Whittington Health NHS

TRUST BOARD

14.00 – 16.30

Wednesday 2 September 2015

Whittington Education Centre Room 7

Whittington Health NHS

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Meeting	**Trust Board – Public**
Date & time	**2 September 2015 at 1400hrs – 1630hrs**
Venue	**WEC 7**

AGENDA

Steve Hitchins, Chairman Anita Charlesworth, Non-Executive Director Paul Lowenberg, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive Stephen Bloomer, CFO Dr Richard Jennings, Medical Director Dr Greg Battle, Medical Director (Integrated Care) Philippa Davies, Director of Nursing and Patient Experience Lee Martin, Chief Operating Officer Norma French, Director of Workforce

Attendees
Lynne Spencer, Director of Communications & Corporate Affairs
Kate Green, Minute Taker

Contact for this meeting: Kate Green (kate.green4@nhs.net) or 020 7288 3554

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Oral*	*Note* 1400hrs
15/101	**Declaration of Conflicts of Interests** *Steve Hitchins, Chairman*	*Oral*	*Declare* 1420hrs
15/102	**Apologies & Welcome** *Steve Hitchins, Chairman*	*Oral*	*Note* 1425hrs
15/103	**Minutes, Action Log and Matters Arising 01 July** *Steve Hitchins, Chairman*	**1**	*Approve* 1430hrs
15/104	**Chairman's Report** *Steve Hitchins, Chairman*	*Oral*	*Note* 1435hrs
15/105	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Note* 1445hrs
Patient Safety & Quality			
15/106	**Safer Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	**3**	*Note* 1455hrs
15/107	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Note* 1505hrs

Performance and Delivery			
15/108	**Financial Performance Month 4** *Stephen Bloomer, Chief Finance Officer*	**5**	*Note* 1515hrs
15/109	**Performance Dashboard Month 4** *Lee Martin, Chief Operating Officer*	**6**	*Note* 1525hrs
15/110	**Workforce KPIs** *Norma French, Director of Workforce*	**7**	*Note* 1535hrs
15/111	**Staff Survey Action Plan 2014/15 Update** *Norma French, Director of HR*	**8**	*Note* 1545hrs
Governance/Regulatory			
15/112	**TDA Oversight Statements** *Siobhan Harrington, Director Strategy & Deputy Chief Executive*	**9**	*Approve* 1555hrs
15/113	**Quality Committee 8 July Minutes** *Anu Singh, Chair of Quality Committee*	**10.a**	*Note* 1605hrs
15/113	**Quality Committee Revalidation Report** *Philippa Davies, Director of Nursing & Patient Experience*	**10.b**	*Note* 1610hrs
15/114	**Finance & Business Development (F&BD) Committee Meeting August 2015** *Tony Rice, Chair of F&BD*	**11**	*Note* 1615hrs
Any other urgent business and questions from the public			
	No items notified to the Chairman		
Date of next Trust Board Meeting			
	07 October 2015 Whittington Education Centre, Room 7 After the Board meeting **on 2 September the Trust will hold its Annual General Meeting at 1700hrs to 1800hrs** to present the Annual Accounts & Annual Report 2014/15		

Register of Conflicts of Interests:
The Register of Members' Conflicts of Interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF - communications.whitthealth@nhs.net.

Whittington Health NHS

ITEM: 15/103
Doc: 01

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00pm on Wednesday 1st July 2015 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Norma French	Director of Workforce
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Steve Hitchins	Chairman
	Richard Jennings	Medical Director
	Paul Lowenberg	Non-Executive Director
	Lee Martin	Chief Operating Officer
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Jo Maybin, who had given birth to a son at the Whittington Hospital in August 2031, and Marsha Jones, Lead Midwife for maternity in-patient services. Jo's baby had been born in a birthing pool at the birthing centre and she described the midwives as "great, flexible and supportive". After the birth however, Jo had required extensive stitching and surgery, and at this stage of her care she described her experience of issues with her care.

Marsha Jones thanked Jo for her invaluable feedback and described the changes that had been made since her feedback which included:

- review and revision of how the matron and ward sisters work together
- bringing in a specialist adviser to train all staff in providing feeding advice
- a pilot project on self-administration
- monthly patient experience workshops
- 'Being our Best' 'Whose Shoes' and 'Footprints' projects.

Philippa Davies extended her apologies to Jo for elements of her care which did not meet the Trust's expectations for high quality standards, and hoped that she would return to the unit to see the improvements. It was noted that the Trust was hoping to make significant environmental improvements to the service which would enhance the experience of mothers giving birth and provide a better working environment for the staff.

Steve Hitchins thanked Jo for sharing her experiences and also thanked Marsha for highlighting the commitment and effort put in by the staff to make the improvements to the service.

15/088 Declaration of Interests

88.01 No Board members declared any interests in any part of the July Board proceedings.

15/089 Welcome and apologies

89.01 Apologies were received from Anita Charlesworth. The Chairman welcomed Norma French, newly-appointed Director of Workforce to her first Board meeting, and Stephen Bloomer, Chief Finance Officer. He congratulated Philippa Davies on her successful appointment as substantive Director of Nursing & Patient Experience.

15/090 Minutes of the previous meeting, matters arising and action log

90.01 Philippa Davies requested an amendment to minute 79.01, saying that the Allocate system had been procured rather than implemented, and that once it was implemented, it would serve to inform future reports. Other than this, the minutes of the meeting held on 3rd June were approved.

Action Log

90.02 It was noted that the Board Assurance Framework (BAF, 41.01) was scheduled on that day's agenda for discussion; this item could therefore be removed.

90.03 Lee Martin informed the Board that key performances in ambulatory care (08.03) and podiatry, intermediate care and rehabilitation (84.03) were now included in the performance report; these items could also therefore be removed.

15/091 Chairman's Report

91.01 Steve Hitchins opened his report by expressing his pleasure at seeing a full complement of executive directors around the table. The only Board vacancy now remaining was that of the non-executive Chair of the Audit & Risk Committee, and a nomination for that post was currently with the Trust Development Authority.

91.02 The previous Saturday Steve had attended the Trust's recruitment day for nurses, which he described as having been very well organised. He had also attended the obesity conference at Haringey, and on Monday joined a group of executive directors in visiting Northumbria Foundation Trust, where they had learned a great deal.

91.03 Steve expressed his congratulations, on behalf of the Board, to the Hanley Road practice on becoming accredited as a training practice. Finally, he paid tribute to the work and career of consultant psychiatrist Sebastian Kraemer, retiring after 35 years of service.

15/092 Chief Executive's Report

92.01 Simon Pleydell began his report by highlighting the nurse recruitment day, saying that 38 people had attended and jobs had been offered to 18. At a time when all Trusts were struggling to recruit nurses he viewed this as a very good day for the Trust, and he expressed his gratitude to all who had been involved in organising the event. Steve Hitchens added that the Trust was also working with the City & Islington College on its nursing course, which Paul Convery confirmed was in considerable demand.

92.03 A positive meeting had been held with the Trust Development Authority (TDA) on the Trust's proposal to develop its maternity and neonatal care service, and a decision should be forthcoming by the end of July. He assured the Board that he had been clear about the importance of the decision to our plans for the future. The Trust had also been pleased to receive local authority planning approval. It was noted that the launch of the community simulation hub was scheduled for 16th

July at Crouch End Health Centre; this was a facility designed to train multi-disciplinary teams to work in a domestic setting and the next phase of the project was to attract customers to generate income.

92.04 There was still no confirmed date for the CQC inspection. Simon informed the Board that the Trust's focus at present was on conversion to its new structure. There remained one outstanding position to fill, that of clinical director for urgent and emergency care. Simon was instigating a new team briefing system, which will help share core messages and create a two way dialogue with all teams across the Trust. The following day Simon was due to attend Islington Council's Overview & Scrutiny Committee to share the latest news and work of the Trust.

92.05 The Trust had recently held an extremely successful day on services for people with learning disabilities. This was a client group who had historically not been well served, as had been borne out by a number of national reports, and Simon reminded Board colleagues that improving such services was one of the Trust's priorities as well as being a pledge the Trust was committed to under its 'Sign up to Safety' commitment. There had also recently been a very successful event for speech and language therapists at the Michael Palin Centre – Siobhan Harrington had attended on behalf of the Board and paid tribute to its success.

92.06 In summary, Simon said that there were two key priorities for the Trust over the coming months – one was the implementation of the new structure, the other the planning and delivery of CIPs, not just for this year but also in planning for the next. It was noted that Whittington Health's position was by no means unusual either in London or elsewhere in the country.

15/093 Safe Staffing Report

93.01 Philippa Davies informed the Board that the report circulated gave details of nurse staffing levels on in-patient wards during the month of May. All areas had been safely staffed, and there had been minimal use of 'specials'.

15/094 End of Life Strategy

94.01 Greg Battle said that the paper reflected the work carried out in acute and specialist palliative care services over the last 8-9 months. The structure of the service, which cares annually for 3-4 hundred people coming to the end of their lives, was outlined. The Trust had participated in the national Care of the Dying Audit, and the results showed a high level of clinical performance although results were less good in areas such as the provision of information. The action plan showed how it was planned to move those areas currently showing as red to green.

94.02 Work was also under way with local hospice services on extended hours. Greg stressed the importance of this work, saying that speaking as a GP he found it a great privilege to be involved in this area. It was important for the Board to be fully aware of the details of the services provided, as securing the best possible care and experience for patients at the end of life was in line with the Trust's clinical strategy. He thanked those who had made a significant contribution, mentioning especially Paula Meale, Ruth Law, Fiona Paterson and Anna Kurowska. There were also plans to organise some local events later in the year involving lay people.

94.03 In answer to a question about areas in the audit where the Trust was showing as red, Greg replied that the Trust was not significantly behind when viewed comparatively with other similar organisations, however the team itself felt that performance in some areas could be improved quickly as they were

straightforward. Richard Jennings added that the audit had been carried out at a time when the service had been severely stretched.

94.04 In answer to a question from Paul Convery about end of life care for those in residential or nursing homes, Greg replied that Whittington Health was at the leading edge of performance in this area with the team going into homes and planning with GPs. Siobhan Harrington praised the way in which the strategy had been framed around the Trust's clinical strategy, adding that the future cancer services strategy would be developed next and be presented to a future Board. The End of Life Care improvement plan would be monitored through the Quality Committee but the Trust Board would receive a report annually. Lynne Spencer had prepared a dynamic Board cycle and will include these important reporting requirements to the schedule.

94.05 Paul Lowenberg asked about plans to increase the out of hours service. Simon Pleydell replied that a distinction had to be made between what could be done within existing services at no cost and what would need funding and thus necessitate discussion with the commissioners. At present no commitment could be made to anything which required additional investment. Richard Jennings added that training for non-palliative care clinicians (such as himself) will be required as they were also involved in end of life care. It was noted that Steve Hitchins would be the non-executive lead in this area.

15/095 Financial Report

95.01 Stephen Bloomer introduced the Month 2 Finance Report, stressing the efforts being made to monitor and manage the cash position tightly. The Trust continued to forecast a £19.5m deficit at year end, but was behind in its CIP programme (77% to date). There were also some risks in the income plan. So whilst the year-end forecast remained unchanged there were some challenges. There had also been a Board-level commitment to do better, and to date this had not been achieved.

95.02 Paul Convery said that it was likely the Overview & Scrutiny Committee would point out that the size of the deficit could end up equivalent to almost 10% of the annual turnover, and asked with what sense of urgency this was being viewed. Simon Pleydell replied that firstly this was a complicated position which had been building up over some years, and secondly there had been several contributory factors which could not have been predicted such as increased NHSLA costs which had risen by £3m. Moreover, the Trust had lost income, a significant proportion of which was down to local authorities reducing their costs. Overall there had been a drop in income of almost £10m.

A two-year plan had been agreed by the TDA, but it was clear that the two next years would be difficult. The report was agreed by the Board.

15/096 Performance Dashboard

96.01 Lee Martin began by setting out the Trust's position on the national indicators. RTT, diagnostics and cancer had been achieved, and ED was improving – figures were already at 94% and gradually rising within that percentage towards 95%. There was slight concern about the 62 cancer waits caused by a significant rise in patient numbers.

96.02 Looking at three key areas, Lee explained the circumstances behind:

- MSK – the Trust was behind on its 6 week community target. A review had been carried out which had revealed that staff annual leave had coincided with an episode of long-term sickness and the service was expected to be back on target by August

- Women seen by HCP or Midwife – a number of improvements had been made within the service and the Trust was also working with commissioners so that performance could be more accurately identified. The new clinical director had also been asked for her views on what might be done to improve performance

- DNAs – factors were different within community and acute services. Postal services and reminder calls were an issue and new contracts were being considered.

96.03 In answer to a question from Paul Lowenberg about ambulatory care assessments, Lee replied that this target was being revised. Paul also enquired about the apparent decrease in face to face contacts within the community, Lee explained that there is a predictable drop in activity on certain dates, activity was not flat, but from the next report it would be possible to see a clear picture of activity against target.

96.04 On page 3 of the report, Richard Jennings pointed out that there was an inaccuracy, the Medical Director did not, as was reported, review every death. Richard Jennings explained that he as Medical Director is overseeing the setting up of a mortality audit process whereby every inpatient death will be reviewed by a team of appropriately trained clinicians, and the learning from these reviewed collated, shared and acted upon in accordance with nationally accepted best practice. Richard Jennings explained that at the moment many departments had well established and high quality mortality and morbidity meetings which give assurance that any concerns around inpatient deaths are currently looked into. The trust-wide process once established will give further assurance that every death will be reviewed.

15/097 Workforce Report

97.01 Norma French reported that the performance had not changed significantly since the last meeting. She added that she would be looking at the quality of the data. Paul Lowenberg welcomed this, saying that the previous month's figures had been unreliable in terms of both numbers and spend, and asked when this work might be completed. Norma replied that there was a significant piece of work to be carried out to lock down these numbers, and she would require having colleagues from Finance, Operations and HR working together to complete it. It was too early to say when the work would be finished, but Norma assured the Board this was a top priority for the future.

15/098 TDA Board Statements

98.01 Siobhan Harrington informed the Board that the TDA would shortly be issuing the statements to be completed in a new format, and the executive team would also be reviewing the content. This month's was broadly in line with that submitted the previous month, and was approved by the Board.

15/099 Board Assurance Framework

99.01 The Board Assurance Framework (BAF) had been circulated in draft format and it had been developed from the former BAF reported to the Board and Audit

Committee during 2014/15. The revised BAF would be further discussed at the Board seminar the following week. Siobhan Harrington felt that this new version was more focused and made a clearer link with the Trust's strategic goals. The seminar discussion would also look at how the BAF was used, and Steve Hitchins, Simon Pleydell and Siobhan would also hold further discussion on how it was best used by the Board. The new Chair of the Audit & Risk Committee would also be invited to comment on the format and process of reporting to the Board. The Board noted the BAF.

15/100 Audit & Risk Committee Assurance Report

100.01 Paul Lowenberg, who had been present at the meetings of the Audit & Risk Committee held on 28th May and 1st June presented the paper. He reported that the Committee had felt there was a lack of integration between CIPs, budget and workforce plan and that until all three were properly joined there remained an element of risk. Lee Martin drew the Board's attention to the significant amount of work that had already gone into linking CIPs to workforce plans.

100.02 Steve Hitchins recorded his thanks, on behalf of the Board, to Anita Charlesworth who had acted as Chair of the Audit & Risk Committee.

15/101 Any other business

101.01 A level 3 heatwave had been declared earlier that day, and deputy director of nursing Doug Charlton was in charge of overseeing additional facilities for patients such as extra fans and cold water. Siobhan Harrington added that the day had just been declared the hottest July on record.

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Action Log

Ref.	Decision/Action	Timescale	Lead
94.04	Cancer services strategy to be presented to a future Board	Nov 2015	LM
94.04	End of Life Care improvement plan to be monitored through the Quality Committee and LS to add to cycle of business for regular reporting.	Completed	LS
94.04	Trust Board to receive an End of Life report annually and LS to add to cycle of business.	Completed	LS

Whittington Health Trust Board

2 September 2015

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**15/105**	**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 note 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:	18 August 2015		

Author name and title:		**Simon Pleydell, Chief Executive**		**Director name and title:**		**Simon Pleydell, 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 to the Trust Board.

1. QUALITY AND PATIENT SAFETY

Care Quality Commission (CQC)

The Trust continues to make good progress to prepare for a full CQC inspection which has been confirmed will take place from week commencing 7 December over a 3 week period. The inspection will identify best practice, as well as highlighting areas which may need improvement.

This is an excellent opportunity for the Trust to showcase its services and for staff to explain how we are implementing our clinical strategy to help local people live longer healthier lives.

Maternity and Neonatal

The Trust continues to work positively with the TDA to secure a decision on the full business case which will help modernise maternity and neonatal facilities. This will be a significant milestone and will help to achieve the Trust's vision to provide safe, personal, coordinated care.

Recruitment Open Day for Nurses and Midwives

On Saturday 5 September Whittington Education Centre will host an open day to support recruitment of nurses and midwives. Teams of clinicians will greet potential candidates and give them a tour of the hospital site and its extensive training facilities. These days are part of an ongoing initiative to showcase the benefits of working for Whittington Health and the excellent training and clinical facilities to potential employees in a relaxed and informal environment.

MRSA Bacteremia

The Trust is pleased to report that it has had no cases of MRSA for this financial year. The Trust has a robust zero tolerance approach to MRSA bacteremia breaches and will continue to keep this as a top patient safety and quality priority.

Clostridium Difficile

Two new cases were reported for June and July (1 in each month). This brings the Trust total to 4 cases for the year to date. The target is for no more than 17 cases in each year. The Trust has reminded colleagues to be extra vigilant with regular awareness raising initiatives on the importance of adhering to infection control procedures to maintain a strong focus on patient safety as the top priority.

New Patient Feedback System

The Trust is committed to being an organisation that continuously improves services and one way to do this is by listening to patient feedback and responding to lessons that are identified. It is important to provide as many opportunities for feedback as possible and

a new patient feedback system called Meridian has now been implemented. This allows patients to complete surveys using ipads on wards at the hospital and in clinics.

Cancer Waiting Time Targets

The Trust is pleased to have achieved all 8 national cancer waiting time targets for the latest reporting period up to July 2015. The cancer targets include important patient safety areas such as two weeks from referral to first appointment, 31 days from decision to treatment and 62 days from referral to treatment waits.

2. ORGANISATIONAL DEVELOPMENT

Integrated Clinical Support Units (ICSUs)

The Integrated Clinical Support Units are now fully operational with the final Clinical Director position filled for Urgent and Emergency Care. Rachel Landau has taken up this position and her background is as a Consultant in Emergency Medicine. She has held the position of Clinical Lead in Emergency Medicine at the Trust from 2001-2012 and is currently the Trauma Lead for the Trust. Rachel has a strong interest in quality and service improvement.

The new CEO team briefing session has also been successfully launched which is supporting greater two way dialogue between senior managerial staff and their teams. This will strengthen communication flows between different staff groups so that as many staff as possible will be able to receive and feedback information on the Trust's plans and performance.

3. FINANCE

The finance paper sets out our Month 4 position which shows at the end of July a deficit of £5.12m which is £57k better than the planned position.

The Trust continues to face a very challenging financial position and is reporting an overspend against the budgeted expenditure by £907k during the first four months of the year. This is largely due to under-performance against the saving targets against the Operating Plan that was planned to significantly increase from July onwards. At the end July, the Trust had achieved £1.7m (56%) of the planned savings of £3.1m year to date.

The Operational Plan submitted to the TDA will help the Trust to deliver its planned deficit for 2015/16 and the required savings programme of £16.5m. The Trust believes this is a realistic Plan that can be delivered and will improve the run rate to help achieve future financial balance.

Strengthening controls on maximising income, not overspending on agreed budgets, maintaining a focus on quality and delivering the savings programme at greater pace will be a major focus in the forthcoming months.

4. HIGHLIGHTS

Annual General Meeting

The Trust Annual Report and Accounts for 2014/15 will be presented to members of the public after the public Board meeting on 2 September. The AGM will commence at 5pm and continue to 6pm. This will be opened by choir members of the charity 'Kissing It Better'. These excellent singers will perform a song to welcome members of the public and to pay tribute to the many achievements of staff throughout the past year.

5. Healthwatch

The Deputy Chief Executive Office/Director of Strategy and Director of Nursing were pleased to attend Islington Healthwatch in August to discuss the Trust's clinical strategy, quality and safety plans and its challenging financial position. Healthwatch members' valuable feedback will help inform the Trust's plans to help local people live longer, healthier lives and to shape closer ways of working between the Trust and Healthwatch.

6. Estate strategy

The Trust has started to develop an estates strategy and we will be involving stakeholders, staff and local communities in this work. Numerous engagement activities will be taking place to receive as many views as possible to help the Trust develop an estate that is fit for purpose to provide high quality working environments for our staff and patients.

7. Lead provider

The Trust was delighted to be announced lead provider during this period for frail elderly services in Islington, and for diabetes in Islington and Haringey. Work is underway with commissioners and our partners to develop the integrated model of care in these boroughs on how to ensure services continue to improve and support patients.

8. Information and technology

The Trust experienced problems in August with the operational functionality of its IT systems. The Trust would like to thank staff for their hard work in managing the disruption to IT services which are now operating efficiently and effectively.

The Trust would like to sincerely apologise to patients affected by the IT issues and to thank them for their patience whilst the Trust swiftly resolved the issues.

Simon Pleydell
Chief Executive Officer

Executive Offices

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www.whittington.nhs.uk

Whittington Health Trust Board

2 September 2015

Title:	Safe Staffing (Nursing and Midwifery)		
Agenda item:	**15/106**	**Paper**	**03**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in July 2015. Key issues to note include: • The majority of areas reported greater than 95 per cent 'actual' versus 'planned' staffing levels. • A number of areas reported 'actual hours worked' over and above those 'planned' which was attributed in the main to the provision of extra support required due to extra beds on wards with more highly dependent patients. • The small increase in 1:1 specials used this month compared to last due to increase in patient care needs. • The Nursing and Midwifery Council (NMC) new Guidance to Registrants with regard to their responsibilities in relation to staffing and patient safety.		
Summary of recommendations:	Trust Board members are asked to note the June UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care, Francis Report recommendations, Cummings recommendations and NICE recommendations.		
Reference to related / other documents:	Fits with clinical strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	August 2015		

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Safe Nurse Staffing Levels

1.0 Purpose

To provide the Board with an overview of nursing and midwifery staffing levels in terms of 'actual' versus 'planned' hours on our wards in July 2015 and an assurance that these levels are monitored and managed daily.

2.0 Background

Whittington Health is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', percentage skill mix ratio of registered nurses to HCAs and the number of staff per shift required to provide safe and effective patient care.

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 30th July 2015 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

As described above, the 'Fill rate indicator return' was completed and submitted. A copy of the UNIFY submission is available on request and is available to view on the trust website.
The 'actual' number of staffing hours planned is taken directly from our nurse roster system, following which a look back exercise is undertaken. There were occasions when planned hours were revised either up or down taking into account an increase or reduction in patient bed numbers. On occasions when there was a deficit in 'planned' hours versus 'actual' hours, staff were moved from other areas to ensure safe staffing levels across our hospital. Staff were also moved to ensure wards/areas were staffed to a safe ratio of permanent versus temporary staff.

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in July 2015. The average fill rate was 105.7% for registered staff and 113.3% for care staff during the day and 102.3% for registered staff and 108.5% for care staff during the night.

Three wards fell below 95% fill rates for qualified nurses but were managed safely by moving staff from other green RAG rated areas and with the assistance of matrons and practice development nurses. Above 100% fill rate occurred in ten areas where nurses were required to care for patients who needed 1:1 care due to mental health and or high dependency and or acuity issues. Above average fill rates in excess of 100% for HCA's continues on wards where vulnerable patients require 1:1 care and where nurses are awaiting their NMC registration.

