Whittington Health
NHS Trust

TRUST BOARD
IN PUBLIC

14:00-17:00
Wednesday
30 January 2019

Whittington Education Centre
Room 7

Whittington Health NHS Trust

Meeting	**Trust Board – Public meeting**
Date & time	**30 January 2019 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

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

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

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

AGENDA

Item	Timing	Title and lead	Action
Standing items			
1	1400	**Patient story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Presentation
2	1425	**Welcome and apologies** *Steve Hitchins, Chair*	Verbal
3	1428	**Declaration of conflicts of Interest** *Steve Hitchins, Chair*	Verbal
4	1430	**19 December 2018 public meeting draft minutes, action log, matters arising** *Steve Hitchins, Chair*	Approve
5	1435	**Chairman's report** *Steve Hitchins, Chair*	Review verbal update
6	1445	**Chief Executive's report** *Siobhan Harrington, Chief Executive*	Review
Quality & patient safety			
7	1455	**Serious incidents report – December 2018** *Dr Julie Andrews, Acting Medical Director*	Review

Item	Timing	Title and lead	Action
8	1505	**Quarter 3 Quality and patient safety report** *Julie Andrews, Acting Medical Director*	Review
9	1520	**Quarterly learning from mortality report** *Julie Andrews, Acting Medical Director*	Review
10	1530	**Nursing and midwifery establishment six monthly (October 18) review** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
Operational performance and planning			
11	1545	**Performance dashboard – December 2018** *Carol Gillen, Chief Operating Officer*	Review
12	1600	**Emergency preparedness resilience and response report** *Carol Gillen, Chief Operating Officer*	Review
13	1610	**EU exit contingency Plan** *Carol Gillen, Chief Operating Officer*	Review
14	1620	**7Day Services Board Assurance** *Julie Andrews, Acting Medical Director*	Review
15	1625	**Financial performance – December 2018** *Stephen Bloomer, Chief Financial Officer*	Review
Governance			
16	1635	**Quarter three delivery of corporate objectives** *Jonathan Gardner, Director of Strategy, Development & Corporate Affairs*	Review
17	1640	**Corporate risk register** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	Review
18	1650	**Draft minutes of Workforce & Assurance Committee, January 2019 meeting** *Professor Naomi Fulop, Committee Chair*	Review
19	1645	**Draft minutes of Quality Committee, January 2019 meeting** *Anu Singh, Committee Chair*	Review
20	1650	**Draft minutes of Charitable Funds Committee. December 2018 meeting** *Tony Rice, Committee Chair*	Review

Item	Timing	Title and lead	Action
21	1655	**Questions from the public on meeting items** *Steve Hitchins, Chair*	Verbal
22	1658	**Any other business** *Steve Hitchins, Chair*	Verbal

Minutes of the meeting of the Trust Board of Whittington Health held in public on Wednesday, 19 December 2018

Present:

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

In attendance:

Janet Burgess MBE	Councillor and Executive Member for Health & Social Care & Deputy Leader, Islington Council London Borough of Islington
Nicole Callender	Maternity Matron (item 1)
James Connell	Patient Experience Manager (item 1)
Jonathan Gardner	Director of Strategy, Development & Corporate Affairs
Casey Galloway	Patient Experience Officer (item 1)
Kate Green	PA to Director of Workforce
Sarah Humphery	Medical Director, Integrated Care
Catherine Nolan-Cullen	Compliance and Quality Improvement Manager (item 1)
Mrs Reich	Patient (item 1)
Beverleigh Senior	Director of Operations, Women's Health (item 1)
Swarnjit Singh	Trust Corporate Secretary
Kate Wilson	Acting Deputy Director of Workforce

1.	**Patient Story**
1.1	James Connell, Patient Experience Manager, introduced Mrs Reich, who was accompanied by her mother.
1.2	Mrs Reich began by informing the Board that she had been a patient at the Whittington for some fifteen years, with nine of her ten children born there. Her last child was born in July 2018, and she reported that the antenatal care she received as 'fantastic'.
1.3	Mrs Reich went on to describe the birth of her baby in July 2018. Following a decision to induce labour, she was admitted on a Wednesday, and taken to the labour ward on the Thursday. When the midwife observed that the birth was not proceeding, it was decided she should have a caesarean section. The spinal block administered did not take effect

	as rapidly as the anaesthetist would have liked, and it had also been necessary to use forceps to deliver the baby. The effects of the spinal block wore off quickly, and Mrs Reich was in pain. She was given medication and transferred to recovery. The baby was transferred to the neonatal intensive care unit and required pain relief throughout the night.
1.4	By the following Monday, Mrs Reich felt unwell, and the area of her caesarean section was red and inflamed. In addition, both patients and staff were feeling the effects of the heatwave. Mrs Reich was examined by a doctor who told her that she was fine and could be discharged. She was told that the heat and inflammation were most likely caused by a reaction to the dressing. The registrar failed, however, to document this in her notes.
1.5	At home on the Wednesday she was visited by a community midwife. Her temperature had risen, and the rash had spread. By Thursday, she knew that something was seriously wrong, so returned to the hospital, where she was diagnosed with serious cellulitis and sepsis. She was admitted to Murray Ward. During the night when she went to the toilet and her wound opened, and the following day she was seen by Jane Preece, Tissue Viability Nurse. Mrs Reich described Jane's treatment as 'phenomenal'. She was then discharged with an open wound which took eight weeks to heal.
1.6	Steve Hitchins apologised for the failures in Mrs Reich's care at the hospital, saying that it was necessary to find out exactly what had happened and why. Julie Andrews echoed this, explaining that there needed to be a thorough investigation. She asked about Cellier Ward's access to doctors, and Beverleigh Senior acknowledged that there had been some difficulties which she and her team were working to address. In answer to a question from Siobhan Harrington about how soon this would be resolved, Beverleigh Senior confirmed that there was a plan to resolve the issue.. She also explained that while postnatal wards did have daily access to junior doctors, but a more senior presence was required. Junior doctors did escalate issues and were actively encouraged to do so.
1.7	Board members agreed that a mother as experienced as Mrs Reich should undoubtedly have been listened to more than she had been. Siobhan explained that the Trust was planning to build a new maternity unit, and would welcome her input. It was acknowledged that the environment had been unsatisfactory, particularly the state of the toilets and the lack of air conditioning during the heatwave. Mrs Reich confirmed she had agreed to engage with the 'Maternity Voices' initiative.
1.8	Deborah Harris-Ugbomah noted the number of days Mrs Reich was in hospital, and asked whether any provision had been made for her to observe the Sabbath. Mrs Reich replied that staff had been extremely pleasant and had been happy to transfer her to a quieter place. On the subject of kosher food, she said that the main problem had been the lack of variety in the food offered: she had eaten the same meal six times in three days. She agreed this was partly because most patients do not stay on the postnatal ward for so long, but also felt the staff were unaware of the process for giving patients a choice. Deborah Harris-Ugbomah urged her to raise any such issues through 'Maternity Voices'.
1.9	Mrs Reich informed the Board that she had been given consent to speak for a number of other patients and highlighted the need for an advocate for Jewish patients. Asked about feedback in response to her concerns, Mrs Reich replied that to date she had not received any. Siobhan Harrington felt that some of these incidents should have been recorded on Datix, and asked Michelle Johnson and Julie Andrews to look into this.

	James Connell would help to co-ordinate an action plan which would be circulated following the Board meeting.
1.10	**The Board:** **i. welcomed the patient story and feedback from Mrs Reich;** **ii. agreed that confirmation be provided the case was recorded on Datix and the learning shared;** **iii. agreed that feedback from Mrs Reich be sought on the redesign of the maternity unit as part of engagement with local mothers; and** **iv. agreed an action to follow up with Mrs Reich our approach to implementing an orthodox Jewish advocate for patients and staff.**
2.	**Welcome and apologies**
2.1	Steve Hitchins welcomed everyone to the Board. Apologies for absence were received from Norma French, Director of Workforce, and David Holt, Non-Executive Director. Steve Hitchins thanked Kate Wilson, Acting Deputy Director of Workforce, for attending on behalf of Norma French.
3.	**Declaration of conflicts of interest**
3.1	No member of the Board declared any interest in the items scheduled for discussion at that afternoon's Board meeting.
4.	**Minutes, action log and matters arising**
4.1	The minutes of the public Board meeting held on 19 December 2018 were approved as a correct record.
4.2	There were no matters arising.
4.3	All items on the action log had been completed. Siobhan Harrington asked for one further action to be noted: feedback from the culture report should be brought to the January 2019 Board meeting.
5.	**Chairman's report**
5.1	Steve Hitchins drew attention to the fact that this meeting was being held earlier in the month than usual due to the Christmas break, and thanked all those who had worked to produce their reports in time. He went on to inform the Board that he had recently been reappointed as Trust Chairman by NHS Improvement, and Board members expressed their congratulations.
5.2	Moving to performance, Steve commented that the Emergency Department (ED) was routinely hectic, but recently there had been yet another surge in activity. Throughout the Trust, he had seen real evidence of improvements made and difficulties resolved, and he and Siobhan Harrington would be writing to all staff to congratulate them for their efforts. They would also be visiting the wards on Christmas Day.
5.3	Since the last meeting, Steve had participated in the following: • the switching on of the Trust's Christmas tree lights, attended by the Mayor of Haringey and Deputy Mayor of Islington • the distribution of mince pies across both community and hospital services • visits to the children's wards from both the Arsenal and Tottenham football teams

	• a visit to the District Nursing team at Crouch End • an extremely positive meeting with around 100 members of the community dental services team • visits to the Outlook Team at St John's Way and the Children's Services Forum at Tynemouth Road.
5.4	Steve Hitchins reminded Board members that this month the Trust was saying farewell to Rob Sherwin, who was spending a year in New Zealand, and welcome to Breeda McManus who would be joining the Trust on a secondment as Deputy Chief Nurse from 31 December 2018.
5.5	**The Board received the verbal update and congratulated Steve Hitchins on his re-appointment by NHS Improvement.**
6.	**Chief Executive's Report**
6.1	Siobhan Harrington reported she was due to attend a meeting of NHS Chief Executives the following day where one of the main items for discussion would be Brexit. The main areas for discussion were expected to be emergency planning, staffing in general, and procurement. Kate Wilson reported on the action taken by the Trust to date to support staff affected; this had included putting on seminars for staff with the Trust's lawyers (including one to one meetings), ensuring that staff had access to all relevant application forms and documentation, and the creation of a designated intranet page including a Q&A section. Michelle Johnson suggested that consideration might be given to doing a little more for managers of affected staff in terms of their understanding of what staff were going through.
6.2	A formal announcement had been made by NHS Improvement and NHS England about leadership appointments, and Sir David Sloman would be taking up the post of Regional Director for London in February 2019. Details of the long-term plan had now been deferred until the New Year.
6.3	Moving to Quality and Safety, Siobhan Harrington acknowledged that 2018 had been an extremely challenging year. An oversight meeting with NHS Improvement had taken place earlier that morning, with the key focus remaining on performance. The Trust had performed well on 'flu vaccinations for staff, achieving 74% against the target of 75% (though an internal target of 80% had been set). The financial position was broadly on plan, with the main emphases remaining on activity, income and cost improvement programme delivery. There had been several interesting events on integrated care in North Islington and North East Haringey, with the main focus being to work closely with both boroughs to progress this agenda.
6.4	Work had now begun on the Trust's estates master planning strategy, with the team starting to work through plans and consult with stakeholders. Indicative results from the staff survey showed that the Trust was on track to achieve its highest ever response rate It was possible that some of the results might be worse than in previous years in view of the recent high profile given to bullying and harassment in the Trust and a perceived failure in some areas to address this. Deborah Harris commented that this could be seen as positive since it demonstrated the Trust had a climate where staff were finding it easier to raise and discuss such issues.
6.5	Four Executive Directors had now begun the 'reverse mentoring' programme, with work beginning on how this might be further rolled out throughout the organisation. This was

	linked to the Workforce Race Equality Standard (WRES) work, and on 21 January 2019 there was to be a half-day workshop, led by Yvonne Coghill OBE, Director, WRES Implementation, NHS England. The BME staff network was also to be launched on 17 January 2019 by Joan Saddler OBE.
6.5	Siobhan Harrington was pleased to report that this month's staff award had been won by the Information Management & Technology team in acknowledgement of all the hard work they had undertaken to implement the new 'Vital Signs Monitoring' electronic observation system. She also reported on the work the Trust had started in the autumn with The Autism Project (TAP), and it was agreed to report back on numbers of young people helped through this initiative in six months' time. Janet Burgess added that Islington Council had an Autism Board on which she would be pleased to welcome Whittington Health representation.
6.6	Naomi Fulop enquired whether the executive team had any specific concerns around Brexit which the Board might usefully discuss. Siobhan replied that the advice from the centre had been to adopt a calm approach' although Stephen Bloomer added that it had been necessary to carry out a substantial amount of work within the Procurement team, where there were concerns about the readiness of some elements of the supply chains. Naomi Fulop felt that given the scale of this work some support might have been offered from the centre, and Siobhan Harrington undertook to raise this at the Chief Executives' forum the following day. There were also implications for the Trust's pharmacy service.
6.7	**The Board:** **i. welcomed and reviewed the report;** **ii. agreed the following actions:** o **provide confirmation on how many people had been helped through the Autism project initiative in six months' time and the roles they had carried out** o **provide additional support to managers of European Union staff affected by Brexit changes** o **raise the impact of Brexit planning arrangements at the Chief Executives' forum** o **provide an evaluation report in six months' time on the aims and outcomes of the reverse mentoring programme**
7.	**Serious Incident (SI) report**
7.1	Julie Andrews informed the Board that the Trust had reported a 'never event' in December 2018 involving a patient having received a never block on the wrong side of the body. This had been queried by the patient and the procedure halted prior to any surgery being performed. Initial work carried out in response to this event had been rapid local education on surgical procedures. The Royal College of Anaesthetists had designed a 'stop before you block' checklist which did not appear to have been followed on this occasion. This would be followed up with a more formalised education programme. The patient concerned had gone on to have the correct procedure.
7.2	All four of the SIs declared during November 2018 were detailed in the report, and comprised the following: • a fall suffered by a mental health patient who had absconded from the Emergency Department

	• a stillbirth • the unexpected death of a patient following elective surgery • a patient sectioned under the Mental Health Act, who had absconded from a ward
7.3	A total of 27 incidents had been declared since 1 April 2018 compared to 38 declared for the whole of the previous year. Deborah Harris-Ugbomah reported that she had observed, when carrying out visits, that that the Trust had good tools for staff and the challenge remained to ensure they were adhered to during busy periods. She also noted that, overall the Trust's safety record remained good.
7.4	**The Board:** **i. recognised the assurances contained within the report demonstrated that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely; and** **ii. agreed that any outstanding feedback from Non-Executive Directors' ward/service visits be provided to Steve Hitchins.**
8.	**Performance dashboard**
8.1	Carol Gillen reported that although the Emergency Department (ED) was the fourth highest performing ED in London performance remained challenging. , it. She confirmed that significant achievements in length of stay had also held off opening winter pressure beds. Performance had also improved in within Urgent Care (averaging 96% with the aim being to achieve 99%), paediatrics, and primary care activity. Ambulance activity had also increased, and work was in hand to understand the causes behind this – it was known for example that there had been a recent shift from Camden. Sarah Humphery was also conducting research with local GPs. The Emergency Care Improvement Programme (ECIP) had carried out two observation visits focusing on front of house, with key areas identified being triaging (a need for more medical involvement), pace and flow.
8.2	Carol Gillen went on to explain that District Nursing targets were achieved in November 2018, but cancer targets had not, and there were action plans to address this in both Haematology and Urology services. There was good progress on delayed transfers of care achieved through working with local partners including the holding of twice-weekly Multi Agency Discharge Event (MADE) meetings. There had also been positive progress within adult community services, although Carol Gillen acknowledged there was scope for improvement within bladder and bowel services. Within Long Term Conditions (LTCs) good improvements had been made, although November 2018 had seen a slight dip in podiatry services. There had been a focus on Musculoskeletal Services, but demand exceeded capacity and needed refreshing as well as more staff.
8.3	Carol requested some time at the January 2019 Board Seminar to discuss the presentation of some of the community data.
8.4	**The Board:** **i. took assurance that the Trust was managing performance compliance and putting into place remedial actions, where required; and** **ii. agreed that an item on community services data be included for the January 2019 Board seminar.**

9.	**Financial report, month 8**
9.1	Stephen Bloomer drew attention to a movement in the trend on income and explained that, if the recent improvement in clinical activity continued its current trend, the Trust would be set to achieve its income plan for the remainder of the year. However, he explained that pay expenditure continued to present a challenge, with the agency spend having risen by 15% compared to the previous three months' average; non-pay expenditure remained on track.
9.2	In terms of delivery of the 2018/19 cost improvement programme (CIP), Stephen Bloomer informed the Board that, at November 2018, the Trust forecast was delivery of £12.3m of its planned CIP target for the year. The Trust was holding £11.8m cash at the end of November, £7.3m higher than plan.
9.3	**The Board reviewed the financial results relating to performance during November 2018 and recognised the need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing cost improvement programme plans.**
10.	**Capital Plan update**
10.1	The capital plan update paper set out both the sources of capital funding for the year and expenditure and committed expenditure to date. Stephen Bloomer reminded Board members that capital funding had been a scare resource nationally for several years, and the Trust was required to have detailed and robust plans for delivery of its capital programme. This was also important in terms of the messages given to staff.
10.2	**The Board received the update on progress with the 2018/19 plan and the methodology for allocating resources in 2019/20.**
11.	**Workforce Race Equality Standard (WRES) Improvement Plan 2019/2020**
11.1	Kate Wilson reminded Board members that WRES data was presented in Summer 2018, but the Director of Workforce had wanted to present a more detailed action plan focused on inclusion. The first two columns in the plan set out the indicators, with the remaining columns showing actions, measurements of success, individual responsibilities and timelines. Kate Wilson drew to the Board's attention WRES indicator 2 (the relative likelihood of BME staff appointed from shortlisting across all posts) and highlighted the requirement for recruiting managers to inform the Director of Workforce for the reason/s for the non-appointment of BME applicants. Siobhan Harrington confirmed that this had been discussed at Trust Management Group, where it was acknowledged that there remained a need to change the culture of the organisation. She added that Whittington Health must learn from the best performers in this area, citing North East London Foundation Trust as a positive example.
11.2	Anu Singh said that if the Trust was able to get this right, there was strong evidence to suggest that improvements in patient care would follow. She had discussed the action plan with Norma French, and they had discussed the possibility of the Board holding a future session to support the team in implementing this agenda.
11.3	Deborah Harris-Ugbomah commended the level of detail contained within the plan, and suggested there was room for further data analysis. Board members fed back on the need for the plan to have SMART targets against which to monitor delivery.
11.4	Siobhan Harrington noted there were only two NHS provider Chief Executives from a BME background in London, and all London NHS provider Chief Executives were committed to delivering improvements in this agenda as a priority to help ensure

	organisations better reflected the communities they served.
11.5	**The Board reviewed the WRES improvement plan and agreed that the Workforce Assurance Committee would monitor delivery of the plan with smart, measurable, accurate, realistic and timely outcome indicators to assess progress.**
12.	**2017/18 Section 75 Annual Report for Islington**
12.1	The Section 75 Annual Report was introduced by Carol Gillen and Janet Burgess. The report had been formally received by the London Borough of Islington's Executive Board in June 2018 and there had been some significant developments since then in terms of integrated working. Section 2 listed some of the key areas of achievement in 2017/18, and Janet informed the Board that since the report had been produced further improvements had been made to the service in order to ensure more appropriate and efficient referrals could be made for those accessing services.
12.2	From next month, services would be provided from three integrated localities; North, Central and West, and would continue the existing close working relationships with health partnerships in doing so. As an example, Janet cited the success of discharge to assess, illustrated by the saving of bed days. Unnecessary hospital admissions were increasingly being avoided, particularly through joint working with the borough's care homes. It was regrettable that many residents had been placed out of borough (Enfield, for example, had far more residential care homes), but on the positive side, Bridgeside Lodge, was one of the very few care homes in the country to have been rated 'outstanding'. Both Carol Gillen and Janet Burgess paid tribute to the work carried out by lead nurse, Tina Jegede, and the ICAT team in this area.
12.3	Janet Burgess said how much the London Borough of Islington valued its relationship with Whittington Health, and it was noted that Jonathan Gardner would be attending a locality meeting the following day to further discuss future working. Steve Hitchins thanked Janet Burgess and Carol for presenting the report.
12.4	**The Board reviewed the content of the 2017/18 section 75 annual report and agreed on the direction of travel indicated between the organisations**
13.	**Board Assurance Framework (BAF)**
13.1	This iteration of the Board Assurance Framework was largely unchanged from that which had been presented to the Audit & Risk Committee in November 2018, other than the removal of the risk around potential financial risks relating to tariff charges. Jonathan Gardner explained that the aim was draw a clear distinction between the BAF and Corporate Risk Register and to ensure the Board received the necessary assurances for each of the tiers. In answer to a question from Tony Rice about the possible inclusion of reputational risk, Jonathan replied that most reputational risks did relate to sections of the BAF.
13.2	Michelle Johnson raised the issue of CQC preparedness, and Jonathan Gardner suggested further consideration be given to how this could be better aligned with the Trust's strategic objectives (high quality safe services). He would pick this up in the next iteration of the document. Siobhan Harrington commended the progress made to date on the BAF whilst emphasising the importance of greater ownership by risk leads. Anu Singh added that more consideration needed to be given to how colleagues around the table were held to account. She said that the format was broadly correct, but questioned how the BAF was owned, interrogated and tested. Deborah Harris-Ugbomah emphasised the

	need to seek prior Board approval before removing any BAF entries.
13.3	Siobhan Harrington informed Board members that the Trust was about to begin a Board Development Programme which made consideration of some of these issues particularly timely.
13.4	**The Board:** **i. received and discussed the updated BAF;** **ii. reviewed risk controls and assurances and scores;** **iii. approved the BAF and agree that effective actions are being taken to mitigate the identified risks to delivery of the trust's strategic objectives;** **iv. agreed that BAF entries should not be removed without the prior agreement of the Board; and** **v. agreed that consideration be given to inclusion of an entry in relation to the CQC inspection and the failure to deliver the Trust's high quality care strategic objective.**
14.	**Any other business**
14.1	Anu Singh enquired what revision/preparation was required of Board members for the CQC core services inspection and well-led framework review. In answer, it was noted that briefing for the well-led review was being prepared by Swarnjit Singh and Michelle Johnson had in place a working group to focus on organisational preparedness for the core services' inspection. In the meantime, Board members were asked to ensure they were up to date with all Fit & Proper Person Test and mandatory training requirements.

Action log, Public Board meeting, 19.12.2018

Item	Action	Lead(s)	Progress
Patient story	Confirm whether this case was recorded on Datix and the learning shared	Julie Andrews / Michelle Johnson	This case was not reported on Datix at the time. It has been agreed that the case will be reviewed with obstetric colleagues as a case for learning. This will be led by anaesthetic lead for obstetrics.
	Seek patient's feedback on redesign of maternity unit as part of engagement with local mothers	Carol Gillen	This is being taken forward through Maternity Voices
	Follow up with the patient regarding our approach to implementing an Identify options to provide an orthodox Jewish advocate for patients and staff	Michelle Johnson	Discussion is underway about identifying a Jewish advocate within the Trust chaplaincy service with the possibility of joint appointment with another local NHS Trust. There has been liaison with the patient.
Matter arising, minutes November 2018 meeting	Workforce culture action plan to January 2019 Board meeting	Norma French	This report will now be considered at the February 2019 meeting
Chief Executive's report	Confirm how many people have been helped through the Autism Project and report back on progress in six months and identify and report back on identified roles to be carried out by people on the autistic spectrum disorder	Norma French	Completed. The January 2019 meeting of the Workforce Assurance Committee

Item	Action	Lead(s)	Progress
			reviewed a report which highlighted that three placements are in place for two years
	Provide additional support to managers of EU staff affected by Brexit changes	Carol Gillen	Ongoing – the Trust is participating in the national scheme to apply for settled status after the UK leaves the EU for permanent contracted EU workers in the health and social care sector.
	Provide an evaluation report on the aims and outcomes from the reverse mentoring initiative in six months' time	Norma French	In hand to be reported to the Workforce & Assurance Committee as part of delivery of the WRES improvement plan
	Raise the impact of Brexit planning arrangements at the national CEO forum	Siobhan Harrington	Completed
Serious Incidents	Provide feedback from ward/service visits to Steve Hitchins	Non-Executive Directors	Completed
Performance dashboard	Include community services' data as an item at the January 20198 Board seminar	Carol Gillen	Completed
Workforce Race Equality Standard	Monitor delivery of the improvement plan through the Workforce Assurance Committee	Norma French	Completed – the plan was discussed at the January meeting of the Workforce Assurance Committee and the next update is due at its

Item	Action	Lead(s)	Progress
			March 2019 meeting
Board Assurance Framework	Ensure that Board approval is obtained prior to the removal of BAF entries	All	Completed - ongoing
	Consider the inclusion of a BAF risk entry in relation to the CQC inspection due in quarter four and the failure to deliver the Trust's high quality care strategic objective	Michelle Johnson	Completed – the updated BAF will contain this entry and also one for 7 Day services following guidance received
Any other business	Complete any outstanding elements of 2018/19 statutory and mandatory training requirements as soon as possible	Non-Executive Directors	
	Confirm compliance with Fit and Proper Person's Test requirements to the Director of Workforce	Non-Executive Directors	

Meeting title	**Trust Board – public meeting**	**Date: 30 January 2019**
Report title	**Chief Executive's report**	**Agenda Item: 6**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	The purpose of this report is to update board members on key national and local developments as well as highlighting and celebrating achievements of the Trust and its staff.	
Purpose:	Review	
Recommendation(s)	Board members are invited to review the report and its content.	
Risk Register or Board Assurance Framework	All BAF entries	
Report history	None	
Appendices	None	

Chief Executive's report

This report provides the Board of Directors with highlights of initiatives within the national health and social care sector as well as providing an update on key local developments of interest in our local health and social care community.

1. National news

NHS Long Term Plan

1.1 On 7 January, NHS England published the NHS Long Term Plan[1]. It highlights the priorities and direction of travel for the NHS for the next ten years and sets out:

- aspirations that will help prevent 150,000 heart attacks, strokes and dementia cases and see three million people benefit from new and improved stroke, respiratory and cardiac services over the next decade
- benefits to patients from services ranging from improved neonatal care to life-changing stroke therapy and integrated support to keep older people out of hospital, living longer and more independent live
- growth in funding for the NHS, with the highest investment in community and primary care, as well as mental health
- a clear theme of the importance of technology and digital support in providing the best care and to support patients and carers to better manage their own health
- the role of the NHS as a more flexible and responsive employer in the future and how, at a national level, action will be taken to tackle the current workforce pressures that we and other trusts are all facing – we look forward to more news on this from national partners later this year
- a focus on productivity and efficiency as well as on the importance of compassionate leadership across the NHS.

1.2 Nearly every page is relevant to what Whittington Health does and also in line with our mission to 'help local people live longer, healthier lives'. The work of one of our consultants is referenced in the section on respiratory disease.

1.3 It makes it very clear that integrated care is the future for the next ten years of the NHS. Building on the integration between community and hospital care, it sets ambitions for networks of local GP practices, community teams and social care working together around their populations to improve health and play a more effective role in prevention. It is also the first major NHS-wide plan to talk about people with learning disabilities and autism when considering action on improving care quality, outcomes and health inequalities.

1.4 Between now and the summer, more engagement is planned for what NHS Long Term Plan means for individual areas and how national ambitions will be met in their community.

NHS Operational planning and contracting guidance 2019/20

1.5 On 10 January 2019, NHS England and NHS Improvement published the 2019/20 operational planning guidance. This sets out the full financial framework, operational planning requirements, national tariff proposals and further guidance on planning at a

[1] https://www.longtermplan.nhs.uk/

system level. The guidance also includes a timetable, as follows, which Trust staff are working towards:

- 14 January – initial plan submission (activity-focus)
- 12 February – draft 2019/20 Trust operational plan
- 21 March – deadline for signature of contracts
- 29 March – deadline for Trust Board approval of 2019/20 budgets
- 4 April – final 2019/20 Trust operational plan submission

CQC appoints new Chief Inspector

1.6 The Care Quality Commission (CQC) has appointed a new Chief Inspector for primary and integrated care. Rosie Benneyworth, a GP and vice chair of the National Institute for Health and Care Excellence (NICE), will take over from current Chief, Steve Field, in March 2019. She will lead on CQC inspections for all primary medical services, including general practice, pharmacy and dentistry and integrated care.

2. Regional and local news

Quality and Safety

2.1 Overall performance against the 95% 4 hour standard for December 2018 was 85.5%. Attendance numbers were high at 9,219 (6% more than last December). The 'minors' performance delivered 97.6% and Paediatrics delivered at 97%. There was unfortunately one 12 hour trolley breach in December. This was a mental health patient and there was a delay in transfer to an appropriate mental health bed. The thanks of the board goes to out to all the teams working during this pressured time.

2.2 Work is ongoing in the emergency department to ensure the recommendations highlighted by the emergency care intensive support team are actioned throughout quarter four with the aim of improving performance against the four hour target and patient experience by:

- ensuring a robust medical rapid assessment and treatment model is in place five days a week initially with a view to extend both days and hours
- look at increasing ambulatory care opening hours to maximise capacity especially at weekends
- streamlining the front of house model (streaming, redirection, rapid assessment and treatment, ambulance handover) to ensure the function is fit for purpose

2.3 Overall, cancer targets were achieved in December 2018. Last month, the re-admission rate was just above the target of 5.5% at 5.9%.Comparing year on year data, the re-admission rate in December 2017 was 7.3% and is now significantly better. Ongoing work is in place including Discharge to Assess and Home First to help avoid patient re-attendance.

2.4 The Trust unfortunately declared a Never Event in December 2018, a wrong site surgical procedure. A patient received a peripheral nerve block on the right side instead of the left side. This was discovered before any surgery was performed and there was no harm caused to the patient. This has led to a renewed focus on 'stop before you block' and surgery safety checklist procedures.

Financial

2.5 The Trust is on plan for December, reporting a surplus of £1.7m (including Provider Sustainability Fund (PSF) income of £2.1m). Year to date, the Trust is meeting the NHS Improvement adjusted plan, with a surplus of £9m including £13.9m of PSF income.

However, challenges remain. The organisation needs to control pay expenditure, and hit activity and CIP plans for the year in order to achieve the planned year end outturn. This is crucial for us to receive the much needed further PSF funding, which will help enable our estates transformation.

Localities

2.6 In line with the Long Term Plan, a number of our teams have been working very closely with the Councils, Mental Health Trusts and GPs to see how we can work in a more coordinated way at a locality level designing a prototype for North Islington and North Tottenham that can be rolled out further. We had launch events before Christmas and 80 front-line staff joined a meeting on the 20th December to put their ideas forward. We will be holding a large networking exhibition in North Islington at the end of March so watch this space for further updates. We are also working with North Central London Partners on the future of the governance for the sector attending borough level events following on from the previous "Inter-great" simulations at the end of last year.

Strategy

2.7 The board is considering how we can update and refine our clinical and organisational strategy in the light of the Long Term Plan and financial challenges and opportunities. Having taken initial feedback from the ICSUs, we are now surveying all staff on their thoughts before taking a draft to our wider stakeholders. We aim to agree a revised strategy in March or April.

Estates masterplanning

2.8 The Trust's estates' team has continued to work with our clinical and non-clinical services throughout January 2019 to develop the design brief for our estates masterplan. This engagement has been informed by the many on-going conversations and discussions our services have with a wide range of partner organisations, patients and the wider community. The Trust will continue to consider the future plans for our services throughout February, while beginning to develop options for the future shape of our estate that will support us to meet future service delivery aspirations and provide high quality environments for our patients and staff. Following a review of the overall programme for completing the masterplan work, a revised completion date is to end of May 2019.

Staff engagement and Workforce Race Equality Standard (WRES)

2.9 On 17th January the Trust welcomed Joan Saddler OBE, Associate Director of Patients and communities at the NHS Confederation, who attended the first anniversary of the Staff Inclusion Network and launched the BME network. She delivered a thoughtful and well-received presentation on the importance and benefits of staff networks. On 21st January Yvonne Coghill OBE and the NHS England national team worked with 100 Trust leaders to help promote best practice in workforce equality and help us respond to the WRES survey results.

NHS staff survey and flu vaccination

2.10 The final response rate this year for the annual NHS staff survey was 48.5%, the highest ever achieved at the Trust. The results will be out in a few months and this important feedback will be used to help improve the culture and working environment for all staff. For the flu vaccination programme which has not yet closed, 79% of Trust staff have, so far, been vaccinated.

Emergency Preparedness

2.11 I would also like to thank Lee Smith, Emergency Planning Officer, for all his efforts helping the Trust have an excellent outcome from its assessment against NHS England's Emergency Preparedness, Resilience and Response Framework.

Staff award – Lead Sonographer

2.12 This month's Staff Excellence Award winner is Melissa DiRubbo, Lead Sonographer, in the Imaging Department. Melissa consistently works above and beyond in her role to help and to improve services not just for patients, but for her team as well. She is a shining example of Whittington Health values. Melissa showed an exceptional level of competence, care, compassion and efficiency when dealing with a patient and her pregnancy. The patient subsequently wrote back with great praise for the dedication and care they received.

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	Serious Incidents – Month 9 (December 2018)	**Agenda item: 7**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Jayne Osborne, Quality Assurance Officer and SI Co-ordinator	
Executive summary	This report provides an overview of serious incidents (SI) submitted externally via the Strategic Executive Information System (StEIS) during December 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.	
Purpose:	Discussion	
Recommendation(s)	The Board is asked to recognise and discuss the assurances contained within this report demonstrating that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely. The Board is invited to focus discussion on steps being taken to: • Ensure we work with Camden and Islington NHS Foundation Trust on the shared production of Serious Incident investigations • Improve the process of managing trauma patients • Investigate and learn from a Never Event	
Risk Register or Board Assurance Framework	Corporate Risk 636. Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.	
Report history	To each public Board meeting	
Appendices	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).	

Serious Incidents' monthly report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during December 2018. This includes serious incident reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.

2. Background

The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director/Associate Medical Director, Chief Nurse and Director of Patient Experience, Chief Operating Officer, Head of Quality Governance and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

The Trust declared two serious incidents during December 2018, bringing the total of reportable serious incidents to 29 since 1st April 2018.

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

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

Never Event

The Trust declared a Never Event in December 2018, a wrong site surgical procedure. A patient received a peripheral nerve block on the right side instead of the left side. This was discovered before any surgery was performed and there was no repeated on-going harm to the patient.

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

Category	Month Declared	Summary
Diagnostic Incident including delay/unexpected Death Ref:20462	Aug 18	A patient was referred by the GP for a targeted CT scan, which unexpectedly showed a subacute bowel obstruction. The patient was then seen again by their GP and referred to ED where the patient was admitted for urgent laparoscopic surgery. The patient subsequently died. There is a concern that the response to the initial CT scan may have been delayed.

Category	Month Declared	Summary
Diagnostic Incident including delay. Ref:24114	Oct 18	An elderly patient had a fall at home resulting in a number of fractures (neck of femur fracture, complex right acetabular fracture and inferior pubic ramus fracture). There may have been a delay in identifying these injures.
Patient fall Ref:27817	Nov 18	A mental health patient absconded from ED prior to being admitted; fell from the roof into the window of a ward resulting in cuts and lacerations to himself and to a patient's relative.
Still Birth Ref:27813	Nov 18	An Intra uterine death was diagnosed by ultrasound following concerns raised by the woman that no fetal movements had been felt.
Unexpected Death Ref:28316	Nov 18	A patient died after deteriorating following an elective surgery for a giant hiatus hernia.
Absconded Patient Ref:28441	Nov 18	A patient under section absconded from a ward whilst staff were attending to another patient. The patient has not been located.
Wrong site surgical procedure - Never Event Ref:29134	Dec 18	A patient received a peripheral nerve block on the right side instead of the left side which was identified prior to surgery.
Unexpected admission to NICU Ref:30069	Dec 18	Baby born by in poor condition at 38 weeks and 2 days gestation and required resuscitation and ventilation. The baby was transferred to tertiary neonatal unit for total body cooling.

3.2 The table below details serious incidents by category reported to the NELCSU between April 2017 – March 2018

STEIS 2017-18 Category	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Safeguarding	0	0	0	0	0	0	0	1	0	0	0	0	1
Attempted self-harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG	0	0	1	1	0	1	0	0	0	0	0	0	3
Diagnostic Incident including delay	0	1	1	1	1	0	1	1	0	1	0	0	7
Disruptive/ aggressive/ violent behaviour	0	0	0	0	0	0	1	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	0	0	0	0	0	0	0	0	1	0	0	1
Failure to source a tier 4 bed for a child	0	0	0	0	0	0	0	0	0	0	0	0	0
Failure to meet expected target (12 hr	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	0	0	0	0	0	0	0	0	2	0	1	3
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	0	1	0	0	0	0	1	0	0	0	0	0	2
Maternity/Obstetric incident mother only	0	0	0	0	1	0	0	0	0	0	0	0	1
Medical disposables incident meeting SI	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0	0	0	1	0	0	0	0	0	0	0	0	1

Nasogastric tube	0	0	0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	0	1	0	0	2	0	1	0	0	1	0	1	6
Sub Optimal Care	0	0	1	0	0	0	0	0	0	0	1	0	2
Treatment Delay	1	1	0	0	0	1	0	0	0	1	0	0	4
Unexpected death	1	0	1	0	0	0	1	0	0	1	0	0	4
Retained foreign object	0	0	0	0	1	0	0	0	0	0	0	0	1
HCAI\Infection Control Incident	0	0	0	0	1	0	0	0	0	0	0	0	1
Total	**2**	**4**	**4**	**3**	**6**	**2**	**5**	**2**	**0**	**7**	**1**	**2**	**38**

3.3 The table below details serious incidents by category reported to the NELCSU between April 2016 – December 2018.

STEIS 2017-18 Category	2016/17 Total	2017/18 Total		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0	0	0	0	0	1	0	1
Apparent/actual/suspected self-inflicted harm	1	0		0	0	0	0	0	0	0	0	0	0
Confidential information leak/Information	6	3		2	0	1	0	0	0	0	0	0	3
Diagnostic Incident including delay	8	7		0	2	0	1	1	1	2	0	0	7
Disruptive/ aggressive/ violent behaviour	0	1		0	0	1	0	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	1		0	0	0	0	0	0	0	0	0	0
Failure to source a tier 4 bed for a child	1	0		0	0	0	0	0	0	0	0	0	0
Failure to meet expected target (12 hr trolley	1	0		0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI	0	3		0	0	0	0	0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	0	0	0	1	0	1	1	7
Maternity/Obstetric incident mother only	2	1		0	0	0	0	0	0	0	0	0	0
Medical equipment/devices/ disposables	1	0		0	0	0	0	0	0	0	0	0	0
Medication Incident	0	1		0	0	1	0	0	0	0	0	0	1
Nasogastric tube	1	0		0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	7	6		1	0	0	0	0	0	0	1	0	2
Sub Optimal Care	4	2		1	0	0	0	0	0	0	0	0	1
Surgical/invasive procedure incident meeting	0	0		0	1	0	0	0	0	0	0	1	2
Treatment Delay	3	4		0	2	0	0	0	0	0	0	0	2
Unexpected death	10	4		0	1	0	0	0	0	0	1	0	2
Retained foreign object	1	1		0	0	0	0	0	0	0	0	0	0
HCAI\Infection Control Incident	0	1		0	0	0	0	0	0	0	0	0	0
Total	**58**	**38**		**6**	**8**	**3**	**1**	**1**	**2**	**2**	**4**	**2**	**29**

4. Submission of SI reports

All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Executive Medical Director or Chief Nurse and Director of Patient Experience). The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in December 2018.

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, and 'message of the week' in Maternity and EIM, and '10@10' in 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.

4.1 The Trust submitted one report to NELCSU during December 2018.

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation reports submitted in December 2018. The Trust submitted one report in December 2018.

Summary	**Actions taken as result of lessons learnt include;**
Diagnostic Incident including delay Ref:2018.23175	An elderly patient had a fall at home, resulting in a fractured neck of femur and multiple rib fractures and the patient was subsequently transferred to the Major Trauma Centre. • A review of the escalation of patientcare in the Rapid Assessment Team (RAT) has been undertaken and training has been carried out with staff as well as learning from being shared with the ED junior doctors and nurses. • A reinforcement of the trauma call criteria with all ED staff and specialty teams to ensure that the Trauma call process has been embedded. • This case has also been shared more widely for discussion at the Regional Trauma Network meeting.

5. Shared learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies. The Trust also runs a series of multi-disciplinary learning workshops throughout the year to share the learning from serious incidents and complaints, and learning is disseminated through 'Spotlight on Safety', the trust wide patient safety newsletter. Themes from serious incidents are captured in quarterly learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning. The Safety and Quality Board Report for Quarter 2 2018/19 focussed on the progress the trust has made against its Quality Account Priorities for 2018/19.

