangement's
- Recruiting for trials will continue. Only stop recruiting when advised by trial sponsor or by formal communication from the government
- Successful bids for EU programme funding until the end of 2020 will receive their full financial allocation for the lifetime of the project.

Whittington Health EU Exit Team

NHS
Whittington Health
NHS Trust

- Whittington Health EU Exit Team in place since 24th of January 2019
- Chaired by Chief Operating Office
- Representation from operational ICSUs, Communications, Procurement, Pharmacy, Workforce, Finance, Information Governance and IM+T

Further Information

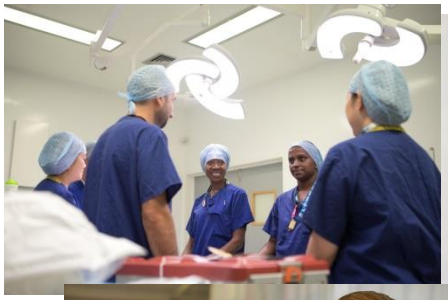
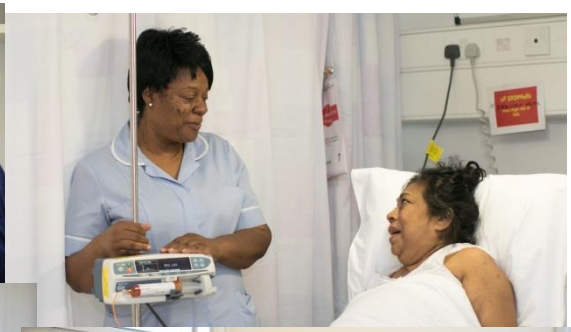
Whittington Health NHS Trust

- https://www.gov.uk/guidance/how-healthcare-providers-can-prepare-for-brexit

- Please contact Lee Smith Emergency Planning Officer for any information or questions via email:
- Lee.smith9@nhs.net

NHS
Whittington Health
NHS Trust

Thank you



I·C A R E
INNOVATION COMPASSIONATE ACCOUNTABLE RESPECTFUL EXCELLENT

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**Cyber security risk update**	**Agenda item: 20**
Executive director lead	Leon Douglas, Chief Information Officer	
Report author	Leon Douglas	
Executive summary	This report • updates the Board on progress against the identified Cyber Security risks, as well as highlights the significant assurance provided by recent internal audit findings. Whittington Health (WH) considers cybersecurity of high importance and recognises the risk through the Board Assurance Framework; and • offers progress highlights on mitigating the Cyber Risk on the Risk Register and highlights a few remaining areas of work. It also makes some straight-forward recommendations to ensure the cyber risk remains mitigated.	
Purpose:	Noting	
Recommendation(s)	Board members are asked to acknowledge and note the progress achieved to date and the recommendations contained within this report.	
Risk Register or Board Assurance Framework	Sustainable 2 - Cyber Security risk	
Report history	Executive Team and Trust Management Group, October 2019	
Appendices	Appendix A – Cyber Security Update Paper Appendix B – Trust Patching Schedule	

Cyber security risk update

Context
The paper updates the Trust Leadership Team on progress against the identified Cyber Security risks, as well as highlights the recent audit findings. Whittington Health (WH) considers cybersecurity of high importance and recognises the risk through the Board Assurance Framework.

Overall, excellent progress has been made in mitigating and resolving risks identified through the various audits and analyses that have been undertaken. It should be recognised that the Trust has made consistent and significant investment in this area to deliver a much higher level of security.

Progress

In summary the major areas of progress are this:

- **End User Hardware** - Computers running out of date operating systems have been eradicated and all connected computers are automatically patched regularly. Trust is currently 4350 machines through 5100 on Windows 10 migration
- **Servers** – all running compliant, fully patched operating systems. Excellent progress made on Jan 2020 end of life systems. Currently due to be complete early Q4 FY19/20 in line with target.
- **Networks** – new firewalls and scanning software including anti-encryption technology deployed.
- **Protection** – ATP deployed across whole IT estate to enhance real time monitoring
- **Processes** – revised and improved procedures from day to day maintenance up to emergency planning level
- **Staff** – ongoing skills department within IM&T. Cyberskills is included in mandatory training for all staff. Periodic, risk based campaigns delivered to staff, most recently linked to ESR phishing attack.

The current areas of focus are:

- Rolling out windows 10 before the end of Windows 7 support. Currently 750 machines to go
- Moving data server farms from Server 2008 to newer versions. Deadline Jan 2020.
- Roll out of Microsoft ATP as part of the Enterprise Wide Agreement for Windows 10 – complete across desktop estate but detailed work for medical devices ongoing.

Areas of risk:

- **Staff** – while generally staff is vigilant and do their best to engage with IM&T on threats or potentially suspicious items we must recognise that they are, for the most part, the target of the most common attacks and the most common source of incidents. The majority of these come from either clicking on content on the web or in emails that give a threat access to their machine or by leaving their machines unlocked and therefore available for others to access. We do have quite extensive secondary protective mechanisms such as traffic scanning systems and anti-virus these systems never completely remove the threat from new variants of viruses and worms. Recent attacks have focussed on staff records and extra staff education has been undertaken with the support of NHS CFS and IG.

