Whittington Health NHS

TRUST BOARD

14.00 – 17.00

Wednesday 04 February 2015

Whittington Education Centre Room 7

Whittington Health NHS

Meeting	**Trust Board**
Date & time	**4 February 2015 at 2.00 – 5.00 p.m.**
Venue	**WEC 7**

AGENDA

To: **Trust Board** Steve Hitchins, Chairman Anita Charlesworth, Non-Executive Director Paul Lowenberg, Non-Executive Director Tony Rice, Non-Executive Director Rob Whiteman, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy CEO Dr Greg Battle, Medical Director (Integrated Care) Lee Martin, Chief Operating Officer Dr Richard Jennings, Medical Director Philippa Davies, Director of Nursing and Patient Experience Ursula Grueger, Deputy Director of Finance
Attendees Chris Goulding, Deputy Director, HR Kate Green, Secretary to the Board	
Contact for this meeting: Kate Green (kate.green4@nhs.net) or 020 7288 3554	

Agenda Item		paper	Action timing
15/015	**Patient Story** *Philippa Davies, Director of Nursing & Patient Experience*	1	Receive (20)
15/016	**Declaration of Interests**	*Verbal*	
15/017	**Apologies**	*Verbal*	
15/018	**Minutes, action notes and matters arising** To approve the minutes of the previous meeting held on 7 January 2015	2	Approve (10)
15/019	**Chairman's Report** *Steve Hitchins, Chairman*	*Verbal*	Receive (10)
15/020	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	3	Receive (20)
Quality			
15/021	**Quality Committee Report** *Anu Singh, Non Executive Director*	4	Receive (10)

Strategy and Policy			
15/022	**Clinical Strategy** *Dr Greg Battle, Medical Director Integrated Care*	5	Receive (10)
Performance and Delivery			
15/023	**Cancer Strategy 2015/16** *Lee Martin, Chief Operating Officer*	6	Receive (10)
15/024	**Monthly Performance Dashboard and workforce report** *Lee Martin, Chief Operating Officer*	7	Discussion (20)
15/025	**Monthly Financial Performance Report** *Ursula Grueger, Acting Director of Finance*	8	Receive (20)
15/026	**TDA Board Statements** *Simon Pleydell, Chief Executive*	9	Approval (20)
Governance & Regulatory			
15/027	**Audit Committee Report** *Rob Whiteman, Non Executive Director*	10	Receive (10)
Workforce: staffing and Agency			
15/028	**Safe Staffing Report** *Phillipa Davies, Director of Nursing and Patient Experience*	11	Receive (10)
15/029	**Whistleblowing Policy** *Chris Goulding, Acting Director HR*	12	Receive (10)
Any other urgent business and Questions from the public			
Date of next meeting:			
15/030	4 March 2015 Whittington Education Centre, Room 7		

Register of Interests:
The register of members' interests is available for viewing during working hours from Kate Green, Trust Board Secretary, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF.

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Whittington Health NHS

ITEM: 15/018
Doc: 2

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00pm on Wednesday 7th January 2015 in the Whittington Education Centre

Present:	Anita Charlesworth	Non-Executive Director
	Philippa Davies	Interim Director of Nursing and Patient Experience
	Ursula Grueger	Deputy Director of Finance (Acting as Director of Finance)
	Chris Goulding	Acting Director of Human Resources
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Graham Hart	Non-Executive Director
	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
	Rob Whiteman	Non-Executive Director
In attendance:	Kate Green	Trust Board Secretary
	Caroline Thomsett	Director of Communications

15/001 Patient Story

01.01 Philippa Davies introduced Phileas, present to recount the experiences of his daughter Christina. Also present were Hellen Odiembo, specialist learning difficulties nurse, and Jessica Fitzgerald, manager of the community specialist nursing team.

01.02 Christina suffered from severe learning disabilities and complex physical needs, and had therefore been admitted to hospital on multiple occasions. On the occasion described here, she had been admitted with a twisted bowel condition which was causing her acute pain. Two 'best interest' meetings had been held, and considerable efforts had been made to ensure correct decisions – with informed consent – had been reached. The outcome was the decision that Christina would not have surgery, as the risk was considered to be too high. At all times throughout the process Christina had received invaluable support from Hellen.

01.03 It was noted that at Christina's pre-assessment appointment the scales on the unit had been broken, and had Hellen not been present to intervene, there was a possibility that Christina would not have been weighed. Because her low weight needed to be taken into consideration prior to surgery, this was particularly important. Phileas made the point that Hellen's intervention into his daughter's care was vitally important, however, the general principle of advocacy on behalf of clients with learning disabilities needed to be further embedded into Trust services across the board. Areas where further improvement was needed included feeding, medication and staff handover.

01.04 Phileas declared himself very happy with the services Christina had received at Edwards Drive, stressing that the most important aspect of her care for him was to have consistency in staff treating Christina who understood her needs. Hellen echoed this, explaining that Christina had difficulties communicating, so it was particularly important that staff both understood her needs and were able to pass on information to colleagues in a way which instilled confidence in her parents.

01.05 Hellen then spoke about her role as a specialist learning disabilities nurse. She had started work at Whittington Health in 2011, and her principle role was to assist professional colleagues in becoming aware of the needs of people with learning disabilities – 80-90% of whom have communications problems. She cited reports which had been published in this field, mentioning particularly 'Death by Indifference', the recommendations from which had led directly to the establishment of her post.

01.06 Hellen asked for the support of the Board in furthering this important work. She drew attention to the annual learning disability awareness week she organised, saying that she was seeking to involve the media in 2015, and adding how much she appreciated the support she had received from the Chief Executive during the previous year's event. She also expressed her gratitude to the consultant body for the manner in which they relayed information to the junior doctors.

01.07 Jessica Fitzgerald managed the community nursing team, and she took Board members through the services offered by that team, from initial assessment through to supporting clients as they accessed mainstream services. She drew particular attention to the 'purple folder', which clients held and took with them to every appointment, which health and social care professionals entered key information into and which also contained an action plan for every client. 75% of Haringey clients now had such a folder, and it was aimed to increase this to 100%. Jessica also described the joint work undertaken with the Emergency Department (ED) looking at pathways for this client group.

01.08 Moving on to describe recent achievements of the team, Jessica said that they had recently been granted permission to share Haringey Council's register of clients with learning disabilities, which was a huge step forward in ensuring clients received access to the most appropriate services for their needs. She went on to describe awards won by the team, in particular the Nursing Times award, Trust excellence award, and last year's Team of the Year award.

01.09 Anita Charlesworth thanked all involved for coming to speak to the Board. Reflecting on a previous presentation concerning a client with learning disabilities, she encouraged Phileas to enlarge on his experience of caring for Christina whilst in hospital. Phileas replied that everything had been fully explained to him and his wife, as Christina's parents, and he did not feel that there was much scope for further improvement. He admitted to having been uneasy at first about leaving his daughter in the care of the staff, however, once Christina's complex needs had become known (she was unable to swallow which made both feeding and medication problematic) and he was able to have confidence in the sharing and passing on of information, there had been no difficulties.

01.10 Richard Jennings added his thanks, saying that it was difficult to overestimate the importance of these issues. He cited the National Confidential Enquiry, which had looked at the circumstances behind 247 client deaths, and said that a study of the

Trust's own declared incidents revealed that on occasion mistakes were made. He had been pleased to learn of Haringey's agreement to share their register with the health service, and hoped that Islington would soon follow suit, as such moves made a vital contribution towards patient safety. Simon Pleydell asked about awareness training for staff, and Hellen replied that this did happen, however, it was negated to some extent by turnover and the use of agency staff. There were however plans to build such awareness training into the Trust's mandatory training requirements. On a positive note, Hellen did feel that staff were in general becoming more aware.

01.11 Philippa Davies invited Hellen to meet with her in order to discuss how she might best support this work. Phileas expressed his thanks for the care Christina had received and in particular the support given by Hellen. In closing, Hellen emphasised the importance of reporting dysfunctional and broken equipment immediately, as had she not been present to ensure Christina was weighed as part of her pre-assessment checks the outcome of her treatment might have been quite different. Steve Hitchins expressed his thanks on behalf of the Board to all who had presented.

15/002 Apologies for absence

02.01 Apologies were received from Greg Battle and Paul Convery.

15/003 Minutes of the previous meeting

03.01 The minutes of the meeting held on 3rd December were approved. There were no matters arising other than those already scheduled for discussion.

03.02 Action notes

68.04 – A presentation was to be given as part of the performance report, this could therefore be removed from the schedule.
100.02 – A bid had now been submitted for the e-rostering system, this could therefore be removed from the schedule.
100.03 – This was scheduled for discussion at the February Board.
143.01 – The cancer services improvement plan would be going to the next meeting of the Cancer Board and then to the February Trust Board meeting.
151.02 – Siobhan had reviewed governor representation at Trust meetings, this could therefore be removed from the schedule.

03.04 The remaining items were scheduled for discussion at the February Board meeting.

15/004 Chairman's Report

04.01 Steve Hitchins began his report by thanking everyone who had contributed to the pre-Christmas events throughout the Trust, in particular local schools and health groups. Events had been well supported which would have a beneficial effect on charities. He also thanked the Arsenal footballers who had visited the children's wards, and had been doing so for some twenty years.

04.02 Steve had recently had lunch on Victoria ward, and had been impressed by the range and quality of the food offered. He said that feedback from patients to whom he had spoken was positive, and that they had noted an improvement in quality since moving to the new contract.

04.03 The following day (8th January) Barbara Windsor would be formally opening the new Macmillan Cancer Information Hub.

04.04 Community engagement events were scheduled for 21st and 26th January, and the first voluntary sector event was to take place on 28th January. Almost 200 health and social care voluntary sector groups had been invited to attend.

04.05 Steve expressed his thanks to all Trust staff for all their work during this time of unprecedented demand.

04.06 It was noted that this was Caroline Thomsett's last Board meeting, and Steve thanked her, on behalf of the Board, for all her work over the past year. He wished her well in her new ventures.

04.07 Steve announced that the Trust had been successful in two recent bidding processes, the first for community gynaecology services in Islington and Haringey, and the second for the retention of the sexual health contract for Haringey. He acknowledged the immense amount of work staff had put in to securing these bids.

15/005 Chief Executive's Report

05.01 Introducing his report, Simon Pleydell drew attention to the national A&E patient survey, where he felt that the Trust's overall position had remained positive despite a slight dip in its position in one or two areas. Overall, he viewed the result as a most creditable performance for the department.

05.02 As at earlier that day, the take-up rate for staff undergoing 'flu vaccinations was 78%, and Simon was confident the target of 80% would soon be achieved.

05.03 Simon invited Lee Martin as Chief Operating Officer to brief the Board on emergency care. Lee said that earlier in the year winter resilience (formerly winter pressures) plans had been drawn up, these had gained the support of stakeholder partners and were now being successfully implemented. The Trust had seen an increase in presentations, but overall was performing well, and some extremely positive feedback had been received from patients. Plans were in place covering what action would need to be taken in the event of any continued increase in demand. Not all national targets had been met, but the vast majority of patients had been seen within the desired timeframes.

05.04 The Trust was performing well in respect of waiting times, and Lee was particularly pleased to inform the Board that delivery on cancer targets was good. The main concern was the Trust's financial position; which now stood at a £6.7m deficit in November, and was forecast to be £7.4m in deficit at year end. This had been declared to the NHS Trust Development Authority (TDA). This was a serious position for the Trust, and Simon Pleydell had written personally to all staff outlining the measures to be taken in the lead-up to the end of the financial year; he would also be meeting with all budget holders individually. In the meantime staff were busy developing financial plans for 2015/16; these would be discussed with the TDA over the next fortnight. Discussions were also ongoing with commissioners to see whether there might be any scope for improving the year end position.

05.05 Simon also drew attention to:

- Ongoing work on the new clinical strategy
- The appointment of the new Chief Finance Officer (CFO) although no start date had yet been confirmed
- The success of bids for community gynaecology and sexual health services
- The radical improvement in complaints response, both in the time taken to respond and the quality of the responses sent
- The Trust's involvement in the forthcoming FGM court case, scheduled to begin on 19th January.

05.06 Rob Whiteman expressed his congratulations to ED staff on maintaining a high level of performance despite the increase in demand, and enquired whether executive colleagues were able to explain the reason for the high demand. Lee Martin replied that data is scrutinised each week – at present the department is seeing a large number of elderly people with chest conditions, but several weeks ago there had been an increase in the number of young people attending. Richard Jennings, who had been on call the previous weekend, said that of 61 people he had seen, 31 had been suffering from respiratory conditions, and they had been quite seriously ill.

05.07 Anita Charlesworth asked about the impact of the ambulatory care centre. Lee Martin confirmed that projections had been largely accurate, adding that services would have struggled to manage in its absence. One positive aspect was that it had been able to take the more complex patients out of the in-patient units, it had also made it possible for sick children to remain at home with their families. Much of the increase demand was connected to winter. Lee added that the aim now was to increase the opening hours of the ambulatory care centre.

15/006 <u>Quality Committee Report</u>

06.01 Anu Singh introduced the report of the Quality Committee held on 26th November, saying that the meeting had begun with a discussion about the ownership of the quality agenda and progress made in this area. Also featuring in discussions was the extent to which learning became embedded into practice change. It had been agreed to revisit the terms of reference of the committee, and it was also noted that for the second time the meeting had not been quorate and this warranted consideration.

06.02 Steve Hitchins enquired about learning and whether appropriate checks were in place to ensure learning was properly embedded and shortcomings identified as a result of serious incidents were not repeated. Anu was confident the requisite systems were in place to ensure this, adding that assurances were also built into the templates for the routine divisional reports.

06.03 Congratulations were expressed to Julie Andrews and her team for their sterling work on infection control.

06.04 In answer to a question from Rob Whiteman about safeguarding training, Philippa Davies replied that there were two issues of note here, one being straightforward capacity, the second being the type of training offered. In regard to the latter, trainers were looking at different ways of offering training in ways which best suited the staff

groups requiring it, and the effects of this were already being felt, with a notable improvement in take-up rates.

15/007 Strategy Development Update

07.01 Introducing this item, Siobhan Harrington informed Board members that there was now a first draft of the Trust's strategy; however she felt that more clinical input was needed. To this end she had enlisted the help of a team of clinicians and there was also now a clinical editorial board. The main themes of the document were prevention, intermediate care, safety and quality and patient empowerment. The stakeholder engagement piece outlined the stage the Trust was at and what progress was being made.

07.02 Work was ongoing to look at the business plans which had been produced by the divisions in December. The Integrated Business Plan (IBP) will be developed following completion of the clinical strategy, and the Long Term Financial Model (LTFM) was also in progress. There was to be an extraordinary Trust Board meeting the following week to look at the maternity and neonatal services Full Business Case (FBC).

07.03 It was noted that a submission on the operational plan for 2015/16 needed to be sent to the TDA next Tuesday. Also taking place that day was the first of the contract meetings with the commissioners. Steve Hitchins informed the Board that he had seen Haringey Council's five year plan, and it fitted well with the Trust's strategy. Anita Charlesworth invited colleagues to consider the plan in the context of the Trust's participation in the Integrated Care Pioneers initiative. Rob Whiteman praised the quality of the document, pointing out that March appeared to be particularly pertinent in terms of the completion of one stage of the work, and querying what followed on from this. Siobhan Harrington replied that work had been ongoing since last summer to introduce a more robust planning structure. The clinical strategy would be complete by the end of March, and work was in hand to ensure that operations colleagues were fully involved in the development of the workforce, financial and contractual processes.

07.04 Tony Rice mentioned the requirements necessary for the Care Quality Commission (CQC) inspection, and Simon Pleydell replied that the key deliverable was to have a plan for 2015/16 that the Board was fully commensurate with and could be tracked back to the business plans developed during the year.

15/008 Performance Report

08.01 Lee Martin began his report by reminding colleagues that the dashboard presented was based on November data. He added that Board colleagues had requested updates on certain specific areas, and to this end he had invited operations colleagues to provide presentations.

08.02 Returning to the dashboard, Lee was pleased to report that the Trust had met the Referral to Treatment (RTT) national target in November, and projections were positive looking forward to December and January. On cancer targets, there had previously been some issues raised around choice, however, in November all targets had been met, and again, projections appeared positive for December and January. Steve Hitchins congratulated the team on these achievements, which he was aware had taken considerable effort. Paul Lowenberg raised a query about the Hospital

Standardised Mortality Ratio (HSMR) figure, and Lee replied that he too had queried this and would discuss it with Paul once he had received an update.

08.03 Paul also asked when the Board might receive details of patient satisfaction surveys from outpatients and community services. Lee replied that this data was now been collected and was being checked, and he hoped that the Board would be able to receive it in February or March. Paul added that he hoped information would be provided by percentage of respondents in order to be able to see a meaningful representation. He also hoped that the Board would soon see a KPI on ambulatory care, and Lee replied that this might be provided in shadow form in March with 'real' information coming in April.

08.04 Phillipa Marszall pointed out that the complaints figure on page 2 should read 79%.

08.05 <u>MSK Services</u>

08.05.01 Beverleigh Senior began her presentation by speaking about the work that had been undertaken to improve access rates. The service had been especially busy and there was little set pattern to rates of demand, but the aim was to see all patients within six weeks of referral, both RTT and non-RTT. Work had been carried out on demand and capacity. There had been a backlog of clients waiting for treatment but this had now been cleared. Much time had been spent validating data. An access policy had also been implemented, and Did Not Attend (DNA) rates had reduced from in the high 20% to below 10%. Beverleigh proceeded to show a graph illustrating waiting times, saying that efforts made had greatly contributed towards an improved working environment for the team. It was noted that the team also now had a qualified prescriber, which was an innovative (and fairly unusual) development.

08.05.02 Paul Lowenberg felt there was a discrepancy between the data presented by Beverleigh and that contained within the performance dashboard. It was noted, however, that the two services highlighted were not comparable.

08.05.03 Finally, Beverleigh showed the Board the front page of the new website which had been developed, and in particular the encouragement given to patients to self-manage their condition, including apps linked to relevant web pages. Lee Martin praised to work of the team, saying that GPs had noted and fed back the differences made to the service as a whole.

08.06 <u>District Nursing</u>

08.06.01 Sarah Hayes introduced her presentation by informing the Board that there had been a 30% increase in demand for services over the past couple of years. Recruitment and retention had therefore been key priorities, as had effective communication. The vacancy rate had now reduced to 5%. The structure of the team had now been altered and was now a better match with the integrated care teams and social services, although a slightly different approach was being taken by the two boroughs of Islington and Haringey.

08.06.02 Further work on integration of the service was to be progressed through the integration steering group, and the Board would receive details of the timetable for this in due course. It was noted, however, that Islington hoped to have its new localities fully functioning by the start of the next financial year, and Haringey was speeding up its

timetable. Much work was being undertaken on continuity of services (end of life care was cited as a particular example).

08.06.03 Sarah showed the Board an illustration of the realigned model for the night service. She also drew attention to new ways of working within the service that had led to increased productivity, including the use of cars and iPADs, the latter meaning that morning handover was now done virtually. As well as increasing productivity, these changes were contributing to staff retention, and improved work/life balance.

08.07 Health Visiting

08.07.01 Lynda Rowlinson reminded Board members that the Health Visiting Call to Action had been launched in 2011, with the aim of increasing the number of health visitors nationally to 4,500 by 2015. This had, she said, been particularly challenging in London. Good progress had however been made – in 2011 the Trust had employed 67.4 whole time equivalent (WTE) health visitors, and there were now 97, an approximate growth of 10 per year. Overall though, there was a shortfall of 57.5 against the agreed trajectory with NHS England. This was a challenge, but there was a cohort of students about to qualify which would increase numbers.

08.07.02 Anita Charlesworth enquired whether or not the Trust was also considering alternative service models, given that the target should be one based around service consequences rather than staff group numbers. This view was wholly endorsed by the Board, whilst they recognised that the increase in health visitor numbers was a national and non-negotiable requirement. Lee Martin said that this point was being addressed through the regular telephone conferences held with NHS England – it was recognised this was a national requirement – and, therefore, one which needed to be reported to the Board - but the Trust continued to push back, recognising the absolute importance of providing the right service rather than a prescribed number of bodies.

08.08 Workforce

08.08.01 Introducing this item, Chris Goulding informed the Board that some of the slides here presented were in an iterative state and should be viewed as work in progress. He said that from October there had been an increase in the overall number of staff of 31 WTE due to winter pressures and the need to open additional beds. Looking at turnover, the main area of interest was the Integrated Care and Acute Medicine (ICAM) division, and Carol Gillen was looking at recruitment and retention in that division. Sickness was now below the threshold, although there was concern at high Bradford scores in some areas. The overtime expenditure within Facilities raised at the previous Board had now steadied, and director Phil Ient was carrying out a benchmarking exercise with other trusts.

08.08.02 Bank and agency spending had reduced, and all efforts were being made to converting posts into fixed term contracts. There were plans to carry out a review of the new appraisal system shortly.

08.08.03 Referring to page 5 of the report, Paul Lowenberg enquired why the Trust appeared to be above establishment on administrative staff. He was reminded that the term was misleading since it included health care assistants and technical staff. Lee Martin would also check since he was sure there was a low proportion of administrative staff within the care divisions. Paul also enquired whether the additional staff employed to

put into place winter pressures measures would not have been included in the original workforce plan, and was told they would not since at the time the plan had been written precise requirements would not have been known. Consideration would however be given to how this might be presented the following year, perhaps with a baseline figure then an additional line built in on top.

15/009 Financial Report

09.01 Ursula Grueger reported that the report for Month 8 showed a deficit of £380k, bringing the year to date deficit position to £6.7m. This continued to be attributable to a combination of underperformance on income and pressures on expenditure, with CIP continuing as previous trends. The capital programme was on track and being carefully managed. The Trust is now declaring a £7.4m deficit at the year end. Work was therefore in hand to bring the position back to balance and moreover to move towards achieving a surplus. It was noted that the £7.4m position was a 'worst case scenario', and that there was an absolute focus in the final quarter to reduce non-essential spend. It would also be important to look at planning for next year, starting the process far earlier and involving more people.

09.02 Rob Whiteman pointed out that the start of the new financial year was now only two and a half months away and, this being the case, wondered whether the Trust would begin by overspending from the beginning of the year. Ursula acknowledged that was every likelihood of this, although every effort would be made to improving the position month by month. She added that the team was also working to make the process itself simpler and more inclusive, i.e. devolving to more people.

09.03 Anita Charlesworth said that a high proportion of the Trust's expenditure was attributable to pay costs. She found it difficult to reconcile the high level of expenditure on bank and agency staff within midwifery with the reduction in service provision and loss of market share. It was noted that head of midwifery Jenny Cleary was looking into this, but there were vacancies in that area. In answer to a question from Paul Lowenberg about a drop in activity to 15% below plan, Siobhan Harrington replied that ED services were 'flatlining' during that period, as were non-elective services; and that activity in surgical lines had grown; it should also be noted that the plan was inflated by 5%. It was agreed to try to insert a more detailed narrative into next month's report.

09.04 In summary, it was agreed that the most important point moving forward was for the Trust to work closely with its commissioners to improve the position for the following financial year.

15/010 TDA Board Statements

10.01 Given the TDA statements had been discussed in detail at the previous meeting, Steve Hitchins asked whether there were any changes of significance, and Simon Pleydell replied that the only change of note was to the financial position, and this had been discussed in full detail with the TDA.

15/011 Register of Interests

11.01 The register of board members' interests, current guidance and sample template form were noted.

15/012 Safe Staffing Report

12.01 Philippa Davies introduced the safe staffing report for nursing and midwifery for the month of November. The Trust continued to operate at safe staffing levels throughout the Trust, and there had been a reduction in the number of HCA 'specials' (set out in Appendix 2).

Questions and comments from the floor

Ron Jacob enquired whether the Trust had any remaining financial reserves, and was told by Simon Pleydell it did not. He also queried the categorisation of the Hanley Road practice – it was explained this was a CQC requirement.

Ron also raised the issue of the fairly high level of DNAs referred to in the performance report and the cost to the Trust of these. Lee Martin replied that the Trust had carried out two audits and implemented five improvements and more recently asked the Intensive Support Team (IST) for advice. He would be presenting the results of this at the next meeting. Lee added that Maureen Blunden was undertaking a pilot on patients' preferred methods of communication. Simon Pleydell pointed out there was, however, little scope for savings since the clinics remained and had to be staffed.

Finally, Ron asked whether the Trust had failed to meet its CIP target because the targets themselves had been unrealistic or there had been a failure to achieve realistic targets. Simon Pleydell replied that each year the Trust was set 'efficiency targets' which involved real money being removed from the system. He acknowledged that some areas had not been successful, saying there was a need to be more realistic and clearer about the delivery of plans.

Helena Kania raised the issue of the PALS office being closed at 3.00pm daily, saying this was not a positive way to encourage feedback from patients. Philippa Davies replied that she was undertaking a review of the service, and there were plans both to increase opening hours and to make the environment more welcoming. Helena also asked about physiotherapy waiting times, saying that six weeks was a long time to wait following an operation. It was clarified that this was a different service, and Lee Martin undertook to provide Helena with more detail. Helena also queried the use of the word 'challenge' in the district nursing presentation. She also expressed disappointment at the lack of detail in the Quality Committee Report, stressing that the real test was whether concerns were adequately flagged to the Board.

Margot Dunn spoke about the Trust's work with Islington and Haringey local authorities, and expressed disappointment commissioning varied so much between the two. It was clarified that commissioning was the responsibility of the CCGs rather than local authorities, and Siobhan Harrington added that the Trust was frequently in discussion with CCG colleagues to address any imbalance within the system and some very real improvements had been brought about through this process. She also made reference to working with CCG and the local authorities over the Better Care Fund.

David Emmett spoke of the possible benefits to Whittington Health as others considered moving to the ICO model. He also wondered whether a decrease in activity might herald an increase in health. Anita Charlesworth mentioned the decrease in admissions brought about through ambulatory care, adding that the Trust needed to ensure this service was properly funded.

Valerie Lang suggested talking to some of the local GP practices to see how they best dealt with DNA problems. She also spoke about non-payment for services, and Siobhan Harrington explained that the block contract system currently in place meant an increase in numbers did not bring with it additional income.

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Action Notes Summary 2014-15

This summary lists actions arising from meetings held July 2014 to December 2014 and lists new actions arising from the Board meeting held on 7th January 2015.

Ref.	Decision/Action	Timescale	Lead
100.03	Nursing establishment – final report would be coming to the Board in February	February	PD
143.01	Cancer services improvement plan – to address specific question on integrated care and to check timing for Board	February	LM
173.04	Benchmarking data on the composition and percentage of different staff groups to be made available to the Board	February	CG
173.04	Change to the layout of tables required plus supporting narrative to accompany them	February	CG
174.06	Finance and Business Development Committee to review the business plan produced for the outsourcing of the catering service	February	UG
06.01	Board to consider revised terms of reference for the Quality Committee and discuss the need for quoracy	March	AS/PD
08.02	To review the HSMR figure in the performance dashboard and feed back to Paul Lowenberg	February	LM
08.03	Key performance indicators on ambulatory care to be incorporated in the dashboard	April	LM
08.08.03	To check the figures relating to administrative staff contained within the workforce report	February	CG
09.03	To increase the narrative relating to the section of the financial report relating to activity	February	UG

Whittington Health NHS

ITEM: 15/018
Doc: 2.1

The minutes of the extraordinary meeting of the Trust Board of Whittington Health held at 11.00pm on Wednesday 14th January 2015 in the Whittington Education Centre

Present:	Philippa Davies	Interim Director of Nursing and Patient Experience
	Ursula Grueger	Deputy Director of Finance (Acting as Director of Finance)
	Chris Goulding	Acting Director of Human Resources
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Steve Hitchins	Chairman
	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:	Friedericke Eben	Medical Programme Director
	Kate Green	Trust Board Secretary
	Sophie Harrison	Assistant Director, Estates
	Phil Ient	Director of Estates & Facilities
	Caroline Thomsett	Director of Communications

1. Apologies for absence

1.1 Apologies were received from Anita Charlesworth, Graham Hart and Rob Whiteman.

2. Maternity and Neonatal Redevelopment Full Business Case

2.1 Chairman Steve Hitchins welcomed all present to this extraordinary meeting of the Whittington Health Trust Board. He explained that the timing of the meeting had been governed by the deadline for submission of the Full Business Case (FBC) to the Trust Development Authority (TDA), which was 16th January. Steve went on to thank everyone involved in the development of the FBC – there were too many to name individually, but he was well aware that staff had been working nights, weekends etc to produce a thorough creditable document. The FBC had been discussed in the Board Seminar held immediately prior to this meeting, and Siobhan Harrington as lead for the development of the FBC was recommending Board approval. The team had, she said, been amazing. The plan for this meeting was that the team would present the FBC, there would then be opportunity for questions from the Board, and finally they would take questions from any members of the public present.

2.2 Friedericke Eben said that since 1995 one of the main aims of the Trust had been to have a new maternity and neonatal unit. Whittington Health as an ICO had received good reviews and a survey carried out in 2013 showed that women liked coming to the hospital. Giving some of the history, Friedericke said that in 1983 the City of London Maternity Hospital had been incorporated into the Whittington Hospital maternity services.

2.3 Friedericke Eben explained that the maternity and neonatal services received extremely positive reviews, especially the new birthing centre. This included positive reviews for the

high risk elements of obstetrics. The unit also provided excellent education opportunities for junior doctors. Friedericke went on to describe recent developments in service provision, including the joining of health visiting with midwifery, the practice of partners being given the opportunity to stay overnight, the weight and nutrition clinic and EPR. New pathways had also been created.

2.4 Friedericke then took Board members through the feedback from the consultation exercise that had been undertaken, and highlighted some of the key responses which raised the question of the current environment. She had also held discussions with local GPs, had recently interviewed five practices, and she mentioned the lack of available information about the service in central and south Islington practices. In summary, then, the service provision is good, but in an environment which is 'poor and unacceptable'.

2.5 The aspiration was to have the maternity and neonatal redevelopment completed by September 2016. Friedericke took the Board through figures from the last ten years, including noting the reduction of deliveries, stressing that new delivery facilities do make a difference. In developing the FBC consideration had been given to eight different options. The implications of each were detailed, starting with the risks inherent in doing nothing. She then took the Board through the preferred option, which was Option 3A – strategic investment with marketing growth. This option contained the following elements:

- Marketing growth assumed
- Activity level increases; by 18/19 deliveries increase to 4,700 and neonatal cots increase from 23 to 27
- Workforce increase in line with increased activity
- Capital investment of £12M.

2.6 The Board was then shown the plans, including the new theatre facilities and neonatal care unit, and it was explained that the design allowed the option for further expansion at a later date. This could be done using a 'drop in' method which would minimise disruption.

2.7 Friedericke Eben described the process behind the financial modelling. She was aware that the preferred option contained an ambitious growth target the Trust needed to deliver on. She added that there had been a rise in costs between the development of the OBC and FBC, works and other costs had risen from £10m to £12m, one million of which was inflationary pressures. In terms of how the redevelopment would affect finances as a whole, the first two years there would be a negative impact, but after this the position would rapidly become positive. To do nothing would result in financial cost to the Trust.

2.8 The next stage was to gain approval from the TDA, and it was hoped that if this was forthcoming work on the redevelopment could begin in the summer 2015. Friedericke Eben thanked everyone for their support, including the many contributors who were not employed by the Trust.

2.9 Paul Lowenberg posed two questions:

- looking at past concerns women had raised, what increase in privacy and reduction in noise would the redevelopment bring
- referring to the letter of support the Trust had received from the CCGs, would the service meet national standards in relation to consultant cover

In answer to the first question Friedericke replied that the new neonatal unit would be much bigger, allowing more space between beds, and with improved facilities for parents. There would also be two single rooms adjacent to the obstetric theatre, in addition to a new 4 bed bay for recovery/high dependency care. Two new delivery rooms would be provided with en-suite facilities. In the interim, Murray ward was being refurbished, and this would contain more single rooms.

Turning to Paul's second question, at the moment the unit has consultant cover of some 80 hours per week, 08.00am – 10.00pm Mondays to Fridays, and five to six hours every Saturday and Sunday. This is in line with current guidelines for the number of deliveries we cover.

2.10 Paul also enquired whether the neonatal service should not be aspiring to be a Level 3 rather than Level 2 service. Friedericke explained the commissioning approach to neonatal units and the neonatal network which means that we should be aspiring to be an excellent Level 2 service, which also fits with the clinical strategy of the organisation as an integrated care organisation.

2.11 Richard Jennings said that he was confident staffing levels were safe and consistent with Royal College guidelines. He invited Friedericke to highlight patient safety advantages of the redevelopment, and she replied that those requiring an emergency caesarean section would no longer have to be moved to main theatres as the new second obstetric theatre would be on hand. She also said that the neonatal unit was not fit for purpose in terms of infection control etc.

2.12 Siobhan Harrington said that the business case was predicated on growth; however activity in the last year had gone down. She emphasised however that the Trust had never marketed the service, but plans were in place to do so now. A detailed plan had also been drawn up on how to regain market share. If the FBC was approved there would be considerable monitoring of activity levels. In addition, the information on the Trust website had been considerably improved including contributions from midwives, obstetricians and other colleagues across the Trust.

2.13 Steve Hitchins emphasised the importance of this development on the Trust's status as an ICO, and the advantages this could offer to patients. The Trust had never before had to market its services, but it was now required to do so. Caroline Thomsett added that work had already begun on marketing, with the approach being that the ICO offered care 'every step of the way'. This was seen as a positive approach by GPs.

2.14 Paul asked for executive colleagues to expand on the key risks. Siobhan replied that a great deal of work had been done. in this area including through the service transformation group. The Trust had the support of its main commissioners, and was expecting anticipating receiving formal support from NHS England later in the day. Siobhan outlined the five key risks as being:

- activity growth assumptions which have already been discussed and are being mitigated through the delivery of the marketing strategy

- the timeline on Town Planning – and we continue to work with colleagues in LBI to mitigate this risk

- increase in capital costs from OBC to FBC, and this has been discussed in detail with the TDA who explained that they would be pragmatic in their consideration of this

- delivery of CIPs which as a Trust we are very focused on and developing realistic detailed plans

- TDA approval of the FBC in the context of our LTFM, and the key mitigation is that we believe the evidence shows that this improves our LTFM.

Finally the NHSE letter of support which we are expecting imminently.

This was echoed by Ursula Grueger, who said that the Board had been provided with the details of the financial analysis of the risk, and she agreed that the greatest concern was that of any possible delay to the scheme. In answer to a question from Paul Lowenberg about capital costs, Sophie Harrison replied that the Trust had used a P21 procurement route, and there was a 'not to be exceeded maximum price' provided works kept to timetable.

2.15 Steve Hitchins asked about lessons learned from the process, and it was agreed that one problem had been the delay between the OBC and FBC. The TDA was now far more closely involved, and the scheme was within their planning pipeline.

2.16 In summary, Simon Pleydell said that the scheme was not without its risks, and there was a clear need to increase the number of births. To do nothing, however, was not acceptable, and the service would gradually become unsustainable without investment. Steve Hitchins asked those in favour of the FBC to indicate their support, and the recommended option was agreed unanimously.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4 February 2015

Title:	Chief Executive's Report to the Board		
Agenda item:	**15/020**	**Paper**	**3**
Action requested:	For discussion and information		
Executive Summary:	Headlines: 1. Care Quality Commission (CQC) preparation 2. Flu campaign 2014/15 – trust target reached 3. Second MRSA bacteraemia 4. Emergency Department performance 5. Referral to Treatment waiting times 6. Cancer standards 7. Impact on Musculoskeletal (MSK) and District Nursing 8. Financial position at month nine (December) 9. Whittington Health – the next five years 10. Barbara Windsor MBE opens MacMillan Cancer Centre 11. Female Genital Mutilation (FGM) trial 12. Further industrial action 29 January 13. New Wi-Fi service 14. Apprentice success at HENCEL awards 15. Kings Fund Quarterly Report 16. Ambulance reports times		
Summary of recommendations:	The Board is recommended to discuss the report.		
Fit with WH strategy:	This report provides and update on key issues that could affect Whittington Health's strategy.		
Reference to related / other documents:	n/a		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	n/a		
Date paper completed:	27 January 2015		

Author name and title:		**Simon Pleydell, Chief Executive**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
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**

The purpose of this report is to update the Board on local, regional and national policy changes that will affect the organisation and set out the key issues facing the Trust.

Quality

1. Care Quality Commission (CQC) preparation

We are beginning to prepare for a full CQC inspection, which is likely to happen in the second quarter of the next financial year. It will be an opportunity to showcase our good work and improvements we've made. The inspection will also enable us to demonstrate that we know our improvement areas and what we are going to do about them. We will be able to show how we gain feedback on the care we provide, learn from our mistakes and share lessons to make changes. All colleagues will be supported to prepare for the inspection as well as offered best practice points for life beyond the CQC visit. We are holding a series of briefing meetings on the expected inspection for all clinical colleagues and everyone who works in patient areas.

2. Flu campaign 2014/15 – trust target reached

The Trust has not only reached the 75 per cent target but its own stretch target of vaccinating 80 per cent of colleagues this winter. Thanks to the efforts of everyone involved, particularly our flu champions, the Trust is again the top trust in London for vaccination rates. Public Health England reported in January that more than 506,000 frontline staff (52.6 per cent) were vaccinated between 1 September and 31 December 2014.

3. Second MRSA bacteraemia

After being MRSA bacteraemia free for a year, we have now had two patients with trust acquired blood stream infections within four weeks. Post infection reviews have been undertaken. Colleagues are being urged to be extra vigilant and reminded of the importance of our infection control procedures.

Performance

4. Emergency Department performance

Our Emergency Department (ED) and subsequent services have seen an increase in demand, particularly the acuity and complexity of the patients. Despite the continued pressure, our performance against the four hour standard improved in December to 0.1 per cent below 95 per cent. Assurance and planning meetings have been held with the NHS Trust Development Authority (TDA) and Islington Clinical Commissioning Group (CCG) to ensure that all possible assistance is being given and patients do not experience delays in their care pathways.

5. Referral-to-Treatment waiting times

In November and December, we met our national standard for patients waiting for planned care. A large amount of coordination and planning went into the drive to reduce the long waiting patients. There is still work to be done and further patients will be treated in February and March.

6. Cancer standards

We met our national standards, and the tumour streams now have processes and systems in place to enable sustained compliance with these strict timescales.

7. Impact on Musculoskeletal (MSK) and District Nursing

Additional demand has not only been placed on the Emergency Department and inpatients beds, we have also seen a large increase in referrals to MSK and to District Nursing. Both teams have been moving colleagues around our locations to ensure that patients receive timely treatment.

Finance

8. Financial position at month nine (December).

There has been a slight improvement in our financial position. Our in-month position at the end of December was a £480k surplus bringing our year-to-date position to a £6.2m deficit. The financial position overall is a combination of income underperformance and expenditure pressures. The favourable position in month is driven by an over performance in NHS clinical income. This reflects the £2m contract variation, £1.2m resilience support and higher than run rate NHS England performance which is paid on Payment by Results (PbR). We continue to exploit additional income opportunities. The main expenditure challenges remain in our Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostic (SCD) divisions. Our improved expenditure compared to month eight is largely due to the corporate division both pay and non-pay position. We continue to forecast a year-end deficit of £7.4m and endeavour to make every effort to reduce our discretionary expenditure. Discussions with our commissioners continue with the aim of improving our year end position.

Other key updates

9. Whittington Health – the next five years

There has been further clinical and public engagement in January with three more trust workshops and three health conversations in Islington, Tottenham and at The Whittington Hospital. There is support for the new mission and vision that has been developed and agreement on the strategic themes. The full clinical strategy is expected to be completed for the next Trust Board in March.

10. Barbara Windsor MBE opens MacMillan Cancer Centre

Barbara Windsor officially opened our Macmillan Cancer Information and Support Centre at The Whittington Hospital in January. The opening included a moving account from Lucy, a Whittington Health patient on the need for a support network when facing cancer. The centre provides information and emotional support to people with or affected by cancer including their carers and families. Cancer patients can be referred from the oncology team, from GPs working in the community or patients can drop in Monday to Friday from 10am to 4pm.

11. Female Genital Mutilation (FGM) trial

The first FGM court case in England and Wales began on 19 January at Southwark Crown Court involving one of our doctors. A second person is accused of aiding and abetting the doctor. Both deny the charges. The alleged incident happened in

November 2012 following a patient giving birth in our maternity unit. The charges and the current trial have had a major impact on colleagues. We have been providing support to everyone concerned, as far as we are able to do so. The trial is expected to last three weeks. We will issue a statement at the end of the case.