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	**Quarterly Safety and Quality Board Report Quarter 3 2018/19 (01 October 2018 – 31 December 2018)**	**Agenda item: 8**
Executive director lead	Dr Julie Andrews, Acting Medical Director	
Report author	Dr Julie Andrews, Acting Medical Director	
Executive summary	This is the regular quarterly paper for the Trust Board to provide an overview of safety and quality across the organisation. It is informed by reporting directly from the patient safety committee and the quality committee. This report provides an update on mortality and the trust hospital standard mortality ratio (HSMR) and summary hospital level mortality indicator (SHMI) figures. The paper discusses the rising SHMI since 2004 and provides recommendations on how to evaluate further for assurance purposes. Infection prevention and control (IPC) performance is included as standard, IPC training remaining a concern with 81% of staff demonstrating evidence of IPC training in the last 2 years. During 2017/2018 there has been one MRSA bloodstream infection diagnosed and there have been 13 patient cases of Clostridium difficile associated diarrhoea (CDAD) against an agreed tolerance of 16. This report also reviews Whittington Health's patient safety incident reporting figures, this demonstrates that incident reporting has reduced between this reporting period (46.37 incidents reported per 1000 bed days Oct 17 to March 18) compared to the equivalent 6 month period a year prior (50.09 incidents reported per 1000 bed days Oct 16 to March 17). Whittington Health is above the national benchmark for the proportion of patient safety incidents reported with no patient harm (80% against national benchmark for like organisations of 77.8%). Recommendations for further promoting patient safety reporting are included. Each quarterly patient safety and quality paper will include a "deep dive" on one of the ICSU/groups reporting to the patient safety or Quality committee. This paper covers output from the resuscitation committee. For information there is also an interim position on influenza impact across the organisation.	

Purpose:	Review
Recommendation(s)	It is recommended that the assurances contained within this paper are recognised.
Risk Register or Board Assurance Framework	Quality and safety category risks on risk register
Report history	Quality Committee, January 2019
Appendices	none

1. Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. The paper provides an update on mortality and SHMI position and recommendations on how to provide further assurance on the rising (but well below average SHMI).

There is a focus on Infection prevention and control performance, a position update from the deteriorating patient and resuscitation committee and the updated position with Influenza across the organisation. As a recent NRLS (national reporting and learning system) report has also been published the summary of this is also shared with trust board to update the organisation's current position with patient safety incident reporting compared to the national figure.

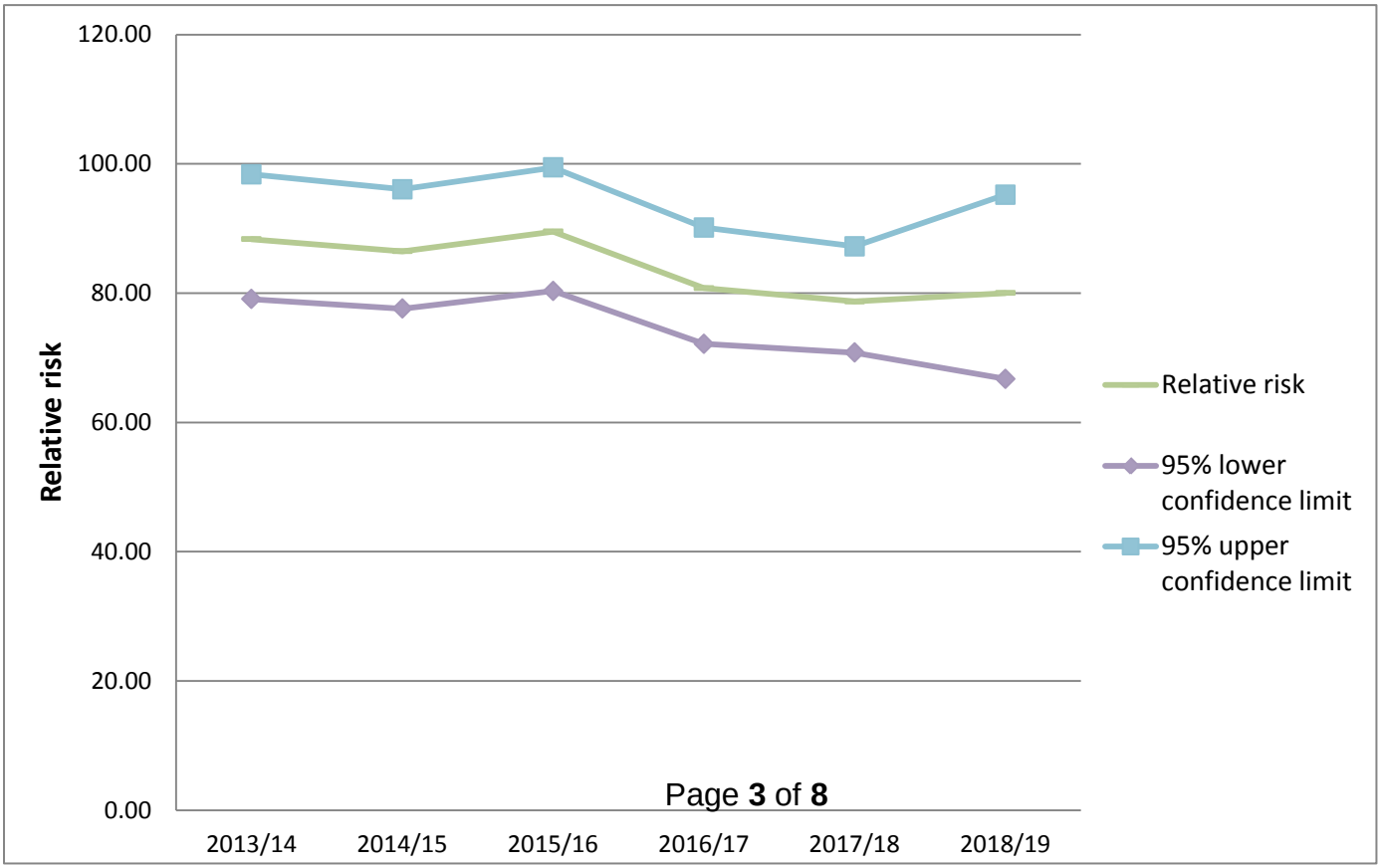
2. Mortality

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

2.1 Hospital Standardised Mortality Ratio (HSMR)

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

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



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

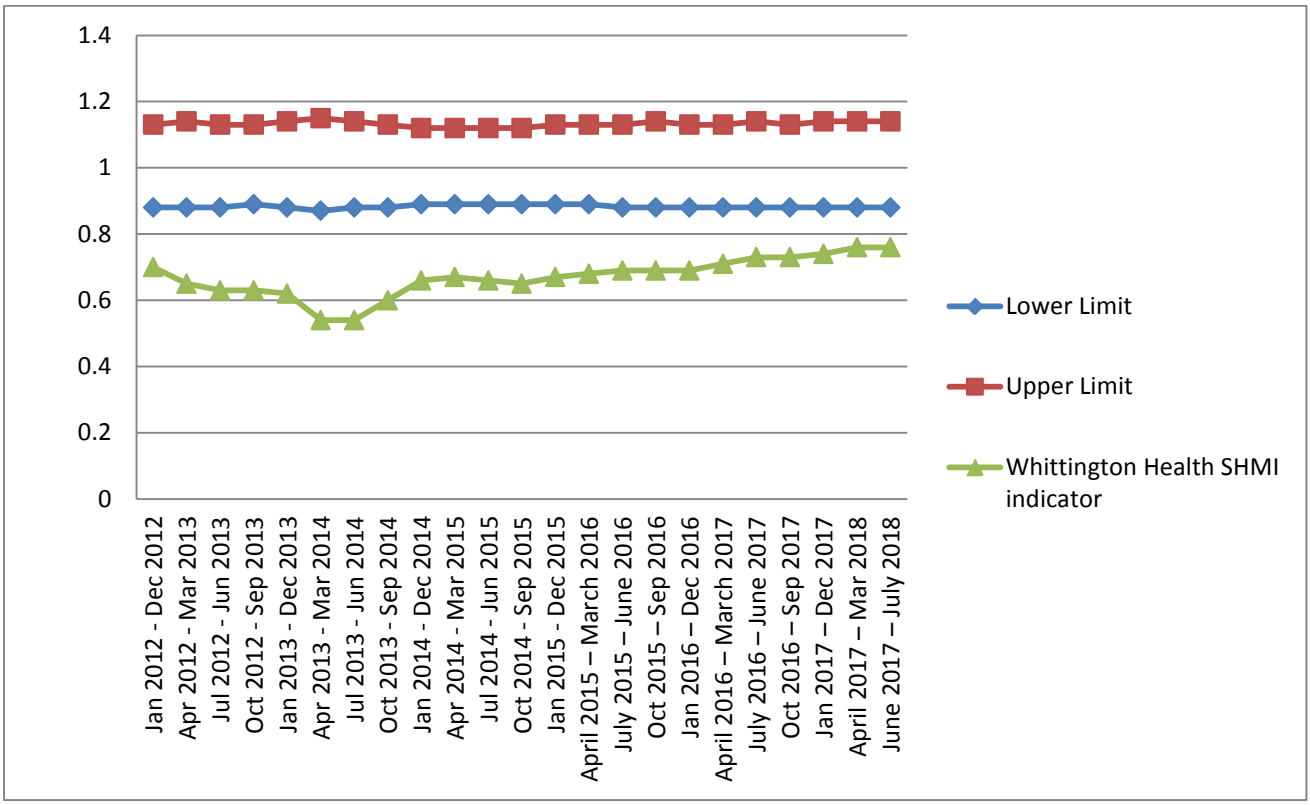
2.2 Summary Hospital-level Mortality Indicator (SHMI)

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

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

Whittington Health SHMI score	**0.7573**
National standard	**1.00**
Lowest national score	**0.6932 (Guy's and St Thomas' NHS Foundation Trust)**
Highest national score	**1.2572**

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



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

There is a slow rise in the Whittington Health SHMI since it reached its lowest point in June 2014. To try to understand this rise the following recommendations are proposed:

a) Current process for Learning from death and departmental patient mortality reviews is used to its maximal potential to ensure all possible learning is captured, shared and embedded. At present around 60-70% of inpatient deaths are systemically reviewed and there is evidence of cross departmental sharing of learning but this could be enhanced with the development of a trustwide mortality review group, which will start in April 2019, and a dedicated mortality co-ordinator.
b) Ongoing project across Information team, national SHMI advisory body, ICSU's and medical directorate to work collaboratively to ensure the coding and other information around SHMI data entry is as accurate and reliable as possible.
c) Systemic and ongoing reviews of patient deaths that occur in the first 30 days post discharge is recommended. Early feedback from this as a pilot has demonstrated that more than 97% of patient deaths in the first 30 days are "expected and therefore "unavoidable" leaving a remaining 3% of patient deaths needing further detailed systematic review between the trust, community teams and the patient's GP practice; this work is ongoing.

3. Infection control report

3.1 MRSA

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

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

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

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

3.2 *Clostridium difficile*

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

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

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

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

3.3 *E.coli* bacteraemias (bloodstream infections)

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

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

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

3.4 Carbapenemase Producing Enterobacteriaceae (CPE)

Since the beginning of April 2018 there have been two new CPE positive patients, both of which are considered non trust-attributable. There have been no new cases of CPE in Quarters 2 and 3 of 2018/19.

3.5 Infection Prevention and Control Training

Infection Prevention and Control mandatory clinical and non-clinical training is now provided predominately via E-learning. As of 31st December 2018, 81% of Whittington Health staff has received recent (within the last 2 years) IPC training.

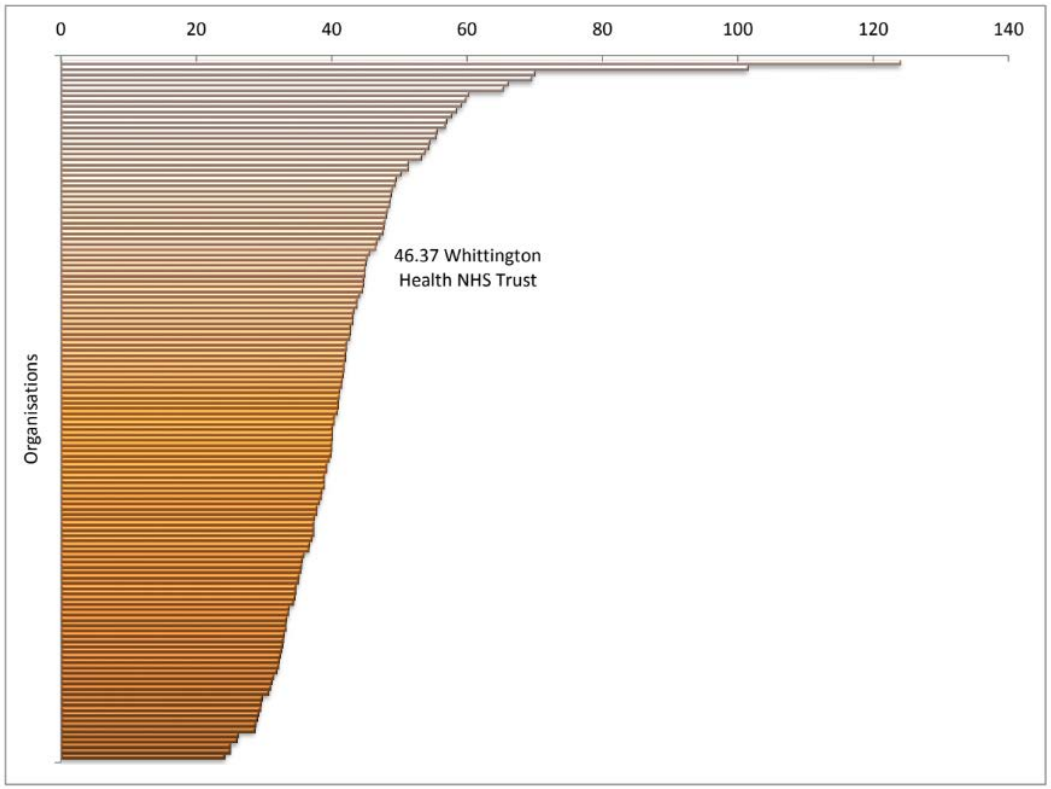
Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff. IPC Link Practitioner study days are held twice a year. The next study day is to be held in April 2019. Face to face IPC training is provided monthly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

4. Incident reporting

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. The NRLS was developed in 2003 to help develop a culture of reporting incidents within the NHS as a way to improve safety in healthcare.

The latest NRLS report published by the NHS Improvement has shown that in the period 1st October 2017 to 31st October 2018 Whittington Health reported 2550 incidents, as compared to 2571 for the period 1st October 2016 to 31st October 2017. This means that for 2017/18 Whittington Health's reporting was 46.37 per 1000 bed days (down from 50.09 the same period 2016/2017).

Chart 3: Comparative reporting rate per 1000 bed days for 136 Acute (non-specialist) organisations (1st October 2017 to 31st October 2018)



It is important to review the incident reporting rate of an organisation to ensure that there is an active safety culture that encourages the reporting of incidents and learning from incidents. Higher reporting correlates well with organisations able to demonstrate well developed learning focused patient safety culture. To ensure greater reporting of patient safety incidents monitored via the patient safety committee, the Quality governance team, risk managers, safety leads (such as medicines safety, maternity, sepsis) ICSU leads and education leads are promoting reporting in areas highlighted as "potential" low reporters.

With regard to the level of harm, nationally 77.8% of incidents were reported as "no patient harm" across similar organisations, Whittington Health are above this benchmark at 80% of patient safety incidents reporting no harm. This is an improved position probably secondary to collaborative

learning ensuring that our patient harm status is correctly assigned by staff, higher numbers of near misses are reported and sharing of learning is more embedded.

Whittington Health has improved the timeframe to report incidents through the NRLS. Between 1st October 2017 and 31st March 2018 the median number of days between a patient safety incident occurring and that incident being reported through the NRLS was 22 days; in the same time period in 2016/17 this was 37 days. This provides evidence that investigation of patient safety incidents culture is more timely.

5. Resuscitation and deteriorating patient committee

Whittington Health has one of the lowest incidences of inpatient cardiac arrest in the country. Cardiac arrest survival rate for the trust is 43.8%, which is significantly above the national average of 21.9%. Whittington Health has the highest survival rate in the country from non-shockable rhythms; this could be due to the size of the hospital (response time is usually under 2 minutes) and patients are moved to Intensive Care quicker than other hospitals. We have the third lowest rate in the country for a cardiac arrest in a ward area; this is mainly due to relatively easy escalation into ITU. However, this does have the effect that we have a substantially higher rate of cardiac arrests in ITU compared to other hospitals.

The deteriorating patient group reports on regularly to patent safety committee on compliance with monitoring plans, treatment escalation plans and failure to escalate the deteriorating patient and it is expected that the recent successful introduction of Electronic observations across the acute site will make this quality improvement work less labour intensive.

Auditing of resus equipment demonstrates an improved position at 92.7% however training needs as outlined by skills for health recommendations will require consideration of a business case for new resuscitation posts to investment group.

6. Interim update on Influenza position across the ICO

By 18th January 2019 79.3 % of our frontline staff had received influenza vaccination as part of our innovative MDT “jab on the job” approach. Comparison to figures available at this point last year suggest that influenza has had less on an impact this winter so far although the milder conditions may be in part responsible for that.

	% of staff vaccinated	Number of influenza cases diagnosed	Number of healthcare associated transmissions	Number of deaths associated with healthcare associated influenza
2017/2018 by end of Jan 2018	76.5%	222	39	2
2018/2018 by end of Jan 2019	79.3%	76	18	0

7. References

1. NHS Digital Indicator Portal, (July 2018, NHS Digital), available from https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current
2. National Reporting and Learning System https://report.nrls.nhs.uk/nrlsreporting/

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	**Learning from death report Quarter 1 2018/19 (1 April to 30 June 2018)**	**Agenda item: 9**
Executive director lead	Dr Julie Andrews, Acting Medical Director	
Report author	Dr Julie Andrews, Acting Medical Director	
Executive summary	The learning from death report covers the first quarter of 2018 (1st April 2018 to 30th June 2018). The report describes: a) How we are performing against our local targets, and national expectations, in systematically reviewing the care of patients who have died whilst in Whittington Health (inpatient and ED deaths); b) What learning we are taking from the themes that emerge from these reviews; and c) What actions we are taking to improve care for our patients, the support given to families/carers and the learning from death process. In Quarter 1 of 2018/19, 1 April to 30 June 2018, there were 109 inpatient deaths. This figure includes all inpatient deaths, deaths in the emergency department and neonatal and intra-uterine deaths over 24 weeks gestation. In Q1, 63.1% of all inpatient deaths were reviewed using a structured mortality review and then a second review in a departmental mortality review meeting, as compared with 50.6% in Quarter 4 2017/18. In Q1 of 2018/19: • 38 out of 42 (90.4%) of all category A deaths were reviewed (desired local performance 90%) • 31 out of 67 (46.2%) of all category B deaths were reviewed (desired local performance 25%) There is no benchmarking of data with other trusts, as trusts are encouraged to track their own performance as it changes over time rather than comparing their performance to that of other trusts. We are introducing an overarching mortality review group from April 2019 which will run concurrently alongside the end of life group. This will review overarching themes of learning, review 3-4 specific mortality	

	reviews and consider the mortality process as a whole with a view to continuous improvement. This paper gives assurance that this important process to strengthen governance, learning and transparency around inpatient death is now well-developed and relatively robustly embedded and that progress continues to be made in developing ways to disseminate the learning and continue to improve the safety and quality of our care. We are working towards improving our compliance figures and extending the learning from deaths process to be able to systemically review deaths in our patients post discharge (up to 30 days post discharge).
Purpose:	It is recommended that the assurances contained within this paper are recognised and that the Board discusses potential opportunities for further improvement. The Board may wish to consider focussing its discussion on: • Further steps that we might take to improve the experience of patients and their families around end of life care and bereavement in light of findings and recent publication from the National Quality Board, July 2018. • The degree of progress we have made in embedding an important new assurance and learning process in a comparatively short time, and what this teaches us about improvement work.
Recommendation(s)	To take assurance from the report that learning from deaths process is well-embedded and providing themes that help us continuously improve the safety and quality of care given to our patients and families/carers.
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	This quarter's report not previously presented. Previous quarters from April 2017 presented to Trust Board
Appendices	Appendix 1: NHS England Trust Mortality Dashboard

1. Introduction

The report covers quarter 1 of 2018/19 (April 1st 2018- 30th June 2018). The report describes:

a) How we are performing against our local targets and national expectations in reviewing the care of patients who have died whilst in this hospital (inpatient deaths),
b) What learning we are taking from the themes that emerge from these reviews,
c) What actions we are taking both to improve our care of patients, support given to families/carers and to improve the learning from death process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with domain 2 of GMC *Good Medical Practice*, for many years. Following the launch of the NHS Quality Board "*National guidance on learning from deaths*[1]" (March 2017) we introduced a systematised approach to reviewing the care of patients who have died in hospital (individual review using a structured mortality review form then a departmental agreement in a mortality meeting). This process formally commenced on 1 April 2017. An overarching mortality review group will commence in April 2019 to ensure that learning across the trust is maximised and the process is reviewed quarterly.

The aims of the learning from death process are to:

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

1. Potential Avoidability of Death – Judgement Scoring System

The "*National guidance on learning from deaths*[2]" was published in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS services through the review of deaths. A retrospective study across 34 English acute hospital trusts conducted in 2015 estimated that 3% of all deaths in hospital were potentially avoidable[3].

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

[3] *HOGAN H, HUTCHINGS, A, BLACK, N ET AL. PREVENTABLE DEATHS DUE TO PROBLEMS IN CARE IN ENGLISH ACUTE HOSPITALS: A RETROSPECTIVE CASE RECORD REVIEW STUDY, BMJ 2015;351:H3239*

The Avoidability of Death Judgement Scoring System (Table 1) was developed by the Royal College of Physicians (RCP) and it is this scoring system that has been adopted by the Trust to conduct Structured Judgement Mortality Reviews by individuals and then reviewed in departments.

Table 1 – Avoidability of Death Judgement Scoring System

Score	Description
1	Definitely avoidable
2	Strong evidence of avoidability
3	Probably avoidable, more than 50/50
4	Possibly avoidable but not very likely, less than 50/50
5	Slight evidence of avoidability
6	Definitely not avoidable

2. Our performance against our local targets for the proportion of deaths that should be reviewed

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

The Trust has set an internal target that 90% of all discharge summaries for patients who die in hospital should be completed.

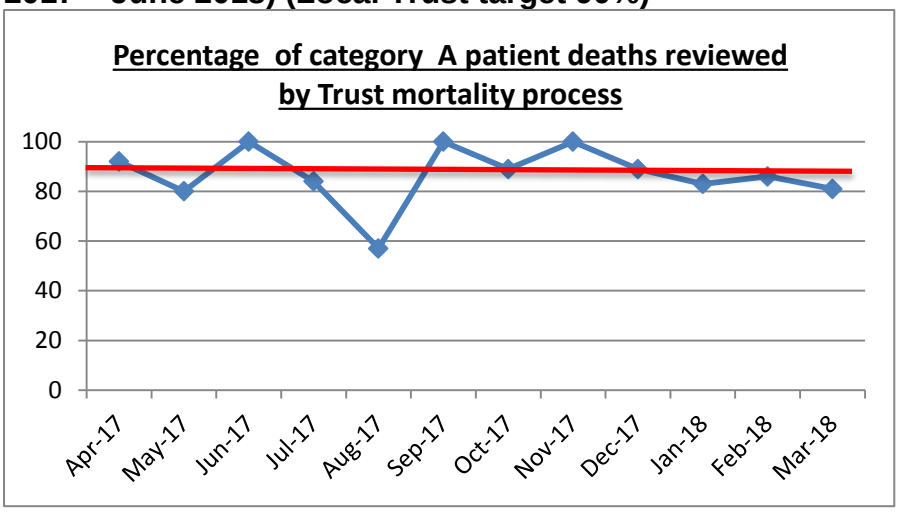
Category A deaths are:

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

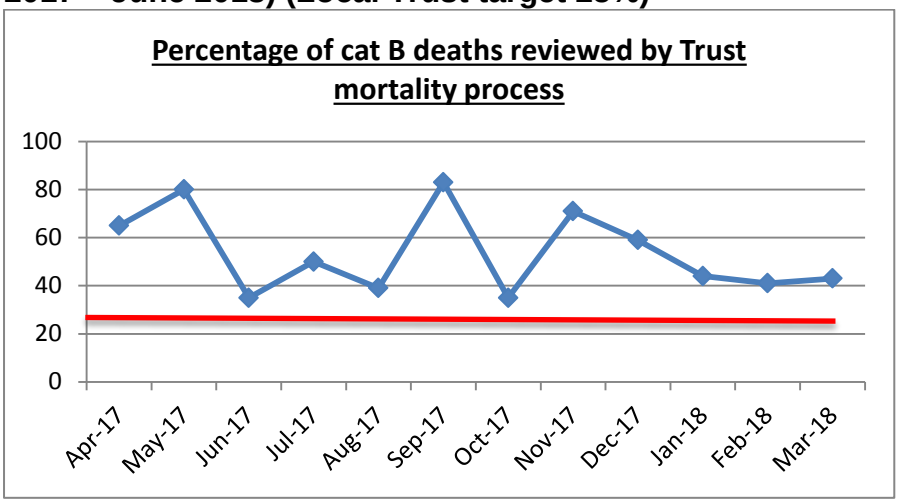
Category B deaths are:

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

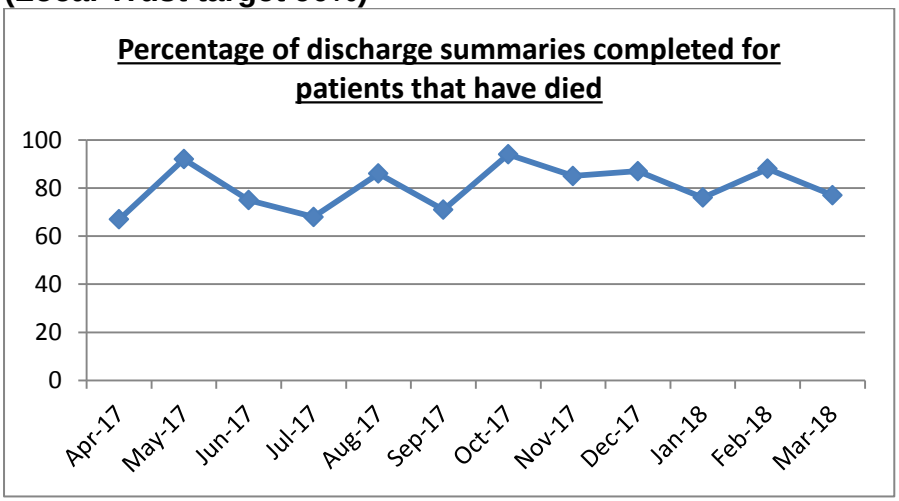
Graph 1: Percentage of 'category A' patient deaths reviewed by Whittington Health (April 2017 – June 2018) (Local Trust target 90%)



Graph 2: Percentage of 'category B' patient deaths reviewed by Whittington Health (April 2017 – June 2018) (Local Trust target 25%)



Graph 3: Percentage of death discharge summaries completed (April 2017 – March 2018) (Local Trust target 90%)



3. NHS Mortality Dashboard

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

There were 109 deaths recorded in Quarter 1. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation.

The dashboard shows that in Quarter 1, 69 of the 109 patient deaths were reviewed, and this was completed using the methodology that has already been described in the April 2017 Trust Board paper "*National Guidance on Learning from Deaths*".

There were no potentially avoidable patient deaths identified in Quarter 1 2018/19 (where potentially avoidable is taken to mean patient deaths with avoidability scores of between 1-3).

Two patient deaths were given an avoidability death judgement score of 4; these two deaths have been fully investigated through the trust governance process; one as a serious incident investigation and the other as an internal root cause analysis investigation.

40 patient deaths out of 109 deaths in Q1 (37%) were not systemically reviewed, but the majority of these (36 out of 40) involved category B deaths. Four category A patient deaths were not reviewed; these were deaths in patients under the following teams; care of the older person (COOP) (1), gastro (2) and critical care (1).

The dashboard outlines the avoidability of death judgement scores for inpatient deaths in Quarter 1 2018/2019 and this is summarised below, in table 2. There were no deaths in patients with learning disabilities this quarter.

Table 2 – Avoidability of death judgement scores for Q1: 2017/18

Avoidability of death judgement scores (of deaths reviewed)	**Number of patients with avoidability score**
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable, more than 50/50	0
4 - Possibly avoidable but not very likely, less than 50/50	2
5 - Slight evidence of avoidability	13
6 - Definitely not avoidable	54

4. Themes from Mortality Reviews

i) Key areas for improvement

a) In some clinical areas and teams, improvements are still required in the standard of documentation in the notes to record the degree to which patients have been kept informed, engaged in shared decision making and given the opportunity to express their wishes.

b) Two mortality reviews found evidence of medicine safety incidents such as missed VTE prophylaxis which had not been reported, the level of harm in those two incidents was either low or none.

c) There were only 2 instances when a palliative care referral was not sent early enough in patient management plans. These have been shared with the EoL Group but this is an improvement compared to previous quarter where this figure has been between 5-7 patients per quarter.
d) The mortality review process found 6 instances in which the reviewers felt that there had been delays in investigating the patient, escalating a change in the patient's condition, or making an appropriate referral to another team. In each case the concerns of the reviewers were shared with the relevant clinical departments so that the learning could be appropriately disseminated and discussed.
e) The mortality review process found clear evidence that we are not yet meeting the Trust's internal target that an electronic discharge summary should be completed for at least 90% of inpatient deaths within 72 hours. This is very important to ensure that we meet the needs of the bereaved family and communicate the death appropriately to the General Practitioner and to other relevant involved clinicians. A specific discharge summary QI group has now been developed.
f) We will identify appropriate project management capacity to support both the departmental and Trust mortality review process.
g) There is no overarching ICO mortality review group. This will commence in April 2019 to provide further assurance on the process and ensuring that learning is maximised.

ii) Notable practice

a) As the mortality review process has developed, most teams have developed a focus on using the reviews through existing or new education structures to share learning. This education and learning is generally highly multi-disciplinary, and gives prominence to trainees in leading on the dissemination of learning.
b) Trainee doctors and senior nurses are now being recruited as reviewers – they are bringing very valuable skills and insight to this role, while at the same time being trained in safety and governance processes.
c) There is good evidence of documented patient, family and carer involvement in EoL decision-making by most teams.
d) The reviews have highlighted themes around EoLC that have directly led to a quality improvement project that involves collecting the views of bereaved families. This initiative was launched on 1 July 2018.
e) The trust has improved in linking the learning from mortality reviews to discussions at Grand Rounds and other educational events in order to share learning.
f) We are starting to network with other NHS trusts in sharing learning from the Trust's mortality review processes.
g) The Trust's mortality review process has led to an improved sharing of expertise between teams. Examples of this are discussion about local improvements in venous thromboembolism (VTE) prevention, earlier planning around patient treatment escalation and earlier referrals to appropriate specialist clinical teams.
h) The Trust's mortality review process is now being formally linked in with other quality and safety governance processes. Examples of this include amendments to refine and improve clinical guidelines (for instance on VTE prevention and palliative care), feeding back to trainee doctors and other staff at the Patient Safety Forum and triangulating with the Complaints/Patient Advice and Liaison (PALs) team and legal team to improve learning and feedback to families.
i) The end of life care lead working with a third sector organisation has managed to secure the funding for 2 end of life care facilitators which will enhance the experience for both patients, families and our staff. Although not a formal adult bereavement service these posts will be able to assist with the support of families/carers after death.

j) For the first time this quarter we have looked at deaths in our patients that die in the 30 days post discharge. 97% of patient deaths in Quarter 1 on review were shown to have an avoidability of death judgement score of 6, that is unavoidable or “expected”. The remaining 3% of patient deaths require a further collaborative mortality review between Whittington Health teams and the patient’s GP to ascertain the avoidiability of death score and whether any further learning may be determined.

5. Potentially Avoidable Deaths

In 2016/17 using a retrospective review of all serious incidents it is estimated there were 7 potentially avoidable deaths; we did not score deaths using a structured judgement scoring system so cannot directly compare data.

In 2017/18 there was one potentially avoidable death in Quarter 1, one potentially avoidable death in Quarter 2, none in Quarter 3 and 2 in Quarter 4. In total for 2017/2018 there were four potentially avoidable deaths; all these deaths were investigated as SIs and learning shared widely.

In Q1 2018/2019 (1 April 2018 - 30 June 2018) there were no potentially avoidable deaths identified.

6. Summary

This paper provides assurance that we now have a robust mortality review process, and that we meet our local targets in terms of the proportion of inpatient deaths that are being reviewed.

This process has highlighted the need to improve our bereavement support to families, and our need to find out more about family and carer experience of EoL care and this has led to the planned quality improvement initiatives that have been described. It is expected our third sector collaboration work with 2 EoLC facilitator posts will be invaluable in this area.

As this has now become a recurrent and permanent process, with a significant workload associated with it, we will develop and embed sustainable support for its continuation, both in terms of recognising this work in job plans, and in providing the administrative/project management capacity to support it. This enhanced capacity would also support the expansion of the pilot looking at mortality reviews in patients that die 30 days post discharge.

Appendix 1: NHS England Trust Mortality Dashboard

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

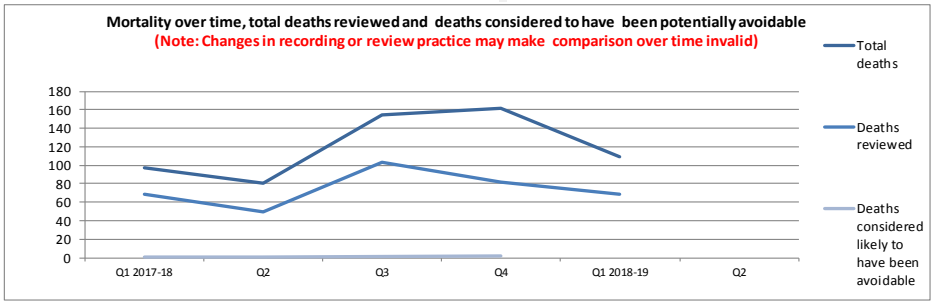
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
33	38	19	27	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
109	162	69	82	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
109	494	69	304	0	4

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



Total Deaths Reviewed by RCP Methodology Score

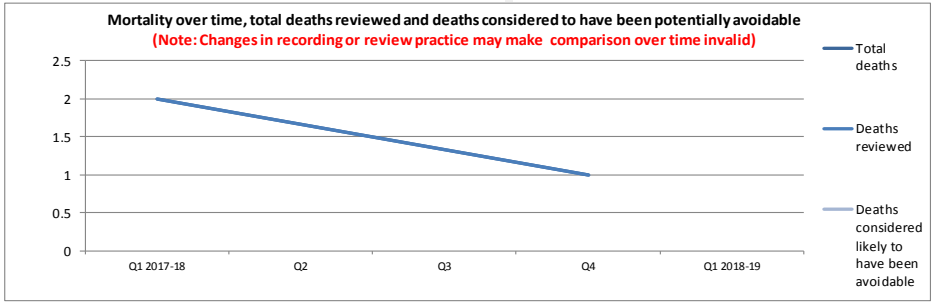
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	5.3%	This Month	3	15.8%	This Month	15	78.9%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	2.9%	This Quarter (QTD)	13	18.8%	This Quarter (QTD	54	78.3%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	2.9%	This Year (YTD)	13	18.8%	This Year (YTD)	54	78.3%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	3	0	3	0	0

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



Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	Six Monthly review of nursing and midwifery establishments (October 2018 Data)	**Agenda item: 10**
Executive director lead	Michelle Johnson, Chief Nurse and Director of Patient Experience	
Report author	Maria Lygoura, Lead Nurse for Safer staffing	
Executive summary	• In line with National Quality Board guidance this report provides an update to the Executive Team Meeting (ahead of NMEC and TMG) on the latest safe nursing and midwifery staffing position. • The review was undertaken using October 2018 data in line with the six monthly reviews. • This review includes a nurse/midwife establishment review of the Emergency Department, Maternity Unit, Inpatient Wards, District Nursing, Health Visiting and School Nursing Services using appropriate methodology for a complexity of clinical areas	
Purpose:	1. For approval, review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure wards, Emergency Department, District Nursing, Health Visiting and School Nursing services are safely staffed. 2. To discuss the potential future workforce challenges	
Recommendation(s)	The Trust Board is asked to: 1. Review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed. 2. Recommendation by Chief Nurse to approve the skill mix and RN reduction as presented in Appendix 2.	
Risk Register or Board Assurance Framework	BAF risk 4 - Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs	
Report history	• Six Monthly Review of Hospital Inpatient Wards Nursing Safer Staffing Establishments (April 2018 Data) • A review of nursing establishments relating to wards areas, the Emergency Department, Maternity, District Nursing, Health Visiting and School Nursing (October 2017 Data) • Francis Report recommendations • Trust Safer Staffing Nursing Establishment Policy	
Appendices	1. Model Hospital Data – September 2018 Refresh 2. Summary Table - Hospital inpatient wards 3. Staff Turnover - October 2018	

1. INTRODUCTION

1.1 This paper provides an update on current ward nursing and midwifery staffing levels following a review of ward establishments undertaken in October 2018. This paper should be considered alongside the information shared each month in the Nursing and Midwifery Safer Staffing Reports. Currently there is National requirement to report formally on hospital inpatient and Emergency Department establishment. As an integrated care organisation Whittington Health is keen to ensure that community nursing levels are reviewed. This review contains information on the recent District Nursing skill mix review and some changes to school nursing and health visiting teams. Future reviews will include increasingly comprehensive reviews of Health Visiting, school nursing and community children's nursing.

1.2 Safer staffing and skill mix reviews were undertaken in October 18 for the following clinical areas

- Adult inpatient
- CYP inpatient
- Simmons House – CAMHS Tier Four Inpatient
- Midwifery – BirthRate Plus ©
- Community children's nursing and specialist nursing
- District Nursing

2. OUR APPROACH TO ENSURE SAFE STAFFING LEVELS

1.3 Hospital ward nursing establishments are formally reviewed every six months to ensure the ward based nursing workforce meets the demands of clinical care provision, delivers safe care with a positive patient experience and fits within the financial strategic objectives of the organisation.

1.4 For the purpose of this review, data for wards was collected via Allocate HealthRoster and QlikView for the month of October 2018. Acuity is assessed and recorded into the Safer Care module of HealthRoster three times a day, and the patient census is recorded at midnight. The calculation for the recommended establishment is based on the Safer Nursing Care Tool multipliers (Shelford Group 2012). The application of recommended nurse patient ratios was also applied as appropriate. Professional judgement is made by ward managers and matrons and validated by associate directors of nursing. The final recommendations are approved by the associate directors of nursing. Information is also reviewed regarding care hours per patient per day.

1.5 There are no nationally validated tools currently available to review safer staffing in District Nursing Services. The Whittington Health District Nursing Service has therefore developed and tested its own skill mix tool which has been used as part of this review.
NHS Improvement has in the last year published and reviewed existing improvement resources including children and young people's services, urgent and emergency care, mental health services, learning disability services and adult inpatients in hospital care. They recommended that there is also a six monthly review of the establishments of the neonatal unit and maternity (this has been undertaken)

3. VACANCY LEVELS

ICSU	October 2017 (%)	March 2018 (%)	October 2018 (%)	Trend
CYP	10.27	14.09	11.5	↓
ACS	33.33	33.33	17.4	↓
EIM	24.5	22.37	25.9	↑
Surgery & cancer	26.64	28.2	24.5	↓
ACW	10.02	8.02	4	↓
Total	**16.1**	**21.2**	**16.6**	↓

1.6 There has been a noticeable improvement in some ICSUs in the vacancy levels for registered nurses and midwives between October 2017 and October 2018 although there is no significant change in the **total** vacancy levels across ICSUs. There is limited change in Emergency and Integrated Medicine (EIM) as newly qualified nurses have not yet commenced their employment (at the time of the review, the majority have now started) and Nursing Associates have not yet obtained NMC registration (due end of January 2019). In Adult Community Services (ACS) and Surgery & Cancer the vacancy level is encouragingly reduced as a result of the skill mix review as well as new starters. The reduction of vacancy rate Children and Young People (CYP) and Acute Patient Access Clinical Support and Women's Services (ACW) is due to successful recruitment and skill mix review.

1.7 WH continues to implement a number of creative recruitment and retention strategies and have joined the NHS Improvement collaborative for retention, taking place over the next six months.

1.8 Turnover of registered nurses and midwives was **10.52%** across the integrated clinical service units (ICSUs) at the end of October 2018. This represents an improvement from March 2018 (12.7%).