Recommendations:

1. Continue to support the engagement with Information Governance and Data Security Training for all staff
2. Continue to communicate with staff about the importance of vigilance for such threats

- **Medical Devices** – WH use a wide array of devices as is the case in most healthcare organisations. Our overall aim is to be able to connect these to integrate the data they capture for clinical use, back it up for legal and safety reasons and to ensure a productive and efficient experience for both staff and patients. The current estate is very mixed with many devices which would be considered insecure if connected to the network. However, progress has been made again in 2019/20 in assessing as many devices as possible, replacing or upgrading those where connectivity was essential or highly desirable and putting procedures in place around the backlog. It should be noted that a number of pieces of key radiology equipment do fall into this category. Given their essential nature and the challenge of replacing these, a temporary secure network has been set up for these. This is an expensive and resource heavy mitigation which we will aim to close as soon as is feasible. It should be noted that considerable ongoing focus and effort will be needed in this area to reduce the risk adequately.

- It is notable that the Trust has made a positive step forward in its assessment of new devices through both the business case process and RAP replacement process. This has largely eradicated the influx of new devices that don't meet the current standards.

Recommendation:

1. Effort and focus continued in working through the backlog. ICSUs to do a detailed review of the medical devices and associated software they use

- **New Threats** – The support and information available to Trusts has improved since the WannaCry incident. One challenge that remains is the ability to deal with innovative new threats. While our defences comply and in some areas exceed the national standards there are regular reports of novel threats, many of which have no initial protection or remediation protocol. This makes it incumbent upon the IM&T team to remain vigilant to new threats, engage with the national information warnings and to refresh their skills as required. It's crucial the Trust maintain sight on Cyber risk and continue to invest in this area as required.

- **Recommendation:**

1. continue to recognise the risk of Cyber Threats
2. Support the ongoing skills and investment required to respond to new threats.

While this report draws out some key areas for the reader the scorecard in attached in Appendix A displays our assessment based on the National Cyber Security Centre guidance and should therefore be recognisable both within the NHS and outside.
The Trust wide patching schedule (Appendix B) is also included to give visibility.

Audit

Whittington Health has a positive approach to internal audit, utilising it as an effective check on the quality and efficacy of the work undertaken. In the area of cybersecurity this has very much supported the positive progress the team have been able to deliver. The cybersecurity design and implementation audit, alongside the Trust compliance with the Data Security and Protection Toolkit were assessed in April/May 2019 with both audits producing a 'Significant Assurance' outcome from the auditors. While this is to be commended and suggests our investments have delivered it is notable that this area

requires constant vigilance and effort to maintain the level of protection we have established.

Conclusion

The Trust should be satisfied while not complacent that it has made significant demonstrable progress in mitigating its cyber risk status. The leadership team should note that focus will need to be maintained in this area.

Appendix A: Whittington Health IM&T – Cyber Security Update, September 2019

1.0 Introduction

Whittington Health IM&T have reviewed its cyber security status following guidance from the '10 steps to Cyber Security' produced by the National Cyber Security Centre (part of GCHQ). The following areas are covered:

Set up your Risk Management Regime
Monitoring
Malware Prevention
User education and awareness
Managing user privileges
Network security
Secure configuration
Removable media controls
Incident management
Home and mobile working

These ten steps demonstrate that cyber security is multi-layered and ever evolving, requiring constant review and updating of internal processes.

2.0 Whittington Health's Current Cybersecurity Status

Set up your Risk Management Regime	

Description	Assess the risks to your organisation's information and systems with the same vigour you would for legal, regulatory, financial or operational risks. To achieve this, embed a Risk Management Regime across your organisation, supported by the Board and senior managers.
Risk	The Trust requires a corporate owned risk management regime for cybersecurity.
Mitigation	1) IM&T risk register maintained. 2) Key risks transferred to DATIX.

Network Security	

Description	Protect your networks from attack. Defend the network perimeter; filter out unauthorised access and malicious content. Monitor and test security controls.
Risk	We need to make sure we have current valid technologies to block against continuous evolving external threats.
Mitigation	1) All Firewalls are the latest generation. The Firewalls get updated every two months with patches unless there are any critical patches released.

	2) Intrusion Detection has been installed to monitor internal network traffic for threats. 3) Web proxies scan non encrypted traffic for malware. 4) Firewall rules have been reviewed and updated. 5) Integrity360 in March 2019 conducted external penetration tests of WH's network. Outcome successful – Inegrity360 failed to penetrate WH's systems. 6) Network Security Policy in place: http://whittnet.whittington.nhs.uk/search/?q=network+security+policy

Monitoring	

Description	Establish a monitoring strategy and produce supporting policies. Continuously monitor all systems and networks. Analyse logs for unusual activity that could indicate an attack.
Risk	Need for visibility and alerting of attempted cyber attacks and vulnerabilities on internet hosted services.
Mitigation	1) Log management and analysis of internet cyber incidents via Log-stash software solution. 2) Advanced traffic monitoring has been implemented (2017) on new firewalls. 3) Application specific logs are continually being integrated into the log management system. 4) Network vulnerabilities scanning, being routinely performed, looking for network connected devices that could be at risk from Malware. 5) Log management of user and administrator activities via ManageEngine configured and implemented (2017).

