Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 30 May 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**30 May 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yua Haw Yoe, Non-Executive Director	Siobhan Harrington, Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse & Director of Patient Experience

Attendees
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Sarah Humphery, Medical Director, Integrated Care
Juliette Marshall, Communications Lead
Norma French, Director of Workforce
Helen Taylor, Deputy Director of Strategy

Secretariat
Susan Sorensen, Interim Corporate Secretary
Kate Green, Minute Taker

Contact for this meeting: susan.sorensen@nhs.net

Agenda Item		Paper	Action & Timing
Standing Items			
18/068	**Patient Story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	*Verbal*	*Receive* 1400hrs
18/069	**Declaration of Conflicts of Interest** *Steve Hitchins, Chair*	*Verbal*	*Receive* 1420hrs
18/070	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Receive* 1425hrs
18/071	**Draft Minutes, Action Log & Matters Arising 25 April 2018** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
18/072	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Receive* 1440hrs
18/073	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Receive* 1450hrs
Patient Safety & Quality			
18/074	**Serious Incident Report Month 1** *Richard Jennings, Medical Director*	3	*Review* 1500hrs
18/075	**Learning from Deaths Quarter 3 Report** *Richard Jennings, Medical Director*	4	Review 1510hrs
18/076	**Quality Account** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	5	*Approve* *1515hrs*

Operational Performance and Planning			
18/077	**Financial Performance Month 1** *Stephen Bloomer, Chief Finance Officer*	6	*Review 1530hrs*
18/078	**Performance Dashboard Month 1** *Carol Gillen, Chief Operating Officer*	7	*Review 16100hrs*
Strategy and Governance			
18/079	**Remuneration Committee Terms of Reference** *Norma French, Director of Workforce*	8	*Approve 1620hrs*
18/080	**Board Assurance Framework** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	9	*Approve 1625hrs*
18/081	**Risk Register Summary Report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	10	*Agreement 1635hrs*
18/082	**Provider Licence self-certification** *Siobhan Harrington, Chief Executive*	11	*Approve 1645hrs*
18/083	**Sub-Committee Minutes:** (as available) Quality Committee (9 May) Workforce Assurance Committee (24 May)	12	*Review 1655hrs*
AOB			
	None notified to the Trust in advance		
Questions from the public on matters covered on the agenda			
	None notified to the Trust in advance		
Date of next Trust Board Public Meeting			
27 June 2018 -1400hrs-1700hrs -Whittington Education Centre, Magdala Avenue, N19 5NF			

Register of Conflicts of Interests:
The Register of Members' Conflicts of Declarations of Interests is available for viewing during working hours from Susan Sorensen, Interim Corporate Secretary at Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or susan.sorensen@nhs.net or www.whittingtonhealth@nhs.net

Whittington Health
NHS Trust

ITEM: 18/071
Doc: 01

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday 25th April 2018 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Chief Executive
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Michelle Johnson	Chief Nurse
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Fiona Isacsson	Deputy COO
	Susan Sorensen	Interim Corporate Affairs Lead

18/49 Patient Story

Michelle Johnson introduced Sita Chitambo, Head of Nursing for Emergency & Urgent Care, Rose Ngore, NE Haringey District Nursing Team and James Connell, Patient Experience Manager. James explained that the patient featuring in that day's story was effectively housebound and therefore unable to attend in person, he had however agreed to his story being filmed.

Herman, a diabetic patient with poor eyesight and severe arthritis, had been admitted to hospital following a hypoglaecemic episode over a year ago. Since his discharge from hospital he has been visited every day by the Haringey district nursing team, and he described his health as much better now. Generally nurses come on time (or telephone if they are going to be late) and although he does not see the same person every day Herman described them all as his friends.

A recording of Herman's daughter and main carer Monique was then played. She explained that not only did someone from the district nursing team attend every morning to administer his insulin and generally manage his diabetes; they also helped to arrange his follow-up arrangements. Asked if she felt there was anything further the team could do for Herman, Monique said that she 'did not think there was much room for improvement' and that they were doing a 'fantastic job'. Rose added that in addition to HCAs and pharmacy technicians there was a specialist diabetes nurse, who helped the team to carry out three-monthly reviews of all diabetic patients.

Siobhan commented on how lovely it was to hear such positive feedback from both Herman and his daughter, and also complimented the film-maker (James Connell) on his technical skills. Steve Hitchins added that it would be good to have all patient stories filmed and made available on the website. David Holt had been pleased to learn of the role of HCAs, and Sita replied that the Trust was fortunate in having a very good professional development team which meant that HCAs were carrying out more specialised care than would previously have been the case, although Michelle Johnson reminded the Board that the role of the nurses in carrying out re-assessments was crucial.

Deborah Harris suggested that there were opportunities here for the nursing staff to engage in some qualitative style research on the benefits of this type of service delivery and she would like to see the nursing cohort put forward some ideas. Michelle would take this suggestion to her Nursing & Midwifery Executive meeting, due to take place later that week. Siobhan added that this was also about the importance of evaluating the services provided by the Trust.

Janet Burgess had been pleased to hear that the district nursing team turned up on time, saying that it was important not to underestimate the importance of this for the patient who was waiting. Richard Jennings also commended the work of the district nursing team, saying that he had accompanied one of the Haringey team on visits and been hugely impressed by the range of services provided and the skills of the staff involved. He also spoke about the costs of insulin and its efficacy in all cases. Sita reiterated the point about the three monthly reviews carried out with the aid of the diabetes nurse specialist, adding that some patients had come off insulin, however all agreed that the main and obvious priority was to carry out risk assessments to ensure patients could be looked after safely at home.

18/50 Declaration of Conflicts of Interest

50.01 No member of the Board declared any interest in any of the business to be transacted that afternoon.

18.51 Welcome and apologies

51.01 Steve Hitchins welcomed everyone to the meeting, and especially Fiona Isacsson, Director of Operations for Surgery & Cancer/Deputy COO, standing in for Carol Gillen. Carol had sent her apologies, as had Graham Hart and Tony Rice.

18/52 Minutes, Matters Arising & Action Log

52.01 Referring to minute 39.03, Fiona asked for an amendment to reflect the fact that it was from October 2018 the Trust would no longer be paid for paper referrals rather than April. Other than this, the minutes of the public Trust Board meeting held on 28th March were approved.

Action log

52.02 05.04: The report on flu was contained within the quarterly quality and safety report to be presented later that afternoon, this item would therefore be closed on the action log.

20.03: Michelle Johnson had now assumed the role of DIPC and was working in tandem with Julie Andrews to ensure a smooth handover; this item could therefore be closed.

25.03: Performance on appraisal and mandatory training dates was being reviewed at the quarterly ICSU performance review meetings; this item could therefore be closed.

34.03: The Trust's response to the CQC report had been circulated to Non-Executive Directors; this item could therefore be closed.

37.01: The nursing safer staffing data had now been incorporated in to the main Performance Dashboard; this item could therefore be closed.

52.03 All other items on the action log were scheduled for discussion later in the year.

18.53 Chairman's Report

53.01 Steve Hitchins began his report by saying how successful this year's Mayors' Walk had been; twenty-nine of the thirty-three mayors had attended, and the Lord Mayor himself had expressed considerable interest in Whittington Health. This was a link which Steve hoped to build on in the future.

53.02 Chris Hopson, Chief Executive of NHS Providers, had visited the Trust, and Michael McDonnell was also due to visit soon.

53.03 Other events attended by Steve included the HSJ Conference, a London-wide digital therapeutic event, and an extremely positive event, held the previous Saturday, for those with Type 1 diabetes.

18/54 Chief Executive's Report

54.01 Siobhan Harrington began her report by telling the Board that she was looking forward to welcoming Sarah Humphery, newly-appointed Medical Director for Integrated Care, and Jonathan Gardner, newly-appointed Director of Strategy, Development & Corporate Affairs to the Trust; both would be starting in early May.

54.02 Looking at performance at Month 12, Siobhan reported that for the 4 hour ED standard, the Trust had achieved 89.43% at year end. Although this fell short of the 95% national standard and the Trust's own planned 90%, she was pleased to note that this was a 3% improvement on last year's performance and also made Whittington health the highest achiever in the NC London sector.

54.03 The winter period had been an extremely busy one, but Siobhan felt that it had been approached in a better planned way, even taking into account the fact that ED activity had been the highest on record. The position on delayed transfers of care had continued to improve, and MADE (multi agency discharge event) events had been well attended and generated positive outcomes.

54.04 There had been definite signs of improvement in recruitment, particularly within nursing (Band 5s). Stephen Bloomer would be presenting the financial report, but Siobhan was pleased to inform the Board that the Trust had achieved its control total at year end and had in fact generated a small surplus. She expressed her thanks to both the executive and finance teams for the immense amount of work that had been put into achieving this.

54.05 Implementation of the Electronic Referral System (ERS) appeared to be proceeding well and Siobhan would continue to keep the Board informed of progress. All Trusts had been sent a letter from the centre reminding them of the importance of cyber-security. It was noted that Deborah Harris-Ugbomah was NED lead in this area. Information Governance compliance stood at 77% and the Trust had achieved Level 2; this was particularly important in the run-up to GDPR.

54.06 The consultation on the restructuring of the ICSUs (a proposed move from seven to five) had been launched on 11th April and the consultation period would end on 10th May. The current and proposed future structures, along with the case for change, had been posted on the intranet as well as having been circulated (though the weekly bulletin) to all staff. All were welcome to submit comments on the proposals. Deborah asked that this documentation be forwarded to NEDs as not all had access to the intranet. Norma added that there would be a formal management response which she would also circulate to all Board members.

54.07 It was noted that the Trust had recently attracted some media attention ("end pyjama paralysis!") concerning its policy of encouraging patients to rise from bed, dress and take part in activities in order to promote a speedy recovery and early discharge; despite the slightly misleading slant depicted in some papers this was felt to be a positive story.

18/55 Serious Incident Report

55.01 Introducing this item, Richard Jennings reported that just two serious incidents had been reported in March. The first concerned a patient who had died after contracting influenza whilst in hospital, and details of this case were contained within the quarterly quality and safety paper. The other serious incident concerned a patient who had suffered a fractured neck of femur following a fall on the ward. Richard informed Board colleagues that much thought had been given to the prevention of falls, and it had been decided to add falls prevention to the mandatory training list. He emphasised that this had not been a decision which had been taken lightly since there were many calls for additional mandatory training modules, but there had been a consensus that this was essential in terms of patient safety.

18/56 Quarterly Safety & Quality Report

56.01 Richard informed the Board that for this quarter, the 'deep dive' contained within this report concerned influenza. He began by informing the Board that the Trust's HSMR and SHMI figures remained positive, with the Trust continuing to have the lowest SHMI score in the country.

56.02 Moving on to Infection Prevention and Control, Richard said that there had been three MRSA bacteraemia during 2017/18. He added that there had recently been an increase in MRSA colonisation on one ward which had required a clear and rapid response (this had included handwashing audits) and since action had been taken no further instances of colonisation had been reported. In answer to a question from Norma French about whether a contributory factor might have been this having been a winter pressures ward with a high level of agency staff, Richard agreed this might have been the case. Michelle said that usually, staff would be deployed from other areas to ensure that winter pressures wards did not have higher levels of agency staff than other wards, but this year the vacancy factor had made this particularly challenging.

56.03 The report also contained an update on the Trust's progress on the Sign up to Safety Initiative. On acute kidney injury, Richard felt there was a need to strengthen the systems for labelling and recording action, he also felt there was a case for looking at data quality. There was still some work to be done on pressure ulcers, and it was also important not to lose focus around services for adults with learning disabilities. Michelle agreed there was work to do around the assessment of pressure ulcers, and stressed that this was a responsibility for all staff and not just nurses. It was noted there had been significant quality improvement around the management of sepsis, and Richard expressed his thanks to all who had been involved in this work.

56.04 Turning to 'flu, Richard informed the Board that this last year had been particularly challenging, with 336 cases recorded as against the previous year's total of 235. The 'B' strain had been more prevalent. A significant change this year had been the infection prevention and control team visiting the wards and ensuring there were stickers in notes and patients were receiving the correct medication. It was impossible to isolate all patients with 'flu given the design and layout of wards, but this was done where the capacity existed.

56.05 Looking in more detail at the three cases of hospital-acquired influenza where patients had died, Richard said that it was possible to see the variation in staff vaccination rates. Whittington Health had achieved the second highest take-up of 'flu vaccination rates in London, but there was still work to be done, and it was noted that Professor Sir Bruce Keogh had called for a national debate about whether staff vaccinations should be mandatory. Michelle added that whilst it was important to respect the personal views of staff, it was equally important to remember their role as leaders in the system.

56.06 Michelle also said that her team would be carrying out a review of the provision of services over winter, and that the impact of 'flu would be an important part of this review. The Board briefly discussed the importance of treating people at home rather than admitting them to hospital where there was a likelihood of them acquiring 'flu; especially important for the frail and/or elderly. The Trust had for several years had the lowest SHMI in the country, but it was important never to become complacent.

18/57 Annual Safeguarding Children Declaration

57.01 Michelle Johnson introduced the paper setting out the annual safeguarding children declaration, which demonstrated that the Trust was compliant with all statutory and mandatory requirements as well as with London-wide standards. She described the required systems and policies and the measures taken to give assurance of the Trust's compliance. The annual report would be brought to the Board in June, then there would be an interim report in six months' time. Both Siobhan Harrington and David Holt expressed their support for this, with Siobhan informing the Board that changes were being made to safeguarding policies and procedures across both Islington and Haringey with which it would be important to have strategic oversight.

57.02 In answer to a question from Anu Singh about how this linked with the reports presented to Quality Committee, Michelle said that there would be more in-depth discussion at that meeting. She also expected there would be issues around safeguarding adults which the Board would need to consider in due course. David Holt enquired about learning from practice, and Michelle assured him that further detail would be included in the annual report to be taken the following month.

18/58 Improving Mental Health care in the Emergency Department

58.01 Putting this item in context, Richard Jennings reminded Board colleagues that in the space of two years seven patients who had accessed the Trust's Emergency Department (ED) had gone on to die at their own hand, each case being an absolute tragedy. Each case had been appropriately investigated, but although issues identified had led to learning for the Trust, no clear themes had been identified. It had therefore been felt appropriate to seek an external view, so together with Camden & Islington Mental Health Trust and the commissioners Verita had been commissioned to conduct a review. The main report was inappropriate for the public domain as it contained too great a level of (patient identifiable) detail, but Richard was able to inform the Board that Verita had been unable to detect any overarching themes either.

58.02 One key finding however was that ED was not the most therapeutic place to be for anyone experiencing mental health problems, another finding was that there were questions to be asked about whether it had been appropriate (in some cases) to allow patients to leave the department.

58.03 David Holt praised the quality of the report and felt positive about the actions that had been taken. He asked whether there were other cost-effective ways similar actions could be taken for other situations which had given cause for concern. Richard said that

Serious Incidents (SIs) were also subject to external scrutiny; Royal Colleges had also been commissioned to carry out reviews and investigations, but there was of course a cost attached to this.

18/59 Financial Report

59.01 Stephen Bloomer began by apologising for the report being circulated late. He was pleased however to report that at Month 12 the Trust had reported a £0.4m surplus, giving a full year surplus of £0.8m. This meant that the Trust had met its revised control total for the year, and was therefore eligible for STF monies. He explained that as many organisations had failed to meet the required targets that made them eligible for additional funding, the Trust had subsequently been awarded an additional £4.7m, giving a revised surplus of £5.4m. David Holt enquired what the year-end position would have been if all additional funding awarded was deducted, and was told that the Trust would have declared a £6-7m deficit, however the position was complicated and Stephen was happy to speak to David in more detail.

59.02 Stephen informed the Board that the Finance & Business Development Committee meeting in September would be looking at a longer-term piece of work with a long term financial plan. It would be important for the Board to fully understand the strategic implications of this, and Siobhan assured the Board that the team would be working on this over the next three to six months.

18/60 Performance Dashboard

60.01 Introducing this item, Fiona Isacsson informed the Board that the 4hr ED target remained challenging, adding that the previous day had seen over 300 ED attendances. An updated action plan has been produced to address this. Moving on to community waits, Fiona informed the Board that a new community dashboard was to be produced from next month, and this had had input from both commissioners and GPs. Steve Hitchins emphasised the importance of such reports reflecting outcomes and not just 'turnstile numbers'. It was noted the nursing safer staffing report was now contained within the main performance dashboard.

60.02 Fiona reported that implementation of the electronic referral service (ERS) was proceeding as planned and there had been some positive feedback from the Centre. She acknowledged that there had been a small number of issues as implementation proceeded but these were being addressed. Weekly meetings were taking place to monitor progress, and there was a process in place to ensure that no patients were 'lost' in the system. There had been a rise from 55% to 78% referrals, so good progress was being made.

60.03 In answer to a question from Steve Hutchins about sickness data, Norma French replied this would be followed up, but she was aware that sickness rates had dropped to around 4%. Norma also informed the Board that there had been an improvement in this quarter's Friends & Family test results, and she would be taking a paper about this to the Trust Management Group (TMG) meeting the week after next. There had also been a focus on appraisal at that quarter's ICSU performance review group meetings, and this was likely to increase if the government's pay offer was accepted.

18/61 Risk Register Summary Report

61.01 Michelle Johnson explained that the Board would be seeing both the risk register and the Board Assurance Framework (BAF) on a six-monthly basis. The paper presented that day gave a summary of all risks with a score of 16 or above, a number of which were not on the BAF. Michelle took the Board through all of the areas covered, and invited

them to consider whether any additional risks should be added to the BAF. Siobhan remarked on the new format of the register, and said consideration would be given to bringing it back to the Board alongside the BAF so that the two documents could be compared. David Holt expressed an interest in the views of the Board sub-committees, and Steve Hitchins said that he would like to see the mitigations planned to address these risks.

61.02 Turning to specifics, the Board expressed concern about the continued risk around medical records which were not located in medical files. They also enquired about the escalator in the main entrance which had been out of order for some three months, and Siobhan undertook to follow this up. Richard Jennings enquired about the mental health security van, and it was agreed this needed to be taken up with the estates department. Yua Haw Yoe said that there had been problems with the doors at Simmons House not working properly and she had been told it would take a further week or two before they could be fixed. Whilst agreeing this was a cause for concern, Siobhan explained that Simmons House was not a Trust asset and therefore this was not entirely in our gift to fix rapidly. Fiona suggested it would be helpful for a representative of the estates department to attend Quality Committee.

18/62 Annual Operational Plan

62.01 Helen Taylor explained that the Trust had produced a two-year operational plan the previous year therefore this paper was an update to the 2017/19 plan. It included the ED recovery plan, a section on community services and the outpatient transformation plan. Quality Improvement work had also been highlighted, as was the way quality impact assessments were carried out prior to the implementation of CIPs. There were also sections on workforce and financial planning, and more detail on fast follower projects.

62.02 In answer to a question from Steve Hitchins about how it was possible to tell whether QI initiatives were working, Helen replied that each project would have to be examined individually, but the methodology itself should demonstrate success. It was noted that Julie Andrews planned to bring back some of the iQUASER work to the next TMG. Fiona Isacsson drew attention to the new performance measures for cancer services, which would have a major impact going forward.

62.03 Both David Holt and Richard Jennings expressed their thanks to Helen on the production of such a clear accessible document, and suggested Leon Douglas be asked to add some words around enablers, although Helen said that the capital planning section contained some detail on this.

18/63 Operational Objectives Update

63.01 Helen Taylor explained that the papers circulated included final outcomes from the 2017/18 objectives and a proposed methodology for the recording of objectives for 2018/19, which, if agreed, would then become part of the performance dashboard. It was noted that contrary to the section in the outcomes about the agency cap, this had been achieved by the Trust during 2017/18.

63.02 Helen added that the team was also looking at how the model hospital might best be used by the ICSUs in their planning processes. David Holt stressed the importance of the Board being given sufficient time to discuss this in detail. Siobhan thanked Helen both for preparing these papers, but more importantly, for acting as Director of Strategy since September.

18/64 Risk Management Strategy

64.01 Michelle Johnson said that the risk management strategy had been amended following discussion at the Trust Board seminar. She felt confident both in its description of how risks were to be managed and also in its relationship with the BAF. She pointed out that Whittington Health had minutes of its sub-committees taken at Board meetings whilst some organisations took reports of committees; consideration needed to be given to this in a manner which did not create additional work. David Holt described the methodology used for Board level risk management at the Planning Inspectorate.

64.02 It was agreed to review the forward plans for each of the Board sub-committees as part of this work, and Susan Sorensen would assist with this task.

18/65 Register of Deed of Execution and Seal

65.01 The report on the use of the Trust's Deed of Execution and Seal for the period 1st April 2017 to 31st March 2018 was formally received and noted by the Board.

18/66 Sub-Committee Minutes

66.01 The minutes of the Quality Committee held on 14th March and the Charitable Funds Committee held on 21st March were received by the Board.

18/67 Nomination & Remuneration Committee Terms of Reference

67.01 This item was deferred to the May Trust Board meeting.

Any other business

There being no other business, the meeting conclude at 4.30pm.

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Action Log

Minute	**Action**	**Date**	**Lead**
13.02	Training need – to increase number of fire marshals in appropriate locations across the Trust. Assurance report to Board within six months and annually thereafter.	July 2018	SB
35.04	"Light touch" Nursing Establishment Review to be carried out in April with report to Board in June.	June 2018	MJ
40.05	Action plans arising from the Staff survey to be brought back to the Board following discussion at the Workforce Assurance Committee	Sept 2018	NF
54.06	Documentation on the ICSU restructuring to be circulated to NEDs	May 2018	NF
59.02	Board to discuss the strategic implications of planning for long-term financial plan following September meeting of the Finance and Business Development Committee	tba	SB

61.01	BAF and Risk Register to be brought to the May Board together. Thereafter each to be presented every six months, separately but alternately.	May 2018	HT for JG
64.02	Forward plans of Board Sub-Committees to be reviewed as part of the risk management process	June 2018	JG

Whittington Health
NHS Trust

Trust Board
30 May 2018

Title:	**Chief Executive Officer's Report for the Trust Board**		
Agenda item:	**18/073**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To receive the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	25 May 2018		

Author name and title:		**Fiona Smith Communications & engagement**		**Director name and title:**		**Siobhan Harrington, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER REPORT

The purpose of this report is to highlight issues and key priorities to the Trust Board.

NHS NEWS

Next steps on aligning the work of NHS England and NHS Improvement

NHSI and NHSE recognise that they need to adapt and transform the way that they work to create an operating model that best supports local health systems and the people they serve and provide a more joined up national; system leadership. NHSI is seeking to change its primary focus from regulation to supporting improvement.

NHSI and NHSE will establish a new NHS Executive Group, co-chaired by the two CEOs and comprising membership of a; national directors and Reginal Directors from the two organisations.

NHSI and NHSE will align their core processes so that all interactions with frontline NHS are conducted once. This includes establishing a single financial and operating planning process for the NHS, a single performance management process and the alignment of regulatory interventions, a single internal management process and a single proves for establishing and reviewing national strategic programmes such as cancer, mental health and digital. The two bodies will establish a joined up and aligned approach to reporting and sharing information about the system.

There are several potential benefits to this approach:

- Reduction in duplication and elimination of contradictory messaging
- Single system framework to support local system focus
- An effective regional level offering enhance local support
- Greater value for money

More information can be found in the NHSI and NHSE published board paper

Carter report on operational productivity in community health services and mental health

NHSI has published a report NHS operational productivity: unwarranted variations following the review led by Lord Carter of the productivity and efficiency of mental health and community health services.

The review, led by Lord Carter, covers the operational productivity of English NHS community and mental health services. Since early 2017, Lord Carter's review team has been working with a cohort of 23 mental health and community trusts, who account for over 20% of total expenditure in the sectors.

The final report makes 16 recommendations and indicates productivity benefits worth £1bn can be achieved by 2020/21.

The review team found that while the Five Year Forward View (5YFV) for mental health services has engendered a clear ambition, delivery programme and strong leadership, there is a lack of national work and evidence base on community services. The report suggests that NHSI and NHSE should do more to recognise and strengthen the role of

community health services. This should bring together existing national work streams within a single delivery plan and support local areas to achieve it.

Recommendations from the report include the following:

- Learning from new models of care to support community health services to play a fuller role in supporting the wider system
- Extend the GRIFT programme to community health
- Driving standardisation in the community health services 'offer'.
- Optimising workforce wellbeing and engagement to improve overall levels of satisfaction, sickness absence and vacancy rates.
- Strengthening the oversight of workforce productivity for services delivered in the community.
- Improving the productivity of the clinical workforce for services delivered in the community.

Haringey and Islington Wellbeing Partnership Workshop

Haringey and Islington Wellbeing Partnership arranged a leadership event to review progress in integrating care across Haringey and Islington. Over 70 leaders from across the health and social care system attended. The meeting was vibrant and energetic – there was a real optimism when reflecting on the changes to pathways that have already been delivered.

The conclusions from the group were that the system needed to focus more on the enablers to support transformational change. These were in line with the recommendations included in the Carter report.

FINANCE

2018/19 Trust Contract

The Trust has agreed the 2018/19 contract with commissioners.

April Month 1 Position

The Trust is reporting a £0.4m deficit at the end of April (month 1) against a planned deficit of £0.3m, per the Trust's annual planning submission to NHSI. Actual performance therefore is an adverse variance of £0.1m against plan.

The key driver for the adverse performance is the continued use of "winter pressure" beds throughout April which are not funded either through base budget allocation or separate winter resilience funding. This additional bed capacity resulted in an increased direct pay cost of £0.2m which was primarily flexible staffing including agency with additional costs being incurred in support services e.g. Estates and Facilities. This activity does not attract the same level of income as the majority of patients are long stay and have exceeded the tariff trim point and therefore attract only excess bed day payments. The ICSUs are working through operational plans to enable this bed capacity to be safely reduced to pre-winter levels.

QUALITY AND SAFETY

Emergency Pathway

Performance against the 95% 4-hour standard was 86.32% in April.

Activity was higher than the same period last year by 4.2%, 8646 attendances (April 18) against 8285 (April17).

Ambulance activity was up by 8% compared to the same time last year; 1775 (April 18) compared to 1641 (April 17).

An extensive improvement plan is in place and is monitored at the AE delivery board (AEDB) chaired by CEO (Whittington Health)

The Chief Operating Officer, myself and CCG colleagues attended an escalation meeting with NHSI and NHSE on 9 May to review end of year ED performance and the Trust's emergency pathway improvement plan. The Trust continues to deliver its recovery improvement plan to meet the trajectory to deliver the 4 – hour standard of 95% by September 2018.

Delayed transfers of care

Improvements continue. Through system-wide working the Trust has met the DToC target reduction although this remains a significant challenge.

Overall occupied bed days delays continue to reduce.

System MADE meetings have increased to twice weekly.

NHS Electronic Referral System

From 16th April Whittington Health have been accepting all GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System.

GP's use of making referrals using eRS is increasing rapidly, and is currently 80% in May 18.

All service managers are reviewing the services' slot capacity daily.

Non Elective C-section rate

There has been an increase in non-elective C sections in month from 14.5% in March to 17.2% in April.

The service has seen an increase in induction of labour rates and a proportion of these patients then go on to have an emergency section. There has been a national increase in inductions as a result of the introduction of the 'Saving Babies Lives' Bundle, which raises awareness of reduction in foetal movement and heart rate.

WORKFORCE

Integrated care Units (ICSUs) restructure

Following a recent consultation, the new structure for the Integrated Clinical Service Units (ICSUs) has now been agreed.

The Executive Team reviewed the views and comments received during the consultation period and following consideration made some changes to the initial proposed structure.

Two of the most significant changes are that NICU/SCBU will stay within Children & Young People's Services and Diagnostics (imaging, pathology and pharmacy) and Outpatients will be brought together into one ICSU with Women's Health – the Women's Health, Outpatients and Diagnostics ICSU.

The new structure is made up of five ICSUs, with an additional post of a Deputy Chief Operating Officer. This will be an evolution of the current structure to best support delivery of our strategy over the coming years. The next steps will be to appoint to the senior posts of the new structure.

Change in Trust Responsible Officer

Dr Richard Jennings, the Trust's Executive Medical Director, was appointed to the role of Trust Responsible Officer (RO) in June 2014.

At its private meeting today, the Board will consider a proposal to transfer the role to Mr Robert Sherwin, Associate Medical Director for Appraisal and Revalidation, on or before 01 August 2018. Dr Jennings will continue to have oversight of fitness to practice issues.

Excellence Award

This month's staff excellence award goes to Julie Belbin, Family Health Advisor at River Place Health Centre.

Julie joined Whittington Health in 2016. Her colleagues describe Julie as passionate about her work. "Julie's life skills benefit not only the families that she works with but also the team. She is an asset to the team….Julie is an excellent communicator and offers a high quality service to her clients.

In the Friends and Family feedback service users say this about Julie:
"Our health care provider Julie Belbin is amazing. She is extremely knowledgeable and warm and has been terrific at sharing this knowledge."
"Julie Belbin has been lovely and so helpful it's changed our lives having this help."
"Julie was super friendly and helpful."
"Julie Belbin is so nice and I have great feeling about everything we were talking about."

INFORMATION TECHNOLOGY

EU General Data Protection Regulation (GDPR)

The EU General Data Protection Regulation (GDPR) came into force on 25 May 2018 and replaces the existing Data Protection Act 1998.

The Trust submitted the 2017/18 IG Toolkit at 77% compliance demonstrating full level 2 compliance with all requirements as a minimum, with several at level 3. The IG Toolkit is formed of various legislation, information security standards and NHS best practice guidelines. The Trust has been compliant with the Data Protection Act 1998 for many years and GDPR builds on this.

The Trust has been carrying out awareness campaigns to ensure all areas of the Trust are compliant with the new data protection regulations. The Trust's IG department have presented materials at committees including the Audit & Risk Committee, Trust

Management Group and the boards of all ICSUs. The Trust is publishing a revised privacy policy on its website to provide members of the public with information on how their information is stored and used.

Siobhan Harrington
Chief Executive

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Trust Board

May 2018

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**18/074**	**Paper**	**3**
Action requested:	It is recommended that the Board recognises and discusses the assurances contained within this report that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via Strategic Executive Information System (StEIS) during April 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis. The Board is invited to consider focussing discussion on: • Steps being taken to learn from incidents in surgery, • Further ways in which we might disseminate learning and be assured that we are learning.		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• 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).		
Reference to areas of risk and corporate risks on the 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.		
Date paper completed:	11/05/2018		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Richard Jennings, Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incident Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during April 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 Governance and Risk and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared six serious incidents during April 2018, which is four more than in this period in 2017.

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 Support Unit.

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

3.2 The table below details the Serious Incidents currently under investigation

Category	Month Declared	Summary
Environment Incident meeting SI criteria Ref: 2655	Jan 18	A fire broke out in the Whittington hospital which was contained in the basement area of the Private Finance Initiative (PFI) Building storage room. The smoke was distributed into the ventilation system resulting in the evacuation of the affected areas. No staff or members of the public were harmed. An extension of the date by which the response must be completed has been agreed with the CCG to provide time for the London Fire Brigade and PFI reports to assist us in finalising our report.
Patient Fall Ref:6532	March 18	Patient had a witnessed fall on the ward, resulting in a fractured neck of femur.
Unexpected Death - influenza Ref:7161	March 18	Patient acquired influenza in hospital and subsequently died.
Unexpected Admission to NICU Ref:8303	April 18	Term baby born in poor condition and admitted to NICU and subsequently transferred to a tertiary unit. Possible hypoxic injury, prognosis unknown at present.
Unexpected Admission to NICU Ref:8308	April 18	Full term baby born in very poor condition, admitted to NICU and subsequently died.

Category	Month Declared	Summary
Confidential Information Breach Ref:8896	April 18	Staff member's medical record inappropriately accessed by another staff member.
Sub optimal Care of deteriorating patient Ref: 9647	April 18	Community patient under the care of the District Nursing service developed several grade 2 and grade 3 pressure ulcers and was admitted to hospital. The patient later died.
Patient Fall Ref: 9654	April 18	A patient sustained a fractured femur following a fall whilst being restrained by hospital security.
Confidential Information Breach Ref:10532	April 18	A set of patient records could not be located after they were received from storage in November 2017.
Treatment Delay Ref:12146	May 18	Following elective laporoscopic cholescystectomy surgery a patient was returned to theatre due to a suspected injury to the common bile duct.
Treatment delay Ref:12153	May 18	A patient developed septic shock five days post-surgery and was returned to theatre requiring a laparotomy.
Diagnostic Incident including delay Ref:12155	May 18	Patient was returned to theatre following an appendectomy due to developing abdominal sepsis.
Diagnostic Incident including delay Ref:12811	May 18	A delay in diagnosing a lung malignancy.

3.3 The table below detail serious incidents by category reported to the NEL CSU 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 Breach	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 trolley breach)	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI criteria	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 criteria	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**

3.4 The table below details serious incidents by category reported to the NEL CSU between April 2016 – April 2018

STEIS 2017-18 Category	2016/17 Total	2017/18 Total		Apr 18	Total 18/19 ytd
Safeguarding	5	1		0	0
Attempted self-harm	1	0		0	0
Confidential information leak/loss/IG Breach	6	3		2	2
Diagnostic Incident including delay	8	7		0	0
Disruptive/ aggressive/ violent behaviour	0	1		0	0
Environment Incident meeting SI criteria	0	1		0	0
Failure to source a tier 4 bed for a child	1	0		0	0
Failure to meet expected target (12 hr trolley breach)	1	0		0	0
HCAI/Infection control incident meeting SI criteria	0	3		0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2
Maternity/Obstetric incident mother only	2	1		0	0
Medical disposables incident meeting SI criteria	1	0		0	0
Medication Incident	0	1		0	0
Nasogastric tube	1	0		0	0
Slip/Trips/Falls	7	6		1	1
Sub Optimal Care	4	2		1	1
Treatment Delay	3	4		0	0
Unexpected death	10	4		0	0
Retained foreign object	1	1		0	0
HCAI\Infection Control Incident	0	1		0	0
Total	**58**	**38**		**6**	**6**

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 April 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 '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 April 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 April 2018. The Trust had seven reports due for submission of which six were submitted and one extension was given by the CCG due to waiting for the final London Ambulance Service NHS Trust (LAS) report to complete the RCA investigation.

Summary	Actions taken as result of lessons learnt include;
Ref:870	A delay in diagnosing pancreatic cancer. • A review of the processes and systems for tracking "target" patients already in place, including the 'suspected cancer' process. A snapshot risk assessment is being undertaken of patients who are waiting longer than three months for first appointments in Gastroenterology, in order to stratify risk and organise investigations to speed up the patients care if appropriate. This includes; (i) Mapping different ways patients can enter the pathway, and testing each one (e.g. booking a patient as "target" on Sunquest ICE). (ii) Review clinic outcome forms to add section for doctors to fill to "upgrade" and "downgrade" from "target" pathway. (iii) Review and create action plan for radiology processes to link significantly abnormal results with potential cancer to the Trust's "target" registry on Somerset. • A system is required to monitor results that are not available at the time of issuing an outpatient letter, and to flag delays in reporting. Each department is reviewing how best to deploy a system to review all radiology results on a weekly basis which will be fed back to the Trust Management Group.
Ref:905	• A young patient died 6 days after having emergency life-saving surgery . After surgery, the patient deteriorated, developing sepsis and was returned to theatre, where the patient had a cardiac arrest and died. The sepsis education programme has been revised to include an increased focus on patients where sepsis may not be easily recognised or masked, with case studies and examples which emphasise masked sepsis symptoms. • The sepsis pathway including the masked symptoms is now part of the junior doctors induction programme so that learning is shared on each intake of new trainees. • Multiple education events have been organised and held within different educational settings so that the learning is shared

Summary	Actions taken as result of lessons learnt include;
	across the multidisciplinary teams. • Targeted education to anaesthetic and surgical teams is being delivered around the 'sepsis bundle', its utilisation and its benefits, including the use of qSOFA as a screening tool and utilising CCOT referrals for unwell patients. • Following a QI project on improving education around measuring respiratory rates, targeted educational sessions to surgical staff were held. These sessions are now being expanded to include 'alert voice pain/unresponsive' (AVPU) and hypothermia education.
Ref:910	A patient deteriorated following laparoscopic surgery for peritonitis caused by a perforated bowel. The patient was returned to theatre for a laparotomy to repair the perforation, but continued to deteriorate and died four days later. • Teaching sessions have been arranged about the optimal management of perforated peptic ulcer and complications for the surgical and intensive care teams with emphasis on the importance of primary repair and a high index of suspicion for leak. This teaching includes a case study which will be discussed at the Trust Patient Safety Forum for junior staff. • A presentation of this SI report and other cases illustrating the importance of documentation of decision making and treatment planning process has been arranged. The aim of this is to embed the need to improve the surgical documentation, including risk assessment with input from anaesthetic and ITU where appropriate in high risk cases. This will also highlight the importance of mental capacity assessment where appropriate and treatment escalation planning. • ITU Consultants and Consultant Surgeons are reviewing their communication channels (both verbal and written) to ensure that speciality review is more effective and timely and the outcome will be documented in the critical care policy.
Ref:1269	Patient had a witnessed fall on the ward, resulting in a fractured neck of femur. • The Trust has introduced STOPfalls training, which is taking place in the actual ward workplace, and being rolled out across Care of the Elderly wards. • On-going ward and bay-based MDT training is being provided to all permanent, bank and agency staff, including Allied Health Professionals and support staff. This has been very well received as staff do not have to leave the wards for training, which has increased the number of staff being trained.
Ref:1986 & Ref:1980	Patient acquired influenza in hospital and subsequently died. • The Trust is reviewing the information we provide to relatives

Summary	Actions taken as result of lessons learnt include;
	and visitors around the risk to patients of contracting flu from visitors. in preparation for a more targeted campaign to give information about flu to visitors for 2018/19. • Targeted flu awareness sessions are to be programmed at staff team meetings on wards where the uptake of the vaccine by staff has been low, led by Infection Control and Occupational Health, emphasising the importance of being vaccinated. • The Trust Senior Executive team, which includes the Executive Medical Director, Chief Nurse and Chief Operating Officer, are in discussion on how to approach the issue of vaccination of front line staff in the light of the former NHS Medical Director's call for there to be a national debate on mandatory vaccination before the next flu season. • The Infection Control Team are considering if it is practical to have a small reserve stock of flu testing kits during winter to supplement ward stock. This will avoid having to wait to replenish stock.