3.1 Additional Staff (Specials 1:1)

When comparing July's requirement for 1:1 'specials' with previous months the figures continue to demonstrate a low level of need as show in **Appendix 2**. Although there has been a rise in the 1:1 requirements in the last month. This rise was due to an increase in the number of specialist mental health nurses for patients with suicidal tendencies admitted across our acute wards including our children's ward. There was also a higher than expected number of vulnerable and elderly patients at risk of falls due to severe confusion, agitation and detoxifying from drugs or alcohol. The number of RMN 'specials' required to

care for patients under a mental health section or for patients with dementia continues to fluctuate.

4.0 'Real Time' management of staffing levels to mitigate risk

Safe staffing levels are reviewed and managed on a daily basis. At the daily 08.30am bed meeting, the Director of Nursing/Deputy Director of Nursing in conjunction with matrons, site managers and other senior staff review all registered and unregistered workforce numbers by ward. Consideration is given to bed capacity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure that all areas are made safe.

Ward shifts are rated 'red' 'amber' or 'green' according to numbers of staff on duty, taking into account patient numbers, acuity and dependency.

- Green shifts are determined to be safe levels and would not require escalation as these constitute the levels expected through the agreed ward establishment.

- Amber shifts are determined to be at a minimum safe level. The matron will be alerted, but no further escalation will be required. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency of patients.

- Red shifts are determined to be at an unsafe level. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability. In exceptional circumstances, activity would be reduced through reduction in the number of beds. This addresses the risk and reduces the shift to an amber rating.

In summary, in July a total of 16/1488 (1.07%) shifts triggered 'red' which was higher than previous months. Of these, 0/837 (0%) occurred in the Division of Integrated Care and Acute Medicine (ICAM), 8/279 (2.9%) in the Women's, Children and Families (WCF) Division and 8/372 (2.2%) shifts were reported to have triggered 'red' in the Division of Surgery, Cancer and Diagnostics (SCD).

5.0 NMC Briefing

The Nursing and Midwifery Council recently issued new guidance with regard to appropriate staffing in healthcare settings. This document sets out clearly the responsibilities of registrants especially those of senior registrants with regard to their responsibilities. This guidance has been circulated widely within the organisation and can be found in **Appendix 3.**

6.0 Conclusion

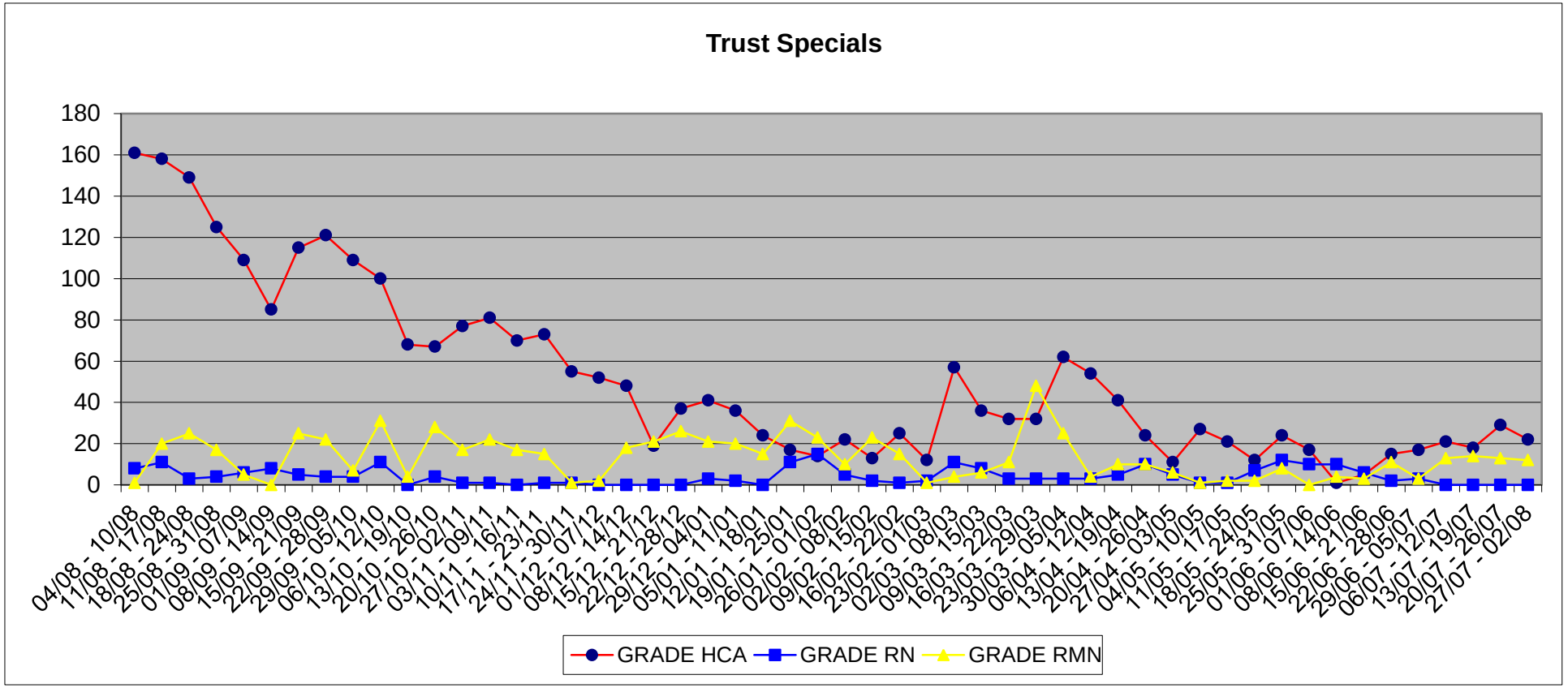
Trust Board members are asked to note the June UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Appendix 1

Fill rate data - summary
July 2015

Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual				
29886 hours	31583 hours	9462 hours	10721 hours	24033 hours	24580 hours	6152 hours	6673 hours	105.7%	113.3%	102.3%	108.5%

July 2015


Trust Specials
180
160
140
120
100
80
60
40
20
0
04/08 - 10/08
11/08 - 17/08
18/08 - 24/08
25/08 - 31/08
01/09 - 07/09
08/09 - 14/09
15/09 - 21/09
22/09 - 28/09
29/09 - 05/10
06/10 - 12/10
13/10 - 19/10
20/10 - 26/10
27/10 - 02/11
03/11 - 09/11
10/11 - 16/11
17/11 - 23/11
24/11 - 30/11
01/12 - 07/12
08/12 - 14/12
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22/12 - 28/12
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16/03 - 22/03
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30/03 - 05/04
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13/04 - 19/04
20/04 - 26/04
27/04 - 03/05
04/05 - 10/05
11/05 - 17/05
18/05 - 24/05
25/05 - 31/05
01/06 - 07/06
08/06 - 14/06
15/06 - 21/06
22/06 - 28/06
29/06 - 05/07
06/07 - 12/07
13/07 - 19/07
20/07 - 26/07
27/07 - 02/08
GRADE HCA
GRADE RN
GRADE RMN

NMC Briefing

Appropriate staffing in health and care settings

What is the NMC's interest in staffing?

The importance of appropriate staffing was reinforced by the Francis Reports into failings at Mid Staffordshire NHS Foundation Trust in England. Appropriate staffing plays an important part in the delivery of safe and effective health and care. Safe staffing can be a complex area and has to take account of multiple factors. It must be matched to patients' needs and is about skill-mix as well as numbers, about other staff as well as nurses, and other settings as well as hospitals. It is the responsibility of health and care providers, which are regulated by system regulators in the four countries of the UK.

As a professional regulator it is not the job of the NMC to set or assure standards related to appropriate staffing.

However, it is a matter that has a bearing on what we do in a number of ways. This briefing sets out some of the regulatory considerations raised by this issue.

What does the Code for nurses and midwives say that relates to staffing?

The Code sets out the core standards of ethics and practice expected from nurses and midwives. It is intended to support registrants in ensuring their practice meets the standard required of the professions.

Environmental factors like staffing levels can affect nurses' or midwives' ability to uphold the values of the Code. The Code says that:

> **You must put the interests of people using or needing nursing or midwifery services first. You must make their care and safety your main concern and make sure that their dignity is preserved.**

This primary duty means that nurses and midwives should be vigilant about safety and quality:

You must work with colleagues to evaluate the quality of your work and that of the team. You must work with colleagues to preserve the safety of those receiving care.

It also means that they have a professional duty to act or speak out if quality and safety may be compromised:

You must act without delay if you believe that there is a risk to patient safety or public protection.

You must raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices.

We require nurses and midwives to uphold nationally agreed standards as well as the Code:

You must tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards.

For nurses and midwives in England, this would include existing guidance developed by the National Institute for Health and Clinical Excellence (NICE) on safe staffing, and the National Quality Board/Chief Nursing Officer's 2013 guidance, *How to ensure the right people, with the right skills, are in the right place at the right time.*

What does the NMC's guidance on Raising Concerns say?

Our Raising Concerns guidance contains a list of examples of concerns that should be raised, including:

Issues to do with care in general, such as concerns over resources, products, people, staffing or the organisation as a whole

The Code, senior registrants and staffing

Appropriate staffing is a collective responsibility of boards and executive teams. Registrants who hold senior positions such as director of nursing are not individually responsible for appropriate staffing, and staffing concerns do not automatically imply a concern about executive level registrants. However, the Code states that:

You must provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare system.

You must identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.

You must acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.

Nurses and midwives must always be able to justify their decisions and actions, should a concern about their fitness to practise be raised. For senior registrants, this may include decisions about how staffing requirements were set, what mechanisms for monitoring these were in place and how well concerns were listened to.

We have always been clear that the Code applies to every registered nurse and midwife whatever their role and scope of practice, including directors of nursing who are members of leadership teams responsible for safe staffing. Recent fitness to practise cases demonstrate that managers and directors can be sanctioned for presiding over poor care just as frontline nurses and midwives can be sanctioned for delivering poor care.

Staffing and fitness to practice

Our fitness to practice processes routinely test and weigh evidence about the responsibility of nurses and midwives and the impact of the care environment. If a nurse is referred to the NMC on the basis of an allegation to do with staffing we may explore whether the registrant:

- raised concerns
- assessed evidence of risk to patients
- sought to mitigate risk

We understand that taking the right decisions about staffing on the ground is not always straightforward. For example, closing a ward to admissions may be in the best interests of patients already admitted and being treated, but may not be in the interests of those waiting for admission in A&E. Also, nurses may be advising operational managers rather than in direct charge. Professional accountability means being prepared to account for tricky decisions and being able to give a robust account of acting on good evidence and in the best interests of patients.

Expectations of registrants will depend on their role and level of seniority – there may be higher expectations of a director of nursing in this regard than of a ward manager, for example. However, all registrants should be aware of their individual and collective responsibilities.

Staffing and education

We set and monitor standards for the education of nurses and midwives, which takes place in higher education institutions (HEIs) and in healthcare settings. Pressures on staffing can have an impact on practice placement settings, where they may make it harder for nurses and midwives to dedicate time to supporting students. We require HEIs to monitor and mitigate risks to practice placements. If we have evidence that staffing levels may be affecting the training environment, we may ask education providers to investigate and provide assurance.

Recruitment challenges and registrations

People must be registered with the NMC to practice as a nurse or midwife in the UK. We uphold the public interest by setting standards for entry to the register and being consistent in their application.

Registration is an important safeguard, but employers have the primary responsibility to make sure they employ staff with the right skills and experience in the right posts.

Staff shortages may lead employers to recruit overseas. Overseas nurses are a valuable resource for UK healthcare providers. It typically takes longer to register oversea applicants to the register. Although EU applications are usually quicker than non-EU applications, employers need to take responsibility in the interest of patients for checks on matters such as language competence that regulators cannot yet require as part of registration.

Regulators have challenging targets for completing registrations because our performance has a direct impact on the front line. But in order to protect the public we must not cut corners when it comes to making sure applicants are who they say they are, and are qualified to do the work of registered nurses and midwives.

However, there are things we can do to help:

- Provide clear guidance on the information we need to manage initial registrations and renewals
- Be proportionate – only require what is necessary to protect the public
- Process registrations as quickly as possible, consonant with taking the necessary steps to check eligibility
- Collaborate as appropriate with workforce bodies leading recruitment and returning campaigns

Working with others

We will inform the appropriate system regulator if we uncover concerns about a provider when we are investigating a fitness to practice referral or as part of our work in quality-assuring nursing and midwifery training. Such concerns could include claims of unsafe staffing or the suppression of concerns raised by staff. We also encourage system regulators to inform us if they have concerns about the conduct or practice of individual nurses and midwives in respect of staffing or any other matter covered by the Code.

References

2nd Francis report

DH (2013) Hard Truths

NQB/CNO (2013) How to ensure the right people, with the right skills, are in the right place at the right time.

NMC website address: http://www.nmc-uk.org/About-Us/Safe-staffing

Nursing and Patient Experience
Direct Line: 020 7288 3589
www.whittington.nhs.uk

Whittington Health NHS

The Whittington Hospital NHS Trust
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Whittington Health Trust Board

2 September 2015

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**15/107**	**Paper**	**04**
Action requested:	For Information		
Executive Summary:	The purpose of this revised report, to be discussed in Part 1 of Trust Board (traditionally discussed in Part 2) is to provide an overview of the reporting and management of Serious Incidents (SI) via StEIS (Strategic Executive Information System), as of the end of July 2015. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
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. NELCSU. SI Reporting. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, Whittington Health Serious Incident policy.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 179**- If we do not meet the timescales for investigating serious incidents this will impact on timely management of patient safety concerns, the patients or carers experience and other external assessments. **BAF 3.10** If integrated risk management is not embedded across the Trust, the Trust will not deliver safe and effective services.		
Date paper completed:	12/08/2015		

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

Serious Incident Monthly Report for July 2015 Data

1. Introduction

The purpose of this report is to provide an update to the Board on the reporting and management of serious incidents as reported via StEIS (Strategic Executive Information System) as at the end of July 2015.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also implementation of any recommendations following investigation and dissemination of learning to prevent recurrence.

2. Background

The Trust is committed to identifying, reporting and investigating serious incidents, ensuring that learning is shared across the organisation and that action is taken to reduce the risk of incidents re-occurring. The Trust endeavours to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk to ensure that safe care is provided to patients through the promotion of a positive reporting and investigation culture.

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The Serious Incident Executive Approval Group (SIEAG) — comprising the Executive Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer and the Head of Integrated Risk Management meets weekly to review Serious Incident investigation reports in addition to investigations into high severity incidents to ascertain 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 6 serious incidents during July 2015 bringing the total to 21 since 1st April 2015. These include incidents that were later downgraded (de-escalated).
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 incidents are also uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC registration requirements.

All serious incidents are reported to the NHS Commissioning Board (via the National Reporting and Learning System; NRLS) which then shares the information with the CQC.

3.2 **The table below details the Serious Incidents currently under investigation**

Category	Month Declared	Summary
Maternity/Obstetric incident	July 15	Unexpected stillbirth of an infant at 35 weeks.
Sub-optimal care of the deteriorating patient	July 15	Patient deteriorated and was transferred to a tertiary referral unit.
Child protection	July 15	Alleged abuse.
Screening issues	July 15	Failure to act on results in a timely manner.
Sub-optimal care of the deteriorating patient	July 15	Following a period of care in ITU patient transferred to ward and condition deteriorated
Diagnostic incident including delay	July 15	Delay in a number of referred patients being seen in a timely manner
Maternity/Obstetric incident	May 15	Unexpected Intrapartum death of a term infant.
Confidential Information leak/IG breach	May 15	An email, with attachment, containing non-sensitive personal confidential data sent to a non-secure email address

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported no serious incidents in June 2015

STEIS 2015-2016 Category	April	May	June	July
Child protection	0	0	0	1
Communication issue	1	0	0	0
Confidential information leak/Information governance breach	1	2	0	0
Diagnostic Incident including delay	0	2	0	1
Drug incident	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus, neonate and infant)	0	1	0	1
Pressure ulcer grade 3	5	1	0	0
Screening Issues	0	0	0	1
Slips/Trips/Falls	1	0	0	0
Suboptimal care of deteriorating patient	0	1	0	2
Total	8	7	0	6

4. Submission of SI reports

All final investigation reports are reviewed at a meeting of the SIEAG chaired by an Executive Director (Trust Medical Director or Director of Nursing and Patient Experience) and has membership from the Executive Operational Team and Integrated Governance Department. The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are expected to attend each meeting when an investigation from their services are 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 cause identified and the actions are aligned with the recommendations, so that lessons are learnt and appropriate action is taken to prevent future harm.

On completion of the report the patient and/or relevant family member are given the opportunity to receive a copy of the report and a 'being open' meeting is offered in line with duty of candour recommendations.

Lessons learned following the investigation are shared with all staff and departments involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in Maternity and Obstetrics and other departments. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted 9 reports to NELCSU in June 2015 and 6 to NELCSU and one screening incident to NHS England in July 2015. Currently there are no overdue incident reports awaiting submission.

4.2. The table below gives a brief summary of the incident and a selection of actions taken as a result of the lessons learnt from the investigation.

Summary	Actions taken as result of lessons learnt
Delayed diagnosis A delay in identification of a baby with Developmental Dysplasia of the Hips (DDH).	• Staff involved have received comprehensive feedback relating to the findings and outcome of the investigation using the report as a tool for reflection and learning. • The report has been circulated widely within the department for the purposes of shared learning including all neonatal trainees and Newborn and Infant Physical Examination (NIPE) course students.
Drug incident (Insulin) A patient was administered an infusion of insulin and dextrose prior to transfer to a tertiary referral unit.	• Insulin prescriptions and intravenous infusions should always be checked against a reference text or guideline before administration. • The Trust is reviewing the feasibility of introducing E prescribing to the Emergency Department to reduce prescribing errors.
Delayed diagnosis Failure to carry out a requested investigation.	• .A revalidation exercise has been undertaken of all patients awaiting an endoscopy to ensure that patients are seen in a timely manner. • Robust administration processes put in place to ensure that investigations do not get omitted or delayed.
Sub-optimal care of the deteriorating patient Failure to escalate concerns when a patient deteriorated. The DNAR form used which had not been clearly rescinded.	• The Whittington Health Adult Do Not Resuscitate (DNAR) Policy (2015) has been updated with explicit advice regarding how the DNAR form should be rescinded and filed at the end of an admission. Specific advice on how to rescind and cancel a DNAR form is outlined as well as advice on how to do so on the Anglia Ice computer system.

Summary	Actions taken as result of lessons learnt
Pressure ulcer grade 3 Patient with reduced mobility acquired pressure ulcers 3 degree in both heels, and right malleolus 2 degree. Patient declined to use the pressure-relieving mattress and pressure-relieving cushion provided.	• A review on pressure area management has been undertaken particularly around SSKIN bundle training and competency assessment, with training sessions across all teams. • An update of pressure area management competencies has been undertaken and now includes a separate competency for the completion of the SSKIN Care bundle.
Communication issue A failure to follow escalation as outlined in the 'unable to gain access protocol (community setting)	• All staff reminded of 'unable to gain access' protocol that ensures important guidelines are followed up one step at a time until a patient's whereabouts is safely ascertained. • Training on the 'unable to gain access' protocol will be undertaken bi-annually/annually.
Confidential Information Leak Confidential Information was sent to an incorrect address. The client had moved to new address.	• The service has reviewed its processes and has initiated a Change of address form (COA) located on RIO the Trust's patient records electronic information system which will be printed before each initial Health Assessment (IHA) and address checked with clients. • An audit of records has been planned to ensure that the change of address form is being used will be undertaken to confirm these are in use. • The service is currently reviewing all their SOPs (Service Operating Procedures) to ensure that this process is embedded. • The report will be circulated widely across the department for the purposes of shared learning.

5. Summary

The Trust Board is asked to comment on this revised reporting style and note the content of the above report.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board
02 September 2015

Title:	Financial Performance Month 4 2015		
Agenda item:	15/108	**Paper**	05
Action requested:	For noting		
Executive Summary:	The paper analyses the financial performance of the Trust covering overall, clinical division and corporate performance, cash and capital.		
Summary of recommendations:	To note the financial results relating to July 2015. The key risks to delivery of the operating plan are shown on page 3..		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meeting statutory duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers (Trust Board: March, April and May 2014). Board Assurance Framework (Section 3).		
Date paper completed:	17th August 2015		

Author name and title:		**Stephen Bloomer, Chief Financial Officer**		**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**

Finance overview | Position Summary

Indicator	Measure	In-Month Plan	In-Month Actual	YTD Plan	YTD Actual
Monitor COSR	score	-	-	1	1
EBITDA margin	%	3.67%	2.57%	0.22%	0.19%
EBITDA achieved	£000s	876	623	211	184
Adjusted net deficit margin	%	-1.98%	-2.96%	-5.41%	-5.30%
Adjusted net deficit achieved	£000s	-472	-719	-5,178	-5,118
Liquidity ratio	days	-	-	-20	-18
Capital Servicing Capacity	times	-	-	-0.30	-0.10
Income	£000s	23,884	24,277	95,717	96,598
Pay	£000s	16,906	17,612	70,550	70,935
Non-Pay	£000s	6,102	6,042	24,956	25,478
CIPs	£000s	1,743	308	3,081	1,477

The Trust remains within Monitor's COSR high risk category and this is not expected to change in 2015/16.

EBITDA performance is largely on track ytd. However, this is mostly due to recognising resilience income earlier than planned.

Finance overview | Statement of comprehensive income

At the end of July 2015, the Trust posted a deficit of £5.12m which is £57k better than the planned position.

During this period, income was £881k greater than planned and this was primarily due to recognising income to fund the winter-capacity that was in operation throughout April, May and June.

The Trust overspent against its budgeted expenditure in July by £646k, and overspent by £907k during the first four months of the year. This is largely due to under-performance against the saving targets against the Operating Plan that were scheduled to significantly increase from July onwards. At the end July, the Trust had achieved £1.7m (56%) of its planned savings of £3.1m ytd.

The Trust ended the month with a cash balance of £7.1m, which was £1.9m more than it had planned. This was due to disputed invoices which were held back due to ongoing negotiations with creditors. We are expecting payments to come in and have started to see results. The Trust's capital expenditure is on track.

The Trust is forecasting to meet its planned 15/16 deficit of £19.5m, but there are a several risks to this outcome, including:

- underachievement of CIP delivery (£6m)
- poor management of expenditure budgets (£3m)
- failure to achieve the income targets set within its major CCG contract (£8m)
- write-off of capital setup costs should the maternity business case not materialise (£1m)
- overspend against resilience funding as the Trust does not have an agreed plan for winter with the CGs (£1m)
- poor record keeping of temporary staff bookings on Health Roster and subsequent control (£1m)

	Month 4 Budget (£000s)	Month 4 Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)	Full Year (£000s)
Total Income	**23,884**	**24,277**	**393**	**95,717**	**96,598**	**881**	**289,762**
Non-Pay	6,102	6,042	59	24,956	25,478	-522	75,685
Pay	16,906	17,612	-705	70,550	70,935	-386	212,220
Contingency	0	0	0	0	0	0	5,187
Total Operating Expenditure	**23,008**	**23,654**	**-646**	**95,506**	**96,414**	**-907**	**293,092**
EBITDA	**876**	**623**	**-252**	**211**	**184**	**-27**	**-3,330**
Depreciation	690	676	15	2,760	2,692	68	9,785
Dividends Payable	410	410	0	1,640	1,641	0	4,921
Interest Payable	255	262	-7	1,020	1,003	17	3,060
Interest Receivable	1	1	1	3	9	6	10
Net Surplus / (Deficit) - before IFRIC 12 adjustments	**-479**	**-724**	**-244**	**-5,206**	**-5,143**	**63**	**-21,087**
Add back impairments and adjust for IFRS & dor	7	5	-2	28	25	-3	1,585
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-472**	**-719**	**-247**	**-5,178**	**-5,118**	**60**	**-19,502**

Finance overview | Statement of financial position

The statement of financial position shows the assets, liabilities and equity held by the Trust and is used to assess the financial soundness of an entity in terms of liquidity risk, financial risk, credit risk and business risk.