Secure Configuration	

Description	Apply security patches and ensure the secure configuration of all systems is maintained. Create a system inventory and define a baseline build for all devices.
Risk	**Patching:** i) Internal – The current IM&T 'patch' update process for internally maintained software had problems with co-ordination across the multiple stakeholders. ii) External – a) Suppliers - Some suppliers (e.g. Astral for Imaging) are refusing to allow internal patching of externally maintained systems (threat of making existing warranties invalid if internal patching occurs although the supplier will not perform the required patches themselves). b) NHS Digital provided programmes e.g. ESR which require old unsupported vulnerable software versions (e.g. Java) in order to operate. Outside Trust's remit as national system.

	Unsupported operating systems: i) Medical devices attached to the network running unpatched or unsupported operating systems still an issue. Principally in pathology and imaging. These represent a cyber threat. ii) Support for Windows 7 devices and 2008 severs (the current main operating system for most devices and servers) only available until January 2020. iii) Ongoing purchasing of new medical devices with out-of-date or near end of life Windows operating systems with no provision for upgrade/patch protection.
Mitigation	1) The Trust Network Security Policy has been updated to include mandatory monthly update of all operating system security patches. 2) A Trust wide co-ordinated patching schedule for all servers has been implemented (with locally maintained agreements on when patching should occur within the one month time limit). Pathology was an exception this is now part of monthly patching. 3) Isolation Firewall solution has been installed to protect internal networks from unpatched and unsupported system this is particularly targeted at medical devices. This is now live and running (early 2018), but some systems still need to be migrated onto the isolation network. 4) Review and/or renegotiate contracts with suppliers which do not meet Trust's standard for maintenance of patching supported software. 5) TMG agreed escalation policy for stakeholders who use unsupported operating systems (an approved process for removing/isolating 'unsupported' devices from the network which pose an existential threat to the organisation). 6) Planning in place for replacement of all PCs and laptops from Windows 7 to Windows 10 by Jan 2020. Capital procurement program in place and upgrade work underway. By Aug 2019, x3500 PCs & Laptops already migrated to windows 10. On target to complete work within required time frame. 7) Planning to upgrade all windows 2008 Servers by Jan 2020, associated licencing, procurement and upgrade work is well underway. There have been challenges with Capital funding in this area, although now largely resolved this has caused some delay to this program of work. Currently still on target for completion on schedule.

Malware Prevention	

Description	Produce relevant policies and establish anti-malware defences across your organisation.
Risk	Active anti-malware defences required across organisation.

Mitigation	1) AV solution has been standardised across the whole organisation to a new version of Sophos (until 2017 community was running McAfee). 2) Perimeter protection scanning of web traffic for malware on the proxy gateway. 3) Sophos Anti encryption-ware protection implemented across network 4) Microsoft Advanced Threat Protection (ATP) has been implemented and providing valuable actionable intelligence from across the PC estate

Removable media controls	

Description	Produce a policy to control all access to removable media. Limit media types and use. Scan all media for malware before importing onto the corporate system.
Risk	Potential for software viruses to be brought into Trust network by 'removable media' used by staff e.g. memory stick.
Mitigation	1) Antivirus solution in place that scans all removable media for software viruses before user is allowed to access memory stick. The policy for their use can be found here - http://whittnet.whittington.nhs.uk/document.ashx?id=2569

User education and awareness	

Description	Produce user security policies covering acceptable and secure use of your systems. Include in staff training. Maintain awareness of cyber risks.
Risk	Training on cybersecurity for all staff at WH. Nor is there a consistent regular campaign on maintaining staff awareness of cyber risks.
Mitigation	1) Mandatory annual training is now provided as part of the new Annual IG training which has been extended to include security awareness (implemented 2017). 2) Work with Communications Team on raising cyber risk awareness and basic protective measures for staff. Content to be owned and updated by IM&T technical services and IG teams. A number of good practice advisory messages have been put out during the course of the year via the communications team.

Managing user privileges	

Description	Establish effective management processes and limit the number of privileged accounts. Limit user privileges and monitor user activity. Control access to activity and audit logs.
Risk	Users should only have the access rights that they need to do the job.

	Any elevated or administrator rights are particularly dangerous if compromised by malware due to the access they permit.
Mitigation	1) A review of existing user privileges has been undertaken, to limit the number of staff with administrative rights, and ensure privileges granted are appropriate to work requirements. 2) User accounts now disabled after 60 days inactivity on a regular basis. 3) A log monitoring software (Manage Engine) has been implemented (2017) to enable monitoring of network domain activities by users.

Incident Management	

Description	Establish an incident response and disaster recovery capability. Test your incident management plans. Provide specialist training. Report criminal incidents to law enforcement. Report cyber incidents to CareCert.
Risk	In the event of a major incident important that incident response and disaster recovery plans have been carefully worked up to minimise impact.
Mitigation	1) Revised Incident response plan signed off by emergency planning group. 2) Planned incident response scenario training has been undertaken facilitated by Lee Smith (2019). 3) Procedures are in place, and routine technical fail over testing/training is undertaken for disaster recover procedures within IM&T.