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 learning from the serious incidents references 1986 and 1980 declared in January 2018 is described in the April 2018 Public Trust Board paper "Quarterly Safety and Quality Board Report Quarter 4 2017/18 (01 January 2018 – 31 March 2018)".

6. Summary

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.

Whittington Health

Trust Board

30th May 2018

Title:	Learning from death – Quarter 3 2017/18 (1st October 2017 – 31st December 2017)		
Agenda item:	**18/075**	**Paper**	**4**
Action requested:	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, • The considerable 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, • Further ways in which learning from this process might be disseminated and further embedded.		
Executive Summary:	This is the third quarterly report to Trust Board on learning from death. The previous reports came to the Trust Board in October 2017 (covering Quarter 1 2017/18) and January 2018 (covering Quarter 2 2017/18). These reports describe: 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, and to improve the learning from deaths process. In Quarter 3 of 2017/18 (Q3), 1st October 2017 – 31st December 2017, there were 155 patient deaths. This includes all inpatient deaths and all deaths in the emergency department. In Q3, 67% of all inpatient deaths were reviewed in a Structured Departmental Mortality Review Meeting, as compared with 62.5% in Quarter 2 of 2017/18. In Q3 of 2017/18: • 93% of all category A deaths were reviewed (desired performance 90%) • 55% of all category B deaths were reviewed (desired 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. This paper gives assurance that this important new 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 quality of our care.				
Fit with WH strategy:	Working together with families and carers				
Reference to related / other documents:	• "*National guidance on learning from deaths*" (NHS Quality Board, March 2017) available from https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf • '*Learning, candour and accountability*', Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf • 'Good Medical Practice' (General Medical Council, 2013), available from https://www.gmc-uk.org/-/media/documents/Good_medical_practice___English_1215.pdf_51527435.pdf				
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on the Trust Quality and Safety Risk Register				
Date paper completed:	22nd May 2018				
Author name and title:	**Julie Andrews, Associate Medical Director**	**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Equality Impact Assessment complete?	**N/A**	**Quality Impact Assessment complete?**	**N/A**	**Financial Impact Assessment complete?**	**N/A**

1. Introduction

This is the third quarterly report to Trust Board on learning from death. The previous reports came to the Trust Board in October 2017 and January 2018. These reports describe:

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, and to improve the learning from deaths process.

There has been an informal system of departmental mortality review processes at Whittington Health, in line with 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 (Structured Judgement Mortality Reviews). This process formally began on 1st April 2017, when Dr Julie Andrews, Associate Medical Director for Patient Safety, was appointed as Trust Mortality Lead.

The aims of this process are to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns,
- Embed a culture of learning from mortality reviews in the Trust,
- Identify, and learn from, episodes relating to problems in care,
- Identify, and learn from, notable practice,
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patients' 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 clearly and transparently recorded and reported.

2. 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/nqb-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/nqb-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.

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

3. 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.

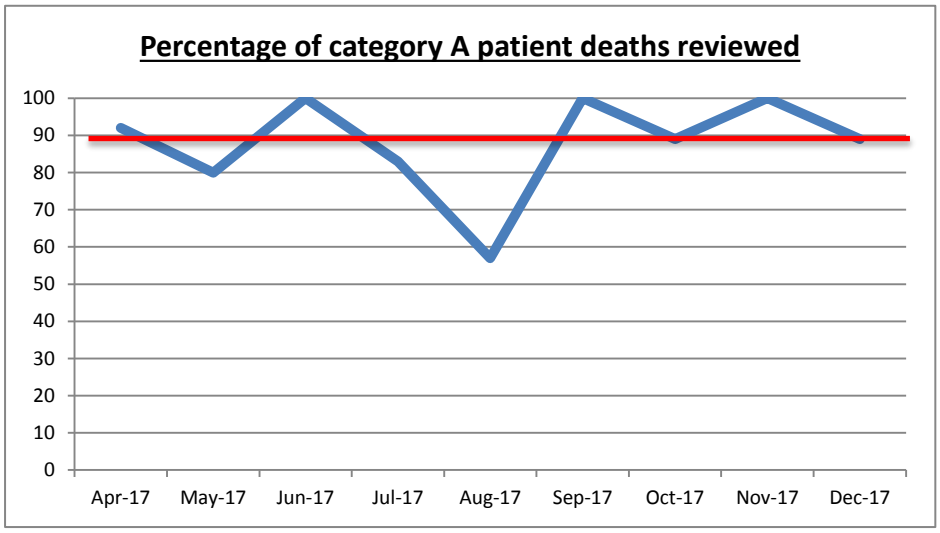
Category A deaths are:

- 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 mental health 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.

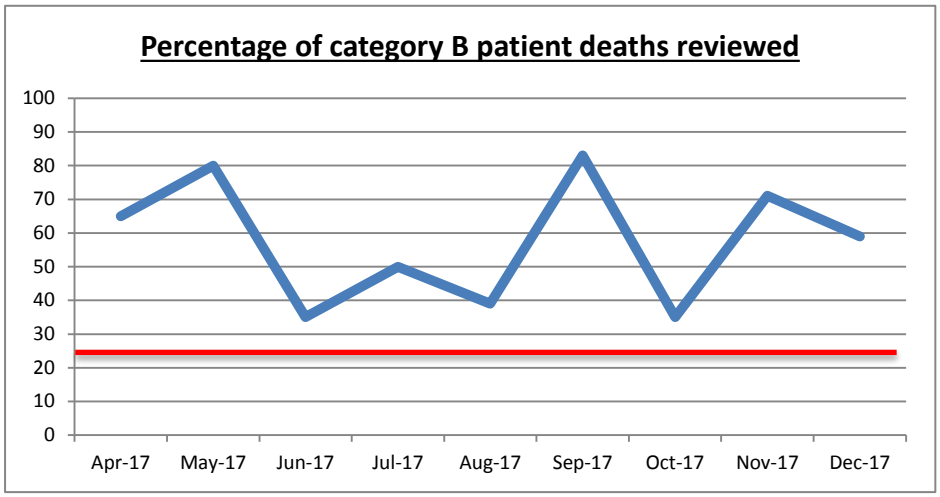
Category B deaths are:

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

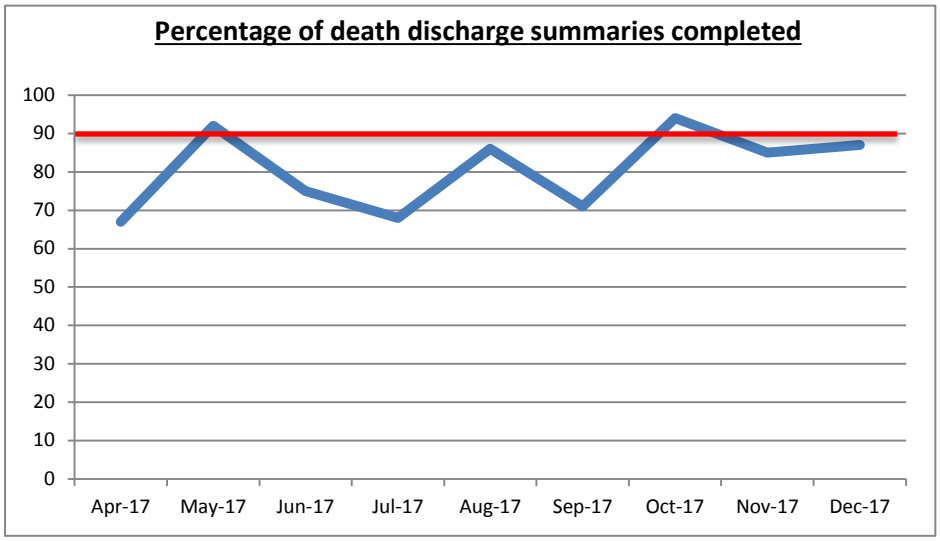
Graph 1: Percentage of 'category A' patient deaths reviewed by Whittington Health (April 2017 – December 2017) (Local Trust target 90%)



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



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



4. 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 A. This dashboard shows data from 1st April 2017 until 31st December 2017. The 'last quarter' referred to is Q3 (1st October 2017 – 31st December 2017), the 'last month' referred to is November 2017, and 'this month' referred to is December 2017.

There were 155 deaths recorded in Quarter 3. This includes all inpatient deaths, all deaths in the emergency department, all neonatal deaths, and all intrauterine deaths above 24 weeks gestation. There were no potentially avoidable patient deaths recorded in Quarter 3 2017/18 (where potentially avoidable is taken to mean deaths with avoidability scores of between 1-3. There was one potentially avoidable death in Quarter 1 and one potentially avoidable death in Quarter 2.

The dashboard shows that in Quarter 3 103 of the 155 patient deaths were reviewed, and this was done using the methodology that has already been described in the April 2017 Trust Board paper "*National Guidance on Learning from Deaths*".

52 patient deaths out of 155 deaths in Q3 (33%) were not systemically reviewed, but the majority of those (48 out of 52) involved category B deaths. Just four category A patient deaths were not reviewed; these were deaths in patients under the following teams; care of the older person (COOP) (1), acute medicine (1), cardiology/COOP (1) and surgery (1). Departments are reminded when category A reviews are outstanding, but further work is needed and is on-going to embed the support structures, including administrative support, to ensure that the risk of reviews being overlooked is minimalised.

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

Table 2 – Avoidability of death judgement scores for Q3: 2017/18

Avoidability of death judgement scores	**Number of patients with each 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	9
5 - Slight evidence of avoidability	7
6 - Definitely not avoidable	87

5. 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) A number of Structured Judgement Mortality Reviews found evidence of medicine safety incidents which had not been reported – three such incidents were found in the reviews of deaths that occurred in Q3, and the level of harm in those three incidents was either low or none. The Structured Judgement Mortality Reviews also found evidence of medicine safety incidents that had already, reassuringly, been correctly reported and had already been investigated and acted upon.
c) The Structured Judgement Mortality Reviews found 15 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 one instance, the reviewers found evidence of delay in the treatment of sepsis. Although none of these apparent care and service delivery problems were felt to have indicated that the death was avoidable, 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.
d) The Structured Judgement Mortality Reviews 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 inpatients deaths. The reviews also showed that the trust's local 'After Death Pro-forma' (Appendix 2) is not being completed as consistently as it should be. These two actions are 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.
e) Other similar sized trusts have a defined bereavement service for adult patients' carers and families, that provide support and information. Whittington Health does have a defined service in Womens' Health ICSU that is highly regarded. In the opinion of the End of Life (EoL) Group and the Mortality Leads, the lack of a defined bereavement service for adults is a gap within our services at Whittington Health. In addition, we do not currently ask our patients', carers and families about their experiences of the EoL care given.
f) Now that the Structured Judgement Mortality Review process is fully established, it is clear that there is a need to recognise within consultant job plans the time needed to act as a reviewer, as well as ensuring that other reviewers, including trainee doctors and other clinicians, have time for this important work. There is also a need to identify appropriate administrative capacity and time to support both the departmental and Trust mortality review process.

ii) Notable practice

a) As the Structured Judgement Mortality Review process has grown. 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 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 will be launched on 1st June 2018 (see Appendix B).
e) The trust has improved in linking the learning from Structured Judgement Mortality Reviews to discussions at Grand Rounds and other educational events in order to share learning. An example is the Grand Round of Wednesday 23rd May 2018, at which two trainee doctors presented the learning from two Structured Judgement Mortality Reviews in which they had played a role as one of the reviewers.
f) We are starting to network with other NHS trusts in sharing learning from Structured Judgement Mortality Review processes.
g) Dr Julie Andrews has been asked, in her role as Learning from Death Clinical Lead, to represent North London at the NHS Improvement Collaborative.
h) The Structured Judgement 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.
i) The Structured Judgement 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.

Although a clear cause and effect relationship cannot be demonstrated, it may be noteworthy that during the time that we have established and developed these various ways to learn from our Structured Judgement Mortality Review process we have also seen an improvement in the timeliness of referral of acutely deteriorating patients to the Critical Care Outreach Team. In Quarter 1 of 2017/18 the proportion of patients who were not referred within the target time was 29%, and this fell to just 11% in Quarter 3 of 2018/19.

6. Summary

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

Recent verbal feedback from NHSI (London) suggests acute trusts in the region are managing to review between 10% and 70% of inpatient deaths, so we appear to be clearly at the higher end of this performance range.

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.

Because this has now become a recurrent and permanent process, with a significant workload associated with it, we now need to develop and embed sustainable support for its continuation, both in terms of recognising this work in job plans, and in providing the administrative capacity to support it.

This paper provides the evidence that this process is now established and making a positive and significant contribution to the patient safety culture of this trust.

Appendix 1: NHS England Trust Mortality Dashboard

Whittington Health: Learning from Deaths Dashboard - December 2017-18

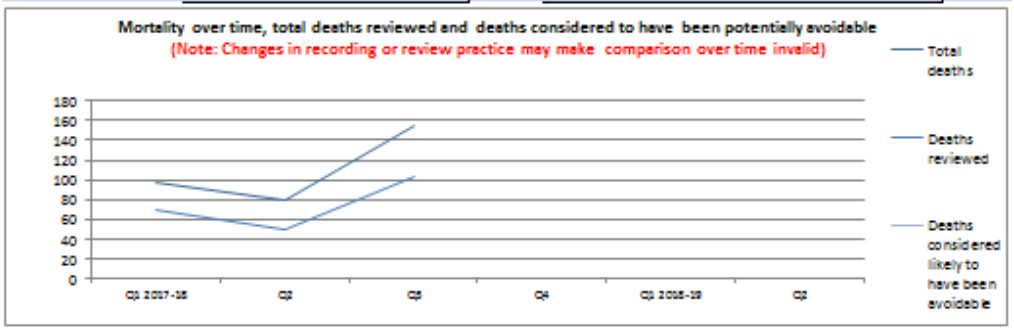
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
59	47	38	37	0	0
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter
155	80	103	50	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
332	0	222	0	2	0

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



Total Deaths Reviewed by RCP Methodology Score

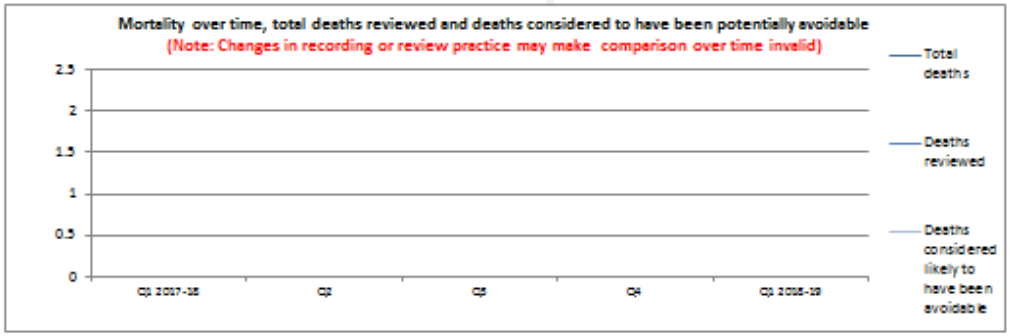
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	4	10.5%	This Month	3	7.9%	This Month	31	81.6%
This Quarter (G	0	0.0%	This Quarter (Q	0	0.0%	This Quarter (QT	0	0.0%	This Quarter (QTD	8	7.8%	This Quarter (QT	7	6.8%	This Quarter	88	85.4%
This Year (YTD	0	0.0%	This Year (YTD	0	0.0%	This Year (YTD)	2	0.9%	This Year (YTD)	16	7.2%	This Year (YTD)	21	9.5%	This Year (Y	183	82.4%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	0	2	0	0	0

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



Appendix 2: After Death Pro-forma

The Whittington Hospital NHS
NHS Trust

PART 1: CONFIRMATION OF DEATH IN HOSPITAL

Please complete at time of death and place in front of the patient's medical records

Patient Name _____

Hospital Number _____ NHS Number _____

Date of Birth _____ Age _____

1) Date of death _____/_____/_____ Certified time of death _____ : _____

2) Print name of clinician who confirmed death _____ Bleep _____

3) Ward _____ Consultant _____

4) Relatives present at death? **Yes / No**

   Name and relationship _____

5) Name of nursing staff present at time of death? _____

6) Has clinician spoken to the family and offered condolences? **Yes / No**

   Name and role of clinician _____

   Name and relationship of family member _____

7) Patient under DOLS? **Yes / No / Unsure**

8) Phone mortuary to inform them of the death (X5330) ☐

Confirming Death
(document in the notes):
- Confirm identity of patient
- Pupils fixed and dilated
- No respiratory effort
- No palpable central pulses
- No heart sounds
- No breath sounds

Trust Board

30th May 2018

Title:	Quality Account 2017-18		
Agenda item:	**18/076**	**Paper**	**5**
Action requested:	To approve the 2017-18 Quality Account		
Executive Summary:	The Quality Account was presented at the board seminar for comments on the 9th May 2018. Amendments have been made following feedback from the board seminar, Quality committee, TMG, executives meeting and Patient Safety Committee. A draft version has been reviewed by our commissioners and their feedback has been addressed and returned to them for a final statement. The content of the Quality Account 2017-18 has been approved by the Quality Committee on the 9th May 2018. The assurance/governance process has been approved by the Audit and Risk committee on the 23rd May 2018. The Trust board are now asked to give final approval of the 2017-18 Whittington Health Quality Account. At the time of writing the remaining outstanding information includes: 1. Approved CQUIN performance data – 24th May 2. Statement from commissioners - 28th May 3. Statement from KPMG 4. Statement on Quality from the CEO		
Summary of recommendations:	The board are asked to approve the Quality Account subject to the above additions.		
Fit with WH strategy:	4.3 To deliver consistent high quality, safe services 4.6 To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population		
Reference to related / other documents:	Detailed requirements for quality reports 2017/18 – NHS Improvement		
Date paper completed:	23/05/18		

Author name and title:		**Wayne Blowers, Quality & Compliance Manager**		**Director name and title:**		**Michelle Johnson, Chief Nurse and Director of Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Quality Account 2017/18: Timeframe for delivery as provided by commissioners and KPMG

Event	Due date	Responsible
Internal deadline: Final date for submission from authors	13th April	Trust (WB/GL)
Draft to Michelle Johnson for review	20th April	Trust (WB/GL)
Internal deadline: Draft to Execs Team Meeting Draft to communications team for formatting and style	23rd April	Trust (WB/GL)
Draft to Trust Management GP	24th April	Trust (WB/GL)
Stakeholder engagement and discussion at CQRG	by 30 April 2018	Trust (WB/GL)
Start of consultation and sharing of draft quality account	01 May 2018	Trust (WB/GL)
Submission of draft QA to KPMG and circulation to external stakeholders	**04 May 2018**	**Trust (WB/GL)**
Board Seminar draft Sign off	06 May 2018	Trust (WB/GL)
Quality Committee approval	09 May 2018	Trust (WB/GL)
Send feedback on compliance with guidance and content, including any requests for amendments	15 May 2018	CCG/CSU Helena Sage
Send amended quality account, if required	22 May 2018	Trust (WB/GL)
Issue of commissioner statement	29 May 2018	CCG via Helena Sage
Submission of final QA to KPMG	31 May 2018	Trust (WB/GL)
Publication of quality account on NHS Choices	**29 June 2018**	**Trust (Communications)**
Discussion of final quality account at CQRG	by 31 July 2018	Trust

Quality Account 2017/18

Front page

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Part 1: Statement on Quality from the Chief Executive

To follow

Part 2: Priorities for Improvement and Statements of Assurance from the Board

As an integrated care organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique position to deliver the strategic objectives of the North Central London (NCL) Sustainability and Transformation Plan (STP), that is, working in an integrated and collaborative way to provide high quality health and social care for our local population.

Our Trust's mission, embedded within our clinical strategy and quality account, is to 'help local people live longer, healther lives'. A key strategic goal is to provide the best possible health and wellbeing for all our community, of which prevention and health promotion are key objectives. These objectives are rooted in our 2017-18 quality priorities.

Priorities for improvement 2018/19

This section of the Quality Account is forward looking and details the quality priorities that the Trust has agreed for 2018/19. The rationale for including these priorities is based on factors such as data from the previous year, clinical or public request, and an ambition to be one of the leading Health Care Trusts.

Our quality priorities for 2018/19 are aligned to the Trust's commitment to improve quality and safety for patients over the coming year. A number of areas chosen as quality improvement priorities last year have been retained for the forthcoming year for one of three reasons:

- the 2017/18 targets were not met,
- we have made significant improvements in certain areas and wish to continue this progress,
- we consider certain areas as highly important to the trust.

We have also introduced new priorities that we believe are important to our patients and the community that we serve.

Our consultation process

Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as learning from serious incidents, reviews of mortality and harm, complaints, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data, to help establish what our 2018/19 priorities should be.

As part of our consultation process, external stakeholders, patients, and staff have been invited to share their views on our proposed quality priorities. A meeting was held with Healthwatch Islington and Haringey in February 2018 to establish further priorities that are important to our consumers and feedback on our draft quality domains.

Further to this, each priority has been refined and agreed by clinicians and managers who will have direct ownership and approved at the relevant Trust committees. The quality account, including the 2018/19 priorities, have been shared with our commissioners and external auditors, whose comments can be seen within the appendices.

Priority 1: Improving Patient Experience

Our Patient Experience Quality Priorities for 2018/19 are below. Progress against these priorities is monitored at the patient experience committee and escalated to the quality committee as required.

Domain	Rationale	Top 10 Priorities
Communication (Trustwide)	Better access to information has been highlighted by patients and is a top PALS/complaints concern	1. Development of a Patient Experience Strategy in consultation with patients and families 2. We will complete a trustwide review of patient information quality and availability and aim to improve information in accessible formats
Food (Hospital)	National in-patient survey results, 2017/18 food priority not met	3. We will better our 'quality of food' score from the 2017 National inpatient survey, which is based on patient feedback 4. We will ensure a full range of food choices are available on all hospital wards
Hospital Transport (Trustwide)	Highlighted by patients and families as a top priority	5. We will ensure 95% of patients arrive 15 minutes prior to their appointment 6. We will ensure 95% of patients are picked up within one hour of their appointment ending 7. We will complete a survey of patients using hospital transport to establish if providing a 'call ahead' has improved patient experience.
Outpatient cancellations (Trustwide)	Patient experiences, resource inefficiencies, Target not achieved in 2017/18, outpatient transformation project taking place	8. We will reduce outpatient clinic cancellations by 3% from our 2017/18 monthly average.
Improve District Nurse continuity of care (Community)	Issue raised in patient feedback, learning from incidents and complaints, build on 2017/18 progress	9. We will improve the continuity of care from district nursing with a particular focus on patients of concern (palliative care patients, those in receipt of continuing healthcare funding, safeguarding concerns and patients with pressure ulcers)
Podiatry (Trustwide)	Highlighted by healthwatch as an area requiring improvement	10. In podiatry we will achieve a 50% increase in Friends and Family Test response rates, whilst maintaining the trust 90% recommendation rate for the service

Our progress on achieving our patient experience priorities will be measured by completing a gap analysis of patient information, analysing local and national patient survey results, and scrutinising board performance and e-community quarterly reports.

Priority 2: Improving Patient Safety

Our Patient Safety Quality Priorities for 2018/19 are below. Progress against these priorities is monitored at the patient safety committee and escalated to the quality committee as required.

Domain	Rationale	Top 10 Priorities
Falls (Hospital)	National and local priority, learning from serious incidents, building on improvement work in 2017/18	1. We will equal or reduce the number of avoidable falls in the hospital resulting in serious harm to patients compared to 2017/18 2. We will increase compliance with our STOPfalls bundle to 85% in our acute assessment units and care of older people wards 3. We will develop a mandatory training package for falls prevention
Acute Kidney Injury (Hospital)	National and local priority, target partially achieved in 2017/18, ongoing priority for the trust	4. The Critial Care Outreach Team will review 90% of patients with a grade 3 AKI within 24 hours of detection 5. We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2019
Pressure Ulcers (Trustwide)	National and local priority, learning from incidents and complaints, target not achieved in 2017/18, trust KPI	6. We will reduce the number of avoidable grade 4 pressure ulcers from 5 in the community and continue to maintain 0 within the hospital
Care of Older People (Hospital)	Care of patients with dementia highlighted by Healthwatch as a priority area, national audit data, national campaign, learning from incidents	7. We will promote John's campaign – '*for the right to stay with people with dementia'* – whilst patients with dementia our in our care 8. We will develop a frailty pathway that will prioritise the care of patients over 75 who have been diagnosed with frailty
Mental Health and Learning Disabilities (Trustwide)	Experience of people with mental health in ED highlighted as an area for improvement by CQC, improving experiences for patients with LD and autism a priority for the trust and highlighted by Healthwatch	9. Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours 10. We will increase the number of people with learning disabilities involved in trust activities e.g. volunteering, hospital guides

Our progress on achieving our patient safety priorities will be measured through falls serious incident reporting and quarterly compliance audits, CCOT and Tissue Viability performance data, a frailty pathway timeline and monthly 'John's Campaign' progress updates.

Priority 3: Improving Clinical Effectiveness

Our Efficiency, Research and Education Quality Priorities for 2018/19 are below. Progress against the patient flow action is monitored through ICSU performance and trust performance reports, clinical research and education are monitored by their respective committees.

Domain	Rationale	Top 10 Priorities
Patient Flow (Hospital)	Delayed transfers of care from the Critical Care Unit to step-down wards highlighted as an area for improvement by the CQC, performance against national target, trust priority	1. We will achieve the national target of 95% of critical care unit ward-able patients being stepped down within 4 hours 2. We will develop a criteria-led discharge process at point of triage within the emergency department 3. We will establish robust pathways between the Emergency Department and specialist onsite assessment units (GAU, AEC, EPU) and aim to stream 6% of presenting patients 4. We will introduce the delirium rapid assessment test - 4AT - and TIME (trigger, investigate, manage, engage) bundle for delirium identification and streaming on the AAU for patients over 65
Clinical Research (Trustwide)	Representative of our patient population (significant Sickle Cell and Thalassemia population), secured funding for haematology research	5. We will increase the number of haematology patients involved in clinical research 6. We will increase the number of clinical specialities and the number of nurses, midwives and AHPs undertaking research in 2018/19 compared to the previous year. 7. We will exceed the 724 patients recruited into research trials during 2017/18
Education and learning (Trustwide)	Importance of sharing learning across the trust, emphasis on looking at themes emerging for pro-active learning, learning from incidents, complaints and claims, build on progress from 2017/18	8. We will increase the number of 'Learning Together' interprofessional workshops from 7 in 2017/18 to 10 in 2018/19 9. Increase teaching satisfaction from 60% to 75% for all medical student placements and increase overall satisfaction for nursing and midwifery courses. 10. We will increase the content available on the Whittington Moodle (electronic platform for education) and aim to develop a minimum of 5 new educational modules.

Our progress on achieving our clinical effectiveness priorities will be measured through monthly research recruitment data, quarterly AHP, Nursing and Midwifery Education reports to ICSU boards, ED performance data, and Quality Improvement project status updates at the two monthly QI group.

Statements of Assurance from the Board

Whittington Health provided 101 different types of health service (41 acute and 60 community services) in 2017/18. Of these services the following were subcontracted:

Organisation details	Service details
Barts Health NHS trust	Service and development support for immunology/allergy
Camden and Islington NHS foundation trust	Mental health services, ILAT contract and psychological service
Highgate therapy LTD	Psychosexual services
UCLH foundation trust	South Hub TB resources
UCLH foundation trust	ENT services
The Royal Free London NHS foundation trust	Provision of PET/CT Scans
The Royal Free London NHS foundation trust	Ophthalmology services
Middlesex University	Provision of Moving and Handling Training Sessions
GP subcontractors – Medical practices Morris House Somerset Gardens Tynemouth road	Primary care anticoagulation service for Haringey CCG
WISH Health Ltd A network of 8 local practices – four in north Islington and four in west Haringey	Primary care services to the urgent care centre at the Whittington hospital

The Trust has reviewed all data available to them on the quality of care in these relevant health services through the quarterly performance review of the ICSU and contract management processes.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

A declaration of interest has been made by each of the outgoing and incoming Executive Directors for Integrated medicine in their roles as General Practitioners at one of the eight local practices linked with WISH Health Ltd.

Participation in Clinical Audits 2017-2018

During 2017/18, 51 national clinical audits including 11 national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in 100% national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2017/18 are listed below. This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the 20 non-mandatory national audits, in which the Trust also participated during 2017/18.

Title of audit	Management body	Participated in 2017/18	If completed, number of records submitted (as total or % if requirement set)
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	29 cases
Case Mix Programme (CMP) - Intensive Care Audit	Intensive Care National Audit & Research Centre	✓	706 cases – 100% case ascertainment rate
Elective Surgery (National PROMs Programme)	NHS Digital	✓	150 cases
Falls and Fragility Fractures Audit programme (FFFAP) – Inpatient Falls	Royal College of Physicians of London	✓	30 cases 100% case ascertainment rate
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians of London	✓	130 cases
Fractured Neck of Femur (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Inflammatory Bowel Disease (IBD) programme / IBD Registry	IBD Registry Limited	✓	68 cases
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	✓	4 cases
Major Trauma Audit	Trauma Audit & Research Network	✓	69 cases - 35-41.1% case ascertainment rate
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research	✓	78 cases

National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	On going
National Audit of Dementia 2017: Delirium Spotlight Audit	Royal College of Psychiatrists	✓	20 cases - 100% case ascertainment rate
National Audit of Intermediate Care	NHS Benchmarking Network	✓	Islington Teams: 48 cases Haringey Teams: 176 cases Total: 224 cases
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	✓	217 cases
Bowel Cancer (NBOCAP)	NHS Digital	✓	62 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	81 cases
National Comparative Audit of Blood Transfusion programme – re-audit of 2016 red cell and platelet transfusion in adult haematology	NHS Blood and Transplant	✓	4 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	NHS Digital	✓	146 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	NHS Digital	✓	56 cases
National Diabetes Audit - Adults - National Core Diabetes Audit	NHS Digital	✓	1825 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	NHS Digital	✓	25 cases – 93% case ascertainment rate
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	102 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	96 cases
National Joint Registry (NJR) - Knee and Hip replacements.	Healthcare Quality Improvement Partnership	✓	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	81 cases

National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	3741 cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	505 cases
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	✓	13 cases – 100% case ascertainment rate
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	101 cases – 100% case ascertainment rate
National Prostate Cancer Audit	Royal College of Surgeons	✓	105 cases
Pain in Children (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	45 cases
UK Parkinson's Audit	Parkinson's UK	✓	20 cases + 10 Prem (Patient Reported Experience Measures) cases
Maternal, Newborn and Infant Clinical Outcome Review Programme data on 16 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal mortality and morbidity confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Medical, Surgical and Child Health Clinical Outcome Review Programme			
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	1 case – 100% case ascertainment

Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases - 100% case ascertainment
Non-invasive ventilation	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases – 100% case ascertainment
Acute Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases – 100% case ascertainment
Cancer in Children, Teens and Young Adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	No applicable cases. Organisational questionnaire submitted
Perioperative Diabetes	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	4 cases– 100% case ascertainment
Pulmonary Embolism	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Study commenced February 2018
Mental Health Clinical Outcome Review Programme			
Suicide by children and young people in England (CYP)	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	If cases identified to WH then participate - none to date
Suicide, Homicide & Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
Safer Care for Patients with Personality Disorder	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
The Assessment of Risk and Safety in Mental Health Services	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme			
Pulmonary rehabilitation	Royal College of Physicians	✓	36 cases
Secondary Care Continuous Audit	Royal College of Physicians	✓	147 cases

Additional (non-mandatory) National Audits undertaken during 2017/18

Title of audit	Management Body	Participated in 2017/18	Status
Cardiac Rehabilitation	Health & Social Care Information Centre, British Heart Foundation	✓	Ongoing data collection
Systematic anti-cancer therapy - chemotherapy dataset	National Cancer Intelligence Network	✓	Ongoing data collection
National study of HIV in Pregnancy and Childhood	NSHPC	✓	Ongoing data collection
7 Day Services Self-Assessment Tool	NHS England, TDA	✓	Completed
London Ambulance Service out of hospital cardiac arrest	London Ambulance Service	✓	Completed
UNICEF Baby friendly initiative Mother's audit	UNICEF	✓	Completed
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	Royal College of Anaesthetists	✓	Completed
The Right Iliac Fossa Pain Treatment (RIFT) Audit	West Midlands Research Collaborative	✓	Completed
ESCP 2017 Snapshot audit - left colon, sigmoid and rectal resections	European Society of Coloproctology	✓	Completed
National Complicated Diverticulitis Audit	Yorkshire Surgical Research Collaborative	✓	Ongoing data collection
Intraoperative Oxygenation in patients undergoing major surgery	Pan London Audit Network	✓	Completed
National Adult Bronchoscopy	British Thoracic Society	✓	Completed
Physiotherapy Hip Fracture Sprint Audit (PHFSA) as part of NHFS	CSP/RCP	✓	Completed
National Adult Bronchiectasis Audit	British Thoracic Society	✓	Completed

UNICEF Baby friendly initiative Stage 2 and 3	UNICEF Baby Friendly Initiative	✓	Ongoing data collection
Improving the assessment of wounds	NHS England / CQUIN	✓	Ongoing data collection
BLISS Family Friendly audit	BLISS Charter	✓	Ongoing data collection
IMAGINE: Ileus MAnaGement INtErnational An international, observational study of postoperative ileus and provision of management after colorectal surgery	EuroSurg Collaborative	✓	Ongoing data collection
Use of Gabapentinoids in UK perioperative pain management – The "GABACUTE" study.	Trainee Audit & Research Network for trainees interested in Pain Medicine	✓	Ongoing data collection
National clinical audit on the management of bullous pemphigoid	British Association of Dermatologists	✓	Ongoing data collection

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2018/19 by ensuring:

- National audit and national confidential enquiries continue as the key component of the Trust's Integrated Clinical Service Units (ICSU) Quality Improvement programme
- Performance outcomes are discussed appropriately and cascaded to all staff grades
- Optimal clinical and managerial leadership is in place to support national project completion
- Learning from excellence is strengthened
- Increased encouragement of patient and carer participation in Trust groups

The reports of 19 **national clinical audits/national confidential enquiries** were reviewed by the provider in 2017/18 and examples of how Whittington Health has taken actions to improve the quality of the healthcare provided can be seen below.

National Audit of Dementia – Care in General Hospitals

This national audit is overseen by the Royal College of Psychiatrists and measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia, whilst a patient in a hospital.

Assessment:*The overall score for this section was 93.2% (national average 83.7%)*

The Hospital scored higher than the national average in initial screening for delirium (68%), clinical assessment (100%) and symptoms of delirium summarised for discharge (100%). A specific care plan is to be developed for patients with delirium and work is being undertaken with the mental health liaison team to incorporate learning into the existing falls training.

Information and Communication: *The overall score for this section was 61.8% (national average 64.8%)*

In order to improve communication and information on dementia, the Trust is introducing the '*This is Me'* form, which enables information to be collected and recorded on the patient. John's Campaign (http://johnscampaign.org.uk/#/about) which provides support for people with dementia, their family and carers is also being promoted trustwide as part of our Quality Account priorities for 2018/19. Dementia awareness has been incorporated into the Trust's current falls training also.

Staffing and Training: All clinical staff should access dementia training within the Trust and this can be supported by the re-introduction of the Dementia Champion Scheme. Out of hours support for staff needs to be improved by ensuring that site managers are trained to provide face-to-face and online support. Furthermore, ward teaching materials should be available in staff areas.

Nutrition: *The overall score for this section was 67.5% (national average 83.8%)*

The national audit highlighted nutrition as an area for improvement. Following the audit results, the trust has implemented changes to ensure that there is finger food available on the wards and to further ensure that this is highlighted in the nursing staff food training days. The introduction of John's Campaign will additionally support the improvement of nutrition, for this cohort of patients.

Discharge: *The overall score for this section was 89.7% (national average 72.7%)*

It is essential that all staff are trained in the principles of the Mental Capacity Act, to include the appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making.

Governance: *The overall score for this section was 34.4% (national average 65.1%)*

It was agreed that all clinical staff should access dementia training which would be achieved through re-introducing the Dementia Champion Scheme. In order to improve the environment and activities on the ward, work is being undertaken with the multi-disciplinary staff team to facilitate this. Carers should also be encouraged to respond to surveys so that valuable support may be provided.