Trade Receivables: The intensified drive to bring down debtors is starting to yield desired results, albeit slowly. However this continues to show a positive trend and the remaining long outstanding balances are expected to be collected over the next few months.

Cash: The cash position was better than plan as we are yet to settle outstanding supplier debts, which are being subject to investigation and negotiation.

Payables: this is showing an improvement compared to the opening position and as the investigation and negotiation continues, is expected to be fall in line with plan over the coming months.

Borrowings: This is higher than Plan as the working capital support is yet to be paid off by PDC funding. Equally, PDC is lower than Plan for the same reason. The Trust is engaging with the TDA on the application process. Interest on the revolving loan facility at the end of July was £78k. Interest on the revolving loan facility at the end of July was £78k.

			Year to Date	Year to Date
	As at 1 April 2015 £000	Plan 31 March 2015 £000	Plan YTD 31 July 2015 £000	As at 31 July 2015 £000	Variance YTD 31 July 2015 £000
Property, plant and equipment	194,918	213,298	193,401	192,856	(545)
Intangible assets	4,481	4,903	4,446	5,072	626
Trade and other receivables	757	533	755	778	23
Total Non Current Assets	**200,156**	**218,734**	**198,602**	**198,706**	**104**
Invento Inventories	1,427	1,356	1,456	1,504	48
Trade ε Trade and other receivables	19,223	16,942	15,298	18,415	3,117
Cash a Cash and cash equivalents	1,347	1,619	5,245	7,131	1,886
Total Current Assets	**21,997**	**19,917**	**21,999**	**27,050**	**5,051**
Total Assets	**222,153**	**238,651**	**220,601**	**225,756**	**5,155**
Trade and other payables	38,847	33,913	34,909	37,799	2,890
Borrowings	1,809	255	1,259	1,136	(123)
Provisions	1,380	557	1,020	1,319	299
Total Current Liabilities	**42,036**	**34,725**	**37,188**	**40,254**	**3,066**
Net Current Assets (Liabilities)	**(20,039)**	**(14,808)**	**(15,189)**	**(13,204)**	**1,985**
Total Assets less Current Liabilities	**220,195**	**233,542**	**183,413**	**185,502**	**(1,881)**
Borrowings	34,950	43,993	34,952	45,483	10,531
Provisions	1,952	1,697	1,952	1,946	(6)
Total Non Current Liabilities	**36,902**	**45,690**	**36,904**	**47,429**	**10,525**
Total Assets Employed	**143,215**	**158,236**	**146,509**	**138,073**	**(8,436)**
Public dividend capital	62,377	87,287	70,877	62,377	(8,500)
Retained earnings	6,187	(14,901)	980	1,146	166
Revaluation reserve	74,651	85,850	74,652	74,550	(102)
Total Taxpayers' Equity	**143,215**	**158,236**	**146,509**	**138,073**	**(8,436)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	

Finance overview | Cost improvement programmes

In month 4 savings amounting to £547k (31%) were delivered against the TDA operating plan of £1.74m. Year to date, £1,716k (56%) has been achieved.

Against divisional schemes, July's performance was 62% and YTD it was 75%.

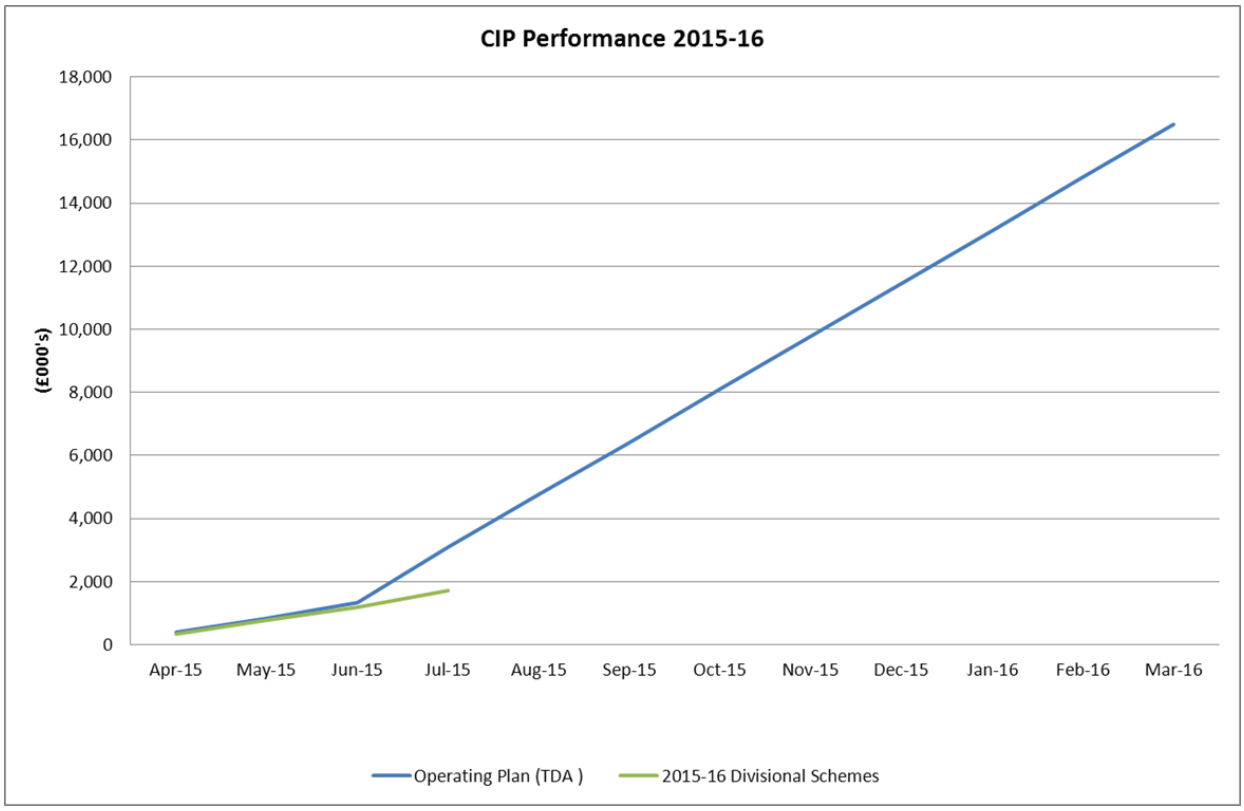
July saw a lower performance against plan compared to previous months. There are three main reasons for this:

- The CIP target in month in the Operating Plan for July is higher than previous months (£1.7m in month4, £0.5m in month3).
- There is a phasing difference between the schemes in the PMO and the Operating Plan. The PMO plans have been phased according to their delivery dates. New schemes replace either unallocated CIPs or failing schemes and will delivery later in the year.
- During contractual discussions it became apparent that several schemes were included in the block contract. The ytd performance of these schemes was taken out of the actuals reported. This resulted in a reduction of the actuals by £237k.
    - Without this reduction the performance in July would have been £784k, which is 89% of all PMO schemes.

Trust-wide schemes of £7.8m are scheduled to start from August. These include the corporate staffing reviews, locality projects and estates reviews.

	Annual	July				YTD			
Integrated Clinical Service Units	Plan £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000
Medicine Frailty and Network Services	1,596	87	1	2%	(86)	266	180	68%	(86)
Surgical Services	1,610	184	151	82%	(32)	413	340	82%	(72)
Emergency and Urgent Care	548	38	22	57%	(16)	151	135	89%	(16)
Womens Services	1,050	103	77	75%	(26)	245	128	52%	(117)
Childrens Services	1,399	110	78	70%	(33)	381	338	89%	(43)
Clinical Support Services	635	56	-19	(34%)	(75)	206	110	53%	(96)
OP and Long Term Conditions Services	747	35	25	71%	(10)	109	68	63%	(41)
Corporate	2,054	266	212	80%	(54)	509	416	82%	(93)
PMO Schemes	**9,639**	**878**	**547**	**62%**	**(332)**	**2,279**	**1,716**	**75%**	**(563)**
Trust-wide Schemes	6,238	0	0	0%	0	0	0	0%	0
Unidentified Schemes	623	0	0	0%	0	0	0	0%	0
Phasing difference between Operating Plan and allocated schemes	0	865	0	0%	(865)	802	0	0%	(802)
	0	0	0	0%	0	0	0	0%	0
	0	0	0	0%	0	0	0	0%	0
Operating Plan	**16,500**	**1,743**	**547**	**31%**	**(1,196)**	**3,081**	**1,716**	**56%**	**(1,365)**

The graph shows the Trust's performance against its plan of £16.5m and an £18m stretch target.



Operations Directorate
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The Whittington Hospital NHS Trust
Magdala Avenue, London N19 5NF

Whittington Health Trust Board
2 September 2015

Title:	Trust Board Report September 2015 (July 2015 data)		
Agenda item:	**15/011**	**Paper**	**06**
Action requested:	For discussion on progress		
Executive Summary:	The following is the Performance and Quality report for September 2015; a number of highlights and areas for focus are identified. Summary of report: **QUALITY** • **Inpatient deaths** remain as expected. • **Completion of valid NHS number**: Remain just below the standard of 95% for SUS submission, but achieved for A&E data set. • **SHMI:** Whittington Hospital mortality rate remains lower than expected for the Trust. • **HSMR:** Continuing to perform better than expected for the national standard. **PATIENT SAFETY** • **Harm Free Care:** Below target due to pressure ulcers, action plan in place with community teams. • **Falls (audit):** Remain at 0.30% • **VTE assessment:** Achieved standard. • **Medication errors causing severe/moderate/low harm:** No severe or moderate medication errors • **Never events:** None. • **CAS alerts:** None outstanding. • **Serious incidents**: Six new SI's reported in July 2015, all incidents are fully investigated and learning is shared. Duty of Candour was achieved for all SI's. **PATIENT EXPERIENCE** • **Family and Friend Test:** Achieves standard and 'you said we did' becoming standardised in clinical areas. • **Mixed sex Accommodation:** No breaches. • **Patient admission to adult facilities for under 16 years of age:** No breaches. • **Complaints:** Below target for 2 of the 3 divisions. Focus on internal processes. • **Patient admission to adult ward for under 16 years of age:** None.		

INFECTION PREVENTION

- **MRSA:** No new cases
- **E.coli:** No new cases
- **MSSA:** One case in July
- **C Difficile:** One new infection, all protocols adhered to.
- **Ward Cleanliness:** Overall cleanliness rate at 97.8%.

ACCESS

Acute

- **First to follow-up:** Acute ratio remains below the national benchmark.
- **Theatre Utilisation:** Focus is now on smaller services provided by other organisations
- **Hospital cancellations:** Achieved for first appointment and just below target for follow up appointment.
- **Patient DNA:** Remain underachieving around 12% for first appointment and 14% for follow up appointment.
- **Hospital cancelled operations:** 3 patients cancelled in July due to running out of theatre time
- **Cancelled ops not rebooked within 28 days:** none
- **RTT 52 week wait:** No patients waited over 52 weeks for first appointment.
- **RTT 18 weeks Admitted Target 90%:** Overall achieved
- **RTT 18 weeks non-Admitted Target 95%:** Overall achieved
- **RTT 18 weeks incomplete Target 92%:** Overall Achieved.
- **Diagnostic waits Target 99%:** Under performance standard due to endoscopy back log and a small number of patient choice within Audiology
- **Cancer:** Overall achieved

Community

- **Service cancellations:** Slightly up in July 2015. Due to IT issues and cancellation of clinics
- **Patient DNA:** Achieved standard.
- **Face to Face contacts:** Monitoring in place and reviewed for contract performance.
- **Appointments with no outcome:** Above target and monitored within services.
- **MSK wait 6 week (non-consultant led):** Below target due to reduced capacity, action plan in place
- **MSK 18 weeks:** Achieved.
- **IAPT:** Achieved.
- **GUM:** below target

EMERGENCY AND URGENT CARE

- **Emergency Department standard:** Achieved

MATERNITY

- **Woman seen by HCP or midwife within 12 weeks and 6 days:** below target action plan in place
- **New birth visits within 14 days:** Below target due to poor performance in one Haringey team and vacancies across the two boroughs within the Health Visiting (HV) Services. Islington now successfully recruited. An agreement has been made with NHS England to use bank HV staff in Haringey during recruitment process.
- **Elective C-section rate:** elective above standard. Emergency achieved standard,
- **Breastfeeding initiated:** Achieved.
- **Smoking at delivery:** Achieved.

Update on proposed areas of focus to be agreed by the Trust Board in July:

Outpatient (acute and community) cancellations, outcome of appointments and DNAs. Action plan in place, review of processes completed, and areas for improvement identified. These being; Customer care training to engage patients in choice of appointments, increased capacity for choice and book, cancellation escalation if consultant cancelling under 6 weeks' notice, offer of choice if cancelled apt by hospital, telephone reminders by call centre staff for high DNA areas. Recruitment of permanent staff for the call centre and medical records. No improvement yet seen as due to IT incident disruption and manual processes being used.

Emergency department 4 hour target
Action plan in place and weekly meetings to monitor action plan, main actions are staffing to demand, skill mix changes, new escalation and delay tracking agreements, whole team approach to afternoon peak of demand. Improvement being seen.

Elective cancellations
Actions in place, these being reinforcement of policy for no cancellations on day, escalation if issues occur with theatre over runs. Improvement being seen.

Readmissions
Review of data completed, surgical team and medical team have established actions to improve. Data being monitored and will be reviewed quarterly due to the 31 day readmission timescale.

MSK 6 weeks
Action plan developed to redistribute capacity and meet demand, improve speed of triage, allocate capacity to specialist clinics and boast capacity when capacity triggers are reached. No improvement has been seen in month as the improvements will commence in August due to patient bookings being 4-5 weeks ahead. Changes will be seen in August and further improvement in September.

Summary of recommendations:	That the board notes the performance
Fit with WH strategy:	Aligns with Trust strategic intent
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or BAF
Date paper completed:	August 2015

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Lee Martin, Chief Operating Officer**	
Date paper seen by EC	**24 Aug**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Sept 2015 Trust Board Report (July data)

Whittington Health NHS

Quality	Threshold	May-15	Jun-15	Jul-15
Number of Inpatient Deaths	-	22	25	25
NHS number completion in SUS (OP & IP)	99%	98.93%	98.60%	arrears
NHS number completion in A&E data set	95%	95.08%	95.33%	arrears

Quality (Mortality index)	Threshold	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
SHMI	-	0.54	0.54	0.60

Quality (Mortality index)	Threshold	Jan-15	Feb-15	Mar-15
Hospital Standardised Mortality Ratio (HSMR)	<100	79.1	71.9	86.9
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	77.0	26.5	146.5
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	80.0	84.0	68.0

Patient Safety	Threshold	May-15	Jun-15	Jul-15
Harm Free Care	95%	94.2%	93.6%	94.7%
VTE Risk assessment	95%	95.0%	95.1%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	2	0	0
Proportion of reported patient safety incidents that are harmful	-	36.1%	36.1%	40.7%
Serious Incident reports	-	7	0	6

Access Standards

Referral to Treatment (in arrears)	Threshold	Apr-15	May-15	Jun-15
Diagnostic Waits	99%	99.1%	95.8%	93.5%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	May-15	Jun-15	Jul-15
Service Cancellations - Community	8%	8.00%	7.54%	8.05%
DNA Rates - Community	10%	7.9%	6.9%	7.5%
Community Face to Face Contacts	-	57,504	63,131	60,388
Community Appts with no outcome	1.0%	3.5%	3.5%	2.1%

Community Access Standards	Threshold	May-15	Jun-15	Jul-15
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	71.0%	81.4%	80.9%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	100.0%	100.0%	arrears
IAPT - patients moving to recovery	50%	51.3%	51.9%	arrears
GUM - Appointment within 2 days	100%	97.4%	97.4%	96.0%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	May-15	Jun-15	Jul-15
First:Follow-up ratio - acute	2.31	1.35	1.35	1.42
Theatre Utilisation	92%	83.9%	81.6%	81.2%
Hospital Cancellations - acute - First Appointments	8%	5.9%	5.6%	5.6%
Hospital Cancellations - acute - Follow-up Appointments	8%	8.3%	7.6%	8.2%
DNA rates - acute - First appointments	10%	11.8%	12.8%	12.4%
DNA rates - acute - Follow-up appts	10%	14.1%	12.7%	14.5%
Hospital Cancelled Operations	0	4	6	3
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	1	1	0

Sept 2015 Trust Board Report (July data)

Whittington Health NHS

Meeting threshold

Patient Experience	Threshold	May-15	Jun-15	Jul-15
Patient Satisfaction - Inpatient FFT (% recommendation)	-	92%	93%	95%
Patient Satisfaction - ED FFT (% recommendation)	-	91%	89%	91%
Patient Satisfaction - Maternity FFT (% recommendation)	-	89%	81%	93%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	34	25	34
Complaints responded to within 25 working day	80%	68%	70%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Infection Prevention	Threshold	May-15	Jun-15	Jul-15
Hospital acquired MRSA infection	0	0	0	0
Hospital acquired *C difficile* Infections	17 (15/16)	1	1	1
Hospital acquired *E. coli* Infections	-	0	0	0
Hospital acquired MSSA Infections	-	0	1	1
Ward Cleanliness	-	98%	98%	98%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Apr-15	May-15	Jun-15
Referral to Treatment 18 weeks - Admitted	90%	95.0%	91.2%	90.9%
Referral to Treatment 18 weeks - Non-admitted	95%	95.1%	95.5%	95.0%
Referral to Treatment 18 weeks - Incomplete	92%	93.1%	92.9%	92.7%

Failed threshold

Emergency and Urgent Care	Threshold	May-15	Jun-15	Jul-15
Emergency Department waits (4 hrs wait)	95%	93.6%	94.4%	95.1%
ED Indicator - median wait for treatment (minutes)	<60	90	95	81
30 day Emergency readmissions	-	204	235	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	3.1%	3.4%	3.0%
Ambulance Handover (within 30 minutes)	0	2	3	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Cancer Access Standards (in arrears)	Threshold	Apr-15	May-15	Jun-15
Cancer - 14 days to first seen	93%	93.2%	92.4%	93.9%
Cancer - 14 days to first seen - breast symptomatic	93%	93.3%	94.7%	93.3%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%
Cancer - 62 days from referral to treatment	85%	95.7%	93.8%	90.0%

Maternity	Threshold	May-15	Jun-15	Jul-15
Women seen by HCP or midwife within 12 weeks and 6 days	90%	86.2%	80.7%	82.8%
New Birth Visits - Haringey	95%	85.6%	87.8%	arrears
New Birth Visits - Islington	95%	92.7%	89.7%	arrears
Elective Caesarean Section rate	14.80%	11.0%	10.2%	17.8%
Breastfeeding initiated	90%	90.2%	87.6%	91.0%
Smoking at Delivery	<6%	2.4%	3.8%	3.7%

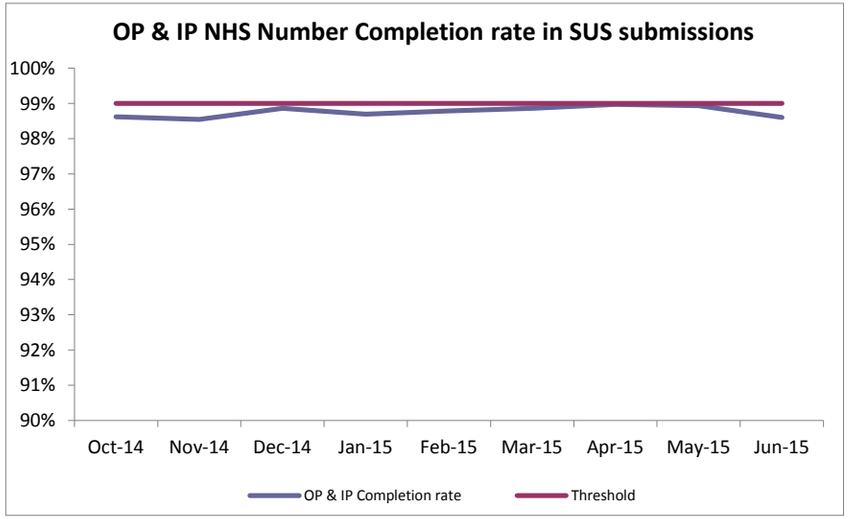
Meeting threshold

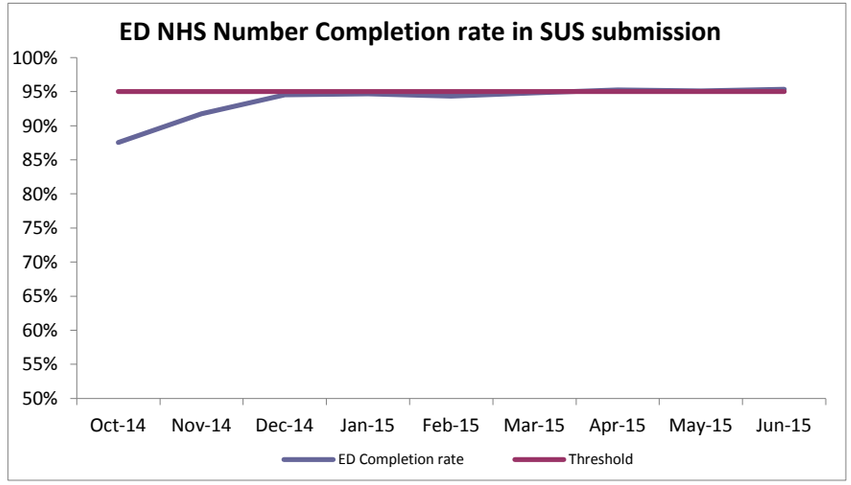
Failed threshold

	Threshold	Trust Actual		
		May-15	Jun-15	Jul-15
Number of Inpatient Deaths	-	22	25	25
Completion of a valid NHS number in SUS (OP & IP)	99%	98.93%	98.60%	arrears
Completion of a valid NHS number in A&E data sets	95%	95.08%	95.33%	arrears

	Standardised National Average	Trust		
		Jan-15	Feb-15	Mar-15
Hospital Standardised Mortality Ratio	<100	79.1	71.9	86.9
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	77.0	26.5	146.5
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	80.0	84.0	68.0

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54
	Apr 2013 - Mar 2014	0.87	1.15	0.54
	Jan 2013 - Dec 2013	0.88	1.14	0.62
	Oct 2012 - Sep 2013	0.89	1.13	0.63
	Jul 2012 - Jun 2013	0.88	1.13	0.63
	Apr 2012 - Mar 2013	0.88	1.14	0.65





Commentary

Inpatient Deaths

Issue: The number of in-patient death remain at expected level.
Action: A cross check to ensure that the new ICSU quality meetings include audits
Timescale: end of September 2015

Completion of valid NHS number

Issue: NHS number completion in SUS and A&E dataset remains just under target.
Action: The ED department has now access to a report identifying missing NHS numbers. by clinician to ensure the last NHS numbers are entered into EPR.
Timescale: Expected to be compliant in October 2015 due to training schedule and new staff commencing

SHMI
WH score remains below the lower limit which therefore, indicates that the mortality rate remains lower than expected at our Trust.

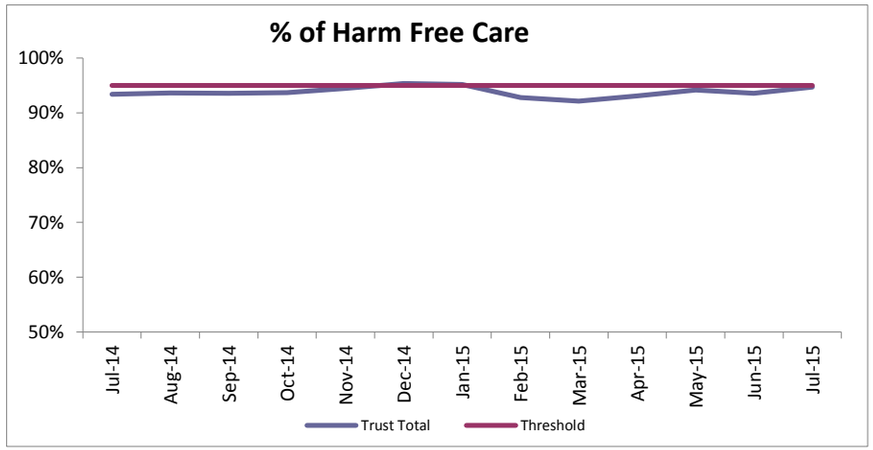
HSMR No update since last report, due to delay in subscription to Dr Foster.
In November 2014 Whittington Health reported 27 in-patient deaths. The standardised mortality rate has returned to an expected level for Whittington Hospital, which means the balance between elective admissions and non-elective admissions are back at expected levels.