Home and Mobile Working	

Description	Develop a mobile working policy. Apply the secure baseline and build to all devices. Protect data both in transit and at rest.
Risk	Risk of insecure devices being used for mobile and remote working.
Mitigation	1) Secure Citrix access to trust systems for remote users. 2) Secure Direct Access solution for remote access from trust laptops 3) Encryption of all Laptops. 4) Mobile Device Management & BYOD Policy which can be found here – http://whittnet.whittington.nhs.uk/document.ashx?id=7602 *all the above are in place at the Trust.

3.0 Summary

Whittington Health was not affected by 'WannaCry' Ransomware in May 2017, and this is largely due to measures which have been put in place since the KPMG audit in 2016.

However there are still gaps within Whittington Health's cyber security which do need to be addressed on an ongoing basis to ensure all reasonable measures are in place. The biggest challenges going forwards are.

- Upgrading and refreshing PCs, servers, infrastructure and software, to continually ensure that they fully supported and cyber safe, this requires ongoing capital investment.
- Working with 3rd party suppliers to ensure that Medical devices are kept patched and cyber safe and are isolated from the main network where appropriate.

National advice is given by NHS Digital, in the form of the Data Security Centre - CareCert initiative. This provides best practice guidance, an advisory service, and a helpline in the event of incidents around threats. We are fully signed up to the Carecert threat advisory service.

Key cyber security highlights of work program for 2019

- Upgrade of the all PCs and Laptops to Windows10 (target completion - Jan 2020)
- Upgrade of all IT servers and systems to new minimum standard of Windows server 2012 (target completion - Jan 2020)
- Maintenance of patch management regime for all systems
- Enforcement of strict rules for equipment to be permitted on the Trust network
- Ongoing - Replacement program to ensure that all infrastructure and systems are fully supported
- Ongoing - Proactive monitoring of network for cyber vulnerabilities and associated remediation work.
- Internal cyber security audit undertaken by Grant Thornton gives "significant assurance"

Calendar 2019

January	February	March	April	May	June
1 Tu New Year's Day 1	1 Fr	1 Fr	1 Mo 14	1 We	**1 Sa**
2 We System C (4AM-7AM)	**2 Sa**	**2 Sa**	2 Tu	2 Th	**2 Su**
3 Th System C (5PM-8PM)	**3 Su**	**3 Su**	3 We System C (4AM-7AM)	3 Fr	3 Mo 23
4 Fr	4 Mo 6	4 Mo 10	4 Th System C (5PM-8PM)	**4 Sa**	4 Tu
5 Sa	5 Tu	5 Tu	5 Fr	**5 Su**	5 We System C (4AM-7AM)
6 Su	6 We System C (4AM-7AM)	6 We System C (4AM-7AM)	**6 Sa**	**6 Mo Early May B. Hol.** 19	6 Th System C (5PM-8PM)
7 Mo 2	7 Th System C (5PM-8PM)	7 Th System C (5PM-8PM)	**7 Su**	7 Tu	7 Fr
8 Tu ICE (4AM -5AM)	8 Fr	8 Fr	8 Mo 15	8 We System C (4AM-7AM)	**8 Sa**
9 We	**9 Sa**	**9 Sa**	9 Tu ICE (4AM -5AM)	9 Th System C (5PM-8PM)	**9 Su**
10 Th JAC (1AM-2AM)	**10 Su**	**10 Su**	10 We	10 Fr	10 Mo 24
11 Fr	11 Mo 7	11 Mo 11	11 Th JAC (1AM-2AM)	**11 Sa**	11 Tu ICE (4AM -5AM)
12 Sa	12 Tu ICE (4AM -5AM)	12 Tu ICE (4AM -5AM)	12 Fr	**12 Su**	12 We
13 Su	13 We	13 We	**13 Sa**	13 Mo 20	13 Th JAC (1AM-2AM)
14 Mo 3	14 Th JAC (1AM-2AM)	14 Th JAC (1AM-2AM)	**14 Su**	14 Tu ICE (4AM -5AM)	14 Fr
15 Tu	15 Fr	15 Fr	15 Mo 16	15 We	**15 Sa**
16 We	**16 Sa**	**16 Sa**	16 Tu Winpath (7:30AM-9AM)	16 Th JAC (1AM-2AM)	**16 Su**
17 Th	**17 Su**	**17 Su**	17 We Winpath (7:30AM-9AM)	17 Fr	17 Mo 25
18 Fr	18 Mo 8	18 Mo 12	18 Th EDMS (5AM-6AM)	**18 Sa**	18 Tu Winpath (7:30AM-9AM)
19 Sa	19 Tu Winpath (7:30AM-9AM)	19 Tu Winpath (7:30AM-9AM)	**19 Fr Good Friday**	**19 Su**	19 We Winpath (7:30AM-9AM)
20 Su	20 We Winpath (7:30AM-9AM)	20 We Winpath (7:30AM-9AM)	**20 Sa**	20 Mo 21	20 Th EDMS (5AM-6AM)
21 Mo 4	21 Th EDMS (5AM-6AM)	21 Th EDMS (5AM-6AM)	**21 Su**	21 Tu Winpath (7:30AM-9AM)	21 Fr
22 Tu Winpath (7:30AM-9AM)	22 Fr	22 Fr	**22 Mo Easter Monday** 17	22 We Winpath (7:30AM-9AM)	**22 Sa**
23 We Winpath (7:30AM-9AM)	**23 Sa**	**23 Sa**	23 Tu Winpath (8AM-9AM)	23 Th EDMS (5AM-6AM)	**23 Su**
24 Th EDMS (5AM-6AM)	**24 Su**	**24 Su**	24 We	24 Fr	24 Mo 26
25 Fr	25 Mo 9	25 Mo 13	25 Th	**25 Sa**	25 Tu Winpath (8AM-9AM)
26 Sa	26 Tu Winpath (8AM-9AM)	26 Tu Winpath (8AM-9AM)	26 Fr	**26 Su**	26 We
27 Su	27 We	27 We	**27 Sa**	**27 Mo Spring Bank Hol.** 22	27 Th
28 Mo 5	28 Th	28 Th	**28 Su**	28 Tu Winpath (8AM-9AM)	28 Fr
29 Tu Winpath (8AM-9AM)		29 Fr	29 Mo 18	29 We	**29 Sa**
30 We		**30 Sa**	30 Tu	30 Th	**30 Su**
31 Th		**31 Su**		31 Fr	