Asthma (paediatric and adult) - Care in the Emergency Department

This audit amalgamates Royal College of Emergency Medicine's previously audited adult and paediatric asthma audit topics.

Aims and objectives

- To benchmark current performance in Emergency Departments (ED) against the national standards of best practice
- To allow comparison nationally and between peers
- To identify areas in need of improvement

Our key successes

- The recording of vital signs, supported by the Asthma nurse holding regular teaching sessions for staff
- A proforma is utilised to promote assessment, discharge/admission criteria and medication dosing
- For paediatric patients, there is also a discharge bundle and information packs

Further improvements are being made for paediatric patients, as follows:

- The introduction of an asthma pathway from community to Emergency Department, ward and back home.

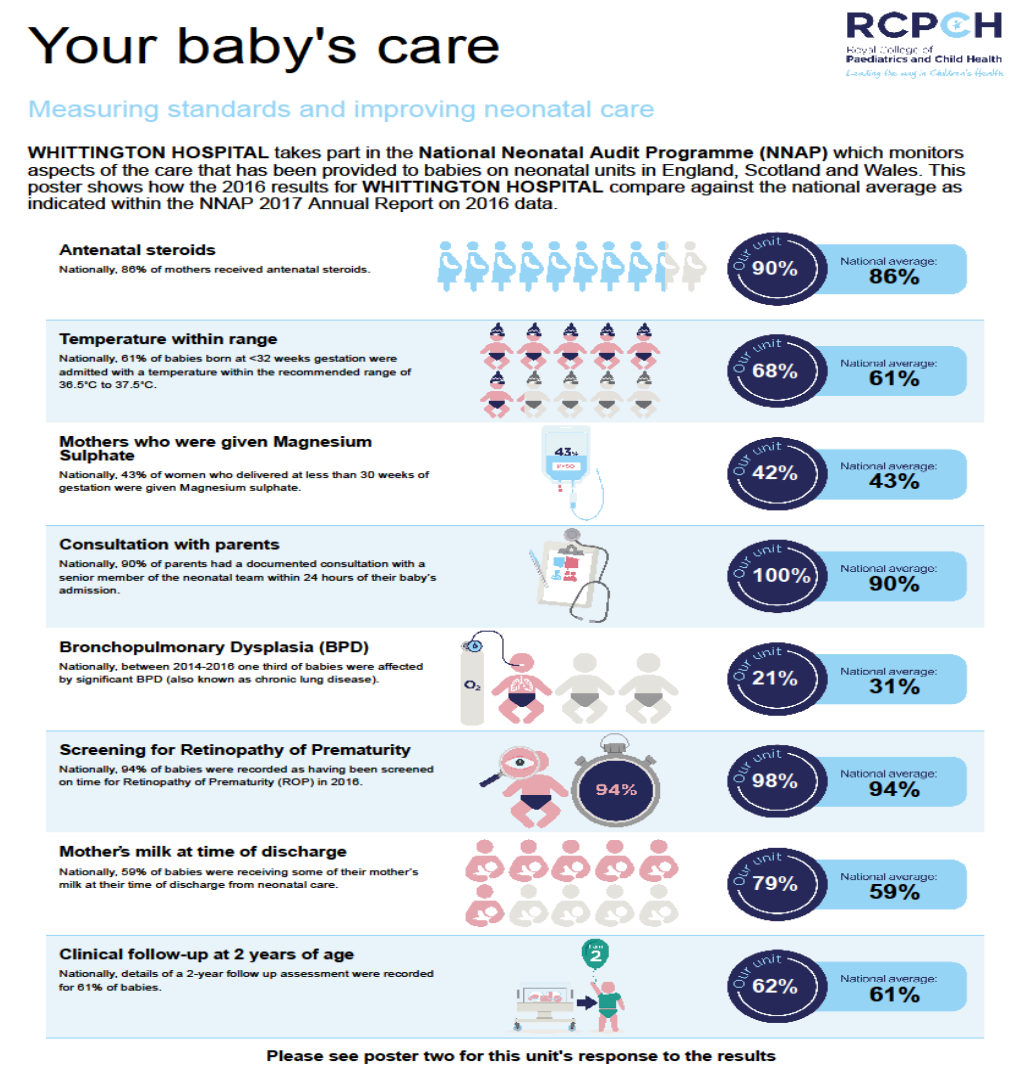
As part of the work to further improve care in ED, the following are either in place or undergoing improvement:

- ED asthma proforma, to improve recording of observations, aid the correct diagnosis and help the patient receive the appropriate medication in the required timeframe;
- There is a Wheeze asthma discharge bundle, that all patients should receive;
- Regular education of staff is ongoing;
- Work is underway with Haringey and Islington regarding ways to ensure that patients discharged from ED always receive their 48 hour follow up;
- A risk assessment tool is in place in the Emergency Department which aims to identify children who are repeat attenders to ED with wheeze and to ensure that they are booked into an appropriate follow up.

Neonatal Intensive and Special Care (NNAP)

NNAP monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. Each year, approximately 95,000 babies born will be admitted to a neonatal unit which specialises in looking after babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

At the Whittington Hospital, 6 out of 8 standards audited achieved above the national average.



Your baby's care

RCPCH Royal College of Paediatrics and Child Health

Measuring standards and improving neonatal care

WHITTINGTON HOSPITAL takes part in the **National Neonatal Audit Programme (NNAP)** which monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. This poster shows how the 2016 results for **WHITTINGTON HOSPITAL** compare against the national average as indicated within the NNAP 2017 Annual Report on 2016 data.

Antenatal steroids
Nationally, 86% of mothers received antenatal steroids.
Our unit 90% | National average: 86%

Temperature within range
Nationally, 61% of babies born at <32 weeks gestation were admitted with a temperature within the recommended range of 36.5°C to 37.5°C.
Our unit 68% | National average: 61%

Mothers who were given Magnesium Sulphate
Nationally, 43% of women who delivered at less than 30 weeks of gestation were given Magnesium sulphate.
Our unit 42% | National average: 43%

Consultation with parents
Nationally, 90% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.
Our unit 100% | National average: 90%

Bronchopulmonary Dysplasia (BPD)
Nationally, between 2014-2016 one third of babies were affected by significant BPD (also known as chronic lung disease).
Our unit 21% | National average: 31%

Screening for Retinopathy of Prematurity
Nationally, 94% of babies were recorded as having been screened on time for Retinopathy of Prematurity (ROP) in 2016.
94%
Our unit 98% | National average: 94%

Mother's milk at time of discharge
Nationally, 59% of babies were receiving some of their mother's milk at their time of discharge from neonatal care.
Our unit 79% | National average: 59%

Clinical follow-up at 2 years of age
Nationally, details of a 2-year follow up assessment were recorded for 61% of babies.
Our unit 62% | National average: 61%

Please see poster two for this unit's response to the results

Actions taken:

- A patient pathway coordinator was appointed to support the clinical follow-up at 2 years of age;
- Magnesium Sulphate and Antenatal Steroids are now maternity targets;
- Neonatal staff continue to encourage the expressing of milk post discharge;
- Data is now collected from the Badger programme on the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia. To encourage this further, the results of the audit have been disseminated to staff.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of **local clinical audits** in 2018/19 by ensuring:

- Reactive audits, vital to patient safety, will be the local priority on the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes;
- Project proposals will be subject to a weekly quality review, prior to formal registration, in order to prevent duplication and to ensure alignment to local speciality priorities;
- Re-launch of the Trust Clinical Audit Registration form. A new, succinct version will facilitate the registration of projects;
- Demonstrable improvements to patient care and/or service provision will be identified monthly, to support Trust Learning from Excellence initiatives;
- Multidisciplinary Quality Improvement sessions will continue to include reflective learning on local clinical audit findings;
- Clinical speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

The reports of 89 **local clinical audits** were reviewed by the provider in 2017/18 and examples of how Whittington Health has taken actions to improve the quality of the healthcare provided is detailed below.

Attention deficit hyperactivity disorder (ADHD) Pathway - From Referral to Diagnosis

The paediatric ADHD service has been running for many years, initially as part of the Neurodevelopmental clinic at The Whittington Hospital, and more recently (since 2011) as a dedicated ADHD Service in Community Paediatrics at The Northern Health Centre.

This project was a re-audit to examine the timeframe of the ADHD pathway from referral to diagnosis and timeliness of feedback to parents. This would determine whether the pathway adheres to advice provided by NICE and to identify further areas for improvement.

The audit identified 15 children referred to the ADHD and Behaviour clinic that were eligible for the pathway. Of these, eleven completed the pathway and four were still in progress at the time of the audit. Of the eleven, two received a diagnosis of ADHD.

Results:

- Varied compliance to NICE guidance
- 100% of referrals to parent training for those who received a diagnosis.
- Compliance was reasonable for the number of children for whom an examination was documented. However, only 27% had a documented neurological examination. Compliance was below standard for the documentation of duration of symptoms, assessment of carer's health, documentation of the young person's views, documentation of dietary history and documentation of advice given about local support.

Actions:

- To reduce the time between 'first appointment to feedback' to a more acceptable wait - as no standard exists; a reasonable time would be 100% within 8 weeks with 80% within 6 weeks. An additional health care professional has been made available to the clinic who can help complete school observations. Administrative support is also

now available to assist with outstanding questionnaires and school liaison.

- The assessment proforma has been amended to include;
  - full examination, neurological assessment and growth measurements;
  - parent/ carer mental health status;
  - dietary history;
  - young person's views (where applicable).
- A post-diagnostic plan proforma has now been implemented

HIV testing in Pneumonia

Identification of HIV cases is of high importance for both the care of the affected individual, and for prevention of onward transmission. While there are a range of medical and social factors that are highlighted in both Trust and British HIV Association guidance as indications for testing, perhaps the most frequent and readily identifiable of these in acute medical admissions is bacterial pneumonia. The aim of the audit project was to determine the rate of HIV test ordering in adult admissions aged 16-75 with a primary diagnosis of pneumonia over a 3 month period, to be achieved through review of HIV test orders and results for patients recorded as having pneumonia as their primary diagnosis.

According to the Trust and The British HIV Association (BHIVA) guidelines, 100% of patients in this group should have been offered HIV testing, however this only occurred in 27% of our patients.

Actions taken:

- Introduction of clinician prompts to Anglia ICE requests for blood cultures, pneumococcal antigen tests and the community-acquired pneumonia bundle to consider requesting a HIV test;
- Provision of education sessions on the importance of HIV testing in acute medicine, including current Trust and National Guidelines through Junior Doctor Teaching.

Protected Meal Times (PMT) – Re-audit

In June 2004, Whittington Hospital introduced protected mealtimes (PMT), an intervention developed to address the common clinical problem of malnutrition in the hospital setting.

This re-audit was to assess if our hospital wards are compliant with the Trust 'Protected Meal Times' Policy ensuring that patients;

- Are provided with sufficient time during meal times for eating and drinking
- Are not disturbed with routine ward activity such as ward rounds
- Are documented as on the red tray system, if assistance with meals is required
- Have easy access to their meals
- Are provided with a safe and clean environment for their meal time

The audit demonstrated an improvement in PMT in the following areas:

- PMT lasted a full hour on 54% of all wards, a significant increase compared to 33% in May 2016.
- The number of individual patients being interrupted during PMT has decreased from 9% in May 2016 to 5%.
- Staff assisting with the meal service has increased to 50% - significantly higher than

38% of staff in May 2016.

- There has been an increase in the provision of hand-wipes, from 55% in May 2017 to 67%. However, only 8% of patients are actively given the opportunity and assistance to use them.
- The percentage of wards with red tray system awareness and appropriate implementation has decreased from 91% in May 2016 to 83%
- The number of patients unable to access their meals has increased from 0.5% in May 2016 to 2%

What actions have we taken?

- All results have been discussed with our cohort of senior nurses, to ensure that patients using the red tray system receive the help they need and have access to their meals.
- Infection Control Team liaison to consider the implementation of signage to promote handwashing/ use of hand wipes.
- Ward wide promotion of the importance of protected meal times is underway to include; laminated posters to be placed around the wards and not just at the entrance, with further information to be provided to visitors. Nursing induction will ensure the tenets of protected meal times are communicated clearly to all new staff.

Participating in Clinical Research

Involvement in clinical research demonstrates the trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

We are three years on from the ratification of the Whittington Health Research strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the quality of studies in which patients can participate (not simply the number), and the range of specialties that are research active, as we recognise that research active hospitals deliver high quality care.

The trust's research portfolio continues to evolve to reflect the ambitions of our integrated care organisation and also reflects the health issues of our local population. The research portfolio includes anesthesia, CAMHS, dermatology, diabetes and endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting, IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, surgery, urology, and women's health.

In 2017/18, 724 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio. This is the highest number recruited for five years and represents an increase of 209 patients compared to last year.

There are currently 39 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 48 and 41 studies in 2016/17 and 2015/16 respectively. Whilst this is a reduction in the number of studies we have improved our recruitment to time and target (RTT) metrics in line with the NIHR High Level Objectives. Resultantly there is improved quality in the delivery of studies despite the total number of studies reducing.

Portfolio adopted studies are mainly, but not solely, consultant led and are supported by the trust's growing research delivery team to facilitate patient recruitment. In addition to the NIHR portfolio studies that are on-going, an additional 20 non-portfolio studies have been commenced so far in 2017/18, an increase of seven studies on the previous year which demonstrates an increase in locally lead and locally focused research. Most non-portfolio research studies are undertaken by nurses, allied health professionals, and trainee doctors and the impact of these studies are frequently published in peer reviewed publications, at conference presentations, and are valuable in their ability to innovate within the trust.

CQUIN Payment Framework

A proportion of Whittington Health's income is conditional on achieving quality improvement and innovation goals between Whittington Health and our local CCGs through the Commissioning for Quality and Innovation payment framework.

Our CQUINs for 2017-19 are:

- Improvement of Staff Health and Wellbeing
- Reducing the impact of Serious Infections (AMR and Sepsis)
- Improving services for people with mental health needs who present to ED
- Transitions our of Children and Young People's mental health services
- Offering advice and guidance
- NHS e-Referrals
- Supporting proactive and Safe Discharge
- Improving the assessments of wounds
- Personalised care and support planning

Further details of the agreed goals for 2017-19 are available electronically at:

https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

For 2017-19, a change in contract meant that the majority of our clinical commissioning group (CCG) income was not contingent on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. However, Whittington Health still worked towards the goals agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

There is a full CQUIN team responsible for the achievement of CQUINs with an operational lead and a clinical lead. There is also a clinical lead and operational lead for each individual CQUIN.

to be completed

2017-19 CQUIN progress

National 1: Improvement of Staff Health and Wellbeing	Improvement of Staff Health and Wellbeing		
	Healthy food for staff, visitors and patients		
	Improving the uptake of flu vaccinations for front line staff		
National 2: Reducing the Impact of Serious Infections (AMR and Sepsis)	Timely identification and Treatment of sepsis in ED & acute inpatient settings		
	Antibiotic review and reduction in antibiotic consumption per 1,000 admissions		Achieved
National 4: Improving Services for People with Mental Health needs who present to ED			Achieved
National 5: Transitions out of Children and Young Peoples Mental Health Services			
National 6: Offering Advice and Guidance			Achieved
National 7: NHS e-Referrals			Achieved
National 8: Supporting Proactive and Safe Discharge			
National 10: Improving the Assessments of Wounds			
National 11: Personalised Care and Support Planning			Achieved

Registration with the Care Quality Commission (CQC)

Whittington health is required to register with the CQC at our hospital and all of our community sites and our current registration status is 'registered without conditions'.

The CQC has not taken enforcement action against Whittington Health during 2017/18.

Between 31st October and 2nd November 2017 the CQC inspected four core services rated as requiring improvement in the last inspection in 2015; Outpatients, Critical Care, Community Children's and Young people's services and Simmons House (Children and Adolescent Mental Health Service). Following this a series of interviews and focus groups were held as part of the trust-wide Well-Led CQC inspection process. The findings identifed that the trust's senior management team had the right skills and abilities to run a service providing high-quality sustainable care and therefore rated the trust Good for being Well-Led.

The inspection highlighted numerous areas of good and outstanding practice and found clear evidence of improvements since 2015. In particular, the outpatient department inproved in three of the five domains and achieved an overall rating of good. It was clear that significant improvements had been made in relation to information governance, team working and leadership. The inspectors commended the outpatient department for the outstanding practice seen in the hospital one-stop breast and skin cancer clinics. The critical care unit also was deemed to have improved and achieved a rating of good in the domain of safety. Other highlighted areas of good practice include:

- Leaders and staff shared a common vision on supporting their local community
- Patient outcomes in critical care were in-line with or better than national averages
- Improvements in how the critical care team manage and learn from incidents
- Multidisciplinary and joint working for children, young people and their families
- Medicines management systems with medicines appropriately prescribed, administered, recorded and stored

The outcome of the improvements made by the trust and seen by the CQC is that the rating for the Hospital has increased from 'Requires Improvement' to 'Good' following the last inspection. The Whittington Health Trust, encompassing our community services and their individual ratings, maintains a rating of 'good' from the 2015 inspection.

The Deputy Chief Inspector of Hospitals, CQC, Ellen Armistead, said: *"While we have highlighted areas that need some improvement many of the services were rated as Good or Outstanding and staff should be proud of those services."*

The trust was issued with four regulatory actions that it must address and improve with priority. These are listed below alongside the actions that the trust has taken to reduce these risks.

"Must do" actions from the CQC:	Trust response
Critical Care – reduce length of time patients are delayed waiting for discharge from CCU	The trust has made this one of its Quality Account priorities for 2018/19 and we are aiming to meet the national target of 95% of ward-able patients being stepped down from CC within 4 hours. The focus is on embedding the FLOW improvement process throughout the hospital in order to improve capacity so that patients are not delayed in critical care. Our acute assessment units, care of elderly wards, general surgery and general medicine wards have been assigned dedicated FLOW co-ordinators to support with patient discharging by unblocking /escalating delays.
Critical Care – ensure equipment is safely maintained and ensure local oversight of risk is appropriate	Critical care have introduced a local servicing log of equipment on the unit in addition to the log kept by medical physics. CC staff now monitor the equipment service dates on a monthly basis and any delays are escalated to Medical Physics. Introducing this additional local oversite measure has created a more robust equipment maintenance and safety checking system and expedites early escalation to medical physics in the event of delays.
Critical care – ensure patients receive safe care and treatment in line with the faculty of intensive care medicine (FICM) core standards	The parenteral nutrition (PN) policy has been reviewed and updated to provide clearer guidance for CC staff on the expectations regarding the use of PN both in and out of hours to ensure the trust complies with FICM standards.
Simmons House – ensure ligature risk assessments are up to date and accurately identify all ligature anchor points on the unit. This must be supported by information in patient risk assessments	The Ligature risk assessment has been reviewed and updated to ensure that all ward areas are included. A targeted assessment has been completed of Simmons House to ensure all ligature anchor points have been included in the ligature risk assessment register. A revised process has been designed to ensure that all patient ligature risks are assessed and documented and nursing care plans have been introduced for all patients who have been risk assessed as at risk of harm from ligature anchor points at Simmons house.

CQC Ratings for services inspected October-November 2017

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Community	Good → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018
Mental health	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018
Overall trust	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018

Ratings for The Whittington Hospital

Critical care	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018
Outpatients	Good ↑ Feb 2018	Not rated	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Overall*	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

Ratings for community health services

Community health services for children and young people	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018
Overall*	Good → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018
Overall	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018

Secondary Uses Service

Whittington Health submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and which included the patient's valid General Medical Practice Code were as follows:

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	97.80%	99.90%
Outpatient care	98.30%	100%
Emergency care	92.60%	99.90%

Information Governance (IG) Assessment Report

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and ensure healthcare improvements.

In 2017/18 Whittington Health continued work to improve IG level two compliance with the Department of Health IG Toolkit. The trust achieved 77% compliance which demonstrates improvement on previous years' scores and shows a year-on-year improvement in compliance with the standards. The area that presents the greatest challenge is achieving the 95% target for all staff to complete IG training annually.

Assessment	Overall Score	Self-assessed Grade
Version 15 (2017-2018)	77%	Satisfactory
Version 14 (2016-2017)	74%	Satisfactory
Version 13 (2015-2016)	65%	Not Satisfactory
Version 12 (2014-2015)	59%	Not Satisfactory

The IG department will continue to target staff with individual emails, Whittington bulletin messages and classroom-based induction sessions in order to increase annual IG staff training compliance. As IG awareness increases throughout the organisation, our risk of an IG serious incident reduces. However, there is room for improvement in terms of staff awareness of policies and procedures and departments complying with IG guidelines, especially when other pressures are continually increasing. We are confident that through increasing IG training compliance and increasing general IG knowledge and awareness, the IG related risks to the Trust will reduce.

Data Quality

The trust monitors the quality of data through the use of quarterly benchmarking reports.

In order to improve data quality in 2018-19 the trust is taking the following actions:

- Introduction of data quality dashboards for services to individually monitor their own data quality as required.
- Strengthening the trust Data Quality Group and ensuring representation from each of the seven Integrated Clinical Service Units (ICSUs). This group is responsible for implementing the annual data improvement and assurance plan and measures the trust's performance against a number of internal and external data sources.
- Taking measures to improve the coding of activity
- Systematic benchmarking of data
- Running a programme of audits and actions plans

Whittington Health has been supplying demographic and risk factor information consistently since the service commenced in October 2015.

Clinical Coding Audit

Whittington Health was subject to the Payment by Results clinical coding audit during the 2017/18 reporting period. Trusts are required to meet 95% accuracy for primary procedure and diagnostic codes, and 90% accuracy for secondary codes.

The error rates reported in the latest (November) published audit for diagnosis coding and clinical treatment coding are:

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
General Surgery 100	100.00	92.17	100.0	90.84
Trauma & Orthopaedic 110	95.24	94.51	93.75	92.63
General Medicine 300	93.48	95.56	92.31	100.00
Gynaecology 502	84.00	89.74	100.00	96.97
Overall	**95.50**	**93.97**	**97.90**	**92.98**

Learning from Deaths

During the period 1 April 2017 to 31 March 2018, 421 Whittington Health patients died whilst in hospital. This includes deaths in our emergency department but excludes deaths 30 days post discharge. This figure also includes intra-uterine deaths greater than 24 weeks gestation. The following number of deaths occurred in each quarter of 2017/18:

- 99 in the first quarter (April-June 2017)
- 80 in the second quarter (July-Sept 2017)
- 155 in the third quarter (October-Dec 2017)
- 155 in the fourth quarter (Jan – March 2018)

By the 31st March 2017, mortality reviews using either case note reviews, structured judgement reviews or Root Cause Analysis (RCA) Serious Incident (SI) methodology had been completed for approximately 70% of deaths occurring in Quarter one to three. Quarter four reviews are still in progress and figures were not available at the date of submission.

The number of deaths in each quarter for which a case record review, structured judgement review or RCA SI methodology was carried out was:

- 69/99 deaths in the first quarter
- 50/80 deaths in the second quarter
- 103/154 deaths in the third quarter

Two patient deaths, representing 0.9% of the patient deaths reviewed during the reporting period April to December 2017 i.e. quarters 1-3, were judged to be more likely than not due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- One representing 0.45% for the first quarter:
- One representing 0.45% for the second quarter
- Zero representing 0% for the third quarter

These numbers have been estimated using the structured judgement mortality review form or equivalent methodology recommended by the Royal College of physicians or by RCA methodology when a serious incident has been declared.

Key learning identified from the review of the death where it was likely that problems in care contributed to the patient's death include;

- Ensuring there are more robust mechanisms in place to ensure that when VTE prophylaxis is suspended in patients (for clinical reasons) that it is restarted as soon as possible.
- Ensuring all patient deaths that involve a possible/probable medical treatment omission are discussed with families/carers as part of our Duty of Candour processes and with the Coroner's office.
- Our trust based pulmonary embolism guidelines could be made easier to read for users by adding in an algorithm and highlighting two other sections.

Actions taken in response to the findings include;

- Presentation of the patient case as an educational case to a wide audience.
- Re-issued the trust guidelines following a lengthy consultation and education period
- Shared the results of the investigation with the family and Coroner
- Enhanced education of issuing medical cause of death certificates
- Enhanced knowledge of the VTE guidelines by clinical teams
- Improved processes of maximising learning from all deaths

There were 0 case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period.

Patient Reported Outcome Measures (PROMs)

The outcomes of these measures are reported one year in arrears. Whittington Health NHS Trust considers that this data is as described because it is produced by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health participated in the PROMs project during 2017/18, although at the time of review, there were not sufficient numbers of responses to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required). In 2016/17 there were also insufficient response numbers at the time of reporting, however subsequent publications eventually showed 226 responses from 572 eligible hospital procedures which demonstrated post-operative health gains in line with national averages.

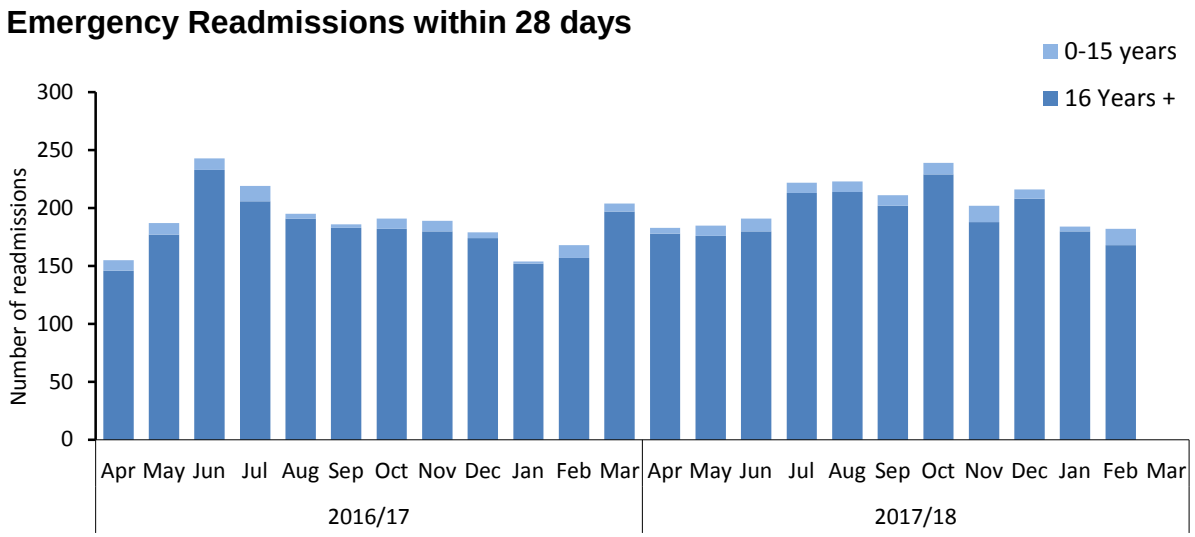
Table 1: Pre-operative participation and linkage

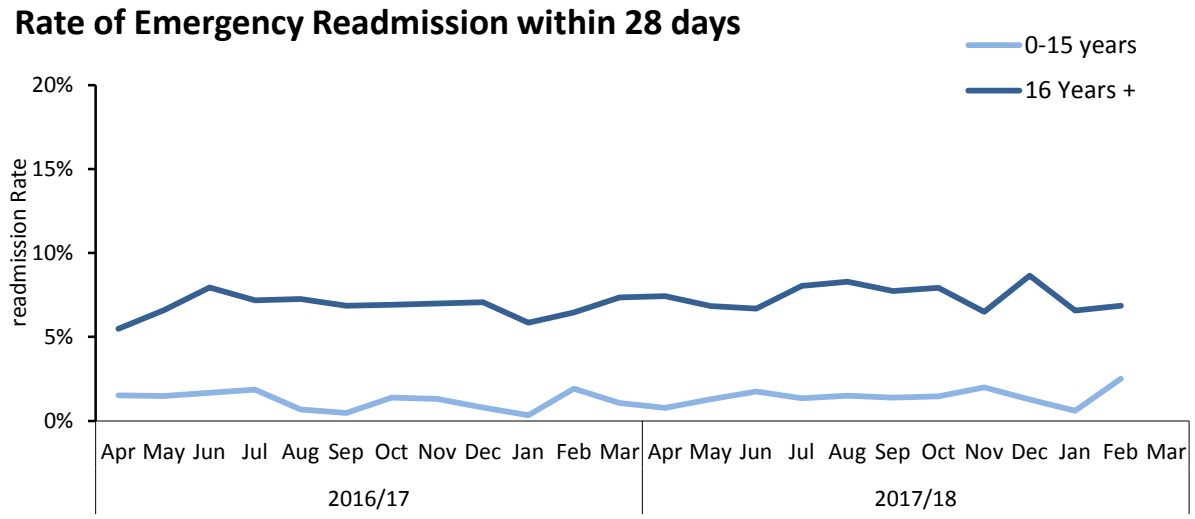
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate	National Linkage Rate
All Procedures (apr17-Sep17)	161	41	25.5%	21	51.2%	70.9%
Groin Hernia (apr17-Sep17)	152	41	27.0%	21	51.2%	67.8%
Varicose Vein (apr17-Sep17)	*	*	*	*	*	81.3%
Hip Replacement	Data not available					
Knee Replacement	Data not available					

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate	National Response Rate
All Procedures (apr17-Sep17)	41	20	48.8%	8	40.0%	29.4%
Groin Hernia (apr17-Sep17)	41	20	48.8%	8	40.0%	30.5%
Varicose Vein (apr17-Sep17)	*	*	*	0	*	25.7%
Hip Replacement			Data not available			
Knee Replacement			Data not available			

Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge





*Data excludes patients between 0 and 4 years at time of admission

Whittington Health NHS Trust considers that this data is as described because it has been produced specifically in line with stated requirements, reviewed thoroughly and compared closely to the metric that is used for routine board and departmental monitoring of readmissions.

The Trust has outlined the following actions to improve its readmissions rates in 2018-19:

- Launching a new clinical pathway for non-elective patients over the age of 75 with frailty that provides early geriatrician input within the Acute Admissions Unit for patients who have potential to be discharged within 48 hours
- In 2018/19 we are continuing to support and up-skill the ward based FLOW Liaison Officers who support timely and safe patient discharge using both Enhanced Recovery (medicine/ surgery) and Red to Green methodologies.

The trust's Responsiveness to the Personal Needs of its Patients

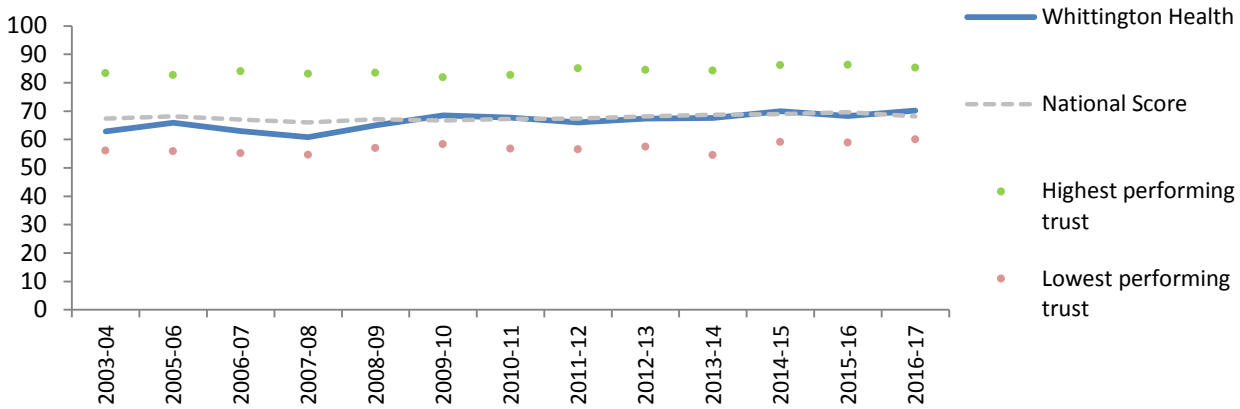
Whittington Health's responsiveness to the personal needs of its inpatients, based on the national inpatient survey, are displayed below. A trust's responsiveness is the weighted average score from five questions (score out of 100) and a higher score is indicative of better performance.

Year	Whittington Health	National Score	Highest performing trust	Lowest performing trust
2003-04	63	67	83	56
2005-06	66	68	83	56
2006-07	63	67	84	55
2007-08	61	66	83	55
2008-09	65	67	83	57
2009-10	69	67	82	58
2010-11	68	67	83	57
2011-12	66	67	85	57
2012-13	67	68	84	57
2013-14	68	69	84	54
2014-15	70	69	86	59
2015-16	68	70	86	59
2016-17	70	68	85	60

In order to improve our responsiveness to the personal needs of our patients in 2018-19 we are:

- Undertaking an action planning workshop which will include representatives from the inpatient wards and estates and facilities
- Highlighting these results at the Patient Experience and Quality Committees
- Making food, transport and communication a quality priority for 2018-19.

Responsiveness to the Personal Needs of Patients



The Whittington Health performance score was two percent higher than the national average in 2016/17 and has achieved a two percent increase compared to the trust's score in 2015/16. This is indicative of a trust that listens to its patients and responds to their needs.

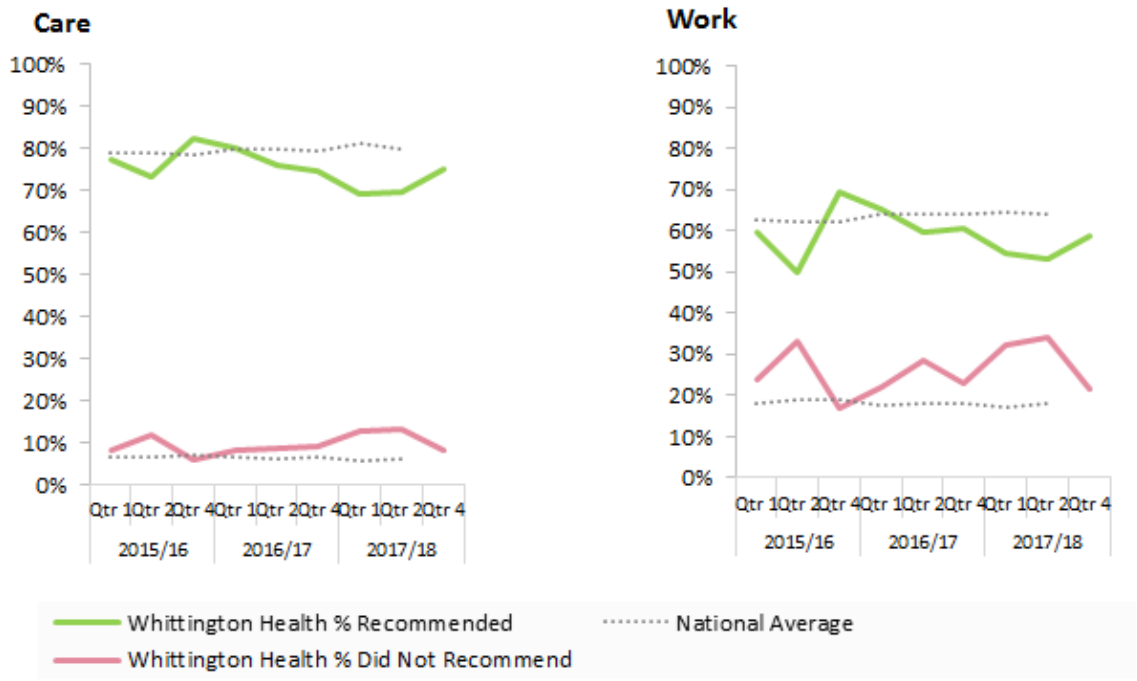
Whittington Health NHS Trust considers that this data is as described because it has been sourced from a recognised national agency in NHS Digital and adheres to a documented and consistent methodology.

Staff Friends and Family Tests

FY	Month	% Whittington staff recommending care	National Average	Highest performing trust	Lowest performing trust
2015/16	Qtr 1	77.5%	79.2%	100.0%	44.3%
	Qtr 2	73.2%	79.0%	100.0%	47.8%
	Qtr 4	82.3%	78.7%	100.0%	50.8%
2016/17	Qtr 1	80.1%	79.9%	100.0%	49.5%
	Qtr 2	76.2%	80.0%	100.0%	43.8%
	Qtr 4	74.6%	79.3%	98.2%	43.6%
2017/18	Qtr 1	69.0%	81.3%	99.6%	54.9%
	Qtr 2	69.4%	79.9%	100.0%	42.9%
	Qtr 4	75.0%			

Note: Staff Friends and Family Test is not conducted in Q3 due to the national staff survey taking place

Whittington Health recommendations compared with national average



The Whittington Health NHS Trust considers that this data is as described because it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

Listening to Our Staff

Whittington Health conducted its seventh national staff survey as an integrated care organisation (ICO). The survey was distributed to all staff who met the criteria, rather than a sample, and achieved a response rate of 42.4% which is an increase of over 6% from last year's 36% response rate. The survey asks members of staff a number of questions on their jobs, managers, health and wellbeing, development, the organisation, and background information for equality monitoring purposes. The purpose is to give staff a voice and provide managers with an insight into morale, culture and perception of service delivery, appraisals and support for development.