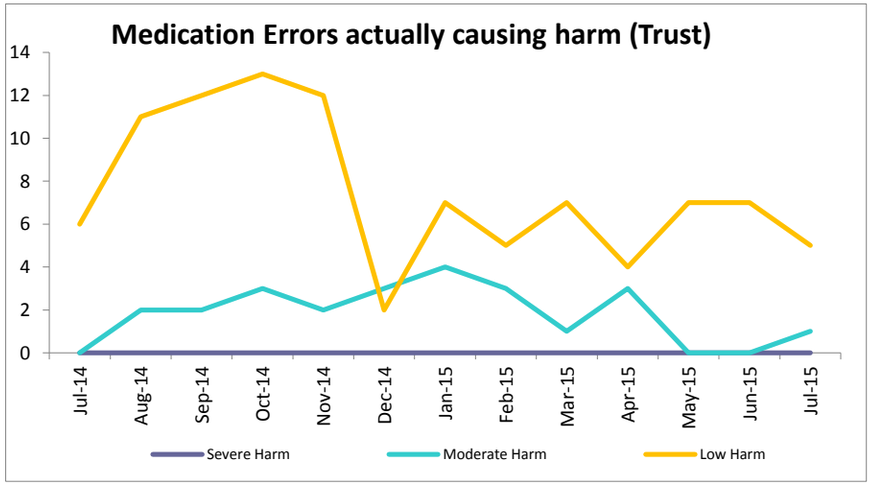
Patient Safety

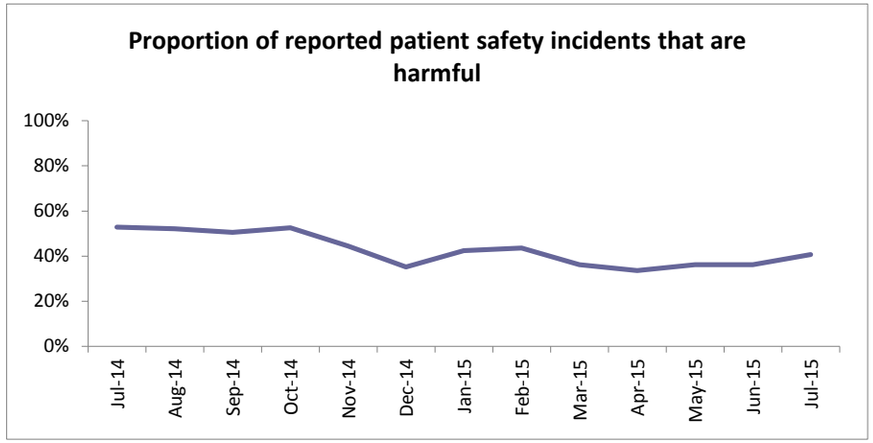
Whittington Health NHS

Data extracted on 07/08/2015

	Threshold	Trust Actual Apr-15	May-15	Jun-15	Jul-15	Trend
Harm Free Care	95%	93.1%	94.2%	93.6%	94.7%	
Pressure Ulcers (prevalence)	-	5.82%	5.12%	5.72%	4.21%	
Falls (audit)	-	0.29%	0.30%	0.29%	0.40%	
VTE Risk assessment	95%	95.9%	95.0%	95.1%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	3	0	0	1	
Medication Errors actually causing **Low** Harm	-	4	7	7	5	
Never Events	0	0	0	0	0	
Open CAS Alerts (Central Alerting System)	-	2	2	0	0	
Proportion of reported patient safety incidents that are harmful	-	33.5%	36.1%	36.1%	40.7%	
Serious Incidents (Trust Total)	-	8	7	0	6	







Commentary

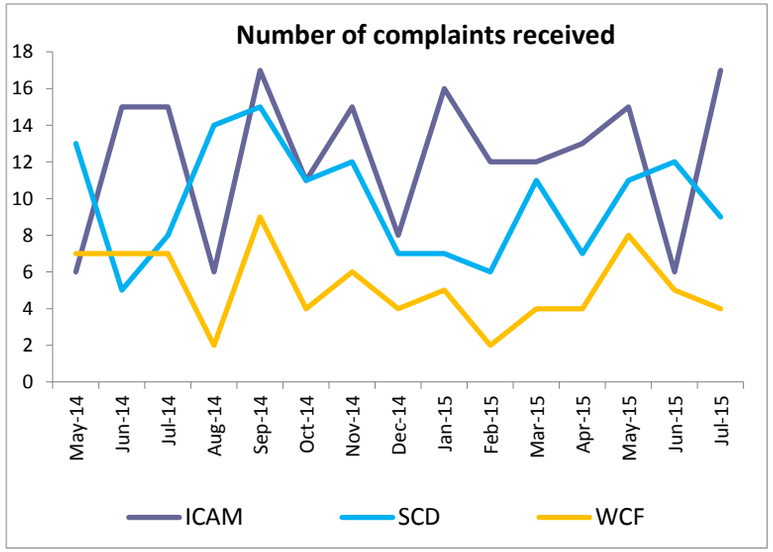
Harm Free Care
Issue: Scoring below target.
Action: Continued HFC monitoring and learning from reviews is in place. Thematic action plan in community in place to monitor the number of pressure ulcers acquired by patients under the care of Whittington Health. This plan is monitored by an overarching pressure ulcer prevention group spanning Haringey and Islington and include partner organisations.
Timescale: On-going

Pressure Ulcer prevalence
Issue: Prevalence is increasing.
Action: A paper was tabled at the last Trust Quality Committee detailing the improvements put in place in the community and identifying the need for education to families around pressure ulcers.
Timescale: On-going

Medication Errors actually causing harm
Issue: No Serious medication error have been reported in April 2015 .
Action: All errors are investigated and appropriate action taken.
Timescale: completed

CAS Alerts
Issue: No CAS alerts open
Action:
Timescale: completed

	Threshold	Trust Actual Apr-15	May-15	Jun-15	Jul-15	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	90%	92%	92%	93%	95%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **		92%	91%	89%	91%	
Patient Satisfaction - Maternity FFT (% recommendation) **	90%	92%	89%	81%	93%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	26	34	25	34	
Complaints responded to within 25 working day	80%	75.00%	67.74%	70.00%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	



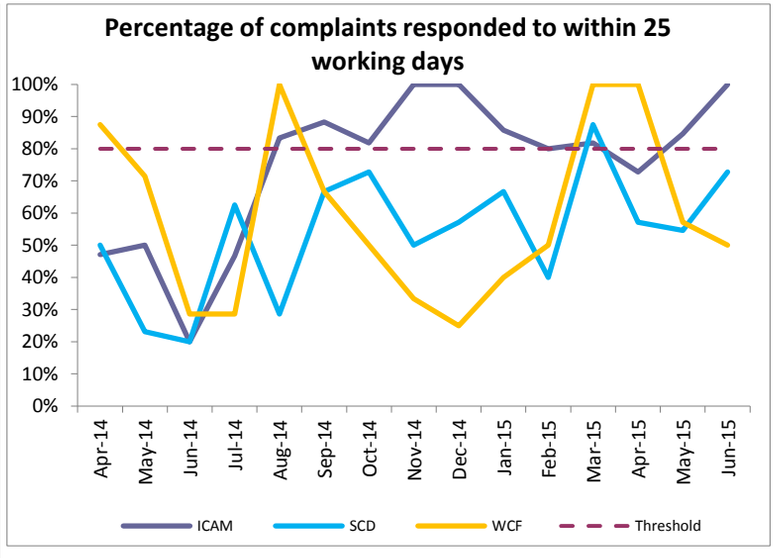
* Complaints responded to within 25 working days are previous months figures (reported in arrears)
** FFT calculation has now changed nationally from Nov 2014

Commentary

Patient Satisfaction - a local standard of 90% has been agreed, all areas meet this standard
Action: continue to raise awareness and role out into community and OPD
Timescale: On-going

Mixed Sex Accommodation
A policy and processes embedded in the services and no breaches for 10 consecutive months.

Complaints
Surgery is starting to improve on complaints response timelines and training continues to assist new managers of senior nurses t complete complaint investigations.



Infection Prevention

Whittington Health NHS

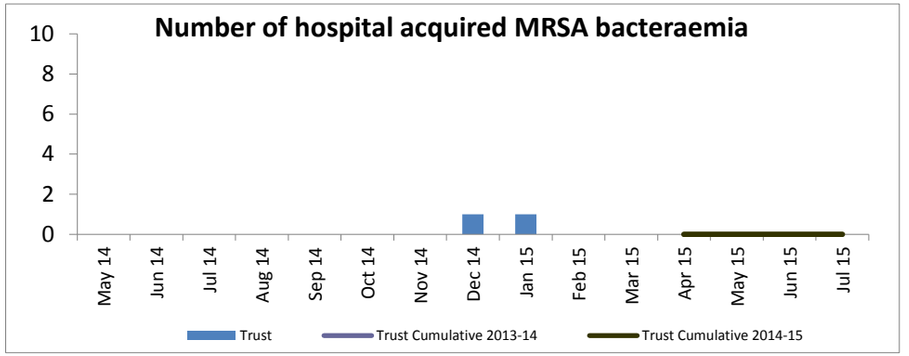
	Threshold	Trust Actual Apr-15	May-15	Jun-15	Jul-15	Trend
MRSA	0	0	0	0	0	
E. coli Infections*	-	1	0	0	0	
MSSA Infections	-	0	0	1	1	

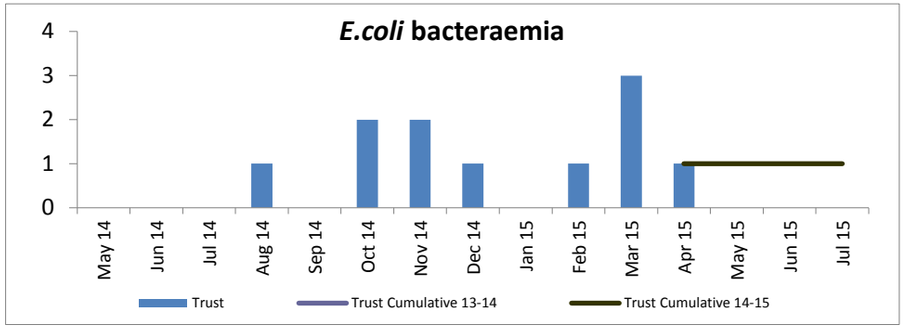
	Threshold	Apr 15	May 15	Jun 15	Jul 15	2015/16 Trust YTD
C difficile Infections	17 (Year)	1	1	1	1	4

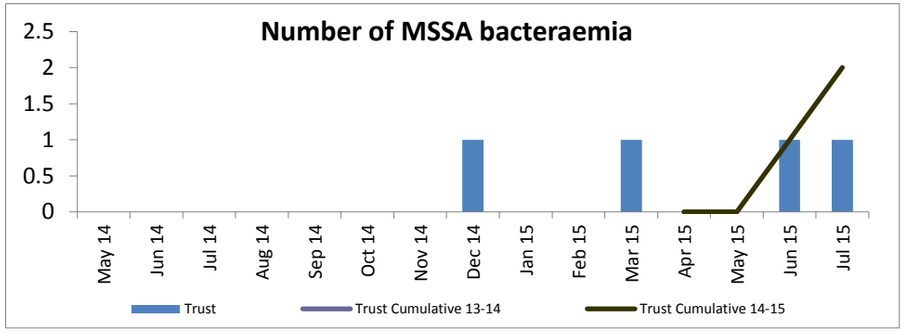
* E. coli infections are not specified by ward or division

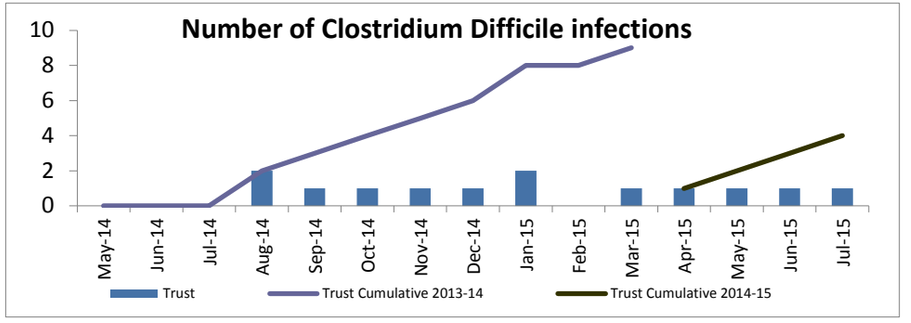
Ward Cleanliness

Audit period	Trust 01/09/14 to 02/10/14	06/11/14 to 16/12/14	19/01/15 to 17/02/15	14/04/15 to 01/05/15	15/06/15 to 10/07/15	Trend
Trust %	98.2%	98.1%	98.3%	98.4%	97.9%	









Commentary

MRSA
No new MRSA infections

MSSA
one case report which is being reviewed.

E.coli Infection
No new MRSA infections

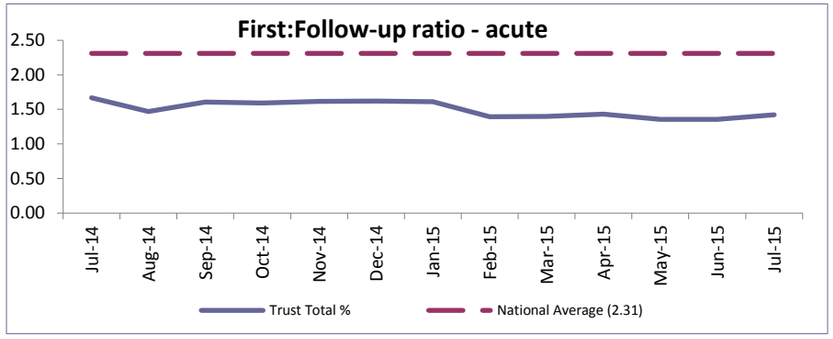
C Difficile
One new C Difficile infection for July 2015. New threshold set for Whittington Health which is to identify less than 17 infections this year.

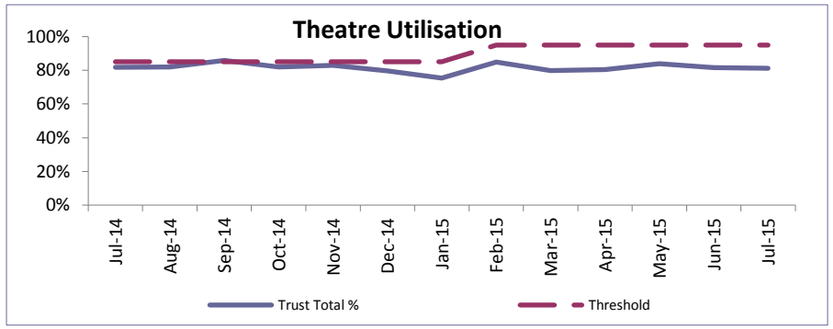
Ward Cleanliness
Issue: Overall percentage remains around 98%
Action: A detailed action plan is in place for infection prevention, cleaning standards and audits are being carried out by Estates and matrons to ensure standards are maintained.
Timescale: In place.

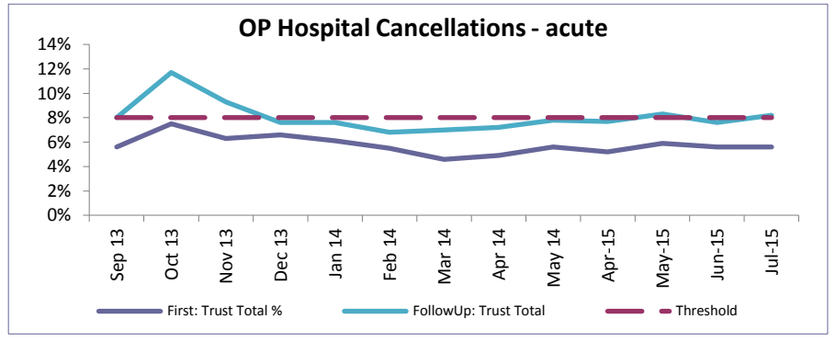
Efficiency and productivity - acute

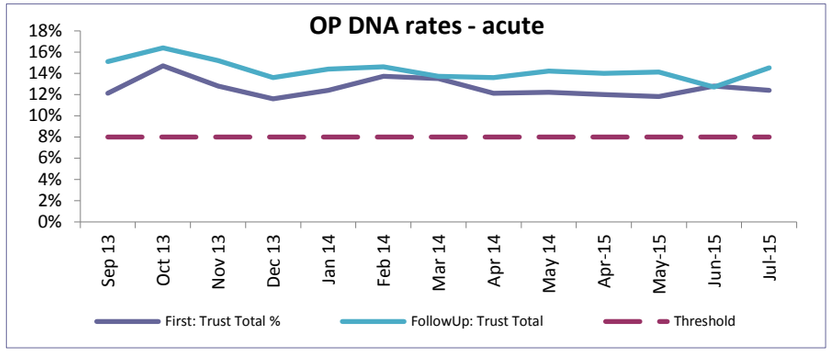
Whittington Health NHS

	Trust						
	Threshold	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Trend
First:Follow-up ratio - acute	2.31	1.40	1.43	1.35	1.35	1.42	
Theatre Utilisation	92%	79.8%	80.4%	83.9%	81.6%	81.2%	
Hospital Cancellations - acute - First Appointments	<8%	5.6%	5.2%	5.9%	5.6%	5.6%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	7.8%	7.7%	8.3%	7.6%	8.2%	
DNA rates - acute - First appointments	10%	12.2%	12.0%	11.8%	12.8%	12.4%	
DNA rates - acute - Follow-up appointments	10%	14.2%	14.0%	14.1%	12.7%	14.5%	
Hospital Cancelled Operations	0	5	6	4	6	3	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	0	0	1	1	0	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	









Commentary

First: Follow-up ratio - acute
The new to follow up rate is continuing to have a steady improvement over time and is well under the national benchmark of 2.31.

Theatre Utilisation
Issue : Under target. Specialities with low utilisation tend to be the low volume specialities Breast, Pain, ENT and urology.
Action : Clinical staff are provided with a report showing activity and usage each week. this is being monitored at the surgical board. The services with low utilisation are meeting with the clinical director and director of operations to agree schedules and patient booking
Timescale : Immediate

Hospital Cancellations - acute
Issue: Both first and follow-up cancellations have remained the same. The percentage is still affected by bringing forward patients into unused clinic slots.
Action: Consultant leave is monitored closely. Booking Team continue to identifying any unused clinic slots to pull patient appointments forward. a review is underway by each Service manager as to the reasons why cancellations are occuring.
Timescale: End of September for the review of cancelations.

Did not attend
Issue: Overall 'Did not attend ' remained around the same.
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment.
Timescale: on-going

Hospital Cancelled Operations
Issue: There were 3 operation cancelled by the hospital in July due to non-clinical reasons, all patients were clinically categorised as routine. All have been rebooked within the 28 day period.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Apr-15	May-15	Jun-15	Jul-15	Trend
Service Cancellations - Community	8%	7.5%	8.0%	7.5%	8.0%	
DNA Rates - Community	10%	6.9%	7.9%	6.9%	7.5%	
Community Face to Face Contacts	-	59,889	57,504	63,131	60,388	
Community Appointment with no outcome	1.0%	2.2%	3.5%	3.5%	2.1%	

N.B. From October 2014, figures include Community Dental activity (SCD)

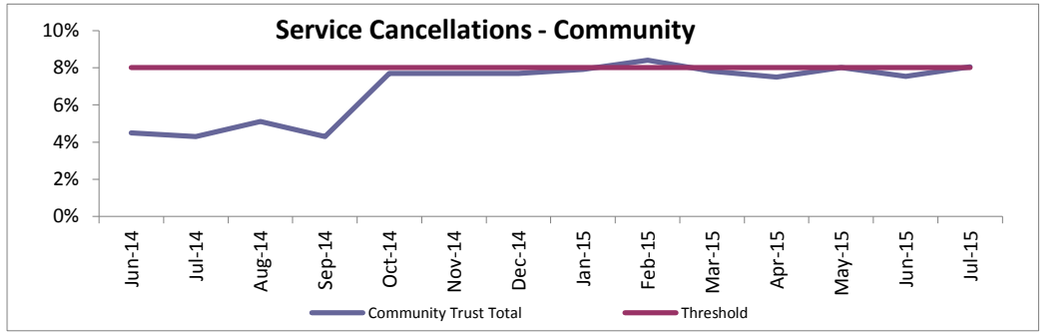
Commentary

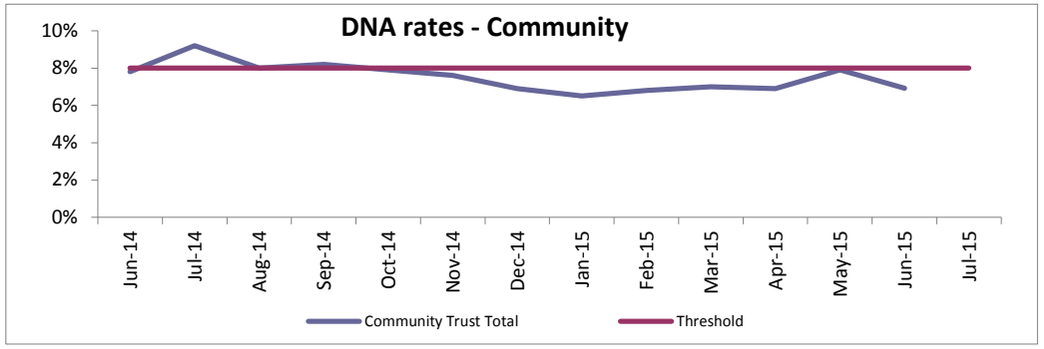
Service Cancellations - Community
Issue: Due to a IT disruption a few clinics needs to be rescheduled, this did not affect patients has it was purely an admin issue
Action: recording of appointments
Timescale: completed

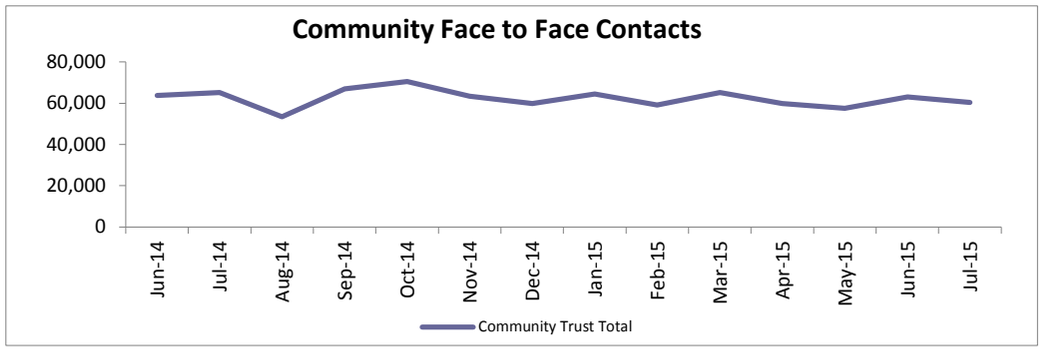
DNA Rates - Community
Community clinics - Achieved.