Calendar 2019

July	August	September	October	November	December
1 Mo 27	1 Th	**1 Su**	1 Tu	1 Fr	**1 Su**
2 Tu	2 Fr	2 Mo 36	2 We System C (4AM-7AM)	**2 Sa**	2 Mo 49
3 We System C (4AM-7AM)	**3 Sa**	3 Tu	3 Th System C (5PM-8PM)	**3 Su**	3 Tu
4 Th System C (5PM-8PM)	**4 Su**	4 We System C (4AM-7AM)	4 Fr	4 Mo 45	4 We System C (4AM-7AM)
5 Fr	5 Mo 32	5 Th System C (5PM-8PM)	**5 Sa**	5 Tu	5 Th System C (5PM-8PM)
6 Sa	6 Tu	6 Fr	**6 Su**	6 We System C (4AM-7AM)	6 Fr
7 Su	7 We System C (4AM-7AM)	**7 Sa**	7 Mo 41	7 Th System C (5PM-8PM)	**7 Sa**
8 Mo 28	8 Th System C (5PM-8PM)	**8 Su**	8 Tu ICE (4AM -5AM)	8 Fr	**8 Su**
9 Tu ICE (4AM -5AM)	9 Fr	9 Mo 37	9 We	**9 Sa**	9 Mo 50
10 We	**10 Sa**	10 Tu ICE (4AM -5AM)	10 Th JAC (1AM-2AM)	**10 Su**	10 Tu ICE (4AM -5AM)
11 Th JAC (1AM-2AM)	**11 Su**	11 We	11 Fr	11 Mo 46	11 We
12 Fr	12 Mo 33	12 Th JAC (1AM-2AM)	**12 Sa**	12 Tu ICE (4AM -5AM)	12 Th JAC (1AM-2AM)
13 Sa	13 Tu ICE (4AM -5AM)	13 Fr	**13 Su**	13 We	13 Fr
14 Su	14 We	**14 Sa**	14 Mo 42	14 Th JAC (1AM-2AM)	**14 Sa**
15 Mo 29	15 Th JAC (1AM-2AM)	**15 Su**	15 Tu Winpath (7:30AM-9AM)	15 Fr	**15 Su**
16 Tu	16 Fr	16 Mo 38	16 We Winpath (7:30AM-9AM)	**16 Sa**	16 Mo 51
17 We	**17 Sa**	17 Tu Winpath (7:30AM-9AM)	17 Th EDMS (5AM-6AM)	**17 Su**	17 Tu Winpath (7:30AM-9AM)
18 Th	**18 Su**	18 We Winpath (7:30AM-9AM)	18 Fr	18 Mo 47	18 We Winpath (7:30AM-9AM)
19 Fr	19 Mo 34	19 Th EDMS (5AM-6AM)	**19 Sa**	19 Tu Winpath (7:30AM-9AM)	19 Th EDMS (5AM-6AM)
20 Sa	20 Tu Winpath (7:30AM-9AM)	20 Fr	**20 Su**	20 We Winpath (7:30AM-9AM)	20 Fr
21 Su	21 We Winpath (7:30AM-9AM)	**21 Sa**	21 Mo 43	21 Th EDMS (5AM-6AM)	**21 Sa**
22 Mo Winpath (7:30AM-9AM)	22 Th EDMS (5AM-6AM)	**22 Su**	22 Tu Winpath (8AM-9AM)	22 Fr	**22 Su**
23 Tu Winpath (7:30AM-9AM)	23 Fr	23 Mo 39	23 We	**23 Sa**	23 Mo Sectra (8PM-10PM)
24 We EDMS (5AM-6AM)	**24 Sa**	24 Tu Winpath (8AM-9AM)	24 Th	**24 Su**	24 Tu Winpath (8AM-9AM)
25 Th	**25 Su**	25 We	25 Fr	25 Mo 48	**25 We Christmas Day**
26 Fr	**26 Mo August Bank Hol.** 35	26 Th Sectra (8PM-10PM)	**26 Sa**	26 Tu Winpath (8AM-9AM)	**26 Th Boxing Day**
27 Sa	27 Tu	27 Fr	**27 Su**	27 We	27 Fr
28 Su	28 We Winpath (8AM-9AM)	**28 Sa**	28 Mo 44	28 Th Sectra (8PM-10PM)	**28 Sa**
29 Mo Winpath (8AM-9AM)	29 Th Sectra (8PM-10PM)	**29 Su**	29 Tu	29 Fr	**29 Su**
30 Tu	30 Fr	30 Mo 40	30 We	**30 Sa**	30 Mo 1
31 We	**31 Sa**		31 Th Sectra (8PM-10PM)		31 Tu