12. Further industrial action 29 January

A number of unions were due to escalate their industrial action on Thursday 29 January in response to the Government's decision on the 2014/15 pay award. Unison, Unite and GMB were calling on their NHS members in England to take strike action for 12 hours between 9am and 9pm. The GMB was also asking its members in the ambulance service to take part in a 24 hour strike from midnight on 29 January, while Unison members in the ambulance service were due to strike from noon to midnight. This will potentially have a widespread effect on the ambulance service and NHS England has declared a London-wide major incident. Other unions involved include the Royal College of Midwives (strike action between 1-3pm). This is a national dispute between the Government and national unions, and not between local unions and employers. A further strike is planned on Wednesday 25 February.

13. New Wi-Fi service

Wi-Fi is now available at The Whittington Hospital for all patients, carers, colleagues and students. This is a free service and a very welcome addition for patients and their families. The service is externally managed by Wi-Fi Spark.

14. Apprentice success at HENCEL awards

Congratulations to two of our apprentices who received acclaim at the Health Education North Central and East London (HENCEL) annual Quality Awards in December. Duncan Matthews won apprentice of the year and Sophie Thompson from Improving Access to Psychological Therapies (IAPT) was highly commended. Both are studying Business and Administration at City and Islington College. More than 120 nominations were received for the awards and 24 shortlisted.

15. Kings Fund Quarterly Report

The King's Fund's latest quarterly monitoring which examines the views of finance directors shows that waiting times for treatment and other key performance indicators are worsening, as the NHS faces increasing demand for services and an unprecedented financial squeeze. The report confirms that NHS finances remain under intense pressure, with more than 40 per cent of directors surveyed for the report forecasting that their trust will end the year in deficit. However, over three quarters reported that their organisation is planning to increase the number of permanent nursing staff it employs over the next six months as care is prioritised.

16. Ambulance reports times

London Ambulance Service NHS Trust has been announced as one of two new pilot sites that aim to reduce wasted ambulance journeys and improve the quality of care for all patients contacting 999. For the most serious calls, where every second counts, ambulances will continue to be dispatched immediately. A number of conditions will be upgraded from "Red 2" to "Red 1" to receive a faster response, and no conditions will be moved in the other direction to a lower priority classification. The call handling time will also be extended by 120 seconds for non-life threatening calls to reduce the number of double dispatches, freeing up more ambulances to respond to more patients, and allow the 999 response to be more accurately targeted to patient need. The first pilot is expected to start in February.

Whittington Health NHS

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Whittington Health Trust Board
4th February 2015

Title:	Quality Committee Report - 15th January 2015		
Agenda item:	15/021	Paper	4
Action requested:	For noting and approval		
Executive Summary:	This summary report details outcomes from the Quality Committee meeting of 14 January 2015 when the following reports were considered: • Divisional Risk and Quality Reports • Serious Incident Report • Quality Performance Report • Infection Control Update • Patient Safety Committee Report • Safeguarding Adults Report (quarter three) • Research and Innovation Report • Emergency Preparedness Report • Supervision of Midwives Report • Care Quality Commission (CQC) Inspection Preparation (verbal update) • Quality Standards (verbal update) • Update on Policy Reviews		
Summary of recommendations:	The Trust Board is asked to receive the report and comment on revised format and content.		
Fit with WH strategy:	The Quality Committee, a sub-committee of the Trust Board, considers issues relating to quality, patient safety and governance.		
Reference to related / other documents:			
Date paper completed:	January 2015		

Author name and title:		**Philippa Davies, Director of Nursing**		**Director name and title:**		**Philippa Davies, Director of Nursing**	
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

QUALITY COMMITTEE – MEETING HELD ON 15th January 2014

SUMMARY REPORT TO BOARD – 19th January 2014

The following Non-Executive Directors were present:

Anu Singh (Chair), Anita Charlesworth, Professor Graham Hart

The following Executive Directors were present:

Philippa Davies, Richard Jennings

Decisions made under delegated authority:

The Quality Committee made no delegated decisions on behalf of the Trust, under the authority delegated to it within its terms of reference.

Outcomes:

Terms of Reference

The Committee agreed the revised Terms of Reference subject to some minor amendments. The final version will be presented to the Trust Board in March for ratification.

Divisional Presentations –

Integrated Care and Acute Medicine (ICAM)

The committee received a clear comprehensive presentation from the Divisional Director of Operations. The presentation highlighted the achievement in complaints handling and improvements in staff appraisal rates. In addition, the division has maintained compliance with the same sex accommodation standard since 1st August 2014.

The committee requested that future reports highlight where there may be risks to quality. The committee recognised the hard work and achievements of the team recognising the recent significant pressures in the Emergency Department.

Surgery Cancer and Diagnostics (SCD)

The committee received a clear comprehensive presentation from the Head of Nursing and the Divisional Director of Operations. The committee discussed the impact current levels of admissions were having on elective cases and were pleased to note the cancellation of elective patients had been minimal. The committee were informed that cancellation was risk assessed and the small number of patients who had been cancelled were sent personal letters of apology from the Divisional Director of Operations. The committee agreed that this was very good practice.

The Trust's Summary Hospital-level Mortality Indicator (SHMI) position was discussed and the Medical Director informed the committee that the recent data was currently being reviewed and that the previous figure had been given a caveat due to the recent problems with Electronic Patient Record (EPR) data.

Women, Children and Families (WCF)

The committee received a presentation from the Head of Midwifery and highlighted the need for a more comprehensive report going forward. A discussion ensued around the importance of having sound governance processes in place.

Mandatory training and appraisal

The committee discussed mandatory training and staff appraisal performance and agreed that compliance remains a concern and that further work is required. The committee requested assurance that there was a robust plan in place to address these issues and as such would like to see a paper brought to the next committee for consideration.

Care Quality Commission – inspection preparation

The committee did not feel assured that each division had a holistic view of their compliance against the CQC standards and agreed that future divisional quality reports needed to provide this assurance.

Performance report

The committee discussed performance with regard to Referral-to-Treatment Times (RTT) and the invitation issued to support other Trusts if capacity allows.

Complaints handling has improved significantly both in terms of response times and quality of responses sent. The committee were assured that the Chief Executive personally reads and signs every response.

The committee discussed the continued inefficiency of the Electronic Staff Record (ESR) and current reporting system and the requirement for issues to be addressed as a priority.

Other matters:

The committee considered the following reports:

1. **Serious Incident (SI) Report –** The committee was informed there were six serious incidents declared in November taking the total to 102 since January 2014. Further assurance was given that a process is now in place for addressing the backlog of SI reports and that lessons learnt were being discussed across divisions.

2. **Infection, Prevention and Control Report –** The committee was informed that the Trust has declared its first hospital acquired MRSA bacteraemia case in 13 months. Lessons learnt have been shared across the organisation.

3. **Safeguarding Adults Report – Q3.** An improvement in Safeguarding Level 2 training was noted.

4. **Research and Innovation Report –** The committee reviewed the report detailing recruitment figures for the adopted studies in the National Institute of Health Research portfolio and welcomed the current research strategy review.

5. **Emergency Preparedness Report –** The committee received assurance that enhanced business continuity plans are in place in addition to effective command and control arrangements.

6. **Supervision of Midwives Report –** The committee was presented with a report highlighting the range of work undertaken by the midwifery supervision team in 2014. The Committee congratulated the team on receiving a successful Local Supervisory Authority (LSA) report in November 2014.

Anu Singh
Non Executive Director
19th January 2015

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The Whittington Hospital NHS Trust
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Whittington Health Trust Board

4th February 2015

Title:	Update on the Trust's clinical strategy development		
Agenda item:	**15/022**	**Paper**	**5**
Action requested:	For discussion and comment		
Executive Summary:	This paper updates the Board on the development of the Trust's clinical strategy for the next five years. It outlines our ongoing engagement process with clinicians, members of the public and other stakeholders. The paper also details our current strategic framework including the mission, vision and strategic themes. The final narrative will be presented to the Trust Board in March.		
Summary of recommendations:	The Board is asked: - To agree the mission, vision and strategic themes for the organisation - To note the ongoing engagement process for the clinical strategy.		
Fit with WH strategy:	This paper centres on the development of the Whittington Health strategy and outlines current and future plans.		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	22nd January 2015		

Author name and title:		**Hannah Finney Strategy and Planning Manager**		**Director name and title:**		**Siobhan Harrington, Director of Strategy and Deputy Chief Executive**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1. Introduction

This paper updates the Board on the development of the Trust's clinical strategy for the next five years.

There has been good engagement to date in developing the strategy, however, over Christmas it was decided to strengthen the clinical engagement. There is support for the mission and vision that has been developed and agreement on the strategic themes. The detail on the narrative is still being completed. It is expected that the full clinical strategy will be completed in time for the March Trust Board.

2. Engagement

Further engagement has been taking place to ensure that the development of the strategy is clinically led and has input from all stakeholders.

2.1. Clinical engagement

There were three clinical engagement workshops through November and December. These were attended by clinicians, operational staff as well as colleagues from Islington and Haringey Clinical Commissioning Groups (CCGs) and local authorities.

To ensure further clinical ownership of the plans, three more workshops have occurred in January and February. These workshops were well-attended and have provided insight that is being incorporated into the final version of the strategy.

Furthermore, a small group of clinicians volunteered to be part of an email conversation providing in-depth feedback on the current strategic framework and any further suggestions. The feedback received from those who responded was detailed and is also being incorporated into the final document. There will be a number of case studies of how care pathways will be improved during the implementation of the strategy.

2.2. Public engagement

There were 'health conversations' conducted with the local community to influence the development of the strategy. Three more have been conducted in January and an online feedback process launched via the Trust's website. Once more, attendees were invited to give their health priorities, concerns and suggestions regarding the future of Whittington Health.

There are a number of local people who are also very interested to become 'patient champions'.

Feedback from these sessions will enable us to ensure that through our strategy we respond to areas of concern from local people.

Communication with the local community regarding the development of the Trust's clinical strategy has also been via the Trust's website, social media, and updates on stakeholder and community websites.

2.3. Engagement with CCGs and Local Authorities

Colleagues from Haringey and Islington CCGs and local authorities attended both sets of clinical engagement workshops.

2.4. Communications strategy

Strategy developments have been communicated through the aforementioned engagement events, through the Trust's intranet and social media, and the Chief Executive's monthly briefing to Trust staff.

Following approval of the Trust's mission and vision, we plan to have a comprehensive communications strategy in place to communicate these across the organisation as a whole.

3. Current strategic framework

There has been broad agreement from stakeholders regarding the 'mission', 'vision' and strategic themes in the Trust's draft strategic framework (see diagram below).

The mission is:

'Helping local people live longer, healthier lives.'

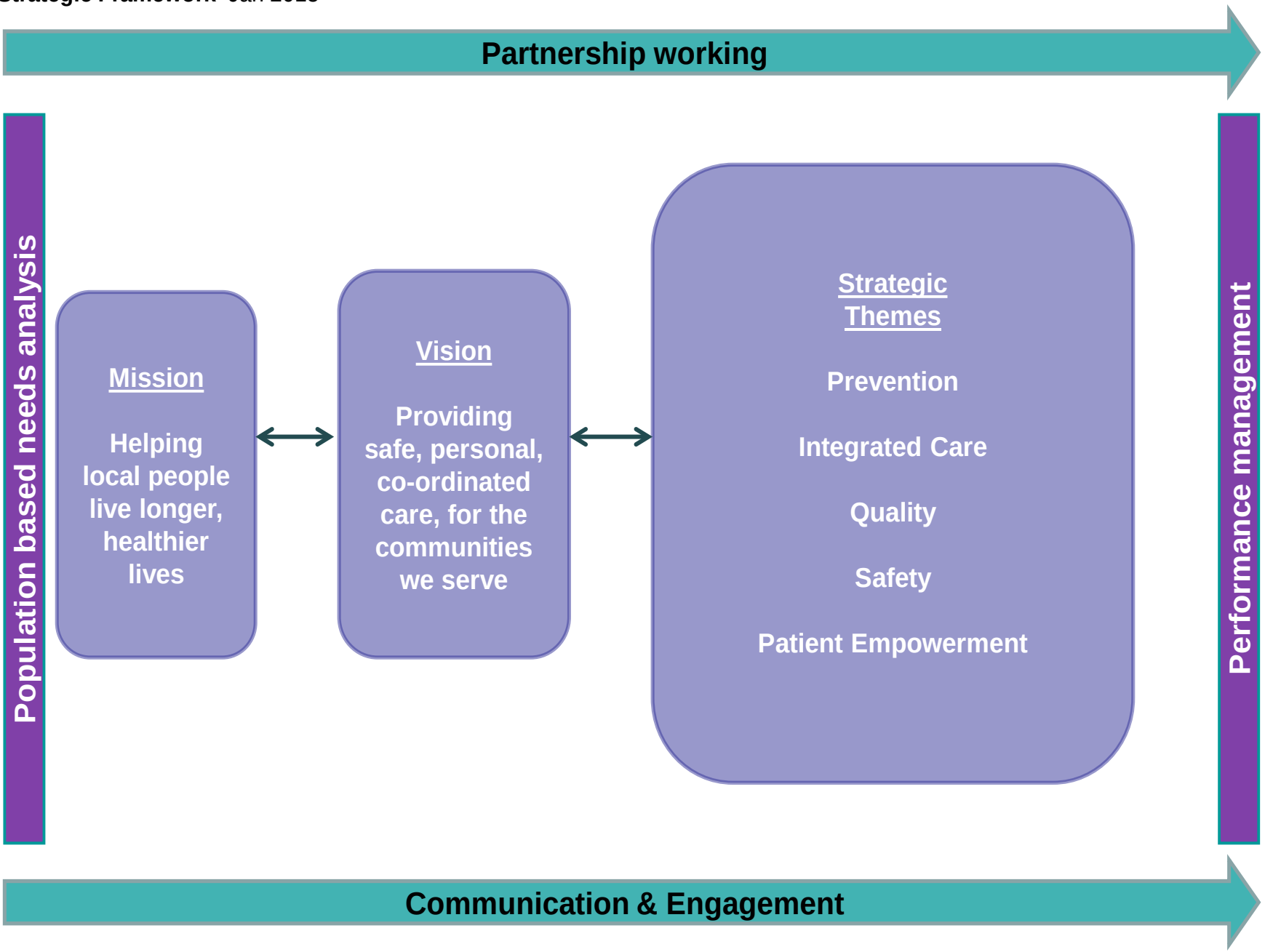
The focus is on prevention and on our local communities.

The vision is:

'Providing safe, personal, co-ordinated care, for the communities we serve.'

Through engaging with our colleagues, there was strong support for this vision encapsulating what we mean by 'integrated care' and that the coordination of care for people will be important over the next five years.

There has been much discussion and debate regarding the strategic themes and these are currently 'prevention', 'integrated care', 'quality', 'safety' and 'patient empowerment'. These will be developed into goals for the organisation and will help inform the corporate objectives in the year ahead.


Partnership working
Population based needs analysis
Mission
Helping local people live longer, healthier lives
Vision
Providing safe, personal, co-ordinated care, for the communities we serve
Strategic Themes
Prevention
Integrated Care
Quality
Safety
Patient Empowerment
Performance management
Communication & Engagement

5. Actions

The Board is asked to:

- To agree the mission, vision and strategic themes for the organisation
- To note the ongoing engagement process for the development of the clinical strategy.

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Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

Title:	Whittington Health Cancer Strategy 2015/16		
Agenda item:	**15/023**	**Paper**	**6**
Action requested:	For discussion		
Executive Summary:	This Paper outlines the Whittington Health Cancer Strategy for 2015/2016		
Summary of recommendations:	To note		
Fit with WH strategy:	**Integrated Care -** Provides a full range of services for cancer patients with excellent integrated care across Whittington Health **No Decision Without Me** - We will transform the way we work by ensuring people and services work together to design and deliver the best care pathways and the best patient experience. **Efficient and Effective Care** - To deliver efficient, effective services that improve outcomes for patients and service users, while providing value for money. **Improving Population Health** - Treating and preventing cancer is a critical part of improving population health. **Culture of Improvement and Innovation -** The service will endeavour to deliver services through a more diverse workforce undertaking different roles and responsibilities.		
Reference to related / other documents:	Cancer Services Business Plan 2015/16		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	23rd January 2015		

Author name and title:		**Pauline Leonard Lead Cancer Clinician & Consultant Medical Oncologist**		**Director name and title:**		**Fiona Isacsson Director of Ops SCD**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

WHITTINGTON HEALTH CANCER STRATEGY 2015/16

Introduction

This paper describes the Cancer Strategy for Whittington Health 2015/2016. This has been produced in collaboration with each Tumour Group. Please find our objective below:

1. Our overarching principle is to deliver patient focussed, clinically effective, safe care locally which provide better value pound for pound by an engaged and healthy workforce. We want to further improve pathways of care to enable faster diagnosis, better tailored treatments with support along the whole patient journey to ensure an excellent experience of care that promotes confidence for self-management and emotionally supported survivorship.

2. To deliver on these principles we need to promote a range of diagnostic tests, which can be accessed directly by primary care within one week of request. In addition to full concise reports within 24 hours of completion of the test, we will add a recommended fast track access clinic to the report for the GP to refer their informed patient for further assessment and investigation.

3. We will provide better cancer prevention strategies and plan to offer a suite of healthy lifestyle choices including smoking cessation support for all patients referred to the Trust on a two week wait investigation of a suspected cancer. Our data show that, overall, 78 per cent of patients referred do not have an underlying suspected cancer. This large cohort of patients in addition to being reassured there is no malignancy will be provided with healthy living information and strategies to reduce their future cancer risk.

4. We are extending our screening programme by offering colorectal screening in addition to our breast screening programme. We need to solidify pathways of care from the screening centres to ensure our patients who are found to have a suspected cancer in the community have their definitive treatment repatriated to Whittington Health.

5. We want to provide faster diagnosis by promoting our drop in centre for a chest x-ray in high risk patients with persistent cough. We want to build on our excellent ambulatory care model by offering primary care an alternative route for senior clinical review and investigation of a suspected cancer avoiding admission via the emergency route.

6. We plan to embed a clinical frailty assessment working in tandem with the care of the elderly physicians to ensure there is equity of services to our patients over 75 years.

7. We want to implement Somerset software (a speciality patient management administration system) by April 2015 to ensure accurate data is collected on all our diagnosed patients not only contributing to the national cancer outcomes and service dataset (COSD) but embed a culture of regular interrogation of our datasets against national benchmarks to ensure there is no variation in providing the best evidenced based care for all our patients with a diagnosis of breast, colorectal, lung and prostate cancer.

8. We will continue to collaborate with our neighbouring specialised centres to provide seamless pathways of care to ensure our local patients who require specialist services have their care transferred in timely way.

9. We want to build networks of supporting services to ensure care is delivered as close to home as possible. In addition to our excellent ambulatory chemotherapy service which provides all chemotherapy including the administering of complex regimens to all patients with breast, colon, lung, upper gastrointestinal and hepato-biliary cancers, we plan to provide chemotherapy in the community and patient homes for those who request it and the governance structures are in place to safely deliver it. We have further developed our malignant haematology service by proving a range of evidence systemic regimens for our local patients. This practice is shared with University College London Hospitals NHS Foundation Trust (UCLH).

10. We are implementing the cancer recovery care package to ensure care is co-ordinated between primary and acute care so that patients are appropriately followed up and timely access back into the acute sector when needed. This includes stratified pathways for follow-up, initially with breast, colorectal and prostate cancers.

11. The opening of our Macmillan Cancer Information and Support Centre has improved further our patient and carer experience. Expanding the team of volunteers and incorporating other specialists who provide complimentary therapies, we will provide patients and their families with the emotional support to enjoy their survivorship.

12. We will further develop our research trials portfolio and apply to join the Clinical Practice Research Datalink, which supports the use of observational studies and lower cost randomised control studies to embed within every day practice as an integrated care organisation.

13. With our history and committed clinicians who have embraced and disseminated the learning from new models of care to drive efficiency and productivity, we wish to develop further this work to provide seamless care without walls. We will encourage our clinical teams to apply to be pilot sites for NHS England supported projects.

14. To achieve our aspirations to provide world-class cancer care for our local population, we need to invest in our workforce. We need to ensure the clinical leadership is engaged and committed to a culture of innovation and improvement. We need to ensure they have the skills and time built into their job plan to enable our strategy to be delivered.

15. We must work with our commissioners to share our vision and plans for future development so novel services which avoid costly secondary care can be reimbursed at a competitive tariff.

16. We will invest any efficiency savings back into the service to develop further innovation and expansion of successful services, which report an excellent patient experience and demonstrate improved clinical outcomes whilst being cost efficient.

17. All of the above is within our reach in the next year. Our major challenge for local cancer care is the quality of care of our admitted in-patients. We need to look at the current pathways and staff skill mix and work across the disciplines to ensure our patients with cancer who are admitted with an emergency related to their disease are managed by a group of staff who have the skills and compassion to address their holistic as well as medical needs.

Recommendation

The Cancer Team ask that the Board note these proposals and feedback with comments.

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Whittington Health Trust Board

4 February 2015

Title:	Trust Board Report February 2015 (December 2014 data)		
Agenda item:	**15/024**	**Paper**	**7**
Action requested:	For discussion and agreement of areas of focus.		

Executive Summary:

The following is the Performance and Quality Report for December 2014; a number of highlights and areas for focus are identified.

National Indicators

Referral-for-Treatment (RTT): During the last six months, a national programme has been underway to reduce the back log of long waiting patients. Whittington Health agreed a trajectory with the NHS Trust Development Authority (TDA) and Islington Clinical Commissioning Group (CCG), lead commissioner. The trajectory was to reduce time waiting for the RTT pathway, time waiting for outpatient appointments and potential subsequent elective surgery. A plan was developed and implemented with achievement of the national standards at the end of November, and continuation into December. Due to the available capacity within elective surgery, we have also been requested to assist other providers and to increase elective patients treated by the end of the financial year.

Target	November 2014	December 2014
Admitted 90%	90.7%	92.8%
Non-Admitted 95%	95.0%	96.1%
Incomplete 92%	92.2%	92.3%

Emergency Care: A resilience plan was agreed with Islington CCG back in the summer of 2014, this was reviewed and a full assurance rating was agreed by NHS England (NHSE) and the TDA. During November and December, significant demand was placed on the emergency care pathway. This was seen in several ways, increased acuity and complexity in older people presenting to the Emergency Department (ED) and also needing subsequent acute admission, an increase in paediatric presentations to ED, increased need for community services provided by our colleagues in mental health, social care and our services in the community.
Increased demand on intensive care and high dependency beds

	was also seen due to the acuity of the presenting patients. Further planning was completed in November and December with Islington CCG and further funding was released to assist with staffing for ED, bed capacity and also community services. Internal assurance meetings have been held each week and assurance meetings have been held with the TDA and NHSE. A significant rise in patients with mental health conditions was also seen and delays experienced with a demand for mental health beds. There was also the need to pause admissions to two wards due to Influenza A, this was for a limited number of days and only reduced the capacity for seven beds for five days. This is standard practice during the winter period and coordinated by the infection control team and access team. Due to the demand on the emergency care pathway, the planned reductions in surgical bed capacity over the Christmas period could not be undertaken to the full plan. The London Ambulance Service (LAS) target was also of concern due to the demands on LAS. An additional staff member was available to assist with ambulance handovers to ensure no delays in the process of transferring patients into ED. A significant rise has also been seen for district nursing teams as providers discharge patients into the care of community teams, these have been from Whittington Health, UCLH, and North Middlesex. It is worth noting that the 14 improvement schemes, including ambulatory care, have made a significant effect on managing the winter demand and reducing the activity to the emergency department. All additional staffing shifts within the resilience plan (winter) have been filled by firstly overtime, then bank, and finally agency to avoid additional cost pressures. All operational senior staff has been 'back to the floor' to assist with the increases in demand, ensure safety and quality, assist with sickness cover and maintain staff morale. Despite the continued pressure the ED four hour standard has improved to 0.1% below 95%. **Cancer targets:** the cancer board has been implementing a cancer improvement plan over the last twelve months and significant improvements have been made. This has been in care delivery, access to services and also in alignment of staffing resource. The continued improvement in performance has been seen in December by the achievement of all the national standards achieved for the second consecutive month. Additional capacity was provided to other providers in November and December and all these patients have been offered appointments.

Areas to note

Proportion of reported patient safety incidents that are harmful: this measure is being reviewed as a new data capture form was introduced in December 2014. The new reporting with be validated and in place by April 2015.

Complaints: Continued support for divisions to improve response rate has been provided. Due to recruitment of a Quality Officer for Surgery, Cancer and Diagnostics (SCD), the trajectory is that this division will improve in January through April.

Infection Control: one incident of MRSA bacteraemia has been reported in December. A review meeting has been held with the frontline staff involved, the governance team and SCD Divisional Director, Head of Nursing, and Director of Operations. The action plan from the meeting has been put in place including reminders for management of venous site, hand hygiene and communication with the patient. The communication of learning form this meeting will also be spread across the organisation.

Summary of report:

QUALITY

- Inpatient deaths: there has been a rise in the number of patients who have died; the main group being older people with respiratory disease.
- Completion of valid NHS number: Improved despite increased continued demand on ED which affects compliance as it is an extra step in the processes, Inpatient and Outpatient Department (OPD) NHS number completion is being led by the Assistant Director for Cancer and Outpatients.
- Summary Hospital-level Mortality Indicator (SHMI): Whittington Hospital mortality rate remains lower than expected for the Trust.
- Hospital Standardised Mortality Ratio (HSMR): the information department are contacting Dr Foster as we believe that a change has occurred in the rebasing the standard factors which changes the relative risk rate. The Board will be updated on this at the meeting.

PATIENT SAFETY

- Harm Free Care: Achieved
- VTE assessment: Achieved
- Medication errors causing moderate/low harm: Action plans in place with close monitoring.
- Never events: none
- Central Alerting System (CAS) alerts: none
- Serious incidents reported: all incidents are fully

investigated and learning is shared.

PATIENT EXPERIENCE

- Friends and Family Test (FFT): the performance has achieved and use of 'you said, we did' displays are in inpatient wards, and will be introduced into OPD
- Mixed Sex Accommodation: no breaches
- Patient admission to adult facilities for under 16 years of age: no breaches

INFECTION PREVENTION

- Hospital acquired C Difficile infection: 1 in December 2014. A review has taken place and the action progressed, increased communication has been provided.
- Hospital acquired E.coli infections: none
- Hospital acquired MSSA infections: 1 in December 2014. The patient was treated following the guidance procedure and was discharged home following treatment.
- Ward Cleanliness: remains at 98%

ACCESS

- Diagnostic waits: Achieved
- 52 weeks wait: none
- Community access: District Nursing and Musculoskeletal (MSK) referrals increasing, plans in place.
- Genito-urinary Medicine (GUM): Change in reporting covering Haringey residents only from December 2014.

November Board – two specific questions had been asked at the November Board meeting. These are detailed below.

<u>MSK Service - Difference between the MSK metrics</u>

There are different metrics with different definitions:

1. The Board metric is based on a count of the number of clock stops (**patients treated**) within the month - the prescribed performance indicator

2. The MSK waiting list charts in the presentation are a count of patients **still waiting to be seen** taken from each of the weekly patient tracking list (PTL) reports (a series of snapshots) – this looks at the size and shape of the waiting list.

<u>Maternity Staffing and costs</u>

Staffing is the biggest cost for a maternity services and we currently have the following staff;

- 9.4 whole time equivalent (WTE) midwives on long term sick leave
- 4.47 staff on maternity / accrued annual leave

	• 5.53 staff have departed maternity in December (left or joined the Health Visiting course) This is **13.6%** of the total number of midwives. We have recruited nine WTE more band six midwives who will be starting to work for the Trust from the 2nd February and the staff returning from maternity leave will be back at work in February. Bookings and birth figures are reviewed and staffing levels adjusted to the presenting demands. **Presentation:** The Access Centre will be providing a project update.
Summary of recommendations:	That the Board notes the performance.
Fit with WH strategy:	All five strategic aims.
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	21st January 2015

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

February Trust Board Report (December data)

Whittington Health NHS

Quality	Threshold	Oct-14	Nov-14	Dec-14
Number of Inpatient Deaths	-	24	27	54
NHS number completion in SUS (OP & IP)	99%	98.6%	98.3%	arrears
NHS number completion in A&E data set	95%	87.5%	91.3%	arrears

Quality (Mortality index)	Threshold	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
SHMI	-	0.63	0.54	0.54

Quality (Mortality index)	Threshold	Jun-14	Jul-14	Aug-14
Hospital Standardised Mortality Ratio (HSMR)	<100	60.56	85.91	101.94
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	17.0	63.3	111.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	71.9	95.7	100.5

Patient Safety	Threshold	Oct-14	Nov-14	Dec-14
Harm Free Care	95%	93.7%	94.4%	95.4%
VTE Risk assessment	95%	95.1%	95.1%	arrears
Medication Errors actually causing Serious/Severe Harm	-	0	0	1
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	1	0
Proportion of reported patient safety incidents that are harmful	-	52.5%	44.4%	arrears
Serious Incident reports	-	7	6	8

Access Standards

Referral to Treatment (in arrears)	Threshold	Sep-14	Oct-14	Nov-14
Diagnostic Waits	99%	100%	99.6%	99.8%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Meeting threshold

Patient Experience	Threshold	Oct-14	Nov-14	Dec-14
Patient Satisfaction - Inpatient FFT (% recommendation)	-	89%	88%	94%

Efficiency and productivity - Community	Threshold	Oct-14	Nov-14	Dec-14
Service Cancellations - Community	2%	7.70%	7.70%	7.70%
DNA Rates - Community	10%	7.9%	7.6%	6.9%
Community Face to Face Contacts	-	68,463	63,382	58,199
Community Appts with no outcome	0.5%	1.2%	3.4%	1.0%

Community Access Standards	Threshold	Oct-14	Nov-14	Dec-14
Community Dental - Patient Involvement	90%	95.0%	99.0%	98.0%
Community Dental - Patient Experience	90%	99.0%	99.0%	100.0%
MSK Waiting Times - % waiting less than 6 weeks when seen that month	100%	93.4%	85.1%	83.5%
MSK Waiting Times - Consultant led (<18 weeks)	95%	80.0%	89.1%	arrears
IAPT - patients moving to recovery	50%	45.0%	47.0%	arrears
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Oct-14	Nov-14	Dec-14
First:Follow-up ratio - acute	2.31	1.63	1.63	1.66
Theatre Utilisation	95%	81.9%	82.9%	79.0%
Hospital Cancellations - acute - First Appointments	<2%	6.6%	6.0%	5.4%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.5%	7.6%	6.7%
DNA rates - acute - First appointments	8%	12.3%	12.8%	14.1%
DNA rates - acute - Follow-up appts	8%	13.3%	14.0%	13.8%
Hospital Cancelled Operations	0	7	15	2
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	0

Failed threshold

Emergency and Urgent Care	Threshold	Oct-14	Nov-14	Dec-14
Emergency Department waits (4 hrs wait)	95%	93.4%	92.4%	94.9%

February Trust Board Report (December data)

Whittington Health NHS

Patient Satisfaction - ED FFT (% recommendation)	-	89%	88%	87%
Patient Satisfaction - Maternity FFT (% recommendation)	-	92%	91%	n/a
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	30	35	26
Complaints responded to within 25 working day	80%	76.67%	71.43%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

ED Indicator - median wait for treatment (minutes)	60	78	85	70
30 day Emergency readmissions	-	270	240	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	2.8%	2.7%	2.7%
Ambulance Handover (within 30 minutes)	0	6	4	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Oct-14	Nov-14	Dec-14
Hospital acquired MRSA infection	0	0	0	1
Hospital acquired *C difficile* Infections	19 YTD	1	1	1
Hospital acquired *E. coli* Infections	-	2	2	0
Hospital acquired MSSA Infections	-	0	0	1
Ward Cleanliness	-	98.2%	98.1%	-

Cancer Access Standards (in arrears)	Threshold	Sep-14	Oct-14	Nov-14
Cancer - 14 days to first seen	93%	91.6%	94.9%	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	90.8%	97.1%	93.5%
Cancer - 31 days to first treatment	96%	100.0%	97.9%	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%	91.1%	98.0%	88.0%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold		Sep-14	Oct-14	Nov-14
Referral to Treatment 18 weeks - Admitted	90%	Projected	84%	84%	90.7%
		Actual	75.6%	83.3%	
Referral to Treatment 18 weeks - Non-admitted	95%	Projected	72%	72%	95.0%
		Actual	91.5%	89.9%	
Referral to Treatment 18 weeks - Incomplete	92%	Projected	80%	80%	92.2%
		Actual	85.7%	84.9%	

Maternity	Threshold	Oct-14	Nov-14	Dec-14
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.9%	92.4%	85.7%
New Birth Visits - Haringey	95%	85.4%	85.0%	arrears
New Birth Visits - Islington	95%	89.8%	91.4%	arrears
Elective Caesarean Section rate	14.80%	12.0%	13.7%	12.9%
Breastfeeding initiated	90%	89.1%	88.7%	92.2%
Smoking at Delivery	<6%	5.4%	4.9%	4.9%

Meeting threshold Additional capacity funding Failed threshold

	Threshold	Trust Actual		
		Oct-14	Nov-14	Dec-14
Number of Inpatient Deaths	-	24	27	54
Completion of a valid NHS number in SUS (OP & IP)	99%	98.6%	98.3%	arrears
Completion of a valid NHS number in A&E data sets	95%	87.5%	91.3%	arrears

	Standardised National Average	Jun-14	Jul-14	Aug-14
Hospital Standardised Mortality Ratio	<100	60.56	85.91	101.94
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	17.0	63.3	111.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	71.9	95.7	100.5

		Lower Limit	Upper Limit	RKE SHMI Indicator
Summary Hospital Mortality Indicator (SHMI)	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: Number of inpatient deaths increased in December.

Action: Analysis of data including age has been done and the increase is seen in respiratory illnesses in older people.

Timescale:

Completion of valid NHS number

Issue: Improving, although continuing demands on A&E affects compliance.

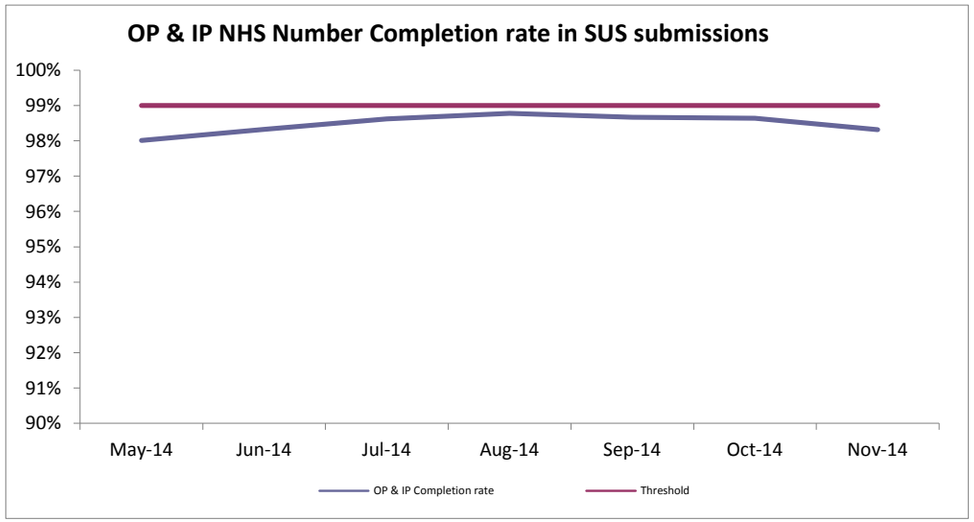
Action: Policies are re-enforce and procedures on completing NHS number in EPR are in place.

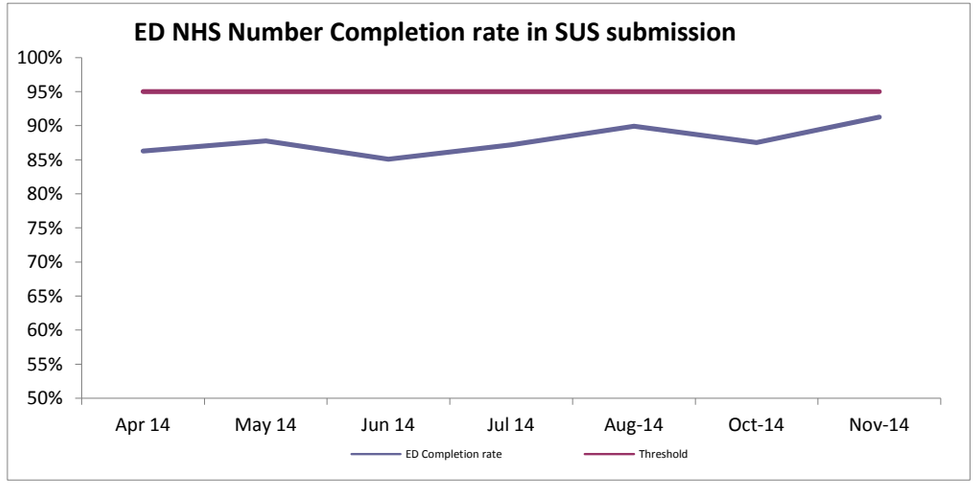
SHMI

WH score remains below the lower limit which therefore, indicates that the mortality rate remains lower than expected at our Trust. The continued improvement appears to be related to an increase in hospital spells whilst inpatient deaths remain constant.

HSMR

Issue: investigating with Dr Foster re change to relative risk index.



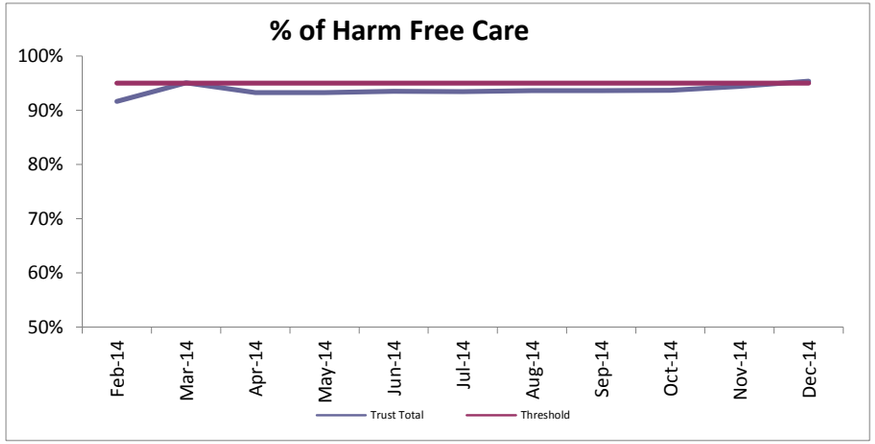


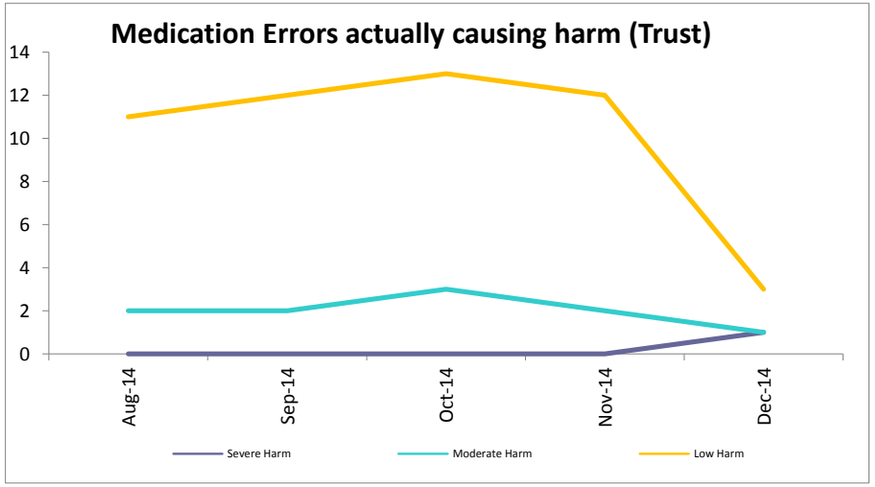
Patient Safety

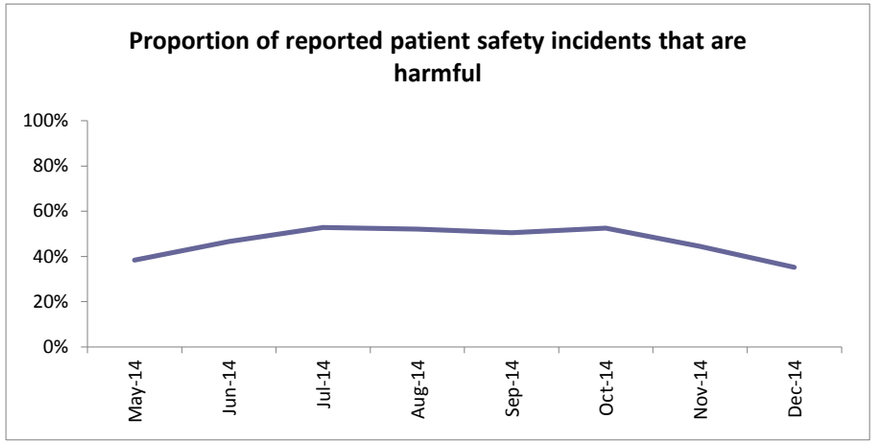
Whittington Health NHS

Data extracted on 13/01/2015

	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	Dec-14 ICAM	Dec-14 SCD	Dec-14 WCF
Harm Free Care	95%	94.4%	95.4%	94.3%	98.8%	100.0%
Pressure Ulcers (prevalence)	-	5.34%	3.88%	4.80%	1.25%	0.00%
Falls (audit)	-	0.18%	0.27%	0.35%	0.00%	0.00%
VTE Risk assessment	95%	95.1%	arrears	Reported one month in arrears		
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	1	1	0	0
Medication Errors actually causing **Moderate** Harm	-	2	1	0	1	0
Medication Errors actually causing **Low** Harm	-	12	3	1	2	0
Never Events	0	0	0	0	0	0
Open CAS Alerts (Central Alerting System)	-	1	0	-	-	-
Proportion of reported patient safety incidents that are harmful	-	44.4%	arrears	arrears	arrears	arrears
Serious Incidents (Trust Total)	-	6	8	8	0	0







Commentary

Harm Free Care

Issue: Achieved target.