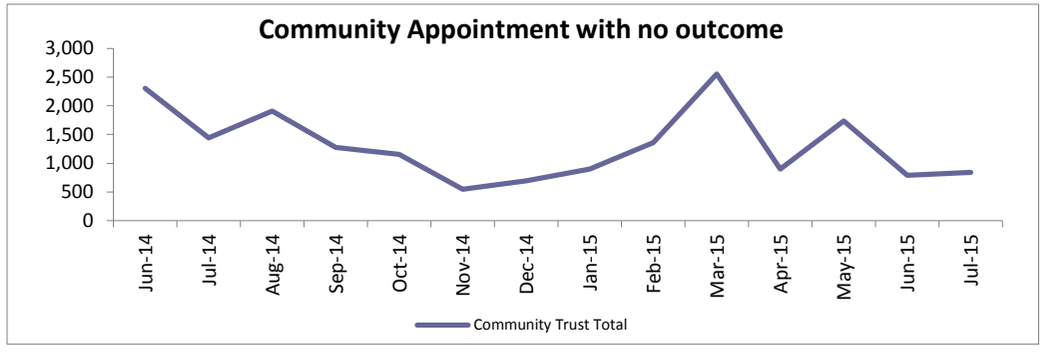
Community Face to Face Contacts
All services are monitored against activity targets

Community Appointment with no outcome
A process is in place to complete all outcomes of appointment within the same timelines as the acute services. this process has been standardised and training provided.
Action: Monitor to ensure the new processes are embedded
Timescale: immediately

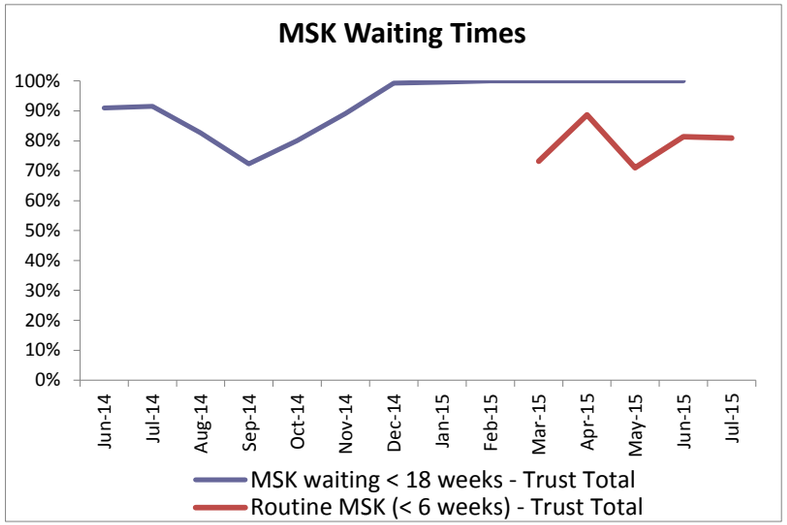








	Threshold	Trust Actual May-15	Trust Actual Jun-15	Trust Actual Jul-15	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	70.0%	35.0%	-	70.0%
District Nursing Wait Time - 2hrs assess (Haringey)	-	94.2%	66.7%	-	94.2%
District Nursing Wait Time - 48hrs for visit (Islington)	-	85.0%	97.7%	-	85.0%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	98.7%	97.4%	-	98.7%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	71.0%	81.4%	80.9%	76.1%
MSK Waiting Times - Consultant led (<18 weeks)	95%	100.0%	100.0%	arrears	100.0%
IAPT - patients moving to recovery	50%	51.3%	51.9%	arrears	51.1%
GUM - Appointment within 2 days	100%	100.0%	97.4%	96.0%	98.3%
Haringey Adults Community Rehabilitation (<6 weeks)	-	76.0%	80.0%	68.3%	75.2%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	70.0%	62.0%	87.5%	72.8%
Islington Community Rehabilitation (<6 weeks)	-	80.0%	83.0%	77.8%	80.0%
Islington Intermediate Care (<6 weeks)	-	53.0%	56.0%	60.6%	56.6%
Islington Podiatry (Foot Health) (<6 weeks)	-	52.0%	66.0%	88.2%	68.5%



Commentary

Dental
Patient Involvement and Experience consistently score above threshold.

District Nursing
The two response times for District Nursing are now reported electronically.
Issue: Referrals for DN are processed in the Central Referral Team and Urgency is taken from the referral form, filled in by the referrer. The referral is then triaged by the Specialist Nurse and the Urgency might be changed, hence the lower scores than previously reported. The true Urgent referrals are mostly phoned through to the Service and are always seen within 2 hours. Examples of urgent referrals are 'End of Life Care change' and 'Blocked catheter'.
Action: Process from Central Referral Team to triaging to be reviewed.
Timescale: End of September

MSK
MSK Waiting Times - Routine MSK (<6 weeks):
Issue: Increased demand and also a reduction in capacity due to AL. The main issue is the capacity for specialist community clinics.
Action: A action plan has been completed following review of the total waiting list and realignment of capacity.
Timescale: immediate
MSK Waiting Times - Consultant led (<18 weeks): Standard is being met.

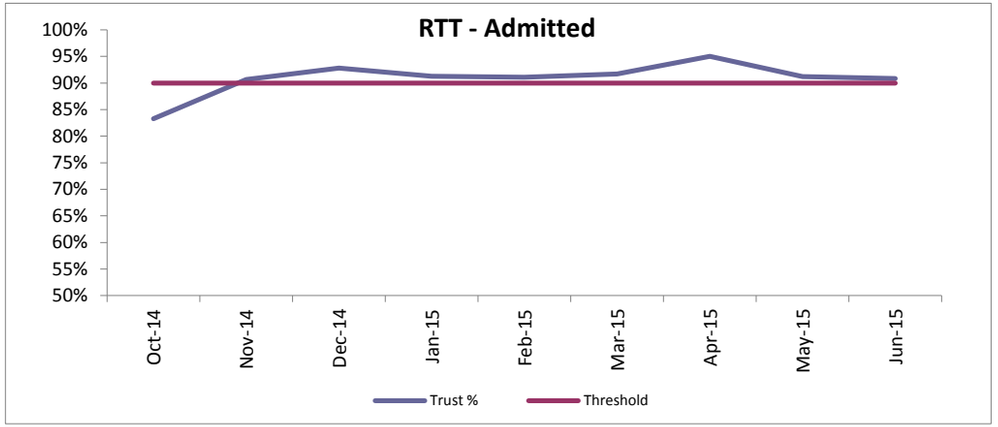
IAPT
Issue: Improving
Action: An extensive improvement plan is in place, and shows 53.5% reliable recovery rate for March 2015.
Timescale: Improvement in patients moving to recovery will be seen from April 2015

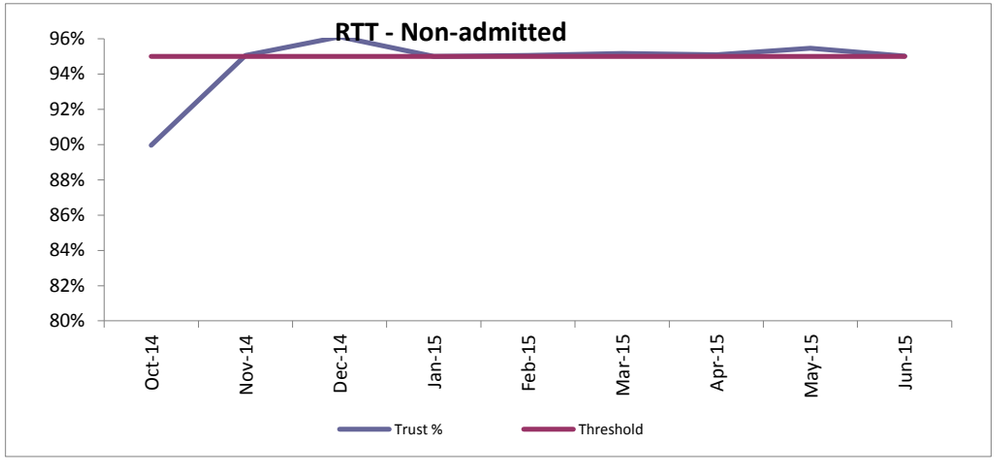
GUM
Issue - staffing reduction due to vacancies
Action - alignment of demand and clinic capacity has taken place

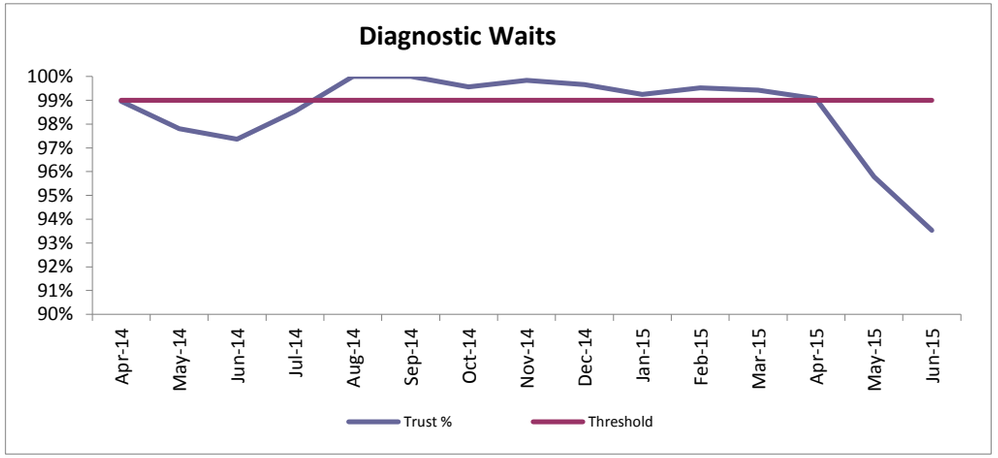
Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

	Trust (arrears)				
	Threshold	Apr-15	May-15	Jun-15	Trend
Referral to Treatment 18 weeks - Admitted	90%	95.0%	91.2%	90.9%	
Referral to Treatment 18 weeks - Non-admitted	95%	95.1%	95.5%	95.0%	
Referral to Treatment 18 weeks - Incomplete	92%	93.1%	92.9%	92.7%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits - 6 weeks	99%	99.1%	95.8%	93.5%	







Commentary

RTT

Achieve standard

Diagnostic Waits

Issues: Endosopy demand has exceeded capacity and a backlog has built. Audiology have a small number patinets who wish to be treated outside the 6 weeks standard,

Action: Enscopy a ction plan in place to increase the capacity for patient bookings, audiology have reviewed capacity and all patinets booked

Timescale: Compliance with the standard by September 2015

Waiting times - OPD appointment

Cardiology 6 Weeks, Dermatology 11 Weeks , Endocrine 9 Weeks, ENT 8 Weeks, Gastroenterology 8 Weeks, General Surgery 4 Weeks , Gynaecology 6 Weeks, Neurology 9 Weeks, Pain 12 Weeks , Rheumatology 3 Weeks, Thoracic Medicine 5 Weeks, Urology 4 Weeks, Vascular 12 Weeks, Ophthalmology 4 Weeks, Trauma and Orthopaedic 6 weeks.

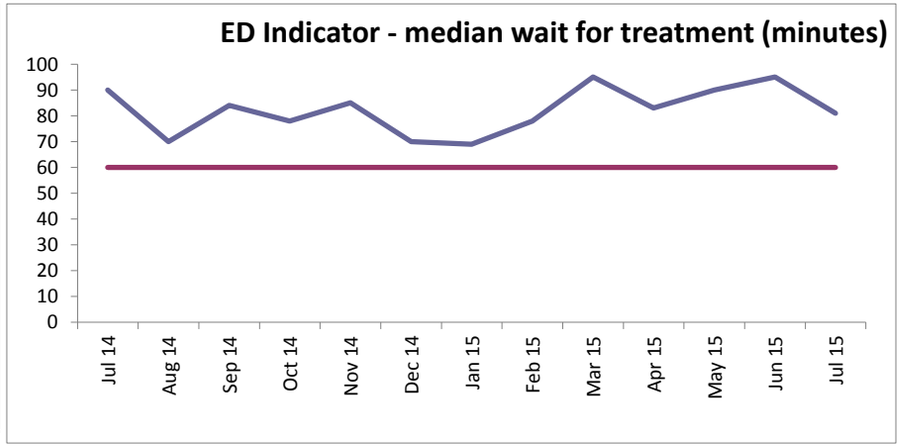
Diagnostic waiting times (radiology) all under 6 weeks (42 days) waiting time standard

Imaging Modality no wait, CT 20 days, MRI 20 days, Nuclear Medicine 5 days, DEXA 20 days, Fluoroscopy 25 days, Ultrasound (Gynae) 10 days, Ultrasound General (Radiologist Lead) 20 days, Ultrasound Paediatrics 35 days, Ultrasound MSKs 30 days, Ultrasound Hernias 25 days, Ultrasound Obstetrics Anomaly 15 days, Ultrasound Obstetrics Growth 15 days, Ultrasound Abdomen & Gynae at Hornsey General 10 days.

Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Jun-15	Trust Actual Jul-15	2015/16 Trust YTD
Emergency Department waits (4 hrs wait)	95%	94.4%	95.1%	94.4%
Emergency Department waits (4 hrs wait) Paeds only	95%	96.6%	97.9%	97.1%
Wait for assessment (minutes - 95th percentile)	<=15	14	13	14
ED Indicator - median wait for treatment (minutes)	60	95	81	87
Total Time in ED (minutes - 95th percentile)	<=240	294	240	292
ED Indicator - % Left Without Being seen	<=5%	6.9%	5.9%	5.8%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	3	arrears	11
Ambulance handovers exceeding 60 minutes	0	0	arrears	0

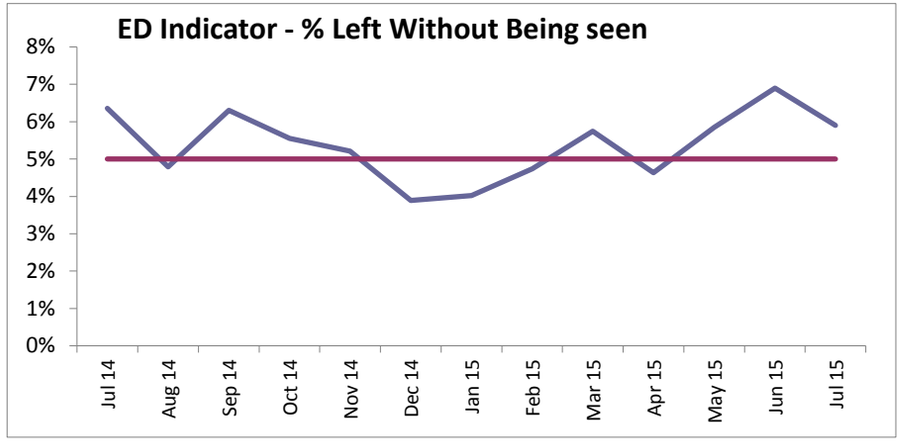


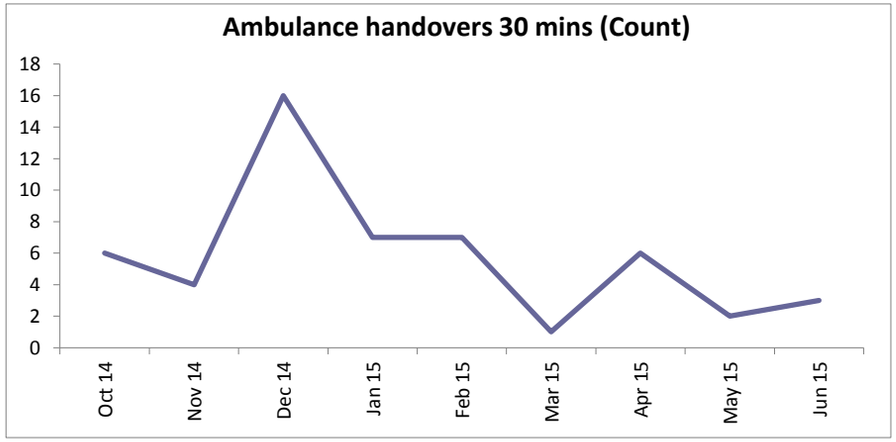
Commentary

The Emergency department team have agreed an action plan to improvement performance against the national standard. July was compliant and further work is underway to sustain improvements.

The themes for improvement are - aligning staffing to demand patterns, training for new senior staff in floor coordination and access management, demand and surge escalation plans, and alignment of ENPs and

ED waits for Paediatrics remain above standard.





Cancer

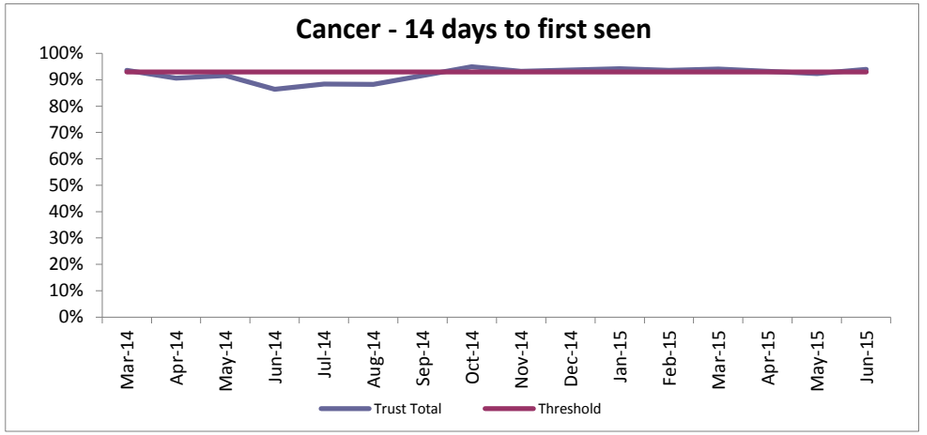
Whittington Health NHS

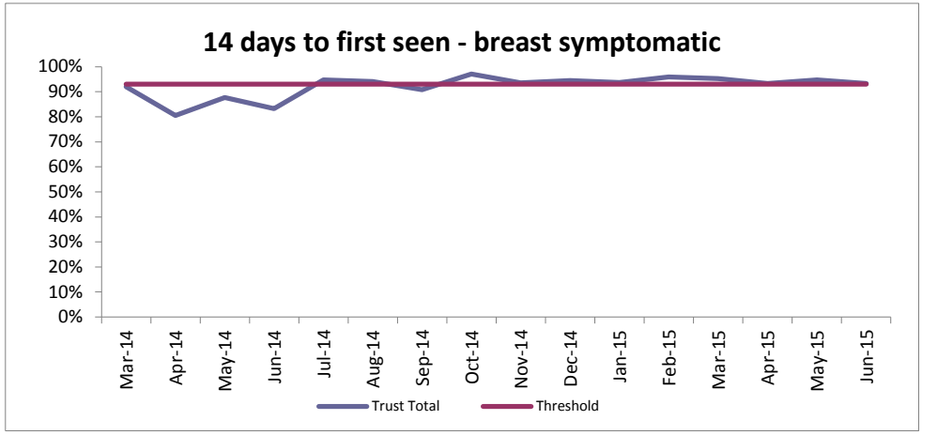
		Jun-15				2015/16 Trust				
	Threshold	Apr-15	May-15	Jun-15	Trend	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.2%	92.4%	93.9%		93.2%	-	-	-	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	93.3%	94.7%	93.3%		93.6%	-	-	-	93.6%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	95.7%	93.8%	90.0%		93.2%	-	-	-	93.2%
Cancer - 62 days from consultant upgrade	-	100%	93%	83%		92.9%	-	-	-	92.9%

Commentary

All cancer targets were achieved this month and met for QRT 1.

The Cancer Patients tracking list is monitored daily and discussed in the weekly PTL meeting

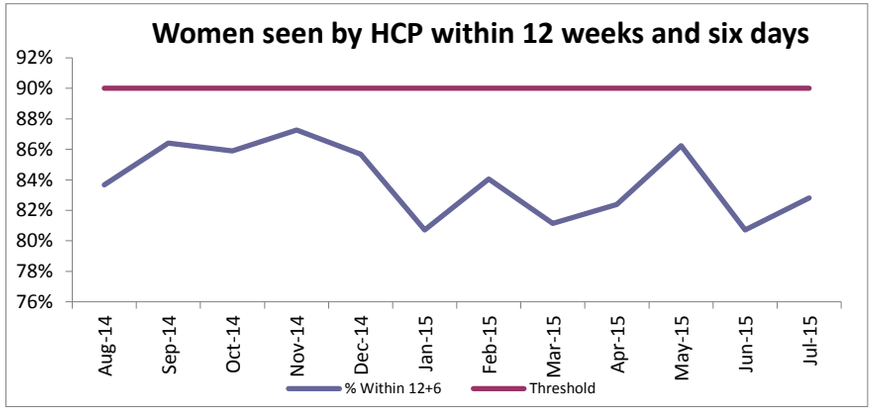


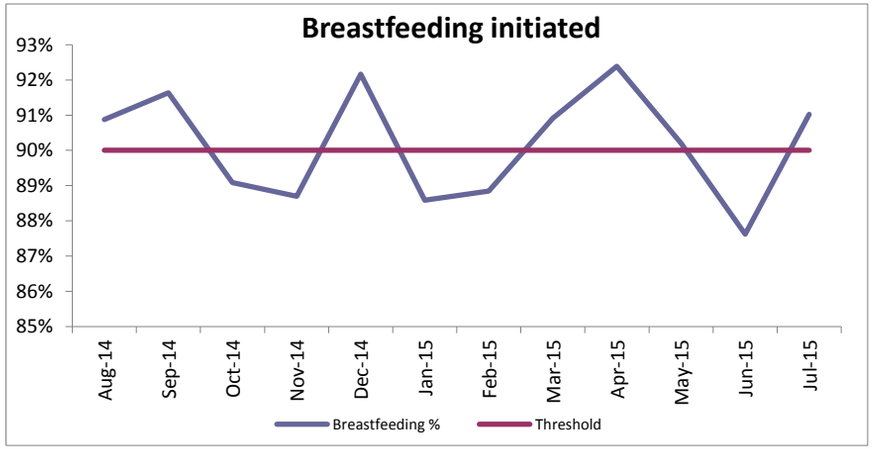


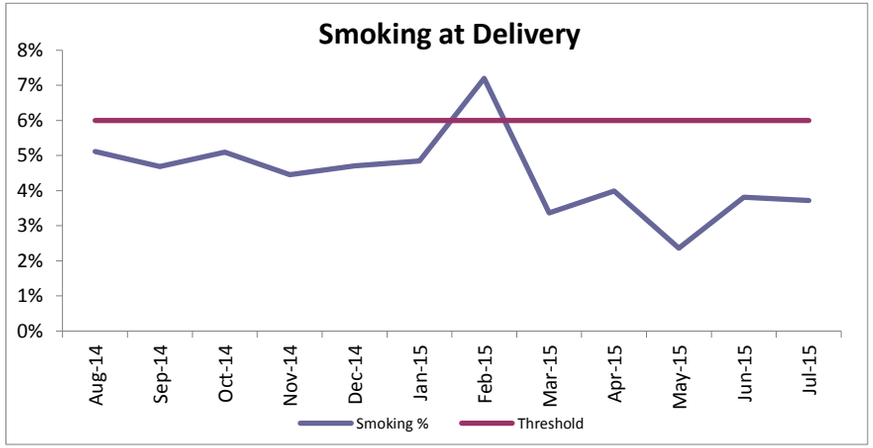
Maternity

Whittington Health NHS

	Threshold	Trust Actual May-15	Trust Actual Jun-15	Trust Actual Jul-15	2015/16 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	86.2%	80.7%	82.8%	82.9%
New Birth Visits - Haringey	95%	85.6%	87.8%	Arrears	80.2%
New Birth Visits - Islington	95%	92.7%	89.7%	Arrears	89.9%
Elective Caesarean Section rate	14.8%	11.0%	10.2%	17.8%	13.0%
Emergency Caesarean Section rate	-	13.0%	22.4%	17.8%	17.9%
Breastfeeding initiated	90%	90.2%	87.6%	91.0%	90.25%
Smoking at Delivery	<6%	2.4%	3.8%	3.7%	3.8%







Commentary

Women seen by HCP or midwife within 12 weeks and 6 days
Issue: The 12+6 target remains challenging across the sector and London.
Action: Women are now being contacted in order to confirm they are attending the scheduled appointment . An issue has been identified with respect to the transfer of data between the maternity system and the Medway EPR. Where by women who have attended within the timescale are being identified as DNA or not booked. Maternity and IT have developed an action plan and will be rectifiying the issue by end of September.
Timescale: By end of September

New Birth Visits
Issue: very poor performance in one Haringey Health Visiting team. Vacancies in one Haringey and one Islington team.
Action: Haringey team leader to deliver action plan to head of service by end of week. Targeted recruitment to vulnerable teams.
Timescale: End September

Caesarean Section rate
Elective Caesarean sections have increased in the month, this is being reviewed by the team.