Calendar 2020

January	February	March	April	May	June
1 We New Year's Day	1 Sa	1 Su	1 We SystemC (4AM-7AM)	1 Fr	1 Mo 23
2 Th	2 Su	2 Mo 10	2 Th SystemC (5PM-8PM)	2 Sa	2 Tu
3 Fr	3 Mo 6	3 Tu	3 Fr	3 Su	3 We SystemC (4AM-7AM)
4 Sa	4 Tu	4 We SystemC (4AM-7AM)	4 Sa	4 Mo 19	4 Th SystemC (5PM-8PM)
5 Su	5 We SystemC (4AM-7AM)	5 Th SystemC (5PM-8PM)	5 Su	5 Tu	5 Fr
6 Mo 2	6 Th SystemC (5PM-8PM)	6 Fr	6 Mo 15	6 We SystemC (4AM-7AM)	6 Sa
7 Tu	7 Fr	7 Sa	7 Tu	7 Th SystemC (5PM-8PM)	7 Su
8 We SystemC (4AM-7AM)	8 Sa	8 Su	8 We	8 Fr Early May Bank Hol.	8 Mo 24
9 Th SystemC (5PM-8PM)	9 Su	9 Mo 11	9 Th	9 Sa	9 Tu
10 Fr	10 Mo 7	10 Tu	10 Fr Good Friday	10 Su	10 We
11 Sa	11 Tu	11 We	11 Sa	11 Mo 20	11 Th
12 Su	12 We	12 Th	12 Su	12 Tu	12 Fr
13 Mo 3	13 Th	13 Fr	13 Mo Easter Monday 16	13 We	13 Sa
14 Tu	14 Fr	14 Sa	14 Tu	14 Th	14 Su
15 We	15 Sa	15 Su	15 We	15 Fr	15 Mo 25
16 Th	16 Su	16 Mo 12	16 Th	16 Sa	16 Tu
17 Fr	17 Mo 8	17 Tu	17 Fr	17 Su	17 We
18 Sa	18 Tu	18 We	18 Sa	18 Mo 21	18 Th
19 Su	19 We	19 Th	19 Su	19 Tu	19 Fr SystemC UAT (2PM-5PM)
20 Mo 4	20 Th	20 Fr SystemC UAT (2PM-5PM)	20 Mo 17	20 We	20 Sa
21 Tu	21 Fr SystemC UAT (2PM-5PM)	21 Sa	21 Tu	21 Th	21 Su
22 We	22 Sa	22 Su	22 We	22 Fr SystemC UAT (2PM-5PM)	22 Mo 26
23 Th	23 Su	23 Mo 13	23 Th	23 Sa	23 Tu
24 Fr SystemC UAT (2PM-5PM)	24 Mo 9	24 Tu	24 Fr SystemC UAT (2PM-5PM)	24 Su	24 We
25 Sa	25 Tu	25 We	25 Sa	25 Mo Spring Bank Hol. 22	25 Th
26 Su	26 We	26 Th	26 Su	26 Tu	26 Fr
27 Mo 5	27 Th	27 Fr	27 Mo 18	27 We	27 Sa
28 Tu	28 Fr	28 Sa	28 Tu	28 Th	28 Su
29 We	29 Sa	29 Su	29 We	29 Fr	29 Mo 27
30 Th		30 Mo 14	30 Th	30 Sa	30 Tu
31 Fr		31 Tu		31 Su	