Action: Continued HFC monitoring and learning from reviews is in place. Thematic Action plan in community in place to reduce the number of pressure ulcers acquired by patients under the care of Whittington Health by addressing issues identified in the investigation of pressure ulcer incidents.

Timescale: On-going

Medication Errors actually causing harm

Issue: the reported Serious medication error has been reviewed and did not occur whilst under the care of Whittington Health. The moderate error relates to prescribed specialist food not being available and a substitute prescribed. Low harm incidents are related to procedural and medical devise errors.

Action: The Serious harm error has now been re-graded to moderate harm. LAS has been informed of the incident to investigate.

Timescale: completed

Proportion of reported patient safety incidents that are harmful

Issue: In arrears due to reporting issues.

Action: The change to the incident form implemented in December 2014 has shown to affect data reporting. Incident reporting form and all incidents reported in December and January to be reviewed and corrected.

Timescale: immediately

Serious Incidents

Issues: 5 out of the 8 SI reported in December 13 were Pressure Ulcers

Action: All serious incidents are investigated and subsequently discussed at divisional level (Divisional Quality Committee), Trust Operational Board, Trust Quality Quality Committee and Commissioning Quality Review Group. After the investigations recommendations are made, notible practice observed, lessons learned shared and an action plan is put in place.

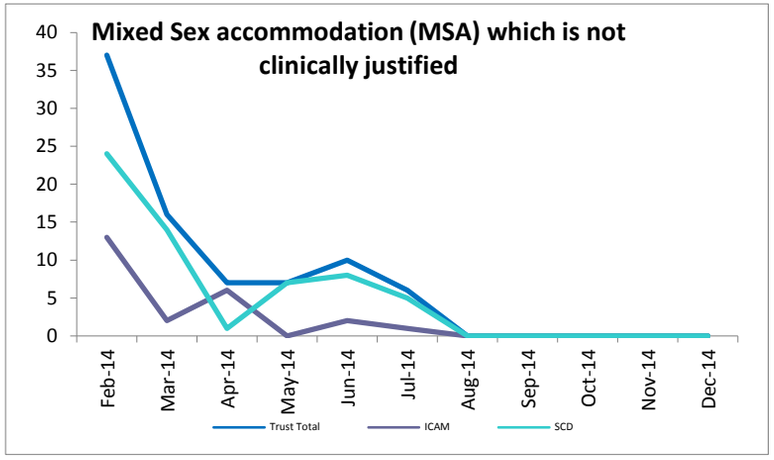
Patient Experience

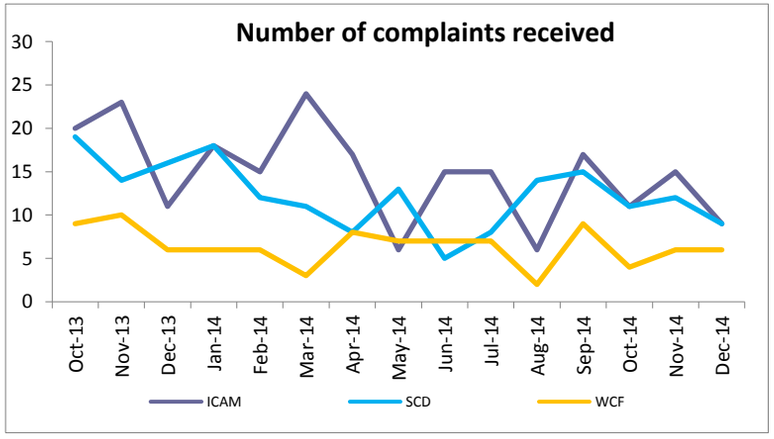
Whittington Health NHS

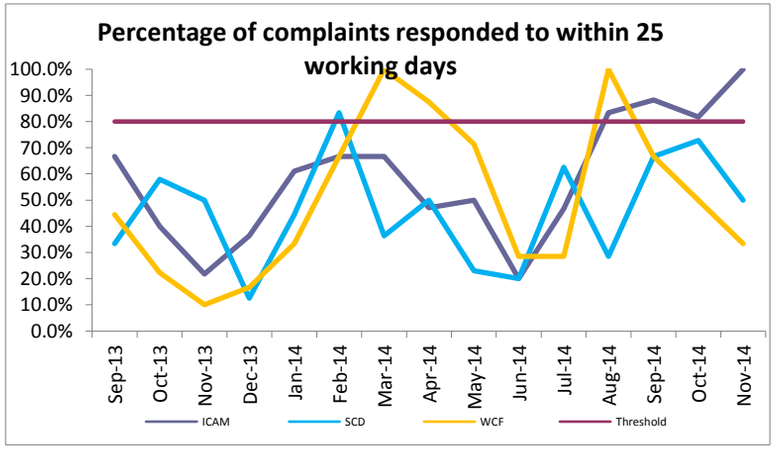
	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	Dec-14 ICAM	Dec-14 SCD	Dec-14 WCF
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	87.5%	93.8%	97.3%	88.0%	100.0%
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	87.9%	87.0%	87.0%	-	-
Patient Satisfaction - Maternity FFT (% recommendation) **	-	90.5%	87.2%	-	-	87.2%
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	0
Complaints (**incl Corporate**)	-	35	26	9	9	6
Complaints responded to within 25 working day	80%	71.43%	arrears	100.0% *	50.0% *	33.3% *
Patient admission to adult facilities for under 16 years of age	-	0	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

The nationally mandated scoring method for FFT has changed to make it simpler and more suitable for NHS Hospital Trusts. It shows percentage of patients satisfied. There are currently no targets set.

Issue: Overall score improved, Maternity FFT manually collated.

Action: Maternity FFT Electronically devise to collate feedback has broken down and feedback is now collated manually. Friend and Family Tests are now becoming embedded. 'You said we did' is being spread across all services. Examples:

Coyle Ward

'You said': Friendly staff who keep you informed, very honest and open. All working very hard around the clock.

'We did': We have shared your feedback with our staff who were pleased to hear our patients had a positive experience. We will continue to remind staff each day as a way of maintaining good practice.

Maternity

'You said': Noisy ward at night'

'We did': Reminding staff and patients to keep noise down at night, turning lights down and reminding people about use of mobile phones '

Timescale: monthly updated with comments follow FFT reports.

Mixed Sex Accommodation

A policy and processes embedded in the services and no breaches for 5 consecutive months.

Complaints

Issue: Overall score fallen by 5%

Action: Action plan embedded, key themes analysed. Report to Quality Committee in January 2015 identified clinical care and communication as the highest categories. Extra support is in place for 2 of 3 divisions.

Timescale: Expectation to be compliant when all divisions have support in place.

Infection Prevention

Whittington Health NHS

	Trust Actual		Dec-14		
	Threshold	Nov-14	Dec-14	ICAM	SCD	WCF
MRSA	0	0	1	0	1	0
E. coli Infections*	-	2	0	-	-	-
MSSA Infections	-	0	1	0	0	0

	Threshold	Dec 14	YTD	ICAM	SCD	WCF
C difficile Infections	19 (Year)	1	14	0	1	0

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

Ward Cleanliness

Audit period

	01/02/14 to 09/04/14	04/03/14 to 03/04/14	09/05/14 to 12/06/14	01/07/14 to 15/08/15	01/09/14 to 02/10/14	06/11/14 to 16/12/14
Trust %	97.5%	97.6%	97.9%	97.7%	98.2%	98.1%

Commentary

MRSA

Issue: The Trust's first patient in 14 months with MRSA bacteraemia was diagnosed on Coyle ward on 19th December. The PIR meeting took place on 6/1/15. The issues identified were compliance with checking and removal of peripheral cannulae and hand hygiene compliance.
Action: Review completed and action plan in place.
Reminder sent to all staff regarding compliance with hand hygiene policy and cannula care.
Ward sister and matron reviewing all patients with cannula daily to monitor compliance with policy.
Timescale: On-going-for review in 4 weeks.

E.coli Infection and MSSA

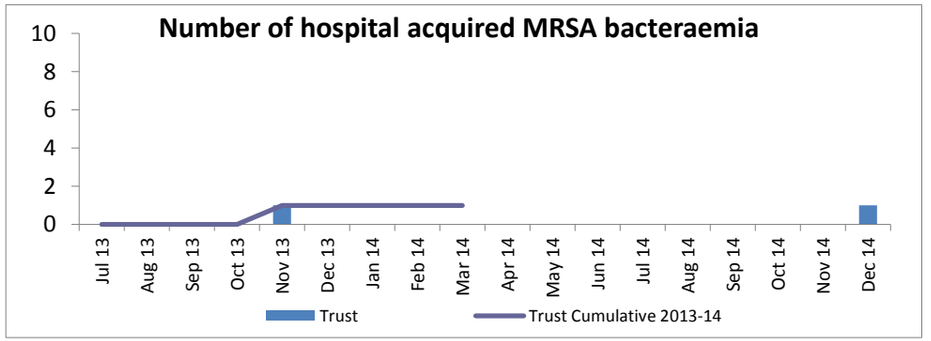
Issue: No new E. coli infections in December. One MSSA identified in December 14.
Action: Action plan in place. Patient placed in side room as per protocol.
Timescale: Immediate

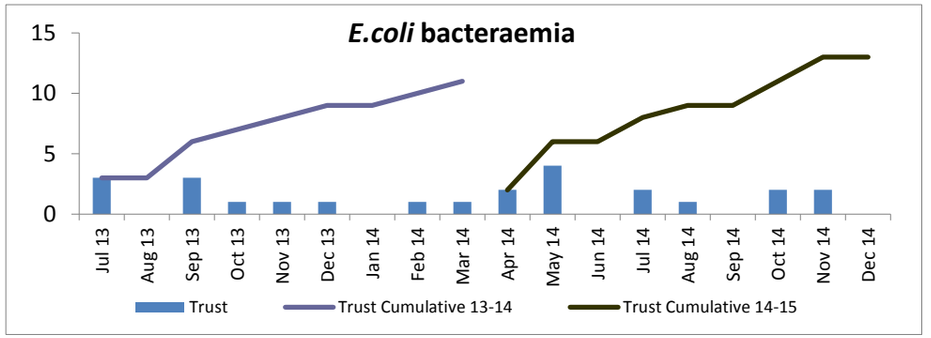
C Difficile

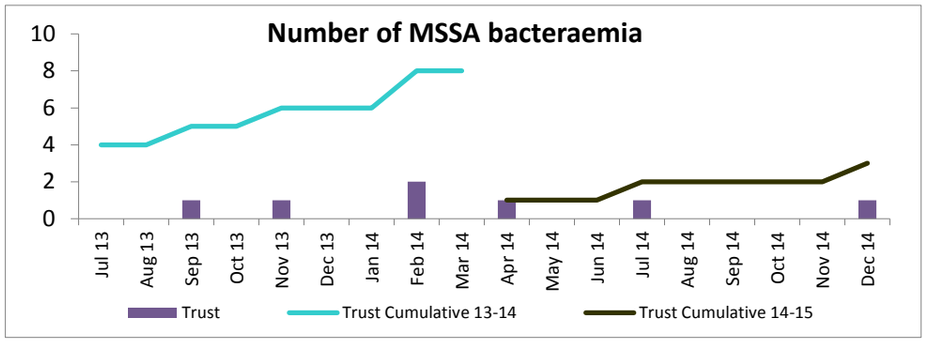
Issue: 14 cases ytd
Action: Plans in place following RCA findings. Meeting held with the infection control nurse, matron and nursing staff to share learning outcomes and provisions that will be put in place.
Timescale: February 2015

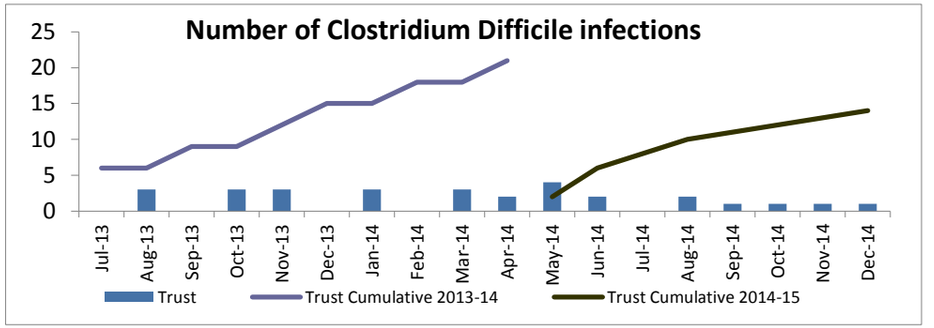
Ward Cleanliness

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.





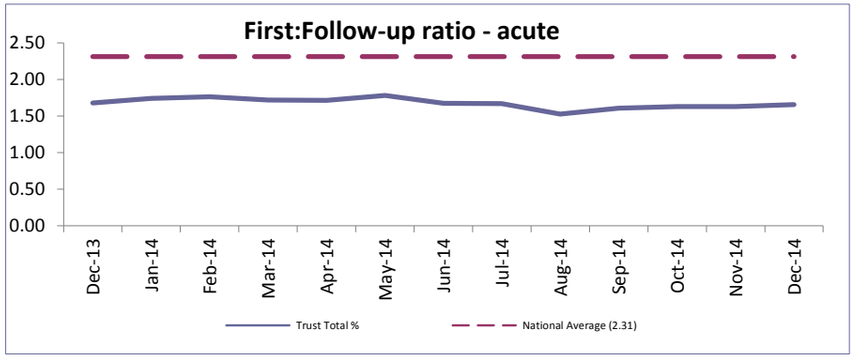


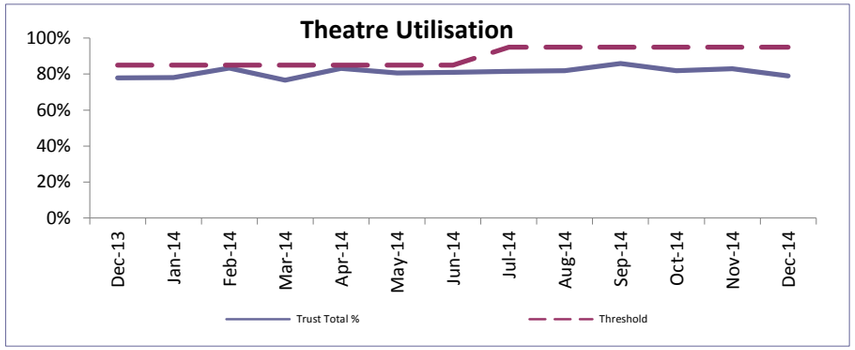


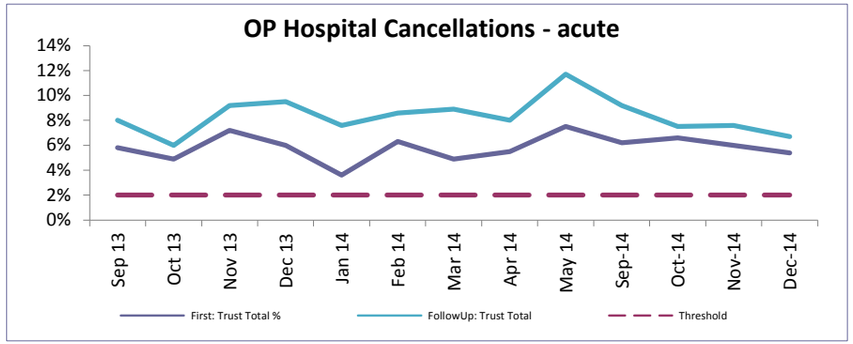
Efficiency and productivity - acute

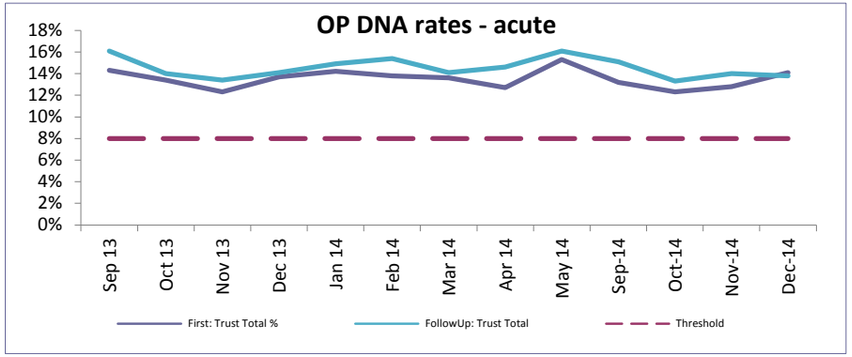
Whittington Health NHS

	Dec-14				
	Threshold	Trust Actual	ICAM	SCD	WCF
First:Follow-up ratio - acute	2.31	1.66	1.94	1.74	1.13
Theatre Utilisation	95%	79.0%	51.2%	77.9%	87.6%
Hospital Cancellations - acute - First Appointments	<2%	5.4%	6.2%	8.1%	2.0%
Hospital Cancellations - acute - Follow-up Appointments	<2%	6.7%	9.2%	7.5%	3.5%
DNA rates - acute - First appointments	8%	14.1%	17.7%	14.7%	10.6%
DNA rates - acute - Follow-up appointments	8%	13.8%	9.2%	15.3%	11.2%
Hospital Cancelled Operations	0	2	0	1	1
Cancelled ops not rebooked < 28 days	0	0	0	0	0
Urgent Procedures cancelled	0	0	0	0	0
Urgent Procedures cancelled (of these how many cancelled 2nd time)	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. The Value Improvement Program for Out Patients will continue to monitor and improve new to follow up ratios by unit.

Theatre Utilisation
Issue : Theatre utilisation fluctuating between 80 and 85% utilisation.
Action : Weekly theatre meetings in place. New activity tracking system is now in place and also there are theatre leaders on the ground every morning to make sure lists start on time. Fluctuation in results within ICAM being investigated.
Timescale: Feedback in March board meeting.

Hospital Cancellations - acute
Issue: Fewer patients are now being moved into earlier appointments and the number of hospital cancellation has come down. Booking Team are continuing to identifying any unused clinic slots to pull patient appointments forward.
Action: Tracking and cancelling at Consultant level are being address.
Timescale: Additional capacity work has now been completed and steady improvement is now expected.

Did not attend
Issue: a slight increase is noted over the festive period.
Action: DNA rates by specialty are being monitored. Learning from Paediatric pilot have been shared.
Timescale: Further reduction of DNA expected after learning is embedded completion January 2015

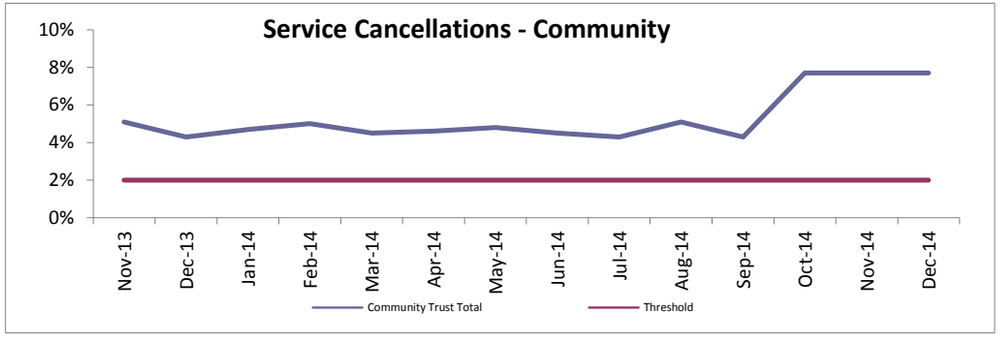
Hospital Cancelled Operations
Issue: There were two cancellations in December due to non-clinical reasons, both patients were clinically categorised as routine. One due to list overrun (complications with earlier patients) and the other due to surgical team not ordering specialist equipment. Both have been rebooked within the 28 day period.

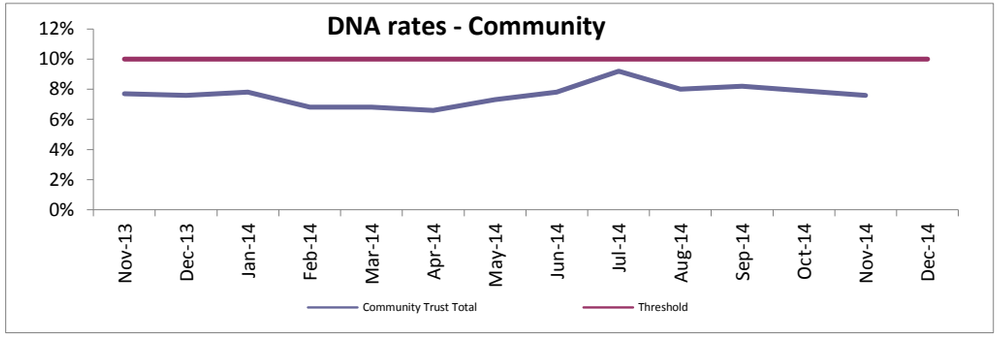
Efficiency and productivity - Community

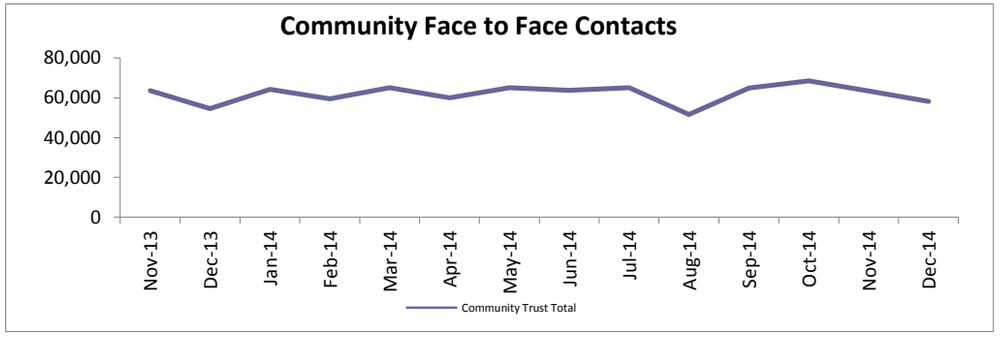
Whittington Health NHS

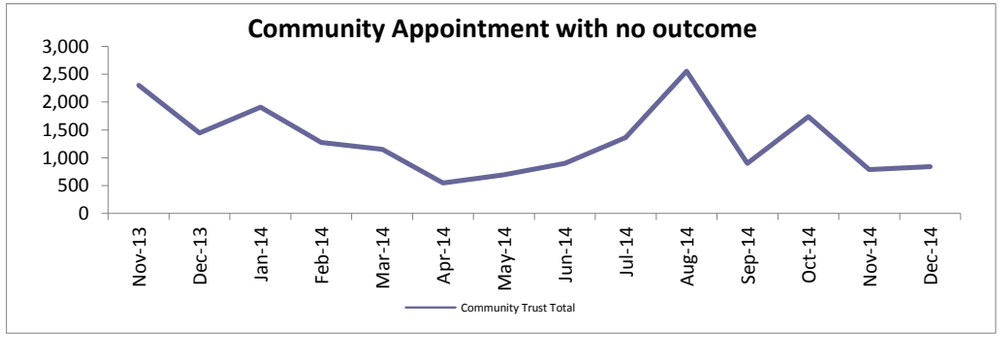
	Dec-14				
	Threshold	Trust Actual	ICAM	SCD	WCF
Service Cancellations - Community	2%	7.7%	7.8%	5.0%	7.6%
DNA Rates - Community	10%	6.9%	6.6%	14.2%	7.6%
Community Face to Face Contacts	-	58,199	41,822	1,406	14,971
Community Appointment with no outcome	0.5%	1.0%	0.8%	0.0%	1.8%

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









Commentary

Service Cancellations - Community
Issue: Community service cancellation remains at 7.7%
Action: The improvement plan for waiting list management in the community continues and includes review of all templates and increase in filling unfilled late cancelations by patients.
Timescale: The threshold to be achieved after completion of additional capacity work in January 2015.

DNA Rates - Community
Community clinics - Achieved.
Community Dental DNA's is increasing slightly from 13 to 14.2%. Actions are being taken to remind patients regarding their appointments including text and phone call reminders.

Community Face to Face Contacts
Face to face contacts have increase by 6%, compared to the same month last year.

Community Appointment with no outcome
November data submission was completed before the final data submission deadline (freeze date)
Issue: Above the threshold, but overall reduced compared to last month.
Action: Teams with high levels of un-outcomed appointments identified and processes to outcome appointments within 48 hours re-enforced.
Timescale: immediately

	Threshold	Trust Actual Oct-14	Nov-14	Dec-14	YTD
Community Dental - Patient Involvement	90%	95.0%	99.0%	98.0%	n/a
Community Dental - Patient Experience	90%	99.0%	99.0%	100.0%	n/a
District Nursing Waiting Times - 2hrs assessment	-	100%	100%	100%	TBC
District Nursing Waiting Times - 48 hrs for visit	-	100%	100.0%	100.0%	TBC
MSK Waiting Times - Routine MSK (<6 weeks)	100%	93.4%	85.1%	83.5%	-
MSK Waiting Times - Consultant led (<18 weeks)	95%	80.0%	89.1%	arrears	90.6%
IAPT - patients moving to recovery	50%	45.0%	47.0%	arrears	-
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%	99.8%

Commentary

Dental

Patient Involvement and Experience consistently score above threshold.

District Nursing

The two response times for District Nursing being 2 hours for assessment and 48 hours are being met. **Issue:** Data collection for both targets is manual. RiO is not able to collate this electronically.
Action: Manual collection of data in place and electronic process being commenced.
Timescale: NHS Elect are supporting capacity and demand modelling in District Nursing.

MSK

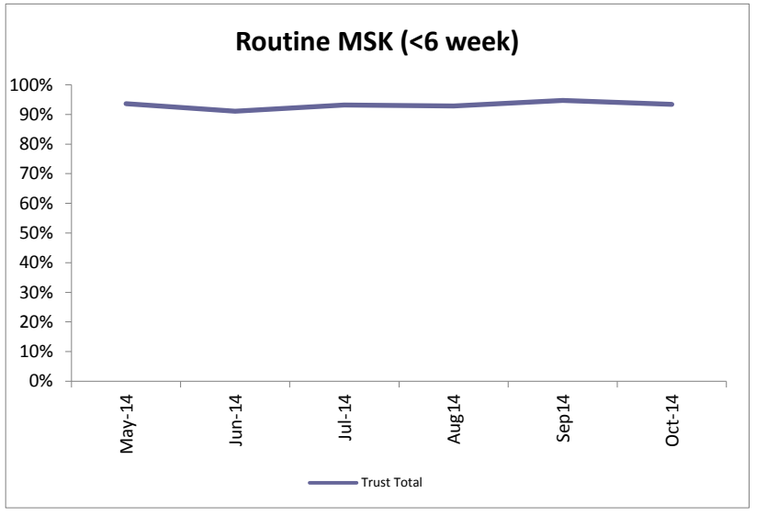
Issue: The 6 weeks and 18 weeks are performing under target, this is mainly due to the increase in demand on the service. Additional staff and also moving clinics to locations with high demand have been undertaken. Upgrade of Patient Record system in November 2014 also changed parameters of reporting which may be affecting the performance figures, however manual checks are being carried out to ensure booking of patients.
Action: Validating work is underway in conjunction with the Information Team.
Timescale: To complete in January 2015.

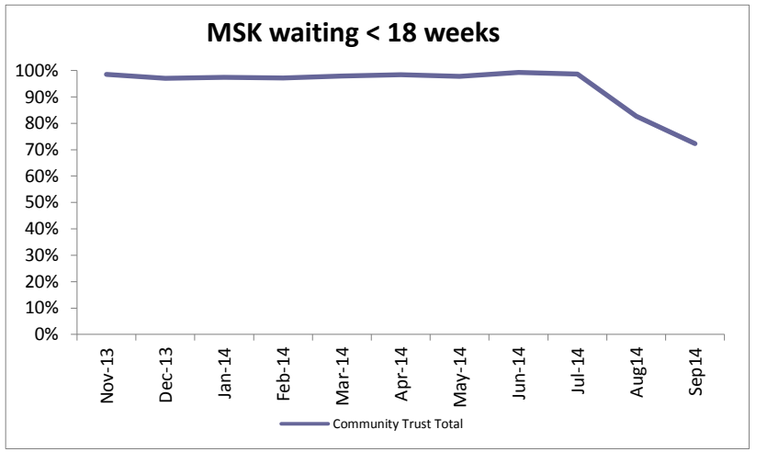
IAPT

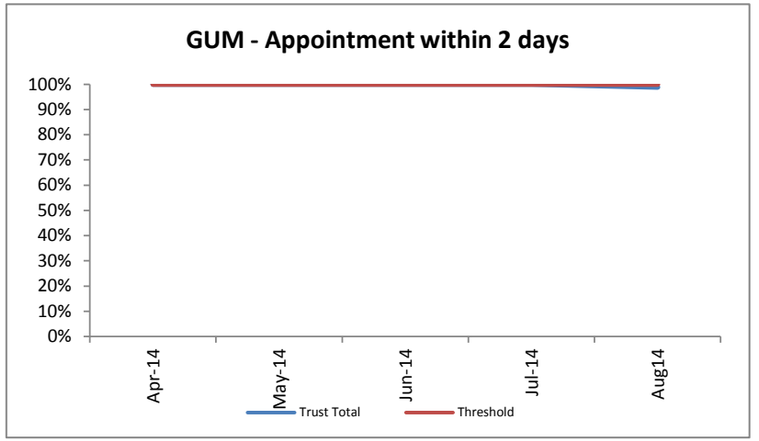
The national measure is improving month on month . An improvement plan is in place, closely monitored jointly with CCG Haringey.
A clinical measure of reliable recovery remains at 55%.

GUM

Please note: Change in reporting for Sexual Health Service Haringey. As of December 2014 only Haringey residents will be included in the figures.







	Nov-14 (arrears)					
	Threshold		Trust Actual	ICAM	SCD	WCF
Referral to Treatment 18 weeks - Admitted	90%	Trust Actual	90.7%	71.4%	90.1%	95.1%
Referral to Treatment 18 weeks - Non-admitted	95%	Trust Actual	95.0%	94.1%	94.1%	98.2%
Referral to Treatment 18 weeks - Incomplete	92%	Trust Actual	92.2%	95.0%	89.3%	98.0%
Referral to Treatment 18 weeks - 52 Week Waits	0		0	0	0	0
Diagnostic Waits	99%		99.8%	100.0%	97.8%	99.2%

Commentary

RTT

Following a 6 months of planned reduction in long waiting patients the RTT targets have been achieved as per trajectory. Additional activity is being planned duruing January, February and March to decrease further waiting for patients.

Diagnostic Waits

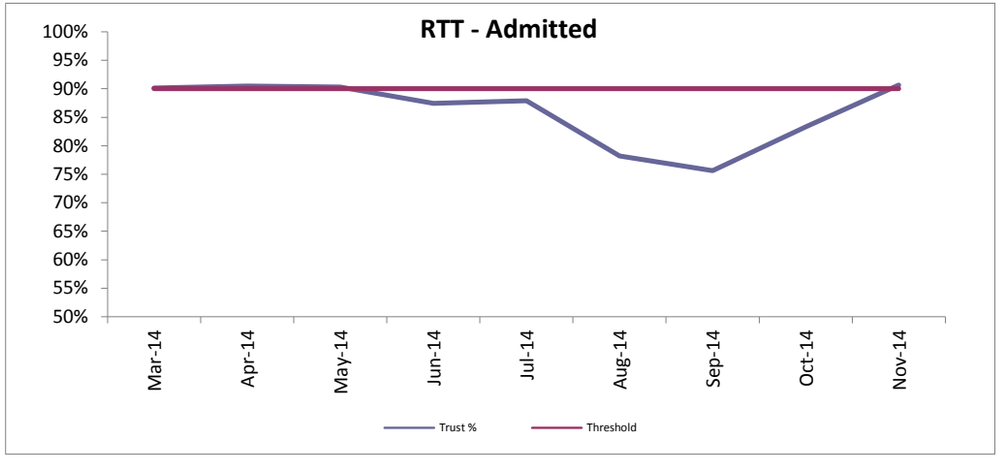
Target achieved.

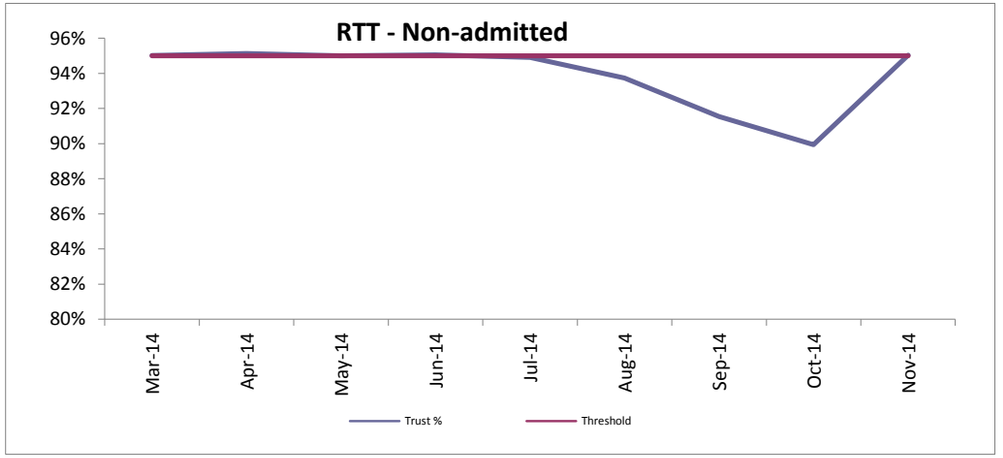
A weekly PTL meeting (waiting list meeting) is chaired with the COO and each waiting list is cross checked and capacity and demand discussed. The current waiting times for first consultant routine appointment within specialisties are below;

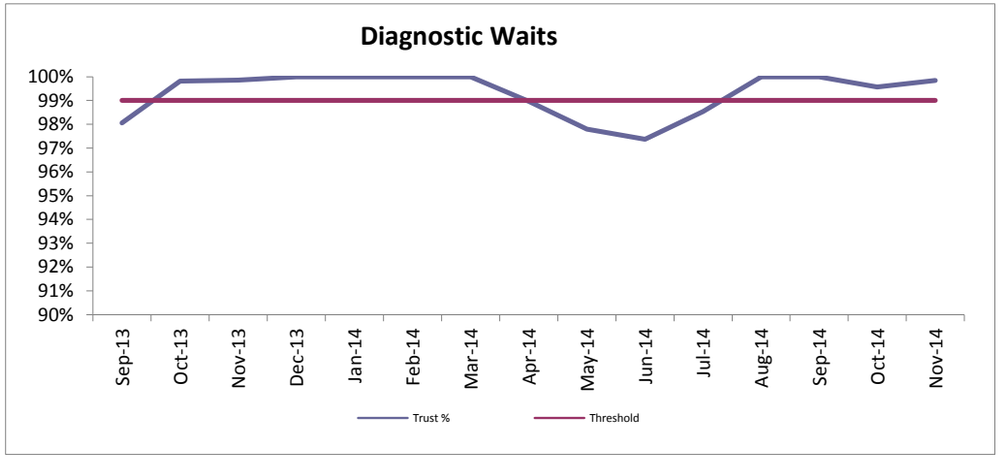
Cardiology 8 Weeks, Dermatology 7 Weeks, Endocrine 10 Weeks, ENT 6 Weeks, Gastroenterology 7 Weeks, General Surgery 7 Weeks, Gynaecology 6 Weeks, Neurology 11 Weeks, Pain 13 Weeks, Rheumatology 6 Weeks, Thoracic Medicine 11 Weeks, Urology 7 Weeks, Vascular 11 Weeks.

Diagnostic RTT (Radiology) waiting times are also below;

CT 4 weeks , MRI 2 weeks , Nuclear Medicine 2 weeks, DEXA 3-4 weeks , Fluoroscopy 2 weeks, Ultrasound (Gynae) 2 weeks , Ultrasound General (Radiologist Lead) 3-4 weeks , Ultrasound Abdomen & Gynae at Hornsey General 2 weeks .



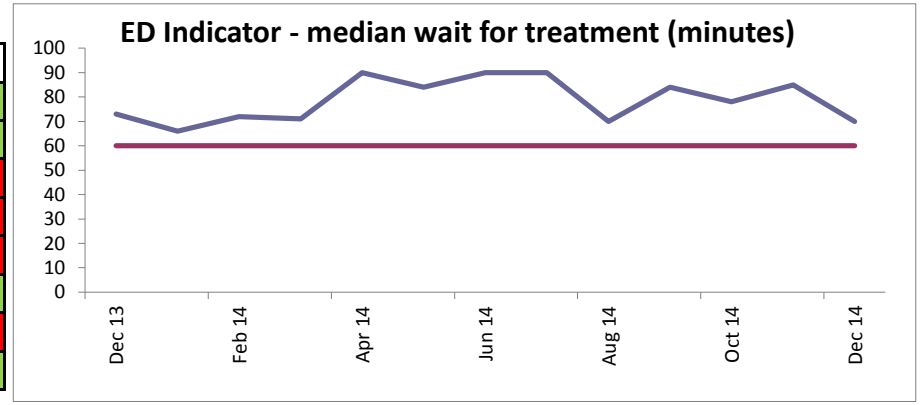




Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	YTD
Emergency Department waits (4 hrs wait)	95%	92.4%	94.9%	95.2%
Wait for assessment (minutes - 95th percentile)	<=15	14	17	15
ED Indicator - median wait for treatment (minutes)	60	85	70	84
Total Time in ED (minutes - 95th percentile)	<=240	360	265	476
ED Indicator - % Left Without Being seen	<=5%	5.2%	3.9%	5.8%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	4	arrears	31
Ambulance handovers exceeding 60 minutes	0	0	arrears	0



Commentary

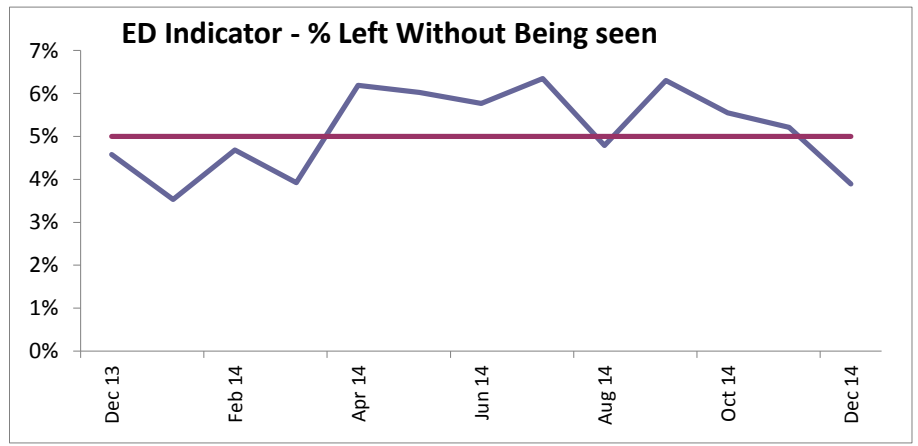
Further increased activity has been seen in A&E in November and December. The Emergency Department standard is 0.1% below target for December 2014. The mean average time from arrival to departure for admitted patients was 272 minutes. Bed pressures were further indicated by an average in patient length of stay of 5.2 days whereas the Q3 average is 4.6 days.