Breastfeeding
Achieved

Smoking

Whittington Health Trust Board

September 2015

Title:	Workforce KPIs July 2015.		
Agenda No	**07**	**Paper**	**15/110**
Action requested:	To update the Trust Board on key workforce performance indicators (KPI's) for July. Where there is a variance against compliance rates for some KPI's the outline plans are set out in summary within the report.		
Executive Summary:	**Highlights this month:** **Turnover** Turnover this month continues to show a gradual upward trend coming in slightly higher for July at 14.8% as compared to the previous months figure of 14.2% **Vacancy rates** Vacancy rates are linked to turnover. There is a high level of vacancies in Corporate Services, however some of this is due to the movement of cost centres between corporate and WCF. **Sickness** The total Trust sickness rate for July saw a slight increase to 3%. Action plans have been developed by each Division/Corporate services to tackle short term absence and relatively high Bradford scores. Further control mechanisms are being put in place for reporting sickness and a programme for addressing long term sickness cases is also being put in place. The Trust has a revised sickness absence policy which has recently been published on the intranet designed to help both support managers expedite the sickness absence management process and support staff to be at work. **Overtime** July saw a 10k reduction in overtime spend from June's figures. There has been an encouraging decrease month on month in overtime spend since May. **Appraisal** The appraisal figures show a 2% decrease from last month. Executive Directors have developed action plans with all their managers and the inputting onto ESR is being centralised by Learning and Development to support managers.		

	Mandatory Training There is a 1% increase in mandatory training for July and the Trust overall rate currently stands at 78%. A review of action plans continues to be part of performance review meetings in divisions and corporate services. The mandatory training workbook is expected to make a significant difference in the completion of mandatory training in the forthcoming year.
Summary of recommendations:	To note the report and the progress being made in key areas to increase compliance rates.
Fit with WH strategy:	Aligns fully to strategic intent.
Reference to related / other documents:	Aligns to HR policies and procedures.
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured in risk registers and board assurance framework as relevant.
Date paper completed:	25th August 2015

Author name and title:		**Jo Bronte HR Manager**		**Director name and title:**		**Norma French Director of Workforce**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Trust Board Report - Workforce (July 2015 data)

Whittington Health NHS

		Trust			
Management of the workforce	**Threshold**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Trust Turnover Rate	<13%	14.1%	14.4%	14.2%	14.8%
Total trust vacancy rate	<13%	12.5%	14.2%	12.6%	12.4%
Sickness rates	<3%	2.8%	2.5%	2.9%	3.0%
Overtime expenditure		51k	62k	54k	44k

		Trust			
Development of the workforce	**Threshold**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**
Appraisal	90%	58%	56%	56%	54%
Mandatory Training	90%	73%	76%	77%	78%

		Trust
Staff FFT Results		**Q1**
Staff who would recommend the trust as a place to work	-	60%
Staff who would recommend the trust as a place for treatment	-	77%

Percentages recommending / not recommending are much as last quarter.

Our response rate of 21% is lower than last quarter (27%) but still well above the national/London averages of 13%/11% in Q4 14/15.

Management of the Workforce - Turnover, vacancy and sickness

Whittington Health NHS

	July 2015	
	Threshold	Trust Actual
Trust Turnover Rate	<13%	14.8%
Total trust vacancy rate	<13%	12.4%
Trust level total sickness rate	<3%	3.0%

Turnover rate

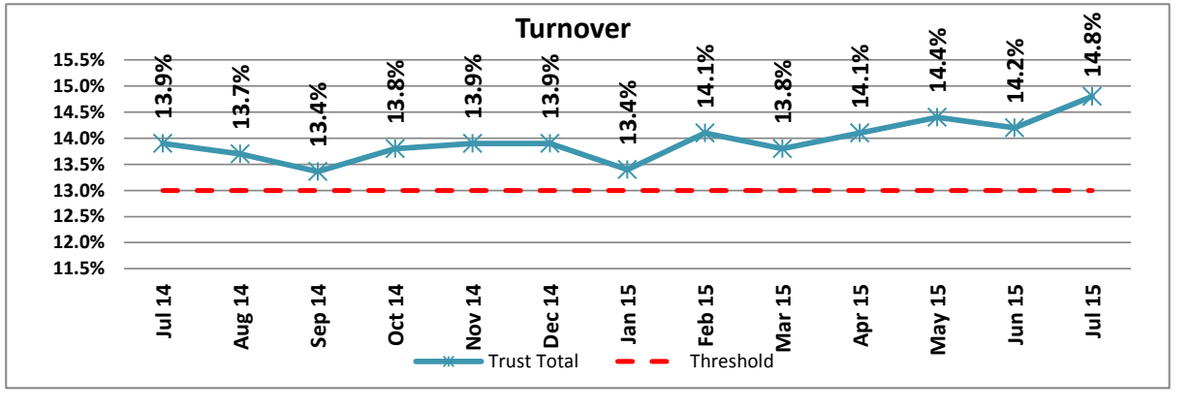
Turnover rate in July has increased slightly from June. A new exit interview policy has been devised and will enable better analysis of reasons for leaving.

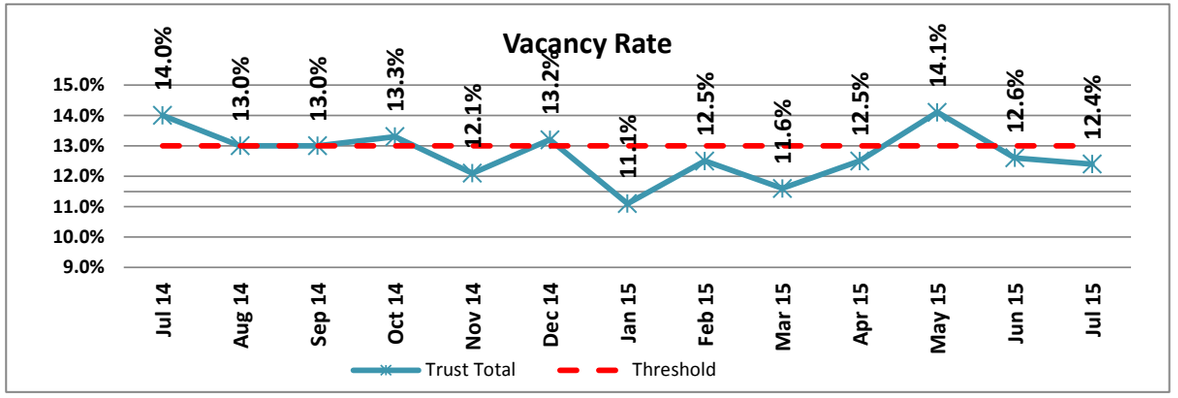
Vacancy Rates

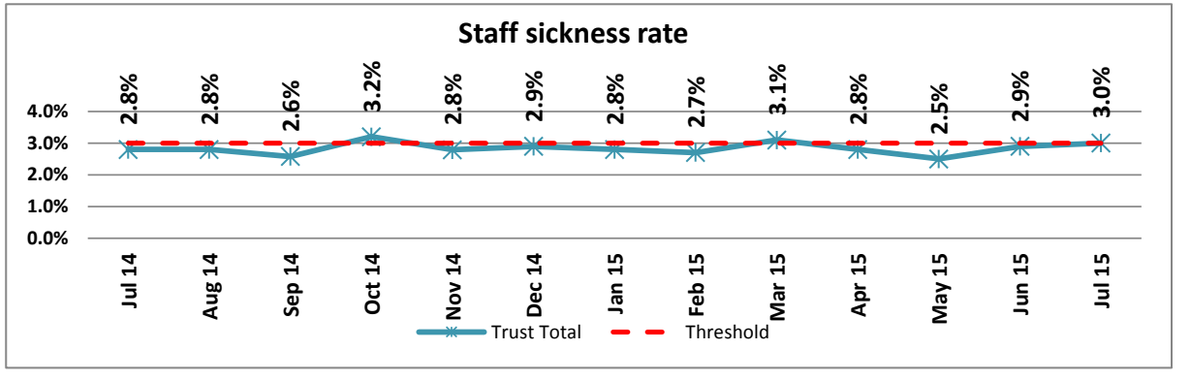
Vacancy rates are linked to turnover and the high level of vacancies in corporate services although some of this change is as a result of the movement of cost centres between corporate and WCF.

Trust Level Sickness rates

The level for sickness rates in July is within the threshold. Action plans have been developed by each Division/Corporate services to reduce short term sickness absence and to tackle high Bradford scores. In addition further control mechanisms will be put in place for reporting sickness and a program of addressing long term sickness cases work is also being put in place.







Management of the Workforce - Overtime, Bank & Agency

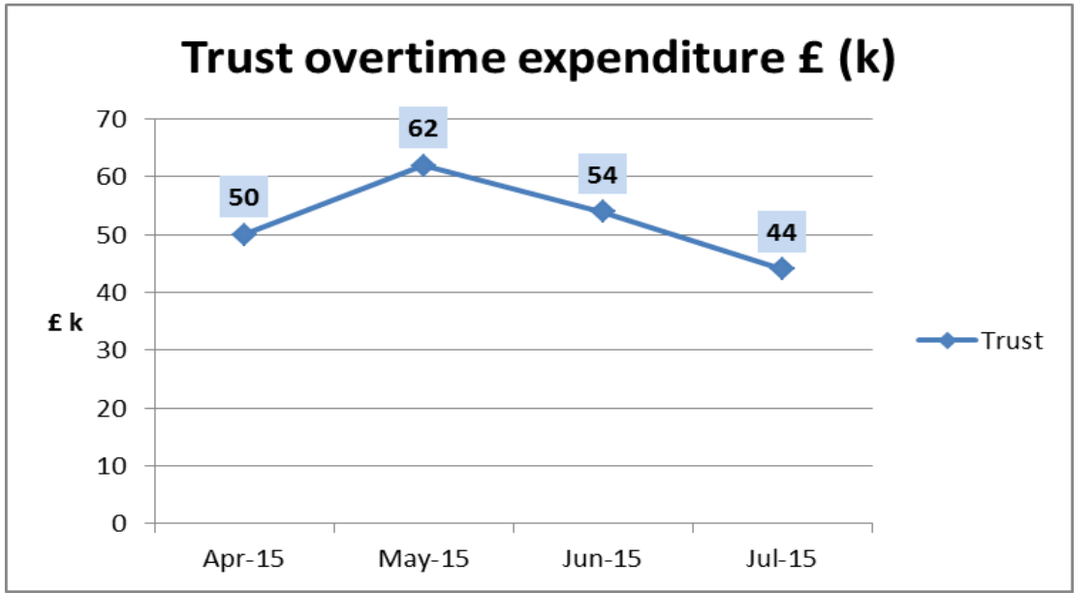
Whittington Health NHS

Overtime expenditure

	July 2015
	Trust
Overtime cost	44k

Overtime

There has been a £10k reduction in overtime expenditure between June and July. The overall overtime expenditure has been decreasing steadily from May. In July Surgery and Children's reduced their overtime expenditure by half in relation to June's expenditure. Additionally, IT services had no overtime to report in July (£3.7k was reported in June).



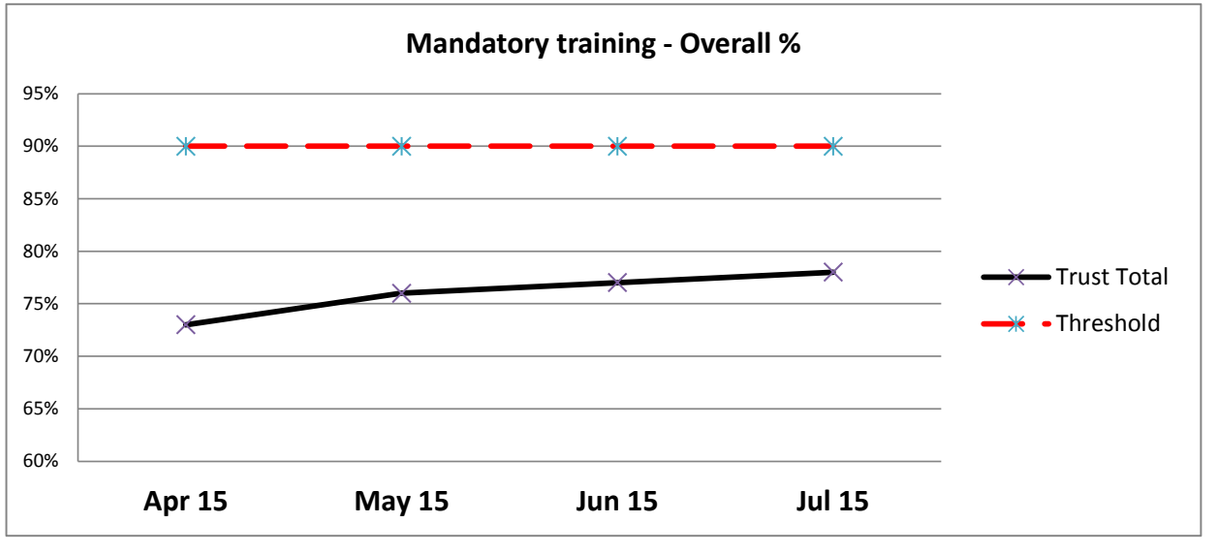
Development of workforce

Whittington Health NHS

	July 2015	
	Threshold	Trust Actual
Percentage of staff with mandatory training compliance	90%	78%
Percentage of staff with annual appraisal	90%	54%

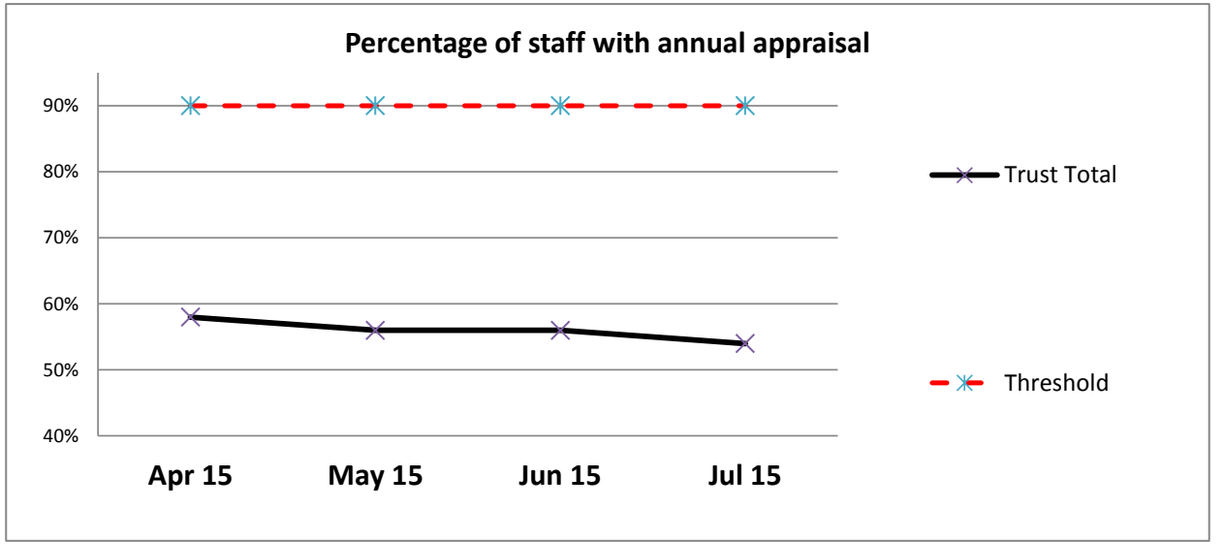
Mandatory training

The Trust compliance rates are below average for other Trusts across London. A review of action plans continues to be part of performance review meetings in divisions and corporate services. As a result each Director has been tasked with forecasting when significant improvements will be made in compliance rates for their staff. A mandatory training workbook has been launched with the purpose of increasing compliance rates and is making a significant difference in the completion of mandatory training. It is expected that this will begin to have a significant impact from July onwards. The overall compliance rate in July has increased by 1%.



Appraisal

The overall rate decreased by 2% in July. The implementation of action plans for the Trust remains a priority. Compliance rates for appraisals continue to be reviewed on a regular basis within management teams. A draft revised appraisal scheme is expected to support improvement in the rates of appraisal once agreed and launched. As with Stat/Man training, appraisal rates are a priority for the Executive Team with regular feedback to directors and ICSUs of performance in their area of



Whittington Health Trust Board

2 September 2015

Title:	Corporate Staff Survey Action Plan 2015		
Agenda item:	**15/111**	**Agenda Number:**	**08**
Action requested:	To note and comment on action taken and progress made against the corporate staff survey action plan, agreed at Trust Board on the 3rd June 2015.		
Executive Summary:	Since Trust Board approved the corporate staff survey action plan in June, significant progress has been made in all seven priority areas, identified from the 2014 staff survey results. The full progress against action plan is attached and some brief highlights are detailed below: **Priority 1** New appraisal process and documentation agreed at TMG and rollout of new simplified appraisal process has started. There is now only one appraisal being used across the Trust. **Priority 2** New Chief Exec Team briefing started with senior managers in July. New internal awards ceremonies agreed and to be launched in September New booklet to be launched in September giving Biogs of Board members and Executive. Also booklets will be part of Corporate Induction for new starters New TMG meetings including Clinical Directors **Priority 3** Clinical strategy informs each Executive member and Clinical director objectives New business planning process underway to align service business objectives to clinical strategy **Priority 4** Executive and Clinical Director Development underway New L&M proposal drafted, offer and accompanying resources to be signed off at TMG **Priority 5** Electronic Staff Record (ESR) training records 2014/15 reviewed in		

	addition to clinical education team database. Data analysed which highlighted, 79% of staff received training opportunities, which is close to the national average of 81%. Categories where training opportunity was lower than the Trust average have been identified and actions are being taken to address these. ESR and recruitment data (past 2 years) has been reviewed by band, Integrated Clinical Service Unit (ICSU), internal vs external appointment and equality monitoring data. Findings indicate a lower rate of promotion for black and Asian staff. In terms of external recruitment to bands 7 and above- clinical staff, there is a higher representation of white ethnic groups and a higher proportion of men. Internal recruitment, 52% of internal recruits were from white ethnic backgrounds but this varied across ICSUs, with the highest being in Outpatients at 80%. Initial findings indicate potential barriers in terms of career progression from bands 6 to 7 and 8a to 8b. **Priority 6** ICSU restructuring completed and top level. Next step in for services to realign themselves to the new structures, removing unnecessary duplication and moving resources to best meet the demands of the new services **Priority 7** Additional E&D events planned in Sept LGBT and November (domestic violence New approved E&D policy updated on the intranet and communications planned to publicise policy commencing in September Equality data production has highlighted the need for further work
Summary of recommendations:	Trust Board is asked to note the contents of this update and the dates of the impending 2015 Staff Survey.
Fit with WH strategy:	Update on our key priorities identified from our staff survey and aligns to our OD and staff engagement strategies.
Reference to related / other documents:	2014 National NHS Survey
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Preparation for CQC inspection in December may detract organisation focus on staff survey priorities.
Date paper completed:	21st August 2015

Author name and title:		**Rai Gallo Leadership Coach**		**Director name and title:**		**Norma French Director of Workforce**	
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**

Paper to: Trust Board

Paper from: Director of Workforce

Date: 2nd September 2015

Subject: Update of National Staff Survey 2014 Action Plan

1.0 Introduction

This paper provides the Trust Board with an update of the 2014 National Staff Survey Action Plan that was presented to the Trust Board in June 2015.

At that meeting, it was agreed that each priority action be assigned to a specific Director. These Director leads have provided the content for this update.

2.0 Background

The staff survey is conducted annually and the Trust commissions The Picker Institute to run its survey as do many other Acute Trusts. This means that in addition to the comparative information which is available through the CQC analysis of the data, the Trust also has access to more detailed comparative data with other Trusts. Whittington Health issues surveys to all staff. Nationally the survey is conducted between October and December each year, with final results being made available to Trusts around March.

The 2015 Staff Survey will commence in October 2015 and the aim is to demonstrate improvements in the priority action areas.

3.0 Recommendations

The Trust Board is asked to note the contents of this update and the dates of the impending 2015 Staff Survey.

DIRECTORATE STAFF SURVEY ACTION PLAN 2015/16

	KEY RESULTS THEME	WHAT & HOW WILL WE DO IT?	WHO IS RESPONSIBLE & WHEN?	HOW WILL WE MEASURE IT?	Sept 15 updates for Trust Board
1	**Identified priority – Percentage of staff being appraised and having a well-structured appraisal. Norma French / Glenn Winteringham**				**Sept 15 update for Trust Board**
1.1	Redesign and simplify the appraisal process and documentation.	• Meeting arranged with key stakeholders to go through the new process and make changes to documentation and existing process • Revised simplified process to TOB for feedback • Charlotte Johnson reviewing existing documentation and applying changes following key stakeholder engagement • Revised appraisal process to be taken to TMG date to be agreed	Head of L&D / Leadership Coach / Director of Workforce	Improved appraisal returns rates NHS 2015 staff survey improvement of quality of appraisal process.	TMG has signed off the new appraisal process and appraisal documentation to be used by the Trust 18/08/15
1.2	Engage all appraising managers in the use of the new scheme.	• Once the revised process has been agreed at TMG a line managers rollout engagement plan will be developed where we will offer line managers drop in sessions across all our sites to	Head of L&D / Leadership Coach	Improved appraisal returns rates NHS 2015 staff survey improvement of quality of	Rollout out plan and training for line managers is being worked on with rollout of the new appraisal process starting

		go through the new paper work • Update the appraisal intranet site with revised process and new documentation		appraisal process.	in September 2015. L&D are in the process of updating the appraisal intranet pages and will be ready to support the rollout training in September 15.
1.3	Improve reporting via ESR?	• Get feedback from managers on why the current reporting is not fit for purpose • Learning and Development will allocate appropriate resource across the Trust to support managers in updating their completed appraisals on the ESR system. • Monthly Appraisal performance reports to be used to effectively target manage those areas that are under performing.	Head of L&D	Improved appraisal returns rates NHS 2015 staff survey improvement of quality of appraisal process.	L&D have allocated resources to support line managers in entering completed appraisals on ESR. Investigations have highlighted inaccuracies in data reporting and L&D are working with Information management to improve quality of data in the reports. Medical staff who have done their appraisals are being given support on updating their records on ESR. Monthly reports are being taken to TMG highlighting exemplar areas and shaming those who are not performing.