Calendar 2020

July	August	September	October	November	December
1 We SystemC (4AM-7AM)	**1 Sa**	1 Tu	1 Th	**1 Su**	1 Tu
2 Th SystemC (5PM-8PM)	**2 Su**	2 We SystemC (4AM-7AM)	2 Fr	2 Mo 45	2 We SystemC (4AM-7AM)
3 Fr	3 Mo 32	3 Th SystemC (5PM-8PM)	**3 Sa**	3 Tu	3 Th SystemC (5PM-8PM)
4 Sa	4 Tu	4 Fr	**4 Su**	4 We SystemC (4AM-7AM)	4 Fr
5 Su	5 We SystemC (4AM-7AM)	**5 Sa**	5 Mo 41	5 Th SystemC (5PM-8PM)	**5 Sa**
6 Mo 28	6 Th SystemC (5PM-8PM)	**6 Su**	6 Tu	6 Fr	**6 Su**
7 Tu	7 Fr	7 Mo 37	7 We SystemC (4AM-7AM)	**7 Sa**	7 Mo 50
8 We	**8 Sa**	8 Tu	8 Th SystemC (5PM-8PM)	**8 Su**	8 Tu
9 Th	**9 Su**	9 We	9 Fr	9 Mo 46	9 We
10 Fr	10 Mo 33	10 Th	**10 Sa**	10 Tu	10 Th
11 Sa	11 Tu	11 Fr	**11 Su**	11 We	11 Fr
12 Su	12 We	**12 Sa**	12 Mo 42	12 Th	**12 Sa**
13 Mo 29	13 Th	**13 Su**	13 Tu	13 Fr	**13 Su**
14 Tu	14 Fr	14 Mo 38	14 We	**14 Sa**	14 Mo 51
15 We	**15 Sa**	15 Tu	15 Th	**15 Su**	15 Tu
16 Th	**16 Su**	16 We	16 Fr	16 Mo 47	16 We
17 Fr	17 Mo 34	17 Th	**17 Sa**	17 Tu	17 Th
18 Sa	18 Tu	18 Fr SystemC UAT (2PM-5PM)	**18 Su**	18 We	18 Fr SystemC UAT (2PM-5PM)
19 Su	19 We	**19 Sa**	19 Mo 43	19 Th	**19 Sa**
20 Mo 30	20 Th	**20 Su**	20 Tu	20 Fr SystemC UAT (2PM-5PM)	**20 Su**
21 Tu	21 Fr SystemC UAT (2PM-5PM)	21 Mo 39	21 We	**21 Sa**	21 Mo 52
22 We	**22 Sa**	22 Tu	22 Th	**22 Su**	22 Tu
23 Th	**23 Su**	23 We	23 Fr SystemC UAT (2PM-5PM)	23 Mo 48	23 We
24 Fr SystemC UAT (2PM-5PM)	24 Mo 35	24 Th	**24 Sa**	24 Tu	24 Th
25 Sa	25 Tu	25 Fr	**25 Su**	25 We	**25 Fr Christmas Day**
26 Su	26 We	**26 Sa**	26 Mo 44	26 Th	**26 Sa Boxing Day**
27 Mo 31	27 Th	**27 Su**	27 Tu	27 Fr	**27 Su**
28 Tu	28 Fr	28 Mo 40	28 We	**28 Sa**	**28 Mo Substitute day** 53
29 We	**29 Sa**	29 Tu	29 Th	**29 Su**	29 Tu
30 Th	**30 Su**	30 We	30 Fr	30 Mo 49	30 We
31 Fr	**31 Mo August Bank Hol.** 36		**31 Sa**		31 Th

Meeting title	**Trust Board – public meeting**	**Date: 30.10.2019**
Report title	**2019/20 Board forward plan**	**Agenda item: 21**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	Board members are presented with the dates of scheduled meetings and the forward plan of agenda items for the remainder of 2019/20 and also for 2020/21.	
Purpose:	Approval	
Recommendation(s)	Board members are invited to receive and note the forward plan for the remainder of 2019/20 and also for 2020/21.	
Risk Register or Board Assurance Framework	BAF entry 1 – Well-Led element of CQC inspection	
Report history	Bi-annual report to Board	
Appendices	1: 2019/20 and 2020/21 Board forward plan	

Updated 2019/20 and 2020/21 Board forward plans (18 October 2019 version)

1. 2019/20 Board forward plan

Agenda items	Lead(s)	Action	24 April 2019	29 May	26 June	31 July	25 Sept	30 Oct	27 Nov	18 Dec	29 Jan 2020	26 Feb	25 Mar
Standing Agenda Items:													
Minutes, matters arising, actions log	CoSec	Approve											
Patient story	CN	Review											
Staff story	CN	Review											
Chairman's Monthly Report	Chair	Receive											
Chief Executive's monthly report	CEO	Review											
Quality and Patient Safety reports:													
Monthly Serious incident report	MD	Review											
Quarterly Quality and patient safety	MD	Review	Q4			Q1			Q2		Q3		
Quarterly Learning from mortality	MD	Review	Q4			Q1			Q2		Q3		
Quality Assurance (CQC)													
Bi-annual integrated safeguarding	CN	Review											
Single gender accommodation declaration	COO	Approve											
2018/19 Annual Quality Account	CN	Approve											
2018/19 Annual Complaints & Compliments report	CN	review											
Annual NHS staff survey	DW	Review											
2018/19 Annual report – IPC	CN	Review											
Safeguarding Children declaration	CN	Approve											
Patient survey results – Picker	CN	Review											
2018/19 Annual report - FTSUG	DW	Review											
Strategies:													
Annual review: risk management strategy and risk appetite statement	CN/DS	Approve											
Workforce	DW	Approve											
Trust Wellbeing Guardian Annual Report	NF	Approve											
Quality Improvement	CN/MD	Approve											
Update Health & Wellbeing Partnership	CEO	Review											
Operational planning and performance:													
Monthly performance dashboard	COO	Review											
Monthly Finance report	CFO	Review											
Annual operational plan and budget	CFO	Approve											
Guardian of Safer Working report	MD	Review				Q1		Q2			Q3		
Six monthly safe nursing and midwifery safe staffing	CN	Review											
Six monthly Digital strategy fast follower update	CIO	Review											
Bi-annual capital update	CFO	Review											
Emergency Preparedness & BCP	COO	Review											
Heatwave Plan	COO	Approve											
Winter Plan	COO	Approve											
Quarterly Assurance on 7 Day Services	MD	Review											
2018/19 Health & Safety Annual Report	DE	Approve											
Data Security & Protection Toolkit	COO	Approve											
Governance:													
Board dates and forward plan	CoSec	Approve											
Quarterly delivery of strategic objectives	CoSec	Review	Q4			Q1		Q2			Q3		
Board Assurance Framework	CoSec	Review											
Operational risk register	CN	Review	Q4			Q1		Q2			Q3		
Audit & Risk Committee annual report	Chair/ CFO	Review											
Register of Directors' interests	CoSec	Review											
Register of deed of execution	CoSec	Review											
District audit Annual report	CFO	Review											
Trust Annual Report & Accounts	DS/CFO	Approve											