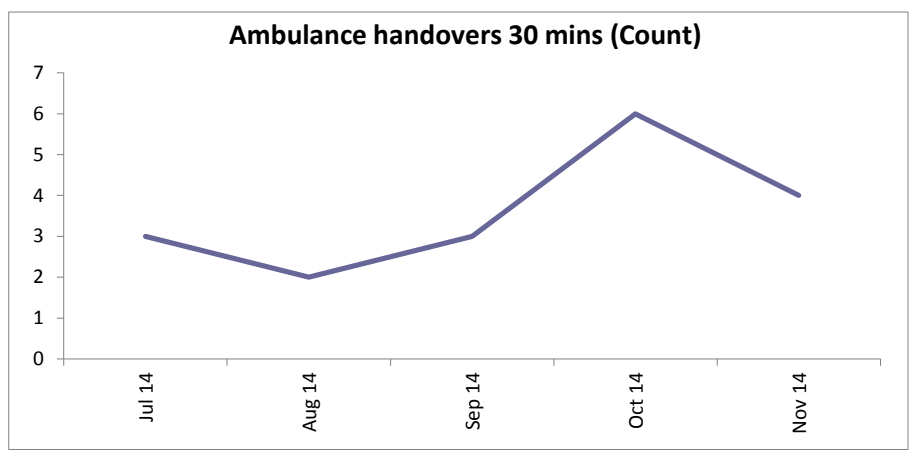
The system resilience group has agreed and gained assurance that the resilience plan (winter plan) was aligned to demand. Further plans have been agree to support emergency care patients and achievement of the national standard.

All additional resources are in place for the first stage plan (resilience 1) and all additional resources will be in place (resilience 2) by the middle of November, and further resources in December (resilience 3).

Whittington Health is working with all providers to ensure patient flow, senior staff have also been asked to support inpatient wards, and access centre to ensure any delays in patient flow are progressed asap. Strong working relationships are being seen with Social Care, London Ambulance Service (LAS), other hospitals and voluntary sector.

Ensuring patient flow has been a essential to allow LAS to hand over patients and return to meet LAS demand.





Cancer

Whittington Health NHS

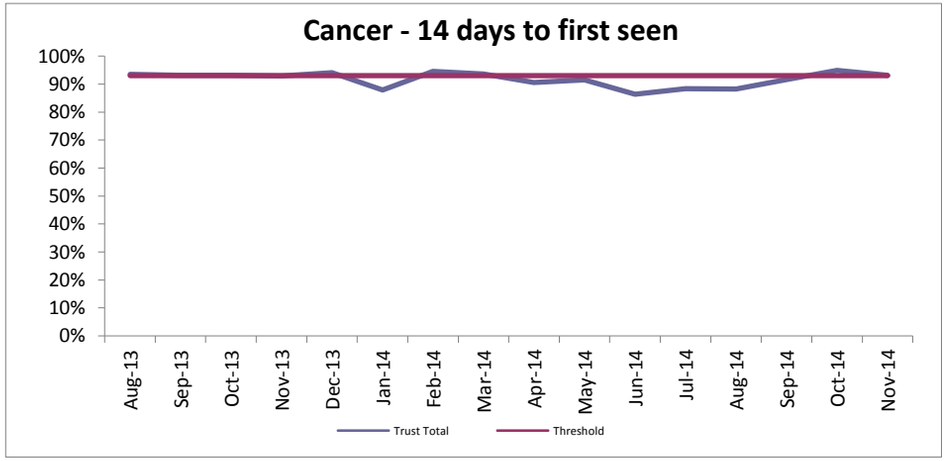
	Threshold	Nov-14 Trust Actual	ICAM	SCD	WCF	2014/15 Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.2%	87.8%	95.1%	89.3%	89.3%	88.9%	94.9%		90.2%
Cancer - 14 days to first seen - breast symptomatic	93%	93.5%	-	93.5%	-	83.7%	93.4%	97.1%		89.3%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%		99.6%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	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%		100.0%
Cancer - 62 days from referral to treatment	85%	88.0%	69.2%	100.0%	-	91.5%	89.6%	98.1%		91.4%
Cancer - 62 days from consultant upgrade	-	0%	-	0%	-	75.0%	100%	-		73.3%

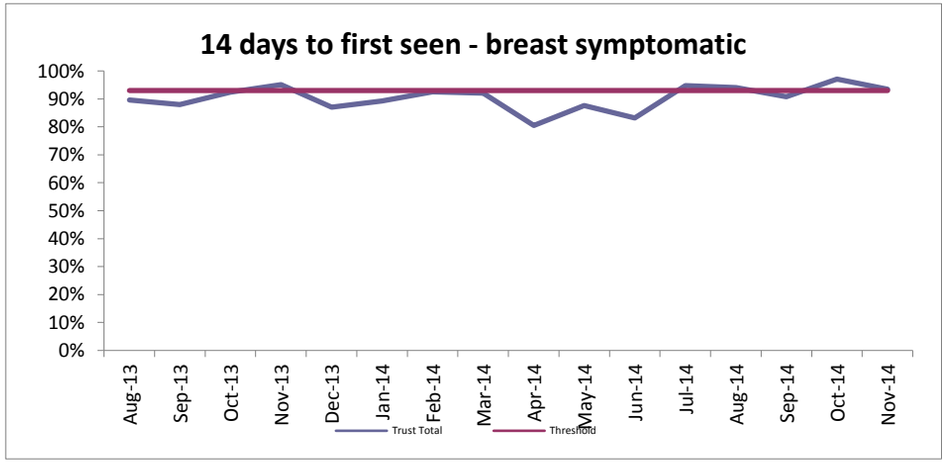
Commentary

Overall all cancer targets were achieved this month.

The Cancer Patients tracker list is monitored daily and discussed in the weekly operational meeting with review at monthly performance meeitngs and quarterly at the cancer board.

Whittington Health also provided support to other trusts who needed additional capacity, all these patients have been treated or offered appointment.





	Threshold	Trust Actual Oct-14	Nov-14	Dec-14	YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.9%	92.4%	85.7%	86.0%
New Birth Visits - Haringey	95%	85.4%	85.0%	Arrears	89.2%
New Birth Visits - Islington	95%	89.8%	91.4%	Arrears	91.2%
Elective Caesarean Section rate	14.80%	12.0%	13.7%	12.9%	10.7%
Emergency Caesarean Section rate	-	19.3%	17.5%	16.9%	19%
Breastfeeding initiated	90%	89.1%	88.7%	92.2%	90.3%
Smoking at Delivery	<6%	5.4%	4.9%	4.9%	5.2%

Commentary

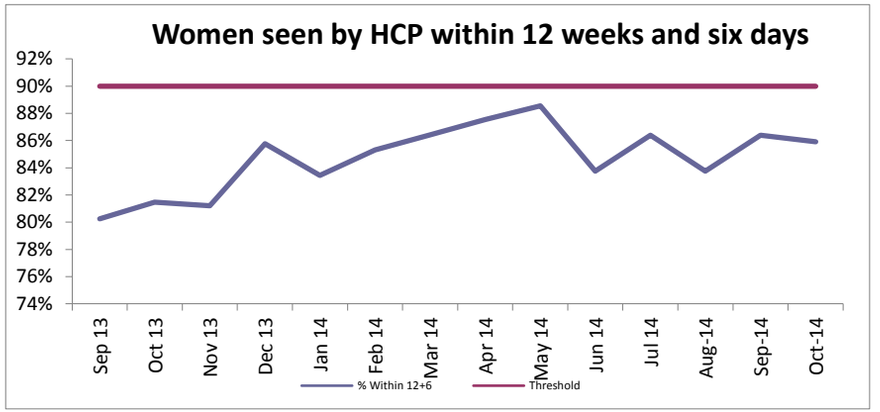
Women seen by HCP or midwife within 12 weeks and 6 days
Issue: Overall performance continues to be below the 90% threshold due to patients choice. Maternity is working on one named Midwife throughout the pregnancy to give continuity of carer.
Action: PAN London Maternity network discussion on-going regarding this measurement.
Timescale: On-going

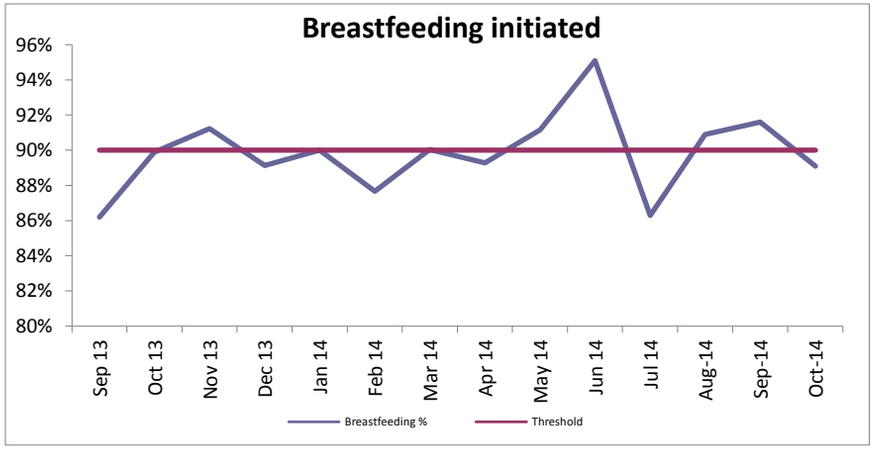
New Birth Visits
Issue: Rates remain around 90% YTD across both boroughs.
Action: Fortnightly conference calls with NHSE from January 2015 until April to update on 'Call to Action' programme increasing levels of HV's. Bespoke work pilot with Haringey Public Health has commenced in Tottenham where deprivation is high and staff numbers are low.
Timescale: On-going

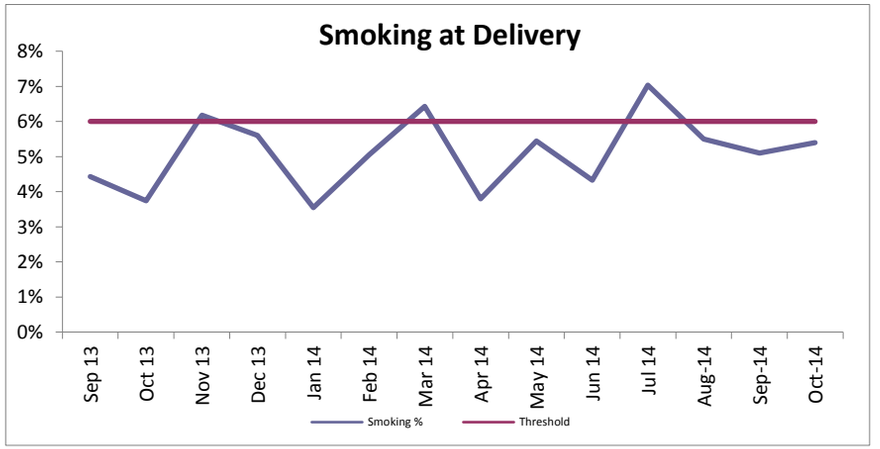
Caesarean Section rates
Issue: The elective C-section rate continues to be below the national average.
Action: Multiple work streams are in place to help reduce rates including improved education for women and a VBAC clinic (Vaginal birth after C-section Clinics).
Timescale: On-going

Breastfeeding
Issue: Achieved
Action: Work completed on the Level 2 Unicef Breastfeeding initiative. Awaiting confirmation to start working towards level 3.
Timescale: Due in December, but no feedback received yet.

Smoking:
Issue: Smoking at time of delivery remains at a compliant position.
Action: Public Health Midwife in discussion with Public Health to secure funding for carbon monoxide screening during antenatal period.
Timescale: On-going







Dashboard Definition page

	Definition	targets or benchmarks
First: Follow-up ratio - acute	Ratio comparing the number of follow-up appointments seen in comparison to first appointments.	National Average - April to September 2013 - is 2.31 Source: Health and Social Care Information Centre.
Theatre Utilisation	Theatre Utilisation is based on total time spent within the scheduled theatre session for each individual patient divided by the available session time. For example, during week ending 30/06/2013, 175 hours out of 233 hours scheduled time in theatres was utilised.	The target threshold rose to 95% from April 2014 but previously it was 85%
Hospital Cancellations - acute - First Appointments	Percentage of total first and follow up outpatient appointments that the hospital cancels and the rebooked appointment results in a delay to the patient.	<2% (Locally defined)
Hospital Cancellations - acute - Follow-up Appointments	As above	As above
DNA rates - acute - First appointments	Percentage of outpatient appointments where the patient does not attend without contacting the trust to cancel the appointment before the appointment time.	8% (Locally defined) - National Average April to September 2013: 8.1% Source: Health and Social Care Information Centre
DNA rates - acute - Follow-up appointments	As above	As above
Hospital Cancelled Operations	Hospital initiated cancellations on day of operation	<0.8% (Locally defined)
Cancelled ops not rebooked < 28 days	The total number of cancelled operations where the national standard (treatment within 28 days following an operation cancellation by the hospital) has been breached.	
Urgent procedures cancelled	Count all urgent operations that are cancelled by the trust for non-medical reasons	

Urgent Procedures cancelled (of these how many cancelled 2nd time)	A count of those urgent operations that have already been cancelled on one or more occasions before	
Cancer - 14 days to first seen	14 day targets relate to patients referred from GP to hospital on a suspected cancer pathway excluding breast patients where cancer not initially suspected. For the purpose of calculating performance in relation to waiting times for suspected cancer patients 'two weeks' is always taken to be 14 calendar days, with the date of receipt of referral being 'day zero'.	National Operational Standard - 93%
Cancer - 14 days to first seen - breast symptomatic	14 day targets relate to patients referred from GP to hospital on a pathway for breast patients where cancer not initially suspected. For the purpose of calculating performance in relation to waiting times is always taken to be 14 calendar days, with the date of receipt of referral being 'day zero'.	National Operational Standard - 93%
Cancer - 31 days to first treatment	This standard covers patients starting a first definitive treatment for a new primary cancer. Patients should be seen within 31 days of the decision to treat to first definitive treatment.	National Operational Standard - 96
Cancer - 31 days to subsequent treatment - surgery	This standard covers patients starting a subsequent treatment. 31 days is measured from decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is surgery, drug treatment or radiotherapy.	National Operational Standard: Surgery - 94% Drug Treatment - 98% Radiotherapy - 94%
Cancer - 31 days to subsequent treatment - drugs	As above - "Cancer - 31 days to subsequent treatment - surgery"	As above - "Cancer - 31 days to subsequent treatment - surgery"
Cancer - 62 days from referral to treatment	This standard covers patients starting a first definitive treatment for a new primary cancer following a target GP referral for suspected cancer.	National Operational Standard - 85%

Cancer - 62 days from consultant upgrade	This standard covers patients who received a first treatment for cancer within 62 days following a consultant decision to upgrade their priority.	No Operational Standard as yet
Referral to Treatment 18 weeks - Admitted	Waiting times for referrals to consultant led services, timed from receipt of referral to treatment or discharge.	90%
Referral to Treatment 18 weeks - Non-admitted	Waiting times for referrals to consultant led services, timed from receipt of referral to treatment or discharge.	95%
Referral to Treatment 18 weeks - Incomplete	Waiting times for referrals to consultant led services, timed from receipt of referral	92%
Referral to Treatment 18 weeks - 52 Week Waits	Count of pathways Waiting times over 52 weeks for referrals to consultant led services, timed from receipt of referral to treatment or discharge	0
Diagnostic Waits	Percentage of patients waiting for a diagnostic test who are seen within six weeks. There are 15 diagnostic tests in this cohort including endoscopy and imaging . Excludes laboratory tests (pathology).	99%
Service Cancellations - Community	The proportion of outpatient appointments that are cancelled by the Trust. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.	
DNA Rates - Community	The proportion of outpatient appointments that result in a DNA or UTA. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.	
Community Face to Face Contacts	The number of attended 'Face to Face' Contacts that have taken place during the month indicated.	
Community Appointment with no outcome	Appointments that do not have an outcome entered by the data entry deadline of the 3rd working day of the month following.	

Women seen by HCP or midwife within 12 weeks and 6 days	Percentage of pregnant women referred before 12 weeks 6 days of pregnancy who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days	90%
New Birth Visits - Haringey	The proportion of new mothers and their babies visited by health visiting services between 10 and 14 days inclusive after birth in accordance with recommended best practice.	
New Birth Visits - Islington	The proportion of new mothers and their babies visited by health visiting services between 10 and 14 days inclusive after birth in accordance with recommended best practice.	
Elective Caesarean Section rate	Women who deliver by elective caesarean section as a percentage of all deliveries	14.8%
Emergency Caesarean Section rate	Women who deliver by emergency caesarean section as a percentage of all deliveries	No target set
Breastfeeding initiated	Breastfeeding initiated before discharge as a percentage of all deliveries	90%
Smoking at Delivery	Women who smoke at delivery against total known to be smoking or not smoking.	<6%
% Harm Free Care	Data is sourced from the Safety Thermometer, a snapshot of the condition of a large number of patients, reporting on falls, catheter UTI and VTE. Pressure ulcer figure comes from incidence data	95%
VTE Risk assessment	Percentage of patients assessed for VTE/ Admissions	Target is 95% and over Monthly

Medication Errors causing actual Harm	Medication Errors recorded on Datix graded by risk. Information is submitted to National Reporting and Learning Service and the trust is ranked as a medium Acute Trust with a median percentage of medication errors of all incidents	There should be zero medication errors causing actual and serious harm but no thresholds currently set for the other grades
Never Events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The incidence of never events may indicate unsafe care. In the unlikely event of such an event occurring, it is reported to STEIS and investigated internally.	There should be zero never events although the CQC guidance states that there is an elevated risk associated with an increase in **estimated total person bed day**s
Open CAS Alerts (Central Alerting System)	Issued alerts include safety alerts, and Medical Device Alerts issued on behalf of the Medicines and Healthcare products Regulatory Agency, the NHS England, and the Department of Health. When an alert is issued we have a deadline in which to respond to confirm whether the alert is applicable to our Trust or to confirm that the recommendations have been implemented. This measure counts the number of issued alerts that remain open in a given month which have not been responded to.	There should not be any CAS alerts that remain open.
Proportion of reported patient safety incidents that are harmful	A high proportion of harmful patient safety incidents may indicate potential safety risks in trusts whose patients are experiencing more harm. Alternatively, it may also highlight trusts with a poorly developed reporting culture, who may tend to report fewer 'no harm' incidents, driving up their proportion of harmful incidents.	No threshold currently set but CQC guidance suggests a statistical method to determine the risk

Serious Incidents	Number of Serious Incidents (SIs) using national framework for reporting agreed by executive directors. The count includes pressure ulcer incidents and the month an incident is reported on STEIS is not necessarily the month the incident took place.	No threshold currently set
Community Dental - Patient Involvement	Based on a Patient rating on whether they were involved as much as they wanted to be in decisions about their care. It is a real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "yes definitely"	Internally set deadlines
Community Dental - Patient Experience	Based on a Patient rating on how they would you rate their overall care. It is a real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "excellent or good"	Internally set deadlines
District Nursing Waiting Times - % waiting less than 6 weeks	The percentage of patients that have waited less then 6 weeks for their initial 'Face to Face' contact following a referral to the District Nursing the Service.	
MSK Waiting Times - % waiting less than 6 weeks when seen that month	Percentage of patients waiting less than 6 weeks for their first attended appointment	100%
MSK Waiting Times - Consultant led (<18 weeks)	Waiting times for referrals to MSK consultant led services, timed from receipt of referral to treatment or discharge.	95%
IAPT - patients moving to recovery	IAPT services conduct routine clinical outcome monitoring to monitor the effectiveness of psychological therapies NICE guidance indicates the delivery of evidence based psychological therapies or depression and anxiety disorders should support recovery for at least 50% of patients completing treatment.	
Mixed Sex Accommodation	Clinically unjustified mixing of genders (i.e. breaches) in sleeping accommodation	Target of 100% single sex accommodation

Complaints	Formal complaints made about Trust services.	No threshold set
Complaints responded to within 25 working day	This measure is reported a month in arrears	The standard response time is 80% within 25 working days
Patient admission to adult facilities for under 16 years of age	A count of inpatient under 16 years staying on specific adult acute wards	No threshold currently set
Number of Inpatient Deaths	Includes all types of admission Patient death defined as discharge method = died	No threshold set
NHS number completion in SUS (OP & IP)	NHS completion rate is calculated against our SUS extracts and is a month in arrears however, the latest month reported represents a flex position so still gives time for improvement (the next month previous represents a freeze position though)	A 99% threshold is set for CCG contract monitoring
NHS number completion in A&E data set	As above	A 95% threshold is set for CCG contract monitoring
SHMI	SHMI is Summary Hospital-level Mortality Indicator and measures whether deaths are higher or lower than expected. Methodology varies from HSMR.	If our score is below the lower limit, our mortality index is banded as 'lower than expected'; if our score falls between the low and high values, our mortality index is 'as expected'; if our score is higher than the upper limit, our mortality index is 'higher than expected'
Hospital Standardised Mortality Ratio (HSMR)	Sourced from DrFoster Healthcare intelligence. Standardises all mortality across the NHS and allows trusts to compare mortalities against an 'expected' figure. This figure is adjusted for variations in hospital case mix.	The standardised expected rate is 100 - trusts below/above this potentially have fewer/more mortality outcomes than expected, based on national data.
Hospital Standardised Mortality Ratio (HSMR) - weekend	As above, but specifically for weekend non-elective admissions. This attempts to identify whether the non-elective admission process during the weekend may produce more mortality outcomes than expected.	as above

Hospital Standardised Mortality Ratio (HSMR) - weekday	As above, but specifically for weekday non-elective admissions. This attempts to identify whether the non-elective admission process on a weekday may produce more mortality outcomes than expected.	as above
Patient Satisfaction - Inpatient FFT (% recommendation)	FFT responded to by patients discharged from acute wards. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Patient Satisfaction - ED FFT (% recommendation)	FFT responded to by patients discharged from ED. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Patient Satisfaction - Maternity FFT (% recommendation)	FFT responded to by patients at 4 points in the maternity pathway. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Hospital acquired MRSA infection	Number of MRSA bacteraemia (bacteria in the blood)	Zero MRSA cases permitted throughout the entire financial year
Hospital acquired *C difficile* Infections	Number of Clostridium Difficile infections (bacterial infection affecting the digestive system)	19 C diff cases permitted throughout the entire financial year
Hospital acquired *E. coli* Infections	Numbers of E.coli bacteraemia cases (presence of bacteria in the blood)	No threshold set
Hospital acquired MSSA Infections	Numbers of MSSA bacteraemia cases (presence of bacteria in the blood)	No threshold set
Ward Cleanliness	The results of on-going facilities cleanliness audits. Results are tallied approximately every 6 weeks, and show the proportion all ward areas examined that passed inspection for cleanliness	Currently no target set
GUM - Appointment within 2 days	The percentage of patients offered an appointment within 2 days	100% should be offered an appropriate appointment
Emergency Department waits (4 hrs wait)	Proportion of all emergency department arrivals that do not wait longer than 4 hours from arrival to departure from the department (excludes planned arrivals)	95% of patients should not wait more than 4 hours
Wait for assessment (minutes - 95th percentile)	The wait from arrival to triage (in minutes) for the patient with the 95th percentile longest wait	The 95th percentile longest waiter should not wait more than 15 minutes

ED Indicator - median wait for treatment (minutes)	The median wait (in minutes) from arrival to time first seen by a 'treating' clinician.	The median wait for treatment should not be more than 60 minutes
Total Time in ED (minutes - 95th percentile)	The wait from arrival to departure from the department (in minutes) for the patient with the 95th percentile longest wait	The 95th percentile longest waiter should not wait more than 240 minutes
ED Indicator - % Left Without Being seen	The proportion of patients arriving in the department that leave of their own accord before they are seen by a 'treating' clinician	Fewer than 5% of patients should leave before being seen
12 hour trolley waits in A&E	The number of patients that wait 12 hours or more from the time a decision is made to admit the patient, to the time the patient is admitted	0 patients should wait longer than 12 hours
Ambulance handovers 30 minutes	The number of patients that wait for 30 minutes or more from the time an ambulance arrives to the time that responsibility for the patient is handed over to a member of our emergency team	0 patients should wait longer than 30 minutes
Ambulance handovers exceeding 60 minutes	The number of patients that wait for 60 minutes or more from the time an ambulance arrives to the time that responsibility for the patient is handed over to a member of our emergency team	0 patients should wait longer than 60 minutes
Ambulatory Care (% diverted)		>5% referrals should be going to ambulatory care

Executive Offices
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

February 4th 2015

Title:	Monthly Performance Dashboard – Workforce Report (December data)		
Agenda item:	**15/024**	**Paper**	**7.1**
Action requested:	For noting.		
Executive Summary:	**Background** The monthly dashboard as it refers to the workforce Key Performance Indicators (KPIs) is a standard report and part of the Performance Report. **Bank and Agency tables** The Board is asked to note that the tables which refer to bank and agency performance have been modified to show bank and agency expenditure broken down by division/corporate departments. **Benchmark comparisons – work in progress** Benchmark comparisons with other trusts in relation to staffing levels and occupational groups also appear this month. The Board is asked to note that this is work in progress. The comparisons selected were from trusts with hospital and community provision. The relative staffing numbers between trusts was an additional factor used. Further work is needed to identify a benchmarking network and the relevant family of comparable trusts to widen the scope to enable more meaningful conclusions to be reached about Whittington Health staffing levels to that of other trusts. A similar exercise to identify a benchmarking network is being developed by finance. **Highlights this month:** **Headcount** The workforce summary table shows actual worked WTE has decreased in December 2014 by 26 (from 4,414 in November to 4,388). **Turnover** The report outline demonstrates that this is a welcome sign and is in line with the strategic direction of travel to reduce agency usage.		

	Integrated Care and Acute Medicine (ICAM) figures are high and in the recent quarterly performance meetings chaired by the Chief Executive, the Director presented an outline retention plan. With a robust recruitment strategy in place and an effective campaign recruiting nurses from overseas, the focus now is on retention. **Vacancy rates** Despite the sharp fall last month, the vacancy rate has returned to 13.2% (Trust threshold 13%). Corporate services have a high vacancy rate which is subject to further analysis. **Sickness** Sickness rates are at 2.9% below the Trust threshold of 3%. From the analysis of absence management across the Trust, the specific priorities are to tackle short term absence and relatively high Bradford scores. The Executive is considering assigning a bespoke resource in conjunction with Human Resources (HR) to support managers to deliver better performance which will reduce occupational sick pay and the use of overtime and bank and agency cover. **Overtime** Both in terms of expenditure and WTE, performance is very positive and a downward trend shows that the focus on reducing overtime is working. **Bank and Agency** Agency figures are down on last month and back on track. **Appraisal** The appraisal figures show no change from last month. The recent quarterly performance meetings, the Chief Executive has emphasised that appraisal rates need to be more of a priority. Despite action plans being in place, Directors will work on incremental percentage increases and review the position by quarter two. This is a key priority for Surgery Cancer and Diagnostics (SCD). **Mandatory Training** There is a 1% increase in the performance on mandatory training compliance rates. Mandatory training compliance was also a key concern at the quarterly performance meetings and each Director has an action plan to increase compliance rates by the year end. Notwithstanding that, the Audit and Risk Committee were informed at their last meeting that the Executive will be redoubling their efforts through corporate initiatives to support the work that Directors are implementing. The Audit and Risk Committee have requested a further report at the March meeting.
Summary of recommendations:	To note the report and the progress in key areas and action to increase compliance rates in other areas.
Fit with WH strategy:	
Reference to related / other documents:	N/A

Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A						
Date paper completed:	21 January 2015						
Author name and title:	**Various Managers who source the workforce data**		**Director name and title:**		**Chris Goulding Acting Director HR**		
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Trust Board Report - Workforce (December data)

Whittington Health NHS

Workforce		Trust							
Headcount	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**
Starting Point for Workforce 14/15	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403
Planned Changes (reductions)	0	(18)	(46)	(63)	(74)	(66)	(111)	(119)	(119)
Contract Additions	4	15	12	17	22	34	46	54	58
Total	**4**	**(3)**	**(34)**	**(45)**	**(52)**	**(31)**	**(65)**	**(65)**	**(61)**
Revised Workforce Plan	4,407	4,399	4,369	4,358	4,351	4,372	4,338	4,338	4,342
Headcount wte Total	4,404	4,397	4,366	4,398	4,429	4,374	4,383	4,414	4,388
Variance to Revised Plan	3	2	3	(40)	(78)	(2)	(45)	(76)	(46)

In total, the number of whole time equivalent staff (WTE) has decreased in December 2014 by 26 (from 4,414 in November to 4,388 in December), with this increase further broken down by staffing type as follows: agency: increase of 6 WTE, bank: decrease 31 WTE, locum: unchanged from last month and substantive: an increase of 1 WTE.

In financial terms, after non recurrent adjustments, actual pay costs for December were £564k higher than plan, compared to £797k higher in November.

In comparison to the revised Workforce Plan for December of 4,342 WTE, the WTE of 4,388 is 46 WTE higher, compared to November, which was 76 WTE higher.

		Trust							
Management of the workforce	**Threshold**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Dec-14**
Trust Turnover Rate	<13%	15.1%	14.1%	14.0%	13.9%	13.7%	13.4%	13.8%	13.9%
Total trust vacancy rate	<13%	13.4%	14.2%	14.3%	14.1%	14.1%	13.2%	13.3%	13.2%
Sickness rates	<3%	2.7%	2.6%	2.8%	2.8%	2.8%	2.6%	3.2%	2.9%
Overtime wte	75	123	118	113	94	113	99.66	92.05	85.34
Overtime expenditure		70,459.70	69,704.27	63,236.55	51,535.17	61,751.31	56,431.72	51,716.56	46,129.40
Bank Hours expenditure	-	1,523	1,580	1,519	1,402	1,602	1,472	1,546	1,437
Agency Hours expenditure *	1m	1,426	1,184	1,491	1,457	1,200	1,210	1,254	1,007

*bank expenditure will fluctuate as agency expenditure reduces

		Trust							
Development of the workforce	**Threshold**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Dec-14**
Appraisal	90%	43%	40%	39%	45%	51%	55%	58%	60%
Mandatory Training	90%	75%	77%	76%	76%	75%	73%	66%	66%

		Trust	
Staff FFT Results		**Q1**	**Q2**
Staff who would recommend the trust as a place to work	-	62%	59%
Staff who would recommend the trust as a place for treatment	-	74%	74%

Staff FFT Results for Q3 and Q4 will not be available until April 2015

Management of the Workforce - Turnover, vacancy and sickness

Whittington Health NHS

	December 2014					
	Threshold	Trust Actual	ICAM	SCD	WCF	CORP
Trust Turnover Rate	<13%	13.9%	19.1%	9.5%	12.6%	11.8%
Total trust vacancy rate	<13%	13.2%	10.1%	10.4%	4.9%	22.9%
Trust level total sickness rate	<3%	2.9%	2.7%	2.4%	3.3%	3.5%

Turnover rate

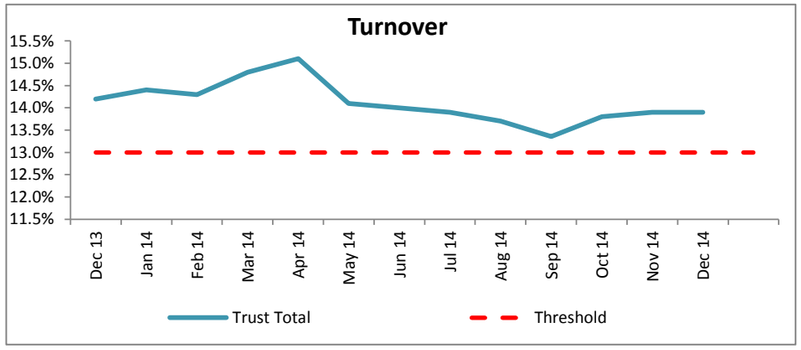
ICAM figures are high and in the recent quarterly performance meetings chaired by the Chief Executive, the Director presented an outline retention plan. With a robust recruitment strategy in place and an effectice campaign recruiting nurses from overseas, the focus now is on retention.

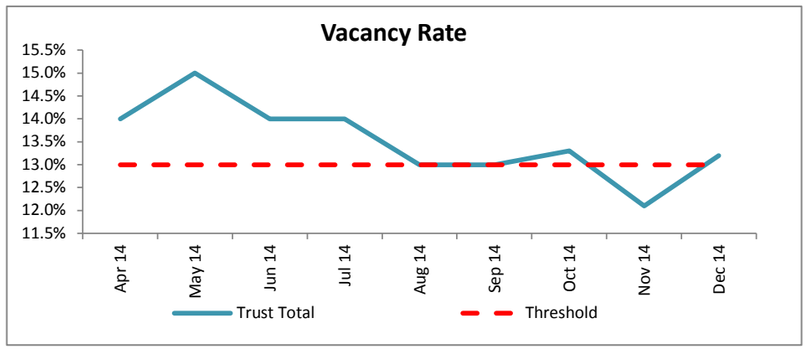
Vacancy Rates

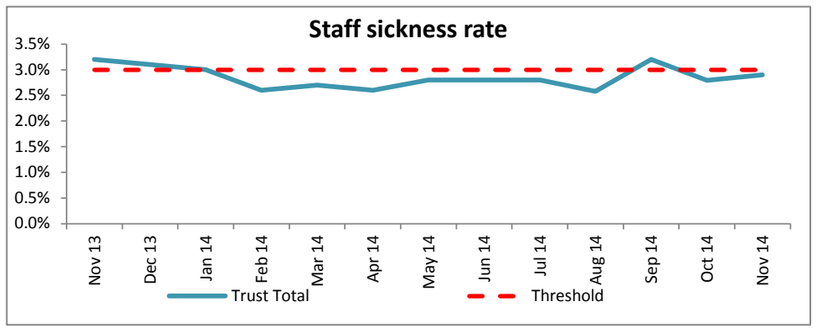
Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis. A verbal update will be available at the Trust Board if the root causes can be identified.

Trust Level Sickness rates

Levels for sickness rates are below the threshold and action plans have been developed by each Division/Corporate services to reduce short term sickness absence and to tackle high Bradford scores.





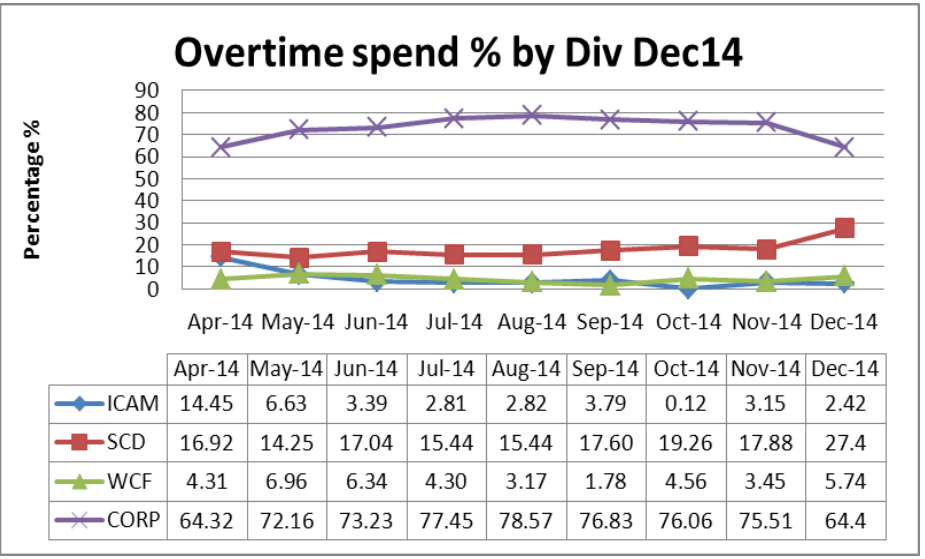


Management of the Workforce - Overtime, Bank & Agency

Whittington Health NHS

Overtime expenditure

	December 2014					
	Trust		ICAM	SCD	WCF	CORP
Overtime cost	£46,129.40		£1,117.07	£12,637.56	£2,649.22	£29,725.55

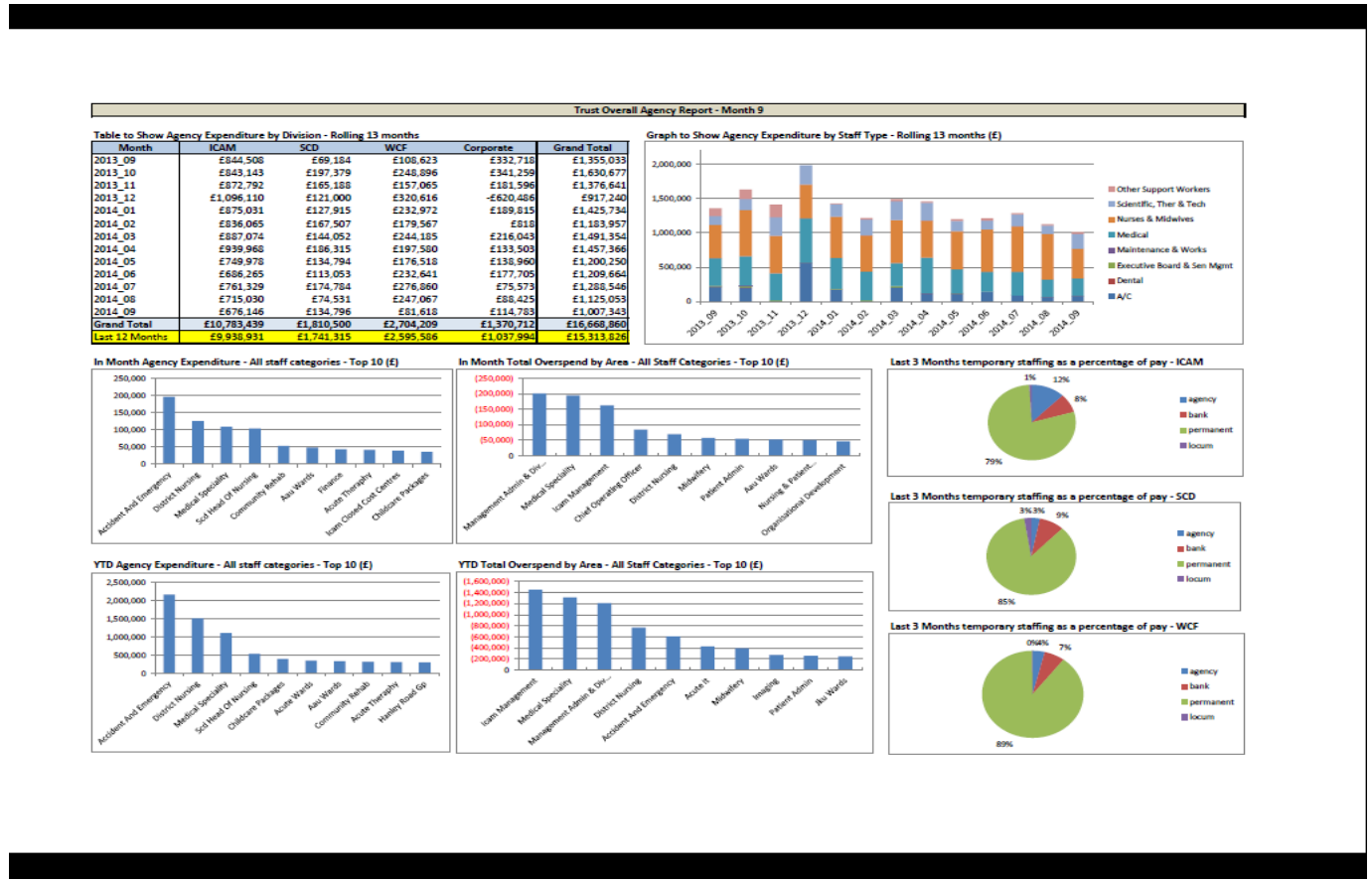


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
ICAM	14.45	6.63	3.39	2.81	2.82	3.79	0.12	3.15	2.42
SCD	16.92	14.25	17.04	15.44	15.44	17.60	19.26	17.88	27.4
WCF	4.31	6.96	6.34	4.30	3.17	1.78	4.56	3.45	5.74
CORP	64.32	72.16	73.23	77.45	78.57	76.83	76.06	75.51	64.4

Overtime

Both in terms of expenditure and WTE, performance is very positive and a downward trend shows that the focus on reducing overtime is working.