Staff Engagement Indicator

The CQC indicator score for staff engagement for Whittington Health is 3.81 (with 1 being poor and 5 being high engagement). This is considered "average" and is very slightly higher (not a statistically significant difference) compared with other similar organisations of a similar type.

Staff Engagement	Whittington Health Scores	National Scores: Acute Community Trusts
Advocacy	**3.75**	**3.75**
I would recommend WH as a great place to work	59%	59%
I am happy with the standard of care provided	71%	69%
Care of patients is a top priority for Whittington Health	77%	75%
Involvement	**3.87**	**3.89**
I am able to make suggestions to improve the work of my team / department	77%	75%
There are frequent opportunities for me to show initiative in my role	75%	73%
I am able to make improvements happen in my area	58%	56%
Motivation	**3.94**	**3.91**
I look forward to going to work	59%	57%
I am enthusiastic about my job	74%	73%
Time passes quickly when I am working	80%	77%
Overall Engagement Score	**3.81**	**3.78**

Top Ranking Scores

For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Whittington Health NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1:

	Indicator	Trust	National
1	Quality of appraisals	3.27	3.11
2	Percentage of staff experiencing physical violence from patients and public	11%	14%
3	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	29%
4	Staff motivation at work	3.94	3.91
5	Percentage of staff / colleagues *reporting* most recent experience of harassment, bullying or abuse	49%	47%

Improvement work throughout the trust has resulted in 'staff motivation at work' appearing in the top five and a positive decrease in staff suffering physical violence from patients, relatives or the public which scored as one of the bottom ranking findings in 2016/17. It is encouraging that staff feel more able to report harassment, bullying or abuse: the rate of reporting has increased by 2% and is 2% above the average. This remains a focus for the trust moving forwards.

Bottom Ranking Scores

	Indicator	Trust	National
1	Percentage of staff feeling unwell due to work related stress in the last 12 months	45%	38%
2	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	31%	24%
3	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	73%	85%
4	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	87%	91%
5	Percentage of staff experiencing discrimination at work in the last 12 months	19%	10%

The trust is particularly concerned with the percentage of staff experiencing discrimination or harassment, bullying or abuse from other staff and feeling unwell due to work related stress. As a result the Trust has launched an anti-bullying scheme and begun training a cohort of advisors to support staff who report experiencing bullying. The Trust has also invested in qualifying in-house mediators, training a pool of internal mediators, and launched a mediation service for staff to access.

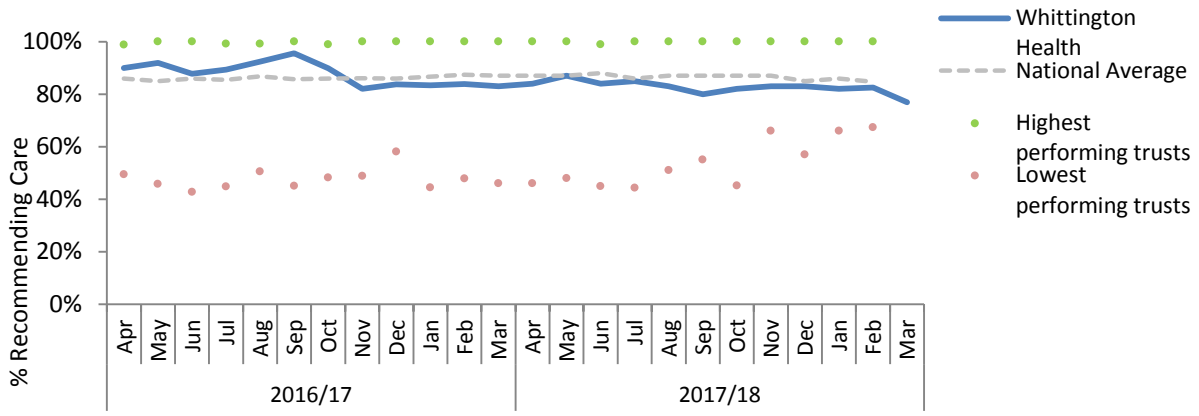
The trust is taking a number of further actions to improve local performance and achieve greater staff satisfaction in 2018-19 following the results of this survey including:

- Local staff recognition arrangements including employee of the month
- Annual Staff Awards ceremony
- Promotion of a Stop/Start service improvement scheme
- Making sure all staff have up to date Personal Development Plans
- Mandating appraisal training for appraisees and appraisers
- Focusing any health and wellbeing events on mental health, stress management and managing work life balance
- Tackling specific identified bullying hotspots in ICSUs
- Providing unconscious bias masterclass training
- Focus groups to understand the reasons behind reported discrimination
- Robust integration of exit interviews to identify themes and 'learning from' opportunities.
- Joining the 'Inclusion Labs' project to help improve our inclusion performance and increasing the Inclusion Team support available.

Patient Friends and Family Tests

Whittington Health NHS Trust is dedicated to giving patients the best possible experience whilst accessing our services. A key aspect towards improving patient care and experience is by listening to the thoughts and views of our patients and service users. We know that improving patient experience and treating our patients with compassion, dignity and respect, has a positive effect on recovery and clinical outcomes. We are dedicated to providing patients with the opportunity to feedback, and to using this feedback to improve patient experience and care. The patient Friends and Family Test (FFT) is used trustwide to determine the percentage of patients that would recommend Whittington Health NHS trust to their friends and family if they needed similar treatment.

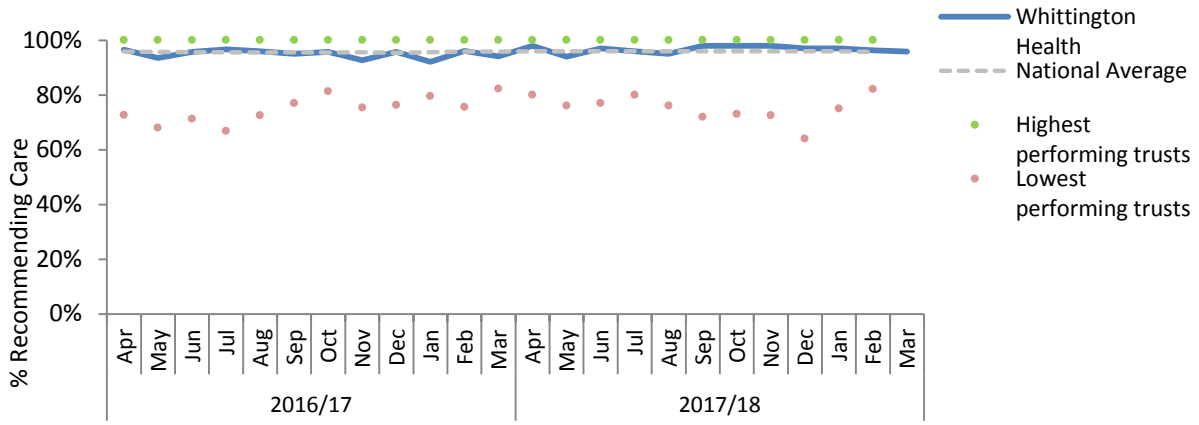
Emergency Department Attenders Recommending Care 16/17 & 17/18



We are constantly aiming to improve our recommendation rate and within the Emergency department we:

- Delivered customer care training for all ED reception staff and new starters
- Conducted regular quality checks by matrons
- Increased consultant establishment and clinical presence
- Sent all Band 6 ED nurses on a leadership study day focussing on standards, communication and developing a culture of quality and safe care.

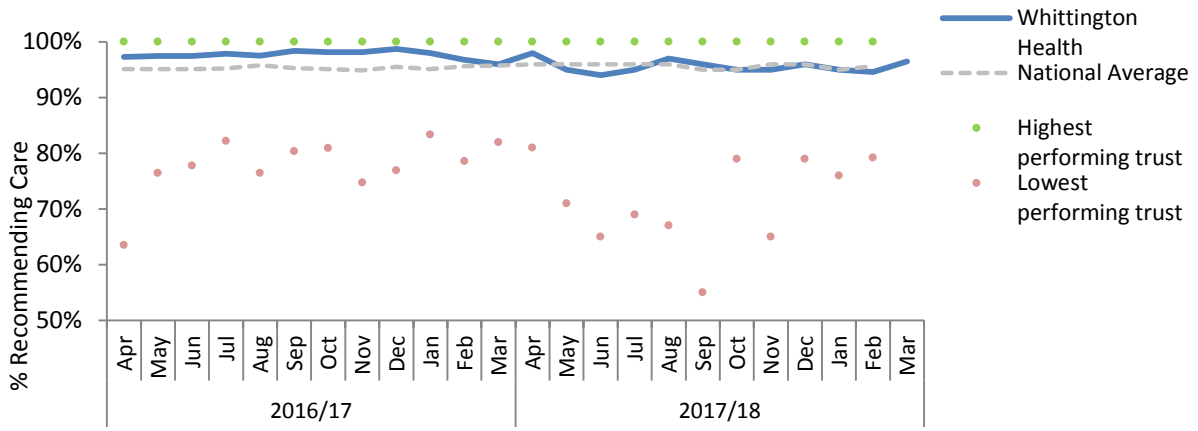
Inpatients Recommending Care 16/17 & 17/18



Within inpatients we have tried to improve response rates and recommendation rates by:

- Writing a "Big Four" each week which is where four key messages are relayed to staff each morning and afternoon at the beginning of their shift. These messages include trust wide updates and themes from compliments, complaints, incidents and feedback from users.
- Day Treatment Centre nurses contacting patients the day after their procedure as a "welfare check" and to answer any questions that they may have. Patients are have found this both helpful and supportive.
- Working with the facilities department to install portable heaters in response to patient feedback
- Creating a new room for visitors on one of our busiest wards. This was in response to patient feedback regarding patients not feeling as though they had enough privacy.

Community Service Users Recommending Care 16/17 & 17/18



The recommendation rate for patients in 2017/18 has frequently exceeded the national average and at times has been close to the rates of the highest performing trusts. For patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is most commonly due to system and processe inefficiencies.

In 2016/17 the trust successfully met its target to increase the number of patient responses collected through the FFT method by 20%. Despite this the response rates remained below the the national average. In 2017/18 we again achieved an increase in the number of responses we received however did not consistently achieve above the national average.

Emergency Department Response Rate (average per month)	
2016/17	9.08%
2017/18	13.74%
Community Responses (Total)	
2016/17	8,986
2017/18	10,694
In-Patient Response Rate (average per month)	
2016/17	17.12%
2017/18	18.30%

We are taking the following actions in 2018-19 to further increase our response rates:

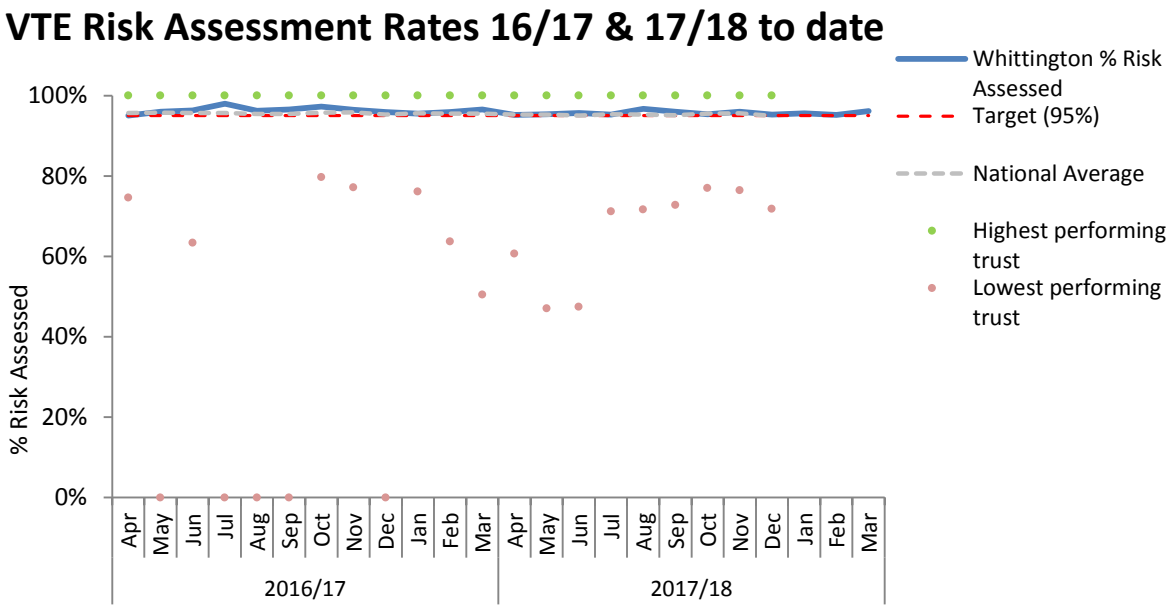
- Recruiting more volunteer ward befrienders to support with collecting FFT,
- Supporting Endoscopy and the Day Treatment Centre with iPads for collecting FFTs,
- Sending themed analysis sent to each ward manager to improve awareness of responses

Replicating the highly successful SMS FFT links in the musculoskeletal physiotherapy department in Podiatry services

Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. At Whittington Health we strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. In 2017/18 we consistently achieved above 95% compliance for VTE risk assessment.

In an effort to continuously improve, our medical colleagues undertake regular audits to ensure VTE compliance is robust and aligned with best patient outcomes.



The Trust considers that this data is as described as it is generated via daily, weekly and monthly reports and is submitted via a dashboard to executive level for assurance.

The trust is taking the following actions in 2018-19 to further improve our VTE rates:

- Introduction of a new 0.5 WTE specialist nurse to improve ward assessments and also to improve links with our ambulatory care department (where most outpatient VTE are diagnosed and managed)

- A review of all guidelines in line with recent NICE changes
- Further improve links and shared learning with other departments, including acute care and surgery, to enforce a consistent approach to VTE assessment and management

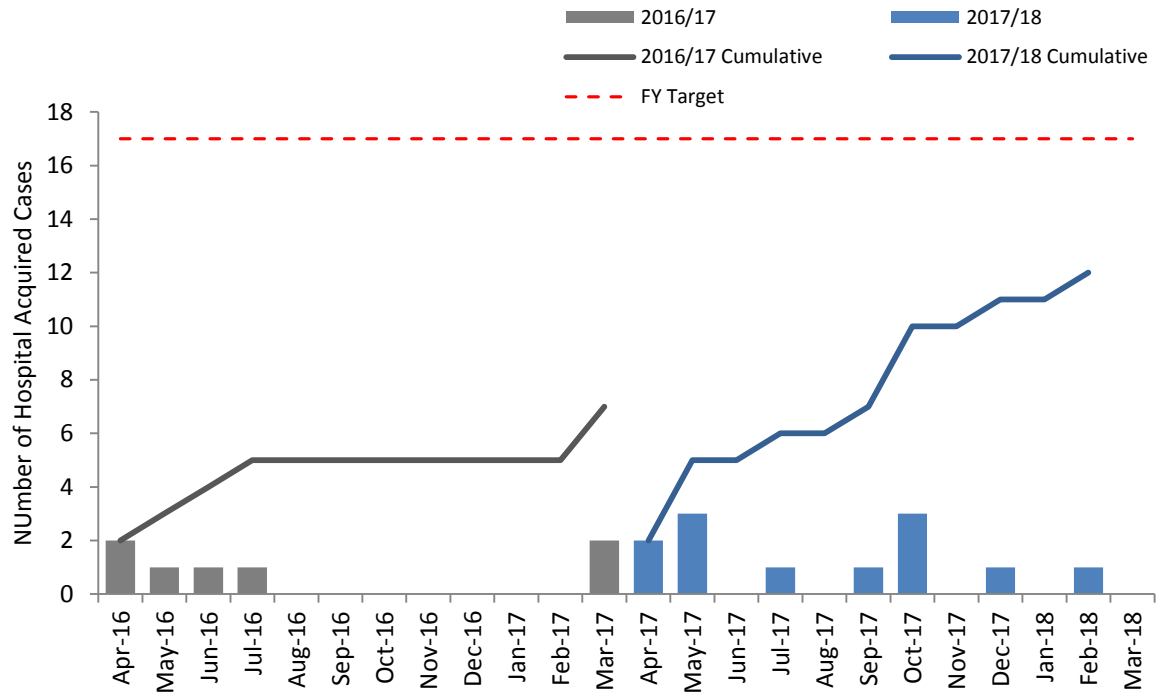
Clostridium Difficile

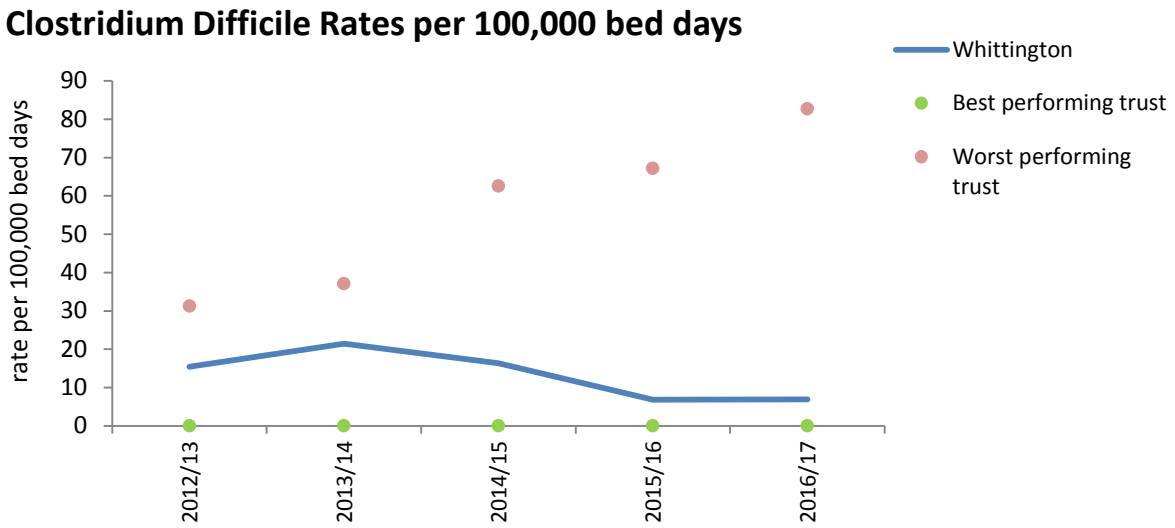
During 2017/18 there have been 11 *Clostridium difficile* infection cases attributable to Whittington Health. For the eleven cases, all but two were unavoidable. Our agreed ceiling trajectory for 2017/18 was set at 17 cases. We have taken a number of actions to reduce the number of *Clostridium difficile* cases that are attributable to Whittington Health including:

- Each patient case of attributable *Clostridium difficile* was thoroughly investigated with a full consultant-led post-infection review focusing on all aspects of the patient pathway from admission to diagnosis. Most cases were deemed as unavoidable.
- There were two cases found on the same ward at the same time which came back as the same ribotype and therefore likely due to cross infection. An action plan was devised and is being reviewed at every Infection Prevention and Control Committee meeting.
- Education sessions specifically on *Clostridium difficile* continue on our acute wards as well as during induction and update teaching sessions.

For 2018/19 our ceiling trajectory has been set at 16.

Clostridium Difficile Rates





Although the Trust has been below the national trajectory for Clostridium difficile infection (CDI) cases for the last three years, the Infection Prevention and Control Team are determined to continue reducing current numbers by:

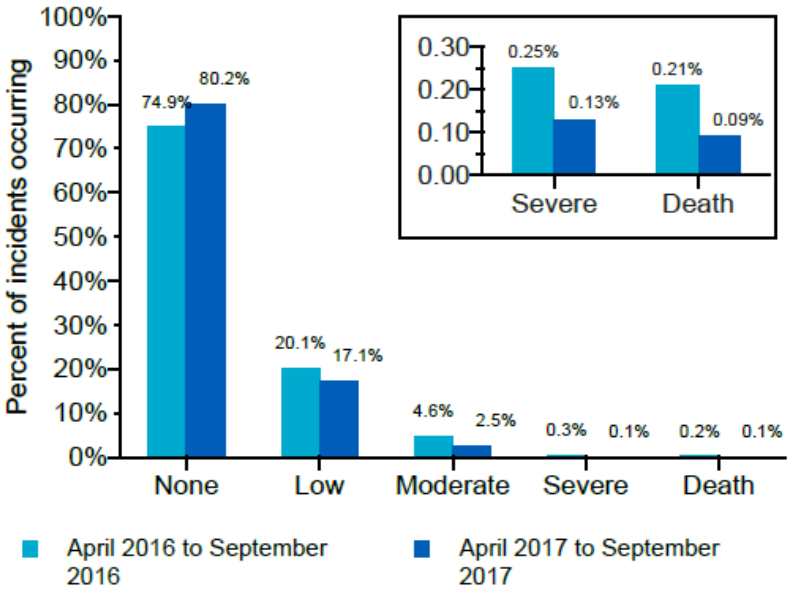
- Continuing post infection reviews (PIR) for all Trust attributable cases and creating action plans for each individual case. These action plans are presented to the Infection Prevention & Control Committee (IPCC) and reviewed at each meeting.
- Completing High Impact Intervention #7 audits on all CDI cases, which look at the compliance with hand hygiene principles by staff.

Patient Safety Incidents

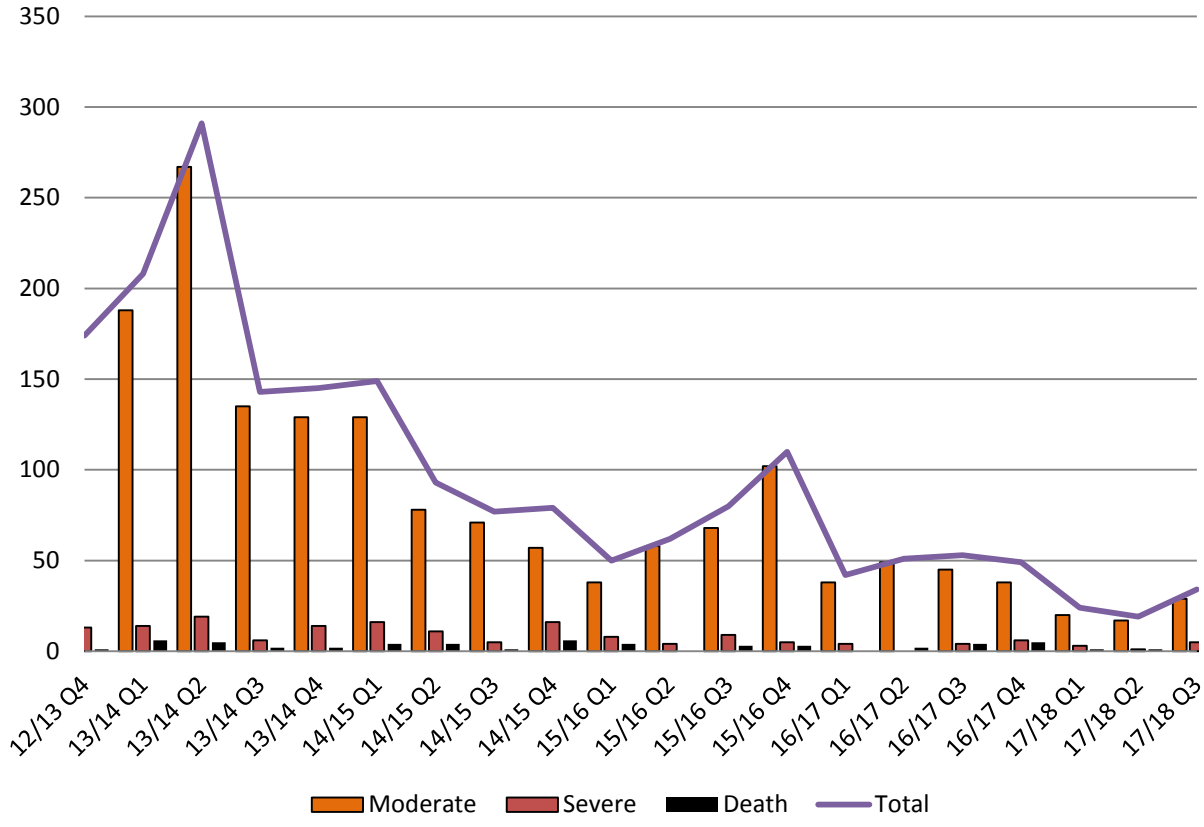
Whittington Health NHS Trust actively encourages incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare. The latest NHS Improvement report shows that we have a very good reporting culture within the organisation, placing us in the top quarter for incident reporting across the country.

Historically, it appeared that the Whittington Health NHS Trust had a higher proportion of incidents causing moderate-severe harm or death compared to the national average for acute non-specialist trusts. However, as the chart below demonstrates, there has been a significant change in the reporting culture in recent years and the classification process for grading the harm of incidents has been aligned with other NHS organisations.

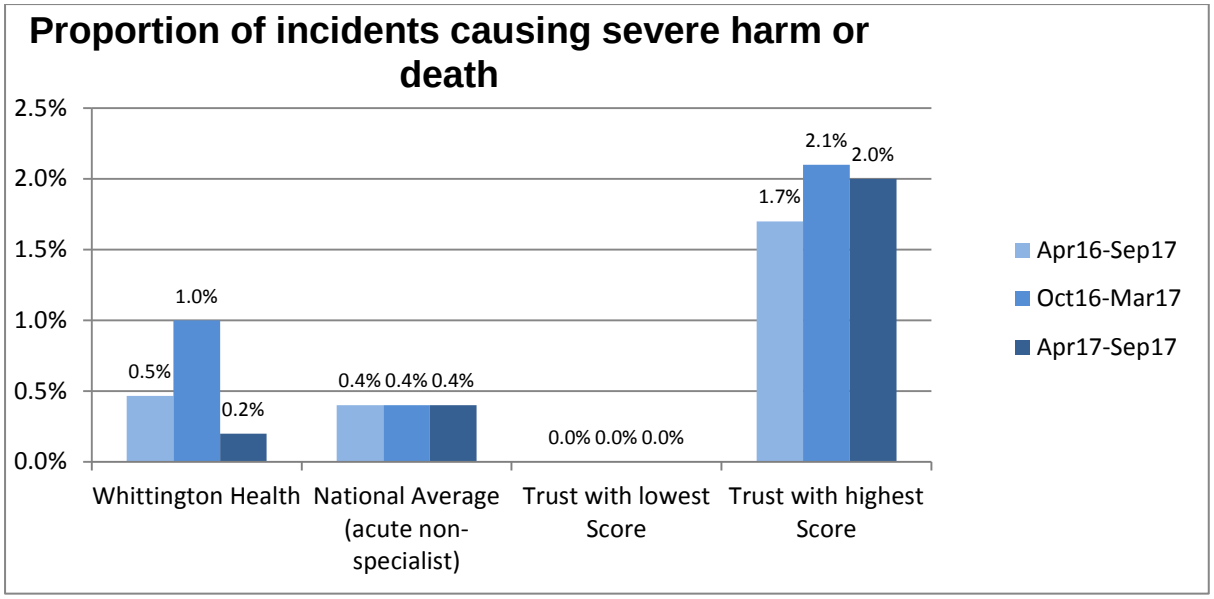
Incident Harm Grading Chart

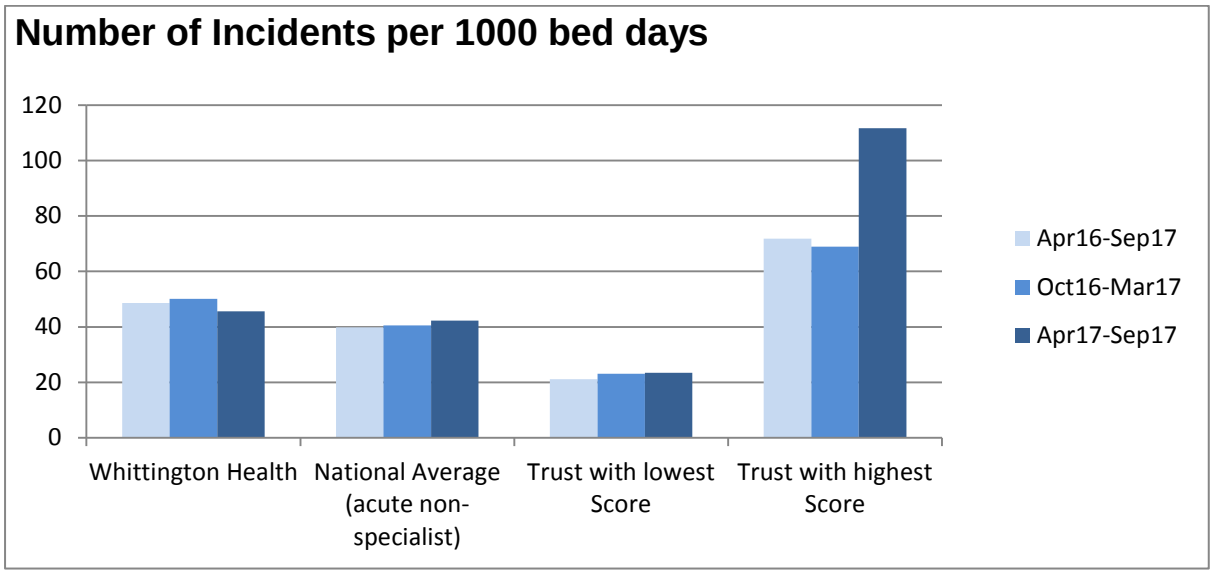


Incidents reported to NRLS
(Moderate,Severe and Death caused by the Incident)



In 2017/18 there were a total of 38 serious incident investigations declared within the trust compared to 58 in 2016/17. During 2017/18 unfortunately the trust recorded one never event. This was related to a retained foreign object during a perineal tear repair in Maternity. This event has been fully investigated and a root cause analysis conducted. The learning from the incident was disseminated across the organisation.





The trust is taking a number of actions in 2018-19 to improve patient safety, including:

- Promoting a culture of openness and transparency with incidents and near misses
- Encouraging shared learning from incidents and aiming to run 10 learning together patient safety workshops in 2018-19
- Improving datix userability and incident grading training
- Expanding the readership and circulation of the two monthly Patient Safety Newsletter
- Focusing on trend analysis in ICSU data/incident reporting

Since 2014 there has been a statutory duty of candor to be open and transparent with patients and families about patient safety incidents which have caused moderate harm or above. The trust complies with its statutory obligations but also strives to apply being open principles for low harm patient safety incidents which do not meet the statutory criteria.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Whittington Health NHS Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas. In 2017/18 all CAS alerts were responded to within the predetermined timeframe for the alert and are a standing agenda item at the trust's Patient Safety Committee.

Seven Day Service Standards

The aim of seven day services is to ensure that patients receive the same high quality of care, irrespective of the day that they arrive into hospital. These standards have been identified as the most likely to have the greatest impact on reducing variation in mortality risk.

The four priority clinical standards for seven day hospital services are:

- time to consultant review (standard 2),
- access to diagnostic tests (standard 5),
- access to consultant-directed interventions (standard 6), and
  on-going review by consultants twice daily for high dependency patients and daily for others (standard 8)

Standard		Data (March 2017)
2	Patients don't wait longer than 14 hours to initial consultant review	68%
5	Patients get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour.	94%
6	Patients get access to specialist, consultant-directed interventions	100%
8	Patients with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds	91%

The data above is completed as a retrospective audit every six months with the results being submitted to NHS England. The most recent data of patients admitted during a seven day period in March 2017 is presented.

The results show that 68% of patients are seen by a consultant (standard two) within 14 hours of admission, which is similar to performance in the previous reporting period. For access to diagnostic tests (standard 5) the trust performs highly across the seven day period and has made further improvements to 24 hour CT scanning accessability, however there remains some limited access to MRI, ultrasound and echocardiography at weekends. Access to specialist, consultant directed interventions (standard 6) is above London and National averages and specialist consultant reviews of high dependency patients (standard 8) are 100% and 91% for the last two reporting periods from September 2016 and March 2017 respectively.

Part 3: Review of Quality Performance

This section provides details on how the trust has performed against its 2017/18 quality account priorities. The results presented relate to the period April 2017 to March 2018 or the most recent available period.

Priority not achieved
Priority achieved

Priority 1: Improving Patient Experience

We aim to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences. Through the Patient Experience Committee we have monitored and reported progress to achieving our priorities. The committee reports quarterly to the Quality committee which is a sub-committee of the trust board.

What were our aims for 2017/18?

- We will reduce the amount of time patients wait for booked transport from home to hospital

Priority 1

In order to achieve this priority we call all patients one day prior to their appointment date to confirm transport arrangements. We have also introduced an additional call from the driver of the transport when they are en route to the pick up. This gives the patient a more precise pick up time enabling them to get ready as close to the appointment time as possible.

Although this service improvement has been positively welcomed by patients we have been unable to gather sufficient data to determine if this has resulted in a reduction in the time patients have had to wait for transport and therefore cannot say that we have met this priority. Because of this we have set a specific target for 2018/19 to gather this information so that we can improve the hospital transport service.

What were our aims for 2017/18?

- We will reduce outpatient clinic appointment cancellations

Priority 2

Despite increased monitoring of demand and capacity across outpatients which has enabled us to be more responsive to service changes, and better management of staff sickness and absence, we have been unable to demonstrate a reduction in outpatient clinic cancellations and this remains at 13.03% for the year.

However, in February 2018 the Trust launched an Outpatient Transformation programme, which aims to improve the productivity and efficiency across all outpatient services. The programme is working to develop a number of 'pilot' initiatives which will be tested, refined and rolled out. Key workstreams include: increasing clinic utilisation by proactively targeting DNAs, patient and Trust cancellations; and the systematic review of all clinic templates – which should provide increased transparency, predictability and capacity.

Future improvements to further reduce cancellations include introducing an electronic referral system in October 2018 which will improve clinic planning and filling.

What were our aims for 2017/18?

- We will reduce noise at night for patients

Priority 3

In order to achieve this priority the trust set up a working group which included representatives from a number of clinical areas that met several times throughout the year to dicuss the best possible strategy for achieving a reduction in noise at night.

The group introduced the following actions taken to address noise at night:

- night-time walkabouts to identify the main sources of noise
- a sleepover on Ifor ward involving young people who reviewed noise and completed questionnaires regarding their experience
- offering ear plugs and eye masks to all inpatients
- provision of headphones to patients with TVs or other devices as necessary
- introduction of desk lights at the nursing stations to reduce lighting
- introduction of noise monitors in some areas to improve staff awareness of the noise levels
- posters displayed to raise awareness with patients and staff of the importance of reducing noise with staff and patients.

The results of the national inpatient survey 2017 show that the trust performed significantly better than the average (i.e. other trusts who were surveyed by Picker) with regards to the question 'bothered by noise at night from staff'. The trust also significantly improved on the question 'bothered by noise at night from other patients' compared to the previous year.

The working group is continuing to ensure that the actions are rolled out trust wide and that we can continue improving in 2018/19.

What were our aims for 2017/18?	
• We will improve continuity of care from district nurses	
Priority 4	For patients in the community receiving district nursing care we know that consistently seeing the same nurse has a positive effect on patient care and experience. For this reason we prioritised improving continuity of care from district nurses in 2017/18. A number of steps have been taken to ensure that the quality of care is consistent and minimises unwarranted variations for those patients who see a number of different healthcare professionals. This includes clearly documented care plans, the provision of ipads for temporary staff so that they have access to patient records and handovers with the team leaders. We also introduced e-community software which enables senior staff allocating district nursing shifts to easily identify the last nurse who saw the patient and prioritise the booking of that nurse. The system enables automated allocation to ensure continuity of staff and also raises alerts if the skill of the nurse allocated does not match the needs of the patient. In March 2018 a patient presented their experience of the service to the trust board. They provided a positive example of how minimising unwarranted variations in care resulted in a very good patient experience notwithstanding the variety of healthcare professionals involved.

What were our aims for 2017/18?

- We will improve the feedback we receive about inpatient food

Priority 5

Quality food whilst an inpatient is important not only for patient satisfaction but also for nutritional value whilst unwell or recovering from illness. In order to improve the quality of food that the trust provides we set up a working group with representation from clinical areas, catering and nutrition and dietetics.

In October 2017, the patient experience team worked with the dieticians to record a video collecting patient feedback on the Trust's food service. Six inpatients discussed their feedback with the team.

Gladys was very happy with the choice of food and the quality "I think it is absolutely lovely, I really enjoy it and I have what I like. And I am a fussy eater!.....they always have a nice choice, and if they cannot offer one meal they will try to make you something else that is nice to compensate for this".

Gordon found the taste of the food good overall and was happy that staff prepared him adequately in advance of meals.

Susan thought that "the choice of food is excellent…….plenty to choose from'. She reported that she had always received the food that she had ordered, and that the dietician team had helped her in ordering extra items. Susan felt that the "food is fantastic, especially when you think about what all of the staff are catering for".

The actions the group took to improve food included:

- Plated food trials on three wards. Local survey feedback has been positive and the trust is developing a business case to deliver this to some inpatient wards permanently. A full comparative analysis is underway.
- Hand wipes taken round to patients at mealtimes that can be given straight from the packet
- Volunteers have received training to support patient mealtimes
- Menu cards have been improved to ensure patients are aware that different portion sizes are available
- Ensuring that menu booklets with the full range of choice are easily accessible to patients and visitors
- The clinical lead dietician has delivered informative and interactive training to staff to support delivery of mealtimes

Despite these improvements the results of the national inpatient survey 2017 showed that the trust performed significantly worse than average (i.e. other trusts that were surveyed by Picker) with regards to the questions 'food was fair or poor' and 'not always offered a choice of food'. Improving food continues to be a priority for the trust and that is why we are continuing to make this a priority in 2018/19.