2	Identified priority- Improved senior management visibility and staff engagement Siobhan Harrington / Lynne Spencer				Sept 15 update for Trust Board
2.1	New Team Briefing Structure	• TMG agreed new process for monthly CEO Team Briefing Meetings and Factsheet • Forward Calendar signed off by SMH/SP with launch date agreed for hospital and community CEO team Briefing meetings and Factsheet • All staff weekly Noticeboard to include 'spotlight' on a member of staff/Board Q&A	Director of Strategy / Director of Communications and Corporate Affairs	Attendance records reported to TMG FAQs produced & published on intranet Survey Monkey staff to measure impact – Q3	Implemented new process for monthly CEO Team Briefing Meetings and Factsheet with targeted members who then brief their teams to create a continuous two way dialogue. All staff weekly electronic Noticeboard revised and new approach to target news and provide signposting to other information sources which is linked to the intranet All staff weekly electronic Noticeboard posted on intranet to provide back copies for all staff Website page introducing Board revised and republished to raise awareness of new permanent leadership team
2.2	Senior Leaders programme of engagement activities	• Out and About calendar of events to be produced and rolled out by senior team; includes deliberative and non-deliberative meetings/events (piggy back	Director of Strategy / Director of Communications and Corporate	Meeting Log and attendance records reported to TMG Meeting Log and	Out and About for senior team via a forward calendar of engagement events produced with clear communication handling

		existing meetings) • Monthly Patient Safety Walkabouts by Board • Lunch in the staff canteen as much as possible and talk to staff informally • Campaign and collage of 'My name is'… to be displayed within the hospital and other community sites • Photographs and bios of the Board to be produced for prominent display in key locations across ICO • New internal Awards Protocol to be launched for nominations of staff. Executive to be present at award ceremonies to congratulate staff. • Social media policy to be agreed – internal CEO Blog, Trust facebook, twitter accounts – increase use by Executive • Corporate Induction monthly sessions – Executive team to be introduced to new staff via new factsheet (picture and bios of Board)	Affairs / Director of Nursing	feedback reports with actions reported to Quality Committee Feedback to Board in Seminars Feedback to Quality Committee & TMG Staff Survey results 2015/16 Reports to TMG on uptake Report to TMG on growth of Executive social media presence Feedback sheets from event	plans agreed. Deliberative and non-deliberative meetings/events (piggy back existing meetings in the community eg Healthwatch meetings) Monthly Patient Safety Huddles by Board members with key actions documented Lunch in the staff canteen as much as possible and talk to staff informally to support higher visibility Continue roll out of campaign 'Hello my name is'… to be targeted within the hospital and community Photographs and bios of the Board to be widely publicised e.g. new booklet to be launched in September and distributed to all staff New internal Awards protocol to be launched in September for staff nominations of staff and new excellence badges

					ordered to recognise outstanding work and achievements. Executive to be present at award ceremonies to congratulate staff. Social media policy agreed at IG Committee – internal CEO Blog, Trust facebook, twitter accounts – increase use by Executive and other staff Corporate Induction monthly sessions – Executive team to be introduced to new staff via new factsheet (picture and bios of Board) Ask the CEO questions via intranet and responses published New graphic design system purchased to enable in house publications to promote wider involvement of engagement activities
2.3	Extended management team meetings	• ICSU Clinical Director group Meetings CEO • ICSU Directors of Operations	Chief Executive / Director of Strategy / Director of		Implemented new TMG with ICSU Clinical Director group members

		Meetings with CEO • Senior managers / Clinicians leadership morning and lunchtime sessions • Middle managers morning / lunchtime sessions • Executive and TMG meetings to be redesigned and rescheduled from July onward	Communications and Corporate Affairs / Director of Nursing	Reports to TMG & Board Seminars Staff Survey 2015/16 Annual review	Implemented senior managers / clinicians leadership morning and lunchtime sessions Implemented middle managers morning / lunchtime sessions CEO clinician drop in sessions bi weekly
3	• **Identified priority - Whittington Health to address uncertainty by implementing a clear vision for the future. Simon Pleydell / Lynne Spencer**				**Sept 15 update for Trust Board**
3.1	Clinical strategy briefings and next steps	• Planning and activity from June onwards	Director of Strategy		Clinical strategy distributed personally to local MPs and other key stakeholders Clinical strategy is included in all relevant briefings and meetings to continually raise awareness and promote Clinical strategy informs Executive and Clinical Directors' objectives
3.2	Clinical strategy, mission, vision, strategic goals - communications handling plan in place	• Promotion of mission, vision, strategic goals and corporate objectives to all staff and external stakeholders - includes activities such as hard copy	Chief Executive / Director of Strategy / Director of Communications	Staff survey 2015/16 Annual business plans produced by	Completed and on-going

		clinical strategy distributed at corporate induction, regular key messages at team briefings and in weekly all staff Noticeboard, written features and links to clinical strategy in partner newsletters e.g. Islington CCG, Haringey CCG, LAs, published on Whittington website and intranet, poster campaign across ICO, pop up boards promoting vision across ICO, templates include mission statement	and Corporate Affairs	ICSU and informed by clinical strategy	
3.3	Realignment of senior management and clinicians	• Development of and implementation of new structure for the Integrated Clinical Service Units (ICSUs) across the ICO Completed. • Recruitment and realignment process underway • Implement new structures for greater clinical leadership across seven ICSUs	Chief Executive / Medical Director / Chief Operating Officer	Annual business plans produced by ICSU and informed by clinical strategy Annual review of realignment reported to Board	Recruitment and realignment process complete with one vacancy yet to complete for a Director of Operations in Clinical Support Services New business planning process underway to support successful realignment and stronger clinical leadership
4	• **Identified priority - Address management behaviours to inspire and motivate staff and act as leaders, encouraging staff to reach their potential. Richard Jennings / Stephen Bloomer**				**Sept 15 update for Trust Board**
4.1	Leadership development programmes to be devised and rolled out across the ICO 2015/16	• Trust wide leadership offer designed for Executive, Operational and Frontline levels • Values agreed – ICARE innovative, compassionate, accountable, respect and	Leadership Coach Chief Executive / Director of Strategy	Signed-off leadership offer from TMG Review values within the 6 month review of ICSUs	Design of L&M offer complete. Offer to be signed-off by TMG with accompanying financial resources. Business case in the process of being drafted.

		excellence	/ Director of Communications and Corporate Affairs	Staff Survey 2015/16	
4.2	Refresh appraisal system	• Launch new appraisal system 2015/16 • Monitor in year compliance of 90% and ensure target is met for the year	Executive to hold managers to account and each level of managers below to mirror a zero tolerance approach to off plan compliance 15/16	New appraisal process signed off at TMG 02/06/15 Quarterly monitoring of appraisal rates to TMG Annual report for appraisal to Board	TMG has signed off the new appraisal process and appraisal documentation to be used by the Trust 18/08/15
4.3	Leadership and development programmes to be devised and rolled out across the ICO 2015/16	• Board development programme to be devised for 2015/16 to forward plan business for Seminars and Away Days	Chief Executive / Director of Strategy / Director of Communications and Corporate Affairs	Annual appraisal of Board Annual self-review of effectiveness of Board	
4.4	Leadership and development programmes to be devised and rolled out across the ICO 2015/16	• Executive development programme to be devised for 2015/16 to forward plan business for Away Days and Workshops	Chief Executive / Director of Strategy / Director of Communications and Corporate Affairs	Annual appraisal of Executives Staff survey 2015/16	First Executive awayday held on the 30th July, clear set of actions agreed by the Executive on how they will operate as a team. Next development date agreed for the 2nd November 15.
4.5	Leadership and development programmes to be devised and rolled out	• Leadership and development programme to be designed and rolled out for new ICSU leaders and across the ICO for wider clinical, operational and frontline	Chief Executive / Director of Strategy / Director of Communications	Annual appraisal of new teams Staff survey 2015/16	Clinical Directors Development workshop agreed for the 24th September. This workshop will inform future Clinical

	across the ICO 2015/16	leaders	and Corporate Affairs / Medical Director		Director Development as agreed by the team.
4.6	Leadership and development programmes to be devised and rolled out across the ICO 2015/16	• Leadership and coaching sessions programme 2015/16 for all staff	Director of Workforce / Leadership Coach	Annual review of coaching sessions	Coaching and Mentoring hub established and is available to all staff who are seeking either coaching or mentoring.
4.7	Schwartz rounds	• 2015/16 programme of Schwartz rounds for clinical leadership development	Medical Director / Director of Nursing	Annual review of Schwartz rounds	Our SR contract expired on the 10th August. Director of Nursing and Medical Director exploring options on the continuation of SR. One option to be explored is to hold joint SR with GP practices within out patch who have funding to run SR's.
5	• **Identified priority – Training, development and career path opportunities – Philippa Davies / Nick Harper**				**Sept 15 update for Trust Board**
5.1	Training and Development	Analysis of Higher Education Institution (HEI) commissions mapped to Training Needs Analysis (TNA) submissions Analysis of in-house T&D opportunities in terms of provision and uptake	Head of Clinical Education	Actions to be determined dependant on the findings	Electronic Staff Record (ESR) training records 2014/15 reviewed in addition to clinical education team database. Data analysed according to band, age, gender, ethnic group and part-time or full time status. Analysis showed that overall, 79%

					of staff received training opportunities, which is close to the national average of 81%. Categories where training opportunity was lower than the Trust average are: Band 1-4 staff and Band 8C and 8D staff Staff 'ethnicity not stated' Staff age group 16-20; 61-65; 66-70yrs • Men • Part time workers Next steps to be determined by end Q2
5.2	Career path opportunities	Analysis of all posts recruited to in past 2 years; • By Grade • By Directorate • By Division	Leadership Coach / Head of L&D	Actions to be determined dependant on the findings	ESR and recruitment data (past 2 years) has been reviewed by band, Integrated Clinical Service Unit (ICSU), internal vs external appointment and equality monitoring data. Findings indicate a lower rate of promotion for black

		• Whether internal appointment • Whether external appointment • Equalities monitoring data			and Asian staff. In terms of external recruitment to bands 7 and above- clinical staff, there is a higher representation of white ethnic groups and a higher proportion of men. In terms of internal recruitment, 52% of internal recruits were from white ethnic backgrounds but this varied across ICSUs, with the highest being in Outpatients at 80%. Initial findings indicate potential barriers in terms of career progression from bands 6 to 7 and 8a to 8b. These results need to be viewed with caution as equality monitoring data in relation to staff records is incomplete. In addition, data viewed / analysed did not include staff who are outside Agenda for Change pay scales. Next steps to be

					determined by end Q2
5.3	Consider introduction of talent mapping and succession planning process	To be explored	Director of Nursing / Director of Workforce by end Q2	To be confirmed once process in place	
6	• **Understand the underlying causes and act where staff have reported excessive workloads – Lee Martin / Clarissa Murdoch**				**Sept 15 update for Trust Board**
6.1	ICSU implementation	ICSU will work through the priorities and align the ICSU to be able to deliver the priorities	Chief Operating Office and Clinical Directors	Underway by end of quarter two	The CD and Directors of Operations are in place, the next stage of realignment is for the structures within the ICSUs to be reviewed and clear defined management and leadership accountabilities stated. Each ICSu has been requested to assess workloads and remove unnecessary meetings, look at removing duplication of tasks and also define essential tasks.
6.2	Activity monitoring	Activity monitoring to be undertaken weekly as part of the PTL meetings	Chief Operating Officer / Director of	Underway with completion by	Acute and community PTL meetings are in place, these have been reviewed

		for acute and community	Operations	quarter two	in-line with the new clinical structure
6.3	Rolling program of staff open session with Operational leadership team	Program agreed starting with DMT meetings and cascade to all teams reporting into directors of operations	Chief Operating Officer / Director of Strategy	Quarter one and two	Meeting structure are being reviewed within the ICSu realignment, this should be completed by the end of September. A monthly operational management meeting for Service Managers has been established and also TMG has been refined to TOM.
7	**Equality and Diversity – Greg Battle / Phil Ient**				
7.1	Celebrate Equality and Diversity week.	• Organise events throughout E&D week, across the Trust • E&D conference to be opened by E&D accountable Exec	Head of L&D / Medical Director Integrated Care	52 attendees to E&D conference Evaluation of event all good / excellent	Domestic Violence Conference scheduled in November 2015 - Domestic Violence Week. Developing workshop/sessions for raising awareness around LGBT , starting in September 2015
7.2	Arrange meeting with BRAP to evaluate our existing approach to Equality & Diversity for	• Meeting to be arranged with BRAP	Head of L&D	Revised E&D strategy	Workshop for HR Professionals & team – September 2015

	Feedback and improvement				Development of a Masterclass workshop for ISCU leads and TMG(Date to be confirmed) Development of Equality/Unconscious bias/bullying and harassment training for line managers
7.3	Action plan to achieve Whittington Health's baseline data for 2015 to be compliant with NHS Workforce Race Equality Standard	• Produce equality data on current workforce, based on WRES guidelines • Updated equality data on personal files via ESR to inform publication of reports. • Recruitment forms capture relevant equality monitoring data • Available equality workforce data by division and staff, used to make informed decisions	Head of L&D	Annual Report Update report to Quality Committee	Approved new Equality policy to be uploaded on intranet with communication plan to publicise its the updated policy – deadline September 2015 Following the initial production of our equality data, this has highlighted a number of gaps. Where further work is required.

Whittington Health NHS

Whittington Health Trust Board

2 September 2015

Title:	TDA oversight report		
Agenda item:	**15/112**	**Paper**	**09**
Action requested:	Approve the self-certification for board governance to report to the TDA for submission of the monthly oversight report. This is a new format and replaces the former template issued by the TDA.		
Executive Summary:	The Trust is required to produce monthly self-certification statements for board governance. The report provides the details for August 2015. The Trust will declare compliance with its board governance statements except the IG Toolkit level 2. The Trust has a plan in place to achieve IG Toolkit level 2 in 2015/16.		
Summary of recommendations:	The Board are asked to approve the compliance statements and identify any gaps or concerns.		
Fit with WH strategy:	Aligns with financial and clinical strategies		
Reference to related / other documents:	Complies with SFI's, SOs and NHS reporting requirements		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks are documented and captured on the Trust Datix risk management software system and/or the corporate risk register and BAF		
Date paper completed:	21 August 2015		

Author name and title:		**Steve Bloomer, Chief Finance Officer & Lynne Spencer, Director of Communications and Corporate Affairs**		**Director name and title:**		**Siobhan Harrington, Deputy Chief Executive and Director of Strategy**	
Date paper seen by EC	**24 Aug**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	

NHS Trust Development Authority oversight report for July and August 2015

1. Introduction

This report is used as the basis for the Trust's response to the TDA monthly oversight reporting requirements. This template replaces the former statement reported to the Board. The Trust is required to confirm compliance with a set of Board self-certificated statements.

These compliance statements should be discussed and approved by the Trust Board with the discussion minuted. The Board should have or request access to assurance in relation to the accuracy of the reports and any associated actions.

2. Board governance statements

		Executive Lead	Compliant (Yes/ risk / No)	Issue	Action plan	Timetable
	For CLINICAL QUALITY, that:					
1	The Board is satisfied that, to the best of its knowledge, and using its own processes and having had regard to the TDA's oversight, (supported by the Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Director Nursing/ Patient Experience	Yes	n/a	n/a	n/a
2	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Director Nursing/ Patient Experience	Yes	CQC announced inspection December 2015.	n/a	n/a

		Executive Lead	Compliant (Yes / At risk / No)	Issue	Action plan	Timetable
3	The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation	Medical Director	Yes	n/a	n/a	n/a
	For FINANCE, that:					
4	The Board is satisfied that the Trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Chief Financial Officer	Yes	For 2014/15 the Trust reported a deficit of £7.3m. The Trust financial position has been affected by historic underachievement of CIP, income, activity, coding and budgetary controls. .	The Trust has appointed a substantive Chief Financial Officer, Steve Bloomer. In June external auditors judged the Trust as a going concern. The Trust is working with commissioners to ensure contracts and payments recognise the actual work done. The Trust has developed a more comprehensive CIP governance structure with detailed tracking including accountability and exception reporting. A CIP PMO has been established which reports to a Steering Group. A Quality Impact Group is in place to ensure a robust process for identifying quality impact scores and validating schemes to protect patient safety and quality am is chaired by the Medical Director or Director of Nursing and Patient Experience. The Trust has begun Phase 1 of a programme of work with external support to identify further schemes and ensure there are detailed plans for 2016/17 so that the Trust achieves financial balance in the future.	March 16

	For GOVERNANCE, that:					
5	The Board will ensure that the Trust has regard to the NHS Constitution.	Director of Comms/Corp Affairs	Yes	n/a	The Trust Board will receive an update paper on the NHS constitution. This national initiative has recently been amended and republished.	Oct 15
6	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Director Nursing/ Patient Experience	Yes	n/a	n/a	n/a
7	An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the AGS pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Deputy CEO/Dir. Strategy	Yes	The Trust has delayed revision and sign off for the risk management strategy in order to realign with the new ICSUs.	The Board will receive a revised risk management strategy in October which aligns with the new ICSUs	Oct 15
8	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant TDA quality and governance indicators; and a commitment to comply with all known targets going forward.	Chief Operating Officer	Yes	ED improvement plan in place Detailed winter planning has commenced	The Trust is committed to achievement against targets. Work continues supported by our CCG colleagues to drive improvements and compliance with the standards which are off target. These are documented within the Board monthly performance reports and reported to the TDA each month. Plans are in place to mitigate areas which are off trajectory.	Ongoing
9	The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Deputy CEO/Dir. of Strategy	No	Non-compliant	An action plan has been agreed with the IG team to achieve Level 2 and is being monitored by the IG Committee. The ICO audit recently reported a 'yellow' result in July 2015.	31 Mar 15

10	The Board will ensure that the Trust will at all times operate effectively. This includes maintaining its Register of Interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Board positions are filled, or plans are in place to fill any vacancies.	CEO	Yes	n/a	n/a	n/a
11	The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	CEO	Yes	n/a	n/a	n/a
12	The Board is satisfied that the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	CEO	Yes	n/a	n/a	n/a

Whittington Health NHS

DRAFT Quality Committee Minutes of 10 July 2015

Present:	Philippa Davies	Director of Nursing & Patient Experience
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman of WH
	Richard Jennings	Medical Director
	Helena Kania	WH Governor
	Lee Martin	Chief Operating Officer
	Anu Singh	Non-Executive Director (Chair of Committee)
	Mary Slow	WH Governor
In attendance:	Ros Basri	Matron, Midwifery Services
	Doug Charlton	Deputy Director of Nursing
	Pauline Frost	Director, Risk & Governance
	Kate Green	PA to Director of Workforce (notes)
	Amanda Hallams	Director of Operations, Women & Family Services
	Fiona Isacsson	Director of Operations, Surgery
	Bernie O'Gorman	Head Nurse, Paediatrics
	Sam Page	Director of Operations, Children's Services
	Lynne Spencer	Director of Communications & Corporate Affairs

15/58 Apologies for absence

58.01 Steve Hitchins apologised for the change of date but this had been necessary to ensure the meeting was quorate. He congratulated Philippa Davies on her substantive appointment as Director of Nursing & Patient Experience. Steve explained that he was chairing the meeting until Anu Singh, Chair arrived who was delayed on public transport.

58.02 Apologies for absence were received from Anita Charlesworth, Nick Harper, Alison Kett, Deborah Clatworthy, Friedericke Eben, Rose Hensman, Carol Gillen, Rob Sherwin, Samantha Grantham and Charlotte Johnson.

15/59 Declaration of Conflicts of Interests

59.01 No member of the committee declared that they had any conflict of interest in the forthcoming proceedings.

15.60 Minutes of the previous meeting, matters arising and action log

60.01 The minutes of the meeting held on 13th May were approved.

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

60.03 Lynne Spencer informed the meeting that she would update the action log following the meeting as several of the items contained within it had been completed and had been included for information only. Helen Kania inquired whether any progress had been made on allowing Governors and Non-Executive Directors access to various IT platforms eg dropbox and the intranet. Lynne replied that this item remained pending with the Director of I&MT, Glenn Winteringham.

60.04 Anu Singh enquired whether it might be possible to connect actions from departmental minutes with the Quality Committee action summary, e.g. she would like to know what progress had been made with appointing someone to help the Women, Children & Families Division with complaints. Lynne agreed to build this into the ongoing governance review and planned future changes for information flows from working groups to Committees and up to Board.

Divisional Quality Performance Reports

15/061 Surgery, Cancer & Diagnostics Division

61.01 Fiona Isacsson introduced the report for the Surgery, Cancer & Diagnostics Division. Appraisal compliance had slightly decreased and mandatory training compliance had improved. Fiona had written formally to two departments – radiology and theatres – asking them to inform her how and by when they would achieve compliance. She added that there was also an issue with recording. Lee Martin said that all services had received coaching, offers of assistance and generally a great deal of support.

61.02 Richard Jennings said that doctors' appraisal was good within the division, however he had conducted one non-medical appraisal and had found that the process was not easy. Steve Hitchins assured the Committee that appraisal is a top priority for the newly-appointed Director of Workforce Norma French. Lee Martin reported that the Learning & Development Team had now designed and tested a new process – the wording had been made simpler and had undergone Plain English checking, and he had tested it himself. This new process awaited Norma French's sign-off. Helena Kania suggested it would be useful to revisit this at a future meeting, and Norma would be asked to consider when it should be brought back to the Committee.

15/062 Integrated Care & Acute Medicine

62.01 The ICAM team had given apologies for absence, and Lee Martin presented the report. Helena Kania said that the summary on the front sheet was helpful and queried the statement that staff development compliance was underachieving at 71%. Lee agreed to check whether this was an error.

62.02 Steve Hitchins said that he had received positive reports about the new 'patient safety walkabouts' and was keen to hear about these in more detail. Philippa Davies replied that consideration was being given to changing the title of these to 'huddles' as it had caused some confusion as the sessions centre around a meeting with a group of staff in a specific area rather than a 'walk around'. Lynne Spencer echoed this, saying that she had just participated in one with Anita Charlesworth and staff preferred the title 'huddle'. She added that she had been particularly impressed by the speed with which the governance team had fed back the report. Philippa Davies said that a quarterly report would be submitted to TMG prior to being presented to the Patient Safety Committee.

15/063 Women, Children & Families

63.01 Sam Page asked the Committee to note that the women's health section had been prepared by Amanda Hallams, who was attending her first meeting that day. She went on to say that the division had performed well in terms of 'harm free care'. Where there had been incidents

resulting in moderate harm or above, a review had been undertaken to check whether duty of candour had been instigated.

63.02 The Friends & Family Test (FFT) was being embedded and publicised across the division, as was the 'You said, we did' material. It was noted that FFT results for the Trust's maternity services showed a high level of satisfaction. Response times for complaints had improved, and the division continued to strive towards ensuring responses were submitted on time. Helena Kania suggested that the 'You said, we did' results should be displayed alongside photographs of staff so that patients could see who was responsible for implementation. Sam replied that photographs were on display in children's wards although not necessarily aligned to the 'You said, we did' material.

63.03 Sam acknowledged there was still some work to do on raising the levels of compliance for appraisal and mandatory training within the division, also inputting data on ESR remained a challenge in some areas. For mandatory training, the division was ensuring the hard copy workbook was disseminated. Anu Singh enquired whether the division was yet in receipt of a member of staff to support them on complaints, and Sam replied that they were receiving considerable support from PALS, i.e. a lead for the division from within existing resources.

63.04 Helen Kania asked whether a briefing on the duty of candour might be made available to Committee members as not all were fully au fait with the background to it and local processes supporting it. Steve Hitchins replied that this would be coming to the Board, along with identifying a Speak Out Champion. Richard Jennings gave a brief overview of the Trust's responsibilities under Duty of Candour, noting that its challenges were both cultural and procedural. Lynne Spencer agreed to circulate a briefing note.

General issues

63.05 Anu Singh stressed the need to ensure that good governance arrangements were in place for the new ICSUs, as under the previous arrangements she was aware that some meetings had been cancelled, others had unsatisfactory minutes etc. She was anxious this be closely monitored. Lynne Spencer assured the Committee that she was working with Simon Pleydell on a governance review to consider how best the structures will work once the ICSU's have fully transitioned and she agreed to keep Committee members informed of progress.

15/064 Performance Dashboard

64.01 Lee Martin introduced the performance dashboard which had been discussed at the Trust Board the previous week and, noting that all QC members had been present at that meeting, invited questions. Steve Hitchins stressed the need for any proposed solutions to ongoing problems to be implemented immediately rather than awaiting formal Committee ratification. In answer to a question from Helena Kania regarding MSK waits, Lee Martin said that waits had been exacerbated by a combination of annual leave and sickness leading to reduced capacity; he anticipated the service would be back on track by mid-August, although there had been a major surge in referrals. Speaking of the progress it had made within the last several months, Steve Hitchins felt this was a highly motivated team with a good manager. Lee added that there had been public holidays over this data reporting period as well, which meant less people were able to access treatment.