Bank and Agency wte usage and expenditure



Trust Overall Agency Report - Month 9

Table to Show Agency Expenditure by Division - Rolling 13 months

Month	ICAM	SCD	WCF	Corporate	Grand Total
2013_09	£844,508	£69,184	£108,623	£332,718	£1,355,033
2013_10	£843,143	£197,379	£248,896	£341,259	£1,630,677
2013_11	£872,792	£165,188	£157,065	£181,596	£1,376,641
2013_12	£1,096,110	£121,000	£320,616	-£620,486	£917,240
2014_01	£875,031	£127,915	£232,972	£189,815	£1,425,734
2014_02	£836,065	£167,507	£179,567	£818	£1,183,957
2014_03	£887,074	£144,052	£244,185	£216,043	£1,491,354
2014_04	£939,968	£186,315	£197,580	£133,503	£1,457,366
2014_05	£749,978	£134,794	£176,518	£138,960	£1,200,250
2014_06	£686,265	£113,053	£232,641	£177,705	£1,209,664
2014_07	£761,329	£174,784	£276,860	£75,573	£1,288,546
2014_08	£715,030	£74,531	£247,067	£88,425	£1,125,053
2014_09	£676,146	£134,796	£81,618	£114,783	£1,007,343
Grand Total	£10,783,439	£1,810,500	£2,704,209	£1,370,712	£16,668,860
Last 12 Months	£9,938,931	£1,741,315	£2,595,586	£1,037,994	£15,313,826

Graph to Show Agency Expenditure by Staff Type - Rolling 13 months (£)

In Month Agency Expenditure - All staff categories - Top 10 (£)

In Month Total Overspend by Area - All Staff Categories - Top 10 (£)

Last 3 Months temporary staffing as a percentage of pay - ICAM

YTD Agency Expenditure - All staff categories - Top 10 (£)

YTD Total Overspend by Area - All Staff Categories - Top 10 (£)

Last 3 Months temporary staffing as a percentage of pay - SCD

Last 3 Months temporary staffing as a percentage of pay - WCF

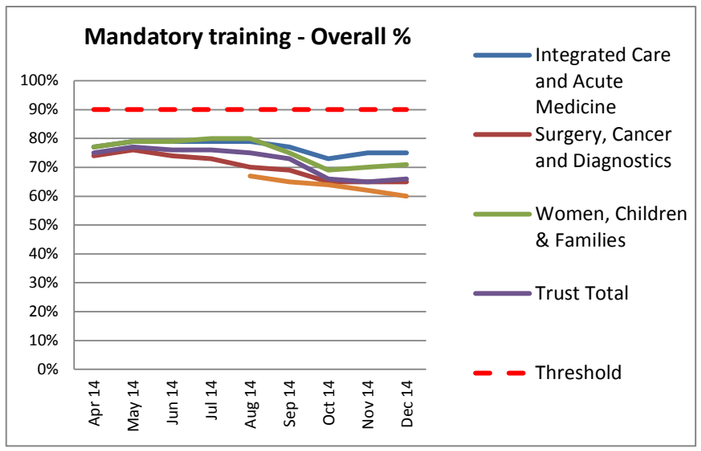
Development of workforce

Whittington Health NHS

	December 2014						
	Threshold	Trust Actual		ICAM	SCD	WCF	CORP
Percentage of staff with mandatory training compliance	90%	66%		75%	65%	71%	60%
Percentage of staff with annual appraisal	90%	60%		70%	40%	67%	54%

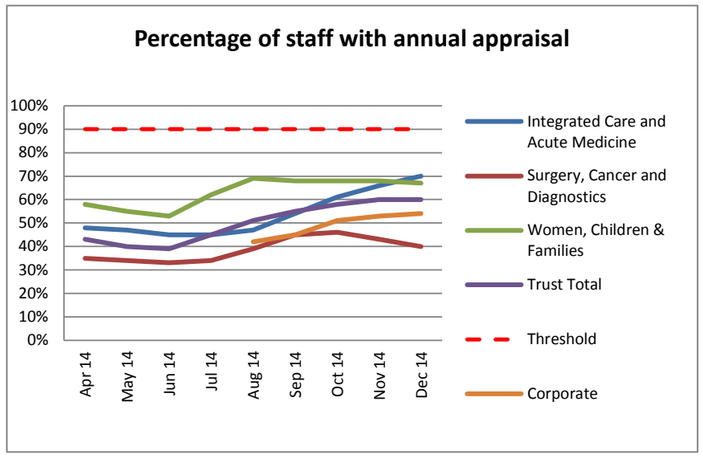
Mandatory training

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. The Trust Management Group (TMG) has received a report at its last meeting recommending further action to improve compliance rates.



Appraisal

There has been a marginal increase in the compliance rate for appraisal. The implementation of action plans for both corporate and the divisions remains a priority.



Benchmarking data on the composition and % of different staff groups by banding and FTE

Whittington Health NHS

The data reported below has been extracted from the HSCIC reporting tool NHS Iview and is based on NHS Workforce information, extracted directly from the Electronic Staff Record unless stated; data was extracted in December 2014 with the most recent month being October 2014.
Unless otherwise stated, the month referred to is October 2014.

The NHS organisations selected as comparators for benchmarking against Whittington Health are Croydon Services, Homerton University Hospital, Lewisham and Greenwich NHS. These organisations are broadly comparable in terms of size and provision of services:

Croydon Health Services - Croydon Health Services provide acute and community healthcare services across the borough of Croydon either in patient's own homes or from clinics and specialist centres, including Croydon University Hospital and Purley War Memorial Hospital in Purley, which recently underwent an £11 million refurbishment and re-opened in the summer of 2013.Around 3,500 staff provide services for a population of over 360,000 people who are relatively young with a high level of ethnic diversity. Reference costs100.8.

Homerton University Hospital - Homerton employs over 3500 staff and provides hospital and community services to Hackney and the City of London. Specialist care includes: obstetrics, neonatology, fetal medicine, fertility, neurorehabilitation, bariatric surgery, and asthma and allergy treatments for patients throughout east London and beyond. The hospital has over 450 inpatient beds, an A&E department, an intensive care unit, state-of-the-art imaging and x-ray facilities, a modern sexual health treatment centre, diabetes centre and eye screening service. Homerton provides a wide range of adult and children's community health services across Hackney and the City, with staff working out of 75 different sites.
Reference costs 87.1

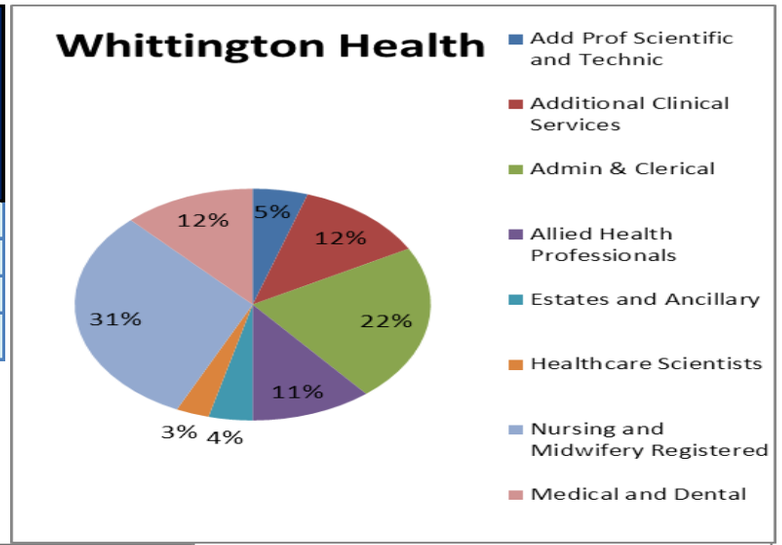
Lewisham and Greenwich NHS - provides NHS services for local people in Lewisham, Greenwich, Bexley and other parts of South East London.
They are responsible for NHS services at: Lewisham Hospital, Queen Elizabeth Hospital in Greenwich, and 11 different health centres in Lewisham.
In addition they provide some services at Queen Mary's Hospital in Sidcup. Reference costs 100.2.

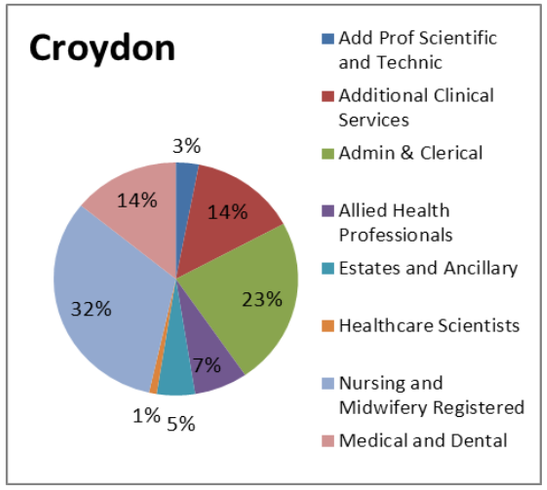
Benchmarking data on the composition and % of different staff groups by banding and FTE

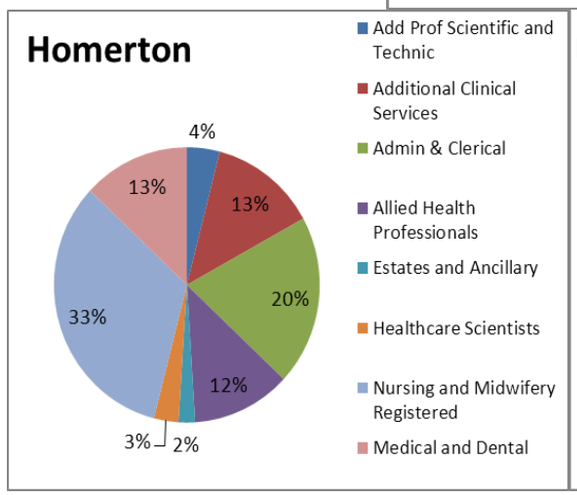
Whittington Health NHS

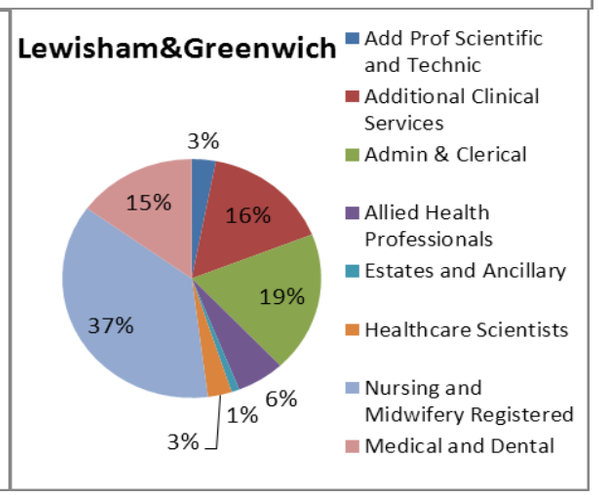
The following table shows FTE figures by staff group for each organisation as well as total FTE. The accompanying pie charts show the actual percentage of staff by staff group.

NHS Organisations	Add Prof Scientific and Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Nursing and Midwifery Registered	Medical and Dental	Total FTE
Croydon	95	435	750	240	145	20	1020	455	**3205**
Homerton	120	435	665	385	55	90	1110	445	**3330**
Lewisham and Greenwich	145	875	1020	340	30	150	1970	800	**5335**
Whittington Health	185	450	815	400	160	105	1175	455	**3780**





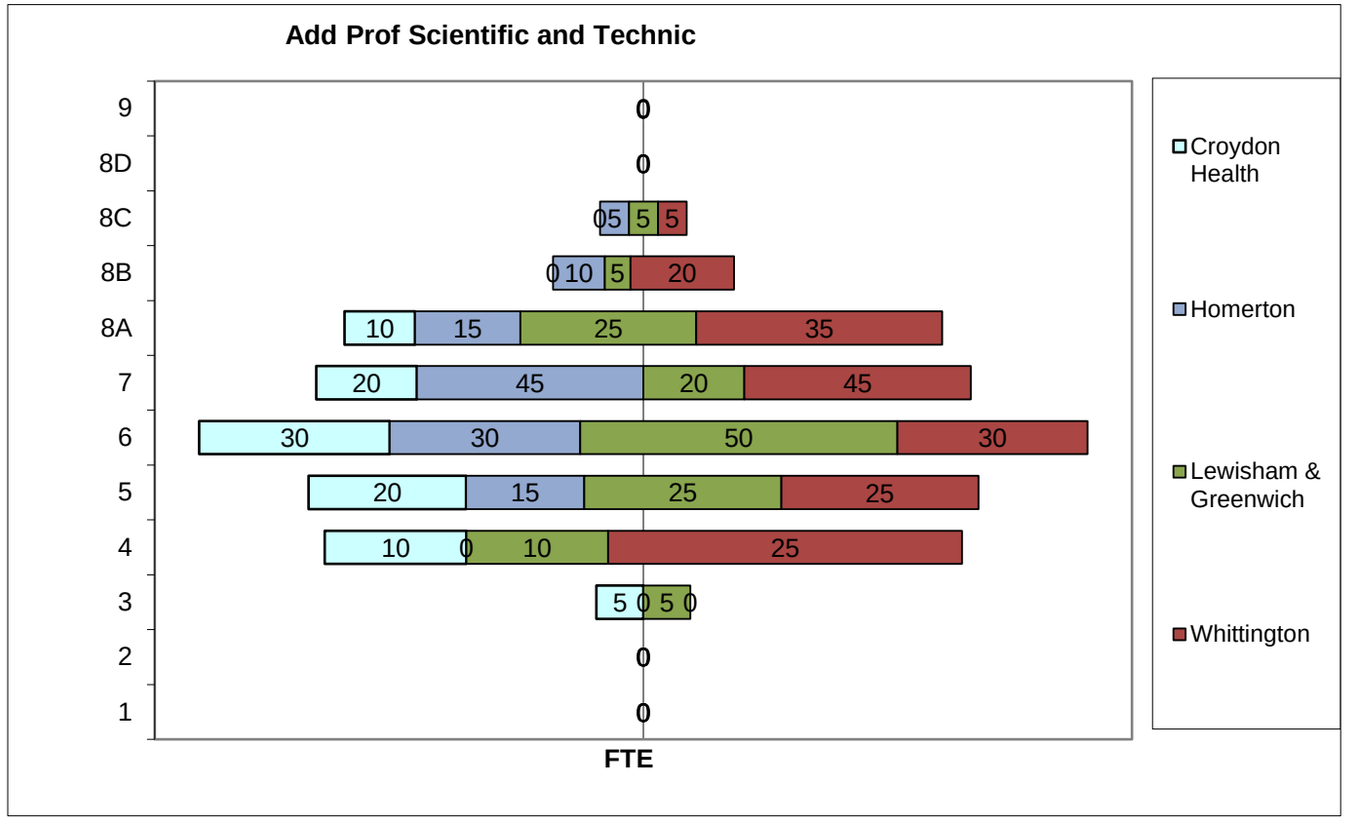




ADD PROF SCIENTIFIC & TECHNIC A4C banding profile by FTE (October 2014)

Roles: Chaplain, Clinical Director, Clinical Psychologist, (Qualified and Trainee) Psychotherapist, Social Worker, Technician, Osteopath, Pharmacist, Physician asst Psychological Therapist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3	5		5	
4	10		10	25
5	20	15	25	25
6	30	30	50	30
7	20	45	20	45
8A	10	15	25	35
8B		10	5	20
8C		5	5	5
8D				
9				
Total FTE	95	120	145	185

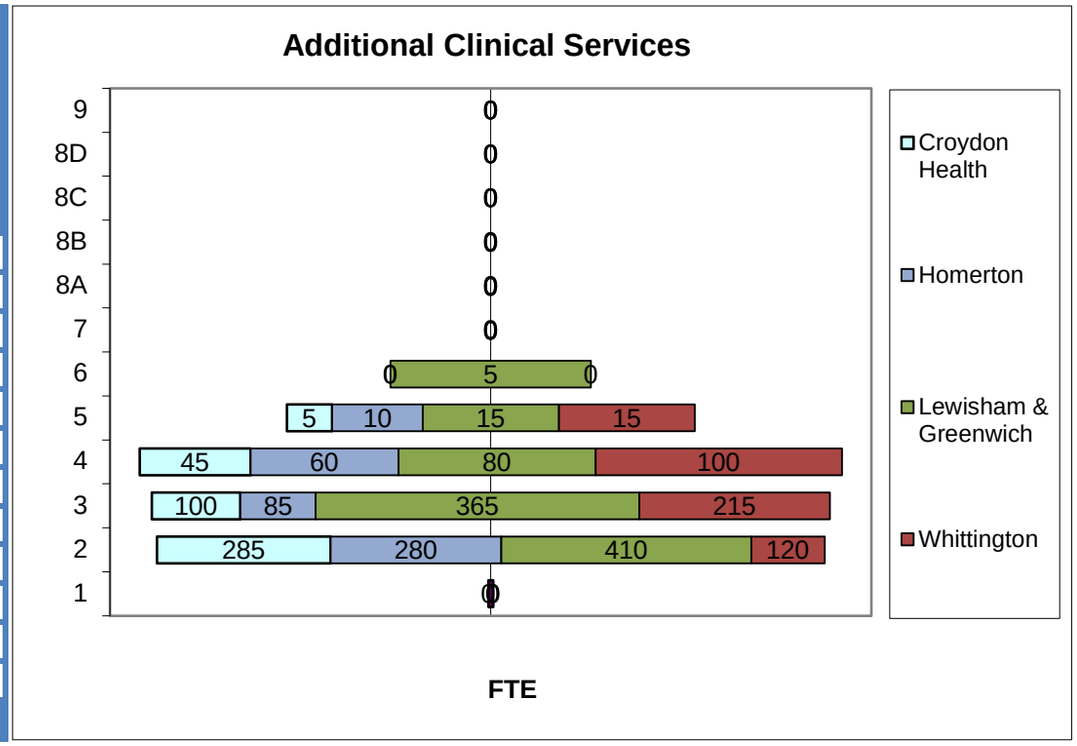


Whittington Health has a much lower proportion of the workforce at Band 6, with them making up 16% within this professional group against 34% at Lewisham & Greenwich, 30% at Croydon Health and 25%.

ADDITIONAL CLINICAL SERVICES A4C banding profile by FTE (October 2014)

Role: Assistant Psychologist, Assistant/Associate Practitioner, Counsellor, HCS worker HCA, Helper/Assistant, Med Laboratory Assistant, Nursery Nurse, Play Specialist Pre-Reg Pharmacist, Technical Instructor, Technician, Trainee Scientist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2	285	280	410	120
3	100	85	365	215
4	45	60	80	100
5	5	10	15	15
6			5	
7				
8A				
8B				
8C				
8D				
9				
Total FTE	435	435	875	450

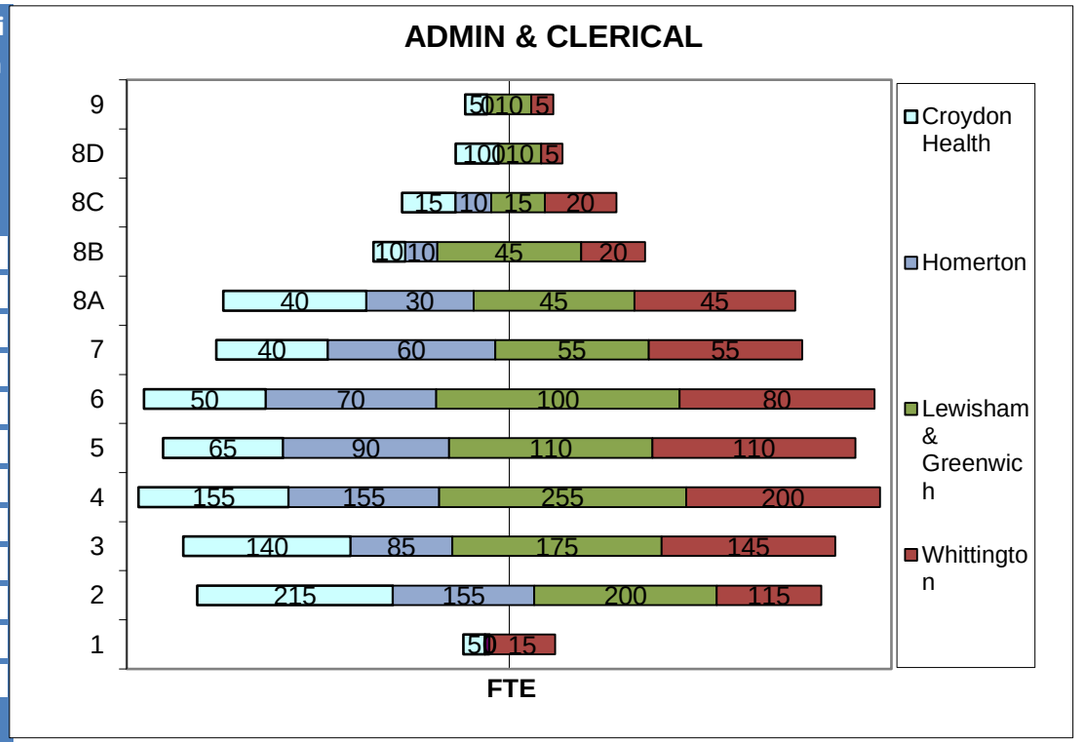


Whittington Health has fewer Band 2 roles in this professional Band 2s but more staff at Band 3 and 4.

ADMIN & CLERICAL A4C banding profile by FTE (October 2014)

Role: Accountant, Adviser, Chair, Clerical Worker, Interpreter, Manager, Medical Secretary Officer, Other Exec Dir, Personal Assistant, Receptionist, Researcher, Secretary, Snr Mgr Technician

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	5			15
2	215	155	200	115
3	140	85	175	145
4	155	155	255	200
5	65	90	110	110
6	50	70	100	80
7	40	60	55	55
8A	40	30	45	45
8B	10	10	45	20
8C	15	10	15	20
8D	10		10	5
9	5		10	5
Total FTE	750	665	1020	815

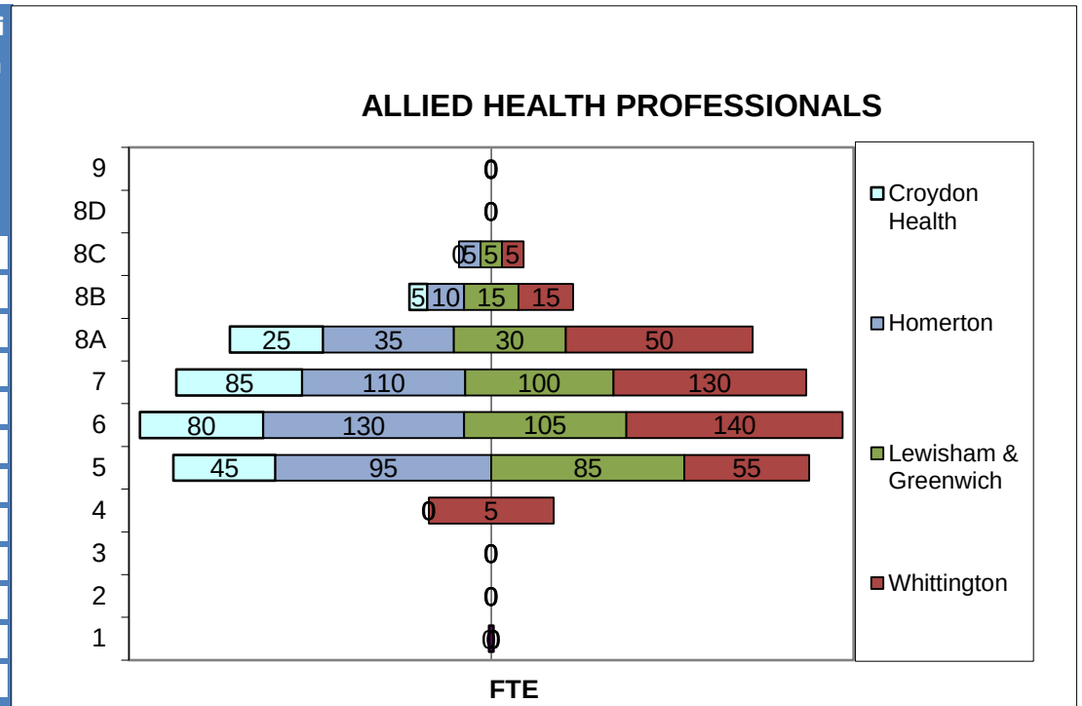


Whittington has fewer Band 2 staff in this professional group at 14% compared with 28% at Croydon Health, 23% at the Homerton and 20% in Lewisham & Greenwich.

ALLIED HEALTH PROFESSIONALS A4C banding profile by FTE (October 2014)

Role: Chiropodist/Podiatrist, Dietitian, Dietician Mgr, Occ Therapist, Occ Therapist Mgr Orthoptist, Physio, Physio Mgr, Physio Specialist Practitioner, Radiographer - Diagnostics Radiographer Diagnostic Mgr, SLT, SLT Mgr.

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3				
4				5
5	45	95	85	55
6	80	130	105	140
7	85	110	100	130
8A	25	35	30	50
8B	5	10	15	15
8C		5	5	5
8D				
9				
Total FTE	240	385	340	400

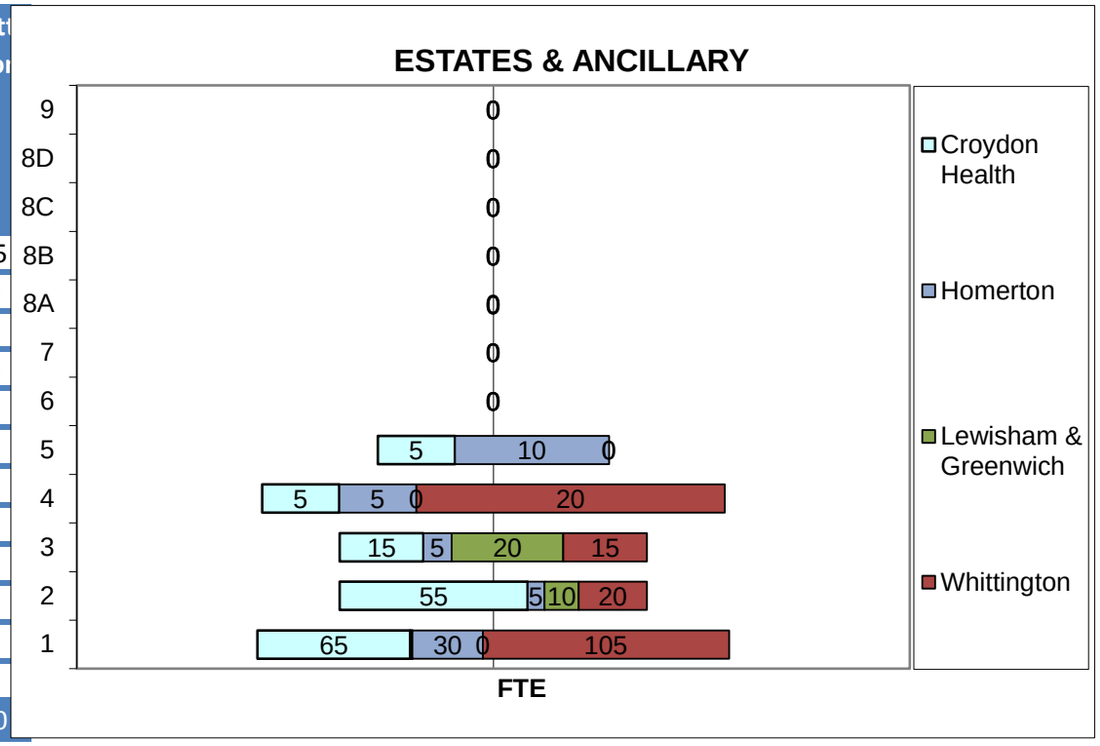


Whittington Health has a much lower proportion of staff in this professional group at Band 5: 14% compared with 25% at the Homerton and Lewisham and Greenwich and 19% at Croydon.

ESTATES AND ANCILLARY A4C banding profile by FTE (October 2014)

Role: Assistant, Chargehand, Gardener/Groundsperson, Porter, Supervisor, Support Worker Technician

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	65	30		105
2	55	5	10	20
3	15	5	20	15
4	5	5		20
5	5	10		
6				
7				
8A				
8B				
8C				
8D				
9				
Total FTE	145	55	30	160



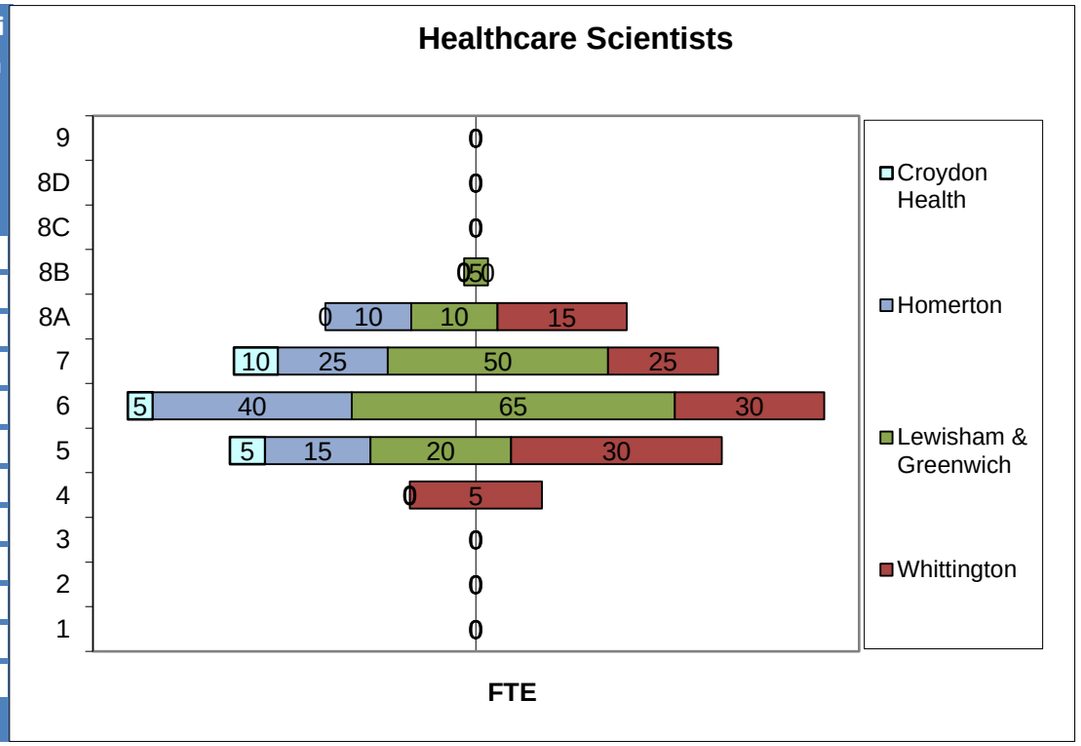
Whittington Health has significantly fewer staff at a high grade for this professional group compared with Croydon and the Homerton.

HEALTHCARE SCIENTISTS A4C banding profile by FTE (October 2014)

Role: Biomedical Scientist, Healthcare Scientist, Manager, Specialist Healthcare Scientist

Associate Specialist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3				
4				5
5	5	15	20	30
6	5	40	65	30
7	10	25	50	25
8A		10	10	15
8B			5	
8C				
8D				
9				
Total FTE	20	90	150	105

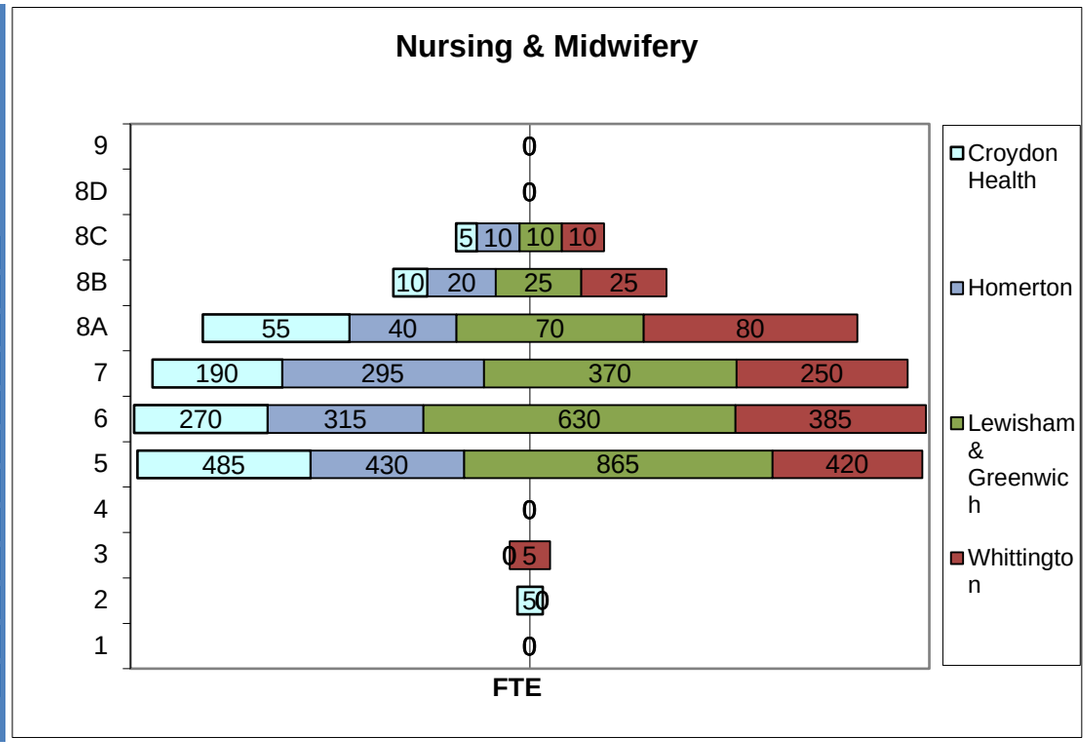


Whittington Health has a much greater proportion at a lower grade than Homerton

NURSING & MIDWIFERY A4C banding profile by FTE (October 2014)

Role: Community Nurse, Community Practitioner, Enrolled Nurse, Midwife, Midwife Mgr,
Midwife Specialist Practitioner, Modern Matron, Nurse Consultant, Nurse Mgr
Sister/Charge Nurse, Specialist Nurse Practitioner, Staff Nurse

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	5			
2				5
3				
4	485	430	865	420
5	270	315	630	385
6	190	295	370	250
7	55	40	70	80
8A	10	20	25	25
8B	5	10	10	10
8C				
8D				
9				
Total FTE	1020	1110	1970	1175

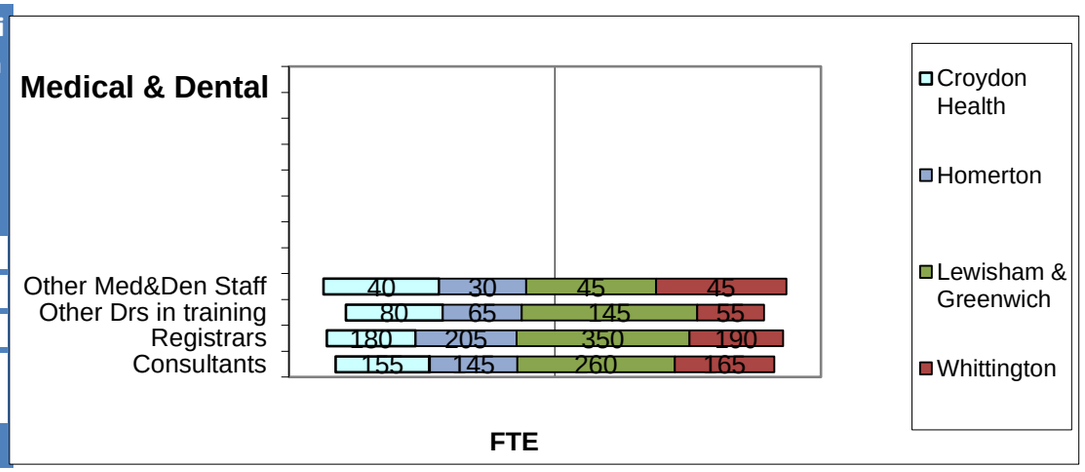


There would appear to be different uses for the coding in ESR across the comparator organisations with HCAs coded to "Additional Clinical Services" making comparisons difficult. For the qualified nursing workforce Whittington Health has a higher proportion at

Band 7: 7% compared with 3.5% at Lewisham&Greenwich, 3.6% at the Homerton and 5.4% at Croydon.

MEDICAL & DENTAL Job role profile by FTE (October 2014)

Job Roles	Croydon Health	Homerton Uni F	Lewisham & Greenwich	Whittington
Consultants	155	145	260	165
Registrars	180	205	350	190
Other Doctors in Training	80	65	145	55
Other Medical and Dental Staff	40	30	45	45
Total FTE	455	445	800	455



Whittington Health has the highest proportion of medical & dental at Consultant: 36% compared with 33% at Homerton and Lewisham & Greenwich and 34% at Croydon. Whittington Health has the lowest proportion of “Other Doctors in Training” at 12% compared with 18% at Croydonand Lewisham & Greenwich and 15% at the Homerton.

Whittington Health NHS

Trust Board
4 February 2015

Title:	**2014/15 Finance Report - December (Month 9)**					
Agenda item:	15/025		**Paper**	8		
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 in month and for the YTD to December 2014.**					
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:	**23rd January 2015**					
Author name and title:		**Ursula Grueger, Deputy Director of Finance**	**Director name and title:**		**Simon Pleydell, CEO**	
Date paper seen by EC ?		**Equality Impact Assessment complete?**	**Risk Assessment undertaken ?**	**N\A**	**Legal advice received ?**	**N\A**

Month 9 Finance Report - Executive Summary

The in-month position is a £480k surplus against a planned surplus of £617k, an adverse variance of £137k. The year to date (YTD) position is a £6.2m deficit against a planned deficit of £0.3m, an adverse variance of £5.9m. The adverse variance is a combination of income underperformance and expenditure pressures.

This financial position represents significant deviation from plan at the start of the year. The Trust is currently forecasting a £7.4m deficit at year end.

Income

The income position is £0.5m favourable in month and £0.3m favourable YTD. The favourable position in month is driven by an overperformance in NHS clinical income. This reflects the contract variation of £2m, resilence support of £1.2m (both phased in over the last five months of the year) as well as higher than runrate NHS England performance, which is paid on PbR. The income position continues to reflect the Trust operating against a block contract arrangement with its main CCGs, which has now been agreed to continue to the end of the 2014/15 financial year.

Where possible the Trust is seeking to exploit other means of securing income such as looking to support other Trusts in addressing their RTT and capacity challenges. RTT Income of £1.6m is reflected in the YTD position.

Non NHS Clinical income is above plan YTD due to road traffic accident, overseas visitors and local authority commissioned sexual health and higher dental activity. Other non patient income is above plan YTD due to mainly additional education and training income as well as some additional research income which is offset with costs.

Expenditure

The expenditure position is £0.8m adverse in month and £7.0m adverse YTD. The major expenditure challenges remain in the Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostics (SCD) Divisions. The improvement in the expenditure position compared to month 8 is largely due to improvements in the corpporate divisions in both pay and non pay.

Pay is £0.5m adverse in month and £2.9m adverse YTD. Key drivers of the in month pay variance include ICAM £480k adverse and SCD £252k adverse.

Non Pay is £0.2m adverse in month and £1.6m adverse YTD. Key drivers of the *in month* are the Corporate divisions (£95k) and SCD (£52k).

Further expenditure reductions are being developed.

The monthly position has resulted in the EBITDA margin of 6.82%, which is below the target of 8.27%. EBITDA stands for earnings before interest, taxation, depreciation and amortisation and is a measure of our ability to generate cash from our operations. It is vital to maintain a healthy cash balance to service our liabilities and finance the Trust's capital programme.

Cost Improvement Plans (CIPs)

The Trust has delivered YTD savings of £5.7m against a plan of £10.4m (55%). There are plans to deliver £9.1m in total for 2014/15 of a target of £15m (61%) and the divisions are working on back up plans to deliver the gap.

Cash and Capital

Cash increased by £1.3m in the month to £2.2m. The capital programme is on track.