Priority 2: Improving Patient Safety

Reducing Falls

What were our aims for 2016/17?

- We will introduce StopFalls bundles across the hospital, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (*AAU)* and *Care Of Older People* wards *(COOP)*

- We will reduce the number of avoidable falls resulting in serious harm to patients year on year

Progress to date

Throughout 2017/18, we introduced the STOPfalls campaign to reduce the number of falls, in particular falls with harm, across the hospital. The STOPfalls bundle was developed in line with the Royal College of physicians guidelines and included:

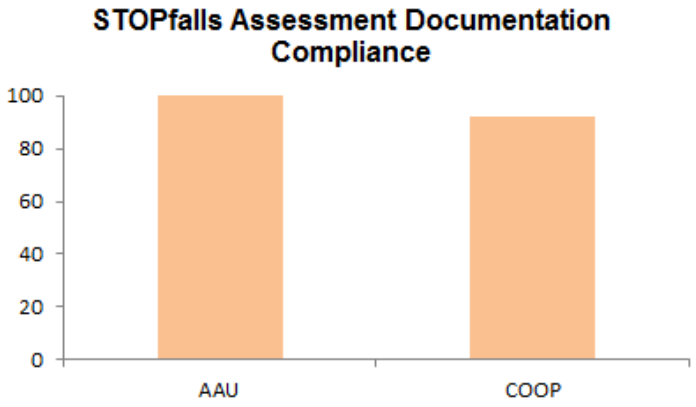
- Multifactorial risk assessment tool
- 'High Risk of Falls' sign for bed space
- Falls risk sign for walking aids
- Falls risk sticker in patient notes
- Falls risk bracelet for patients
- Yellow magnets on whiteboards to indicate falls risk

Whittington Health was one of twenty trusts participating in the National Falls Collaborative with NHSi and through the use of quality improvement methodology implemented a series of changes designed to embed the STOPfalls bundle in practice.

The first critical step in the STOPfalls bundle is the identification of patients that are at high risk of falls through a multifactorial risk assessment tool. This provides a systematic way for staff to check a patients risk of falls and gives prompts to staff to address the specific needs of patients to reduce the likelihood of a fall. The target set in 2017/18 therefore focused on the completion of the falls risk assessment documentation. For 2018/19, this target has expanded to incorporate the other aspects of the STOPfalls bundle.

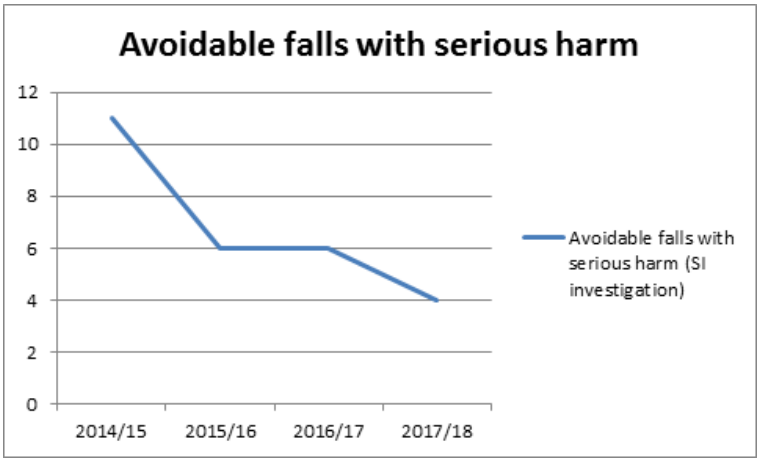
Priority 1

The falls assessment documentation has been audited on a quarterly basis in 2017/18 and has shown 100% compliance on the Acute Assessment Units and an increase from 82% in quarter one to 87% in quarter three on the care of the older people wards.



Since 2014/15 we have had a continuous goal of achieving a year on year reduction in the number of avoidable serious harm falls. We define 'avoidable' falls as those where processes designed to stop falls were not followed; a root cause analysis investigation is completed for each serious harm to identify if any system failures or human error contributed to the fall and what learning we can share across the trust to prevent reoccurrence. Unfortunately, despite all the efforts of hospital staff, carers and patients some falls are unavoidable. This is primarily due to the constant need to balance a patient's falls risk against their right to privacy and dignity, and their need to be mobile and independent to aid recovery.

The trend has shown sustained improvement from 11 incidents in 2014/15 to six in both 2015/16 and 2016/17. This year there were seven serious harm falls reported publicly as Serious Incidents. Following investigation in three of these incidents no care or service delivery problems were identified; the fall was found to have been unavoidable. As a result the number of avoidable falls with serious harm in 2017/18 fell to four.



One of the reasons falls with harm have declined this year is because of the introduction of our STOPfalls improvement project. The introduction of a multifaceted bundle of falls prevention measures has been introduced on the care of older people wards and acute assessment units and includes:

- Ward-based training provided to all staff on the Stop Falls bundle
- STOPfalls assessment tool embedded within the standardised patient admission booklet
- "Baywatch" initiative introduced. "Baywatch" is an MDT approach to maintaining patient safety through a card tag system which supports constant bay supervision. If the named nurse needs to leave the bay unattended, another staff member will be asked to be on "Baywatch" until the nurse returns; this can include doctors, nursing staff, porters, domestics and operations staff.
- "Grab bags" in use in toilets which are single-use bags consisting of toileting essentials for patients. This was introduced as a result of falls reported where patients were left unattended in the bathroom in order for staff to search for these toileting items (ie wipes, pads)
- Falls discussed as part of Board Rounds (yellow magnets indicate high risk)
- Regular staff meetings with the senior ward leadership team to raise awareness of STOPfalls

Priority 2

Pressure Ulcers

What were our aims for 2017/18?

- To achieve a year on year reduction in all grades of pressure ulcers across the ICO
- To develop a cross borough target on the 'React to Red Initiative'

Progress to date

Avoidable pressure ulcers are a key indicator of the quality and experience of patient care and are associated with longer stays in hospital and can lead to serious life-threatening complications, particularly in vulnerable patients. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem and 700,000 people are affected by pressure ulcers each year (NHS Improvement, 2016).

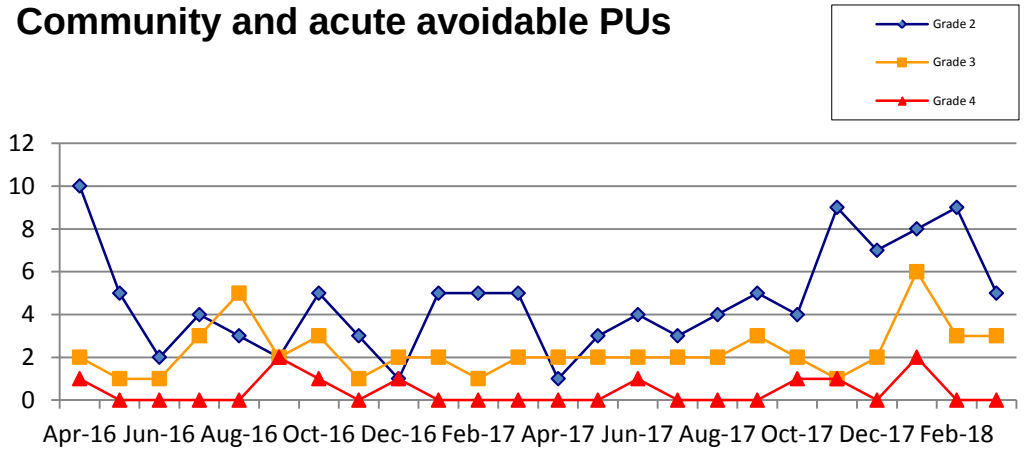
Reported pressure ulcers are classified as either avoidable or unavoidable. These incidents are assessed by the Tissue Viability Nursing team to confirm whether the pressure ulcer was classified correctly.

Priority 1

In order to achieve an annual reduction in pressure ulcers the trust has:

- introduced visual beside aids to assist staff in ensuring patients at risk are turned regularly
- increased senior nurse reviews to particularly focus on pressure ulcer prevention and management
- raised the profile of our tissue viability nursing team with ward staff
- carried out a 72 hour review of care for all avoidable pressure ulcers
- improved multidisciplinary team awareness of pressure care prevention and monitoring
- dedicated time on the morning ward round to ensure we are clearly documenting location and stage of any pressure injuries

We are incredibly proud that for the third year running we have not reported any avoidable grade four pressure ulcers within the hospital. We recognise the continued vigilance, management and escalation of pressure ulcers by staff on a daily basis to achieve this outcome. Within district nursing services we have reported five avoidable grade four pressure ulcers which is the same as in 2016/17.



Despite the improvements that we have implemented and the continued hard work of staff 2017/18 has seen a 25% increase in grade three and 21% increase in grade two pressure ulcers across the trust. It is for this reason that we are keeping this as a quality priority for 2018/19 as we are determined to reduce the number of avoidable pressure ulcers reported.

Priority 2

As part of our commitment to reducing avoidable pressure ulcers, providing education and raising awareness are essential. Consequently, the trust aimed to deliver a react to red initiative across Islington and Haringey.

We can confidently say that we have achieved this target by:

- raising awareness at an Islington carers hub meeting
- raising awareness at a GP training session
- uploading educational information onto the local GP portal
- raising awareness through the adult safeguarding group Islington
- publishing an article in the local Islington newsletter
- distributing information leaflets to pharmacists, care agencies, practice nurses and GPs

Learning Disabilities

What were our aims for 2017/18?

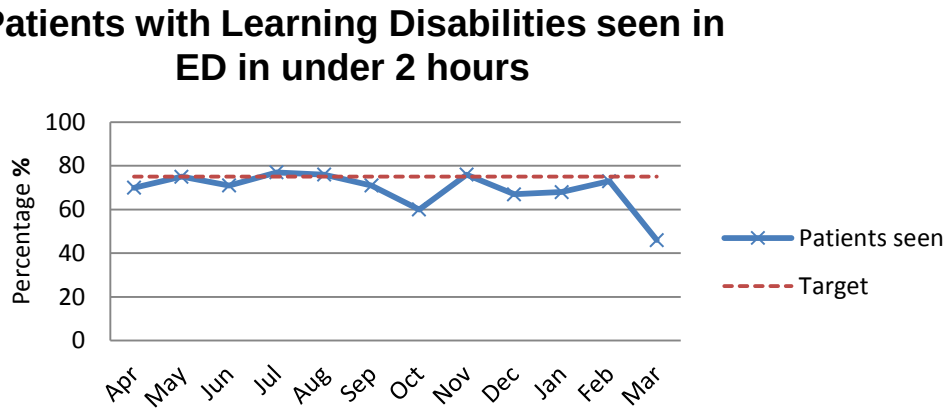
- 75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment (i.e. seen in under two hours)
- To introduce a care pathway for mothers with learning disabilities in the hospital
- All children and young people entering CAMHS for a choice appointment will be screened for Learning Disabilities

Progress update

Priority 1

In conjunction with our stakeholders in 2017/18 we agreed to make reasonable adjustments for patients attending the emergency department with learning disabilities. We have introduced an alert on Medway to highlight to staff when a patient with LD attends the ED. Staff are then able to prioritise the patient and aim to see them within two hours.

The ED has been successful in seeing 68% of patients with learning disabilities in under two hours, however we have not been able to meet our target of 75 percent.



We recognise the importance of making reasonable adjustments for our patients and that is why we are continuing to prioritise triaging patients with learning disabilities that present to the emergency department in 2018/19. We can attribute the unusual reduction in performance in March 2017 to the leaving of our LD nurse specialist. We are currently recruiting into this vacant role.

Priority 2

In line with guidance from the 2015 paper 'Hidden voices of maternity – Parents with learning disabilities speak out' and following a series of listening events and feedback from patients we aimed to establish a care pathway for mothers with learning disabilities.

This pathway and protocol have now successfully been approved and the next steps are to embed it into practice.

Priority 3

In 2017/18 we have screened all children and young people for learning disabilities that have entered our Children and Adolescent Mental Health Service.

Medicines Safety

What were our aims for 2017/18?

- We will achieve a 10% increase in medication errors reported across the Integrated Care Organisation
- We will achieve a 10% reduction in medication errors with harm

Progress update

Priority 1

In 2017/18 we aimed to increase our reporting of medication incidents. High levels of reporting allow for better trend identification and learning and infers an open and transparent organisational culture. The data from the year shows that whilst we have not achieved our 10% increase in reporting we have achieved an impressive 5% compared to the number reported in 2016/17. Despite not achieving our aim the trust continues to be within the top quartile of incident reporting rates nationally.

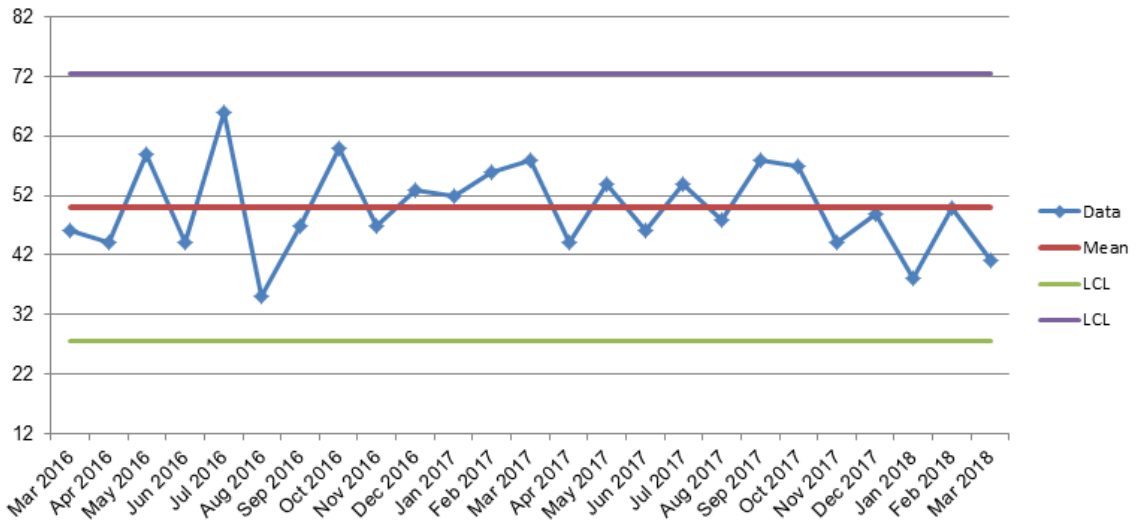
Priority 2

Medication incidents as a percentage of total patient safety incidents reported nationally in 2017/18 was 10.8%. Within the Whittington Health NHS trust, medication incidents accounted for 10.4% which is in line with national figures.

From April 2017 to September 2017, 10.6% of all our incidents were medication related

Reducing medication errors was given priority by the trust in 2017/18 and we set ourselves an aim of 10% for the year. Unfortunately we have been unable to reduce medication errors with harm despite the hard work that has gone into achieving this priority. The data for 2017/18 shows an increase of 2% in low, moderate and severe errors when combined. It is important to note that whilst a number of incidents are described as causing harm, it is often inadvertent harm, i.e. an allergic reaction from a medicine where this was not previously known results in harm, but may not have been avoidable. When looking at the harm severity individually the trust did not report any severe harm medication incidents.

Medication incidents between March 2016 and March 2018



Sepsis

What were our aims for 2017/18?

1. To achieve the national CQUIN for sepsis (90% of eligible patients in the emergency department (ED) screened for sepsis) with a particular focus on sepsis developing during inpatient stay

2. We will work in partnership with local CCG's to raise patient awareness of sepsis including the distribution of "Could it be sepsis" leaflets distributed to relevant local healthcare provider centres.

Progress update

The trust acknowledges sepsis as a potentially life threatening condition, triggered by infection. The UK Sepsis Trust estimates sepsis kills 40,000 people every year. Caught early, outcomes are excellent and therefore screening patients early for signs of sepsis is critical.

Priority 1

In 2017/18 we screened 93.5% of eligible patients in the emergency department for sepsis. This marks a continued improvement throughout the year from 88% in quarter one, to 95% in quarter four. Sepsis screening on the wards has also improved and between July 2017 and March 2018 we achieved over 95% screening of patients. Another achievement that the trust is particularly proud of is that between October and December 2017 and January and March 2018, 100% and 98% of patients with sepsis received antimicrobials within one hour of recognition, respectively, against a target of 90%.

These successes have been achieved by providing specific feedback to the emergency department on all patients that were either missed at the screening stage or did not receive antimicrobials within the target timeframe to ensure lessons are learnt and further improvements can be made.

Following the excellent outcomes achieved in sepsis recognition and management we received the following letter of congratulations:

I am delighted to inform you that you are one of the trusts which has seen the greatest improvements in timely identification and timely treatment of sepsis from the data we have received on the CQUIN.

I would like to congratulate you and your colleagues for all the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place. Please pass my thanks on to the staff concerned for their achievements in improving the care for patients with sepsis.

Celia Ingham Clark
Medical Director for Clinical Effectiveness
NHS England

Priority 2

We have also been successful in meeting our 2017/18 priority to raise awareness of sepsis. We achieved this by providing training to local GPs, mandating training for community nurses and introducing training programmes across all Haringey and Islington nursing homes. We are also additionally working with the Haringey Quality and Patient Safety Manager to establish a GP sepsis link from each GP surgery.

We were delighted that 263 members of our community and hospital staff attended our sepsis awareness day which highlighted the importance of early recognition of the signs of sepsis and showcased the improvements we had made as a trust managing sepsis.

Pre-hospital sepsis alerts have consistently achieved over 50% between October and December 2017 which is a significant improvement compared to the 10% we achieved in 2014/15. This important recognition process highlights the work we have done in the community in promoting sepsis awareness and early identification of symptoms.

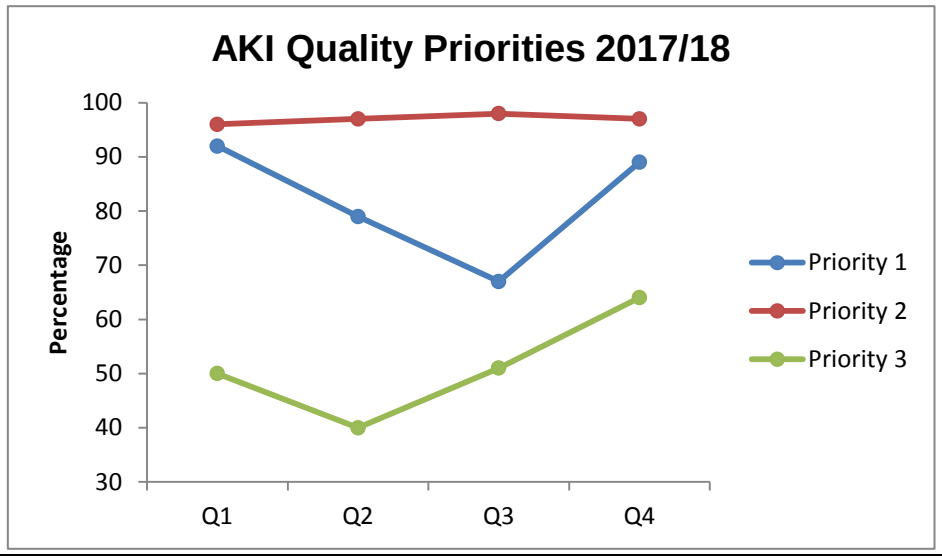
Acute Kidney Injury (AKI)

What were our aims for 2017/18?

1. At least 75% of patients with AKI include an AKI diagnosis in their discharge letter
2. At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team (CCOT) within 24 hours.
3. 90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours

Progress update

In the UK up to 100,000 deaths in hospital are associated with Acute Kidney Injury. 'Think Kidneys', the NHS national campaign focusing on prevention and management of AKI estimate that up to 30% could be prevented with the right care and treatment (thinkkidneys.nhs.uk 2018). In 2017/18 the trust continued to prioritise AKI recognition and management and set three ambitious targets to improve patient safety.



Priority 1	In 2016/17 57% of inpatients diagnosed with an AKI had an accurate discharge letter detailing this information. In 2017/18 we set a target of 75% and at year end have achieved an average of 82% based on quarterly audits of discharge letters against clinical notes and test results. This is a significant 25% improvement and highlights the importance we have placed on improving communication between hospital and community services and the need for accurate discharge summaries. Work is ongoing to further improve the accuracy of our AKI reporting and documentation and in 2018/19 we are aiming to achieve 90%.
Priority 2	Timely reviews of patients diagnosed with a grade three acute kidney injury by the CCOT are known to reduce the risk of patient deterioration and the need for subsequent care. The CCOT are alerted to all grade three AKI diagnoses and aim to review these patients within 24 hours. Through the introduction of improved AKI alerting systems and earlier recognition of grade three AKIs we have been able to exceed our 2017/18 target of 90% of patients seen within 24 hours. We have consistently achieved above 95% and have averaged 97% for the year. In the previous year the trust averaged 80%of reviews within 24 hours and this clearly demonstrates the quality work the trust has undertaken to improve patient safety with AKI.
Priority 3	Medicine safety reviews are a key part of medicines management and help to ensure that patients are prescribed the most appropriate medications for their AKI diagnosis. Aiming to do this within 24 hours helps to ensure patients are getting the most effective treatment as early as possible. In 2017/18 we set ourselves an ambitious target of reviewing the medication of 75% of patients diagnosed with a grade three AKI within 24 hours. Whilst we have successfully improved from an annual average of 10% in 2016/17 to 45% in 2017/18 we unfortunately did not meet our annual quality priority target. The second half of 2017/18 has seen a very positive trajectory and in the last four months of the year we have consistently achieved above 55%. We are confident that we can continue this sustained improvement into 2018/19 and have identified further areas that we can streamline to improve the number and efficiency of medicines reviews within 24 hours to further improve patient safety. In light of the patient safety implications involved with this we are continuing to prioritise medicine safety reviews in AKI in 2018/19.

Priority 3: Improving Clinical Effectiveness (Research & Education)

Clinical effectiveness can be measured using various methods including clinical audit, to ensure high quality patient care and outcomes.

Research

What were our aims for 2017/18?
• We will increase by 10% the number of national Institute of health research (NIHR) programmes in which we participate • We will achieve the recruitment target, set by the north Thames CLRN, for patients recruited into NIHR portfolio studies.

Progress to date	
Priority 1	In 2017/18 we did not achieve our target of increasing the number of NIHR research studies compared to the year before (39 compared to 48). However, working with the North Thames Clinical Research Network we have improved our recruitment to time and target metrics in line with the NIHR High Level Objectives which has improved the overall quality of studies (and number of patients recruited).
Priority 2	In 2017/18 the research delivery far exceeded the North Thames CLRN recruitment target, the target was set at 474 patients and we recruited 724 patients.

Education

What were our aims for 2017/18?
• We will continue to provide access to 'learning together from patient safety incidents and complaints workshops' based on real patient stories and aim to deliver 10 structured inter-professional learning events in 2017/18 • 100% of students placed at WH will have access to a named educational and clinical supervisor or mentor • We will expand our portfolio of inter-professional learning opportunities for staff by offering training in making every contact count and access to the training offered by Haringey and Islington community education provider networks • We will offer upskilling opportunities to health professionals on how to teach and support people to self-manage their long term condition by offering the advanced development programme across Islington and Haringey

- We will evaluate the access group, currently running in the East of Haringey's improving access to psychological therapies service, which Turkish patients are offered before the delivery of individual CBT. We aim to establish its effectiveness in improving outcomes, and reducing DNAs and dropouts in this BME community

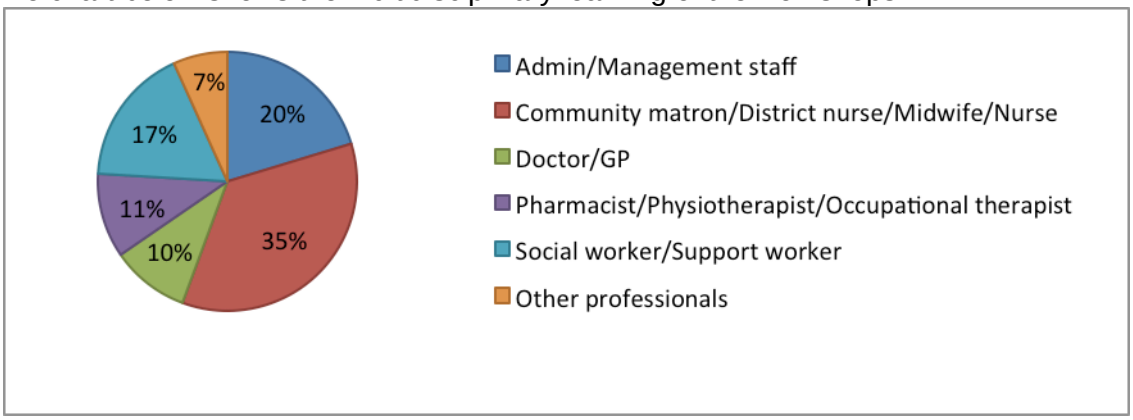
Progress to date

Priority 1

In 2017/18 the trust ran seven half day 'Learning together' workshops based on real patient stories from serious incidents that have happened at Whittington Health. Each workshop discussed a number of key themes and focused on shared learning and quality improvement.

Themes including adult safeguarding, cross-organisational working, discharge planning, end of life, handover, information sharing, learning disability, mental and physical health, pressure ulcers, sepsis and team working were explored. All workshops were facilitated by Whittington Health staff (from various professional backgrounds) and opened up to colleagues working in health, social care and charity sectors in Camden, Haringey and Islington. In total, the workshops were attended by 290 professionals from various backgrounds, with an average attendance of 40 people per workshop. Learning materials from all sessions have been made available on Whittington Moodle to share learning within Whittington Health and with other local health and social care colleagues such as district nurses, GPs or social workers.

The chart below shows the multidisciplinary learning of the workshops.



Priority 2

The trust has made it a requirement for all students to have a learning portfolio in which to keep a log of education and training activities and reflective practice throughout their undergraduate training. As part of this process, all students must have access to a named mentor or supervisor.

In 2017/18 there were approximately 800 medical students, 550 nursing students and 190 midwifery students completing their clinical placements at the Whittington Health NHS trust. Over the last year every student has been given access to 'NHS ePortfolio' or a 'Practice Assessment Document' and has been allocated a named mentor or educational/clinical supervisor.

Priority 3	Education and training activities offered via Haringey and Islington Community Education Provider Networks have focused on the development and delivery of sustainability and transformation plans. The focus remained on recruitment, retention and continuing professional development of staff working across health and social care. New networks such as the North London Partners Quality Improvement network and Trainee and Newly Qualified Professionals network have been established to support workforce development across North Central London. Furthermore, in 2017/18 we ran four pilot simulation based MECC sessions with a view to continue running these in the future.
Priority 4	"The Advanced Development Programme (ADP) – Communication Skills for Supporting Self-Management & Behaviour Change" is a training programme for health professionals from multi-disciplinary backgrounds open to anyone who works with people with long term conditions in Islington or Haringey. The course provides strategies and skills to support people with long-term conditions to optimally self-manage. It draws on best practice from clinical communication skills, motivational interviewing and Cognitive Behavioural Therapy (CBT) approaches. During 2017/18, 67 participants started and 63 completed the course across Islington and Haringey. Overall the feedback from participants was positive; 85% of participants reported in the training questionnaire that they felt 'more' or 'much more' confident/ knowledgeable/important/likely' following the course. Participant feedback includes: • *Thank you for an incredibly informative and well delivered session!* • *Given me more insight into how and why it's so beneficial to get the patient on board with changing their own lifestyle.* • *I have started communicating the skills I have learnt during these sessions to my colleagues as I feel they are incredibly beneficial.* • *I found the advice regarding open ended questions the most helpful and made the biggest difference within my practice.* • *I am more focussed on patient centred goals, rather than what I think should be the goals.* • *Getting patients to explain their own ideas rather than enforcing my ideas.* Due to the success achieved this year we are planning to deliver another six ADP courses to Islington and Haringey professionals in 2018/19.

Priority 5

This priority aimed to discover whether attending the Turkish language Access Group prior to intervention led to benefits in terms of therapeutic outcomes and engagement. In assessing the impact of the course, the project used a number of quantitative variables which showed no difference between people who attended the group prior to intervention, and those who received only an intervention, suggesting the group does not lead to improvements in these areas.

A number of reasons have been identified which may explain the feedback, including confusion about the purpose of the group (29% of respondents reported that the group was not helpful as it did not improve their symptoms. However, this is not what the group aimed to do; rather it aimed to enable clients to benefit more from their intervention). However, despite this 79% of respondents indicated that the group was helpful to them.

These results suggest several future directions for the Turkish language Access Group. Firstly, the purpose of the group needs to be clearly explained, and participants' expectations discussed at the beginning of the first session. Secondly, it could be useful to consider the mix of diagnoses present in a group. Although practical considerations limit the ability to have diagnosis specific groups (and the evidence base does not indicate it is desirable), it may be useful to note if one person has a very different need to others.

Part 4: Other Information

Local Performance Indicators

Goal	Standard/benchmark	Whittington Performance	
		17/18	*16/17*
ED 4 hour waits	95% to be seen in 4 hours	**89.43%**	87.4%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	**92.2%**	93.0%
RTT patients waiting 52 weeks	No patients to wait more than 52 weeks for treatment	**5**	0
Waits for diagnostic tests	99% waiting less than 6 weeks	**99.1%**	99.5%
Cancer: Urgent referral to first visit	93% seen within 14 days	**94.7%**	96.2%
Cancer: Diagnosis to first treatment	96% treated within 31 days	**100.0%**	100.0%
Cancer: Urgent referral to first treatment	85% treated within 62 days	**87.5%**	87.4%
Improved Access to Psychological Therapies (IAPT)	75% of referrals treated within 6 weeks	**96.0%**	94.5%

The Whittington Health NHS Trust considers that this data is as described because it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

In 2017/18 the trust has performed well compared to benchmarking for local performance indicators and has exceeded standards for Cancer, IAPT, diagnostic test and RTT 18 week waits. However, there are two areas where the trust has not met these standards and is taking the following actions to achieve the 'ED 4 hour wait' and 'RTT patients waiting 52 weeks' goals.

Examples of actions include:

- Establishing better and more robust pathways between the emergency department triage service and specialist inpatient assessment units.
- Revision and recruitment of the emergency department workforce in order to facilitate rapid assessment treatment (RAT) criteria led discharges
- Developing enhanced roles for nurses and health care assistants within the emergency department.
- Establishing a Frailty Pathway that enables early frailty team input to optimise management/ discharge support and reduce Length of Stay (LoS) and readmission rates
- Training and promotion of a pre-11 a.m discharge culture
- System wide improvement: working with Haringey and Islington and the wider Sustainability and Transformation Programmes to improve the performance of ED.

Summary Hospital-Level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following admission to hospital and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI score represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly below 100 indicate a lower than expected number of mortalities (and vice versa for values significantly above).

Patients who are coded as receiving palliative care are included in the calculation of the SHMI. The SHMI does not make any adjustment for patients who are coded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care.

Using the most recent data published in March 2018 which covers the period from October 2016 to September 2017, the SHMI score for the Whittington is 0.727

Lowest National Score: 0.727 (Whittington Health NHS Trust)
Highest National Score: 1.247

The Whittington Health NHS Trust considers that this data is as described as it is produced by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health is taking the following actions to further improve this score and the quality of its services, by:
• Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;
• Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed

Annex 1: Statements from external stakeholders

Statements from Commissioners and local Healthwatch organisations

Healthwatch Islington feeback

"Healthwatch Islington hosted a meeting with Whittington colleagues about the Quality Account objectives. We discussed progress from last year and areas of focus for the year ahead.

We are liaising with the Trust around community services, waiting times continue to be long and administration of appointments could be improved. We hope to work with the Trust on improving this in the year ahead.

We welcome the Trust's work to develop their Patient Experience Strategy ".

Best wishes

Emma Whitby, Chief Executive

healthwatch Islington

Healthwatch Haringey feedback

We agree with the patient experience priorities for 2018/19, subject to the comment below, and note that they have been identified in consultation with patient representatives.

An area of concern which has been highlighted in performance reports but not referenced in the Quality Account relates to the Memory Clinic and the very significant gap between the target and actual waiting times. We would like to see this identified as a priority for improvement in 2018/19.

We look forward to working with the patient experience committee to monitor progress against the targets and working in partnership with the Trust over the coming year.

Mike Wilson

Director

healthwatch Haringey

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

By writing to:

The Communications Department,
Whittington Health,
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The Whittington Health NHS Trust 2017-18 Quality Account will be published on the NHS Choices website on the 29th June 2018.

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Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, in particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes;
- Papers relating to the Quality Account reported to the Board;
- Feedback from Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment;
- feedback from Commissioners;
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Trust Board

30 May 2018

Title:	April (Month 1) 2018/19 – Financial Performance		
Agenda item:	**18/077**	**Paper**	**6**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust is reporting a £0.4m deficit at the end of April (month 1) against a planned deficit of £0.3m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.1m. The key drivers for the adverse variance are the performances against income and against depreciation. The combined pay and non-pay expenditure position is favourable against plan.		
Summary of recommendations:	To note the financial results relating to performance during April 2018		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	22 May 2018		

Author name and title:		**Anis Choudhury Head of Financial Planning and Analysis**		**Director name and title:**		**Stephen Bloomer Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Financial Overview

The Trust is reporting a £0.4m deficit at the end of April (month 1) against a planned deficit of £0.3m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.1m.

The key driver for the adverse performance is the continued use of escalation beds throughout April which are not funded either through base budget allocation or separate winter resilience funding. The beds drove an increased direct pay cost of £0.2m which was primarily flexible staffing including agency with additional costs being incurred in support services e.g. Estates and Facilities. The beds do not attract the same level of income as the majority of patients are long stay and have exceeded the tariff trim point and therefore attract only excess bed day payments.

Statement of comprehensive income

2018/19, Month 01 (April 2018)

Statement of Comprehensive Income	Month 1 TFMS Plan (£000s)	In Month Actual (£000s)	Variance (£000s)	Full Year Plan (£000s)
NHS Clinical Income	22,513	22,767	254	262,754
Sustainability & Transformation Funding (STF)	*469*	*469*	0	*9,380*
	22,982	23,236	254	272,134
Non-NHS Clinical Income	1,468	1,146	(322)	17,616
Other Non-Patient Income	2,128	1,949	(179)	36,187
Total Income	**26,578**	**26,331**	**(247)**	**325,937**
Pay	(18,651)	(18,928)	(277)	(222,445)
Non-Pay	(6,953)	(6,382)	571	(82,986)
Total Operating Expenditure	**(25,604)**	**(25,310)**	**294**	**(305,431)**
EBITDA	**974**	**1,021**	**47**	**20,506**
Depreciation	(540)	(706)	(166)	(6,480)
Dividends Payable	(430)	(407)	23	(5,174)
Interest Payable	(276)	(281)	(5)	(3,341)
Interest Receivable	1	6	5	12
P/L on Disposal of Assets	0	0	0	0
Total	**(1,245)**	**(1,388)**	**(143)**	**(14,983)**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(271)**	**(367)**	**(96)**	**5,523**
Add back impairments and adjust for IFRS & Donate	(7)	(7)	0	848
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(264)**	**(360)**	**(96)**	**4,675**

Income & Activity

In terms of monthly income run-rate April has reduced working days, caused by a bank holiday and therefore has a lower plan. Clinical income overall was below plan despite having additional unplanned bed capacity available for the whole month.

Planned care Elective, Day Case and Outpatients were below plan by £0.4m despite operational emphasis to drive performance in these areas in the first quarter as traditionally this has been challenging to the organisation. The Medicine and Surgery ICSUs were furthest from plan primarily in Trauma and Orthopaedics and General Surgery. Unplanned care was ahead of plan by £0.4m driven primarily by non-elective inpatients.

Other income was behind plan driven primarily by lower education income which is likely to be phasing.

The tables below provide the split of income and activity by category.