1.9 The recent reduction of the International English Language Testing System (IELTS) pass mark by the NMC will also enable overseas practitioners, currently employed as assistant practitioners, to obtain their NMC registration. The first cohort of Nursing Associates will qualify in January 2019 and 16 of the cohort (n=19) will fill nurse vacancies at Whittington Health. A decision has been reached to safely replace approximately 15%- 20% of band 5 posts with Band 4 Nursing Associate posts in the adult settings. We anticipate that this group of staff will increasingly become integrated more into the qualified nursing workforce.

4. FINDINGS

1.10 Adult Hospital Wards

4.1.1 During the review period there were high occupancy levels on all of the medical wards. Consistently reported bed occupancy rates of 95% and above.

4.1.2 In October 2018, additional escalation beds continued to be open on Coyle and Victoria wards, above the funded bed/nursing establishment, and in addition to this on some days there were also eight extra '"plus one"' beds opened on some wards in line with the Emergency Department escalation protocol (plus one beds do not require additional staffing).

4.1.3 During the reference period, there was particularly high acuity and dependency on Cloudesley, Meyrick, Victoria and Coyle wards alongside a high number of patients requiring enhanced care due to their mental health needs or being at high risk of falls. Comparison of acuity and dependency levels between April and October 2018 shows an increased number of patients requiring 1b level of care (dependency on staff).

4.1.4 Internal establishment review and challenge session with the chief nurse, deputy chief nurse the Associate directors of nursing (ADON), management accountant and NHSI director of nursing recommended further adjustments to staff skill mix and staff to patient ratio, this has been undertaken as part of this review. Conversion of Band 5 RN positions to Band 4 Assistant Practitioners and Nursing Associates positions are in progress.

1.11 Maternity

4.2.1 A systematic staffing assessment was undertaken in October 2018 with the use of BirthRate Plus® (BR+) framework. BirthRate Plus® is a tool endorsed by the Royal College of Midwives and NHSI for determining safe staffing and is a framework which recommends an establishment and skill mix based on the complexity of the mothers that use the service. There is a recommendation that a three yearly BR+ is undertaken. Last undertaken at Whittington Health in 2015.

4.2.2 The current ratio of midwife to births is 1:28 based on 3,762 births a year (actual births rather than planned). BirthRate Plus® deems this ratio as adequate and is in line with the recommended establishment using the North Central London calculator.

4.2.3 The ratio is reviewed monthly by the Associate director of Midwifery using the North Central London calculator as a validation tool.

1.12 Neonatal Unit (NNU)

4.3.1 The British Association of Perinatal Medicine (BAPM) recommends an establishment of 61.54 WTE for ratio of neonatal nurses for intensive care, high dependency and special care cots and includes the ratio of qualified in speciality nurses (QIS) recommended. Current establishment for the reference period was 59.46 WTE which is considered sufficient and well within the BAPM guidance.

BAPM is one of the tools supported in the recent improvement resource published by NHSI in November 2018.

4.3.2 The bed/cot occupancy decreased since the last review from 76.38% to 73%. As there are a number of vacancies this is monitored with staffing levels (permanent and temporary) reviewed each shift to ensure there is no over establishment, A detailed review is planned for April 2019 to determine staff to client ratio and skill mix in line with bed occupancy.

1.13 Ifor ward (Children's Ward)

4.4.1 Reduction of bed capacity to 19 beds in August 2018 (from 23). Current establishment is considered adequate for the bed occupancy and dependency of children. There is a high level of dependency with children and young people with mental health needs.

4.4.2 RCN guidelines suggest that staffing establishment for RNs would not be sufficient if the ward was opened to 23 beds.

4.4.3 Further establishment review is planned for April 2019 to determine alignment against national standards, part of this process will review the supervisory status of the Band 7 Ward Manager and Band 8 Matron.

4.5. **Simmons House (specialist children and young people mental health unit)**

4.5.1 Staff remodelling was undertaken in October 2018 which resulted in the reduction of the establishment and skill mix but has not altered the planned daily staff to client ratio. There has been an increase in the number of health care support workers across the rota and reduction in RN posts.

4.5.2 Further establishment review is planned for April 2019 to determine alignment against national standards, part of this process will review the supervisory status of the Band 7 and Band 8 RMNs.

4.6. **District Nursing**

4.6.1 Staff remodelling was undertaken in September 2018 which resulted in altering the skill mix by increasing the number of care support workers, Nursing Associates and Assistant Practitioners, whilst decreasing the number of registered nurses and the introduction of a practice development team.

4.7. **Health Visiting**

4.7.1 Staff remodelling was undertaken in October 2018 which resulted in conversion of 3.74 Band 7 posts to 4.45 Band 6 posts

5. COMPARISON WITH PEER TRUSTS - MODEL HOSPITAL

5.5. Key Model Hospital data is shown in Appendix 1.

5.6. The care hours per patient day remains in quartile 4 and marginally above the national median for peer organisations.

5.7. The cost per care hour remains in quartile 2 and suggests value for money.

5.8. The proportion of harm free care is in quartile two and close to the national median for peer organisations. It should be noted however that this graph illustrates all participant Trusts of similar size, and not just Integrated Care Organisations.

5.9. Trusts with significant community services are expected to have a lower performance in the "*harm free care"* indicator as it is taken from the Safety Thermometer which counts old as well as new episodes of harm using a point prevalence method.

5.10. The Trust is a pilot for the "New Model Hospital Community and Mental Health data". This will separate out hospital and community data. The benchmarking for this data is underway across England. Publication is expected later in 2019.

6. FINANCIAL IMPLICATIONS

6.1. Following the April 18 establishment review approximately £160,000 was released for cost improvement. This was quality impacted assessed and approved.

6.2. The October 2018 review has enabled further skill mix across the Trust and will lead to reduction in cost.

7. RECOMMENDATIONS

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

7.2. Review of skill mix and RN ratio in Care of the Older Peoples Unit as there is consistently high number of patients with high acuity and dependency level.

7.3. Review the ward manager supervisory status as there is discrepancy across the adult and child inpatient wards. This will take place within the next three months.

7.4. Appropriateness of staffing in Neonatal Unit to be reviewed on a daily basis using the Badgernet system and safe care tool in response to flexing of cots and ensuring safe staffing is maintained with no excess booking of staff.

7.5. The ratio in midwifery to be reviewed monthly by the Associate director of Midwifery using the North Central London calculator with closer monitoring of actual deliveries against plan and staff areas accordingly.

7.6. Review establishment in April 2019 against national standards for Ifor ward and Simmons House.

7.7. Monitor nurse sensitive indicators in District Nursing services and evaluate changes that could be attributed to the new skill mix model.

7.8. The Emergency Department conducts a full pilot of the safer nursing care tool within the next six months (post height of winter period).

8. NEXT STEPS

8.1. The next establishment review will take place in April 2019, with data checks, validation and teaching where necessary, for the adult wards.

8.2. Other hospital areas that will be reviewed are:
Emergency Department - Day Treatment Centre – Outpatients - Endoscopy unit
Health Visiting - School Nursing - Community Children's Nursing

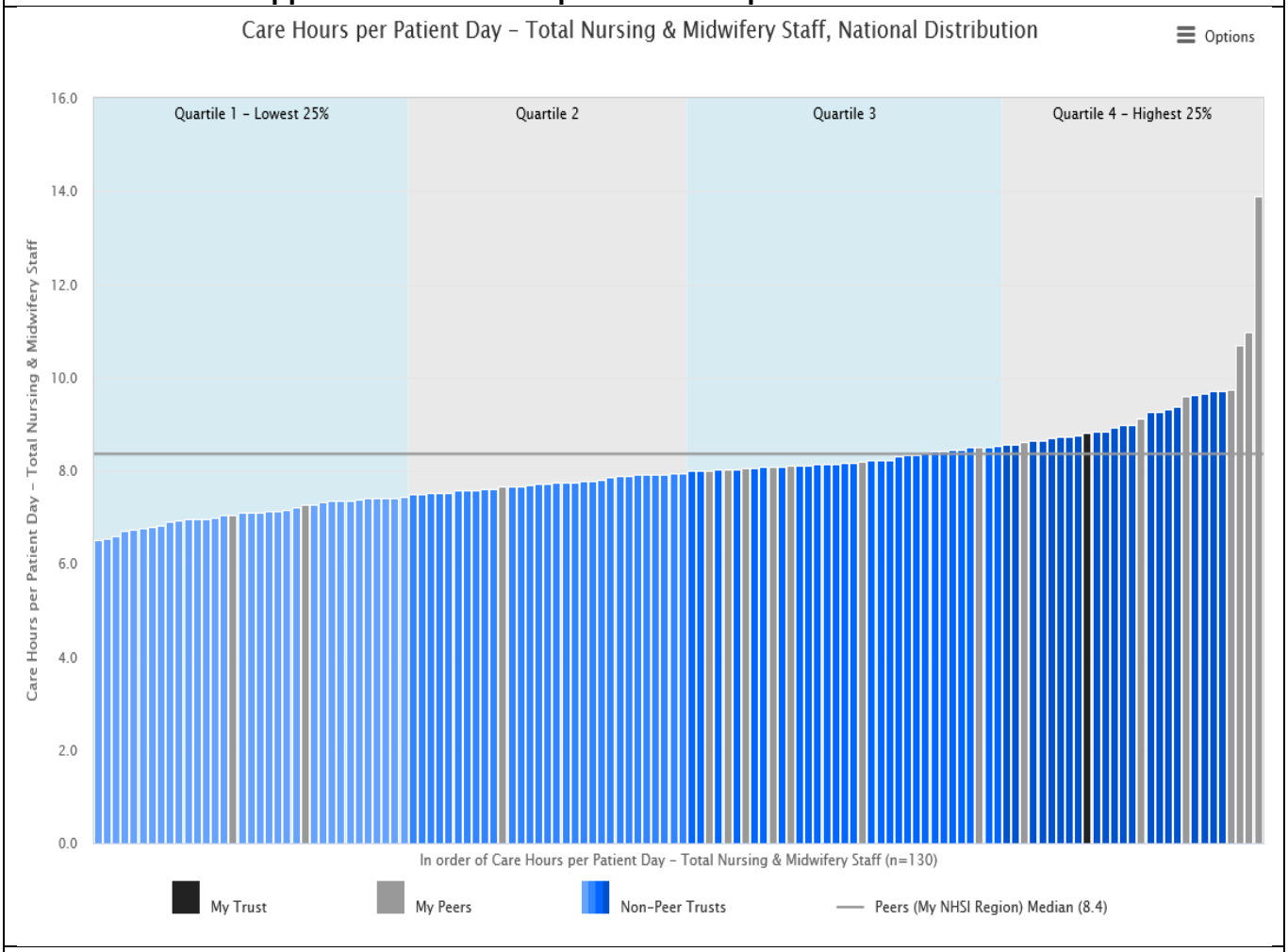
8.3. Ward based Allied Health Professionals who are part of the roster will be included as part of the Care Hours per Patient Day (CHPPD) data within the next year.

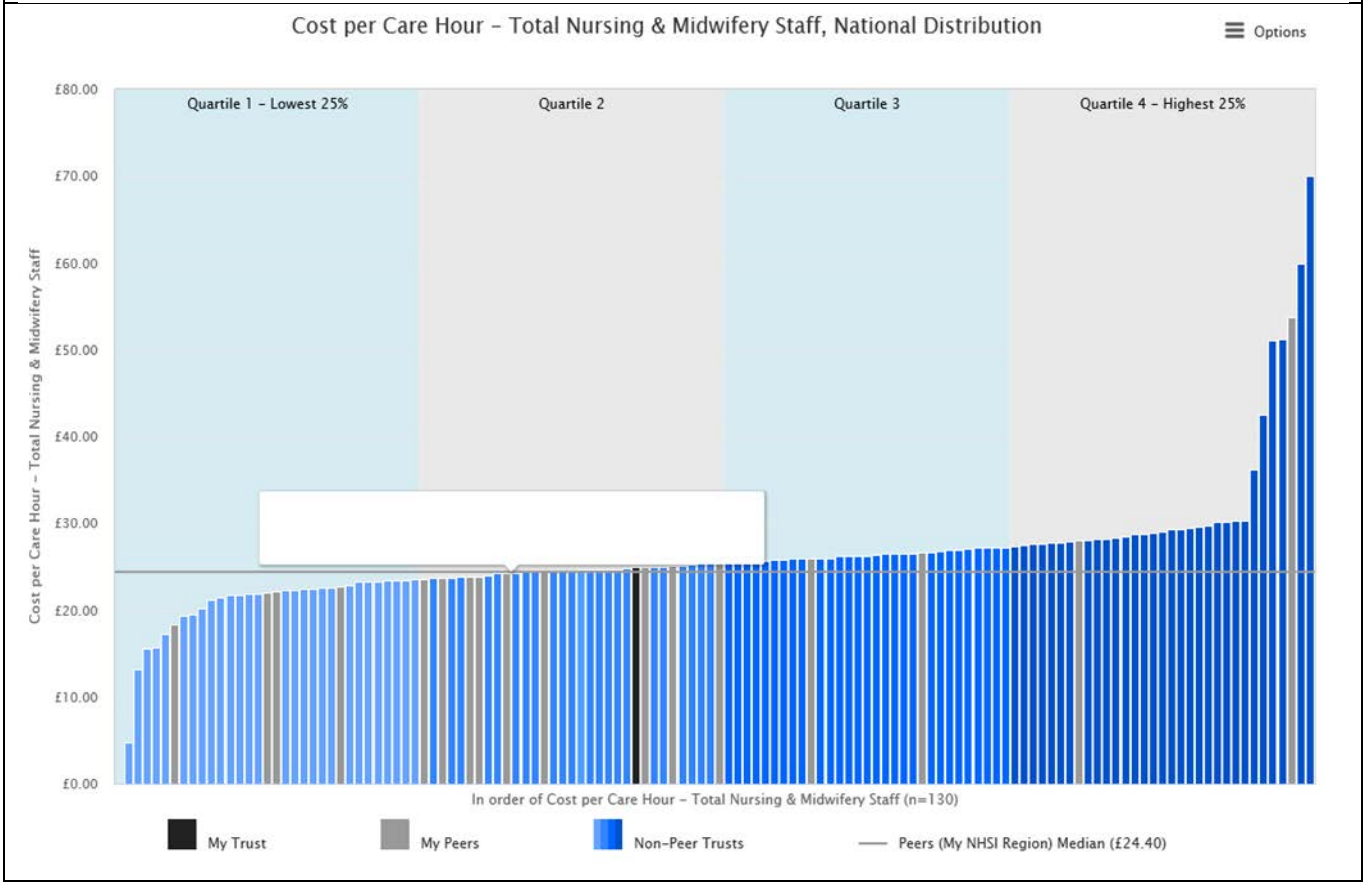
8.4. Work will continue to align the budgeted establishment with the safer staffing requirement on HealthRoster. The demand template on HealthRoster and the budget will be aligned following adjustment to uplift of 21% and be complete within the next 4 months.

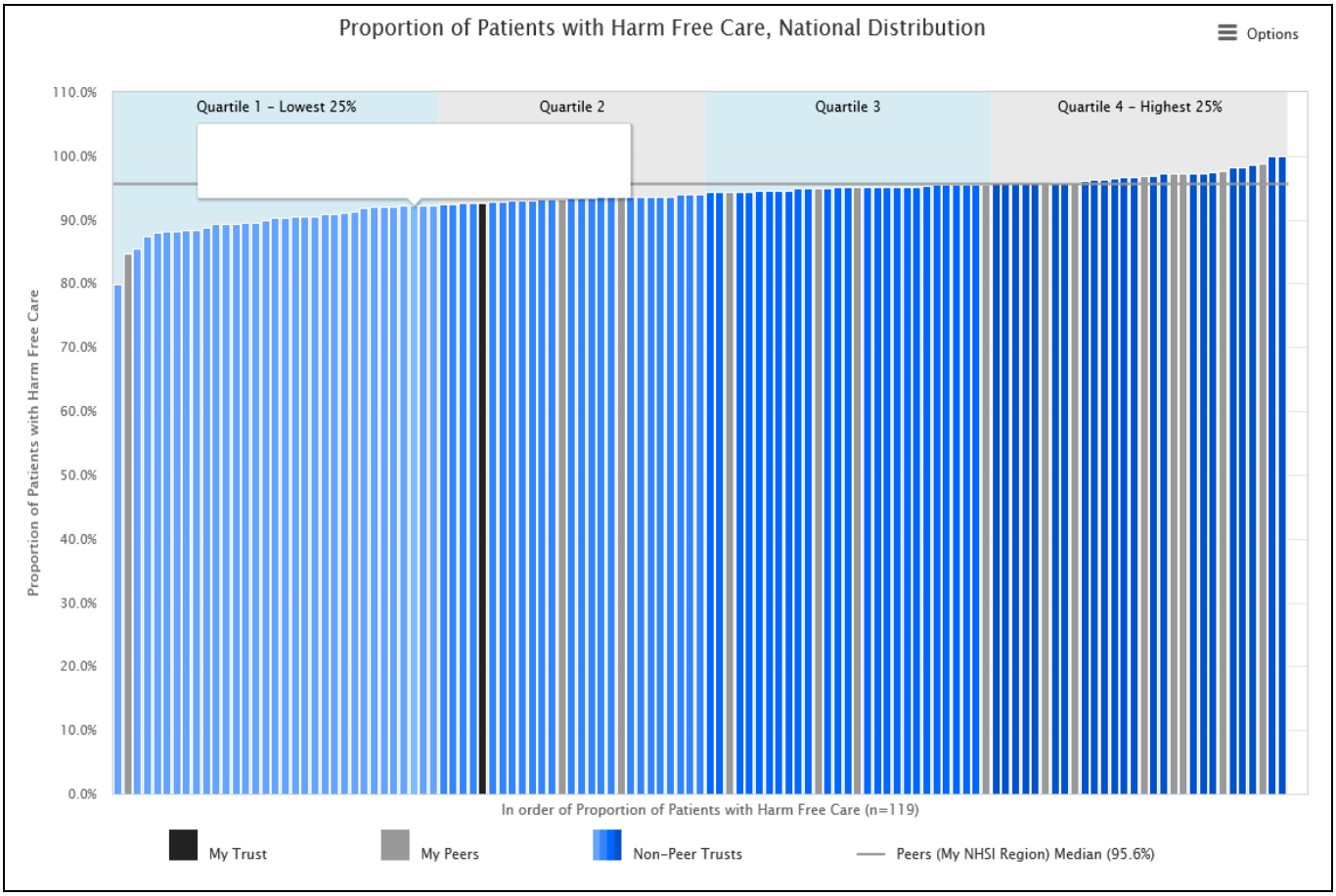
9. THE TRUST BOARD IS ASKED TO:

9.1. Review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed.

9.2. Recommendation by Chief Nurse to approve the skill mix and RN reduction as presented in Appendix 2


Care Hours per Patient Day – Total Nursing & Midwifery Staff, National Distribution
Options
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
Quartile 4 – Highest 25%
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Care Hours per Patient Day – Total Nursing & Midwifery Staff
In order of Care Hours per Patient Day – Total Nursing & Midwifery Staff (n=130)
My Trust
My Peers
Non-Peer Trusts
Peers (My NHSI Region) Median (8.4)


Cost per Care Hour – Total Nursing & Midwifery Staff, National Distribution
Options
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
Quartile 4 – Highest 25%
£80.00
£70.00
£60.00
£50.00
£40.00
£30.00
£20.00
£10.00
£0.00
Cost per Care Hour – Total Nursing & Midwifery Staff
In order of Cost per Care Hour – Total Nursing & Midwifery Staff (n=130)
My Trust
My Peers
Non-Peer Trusts
Peers (My NHSI Region) Median (£24.40)


Proportion of Patients with Harm Free Care, National Distribution
Options
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
Quartile 4 – Highest 25%
110.0%
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Proportion of Patients with Harm Free Care
In order of Proportion of Patients with Harm Free Care (n=119)
My Trust
My Peers
Non-Peer Trusts
Peers (My NHSI Region) Median (95.6%)

Appendix 2: Summary Table - Hospital inpatient wards											
	Funded Beds	WTE Following April 18 Review	SNCT April 18 (WTE)	SNCT Oct 18 Funded beds	Planned RN:Pt Day	Planned RN:Pt Night	Staff to Bed Ratio	Ward summary	Comments	Recommendations following Nov 18 challenge	Financial gains
Coyle	24 +7 +1	37.03	42.89	37.48	1:6	1:8	1 : 4	Non-elective orthopaedic, trauma, general surgery.	Ward manager (W/M) 100% supervisory (SUPV) between Coyle and Th'good wards	Maintain current funded establishment Convert one Band 5 RN to Band 4 AP on every shift	Conversion of 5 Band 5 RNs to Band 4 APs
Thorogood (Th'good)	10 +1	14.00	11.46	12.1	1:5	1:5	1 : 3.3	Small ward	W/M 100% SUPV between Coyle and Th'good	Convert one Band 5 RN to Band 4 AP on every day shift	Conversion of 2.5 Band 5 RNs to Band 4 APs. Reduction of Band 7 to 6
Mercers	16 +2	25.20	22.94	27.24	1:3	1:5	1 : 3.5	6 HDU/L2 beds	W/M in numbers with one management day	Convert 3 Band 5 RNs to 3 Band 4 APs	Conversion of 3 Band 5 RNs to 3 Band 4 APs
Cloudesley	25	33.28	33.36	40.81	1:6	1:8	1 : 3.7	High No of pts requiring enhanced care. Complex discharges	W/M supervisory	W/M 50% SUPV Converted 2 Band 5 RNs to Band 4 AP/NA: Total No of AP/NA = 6 Increase establishment by 2 WTE to be able to maintain RN to Pt ratio	absorbed to fund the increase of 2WTE in
Meyrick	25 +1	32.08	36.36	39.52	1:6	1:8	1 : 3.7	High No of pts requiring enhanced care. Complex discharges	W/M supervisory	W/M 50% SUPV Converted 2 Band 5 RNs to Band 4 AP/NA: Total No of AP/NA = 6 Increase establishment by 2 WTE to be able to maintain RN to Pt ratio	absorbed to fund the increase of 2WTE in
Bridges Rehab Unit	14	19.30	18.40	22.07	1:7	1:7	1 : 3.5	Rehab unit, high level of dependency (1b), Complex discharges	W/M supervisory	Convert one Band 5 RN to Band 4 AP on every shift	Conversion of 5WTE Band 5 to 5 Band 4
Nightingale	21 +2	30.58	31.94	30.5	1:5	1:5	1 : 3.5	4 HDU/L2 beds	Converted one Band 5 RN to Band 4 AP on	W/M to be 50% SUPV W/M supervisory	Watch and wait

									every shift		
Montuschi	16 +1	21.60	24.80	26.4	1:4.5	1:4.5	1 : 4	4 HDU/L2 beds	w/m supervisory Will trial conversion of one Band 5 RN to Band 4 AP on every night shifts	W/M to be 50% supervisory Watch and wait	
Victoria	26 +7	38.94	40.98	40.82	1:6	1:8.5	1 : 3.5	Mixture of highly acute medical pts: Sickle care, gastro w/ encephalopathy complex D/C	w/manager in the numbers	W/M to be 50% supervisory Increase the number of Band 4 AP/NAs to a total of 6	Conversion of 2WTE Band 5 to 2 Band 4
MSN – Acute Assessment Unit	16 +1	29.62	24.42	28.35	1:3.5	1:5	1 : 3	High flow ward receiving patients for ED	Converted one Band 5 RN to AP on every day shift. Band 5 pharmacy Tech on Trial replacing B5 RN	100% supervisory W/M between MSN and MSS	Absorbed to fund the increase of 2WTE in COOP
MSS –Acute Assessment Unit	18	29.62	24.45	28.168	1:4	1:4.5	1 : 3	High flow ward 6 HDU/L2 Beds	Converted one Band 5 RN to AP on every day shift. Band 5 pharmacy Tech on Trial replacing B5 RN	100% SUPV w/m between MSN and MSS	Absorbed to fund the increase of 2WTE in COOP

	Funded Beds	**Funded Establishment Oct '18**	**RCN recommended WTE**	**Current Planned Staffing levels**	**RCN recommended RN to child ratio**	**Occupancy Split**	**Average RN to child ratio**	**Ward summary**	**Comments**	**Recommendations following Nov 18 challenge**
Ifor Children's ward	19	36.2	41.90	Day: 5+1 Night: 4+1	Under 2: 1:3 Over 2: 1:4 HDU: 1:2	Under 2: 56% Over 2: 44%	1:4	Young people between the ages of 0-16	w/m in numbers	review the supervisory status of the Band 7 ward manager and Band 8 matron

	Funded Beds	**Funded Establishment Oct '18**	**BAPM Recommendations WTE**	**Current Planned Staffing levels**	**RN to Baby/Child**	**Ward summary**	**Comments**	**Recommendations following Nov 18 challenge**
NNU	23	62.98	61.54	Day: 9+1 Night: 9+1	Ventilated : 1:1	Intensive care, high dependency and special	The occupancy decreased since the last	review in April 2019 the skill-mix and ratio in view of occupancy

					HDU: 1:2 Special care: 1:4	care level 2 unit. receives acute referrals from local level 1 units	review from 76 % to 73%	flexing

	Funded Beds	Births per Year	Funded Establishment Oct '18	Birth Rate + ® Recommends WTE	Current Births per WTE	Ward summary	Comments	Recommendations following Nov 18 challenge
Midwifery	55	3,762	180.6	180.43	1:28	Labour Ward, Birth Centre, Postnatal, Antenatal, transitional, inductions of labour, Triage of ante and postnatal mothers & babies	Currently there is a 90:10 spilt of RM: Support worker.	Review skill mix with band 2 and 3 Maternity Support workers

Appendix 3: Staff Turnover - October 2018			
Staff Group	Nursing and Midwifery Registered		
	Leavers FTE	Average FTE	Turnover %
Adult Community	10.53	99.98	10.53
Children & Young People	48.52	270.95	17.91
Emergency & Integrated Medicine	16.93	272.82	6.21
Surgery & Cancer	19.41	174.90	11.10
Acute Patient Access Clinical Support Service and Women's Health	8.69	170.78	5.09
Grand Total	104.08	989.42	10.52

Meeting title	**Trust Board – public meeting**	**Date: 30 January 2019**
Report title	**Integrated performance report**	**Agenda Item: 11**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Hester de Graag, Risk and Quality Manager	
Executive summary	**Emergency Department (ED) four hours' wait:** Overall performance against the 95% 4 hour standard for December 2018 was 85.5%. Attendance numbers were high at 9,219 (on average 297 per day). The 'minors' performance delivered 97.6% and Paediatrics delivered at 97% in December. There was one 12 hour trolley breach in December. This was a mental health patient and there was a delay in transfer to an appropriate mental health bed. Lessons have been learnt around early escalation. Camden and Islington NHS FT lead on the 72 hour report. **Non-elective re-admission** Re-admission rate is just above the target of 5.5% at 5.9%, however still under the year average. Comparing year on year the re-admission rate in December 2017 was 7.3%, now significantly better at 5.9% Ongoing work is in place including Discharge to Assess and Home First to avoid patient re-attendance, and well as improvement to data quality.	
Purpose:	Review and assurance of Trust performance compliance	
Recommendation(s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan	
Risk Register or Board Assurance Framework	The following BAF entries are linked: risk 3 – failure to hit national and local performance targets risk 4 – failure to recruit and retain high quality substantive staff risk 14 – failure to provide robust urgent and emergency pathway for people with mental health needs risk 17 – organisational culture	
Report history	Trust Management Group, January 2019	
Appendices	none	

Whittington Health NHS

Integrated Performance Report

January 2019

Month 9 (2018 – 2019)

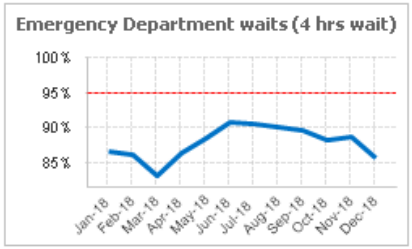
Date & time of production: 24/01/2019 10:03

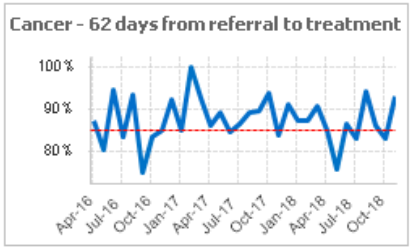
Summary Page - Indicators

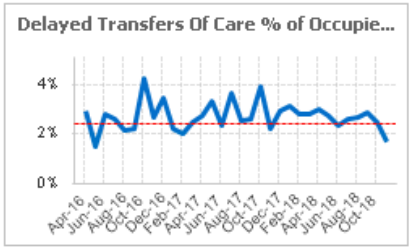
Category	Indicator	17_18 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	88.6%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	75	76	95	91	87	79	74	63	75	79	88	91	81
Cancer	Cancer - 14 days to first seen	**>93%**	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%		93.5%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%		85.5%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.4%	4.9%	5.9%	6.0%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%		2.5%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.2%
Outpatients	Outpatients - FFT % Positive	**>90%**	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	91.5%
Community	Community - FFT % Positive	**>90%**	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.4%
Staff	Staff - FFT % Recommend Care	**>70%**			75.0%			77.3%			77.4%				77.3%
Community	% seen <=2 hours of Referral to District Nursing Night Service	**>80%**	96.0%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	91.4%
Community	% seen <=48 hours of Referral to District Nursing Service	**>95%**	91.8%	92.2%	88.2%	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	90.7%
Community	Haringey New Birth Visits - % seen within 2 weeks	**>95%**	91.7%	93.3%	90.8%	89.7%	92.6%	93.4%	90.4%	92.1%	91.8%	91.2%	92.1%		91.7%
Community	Islington New Birth Visits - % seen within 2 weeks	**>95%**	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%	96.5%	92.5%	93.4%		94.7%

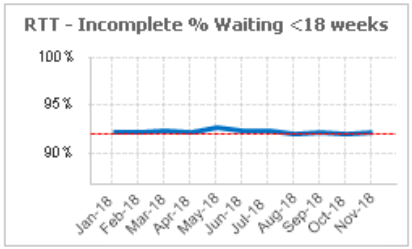
Date & time of production: 24/01/2019 10:03

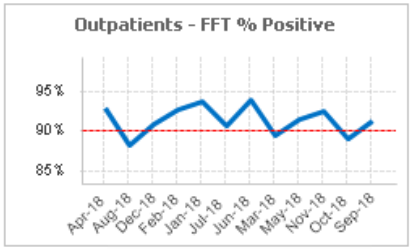
Summary Page - Indicators

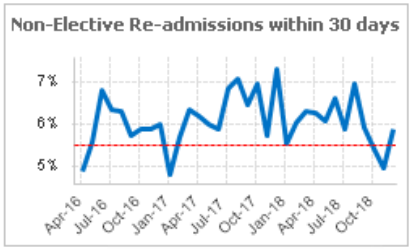












Date & time of production: 24/01/2019 10:03

Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	0	1	0	1	2	0	0	2	2	1	1	3	12	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0		0	
All Areas	Actual Falls	400	38	27	43	37	52	33	33	26	28	36	31	35	311	
All Areas	Avoidable Category 3 or 4 Pressure Ulcers	0	9	3	3	2	4	2	1	4	0	1	2	2	18	
All Areas	Harm Free Care %	>95%	93.4%	92.2%	93.9%	93.3%	93.0%	91.0%	92.6%	92.3%	93.2%	94.5%	92.3%	93.5%	92.9%	
Maternity	Non Elective C-Section % Rate	<15%	18.8%	22.0%	14.5%	17.2%	19.9%	18.1%	25.9%	19.9%	19.2%	18.8%	21.5%	25.5%	20.6%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	1	0	0	0	0	1	0	0	0	0	0	0	1	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	19.4%	18.6%	21.5%	19.8%	18.4%	16.6%	16.9%	16.6%	17.0%	19.1%	16.7%	21.0%	18.0%	
All Areas	Serious Incidents	0	7	1	2	6	8	3	1	1	2	2	4	2	29	
Admitted	VTE Risk Assessment %	>95%	95.1%	95.2%	96.2%	95.9%	95.1%	95.0%	96.2%	94.5%	94.9%	95.2%	96.9%		95.5%	
Admitted	Mixed Sex Accomodation Breaches	0	0	0	0	5	7	0	0	0	0	1	0	0	13	

Date & time of production: 24/01/2019 10:03

Safe Services - Commentary

HCAI C Difficile
There have been three new Trust attributable C. difficile cases in December 2018, all of which were on Cloudesley Ward. Investigations are taking place to establish if there has been cross infection. We are awaiting ribotyping to determine the likelihood of cross infection in these cases.

Pressure Ulcers
Whittington Health reported four avoidable Category 3 Pressure Ulcers, all in the District nursing teams. 2 in November and 2 in December 2018. Insufficient assessment or re-assessment and lack of updating of the pressure ulcer prevention care were the main reasons for the pressure ulcers to develop or deteriorate. The District Nursing service continues to closely manage the caseload to make sure the service has capacity to complete quality assessment.

Non elective C-section
Rate has increased to 25.5%. Actions: Lead matron for labour ward and obstetric lead to commence regular reviews of non-elective caesarean sections. This will include a review of mother and baby outcomes and see if there are any lessons to be learned. Expected completion of review - February 2019.

Serious Incidents
Two SIs declared in December 2018
1. [S&C] 2018.29134 – A57427 Never Event- Wrong Site Surgery. A patient who was due for an elective left shoulder replacement received an interscalene block on the wrong side.
2. [WHOD] 2018.30069 – Unexpected admission to NICU. The baby was born in a poor condition.

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	81.9%	82.6%	76.9%	78.7%	80.4%	81.9%	83.7%	83.5%	82.8%	80.9%	82.3%	81.0%	81.6%	
ED	ED - FFT Response Rate	>15%	12.8%	15.3%	14.1%	15.2%	14.1%	14.1%	12.2%	14.1%	12.8%	13.1%	11.9%	12.0%	13.2%	
Admitted	Inpatients - FFT % Positive	>90%	96.5%	96.4%	95.9%	96.3%	96.4%	98.4%	97.0%	97.9%	97.0%	96.8%	97.8%	98.1%	97.3%	
Admitted	Inpatients - FFT Response Rate	>25%	17.4%	17.9%	16.2%	16.4%	22.2%	17.7%	18.1%	15.6%	13.6%	12.4%	20.5%	18.1%	17.2%	
Maternity	Maternity - FFT % Positive	>90%	95.9%	99.3%	97.0%	95.8%	92.8%	93.2%	95.9%	95.3%	95.5%	95.3%	92.8%	92.9%	94.5%	
Maternity	Maternity - FFT Response Rate	>15%	56.3%	61.0%	18.7%	58.5%	49.4%	45.2%	53.2%	67.2%	49.3%	40.0%	42.9%	48.9%	50.7%	
Outpatients	Outpatients - FFT % Positive	>90%	93.8%	92.8%	89.6%	93.0%	91.5%	94.0%	90.6%	88.3%	91.3%	89.0%	92.6%	91.0%	91.5%	
Outpatients	Outpatients - FFT Responses	400	420	461	249	327	445	348	310	223	138	328	484	233	2836	
Community	Community - FFT % Positive	>90%	95.4%	94.6%	96.5%	96.2%	95.9%	96.6%	96.9%	96.4%	95.7%	95.5%	97.1%	97.9%	96.4%	
Community	Community - FFT Responses	1500	875	1157	779	1206	1181	1148	869	890	1122	1159	998	622	9195	
Staff	Staff - FFT % Recommend Care	>70%			75.0%			77.3%			77.4%				77.3%	
All Areas	Complaints responded to within 25 working day	>80%	76.9%	87.5%	92.0%	71.4%	78.3%	92.6%	95.0%	93.8%	92.3%	95.0%	95.8%	84.2%	87.9%	
All Areas	Complaints (including complaints against Corporate division)	N/A	30	21	33	33	30	39	27	21	14	24	30	24	242	

**Staff FFT % Recommended Care or Dec-17 is based on the Staff Survey results (not the Staff FFT).

Caring Services - Commentary

FFT

For December 2018 there was a slight decline in the response rate for **Inpatient FFT** from November (18% in December from 21% in November). Though a decline on November, December's response rate continues the improvement from quarter 2, where Inpatients scored an average response rate of 16% across that quarter. The improved response rate in day cases has been sustained (11% in November; 8% in December), and though it is still below the Trust set KPI, it is positive to see that the enhanced efforts of staff to collect FFT in the area has been sustained. There was a decrease in response rate on Coyle ward (20% for Coyle in November; 5% for Coyle in December) which the patient experience manager will pick up on to support the ward team. The inpatient areas almost uniformly exceeded the 90% KPI for positive feedback, with no individual area scoring lower than 88% for positive recommendations.

There were sizeable decreases in the response totals for both **Outpatients** and **Community** in December. This decrease replicates a similar decrease in responses for December 2017. One of the primary contributory factors towards this seemingly annualised drop in responses is due to the bank holidays and reduced volunteer support offered in December. The voluntary service team has recruited additional volunteer support in January and are inducting several of these towards supporting with FFT data entry. Another potential factor resulting in the decreased figures is the possibility that there were fewer outpatient and community appointments due to the festive period. The Information Technology team supported the maintenance of iPads for the collection of patient feedback. Two of these iPads are for allocation with the community teams at St Ann's. The introductions of these iPads have been delayed due to technical reasons. As the maintenance of these iPads has now been completed, the patient experience team forecasts that these iPads will be installed by the end of January 19.

There was a small increase in response rate for ED in December (12% from November's 11.9%), and a small decrease in recommend rate (81% from November's 82%). The child-friendly paediatric survey that the patient experience team had been working on with the ED team was implemented and introduced to the team in December. The ED paediatric team are collecting feedback through a handheld iPad. Maternity continue to exceed both set KPIs for positive recommendations and response rate: 92.9% recommend against the KPI of 90%; 48.9% against the KPI of 15%. The excellent performance here has been sustained throughout 2017/18 and throughout 2018/19 thus far.

Caring Services - Commentary

Complaints

During December 2018 the Trust was due to close 24 complaints; 19 complaints required a response with 25 working days and 5 were allocated 40 working days for investigation due to their complexity. In regard to the 25 working day target of 80%, the Trust achieved a performance of 84% (16/19).

- Of the five complaints allocated 40 working days, two complied with the target.
- At the time of reporting, 4 complaint responses remain outstanding (two '25' day and two '40' day complaints, one for CYP, one EIM & two for S&C)

The complaints were allocated to S&C 38% (9), EIM 25% (6), ACW 17% (4), ACS 8% (2), CYP 4% (1), E&F 4% (1) & Finance 4% (1).

Severity of complaints: 54% (13) were designated 'low' risk; 38% (9) were designated 'moderate' and 8% (2) were designated as 'high risk'. A review of the complaints due a response in December shows that 'attitude' 21% (5), 'nursing care' 17% (4) 'communication' 13% (3), and 'medical care' 13% (3) were the main issue for patients.

- In regard to 'attitude', 40% (2) complainants raised concerns about 'rudeness or disrespect', 40% (2) of the complainants were concerned about 'sharp, harsh or abrupt attitude' inappropriate behaviour' and 20% (1) complainant raised a concern about 'inappropriate behaviour'.
- In regard to 'nursing care', 50% (2) complainants felt that a 'poor standard of care' had been provided, 25% (1) complainant was concerned about 'poor pain control', and 25% (1) complainant cited 'poor practice (i.e. infection control/hygiene lapses)' as the reason.
- In regard to 'communication', 67% (2) complainants were concerned about 'inadequate communication about an operation' and 33% (1) complainant was concerned about 'poor verbal communication'.
- In regard to 'medical care' 100% (3) complainants were concerned about 'inadequate treatment' being provided.

Of the 20 complaints that have closed, (including those allocated 40 working days), 35% (7) were 'upheld', 50% (10) were 'partially upheld' and 15% (3) were 'not upheld' meaning that, currently, 85% were upheld in one form or another.

Caring Services - Commentary

PALS
During December 2018, the Trust logged 74 PALS enquiries. (There are a number of other PALS queries that have been actioned with the relevant ICSU/service but have not been logged on Datix - this is in progress to ensure they are all logged.).

34% (25) related to Emergency & Integrated Medicine, 24% (18) related to Surgery & Cancer, 22% (16) related to Acute Patient Access, Clinical Support Services and Women's Health (ACW), 11% (8) related to Adult Community Health Services and 3% (2) related to Children & Young People Services, the remainder related to other Trust service and areas.

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

39% (28) related to 'Communication' with 'clarity/confusing' and 'delay in written communication' cited as the main reasons
15% (11) related to 'Attitude' with 'rudeness' and 'inappropriate behaviour' cited as the main reasons
12% (9) related to 'Appointments' with 'long wait' and 'cancellation' cited as the main reasons.

GP concerns
During December 2018, the Trust logged 2 concerns from GP Practices relating to individual patient concerns

One of these related to 'communication' with 'no reply to telephone contact' being cited as the reason, and the other related to 'delay' with 'delay in being seen' the areas involved were District Nursing and Urology .

Compliments
During December 2018, 24 compliments were logged onto Datix.