Statement of Comprehensive Income	Full Year	December			YTD		
	Budget (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)
Nhs Clinical Income	246,955	20,613	21,118	504	185,166	184,033	(1,133)
Non-Nhs Clinical Income	16,332	1,358	1,273	(85)	12,260	12,915	655
Other Non-Patient Income	26,176	2,164	2,269	105	19,440	20,185	763
Total Income	**289,464**	**24,135**	**24,660**	**525**	**216,866**	**217,133**	**285**
Non-Pay	69,880	5,592	5,829	(237)	52,262	53,875	(1,614)
Pay	206,047	16,618	17,150	(532)	154,947	157,874	(2,926)
Savings	(3,303)	(72)	0	(72)	(2,477)	0	(2,477)
Total Expenditure	**272,624**	**22,138**	**22,979**	**(841)**	**204,732**	**211,749**	**(7,017)**
EBITDA	**16,840**	**1,997**	**1,681**	**(316)**	**12,134**	**5,384**	**(6,751)**
EBITDA %	**5.82%**	**8.27%**	**6.82%**	**-1.46%**	**5.60%**	**2.48%**	**-3.12%**
Interest Payable	2,820	235	241	(6)	2,115	2,136	(21)
Interest Receivable	30	3	2	(1)	23	19	(4)
Depreciation	9,724	810	720	90	7,293	7,616	(322)
Dividends Payable	4,326	361	248	113	3,245	3,132	113
Donated Asset Additions	0	0	0	0	0	19	19
Net Surplus / (Deficit) - before IFRIC 12 adjustments	(0)	594	474	(119)	(496)	(7,461)	(6,966)
Add back impairments and adjust for IFRS & donated assets	285	24	6	(18)	214	1,288	1,074
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**285**	**617**	**480**	**(137)**	**(282)**	**(6,173)**	**(5,892)**
Previous Month : adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**285**	**137**	**(380)**	**(517)**	**(899)**	**(6,654)**	**(5,754)**
Movement from Month 7 to Month 8 (+ve(Green) is Favourable)	**(0)**	**480**	**860**	**380**	**617**	**480**	**(137)**

Whittington Health Cost Improvement Programme Report - Month 9

	Annual	November				YTD				Forecast			
	Plan £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Fcst £'000	% achieved	Var £'000
ICAM	1,768	157	72	46%	(85)	1,269	471	37%	(797)	1,768	1,408	80%	(360)
SCD	1,179	89	60	67%	(29)	847	422	50%	(424)	1,179	636	54%	(544)
WCF	1,299	108	43	40%	(65)	974	337	35%	(637)	1,299	534	41%	(765)
Corporate	1,519	132	123	94%	(8)	1,124	1,016	90%	(109)	1,519	1,612	106%	93
Total Divisional Schemes	**5,764**	**485**	**298**	**61%**	**(187)**	**4,214**	**2,247**	**53%**	**(1,967)**	**5,764**	**4,189**	**73%**	**(1,576)**
Productivity & Efficiency	5,347	469	76	16%	(393)	3,939	783	20%	(3,157)	5,347	1,382	26%	(3,965)
VIPs	3,388	427	33	8%	(394)	1,857	136	7%	(1,722)	3,388	353	10%	(3,035)
Total Productivity & Efficiency and Transformational Schemes	**8,735**	**896**	**109**	**12%**	**(787)**	**5,797**	**919**	**16%**	**(4,878)**	**8,735**	**1,735**	**20%**	**(7,000)**
Non Recurrent Benefits	500	42	42	100%	0	375	375	100%	0	500	500	100%	0
Non Recurrent Under Spends	0	0	350		350	0	2,193		2,193	0	2,653		2,653
Total Non Recurrent Items	**500**	**42**	**391**		**350**	**375**	**2,568**		**2,193**	**500**	**3,153**		**2,653**
Total delivery against planned schemes	**15,000**	**1,423**	**798**	**56%**	**(625)**	**10,386**	**5,734**	**55%**	**(4,652)**	**15,000**	**9,077**	**61%**	**(5,923)**
Unidentified Schemes	0	0	0		0	0	0		0	0	5,923		5,923
Trust Total	**15,000**	**1,423**	**798**	**56%**	**(625)**	**10,386**	**5,734**	**55%**	**(4,652)**	**15,000**	**15,000**	**100%**	**0**

Month 9 CIP Summary

The CIP delivery underperformance YTD has continued into month 9.

In month 9 £798k (56%) CIP delivery was achieved compared to a plan of £1,423k. This includes a benefit from non recurrent underspends of £350k.

YTD delivery is £5,734k (55%) compared to a YTD target of £10,424k. YTD delivery includes a benefit from non recurrent underspends of £2,193k.

The divisional schemes are forecasting £4,189k delivery (73%) against the target of £5,764k.

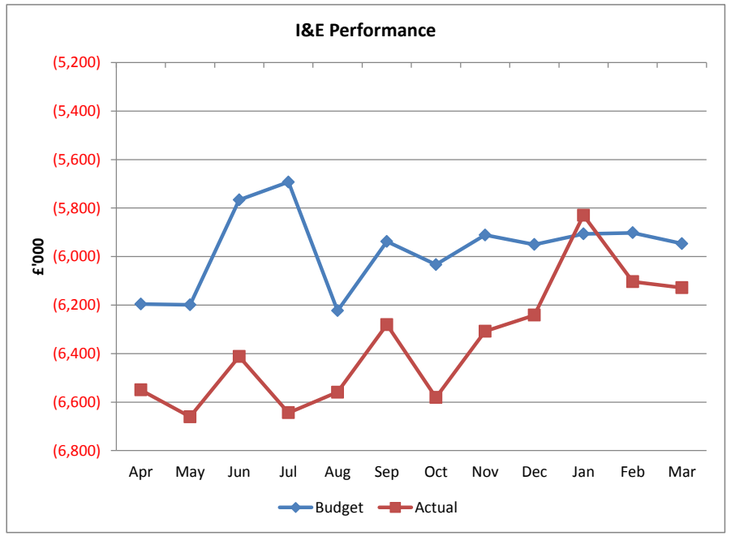
The productivity & efficiency schemes are forecasting £1,382k delivery (26%) against a target of £5,347k.

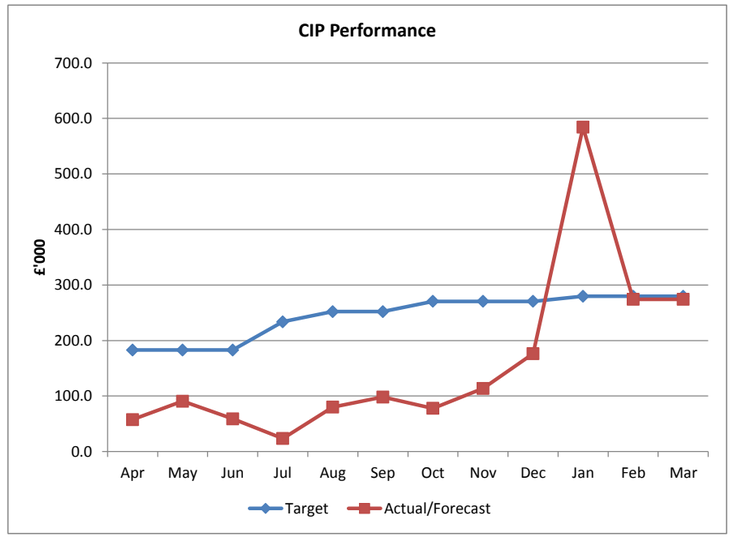
The VIP transformational schemes are forecasting £353k delivery (10%) against the target of £3,388k.

The £5,923k gap has been phased to deliver over the last 3 months of the financial year.

ICAM Divisional Position - Month 9 (December 14)

Income & Expenditure	Ann Plan £'000	In Month Plan £'000	In Month Act £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Act £'000	Year To Date Var £'000
Nhs Clinical Income	7,674	640	827	188	5,756	6,914	1,159
Other Income For Pat Care	1,783	149	147	(2)	1,337	1,314	(23)
Other Non-Patient-Devolved	671	58	58	(0)	522	443	(79)
Other_Non-Patient_Non-Dev	0	0	(34)	(34)	0	0	0
Income	10,128	846	997	151	7,615	8,671	1,057
A/C	5,243	433	484	(52)	3,945	4,369	(424)
Executive Board & Sen Mgmt	486	71	65	6	364	368	(3)
Medical	13,389	1,092	1,251	(159)	10,137	11,338	(1,201)
Nurses & Midwives	28,694	2,380	2,480	(100)	21,580	23,168	(1,588)
Other Support Workers	199	17	36	(20)	150	323	(174)
Scientific, Ther & Tech	16,975	1,412	1,429	(17)	12,733	13,243	(509)
Pay Reserve	(1,638)	(139)	0	(139)	(1,195)	0	(1,195)
Pay	63,347	5,267	5,746	(480)	47,714	52,808	(5,094)
Establishment	458	38	40	(1)	343	459	(116)
Ext Cont Staffing & Cons	115	6	8	(3)	52	409	(357)
Healthcare From Non Nhs	548	46	29	17	411	26	385
Miscellaneous	362	30	33	(2)	271	265	6
Non-Pay Reserve	(253)	(21)	0	(21)	(190)	0	(190)
Premises & Fixed Plant	392	33	49	(17)	294	522	(228)
Supplies & Servs - Clin	16,450	1,368	1,396	(29)	12,347	12,091	256
Supplies & Servs - Gen	373	31	(63)	94	281	326	(45)
Non Pay	18,445	1,530	1,492	38	13,810	14,099	(289)
Income Less Direct Costs	(71,664)	(5,950)	(6,241)	(291)	(53,909)	(58,236)	(4,327)





Income and Expenditure Commentary

The position at month 9 is £291k adverse in month and £4,329k adverse YTD.

NHS Clinical Income is £188k favourable in month due to Winter Resilience income within the position. YTD the position is £1,159k favourable due to prison income recognised in month 1 (£0.5m), additional CCG investments and RTT and winter resilience funding.

Other Income is £36k adverse in month due to IAPT training income now help centrally, with expenditure budget given to division. £102k adverse YTD due to lower than budgeted income for flexible trainees.

Pay is £480k adverse in month and £5,094k adverse YTD.

Nursing is £100k adverse in month and £1,588k YTD due to high agency spend within ED, District Nursing and in Acute Wards. This is high due to vacancies, specialing and high dependency patients on the wards. This variance is offset in part (£54k) with winter resilience income.

Medical is £159k adverse in month and £1,201k adverse YTD. This is due to 3 x agency consultants within medical specialties (gastroenterology x2 and rheumatology) covering vacancies, long term sick leave and maternity. In addition, agency spend on middle grade doctors in ED is higher than planned due to vacancies, high activity, and extra winter staffing. ED overspend (£35k) is offset with winter resilience income.

Unallocated CIP and VIP is leading to a £139k adverse variance in month and £1,195k adverse YTD.

Non-Pay - YTD Adverse £289K; £38k favourable in month due to low spend in wheelchairs (big order in M8). YTD adverse; £341k due to Prison expenditure accounted for in month 1, with no budget (service now decommissioned). This is partially offset by Pharmacy drugs underspend.

CIP Commentary

CIP figures below include Divisional Schemes, Divisional VIP & P&E and N\R Underspend. This will therefore make it difficult to compare to the Trust CIP performance report, with VIP, P&E & N\R not being broken down by division.

In month 9, the division delivered £176k against a plan of £271k. Year to date the division has delivered £772k against a plan of £2,098k.

In month commentary:

ED Nursing - Only additional nursing spend is now offset by winter resilience income.

District Nursing - Cohort of new nurses have started in November and December. This has helped reduce DN run rate, but as yet run rate hasn't been reduced sufficiently to achieve CIP.

Ward Nursing - Saving no longer achievable due to new nursing model

TB - TB income is due to come into the ICAM budget in M10-M12, therefore achieving the CIP for TB in full.

VIP - Emergency Care and Ambulatory Care VIPs not yet delivering. Locality based teams VIP moved to COO cost centre. Emergency care VIP is non-recurrently achieved through winter pressure money funding the twilight shift.

Divisional Actions

Forecast I&E improvement in final 3 months of the year based on significant recruitment, challenging targets set for district nursing and ward specialing expenditure improvement and additional TB income.

ED - 2 x middle grade doctors are due to start date of January. Nursing vacancies are set to be filled by trust wide nursing recruitment drives. Winter resilience is currently funding additional medical and nursing shifts. In month 9 ED was on budget.

District Nursing - Phased recruitment plan in place to reduce agency spend. New nurses have started in November and December, with more expected in January. Savings are delayed due to double running costs for 2 week induction for new starters. Weekly teleconference with Finance lead looking at spend & capacity. Activity levels continue to increase, so savings due to productivity and efficiency have not materialised. Discussions with commissioners to be had regarding reimbursement for this.

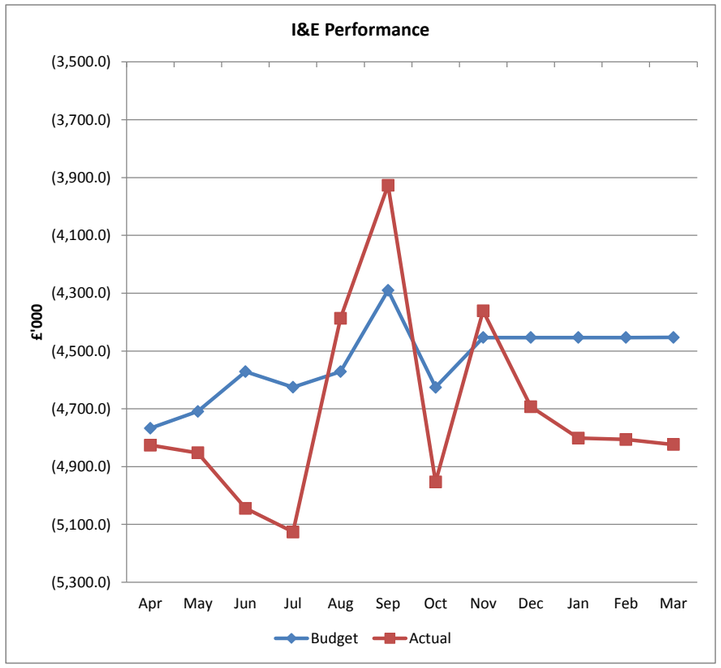
Ward Nursing - Corporate Nursing to look into required budget for specialing and what processes are required to control the spend. Higher scrutiny of agency spend has lead to reduced run rate in M9, with this set to continue for the remainder of the year.

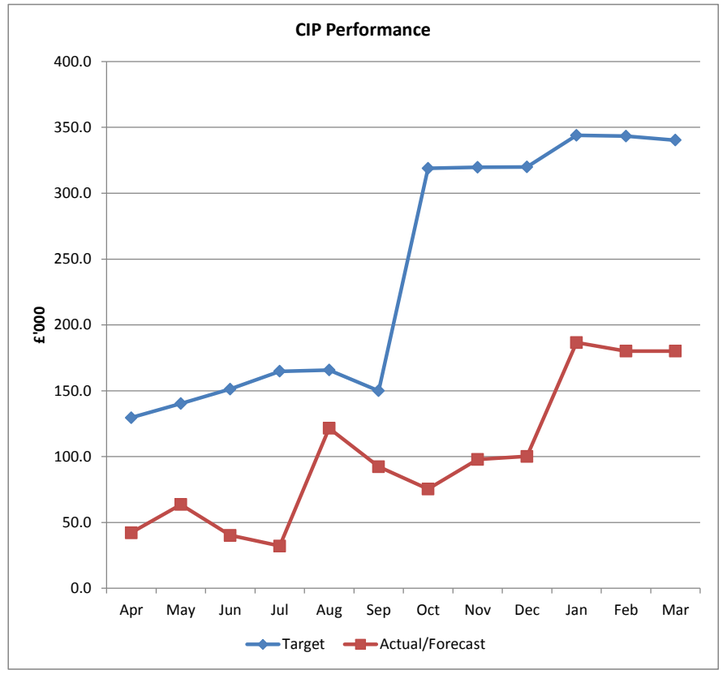
Consultant Agency - 1 x Gastroenterology post offer accepted. Expected to be in post by end of January. 1 x post going out to advert fixed term, expected to be recruited into post by April. 1 x agency consultant has finished in August. Additional activity of UCLH work set to offset overspend in Q4.

Underachieved CIPs - Additional income expected from TB activity, and recruitment of consultant to permanent posts in Gastroenterology, with income from UCLH activity offsetting remaining overspend. All non-essential vacancies to continue to be held vacant where possible.

SCD Divisional Position - Month 9 (December 14)

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Nhs Clinical Income	819	68	153	84	614	2,403	1,789
Other Income For Pat Care	1,028	87	118	31	768	1,034	266
Other Non-Patient-Devolved	740	34	38	4	577	492	(84)
Other_Non-Patient_Non-Dev	640	53	66	13	480	493	13
Income	3,227	242	374	132	2,439	4,422	1,983
A/C	4,040	311	406	(95)	3,106	3,891	(785)
Dental	2,344	195	192	3	1,758	1,742	16
Executive Board & Sen Mgmt	566	47	47	1	425	319	105
Medical	16,165	1,375	1,322	53	12,141	12,259	(118)
Nurses & Midwives	15,069	1,274	1,267	8	11,246	11,335	(89)
Other Support Workers	376	31	27	4	282	261	21
Scientific, Ther & Tech	8,356	700	732	(32)	6,256	6,498	(243)
Pay Reserve	(1,640)	(194)	0	(194)	(1,057)	0	(1,057)
Pay	45,277	3,740	3,992	(252)	34,156	36,306	(2,150)
Establishment	280	23	30	(6)	210	331	(121)
Ext Cont Staffing & Cons	176	(22)	12	(34)	132	109	23
Miscellaneous	334	28	41	(13)	250	395	(145)
Non-Pay Reserve	(65)	(11)	0	(11)	(33)	0	(33)
Premises & Fixed Plant	591	49	66	(16)	443	529	(86)
Supplies & Servs - Clin	10,799	910	881	29	8,069	8,515	(446)
Supplies & Servs - Gen	554	47	47	(0)	414	406	7
Non Pay	12,669	1,024	1,076	(52)	9,485	10,286	(800)
Income Less Direct Costs	(54,719)	(4,522)	(4,694)	(172)	(41,203)	(42,170)	(967)





Income and Expenditure Commentary

The position at month 9 is £172k adverse in month and £967k adverse YTD. Against forecast for the month the Division over-performed by £165k.

Income is £132k favourable in month and £1,983k favourable YTD driven by £1,348k of RTT income recognised YTD along with income from Dental Out of Hours service. Additionally, Resilence 2 funding of £35k was also accounted for in-month as well as income from UCH of £5.4k in-month.

Pay is £252k adverse in month and £2,149k adverse YTD. Against the average runrate of last 8 months the cost of pay in M09 improved by £48k.

Nurses & Midwives is £8k favourable in month and £89K adverse YTD. The improvement is largely due to the escalation bed budget in Coyle and reduction of temporary staffing usage in Theatres by £49K.

Admin and clerical is £95k adverse in month and £785k adverse YTD. This is driven largely by the delayed implementation of TPE (bank admin) and bank spend within Imaging.

Unallocated CIP and VIP is leading to a £194k adverse variance in month and £1,057k adverse YTD. This is because the Planned Activity VIP target was phased from M07.

Non Pay is £52k adverse in month and £800k adverse YTD. This is largely due to costs within theatres (due to RTT activities) and pathology on clinical consumables, prosthetics and reagents.

CIP Commentary -

In month 9 the division delivered £100k against a plan of £320k

Year to date the division has delivered £666k against a plan of £1,860k.

2 % schemes - the division continues to breakeven against the in-month target of £88K since Nov. This includes the non-recurrent schemes. Delivered 73% of the schemes YTD.

Productivity Target - This is under-performing in-month. However it is forecasted to improve through increase in referrals from UCLH for breast and spinal work.

VIP - Transformation stretch target in Diagnostics and parts of Outpatient pathway target have been profiled from Q1 & Q2 which remains un-identified and therefore unachieved. Planned Activity VIP was profiled from M07 which is also unachieved. There are further financial pressures due to extra beds in wards.

Imaging - WLI payments plus bank & agency spend to cover vacancies remains high. Non pay continues to increase.

Theatres schemes - CIP schemes for Theatres are significantly improving by delivering 73% of the schemes as opposed to 23% on average in previous months.

Divisional Actions

Imaging
- A full budget review continues to reduce spend.
- Non Pay is also projected to reduce from Nov 14 when CT injectors scheme is implemented.

Theatres
- Recruitment continues for theatres and reliance on bank and agency spend has reduced.
- We cotinue to work to achieve the final 25% of CIP for theatres.
- Non pay spend is linked to activity. A solution to materials management has been proposed to help with stock control.

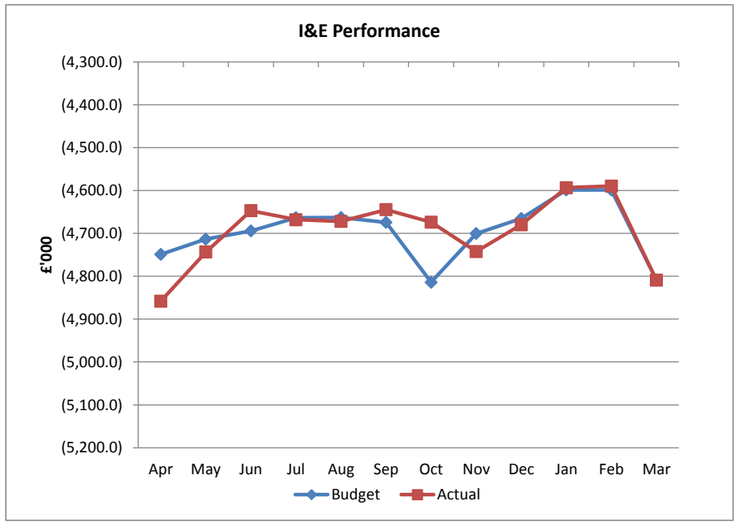
Outpatient Staffing
- Most staff should be in new roles from Q4 onwards.

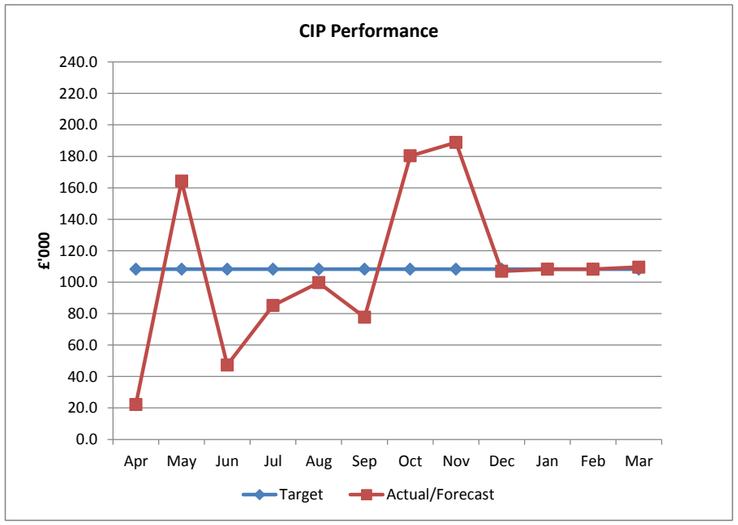
WLI
- The division is constantly engaging with other NHS organisations to bringing in more referrals especially for T&O, spinal and General Surgery services improving utilisation and productivity, building relationships and commercially increasing contribution.

The division is continuously reviewing its financial position and focusing on improving the forecast position for the year.

WCF Divisional Position - Month 9 (December 14)

Income & Expenditure	Ann Plan £'000	In Month Plan £'000	In Month Act £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Act £'000	Year To Date Var £'000
Nhs Clinical Income	1,042	88	151	63	778	1,147	369
Other Income For Pat Care	7,276	602	622	20	5,471	5,826	355
Other Non-Patient-Devolved	304	27	33	7	251	325	73
Other_Non-Patient_Non-Dev	0	0	7	7	0	41	41
Income	8,622	717	814	96	6,500	7,339	839
A/C	4,575	383	411	(27)	3,428	3,612	(184)
Executive Board & Sen Mgmt	666	53	36	17	507	381	126
Medical	11,314	947	1,000	(53)	8,517	8,753	(236)
Nurses & Midwives	31,296	2,579	2,573	5	23,544	23,366	178
Other Support Workers	39	3	11	(8)	30	99	(69)
Scientific, Ther & Tech	13,196	1,096	1,140	(44)	9,936	10,000	(63)
Pay Reserve	(373)	(31)	0	(31)	(280)	0	(280)
Pay	60,714	5,030	5,171	(141)	45,681	46,210	(530)
Establishment	481	39	50	(11)	361	474	(113)
Ext Cont Staffing & Cons	78	7	10	(3)	59	67	(8)
Miscellaneous	293	23	34	(11)	190	298	(108)
Non-Pay Reserve	1	0	0	0	0	0	0
Premises & Fixed Plant	548	47	42	4	408	439	(31)
Supplies & Servs - Clin	2,507	209	163	46	1,879	1,980	(100)
Supplies & Servs - Gen	345	29	24	5	259	200	59
Non Pay	4,253	352	322	31	3,157	3,457	(301)
Income Less Direct Costs	(56,344)	(4,666)	(4,680)	(14)	(42,338)	(42,329)	8





Income and Expenditure Commentary

The WCF position at month 9 is £14k adverse in month and £8k favourable YTD.

Patient Care Income is £83k favourable in month and £724k favourable YTD, which relates to income for new investments where budgets are not yet set, higher GUM activity, new born screening income and YTD RTT funding of £121k.

Other Income is £14k favourable in month and £114k favourable YTD driven by additional education and training and schools income.

Pay is £141k adverse in month and £530k adverse YTD.

Medical is £53k adverse in month and £236k adverse YTD. Of the in-month variance £9k relates to a backdated incremental payment, the balance relates to junior doctor agency expenditure in Obstetrics and Gynaecology and unfunded maternity and sick leave cover. The YTD adverse variance is largely driven by junior doctor agency expenditure in Obstetrics and Gynaecology which has reduced over the past two months. Community paediatrics is also adverse due to part time junior doctors on the rota.

Scientific, Ther & Tech is £44k adverse in month and £63k adverse YTD. Of the in-month variance £9k relates to a new investment within Community CAMHS for which there is corresponding income. The balance relates to therapy services across Paediatric Integrated Care.

Non Pay is £31k favourable in month which is driven by a reduction in spend on clinical supplies and services predominantly on the labour ward and in sexual health. The adverse YTD position of £301k is driven by additional equipment requirements as well as increased activity in special schools, professional services for the preparation of tenders and the costs of setting up new services.

CIP Commentary

CIP figures below include Divisional Schemes, Divisional VIP & P&E and non recurrent underspend. This will therefore make it difficult to compare to the Trust CIP performance report, with VIP, productivity & non recurrent savings not being broken down by division.

In month 9, the division delivered £107k against a plan of £108k.

Year to date the division has delivered CIPs of £973k against the YTD plan of £974k.

Of the £973k delivered YTD, £337k is recurrent and £636k is non-recurrent.

The Division is forecasting that the 2014-15 CIP plan will be achieved in full through recurrent and non-recurrent CIPs.

Although most areas have identified recurrent CIPs, Obstetrics and Gynaecology is an area where this has proved difficult to do.

There are no VIP schemes to report on within WCF.

Divisional Actions

Agency reduction

Close management of sickness levels and vacancies will be key in managing and reducing the bank, agency and locum spend in the coming months.

Recruitment to vacancies are continuing in areas where agency staffing is currently used.

Newly qualified health visiting and midwifery students have taken up their positions, with reductions in agency spend already partly reflected in December, which will continue over the next couple of months.

Obs and Gynae had a gap of 2 WTE in junior doctor rota but one post has now been recruited to and a further post is being recruited to.

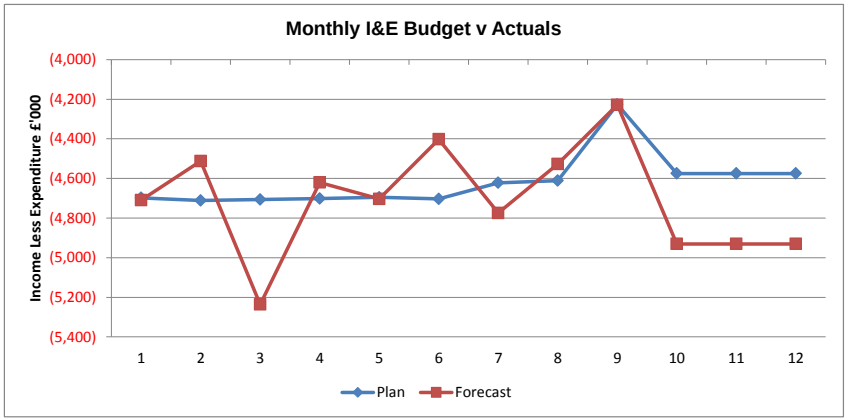
Recent recruitment into NICU has been successful which should result in a reduction in bank agency expenditure from January, when staff have undergone the necessary training.

Income

Ensure all income due is invoiced appropriately for existing contracts and new investments.

Corporate Divisional Position - Month 9 (December 14)

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Organisational Development	2,163	190	224	(34)	1,635	1,929	(294)
Ict	6,642	197	211	(14)	4,983	5,066	(83)
Finance	4,052	338	341	(3)	3,037	3,166	(128)
Trust Secretariat	1,695	137	148	(12)	1,285	1,460	(175)
Chief Operating Officer	1,187	40	119	(79)	1,067	1,321	(253)
Nursing & Patient Experience	9,508	804	796	8	7,097	7,115	(19)
Procurement	789	66	47	19	592	537	55
Medical Director	1,053	88	17	71	790	576	214
Facilities	28,314	2,369	2,325	44	21,191	20,629	563
Total	**55,402**	**4,227**	**4,228**	**(1)**	**41,678**	**41,798**	**(120)**



ICT Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Income	22	2	3	1	17	20	3
Pay	2,977	(109)	(84)	(25)	2,234	2,471	(237)
Non-Pay	3,688	307	298	9	2,766	2,614	152
Total	**(6,642)**	**(197)**	**(211)**	**(14)**	**(4,983)**	**(5,066)**	**(83)**

Facilities Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Income	1,841	133	127	(6)	1,443	1,574	130
Pay	11,178	900	784	117	8,477	7,493	983
Non-Pay	18,978	1,601	1,668	(67)	14,158	14,709	(551)
Total	**(28,314)**	**(2,369)**	**(2,325)**	**44**	**(21,191)**	**(20,629)**	**563**

Nursing & Patient Experience Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Non-Pay	6,075	499	465	34	4,555	4,658	(103)
Non-Nhs Clinical Income	0	0	(10)	10	0	(29)	29
Other Non-Patient Income	(3)	(0)	(15)	14	(2)	(77)	75
Pay	3,435	305	355	(51)	2,543	2,564	(20)
Total	**2,642**	**804**	**796**	**8**	**7,097**	**7,115**	**(19)**

Commentary

The corporate position at month 9 is £1k adverse in month and £120k adverse YTD.

COO - £79k adverse in month and £253k adverse YTD. As reported in month 8, the **forecast position** at year end worsened due to the transfer of a CIP target of £710k (Locality based VIP) from ICAM to COO. There has been no progress to date in achievement of this VIP.

Facilities - The forecast for Estates remains favourable to the end of the year. The £44k favourable variance in M9 is largely driven by reduced expenditure on Communty Estates.

ICT - A schedule of annual non pay expenditure contracts has been agreed with ICT for 2014/15. The YTD ICT bottom line reflects the agreed schedule and is a key driver for the £14k YTD adverse variance, which is an improvement of £54k on the previous month. The adverse YTD position is expected to improve during the remaining months of 2014/15.

Organisational Development - YTD adverse position driven by underperformance against the Occupational Health income target and staffing CIPs.

Finance - YTD adverse position has marginally detriorated by £3k in December. Agency staff continue to be replaced with permanent staff and posts have been held vacant when staff have been transferred to other divisions.

Trust Secretariat – YTD adverse position driven by a number of posts being covered by interim staff. The in month £12k adverse variance continues to be an improvement, compared to the in the average YTD monthly adverse variance of 19k.

Acute Activity Analysis

Activity by PoD Type

		December			YTD		
PoD Group	**Annual Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Adult Critical Care	7,745	645	706	61	5,808	5,438	(370)
Block Contract/Adjustments	0	0	0	0	0	0	0
Day Cases	19,179	1,598	1,496	(102)	14,384	15,219	835
Direct Access	1,014,339	84,528	67,025	(17,503)	760,755	739,835	(20,920)
ED Attendances	104,069	8,672	7,604	(1,068)	78,052	69,516	(8,536)
Elective Inpatients	2,752	229	170	(59)	2,064	2,102	38
Excess Beddays	7,301	608	1,559	951	5,475	6,155	680
Maternity Pathway	8,943	745	692	(53)	6,707	5,923	(784)
NICU High Dependancy Beddays	1,942	162	281	119	1,457	1,481	24
NICU Intensive Care Beddays	880	73	46	(27)	660	427	(233)
NICU Special Care Beddays	5,171	431	308	(123)	3,878	2,964	(914)
NICU Transitional Care Beddays	6,350	529	176	(353)	4,763	3,629	(1,134)
Non-Elective Inpatients	29,445	2,454	2,132	(322)	22,084	20,877	(1,207)
Other Activity	69,572	5,798	1,852	(3,946)	52,179	39,654	(12,525)
Outpatient 1st Attends	61,195	5,100	3,549	(1,551)	45,896	43,941	(1,955)
Outpatient Diagnostic Imaging	23,529	1,961	1,786	(175)	17,647	16,606	(1,041)
Outpatient Follow Ups	152,207	12,684	7,761	(4,923)	114,155	101,865	(12,290)
Outpatient Procedures	21,099	1,758	1,235	(523)	15,824	10,859	(4,965)
Paediatrics High Dependency	256	21	0	(21)	192	315	123
TOTAL	**1,535,974**	**127,998**	**98,378**	**(29,620)**	**1,151,980**	**1,086,806**	**(65,174)**

Commentary

Critical care activity has increased by 231 (49%) compared to November 2014, as a result of improved data capture.

Day case activity is 102 below the Month 9 target of 1,598. NB This line also includes the additional RTT activity (national).

Direct access 'actual' activity has reduced in month by 10,412 (13%) as compared to November 2014. An investigation is on-going to understand this trend, to determine if this is 'seasonality' driven or other.

ED attendance, non elective inpatients and some of 'other' activity are all part of the emergency care pathway. This is reduced due to the impact of admission avoidance schemes and ambulatory care centre.

Elective inpatient activity is below plan, with this line in YTD terms including the additional national RTT work.

Maternity actuals have increased by 17 (3%), compared to November 2014. Actual activity has been lower than plan for the first few months of the year. NICU activity has also been lower the first quarter of the year and continues to increase, with December activity higher than November, by 294 in total for all NICU lines..

OPD activity continues to be below plan due to catch up of data recording, for example in anticoagulation. OPD is also impacted by CQUIN and QIPP schemes.

Outpatient procedures are expected to increase in future months, as the pathways are now in place and data recording is being monitored.

Activity By Commissioner

		December			YTD		
Commissioner	**Annual Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS England	17,697	1,475	1,216	(259)	13,273	11,554	(1,240)
NHS Islington CCG	842,508	70,209	54,907	(15,302)	631,881	599,637	(32,433)
NHS Haringey CCG	521,106	43,425	33,074	(10,351)	390,829	370,383	(20,637)
NHS Camden CCG	30,086	2,507	1,839	(668)	22,564	18,958	(3,625)
NHS City and Hackney CCG	19,066	1,589	754	(835)	14,299	10,782	(3,525)
NHS Enfield CCG	11,822	985	943	(42)	8,866	9,970	1,088
NHS Barnet CCG	69,945	5,829	3,963	(1,866)	52,459	46,634	(5,858)
Other CCG	23,745	1,979	1,682	(297)	17,808	18,888	1,055
TOTAL	**1,535,974**	**127,998**	**98,378**	**(29,620)**	**1,151,980**	**1,086,806**	**(65,174)**

Commentary

The NHS England variance due to critical care activity and time lag in payment of high cost drugs.

Acute Income Analysis

Income Analysis

PoD Group	Annual Plan £'000	December Plan £'000	December Actual £'000	December Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Adult Critical Care	£ 10,160	£ 847	£ 926	£ 80	£ 7,620	£ 7,083	-£ 537
Block Contract/Adjustments	£ 10,997	£ 916	£ 1,016	£ 100	£ 8,248	£ 9,127	£ 880
Day Cases	£ 11,899	£ 992	£ 963	-£ 28	£ 8,924	£ 9,644	£ 720
Direct Access	£ 10,965	£ 914	£ 845	-£ 68	£ 8,224	£ 8,868	£ 644
ED Attendances	£ 11,434	£ 953	£ 849	-£ 104	£ 8,576	£ 7,755	-£ 820
Elective Inpatients	£ 9,142	£ 762	£ 543	-£ 219	£ 6,856	£ 6,589	-£ 267
Excess Beddays	£ 2,140	£ 178	£ 194	£ 15	£ 1,605	£ 1,476	-£ 129
Maternity Pathway	£ 9,945	£ 829	£ 703	-£ 126	£ 7,459	£ 6,678	-£ 781
NICU High Dependancy Beddays	£ 1,717	£ 143	£ 248	£ 105	£ 1,288	£ 1,309	£ 21
NICU Intensive Care Beddays	£ 1,012	£ 84	£ 53	-£ 31	£ 759	£ 491	-£ 268
NICU Special Care Beddays	£ 1,974	£ 165	£ 118	-£ 47	£ 1,481	£ 1,132	-£ 349
NICU Transitional Care Beddays	£ 2,425	£ 202	£ 67	-£ 135	£ 1,818	£ 1,386	-£ 433
Non-Elective Inpatients	£ 42,876	£ 3,573	£ 3,563	-£ 10	£ 32,157	£ 29,813	-£ 2,344
Other Activity	£ 2,010	£ 167	£ 108	-£ 59	£ 1,507	£ 1,081	-£ 426
Outpatient 1st Attends	£ 8,916	£ 743	£ 655	-£ 88	£ 6,687	£ 6,600	-£ 87
Outpatient Diagnostic Imaging	£ 2,655	£ 221	£ 203	-£ 19	£ 1,991	£ 1,840	-£ 151
Outpatient Follow Ups	£ 11,631	£ 969	£ 808	-£ 162	£ 8,724	£ 8,188	-£ 535
Outpatient Procedures	£ 3,596	£ 300	£ 217	-£ 83	£ 2,697	£ 1,954	-£ 743
Paediatrics High Dependency	£ 263	£ 22	£ -	-£ 22	£ 197	£ 323	£ 126
TOTAL	**£ 155,757**	**£ 12,980**	**£ 12,078**	**-£ 902**	**£ 116,818**	**£ 111,338**	**-£ 5,480**

Income by Commissioner - £000's

NHS England	£ 13,942	£ 1,162	£ 953	-£ 209	£ 10,457	£ 8,880	-£ 1,577
NHS Islington CCG	£ 64,371	£ 5,364	£ 5,015	-£ 349	£ 48,278	£ 45,696	-£ 2,583
NHS Haringey CCG	£ 49,898	£ 4,158	£ 3,944	-£ 214	£ 37,424	£ 36,641	-£ 783
NHS Camden CCG	£ 5,280	£ 440	£ 389	-£ 51	£ 3,960	£ 3,079	-£ 881
NHS City and Hackney CCG	£ 4,776	£ 398	£ 259	-£ 140	£ 3,582	£ 3,213	-£ 369
NHS Enfield CCG	£ 2,892	£ 241	£ 333	£ 92	£ 2,169	£ 2,454	£ 285
NHS Barnet CCG	£ 9,056	£ 755	£ 683	-£ 72	£ 6,792	£ 6,642	-£ 151
Other CCG	£ 5,541	£ 462	£ 504	£ 42	£ 4,156	£ 4,733	£ 578
TOTAL	**£ 155,757**	**£ 12,980**	**£ 12,078**	**-£ 902**	**£ 116,818**	**£ 111,338**	**-£ 5,480**

Commentary

In month 9 the Trust financial position continues to show the acute income position to be reflected as though the Trust were under a block contract.

The tables presented on this page show the position for the first 9 months of the year as if the Trust were on a pure PbR acute contract and therefore this does not reflect the actual Trust income position. The position shows an *under performance* of £0.9m in month and an *under performance* of £5.5m YTD.

Actions taken to resolve data capture and coding issues are showing results. There will be continued focus on this. Income on our acute medical pathway continues to be below plan and there is work with commissioners on developing our approach to funding ambulatory care for 2015/16.