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
Accident and Emergency	944	929	(15)	944	929	(15)
Adult Critical Care	619	517	(102)	619	517	(102)
Community Block	5,934	5,934	(0)	5,934	5,934	(0)
Day Cases	1,136	1,019	(118)	1,136	1,019	(118)
Diagnostics	248	252	3	248	252	3
Direct Access	974	953	(21)	974	953	(21)
Elective	782	584	(197)	782	584	(197)
Maternity - Deliveries	1,152	873	(279)	1,152	873	(279)
Maternity - Pathways	735	731	(4)	735	731	(4)
Non-Elective	3,109	3,925	816	3,109	3,925	816
OP Attendances - 1st	880	905	25	880	905	25
OP Attendances - follow up	785	711	(74)	785	711	(74)
Other Acute Income	3,286	3,124	(163)	3,286	3,124	(163)
Outpatient Procedures	378	389	11	378	389	11
Total SLA	**20,962**	**20,845**	**(117)**	**20,962**	**20,845**	**(117)**
Marginal Rate	0	0	0	0	0	0
	20,962	**20,845**	**(117)**	**20,962**	**20,845**	**(117)**
Other Clinical Income	3,510	3,535	25	3,510	3,535	25
Other Non Clinical Income	2,106	1,953	(153)	2,106	1,953	(153)
Total Other	**5,616**	**5,488**	**(128)**	**5,616**	**5,488**	**(128)**
Grand Total	**26,578**	**26,332**	**(245)**	**26,578**	**26,332**	**(245)**

Category	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	5,794	5,847	53	5,794	5,847	53
Adult Critical Care	537	445	(92)	537	445	(92)
Day Cases	1,465	1,396	(69)	1,465	1,396	(69)
Diagnostics	2,516	2,514	(2)	2,516	2,514	(2)
Direct Access	95,518	90,268	(5,250)	95,518	90,268	(5,250)
Elective	199	170	(29)	199	170	(29)
Maternity - Deliveries	315	238	(77)	315	238	(77)
Maternity - Pathways	694	695	1	694	695	1
Non-Elective	1,701	1,783	82	1,701	1,783	82
OP Attendances - 1st	4,879	4,940	61	4,879	4,940	61
OP Attendances - follow up	12,651	11,365	(1,286)	12,651	11,365	(1,286)
Other Acute Income	12,124	10,673	(1,451)	12,124	10,673	(1,451)
Outpatient Procedures	2,179	2,398	219	2,179	2,398	219
Grand Total	**140,571**	**132,732**	**(7,839)**	**140,571**	**132,732**	**(7,839)**

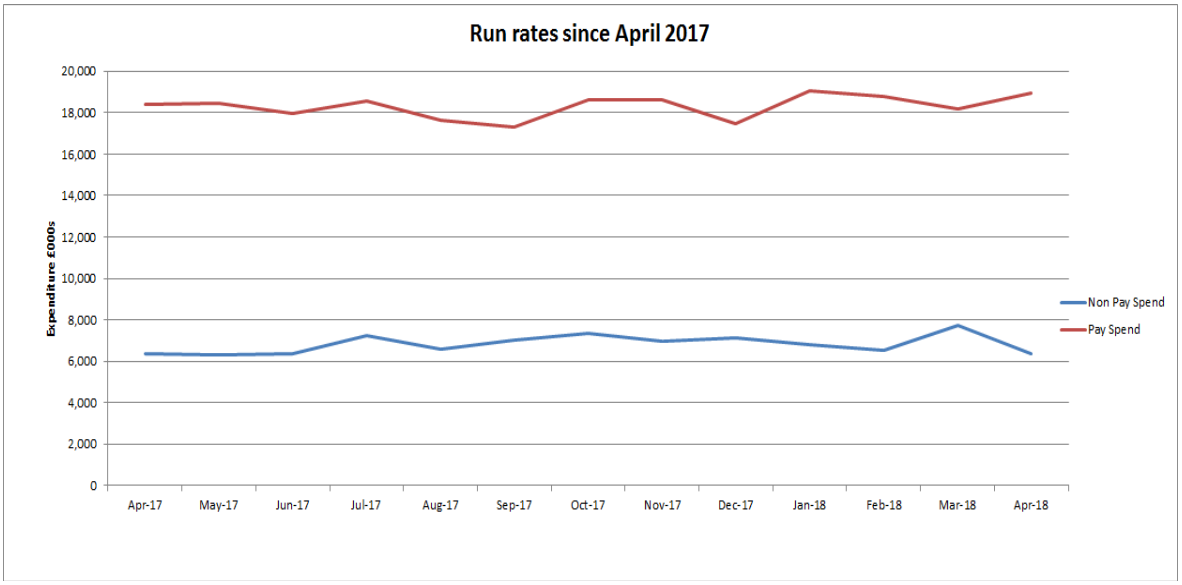
Monthly Run Rates – Expenditure

The combined expenditure position is favourable driven by a non-pay variance. The highlights are:

- **Pay**
  - Total pay expenditure for April was £18.9m, which is £0.7m higher than both the month 12 pay spend and the twelve month rolling average.
  - It is worth noting that the Trust has accrued a notional 1% pay rise for all substantive staff to mirror the inflator applied to the national tariff and therefore reflected in the Trusts income position, this equated to a cost of £0.2m for April. Whilst it is highly likely, the formal confirmation of the new agenda for change pay settlement has not been received so there will be a further uplift to the pay costs. It is assumed that this will be funded centrally and it will not impact on the Trust's bottom line position.
  - During April the Trust continues to operate additional winter escalation bed capacity. The cost of this was £0.2m.
  - Within total pay expenditure agency staff related costs were £1.0m. This is 5.5% of the total pay costs for the month down from 6.2% in month 12 but higher than the 4.3% average for 2017/18. It is also £0.1m less than the month 12 total. The agency ceiling target for 2018/19 target is £8.8m (£9.5m 17/18) and therefore the reduction in month 1 was not at the required level to achieve the target for the year.

- **Non Pay**
  - Non pay expenditure for April was £6.4m, which is £0.5m lower than average in 2017/18 and £0.3m (£1.4m in total) less than the recurrent month 12.
  - April's lower non pay spend is aided by £140k reduction on medical supplies and equipment due to expected costs for 2017/18 not materialising and being released.

The graph below provides the pay and non-pay expenditure run rates over a 13 month period from April 2017 to April 2018.

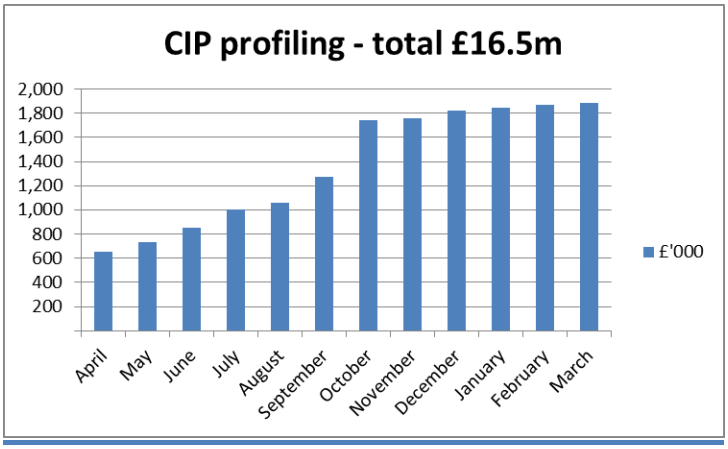


Cost Improvement Programme

The Trust has a challenging CIP target for 2018/19 of £16.5m (5%). The plan is split between a 2% target for cost improvement within each ICSU (£5.2m), flow through of benefit from 2017/18 (£2.7m) area and £8m as large centrally driven schemes.

At the end of month one the Trust has £14.5m worth of plans (88%) of the target but risk adjusted this is reduced to £10.4m (63%) of the target. The PMO is continues to work with the ISCU's and corporate functions to identify and develop plans to ensure delivery and Trust Management Group is overseeing progress and responsible for taking corrective actions.

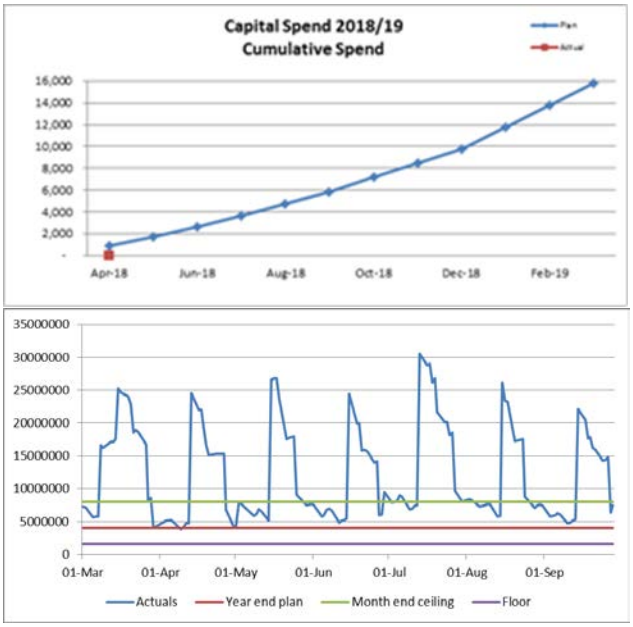
The key achievement in month one was the closure of 5 intensive care beds in Surgery.



The Trust is targeting planned schemes above the £16.5m requirement. The £19m initial expectation has been developed to allow for slippage of schemes that are either delayed in delivery or do not meet the quality impact assessment criteria.

£k	Area	Initial Expectation	# Schemes	In Year Value	%	Gap	Risk Adjusted Value	%	Gap
	Flow Through	3,000	74	2,673		-327	2,417		-583
	SUBTOTAL	**3,000**	**74**	**2,673**	89%	**-327**	**2,417**	81%	**-583**
ICSUs	CSS	600	28	638	106%	38	449	75%	-151
	CYP	940	10	555	59%	-385	424	45%	-516
	EUC	500	8	440	88%	-60	280	56%	-220
	IM	710	17	658	93%	-52	554	78%	-156
	PPP	290	14	267	92%	-23	153	53%	-137
	SUR	910	32	967	106%	57	674	74%	-236
	WH	360	21	397	110%	36	353	98%	-7
	IM&T	130	6	181	139%	51	136	104%	6
	E&F	510	14	728	143%	218	546	107%	36
	CORP	340	20	319	94%	-21	255	75%	-85
	SUBTOTAL	**5,290**	**170**	**5,148**	97%	**-142**	**3,822**	72%	**-1,468**
Transformation	ICU	1,000	1	500	50%	-500	375	38%	-625
	Income opportunities	250	2	250	100%	0	225	90%	-25
	Outpatients	3,000	8	3,000	100%	0	1,625	54%	-1,375
	Community	2,000	24	1,588	79%	-413	885	44%	-1,115
	IMV	1,000	7	750	75%	-250	672	67%	-328
	Networking	2,000	10	261	13%	-1,740	136	7%	-1,864
	Organisational Structure	500	1	350	70%	-150	263	53%	-238
	Trust wide schemes	1,000	4	10	1%	-990	10	1%	-990
	SUBTOTAL	**10,750**	**57**	**6,708**	62%	**-4,042**	**4,190**	39%	**-6,560**
	TOTAL	**19,040**	**301**	14,529	76%	**-4,511**	10,430	55%	**-8,610**
	CIP DELIVERY REQUIRED	**16,500**			88%	**-1,971**		63%	**-6,070**

Statement of Financial Position



THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 30 April 2018	Plan 30 April 2018	Year to Date Plan variance 30 April 2018
	£000	£000	£000
Property, plant and equipment	214,414	216,740	(2,326)
Intangible assets	4,743	4,311	432
Trade and other receivables	749	656	93
Total Non Current Assets	**219,906**	**221,707**	**(1,801)**
Inventories	1,425	1,355	70
Trade and other receivables	34,740	29,001	5,739
Cash and cash equivalents	4,147	4,605	(458)
Total Current Assets	**40,312**	**34,961**	**5,351**
Total Assets	**260,218**	**256,668**	**3,550**
Trade and other payables	41,649	35,626	6,023
Borrowings	20,195	1,865	18,330
Provisions	1,391	1,391	0
Total Current Liabilities	**63,235**	**38,882**	**24,353**
Net Current Assets (Liabilities)	**(22,923)**	**(3,921)**	**(19,002)**
Total Assets less Current Liabilities	**196,983**	**217,786**	**(20,803)**
Borrowings	38,282	59,501	(21,219)
Provisions	943	842	101
Total Non Current Liabilities	**39,225**	**60,343**	**(21,118)**
Total Assets Employed	**157,758**	**157,443**	**315**
Public dividend capital	64,679	64,679	0
Retained earnings	(5,463)	(5,809)	346
Revaluation reserve	96,542	96,573	(31)
Total Taxpayers' Equity	**157,758**	**157,443**	**315**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Overall, the value of the balance sheet is £0.3m away from plan. Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £1.9m lower than plan for two reasons (1) the planned expenditure is £0.8m less as no capitalised expenditure has occurred in month 1 (2) the opening balance was £1.1m below originally expected levels due to a change in planning assumptions;

- **Receivables (Debtors)** are £5.8m more than plan driven by bonus STF funding received in month 12 which is unpaid;

- **Payables (Creditors)** are currently £6m driven primarily by capital creditors from months 11 and 12

- **Borrowings:** there is currently a significant difference between the operating plan submission and the month 1 reporting of the split between the value of loans repayable in less than 1 year and those repayable in more than 1 year. This discrepancy is caused by NHS Improvement (NHSI) requesting a differing treatment of the loan repayments in the operating plan submission compared to terms on the loan agreement. The Trust is still in discussion with NHSI to clarify loan repayments terms.

- **Cash and cash flow:** overall The Trust is holding £4.1m in cash as at the end of April 2018 (£0.4m lower than plan). The Trust has modelled its cash flow for the whole of 2018-19 to assess whether/when cash support will be required. The chart above shows the results of the current modelling and reflects the assumptions used in the revised 2018-19 planning submission to NHSI in April 2018 and concluding that no cash support should be required during 2018/19. As a result of the scheduled receipt of £4.5m in additional STF funding, the forecast cash flow line currently sits ahead of plan for most of the year.

Executive Offices
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Whittington Health NHS

Whittington Health Trust Board
Wednesday 30th May 2018

Title:	Trust Performance report April 2018 (March 2018 data)		
Agenda item:	**18/078**	**Paper**	**7**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Performance against the 95% target for April was 86.32%. Activity was up on last year by 4.2%, 8646 attendances (April 18) against 8285 (April17). Ambulance activity was up by 8% compared to the same time last year; 1775 (April 18) compared to 1641 (April 17). An extensive improvement plan is in place and is monitored at the AE delivery board (AEDB) chaired by CEO (Whittington Health) **Complaints** Under achieving after 2 month of achieved target. Plan being developed to improve the quality and timeliness of responses. **Community waiting times** As part of the Community Improvement Programme a revised community dashboard was expected to be ready for the May Board 2018, however this has been delayed until June 2018. **eRS** From 16th April Whittington Health have been accepting all GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System. GP's use of making referrals using eRS is increasing rapidly, showing over 80% in May 18. The increase in slot issues is a reflection of capacity and demand within services. All service managers are reviewing the services' slot capacity daily.		
Summary of recommendations:	That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	N/A		
Reference to risk and corporate risks on the BAF:	N/A		
Date paper completed:	22nd May 2018		

Author name and title:		**Hester de Graag, Risk and Quality Manager**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Whittington Health NHS

Integrated Performance Report

May 2018

Month 1 (2018 – 2019)

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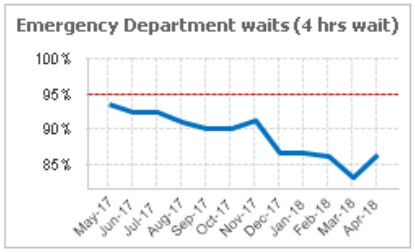
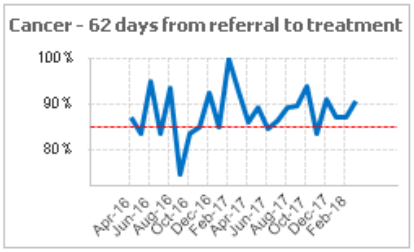
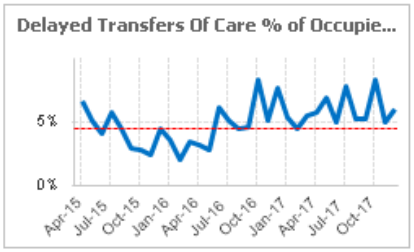
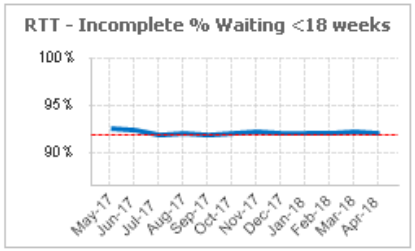
Summary Page - Indicators

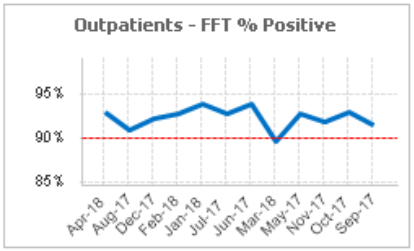
Category	Indicator	17_18 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	>95%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	86.3%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	68	63	59	64	72	82	82	81	75	77	95	91	91
Cancer	Cancer - 14 days to first seen	>93%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%		
Cancer	Cancer - 62 days from referral to treatment	>85%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%		
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.0%	5.8%	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.4%	6.4%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	6.9%	5.0%	7.8%	5.2%	5.2%	8.3%	5.0%	6.0%	7.3%	6.2%	6.1%		
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.1%
Outpatients	Outpatients - FFT % Positive	>90%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	93.0%
Community	Community - FFT % Positive	>90%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	96.2%
Staff	Staff - FFT % Recommend Care	>70%		69.0%			69.4%			70.6%			75.0%		

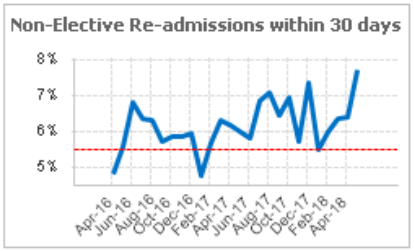












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	3	0	1	0	1	3	0	0	0	1	0	1	1	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	44	45	34	31	27	34	28	35	38	27	43	37	37	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	2	3	2	2	3	3	3	3	9	3	3	2	2	
All Areas	Harm Free Care %	>95%	93.9%	96.6%	93.5%	93.9%	95.1%	94.1%	93.5%	94.2%	93.4%	92.2%	93.9%	93.5%	93.5%	
Maternity	Non Elective C-Section % Rate	<15%	18.9%	19.7%	22.5%	18.8%	19.8%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	17.2%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	0	1	0	0	0	0	1	0	1	0	0	0	0	
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	16.6%	18.3%	17.3%	21.7%	17.1%	16.5%	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	19.8%	
All Areas	Serious Incidents	0	4	4	3	6	2	5	2	0	7	1	2	6	6	
Admitted	VTE Risk Assessment %	>95%	95.4%	95.6%	95.3%	96.7%	96.0%	95.3%	96.0%	95.2%	95.1%	95.2%	96.2%			

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Safe Services - Commentary

HCAI C Difficile
The trust reported 1 HCAI C Difficile. All actions were completed.

Falls
There were 37 falls reported in April 2018. Four low harm incidents and 1 moderate fall. The moderate patient harm fall was investigated using the 72 hour report process and an Internal RCA will be completed.

Pressure Ulcers
In April 18 there were two reported avoidable pressure ulcers attributed to district nursing. Whilst under the care of South West Islington DN team a patient developed a category 3 pressure ulcer and a patient under the care of North Islington DN team developed a category 4 pressure ulcer. In both instances the service delivery issue identified was that the patients had not had full holistic assessments completed as per policy. Therefore there was no prevention plan or carer information was provided.

An action plan which captures all the recurring themes from these incidents and previous incidents is being shared across the district nursing service so all teams can learn from the incidents.

Harm Free Care
This figure included new and old harm and scores consistently under the target due to the number of Pressure Ulcers in the community.

Safe Services - Commentary

Non Elective C-section rate

17.2% - Increase from previous month (14.5%). The service has seen an increase in induction of labour rates and a proportion of these patients would then go ono to have an emergency section. There has been a national increase in inductions as a result of the introduction of the 'Saving babies lives' Bundle, which raises awareness of reduction in foetal movement and heart rate. Working group has been developed to review the induction pathway and will start shortly.

Serious Incidents

1. [CYP] 2018.10532 Confidential information leak/information governance breach meeting SI criteria
2. [EUC] 2018.9654 Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria
3. [EUC] 2018.9647 Sub-optimal care of the deteriorating patient in District Nursing meeting SI criteria
4. [CSS] 2018.8996 Confidential information leak/information governance breach meeting SI criteria
5. [WFS] 2018.8303 Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)
6. [WFS]2018.8308 Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	87.4%	84.0%	85.5%	83.0%	80.4%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	78.7%	
ED	ED - FFT Response Rate	>15%	15.6%	13.8%	13.1%	13.7%	12.6%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	15.2%	
Admitted	Inpatients - FFT % Positive	>90%	94.2%	97.0%	95.8%	95.2%	97.7%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.3%	
Admitted	Inpatients - FFT Response Rate	>25%	22.7%	19.8%	20.9%	14.9%	16.0%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	16.4%	
Maternity	Maternity - FFT % Positive	>90%	90.2%	88.1%	92.7%	89.4%	92.4%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	95.8%	
Maternity	Maternity - FFT Response Rate	>15%	22.2%	20.1%	23.5%	30.1%	18.5%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	58.5%	
Outpatients	Outpatients - FFT % Positive	>90%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	93.0%	
Outpatients	Outpatients - FFT Responses	400	623	537	485	338	433	569	593	336	420	461	249	327	327	
Community	Community - FFT % Positive	>90%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	96.2%	
Community	Community - FFT Responses	1500	1192	970	1224	858	940	731	638	605	875	1157	779	1206	1206	
Staff	Staff - FFT % Recommend Care	>70%		69.0%			69.4%			70.6%			75.0%			
All Areas	Complaints responded to within 25 working day	>80%	83.3%	93.9%	76.0%	81.0%	72.2%	72.7%	68.8%	88.2%	76.9%	87.5%	92.0%	71.4%	71.4%	
All Areas	Complaints (including complaints against Corporate division)	N/A	24	38	32	24	25	26	24	18	30	21	33	33	33	

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Caring Services - Commentary

FFT

ED has again met the target response rate of 15%, with 15.2% of patients discharged completing the FFT. This is the second time in three months that ED has exceeded the response rate target, and this spell marks the first time that has occurred since April and May 2017. Patient recommend rates remain below 80% in ED for a second consecutive month (March 2018 77%, April 2018 79%). The patient experience team are working with the ED matron on completing the patient experience action plan for the area.

Inpatient responses remain the same as they were for March 2018, with a 96% recommend rate and a 16% response rate in April 2018. Day-case reporting in the area continues to return a lower proportion of responses than the inpatient wards, with a 6% response rate in April 2018. The patient experience team will work with the Day-case teams to improve the FFT responses.

Outpatients improved their recommend and response rates from March: recommend rates improved from 89.6% in March to 93% in April; number of responses improved from 249 in March to 327 in April.

Community responses have improved to their second highest number of responses over the past 12 months, with 1,206 in April. The recommend rate remains high at 96%. The maternity areas continue to excel with an improved response rate of 58.5% in April and a recommend rate of 95.8%.

FFT quotes from Bridges Rehab Ward:

- *I have enjoyed it here and I didn't want to go. I was looked after well very caring staff. I shall miss you all*
- *Doctors professional and nice*
- *Pretty good*
- *Enjoyed my stay and staff all the team was good*

Caring Services - Commentary

Complaints

During April 2018 the Trust closed 33 complaints; 28 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 71%.

- Three complaints allocated 25 working days remain outstanding and overdue, i.e. IM (2) and EUC (1).
- In addition, three 40 working day complaints also remain outstanding and overdue, i.e. IM (2) and S&C (1).
- 20% of complaints (1) allocated 40 working days hit their target.

The majority of complaints were allocated to EUC 30% (10), IM 27 % (9) and S&C 24% (8).

Severity of complaints: 42% (14) were designated 'moderate', 52% (17) were designated 'low' risk and 6% (2) were designated 'high'.

- Of the two complaints designated high risk, one related to 'medical care' (i.e. inadequate treatment provided), and one related to 'admission, discharge transfer arrangements' (i.e. patient discharged too early).

A review of the complaints for April shows that 'medical care' 27% (9) continues to be the main issue for patients. In April this was followed by 'attitude' 12% (4) and 'nursing care' 12% (4).

- In regard to 'medical care,' 67% of patients (6) felt that 'inadequate treatment' had been provided, with the remaining 3 complaints indicating 'no treatment', 'missed diagnoses' and 'no diagnoses'.
- In regard to 'attitude', 50% of patients (2) stated that staff had displayed 'inappropriate behaviour'. The remaining two complaints indicated that staff were 'rude and/or disrespectful' and 'inconsiderate/uncaring/dismissive'.
- In regard to 'nursing care', 100% of the complaints received indicated that 'a poor standard of care' had been provided.

Of the 27 complaints that have closed, (including those allocated 40 working days), 41% (11) were 'upheld', and 22% (6) were 'partially upheld' meaning that, currently, 63% have been upheld in one form or another.

Development of an action plan is in progress to address areas of complaints management; improving response time and quality of responses and will include discussion between PALS and Complaints and the ICSU.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	91.6%	93.3%	94.5%	92.3%	93.2%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	95.4%	95.4%	
Maternity	Smoking at Delivery	<6%	3.4%	5.7%	7.5%	4.8%	7.1%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	7.0%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.0%	5.8%	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.4%	6.4%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	83.7	75.5	69.6	77.0	44.6	86.3	89.6	75.2						
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	76.7	104.5	71.8	91.6	38.2	98.9	96.9	44.6						
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14		0.73			0.73									
Admitted	Mortality rate per 1000 admissions in-months	14.4	7.6	6.5	6.4	7.2	2.6	8.6	8.5	12.0	9.4	9.9	10.3	7.3	7.3	
Community	IAPT Moving to Recovery	>50%	53.0%	56.4%	52.3%	56.5%	55.1%	50.8%	53.0%	50.9%	47.5%	51.4%	59.4%			
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%					85.0%	94.1%	84.4%	71.7%	93.0%	78.9%	87.5%	90.3%	90.3%	

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Effective Services - Commentary

Smoking at delivery

Smoking at delivery has increased to 7%; however the overall 5.4% average remains within target. April is also a low birth month traditionally (average birth a month is over 300 births) and this affects the figures (20/285).

The service has been proactive in updating staff training as well as ensuring machines are calibrated and functioning. Coding for offer of CO screening is still not correct on Medway. 0 is used for declining the screening as well as not offered and this is problematic, but there is no immediate solution.

We have met with smoking cessation providers to strengthen our referral pathways and reporting mechanisms.

Non Elective re-admission within 30 days

Re-admission rate for the trust remained 6.4%.

Discharge to assess pathway 1 (Islington) readmissions are being audited on-going on a monthly basis and will be reported on a quarterly basis hence forth (Apr - Jun etc).

Bridges rehab pathway 2; 2017 readmission audit in process and will be available to report June 2018.

Speech and Language Therapy in hospital: Re-admission monitored closed and going up: March: 2.9% and April: 3%.

Medical wards Quality Improvement project completed for the month of February and March 2018 and key recommendations were:

- Sharing details of care agency on discharge
- Liaise with frailty fellow to do a ‘census’ of available services and identify opportunities for intermediate care of group at high risk of readmission (Rockwood score of ≥6).
- Improved identification of moderate – severe frailty and ‘last year of life’. Liaison with palliative care on the development of pathways and services to continue ACP / TEP / DNAR in community and better early communication with GP.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	86.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	68	63	59	64	72	82	82	81	75	77	95	91	91	
ED	Ambulance handovers waiting more than 30 mins	0	14	40	27	23	35	38	15	34	34	37				
ED	Ambulance handovers waiting more than 60 mins	0	0	7	4	2	1	0	3	11	12	3				
ED	12 hour trolley waits in A&E	0	4	3	2	4	3	0	0	0	0	0	0	0	0	
Cancer	Cancer - 14 days to first seen	>93%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%			
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	94.1%	100.0%	100.0%	95.9%	98.1%	98.9%	100.0%	100.0%	97.9%	95.0%	97.0%			
Cancer	Cancer - 62 days from referral to treatment	>85%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%			
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Cancer	Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Cancer	Cancer - 62 Day Screening	>90%		100.0%		100.0%										
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.1%	99.0%	99.0%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.1%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	3	1	1	0	0	0	0	0	0	0	0	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1		
Indicator	17_18 Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	2018-2019	Performance
Breast	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%			
Gynaecological	>85%	100.0%	0.0%	50.0%	66.7%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%			
Haematological (Excluding Acute Leukaemia)	>85%	50.0%	100.0%				100.0%					100.0%			
Lower Gastrointestinal	>85%	100.0%		87.5%	50.0%	100.0%	71.4%	76.9%	85.7%	75.0%	66.7%	100.0%			
Lung	>85%		100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	50.0%				
Other	>85%											100.0%			
Skin	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%		100.0%	100.0%	100.0%			
Testicular	>85%	100.0%	100.0%		100.0%										
Upper Gastrointestinal	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	66.7%	0.0%	50.0%				
Urological (Excluding Testicular)	>85%	80.0%	61.5%	57.1%	50.0%	57.1%	94.1%	100.0%	83.3%	100.0%	100.0%	66.7%			
Sarcoma	>85%							0.0%				50.0%			

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2017-2018	Performance
Breast	>93%	94.8%	98.6%	99.2%	93.9%	98.3%	98.7%	97.3%	99.0%	98.8%	95.1%	95.4%		97.1%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Gynaecological	>93%	97.8%	96.5%	96.2%	100.0%	100.0%	96.5%	100.0%	100.0%	96.2%	98.5%	94.4%		97.8%	
Haematological	>93%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	88.9%	100.0%	100.0%	50.0%	83.3%		93.3%	
Lower Gastrointestinal	>93%	87.3%	93.9%	89.3%	88.0%	89.7%	79.7%	93.9%	90.6%	87.2%	90.7%	91.8%		89.4%	
Lung	>93%	100.0%	92.9%	100.0%	100.0%	90.5%	100.0%	84.2%	100.0%	96.2%	95.2%	94.1%		95.4%	
Other	>93%	100.0%												100.0%	
Skin	>93%	99.4%	98.6%	99.4%	99.4%	98.7%	97.1%	100.0%	100.0%	98.0%	98.6%	99.3%		98.9%	
Upper Gastrointestinal	>93%	43.3%	77.6%	83.8%	79.5%	57.7%	77.8%	78.8%	60.0%	73.5%	80.8%	98.3%		76.8%	
Urological	>93%	100.0%	95.7%	98.2%	100.0%	95.9%	100.0%	98.5%	100.0%	98.9%	97.3%	95.5%		98.1%	

Community Average Waits

Community Average Waits from Referral Received Date to Date First Seen – April 2018

Local Specialty Code	Routine Avg Adjusted Wait (in weeks)	Routine Target	Total Routine Patients 1st Seen	Urgent Avg Adjusted Wait (in weeks)	Urgent Target	Total Urgent Patients 1st Seen
Adult Wheelchair Service	3.8	12	31			0
Bladder And Bowel Management	17.8	12	114	21.57	2	1
CAMHS	6.5	8	136	0 Days	5 Days	1
Cardiology Service	2.2	6	26	2.86	2	2
Child Development Services	11.2	18	50			0
Community Children's Nursing	1.0	18	73	0.04	6	4
Community Paediatrics Services	11.6	16	19	5.74	6	40
Community Rehabilitation (CRT)	3.4	12	127	2.16	2	35
Community Rehabilitation (ICTT)	5.6	12	250	5.41	2	73
Diabetes Service	5.4	6	97	0.71	2	3
Family Nurse Partnership	4.5	12	18			0
Health Visiting	2.2	8	1023	12.07	2	2
Intermediate Care (REACH)	4.1	6	92	1.88	2	19
Looked After Children	3.5	52	9			0
Lymphodema Care	4.3	6	14			0
Musculoskeletal Service - CATS	4.6	18	280	2.71	6	1
Musculoskeletal Service - Routine	3.8	8	1483	1.66	2	21
Nutrition and Dietetics	4.6	8	176			0
Occupational Therapy	19.1	18	26			0
Paediatric Wheelchair Service	6.5	12	10			0
Physiotherapy	7.7	18	96			0
PIPS	3.4	12	6			0
Podiatry (Foot Health)	6.2	8	569	2.47	2	10
Respiratory Service	4.6	6	75	8.28	2	31
School Nursing	4.4	12	66			0
Speech and Language Therapy	9.5	18	150			0
Tissue Viability Service		-	0	1.59	2	65

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Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time

Performance against the 95% target for April was 86.32%. This was unfortunately lower than April 2017 which was at 91.14%. Q1 performance (18/19) was 86.83% which was lower than the same quarter the year previous (92.36%). Overall performance against the 95% target for 17/18 improved in comparison to 16/17, where we reported 89.43%, an increase of 3% on 16/17.

Activity was up on last year by 4.2%, 8646 attendances (April 18) against 8285 (April17). The situation this year was exacerbated by an increase in complex DTOCS and high acuity on the wards.

Ambulance activity was up by 8% compared to the same time last year; 1775 (April 18) compared to 1641 (April 17).
Ambulance handover time 30 and 60 minutes has not yet been validated on the LAS portal.

Actions: The trust has implemented weekly MADE (Multiple Discharge Events), attended by senior representatives from both Haringey and Islington which aim to increase to bi-weekly (Tues and Thurs) from May 2018.

There is also continued focus on medically optimised < 2 %, over 21 day 'stranded patients' < 18% and over 7 days 'stranded patients' <40%.

The following are the main areas of focus specific to ED:

- RAT (Rapid Assessment and Treatment) refocus and achieve target time to treat.
- Fit to Sit: In place from end of February 2018 and overseen by Lead Matron. To create cubicle/assessment capacity to optimise flow within ED department.
- Percentage of ED Activity Diverted to AEC: due to a system update this data is currently not available for April 2018.
- A review of Consultant, Registrar and Junior Doctor shift times (in line with demand) is taking place to ensure the department has the right capacity at the right time to manage demand.

The improvement is monitored at the AE delivery board (AEDB) chaired by CEO (Whittington Health)

Responsive Services - Commentary

Cancer

The cancer standard for 2ww, 31 day and 62 day has been achieved by the Trust overall for Q1, Q2, Q3 and Q4.
The areas which are under the standard as individual tumour groups are:

2ww: Upper GI: 91.78%, 12 breaches out of 146
Haematology: 83.33%, 1 breach out of 6

Action: Endoscopy has increased the number of target lists from 9 to 10 on a weekly basis since beginning of April.

62 day report: Gynaecology: 0% 0.5 breach out of 0.5. Incidental findings, patient referred from Haematology at 38 day on the pathway then transferred to UCLH.
Sarcoma: 92% 0.5 breach out of 6.5 , Shared breach with RFH.
Urology: 66% 2 x 0.5 breach out of 3, 1 shared breach with UCLH & 1 shared breach with RFH .

Action: work in progress with Imaging to improve diagnostic turnaround time which will improve ITT compliance.

Community waits

Bladder and bowel: the service is acknowledged to have ongoing challenges around recruitment and increasing demand which are replicated nationally. It is now part of the Community Services Improvement Project and has a project plan in place focusing on making operational efficiencies and skill mixing with a planned improvement in waiting times.
Cardiology: Improving, last month 3.14 weeks, this month 2.86 weeks. Some small delays related to patient choice.
Community rehab ICTT and CRT: SLT are struggling to meet two week capacity and action plan in place.
Health visiting: 2x cases showing as 12 weeks wait for urgent waits (target 2 days) - data inputting error. Actions in place to improve PTL.
Occupational Therapy: Due to OT vacancies and difficulties in recruiting; currently recruiting to B7 and B8a starting in July 2018.
Podiatry: Improving, last month 3.23 weeks, this month 2.47 weeks. Podiatry is part of the Community Improvement project.
Respiratory Services: Routine referrals are incorrectly graded as urgent referrals at Central Booking level. Plan in place to correct this for July 2018 Performance report.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	9	9	2	6	8	15	9	10	8	2	8			
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	5	1	1	0	0			
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0			
Admitted	Delayed Transfers Of Care - Days Lost	N/A	300	210	334	250	247	398	211	282	334	269	312			
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	6.9%	5.0%	7.8%	5.2%	5.2%	8.3%	5.0%	6.0%	7.3%	6.2%	6.1%			
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	52.8%	48.7%	58.0%	61.4%	59.0%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	59.3%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	96.5%	94.7%	94.7%	97.3%	98.8%	95.0%	97.5%	94.5%	95.0%	93.6%	94.5%			
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	93.8%	91.9%	88.7%	89.3%	89.4%	91.6%	88.6%	85.9%	91.7%	93.4%	90.1%			
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.1%	96.1%	91.7%	94.6%	94.8%	92.1%	96.6%	95.3%	96.3%	94.1%	96.4%			
Community	Haringey - HR1 % carried out before child aged 15 months		37.7%	46.4%	44.9%	39.9%	33.2%	68.7%	67.1%	60.8%	67.0%	67.8%	65.3%			
Community	Haringey - HR2 % carried out before child aged 30 months		35.2%	38.3%	48.9%	36.0%	51.1%	44.8%	44.1%	38.3%	61.0%	68.4%	61.1%			
Community	Islington - HR1 % carried out before child aged 15 mths		66.7%	71.2%	60.9%	68.8%	72.9%	66.7%	67.8%	67.9%	73.3%	78.9%	81.6%			
Community	Islington - HR2 % carried out before child aged 30 mths		75.8%	72.7%	79.8%	72.5%	73.0%	65.6%	75.3%	71.9%	70.3%	70.1%	76.7%			
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		29.1%	34.0%	42.1%	30.9%	35.2%	31.1%	33.0%	32.8%	20.4%	25.8%	34.4%			
Community	Islington - 8wk Review % carried out before child aged 8 weeks		30.2%	44.6%	48.1%	48.7%	41.6%	55.7%	60.5%	60.5%	55.5%	71.1%	65.7%			

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Responsive Services - Commentary

Hospital Cancelled operations

Issue 8 operations cancelled due to non-clinical reasons in March 2018

T&O	3	hospital beds unavailable
General Surgery	2	one hospital bed unavailable and one notes were missing
Urology	3	surgeon unavailable

Action All patients rebooked within 28 days

All consultants are asked to check their theatre lists two weeks in advance to ensure that they are booked properly

Timescale: already in place

Cancelled operations not booked within 28 days

There were no cancelled operations not booked within 28 days.