29% (7) related to Surgery & Cancer, 25% (6) related to Emergency & Integrated Medicine, 21% (5) related to ACW, 17% (4) related to Adult Community Services, 4% (1) related to Estates & Facilities and 4% (1) related to Patient Experience.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	92.7%	92.0%	94.2%	95.8%	93.4%	94.2%	91.2%	91.5%	91.7%	93.2%	93.2%	89.6%	92.6%	
Maternity	Smoking at Delivery	<6%	3.8%	5.2%	4.5%	7.0%	5.0%	8.3%	3.7%	6.6%	7.0%	3.4%	6.1%	5.0%	5.8%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.5%	6.0%	6.3%	6.3%	6.1%	6.6%	5.9%	7.0%	5.9%	5.4%	4.9%	5.9%	6.0%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	76.1	75.7	99.6	89.6	71.0	79.4	92.2	81.0					82.4	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	87.6	77.0	110.8	93.5	59.5	80.9							77.8	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.76			0.76							0.76	
Admitted	Mortality rate per 1000 admissions in-months	14.4	9.3	10.0	10.3	7.3	7.7	6.4	5.3	4.7	5.0	5.5	6.8	8.4	6.4	
Community	IAPT Moving to Recovery	>50%	47.5%	51.4%	59.4%	56.3%	53.4%	59.0%	52.4%	55.7%	57.0%	62.5%	57.4%		56.6%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	96.0%	88.9%	90.2%	86.7%	91.4%	97.6%	95.5%	92.9%	90.9%	89.2%	82.5%	95.8%	91.4%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	91.8%	92.2%	88.2%	84.2%	91.1%	85.7%	93.8%	89.7%	90.8%	93.8%	96.1%	95.9%	90.7%	
Community	% of MSK pts with a significant improvement in function (PSFS)	>75%	89.3%	82.7%	78.1%	80.1%	74.0%	69.5%	76.5%	81.7%	68.5%	83.0%	82.6%	75.7%	77.6%	
Community	% of Podiatry pts with a significant improvement in pain (VAS)	>75%		18.9%	51.5%	77.8%	77.4%	84.8%	84.8%	90.0%	77.8%	83.7%	95.1%	81.5%	83.9%	
Community	ICTT - % Patients with self-directed goals set at Discharge	>70%	76.5%	70.4%	78.5%	73.6%	86.7%	80.2%	75.5%	70.5%	78.0%	71.2%	80.0%	75.3%	77.1%	
Community	ICTT - % GAS Scores improved or remained the same at Discharge	>70%	93.4%	96.0%	96.8%	90.6%	93.8%	93.2%	94.8%	94.5%	94.0%	89.4%	96.9%	95.3%	94.0%	
Community	REACH - % BBIC Scores improved or remained the same at Discharge	>75%				100.0%	100.0%	85.7%	57.1%	100.0%	100.0%	100.0%	100.0%	88.9%	92.4%	
Community	Nutrition and Dietetics - % Weight Loss Achieved at Discharge						100.0%	0.0%	100.0%	60.0%	66.7%	66.7%	100.0%	76.9%	72.9%	
Community	Nutrition and Dietetics - % Weight Maintained or Gained at Discharge					66.7%	100.0%	100.0%	87.5%	83.3%	80.0%	91.7%	100.0%	72.7%	85.9%	

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Effective Services - Commentary

Breastfeeding initiated

Breastfeeding initiation rate down in December 2018 to 88.8% (from 91.8% in November). Breastfeeding rates just below target for the first time in over a year. This likely due to the move to collecting all data directly on Medway. This is monitored weekly and it is expect to see an improvement in March 19.

Non-elective re-admission

Re-admission rate is just above the target of 5.5% at 5.9%, however still under the year average. Comparing year on year the re-admission rate in December 2017 was 7.3%, now significantly better at 5.9% Ongoing work is in place including Discharge to Assess and Home First to avoid patient re-attendance, and well as improvement in data quality.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	86.5%	86.1%	83.1%	86.3%	88.4%	90.6%	90.5%	90.0%	89.6%	88.2%	88.5%	85.5%	88.6%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	75	76	95	91	87	79	74	63	75	79	88	91	81	
ED	Ambulance handovers waiting more than 30 mins	0	34	37	69	22	41	16	18	9	12	18	15		151	
ED	Ambulance handovers waiting more than 60 mins	0	12	3	18	8	0	1	0	10	2	0	0		21	
ED	12 hour trolley waits in A&E	0	0	0	0	0	0	0	2	0	0	0	0	1	3	
Cancer	Cancer - 14 days to first seen	>93%	94.9%	94.2%	95.4%	94.2%	97.5%	94.4%	94.4%	93.1%	90.1%	89.6%	93.7%		93.5%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	97.9%	95.0%	97.0%	97.6%	96.3%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%		99.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	87.2%	90.7%	84.8%	75.5%	86.5%	82.9%	94.2%	86.2%	83.1%	93.3%		85.5%	
Cancer	Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%									89.5%	81.4%	93.3%		87.6%	
Cancer	Cancer ITT - % of Pathways sent before 38 Days	>85%									62.5%	60.0%	81.8%		70.8%	
Cancer	Cancer - % Pathways received a Diagnosis within 28 Days of Referral					65.2%	61.9%	50.0%	93.0%	93.0%	80.4%	83.6%	86.1%		83.9%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%	100.0%											
Cancer	Cancer - 62 Day Screening	>90%							100.0%	100.0%		100.0%	75.0%		83.3%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.1%	99.2%	99.1%	99.0%	99.0%	99.1%	97.7%	99.0%	99.1%	99.1%	99.0%	98.9%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	1	1	0	2	
Access	RTT - Incomplete Waiters Backlog at Month End	16227	15224	15648	16227	16158	16502	16716	16567	16363	16260	16232	16202	16042	147042	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

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

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3		
Indicator	17_18 Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	2018-2019	Performance
Breast	>93%	98.8%	95.1%	95.4%	97.8%	98.7%	97.3%	98.2%	97.5%	96.4%	94.0%	97.3%		97.2%	
Childrens	>93%	100.0%	100.0%		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	96.2%	98.5%	94.4%	89.9%	97.7%	100.0%	100.0%	98.0%	97.4%	95.6%	96.4%		96.9%	
Haematological	>93%	100.0%	50.0%	83.3%	100.0%	70.0%	91.7%	11.1%	37.5%	62.5%	92.9%	91.7%		72.5%	
Lower Gastrointestinal	>93%	87.2%	90.7%	91.8%	92.5%	96.6%	96.5%	87.2%	88.2%	82.4%	73.0%	87.3%		88.6%	
Lung	>93%	96.2%	95.2%	94.1%	100.0%	100.0%	92.9%	92.0%	100.0%	90.0%	80.0%	100.0%		94.6%	
Other	>93%														
Skin	>93%	98.0%	98.6%	99.3%	97.4%	97.8%	94.6%	99.5%	98.8%	97.4%	98.0%	97.5%		97.7%	
Upper Gastrointestinal	>93%	73.5%	80.8%	98.3%	81.8%	97.6%	78.3%	72.4%	55.0%	20.6%	59.6%	89.2%		69.4%	
Urological	>93%	98.9%	97.3%	95.5%	93.6%	98.0%	89.0%	89.8%	94.7%	97.4%	97.9%	86.4%		93.4%	

Responsive Services - Commentary

ED

Overall performance against the 95% 4 hour standard for December 2018 was 85.5%. Attendance numbers were high at 9,219 (on average 297 per day). The 'minors' performance delivered 97.6% and Paediatrics delivered at 97% in December. The median wait for treatment did increase in December to 91 minutes against a national standard of 60 minutes. Ambulance activity has also continued to increase and there was 1,957 ambulance arrivals in December which is 7% increase from December 2017. Performance against ambulance handover targets has remained good with 98.7% of patients 'offloaded' within 30 minutes of arrival to hospital.

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

There was one 12 hour trolley breach in December. This was a mental health patient and there was a delay in transfer to an appropriate mental health bed. Lessons have been learnt around early escalation. Camden and Islington NHS FT lead on the 72 hour report.

Actions:

ECIST attended the Emergency department to observe the front of house (first 60 minutes) work in particular. Their recommendations include:

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

Work is ongoing in the department to ensure the above points are actioned throughout Q4 with the aim of improving performance against the 4 hour target and patient experience.

Cancer

Overall Cancer targets achieved.

Community Average Waits

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen
ACS	Bladder and Bowel - Children	>95%	12	45.50%	90.50%	81.30%	9.2	16	>95%						0
ACS	Community Matron	>95%	6	96.40%	96.60%	97.10%	0.9	34	>95%	2			100.00%	0	1
ACS	Adult Wheelchair Service	>95%	8	95.00%	91.70%	86.70%	4.9	30	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	92.90%	95.10%	96.40%	3.2	56	>95%	2	60.00%	69.00%	53.80%	2.6	26
ACS	ICTT - Other	>95%	12	92.80%	92.00%	84.10%	5.5	232	>95%	2	78.30%	65.20%	70.90%	1.5	55
ACS	ICTT - Stroke and Neuro	>95%	12	93.20%	85.40%	74.20%	7.1	31	>95%	2	73.90%	73.70%	76.50%	1.6	34
ACS	Intermediate Care (REACH)	>95%	6	90.20%	80.90%	81.60%	3.3	103	>95%	2	84.30%	82.20%	93.20%	0.7	44
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	4.7	6	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	47.60%	43.20%	47.60%	17.7	126	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	69.90%	59.70%	63.50%	5.3	502	>95%			66.70%	0.00%	2.4	1
ACS	Musculoskeletal Service - Routine	>95%	6	72.90%	69.80%	71.80%	4.8	1416	>95%	2	33.30%	100.00%			0
ACS	Nutrition and Dietetics	>95%	6	90.10%	94.20%	100.00%	2.6	176	>95%	2	100.00%	100.00%			0
ACS	Podiatry (Foot Health)	>95%	6	83.40%	87.60%	84.80%	4.1	539	>95%	2		100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.6	14	>95%						0
ACS	Tissue Viability	>95%	6	93.00%	100.00%	94.60%	1.3	56	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.5	22	>95%	2	83.30%	100.00%	85.70%	1	7
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.9	74	>95%	2			100.00%	2	1
EIM	Respiratory Service	>95%	6	100.00%	100.00%	97.90%	1.9	48	>95%	2	100.00%	100.00%	100.00%	0.6	1
EIM	Spirometry Service	>95%	6	76.10%	84.80%	76.50%	5.5	34	>95%	2					0

Date & time of production: 24/01/2019 10:03

Haringey Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen
ACS	Speech and Language Therapy	>95%	6	32.10%	39.40%	34.90%	10.5	43	>95%	2	100.00%		0.00%	13.1	1
ACS	Bladder and Bowel - Children	>95%	12					0	>95%						0
ACS	Community Matron	>95%	6	100.00%	92.30%	100.00%	0.5	6	>95%	2					0
ACS	Adult Wheelchair Service	>95%	8	94.90%	91.70%	86.20%	5.1	29	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	100.00%		100.00%	2	1	>95%	2	100.00%	0.00%	0.00%	2.4	1
ACS	ICTT - Other	>95%	12	92.30%	91.30%	84.00%	5.6	212	>95%	2	78.60%	66.30%	71.20%	1.5	52
ACS	ICTT - Stroke and Neuro	>95%	12	93.00%	87.00%	75.90%	7	29	>95%	2	72.70%	75.70%	78.60%	1.6	28
ACS	Intermediate Care (REACH)	>95%	6	100.00%	100.00%	100.00%	3	3	>95%	2	100.00%				0
ACS	Paediatric Wheelchair Service	>95%	8	100.00%	100.00%	100.00%	4.7	6	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	41.20%	40.00%	43.80%	19	48	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	73.20%	61.00%	61.60%	5.6	284	>95%			50.00%			0
ACS	Musculoskeletal Service - Routine	>95%	6	78.10%	68.70%	70.10%	4.8	723	>95%	2		100.00%			0
ACS	Nutrition and Dietetics	>95%	6	89.90%	97.00%	100.00%	2.6	115	>95%	2					0
ACS	Podiatry (Foot Health)	>95%	6	80.70%	85.70%	82.50%	4.1	275	>95%	2		100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.3	6	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	100.00%	100.00%	1.2	18	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	2.9	14	>95%	2	100.00%	100.00%	0.00%	2.4	1
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	2.2	44	>95%	2			100.00%	2	1
EIM	Respiratory Service	>95%	6	100.00%	100.00%	96.30%	2	27	>95%	2		100.00%			0
EIM	Spirometry Service	>95%	6	75.60%	84.80%	75.80%	5.5	33	>95%	2					0

Date & time of production: 24/01/2019 10:03

Islington Adult Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
ICSU	Service	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen	% Target	Target Weeks	Oct-18	Nov-18	Dec-18	Avg Wait (Dec-18)	No of Pts First Seen
ACS	Speech and Language Therapy	>95%	6	44.60%	59.40%	66.70%	7.6	45	>95%	2					0
ACS	Bladder and Bowel - Children	>95%	12	20.00%	90.00%	85.70%	8.9	7	>95%						0
ACS	Community Matron	>95%	6	95.30%	97.60%	96.30%	0.9	27	>95%	2			100.00%	0	1
ACS	Adult Wheelchair Service	>95%	8					0	>95%	2					0
ACS	Community Rehabilitation (CRT)	>95%	12	92.50%	95.00%	96.10%	3.3	51	>95%	2	58.80%	69.40%	56.00%	2.6	25
ACS	ICTT - Other	>95%	12	100.00%	100.00%	71.40%	5.8	7	>95%	2	0.00%	33.30%			0
ACS	ICTT - Stroke and Neuro	>95%	12			100.00%	3.3	1	>95%	2	100.00%	0.00%		2.1	5
ACS	Intermediate Care (REACH)	>95%	6	90.40%	81.00%	80.40%	3.4	97	>95%	2	83.10%	81.20%	93.20%	0.7	44
ACS	Paediatric Wheelchair Service	>95%	8					0	>95%						0
ACS	Bladder and Bowel - Adult	>95%	12	55.40%	58.30%	62.50%	15.7	48	>95%						0
ACS	Musculoskeletal Service - CATS	>95%	6	65.20%	57.80%	65.90%	5	214	>95%			100.00%	0.00%	2.4	1
ACS	Musculoskeletal Service - Routine	>95%	6	66.90%	69.80%	76.60%	4.6	593	>95%	2	50.00%				0
ACS	Nutrition and Dietetics	>95%	6	92.90%	96.00%	100.00%	2.6	57	>95%	2	100.00%				0
ACS	Podiatry (Foot Health)	>95%	6	86.20%	89.40%	87.30%	4.2	260	>95%	2		100.00%			0
ACS	Lymphodema Care	>95%	6	100.00%	100.00%	100.00%	1.8	8	>95%						0
EIM	Tissue Viability	>95%	6	100.00%	100.00%	94.70%	1.3	19	>95%						0
EIM	Cardiology Service	>95%	6	100.00%	100.00%	100.00%	1.8	8	>95%	2	80.00%	100.00%	100.00%	0.8	6
EIM	Diabetes Service	>95%	6	100.00%	100.00%	100.00%	1.5	30	>95%	2					0
EIM	Respiratory Service	>95%	6	100.00%	100.00%	100.00%	1.8	21	>95%	2	100.00%	100.00%	100.00%	0.6	1
EIM	Spirometry Service	>95%	6					0	>95%	2					0

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Children's Community Waits Performance

		Routine Referral Urgency							Urgent Referral Urgency						
Service	Team Group	% Target	Target Weeks	Oct-18	Nov-18	Dec-19	Average Wait (Dec)	No. of Initial Contacts (Dec)	% Target	Target Weeks	Oct-18	Nov-18	Dec-19	Average Wait (Dec)	No. of Initial Contacts (Dec)
CAMHS	CAMHS Core - Islington	>95%	8	54.00%	64.10%	70.30%	5.5	118	>95%	2	100.00%	76.90%	100.00%	0.8	13
	CAMHS NDT / ADHD - Islington	>95%	8	8.30%	15.80%	20.00%	20.9	5	>95%	2					0
	CAMHS Schools - Islington	>95%	8	81.30%	91.20%	95.00%	4.2	20	>95%	2					0
Community Children's Nursing	Community Children's Nursing - Haringey	>95%	2	100.00%	100.00%	33.30%	5.5	3	>95%	1					0
	Community Children's Nursing - Islington	>95%	2	86.80%	95.80%	85.90%	1	71	>95%	1	100.00%		100.00%	0.1	4
Community Paediatrics Services	Community Paediatrics - Haringey (SCC)	>95%	12	0.00%	0.00%	0.00%	70.4	4	>95%	1	0.00%	0.00%	0.00%	23.9	8
	Community Paediatrics - Haringey (NDC)	>95%	12	83.30%	100.00%	100.00%	0.9	1	>95%	1	0.00%	0.00%	0.00%	11.9	16
	Community Paediatrics - Haringey (Child Protection)	>95%	12	100.00%	100.00%	100.00%	1	21	>95%	1	100.00%	0.00%			0
	Community Paediatrics - Haringey (Other)	>95%	12	100.00%	100.00%	85.70%	3.5	7	>95%	1	25.00%				0
	Community Paediatrics - Islington	>95%	12	51.40%	37.50%	45.80%	12	24	>95%	1	100.00%	100.00%	100.00%	0.3	12
Family Nurse Partnership	Family Nurse Partnership - Haringey	>95%	12	66.70%	100.00%	83.30%	4.9	6	>95%						0
	Family Nurse Partnership - Islington	>95%	12	33.30%	100.00%	60.00%	8.1	5	>95%						0
Haematology Service	Haematology Service - Islington	>95%	12	100.00%	100.00%	100.00%	0.4	12	>95%						0
IANDS	IANDS	>95%	8	64.30%	15.40%	57.10%	6.3	7	>95%				100.00%	1	1
	IANDS - SCT	>95%	20	75.00%	41.70%	12.50%	21.2	8	>95%						0
Looked After Children	Looked After Children - Haringey	>95%	4	82.40%	88.90%	100.00%	2.1	11	>95%						0
	Looked After Children - Islington	>95%	4	78.60%	87.50%	92.30%	2.5	13	>95%						0
Occupational Therapy	Occupational Therapy - Haringey	>95%	8	43.50%	50.00%	28.60%	15.1	14	>95%	2	0.00%				0
	Occupational Therapy - Islington	>95%	8	100.00%	70.00%	83.30%	4.5	12	>95%	2		0.00%			0
Child Development Services	Paediatrics Nutrition and Dietetics - Haringey	>95%	8	75.00%	87.50%	100.00%	1.5	5	>95%						0
	Paediatrics Nutrition and Dietetics - Islington	>95%	8	66.70%	64.30%	100.00%	4.8	3	>95%						0
Physiotherapy	Physiotherapy - Haringey	>95%	8	63.00%	56.50%	68.20%	6.4	22	>95%						0
	Physiotherapy - Islington	>95%	8	80.40%	93.10%	96.20%	3.3	52	>95%						0
PIPS	PIPS	>95%	12	100.00%	100.00%	100.00%	2.8	8	>95%						0
Speech and Language Therapy	SALT - Haringey	>95%	6	35.20%	39.80%	33.30%	11.6	45	>95%	2	100.00%		0.00%	13.1	1
	SALT - Islington	>95%	6	38.10%	55.20%	61.50%	6.1	39	>95%	2					0
	SALT - MPC	>95%	18	92.30%	80.00%	72.70%	11.6	22	>95%	2					0
School Nursing	School Nursing - Haringey	>95%	12	85.40%	87.30%	90.20%	4.7	61	>95%						0
	School Nursing - Islington	>95%	12	79.30%	89.50%	100.00%	3.2	10	>95%						0

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Responsive Services - Commentary

Adult Community Waiting times

Service	Summary of improvement work undertaken during December 2018. Was CSIG Waiting Time Improvement Target / Was Trust Board KPI met? If not, please give reasons.	Mitigating actions being taken (if target was not met)	What improvement measures are planned for the next 3 months? Expected date for target to be achieved.
Bladder and Bowel	• CSIG target of 75% for December with respect to waiting times for routine appointments, not met. • 53.1% of patients received routine appointment in 6 weeks during November. This represents an improvement of 4.6% since November. • The fragility of the service has been recognised and proposals are being developed alongside improvement work, to develop a new integrated pathway.	• Process mapping sessions, which were held on 7 and 14 December, these looked at the current patient pathways for paediatric and adult, community and hospital based continence services. • Regular monitoring of the Patient Tracker List (PTL). • The service has written to patients on referral list informing of current waiting times and advising they will contacted when appointments become available *(this approach was suggested by patients through feedback).*	• Proposals for a new integrated Continence pathway, with a single point of access are also being developed. • A co-design session, building on the process mapping session held in December, is being held on 30 January. This session will bring together staff from Whittington Health, the Clinical Commissioning Groups (CCGs) and service users, to think about the development of a new continence pathway. • Camden's withdrawal will mean that clinic time for patients from Haringey and Islington can be increased. This will mean that patients are seen more quickly.
Nutrition and Dietetics	• The service achieved 100% of patients being seen within the 6 week target time for routine appointments in December. • The CSIG target of 95% was exceeded. • Average waiting time for routine appointments in December was 2.6 weeks.	• Not applicable – target met.	• The following measures continue to be undertaken on a weekly basis: • Clinical diary management to ensure all appointment slots are utilised. • Checks by administration team to ensure that opt in letters sent in a timely manner (noticing delays of up to 2 weeks). Housebound patients have appointments booked within 6 weeks. • Triage undertaken on a daily basis with minimal delay.

Lymphedema	• CSIG target of 95% with respect to waiting times for routine appointments was exceeded in December, with 100% being achieved.	• Not applicable – target met.	• Continuing with current measures of bringing new referrals forward into cancellation slots where possible. • Continued flexible working between Islington and Haringey sites to respond to any increases in referrals for each area, rather than specific fixed clinic dates for each area regardless of demand.
Podiatry	• The service achieved 84.6% with respect to waiting times for routine appointments. • CSIG target of 95% for November, with respect to waiting times for routine appointments, was not met. • Blitz clinics for new patients were run in December in order to maintain capacity through the holidays. • DNA *('did not attend')* rates for December, have been reviewed and by the service manager. Approximately 18% of these were for new patients and this has impacted on the service's ability to reach the 95% target time for routine appointments. • The service manager has reviewed demand and capacity within the service; the mean capacity available is greater than the mean number of referrals received. • Issues with respect to the issuing of opt in and appointment letters being received late and a six week gap from transfer to the issuing of appointment letters have been identified by the service manager. • This has resulted in patients missing appointments. These issues are being investigated by the Central Bookings Team.	• Extra capacity is being created in January to mitigate against the number of appointments lost through DNAs. • Additional capacity also will be provided through a new Band 6 Podiatrist and the overbooking of sessions, where possible, during January and February. • A request has been made to the Information Team for a report to capture number of patients, booked within six weeks of receipt of referral, who DNA/cancelled their appointment resulting in lost activity. • It is essential that the Central Bookings Team is working at an optimal level, in order to ensure there are no unnecessary delays in the new patient referral pathway.	• If the extra capacity measures described in the previous column are successful, the services manager anticipates that 90% could be achieved in January; however, this is also partly reliant on DNAs not increasing and issues with respect to delayed appointment letters being resolved. • The service is optimistic that 95% of routine appointments can be made within the target time of six weeks, in February, once the measures above are embedded.

Diabetes	• The service achieved 100% with respect to achieving the target waiting time of six weeks for routine appointments. • This is the third month that the service has achieved 100% and exceeded its CSIG target.	• Not applicable. Target met.	• To consolidate and maintain 100% waiting times target. • Embedding triaging within 24 hours of getting GP referrals. • To ensure all patients are seen within 2-3 weeks after GP referral. • To ensure all face to face appointments are recorded appropriately and telephone clinical advice before first appointment for a new patient is recorded as 1st telephone consultation achieve.
Respiratory	• CSIG target of 95% for December, with respect to waiting time target for routine appointments, was exceeded with 97.9% achieved for routine appointments. • The service has consistently made an Improvement in waiting times for routine appointments since September 2018. • *(See separate commentary for Spirometry).*	• Not applicable - target met.	• Daily triaging of new referrals. Patients contacted the same or following day on receipt of referral to discuss referral and accepted/discharged as necessary. • If criteria met next appointment offered where waiting times are lowest. • All patients booked at any venue with capacity to be seen within 6 weeks regardless of where the exercise venue is. • Patients who cannot commit programme, but would like to attend in the next 3 months now discharged and can self-refer by contacting the service when ready to start. • If unable to contact patient the referral is discharged but to ease the workload of asking GP to refer back, a letter is sent to both the GP/Referrer and patient offering a self-referral if contacts with in next 3 months • Ad hoc clinic appointments can be added throughout week if there is capacity at any of the sites, which does not clash with another service.
Spirometry	• The service achieved 75.8% with respect to waiting time target for routine appointments. • CSIG target of 95% with respect to waiting times for	• Patients returning phone calls post CUBY several weeks after discharge. The admin team is then reversing the referral multiple reasons, (most often exacerbation or not well enough to attend).	• Monitoring output of LTC admin and action plan being complied. • Weekly review of Patient Tracker List (PTL).

	routine appointments, during December was not achieved. • Winter period/flu season- our patient cohort most affected at this time of year and the service expects to see missed appointments and/or DNAs.	• All urgent referrals now removed and no longer being incorrectly sent to CRAT. • The service continues to triage 3 days per week so that CUBY letters can be sent by admin for the patient to book appointments quickly. LTC admin has dedicated time for respiratory so that CUBYs are discharged at the correct time avoiding long waits building up in the PTL.	• Continuing to ensure triaging is undertaken three days per week. • Explore potential automated SMS from RiO - liaise with RiO.
REACH	• CSIG target of 85% for routine appointments was not met in December. The service achieved 81% for routine appointments during December. • The physiotherapy team is currently operating at 50% reduced capacity due to vacant posts and delays in recruitment. This has impacted on the service's ability to meet the CSIG target this month. • In total 18 patients not being seen with the target time for routine appointments during December.	• Measures and an action plan to improve performance with respect to target times for urgent appointments are being developed. • With regard to recruitment issues; a new Band 6 physiotherapist started on 2 January and a part time, temporary, Band 5 physiotherapist will start on 14 January. • Speech and Language Therapy (SLT) – Band 6 locum started on 7 January, using winter pressures funding, this post is focusing on supporting hospital discharges/urgent referrals. • Band 6 SLT post recruited to; however, they cannot start until March due to the notice period they are required give.	• With respect to SLT – REACH service lead meeting with C&I service manager and SLT leads on 24 January to map current SLT provision for patients with dementia. • Testing new diary templates in January to create more capacity in team • Working with acute SLT lead to streamline clinical pathway for VF clinics and provision of LSVT programmes • On track to meet CSIG target of 95% with respect to routine appointments by March 2019.
MSK CATS **Physiotherapy**	• CSIG target of 95% with respect to waiting times for routine appointments was not met in December. • 63.4 % MSK CATS patients were seen within the target waiting for routine appointments, of 6 weeks. There has been a 3.4% improvement on last month. • An increase in overall referral rates from practices (i.e. those not in the SPOA pilot, where an increase in referral rates was anticipated), has impacted on waiting times and this was not anticipated.	• New APPs starting between September 2018 and January 2019 linked with SPOA funding have improved capacity. • One extra APP post is being established to provide additional capacity and to address the increased referral rate not anticipated in non-pilot practices over the last year. The service will recruit to this new within four months. • From 7 November APPs in the MSK CATS service are working additional bank shifts (using vacant	• As described under mitigating actions. • Recruiting additional APP to the CATS service. • Continue to maximise capacity using current staff and working overtime. • Expected to continue to improve our target of 6 week wait in January with new starters all fully inducted and at full capacity. • Substantive staff working bank hours to maintain

	• Since the SPOA pilot began, the number of referrals received has increased by approximately 200 per month in comparison with the 2016/17 baseline data.	post money) to create additional capacity and to ensure triaging is undertaken on a daily basis. • Extra administrative support from bank is also being provided to ensure no unnecessary delays linked to triage and allocation of patients to the correct service are avoided. • Process review of the administration of referrals starting from 02 January is reducing the time taken from receiving referrals to allocation to correct service.	triage and increase clinical activity levels. • Plan to achieve 70% of patients seen within 6 weeks by end of January with further improvements in subsequent months.
Routine **MSK Physiotherapy**	• CSIG target of 95% with respect to waiting times for routine appointments was not met for December. • 71.8% of patients in MSK routine physiotherapy were seen within the 6 week waiting time for routine appointments. There was a 1.6% improvement on the last month. • There has been a 15% increase in referral rates to MSK physiotherapy in last three months, compared to data for the same period in the last two years. Again, there has been a greater referral rate than anticipated from SPOA pilot, in addition to the increase anticipated as a result of the pilot.	• Support with central booking administration and additional admin staff to ensure booking to maximum capacity each day. • Agency physiotherapy staff are being used to cover vacancies while recruitment is underway. MSK SPOA pilot funding to provide additional capacity. • Improved efficiency is being achieved by filling all available diary gaps. The service manager is also undertaking robust daily checks to ensure that there are no delays with triage and allocation of patients to the correct service. • Improved timing of triage and service allocation to prevent unnecessary delays – supported by bank B2 admin role and review of processing to improve efficiency of administration processes • Moving staff locations to ensure staffing levels at each site reflects the demand for appointments at these sites. • Bank b2 administrative support is being used to	• As described under mitigating actions. • Improve efficiency of triage and allocation to correct service, with close monitoring on daily basis and liaison with central booking. • Continue to fill available gaps in diaries; with dedicated admin time to call patients and fill these even at short notice and this has improved over the l4 weeks. • Working closely with central booking service with regular meetings to improve efficiencies in management of referrals prior to booking initial appointments • Staff moving sites over next few weeks as current diary bookings allow. • The service anticipates that 75% of patients seen within 6 weeks by end of January.

		support prompt booking of appointments. • Telephone appointments offered to the longest waiting patients to ensure that they receive useful advice and guidance prior to attending clinic.	
ICTT –Stroke /Neuro **ICTT- Other**	CSIG targets of 95% for Routine appointments not met for both services in December 2018. Performance for ICTT stroke/Neuro was – 75% .Down from 85.1% of the previous month. Variance -10.1 % ICTT other was -84.1% down from 91.7 % in November. Variance of -7.6% Reason: -Number of working days down by three compared to the previous month. 19 days in December compared with 22 days of November -Team capacity was reduced: SLT team was running at 30% capacity due to maternity leave and unplanned absence of bank staff covering secondment. Physiotherapy Staff: Unplanned absences and vacancies Occupational Therapy: Was down to 66% of the normal capacity due to vacancy and temporary staff absence. Admin staff: Down 50% due to vacancy. This affected the management of bookings and waiting list.	Working with recruitment team to complete recruitment into vacant permanent posts. B5 Physiotherapist started 2nd January OT stroke recruitment on track Recruitment of Temporary bank staff to cover SLT vacancy. Start date 28th January. Admin recruitment now completed and staff to start mid-February. This will improve number of bookings and management of booking into slots. It will also free up clinical staff time from the task. Patient tracking list to be monitored closely.	-Weekly monitoring of the Patient tracking list (PTL) to avoid 12 week breaches. -Work with podiatry lead to trial the demand and capacity tool to give a clear understanding of the true capacity of the team. -Creation of extra new patient slots to clear waiting list. -Complete recruitment into permanent and temporary (FTC) posts. - with all measures put in, it is expected that routine targets will reach 90% and over and more improvement is expected by the end of March

Children Services Waiting times

Service	Summary of improvement work undertaken during October2018. Was CSIG Waiting Time Improvement Target / Was Trust Board KPI met? If not, please give reasons.	Mitigating actions being taken (if target was not met)	What improvement measures are planned for the next 3 months? Expected date for target to be achieved.
CYP Continence	• CSIG target of % for December with respect to waiting times for routine appointments, not met. • 85.7% of patients received routine appointment in 6 weeks during December. This represents a slight decrease of 4.3% since November. • The fragility of the service has been recognised and proposals are being developed alongside improvement work, to develop a new integrated pathway.	• Process mapping sessions, which were held on 7 and 14 December, looked at the current patient pathways for paediatric and adult, community and hospital based continence services. • Regular monitoring of the Patient Tracker List (PTL). • The service has written to patients on referral list informing of current waiting times and advising they will contacted when appointments become available *(this approach was suggested by patients through feedback).*	• Proposals for a new integrated Continence pathway, with a single point of access are also being developed. • A co-design session, building on the process mapping session held in December, is being held on 30 January. This session will bring together staff from Whittington Health, the Clinical Commissioning Groups (CCGs) and service users, to think about the development of a new continence pathway. • Camden's withdrawal will mean that clinic time for patients from Haringey and Islington can be increased. This will mean that patients are seen more quickly.
CAMHS (Islington)	• Additional 10 choice appointments per week to reduce the backlog of initial assessments. Agency staff recruited to start 22nd of November until March 2019 (Locum Consultant Psychiatrist). • The increase in initial assessments has created an increase in wait times for treatment pathway appointments. Some capacity lost through removal of the transformation funding. We will need to realign the substantive capacity following the re-structuring and consultation to address the wait times. Agency spend can be re-directed to pathway work once initial assessments are addressed. • Implementation of SPA underway. Scheduled to launch June 2019. Agreed that CAMHS CWP team will be located in this team, to support CAMHS Intake team and provide interventions for mild-moderate	• Implementation over next period of improvement work already noted • Trust continues to meet monthly with commissioners as part of Contract Performance Notice process, which oversees a range of more detailed service level actions • Agreement with commissioners that current waiting time will not be met sustainably once short-term capacity is withdrawn and in the absence of SPA which is key to controlling demand for Tier 2 CAMHS services • SPA is planned for implementation in June 2019 • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations CYP.	• Agency staffing in place to support reduction of historic backlog of choice appointments (anticipate that this will be cleared by mid-January 2019) • Realigned substantive capacity and redirect agency capacity as required to manage expected demand for treatment pathway appointments, to keep this within an acceptable waiting timeframe prior to SPA implementation • Finally, the ICSU will be recruiting an Associate Director of CAMHS / Mental Health who will oversee the improvements in the longer term, anticipated completion of recruitment, February 2019 • Continue monthly CYP Waiting Time Improvement meeting and monitor performance

	presentations. • Recruitment: Shortlisted for key vacancy in Consultant Psychiatry/Clinical Lead post		
Community Children's Nursing (Haringey & Islington)	**Haringey** • Significant dipped from 100% to 33.3% **Islington** • Decrease from 96.1% to 85.9%	• Performance for both Haringey and Islington below target • CCN Life Force – one of patients passed away as work needed to be done in organising equipment to be collected from home and this affects referrals not being picked up on time • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations for CYP.	• Merging stand-alone nursing service with wider team – February 2019 (awaiting confirmation from commissioner) • Continuation of Data Quality improvement support – February 2019 • Continue monthly CYP Waiting Time Improvement meeting and monitor performance
Community Paediatrics Service	**Haringey:** • Social Communication – continues to be the area of concern as consultant led assessment of ASD for all CYP up to the age of 12 • Project commenced looking at moving to a therapy led assessment model for 0-5's and suggestion to commissioner that 5-12's move to a CAMHS led model (included in Provider Intentions Letter) • Waiting Time will remain 52w+ until the review and new model is agreed and historic backlog cleared • Neuro-developmental – waiting time impacted by long-term sickness of substantive consultant, currently being covered by remaining establishment • Phased return for sick Consultant NDC **Islington:** • Following historic issues around data entry and management of clinical systems, the service is now working with newly appointed Project	**Haringey:** • Target achieved for NDC and Child Protection, 100% • Completion of ASD assessment model project • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager • Explore Streamline Admin Process with Service Managers and Project Manager i.e. process mapping of referral's journey **Islington:** • Islington Target increased form 33% to 45% • Improvements in data quality processes as part of new project • Re-assessing demand and capacity when new consultant comes into post • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager • Fortnightly appointment meetings with Admin	• Completion of ASD assessment model project – February 2019 (benefits not expected for 12 months) • Commencing new project which will implement a range of UCLP recommendations – led by newly appointed Project Manager – March 2019 • Improvements in data quality processes as part of new project in both Haringey and Islington as part of project above – March 2019 • Re-assessing demand and capacity when new consultant comes into post in Islington – March 2019 • Reduction in waiting times reductions improvement within 3- 4 months • Streamlined admin processes will be measured by clinic data outcomes 3- 4 months improvement - March 2019 • Continue monthly CYP Waiting Time Improvement meeting and monitor performance

	Manager to improve data quality • Long-term consultant vacancy now recruited into	team and disseminating to clinical lead demand and capacity issues • Exploration into Admin referral processes and capacity issues with Service Managers and Project Managers • Deputy Service Manager to attend NHS improvement Course Breach and root cause analysis RTT, demand and Capacity duration 3 Months for six sessions • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations CYP	
Family Nurse Partnership (Haringey & Islington)	**Islington:** • Performance dropped from 100% to 60.0% • The nature of the service which deals specifically with young vulnerable and hard to reach families means that engagement can take significant time from the start to the face to face contact which impacts on the data presented. • The team is fully staffed but is managing planned long term sick leave of one full time nurse and the additional work of supporting clients during the decommissioning of the Camden service as both practitioners have now left. • There is a work plan in place. **Haringey:** • Decline in performance from 100% to 83.3% • Face to Face first appointment often takes a period of time as FNP clients are pregnant teenagers with often chaotic lifestyles and suspicious of authority . Family Nurse is tenacious in engaging them in the programme. • This is a team of 4 Nurses - One nurse has gone on maternity leave and her cases had to be transferred to the existing family nurses. Unable to allocate new cases until new nurse comes into post so clients will remain on waiting list.	**Islington:** • Work plan in place to address staffing level **Haringey:** • New Nurse appointed and joins team in February 2019	**Islington:** • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations CYP **Haringey:** • New nurse builds cases incrementally as she has to train to be a family nurse, improvement will then take place. • Cases being reviewed with a possibility of graduating families earlier from the programme if appropriate; This will have an impact on releasing capacity

Haematology Service (Islington)	• The target is achieved for December 2018, 100%	• The target is achieved for this month December, 100%	• Monitor and review next month
IANDS (Islington)	• Service has achieved the 20 week waiting time target for social communication assessment in under 5s. • The model we presented was based on 12 new referrals a month; this however has increased to 16 over the last 4 months, so there is an increase in pressure to maintain this target. • There have been improvements in terms of staffing with one member of staff is back at work from LTS • In SCT, the average wait for assessment for children from October to November remains the same at 22 weeks. • Waiting times in SCT are due to increase - there is a steady increase of referrals, CCG funded post coming to an end and gaps is SLT time due to staffing changes within the service	• Service and commissioners continue to meet regularly to review impact of additional resource reduction, anticipated to feature in contract discussions for 2019/20 • Implementation of a new model to streamline assessment and diagnostic pathway is underway	• We will monitor the impact of the implementation of new service model, which will continue to be reviewed over the next 3-6 months with commissioners at on-going engagement meetings • Local data quality meeting i.e. Rio/data entry took place January 9, 2019, actions to be implemented especially around access, data entry and Rio SOP • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations CYP.
Looked After Children (Haringey & Islington)	**Islington:** • Slight decrease from 80.0% to 90.9% **Haringey:** • The target is back to 100%	Both boroughs continue to be challenged by the pitfalls of predominantly being an outreach service; there are often peaks and troughs throughout the year which invariably can be out of the control of the service.	• Monitor and review next month
Occupational Therapy (Haringey and Islington)	**Haringey:** • Still underperforming against the target wait • Only 25% of children seen in under 8 weeks • Most children are seen within 18 weeks which is the agreed target week within the service specification • Data has to be adjusted in Qlikview to reflect true value of team's productivity. **Islington:** • Dipped from 76.5% to 80.0%	**Haringey:** • Haringey Therapy Review, which is nearing completion with short report to CSIG in January 2019. • Average waits are reducing due to full staffing and review of systems **Islington:** • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of	**Haringey:** • Staffing level continues to drive improved performance. • Involvement in data entry improvement to enable all data to be captured effectively. **Islington:** • Improvement of data entry (local service) and follow up meeting with the Rio team to recommend changes **Haringey and Islington:** Local data quality meeting i.e. Rio/data entry took place January 9, 2019, actions to be implemented especially around access, data entry and Rio