PoD Group	Annual Plan £'000	November Plan £'000	November Actual £'000	November Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	M9-M8 £	M9-M8 %
Adult Critical Care	£ 10,144	£ 845	£ 623	-£ 222	£ 6,763	£ 6,024	-£ 739	303,040	49%
Block Contract/Adjustments	£ 11,725	£ 977	£ 1,026	£ 48	£ 7,817	£ 8,208	£ 391	-9,520	-1%
Day Cases	£ 11,883	£ 990	£ 1,090	£ 100	£ 7,922	£ 8,645	£ 723	-126,526	-12%
Direct Access	£ 10,966	£ 914	£ 929	£ 15	£ 7,311	£ 7,985	£ 674	-83,844	-9%
ED Attendances	£ 11,412	£ 951	£ 861	-£ 90	£ 7,608	£ 6,906	-£ 702	-12,299	-1%
Elective Inpatients	£ 9,136	£ 761	£ 785	£ 23	£ 6,090	£ 5,999	-£ 91	-241,483	-31%
Excess Bed days	£ 2,136	£ 178	£ 147	-£ 31	£ 1,424	£ 1,317	-£ 107	46,113	31%
Maternity Pathway	£ 9,937	£ 828	£ 778	-£ 50	£ 6,624	£ 5,992	-£ 633	-74,831	-10%
NICU High Dependency Bed days	£ 1,717	£ 143	£ 179	£ 36	£ 1,145	£ 1,062	-£ 83	68,951	38%
NICU Intensive Care Bed days	£ 1,012	£ 84	£ 18	-£ 66	£ 675	£ 438	-£ 237	34,479	188%
NICU Special Care Bed days	£ 1,974	£ 165	£ 101	-£ 64	£ 1,316	£ 1,013	-£ 303	16,799	17%
NICU Transitional Care Bed days	£ 2,424	£ 202	£ 13	-£ 189	£ 1,616	£ 1,172	-£ 444	54,215	418%
Non-Elective Inpatients	£ 42,815	£ 3,568	£ 3,308	-£ 260	£ 28,543	£ 26,224	-£ 2,319	254,958	8%
Other Activity	£ 2,001	£ 167	£ 96	-£ 71	£ 1,334	£ 960	-£ 374	12,277	13%
Outpatient 1st Attends	£ 8,902	£ 742	£ 689	-£ 53	£ 5,934	£ 5,919	-£ 16	-34,106	-5%
Outpatient Diagnostic Imaging	£ 2,653	£ 221	£ 192	-£ 29	£ 1,769	£ 1,646	-£ 123	10,581	6%
Outpatient Follow Ups	£ 11,615	£ 968	£ 816	-£ 151	£ 7,743	£ 7,303	-£ 440	-8,744	-1%
Outpatient Procedures	£ 3,590	£ 299	£ 248	-£ 51	£ 2,393	£ 1,735	-£ 659	-31,144	-13%
Paediatrics High Dependency	£ 262	£ 22	£ -	-£ 22	£ 175	£ 255	£ 81	0	#DIV/0!
TOTAL	**£ 156,304**	**£ 13,025**	**£ 11,899**	**-£ 1,126**	**£ 104,203**	**£ 98,801**	**-£ 5,401**	178,916	2%

Income by Commissioner - £000's

NHS England	£ 14,654	£ 1,221	£ 892	-£ 329	£ 9,769	£ 7,759	-£ 2,010	60,663	7%
NHS Islington CCG	£ 64,425	£ 5,369	£ 4,973	-£ 396	£ 42,950	£ 40,609	-£ 2,342	41,672	1%
NHS Haringey CCG	£ 49,899	£ 4,158	£ 4,016	-£ 142	£ 33,266	£ 32,563	-£ 703	-71,448	-2%
NHS Camden CCG	£ 4,956	£ 413	£ 400	-£ 13	£ 3,304	£ 2,693	-£ 611	-11,293	-3%
NHS City and Hackney CCG	£ 4,768	£ 397	£ 268	-£ 130	£ 3,179	£ 2,940	-£ 239	-9,255	-3%
NHS Enfield CCG	£ 2,921	£ 243	£ 258	£ 15	£ 1,947	£ 2,100	£ 152	74,537	29%
NHS Barnet CCG	£ 9,097	£ 758	£ 635	-£ 123	£ 6,065	£ 5,939	-£ 126	47,155	7%
Other CCG	£ 5,584	£ 465	£ 457	-£ 8	£ 3,723	£ 4,200	£ 477	46,885	10%
TOTAL	**£ 156,304**	**£ 13,025**	**£ 11,899**	**-£ 1,126**	**£ 104,203**	**£ 98,801**	**-£ 5,401**	178,916	2%

Acute Activity and Income Variances by Division

In Month Activity Variance - December

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	0	0	61	0	**61**
Block Contract/Adjustments	0	0	0	0	**0**
Day Cases	0	-84	51	-69	**-102**
Direct Access	0	157	-17,660	0	**-17,503**
ED Attendances	0	-1,068	0	0	**-1,068**
Elective Inpatients	0	-10	-45	-4	**-59**
Excess Beddays	0	830	122	-0	**951**
Maternity Pathway	0	0	0	-53	**-53**
NICU High Dependancy Beddays	0	0	0	119	**119**
NICU Intensive Care Beddays	0	0	0	-27	**-27**
NICU Special Care Beddays	0	0	0	-123	**-123**
NICU Transitional Care Beddays	0	0	0	-353	**-353**
Non-Elective Inpatients	0	-16	-30	-276	**-322**
Other Activity	0	-988	16	-2,973	**-3,946**
Outpatient 1st Attends	0	-212	-472	-866	**-1,551**
Outpatient Diagnostic Imaging	0	-103	-59	-13	**-175**
Outpatient Follow Ups	0	-1,979	-167	-2,777	**-4,923**
Outpatient Procedures	0	-136	-113	-274	**-523**
Paediatrics High Dependency	0	0	0	-21	**-21**
TOTAL	**0**	**-3,611**	**-18,297**	**-7,712**	**-29,620**

In Month Price Variance £000's - December

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	£ -	£ -	£ 80	£ -	**£ 80**
Block Contract/Adjustments	£ 100	£ -	£ -	£ -	**£ 100**
Day Cases	£ -	-£ 48	£ 62	-£ 43	**-£ 28**
Direct Access	£ -	£ 137	-£ 205	£ -	**-£ 68**
ED Attendances	£ -	-£ 104	£ -	£ -	**-£ 104**
Elective Inpatients	£ -	-£ 10	-£ 204	-£ 4	**-£ 219**
Excess Beddays	£ -	£ 17	£ 18	-£ 19	**£ 15**
Maternity Pathway	£ -	£ -	£ -	-£ 126	**-£ 126**
NICU High Dependancy Beddays	£ -	£ -	£ -	£ 105	**£ 105**
NICU Intensive Care Beddays	£ -	£ -	£ -	-£ 31	**-£ 31**
NICU Special Care Beddays	£ -	£ -	£ -	-£ 47	**-£ 47**
NICU Transitional Care Beddays	£ -	£ -	£ -	-£ 135	**-£ 135**
Non-Elective Inpatients	£ -	£ 116	-£ 57	-£ 70	**-£ 10**
Other Activity	£ -	-£ 47	£ 0	-£ 13	**-£ 59**
Outpatient 1st Attends	£ -	-£ 34	-£ 68	£ 14	**-£ 88**
Outpatient Diagnostic Imaging	£ -	-£ 13	-£ 5	-£ 0	**-£ 19**
Outpatient Follow Ups	£ -	-£ 108	-£ 15	-£ 38	**-£ 162**
Outpatient Procedures	£ -	-£ 17	-£ 12	-£ 54	**-£ 83**
Paediatrics High Dependency	£ -	£ -	£ -	-£ 22	**-£ 22**
TOTAL	**£ 100**	**-£ 111**	**-£ 407**	**-£ 484**	**-£ 902**

YTD Activity Variance

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	0	0	-370	0	**-370**
Block Contract/Adjustments	0	0	0	0	**0**
Day Cases	0	448	657	-271	**835**
Direct Access	0	4,682	-25,602	0	**-20,920**
ED Attendances	0	-8,536	0	0	**-8,536**
Elective Inpatients	0	58	-74	55	**38**
Excess Beddays	0	678	-75	77	**680**
Maternity Pathway	0	0	0	-784	**-784**
NICU High Dependancy Beddays	0	0	0	24	**24**
NICU Intensive Care Beddays	0	0	0	-233	**-233**
NICU Special Care Beddays	0	0	0	-914	**-914**
NICU Transitional Care Beddays	0	0	0	-1,134	**-1,134**
Non-Elective Inpatients	0	-84	-308	-815	**-1,207**
Other Activity	0	-4,354	867	-9,038	**-12,525**
Outpatient 1st Attends	0	-295	-2,271	612	**-1,955**
Outpatient Diagnostic Imaging	0	-294	-542	-205	**-1,041**
Outpatient Follow Ups	0	-8,340	2,839	-6,789	**-12,290**
Outpatient Procedures	0	-1,190	-2,006	-1,769	**-4,965**
Paediatrics High Dependency	0	0	0	123	**123**
TOTAL	**0**	**-17,225**	**-26,888**	**-21,061**	**-65,174**

YTD Price Variance £000's

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	£ -	£ -	-£ 537	£ -	**-£ 537**
Block Contract/Adjustments	£ 1,480	-£ 600	£ -	£ -	**£ 880**
Day Cases	£ -	£ 240	£ 654	-£ 174	**£ 720**
Direct Access	£ -	£ 1,038	-£ 394	£ -	**£ 644**
ED Attendances	£ -	-£ 820	£ -	£ -	**-£ 820**
Elective Inpatients	£ -	£ 65	-£ 455	£ 123	**-£ 267**
Excess Beddays	£ -	-£ 19	-£ 46	-£ 64	**-£ 129**
Maternity Pathway	£ -	£ -	£ -	-£ 781	**-£ 781**
NICU High Dependancy Beddays	£ -	£ -	£ -	£ 21	**£ 21**
NICU Intensive Care Beddays	£ -	£ -	£ -	-£ 268	**-£ 268**
NICU Special Care Beddays	£ -	£ -	£ -	-£ 349	**-£ 349**
NICU Transitional Care Beddays	£ -	£ -	£ -	-£ 433	**-£ 433**
Non-Elective Inpatients	£ -	-£ 600	-£ 927	-£ 817	**-£ 2,344**
Other Activity	£ -	-£ 323	£ 1	-£ 105	**-£ 426**
Outpatient 1st Attends	£ -	£ 19	-£ 340	£ 234	**-£ 87**
Outpatient Diagnostic Imaging	£ -	-£ 73	-£ 66	-£ 12	**-£ 151**
Outpatient Follow Ups	£ -	-£ 592	£ 273	-£ 216	**-£ 535**
Outpatient Procedures	£ -	-£ 148	-£ 246	-£ 349	**-£ 743**
Paediatrics High Dependency	£ -	£ -	£ -	£ 126	**£ 126**
TOTAL	**£ 1,480**	**-£ 1,812**	**-£ 2,083**	**-£ 3,065**	**-£ 5,480**

Statement of Financial Position

	As at 1st April 2014	As at 31st December	Forecast 31st March 2015	Plan 31st March 2015
	£000	£000	£000	£000
Non Current Assets				
Property, plant and equipment	179,975	182,722	187,317	180,105
Intangible assets	5,428	4,464	4,023	4,295
Trade and other receivables	702	955	533	610
Total Non Current Assets	**186,105**	**188,141**	**191,873**	**185,010**
Current Assets				
Inventories	1,295	1,565	1,456	1,290
Trade and other receivables	17,527	19,309	14,994	6,930
Cash and cash equivalents	5,123	2,223	5,596	3,976
Total Current Assets	**23,945**	**23,097**	**22,046**	**12,196**
Total Assets	**210,050**	**211,238**	**213,919**	**197,206**
Current Liabilities (amounts due in less than one year)				
Trade and other payables	36,010	36,749	45,187	27,154
Borrowings	1,377	1,360	2,344	2,542
Provisions	1,238	375	417	198
Total Current Liabilities	**38,625**	**38,484**	**47,948**	**29,894**
Net Current Assets (Liabilities)	**(14,680)**	**(15,387)**	**(25,902)**	**(17,698)**
Total Assets less Current Liabilities	**200,785**	**203,528**	**217,775**	**202,708**
Non Current Liabilities (amounts due greater than one year)				
Borrowings	36,758	34,716	34,419	34,028
Provisions	2,015	1,863	1,915	2,190
Total Non Current Liabilities	**38,773**	**36,579**	**36,334**	**36,218**
Total Assets Employed	**132,652**	**136,175**	**129,637**	**131,094**
Taxpayers' Equity				
Public dividend capital	56,461	62,111	56,721	56,671
Retained earnings	15,277	7,989	6,788	18,918
Revaluation reserve	60,914	66,075	66,128	55,505
Total Taxpayers' Equity	**132,652**	**136,175**	**129,637**	**131,094**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**

Commentary

A revaluation of land and buildings took place earlier in the year which increased both property, plant and equipment (PPE) and the revaluation reserve by £5.3m. This was partially offset by impairments of £1.2m which reduced both PPE and retained earnings, but are excluded from the breakeven duty. A further revaluation is expected at the year end, which cannot yet be quantified.

The revaluation also increased asset lives, thereby reducing the depreciation charged to both PPE and retained earnings. PPE additions are below plan for the year to date, but forecast to meet the capital resource limit by the year end.

Cash increased during the month by £1m mainly due to the receipt of temporary public dividend capital of £5.6m, with a corresponding increase in taxpayer's equity. This receipt was partially offset by the clearance of a backlog of payments. Cash is subject to various risks, mainly involving receivables, payables and CIP delivery.

There has been a reduction over the year in retained earnings due to the impairment and the income and expenditure deficit. Recovery of the latter is dependent upon CIP delivery.

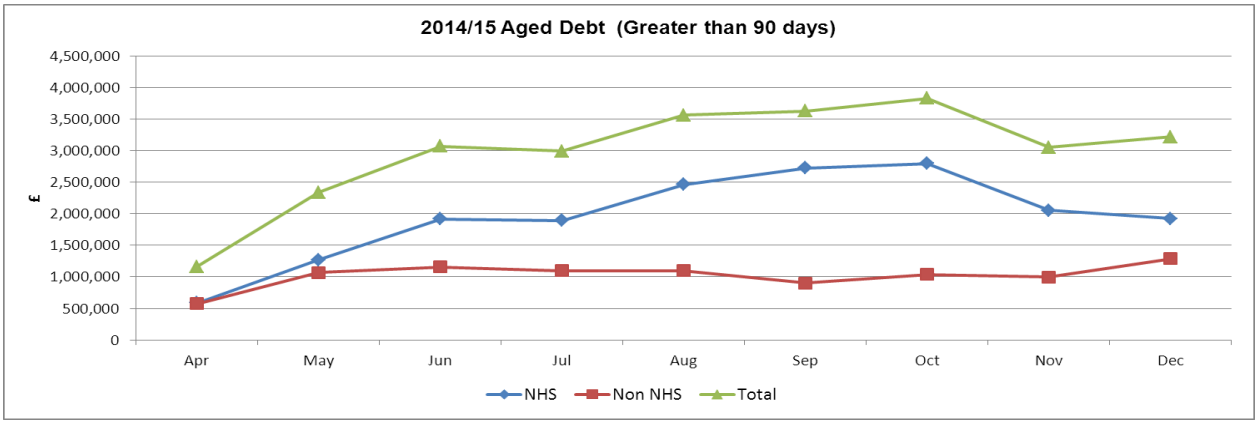
Month 9 (December) Aged Debtors Analysis
Period End Date: 23/12/2014

£	Sum of Outstanding debtors	Days Range						
	NHS	30 Days & Under	30 to 60 Days	60 to 90 Days	Over 90 Days	Over 365 Days	Greater than 90 Days	Grand Total
1	NHS ISLINGTON CCG	2,060,339	11,416	25,511	294,450	52,963	347,413	**2,444,678**
2	NHS HARINGEY CCG	971,649	18,271	12,435	37,262	7,837	45,099	**1,047,454**
3	THE ROYAL FREE LONDON NHS FT	292,663	181,972	15,710	111,514	0	111,514	**601,859**
4	NHS CITY & HACKNEY CCG	0	(74,754)	(18,665)	482,792	0	482,792	**389,373**
5	THE UCL HOSPITALS NHS FOUNDATION TRUST	65,153	19,239	29,090	122,778	24,278	147,056	**260,538**
6	NHS ENFIELD CCG	25,283	43,102	32,000	150,123	0	150,123	**250,508**
7	NHS BARNET CCG	7,355	0	0	203,072	0	203,072	**210,427**
8	CNWL NHS FOUNDATION TRUST	56,504	18,322	0	100,185	0	100,185	**175,011**
9	NHS BRENT CCG	2,887	125,707	(3,831)	10,059	0	10,059	**134,822**
10	ROYAL FREE LONDON NHS FT	77,926	24,744	3,523	22,385	0	22,385	**128,578**
Top 1	**Top 10 NHS Total:**	3,559,760	368,019	95,772	1,534,621	85,078	1,619,698	**5,643,249**
	All Other NHS Total:	940,352	7,873	(223,282)	270,898	35,267	306,166	**1,031,108**
	NHS Total	**4,500,112**	**375,891**	**(127,510)**	**1,805,519**	**120,345**	**1,925,864**	**6,674,357**
	NHS Total Previous Month	**1,860,443**	**(45,367)**	**364,631**	**1,907,757**	**147,448**	**2,055,204**	**4,234,911**
	NHS Total Movement (Month 8 to Month 9)	**2,639,668**	**421,258**	**(492,141)**	**(102,238)**	**(27,102)**	**(129,340)**	**2,439,446**

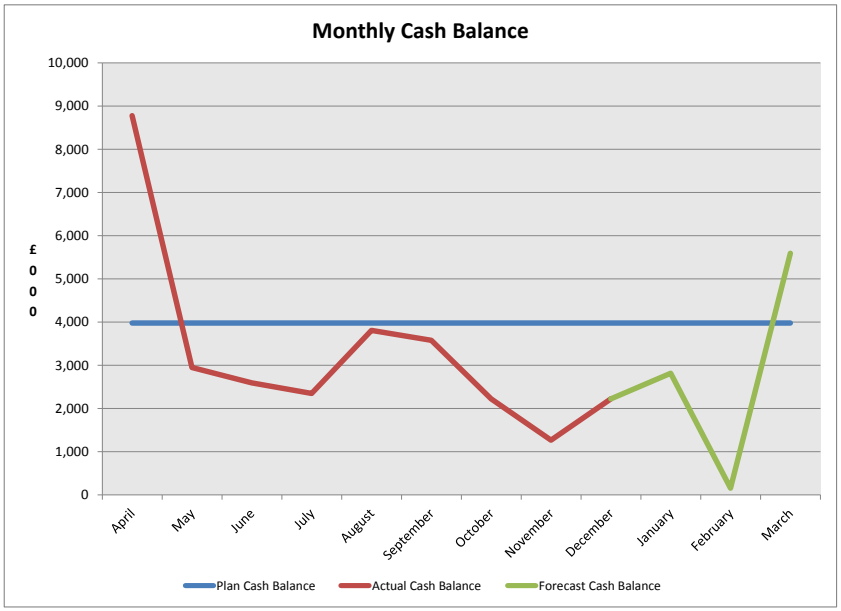
£	Non NHS	30 Days & Under	30 to 60 Days	60 to 90 Days	Over 90 Days	Over 365 Days	Greater than 90 Days	Grand Total
1	LONDON BOROUGH OF HARINGEY	607,873	256,795	501,258	221,519	(4,325)	217,194	**1,583,121**
2	OVERSEAS VISITOR (SH)	50,368	47,220	42,498	116,528	0	116,528	**256,614**
3	LONDON BOROUGH OF ISLINGTON	203,596	0	3,018	4,915	26	4,941	**211,555**
4	THE HIGH ROAD SURGERY	0	0	0	159,613	0	159,613	**159,613**
5	ACTION FOR STAMMERING CHILDREN	105,606	0	0	0	0	0	**105,606**
6	HIGHBURY GRANGE HC	11,084	0	0	75,306	0	75,306	**86,390**
7	LONDON BOROUGH OF CAMDEN	23,435	633	55,803	2,227	0	2,227	**82,097**
8	LONDON BOROUGH OF HACKNEY	9,106	0	38,021	428	31,760	32,187	**79,315**
9	RIVER PLACE GROUP PRACTICE	22,961	0	0	49,320	0	49,320	**72,282**
10	THE RISE PRACTICE	10,916	0	0	49,356	0	49,356	**60,273**
	Top 10 Non NHS Total:	1,044,948	304,648	640,598	679,211	27,461	706,672	**2,696,866**
	All other Non NHS Total:	332,790	82,929	50,680	369,041	214,380	583,421	**1,049,819**
	Non NHS Total:	**1,377,737**	**387,577**	**691,278**	**1,048,252**	**241,841**	**1,290,093**	**3,746,685**
	Non NHS Total Previous Month	**934,361**	**740,031**	**405,066**	**783,896**	**211,359**	**995,255**	**3,074,713**
	Non NHS Total Movement (Month 8 to Month 9)	**443,376**	**(352,454)**	**286,212**	**264,356**	**30,481**	**294,838**	**671,971**
	Grand Total	**5,877,849**	**763,468**	**563,768**	**2,853,772**	**362,186**	**3,215,957**	**10,421,042**
	Grand Total Previous Month	**2,794,804**	**694,664**	**769,697**	**2,691,653**	**358,807**	**3,050,459**	**7,309,624**
	Grand Total Movement	**3,083,045**	**68,804**	**(205,929)**	**162,119**	**3,379**	**165,498**	**3,111,418**

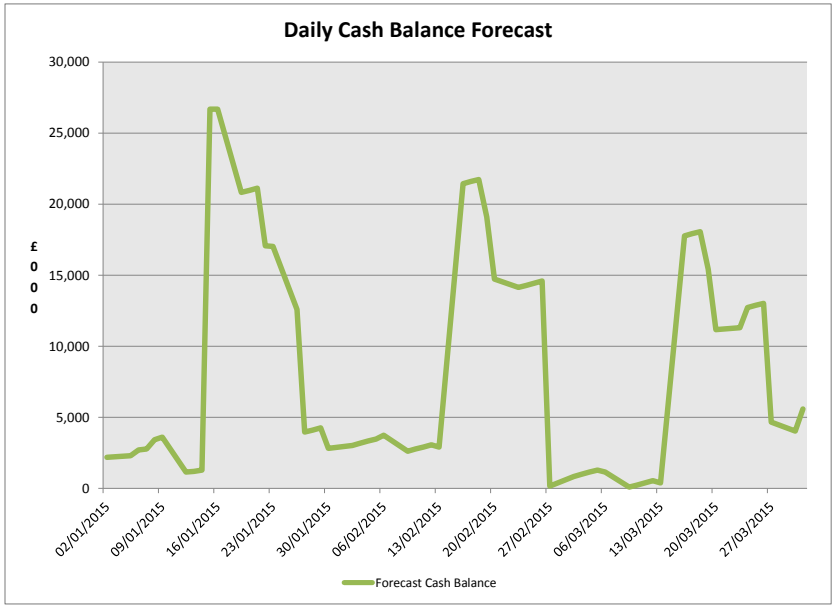
Commentary

Aged Debt 'Greater than 90 days' has increased by £0.2m to £3.2m in Month 9. Material aged debt over 90 days include:
Rent and Rates charges to L.B. Haringey, CNWL and various GP Surgeries(£714k). 2013/14 payments relating to changes in the way the Trust is paid for the maternity pathway total £540k and while our lead commissioners Islington and Haringey have paid their bills, other CCGs are yet to pay.
Outstanding debt of £400k relates to the NHSE Community Dental Contract which was transferred out of CCG contracts in 13/14. A swift resolution is required in order to also secure the correct contract value for 14/15.Other amounts include £305k of NCA (Non Contractual Activity), outstanding SLA performance debts(£392k) Debts with UCLH (£147K), Royal Free (£221k) and a number of other smaller debts including overseas patients.



Cash Forecast for the Trust





Commentary

The principal cash inflows are clinical SLA receipts, typically around £19m in the middle of the month. Cash decreases sharply in the latter part of the month due to income tax, NI and pension contributions totalling £7m and the monthly payroll of around £9.5m on the 27th of the month. Any cash available after allowing for these obligations is used to service the weekly payment of creditors. The underlying payment run is normally around £1m but there are numerous variables which can have a significant impact on the value. Major payments distorting these values are accounted for specifically in the forecast.

Income is invoiced as promptly as possible, and outstanding debts chased regularly. Prioritisation is on the basis of materiality, notably the clinical SLAs. Creditors are prioritised by due date, with payments being restricted if there is insufficient cash to pay eveyrything due.

The forecast shows what is necessary in order to meet the year end target and thereby meet the EFL. Major assumptions in this forecast comprise reduced payments from the CIP and below average payment runs. Failure to meet any of these conditions may compromise the statutory duty to operate within the EFL.

In December, the Trust received a £5.6m cash loan, in the form of temporary PDC. This is forecast to be repaid in January.

The most significant outstanding payments are to Community Health Partnerships. These payments are forecast in February, with a consequent dip in the cash balance.

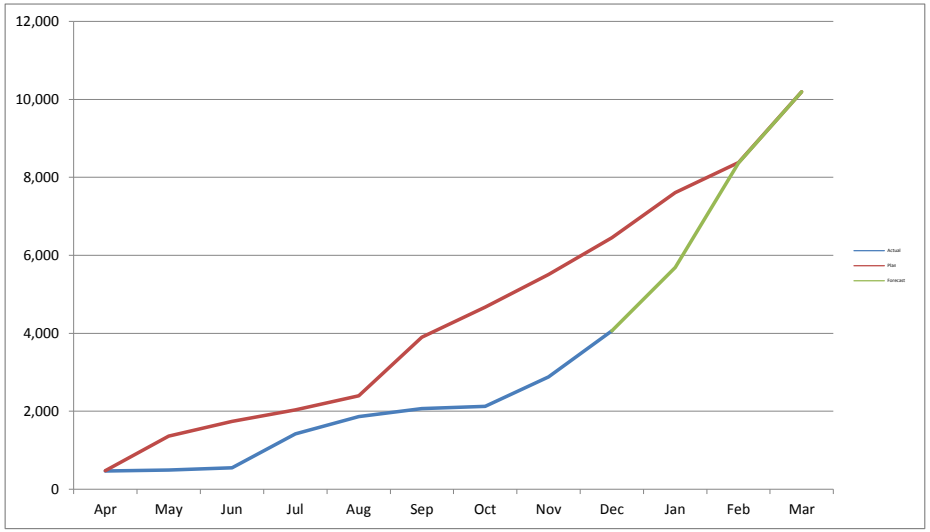
Action needed to meet the cash target and associated EFL comprises ensuring that all income is invoiced as soon as possible, and reducing expenditure in line with the CIP.

Capital Spend Performance and Forecast

	Annual	Current Month			YTD			Forecast Outturn		
	Plan	Plan	Act	Var	Plan	Act	Var	Plan	Forecast	Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates	5,618	695	636	59	3,177	2,102	1,075	5,618	5,618	-
IT	810	145	409	-264	345	1,250	-905	810	810	-
Equipment	1,514	100	0	100	1,329	310	1,019	1,514	1,514	-
Business Cases	336	0	0	0	0	0	0	336	336	-
Leases	1,922	0	143	-143	1,598	403	1,195	1,922	1,922	-
Total	**10,200**	**940**	**1,188**	**-248**	**6,449**	**4,065**	**2,384**	**10,200**	**10,200**	**-**

CRL	10,200
Variance	0

Spend against Capital Programme



Commentary

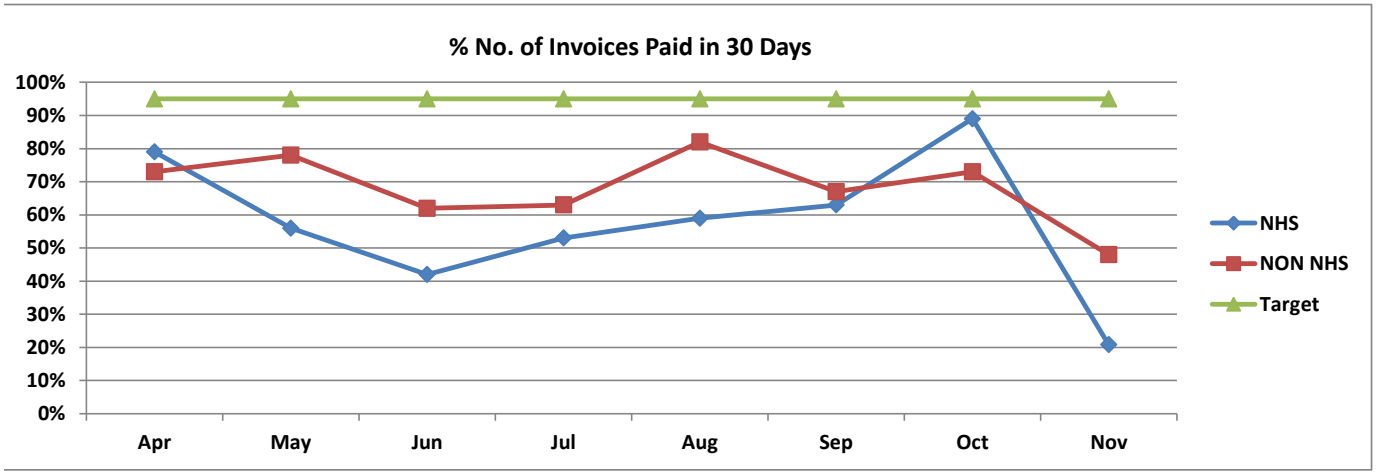
- The Capital Accountant meets regularly with project managers and monthly at the Capital Monitoring Group (CMG) to report progress against plan.

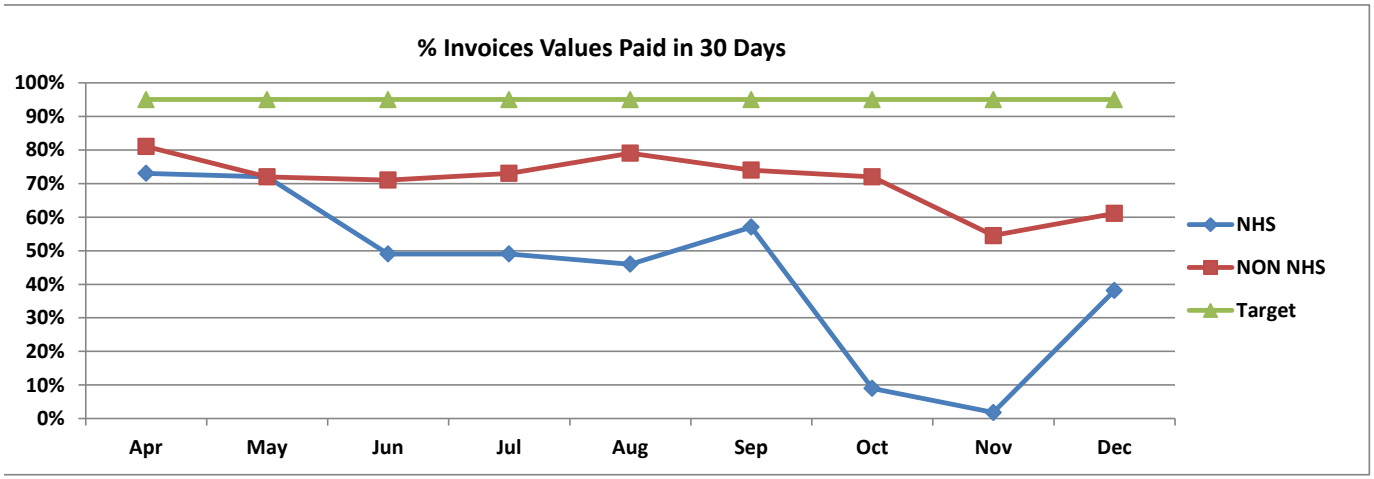
- The year to date actuals are showing an underspend against plan due to delays & changes to the capital programme to meet the Trust's priorities. The CMG is still forecasting to spend the £10.2m as planned.

- The in month variance is due to the IT month 1-9 capital project cost and the delayed leased ultrasound

- The Trust is expecting to spend up to it's Capital Resource Limit (CRL).

Best Practice Payment Code





Commentary

The Trust is currently falling short against its requirement of paying 95% of invoices within 30 days.

Part of the reason for the poor performance is due to active management of working capital, which is planned to continue during the remainder of the 2014\15 financial year.

Performance against the BPPC has improved in December, with backlog payments being made for invoices which are over the 30 day target.

In December, the Trust received applied for and received a £5.6m cash loan (temporary PDC), which has been used to clear backlog payments.

Continuity of Services Risk Rating (COSR)

Metric	Definition	Parameters 1	2	3	4	Actual YTD	Forecast Outturn	Plan Outturn
Working Capital Balance (£'000) (+/-)						(16,952)	(20,137)	(18,988)
Annual Operating Expenses (£'000) (+)						211,862	280,024	271,133
Liquidity Ratio (Days)						(22)	(19)	(25)
Liquidity Rating	Working Capital Balance x 360 / Annual Operating Expenses	**<-14**	**-14**	**-7**	**0**	**1**	**1**	**1**
Revenue Available for Debt Service (£'000) (+)						5,402	9,440	16,786
Annual Debt Service (£'000) (+)						7,617	10,422	10,358
Capital Servicing Capacity (Times)						0.7	0.9	1.6
Capital Servicing Capacity Rating	Revenue Available for Debt Service / Annual Debt Service	**<1.25**	**1.25**	**1.75**	**2.50**	**1**	**1**	**2**
Weighted:								
Liquidity Rating - 50%						**0.5**	**0.5**	**0.5**
Capital Servicing Capacity Rating - 50%						**0.5**	**0.5**	**1.0**
Overall Continuity of Services Risk Rating						**1**	**1**	**2**

The Continuity of Services Rating (COSR) represents the financial risk rating used by Monitor, where a score of "one" highlights an organisation as "high risk". The table shows that WH is in this high risk category

Whilst this demonstrates the need for improvement this should be assessed in light of two key factors. Firstly, our current financial performance is materially below plan and supports an assessment of high risk. Secondly, a strong COSR performance relies upon a strong working capital position and our balance sheet has been recognised as, historically, weak. We therefore find ourselves at a disadvantage under this measure, for example, compared to Foundation Trusts that have high cash balances from previous land and property sales even though they may also report an in year deficit.

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The Whittington Hospital NHS Trust
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Whittington Health Trust Board

4th February 2015

Title:	**NHS Trust Development Authority (TDA) – Self-Certification**		
Agenda item:	**15/026**	**Paper**	**9**
Action requested:	***For approval***		
Executive Summary:	The NHS Trust Development Authority (TDA) has published their Accountability Framework for NHS Trust Boards which details a clear set of rules and principles under which NHS Trusts should all operate. Within the framework, the NHS TDA describes their monthly self-certification process, which is based on compliance to a number of the conditions within Monitor's Provider Licence and a set of Board Statements.		
Summary of recommendations:	Under the NHS TDA assurance process, a self-certification submission is required each month. Therefore, the Board is asked to retrospectively sign-off the return for December 2014, which was submitted to the TDA on 21 January 2015 and agree the status for the January 2015 return. The Trust Board is also asked to discuss and agree any reporting issues in anticipation of the January 2015 and future returns.		
Fit with WH strategy:	n/a – regulatory requirement.		
Reference to related / other documents:	Self-certification is monthly.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	21 January 2015		

Author name and title:		**Ursula Grueger Deputy Director of Finance**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC	**-**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Ursula Grueger

Enter Your Email Address: Ursula.Grueger@nhs.net

Full Telephone Number: 020 72883844 Tel Extension: 3844

SELF-CERTIFICATION DETAILS:

Select Your Trust: The Whittington Hospital NHS Trust

Submission Date: 21/01/2015 Reporting Year: 2014/15

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

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 model (supported by 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.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE:	n/a
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance: 21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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 requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance: 21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework 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.

6. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE: Comment where non-compliant or at risk of non-compliance	n/a

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE: Comment where non-compliant or at risk of non-compliance	Finance - forecast outturn position of £7.4m reported to TDA on 15/12/14. Work continues to improve the position in terms of both income and expenditure.

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Trust business planning process in place. Divisional business plans reviewed by Trust Board and Trust Management Group in December.

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Board Assurance Framework being updated with further work to refresh strategy of the organisation

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

18 weeks Performance for November - admitted adjusted 90.70%, non-admitted 95.04%, incomplete 92.24%

Performance was in line with agreed trajectory.

A and E 4 hour target for November:- 92.38%

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The Trust is working through its workplan to deliver Level 2 Compliance. Key challenge is delivering the 95% target for IG training.

BOARD STATEMENTS:

For GOVERNANCE, that

12. 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.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

31/12/2014

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Permanent CEO and CFO recruited.
All remaining Board positions are filled.

BOARD STATEMENTS:

For GOVERNANCE, that

13. 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.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

14. 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.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Ursula Grueger

Enter Your Email Address: Ursula.Grueger@nhs.net

Full Telephone Number: 020 72883844 Tel Extension: 3844

SELF-CERTIFICATION DETAILS:

Select Your Trust: The Whittington Hospital NHS Trust

Submission Date: 21/01/2015 Reporting Year: 2014/15

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	n/a
	Timescale for compliance:	21/01/2015
2. Condition G5 Having regard to monitor Guidance.	Yes	n/a
	Timescale for compliance:	21/01/2015
3. Condition G7 Registration with the Care Quality Commission.	Yes	n/a
	Timescale for compliance:	21/01/2015
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	n/a
	Timescale for compliance:	21/01/2015

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	n/a
Timescale for compliance:	21/01/2015	
6. Condition P2 Provision of information.	Yes	n/a
Timescale for compliance:	21/01/2015	
7. Condition P3 Assurance report on submissions to Monitor.	Yes	n/a
Timescale for compliance:	21/01/2015	
8. Condition P4 Compliance with the National Tariff.	Yes	n/a
Timescale for compliance:	21/01/2015	

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	n/a
Timescale for compliance:	21/01/2015	

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	n/a
Timescale for compliance:	21/01/2015	
11. Condition C2 Competition oversight.	Yes	n/a
Timescale for compliance:	21/01/2015	
12. Condition IC1 Provision of integrated care.	Yes	n/a
Timescale for compliance:	21/01/2015	

Submit

Whittington Health NHS

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Whittington Health Trust Board

4th February 2015

Title:	Audit and Risk Committee: Update to the Board		
Agenda item:	**15/027**	**Paper**	**10**
Action requested:	For information		
Executive Summary:	To update the Board on the work and recommendations conducted at the January 2015 Audit and Risk Committee.		
Summary of recommendations:	None		
Fit with WH strategy:	The Audit and Risk Committee is a sub-committee of the Board, established to provide the Board of Directors with a means of independent and objective review of financial and corporate governance and risk management. In addition the committee shall provide assurance of the independence of both external and internal audit.		
Reference to related / other documents:	Previous reports to the Trust Board.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Strategic Goal 3: Delivering efficient and effective services (ref 3.1 to 3.12).		
Date paper completed:	20th November 2014		

Author name and title:		**Ursula Grueger, Deputy Director of Finance**		**Director name and title:**		**Rob Whiteman 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**

Audit and Risk Committee Update to the Board

Meeting Date – 15th January 2015

1. The Audit and Risk Committee met on the 15th January 2015, chaired by Rob Whiteman, non-executive director (NED).

2. The chair asked for a joint update paper on the Data Quality Improvement Plan from Finance and Human Resources (HR).

3. The Workforce Plan will come to the May committee with assurance of work being undertaken.

4. External Audit (KPMG) presented a progress and technical update report. The committee agreed that the Use of Resources item presented should be discussed at a private meeting of the Trust Board. In addition, the Deputy Director of Finance would bring a paper on securing economy, efficiency and effectiveness.

5. Following discussion on Service-Line Reporting (SLR), the Chair requested a report on how the tools will be used.

6. There was a discussion on the future Information Governance Internal Audit Report and the possibility of the Internal Auditor attending the Trust Management Group twice a year.

7. The committee ratified the Counter Fraud and Corruption Policy.

8. The committee decided to look at the policy for obtaining upfront payment from Overseas Visitors and discuss in the summer.

9. The committee reviewed the list of bad debts for write off and tender waivers and it was agreed that the Deputy Director of Finance would discuss the Value for Money (VfM) rating with procurement and the Trust Management Group.

10. The Mandatory Training Report was discussed in detail. The Deputy Director of HR will bring back temporary staffing figures within a further review paper to the next committee meeting in March.

11. The committee reviewed the Board Assurance Framework (BAF) and the Corporate Risk Register in detail and welcomed the new Director of Risk and Governance to the committee. The committee discussed the failure to deliver on income targets in relation to Emergency Care and the increase in attendance. The committee was happy for the Corporate Risk Register to progress to the Trust Board for discussion.

12. The committee reviewed the Deep Dive Risk Management Report from the Women, Children and Families division and found it very helpful.