Delayed transfers of care

Improvement continues after winter period. Through system-wide working the Trust were able to reduce DToCs to meet the external target during March across the board – something that has been a significant challenge in previous months. Overall occupied bed days delays continue to reduce. MADE meetings now increased to twice weekly.

New Birth Visit

Islington: 96.7% Good improvement and back to achieving target (95%)

Haringey: 90.2% Disappointing fall in performance due in part to HV vacancies (8.37 FTE HV vacancies out of 44.0 FTE establishment (19% vacancy)) but also lack of management oversight in one team due to sick leave; strong correlation between FTE HVs in post and NBV performance. Improvement plan in place to achieve 95% target

Responsive Services - Commentary

Mandated HCP: Health Reviews at 8 weeks, 1 and 2-2 1/2 years

- 1 year review at 15 months: good progress continues for Islington service - highest performance to date at 81.6%. Haringey fall from 67.8% last month to 65.3%; however, plan in place to achieve agreed trajectory
- 2 - 2 1/2 review at 30 months: Islington have shown further significant improvement at 76.7%; Haringey has fallen on previous month 68% to 61.1%; plan in place to achieve agreed trajectory.
- 6-8 week review: slight fall in performance for Islington from 70.6% to 65.7% but remain on track within year. Haringey have improved to 34.4% but remain below expected target of 60% - improvement plan and agreed trajectory in place

Haringey is working to improve all aspects of the mandated HCP with a robust service improvement action plan.

<u>Trajectory targets agreed for HCP mandate KPIs:</u>
- NBV - 95%
- 6-8 weeks - 50% (40% by Q2)
- 1 year review at 15 months - 80% by Q2
- 2 year review at 30 months - 80% by Q2
- Integrated 2 year review at 30 months - 65% (30% by Q2)

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	79%	79%	78%	78%	75%	71%	69%	71%	71%	72%	69%	70%		
HR	Mandatory Training % Rate	>90%	82%	82%	82%	82%	79%	80%	80%	81%	81%	81%	83%	83%		
HR	Permanent Staffing WTEs Utilised	>90%	88.9%	87.4%	86.1%	87.4%	87.3%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.4%	
HR	Staff FFT % recommended work	>50%		54.5%			53.3%			59.5%			58.6%			
HR	Staff FFT response rate	>20%		18.2%			21.5%			39.1%			17.3%			
HR	Staff sickness absence %	<3.5%	3.28%	3.54%	3.22%	3.40%	3.30%	3.61%	3.57%	3.65%	4.01%	3.73%				
HR	Staff turnover %	<10%	14.4%	14.0%	14.7%	15.0%	14.4%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%	13.9%	
HR	Vacancy % Rate against Establishment	<10%	11.1%	12.6%	13.9%	12.6%	12.7%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.6%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		87.1%	85.7%	87.3%	85.9%	79.6%	85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	93.5%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		121.2%	111.4%	114.3%	110.7%	122.8%	133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	175.6%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		93.7%	92.4%	92.3%	92.8%	102.8%	96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	101.1%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		124.1%	118.1%	128.2%	113.8%	136.7%	146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	174.3%	
HR	Safe Staffing Alerts - Number of Red Shifts		0	0	0	121	55	32	16	33	31	12	19	18	18	

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

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Trend
Medical	Average staff cost per patient		91	95	96	97	97	95	94	93	98	104	96	
Nursing	Average staff cost per patient		169	169	171	171	164	165	167	198	167	182	181	
Other	Average staff cost per patient		198	194	209	205	209	196	193	214	191	195	166	

Well Led Services - Commentary

Human Resources

Staff turnover increased in April. Due to the budget entry process for the new financial year it is not possible to produce an accurate vacancy factor for April; therefore 2 months, April and May, will be reported in June.

Due to the change in Board dates sickness absence is now reported a month in arrears. In February sickness was at 3.7% and it had reduced to 3.07% (fractionally above target) in March, most likely due to seasonal improvement.

Plan to improve Mandatory training and Appraisal for 2018/19 to be developed with Operational Directors and Service Managers.

Safe Staffing

The Trust reports each month its ability to align the planned nursing requirement with the 'actual' number of staffing hours. The 'actual' is taken directly from the nurse roster system (Healthroster). On occasions when there is a deficit in 'planned' hours versus 'actual' hours, staff are redeployed between wards and other areas to ensure safe staffing levels across the organisation. The staffing levels on all wards are reviewed each morning to ensure staffing levels are safe. Prior to the meeting the Matrons are asked to apply "professional judgement" as a subjective indicator to the objectivity of an "hours short / excess" matrix.

Band 4 Assistant Practitioners have been appointed to take on a number of tasks traditionally allocated to registered nurses. At present the Assistant Practitioners are being assigned Registered Nurse shift

As the temporary staffing requirement is being reviewed in detail, it is clear that when shifts cannot be filled by RNs these are converted to HCA in order to maintain safe staffing levels. This will therefore also over deliver on the percentage fill rate for care staff.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Activity
ED	ED Attendances	**8285**	8699	8239	8537	7853	8051	8816	8549	8579	8897	8082	9217	8646	
ED	ED Admission Rate %		16.1%	16.0%	15.1%	15.8%	16.5%	17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	
Community	Community DNA Rate %	**<10%**	7.0%	7.6%	7.3%	7.8%	7.7%	8.1%	8.0%	6.8%	7.6%	7.6%	7.6%	7.8%	
Community	Community Face to Face Contacts		62921	61540	59806	51863	57468	57606	60655	50448	59932	54090	60081	55285	
Admissions	Elective and Daycase		1790	1931	1904	1830	1828	1907	2004	1587	1944	1735	1876	1710	
Admissions	Emergency Inpatients		2211	2131	2163	2136	2242	2456	2368	2180	2216	1910	2249	2182	
Referrals	GP Referrals to an Acute Service		7600	7044	6827	7143	6765	7435	7452	5747	7617	7143	7684	6923	
Referrals	% of GP Referrals that were completed via ERS		19.7%	21.5%	23.3%	29.1%	31.3%	33.9%	35.9%	39.0%	48.3%	46.1%	49.1%	60.6%	
Referrals	% e-Referral Service (e-RS) Slot Issues	**<4%**	32.7%	39.1%	35.7%	25.0%	22.4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	18.2%	
Maternity	Maternity Births	**333**	329	322	314	319	344	347	337	332	321	253	315	291	
Maternity	Maternity Bookings	**377**	483	364	380	378	338	420	385	302	405	375	370	400	
Outpatients	Outpatient DNA Rate % - New	**<10%**	11.9%	11.3%	11.8%	12.6%	11.4%	11.0%	10.2%	11.1%	10.9%	10.9%	10.7%	10.0%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	11.7%	10.2%	11.6%	12.0%	11.1%	10.2%	10.2%	10.7%	12.0%	9.9%	10.9%	10.3%	
Outpatients	Outpatient New Attendances		9405	9115	8635	8753	8884	9777	10112	8002	10489	9195	9558	9232	
Outpatients	Outpatient FUp Attendances		18622	18992	17822	17408	17443	19485	19279	15898	18885	16538	17699	16822	
Outpatients	Outpatient Procedures		6098	6354	5748	5787	6471	7097	7451	5836	7410	6809	7038	6728	
Theatres	Theatre Utilisation	**>85%**	85.9%	82.7%	83.4%	80.8%	81.2%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	

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Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Trend
Average Tariff	Daycases		727	709	699	704	693	687	717	710	697	684	614	
Average Tariff	Elective		2701	3726	4014	3535	4042	3959	3525	3526	3403	3550	3710	
Average Tariff	Non-Elective		1883	2356	2199	2335	1693	2188	2180	2561	2670	2362	2194	

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Activity - Commentary

eRS

From 16th April Whittington Health have been accepting all GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System. All exception have been agreed and Whittington Health have weekly implementation group in place represented by all services, eRS leads in Haringey and Islington CCG and Local and regional NHS Digital.

GP's use of making referrals using eRS is increasing rapidly, showing over 80% in May 18. The increase in slot issues is a reflection of capacity and demand within services. All service managers are reviewing the services' slot capacity daily.

Maternity births

Number of births in April is lower than last month; this is as expected for the time of the year.

DNA

There has been a continued decrease in DNA rates across majority of the 17 services which are now using DrDoctor; however we have also seen a steady increase in last minute cancellations (LMC). A roll out date for the access centre has been agreed for October 2018. This delayed roll out date will allow eRS to transition to business as usual and not overload the access centre with additional work in terms of appointment management via a new system. In the time between now and October 2018, clinic codes will be migrated over from the old text reminder service (Remind+) to DrDoctor for text reminders only, with the plan to seamlessly switch on the rescheduling feature in October.

Workforce Directorate
Direct Line: 020 7288 3696
www.whittington.nhs.uk

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Trust Board
30 May 2018

	Remuneration Committee Terms of Reference		
Agenda item:	**18/079**	**Paper**	**8**
Action requested:	For review and approval in advance of the Remuneration Committee on **13th June 2018.**		
Executive Summary:	The Terms of Reference for the Remuneration Committee were presented to the Trust Board in June last year. It is good practice to periodically review such Terms of Reference in the wider scheme of governance of the Trust and specifically the context of wider scrutiny and accountability with regard to senior NHS pay. In addition to existing requirements based on Nolan with regard to standards in public life, Hutton in respect of public sector pensions, and Greenbury principles on executive pay openness, more recent requirements, most notably the adoption of the Fit and Proper Persons Test in late 2014, place an onus on Remuneration Committees to ensure that their arrangements conform to changes in governance.		
Summary of recommendations:	To agree the Terms of reference and to use these as a basis for directing an associated annual work programme for the Committee.		
Fit with WH strategy:			
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Component of sound governance framework		
Date paper completed:	13 March 2018		

Author name and title:				**Director name and title:**		**Norma French Director of Workforce**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

WHITTINGTON HEALTH NHS TRUST
Remuneration Committee
Terms of Reference

1. Constitution

The Board of Directors (the "Board") established a standing Committee of the Board known as the Remuneration Committee (the "Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Duties of Remuneration Committee

2.1 In consultation with the Chief Executive (CEO), to regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust Board (Board-Level Directors and Non-Executive Directors) and make recommendations to the Board with regard to any changes.

2.2 Make recommendations to the Board to improve its own governance and effectiveness.

2.3 Give full consideration to and making plans for succession planning for the Chief Executive and other directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the board in future;

2.4 To ensure that Board-Level Directors and Non-Executive Directors meet the requirements of the 'Fit and Proper' Persons Regulations.

2.5 Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, agree a description of the role and capabilities required for a particular appointment.

2.6 To consider any matter relating to the continuation in office of any Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Trust.

2.7 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

2.9 To keep under review a remuneration framework for Board-Level Directors.

2.10 In accordance with all relevant laws, regulations and Trust policies, determine the terms and conditions of office of the Board-Level Directors, including all aspects of salary and the provision of other benefits (for example allowances or payable expenses).

2.11 Determine the levels of remuneration and terms of employment for Board-Level Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

2.12 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Board-Level Directors.

2.13 Approve the arrangements for the termination of employment of any Board-Level Director and other contractual terms, having regard to any national guidance.

2.14 Approve contractual severance payments over £50,000 to all staff.

2.15 Approve any non-contractual severance payments to all staff.

2.16 The chair and another non-executive director are authorised to approve the following outside the meeting:

- any redundancy/ capitalised pension cost in excess of £50,000;
- salaries for newly advertised director posts.

Where such actions are taken, these will be reported to the next meeting of the Committee.

2.17 Ensure that any proposed settlement agreement is justified and that it is drafted in such a way as not to prevent proper public scrutiny by NHS Improvement, the Department of Health or external auditors.

2.18 Oversee the performance review arrangements for the Board-Level Directors and Non-Executive Directors ensuring that each receives an annual appraisal

3. Membership and attendance

3.1 The membership of the Committee will comprise::

- Chairman of the Board (Chair)
- All Non-Executive Directors
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding their terms of conditions and remuneration.

3.2 The Director of Workforce shall normally be invited to attend meetings in an advisory capacity. Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

4. Reporting

4.1. The minutes of the Committee meetings shall be formally recorded and a summary of the proceedings submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure, or Executive action.

4.2. The Committee will report annually to the Trust Board in respect of fulfilment of its functions as set out in these terms of reference and shall ensure that the necessary disclosures in relation to appointments and remuneration are accurately reported in the required format in the Trust's annual report.

4.3 The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

5. Quorum

5.1 The membership of the Committee is all Non-Executive Directors. The Trust Chair shall chair the Committee. In the absence of the Chair, the Senior Independent Director or Deputy Chair shall chair the meeting.

5.2. For any decisions relating to the appointment or removal of the Board-Level directors, membership of the Committee should include the Chief Executive as required under Schedule 7 of the NHS Act 2006. The Chief Executive shall not be present when the Committee is dealing with matters concerning their appointment or removal.

5.3 A quorum will be three members.

6. Frequency of meetings

6.1 The committee shall meet at least once a year.

7. Authority

7.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Monitoring Effectiveness

8.1 The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties.

9. Other Matters

9.1 The Secretary to the Committee shall be the Director of Strategy, Development and Corporate Affairs.

9.1 Minutes of the last Remuneration Committee will be taken in the private Trust Board meeting.

10. Review

10.1 These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Reviewed: May 2018

Whittington Health
NHS Trust

Trust Board

30th May 2018

Title:	Board Assurance Framework		
Agenda item:	**18/080**	**Paper**	**9**
Recommendations:	For review and approval		
	The Audit and Risk Committee requested a review of the way in which the Board Assurance Framework (BAF) is presented. The Committee also requested that the Board "Risk Appetite" is reflected in the BAF and the BAF presented to the Board today now indicates the approach to managing tolerable risk once risk appetite for each risk has been agreed. Having reviewed the BAF following Audit & Risk Committee, a revised BAF was presented at the Board seminar in April 2018. The BAF presented at today's Board builds on the feedback received from the Board seminar. The next steps in the work to review the BAF is to review the BAF risks for 2018/19, determine the Board risk appetite for each risk and determine the management of the risk based on the "Tolerable Risk" approach outlined in the attached paper. Indicative "Risk Appetite" scores have been included for discussion by the Board. Following today's discussions officers will undertake a full update of the 2018/19 BAF and this will be presented at a future Board meeting.		
Reference to related / other documents:	Trust objectives		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF		
Date paper completed:	17/05/18		
Paper previously presented at:	Audit & Risk Committee Executive Committee Trust Management Committee		

Author name and title:	**Helen Taylor**	**Director name and title**		**Jonathan Gardner Director of Strategy, Development and Corporate Affairs**	
Equality Impact Assessment complete?		**Quality Impact Assessment complete**		**Financial Impact Assessment complete?**	

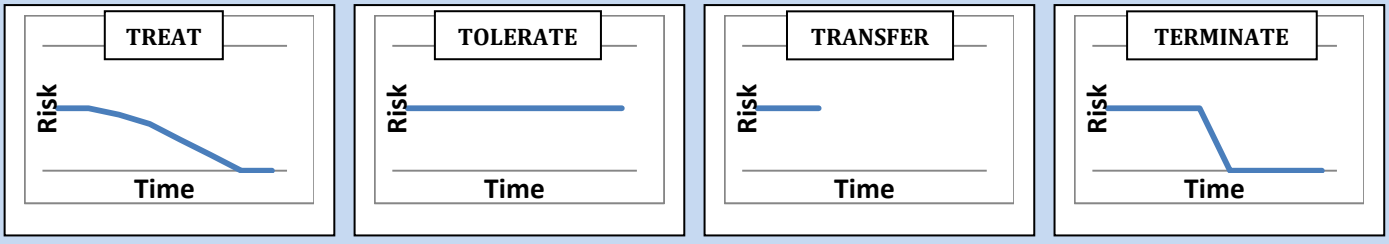
Proposed Board Assurance Framework

Responsible Leads and Assurance Committees		
Risk ID	Lead Committee	Executive Lead
2	TB	Richard Jennings Stephen Hitchins
3	TMG, TB	Carol Gillen
4	WAC	Norma French
5	F&BD	Stephen Bloomer Tony Rice
9	TMG	Carol Gillen
10	TMG	Carol Gillen
14	TMG	Carol Gillen
15	TB	Stephen Bloomer Stephen Hitchins
16	TB	Stephen Bloomer
17	WAC	Richard Jennings

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

Summary of Principle Risks				
Risk ID	Description	Current Score	Appetite Score	Change
2	Failure to provide an ongoing service to LUTS patient	8	8	↔
3	Failure to meet performance targets in ED	8	6	↔
4	Inability to increase substantive workforce capacity	12	8	↔
5	Failure to deliver CIPs and transformation savings for 2017/18 and failure to plan for 2018/19	10	10	↔
9	Failure to align Whittington Health's population health model to the final NCL STP	8	8	↔
10	Failure to sustain the breast service due to workforce changes	8	8	↔
14	Failure to deliver safe and high quality urgent and emergency pathway resulting in patients waiting for care and for treatment with risk identified in care of people with mental health care needs.	12	12	↔
15	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience.	12	12	↑
16	Failure to establish cyber security across the trust	8	8	↔
17	Failure to deliver compliant junior doctor rotas across the Trust	8	8	↔

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



Whittington Health NHS

Board Assurance Framework

Risk: Failure to provide an ongoing service to LUTS patients	**Risk ID**: 2

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver an ongoing, high quality, safe service to LUTS patients.	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Medical Director	**Previous Risk Score**: 2 x 4 = 8
	Risk register codes: w32973 Steis 2015 33773 Surgery ICSU	**Current Risk Score:** 2 x 4 = 8
		Risk Appetite: 2x4=8 (terminate)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Since the temporary suspension the service has continued without interruption. The Consultant is continuing to work in the post and is on a fixed term contract. Improvement plan in place against the RCP review recommendations.	Updates to Action plan developed in response to the RCP report TB updates on progress against action plan

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

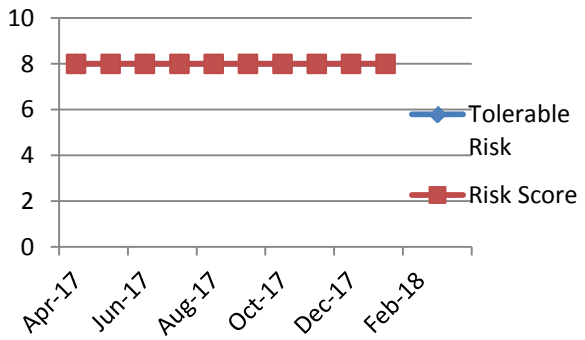
1. Multidisciplinary meetings to ensure governance process and patient safety are not currently in place.
2. Succession plan for clinical leadership not finalised.

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Ongoing regular review and update of the action plan.	Executive Team Trust Board	In place and ongoing
The Executive Medical Director is gathering information to learn from the previous attempts to run an MDT to inform the setup of a sustainable MDT for the future.		In place and ongoing

Assurance Progress:

February 2017: Desk top review completed. Children's pathway agreed in principle UCLH/WH and CCG meeting taken place. Met with JML Service user meeting March 2017.
May 2017: Discussion with UCLH, the commissioners, UCL and engagement with patients to secure a sustainable future for the service. Further desktop review against RCP action plan completed.
January 2018: Joint clinic proposal in development with UCLH. Meeting with commissioners re specification 18/1/18. Job description in development.



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Failure to meet performance targets in ED	**Risk ID**: 3

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Operating Officer	**Previous Risk Score**: 2 x 4 = 8
	Risk register codes: 683	**Current Risk Score:** 2 x 4 = 8
		Risk Appetite: 2x3=6 (treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Performance management monitoring, Improvement plan includes work with intermediate care/discharge to assess work monitored at operational meetings, Monthly whole system delivery group, Enhanced recovery programme in place.	Monthly performance reports to TMG and TB ED consultant recruitment SI reports to TB Monthly whole system improvement group

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

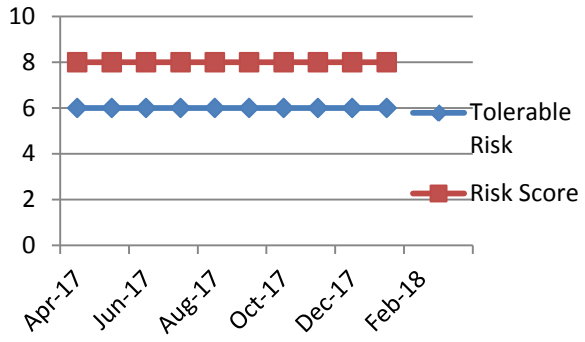
1. ED Target not met although agreed trajectory April 2017 was met

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
ECIP review and report plus full capacity protocol set up.	ICSU performance reviews	In place and ongoing
Oversight of whole system improvement plan.	Trust Operational meetings	In place and ongoing
Ongoing recruitment of consultants for ED	TMG	In place and ongoing
Bed management and escalation policies all in place	TB	In place and ongoing
Red to Green programme in place - to support improvements in flow cycles of perfect week in place	TB	In place and ongoing

Assurance Progress:

ECIP progress achieved and trajectory in April on track to achieve and on track for May.
CEO chair of Urgent and Emergency Care work stream at STP level
4 out of 6 ED Consultants recruited
Q1 STP trajectory achieved.
Embedding improvement work with the support of ECIP and PMO clinical lead.
Including plus one in place for winter 17/18
Discharge 2 assess progressed with implementation for September



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Inability to increase substantive workforce capacity **Risk ID**: 4

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Develop and support our people and teams	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Director of Workforce	**Previous Risk Score**: 4 x 3 = 12
	Risk register codes: 693,859,797,868	**Current Risk Score:** 4 x3 = 12
		Risk Appetite: 4x2=8 (treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
HR business partners in place Recruitment and retention strategy e-rostering and real time data Staff survey action plans 'You said we did'	Workforce Assurance Committee (WAC) Weekly Vacancy Scrutiny Panel Meetings Staff Survey weekly tracking of temporary staffing by executive team

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

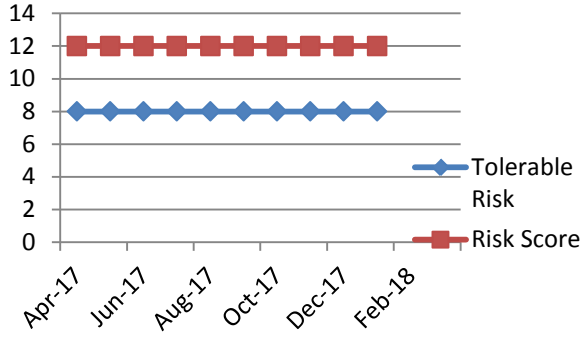
Agency send greater than planned

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Implement recruitment and retention strategy	ICSU performance reviews	In place and ongoing
Monitor WAC work plan and strengthen controls and compliance with agency gap and continue to monitor KPIs	Trust Operational meetings	In place and ongoing
Develop rotations with UCLH and agreements for staff working across organisations	TMG	In place and ongoing
Action to improve retention.	TB	In place and ongoing

Assurance Progress:

Regular recruitment days held including some international recruitment
Workforce Assurance Committee meeting regularly
New bank rates agreed
Director input into overseas recruitment
Calendar of recruitment events
Exit interviews conducted



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Failure to deliver CIPs and transformation savings for 2018/19	**Risk ID**: 5

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Develop our business to ensure we are financially sustainable	**Initial Risk Score**: 5x5=20
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Financial Officer	**Previous Risk Score**: 2 x 5 = 10
	Risk register codes: 784,780,880,723,772	**Current Risk Score:** 2 x 5 = 10
		Risk Appetite: 2x3=6 (treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
PMO in place Quarterly performance reviews Fortnightly CIP delivery board ICSU deep dives at FB&D QIA process in place	Finance and Business Development Committee F&BD Internal Audit reports and recommendations Reports to TMG

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

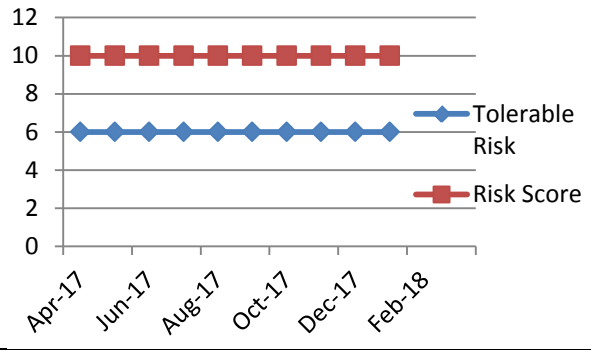
1. Unidentified CIP

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
PMO and BCG working with ICSU to identify CIP	PMO and ICSUs	16th May 2018
Transformational Projects	PMO and TMG	in place
Shared Services	F&BD	In place and ongoing

Assurance Progress:

Monitoring and governance in place.
Weekly road map check–ins
CIP delivery Group
Senior Finance Support for the PMO
BCG appointed for Outpatient Project
Pathology proof of concept with NWLP April-Dec18
Each ICSU to identify 2% saving.
CIP delivery dashboard developed



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk:Failure to align Whittington Health's population health model to the final NCL STP **RISK ID**: 9

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Further develop and expand our partnership and engagement	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Director of Strategy	**Previous Risk Score**: 2 x 4 = 8
	Risk register codes:	**Current Risk Score:** 2 x 4 = 8
		Risk Appetite:2x3=6 (treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Engagement with NCL STP process Clinical collaboration with UCLH Business development Close working with the STP Care Closer to Home agenda	Trust Board NCL Strategy Directors Group UCLH and WH Clinical Collaboration Board TMG Health and Wellbeing Partnership Sponsor Board

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

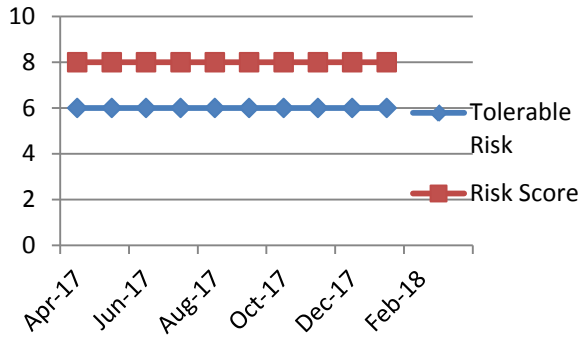
1. Public engagement not fully developed.
2. CHIN development has been primary care focused

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Progress the work Haringey and Islington Wellbeing partnership	TB H&I WB Partnership Sponsor Board	In place and ongoing
Engage Fully with primary care	TB TMG	In place and ongoing
review ICUS business plans re integrated care And Care Closer to Home	TB	In place and ongoing

Assurance Progress:

Joint governance in place and Programme Director for Haringey and Islington Wellbeing Partnership in place.
WH leading Frailty work stream.
Clinical engagement in place for the work streams identified and in place.
Community improvement project underway jointly chaired by partnership and WH COO.



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Failure to sustain the breast service due to workforce changes	**Risk ID**: 10

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Operating Officer	**Previous Risk Score**: 2 x 4 = 8
	Risk register codes: 768	**Current Risk Score:** 2 x 4 = 8
		Risk Appetite:3x2=6 (terminate)
		Date last reviewed: May 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Recruitment successful. Post holders in place in July 2018. Locum surgeon and radiologists covering while posts vacant. joint working with UCLH	TMG UCLH Clinical collaboration board Quarterly performance reviews

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

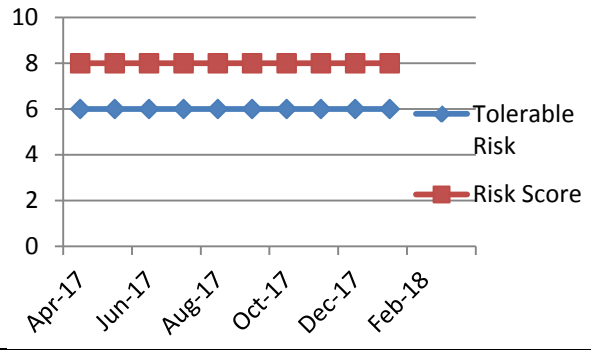
1. Joint MDT
2. Annual leave cover through joint posts

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Joint MDT with UCLH in development	TMG	Sept 2018
Business case for Joint posts for surgery and radiology with UCLH in development	TMG	May 2018
develop business continuity plans between UCLH a and WH	TMG	Sept 2018

Assurance Progress:

Progress being made in developing relationships between clinical colleagues at UCLH.
Post holders to start in July 2018 when will have a substantive team
Business cases for cover in progress.



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Failure to deliver a safe and high quality urgent and emergency pathway for patients with mental health care needs resulting in patients waiting for care. **Risk ID**: 14

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Operating Officer	**Previous Risk Score**: 2 x 4 = 12
	Risk register codes: 683	**Current Risk Score:** 2 x 4 = 12
		Risk Appetite: 2x2=4 (treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
ECIP review identified areas of improvement and action plan in place Working with C&I to improve pathways	TMG Urgent and Emergency Care Board Real time information Monthly whole system review group

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

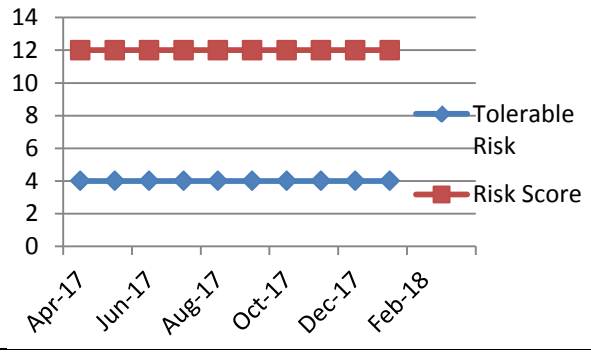
1. Shortage of mental health bed and mental health providers to respond effectively

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
ECIP review and report plus full capacity protocol set up.	ICSU performance reviews	In place and ongoing
Oversight of whole system improvement plan.	Trust Operational meetings	In place and ongoing
Ongoing recruitment of consultants for ED	TMG	In place and ongoing
Bed management and escalation policies all in place	TB	In place and ongoing
Red to Green programme in place - to support improvements in flow cycles of perfect week in place	TB	In place and ongoing

Assurance Progress:

External review of mental health pathway and learning from recent incidents.
CEO chair of Urgent and Emergency Care workstream at STP level.
Clear whole system actions and recommendations set out and action plan to be monitored at ED delivery board.



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

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

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Financial Officer	**Previous Risk Score**: 3 x 4 = 8
	Risk register codes91,697, 817,680, 820,807,750,746	**Current Risk Score:** 3 x 4 = 12
		Risk Appetite: 3x2=6(treat)
		Date last reviewed: May2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Capital programme addresses all red risks. The Trust is currently reviewing how it might develop a master plan to improve the whole estate over time	TB FB&D

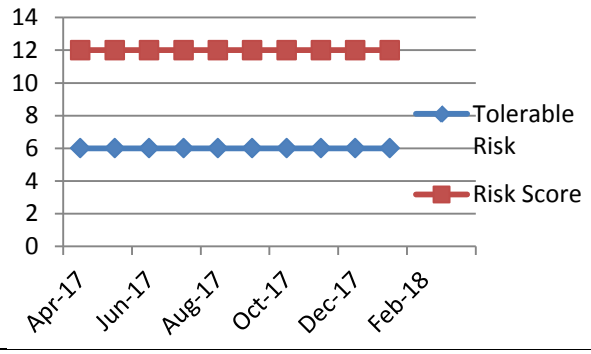
Gaps in controls & assurances: (What additional controls and assurances should we seek?)

Signed off estates development plan

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Ensure capital plan addresses all red risks	Capital monitoring F&BD	in place
Determine the best route for developing an estates masterplan	TB	Sept 2018

Assurance Progress:



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: **Breach of the established cyber security arrangements.** **Risk ID**: 16

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Financial Officer	**Previous Risk Score**: 2 x 4 = 8
	Risk register codes: 796	**Current Risk Score:** 2 x 4 = 8
		Risk Appetite: 5x1=5 terminate)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Patching programme in place investment as part of capital programme CIO in place. Procurement processes to ensure new equipment is protected.	Audit and Risk Committee Capital Monitoring Group ICSU quarterly performance Information Governance Committee

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

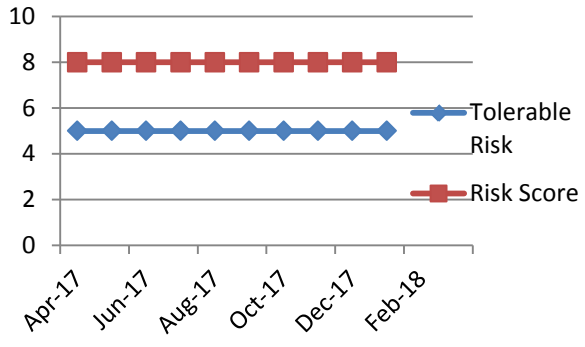
1. Some equipment suppliers not providing adequate patching.

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Delivery of digital strategy-fast follower exemplar programme	TMG	Starts April2018
Continue to network with other Trusts to ensure shared learning	Trust Operational meetings	In place and ongoing
Escalation protocol across NCL	TMG	Autumn 2018

Assurance Progress:

Investment in the latest technologies to strengthen cyber security
Monthly patches rolled out across the organisation to mitigate vulnerabilities,



Additional Comments on Performance:

Whittington Health NHS

Board Assurance Framework

Risk: Failure to deliver compliant junior doctor rotas across the Trust	**Risk ID**: 17

CQC Domain: Caring /Effective /Responsive /Safe / Well-led	**Corporate Objective:** Deliver quality patient safety and patient experience	**Initial Risk Score**: 4x4=16
		Previous Risk Score: 2 x 4 = 8
CQC Outcomes 4: Care & welfare of people who use services	**Board Lead**: Chief Operating Officer	**Current Risk Score:** 2 x 4 = 8
	Risk register codes:	**Risk Appetite**: **4x2=8(**treat)
		Date last reviewed: Jan 2018

Controls: (What are we currently doing about the risk?)	**Source of Assurances and Lead Committee: (How do we know if the things we are doing are having an impact?)**
Workforce strategy in place WAC KPIs monitored HR business partners in place Recruitment and Retention Strategy agreed	WAC ICSU quarterly performance Weekly tracking of temporary staff by executive team

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

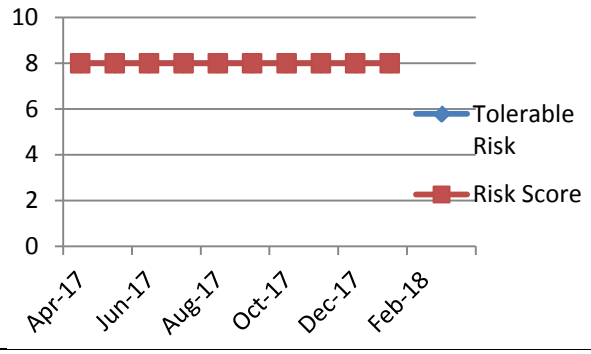
1. Agency spend greater than planned
2. Rotas in some areas non-compliant

Mitigating actions: what more should we do?

Action	Lead Assurance Committee	Deadline
Implement recruitment and retention strategy	ICSU performance reviews	In place and ongoing
Monitor WAC work plan and strengthen controls and compliance with agency gap and continue to monitor KPIs	Trust Operational meetings	In place and ongoing
Develop rotations with UCLH and agreements for staff working across organisations	TMG	In place and ongoing
Action to improve retention.	TB	In place and ongoing
Junior Medical Staffing Taskforce to be established - Chaired by Medical Director	TB	May 2018

Assurance Progress:

Regular recruitment days held including some international recruitment
New bank rates agreed
Director input into overseas recruitment
Calendar of recruitment events
Exit interviews conducted



Additional Comments on Performance:

Whittington Health
NHS Trust

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Direct Line: 020 7288 3063
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Magdala Avenue
London N19 5NF

Whittington Health Trust Board

30th May 2018

Title:	**Risk Register Summary Report, May 2018 Update**		
Agenda item:	**18/081**	**Paper**	**10**
Action requested:	For agreement		
Executive Summary:	This paper provides a brief overview of the risk management structure and a summary of the high level risks (NPSA risk score ≥16) currently on the Risk Register in May 2018. This is an update The Trust has set a lower threshold for risks reviewed at Board sub-committees (≥15) to ensure Executive and Non-Executive Director oversight. The Non executive directors and the executive lead for the committee have responsibility to escalate any risks scored 15 to the Trust Board as required. All risks <15 are managed at an ICSU and corporate level and escalated to the relevant Board sub-committee as required.		
Summary of recommendations:	• 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 to the BAF.		
Fit with WH strategy:	Clinical Strategy, Estates Strategy, Recruitment and Retention strategy		
Reference to related / other documents:	As above		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risk Resister works in conjunction with the BAF to provide the Board with assurance that appropriate actions are taken to remove, reduce or transfer any risk to the corporate objectives.		
Date paper completed:	18/5/18		

Author name and title:		**Gillian Lewis, Head of Governance and Risk**		**Director name and title:**		**Michelle Johnson, Chief Nurse and Director of Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

1 INTRODUCTION

Whittington Health is 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 currently on the Risk Register. Risk management overview

1.1 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 Integrated Clinical Service Unit (ICSU), Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as Organisation wide risk. All risks are then categorised under key headings and given a risk grading. 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 >15 RISK REGISTER UPDATE APRIL 18

2.1 Risk Register **Update, May 2018**
As at 1/5/18, the Trust currently has four risks scored as ≥20 and eighteen risks graded as 16. There are sixteen risks scored as 15 which are monitored at Board sub-committee level.