		Operation CYP.	SOP
Paediatrics Nutrition and Dietetics (Haringey and Islington)	• Both boroughs have reached 100% target for the month of December 2018. Significant improvement from 85.7% (Haringey) and 64.3% (Islington)	• The target is achieved for this month, 100%	• Monitor and review next month
Physiotherapy (Haringey and Islington)	**Haringey and Islington:** • Islington performance continues to improve and now at 96.1% which is within the target • Haringey service at 68.2% with slight increase from previous month which was 57.1%. Most services achieving an 8 week target and all children seen within 15 weeks. Those waiting longer are children in early years where there is current vacancy. • Fully engaged in Therapy Review and have now established a stand-alone MSK service for those children who require urgent physio services which continues to achieve a 6 week wait • However, mainstream physio service still has vacancies, which are presently being covered by agency	• Completion of Haringey Therapy Review, due to be presented at CSIG in January • Discussions with commissioners around continued development of Haringey MSK services • Continued use of agency and aiming to recruit to vacancy • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operation CYP.	• Implementation of new model of physiotherapy and MSK service will be undertaken over the next 3-6 months in line with review recommendations • Consideration for Band 6 physiotherapy rotation across Whittington Health with adults and children's service to support recruitment and retention • Further development of student programme across CYP services
PIPS (Haringey)	• The target is achieved for this month, 100% • Waiting for new psychologists to join in the new year which will bring more capacity to increase our new referrals	• The target is achieved for this month, 100%	• Monitor and Review Next Month
School Nursing (Haringey and Islington)	**Haringey:** • The target slightly improved from 87.0% to 89.1%. target • In addition, long term substantive vacancies have now been appointed into for Band 5, Band 7 and Team Leader positions • Agency staff in situ to help with capacity • Enuresis clinic has been a custom and practice service for SN for years, but it is not a commissioned service and there is no local KPI targets - this has an impact on	• Both boroughs will see improvements in performance when recruitment pipelines are completed and data quality processes are improved • Recruitment: 2 new Band 5s community nurses joined team and a Band 7 appointed to start in February 2019 • Haringey wide review of bowel and bladder services (Enuresis clinic is part of the review) • Highlighted need and gap to commissioners • Data quality issues have been identified and the	• Review of all roles if unsuccessful in further recruitment efforts & consider introduction of Band 4 community nursery nurses to support primary school provision. • Consideration of international students (in discussion with recruitment team) • As above and in addition continued work with recruitment team e.g. SN will feature in a recruitment

	the waiting list due to a reduced clinic to one nurse to accommodate Enuresis clinic - if Enuresis provision in SN Haringey is stopped, there would be a gap for the families who use and value the clinic. **Islington:** • Target met from 89.2% to 100% this is due to recruitment issues managed with both bank and agency staff. • Review of internal structures ongoing as team and service redesigned to support embedding changes agreed. • Ongoing issues with finance process and recruitment process has meant the loss of those verbally offered place at interviews.	service is now working with newly appointed Project Manager	video • Performance expected to be at 95% by February 2019 (dependant on outcome of the review)
SALT (Haringey/Islington and MPC)	**Haringey:** • 34.1% seen within 6 weeks • All children in mainstream schools seen within one term of referral • Children in community clinics now waiting under 18 weeks which is significant improvement since this time last year. • Service fully engaged in Therapy Review and awaiting conclusions to this process • Clinical Director also working with service to look at skill mix and different use of capacity to meet demand across the different pathways • Patient feedback indicates service is highly regarded, but limited in terms of universal offer, resulting in high numbers of children being identified for targeted and specialist levels of intervention **Islington:** • Improvement from 57.4% to 67.6% • Waiting Times have increased due to staffing issues including sick leave and maternity leave **MPC:** • Performance for month of December 77.8% • Dashboard has now been adjusted to agreed 18 weeks target. Average wait of 9.7 weeks with 9 new patients	• Completion of Haringey Therapy Review, due to be presented at CSIG in January 2019 • Skill-mix and other minor adjustments identified by Clinical Director to be agreed and implemented in both Haringey and Islington • Increase in demand as a result of the HV implementation HCP continues to be a challenge as the short term increase in temporary staffing has now ceased • Therapy meeting across Islington and Haringey 09.01.19 – a few actions have been identified including Rio recording, data entry, access and clarity in appointment outcomes. Further work to be done to ensure staff are entering correct data in Rio • A monthly CYP Waiting Time Improvement meeting which will focus on (1) improving performance and (2) identifying measures on how to meet and maintain agreed target weeks. The first meeting will be on the 21st of January and will be chaired by the Director of Operations CYP. **MPC** • The service manager has assigned a team member to	• Skill-mix and other minor adjustments identified by Clinical Director to be agreed and implemented in both Haringey and Islington – December 2019 • Recommendations/actions from Rio Recording meeting will have a positive impact on data quality and better picture of patient's referral to treatment (patient journey) **MPC** • Consultant Speech and Language Therapist still recovering from broken arm resulted to decrease in

	still below 95%. • Two referrals seen beyond the agreed target week due to data entry issues	scrutinise PTL, correct data entry errors and remind team at weekly meetings to discharge patients from waiting lists	performance; performance will gradually improve once staff is fully recovered. • Two staff are now fully trained so more staff to offer clinical service which will reduce waiting list

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	8	2	8	3	5	1	4	1	2	8	10	4	38	
Theatres	Cancelled ops not rebooked < 28 days	0	1	0	0	0	0	0	0	0	0	1	2	0	3	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	334	269	312	292	281	212	230	238	236	233	157		1879	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	3.2%	2.8%	2.8%	3.0%	2.7%	2.3%	2.6%	2.7%	2.8%	2.5%	1.7%		2.5%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	52.6%	47.5%	61.7%	59.3%	62.5%	63.7%	57.3%	50.0%	40.7%	49.4%	50.0%	58.8%	54.6%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	95.0%	93.6%	94.5%	93.9%	92.7%	93.8%	93.3%	96.1%	95.1%	96.8%	95.8%		94.6%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.7%	93.3%	90.8%	89.7%	92.6%	93.4%	90.4%	92.1%	91.8%	91.2%	92.1%		91.7%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		64.1%	71.7%	84.8%	69.9%	78.4%	80.2%	82.9%	82.6%	80.6%	89.5%	87.9%		82.5%	
Community	Haringey - HR1 % carried out before child aged 15 months		67.0%	67.1%	63.8%	63.5%	73.6%	66.4%	71.6%	62.4%	71.5%	71.0%	73.4%		69.0%	
Community	Haringey - HR2 % carried out before child aged 30 months		60.0%	68.1%	59.5%	56.9%	62.5%	58.9%	65.1%	67.0%	64.1%	61.6%	60.4%		62.0%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	96.2%	95.1%	96.4%	94.4%	93.5%	93.1%	98.3%	95.3%	96.5%	92.5%	93.4%		94.7%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		78.7%	85.7%	78.3%	80.4%	86.2%	92.8%	91.8%	95.5%	97.0%	96.7%	93.5%		91.7%	
Community	Islington - HR1 % carried out before child aged 15 mths		69.8%	79.0%	83.9%	69.8%	81.3%	76.5%	82.1%	79.5%	87.4%	77.6%	81.6%		79.2%	
Community	Islington - HR2 % carried out before child aged 30 mths		71.4%	69.3%	76.0%	78.1%	75.1%	77.6%	79.3%	80.1%	81.4%	80.6%	82.2%		79.3%	

Date & time of production: 24/01/2019 10:03

Responsive Services - Commentary

Hospital Cancellations

There were two target cancellations in Urology. Both were cancelled in same theatre session, as the previous case was clinically more complicated than expected, therefore theatre ran out of time on the session.
There were two Orthopaedic cancellations where further Pre-Operative Assessment was required.

All cases were rebooked and completed within the 28 days target.

Service	Summary of improvement work undertaken during October2018. Was CSIG Waiting Time Improvement Target / Was Trust Board KPI met? If not, please give reasons.	Mitigating actions being taken (if target was not met)	What improvement measures are planned for the next 3 months? Expected date for target to be achieved.
Health Visiting	**Haringey:** • New Birth Visits, increase from last month to 92.1 % against the 95% target • Challenges recruiting to Band 6 vacancies within service, discussions underway around new solutions to recruitment challenges jointly with Islington (Diminished pool of qualified HVs is a London wide and national challenge) • 8 week review sees a continuous improvement @88% • HR1 increase at 73.4% • HR2 60.4% **Islington:** • New Birth Visits, slight deterioration from 96.5% to 92.5% • 8 week review continues to exceed target at 96.6% • HR1 within 15 months sees deterioration from previous month from 87.4% to 77.9%, which is	**Haringey:** • Service has undertaken analysis to identify specific team/practice issues contributing to performance challenges • Targeted work underway to (1) support specific teams in the East of Haringey with local processes and data quality (2) target clinics with highest WNB/DNA rate e.g. Triangle Children's centre area(process in place) **Islington:** • Brightstart model has been implemented this month • Commissioners are expecting there to be a bedding in period which may impact on performance	**Haringey:** • Continue work with Islington on skill mix options to alleviate vacancy issues in both boroughs for Band 6 HV positions • Discussions now underway to look at implementing a Bright Start model in Haringey to align our approach to universal services to across both boroughs **Islington:** • Continue to implement Bright start model • Service is engaging in ICSU Data Quality project to ensure validation of notes and outcoming of appointments is improved from current position

	only slightly below of target of 80% • HR2 within 30 months slight improvement from 68.6% to 70.9%, against a target of 80%		

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	70.8%	71.6%	68.9%	70.2%	70.8%	71.5%	73.6%	73.2%	74.7%	77.0%	76.0%	73.2%	73.3%	
HR	Mandatory Training % Rate	>90%	81.1%	80.8%	82.6%	82.9%	83.0%	82.8%	82.5%	83.7%	82.2%	82.4%	81.1%	80.7%	82.4%	
HR	Permanent Staffing WTEs Utilised	>90%	87.3%	87.3%	87.3%	87.4%	87.2%	86.2%	86.3%	86.7%	86.4%	87.3%	87.2%	88.0%	87.0%	
HR	Staff FFT % recommended work	>50%			58.6%			60.8%			64.4%				61.9%	
HR	Staff FFT response rate	>20%			17.8%			16.5%			8.0%				12.3%	
HR	Staff sickness absence %	<3.5%	4.01%	3.73%	3.02%	3.27%	3.47%	3.41%	3.52%	3.10%	3.52%	3.92%	3.81%		3.50%	
HR	Staff turnover %	<10%	14.4%	14.7%	14.6%	13.9%		14.0%	13.5%	13.1%	12.8%	12.7%	12.7%	12.0%	13.1%	
HR	Vacancy % Rate against Establishment	<10%	12.7%	12.7%	12.7%	12.6%	12.8%	13.8%	13.7%	13.3%	13.6%	12.7%	12.8%	12.0%	13.0%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		78.9%	78.8%	86.4%	93.5%	79.7%	84.3%	82.7%	83.4%	82.3%	76.8%	76.7%	74.9%	81.2%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		131.5%	137.9%	159.4%	175.6%	141.9%	121.9%	120.2%	134.2%	139.9%	130.4%	130.4%	125.3%	133.9%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		89.1%	89.3%	97.7%	101.1%	86.4%	87.9%	86.8%	87.9%	86.6%	85.3%	85.3%	79.2%	86.9%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		148.2%	143.9%	161.8%	174.3%	145.1%	116.0%	114.1%	140.5%	138.0%	79.6%	83.0%	131.1%	120.2%	
HR	Safe Staffing Alerts - Number of Red Shifts		31	12	19	18	8	0	1	1	2	0	0	0	30	
HR	Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		8.2	8.4	8.6	8.7	9.3	9.4	10.0	9.0	8.8	9.2	8.8	10.2	9.3	

**Staff FFT % Recommended Work and Staff FFT Response Rate for Dec-17 is based on the Staff Survey results (not the Staff FFT).

Date & time of production: 24/01/2019 10:03

Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Trend
Medical	Average staff cost per patient		98	104	96	101	88	92	97	101	103	86	94	
Nursing	Average staff cost per patient		167	182	181	182	172	181	174	180	183	168	168	
Other	Average staff cost per patient		191	195	166	203	179	196	226	234	208	185	192	

Well Led Services - Commentary

Human Resources

Vacancy rates against establishment have reduced slightly, due primarily to newly qualified nursing staff starting in post, and an AHP recruitment drive. There are further Nurse Recruitment open days planned and a revised International recruitment plan is imminent. Turnover has reduced slightly though it remains above target and, as previously reported, a relaunched approach to exit interviews will enable more focused action to be directed on particular turnover hotspot areas and enable attention to be directed to these. The pilot is underway, and has been extended into January 2019. Sickness (reported a month in arrears) has had remained stable, and is just over the Trust target at 3.8%. This is attributed to seasonal illnesses. Appraisal rates have reduced slightly but this is mainly attributed to block appraisals in corporate areas. A training pilot for improving data on appraisals and mandatory training on ESR is underway. The Staff survey rate was 48.5%, which is the highest response rate the Trust has had. Results will be released from March 2019.

Well Led Services - Commentary

% DAY fill rate-nurses

All wards received adequate staffing levels during December 2018. There was an increased number of unfilled registered shifts but there were no Red shifts reported. The Lead Nurse for safer staffing continues to work with the ward managers to ensure that data quality is improved as staff are moved between wards to flex capacity. Band 4 Assistant Practitioners continue to cover Band 5 nurses (see below) and this will have an impact on the % fill rate for registered and un-registered. It is anticipated that the data template submitted to NHSI will change in 2019 to accommodate nursing associates (band 5) who will be on the NMC register from March the 1st.

% Day fill rate-HCAs

The trend of increasing numbers of patients needing enhanced one to one care including those at risk of falls and those with mental health needs has continued. 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. Cavell ward was closed for 9 Days in December which impacted on the fill rate data. There has been significant increase in enhanced care for patients under Mental Health and falls risk.
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.

% night fill rate-nurses

All wards received adequate staffing levels during December 2018 and there were no Red shifts reported. Band 4 Assistant Practitioners continue to cover Band 5 nurses (see below) and this will have an impact on the % fill rate for registered and un-registered. It is anticipated that the data template submitted to NHSI will change in 2019 to accommodate nursing associates (band 5) who will be on the NMC register from March the 1st.

% night fill rate-HCAs

There has been significant increase in enhanced care in Acute Assessment Units for patients under Mental Health and falls risk.
Thorogood has needed fewer HCAs overnight due to the nature of the patients receiving care (planned post-surgical) and the size of the ward. Ifor (paediatric ward) has flexed the number of open beds at times during the month in line with demand.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Q3 Dec-18	Activity
ED	ED Attendances	8285	8897	8082	9217	8645	9226	8699	9287	8157	8897	9082	9245	9219	
ED	ED Admission Rate %		15.3%	14.7%	14.8%	15.6%	15.8%	15.9%	15.4%	15.5%	15.2%	15.0%	16.2%	15.9%	
Community	Community DNA Rate %	<10%	7.6%	7.6%	7.7%	7.9%	8.1%	8.0%	8.5%	8.1%	7.7%	7.7%	7.5%	8.0%	
Community	Community Face to Face Contacts		60090	54292	60417	55901	63920	62523	61409	54895	57795	63864	63747	51193	
Admissions	Elective and Daycase		1944	1735	1879	1721	1839	1880	1763	1821	1922	2267	2220	1794	
Admissions	Emergency Inpatients		2219	1903	2241	2181	2338	2237	2218	2193	2163	2185	2290	2242	
Referrals	GP Referrals to an Acute Service		7874	7362	7891	7162	7688	7618	7569	7060	6892	8293	7984	6688	
Referrals	% of GP Referrals that were completed via ERS		46.0%	44.1%	47.0%	58.2%	73.7%	79.6%	82.6%	82.9%	84.8%	87.4%	89.0%	85.5%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	13.3%	16.8%	17.4%	18.2%	12.2%	10.1%	8.8%	10.5%	11.9%	13.0%	12.7%	10.7%	
Maternity	Maternity Births	333	321	253	315	291	323	282	297	321	312	296	299	281	
Maternity	Maternity Bookings	377	405	375	370	400	369	317	376	330	334	398	363	327	
Outpatients	Outpatient DNA Rate % - New	<10%	10.9%	10.9%	10.7%	10.0%	10.9%	10.1%	10.6%	11.2%	11.2%	10.7%	10.7%	10.6%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	12.1%	10.0%	10.9%	10.2%	12.1%	10.2%	10.3%	10.6%	10.2%	10.4%	10.4%	10.3%	
Outpatients	Outpatient DNA Rate % - Overall	<10%	11.6%	10.4%	10.8%	10.1%	11.6%	10.2%	10.4%	10.8%	10.6%	10.5%	10.5%	10.4%	
Outpatients	Outpatient New Attendances		10507	9224	9631	9309	10246	9667	9649	9097	8888	10474	10140	8315	
Outpatients	Outpatient FUp Attendances		18893	16594	17807	17411	18731	18306	18790	18105	17272	20233	18992	15396	
Outpatients	Outpatient Procedures		7410	6828	7095	6786	7421	7206	7607	6900	7359	8160	7971	7068	
Theatres	Theatre Utilisation	>85%	85.6%	87.2%	88.8%	85.3%	83.6%	82.5%	78.2%	82.3%	82.1%	80.7%	79.6%	80.9%	

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Average Tariff for Inpatient PODs

Category	Point of Delivery (POD)	17_18 Target	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Q1 Jun-18	Q2 Jul-18	Q2 Aug-18	Q2 Sep-18	Q3 Oct-18	Q3 Nov-18	Trend
Average Tariff	Daycases		697	684	614	740	686	678	703	653	655	701	696	
Average Tariff	Elective		3403	3550	3710	4033	3831	3778	3857	3210	2963	3483	3565	
Average Tariff	Non-Elective		2670	2362	2194	2484	2511	2564	2272	1684	1590	1850	2087	

Activity - Commentary

e-RS
Improving trend.

DNA
Trust wide this continues to gradually decrease and month end was recorded at 10.5%. Plans are in place to alter the text messages to patients to communicate the cost implications of a DNA appointment and to also highlight the fact that they have potentially denied another patient an earlier appointment. This will be tested within Gastroenterology, starting at the end of January 19, to see if it has a positive effect on their high DNA rate. Expected impact will be reflected in March 19 position.

Theatre Utilisation
Overall for December was 80.9% (up from 79.6%). We continue the work with Pre-Operative Assessments and Admissions. The expectation is that Theatre Utilisation will be at 85% for January 2019.

Meeting title	**Trust Board – public meeting**	**Date: 30 January 2019**
Report title	**NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework.**	**Agenda Item: 12**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Lee Smith, Emergency Planning Officer	
Executive summary	The purpose of this report is to highlight the Trust's excellent assessment outcome by NHS England in being fully compliant with the requirements of the Emergency Preparedness, Resilience and Response (REPRR) Framework 9see appendix 1). Actions from the NHS EPRR Assurance report (see appendix 3) are shown in bold in 2019 EPRR action plan (see appendix 2).	
Purpose:	Review	
Recommendation(s)	Board members are asked to review the report and take significant assurance from the positive outcome achieved through full compliance with standards 1-69.	
Risk Register or Board Assurance Framework	BAF risk 3	
Report history	None	
Appendices	1: Whittington Health 2019 EPRR report 2: EPRR action plan 2019-2020 3: NHS EPRR Assurance Annual Report	

2018 EPRR Assurance Report

Whittington Health NHS Trust

Version number: 1

First published: 05/12/2018

Prepared by: Rey Aziz, NHS England (London);
Roshan Abdool-Raheem NHS England (London)

Classification: OFFICIAL

Contents

1 2018-19 Assurance review summary

The 2018-19 annual EPRR assurance process is used in order to be assured that NHS Organisations in London are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

The process this year is broadly similar to that followed in 2017-18; however where possible it incorporates learning from feedback received through the post assurance debrief process.

The EPRR Core Standards have however been reviewed for 2018 and a new self-assessment tool for organisations is in place for organisations to submit returns. The guidance pertaining to the key changes in the core standards were circulated to each NHS organisation.

Within North East and north Central London the NHS England (London) patch team undertook an assurance review process with the following organisation types:

- Acute hospital service providers
- Community service provider (this includes NHS Trusts, Foundation Trusts and social enterprises)
- Mental health service providers
- Specialist health service providers
- NHS 111 service providers
- Clinical Commissioning Groups

For acute Trusts additional site visits were arranged to review specific requirements regarding Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe).

All organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR which would provide the framework for the assurance review meetings furthermore the review meetings would also have a broader oversight and ensure that plans and arrangements were being updated with relevant learning and guidance.

At the review meeting the EPLO described the progress the Trust had been making over the course of the year highlighting in particular, the positive engagement from staff across the Trust with regards to training, as well as a focus through workshops on improving business continuity resilience.

2 Assurance review process

The assurance process for Whittington Health was conducted as follows,

Assurance Meeting	Date of Visit	Assurance Review attendance
CBRNe/HAZMAT assurance and site visit	01/11/2018	**Whittington Health NHS Trust**: Lee Smith. **NHS England (London):** Rey Aziz (Chair), Roshan Abdool-Raheem. **London Ambulance Service NHS Trust:** Andrew Godfrey (CBRN Training Officer).
Main Assurance Meeting		**Whittington Health NHS Trust:** Lee Smith, Carol Gillen. **NHS England (London):** Rey Aziz (Chair), Roshan Abdool-Raheem. **BHRUT:** Keith Donnelly (Peer Reviewer), Louise Nicholas (Observer).

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2018-19 Assurance Process Letter (1st August 2018), the overall level of compliance is based on the total percentage of amber and red ratings.

In respect of Whittington Health for Core Standards 1 – 69, the Trust did not receive any amber or red scores therefore Whittington Health has an assessed level of **FULL**.

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

The Trust received no amber or red ratings for the respective core standards. The assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.1.2 Deep dive outcomes – Command & Control

The Trust received no amber or red ratings for the respective deep dive standards. The assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.2 CBRNe/ HAZMAT Assurance Visit Outcomes

The Trust received no amber or red ratings for the respective CBRNe/HAZMAT core standards. The assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.2.1 CBRNe/HAZMAT equipment list outcomes

The London Ambulance Service (LAS) CBRN Training Officer in attendance with NHS England (London) colleagues and Whittington Health EPLO reviewed the equipment located at the site and confirmed that the Trust was able to demonstrate how it met the requirements within the equipment list.

4.3 Assurance review meeting agreed actions

NHS England (London) EPRR / Panel-agreed actions as follows:

1. The Trust to review the contact details for stakeholders and other partners on a regular basis (Core Standard 12 & 56).
2. The Trust to consider use of flow diagrams to replace some text, move the JESIP and METHANE models to an appendix and replace references to warm and cold zones to clean and dirty (Core Standard 57).
3. The Trust to revise section on faulty suit return which states return to NARU, this should be replaced by RESPIREX (Core Standard 57).
4. The Trust would obtain details on student placement policy from NHS England (London).
5. The Trust to provide the debrief report for the last Exercise held in October when it is finalised.
6. The Trust to obtain latest flow charts to include in their CBRNE HAZMAT Plan from LAS.

5 Next Steps: Action Plans and Governance

Whittington Health is required to submit, within two weeks of the date of this report the following documentation to england.london-assurance@nhs.net:

- The organisation's final EPRR RAG scores, as agreed at the review meeting using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Red or Amber using the self-assessment tool
- A declaration of the overall level of compliance achieved from the AEO

6 Conclusion

Overall, the Trust clearly demonstrated its commitment to EPRR, their assurance submission was timely and the plans included as evidence were very comprehensive in their detail.

At the review meeting the EPLO confirmed availability of additional supporting documentation to further support their self-assessment and as such only minor recommendations were noted in relation to the core standards. Moreover, it was noted that the EPLO's approach at the Trust through a variety of training sessions had ensured a good level of engagement and commitment from Trust staff.

Taking into consideration the Trusts positive position, the challenge for the Trust over the next year will be on maintaining the standard achieved this year, this will need to be set out in a clear action plan which includes all planned training and exercises.

In addition, the Trust should consider the comments made by the panel on its Major Incident and CBRNe/HAZMAT Plans and this will be followed up by the NHS England (London) NENC EPRR Engagement Officer as part of the ongoing engagement work.

Finally, on behalf of the NHS England (London) NENC EPRR Team, thank you to all colleagues involved in the assurance process for Whittington Hospital NHS Foundation Trust.

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

EPRR Core Standards					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG rating**	**Agreed 2018 RAG rating**	**RAG rating rationale and review meeting comments**
Governance					
1	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

		• identified risks • outcomes from assurance processes.			
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Duty to maintain plans					
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate. Action – The Trust to review the contact details for stakeholders and other partners on a regular basis.
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
16	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

		disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.			
17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
18	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

		'protected individuals'; including VIPs, high profile patients and visitors to the site.			
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Command & Control					
24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
25	**Trained on call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Training & exercising					
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must:	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

		• identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.			
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Response					
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
31	**Access to planning arrangements**	Version controlled hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
33	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
35	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Warning & Informing					

37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Cooperation					
40	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
41	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Business Continuity					
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
CBRN					
56	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate. Action – The Trust to review the contact details for stakeholders and other partners on a regular basis.
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate. Action – The Trust to consider use of flow diagrams to replace some text, move the JESIP and METHANE models to an appendix and replace references to warm and cold zones to clean and dirty. Action – The Trust to revise section on faulty suit return which states return to NARU, this should be replaced by RESPIREX.
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

		• List of required competencies • Arrangements for the management of hazardous waste.			
59	**Decontamination capability availability 24/7**	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
61	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
63	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
65	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

Deep dive					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG**	**Agreed 2018 RAG rating**	**Assurance review meeting comments**
Incident coordination centres					
1	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
2	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
3	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
4	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate its functions as defined in the EPRR Framework.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
Command structures					
5	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
6	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
7	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
8	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	**Fully compliant**	**Fully compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.

Insert Organisation name: Whittington Health NHS T	GREEN - arrangements	GREEN - Assured
Insert Organisation type(s): Integrate	Select your org	AMBER - draft or	AMBER - Partially assured, seeking
Insert name of completing officer; Le	type using Aut	RED - arrangements not	RED - Not assured; insufficient evidence
Insert name of authorising officer; Ca	dropdown arro	N/A - Not applicable to organisation	N/A - Not applicable to organisation
Insert submission date 21/01/2019		N/R - Not rated by reviewing team	N/R - Not rated by reviewing team

NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Category 1 & 2		Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Time line
	Acute trusts	Community providers				
Establishment of a Mass Casualty Working Group	X	X	Action Tracker		Review and Updates from NEL Essex Trauma Networks. **Provide Exercise report from Asclepius to NHSE**	May-21
Establishment of a Mass Countermeasures/Prophylaxis Working Group	X	X	Action Tracker. Stuart Richardson Completed as part of the Pharmacy Major Incident Plan		Emergo Table Top Exercise of Mass Counter Measures.	Sep-21
Ratification of Evacuation Plan	X	X	Action Tracker. Has been reviewed by the Islington LRF 2016		Review of Evacuation Plan and cross check against Fire Policy. Table Top Exercise to test plan. Significant updates to Fire Response ans Evacuation Proceedure. Monthly Fire Evacuation Drills, prioritised from high to low criticality	Mar-21
Review of skill mix that are CBRN trained on each shift in ED.	X	X	Engagement with Fiona Long establish CBRN identification on the Health Roster		EUC Matrons to reivew skill mix with each rota in relation to identified staf trained on CBRNE. Ongoing additiona to e-roster system.	Feb-17

Ratification of CBRN plan	X	X	Action Tracker. Has been reviewed by the Islington LRF 2016. Has been reviewed bt NENC NHS England. Has been reviewed by LAS		Plan signed off . Review of CBRNE plan and response to feedback from NHSE EPRR feedback. **Move JESIP and METHANE to the Appendix and replace sections of text with flow diagrams. Update referances to Cold and Dirty Zones. Trust tp update section of faulty suit return in line with NARU guidance. Obtain latest flow charts from LAS.**	Mar-19
director-level representation at the LHRP; and	X	X	NHS England (London) to provide single answer regarding London LHRP arrangements, however this may differ outside London	N/R	NHS England (London) to provide single answer regarding London LHRP arrangements, however this may differ outside London	N/R
representation at the LRF.	-	-			EPO committed to attend LRF's throughout 2019.	2019
All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing,	X	X		N/R	NHS England (London) to provide single answer	
Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the	X	X	EPRR policy 2018, Section 6.1, Page 10. Emergency Management Action Log. EPRR Executive Committee report on changes and current position		Action tracker updated after each cold debrief. Ongoing. Actions discussed at bi-monthly Emergency Management Steering Committee	2018

Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X		X	Emergency Management Steering Committee work plan and is being discussed at this committee if it should be added to the Corporate		Quarterly engagement with with Risk Manager at Whittington health NHS Trust.	2019
All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and	X		x	Major Incident Plan September 2017		Major Incident Response Plan signed off in 2017. The plan will be reviewed and ammended throughout 2018	2018
be based on risk-assessed worst-case scenarios;	X		X	EPRR Policy, Section 6.2, Page 11-12. Emergency Management Steering Committee TOR.			**2019**
make sure that all arrangements are trialled and validated through testing or exercises;	X		X	EPRR Policy, Section 6.3, Page 12 &13. Training Programme. Post incident/exercise reports - network outage incident debrief report April 2013		Post Live Exercise Asclepius Report to be circulated to stakeholders after AEO sign off	2018
make sure that the funding and resources are available to cover the EPRR arrangements;	X		X	There is an emergency preparedness budget, which covers the EPO role. EPO JD, business case and EC approval. If additional funding is required a business case with evidence will need to		Business case to replace Airpager Bleeps, February. Business case to establish service agreement with old decontamination tent. Business case to replace existing radio's	2018

plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X		X	Whittington staff are working with the security department of the prison responsible for the contingency plans, to ensure healthcare services are included.		Review on local and national risk registers every quarter and as required	2019
include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X		X	Emergency Management Steering Committee TOR. Action Card of Estates &Facilities from major incident plan.		One to One meetings monthly with Director of Envornment. Review and follow up of corporate business continuity plans	2018
Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:	X		X				2019
refer to all relevant national guidance, other supporting and threat-specific plans (eg pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X		X	EPRR Policy, Section 6.2, Page 11&12. Major Incident Plan Section 11, page 43, section 14 page 49		Ongoing reivew of evidence, policies updated yearly and as required	2019
refer to all other associated plans identified by local, regional and national risk registers;	X		X	EPRR Policy, Section 6.1, page 10&11. Major Incident Plan Section 11, Page 43.		Review of National and Regional Risk Registers quaterly	2019

have been written in collaboration with all relevant partner organisations;	X	X	EPRR Policy, Section 6.2, Page 12. Major Incident Plan Section 13 page 47. Due to go out to the BRF's (Islington , Haringey) for consultation to relevant partner agencies.		Circulation of emergecny plans to LRF's , Trust Operational Board, Emergecny Management Committee and Trust Board for sign off . Review and action all feedback points from NHSE against core standard requirements. **The trust will check to see what the NHS policy is in relation to student placement with the view of supporting students in 2019 ans onward**	2019
refer to incident response plans used by partners, including LRF plans;	X	-	EPRR Policy, Section 6.2, Page 12.Major Incident Plan Section 11, Page 43.		Review of incident plans and feedback	2019
have been written in collaboration with PHE;	X	-	EPRR Policy, Section 6.2, Page 12. CBRNe procedure under review following audit, action plan in place.		Engagement through the LRF and NHSE	2019
have been written in collaboration with all burns, trauma and critical care networks; and	X	X	The MI plan is soon to go for consultation with key networks. MI plan section 3 page 22-23.		Ensure that all contact details for internal and external contacts are updated quaterly. **This plan is in accord with the 2018 EPRR Assurance report.**	2019
define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors	X	X	**Not rated in 2013**	N/R	Pevent is reported on quarterly. This portfolio is currently being managed by Terresa Randwick. The submission of reports can be arranged for the yealy assurance review.	2019
be approved by the relevant board;	X	X	EPRR Policy, Section 6.2, Page 12.Major Incident Plan page 1		yearly review for evidence updates	2019

be signed off by the appropriate Senior Responsible Officer;	X		X	EPRR Policy, Section 6.2, Page 12.Major Incident Plan page 1		yearly review for evidence updates	2019
set out how legal advice can be obtained in relation to the CCA;	X		-	EPRR Policy, Section 6.2, Page 12. MI plan section 12 page 45. The Legal Services team have an arrangement with our Trust solicitors Bevan Brittan for out of hours		yearly review for evidence updates	2019
identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X		X	EPRR Policy, Section 6.2, Page 12.Major Incident Plan page 4, Section 13, page 47-48.		Communication and control aspects of plan to be tested in 2018. Training of Bronze and Silver in relation to briefing and using the IIMARCH communication model. 38 new 2 way pagers will be aquired in February. The pagers will be commisioned in March. There will be training and testing conducted in February. There will be monthly pager testing of the 38 new pagers starting in March. The pagers will also be tested as part of communication Exercise in 2018.	2019
explain how internal and external consultation will be carried out to validate the plan;	X		X	EPRR Policy, Section 6.2, Page 12. Major Incident Plan Section 13, page 47-48		Circulate all plans to Heads of Nursing, Operational Directors, Clinical Directors and Sepcific workplace sectors for feedback. Circulation of core plans within the LRF's	2019
include version controls to be sure the user has the latest version;	X		X	EPRR Policy, Section 6.2, Page 12.Major Incident Plan page 4			2019
set out how the plan will be published – for example, on a website;	X		X	EPRR Policy, Section 6.2, Page 12. Major Incident Plan Section 13, page 47		Updating of intranet and hardcopies ongoing. Review of	04/04/2019
include an audit trail to record changes and updates;	X		X	EPRR Policy, Section 6.2, Page 12.Major Incident Plan page 4		Record changes identified on all key dcouments.	2019

explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X		X	EPRR Policy, Section 6.2, Page 12. Major Incident Plan Section 12, page 45. There is currently no agreement for this, there is an emergency preparedness budget covers only the role of EPO. Agreed expenditure would involve the Chief Finance Officer.		Budget	2018
demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X		X	EPRR Policy, Section 6.2, Page 12. Major Incident Plan Section11, page 43.		Risks manageged through the quality and risk group. All incidents are reported on the DATIX system. Risk specific to emergency planning and business continuity are esclated through internal and external processess	2019
Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.	X		X				2019
Key staff must know where to find the plan on the intranet or shared drive.	X		X	Training programme including records of staff trained, Training material - ppt. Major Incident Plan Section 13, page 47, 48.		The training needs analysis for 2018/2019 has been established. The training activity related to the local, regional and national risks. The addition of non-core training will be added throughout the year. Additional training may be added as part of the debreifing process.	2019
There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X		X	EPRR policy, section 6.3, page 12 &13. Training programme			2019

Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X		X	EPRR Policy, Section 6.3, page 13 Training programme including records, training material - ppt.			2019
It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X		X	EPRR Policy, Section 6.3, page 12. Training programme including records, training material - ppt.		All training is loaded onto the Training Tracker.	2019
It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X		X	EPRR Policy, Section 6.3, page 12. Training programme including records, training material - ppt.		The EPO is a Loggist Trainer. There are loggist courses every month. The courses have been open up to externals	2019
Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols	X		X			Communications Exercise with Page One system and new pagers	2018
Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X		X	Major Incident Plan, Section 3, Page 14, 15			2019
Set out the procedures for escalating emergencies to NHS England area teams, regions, national office and DH	-		X	Major Incident Plan Section 3, Page 12. Section 4 page 19. Action Card Gold and Silver.		updated with new NHSE sitrep template now included in handbook, major incident plan and gold on call drop box. Ongoing and regular update of the handbook.	2019

Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X		X	EPRR policy section 7.1, page 16. Major Incident Action card for Gold and Silver on call			2019
Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X		X	EPRR Policy, Section 7.1, Page 15 &16. MI action cards of gold and silver on call. On call staff rota. Silver on call rota administration protocol.		EPO to review on call rota weekly with 3 month rolling rota to be distributed one month before on call commenses	2018
Set out the responsibilities of key staff and departments.	X		X	Major Incident Plan, Section 3, page 17.		Additionally Business Continuity Plans include key roles	2018
Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X		X	EPRR Policy, Section 3 , page 7. Major Incident Plan section 2 page 10-11, section 3 page 17. Action Card Gold Commander			2019

Explain how mutual aid arrangements will be activated and maintained.	X		X	As a recently created shared service of six trusts, we have access and direct control of differing purchase ordering systems and different supply chains including inventory locations in the event of disruption to our supplies. This would be called into operation depending on the scale and severity of the disruption. We have already used this contingency when we lost the use of our systems at WH acute site in 2012; that is, we operated from the Royal Free site to maintain business continuity and it worked effectively. The shared service is owned and managed by the six participating trusts under			2019
Identify where the incident or emergency will be managed from (the ICC).	X		X	Major Incident Plan section 2 page 9-13			2019

Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	X	Major Incident Plan, Section 6, Page 26, section 13 page 47.			
Best Practice: Use an electronic data-logging system to record the decisions made.***Best Practice:*** Use an electronic data-logging system to record the decisions made.***Best Practice:*** Use an electronic data-logging system to record the decisions made.***Best Practice:*** Use an electronic data-logging system to record the decisions made.***Best Practice:*** Use an electronic data-logging system to record the decisions made.	X	-	**Not rated in 2013, unless organisation provides evidence**	N/R	**Not rated in 2013, unless organisation provides evidence**	
Best Practice: Use the National Resilience Extranet.***Best Practice:*** Use the National Resilience Extranet.***Best Practice:*** Use the National Resilience Extranet.***Best Practice:*** Use the National Resilience Extranet.***Best Practice:*** Use the National Resilience Extranet.	X	X	**Not rated in 2013, unless organisation provides evidence**	N/R	**Not rated in 2013, unless organisation provides evidence**	N/R

Refer to specific action cards relating to using the incident response plan.	X		X	Major Incident Plan, Section 15, Action Cards - gold, silver and bronze.		Yearly review of action cards to be complete before September	2019
Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X		X	Major Incident Plan, Section 6, Page 26-30. Action Card silver & gold.		Yearly review of action cards to be complete before September	2019
Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X		X	Major Incident Plan section 3 page 24. An action with in gold, silver, bronze action cards. EPRR policy section 7 page 16. Gold and Silver		Yearly review of action cards to be complete before September	2019
Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998, the General Data Protection Regulation (GDPR) 2016 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X		X	Major Incident Plan section 7, page 31-32. Section 12, page 45 and Section 15 Action card Communication Team.		Yearly review of action cards to be complete before September	2019

Have agreements in place with local 111 providers so they know how they can help with an incident	X		X	we have a liaison (named contact) with the 111 provider and there is regular contact with them from our ED department		Plan to update the NHS 111 contact in the Gold and Silver handbook.	2019
Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X		X	Major Incident Plan, Section 8, Page 33-35		Review any changes to the Telecommunications systems with the Telecommunications manager.	2019
Describe how stores and supplies will be maintained.	X		X	Major Incident Plan Section 5 Page 25. Recently created shared service of six trusts, we have access and direct control of differing purchase ordering		Regular reviews and updates from PPS procurment in relation to potential impacts to supply chains. Co-ordinated planning in relation to EU Exit.	2019
Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X		X	Burns, paediatrics, contamination in MI Plan section 3 page 20-22			2019
Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X		-	Major Incident Plan, Section 9, Page 40. Communications team Action Card No.			2019
Explain the process of recovery and returning to normal processes.	X		X	EPRR Policy, section 8, page 18. Major Incident Plan, section 9, page 36-41.			2019

Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X		X	EPRR Policy, section 8, page 18. Major Incident Plan, section 9, page 36-38			2019
Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X		X	Major Incident Plan, Section 9, Page 40-41			2019
Set out how surges in demand will be managed.	X		X				
Explain who will be responsible for managing escalation and surges.	X		X	Major Incident Plan, Section 4, Page 25.			2019
Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X		X	Major Incident Plan, Section 4, Page 25. Bed Management Policy. ED Escalation Full Capacity Policy			2019
Link the Incident Response Plan to threat-specific incidents	X		X				
CBRN incidents;	X		X	EPRR Policy, section 6.2, page 12. Major Incident Plan page 1, Section 3 page 21, section 11 page 43. CBRN plan EPRR Policy, section		Assurance has been covered separately for Acute organisations in London	2019

mass casualty incidents;	X		X	EPRR Policy, section 6.2, page 12. Major Incident Plan section 3 page 20.		Ammendments and updates to the plan in relation to Mass Casulaty Evidence. Update to the Major Incident plan will reflect developments achieved by the NHS Mass Casualties Workshops in 2018.	2019
pandemic flu;	X		X	EPRR Policy, section 6.2, page 12.		The Pandemic Flu plan will be updated. Exercise planned for 27th of February	2019
patients with burns requiring critical care; and	X		X	MI plan section 3 page 21			2019
severe weather.	X		X	EPRR Policy, section 6.2, page 12. Major Incident Plan page 1, section 11 page 43. Heatwave Plan 2017.		Update Yearly before the start of summer	2018
All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable	X		X	Section 2, Page 9-13Major Incident Plan, Section 2, Page 9-13Major Incident Plan, Section 2, Page 9-		Incident Board for the ICC based on process adopted from the Trauma Network Exercise Eskimo. Review of all folders in the Operational Coordination Centre and Incident Response Centre	2018
There must be a plan setting out how the ICC will operate.	X		X	Major Incident Plan, Section 2, Page 9 - 13..			2019
There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X		X	Major Incident Plan, Section 2 page 13,section 15 Actions Cards - Silver and Bronze			2019

There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	X	Major Incident Plan, Section 3, page 24 Actions Cards - Silver and Bronze. EPRR policy section 7 page 16.			2019
Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	X	MI plan section 2 page 13			2019
All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:	X	X	BCP Policy. BCP Plan. Emergency Management Action Log. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.		Business Continuity Plans will be reviewed every 2 weeks by the Trust Operational Management Group. All plans are accounted for on the BCP Audit. Phase 2 of the Audit will commense early this year	2018
make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	There is an emergency preparedness budget, which covers the EPO role. EPO JD, business case and EC approval. If additional funding is required a business case with evidence will need to be provided to the appropriate board to agree.			