Agenda items	Lead(s)	Action	24 April 2019	29 May	26 June	31 July	25 Sept	30 Oct	27 Nov	18 Dec	29 Jan 2020	26 Feb	25 Mar
SOs/SFIs/Scheme of delegation	CFO/DS	Approve											
Annual review of Board Committee TORs	CoSec	Approve											
Provider licence self-certification	DS	Approve											
Charitable Funds Annual Report & Accounts	CFO	Review											
2018/19 Research & Development AR	MD	Approve											
Annual Medical/Doctors' revalidation	MD	Approve											
Annual WLF self- assessment	CoSec	Review											
Annual workforce equality submissions RES & NHS EDS reports	DW	Approve											
Annual statutory public sector equality duty	DW/CN	Approve											
Annual equality delivery system grading	DW/CN	Approve											
Annual Gender pay gap	DW	Approve											

2. 2020/21 Board forward plan

Agenda items	Leads	Action	29 April 2020	27 May	24 June	29 July	30 Sept	28 Oct	25 Nov	16 Dec	27 Jan 2021	24 Feb	31 Mar
Standing Agenda Items:													
Minutes, matters arising, actions log	CoSec	Approve											
Patient story	CN	Review											
Staff story	CN	Review											
Chairman's Monthly Report	Chair	Receive											
Chief Executive's monthly report	CEO	Review											
Quality and Patient Safety reports:													
Monthly Serious incident report	MD	Review											
Quarterly Quality and patient safety	MD	Review	Q4			Q1			Q2		Q3		
Quarterly Learning from mortality	MD	Review	Q4			Q1			Q2		Q3		
Quality Assurance (CQC)													
Bi-annual integrated safeguarding	CN	Review											
Single gender accommodation declaration	COO	Approve											
2018/19 Annual Quality Account	CN	Approve											
2018/19 Annual Complaints & Compliments report	CN	review											
Annual NHS staff survey	DW	Review											
2018/19 Annual report – IPC	CN	Review											
Safeguarding Children declaration	CN	Approve											
Patient survey results – Picker	CN	Review											
2018/19 Annual report - FTSUG	DW	Review											
Strategies:													
Annual review: risk management strategy and risk appetite statement	CN/DS	Approve											
Workforce	DW	Approve											
Trust Wellbeing Guardian Annual Report	NF	Approve											
Quality Improvement	CN/MD	Approve											
Update Health & Wellbeing Partnership	CEO	Review											
Operational planning and performance:													
Monthly performance dashboard	COO	Review											
Monthly Finance report	CFO	Review											
Annual operational plan and budget	CFO	Approve											
Guardian of Safer Working report	MD	Review	Q4			Q1		Q2			Q3		
Six monthly safe nursing and midwifery safe staffing	CN	Review											
Six monthly Digital strategy fast follower update	CIO	Review											
Bi-annual capital update	CFO	Review											
Emergency Preparedness & BCP	COO	Review											
Heatwave Plan	COO	Approve											
Winter Plan	COO	Approve											
Quarterly Assurance on 7 Day Services	MD	Review											
2018/19 Health & Safety Annual Report	DE	Approve											
Data Security & Protection Toolkit	COO	Approve											
Governance:													
Board dates and forward plan	CoSec	Approve											
Quarterly delivery of strategic objectives	CoSec	Review	Q4			Q1		Q2			Q3		
Board Assurance Framework	CoSec	Review											
Operational risk register	CN	Review	Q4			Q1		Q2			Q3		
Audit & Risk Committee annual report	Chair/ CFO	Review											
Register of Directors' interests	CoSec	Review											
Register of deed of execution	CoSec	Review											
District audit Annual report	CFO	Review											
Trust Annual Report & Accounts	DS/CFO	Approve											
SOs/SFIs/Scheme of delegation	CFO/DS	Approve											

Agenda items	Leads	Action	29 April 2020	27 May	24 June	29 July	30 Sept	28 Oct	25 Nov	16 Dec	27 Jan 2021	24 Feb	31 Mar
Annual review of Board Committee TORs	CoSec	Approve											
Provider licence self-certification	DS	Approve											
Charitable Funds Annual Report & Accounts	CFO	Review											
2018/19 Research & Development AR	MD	Approve											
Annual Medical/Doctors' revalidation	MD	Approve											
Annual WLF self- assessment	CoSec	Review											
Annual workforce equality submissions RES & NHS EDS reports	DW	Approve											
Annual statutory public sector equality duty	DW/CN	Approve											
Annual equality delivery system grading	DW/CN	Approve											
Annual Gender pay gap	DW	Approve											