64.02 In answer to a query from Anu Singh about a downward trend in harm free care, Philippa Davies replied that this position was attributable, in the main, to pressure ulcers within the community and that work continues to keep this area high profile for continuous improvement.

15/065 Director of Nursing Patient Safety Report

65.01 Doug Charlton reported that although the number of falls continued to fluctuate the level resulting in moderate or severe harm continued to reduce, with no such incidents declared so far this year. There had also been an overall reduction in the number of pressure ulcers declared. Safeguarding alerts continued to rise and this was due to training and increased awareness. The amount of staff trained had now risen to 83%, and Doug paid tribute to the hard work of interim safeguarding lead Chris Dyson who had trained almost 800 staff over the past few months.

65.02 The number of mental capacity assessments continued to rise, and there was increased awareness of Deprivation of Liberty issues as further training sessions were being provided.

65.03 The Trust has now implemented training in relation to the Government's 'Prevent' strategy, which requires healthcare professionals to be alert to signs of violent extremism and report on them if identified or suspected. In answer to a question from Steve Hitchins about the Trust's role in domestic abuse cases, Doug replied that this was also a training issue, relating to identifying possible cases and referring them on to the appropriate service. A new bar code label sticker has been introduced in the Emergency Department which can be fixed to common items such as lipsticks, pens etc, which contains helpline numbers for use in an emergency. Lee Martin added that he had been working with the police on information collected at triage (the Cardiff Model) - the first set of information had been shared the previous week, and it was found that injuries were most commonly the result of bag snatching or mobile phone stealing. Helena Kania expressed some concern about the reference to 'financial abuse', saying that she would discuss this further with Doug outside the meeting.

65.04 Anu Singh stressed the importance of responding appropriately to patients with learning disabilities, saying that there was a need for a greater focus on this client group whose needs were often overlooked, as was borne out by several national reports. Richard Jennings replied that for this very reason responding to the needs of people with learning disabilities was one of the Trust's pledges under the 'Sign up to Safety' initiative – it was also a priority in the Quality Account. He said that a report could be brought to the Quality Committee about this and that he would discuss this further with Philippa and Doug to agree when this would be available.

16/066 Director of Nursing Patient Experience Report

66.01 Philippa Davies informed Committee members that the terms of reference for the patient experience committee had been reviewed in June and some focused work agreed for the coming year. There was shortly to be another national in-patient survey with a focus on patients who had received in-patient care in July. The response rate for the previous survey

had been low therefore much was being done to publicise the survey at ward level and at discharge.

66.02 Moving on to the Friends & Family test (FFT), it was noted that work was progressing well in terms of the implementation of the new patient experience feedback system 'Meridian'. This will result in the centralisation of the FFT alongside other ongoing surveys. The number of responses to FFT within community services had gradually increased since being implemented in the community in January. The first report of the 'Kissing it Better' initiative showed the range of activities that had taken place since the launch of the scheme in March – these included beauty therapy, arts and crafts and music.

66.03 Volunteers' week had taken place from 1–7 June, and Steve Hitchins had issued certificates to several long-standing volunteers. Steve added that once people had volunteered for six months they were often signed on to the staff bank, thus making volunteering a route to employment. The service was being further developed, and Anu enquired whether there was an action plan in relation to improving patient experience. Philippa reported that Phillipa Marszall was putting together on overarching plan which would be presented and discussed at the Patient Experience Committee prior to being brought to the Quality Committee.

16/067 <u>Serious Incident Report</u>

67.01 Pauline Frost introduced the Serious Incident (SI) report which gave an overview of all serious incidents which had taken place between 2nd May and 16th June. Seven SIs s had been reported for this period, one of which was a pressure ulcer. Seventeen investigations had been completed and submitted to the Commissioning Support Unit, and by the end of the following week no reports would be outstanding. In future SI reports would be taken to the public board meetings.

67.02 Mary Slow expressed her concern over the medication error incident. Philippa Davies said that this incident had been discussed at the SI Panel, and the Panel had been pleased at the rapid escalation of the incident and the immediate action taken to put things right. Richard Jennings added that where an incident resulting in avoidable harm had taken place it was the responsibility of the Trust to take to respond appropriately and to ensure that measures were put in place to prevent, as far as possible, any recurrence. Richard reported that the implementation of electronic prescribing has already reduced medication errors.

67.03 Helena Kania asked about the information governance incidents and the status of the SI report which dated back to 2013. On the latter, Richard replied that this report was now complete and was due to be discussed at the next SI Panel. Sam Page explained that one of the information governance incidents involved a copy of an assessment for a looked after child being sent to an incorrect address – this was due to the fact that the Trust had been sent the wrong address and additional checking mechanisms have been put in place to reduce the chance of any repetition of such an event. The second incident had involved a medical handover sheet being found by another doctor in a public place. Patient information was not permitted to be taken outside of the hospital, and processes have been put in place to remind staff of their duty to safeguard patient information to prevent this happening in the future. Lynne Spencer added that the Trust has now appointed a substantive assistant director with responsibility for information governance which will

strengthen the focus on IG, and Steve Hitchins enquired how long is was likely to be before all such records came in electronic form. Sam confirmed this was the intention and was something the doctors wished to happen so had been included as a priority within the I&MT department.

15/68 Serious Incident Annual Report

68.01 Pauline Frost informed the Committee that the Trust had reported 112 serious incidents during 2014/15, however 11 of these were de-escalated leaving a total of 101. 35 of these had been declared during Q1, following which the number of incidents had decreased during the second and third quarters. Going forward figures for pressure ulcers would look different as they were to be reported as 'clusters'. In answer to a question from Steve Hitchins about whether overall figures represented a statistical anomaly or real improvement, Pauline felt the latter given all the improvement measures that had been put into place. A great deal of work had been done to provide the assurance that the organisation was continuously improving. Graham Hart added that the increase in patients treated supported the improvement journey.

15/69 Bi-annual review of ward nurse staffing levels

69.01 Doug Charlton reported to the Committee that every six months the Trust undertook a complete review of ward nurse staffing levels and he presented a report detailing a review using the Safer Nursing Care Tool. . During the period, a number of additional beds had been open due to winter pressures. Overall, it was judged that number of staff by ward did not require further adjustment and it was noted that the Board also received assurance regarding safe staffing levels through the monthly safe staffing report. Philippa Davies reported that a larger review will be carried out in October using the Safer Nursing Care Tool Nursing which included hours per Patient Day methodology, Professional Judgement and benchmarking with other organisations.

15/70 Nursing & Midwifery Revalidation

70.01 Doug Charlton presented a paper on the proposed revalidation of nurses and midwives, which detailed actions being taken to ensure organisational readiness to support implementation from April 2016. An action plan has also been requested and sent to the Trust Development Authority (TDA).

The Nursing & Midwifery Council (NMC) now require nurses and midwives to be revalidated every three years, which would bring them in line with the process introduced for medical staff post Francis. This would require major changes to the code of professional conduct, and there were now new requirements on:

- Fundamentals of care
- Duty of candour
- Raising concerns
- Delegation and accountability
- Professional duty to take action in an emergency.

70.02 Whittington Health would be linking the process with appraisal, i.e. those who have not undergone an appraisal will not qualify for revalidation, and it was noted that receiving one's appraisal was the responsibility of the individual practitioner and not the organisation. In answer to a question from Anu Singh about whether the Trust would have sufficient time to prepare for this, Doug replied that revalidation for nursing and midwifery staff would not begin until April 2016 so there is ample time to prepare. Graham Hart enquired whether the process would be an on-line one, and Doug replied that it was possible in the future.

70.03 Graham Hart reported how important it was for the Quality Committee to monitor this process, even if there were individual responsibilities attached, since this was about supporting staff to maintain their registration. It was noted that a task and finish group including HR representation had been established. Fiona Isacsson said that her division had been looking at job planning for nurses – this showed what proportion of time was spent on face-to-face contacts and was therefore pertinent to the revalidation process.

15/71 Policies Review

71.01 Pauline Frost informed the Committee that the following policies had now been ratified and placed on the intranet:

- Counter Fraud Policy and Response Plan (revised)
- Managing and Responding to External Reviews Policy (revised)
- Toys – Cleaning and Management SOP
- Adult Ambulatory Emergency Care Service SOP
- Whittington Health District Nursing Service SOP
- The Management of Adult, Paediatric and Neonatal Resuscitation Policy (revised)
- Adult Do Not Attempt Resuscitation Policy (revised)
- Time off for Trade Union Duties and Activities Policy (revised)
- Providing References for Outgoing Employees Policy (revised)
- Secondment Policy (revised)
- Disruption of Staff Travel Arrangements Policy (revised)
- Complaints Handling Policy (revised).

71.02 There had been a meeting of the Policy Agreement Group the previous day, and good progress was being made on reviewing and updating legacy policies. In addition the HR team had now held two day-long events with staff side representatives to discuss specific HR policies. Helena Kania requested a copy of the Trust's complaints procedure. Pauline also paid tribute to the work carried out by Sarah Crook on clinical guidelines.

15/72 Diversity & Equality Annual Report

72.01 There were no questions and Anu Singh invited members to e-mail Charlotte Johnson with any questions on the report.

15/73 Quality Risk Register

73.01 Lynne Spencer said that there had been a workshop and discussions about risk management and the Trust's appetite for risk at the Trust Board and at a Board Seminar. She felt that while management of risk registers was strong at a divisional level what needed strengthening was triangulation of risks from divisions up to Committees and on to the BAF. This work was already underway and the Board had agreed that each Committee Executive lead would be responsible for ensuring the documentation of risks identified within reports presented to Committees. These will be recorded onto new Committee Risk Registers with regular progress updates on mitigating actions to show movement of risks. These risks will

feed into the BAF to ensure a robust process. Steve Hitchins expressed his concern at having several risk registers across the Trust, he felt there should be one. Lynne replied that there would always be risk logs, risk registers at divisional level but that there will be only one corporate risk register which gave a summary of all the Committee Risk Registers. This will demonstrate clear oversight of risks by the Board and is 'custom and practice' within the NHS. Lynne and Pauline Frost will be developing this process to ensure all relevant data was recorded on Datix and to prepare a revised risk management strategy that will be presented to the October Board for ratification. Helena Kania said that whatever system was decided upon the presentation of it would be critical, and she would be pleased to comment on the presentation of risks to the Quality Committee in future.

15/74 Pressure Ulcer Presentation

74.01 Tissue Viability Specialist Jane Preece said that her presentation aimed to give a picture of what stage the Trust had reached in this area of work as well as what needed to be done moving forward. She showed the Committee data which favourably compared Whittington Health's performance to the average national.

74.02 The team had a large caseload comprising 6117 patients. Staff were able to offer advice, support and a degree of influence over the patients they see, the problem was accessing the wider community. There was an expectation that we keep carers up to date with information. Whilst paid carers were easy to find, informal carers (i.e. relatives and/or friends) are harder. Helena suggested some avenues that might be explored including Women's' Institutes and Residents' Associations. Philippa expressed her congratulations to the team that the last Grade 4 pressure ulcer declared by the Trust had been in January 2015 and that reduction in this type of harm demonstrated good nursing care on our wards. Steve Hitchins echoed this, saying that he had been on a visit with Samantha Grantham and had viewed the processes in place regarding pressure area care.

74.03 Jane expressed the view that there would always be certain things that could be done better, and a campaign was underway. The group had met the previous day, and they now had a logo representing the theme of the campaign, which was 'react to red'. Consideration was also being given to a hotline or e-mail address and perhaps using Twitter to signpost a helpline. They had also recently been given approval for air mattresses for trolleys in ED.

74.04 The Committee thanked Jane for her presentation and praised the 'fantastic' work of the team as a whole. It was noted that Jane had been invited to present at the Clinical Quality Review Group. Finally, Jane informed the Committee there was to be a national 'stop pressure ulcer day' on 19th November.

15/75 Infection Prevention & Control Report

75.01 Tricia Folan began by apologising for the annual report having been circulated the previous day, however the team had wanted quality committee members to have early sight of it and there would be ample opportunity to discuss it at the September meeting.

75.02 No cases of MRSA bacteraemia had been declared so far this year, however since this report had been compiled four C. difficile cases had been declared on medical wards. The first three of these had been fully investigated and no lapses of care had been identified, although in one case there was an issue concerning extended antibiotics. There had been a

second case of Carbapenamase producing Enterobacteriaceae; this was in a patient who had not travelled but is a regular in-patient. He was now well, and there had been no transmissions.

75.03 The team had carried out all except one of the prevention and control audits and areas graded red had an action plan in place. Anu Singh said that where there were repeat areas the Board needed to be aware. Tricia explained that some reds were directly attributable to the age and state of buildings. Refurbishment programmes were being phased and Fiona Isacsson explained to the Committee members how what this would entail. The other area consistently graded red was out-patient physiotherapy, and this would remain red until a decision was made as to whether refurbishment works were to be carried out or the service was moved.

75.04 Graham Hart commented on the very good standard of infection prevention and control at Whittington Health, and described the report as 'superb'. Richard Jennings echoed these sentiments, saying that he was well aware that the high standard was attributable to the hard work and commitment of the whole team, but particularly Director of Infection Prevention & Control Julie Andrews.

15/76 Any other business

76.01 Lynne Spencer reported that two of the Trust's consultants had recently been presented with awards by UCL medical school. The Committee joined with her in extending congratulations to Amali Lokugamage for her Excellence in Medical Education award and Caroline Fertleman for her experienced teacher award.

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Action Summary

Ref.	Decision/Action	Timescale	Lead
61.02	Appraisal - new process awaited Norma French's sign-off. Helena Kania suggested it would be useful to revisit this at a future meeting, and Norma would be asked to consider when it should be brought back to the Committee.	November	NF
62.01	ICAM - Helena Kania said that the summary on the front sheet was helpful and queried the statement that staff development compliance was underachieving at 71%. Lee agreed to check whether this was an error.	September	LM
63.05	Lynne Spencer assured the Committee that she was working with Simon Pleydell on a governance review to consider how best the structures will work once the ICSU's have fully transitioned and she agreed to keep Committee members informed of progress.	November	LS
65.04	Learning disabilities – a report could be brought to the Quality Committee and he would discuss this further with Philippa and Doug to agree when this would be available.	November	RJ/PD

66.03	Volunteers - The service was being further developed, and Anu enquired whether there was an action plan in relation to improving patient experience. Philippa reported that Phillipa Marszall was putting together on overarching plan which would be presented and discussed at the Patient Experience Committee prior to being brought to the Quality Committee.	November	PD
54.02	To explore the possibility of NEDs and Governors having access to the Trust's intranet and/or Dropbox folders for relevant meetings	September	LS
57.02	To provide the committee with a report on medical appraisals	November	RJ
60.03	Lynne agreed to build this into the ongoing governance review and planned future changes for information flows from working groups to Committees and up to Board.	Closed on forward planner	LS
62.02	Patient safety walkabouts Q reports will be reported to TMG quarterly in future after they have been reported to Patient Safety Committee.	Closed on forward planner	LS
63.04	Richard Jennings gave a brief overview of the Trust's responsibilities under Duty of Candour, noting that its challenges were both cultural and procedural. Lynne Spencer agreed to circulate a briefing note to members.	Closed	LS
65.	Helena Kania expressed some concern about the reference to 'financial abuse', saying that she would discuss this further with Doug outside the meeting.	Closed	DC
71.02	Helena Kania requested a copy of the Trust's complaints procedure.	Closed	LS
73.01	Risk Register - Helena Kania would be pleased to comment on the presentation of risks to the Quality Committee in future.	Closed	LS

Executive Offices

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The Whittington Hospital NHS Trust

Magdala Avenue

Whittington Health Quality Committee

8th July 2015

Title:	Nursing & Midwifery Revalidation
Action requested:	The Committee is asked to receive this report on the progress with plans to oversee the implementation of nursing revalidation.
Executive Summary:	This paper provides an overview of the changes the Nursing & Midwifery Council (NMC) are making to the requirements that nurses and midwives must meet when they renew their registration every three years. The paper includes the actions being taken to ensure organisational readiness and that there is a robust system in place which supports implementation of nurse and midwife revalidation from April 2016.
Fit with WH strategy:	SG1
Reference to related / other documents:	Fits with clinical strategy
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or board assurance framework
Date paper completed:	20TH May 2015

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing**		**Director name and title:**		**Philippa Davies Director of Nursing & Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1. Introduction and Executive Summary

This paper provides an overview of the changes the Nursing & Midwifery Council (NMC) is making to the requirements that nurses and midwives must meet when they renew their registration every three years. The paper includes the actions being taken to ensure organisational readiness and to ensure there is a robust system in place which supports implementation of revalidation from April 2016. The process will apply to Registered Nurses and Midwives, throughout the paper only registered nurses will be referred to.

2. What are revalidation and the key changes proposed by the NMC?

2.1 Background

Revalidation will be the process by which registered nurses will demonstrate to the NMC that they continue to be fit to practice. Revalidation will take place every three years and will replace the current post registration education and practice (PREP) standards. The aim is to improve upon current PREP system by setting new requirements for registered nurses. Under revalidation registered nurses will have to declare they have;

- Met the requirements for practice hours (practice for at least 450 hours during the previous 3 years)
- Met the requirements for continuing professional development (undertaken at least 40 hours of continuing professional development relevant to the registrants scope of practice as a nurse with a minimum of 20 hours being participatory learning)
- Reflected on their practice based on the requirements of the NMC Code (2015), using feedback from service users, patients relatives colleagues and others.
- Provide a health and character declaration and declare any conviction for criminal offence or the issuing of a formal caution
- Professional indemnity arrangements – confirmed the registered nurse has or will have when practicing, appropriate cover under an indemnity scheme
- Receive confirmation from a third party (referred to as a confirmer) that their declaration is reliable in accordance with the NMC Code (2015)

Revalidation aims to protected the public, increase public confidence in nurses and help those on the NMC register to meet the standards required of them.

The prosed revalidation for nurses and midwives by the NMC is not the same as medical revalidation undertaken by the General Medical Council (GMC), the NMC register is much larger and the people on it practice in a more diverse health care settings. The NMC operates under different legislation from the GMC and the NMC legislation around revalidation does not allow for the introduction of responsible officers.

3. Key changes to the Revised Code (of Practice)

3.1 The Code

The Code describes the professional standards of practice for nurses and midwives. These standards are collected into four themes:

1. Prioritise People
2. Practice effectively
3. Preserve safety
4. Promote professionalism

There are new requirements on:

- Fundamentals of care – this covers the essential aspects of caring for a patient, including making sure a patient has adequate access to nutrition and hydration.
- Duty of Candour – nurses should be open and honest, with colleagues, patients and health care regulators when things go wrong
- Raising Concerns – nurses should raise concerns without delay if they are aware of a threat to patient safety or public protection
- Delegation and Accountability – nurses should make sure they delegate task and duties appropriately and those they delegate to complete task to the required standard.
- Professional Duty to take action in an emergency – nurses should take action in an emergency, when off-duty, within the limits of their competence.

The Code is clear that responsibility for those receiving care, also lies with those nurses working in policy, education and management roles.

3.2 Responsibility

Nurses and Midwives are responsible and will be held accountable for their own revalidation process. Every three years at the point of renewal of registration, nurses will need to demonstrate the requirements of revalidation and their fitness to practice in order to remain on the NMC register.

From April 2016, all nurses who are due to re-register at that point will start using revalidation. This means by April 2019 everyone on the NMC register will have undergone revalidation.

3.3 Provisional Guidance Testing

The NMC have produced provisional guidance which is being tested in a number of provider organisation and locations where registered nurses work. They are testing guidance for individuals and third party confirmers as well as evidence logs and templates.

4. National Approach

Each region within the United Kingdom has established a Nursing and Midwifery Revalidation and Implementation Programme Board. In England this is chaired by Jane Cumminings- Chief Nursing Officer NHS England. Terms of reference have been agreed and a communication strategy commenced with the establishment of regional programme boards.

5. NMC Approach

The NMC have commissioned KPMG to ascertain the state of readiness. It is understood that they will work with approximately 150 organisations across all 4 countries of the United Kingdom and undertake an assessment of organisational readiness.

6. Trust Approach

6.1 Nursing Revalidation Task & Finish Group

A Nursing & Midwifery revalidation task and finish group has been established and held its inaugural meeting in on 19th May 2015. Terms of Reference (TOR) have been agreed and key stakeholders have been identified to attend monthly meetings. The group is chaired by their Deputy Direct of Nursing Dr Doug Charlton reports to the Director of Nursing.

The core role of the group is to:

- Develop and oversee the delivery of a nursing revalidation implementation plan which ensures there are effective systems in place
- Identify and mitigate potential system risks and escalate as required to the Director of Nursing
- Work with the Communication Team to develop a communication strategy
- Develop the internal process required to support nursing revalidation for individuals and confrmers
- Provide guidance on collation, collection of evidence requirements to support revalidation

6.2 Initial actions

Whilst the outcome of the learning from pilot sites and the final NMC Guidance is awaited, the group have agreed first actions based on provisional guidance.

The T&F Group has suggested aligning the process to annual appraisal which is an approach being adopted by most employers, line managers of nurses are usually best placed to be a third party confirmer. Where a registrant's line manager is not another registrant this will be undertaken by the person who is identified as professional line of accountability within the posts holders' job description

The group will use the provisional guidance to develop a framework for the Trust and is planning the first series of communications with key stakeholders which is aimed at raising awareness.

Three companies who provide software for managing the revalidation process along with appraisal have been invited to the Trust 1st June to demonstrate the software.

Core group members will lead awareness communication within the Division/Service.

Dates for variety of nursing forums are in the process of being planned.

7. Recommendations

The Committee is asked to receive this report on the progress with plans to oversee the implementation of nursing revalidation.

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The Whittington Hospital NHS Trust
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Whittington Health Trust Board

2nd September 2015

Title:	Finance and Business Development Committee: Update to the Board		
Agenda item:	**15/114**	**Paper**	**11**
Action requested:	For information		
Executive Summary:	To update the Board on the work and recommendations conducted in the 27th July Finance and Business Development Committee, chaired by Tony Rice, Non-executive Director (NED).		
Summary of recommendations:	None		
Fit with WH strategy:	The Finance and Business Development Committee is in place to review the financial performance, business development and investment decisions of the Trust. The committee's focus is on assurance around risks (financial, delivery and regulatory) in both plans and execution of plans. The committee will seek assurances, mitigations and recovery action plans where appropriate.		
Reference to related / other documents:	SOs and SFIs		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Strategic goal three: Delivering efficient and effective services (ref 3.1 to 3.12). Strategic goal five: Fostering a culture of innovation and improvement (ref 5.1 to 5.3 & 5.5).		
Date paper completed:	25th August 2015		

Author name and title:		**Stephen Bloomer, Chief Finance Officer**		**Director name and title:**		**Tony Rice Non-Executive Director**	
Date paper seen by EC	**-**	**Equality Impact Assessment complete?**	**N/A**	**Quality Impact Assessment complete?**	**N/A**	**Financial Impact Assessment complete?**	**N/A**

Finance and Business Development Committee: update to the Board

Meeting – 27th July 2015

The Finance and Business Development Committee met on 27thJuly 2015, chaired by Tony Rice, Non-Executive Director (NED) and was attended by Paul Lowenberg, David Holt, Simon Pleydell Lee Martin, Lynne Spencer, Siobhan Harrington, Stephen Bloomer and Vicky Cirillo. The committee discussed the following items:

1. The Baker Tilly Action Plan and the work of the Income Steering Group.

2. The Finance Position for Month 3 and the Committee was informed of the process for ICSUs to allow them to take action if needed.

3. The Reference Cost submission and the emerging picture on the process for going to the ITFF for deficit and capital funding in 2015/16.

4. The need to work on disaggregation of community activity is to be progressed and will return to the committee in October.

5. Cost Improvement Plan (CIP): - The committee reviewed the current position and plans going forward. There were deep dives into two areas being:

    a. The committee received an update on the detailed Procurement savings schemes and an outline of the governance structure.

    b. Nurse & Agency Savings

6. ICAM presented their financial position and plans.

7. It was agreed that the Business Strategy would be reviewed in October.

8. The committee agreed amendments to the Risk Register.

-- end --