set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X		X	There is no emergency preparedness budget set up, but one can be via the Chief Finance Officer, funds can be made available.			
develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X		X	BCM policy section 3, page 5. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X		X	Strategic BCP section 9, page 8. service continuity plans section 1, page 2. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.		ICSU specific business continuity work shops will be conducted through out the year. Business continuity testing will continue in 2018 specific to each service area.	2018
Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X		X			Strategic Business Continuity Plan to be reviewed yealy.	2019

Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X		X	BCM policy section 1, page 4. Strategic BCP section 2, page 5.		Policy updated in 2018	2018
Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X		X	BCM policy page 1. section 8,9 page 8.			2018
Organisations must make clear how their plan will be published, for example on a website.	X		X	Strategic BCP section3, page 6. BCM policy page2.			2018
The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X		X	BCM policy section 4, page 7.			2018
There must be an audit trail to record changes and updates such as changes to policy and staffing.	X		X	Strategic BCP page 3. BCP policy page 3.			2018
The planning process must take into account nationally available toolkits that are seen as good practice.	X		X	**Not rated in 2013, unless organisation provides evidence**	N/R	**Not rated in 2013, unless organisation provides evidence**	N/R
Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption	X		X				2019

Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X		X	Strategic BCP section 11, page 9-13. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.		All critical business continuity plans have been reviewed. Phase 2 of reviewing non-critical plans will be conducted this year.	2018
Plans must be maintained based on risk-assessed worst-case scenarios.	X		X	Strategic BCP section 11, page 9-13. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			**2019**
Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action);	X		X	been carried out for: people, premises, suppliers and partners, technology, information, and fuel supply. These are all included within the BCP section 11 page 9-13 and appendix 11 page 56. They are due for		All core plans will be reviewed and updated in advance of the next NHSE assurance process in the later part of this year,	2019

Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	Strategic BCP section 9, page 8, section 11, page 9-13, Service continuity plans section 1 page 2-4. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.		New template used by ICSU directors in 2017, review of NHS E BCP evidence for inovation will continue this year	2019
They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how	X	X	Service continuity plans section 1 page 3. Action log shows currently BCM is under review - policy strategic plan and service			2019
Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	This is linked to the Emergency Management Steering Committee work plan and is being discussed at this committee if it should be added to the Corporate Risk register. EPO has had training in order to add the risk to corporate risk register.			2019
Business continuity plans must set out how the plans will be called into use, escalated and operated.	X	X				2019

Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X		X	Strategic BCP section 12, page 14. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X		X	Strategic BCP section 12, page 14-16. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X		X	Strategic BCP section 12, page 14-16, section 15 action cards page 18 & 21. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X		X	page 14-16. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health			2019

the responsibilities of key staff and departments;	X		X	Strategic BCP section 15, page 18-21. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X		X	Strategic BCP section 15, page 18 & 19. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019

how mutual aid arrangements will be called into use and maintained;	X		X	As a recently created shared service of six trusts, we have access and direct control of differing purchase ordering systems and different supply chains including inventory locations in the event of disruption to our supplies. This would be called into operation depending on the scale and severity of the disruption. We have already used this contingency when we lost the use of our systems at WH acute site in 2012; that is, we operated from the Royal Free site to maintain business continuity and it worked effectively. The shared service is owned and managed by the six participating trusts under formal governance arrangements; WH hosts the shared service.			2019

where the incident or emergency will be managed from (the ICC);	X		X	Strategic BCP section 14, page 16-17. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
how the independent healthcare sector may help if required; and	X		X	5 beds in local private nursing home to support discharge of people who do not need acute care.			2019
the insurance arrangement that are in place and how they may apply.	X		X	we have the following insurances in place: Employee Liability Insurance - The NHS Litigation Authority Liabilities to Third Parties Scheme (LTPS), vehicle fleet - motor insurers are "QBE Insurance (Europe), Limited". We also have separate insurance for our premises. The BCP is under review as outlined within the action plan, in the new version a reference to the insurance arrangements will be included and inserted within the action cards.			2019

Business continuity plans must describe the effects of any disruption and how they can be managed. **Plans must include:Business continuity plans must describe the effects of any disruption and how they can be managed.** **Plans must include:**	X	X				2019
contact details for all key stakeholders;	X	X	BCP appendix 8. page 38 &13, page 71.			2019
alternative locations for the business;	X	X	BCP section 19, page 22			2019
a scalable plan setting out how incidents will be managed and by whom;	X	X	BCP section 15, page 17-19. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
recovery and restoration processes and how they will be set up following an incident;	X	X	Strategic BCP section 23, page 29. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019

how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X		X	Strategic BCP appendix 2 & 3 page 32 & 33. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019
how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X		X	Strategic BCP section 20, page 24-26. Appendix 7 page 37. Action log shows currently BCM is under review - policy strategic plan and service continuity plans to update with changes in the health system and new guidance and standards.			2019

how staff will be accommodated overnight if necessary;	X		X	There is emergency accommodation available at the hospital site every night in case some one is stranded due to bad weather/transport issues etc. The request is put into security who hold the hard copy forms for emergency out of hours accommodation to be completed. A room is authorised by security and keys provided - (all keys kept with security). The BCP is under review and shown within the action plan. This will be included within the new version.			2019
how stores and supplies will be managed and maintained; and	X		X	Strategic BCP section 20 page 23.			2019

details of a surge plan to maintain critical services.	X		X	MI Plan section 4 page 25. As a recently created shared service of six trusts, we have access and direct control of differing purchase ordering systems and different supply chains including inventory locations in the event of disruption to our supplies. This would be called into operation depending on the scale and severity of the disruption. We have already used this contingency when we lost the use of our systems at WH acute site in 2012; that is, we operated from the Royal Free site to maintain business continuity and it worked effectively. The shared service is owned and managed by the six			2019
Business continuity plans must specify how they will be used	X		X				2019

Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	X	Training Programme, Incident reports - Network Outage debrief report and action plan.			2019
Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	X	Strategic BCP section 4, page 7. BCP policy section 9 page 9.			2019
Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	X	BCM policy section 10 page 9. Executive Committee report on status of plans			2019
Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	X	network outage debrief report and action plan. Executive Committee report, Emergency Management action log.			2019
Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:	X	X			Regular one to one and seminars conducted throughout 2018 and in 2019.	2019
details of the training provided to staff and how the training record is maintained;	X	X	BCP policy section 9, page 9. Training programme, including record. PowerPoint presentation on BC exercises.		ICSU directors review business continuity plans each month within the Trust Operational Management Group.	2019

reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X		X	EPRR policy section 6.3 page 12-13. training needs analysis, training programme, training materials - PPT MI and BC presentations		Core apsects of the EPRR BCP training program established.	2019
details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X		X	training needs analysis, training programme, training materials - PPT MI and BC presentations			2019
details of how suitable knowledge and skills will be achieved and maintained.	X		X	training needs analysis, training programme, training materials - PPT MI and BC presentations			2019

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE
2018/2019 ANNUAL REPORT

1.0 EXECUTIVE SUMMARY

All NHS Organisations are required to prepare for and respond to a wide range of incidents or emergencies that could impact on health or patient care. These could be anything from extreme weather events, infectious disease outbreaks, terrorist attacks to major transport accidents. Furthermore, NHS Organisations must be internally resilient and be able to respond safely to such incidents, or other internal disruptions, whilst maintaining its services to patients.

The Civil Contingencies Act (CCA) 2004 places a number of duties on both Category 1 and 2 responders to ensure they are adequately prepared to respond to an emergency. The Trust is defined as a Category 1 responder under the CCA 2004 and therefore has a legal obligation to comply with a number of statutory duties. The CCA 2004 brings together both Category 1 and 2 responders within a framework to ensure greater consistency and co-operation at the local level.

The Trust continues to be represented and involved at appropriate levels in the various London wide Emergency Preparedness, Resilience and Response (EPRR) arrangements. The Trust undertakes various training and exercising initiatives relating to Emergency and Business Continuity and also participates as appropriate in exercises run by partner organisations, and those on a larger scale run across sector.

2.0 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The CCA 2004 places duties on all trusts to cooperate and share information with, and to coordinate efforts and work jointly with, partner organisations in Local Resilience Forums to ensure that emergency planning and preparedness is properly coordinated within each area, thus facilitating effective response to Major Incidents, and other emergencies or significant service interruptions.

The NHS England Emergency Preparedness Framework 2015, core standards and a number of significant guidance documents have informed the Trust's emergency planning. Some of these are specifically referred to below in the relevant sections of this report.

It is essential that the Trust Board be kept appropriately informed regarding EPRR, which includes planning for major incidents and emergencies, business continuity issues and any other scenarios with the potential to seriously disrupt the running of the Trust or the delivery of its services.

3.0 RESPONSIBILITY AND ACCOUNTABILITY

The Health and Social Care Act 2012 places upon NHS-funded organisations the duty of Accountable Emergency Officer with regard to emergency preparedness, resilience, and response (EPRR) (Section 46.9). In line with NHS England guidance, Carol Gillen Chief Operating Officer (COO) has been designated to take responsibility for EPRR on behalf of the organisation known as the Accountable Emergency Officer (AEO). The COO is responsible for ensuring that the Trust has a Major Incident Plan in place based on the duties of the CCA i.e. risk assessment, cooperation with partners, emergency planning, business continuity management, communication with the public and information sharing. This is supported on a day to day management of emergency response by the Emergency and Business Continuity Planning Officer Lee Smith.

4.0 FRAMEWORK FOR EMERGENCY PREPAREDNESS WORK WITHIN WHITTINGTON HEALTH NHS TRUST

The Emergency Management Steering Committee has met throughout the year in order to ensure that the emergency preparedness agenda continues to progress and to facilitate the increasingly requirement to have standardised Trust wide business continuity plans The group is chaired by Carol Gillen and includes senior representatives from each Directorate as well as a number of other key individuals from specific services.

The work of this group is critical to the Trust's ability to respond effectively to any emergency or major incident, and to its ability to continue to deliver agreed levels of services during any crisis. Directors are therefore expected to give the work and requirements of the group high priority, ensure they actively support it, and ensure all within 'their' services comply with its requirements and expectations. The committee reports through to Trust Operating Board (ToB) which in turn reports directly to the Executive Committee (EC).

An EPRR policy and Business Continuity Management (BCM) policy has been written to outline how emergency management will be implemented into the Trust to ensure we are meeting our legal obligations.

5.0 NHS ENGLAND EPRR AND CBRN CORE STANDARDS ANNUAL ASSURANCE

This year Whittington Health NHS Trust was reviewed on the 11th of November by the North East North Central NHS England Assurance Team. The review focused on business continuity and EPRR. There was a "Deep Dive" Incident Coordination and Command Structures. The review of Whittington Health NHS Trust was assessed for compliance against the EPRR Core Standards.

The EPRR Core Standards set out by NHS England enable the Trust to co-ordinate activities and provide a consistent cohesive framework for self-assessment, peer review and assurance processes. There is also core standards related to the response to chemical, biological, radiation, and nuclear (CBRN) incidents.

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2018

The assurance review process was conducted as follows:

Assurance Meeting	Date of Visit	Assurance Review attendance
CBRNe/HAZMAT assurance and site visit	01/11/2018	**Whittington Health NHS Trust**: Lee Smith. **NHS England (London):** Rey Aziz (Chair), Roshan Abdool-Raheem. **London Ambulance Service NHS Trust:** Andrew Godfrey (CBRN Training Officer).
Main Assurance Meeting		**Whittington Health NHS Trust:** Lee Smith, Carol Gillen. **NHS England (London):** Rey Aziz (Chair), Roshan Abdool-Raheem. **BHRUT:** Keith Donnelly (Peer Reviewer), Louise Nicholas (Observer).

Deep Dive Governance Questions 2018

There were eight Deep Dive questions in relation to Incident Coordination Centres and Command Structure. All eight questions were graded as fully compliant. For further detail, the 2018 EPRR Assurance report for Whittington Health

The Trust will go through annually an assurance review with NHS England (London) against the core standards, this year that has involved a self-assessment involving RAG rating using Red, Amber Green system – see below.

Red = Not compliant with core standard and no evidence of progress

Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.

Green = fully compliant with core standard.

This was followed by a challenge and review session involving NHS England (London), Clinical Commissioning Group (CCG) and a peer reviewer (Emergency Planning Officer from another Acute Trust) where we went into more detail on each of the core standards and they asked for more evidence to support the RAG rating. This was also carried out in a similar way with the CBRN core standards but was attended by London Ambulance Service instead of the CCG.

The tables below show the results of the 2013, 2014, 2015, 2016 and 2017 EPRR and CBRN core standard assurance illustrating a significant improvement over the 12 months with work on EPRR. NHS England (London) also informed that the Trust that the overall score for this year 2018-2019 is "**FULL**" compliance. This indicates an improvement on last year. The trust has no red or amber ratings.

EPRR and CBRN **2018** assurance outcome

NHS England Core Standards	**Core Standards total:**	**Assessment outcome Red**	**Assessment outcome Amber**	**Assessment outcome Green**
EPRR	55 (1-55)	0	0	55
CBRNE	14(56-69)	0	0	14
Governance Deep Dive Qu	6	0	0	6

EPRR and CBRN **2017** assurance outcome

NHS England Core Standards	**Core Standards total:**	**Assessment outcome Red**	**Assessment outcome Amber**	**Assessment outcome Green**
EPRR	52 (1-52)	0	0	52
CBRNE	14(53-66)	0	1	13
Governance Deep Dive Qu	6	0	0	6

EPRR and CBRN **2016** assurance outcome

NHS England Core Standards	**Core Standards total:**	**Assessment outcome Red**	**Assessment outcome Amber**	**Assessment outcome Green**
EPRR	52 (1-52)	0	3	49
CBRN	14 (53-66)	0	2	12
Business Continuity	6	0	0	6

EPRR and CBRN **2015** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	52 (1-52)	0	5	52
CBRN	14 (53-66)	0	4	10
Pandemic Flu	4	0	0	4

EPRR and CBRN **2014** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	47	0	4	43
CBRN	14	0	4	10

EPRR and CBRN **2013** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	109	3	46	60
CBRN	23	3	8	12

Assurance Review Team Summary 2018

The trust has agreed with the assessment from the NHS England Assurance Team. The trust has provided a self-rating of full compliance in accord with the request to self-assess rom NHS England.

Action plans and governance

Within two weeks of the assurance review meeting being held, the Accountable Emergency Officer must submit the following documentation: NHS England (London) also informed that the Trust that the overall score for this year is "**Full**" compliance. This indicates an improvement on last year. Areas of good practice identified by NHS England include business Continuity Management.

EPRR and CBRN **2019** overall assurance outcome

- Results of the organisation's final EPRR RAG scores, as agreed at the review meeting
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Amber which has been submitted
- A declaration of the Level of Compliance achieved (see below)

To enable a national-level overview of EPRR capability each organisation is asked to provide a single self-assessed Level of Compliance, approved by the AEO. This is intended to summarise whether organisations believe they are fully, substantially, partially or non-compliant against the core standards as a whole. The definitions of each term are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address the entire core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address several core standard themes that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address multiple core standard themes that the organisation is expected to achieve.

Action plans and governance

Within two weeks of the assurance review meeting being held, the Accountable Emergency Officer must submit the following documentation: NHS England (London) also informed that the Trust that the overall score for this year is "**Substantial**" compliance. The NHS EPRR Assurance Process team for this year concurred that the Trust has achieved "**Substantial**" compliance. This signifies an improvement on last year. Areas of good practice identified by NHS England include Business Continuity Management

6.0 EMERGENCY PLANNING – MAJOR INCIDENT EXERCISING

- In November 2017-2018 the trust rolled out 2- way pager training, which significantly increased resilience in relation to critical communications in the event of an incident.
- The Emergency Planning and Environment teams now conduct monthly Fire Evacuation and Radio Communications Exercises. This has successfully tested the resilience of clinical teams to act swiftly in coordination with incident response teams.
- In April in 2018. The Emergency Planning Team conducted Communication and Command post training. This Training provided the latest updates of providing communication with internal and external partners.
- In 2018 a comprehensive Winter Wash Up debrief with NHS Elect. This enables the planning team to develop exercises and training. The training included staff resilience, business continuity workshops and full capacity exercising for trust staff in preparation for this winter and challenges in business as usual.
- Throughout 2018 we provided regular testing of our CBRNe capability which improved learning, preparedness and capability of our response.
- In the second half of 2018 we have increased our Loggist Training which is now conducted internally on a monthly basis. Participants in the training complete an exercise at the end of the training.
- On the 21st of November 2017, Whittington Health NHS Trust conducted Exercise Asclepius. Exercise Asclepius was a live simulation that focused on the interoperability between the Metropolitan Police, London Ambulance Service, St John's Ambulance and the NHS. We had representation across the sector with delegates from Local Authorities, Police, LFB, LAS and NHS England present. The exercise tested Whittington Health NHS Trust's capability in response Major Incident Terror scenario.
- On the 15th of November 2017 Whittington Health NHS Health participated in the Exercise Eskimo. The exercise was conducted by Public Health England in Conjunction with NHSE NENC EPRR Network Team. The Exercise (Emergo) tested the NENC and Essex Trauma Networks response to a mass casualty terror incident.

6.1 Pre planning - major events

Under emergency management there is also a process to plan for pre identified major events (internally or externally) or upgrades to critical systems. There is a standard template in place which covers:

- Operations
- Logistics
- Communications – internal & external
- Planning – response & recovery

This process has been used for the following events:

- EU Exit Planning
- Industrial Action – Health Unions; Junior Doctors; Fire Brigades Union & London Underground
- EPR PAS/ED & BI planned upgrade;
- Medway planned upgrades;
- PACS - imaging planned upgrades;
- JAC updates
- Pathology system planned upgrade;
- Monthly generator tests;
- Vacuum plant changeover.

- Medical Gasses Maintenance
- Critical Infrastructure updates
- SCBU environmental clean
- Road Works
- Evacuation Matt training on site and in community.

Following each event, a debrief is carried out by the Emergency & Business Continuity Planning Officer with key leads to identify learning in preparation for future major events.

7.0 SERIOUS WEATHER RELATED DISRUPTIONS

There is now a heatwave and cold weather plan for the Trust which follows national guidance. As well as this the advance information and warnings available to the Trust has improved.

The Meteorological Office issues a range of warnings (detailing severity and levels of 'confidence'
In the forecast) which are sent to the Emergency Planning and Business Continuity Officer, Site Managers and silver and gold on call. Thus enabling services to receive (and respond as appropriate to) a range of severe weather related threats and potential service disruptions, without having the receipt of this information delayed by channelling it through one individual or office.

8.0 BUSINESS CONTINUITY MANAGEMENT

The Trust has undertaken initial work on Business Continuity Planning concentrating in the first instance on each Directorate attempting to prioritise services in terms of criticality, and considering the minimum staff levels (and to some extent, skill mix) required to continue delivering these services. However this is still a work in progress as there is variation in the quality and standard of the individual service plans. A new Trust template has been agreed and good progress has been made in completion by the services.

Other significant improvements within this area relate to the following - implementation of:

- Business Continuity Management Policy
- Strategic Business Continuity Plan
- Service/Department Business Continuity Plans

9.0 CBRN RESPONSE PROCEDURES

The CBRN response procedure was updated this summer by the newly established CBRN subcommittee from the Emergency Management steering committee. Training and testing of key staff in the use of the decontamination equipment is carried out monthly lead by CBRN lead in ED and supported by Security. There are some changes with regards to methods of decontamination, the new guidance and DVDs are being produced by NHS England which will be distributed to provider Trusts in due course. The course content for CBRN has changed in 2017; we have increased resilience by adding Paul Abdey Resuscitation Lead to the Training Team, whom qualified in September 2016. We have also increased our resilience and engagement with the EUC by appointing Joanne Poulter as the CBRNE/Major Incident link nurse. Our EUC Professional Development Nurse Joanne Poulter has completed the CBRNE trainer course in 2018. Whittington Health NHS trust has received 17 new PRPS suits from NHS England in early 2018.

10.0 PANDEMIC INFLUENZA PLAN

The pandemic influenza plan has had a complete revision following new guidance and best practice. A new pandemic influenza subcommittee has been established from the Emergency Management Steering Committee to oversee this review. The plan is planned for sign off by the end of December 2016. The Plan was reviewed on the 30th of September and was fully compliant with national standards. The plan continues to receive positive feedback from NHS England in 2016. The pharmacy Mass Prophylaxis Plan was reviewed, upgraded and included in the Pharmacy Major Incident Plan on 5th of July 2017.

10.1 Ebola virus disease

Through the pandemic influenza subcommittee there has been a review of the current guidance from Public Health England and NHS England and the Trust viral haemo fever policy to ensure we are following current guidance.

The Trust has been working closely with partners, including Public Health England and NHS England, to review existing preparedness against the following headings:

- Ensuring that updated viral haemorrhagic fever (VHF) algorithm and associated information is cascaded appropriately
- Engaging in multi-agency preparations
- Personal protective equipment (PPE) stock and resupply mechanisms
- Training of staff in the correct use of PPE and any processes in place
- The mechanism and process for identification and isolation of a suspected case

11.0 COOPERATING AND COLLABORATING WITH MUTLI AGENCY PARTNERS

The Accountable Emergency Officer will ensure there is Trust engagement with the Local Health Resilience Partnerships (LHRP). The Trust's Emergency Planning and Business Continuity Officer continued to maintain positive working relationships with NHS England (London). The Trust representatives regularly attend the North East and North Central London NHS EPRR Network Meeting, Network Learning Set and both the Borough Resilience Forum in London Borough of Islington and Haringey. The Emergency Officer will be taking on the role of Chair for the NHS England Acute Learning set in 2018, which provides Emergency Planners in London with training and support.

12.0 SUMMARY

The aim of the Trusts Emergency Preparedness arrangements, including its Emergency and Major Incident Plan, and associated Business Continuity arrangements, is to mitigate loss once an incident occurs; to (as a minimum) maintain previously agreed essential levels of service; and to return to 'normal' service as soon as possible following an interruption. The work of the Emergency Management steering committee and its representatives over the last year has increased the level of engagement of senior managers around the Trust in these processes, leading to significant progress in some areas.

The Trust continues to update its arrangements and amend them in line with national guidance, external advice and experience. Other supporting arrangements i.e. Evacuation plan and rigorous review of the Business Continuity plans across services will be implemented and actioned accordingly throughout 2018.

13.0 ACTION PLAN 2018/2019

It is anticipated that much of the workload for the Trusts Emergency Management Steering Committee over the coming year 2019 will related the Integrated Care Organisation and feedback from the NHS Assurance team. The feedback points from NHS England's Assurance team can be reviewed in the attached document EPRR Action Plan 2019.

Carol Gillen
Chief Operating Officer
(Accountable Emergency Officer & Emergency Planning Liaison Officer)

Lee Smith
Emergency and Business Continuity Planning Officer

Meeting title	**Trust Board – public meeting**	**Date: 31.1.2019**
Report title	**EU exit contingency plan**	**Agenda item: 13**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Lee Smith, Emergency Planning and Business Continuity Officer	
Executive summary	Board members are presented with an update on work that has taken as part of contingency planning for the UK to leave the EU on 29 March 2019 without a deal in place: • In October 2018, the Trust's Management Group reviewed the impact risks associated with a Brexit no deal scenario, particularly in the areas of workforce, legalities, finances, procurement and medicines and drugs • An EU Exit Planning Group, chaired by the Chief Operational Officer, has been established and its terms of reference agreed. It meets fortnightly and ensures delivery of the strategy set out by the Whittington Health Executive Team in relation to the UK not reaching a deal • A draft plan has been prepared covering the seven areas set out by NHS England, NHS Improvement and the Department of Health and Social Care in their guidance to all Trusts in December 2018: o supply of medicines and vaccines o supply of medical devices and clinical consumables o supply of non-clinical consumables, goods and services o workforce o reciprocal healthcare o research and Clinical Trials o data sharing, processing and access • All directorates are preparing a response in the Integrated Care Organisation to minimise impact to all services • Each Integrated Clinical Service Unit and corporate areas are reviewing their business continuity plans • A detailed risk assessment has been undertaken and mitigating actions and methods to be used are highlighted in appendix 1	
Purpose:	Review	
Recommendation(s)	Board members are asked to: i. receive this update on contingency planning for the UK to leave the EU in the event of a no deal outcome at the end of March	

	2019; and ii. take assurance from the work that has already taken place and continues to ensure the Trust minimises any adverse impact upon services and patients.
Risk Register or Board Assurance Framework	A risk assessment was completed for the EU Exit Planning Group and is kept under review. The risk of an adverse impact from Brexit is also linked to Board Assurance Framework risk entry 4: Failure to recruit and retain high quality substantive staff
Report history	Trust Management Group: 30 October 2018 and 15 January 2019
Appendices	1: EU exit contingency plan risk mitigation actions/methods

Appendix 1: EU exit contingency plan risk mitigation actions/methods:

Service	Risk reduction actions/method
Procurement	
1.0 Pharmaceutical Supplies	DHSC 6 week supply of medicines. Medicines Supply Contingency Planning Programme
1.1 Loss of Supply of critical medical supplies in 'no deal outcome'	Review of critical pharmaceutical suppliers, check of alternate suppliers not exposed to risk
2.0 Disruption to logistic Supply of Medicine	Local, regional and national logistics networks review and contingencies
2.1 Increase cost of medicine due to *No Deal*	Consider alternative suppliers that are more cost effective. Finance Team with all ICSUs to establish account of cost relative to 'no deal'
3.0 Cost associated with industry regulation and increasing technology costs	PPS have conducted a service and supply audit. Critical and Non-Critical suppliers have been identified. PPS will work closely with the DHSC for support.
4.0 Disruption of supply to radioactive materials, kit and parts	Integrated planning between DHSC and the British Nuclear Society and the Royal College of Radiologists
5.0 Disruption of supply of blood components and products affecting transfusion services	If there is no deal, the current blood safety and quality standards are not planned to change. Identify supplies at risk and make contingency arrangements
6.0 Disruption to IM+T supply chain	Procurement has conducted a review of suppliers for IM+T. Alternate suppliers will be sought if no deal impacts on supply
7.0 NHS Supply Chain Disruption	In the event of a loss of supplier there will need to be a rapid change of supplier. All suppliers have been reviewed and risk assessed. Procurement will work with the DHSC to determine local and national mitigation
8.0 Cold Chain supplies for Pathology	Self-assessment of cold chain supplies conducted by PPS. Identification of suppliers at risk. Alternate supply and storage to be reviewed by pathology and procurement
Financial	
9.0 Further increased costs of goods and services from the EU if the pound weakens	Short term mitigation can include currency hedging, consider currency protection in contracts. Consider alternate suppliers less impacted by currency variation
10.0 Further pound devaluation as a result of No Deal news	
Workforce	
11.0 Disruption to employing staff from the EU/	Agreement to pay for UK Settlement Scheme for EU employee's currently working for

Service	Risk reduction actions/method
EEA.	the trust. EU Employees have been contacted individually to provide support and information. EU staff living in the UK will be able to apply for settled status. EU staff employed here who arrive before 31 December, will be able to apply to settle after 5 yrs. Doctors and Nurses are exempt from the cap on skilled worker visa. No restrictions on numbers employed via the Tier 2 visa route
12.0 Divergence in professional standards. Challenges with recognising skilled labour internationally. Potential increase in cost of process	Workforce HR department to monitor legal and professional guidance from professional bodies. ICSU's to work closely with Workforce to identify challenges that emerge.
Research and development	
13.0 Disruption to EU medical trials participation may cause a decrease in research and development in the UK	Cabinet office has guaranteed funding for UK EU partnered research funding. The UK will have the capacity to make successful bids for EU research projects until the end of 2020 in a no deal situation.
14.0 Time delays in seeking medicines approval in the UK. Possible change to arrangements to access UK markets	Pharmaceutical companies are currently reviewing processed to access UK markets and being supported by the DHSC. Pharmacy will monitor for further updates.
Reciprocal health care arrangements	
15.0 Arrangements for reimbursement of treating EU citizens after provision of care	Woking in partnership with DHSC, NHS England and NHS Improvement, Irish citizens will be exempt due to alternate agreement. There will further updates on reciprocal health rights on the 29th of March. Cabinet Office is working to sustain mutual reciprocal agreements.
16.0 Possible increase in demand for health care services if expats in the EU are required to return to the UK	Ex pats will have access to health care in the UK. In a no deal scenario there may be increased demand for health care services if a reciprocal agreement is not agreed.

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	7 Day Hospital Services Self-Assessment	**Agenda item: 14**
Executive director lead	Julie Andrews, Acting Medical Director	
Report author	Julie Andrews, Acting Medical Director	
Executive summary	The 7 Day Hospital Services (7DS) Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. This work is built on ten clinical standards, four of which were prioritised for delivery to ensure that patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant-directed review every day of the week. •Standard 2: Time to initial consultant review •Standard 5: Access to diagnostics •Standard 6: Access to consultant led interventions •Standard 8: Ongoing daily consultant-directed review	
Purpose:	Guidance from NHS Improvement askes provider Boards to review self-assessment against the 7 Day Services' standards twice a year	
Recommendation(s)	The Trust Board is asked to consider the 7 day hospital services self-assessment at appendix 1, in particular the green-rated performance against clinical standards 2, 5, 6 and 8 and to discuss any required changes.	
Risk Register or Board Assurance Framework	BAF risk entry 3 - Failure to hit national and local performance targets results in low quality care, financial penalties and decommissioning of services – is being reviewed and updated to include the operational performance requirements of 7 day services	
Report history	None. The requirement is for provider Boards to review self-assessment against the standards twice a year in the spring and autumn	
Appendices	1: Self-assessment template	

7 Day Hospital Services Self-Assessment

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

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

Priority 7DS Clinical Standards

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

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

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

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

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10

7DS and Urgent Network Clinical Services

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

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met.

Template completion notes

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

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	**December (Month 9) 2018/19 – Financial Performance**	**Agenda item: 15**
Executive director lead	Stephen Bloomer, Chief Financial Officer	
Report author	Kevin Curnow, Operational Director of Finance	
Executive summary	The Trust is reporting a surplus (including Provider Sustainability Fund (PSF) income of £2.1m) of £1.7m for the month of December (month 9) which is ahead of plan. Year to date the Trust is meeting the NHS Improvement adjusted plan, with a surplus of £9m including £13.9m of PSF income. Income performance is marginally behind plan in month with a negative variance of £0.1m after adjusting for agenda for change funding and High Cost Drugs (£2.2m year to date). Pay costs remain above budget, £0.4m in month (£2.6m year to date) and are at such a level to be causing significant concern regarding the achievement of the Trusts year end control total. Immediate action is required to bring over established pay budgets back to plan. The Trust is currently forecasting to achieve its control total but this will require much greater scrutiny of pay expenditure in the remaining three months and the settlement of the current Agenda for Change £0.8m funding shortfall for the agreed three year, national pay deal (2018/19 – 2020/21). The Trust is forecasting Cost Improvement Programme (CIP) delivery of £13.3m (£12m recurrently) against a £16.5m target, with £9.3m (£8.4m recurrently) delivered to date. The Trust has spent £5.1m to date of its capital allocation with planned capital expenditure remaining at £14.8m and does not have a cash flow risk.	
Purpose:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.	
Recommendation(s)	To note the financial results relating to performance during December 2018 recognising to need to improve income delivery, reduce agency spend and improve the delivery of run rate reducing CIP plans.	
Risk Register or Board Assurance Framework	BAF risks 5 and 10	
Report history	Trust Management Group, January 2019 meeting	
Appendices	1 – month 9 finance report	

Appendix 1: December (Month 9) 2018/19 – Financial Performance

Financial Overview

The Trust is reporting a £1.7m surplus in December including £2.1m of PSF, which is a positive variance to plan of £0.2m for the month. The year to date position of a £9m surplus including £13.9m of PSF, is in line with the planned control total.

In month, total Income was £0.1m ahead of plan. There were positive income variances relating to Outpatient attendances and procedures £0.4m, Emergency Department £0.05m and Agenda for Change funding of £0.3m, although this variance is offset in pay.

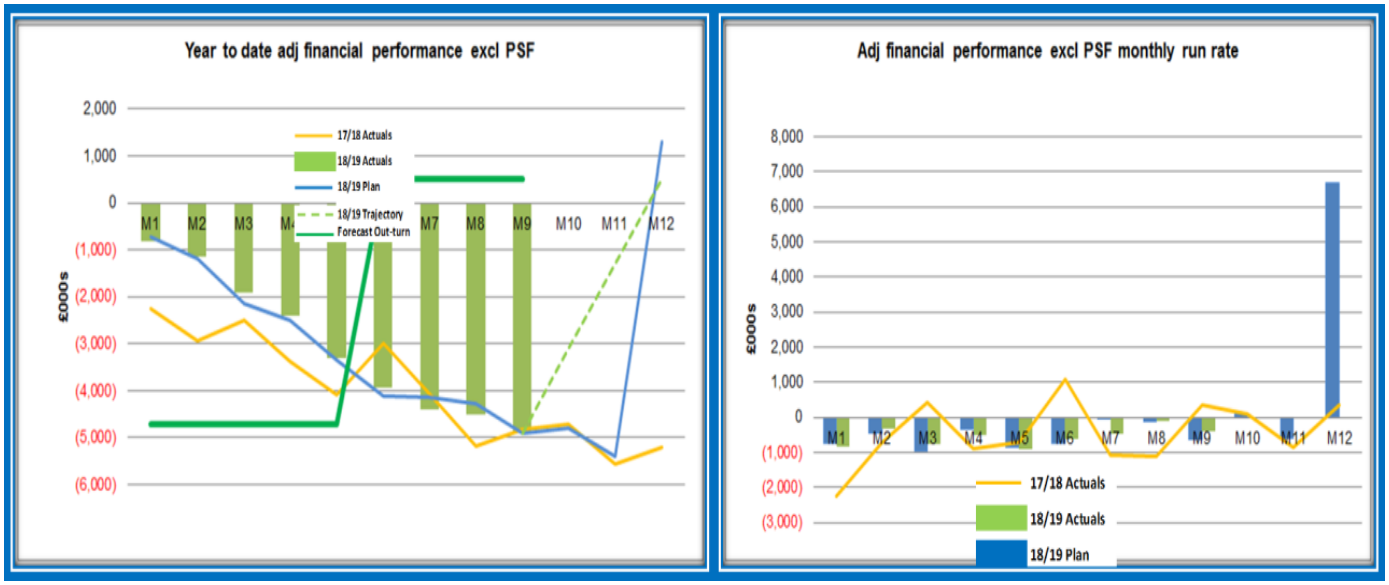
Non-pay is underspent in month by £0.4m as a result of the favourable settlement of legacy disputes and supplier commitments.

The pay spend in December continues the trend of being in excess of budget due to the usual agenda for change payment but also significant pressures relating to bank spend. The cumulative agency spend is £9.4m, in month, the spend was £0.7m after adjusting for £0.2m of prior year provisions released. The Trust has challenged each ICSU to cap agency spend at £11.4m for the year. This will require action to reduce spend to less than £0.7m a month.

There is significant concern relating to the pay spend in the EIM ICSU, further detail is provided in later in this report. This ICSU is receiving additional support and scrutiny to reduce the number of temporary staffing hours being booked. Without a reduction in the pay spend with jeopardise the organisations ability to achieve its control total for 2018-19.

The table below shows the summary position for the month and year to date.

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	Variance (£000s)	FULL YEAR BUDGET (£000s)
Clinical Income	22,969	22,700	(269)	210,728	208,788	(1,940)	260,376
Other Non-Patient Income	2,176	2,363	187	20,176	19,965	(211)	47,536
High Cost Drugs	656	589	(67)	5,908	6,479	571	7,877
Pay Award Funding	0	264	264	0	2,471	2,471	0
Total Income	**25,802**	**25,917**	**115**	**236,812**	**237,704**	**892**	**315,789**
Pay	(18,455)	(18,821)	(366)	(167,206)	(169,830)	(2,625)	(222,445)
Non-Pay (excl HCD)	(6,052)	(5,695)	356	(56,340)	(54,357)	1,983	(74,057)
High Cost Drugs	(669)	(592)	78	(6,044)	(6,369)	(326)	(8,052)
Total Operating Expenditure	**(25,176)**	**(25,109)**	**67**	**(229,590)**	**(230,557)**	**(967)**	**(304,554)**
	626	**808**	**182**	**7,222**	**7,147**	**(75)**	**11,235**
Depreciation	(541)	(509)	32	(4,874)	(4,801)	73	(6,500)
Dividends Payable	(431)	(431)	0	(3,877)	(3,877)	0	(5,263)
Interest Payable	(278)	(289)	(11)	(2,503)	(2,500)	3	(3,341)
Interest Receivable	1	9	8	9	68	59	12
P/L on Disposal of Assets	0	0	0	0	0	0	6,000
Total	**(1,249)**	**(1,219)**	**30**	**(11,245)**	**(11,110)**	**135**	**(9,092)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(623)**	**(411)**	**212**	**(4,023)**	**(3,963)**	**60**	**2,143**
Provider Sustainability Fund (PSF)	2,138	2,138	(0)	13,897	13,897	*0*	*21,380*
Net Surplus / (Deficit) - before IFRIC 12	**1,515**	**1,727**	**212**	**9,874**	**9,934**	**60**	**23,523**
Add back							
Impairments	0	0	0	0	0	*0*	51
IFRS & Donate	(27)	6	33	(890)	(942)	*(52)*	(899)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**1,488**	**1,733**	**245**	**8,984**	**8,992**	**8**	**22,675**


Year to date adj financial performance excl PSF
2,000
1,000
0
(1,000)
(2,000)
(3,000)
(4,000)
(5,000)
(6,000)
£000s
M1
M2
M3
M4
M7
M8
M9
M10
M11
M12
17/18 Actuals
18/19 Actuals
18/19 Plan
18/19 Trajectory
Forecast Out-turn
Adj financial performance excl PSF monthly run rate
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
(1,000)
(2,000)
(3,000)
£000s
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12
17/18 Actuals
18/19 Actuals
18/19 Plan

Income and activity

The Trust's reported income position, excluding High Cost Drugs and Devices and Agenda for Change funding, is a year to date adverse variance of £2.2m. This is an adverse performance of £0.1m in month. ICSU recovery plans aimed to exceed plan and therefore this performance makes it increasingly difficult for the Trust to achieve the Control Total.

Day Case and Elective activity is 10% ahead of the year to date activity plan but £0.6m behind the income target. The underperformance continues to be within Trauma & Orthopaedics, Urology and General Surgery specialties valued at £1.4m.

Non elective activity excluding maternity activity is on plan, at £32m income year to date. Activity has recovered from previous months where is was adverse to plan. Uncoded activity was higher than previous months, £2.7m for 1,851 spells in Month 9. Maternity deliveries and pathways payments continue to under-perform against plan with a £1.1m adverse variance.

Outpatients' continue to over perform by £0.4m in month, £1.3m year to date with activity is 10% ahead of plan. The over-performance is within Diagnostics Imaging, Gynaecology and Trauma & Orthopaedics specialties. However there is underperformance in Paediatrics, Dermatology and Gastroenterology.

Unplanned care in A&E & UCC activity is 4% ahead of the year to date plan and ambulatory care remains above planned levels by £0.4m year to date.