2.2. There are three key themes from the current high level risks on the risk register;

- Workforce and recruitment
- Facilities and estates
- Financial

2.3 These risks have all been escalated for inclusion on the BAF due to the strategic implications and are monitored by the Trust Board through this assurance mechanism. However a brief summary of the risks and key mitigating actions is outlined below.

2.4 Workforce and Recruitment

DATIX	ICSU	Category	Title	Current risk scoring
693	Integrated Medicine ICSU	Human Resources and Workforce	Nurse Staffing Levels in Integrated Medicine ICSU	20
859	Emergency and Urgent Care ICSU	HR and Workforce	High vacancy rate in District Nursing Service	16

797	Emergency and Urgent Care ICSU	HR and Workforce	Inadequate consultant provision AAU (Acute Assessment Unit)	16
868	Surgery and Cancer	HR and Workforce	Impact of exclusion of consultant surgeon	16

2.5 Each ICSU has a specific action plan to mitigate the risk, including short-term provision such as the use of bank and agency 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).*** 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.

2.6 Facilities and Estates

DATIX	ICSU	Category	Title	Current risk scoring
91	Women's Health ICSU	Estates or Infrastructure	Labour ward has 1 obstetric theatre.	20
697	Women's Health ICSU	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
680	Facilities and Estates	Estates or Infrastructure	Hospital roof maintenance to K and F block	16
820	Facilities and Estates	Estates or Infrastructure	Whittington Hospital Escalators in A Block	16
807	Facilities and Estates	Estates or Infrastructure	Works arising from fixed electrical installation testing	16
750	Facilities and Estates	Patient Safety and Quality	Mental Health Patient Security Van does not meet current CQC standards	16
746	Facilities and Estates	Patient Safety and Quality	Northern Health Centre- Lift Reliability Issues	16

2.7 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 monitor actions against this risk through the BAF process, including implementation of the Estates Strategy.

2.8 Financial

DATIX	ICSU	Category	Title	Current risk scoring
784	Finance	Financial	Failure to deliver CIPs and savings to £16.5m 2018/19	20
780	Finance	Financial	Budget Control	16
880	Finance	Financial	Failure to achieve planned activity levels	16
723	Emergency and Urgent Care (EUC) ICSU	Financial	Finance deficit in EUC ICSU	16
772	Surgery and Cancer ICSU	Financial	Not meeting CIP target and financial balance for 2018/19	16

2.9 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 CIPS and transformation savings**) which is monitored through this assurance process.

2.10 Other ≥16 risks which are reflected on the BAF and monitored by Trust Board through this mechanism

Risk Title	Score	Reflected on BAF	Key actions
768: Failure to maintain the breast service	16	BAF10 Failure to sustain the breast service due to workforce changes	• Agreed as a priority clinical area to collaborate with UCLH. • Joint post for surgery with UCLH recruitment complete. • Advert for substantive Breast radiologist agreed and candidates interested in applying. • Consultant mammographer in place. • Still one gap in surgical consultant team. In discussion with FL and UCLH to help support WH.
796: Imaging & Pathology IT Cybersecurity Risk	16	BAF16: Failure to establish cyber security across the Trust	• Digital strategy in place • Internal cyber security audit completed • Capital funding for firewalls has been confirmed and orders now being placed. • Departments developed schedules of all impacted devices, including upgrade and patching of medical devices where possible.
683: Overcrowding ED	16	BAF 3: Failure to meet performance targets in ED BAF 14: Failure to deliver safe and high quality urgent and emergency pathway	• MH Emergency Care Improvement Plan recommendations to be implemented system wide • CD oversight on clinical rotas • Consultant recruitment continues • Advanced Nurse Practitioner appointed • Head of Nursing attending daily bed meets to review capacity

			• Introduction of ED checklist • Introduction of Fit to Sit • Introduction of Nurse Led Rapid assessment of patients coming via Ambulance • Twilight shifts sustained • Increased nursing numbers on both day and night

2.11 ≥16 risks not currently on BAF

Risk	Department	Category	Title	Score	Comments and Key actions
855	Clinical Support Services ICSU	Patient Safety and Quality	Radiology reporting Backlog	16	Following an information request from the CQC (national review) the Trust identified a large backlog of potentially unreported radiology reports, dating back to 2014 (4000records). • The risk was escalated to Executive Team, CQC and commissioners, and an action plan put in place to review the backlog. • As at 16/4/18 the backlog was reduced to 208 reports. To date, no patient harm has been identified as a result of the backlog with the reports primarily relating to erroneous filing. • Internal RCA Investigation in progress to identify the root cause of the backlog and understand why the backlog was

					not identified sooner.
876	Patient Access, Prevention and Planned Care ICSU	Information Technology	Failure to transition effectively to and implement Electronic Referral System	16	Risk that the trust may lose income if not ready for the switch off of paper referrals on 16/4/18. • NHS Digital supporting the trust to set up all clinics on ERS ready for switch off on 16/4/18 • Clinical maintenance team to build capacity into clinics, linked with ERS and DoctorDoctor • Operational Directors for each specialty implementing action plans to create capacity to manage existing waiting lists for slots, against making others available for GPs to book.
	Organisation wide	Information Governance	Medical records not located in medical files	16	There are currently some patient records that have not been filed within the patient case notes and are held loosely in Health Records or other areas of the trust. • Project in progress to file all loose notes in the appropriate record. • On going filing of high risk documentation while project work is completed to introduce more robust process
688	Surgery and Cancer	Patient Safety and Quality	688: ITU bed occupancy and flow	16	• Review of occupancy of ITU and strategy for optimal usage of ITU bed base discussed at TMG in March 2018,

					in line with COCA recommendations. • Admission and discharge criteria for IT reviewed

3.0 RECOMMENDATIONS AND CONCLUSION

3.1 The format of this report is new and comments on design and information content would be welcomed.

3.2 The majority of the >16 risks are reported on the BAF and this provides assurance that the mechanism for raising concerns from front line to board are in place.

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Whittington Health Trust Board

30th May 2018

Title:	**Provider Licence Self-Certification 2018: Condition G6**		
Agenda item:	**18/082**	**Paper**	**11**
Action requested:	Decision on Board Sign-off of the proposed Declaration		
Executive Summary:	This paper sets out the background to the required declaration in relation to the NHS Provider Licence. It involves a self-certification process to establish whether or not the Trust is compliant with Condition G6, and if not, to provide an explanation of the reasons for non-compliance and a statement of remedial action. The Executive Management Team has reviewed the evidence of compliance and the sources of assurance, and subject to the assessment of the robustness of action plans relating to the achievement of access targets, recommends that the Board makes a declaration of compliance in accordance with the template provided by the NHSI. This is the first stage of a two-stage process. The Board will consider its compliance with Condition FT4 – Governance Arrangements – at the June meeting of the Trust Board.		
Summary of recommendations:	For approval.		
Fit with WH strategy:	The Trusts 4 key corporate objectives reflect the letter and the spirit of the NHS Provider Licence.		
Reference to related / other documents:	Health and Social Care Act 2012 The NHS Constitution, GDPR		
Reference to areas of risk and corporate risks on the BAF	Particular risks relating to the Provider licence are BAF3, BAF5 BAF14, BAF15		
Date paper completed:	22.05.2018		

Author name and title:		**Susan Sorensen Interim Corporate Secretary**		**Director name and title:**		**Jonathan Gardner Director of Strategy and Corporate Affairs**	
Date paper seen by EC	**14/5/18**	**Equality Impact Assessment complete?**	**na**	**Quality Impact Assessment complete?**	**na**	**Financial Impact Assessment complete?**	**na**

Provider Licence Self-Certification:2018

1. Introduction

1.1 All NHS Trusts are required to complete an annual self-certification in relation to the NHS Provider Licence. Last year was the first year that trusts self-certified. Although they are exempt from needing to hold the licence, they are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate. These are:

- Condition G6(3) - The provider has taken all precautions necessary to comply with the licence, the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and the NHS Constitution.
- Condition FT4(8) – The provider has complied with required governance arrangements.

1.2 Trusts may use any process they consider appropriate and which ensures that the board as a whole fully understands whether or not they can confirm compliance.

1.3 A paper proposing a means of providing the Board with the necessary assurances was discussed by Executive Management Team on 14th May 2018. Board sign-off is required by the end of May for Condition G6, and by the end of June for Condition FT4. In both cases the Trust must publish its declaration within a month of sign off.

2. Condition G6 – Compliance with the Provider Licence, NHS Acts and NHS Constitution

2.1 The Board should be able to derive assurance on compliance from its comprehensive range of policies, strategy statements and documented procedures. These are published on the trust's intranet and disseminated to staff as and when required, e.g. for the purposes of induction, initial training and continuous professional development.

2.2 Ongoing compliance needs to be monitored through systematic performance review and reporting via day-to-day management processes, working groups, Board Committees and the Board itself. In addition, a number of sources of external review contribute to the Trust's assurance, notably CQC, NHSI and Auditors.

2.3 Given the broad scope of the requirement for compliance implied in Condition G6, the analytical framework for providing assurance is based in this paper on the seven key principles that govern how the NHS operates and which are summarised in the NHS Constitution. Using this categorisation, the key components of the evidence of system compliance available to the Board are set out below. This list is by no means exhaustive but picks out examples of recent sources of evidence.

2.4 All these sources of Board assurance are in addition to the Board's annual review of the Risk Management Strategy and the bi-annual scrutiny of both operational risks above a pre-determined threshold and the key risks to the achievement of strategic objectives identified in the Board Assurance Framework.

Evidence base for assessment of compliance with Condition G6 of the Provider Licence, analysed by the NHS 7 Guiding Principles

Evidence	Monitoring procedure
1. Provision of a comprehensive service available to all….	
Operational Objectives	TB quarterly
Equality and Inclusion Report	TB annual
2. Access to service based on clinical need……	
Executive Report on performance against targets	EMT weekly report
Electronic Referral System	TMG
3. Highest standards of professionalism and excellence	
Staffing metrics	EMT weekly report
Visible Leadership Implementation plan	EMT
GMC Training Survey	TMG
Serious Incident Reports	TB monthly, NHSI
Serious Case Reviews	TB monthly
Reputational issues	TB monthly
Medical staff exclusions and restrictions	TB monthly
Quality and Patient Safety Report	TB quarterly
Learning from Mortality Report	TB quarterly
Integrated Safeguarding Report	TB bi-annual
Quality Account	TB annual
Staff Survey	TB Annual
Infection Prevention and Control	TB annual
Nursing, Midwifery and AHP strategy	TB annual
Dashboard Report	TB monthly
CQC report	CQC, TB Annual
R&D Report	TB annual
Education update	TB annual
Nursing and Midwifery revalidation	TB annual
Report from Quality Sub-Committee	TB following meetings
Report from Workforce sub-committee	TB following meetings
4. Patient at the heart of everything done	
Staff Friends and Family test	TMG quarterly
Single Sex accommodation declaration	TB annual
Quality and Patient Safety	TB annual
Patient Survey Results	TB annual
End of Life Care	TB annual
5. Working across organisational boundaries in partnership with other organisations	

Strategy paper on Care Closer to Home	TMG
Improving Mental Health Care in ED	TB April 2018 – Report from Verita
Section LBI Annual Report	TB Annual
GP Federations update	TB ad hoc
6. Committed to providing best value for money, and most effective fair and sustainable use of finite resources	
CIP transformational schemes	EMT weekly
Estates Development Plan	TB ad hoc
Capital Investment Strategy	TB Annual
Business Continuity Plan	TB annual
Finance Report	TB monthly
Contract and Business Development report	TB monthly
Operational Plan and Budget	TB annual
Capital update	TB bi-annual
Fast Follower digital update	TB bi-annual
Audit Committee Annual Report	TB Annual
District Audit Annual Report	District Audit annual
Annual Report and Accounts	TB annual
SOs and SFIs	TB annual
Statement of internal control	TB annual
Report from Finance and Business Development Sub-committee	TB following meetings
Finance report on specific issues	TB ad hoc
Audit and Risk Committee reports	TB following meetings
7. Accountable to the public, communities and patients served	
Patient Stories	TB monthly
Freedom to Speak Up Guardian report	TB annual
Report on Health & Wellbeing Partnership	TB ad hoc
Charitable Funds Committee report	TB annual, Charity Commission
Annual Report and Accounts	TB Annual, NHSI
GDPR: Report to Board on Readiness	Audit & Risk Committee, TB May 2018
IG Toolkit Level 2 compliance	TB annual

2.5 On the basis of the above analysis, it is judged that compliance with G6 can be assured in so far as the specified requirements in the NHSI guidance are met:

a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence, and
b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

2.6 However the Board will be aware that the Trust has not always been able to comply with some of the performance standards specified in the NHS Constitution and it is therefore advisable, if not essential, that these are highlighted and evidence identified of timely and robust action plans to restore target performance. It should be noted that the NHS Constitution distinguishes between patients' rights (18 week RTT for non-urgent referrals

and 2 week RTT for suspected cancer) and NHS pledges for other maximum waiting times.

2.6 One other right in the NHS Constitution which the Board may wish to identify as requiring action in the light of the recent staff survey and FFT report is the staff right "to expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying and harassment)".

2.7 With the exception of the four hour wait in ED, all other access targets have been met. Progress towards compliance with the ED target is being addressed through the implementation of the ED Improvement Plan.

3. Condition FT4 – The provider has complied with required governance arrangements

3.1 This condition requires evidence that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3.2 In order to fulfil this condition the Trust shall need to demonstrate:

a) effective Board and Committee structures

b) clear responsibilities for its Board, committees reporting to the Board and for staff reporting to the Board and those Committees: and

c) clear reporting lines and accountabilities throughout its organisation.

3.3 The current review and update of the Board and committee structure should enable assurance to be given on compliance with this condition. It is important that in reviewing the terms of reference of all decision-making and advisory groups it is absolutely clear what the reporting arrangements are in place including their method and frequency.

3.4 There are two further paragraphs set out in the Provider Licence under the heading of governance arrangements, but these seem to repeat a lot of required evidence which is also covered under condition G6 discussed above. As the self-certification on condition is due by the end of June, this will be completed in the first half of June following the update of the committee structure.

4. Conclusion and Recommendation

4.1 The Board is asked to:

a. Consider the compliance evidence set out in the section on condition G6

b. Where compliance is not complete (e.g. where performance standards have not been met), determine whether action plans for the required improvement are in place and sufficiently robust.

c. Decide whether the Board is in a position to make the model declaration set out below

d. Note that further assurance on compliance with Condition FT4 on governance arrangements will be brought to the June meeting of the Trust Board along with updated Standing Orders and Standing Financial Instructions.

4.2 Subject to the Board's approval, it is recommended that the Chair signs the following declaration to be published on the Whittington Health website

5. Declaration

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee confirm that they are satisfied that, in the Financial Year ended 31 March 2018, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Where the Trust has not been able to achieve the ED waiting time targets set out in the NHS Constitution, the Directors are satisfied that the implantation of the ED Improvement Plan will enable the Trust to move towards consistent compliance.

Whittington Health NHS Trust

Trust Board
30 May 2018
Item 18/083
Doc 12

Minutes
Quality Committee, Whittington Health

Date & time: 10th May 2018 at 14:00 – 16:00

Venue: Room 6 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
Richard Jennings (RJ), Medical Director
Yua Haw Yoe (YHY), Non-Executive Director

In attendance
Dorian Cole (DCo), Head of Nursing, **PPP**
James Connell (JC), Patient Experience Manager
Fiona Isacsson (FI), Operations Director, **S&C**
Leanne Rivers (LR) Patient Representative
Alison Kett (AK), Head of Nursing **IM**
Wayne Blowers (WB), Quality Improvement and Compliance Manager
Kelly Collins (KC), Lead Nurse, **PPP**
Sita Chitambo (SC), Head of Nursing. **EUC**
Collette Datt (CD), Head of Nursing, **CYP**
Louise Roper (LR), Quality and Risk Manager. **S&C**
Sharon Pilditch (SP), Matron, **S&C**
Manjit Roseghini (MR), Head of Nursing, **WH**
Adam Burrell (AB), Integrated Governance Manager (Minutes)
James Connell (JC), Patient Experience Manager

Agenda items

1.1	**Welcome & Apologies**	**Chair**
	AS welcomed the committee.	

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

1.3	Minutes of the previous meeting	Chair
	AS referred the committee to the minutes from the previous meeting in March 2018. No amendments to the minutes were noted.	

1.4	Matters Arising	Chair
	No matters were raised.	

Actions	Deadline	Owner
None		

2.1	CQC inspection update	
	The paper was taken as read. MJ reported on the findings from the CQC inspection report. MJ highlighted that the trust was issued with four regulatory actions and 30 actions for improvement. The four regulatory actions have been completed or there is a timeline for completion. MJ informed the committee that the trust has developed an improvement plan of 51 actions in order to address the concerns of the CQC. The improvements are monitored by the specific services and ICSU boards, and escalated as required using the CQC insight report to the Trust Management Group. FI stated that previously the trust had been following a local agreement on critical care unit (CCU) mixed sex accommodation breaches in relation to specialty bed requirements when step down is required for patients. The CCG and NHSI were informed of this, and the Trusts has now moved to follow the national guidelines on reporting delayed discharges/mixed sex breaches. A new escalation policy has also been put into place and incidents are reported on Datix when breaches occur. DHU queried whether it was possible to see if we could obtain the mixed sex breach data for ITUs submitted by other trusts for comparison. FI also noted the work on the critical care unit in relation to ensuring that equipment is safely maintained. FI also noted that this had been raised at the Medical Devices Committee. FI highlighted that there had been learning with regards to ensuring that purchased equipment are bought through the correct process, to ensure that they are added to the medical physics asset register.	

Actions	Deadline	Owner
Trust wide learning lesson from Quality Committee - To share the learning on ensuring the right process is followed when acquiring new equipment (Including Charitable Funds). This item to be added to the Spotlight On Safety	01/06/2018	AB
To explore whether we can obtain data on the number of mixed sex breaches reported by other trusts.	July 2018	MJ
To review Critical Care and Bed management policies to ensure they reflect the change of reporting.	July 2018	FI

2.2	Quality Account
	WB presented the paper and took it as read. The 2017/18 Quality Account was presented to the Quality Committee to gain approval for the content of the document. WB highlighted that this is an annual public document, which aims to improve public accountability for the quality of care that we provide. WB highlighted that there had been contributions by all ICSUs and highlighted that the Quality Account must meet the requirements set annually by NHS Improvement. The paper had been previously been to Trust Board and it was highlighted that it needed greater emphasis on how these target relate to the community services and that this needs to be made explicit in the report. CD highlighted that patient information leaflets had been a concern for the CYP ICSU and that they would like to increase the languages available for patients. MJ highlighted that this was an issue faced by all trusts, as there were financial and risk factors in using external company's translation services. DC highlighted that pictorial leaflets can be useful for targeting multiple languages in the Whittington Health community and that Public Health data could be used to target common languages in our community. It was also raised that ensuring resources were available online was important so that patients can access free online translation services. MR rose that NICE provide great advice on using translation services and that NHS England authenticate websites that are safe for patients to use. WB highlighted that the Information leaflet policy had recently been updated and was available on the intranet. Overall the Quality Committee felt that the content of the document fairly represented the quality of care that the trust provides. They felt that it was reflective of the discussions held by the Committee over the previous year and the Committee were confident that is born out of the right culture and principles. The Quality Committee were happy to approve the content of the document. The report will need to be sent to the Audit and Risk Committee to approve the assurance process of the report before it is submitted.

Actions	Deadline	Owner
To share the Quality Account with the ICSU leadership teams to ensure that all of the ICSU triumvirate have received the document.	June 2018	WB
To share the new Information Leaflet Policy via email to the relevant parties.	July 2018	WB

3.1	Emergency and Urgent Care ICSU
	SC presented the paper which was taken as read. SC highlighted that they have reduced the number of outstanding Duty of Candours within the division. SC highlighted that the remaining Duty of Candours need to be reviewed by the risk manager to ensure that all the requirements had been met.

	LR queried the number of medication incidents with the ICSU. KC and SC stated that there where high numbers of medication incidents in the community due to the size of the district nursing service. The ICSU is actively encouraging the reporting of medication errors as it leads to an open and transparent culture and encourages quality improvement. SC noted the number of pressure ulcers reported within the ICSU. MJ highlighted that these figures put into the context of the number of face to face contacts. SC discussed overcrowding in the emergency department that the ICSU had faced. SC highlighted that they were taking a number of actions to address this including RAT (Rapid Assessment and Treatment) and the Fit to Sit campaign.

Actions	**Deadline**	**Owner**
To help the division to review the number of items currently held on the risk register.	July 2018	GL

3.2	**Surgery and Cancer ICSU**
	FI presented the paper which was taken as read. FI highlighted the difficulties faced by the division with regards to bed flow for CCU ward able patients. MJ highlighted that this was a trust wide issue and that it would take a cross-ICSU response to resolve. MJ also noted that it had been a tough and challenging winter and commented on the fantastic management by the division during this difficult period. FI highlighted that over the winter months Coyle ward have worked extremely hard in challenging circumstances to deliver a high standard of patient care. Coyle ward have had two Band 4 Assistant Practitioners join the team which has been a great success. MJ raised whether there needs to be a direct focus on the recruitment of nurses to surgery with a structured campaign highlighting the great selling points of working in the Surgery and Cancer ICSU at the Whittington. RJ highlighted the challenges to patient safety in the Surgery and Cancer ICSU. RJ raised that improvements needed to be made with regards to communication and handovers within the ICSU. RJ noted that there would be challenges to finding a model of consensus between medical and surgical staff and that external facilitation may help to arrive at the right model of care. A cross ICSU post for medicine and surgery has been approved who will assist with governance in both ICSUs. FI highlighted the work of the cancer and urology services. RJ raised that our data on bariatric data was excellent and had been highlighted at the Getting It Right First Time (GIRFT) conference. FI noted that the cancer standards had only not been achieved once. FI highlighted that the team was working exceptionally hard and endoscopy has seen good improvements.

Actions	**Deadline**	**Owner**
No further actions		

4.1	Quality and Safety Risk Register	
	WB presented the risk register update which focuses on risks scored greater than 15. WB highlighted that the estates risks are included under the new reporting structure at the trust, and that actions associated with estate risks greater than 15 are within the remit of the quality committee. MJ questioned whether Risk 830 (Haringey Community Paediatric Consultant Gaps in Child Protection Rota) should have been reduced yet, as the substantive posts had not been filled. The risk entry to be reviewed. DHU noted that risk 773 (Risks associated with LUTS service) had been downgraded. DHU requested that this be circulated to the NEDS. FI noted that on the risk 876 (Failure to transition effectively to and implement ERS risk), the date should be October 2018, not May. Risk 728 (Medical records not located in medical files) was raised and it was requested that the risk be reviewed due to the new GDPR laws.	

Actions	Deadline	Owner
Director of Estates to be added on the terms of reference	July 2018	MJ

4.2	Aggregated Incidents, Complaints and Claims Q4	
	AB presented the paper which was taken as read. AB highlighted that this is the highest number of incidents that the Whittington Health has ever reported. Our reporting culture continues to improve, and quarter four shows that we continue to achieve excellent levels of reporting compared nationally. AB noted that NRLS and STEIS will see a shift in some key areas with a re-focus on learning for improvement, supporting patients to be involved in the reporting-learning cycle and making better use of the knowledge and skills that NHS Improvement hold. AB highlighted that identifying and managing the deteriorating patient had been identified as a contributing factor in a number of patient safety incidents and as result this reports spotlight focuses upon this theme. There were common themes which have been identified which could be grouped under two broad headings; lack of communication / failure to escalate and lack of education or understanding in the use of early warning tools and guidance. LR raised questions regarding the escalation of clinical deterioration in patients. The role of volunteers in escalating concerns and the correct pathways was discussed by the committee. It was highlighted that it is everyone's responsibility to ensure that patients are kept safe within the hospital. MJ highlighted that the further exploration and decision regarding implementation of the nationalNEWS2 scoring system needs to be carefully considered. As a fast follower in the Global Digital Exemplars scheme the trust has the potential to move to the	

	NEWS scoring system. NHS England's aim for all acute hospital trusts to fully adopt NEWS2 for adult patients by March 2019 and MJ highlighted that the implementation of this needs to be carefully considered within a multi-disciplinary approach.

Actions	Deadline	Owner
No further actions		

4.3	Patient Safety Q3 report	
	RJ noted that this paper has already been to public board. RJ reported that this paper examined Q4 and took a deep dive into the safety issues around influenza and highlighted the learning. Included in the report were measures the trust should take for next year's flu season. RJ highlighted the flu vaccination uptake variance within the trust and discussed how we can support our staff to take the vaccine, where vaccination rates are low. The committee acknowledged that this was a sensitive issue due to the different beliefs held by staff. AS thanked RJ for this report.	

Actions	Deadline	Owner
No further actions		

4.5	Patient Experience Report (Q4)	
	JC presented the paper which was taken as read. JC reported that the Picker 2017 Inpatient Survey results had now been received. With regards to the results, JC stated that they were broadly similar to the previous year. JC noted that there had been improvements with the noise at night project. They have submitted an application in January for charitable funds in order to purchase equipment that will help patients and staff in improving the noise at night for inpatients. The patient experience team has also created a task and finish group to create an admission pack for patients admitted onto the inpatient wards. MJ noted that the noise at night project should be in the report but felt that it did not need a separate piece of work. JC highlighted that through the second and third quarter of 2017/18, the collection of FFT responses in the Trust's community sites had been trending downwards. The patient experience manager has therefore been working closely with community sites to increase the number of FFT responses through increased administrative support and the introduction of an SMS service for FFT alerts in Podiatry. AS highlighted a great video on patient safety by JC at trust board. It was discussed at the committee whether patient stories could be shared at the quality committee with each ICSU presenting a different account. Each ICSU could decide the manner in which the report was presented. MJ stated that she would follow this up with the executives to see the best way to present this data. MJ thanked JC for the report.	

Actions	Deadline	Owner
To look at how patient stories can be incorporated into the quality committee agenda	July 2018	MJ/AS

4.6	Revised Quality Committee TOR	

	WB presented the revised quality committee terms of reference. WB highlighted that the Health and Safety committee will present an annual report to the Quality committee and with exception. WB also noted that Safeguarding Adults and Children will present six-monthly rather than quarterly.

Actions	**Deadline**	**Owner**
No further actions.		

4.7	**Nursing Quality Indicators**	
	MJ presented the paper which was taken as read. MJ acknowledged the difficulties in getting staff to attend mandatory training during the winter pressures. MJ thanked the ICSU's for their hard work.	

Actions	**Deadline**	**Owner**
No further actions		

5.	**Minutes from Reporting Groups – for information only**	
	AS referred the committee to the minutes from the reporting groups. No concerns were raised.	

7. Any other business

The next Quality Committee is scheduled for **Wednesday 11th July 2018**, from 2pm-4pm in WEC Room 6.

Future dates:

- 12th September 2018
- 14th November 2018

DRAFT

Whittington Health NHS

Trust Board 30 May 2018
ITEM 18/083
Doc 12.1

WORKFORCE ASSURANCE COMMITTEE

Minutes of the meeting held on Thursday 24th May 2018

Present:	Stephen Bloomer	Chief Finance Officer
	Helen Gordon	Deputy Director of Workforce
	Graham Hart	Non-Executive Director (WAC Chair)
	Steve Hitchins	Trust Chairman
	Helen Kent	Assistant Director of Learning & OD
	Michelle Johnson	Chief Nurse
In attendance:	Lawrence Anderson	Medical HR Business Partner
	Paul Attwal	Director of Operations, Integrated Medicine
	Jo Bronte	HR Business Partner
	Kate Green	PA to Director of Workforce (minutes)

18/11 Welcome and Introductions

11.01 Graham Hart welcomed everyone to the meeting.

11.02 Apologies for absence were received from Norma French, Carol Gillen and Jana Kristienova.

18/12 Minutes of the meeting held on 14th February

12.01 Graham Hart asked for the following amendments to be made to the minutes of the meeting held on 14th February:

- Minute 04.02 In the first line, board should begin with a small rather than a capital b
- Minute 04.06 In the first line 'ream' should read 'team'
- Minute 05.05 In the sixth line 'Graham' should read 'Graeme' (Muir).

12.02 Other than these amendments the minutes of the Workforce Assurance Committee (WAC) held on 14th February were approved.

18/13 Matters arising and action log

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

13.02 Paul Attwal was present at the meeting to speak about workforce issues within the Integrated Medicine ICSU.

13.03 It was confirmed that Richard Jones would attend the September WAC to update members on the new case management system.

18/14 Quarter 4 Workforce Report

14.01 Introducing this item, Helen Gordon commented on how helpful it was to have Paul Attwal present to elaborate on workforce issues in the Integrated Medicine ICSU. She also informed the meeting that there was an error on page 5 of the dashboard and tabled a corrected version. Helen went on to highlight key points, as follows:

- Bank and agency – the report showed a spike in agency usage for the quarter and an overall increase in temporary staffing. She intended to drill down into this in order to understand what had occurred and to look at trends and issues.

- There had been an improvement in mandatory training, attributable to some very good work in the ICSUs working with the HR business partners and also to Tanika's team working on some data cleansing.

- There had been a 1% reduction in vacancies due to recent nursing and HCA recruitment. Details of recruitment activity were provided in her report. More detail was provided in the recruitment and retention paper which would be discussed later in the meeting.

14.02 Michelle informed the committee that a number of assessment centres had been held, including an event for midwifery that week attended by some 50 applicants. There was a need, she emphasised, to understand why candidates who had initially shown interest in joining Whittington Health later withdrew. Helen Gordon replied that the recruitment team was doing everything possible to retain interested candidates, but it was an 'applicants' market', and well known that many applied for positions at more than one Trust in the knowledge that they could choose later on in the process. Michelle asked for details of the retention rate to be provided in future.

14.03 The meeting briefly discussed the benchmarking data contained in the report, noting that the Trust compared well to similar organisations. There was also some mileage in looking at data alongside the Model Hospital. Steve Hitchins commended the team for their achievements to date, but said there was still some way to go, and he asked for more detail on the gap between offers and start dates, questioning whether people were discouraged by long waits. Helen reiterated the point made earlier about applicants accepting multiple offers, adding that the recruitment team did not have the capacity to act as relationship managers and could not continually chase applicants, although they had made great strides in efficiency.

14.04 Moving onto sickness, it was noted that there had been an increase in coughs and colds that quarter, but this was to be expected at that time of year. There had also been an increase in anxiety, stress and depression, and the Trust was addressing this through initiatives such as mental health training for staff. Further exploration was being carried out within individual ICSUs. It was noted there was a high rate of 'other' recorded as reasons for sickness absence, and suggested that one reason for this might be that relatively junior staff inputting data did not feel able to requests details due to respect for confidentiality. Helen Gordon felt there was a need for further exploration into the 'manager self service' aspect of the electronic staff record.

14.05 The process for conducting exit interviews needed to be addressed as once again there had been a failure to issue the exit interview template to staff leavers due to the absence of a member of staff within employee services. Helen was taking this up with the relevant manager. It was stressed however that exit interviews should not just be a paper exercise but should be conducted face to face with the appropriate manager, and Helen had asked the HR business partners to follow this up with their respective ICSUs.

14.06 The meeting discussed other retention initiatives including rotational opportunities and the capital nurse rotation with Great Ormond Street. Michelle Johnson referred to a 'retention trolley' initiative being carried out which she would be happy to demonstrate to the committee. It was acknowledged that applicants have varying aspirations – a 23 year old may want something quite different from a 43 year old. There was also a role for independent financial advisors.

Jo Bronte added that the team had recently conducted some staff engagement roadshows within both hospital and community settings ('we said, we did') focusing on the staff survey action plan and with the aim of improving staff experience.

14.07 Stephen Bloomer felt that it was important to be clear about the gaps in establishment and how these would be addressed. Helen Gordon advised that this was a matter of workforce planning, and Graham Hart said that he planned to hold an off-line conversation with Norma French about this. It was emphasised that the focus must be on ensuring quality and safety. The next WAC meeting would look at the wider workforce plan. It was also suggested the terms of reference be reviewed. Paul Attwal spoke about the opportunities presented by the ICSU restructuring exercise.

18/15 Integrated Medicine ICSU

15.01 The slides presented had been produced for the quarterly ICSU performance review meeting held the previous month, and Jo Bronte began by reporting on staff sickness, which was, she felt, at an acceptable level within Integrated Medicine. Staff turnover however remained a challenge, especially on the medical wards. Committee members were familiar with the various recruitment initiatives which had been carried out over the last couple of years including overseas recruitment but there was still much to do. Anecdotal evidence suggested that many newly-recruited Band 6s move on fairly rapidly and work was in hand to ensure the reasons for this were fully understood and could be addressed.

15.02 There had been some improvement on mandatory training and appraisal compliance since the previous quarter, and the ICSU had plans in place to ensure further improvement. Staff survey results had also been discussed, with staff keen to address the various themes that had been identified. Jo also highlighted the positive work that had been carried out in individual teams to address priorities, citing community rehabilitation as an example.

15.03 Other areas highlighted included:

- the high vacancy factor
- the hope that the closure of winter beds would alleviate some pressures
- the health roster and annual leave planning
- the enhanced care policy
- bank and agency spend within the ICSU.

15.04 The meeting discussed the effects on staffing of annual leave planning, as there was some evidence to suggest that additional pressures were caused by many staff taking leave in the last quarter of the financial year. Graham Hart took the view that staff should be able to plan for annual leave a year in advance. Comparisons were made with a system used by some whereby leave was planned on a tiered system whereby a different group of staff were given priority of choice each year (but could 'trade' with colleagues if they so wished').

15.05 The committee had been interested to learn about the different challenges facing the Integrated Medicine ICSU, and Paul emphasised the importance of planning and of proper scrutiny. Graham thanked Paul and Jo for attending.

18/16 Guardian of Safe Working Quarter 4 Report

16.01 Introducing this item, Lawrence Anderson informed the committee that 123 exception reports had been received in Quarter 4, the vast majority of which had come from FY1s. This did however represent a decrease from the previous quarter, which was encouraging. The main issue remained staff finishing shifts late. More detail would be provided in the annual report which Lawrence and Caroline were currently putting together and which would be presented at the next meeting.

16.02 Stephen Bloomer enquired about how the number of exception reports received compared to other organisations. Lawrence replied that it was difficult to compare; taking UCLH as an example, less reports had been received, but whether this was because junior doctors were not facing the same pressures or because Whittington Health was actively encouraging reporting was impossible to say.

16.03 In answer to a question from Steve Hitchins about whether other Trusts paid or did their best to offer time off in lieu Lawrence replied that this information was not widely available. He did say, however, that he felt there was some potential for looking at rotas to see whether they could be structured in a more efficient way.

16.02 There was still an issue with poor attendance at the junior doctors' forum, and Lawrence planned to raise this with the junior doctors' representatives.

18/17 Recruitment and Retention Action Plan

17.01 Helen Gordon informed the committee that she had carried out a stocktake of what had gone well, what remained to be done, and immediate action required. She added that the market shifted rapidly therefore responding to that was one of the key challenges. The next step was to look in more detail at retention. Steve Hitchins said that it would be helpful to see a recruitment and retention trajectory. He also asked whether the Trust was working with local schools and colleges and was assured that the team had strong links, attended open days and issued invitations.

18/18 Employee Relations Activity

18.01 Helen Gordon informed committee members that the Employee Relations Manager was now holding regular meetings with the Staff Side chairs, which was proving successful both in ensuring they were well informed and also in ironing out issues as necessary in a timely fashion. Delays in resolving cases had worsened slightly, and Helen explained this was due to both a lack of management time and union time as well as the complexity of some of the cases. Every effort was being made to resolve this and improve response times.

18.02 Helen confirmed that 'facilities time' was being reviewed in line with the current Partnership Agreement in order to ensure there was sufficient TU time to deal with all issues including consultations and casework.

18.03 A new mediation scheme had now been launched for staff.

18/19 Diversity Update

19.01 Helen Kent reported on recent activity within her team. Meetings had been held to establish staff inclusion networks, and the Trust was actively participating in the London Leadership Academy Pilot Inclusion Labs.

19.02 Several masterclasses had now taken place, with Task and Finish Groups now being established. Helen was also pleased to inform the committee that the Trust had now trained an addition nine Speak Up Champions.

19.03 The previous week had been Diversity & Human Rights week. A variety of events had been full week of events for EDI, Human Rights and Learning at Work Week, most of which had been well attended.

18/20 Apprenticeship Procurement

20.01 Helen Kent provided an update on the procurement process for apprenticeships, and her report had been provided to brief the committee on the tendering process and to provide assurance that some excellent providers had been identified. The Trust was also participating in the North Central London Trainee Nurse Associate test site and hoping to procure nursing associates to start at the end of the year. Whittington Health is also joining a pilot for apprenticeships for specialist practitioners (health visitors and district nurses) which was felt to be an extremely positive step.

18/21 Date of next meeting

21.01 The next meeting of the Workforce Assurance Committee would take place on 18 September.

Concluding, Graham thanked everyone for the work they had put in to providing papers for the committee.