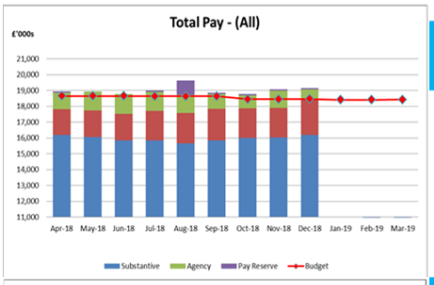
Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	1,188	1,235	47	10,540	10,758	218	8,740	9,219	479	77,523	80,468	2,945
Ambulatory Care	276	335	59	3,051	3,456	404	1,165	1,308	143	12,702	13,790	1,088
Adult Critical Care	640	1,526	886	5,674	5,528	(146)	1,463	1,333	(130)	11,901	10,244	(1,657)
Community Block	5,857	5,857	0	52,943	52,867	(76)	0	0	0	0	0	0
Day Cases	920	998	78	10,170	10,231	61	1,532	1,917	385	11,911	13,459	1,548
Diagnostics	201	278	77	2,223	2,656	434	2,635	3,120	485	20,485	23,703	3,218
Direct Access	788	419	(370)	8,718	9,078	360	99,505	96,816	(2,689)	773,318	766,555	(6,763)
Elective	632	670	38	6,994	6,347	(647)	207	217	10	1,613	1,462	(151)
High Cost Drugs	654	607	(47)	5,889	6,366	477	0	0	0	0	0	0
Maternity - Deliveries	1,132	1,008	(124)	9,208	8,574	(634)	310	286	(24)	2,524	2,405	(119)
Maternity - Pathways	770	660	(110)	5,987	5,480	(507)	727	615	(112)	5,651	5,290	(361)
Non-Elective	3,294	3,323	29	32,202	32,281	79	1,556	1,843	287	12,649	13,090	441
OP Attendances - 1st	712	866	154	7,878	8,623	744	4,971	5,236	265	38,603	42,132	3,529
OP Attendances - follow up	636	735	99	7,029	6,982	(47)	13,135	12,159	(976)	92,285	99,353	7,068
OP Procedures	306	413	107	3,380	3,951	571	2,262	3,033	771	17,573	21,793	4,220
Other Acute Income	1,467	955	(513)	11,166	12,006	840	7,732	8,274	542	60,025	48,421	(11,604)
CQUIN	452	473	20	4,292	4,272	(19)	0	0	0	0	0	0
Total SLA	**19,925**	**20,357**	**432**	**187,345**	**189,456**	**2,111**	**145,941**	**145,376**	**(565)**	**1,138,763**	**1,142,164**	**3,402**
Marginal Rate	0	0	0	0	(240)	(240)						
	19,925	**20,357**	**432**	**187,345**	**189,216**	**1,871**						
Other Clinical Income	3,700	2,861	(839)	29,291	25,956	(3,335)						
Other Non Clinical Income	2,176	2,698	522	22,314	24,669	2,356						
Total Other	**5,877**	**5,559**	**(317)**	**51,605**	**50,625**	**(980)**	**0**	**0**	**0**	**0**	**0**	**0**
Total	**25,802**	**25,916**	**114**	**238,950**	**239,842**	**892**	**145,941**	**145,376**	**(565)**	**1,138,763**	**1,142,164**	**3,402**
PSF	2,138	2,138	0	11,759	11,759	0						
Revised Total	**27,940**	**28,054**	**114**	**250,709**	**251,601**	**892**						

Monthly run rates – expenditure

The year to date combined expenditure position is £1m adverse to plan. Key points of note include:

- **Pay and Activity Correlation**
  - Total pay expenditure for November was £18.8m which is over £0.4m in excess of budget
  - Within total pay expenditure, agency costs were £0.7m. The total agency spend is £9.4m. Total temporary spend in month was £2.5m.
  - The Trust continues to review its electronic rota system to ensure all rotas reflect the establishment and actual staffing levels match the plan.
  - The Trust is also reviewing its shifts that remain 'open' on the staff booking system to correctly record the agency liability.
  - The adverse pay spend threatens to jeopardise the Trusts ability to meet its year end control total

The charts below provide some further detail on the pay costs along with WTEs and temporary staffing hours for the Trust for this financial year.



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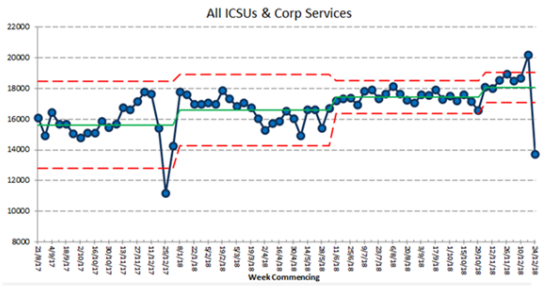
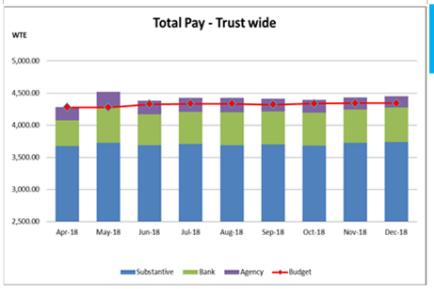
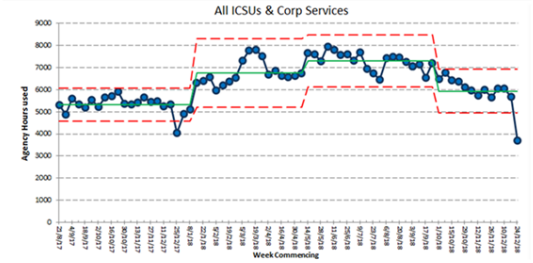
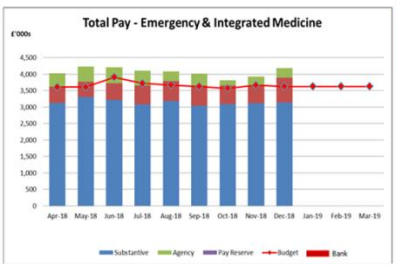




Agency



During the month there has been significant concern relating to the use of WTEs above funded establishments, particularly within the Emergency & Integrated Medicine ICSU. In this ICSU, the over-establishment amounts to almost 70 WTEs. Further pay detail relating to the ICSU is provided below.



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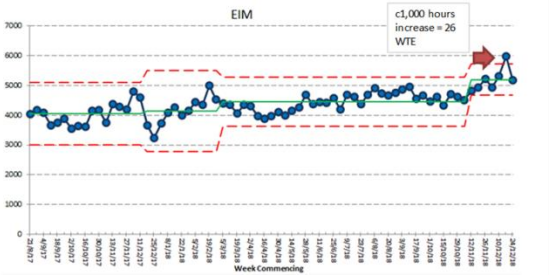
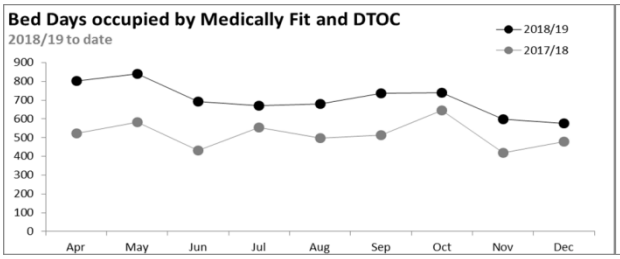
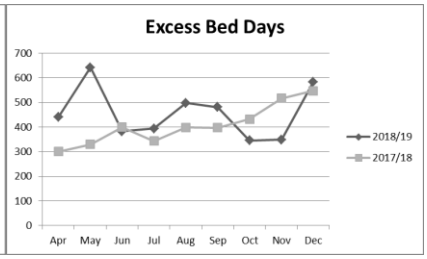
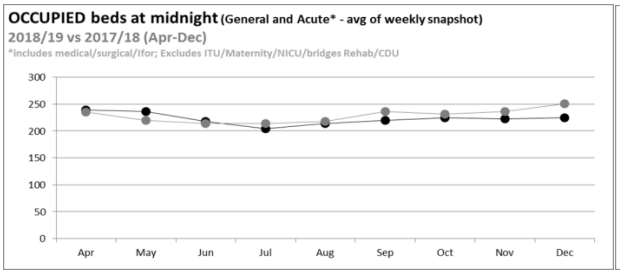
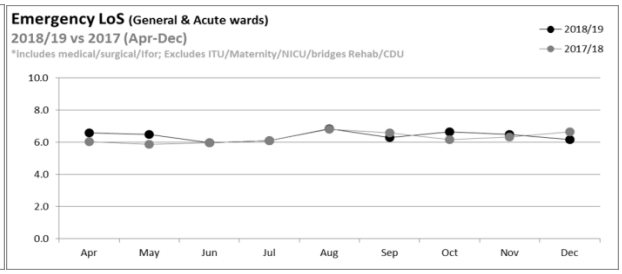


The number of occupied bed days for medically fit and DTOC patients remains above the levels experienced last year, although a reducing level to those from earlier in the year it still drives the requirement for additional temporary staff with a reduced level of tariff income. There was a significant increase in the number of Excess Bed Days in December, marginally higher than last year. The occupied beds are less than last year and have remained stable in the last few months. Likewise the Emergency Length of Stay has reduced and now less than last year.

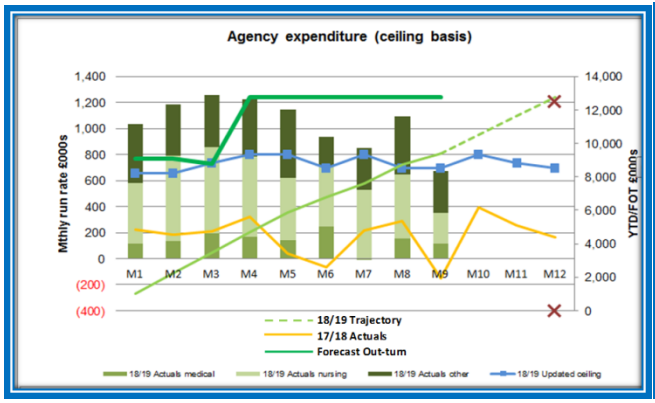


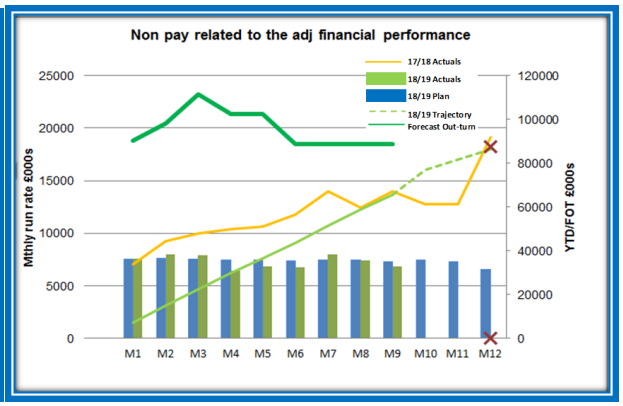






- **Non Pay**
  - Non pay expenditure for December was £6.3m, including High Cost Drugs.
  - This spend is £0.5m less than the £6.8m average because of a lower than planned High Cost Drugs spend (offset in income) and the positive settlement of legacy supplier and customer debts





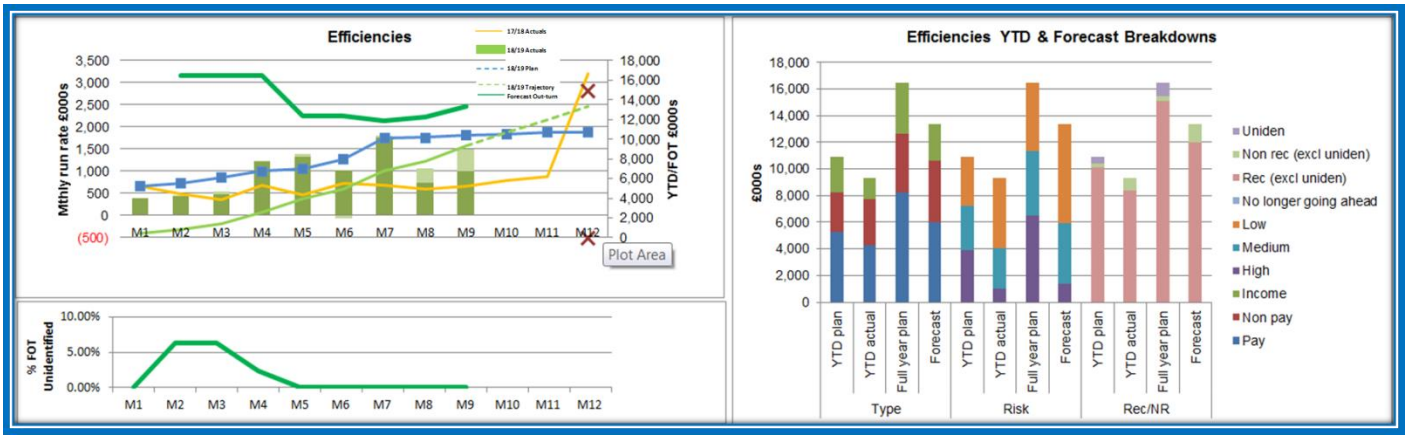
Cost Improvement Programme (CIP)
The original Cost Improvement Programme target was £16.5m, split by programme area being:

- Flow Through – £2.7m
- ICSU 2% targets – £5.5m
- Transformation Schemes – £8.3m

The Trust is forecasting CIP delivery of £13.3m, a shortfall of £4.2m from the original target. Of the £13.3m, £12m is forecast to be delivered recurrently.

In-year delivery – Month 9
At the end of month 9 the Trust's planned delivery was £10.9m of CIP, against which £9.3m (£8.4m recurrently) has been delivered, equating to 85%. Analysed by programme area:

Forecast delivery
During December the Trust has forecast that it will deliver £12m of recurrent CIPs for the year (£11.8m in month 8) with a further £1.3m non recurrently. The Trust is encouraging ICSUs to deliver non recurrent mitigations to close any gap in delivery of the original target, and to identify additional, recurrent CIP plans to replace those that have either not delivered or not delivered to the levels originally intended.

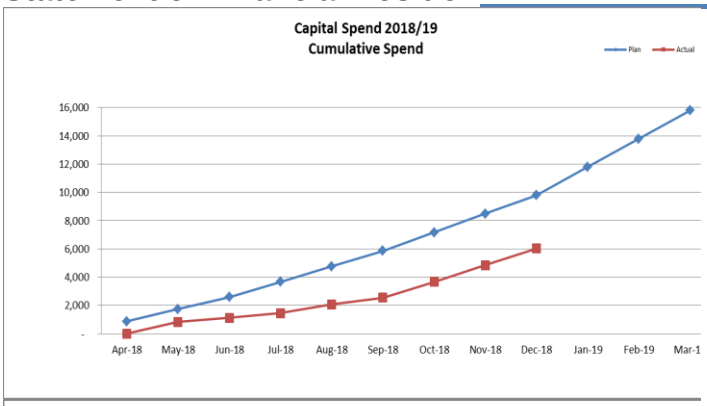


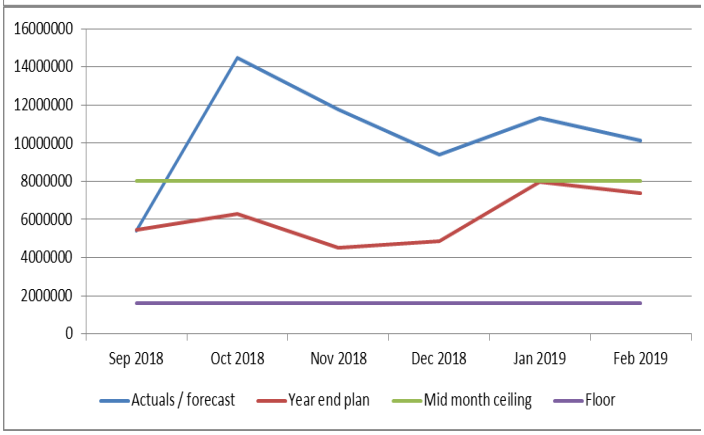
Forecast by programme area:

- Flow through – £2.7m (100%)
- ICSU 2% targets – £4.6m (80%)
- ICSU 2% target delivered non recurrently - £1.3m
- Transformation Schemes – £4.7m (54%)

Within the ICSUs, the key areas of focus will be for Adult Community and Children & Young People as the furthest away from plan in terms of forecast delivery. However, attention also needs to be given to Surgery & cancer as 33% of their forecast is delivered via non-recurrent means rather than true CIPs. Within Transformation Schemes key areas for focus are those in relation to Outpatients, Community and Improving Medical Value.

Statement of Financial Position





THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 Dec 2018 £000	Plan 31 Dec 2018 £000	Year to Date Plan variance 31 Dec 2018 £000
Property, plant and equipment	214,952	220,603	(5,651)
Intangible assets	5,352	4,909	443
Trade and other receivables	1,394	656	738
Total Non Current Assets	**221,698**	**226,168**	**(4,470)**
Inventories	1,480	1,355	125
Trade and other receivables	34,500	32,886	1,614
Cash and cash equivalents	9,394	4,868	4,526
Total Current Assets	**45,374**	**39,109**	**6,265**
Total Assets	**267,072**	**265,277**	**1,795**
Trade and other payables	40,059	38,604	1,455
Borrowings	18,803	18,953	(150)
Provisions	1,161	1,391	(230)
Total Current Liabilities	**60,023**	**58,948**	**1,075**
Net Current Assets (Liabilities)	**(14,649)**	**(19,839)**	**5,190**
Total Assets less Current Liabilities	**207,049**	**206,329**	**720**
Borrowings	38,151	41,107	(2,956)
Provisions	839	842	(3)
Total Non Current Liabilities	**38,990**	**41,949**	**(2,959)**
Total Assets Employed	**168,059**	**164,380**	**3,679**
Public dividend capital	64,679	65,679	(1,000)
Retained earnings	5,174	128	5,046
Revaluation reserve	98,206	98,573	(367)
Total Taxpayers' Equity	**168,059**	**164,380**	**3,679**

Overall, the value of the balance sheet is £3.7m higher from plan. The main reason behind this is the increased surplus made by the Trust as a result of additional Provider Sustainability Funding (PSF). Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £5.1m lower than plan. Capital spend in months 7-9 were in line with plan but did not reduce the slippage carried forward from previous periods. However, each area of spend (Estates, IM&T, Medical Equipment and PMO) all have robust plans to spend their allocations. The Trust advised NHSI in month 5 that it is likely to undershoot the plan by £1.0m; it is on target to reach the revised target of £12.7m.

- **Receivables (Debtors)** are £2.4m higher than plan. The increase is being driven by the accrual of core and incentive Provider Sustainability Funding (PSF). Based on the assumption that yearend control totals will be met, the Trust accrued a further £2.2m in month. £2.4m of this was settled in month 9, but the incentive element (£12m at year end) is not expected to be settled until July 2019. Overall receivables are £4m lower than month 8 based on the receipt of the PSF above, as well as the settlement of approximately £2m of old year debts.

- **Payables (Creditors)** are currently £1.5m above plan. This is a significant improvement on month 8 – the Trust has settled some significant prior year creditors as well as clearing some current year accruals that had not been invoiced.

- **Cash and cash flow:** the Trust is holding £9.4m in cash at the end of December 2018. This is £4.5m higher than plan, and reflects the points raised on creditor management above. £3m of the balance is invested with the National Loans Fund.

  The Trust has modelled its cash flow for the whole of 2018-19 and concluded that no cash support should be required during 2018/19. As a result of the Trust's revised control total, we

expect cash balances to be significantly higher than expected balances in the Trust's initial operating plan for the rest of 2018-19.

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	**2018/19 strategic objectives – quarter three outcome**	**Agenda item: 16**
Executive director lead	Jonathan Gardner, Director of Strategy, Development & Corporate Affairs	
Report authors	Swarnjit Singh, Trust Corporate Secretary and Executive Directors	
Executive summary	Board members are presented with the quarter three outcome for the delivery of 2018/19 strategic goals. Board members' attention is drawn to the following highlights and concerns: • Good progress on integrating and coordinating care through the localities work • Robust monitoring of quality and safety through the Patient Safety Committee and Quality Committee • Maintained performance of key targets • Further work needed on "supporting patients and users to be active partners" • Continued development of QI and education work streams • Reduced agency spend but insufficient to help deliver targets	
Purpose:	Review	
Recommendation(s)	The Trust Board is asked to receive and review the quarter three outcome for progress with delivery of the Trust's strategic objectives.	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Quarterly report to Board	
Appendices	1: Whittington Health 2018/19 strategic objectives 2: 2018/19 strategic objectives' scorecard	

Appendix 1: Whittington Health 2018/19 strategic objectives

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

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

Our Values:

Our objectives:

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

Whittington Health Strategic Goals	Sub priorities	Progress
1. To secure the best possible health and wellbeing for all our community	Improve our clinical effectiveness as outlined in the quality account. (MJ)	1. Patient Flow – some of the priorities achieved, more work to embed criteria led discharge from hospital wards. 2. Clinical Research - more work needed around number of nurses, midwives and Allied Health Professionals identified as being involved in clinical research. Reporting to quality committee 3. Education and learning – progress made on education survey more work to do to ensure integrated education opportunities are maximised and mandatory training is achieved at the required levels.
	Deliver the better births action plan (CG)	WH is part of LMS (local maternity services) and are leading 'continuity of care' which is one of the elements of the LMS action plan. Target by March 2019 is for 20% (aggregated across the sector) of women booked onto continued care pathway. The key challenge will be around intrapartum care and will inevitably involve review of staffing model. Funding available for project management on submission of action plan (December 2018). On track with timescale. 'As part of the plans to implement 'continuity of care' models in maternity services we have submitted our plans to the LMS and funds have been approved for project management. The current timescale for achieving 20% aggregate across the sector will not be met but it is anticipated that the initiation towards reviewing staffing models will commence by March 2019'
	Move community children's services from 'Requires	Out of the 62 actions for Children & Young People (CYP) Integrated Clinical Service Unit (ICSU) in the Care Quality Commission (CQC) action plan, 7 are currently rated yellow. These are: meeting mandatory training targets; meeting

Whittington Health Strategic Goals	Sub priorities	Progress
	Improvement' to Good (CG)	appraisal targets; community service wait times; redesign of community paediatric services; improving condition of estates – Northern Health Centre and St Ann's; separate area for CYP in outpatients' department; Simmons House Incident Reporting Policy. 1. The ICSU has continued to make positive progress towards delivering the Trust-wide target for both mandatory training and appraisals. The ICSU Board reviews the progress monthly and the ICSU Risk Manager and Business Manager have targeted specific services / teams with low compliance. The ICSU Board continues to identify anomalies between service / team records and ESR which the HR Business Partner has been tasked with resolving. These issues have been identified across all professional groups. 2. The ICSU now has a dedicated project manager working the Community Paediatric Teams both in Haringey and Islington to begin implementing the recommendations of the UCLP Review of both services. This includes changing the assessment model for CYP with Autism in Haringey and wider improvements around systems and processes impacting on data quality and overall productivity. 3. The Trust have identified the remedial works required to improve the physical state of the Northern Health Centre which forms part of the 2018/19 capital programme. The St Ann's site will also be redeveloped as part of the Camden and Islington Foundation Trust estates transformation programme. The Trust is also in the process of completing the Master Planning for the wider Estates Strategy which will include re-looking at the community estates requirements in line with future clinical models and service change. 4. Simmons House Incident Reporting is now in line with the risk management process used throughout the ICSU, supported by the ICSU Risk Manager and monitored by the ICSU Board.

Whittington Health Strategic Goals	Sub priorities	Progress
2. To integrate and coordinate care in person-centred teams	Develop Haringey and Islington Wellbeing Partnership and actively participate in NCL STP (JG)	We continue to work closely with the partnership at all levels and we are beginning to take more of a lead in some of the areas such as locality working (mentioned below). We are also attending the Islington and Haringey "Inter-great" events to help design the future governance of the sector.
	Develop our community teams around the emerging neighbourhoods and CHIN networks (JG)	We are working closely with partners on leading the locality prototypes in North Tottenham and North Islington. We have held 2 launch events with CEO support, and 2 senior manager meetings to set the framework and begin to design a new operating model. There has also been a meeting with 80 people from the front line, including service users, to set the agenda, direction of travel and action plan. There will be a large expo event at the end of March in Islington.
	Collaborate with UCLH and other NHS providers to improve efficiency and resilience (JG)	Progress is being made on all the projects of Breast, Maternity and Chronic Lower Urinary Tract infection service. We are also making progress with UCLH on a joint response to the NCL orthopaedic reconfiguration plans.
	Maintain treatment and waiting time standards for our mental health patients (CG)	• Ongoing weekly monitoring of mental health waits – update and assurance at A&E Delivery Board meeting. • Maintain and monitor correct escalation processes are maintained in hours and out of hours • Optimise use of Mental Health suite – instigated weekly teleconference with senior Camden & Islington team to monitor progress against expected improvement. • Improvement against target (50% of Mental health patients transferred to MH suite) over past quarter – averaging 43% and exceeded target on two weeks.

Whittington Health Strategic Goals	Sub priorities	Progress
3. To deliver consistent, high quality, safe services	To move from Good to 'Outstanding' in our CQC rating.	• Reporting to Quality Committee and the Trust Board on quarterly basis on preparation for future CQC inspections. • Fortnightly Good to Outstanding Preparatory Meetings in place – chaired by the Chief Nurse. • Our new Quality Assurance Manager started in December 2019 and is completing Trust CQC risk assessment and information pack for services. • CQC risk assessment will be added to risk register. • CYP, ACS & ACW Integrated Clinical Service (ICSUs) have completed self-assessments across their services other ICSUs and corporate areas are underway. • Peer reviews continue and ICSUs have nominated staff reviewers; also, managers from partner agencies & Trusts have participated in or have volunteered to do peer reviews. • Deputy Chief Nurse environment walkabout to start fortnightly in hospital & community from January 2019 • The board is conducting a self-assessment of the well-led framework and has invited Deloitte to support the board in further development.To initiate 'de-clutter day' per month – to start January 2019; communication to advertise using Screensaver & Bulletin
	Improve patient safety through achieving the priorities of the quality account (MJ)	• These improvements are monitored through the monthly Patient Safety Committee • Assurances provided to the Trust Board through the Quarterly Quality and Safety Board Report • Significant measurable progress is being made with all of the Quality Account priorities, as reported in the public Trust Board paper Quarter 2 2018/19 Quarterly Quality and Safety Board Report
	Deliver actions to meet CQC areas for	A small number of actions remain amber-rated, these are monitored through CQC prep planning meetings, peer reviews reporting to the Quality committee

Whittington Health Strategic Goals	Sub priorities	Progress
	improvement (MJ)	quarterly. Progress being made with the seven actions still in progress; actions for critical care now closed
	Improve community services (CG)	Community services improvement group (CSIG) in place since March – good progress with adult community services supported by dedicated project management resource. Separated Children and Young People (CYP) from Adults CSIG so that more focus can be given to specific challenges within CYP community. Increased Project management resource in place from 22nd October. Significant improvement in Adult services waiting times – with a number of services achieving trajectory (see trust board report). Focus on CYP has been on improving data quality which is underway supported by PM resource. Improvement plan with trajectories agreed for service areas.
	Deliver quality improvement plans to support achievement of four-hour target (CG)	Focus on key improvement at front of house to improve time to treat and flow through department. Focus on reducing length of stay through a number of improvement initiatives including MADE, SAFER and whole systems working, Year to date performance is 89.2% Review by Emergency Care Improvement Programme team of Rapid Assessment and Treatment (RAT), clinical handover and optimisation of pathways Key focus following review includes – reducing variation in RAT with consistent Medical staffing from 11- 17.00 Reduce variation in streaming Optimising pathways including AEC –

Whittington Health Strategic Goals	Sub priorities	Progress
		Focus on Fit2sit
	Achieve cancer and referral to treatment national standards (CG)	• Key focus on diagnostic capacity more specifically endoscopy. Part of Cancer collaboration Quality Improvement (QI) action learning set to support improvement in pathway. • 62 days prostate cancer – working with North Central London Cancer Collaborative to reduce variation - plan to get agreement in early November • Refocus cancer PTL, supported by weekly dashboard with monitoring at trust operational meeting • Cancer 2 weeks compliant in Q1; 62 days non-compliant • Compliant in 62 days for Q2 • No compliant in 2 W – challenges have been around diagnostic capacity (endoscopy) which have now been addressed • .There remains some challenges in relation to prostrate pathway however workforce issues are being addressed including plan to train nurse cystoscopist
4. To support our patients and users in being active partners in their care	To deliver the refreshed patient experience strategy (MJ)	• The Patient Experience Strategy 2019-2021 was positively received and approved at January's Quality Committee. The finalised version is to be presented to the Trust Board in February 2019.
	Ensure patients representatives are included in quality improvement projects and service redesign (JA)	• Work underway to engage people with lived experience in Q4 (2018/19). Patient co-production in key patient safety/pathway QI work including falls, sepsis, asthma and COPD.
	Ensure patient	Patient representative on Quality committee and patient experience committee.

Whittington Health Strategic Goals	Sub priorities	Progress
	representatives are equal members on board sub committees (JG)	This is also highlighted on the draft patient experience strategy. Plans include Building and maintaining a database of patient and carers who would like to work as partners with the trust; Maintaining a record of focus groups and patient forums; Evidence of patient representatives on committees, projects and toolkits; Evidence of involvement of Healthwatch
	Expand our supported self-management approach to one or more additional areas within Whittington Health (e.g. rheumatology) and measure impact (CG)	Business manager for prevention due to start on November 1st. AS and service to agree capacity for Whittington Health prevention projects. Business manager has started within the ACS ICSU which has allowed prevention lead to identify potential business opportunities. Rheumatology self-management courses (similar to Diabetes) for 19/20 reflected in provider intentions letter – currently in discussion with commissioners.
	Become a recognised expert provider of prevention and supported self-management services in adults and children (CG)	• Appointed Trust Smoking Cessation Lead. • Business manager for prevention due to start November 1st. Capacity for new business and income target to be agreed at CIP board and Trust Board Challenge Day- as above • Trust smoking lead (interim deputy COO/DOO ACS) completed baseline assessment of TRUST compliance against NICE evidence based standards
5. To be recognised as a leader in the fields of medical and multi-professional education, and	Continue to host the Haringey and Islington CEPN (JG)	Community Education Provider Network (CEPN) procurement is complete and contracts have now been signed. No update this quarter.
	Develop the multi-professional integrated	• An increasing number of multi-professional educational meetings and initiatives are being held, and these are often explicitly linked with patient

Whittington Health Strategic Goals	Sub priorities	Progress
population-based clinical research	education work for WH and others (JA)	safety learning • Moodle is being continuously improved and developed as a platform for multi-professional education • The Whittington Health Library Service provides initiatives both within and outside. Whittington Health to promote multi-professional learning; a recent example is work with Islington Council and its Library Services.
	Continue to be recognised as an excellent education provider (JA)	A joint initiative has been led by the medical, nursing and workforce directorates to refresh the Whittington Health Integrated Education Strategy; it is anticipated that this work will proceed through 2019/20.
6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	Expand Quality Improvement training (JA)	• The trust has created and appointed to Associate Medical Director of Quality Improvement and operational lead for QI • The trust continues to roll out the Quality Improvement strategy • The number of staff being training in Quality Improvement is continually increasing and training is now delivered in house 4 times a year. • We have joined QI networks across NCL
	Develop the generic worker roles with the local authorities (JG)	This is part of the locality working groups for North Tottenham and North Islington as mentioned above.
	Begin to integrate physical and mental health roles and services (JG)	This is part of the locality working groups as above, and specifically the operational teams have created a two weekly meeting between district nurses and mental health workers and social care workers to look at specific groups of residents who might benefit from a more proactive preventative MDT approach. Locality work to include mental health and physical health integration standards

Whittington Health Strategic Goals	Sub priorities	Progress
		for improvement building on work by Islington CCG. Integrated physical and mental health clinics for inpatients delivered at C and I site by WH consultant clinicians.
7. To recruit and retain high quality engaged staff	Plan and deliver actions to deal with the issues raised in the culture survey (NF)	Listening events being undertaken through October and November with an agreed action plan to be ratified by Trust Board in February 2019.
	Recruit and maintain sustainable workforce reducing turnover and maintaining at lower levels (NF)	Ongoing recruitment initiatives for nursing and midwifery staff with resources for dedicated team and overseas recruitment identified for 2019. A new Clinical Recruitment and Retention Group co-chaired by the Chief Nurse and Director of Workforce meets monthly and is identifying a calendar of initiatives for all non-medical staff
8. To deliver efficient and financially sustainable services	Deliver £16.5m savings through CIPs to deliver 2018/19 control total (CG)	The Trust is forecasting to achieve £13.3m of CIP delivery (£12m recurrently) against a target of £16.5m, with £9.3m (£8.4m recurrently), delivered to date. The primary focus to make £1.34m non-recurrent initiatives recurrent to bolster CIP position.
	Reduce agency / bank spend (CG)	Pay expenditure continues to be in excess of budget at month nine due to pressures caused by the three year Agenda for Change pay deal and also due to bank staffing expenditure. The cumulative agency spend at month nine was £9.4m and each ICSU has been tasked with helping to deliver a year end agency expenditure total of £11.4m.
	Use Carter measures to improve productivity, including e-rostering	Carter measures are used by the Programme Management Office (PMO) and wider corporate services to identify potential productivity gains. . Pharmacy services are fully compliant and the introduction of e-rostering has been extended

Whittington Health Strategic Goals	Sub priorities	Progress
	and back office (CG)	to help assist the medical value project.
	Use GIRFT and Model Hospital to identify improvement priorities (CG)	Model Hospital & Getting It Right First Time (GIRFT) programme are used by the Programme Management Office and wider corporate services to identify potential productivity gains. This work being feed into the ICSU/departmental GIRFT visits and features within the Trust's five year CIP Plan. Most of the Trust's specialities have undertaken GIRFT reviews: the most recent was trauma and orthopaedics for which an action plan has been developed. The new Deputy Medical Director will lead on this work.
9. To deliver innovative estate, IT and other support services that enable the clinical objectives	Deliver strategic estates plan and link to NCL STP (SB)	Estates Master Plan being developed and the Trust is working with the NCL Sustainability & Transformation Partnership (STP) on wider Estates Strategy
	Progress digital fast follower projects (SB)	The Trust has made quick progress implementing Careflow Vitals across adult inpatient wards over Q3. In addition a successful early implementation of Careflow Connect communications tool has taken place in the Flo team and is now being expanded to other early adopters. Additional improvements and data sources have been added to both the shared care record, CareCentric, and the PACS image store to improve clinical decision making. Finally, the Emergency Department has made good progress on the journey to paperless by mapping processes and designing the data capture prototypes.

Meeting title	**Trust Board – public meeting**	**Date: 30.1.2019**
Report title	**Quality and Safety Corporate Risk Register summary report**	**Agenda item: 17**
Executive director lead	Michelle Johnson, Chief Nurse & Director of Patience Experience	
Report author	Claire Challinor, Patient Safety & Quality Improvement Manager	
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 January 2019. The Trust has set a threshold for risks reviewed at Board Committee level (≥15) to ensure Non-Executive Director oversight. The Non-Executive Director who chairs the committee will escalate any ≥15 risks to the Trust Board as required. All risks <15 are managed at an Integrated Clinical Service Unit (ICSU) and corporate directorate level and escalated to the relevant Trust Board Committee as required. A review of the current risk around preparation for CQC inspection in the near future is being completed and will be added to the risk register following approval process. The initial review suggests this will be rated as moderate. A recommendation of entry onto the BAF will also be made as a risk to achievement of the corporate objectives of the trust. There are also three new risks in process that have received an initial grade of ≥16 or above and they will be presented to the relevant Trust committee for approval before inclusion in this report.	
Purpose:	The Board are requested to review and approve this paper.	
Recommendation(s)	• The Trust Board are asked to review all ≥16 risks and agree there is adequate mitigating actions and assurance to manage these risks • The Trust Board are asked to consider if any ≥16 risks not currently on the Board Assurance Framework (BAF), should be added	
Risk Register or Board Assurance Framework	Board Assurance Framework Risk Entry	
Report history	The ≥15 graded risk register has been presented at January's Quality Committee	
Appendices	None	

RISK REGISTER SUMMARY REPORT

1. INTRODUCTION

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

2. RISK MANAGEMENT OVERVIEW

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

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

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

3. ≥ 16 RISK REGISTER

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

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

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

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

this way the Trust can identify patterns and promote best practice throughout the organisation.

4. RELATIONSHIP BETWEEN RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

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

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

5. RISK REGISTER UPDATE: JANUARY 2019

5.1 As at 16/01/19, the Trust currently has three risks graded as ≥20 and fifteen risks/graded as 16. There are nineteen risks graded as 15 which are monitored at Board Committee level.

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

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

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 is outlined below.

- **Workforce and Recruitment**

DATIX	ICSU/Directorate	Category	Title	Current risk grading
913	Surgery & Cancer	HR and Workforce	Gaps in consultant cover for on call rotas	16
950	Surgery & Cancer	HR and Workforce	Lack of middle grade doctors on the rota leading to a lack of senior cover on CCU.	16 (New Risk)

DATIX	ICSU/Directorate	Category	Title	Current risk grading
951	Acute Patient Access Clinical Support Services and Women's Health	HR and Workforce	Lack of psychologists to cover maternity clients with perinatal psychology needs	16 (New Risk)

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

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

The following four risks have been downgraded since the previous report:

693: Nursing staffing levels in the EIM ICSU – now 12

859: High vacancy rate in District Nursing – rejected (no increase in un-allocated visits and no evidence of increase in patient safety incidents due to staffing pressures

797: Inadequate consultant provision in AAU (Acute Assessment Unit – now graded 4

881: Potential of lack of hospital children's psychiatry cover from July 2018 – now 12

- **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.	20
697	Acute Patient Access Clinical Support Services and Women's Health	Patient Safety and Quality	Maternity and neonatal redevelopment	20
817	Facilities and Estates	Estates or Infrastructure	Building environmental planned preventative regime for heating, ventilation and air conditioning systems	16
807	Facilities and Estates	Estates or Infrastructure	Works arising from fixed electrical installation	16

DATIX ID	ICSU/Directorate	Category	Title	Current risk grade
			testing	
892	Facilities & Estates	Patient Safety	Fire Safety Management System needs to implement all elements within a new Fire Safety Policy	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 15: Failure to modernise the Trust's estate**). The Trust Board monitors actions against this risk through the BAF process, including implementation of the Estates Strategy.

- **Financial**

DATIX	ICSU/Directorate	Category	Title	Current risk grading
784	Finance	Financial	Failure to deliver CIPs and savings to £16.5m 2018/19	20
780	Finance	Financial	Budget Control	16
723	Emergency Medicine	Financial	Finance deficit in EUC ICSU	16
772	Surgery and Cancer	Financial	Not meeting CIP target and financial balance for 2018/19	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 2018/19. This has been identified as a strategic risk to our corporate objective to 'Develop our business to ensure we are financially sustainable.' (**BAF 5: Failure to deliver cost improvement plan and transformation savings**) which is monitored through this assurance process.

6. ≥16 RISKS NOT CURRENTLY ON BAF

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and key actions
728	Trust wide	Information Governance	Medical records not located in medical files	16	Project in progress to file all patient notes in the appropriate record with filing underway.
903	Acute Patient Access	Diagnostics	Ineffective communic-ation	16	Communication pathway for screening samples between UCLH & Whittington maternity units requires further

DATIX	ICSU/ Directorate	Category	Title	Current risk grading	Comments and key actions
	Clinical Support Services and Women's Health		pathway for screening samples		improvement. There are clear mitigating actions in place to reduce risk.
897	Children & Young People	Patient Access	Haringey CYP MSK service will be out of contract December 2018	16	Haringey community children and young people's physiotherapy MSK service has not been commissioned. To mitigate the lack of provision an interim service is being provided by Islington's CYP MSK service with work to address with commissioners.

7. RECOMMENDATIONS TO THE BOARD

7.1 The Trust Board are asked to:

- review all ≥16 risks and agree there is adequate mitigating actions and assurance to manage these risks.

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

Item 18	Workforce & Assurance Committee – Draft minutes of the meeting held on Friday 18th January 2019

Present:

Stephen Bloomer	Chief Finance Officer
Norma French	Director of Workforce
Naomi Fulop	Non-Executive Director (in the Chair)
Carol Gillen	Chief Operating Officer
Steve Hitchins	Trust Chairman
Michelle Johnson	Chief Nurse & Director of Patient Experience
Helen Kent	Assistant Director of Learning & OD
Jana Smith	Assistant Director of Integrated Care Education
Kate Wilson	Acting Deputy Director of Workforce

In attendance:

Lawrence Anderson	Medical HR Business Partner & Acting Head of Resources
Kate Green	PA to Director of Workforce (Minutes)
Graeme Muir	Postgraduate Medical Education Manager

Apologies:

Swarnjit Singh	Trust Corporate Secretary

19/01 Welcome and Introductions

01.01 Naomi Fulop welcomed everyone to the meeting and introductions were made.

01.02 Naomi informed the meeting that the agenda had been re-ordered so as to take the Medical Education Report before the report of the Guardian of Safe Working since there was considerable overlap between the two which would aid and inform discussion.

19/02 Minutes of the last meeting

02.01 Referring to minute 29.02, Helen Kent offered clarification on the levy funds. She explained that the 'expired funds policy' (previously known as the 'sunset policy' enabled organisations to transfer up to 10% of the budget to another organisation. There was however a process to go through before expiry; this could not be decided at the point of expiry. Helen was happy to offer further information on how this was done

02.02 The minutes of the meeting held on 21st September 2018 were approved.

19/03 Matters arising

03.01 Norma French informed the committee that she had just completed shortlisting for the substantive Deputy Director of Workforce, and interviews for this post would be held within the next few weeks.

19/04 2018/19 Quarter 2 Workforce Report

04.01 Introducing this item, Kate Wilson highlighted the following key points:

- Sickness rates for Quarter 2 had stood at 3.6% across ICSUs. Women's Health was an area of concern, but figures in this area were affected by several staff who had been on long-term sickness absence, and Kate assured the committee that all such cases were being appropriately managed. Steve Hitchins enquired whether there had been a worsening of the position; Kate explained that sadly there were several instances where staff were suffering from cancer which naturally affected long-term sickness rates. Norma added that this data was also presented at the ICSU quarterly performance review meetings, through which she was able to check that all cases were being managed appropriately in line with Trust policy. She confirmed there was no upward trend

- Turnover was down slightly for the quarter, and work was in hand to target specific areas of concern such as AHPs. The overall vacancy rate remained broadly static.

- Bank and agency usage had increased, but this was to be expected at this time of year. More recent figures showed a decrease in the use of agency staff, largely because of the work that had gone on to encourage those staff to move on to the staff bank. The bank bonus scheme had run from mid-December to mid-January so it was too early to measure its effect, but data on this would be available at the next meeting.

- Staff appraisal rates for the quarter stood at 74% against the target of 90%. Kate explained that for both appraisal and mandatory training there was a focus not only on driving up rates but also working through some data quality issues.

04.02 Steve Hitchins inquired what progress had been made in respect of diverse interview panels. Norma replied that no relevant interviews had been held in December, since the scheme was only applicable to posts graded 8A or above, however three were imminent – the Deputy Director of Workforce and two ICSU Directors of Operations. BME representation had been secured for all three. She added that work was in hand to make the process smoother. Michelle added that there will also be so important learning to be taken from the BME panel members. Another strand from the action plan was that where a BME candidate was interviewed but not appointed, the interview panel chair would be required to write to the Director of Workforce to explain the reason/s for this.

04.03 Naomi said that she was pleased to see that trends over time were set out in the report, and enquired whether the increase in vacancy was likely to continue. Norma replied that the aim remained to reduce this figure, and the Q3 report would include both the cohort of recently-qualified nurses and recently recruited AHPs. Michelle added that there was also a major focus on retention. Steve Hitchins asked whether there had been a fall in the number of exit interviews carried out. Kate explained that the data shown in this report had come from a pilot initiative, and there had not been a huge take-up. Together with Sarah Hayes, she had attended the launch of the NHSI retention collaborative, to which Whittington Health had signed up, and there had been much discussion on the relative merits of exit interviews, with many feeling that it was equally (if not more) important to meet regularly with staff throughout the year, as once people had made a decision to leave the organisation they were less likely to engage. Michelle suggested this might be done through 'career conversations'. The conference had also commended the introduction of

alumni, through which contact with former staff could be kept live, and encouragement given to return once they had gained the experience they had sought.

04.04 In answer to a question from Steve Hitchins about the phraseology of the question about whether staff were atheists or had no religion, Kate thought that the wording was standard and came from NHS Employers, but would check. Trust data did serve to inform the national census.

19/05. Medical Education Report

5.1 Graeme Muir informed committee members that the report circulated contained data drawn not just from the annual GMC survey of trainees, but also other fora where students had the opportunity to voice opinions and raise issues including face-to-face at appraisals, HEE and informal discussion. Information from the GMC trainer survey had also been included for the first time.

5.2 Beginning with the positives, Graeme was pleased to report that Whittington Health continued to receive excellent feedback for having a supportive environment, and had scored the highest in London for teamwork. Trainees felt able to report and discuss issues without feeling threated, which showed that the Trust had fostered an open culture. The GMC trainee survey contained 32 'green flags', up from 6 awarded the previous year. The Trust had also scored highly in the report made by the Royal College of Paediatrics. Also positive was the high number of exception reports submitted, as it was known that in some Trusts pressure had been placed on trainees not to submit exception reports, and nationally, there were four Trusts where none had been submitted.

5.3 Survey results contained the same number of 'red flags' as the previous year's had done. Norma enquired whether these had been in the same areas, and Graeme replied that some were replicated; curriculum coverage for example (particularly difficult for a DGH), and some could be explained by expectation management. He felt that there were some instances where trainees could take steps to improve opportunities, for example by volunteering to help in obstetrics when their own areas were less busy. Michelle made the point that they would also have to be well received, and there was some way to go before this was fully achieved. ED was reported as being a difficult area for trainees, but there was agreement that this reflected the environment and pressures there. There were also some data challenges – only four trainees had been assigned to ED, but there had been responses from 13, indicating that all trainees who had worked there had been surveyed. Lawrence made the point that feedback from GP trainees would have resulted in quite different outcomes.

5.4 Looking at exception reporting, it was noted that it had been an extremely hot summer, followed by the usual winter pressures. Victoria ward alone had accounted for over 50% of foundation exception reporting. Stephen Bloomer enquired what happened when such a cluster occurred, and Graeme said that often the Trust would receive a visit; last year this had been the case for trauma and orthopaedics. Such visits were designed to be constructive; those visiting would try to speak to both consultants and trainees, and look at the previous year's data as well as reports from training directors. Jana added that there was a drive to increase community placements, and if an area received a red flag for three consecutive years, those training places would be removed from the hospital. Norma said that this what made it so important to scrutinise trends. Graeme reported that Tim Briggs from Getting it Right First Time (GiRFT) had was recommending prioritising allocating placements to GiRFT achievers.

5.5 In answer to a question about what was expected of the Trust's Clinical Directors, Graeme replied that reports were made available to them, including data on exception reporting. Stephen Bloomer suggested that where there were repeated concerns, CDs could be asked to attend WAC in order to explain causes. On exception reporting, it was felt that because the financial implications had little impact on the Trust as a whole less notice was taken of them; but Graeme emphasised trainees were very upset by the high number of reports and the pressures they showed. The committee agreed to recommend that Medical Education reports should be presented to each of the ICU Boards, with action plans coming back to the WAC. Reports could also be included in the ICSU quarterly performance review meetings.

5.6 In summary then, the Trust was performing well in this area, but trainees were under considerable pressure.

5.7 Moving to the trainer survey, Graeme reported that it had been noted that some education and training opportunities were lost due to workload, and there was also marked disengagement from the consultant body. Stephen Bloomer asked whether it was possible to check on the amount of training made available as opposed to perception, and Graeme commented that it was definitely hard for trainees to attend regional training events.

5.8 Kate Wilson briefed the committee on two trainees who had carried out an excellent piece of work on the BMA's Fatigue & Facilities Charter.

5.9 The committee went on to discuss the governance arrangements pertinent to this report and the questions it raised. Reports were received by the Postgraduate Medical Education Board, but this Board was not formally connected to the Trust's committee structure. Naomi spoke of the WAC's responsibility to respond appropriately to reports it received, and Norma said that Julie Andrews as acting Medical Director should be made aware of WAC's concerns. Carol added that ICSUs also needed to be very clear about these issues. The possibility of losing training places constituted a considerable risk to the Trust, and Stephen Bloomer felt that the ICSUs should be made more accountable for difficulties encountered in their own specialties. It was agreed that the ICSU Boards receive the report via their HRBP

5.10 Graeme went on to speak briefly about the eight 'high impact areas'. He had concluded that there was a need to look at what trainees were currently required to do, and to ascertain whether they were in fact the most appropriate people to carry out that task – some, for example, had physicians' associates preparing discharge summaries. Norma replied that work on this was beginning in some areas, citing nurse endoscopies as an example.

5.11 Graeme discussed the need for trainees to take proper rest breaks, saying that he was involved in the Quality Improvement Project mentioned in minute 5.8 above. The task and finish group for that project had met earlier in the week, and he was confident that much would be done to improve conditions for staff working at night/out of hours. It had been estimated, he said, that working a full night shift had the equivalent effect to someone attempting to drive after drinking – the implications for patient safety were obvious. The survey carried out to inform the project had also flagged out of hours catering as being an area requiring improvement, and it was also noted there was a CQUIN associated with this area.

5.12 The committee discussed trainee involvement within the Trust's corporate governance structure, and it was noted that junior doctors were represented on the Medical Negotiation

Sub-Committee. It was felt that more could be done to strengthen relations between trainees and managers; Imperial, for example, had a well-established shadowing programme. A Trust Consultant had arranged some shadowing/mentoring for doctors, and Jana suggested such initiatives were likely to be strongly championed by Julie Andrews.

5.13 Graeme had met with IM&T colleagues to discuss Trust intranet opportunities for a recognition portfolio, and Michelle suggested he link in with an initiative recently discussed at Quality Committee, details of which she would be happy to share. He was also planning a 'Wall of Wonder', to be hosted by the Whittington Education Centre (WEC) where trainees' achivements could be displayed; the aim being to demonstrate that although they do work very hard, they are valued and appreciated.

5.14 In answer to a question from Steve Hitchins about where education fell within the STP, Graeme felt that from his point of view arrangements were relatively informal at present; though he did spend time finding out what colleagues from other Trusts were doing and comparing notes. Medical Education Managers met quarterly, as well as regularly with Directors of Medical Education.

5.15 Stephen Bloomer enquired whether there might be any opportunities for income generation. Graeme confirmed that this was a matter for consideration, and he would look at what courses might be marketed. Asked about the considerable changes that had taken place at HEE, Graeme agreed that that organisation had been through an extensive change management programme, losing some 40% of its income and 30% of its staff. He felt, however, that the consequent changes were likely to have more impact outside London.

19/06 <u>Guardian of Safe Working Report</u>

06.01 Lawrence Anderson had circulated reports covering the first three quarters of 2018/19. During this period the Trust had received a total of 448 exception reports, the vast majority of which had been submitted by FY1 doctors, mostly from within medicine. This equated to almost 400 hours' additional work, equivalent to eight doctors. Associated costs were not huge (under £7k). Lawrence informed the committee that he was currently seeking expressions of interest for a new Guardian of Safe Working; Caroline Fertleman having submitted her resignation. He would use this opportunity to see how the role might be strengthened going forward. The appointment was an internal one, which attracted additional PAs for taking on the role.

19/07 <u>Employee Relations Activity</u>

07.01 Kate Wilson began this report by saying that the team had made strenuous efforts to reduce time taken to resolve, both for disciplinary and grievance cases. There were varied reasons for delays, but in the main these were attributable to investigators' workloads and failure of formal processes. The new records system (Selenity) was working well, and fortnightly case reviews had been established. Kate was pleased to report that the quarterly report showed no non-medical cases which had exceeded 90 days, which was a huge improvement. There were three medical cases which had breached this standard, and Kate explained that was attributable to the application of the Maintaining High Professional Standards processes. Norma commended the team for their efforts, especially since the time taken to resolve cases had featured heavily in the cultural survey.

07.02 The Fair Treatment Panel had been established, and both Michelle and Carol as members confirmed that constructive discussions had been held. In answer to a question about whether staff side was supportive of the improvements made to the HR processes, Kate

replied that staff side was indeed supportive, and its Co-Chairs met regularly with the HR Business Partners. She did feel, however, that more work was now needed to strengthen the informal stage, although the Trust did now have trained coaches and mediators in place.

07.03 She would be introducing new guidance to inform informal processes. Norma echoed this, saying that she felt middle and junior managers particularly needed to be empowered to have 'difficult conversations' with staff. Kate said that the introduction of the managers' passport (31st March) would be of assistance here. The rolling programme of training had received extremely positive feedback. Naomi asked whether it would be possible to include trends within future reports, and Kate said she would ensure this was done.

19/08 <u>WRES Work Programme</u>

08.01 Introducing this item, Norma reminded the committee that the WRES Report and work programme had already been to the Trust Board (ideally, she said, it would have been brought to WAC first, but the timing of the respective meetings had precluded this). Since the Trust Board meeting Norma had shared the action plan with all ICSUs, she had also written to all named action leads.

08.02 Norma reported that the following Monday the Trust would be welcoming NHS England's Director of WRES Implementation, Yvonne Coghill OBE, to a WRES workshop. She hoped that some committee members planned to attend. Joan Saddler OBE had also attended the launch of the Trust's Inclusion Networks held on 17th January, where Norma had been delighted to note the energy and enthusiasm in the room. New Facebook sites had also been launched.

08.03 The monitoring of the Improvement Plan sits with the WAC and they will receive their first update at the next meeting

19/09 <u>Listening Events</u>

09.01 Norma French gave a brief report of the Listening Exercise conducted during the last three months of 2018, which she estimated had reached between five and six hundred staff. She and Siobhan were now preparing the report of the exercise, which would be taken to the Trust Board in February.

19/10 <u>New Consultant Development Programme</u>

10.01 Helen Kent introduced this item by saying that since her paper a date had been identified for the first session; this would take place on 4th April. There had been a good response from amongst the 66 consultants who had joined the Trust over the previous 2-3 years (some of whom had left the Trust but then returned). Julie Andrews had personally championed this initiative, on which consultants Ruth Law and Becs Sullivan had both worked. Steve Hitchins said that mentioning was frequently mentioned (and offered) at AACs on which he sat, and he wondered how much this was happening. One of Helen's team had mentioned there was a consultant who had worked on a mentoring programme (formerly Celia Bielawski) and this would be followed up outside the meeting. Jana added that the mentoring function that had sat with the Deanery had now been transferred to the Leadership Academy. Naomi suggested this might be followed up at appraisal; mention was also made of values-based recruitment.

Any other business

Terms of Reference

11.01 Naomi had seen reference to the review of all Board sub-committee terms of reference, and Steve Hitchins confirmed this, saying there was a need to ensure better consistency across the different committees. This was being taken forward by Swarnjit Singh.

Forward Pan

11.02 Naomi felt it would be helpful to produce a forward plan for the WAC. There was a consensus that it would be useful to include more in-depth discussions with ICSUs. Stephen Bloomer asked whether the committee might look at the workforce contribution for the annual planning submission, but even had the timing of this been possible, this was felt to be an overly operational function for a Board sub-committee. Assurance was required, but not in a way that would slow down the process. This could be further discussed outside the meeting.

Workforce Report

11.03 Carol Gillen asked if the next report could include some of the metrics concerning recruitment, perhaps set against stretch targets. Kate suggested this could be included as part of the new pipeline report.

Action log, Workforce Assurance Committee meeting (WAC), 18.01.2019

Item	Action	Lead	Progress
Quarter 2 Workforce Report	• Impact of the bank bonus scheme to be included in the next workforce report to the WAC • Future reports to include metrics for recruitment	Kate Wilson Kate Wilson	
Medical Education Report	• Medical Education Report to be presented to ICSU Boards or presented at Quarterly Performance Review meetings • Subsequent action plans to be brought back to WAC • Medical Director to be made aware of WAC's concerns about some of the issues raised in the report	Graeme Muir GM/ICSUs Norma French	
WRES Work Programme	WAC to monitor progress on the WRES Work Programme through its becoming a standing agenda item	Secretariat	
New Consultant Development Programme	To check which consultant leads on mentoring and what opportunities may be available to new consultants	Helen Kent	
Terms of Reference	To approve WAC draft terms of reference before their presentation to the March Trust Board	Chair Norma French	
WAC Agenda for 2019/20	To draw up a forward plan for consideration at the next meeting.		

Minutes
Quality Committee, Whittington Health

Trust Board 30.1.2019
ITEM : 19

Date & time:	Wednesday 9th January 2019
Venue:	Room 10 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS), Non-Executive Director
Members Present:	Michelle Johnson (MJ), Chief Nurse & Director of Patient Experience Deborah Harris-Ugbomah (DHU), Non-Executive Director Julie Andrews (JA) Acting Medical Director Carol Gillen (CG) Chief Operating Officer
In attendance	Claire Challinor (CC) – Patient Safety & QI Manager Sita Chitambo (SC) Associate Director of Nursing Emergency & Integrated Medicine Dorian Cole (DCo) Associate Director of Nursing – Children & Young People Services Adrien Cooper – (AC) Director of Environment Rose Hensman (RH) Associate Director of Nursing - Maternity Breeda McManus (BM) Deputy Chief Nurse Kat Nolan-Cullen (KNC) – Compliance & QI Manager Steven Packer (SP) Assistant Director of Facilities Sharon Pilditch (SP) Matron for Surgery Theresa Renwick (TR) Adult Safeguard Lead Stuart Richardson (SR) Chief Pharmacist Leanne Rivers (LRi) Patient Representative Lynda Rowlinson (LRo) Interim Head of Governance and Risk Paula Ryeland (PR) – QI Lead Swarnjit Singh (SS) Trust Corporate Secretary Laura Sirona (LS) - Student Health Visitor Andy Stopher (ASo) Director of Operations Adult Community Services Carolyn Stewart (CS) Minute taker

Agenda items

1.1	**Welcome & Apologies**	**Chair**
	AS welcomed the committee and thanked everyone for attending the meeting, particularly as it was scheduled later than the usual time. Apologies were received an recorded from : Yua Haw Yoe (YHY), Fiona Isacsson (FI), Helen Taylor (HT), Nick Harper (NH), Debbie Clatworthy (DCl), Nigel Kee (NK) & James Connell (JC)	

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

1.3	**Minutes of the previous meeting**	**Chair**
	No amendments were requested to be made to the minutes of the previous meeting held on 14th November. The minutes were approved.	

Action Log	**Deadline**	**Owner**
All items on the action log were either completed and closed or on the agenda.		

1.4	**Matters Arising**	**Chair**
1.4.1	MJ updated that she had contacted HealthWatch in regard to attending Quality Committee but they had said they would assess their availability but would welcome feedback and relevant papers from the meetings.	

Actions	**Deadline**	**Owner**
Feedback from Quality Committee to Healthwatch	March 2019	MJ

2.1	**Nursing & Midwifery Strategy – Annual Update Report**	
	This item was deferred to the May Quality Committee.	

Actions	**Deadline**	**Owner**
Item for May agenda	May 2019	MJ

2.2	**Aggressive behaviour by patients towards staff**
2.2.1	AC reported that the Challenging behavior policy had been updated and is going through approval process. There will be a full implementation plan for this policy. DCo/AC and ASt are working on this. The policy will be presented to the Policy Approval Group (PAG) in the first instance. A working group is being established to take the policy forward.

Actions	**Deadline**	**Owner**
ASt to set a date for first meeting to discuss Terms of Reference (TOR)	January 2019	ASt

2.3	**Patient Experience Strategy**
2.3.1	LR briefed the Committee on the report in that it is near completion. PA and JC will finalise for publication. The focus is on 3 key ambitions: • Improve information provided for patients and carers • Work with patients and carers for service improvement • Integrated holistic care from start to finish.
2.3.2	Ambitions were considered, taking into account previous strategy achievements. AS asked for comments. ASt stated that it was a good presentation but a plan needs to be developed to make it happen. The plan will go to the Patient Experience Committee (PEC) for review before going to the Trust Board in February 2019 for final approval.
2.3.3	SS queried whether consultation had been held with stakeholders. LRo advised that work had started on this10 months ago and that focus groups were held with Healthwatch and at stakeholder events. SS stated that this would provide good evidence for the well led CQC inspection.
2.3.4	AS commented that although this was a long overdue paper, the ambitions were spot on and contained good metrics. However, it did not capture where we plan to get to "Outstanding". She added that there is a lot more we can do with regard to ambition. MJ stated that the focus is on this 1st year and should cover what we should look like in 3 years' time. LRi advised that she had some amendments and comments for the paper and would send to JC.
2.3.4	AS summed up that the Committee is happy to approve the content with the caveat to finalise and add LRi's comments and to consider what Outstanding patient experience will look like at the end of the period of the strategy.

Actions	**Deadline**	**Owner**
LRi to email JC with comments and amendments	January 2019	LRi

3.1	**Acute Patient Access, Clinical Support Services & Women's Health (ACW) Report**	
3.1.1	SR apologised for the paper not being on the current template. He referred to the front sheet of the paper that described key information. RH advised that incidents and risks had been amalgamated and there is a clear picture of these and ICSU leads are taking these forward. The risks that are currently on the risk register for ACW have been reviewed and mitigations in place.	
3.1.2	SR advised that the Medicines Barcoding for the Safety" project group had been set up and it was progressing to enhance safety of medicines administration across the hospital. The Patient Story that went to the December Trust Board came from Women's Health. The Trust has been successful with the CNST rebate of 500k for the last quarter.	
3.1.3	Meetings with American Airlines had taken place to raise the profile for maternity services with fund raising and marketing strategies. Planning to host events to coincide with the Cellier Ward re-opening.	
3.1.4	MJ queried ambitions regarding engagement and advised that she had attended a Maternity Voices meeting where all of the attendees were of a similar demographic. She raised the question of how we can encourage others to attend. RH replied that in between quarterly meetings the Maternity Voices participating lead goes out to different groups meeting a lot of women outside the meetings. She added that the Maternity Voice meeting is an open forum and every woman is invited. All other Trusts in the area have struggled with attendance to these forums. There has been a considerably increased attendance at WH meetings. In order to seek diversity around the forum table it was suggested that this could connect with Community Forums and that RH should discuss further with Jonathan Gardner (JG).	
3.1.5	SR referred to areas of good practice, where in the last 2-3 months daily safety huddles in the community midwifes team had been launched. This gave staff the opportunity to talk about home births, challenges and any difficulties on a daily basis. This had proved to be very successful with staff. It also complements the safety huddles in the Post- Natal ward. AS stated that this was a good example of our learning. SF highlighted that there had also been an increase in radiology services and pharmacy FFT results and that Travel Health had also been launched in the wholly owned subsidiary Whittington Pharmacy.	
3.1.6	DHU asked SR/RH if they could consider promoting maternity services to coincide with the Women's National Day 8th March and it was agreed that this should be discussed further within the ICSU.	
3.1.7	Referring to the risk register, AS asked about improvements being made to the toilets in the post-natal ward. RH replied that refurbishment plans had already been drawn up and the post- natal ward had been temporarily relocated to start the work which will include the toilets and showers as well as sleeping areas for partners. This work will commence towards the end of March.	

3.1.8	Referring to page 22 of the report with regard to MRI waiting times, CG stated that the figures should be compared against the London Quality Standards and Cancer Standards. She added that Sam Barclay and Sandra Harding-Brown are discussing this.

Actions	**Deadline**	**Owner**
3.1.4 Connecting Maternity Voice meetings with Community Forum via JG. RH to link up with JG	Jan 2019	RH/JG
3.1.6 Discussion with Maternity ICSU to discuss Women's National Day	Jan 2019	SR/RH

3.2	**Children & Young People's Services Report**
3.2.1	The report was taken as read and DCo highlighted the following items:
3.2.2	An internal RCA had been completed and would be discussed at the SIEAG panel next Monday. It related to an incident of MH Act paper being completed incorrectly.
3.2.3	Three items on the corporate risk register: • Lack of Haringey CCG MSK services. WH is providing the services funded through the Islington contract. Discussing how to resolve with the possibility of off-setting activity around North Middlesex. • Issue regarding old laptops in the community reported via an RCA. Business case currently going through for replacements. Information Commissioner was satisfied with our response to the incident and advised that no further action is required. There have been quite a few incidents reported regarding obsolete equipment. MJ advised that this was discussed at the Investment Committee this week and it was agreed that it was approved to progress at speed. • Due to a 72% increase in average monthly referrals to the Haringey Autism Spectrum Disorder diagnosis service, a review of the service is being carried out by the Clinical Director with the possibility of adapting the AHP model. Waiting times should come down in the long term as a result.
3.2.4	DCo referred to P17 of the report and the Presentation from the Islington Community CAMHS team presented to the CYP Board, showcasing their work with the local schools to discuss managing stress and mental health issues.
3.2.5	The Simmons House Team Clinical Outcome Research paper (published in July 2018) had been published in the Child and Family Clinical Psychology Review No 6 Autumn 2018 (Wynter and Clark) https://shop.bps.org.uk/publications/child-and-family-clinical-psychology-review-no-6-autumn-2018.html).. 130 young people inpatient admissions in Simmons

	House were examined and the paper highlighted a range of outcome measures showing significant changes in children's wellbeing.
3.2.6	The CYP ICSU is moving forward with the Quality Improvement (QI) implementation plan. Colette Datt, Nurse Consultant, is the CYP QI lead. The work programme is being linked up with CQC preparation.
3.2.7	21 of the CYP ICSU work programmes have been submitted to the Academy of NHS Fabulous Stuff this quarter. Six of these have been shortlisted to present at the Fabulous Academy Conference. This has tied in with the Qualty Improvement strategy. The CCN Hospital@Home has been participating and highlighted. MJ advised that there had been an enquiry from Scotland regarding our Hospital@Home service.
3.2.8	AS asked how this could be shared between the ICSUs and it was suggested that it should be discussed at the divisional performance reviews. PR advised that the QI website will be ready by next week and this could be featured there.
3.2.9	It was agreed that QI should be a standing item on the Quality Committee agenda and "Where do we share innovation?" is raised at the next Trust Board.
3.2.10	Referring to the CQC inspection at Simmons House, AS asked if there were any outstanding actions at Simmons House from the previous inspection. DCo replied that the ligature risk was addressed and that all ligature assessments have now been completed and presented to the Patient Safety Committee. This highlighted areas where improvements are required to low risk areas. He added that the only issue around CQC requirements would be with regard to mandatory training and appraisals, which is due to the lack of data. The Committee agreed that this should be raised at the next Trust Board.
3.2.11	AS thanked DCo for presenting and to congratulate his team on the excellent report.

Actions	**Deadline**	**Owner**
3.2.6 Quality Improvement (QI) to be standing item at Quality Committee	From March 2019 onwards	LR
3.2.6 Mandatory training and appraisals data to be raised at Trust Board	January 2019	MJ

3.3	**Nursing & Midwifery Quality Indicators (NQIs)**	
3.3.1	MJ advised the Committee that the NQIs go to the Nursing & Midwifery Executive Committee (NMEC) and queried whether it was required to be presented to Quality Committee as a standing item. It was agreed that AS and MJ would discuss this outside the meeting.	

Actions	**Deadline**	**Owner**

Discussion regarding regular NQI submission to Quality Committee	March 2019	AS/MJ

4.1	**Central Alert System (CAS) annual report**	
4.1.1	LRo advised the Committee that the report was for noting. It contains safety alerts from January to December 2018 and includes a breakdown of the numbers and highlights the different types of alerts and actions. The report update was to provide the Quality Committee the assurance that CAS alerts are being dealt with in a timely fashion. SR added that all medicine CAS alerts are reviewed in pharmacy.	
Actions	**Deadline**	**Owner**
	None	
4.2	**Quality Assurance Report**	
4.2.1	LRo advised the committee that CQC "Good to Outstanding" preparation, fortnightly prep meetings which include a wide membership of key people were now starting. AS asked if service users were invited to attend and MJ replied that as these are preparatory meetings, it would be more appropriate for service users to join peer reviews. There is a programme for peer reviews and JC is leading on this. KNC, our compliance manager, will be working on a risk assessment with regard to planning.	
4.2.2	LRo added that the updated Action plan (from the previous CQC inspection) is accountable to JG at the Trust Management Group (TMG). The current focus is on areas that "Requires Improvement". A team of key leads is now in place to focus on CQC inspections preparation. MJ stressed that there will also be deep dive investigations on particular areas where the CQC might focus on.	
Actions	**Deadline**	**Owner**
None		

4.3	**Patient Led Assessment of the Care Environment (PLACE) report**	
4.3.1	SP advised the Committee that the PLACE audit took place in May 2018 and is a non- clinical audit of the hospital environment. The team comprised 6 staff and 7 non staff from Haringey Health Watch. The report details all areas covered. The audit covered a mix of maternity, medical and surgical wards. Scores are benchmarked against the national average. The results were down on the national average for cleaning with most other areas reporting as average. Food results fluctuate and are subjective on the day.	
4.3.2	AS asked if there is an on-going actin plan and SP replied that all actions that are picked up are dealt with soon after being identified. There is also a food focus group. Dementia and privacy requirements are also considered. The next inspection is scheduled for September 2019 as the assessment tools are being reviewed beforehand.	

4.3.3	SS suggested that this should come to Quality Committee earlier in the year. However, SP pointed out that although the audit was carried out in May, the national programme was in September and the results wouldn't be available until October. SS requested that SP create a timetable and work plan for circulation to the Quality Committee members and include the website link to the national report.
4.3.4	It was agreed that awareness that anyone can do the audit should be increased. SP to liaise with KNC to fit in with peer reviews.

Actions	**Deadline**	**Owner**
4.3.3 Timetable and work plan be circulated to QC members 4.3.4 Increase audit awareness and fit in with peer reviews	March 2019 ASAP	SP SP/KNC

4.4	**Adult and Children's Safeguarding 6 monthly report**	
4.4.1	The Adult & Children's Safeguarding Report was taken as read. TR discussed the following headlines from the report: – 60% increase in numbers of adult safeguarding concerns this year from last year. Our staff are appropriately contacting social services to discuss as to whether these are safeguarding issues or not. – With regard to the comparison against national statistics, TR advised that we are performing well. There has been a 34.5% increase in Deprivation of Liberty Safeguard (DoLS) referrals. This was discussed at the Adult Safeguarding Board last month. TR added that it is likely that we are still under reporting on DoLS but it is increasing. – Training Compliance for safeguarding adults is at 74% level 2 with a target of 85%. There was an increased focus on compliance 3 years ago so we are still within that cycle. Additional training sessions have been set up. – The Mental Capacity Act (MCA) is complex for staff to understand and has been identified in CQC reports for MH Trusts as well as other trusts. We are looking to "take things back to basics" and TR has created a new MCA training course across the wider community education partnership networks and includes Police, GPs, Care Homes, Age UK and others to identify how capacity should be assessed.	
4.4.1	ASt stated that this is an encouraging uptake of training and safeguarding alerts, but queried the investigation of alerts that hadn't been investigated. TR advised that when a concern is raised, it is sent to the Local Authority who has responsibility to investigate.	
4.4.2	SS was pleased to see modern slavery within the report. He also asked how many Home Office referrals had been made. TR responded that the Trust had	

	reported 1 in the last year and there was often uncertainty whether the referral should be made. The Trust has reported 4 in the last 2-3 years. TR stressed the importance of staff understanding the PREVENT responsibilties and not overreacting and added that she is mindful at PREVENT training of any recent incidents where staff might have been affected.
4.4.3	AS thanked TR for the excellent report and for attending. The Children's section of the report was taken as read.

Actions	**Deadline**	**Owner**
None		

4.5	**Quality Account Update**	
4.5.1	LRo referred to the Quality account 2018 and advised that the priorities to be included in the 2019/20 report would come under the theses of Patient Experience, Patient Safety and Clinical Effectiveness. This should be completed in March.	
4.5.2	With regard to Patient Safety priorities the report highlighted 10 key actions including RAG rating priorities. No red areas were identified and there were 3 amber areas; and several of amber going to green. MJ concurred that good progress is being made and asked for clarification on how red ratings are monitored. LRo confirmed that these go to the Patient Experience Committee (PEC), the Patient Safety Committee (PSC) and Clinical Effectiveness groups and then to the specific relevant groups, ie the Falls Group, etc.	
4.5.3	LRo stated that updating the action plan on priorities is still in progress but will be completed by March. Reminders will be sent out to all concerned. MJ advised that we are still waiting for the template of the areas for the report 2018/2019 Quality Account. Priorities for next year are local but we cannot choose what is included in the report. National priorities will be confirmed.	
4.5.4	LRi asked why Learning Disability (LD) is prevalent in several reports and why it is considered a priority. JA responded that LD is considered a high at risk for patient safety concerns and patient experience. From national and local work, death rates are higher and the moderate harm risk is also higher for people with LD. AS thanked LR for presenting the paper.	

Actions	**Deadline**	**Owner**
None		

4.6	**Quality & Safety Risk Register (risks >15)**	
4.6.1	The Corporate risk register includes all risks scored at 15 and above LRo updated that there had been no risks closed since the last report; 2 risk reductions; not increased risk rated and that 4 new risks had been added.	

4.6.2	AS asked if the Risk Register is up to date and accurate. MJ replied that it is accurate but reviews have not all been completed. It was agreed that this should be flagged up to the Trust Board. It was noted that in future CC will be reviewing the Risk Register. It was requested, and agreed, that everyone with a 15+ risk should send it to LRo who would review with AS and MJ within the next 4 weeks.
4.6.3	SS asked about the assurance of consistency of scoring with national guidance and that the Chief Finance Officer had also asked the same question as these could incur high capital risk and he is seeking assurance that the risks are rigorously controlled before they are entered on the risk register.
4.6.4	LRo advised that she had met with the internal auditors with regard to internal audit of governance and risk assessment and it was requested that the audit feedback and recommendations would return to the next Quality Committee. This should also be flagged to the Trust Board.

Actions	**Deadline**	**Owner**
4.6.2 Risks 15> to be sent to LR within next 4 weeks for review with AS & MJ	6 Feb 2019	ALL
4.6.4 Internal audit feedback/recommendations to be on next QC agenda	March 2019	LRo
4.6.4 Trust Board to be made aware of audit feedback/recommendations	Jan Trust Board	AS/MJ

4.7	**Trust Policies – Policy for the Management and Development of Policies – for review**	
4.7.1	LRo advised that she is waiting for SS to provide the comments on the content of this policy so that it can be presented to the Quality Committee. SS recommended that it does not need to come to Quality Committee and will be presented to TMG for approval. MJ requested that SS provides the information as soon as possible. KNC is reviewing policy renewals and all safeguarding policies have been updated. The Policy Approval Group (PAG) frequency of meetings has been increased.	

Actions	**Deadline**	**Owner**
Management & Development of Policies comments required	ASAP	SS

5.1	**Minutes from reporting Groups – for information only**	
5.1	The minutes from reporting groups were taken as read.	
6.1	Any Other Business	
6.1	LRo advised the committee that Phillipa Alston (PA), Head of Patient Experience, was leaving the Trust at the end of February and going to work at Barnet CCG. AS asked LRo to thank PA on behalf of the committee for all her efforts over the years and wished her well in her new role.	

Item 20	**Draft minutes of The Whittington Health Charitable Funds Committee meeting held on 12 December 2018**

Present	Name	Initials	Title
	Tony Rice	TR	Non-Executive Director (Committee Chair)
	Steve Hitchins	SH	Non-Executive Director (Trust Chairman)
	Stephen Bloomer	SB	Chief Finance Officer
	Jon Ware	JW	Head of Financial Services
	Jonathan Gardner	JG	Director of Strategy, Development & Corporate Affairs
	Siobhan Harrington	SMH	Chief Executive Officer
	Juliette Marshall	JM	Director of Communications
	Dan Fletcher	DF	Kingston Smith *for item 18/043, 9a*.
	Rob Smith	RS	Griffin Stone Moscrop & Co. *for item 18/036*
	Vivien Bucke	VB	Business Support Manager, Finance

Item	Discussion	Action
18/033	**Welcome, Apologies for Absence** & **Declarations of Interest**	
33.1	Apologies were received from Michelle Johnson, Naomi Scott and Hugh Montgomery and no Declarations of Interest were received.	
18/034	**Approval of Minutes of the meeting held on 10th October 2018**	
34.1	The minutes were agreed as an accurate record with the following amendment to the spelling of 12. 'Simmons House'.	
18/035	**Action notes**	
35.1	1. Kanitz Fund Monies the shopping list had been brought here for review. 5. JW had communicated the need to spend monies to fund holders and this will be followed up with further statements. 7. Application for a display to recognise long serving staff; Agreed to take as Chairman's action before the next Committee in March. **Previous outstanding actions:** 2. SH asked about patient leaflet templates and JM stated they would redone to highlight the need for extra content. SH felt it would be useful if the leaflets could be on the website which is currently out of date with names listed. **Action: JM** 4. Evaluation of text /phone donations demonstrated little income. Consideration on whether to continue with this means of giving to follow the strategic review. **Action: JM**	**AP01** **AP02**

18/036	**Annual Report and Accounts for 2017/18**	
36.1	JW introduced Rob Smith, Partner at Griffin Stone Moscrop and Co. The firm had been selected following an exercise undertaken among local firms. The Trust received back three quotes and Griffin Stone Moscrop and Co. was the most competitive and flexible. RS had been helping Finance with the independent examination of the Charitable Fund accounts this year. The Committed noted this was an independent examination and not an audit because the yearly income was below the threshold to mandate an audit.	
36.2	JW stated three papers had been tabled as part of item 3. 3a was a covering paper for the accounts, 3b the accounts themselves and 3c the annual report that JM and JW had written in partnership. Revised accounts were tabled following the independent examination process. The date for the Charity to report to the Charity Commission is 31 January. The main statements were in line with what had been reported to the Committee during the year. The main headlines were: • Income slightly higher than previous year, one off legacy and slightly stronger underlying fundraising. • Expenditure 10% lower than the previous year, one sizeable bid, but no other large items. • Balance sheet main headline is probably around the value of investments, which fell off in quarter 4 and caused an overall loss on the year. Performance has been stronger in the first two quarters of 2018-19.	
36.3	The main changes that had been made to the accounts as a result of the work done by the independent team were set out in paragraph 2.6. The changes made were not significant, increasing income by £21k.	
18/037	**Independent Examiners Report on the Accounts**	
37.1	SH asked that the name be changed to Whittington Health. **Action: JW**	**AP03**
37.2	JW highlighted the revised set of accounts would go to the Charity Commission on 31st January. The main statements were in line as had been reported all year but it was worth reporting income was slightly higher containing a one off donation plus marathon & fun runs. Apart from the ITU equipment there were no major bids over £20k.	
37.3	RS confirmed for any income over £25k per annum a charity is obliged to have an examination but if over £1m income have to undertake an audit. RS had identified a few minor changes and presentational changes. RS outlined the company scope and had advised on some issues i.e. rounding to the pound and not the thousand but was essentially happy with the examination. JW confirmed the process hadn't felt too different to an audit but felt this has been a very efficient process and enjoyed working with RS and his team. The Committee approved the accounts.	
18/038	**Financial Report Month 7 2018/19**	
38.1	JW reported that there had been relatively little change from the meeting in October. Income was slightly ahead of 2017-18, expenditure	

	significantly behind. There weren't any bids of significant value coming through, but the Trust will hopefully see the impact of some amounts coming through for Kanitz before January / February.	
38.2	JW stated the other points to raise were in relation to the balance sheet: • Creditors reducing due to the settlement of salary recharges. • Donation for maternity had happened in line with what the Committee agreed at the previous meeting.	
18/039	**Fund Balances**	
39.1	JW reported this was the usual paper setting out the breakdown of funds by the various categories and taking into account significant movements in those balances. • As alluded to in the Finance paper, there had not been a lot of movement in fund balances. Overall increase of £7k in the year, total is £3.7m. • Generally, the movement had been up on restricted, down on unrestricted funds and this was largely due to the one-off donation previously mentioned and where that had been placed (in ringfenced funds).	
18/040 40.1	**Applications for Funding and Revised Proposal** JW reported there were no applications for funding over £5k that the Committee members formally needed to approve and the committee noted this fact.	
40.2	SB said that while there had been a goal to spend more money this had not materialised. While formal guidance existed JM had met with JW on how to provide clearer information for the Intranet pages, setting out what the charity can and cannot pay for. The text had been agreed and JM said she would monitor the impact this had. SB reiterated Finance had made clear it did not refuse bids but generally sends them back requesting staff make clear why the charity was being asked to pay for an item as this is important for the Charities Commission. This formed part of the clarity of information to be provided. **Action: JM**	**AP04**
40.3	In addition, JW confirmed that he had run sessions as part of the Budget Holder Training and the main focus had been what is a charitable funds bid.	
40.4	TR enquired about Singing for your lungs and JW confirmed transfer (for £5k) from the Nightingale fund had been agreed by Nigel Kee.	
18/041	**Kanitz Fund**	
41.1	The Committee reviewed the Fund and noted not all of the legacy had been committed despite the previous efforts. It was noted SH and SB would work with the team to agree the final commitments.	
18/042	**General Fundraising**	
42.1	JM reported on the October – November 2018 fundraising activities. She highlighted that Arsenal Football Club were still considering whether to	

	make a contribution to the Ifor Ward Play Terrace project and that the new contactless giving points trial had started this week. The Committee noted the report.	
18/043	**Update on Fundraising Strategy**	
43.1	JM reported the Trust had become a member of the association of charities and had been sent a list of events which will be passed to the Chair of the Committee. **Action: JM**	**AP05**
43.2	JM introduced Dan Fletcher the Director of Fundraising from Kingston Smith who spoke of his experience and involvement in capital projects and set out his proposals around conducting a strategic review of the charity in order to inform future direction and conducting a capital programme feasibility study on a potential future major capital campaign. Dan Fletcher left the meeting and JM spoke to the Addendum paper (9b) which included the proposal and associated costs. The recommendation was to go forward with the strategic review at this stage, with some minor amendments to slightly reduce the cost, and re-visit the option for the capital programme feasibility study at a later point. All agreed. **Action: JM**	**AP06**
43.3	JM spoke to the rest of the paper, which also included a summary of quotes from four suppliers that had been approached to undertake fundraising for the Ifor Ward Play Terrace and provide interim fundraising support for general activity. Two had declined to quote for the project and of the two which had, JM reported that Compton Fundraising was the clear recommended bid for the Ifor Play Terrace and interim support on a 3 days per week basis. The other supplier had less NHS experience and JM felt the quote from this company is still not feasible, even after asking them to increase the time commitment in their quote. The recommendation is to move forward with Compton who have lower cost for greater resource, they have more NHS experience. SMH/TR felt there should be an incentive agreement. All agreed to appoint Compton. **Action: JM**	**AP07**
18/044	**AOB**	
44.1	The Item tabled related to season ticket loan. JW stated this paper had been brought to the committee as the administration of season ticket applications falls under charitable funds. It was felt around the trust that current restrictions on issuing season ticket loans were not helping the Trust demonstrate that it is a good and flexible place to work. In addition, it did not help with staff retention.	
44.2	The paper had been circulated to Executives, but there was a role for the Committee and he asked committee members to approve the changes in the policy approach, and then executives will communicate the changes to staff, to those processing the claims and to HR who own the policy.	
44.3	The committee approved the proposed change to season ticket policy so that new substantive staff are immediately eligible for a season ticket loan, and can start to make deductions in their first pay packet.	
	Next Meeting: 26th March 2.00-4.00 p.m.	