13. The committee agreed to tender for a new Internal Audit contract next year as TIAA's contract expires.

--end--

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Whittington Health Trust Board

4th February 2015

Title:	Safe Staffing (Nursing and Midwifery) Report		
Agenda item:	**15/028**	**Paper**	**11**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in December 2014. Key issues to note include: • Most areas had greater than 95 per cent 'actual' versus 'planned' staffing levels • One area fell below 95 per cent of planned Registered General Nurse (RGN) hours required but were covered by senior nursing staff (matrons, professional development nurses, specialist nurses) working to support as necessary. • A number of areas reported 'actual hours' worked over and above those 'planned' which was attributed in the main to the provision of Registered Mental Nurses (RMNs), RGNs or Healthcare Assistants (HCAs) to support patients under a Mental Health Section, increased dependency and 1:1 'specialing' of some of our vulnerable patients. • The Emergency Department triggered 15 red shifts in December, which related to a shortage of paediatric nurses. Shifts were supported by moving staff from paediatric in-patient and ambulatory care services.		
Summary of recommendations:	Trust Board members are asked to note the December 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:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	January 2015		

Author name and title:		**Alison Kett – Deputy Director of Nursing and Patient Experience**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Safe Staffing Report
December 2014

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 December 2014 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 General Nurses (RGNs), 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.

As of June 2014, all hospitals with in-patient beds were required to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts and Registered and Un-registered staff. This fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st December 2014 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's 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. During December, bed numbers increased on the rehabilitation ward and a surgical ward to support further admissions due to 'winter pressures'. 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 December 2014. Average fill rate was 104.8% for registered staff and 131.3% for care staff during the day and 103% for registered staff and 114.2% for care staff during the night.

Above average fill rates in excess of 100% for qualified nurses occurred on two wards. One related to an additional RGN being booked to care for a patient subject to a mental health 'section' and the other related to an additional RGN for a number of patients requiring high dependency care. HCA fill rates in excess of 100% relate to the requirements of our vulnerable patients who, following risk assessment are judged to require 1:1 care where

care demand on a particular shift exceeds capacity. On wards where one HCA is planned, provision of an additional HCA raises the percentage to 200% for that shift.

In the first week of August 2014, the number of HCA 'specials' used for patients on our wards was 162. By the last week of December only 37 HCA 'specials' were required, under a quarter of the original number. There has been no increase in the number of patients sustaining falls or reported adverse incidents as a result of this decrease and senior staff on wards feel more empowered to manage their own requirements.

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.

Details of wards that initially triggered 'red' in December can be seen in Appendix 3. In summary, in December a total of 32/1488 (2.15%) shifts triggered 'red' which is fractionally higher than previous months but continues to be very low. Of these, 22/837 (2.63%) occurred in the division of Integrated Care and Acute Medicine (ICAM), 5/279 (1.8%) in the Women, Children and Families (WCF) division and 5/372 (1.34%) shifts were reported to have triggered 'red' in the division of Surgery, Cancer and Diagnostics (SCD).

Out of the 22 shifts which triggered red in ICAM, 15 were in the paediatric emergency department due to paediatric nursing vacancies. ICAM covered rotas with support from paediatric inpatient and ambulatory care services. Additional paediatric nurses have been recruited and are in the recruitment process.

Of all shifts that initially triggered 'red', 8 were related to 'early' duty shifts, 12 to 'late' duty shifts and 14 to 'night' duty shifts.
The challenges of ensuring adequate staffing levels on wards during December can be attributed to the following:

- Nursing vacancy rates in the Paediatric Emergency Department, which are reducing as a result of local and overseas recruitment.
- A patient requiring 1:1 care by a Registered Mental Nurse (RMN).
- Continued demand for staff to provide 1:1 care for our vulnerable patients, particularly on three wards.
- A high dependency patient on one ward.

5.0 Conclusion

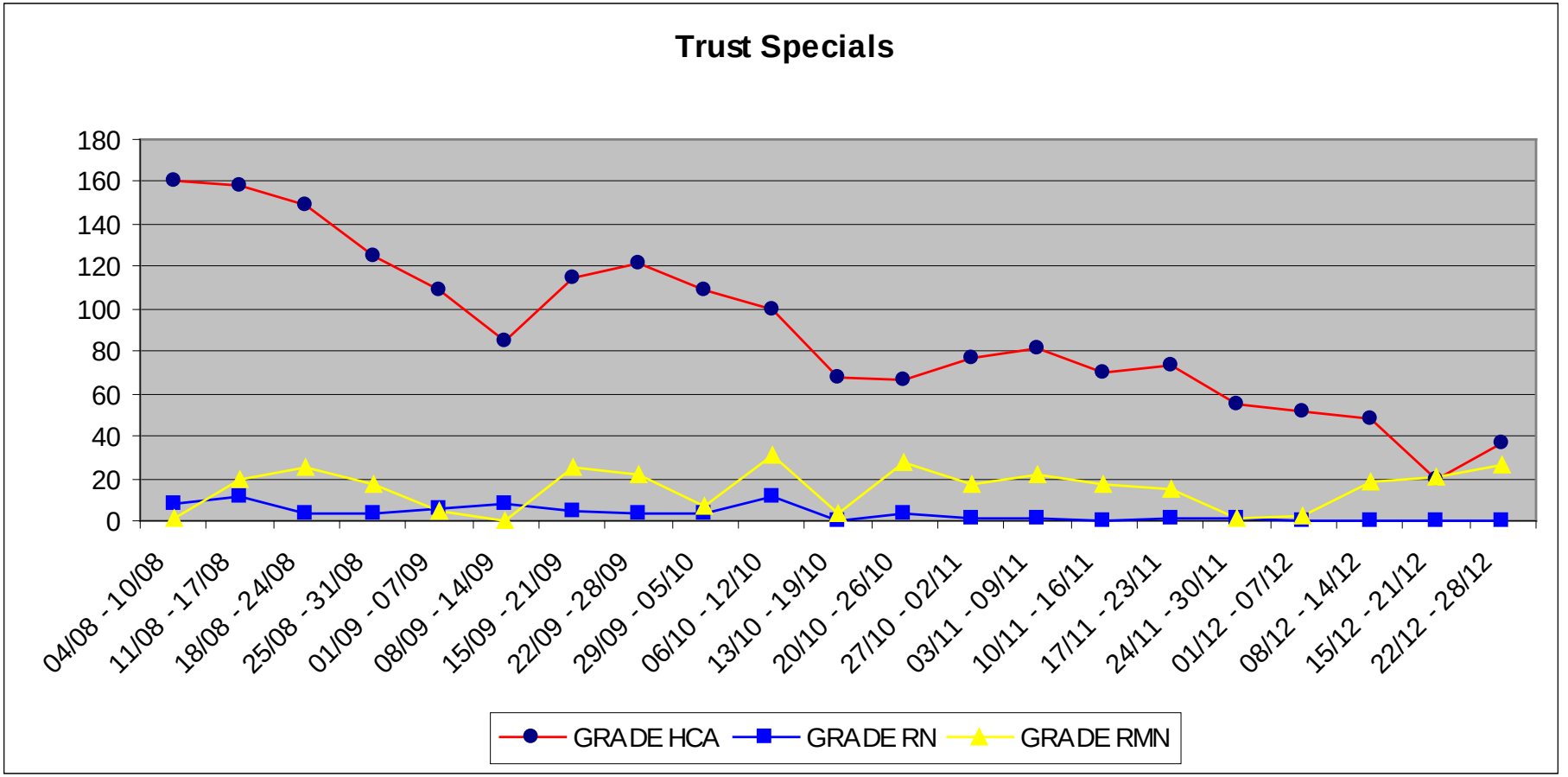
Trust Board members are asked to note the December UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Appendix 1

Fill rate data - summary
December 2014

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	104.8%	131.3%	103%	114.2%
34,639 hours	35,688 hours	10,378 hours	13,114 hours	28,776 hours	29,092 hours	6,819 hours	8,518 hours				

Appendix 2


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
15/12 - 21/12
22/12 - 28/12
GRADE HCA
GRADE RN
GRADE RMN

Appendix 3

				December – SHIFT DATA							
Division	Speciality	Ward		Total No. of shifts available	Early	Late	Night	Number of shifts where staffing fell below agreed staffing levels and triggered 'Red'	% of shifts where staffing fell below agreed staffing levels and triggered a 'Red' rating	RAG rating following action taken	DoN statement of actions taken to ensure safe staffing levels
ICAM		Meyrick		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		Cloudesley		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Elderly Care	Cavell		93	0	2	0	2	2.15		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Cardiology	Montuchi		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Respiratory	Nightingale		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Gastro/Haem/Onc	Mercers		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		MSS		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	MAU	MSN		93	1	1	0	2	2.15		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Emergency	ED		93	2	2	11	15	6.67		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		837	3	8	11	22	2.63		
SCD	ITU	ITU		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Surgical	Victoria		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Ortho (Trauma)	Coyle		93	2	3	0	5	5.38		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Ortho (planned)	Thorogood		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		372	2	3	0	5	1.34		
WCF	Paediatrics	IFOR		93	0	0	1	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Maternity	All mat wards		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Neonatal ITU	NICU/SCBU		93	1	1	2	4	4.3		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		279	1	1	3	5	1.8		
		TRUST TOTAL		1,488	6	12	14	32	2.15		

Whittington Health NHS

HR and OD Department
Direct Line: 020 7288 5048
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4 February 2015

Title:	Whistleblowing Policy and Procedure		
Agenda item:	**15/029**	**Paper**	**12**
Action requested:	The Trust Board approves the revised Whistleblowing Policy.		
Executive Summary:	The Trust Board is asked to consider the updated Whistleblowing Policy and Procedure. The revised policy takes account of the changes in the relevant legislation, namely The Public Interest Disclosure Act (PIDA) 1998 (as amended by the Enterprise and Regulatory Reform Act 2013) and sets out the organisation's approach to openness and transparency so that workers are encouraged to speak up about genuine concerns. The procedure has been amended to set out more clearly, how and to whom individuals can raise concerns. It also explains the mechanism for how concerns will be investigated. Roles and responsibilities are, therefore, clearly identified. The revised policy states that human resources (HR) will hold a register of formal complaints, which will be monitored by the audit and risk committee every 12 months. The policy will be reviewed on a three yearly cycle in line with other HR policies. The policy has now been the subject of extensive consultation with staff-side and most of the proposed changes have been incorporated. These changes specifically related to procedure and the respective roles and responsibilities within the policy.		
Summary of recommendations:	The Trust Board is asked to approve: 1) the revised Whistleblowing Policy and Procedure 2) that the policy is implemented from 1 March 2015 3) that the Audit and Risk Committee will review the register of whistleblowing cases every 12 months 4) that the policy will be reviewed every three years in line with changes in legislation or other organisational changes.		

Fit with WH strategy:	Ensure the Trust has up-to-date and fit for purpose HR policies and procedures.
Reference to related / other documents:	The Trust's Disciplinary Policy and Procedure. Public Accounts Commons Committee ninth report of session 2014/15 as it refers to the NHS Whistleblowing guidance and recommendations HC 593.
Reference to areas of risk and corporate risks on the Board Assurance Framework:	The Trust requires an up-to-date and relevant Whistleblowing Policy and Procedure in order to comply with changes in relevant legislation.
Date paper completed:	20 January 2015

Author name and title:		**Jo Bronte HR Manager**		**Director name and title:**		**Chris Goulding DD, HR Operations**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Whistleblowing Policy and Procedure

Reference/Number	*To be supplied by Corporate Policy Officer*		
Version:	Two		
Ratified by:			
Ratification Date:			
Approval Committee			
Date Approved:			
Date Issued:			
Executive Owner:	Chris Goulding, Deputy Director HR		
Name of Author(s) and Job Title(s):	Jo Bronte, HR Manager		
Target Audience:	All staff		
Review date: 3 years after ratification date			
Procedural document linked to/Tagged:	**Tick as appropriate**	✓	
	Regulatory Compliance		
	Organisation-wide	✓	
	Directorate		
	Service		
	Shared document		

Dissemination and Implementation

Responsible person for coordinating dissemination and implementation		Jo Bronte, HR Manager	
Methods of dissemination	Intranet	Whittington Health Noticeboard	Email to key Stakeholders
(Delete as appropriate)	Yes	Yes	Yes

Consultation

List of those consulted	Staff-side sub group TMG
Period of consultation	November 2014 -

Version Control Summary

Version No	Description of change	Author	Date
One	Harmonisation of policies from predecessor organisations on formation of Whittington Health ICO (amended July 2013 to reflect legislative changes)	Unknown	*May 2012*
Two	Review to update policy and make the procedure clearer	Jo Bronte	

Contents

1.0 INTRODUCTION: POLICY STATEMENT

1.1 Whittington Health encourages a culture of openness and dialogue endorsed by positive working relationships. The Trust promotes an environment which enables everyone working for the Trust to raise concerns in a responsive way, without fear of victimisation, censorship or reprisals, which contributes to a safer and higher performing Trust for all.

1.2 The Public Interest Disclosure Act (PIDA)1998 (as amended by the Enterprise and Regulatory Reform Act 2013) provides a clear signal that it is safe and acceptable for all workers to raise any specific concerns they may have that they reasonably believe are in the public interest (often known as 'whistleblowing'). By providing strong protection for those who raise concerns, the legislation helps ensure that employers address the message and not the messenger. It is a safety net for the Trust, those who work for it and users of its services. The fundamental principle behind the legislation is to improve governance and accountability within organisations.

1.3 Essentially, under PIDA, workers who act honestly and reasonably are given automatic protection for raising a matter internally. Further information on the PIDA can be found at: http://www.pcaw.org.uk/

1.4 This document sets out the Trust's position and provides guidance on how people working for the Trust can raise their concerns whilst being fully protected. In doing this the procedure draws together the *NHS Constitution 2013* and the *Public Interest Disclosure Act 1998,* and is based on the British Standards Code of Practice July 2008 and illustrates how these should operate locally at Whittington Health.

1.5 Workers who raise concerns that they reasonably believe are in the public interest and do so not for personal gain will be protected under statute law from suffering detriment, recrimination, harassment and victimisation by the Trust, its workers and agents.

1.6 A whistleblowing concern is about a risk, malpractice or wrongdoing that affects others. It could be something which adversely affects patients, the public, other workers or the organisation itself. This is distinct from a grievance which is, by contrast, a dispute about an employee's own employment position and has no additional public interest dimension. A whistleblowing concern is where an individual raises information as a **witness**, whereas a grievance is where the individual is a complainant. If you are uncertain which policy should be used, please seek advice from Human Resources.

1.7 It is important that workers feel that they are able to raise genuine issues and to feel confident that their position will not be jeopardised or that harassment or bullying will not take place as a result of their actions. Disciplinary action will not be taken against the individual raising the concern as a direct result of raising a concern. The Trust regards the ability to raise issues of concern as very important, and is therefore anxious that staff feel able to do so, and will protect

staff from any form of victimisation, providing it is not a deliberately false or malicious allegation.

1.8 When raising a concern, it will be helpful to know how the worker thinks the matter might be best resolved. If the worker has any personal interest in the matter, they should inform the Trust at the outset. If the Trust considers that the concern falls more properly within the grievance (inc. bullying and harassment) procedure or other relevant procedures, it will inform the worker accordingly.

1.9 The Trust aims to promote the positive aspects of whistleblowing and in doing so move away from the negative perception of the word.

1.10 The Trust will not tolerate any detriment, reprisals, bullying, harassment or victimisation against any worker or other individual because he or she has raised a concern under this policy, and will treat any such instance as a disciplinary matter which may lead to dismissal of the perpetrators or sanctions against those acting as agents of the Trust.

1.11 The Trust has a Counter Fraud Policy and Response Plan which provides information on fraud reporting procedures. Further details are contained in Section 8 under the heading 'Fraud, Corruption and Bribery.'

1.12 In addition, this document complements professional or ethical rules and guidelines, such as for nurses in NMC Code of Practice (para 32 to 34) and for medical staff in Good Medical Practice on raising and escalating concerns.

2.0 PURPOSE

2.1 This Whistleblowing Policy and Procedure sets out the Trust's position and provides guidance on how people working for the Trust can raise their concerns whilst being fully protected.

3.0 SCOPE

3.1 This policy and procedure applies to all workers employed by the Trust, Executive and Non-Executive Directors, bank workers, agency workers, students, volunteers, contractors, secondees and those holding honorary contracts. Whittington Health views the contribution made to its services by all those who work for it as an essential element of caring for patients and values issues raised by workers, particularly relating to situations where there is the possibility of harm, danger or a breach of safety to patients in a clinical or research capacity.

3.2 Managers at the Trust will always take concerns seriously and give them due and sympathetic consideration. There may be occasions when they will wish to seek specialist advice from other health care professionals.

3.3 The Trust's view is that individual workers in the NHS have a right and a duty to raise any matters of concern they may have about health service issues related to

the delivery of care, research or services to a patient/s within the Trust, or any other matter that can be said to be in the public interest.

4.0 DEFINITIONS

4.1 Where concepts have a particular meaning for this procedure the definition is given within this document.

4.2 The term 'workers' will be used throughout this policy to refer to all those defined under section 3.1 of the policy.

5.0 DUTIES

5.1 Managers are responsible for:

5.1.1 Ensuring that all staff are familiar with and have access to this policy.
5.1.2 Complying with the Trust's procedures and principles as outlined.
5.1.3 Ensuring concerns raised are taken seriously and responding to concerns in a timely fashion.
5.1.4 Evaluating the basis of any claim brought to their attention and referring upwards to a more senior manager if appropriate.

5.2 Human Resources are responsible for:

5.2.1 Ensuring staff are made aware of this policy and how they can access it.
5.2.2 Advising managers and individuals in the application of the policy and procedure.
5.2.3 Monitoring the application of the policy to ensure it is applied in a fair and consistent way to each concern raised.
5.2.4 Keeping a register of formal Whistleblowing concerns, monitoring and auditing the number and nature of claims made, actions taken, and reporting this information to the Trust Board on a regular basis.

5.3 Employees are responsible for:

5.3.1 Raising the concern as soon as possible in an objective and factual way, using this policy and accompanying procedure.
5.3.2 Keeping records where possible of any incidents and potential witnesses.
5.3.3 Cooperating with any investigation, if appropriate, including being available for interview (notice will be given), providing a statement and/or documentation.
5.3.4 Maintaining confidentiality of patients and staff.

6.0 PROCEDURE FOR DEALING WITH WORKERS CONCERNS

6.1 Step One - Informal Stage

6.1.1 If a worker has a concern about risk, malpractice or wrongdoing at work, they should raise it first with their immediate manager, supervisor or lead clinician. If the

concern is about the worker's line manager then the individual should refer their concern to the director of a service or to their trade union representative as appropriate. The manager/clinician (or director) is responsible for meeting with the worker to understand the issues and seek to resolve the problem immediately or escalate for help.

For concerns about fraud, corruption and bribery, please refer to section 8.0 of the document.

6.1.2 Where a concern can be acted upon, action should be taken promptly and the individual notified quickly of the action taken insofar as this does not prejudice the Trust's legal obligations of confidentiality to its patients and other staff as per 6.2.12 below.

6.1.3 Individuals or representative organisations who raise a concern should receive feedback in writing as quickly as possible taking into account the seriousness of the concern but, in any event, within ten working days of the meeting with the manager/clinician confirming what action (if any) has been taken. Information provided in accordance with this paragraph shall be subject to the Trust's legal obligations of confidentiality to its patients and other staff as per 6.2.12 below.

6.1.4 If the person dealing with the concern decides that no action is warranted, they must discuss this with their respective manager/director prior to the decision being notified to the individual who has raised the concern or representative organisations. Where action is not considered appropriate, then the individual should be given a prompt and thorough explanation of the reasons for this. They should also be advised that they can raise this issue in accordance with Step Two, detailed below.

6.1.5 Workers must report their concerns without delay if they witness or suspect there is immediate risk.

6.2 Step Two - Formal Stage

6.2.1 This stage should be applied if having followed Step One, a worker is dissatisfied with the outcome. Step Two should also be followed if the worker feels unable to report matters to their line manager or director of service informally (e.g. if their line manager/ director of service is at the centre of the concern).

6.2.2 The concern should be in writing to the appropriate director. The director must seek advice from the HR Director/Deputy Director. The worker's concerns will be acknowledged normally within five working days.

6.2.3 The director who receives the concern will appoint a designated officer, normally a senior manager to investigate the concern. This may involve an informal review, an internal inquiry or a more formal investigation. The worker will be told the name of the person handling the matter, how they can contact them and what further assistance may be needed from them. The designated officer should not have been involved in the case previously, should have no conflict of interest and be impartial.

6.2.4 If the concern made is about an Executive Director the concern will be investigated by the Chief Executive or Chairman.

6.2.5 If the concern made is about the Chief Executive the concern will be investigated by the Non-Executive Director (Audit and Risk Committee Chair), or the Chairman.

6.2.6 If the concern raised is about a Non-Executive Director (including the Chairman) the concern will be investigated by the Non-Executive Director (Audit and Risk Committee Chair).

6.2.7 If the concern raised is about the Non-Executive Director (Audit and Risk Committee Chair) the concern will be investigated by the Chairman.

6.2.8 The outcome of the investigation will be reported back to the director usually within 28 working days to decide what action is required.

6.2.9 In exceptional circumstances, if the designated officer responsible for investigating the concern raised requires longer than 28 working days, the reason will be notified to the individual who has raised the concern with an expected date of completion.

6.2.10 The issue should however obviously be dealt with immediately if it has urgent patient care or other such serious implications.

6.2.11 Following consideration of the report by the appropriate director or Non-Executive Director a written response will be provided to the individual raising the concern usually within 10 working days, thereafter. The written response should contain details of what actions are to be taken together with a timetable or if no action, the reasons why.

6.2.12 The Trust will give as much feedback as it properly can, however it does have legal obligations of confidentiality to its patients and other staff. Therefore, the Trust may not be able to freely provide full feedback, taking into consideration the requirement for confidentiality in disciplinary and capability cases.

6.2.13 Any anonymous concerns should be raised with the relevant Executive Director. Concerns will be considered and may be investigated, but if the Trust does not know who has raised a specific concern, it will be more difficult to look into the matter, protect the individual and provide appropriate feedback. If an anonymous concern is raised and found to be deliberately false or malicious or then disciplinary action may be taken against the individual raising the concern if identified.

6.2.14 Workers making **deliberately false or malicious** allegations will be subject to disciplinary action in accordance with the Trust's disciplinary procedure. However, if the individual has a reasonable belief that the disclosure is made in the public interest (effectively this means acting honestly) it does not matter if they are mistaken or if there is an innocent explanation for their concerns. Disciplinary action would not be taken in these circumstances.

6.2.15 A central register of all formal concerns raised will be logged and maintained by the Director of HR. This will allow for the effective acknowledgement, monitoring and progress of reported disclosures. This log will be available to the Audit and Risk Committee.

7.0 REFERRAL TO A REGULATORY BODY

7.1 The Trust believes that this policy should enable almost all concerns to be raised internally and hopes that it provides workers the reassurance to do so. However, we recognise that there may be exceptional circumstances where the individual can properly report a concern to an outside body.

7.2 Before reporting concerns to a regulatory organisation, it is recommended that advice is sought (see section 11). The Trust should also be informed of the individual's actions.

7.3 In order for the concern to be investigated and for individual protection under current legislation, this should normally be with a recognised healthcare organisation that has the authority to investigate the issue. This could be the regulator of health and social care services or a regulator of health professionals.

8.0 FRAUD, CORRUPTION AND BRIBERY

8.1 All allegations of suspected fraud, bribery and corruption must be reported to either the Chief Finance Officer, the Trust's nominated Local Counter Fraud Specialist (LCFS), or by calling the NHS Fraud and Corruption Reporting Line. All reports will be assessed and, where necessary, investigated in accordance with the Trust's Counter Fraud Policy and Response Plan.

8.2 In addition, where allegations involve an Executive Director or Non-Executive Director (NED) the information can also be reported to the Audit and Risk Committee Chair.

8.3 The contact details for reporting fraud, corruption and bribery are as follows:

8.3.1 Chief Finance Officer on: 020 7288 3190

8.3.2 Local Counter Fraud Specialist (LCFS) on: 020 7953 8353

8.3.3 NHS Fraud and Corruption Reporting Line on: 08000 724 725.

9.0 CONFIDENTIALITY

9.1 It is recommended that concerns are raised openly, and that workers raising concerns identify themselves. This makes it easier for the concern to be investigated and is the best way for the individual to be protected under the Act. It is recognised that there may be circumstances when the individual raising a concern would like to keep his/her identity confidential. In such instances, the individual should say so at the outset. The individual should realise however that

there may be practical or legal limits to this confidentiality where the concern cannot be resolved without their identity being revealed, and the individual will be informed of this at the outset.

9.2 Whilst the Trust is committed to encouraging a policy of openness, workers are expected to respect this commitment by observing the appropriate procedures for raising concerns.

9.3 In particular, all workers have a duty of confidentiality to patients and any unauthorised disclosure of personal information identifiable to a specific patient could be regarded as a breach of duty and as such might result in disciplinary action being taken. This applies even where an individual believes that he or she is acting in the best interests of a patient or client, by disclosing personal information. It is strongly advised that individuals seek advice from Human Resources or their professional organisation before taking any such action

9.4 Consideration should be given to the stage at which the subject of any disclosure(s) is informed of the concern raised about them. The Trust will need to carefully balance the risks of when to do this at each stage.

9.5 Individuals who have a concern raised about them will have the right to know details of the concern and any possible consequences, the right to respond and the right of representation.

10.0 INDEPENDENT ADVICE AND SUPPORT

10.1 If individuals are unsure whether to use this procedure or want confidential independent advice at any stage, they should contact:

10.1.1 Their trade union or professional association.
10.1.2 The independent charity Public Concern at Work on 020 7404 6609 or helpline@pcaw.co.uk. Their legal advisors will give free confidential advice at any stage about how to raise a serious concern at work.
10.1.3 The NHS Whistleblowing helpline on 08000 724 725.

11.0 THE PUBLIC INTEREST DISCLOSURE ACT 1998

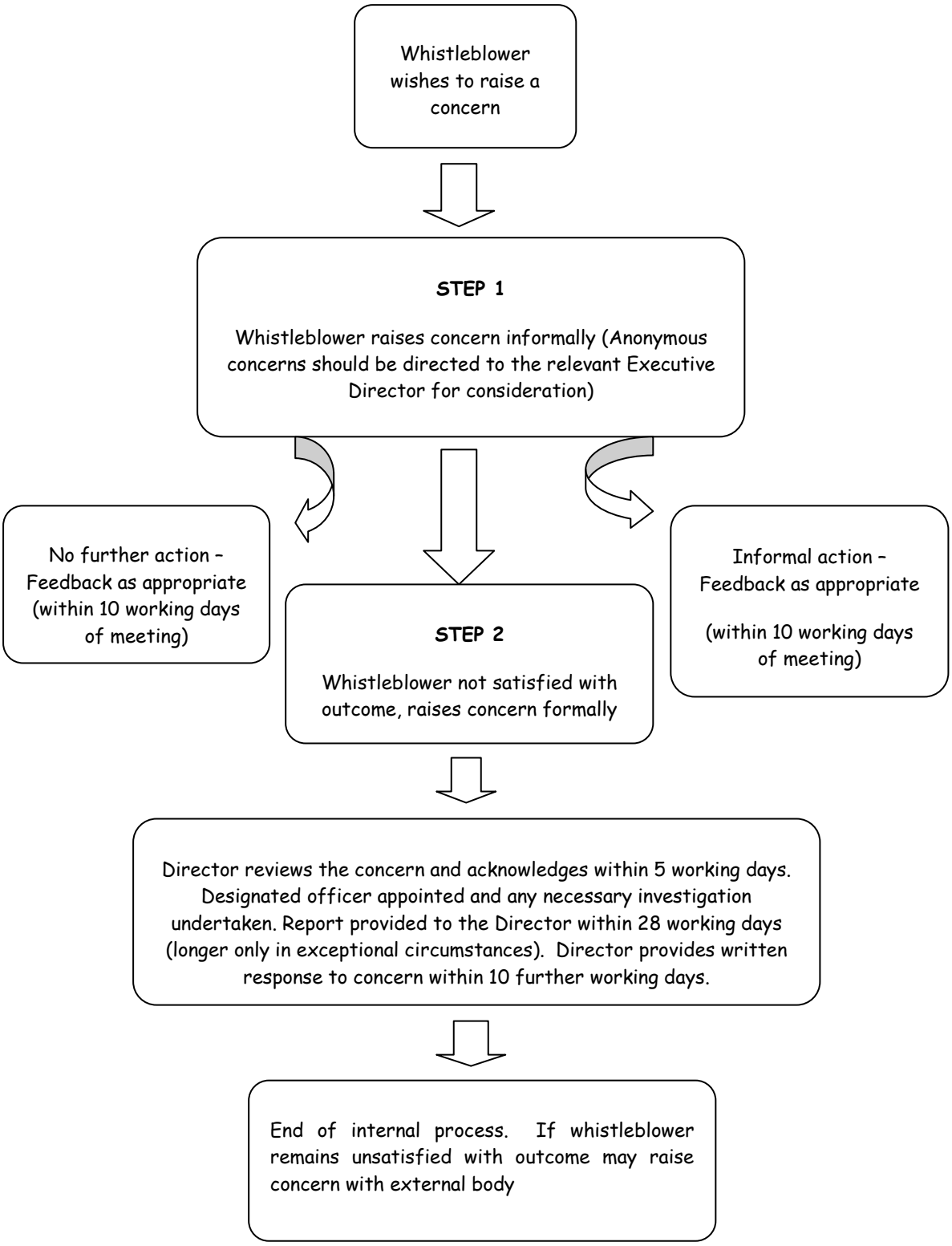
11.1 In addition to the local procedures, the Public Interest Disclosure Act 1998 provides specific rights for those who disclose information to a third party about an alleged wrongdoing.

11.2 If an individual has a concern, and wishes to consider seeking protection under the Public Interest Disclosure Act when raising it, they should seek advice from their trade union or an independent advisor.

12.0 MONITORING COMPLIANCE and EFFECTIVENESS

12.1 Whistleblowing cases will be monitored by the HR Directorate and reported to audit and risk committee. The Whistleblowing policy will be reviewed in line with the Trust's cycle of policy review, subject to consultation with staff representatives recognised for that purpose.

13.0 APPENDIX ONE – WHISTLEBLOWING FLOWCHART



14.0 APPENDIX TWO –
WHITTINGTON HEALTH EQUALITY IMPACT ASSESSMENT REPORT

1. Name of Policy or Service

Whistleblowing Policy and Procedure

2. Assessment Officer

Assessment undertaken by joint staff-side chair and Deputy Director of Human Resources

3. Officer responsible for policy implementation

All trust managers – policy is trust-wide

4. Date Equality Impact Assessment Completed

October 2014

5. Description and Aims of Policy/Service

Whittington Health is committed to encouraging a culture of openness and dialogue endorsed by positive working relationships. The Trust is keen to promote an environment, which enables staff everywhere to feel able to raise concerns in a responsible way without fear of victimisation or censorship.

6. Initial Screening

An initial assessment has been carried out to explore whether the Trust's staff raising healthcare concerns policy is likely to have a detrimental impact in terms of people included in one or more of the following equality categories:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion and belief
- Pregnancy and maternity
- Gender Reassignment

7. Outcome of initial screening

The policy was revised in partnership.

No direct adverse impact could be seen in terms of the protected groups.

The policy explicitly seeks to provide a fair and consistent process for staff raising healthcare concerns.

Assistance may be obtained from union representatives for employees for whom English is an additional language or who have difficulty expressing themselves on paper.

A full impact assessment was not necessary following initial review.

8. Monitoring and review

The policy will be reviewed` every third year.

9. Publication

This impact assessment will be scrutinised by the Trust's Equality Impact Assessment (EIA) group on behalf of the Trust Board, prior to publication through the hospital's website.

Whittington Health NHS

ITEM: 15/018
Doc: 2

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00pm on Wednesday 7th January 2015 in the Whittington Education Centre

Present:	Anita Charlesworth	Non-Executive Director
	Philippa Davies	Interim Director of Nursing and Patient Experience
	Ursula Grueger	Deputy Director of Finance (Acting as Director of Finance)
	Chris Goulding	Acting Director of Human Resources
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Graham Hart	Non-Executive Director
	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
	Rob Whiteman	Non-Executive Director
In attendance:	Kate Green	Trust Board Secretary
	Caroline Thomsett	Director of Communications

15/001 Patient Story

01.01 Philippa Davies introduced Phileas, present to recount the experiences of his daughter Christina. Also present were Hellen Odiembo, specialist learning difficulties nurse, and Jessica Fitzgerald, manager of the community specialist nursing team.

01.02 Christina suffered from severe learning disabilities and complex physical needs, and had therefore been admitted to hospital on multiple occasions. On the occasion described here, she had been admitted with a twisted bowel condition which was causing her acute pain. Two 'best interest' meetings had been held, and considerable efforts had been made to ensure correct decisions – with informed consent – had been reached. The outcome was the decision that Christina would not have surgery, as the risk was considered to be too high. At all times throughout the process Christina had received invaluable support from Hellen.

01.03 It was noted that at Christina's pre-assessment appointment the scales on the unit had been broken, and had Hellen not been present to intervene, there was a possibility that Christina would not have been weighed. Because her low weight needed to be taken into consideration prior to surgery, this was particularly important. Phileas made the point that Hellen's intervention into his daughter's care was vitally important, however, the general principle of advocacy on behalf of clients with learning disabilities needed to be further embedded into Trust services across the board. Areas where further improvement was needed included feeding, medication and staff handover.

01.04 Phileas declared himself very happy with the services Christina had received at Edwards Drive, stressing that the most important aspect of her care for him was to have consistency in staff treating Christina who understood her needs. Hellen echoed this, explaining that Christina had difficulties communicating, so it was particularly important that staff both understood her needs and were able to pass on information to colleagues in a way which instilled confidence in her parents.

01.05 Hellen then spoke about her role as a specialist learning disabilities nurse. She had started work at Whittington Health in 2011, and her principle role was to assist professional colleagues in becoming aware of the needs of people with learning disabilities – 80-90% of whom have communications problems. She cited reports which had been published in this field, mentioning particularly 'Death by Indifference', the recommendations from which had led directly to the establishment of her post.

01.06 Hellen asked for the support of the Board in furthering this important work. She drew attention to the annual learning disability awareness week she organised, saying that she was seeking to involve the media in 2015, and adding how much she appreciated the support she had received from the Chief Executive during the previous year's event. She also expressed her gratitude to the consultant body for the manner in which they relayed information to the junior doctors.

01.07 Jessica Fitzgerald managed the community nursing team, and she took Board members through the services offered by that team, from initial assessment through to supporting clients as they accessed mainstream services. She drew particular attention to the 'purple folder', which clients held and took with them to every appointment, which health and social care professionals entered key information into and which also contained an action plan for every client. 75% of Haringey clients now had such a folder, and it was aimed to increase this to 100%. Jessica also described the joint work undertaken with the Emergency Department (ED) looking at pathways for this client group.

01.08 Moving on to describe recent achievements of the team, Jessica said that they had recently been granted permission to share Haringey Council's register of clients with learning disabilities, which was a huge step forward in ensuring clients received access to the most appropriate services for their needs. She went on to describe awards won by the team, in particular the Nursing Times award, Trust excellence award, and last year's Team of the Year award.

01.09 Anita Charlesworth thanked all involved for coming to speak to the Board. Reflecting on a previous presentation concerning a client with learning disabilities, she encouraged Phileas to enlarge on his experience of caring for Christina whilst in hospital. Phileas replied that everything had been fully explained to him and his wife, as Christina's parents, and he did not feel that there was much scope for further improvement. He admitted to having been uneasy at first about leaving his daughter in the care of the staff, however, once Christina's complex needs had become known (she was unable to swallow which made both feeding and medication problematic) and he was able to have confidence in the sharing and passing on of information, there had been no difficulties.

01.10 Richard Jennings added his thanks, saying that it was difficult to overestimate the importance of these issues. He cited the National Confidential Enquiry, which had looked at the circumstances behind 247 client deaths, and said that a study of the

Trust's own declared incidents revealed that on occasion mistakes were made. He had been pleased to learn of Haringey's agreement to share their register with the health service, and hoped that Islington would soon follow suit, as such moves made a vital contribution towards patient safety. Simon Pleydell asked about awareness training for staff, and Hellen replied that this did happen, however, it was negated to some extent by turnover and the use of agency staff. There were however plans to build such awareness training into the Trust's mandatory training requirements. On a positive note, Hellen did feel that staff were in general becoming more aware.

01.11 Philippa Davies invited Hellen to meet with her in order to discuss how she might best support this work. Phileas expressed his thanks for the care Christina had received and in particular the support given by Hellen. In closing, Hellen emphasised the importance of reporting dysfunctional and broken equipment immediately, as had she not been present to ensure Christina was weighed as part of her pre-assessment checks the outcome of her treatment might have been quite different. Steve Hitchins expressed his thanks on behalf of the Board to all who had presented.

15/002 Apologies for absence

02.01 Apologies were received from Greg Battle and Paul Convery.

15/003 Minutes of the previous meeting

03.01 The minutes of the meeting held on 3rd December were approved. There were no matters arising other than those already scheduled for discussion.

03.02 Action notes

68.04 – A presentation was to be given as part of the performance report, this could therefore be removed from the schedule.
100.02 – A bid had now been submitted for the e-rostering system, this could therefore be removed from the schedule.
100.03 – This was scheduled for discussion at the February Board.
143.01 – The cancer services improvement plan would be going to the next meeting of the Cancer Board and then to the February Trust Board meeting.
151.02 – Siobhan had reviewed governor representation at Trust meetings, this could therefore be removed from the schedule.

03.04 The remaining items were scheduled for discussion at the February Board meeting.

15/004 Chairman's Report

04.01 Steve Hitchins began his report by thanking everyone who had contributed to the pre-Christmas events throughout the Trust, in particular local schools and health groups. Events had been well supported which would have a beneficial effect on charities. He also thanked the Arsenal footballers who had visited the children's wards, and had been doing so for some twenty years.

04.02 Steve had recently had lunch on Victoria ward, and had been impressed by the range and quality of the food offered. He said that feedback from patients to whom he had spoken was positive, and that they had noted an improvement in quality since moving to the new contract.

04.03 The following day (8th January) Barbara Windsor would be formally opening the new Macmillan Cancer Information Hub.

04.04 Community engagement events were scheduled for 21st and 26th January, and the first voluntary sector event was to take place on 28th January. Almost 200 health and social care voluntary sector groups had been invited to attend.

04.05 Steve expressed his thanks to all Trust staff for all their work during this time of unprecedented demand.

04.06 It was noted that this was Caroline Thomsett's last Board meeting, and Steve thanked her, on behalf of the Board, for all her work over the past year. He wished her well in her new ventures.

04.07 Steve announced that the Trust had been successful in two recent bidding processes, the first for community gynaecology services in Islington and Haringey, and the second for the retention of the sexual health contract for Haringey. He acknowledged the immense amount of work staff had put in to securing these bids.

15/005 Chief Executive's Report

05.01 Introducing his report, Simon Pleydell drew attention to the national A&E patient survey, where he felt that the Trust's overall position had remained positive despite a slight dip in its position in one or two areas. Overall, he viewed the result as a most creditable performance for the department.

05.02 As at earlier that day, the take-up rate for staff undergoing 'flu vaccinations was 78%, and Simon was confident the target of 80% would soon be achieved.

05.03 Simon invited Lee Martin as Chief Operating Officer to brief the Board on emergency care. Lee said that earlier in the year winter resilience (formerly winter pressures) plans had been drawn up, these had gained the support of stakeholder partners and were now being successfully implemented. The Trust had seen an increase in presentations, but overall was performing well, and some extremely positive feedback had been received from patients. Plans were in place covering what action would need to be taken in the event of any continued increase in demand. Not all national targets had been met, but the vast majority of patients had been seen within the desired timeframes.

05.04 The Trust was performing well in respect of waiting times, and Lee was particularly pleased to inform the Board that delivery on cancer targets was good. The main concern was the Trust's financial position; which now stood at a £6.7m deficit in November, and was forecast to be £7.4m in deficit at year end. This had been declared to the NHS Trust Development Authority (TDA). This was a serious position for the Trust, and Simon Pleydell had written personally to all staff outlining the measures to be taken in the lead-up to the end of the financial year; he would also be meeting with all budget holders individually. In the meantime staff were busy developing financial plans for 2015/16; these would be discussed with the TDA over the next fortnight. Discussions were also ongoing with commissioners to see whether there might be any scope for improving the year end position.

05.05 Simon also drew attention to:

- Ongoing work on the new clinical strategy
- The appointment of the new Chief Finance Officer (CFO) although no start date had yet been confirmed
- The success of bids for community gynaecology and sexual health services
- The radical improvement in complaints response, both in the time taken to respond and the quality of the responses sent
- The Trust's involvement in the forthcoming FGM court case, scheduled to begin on 19th January.

05.06 Rob Whiteman expressed his congratulations to ED staff on maintaining a high level of performance despite the increase in demand, and enquired whether executive colleagues were able to explain the reason for the high demand. Lee Martin replied that data is scrutinised each week – at present the department is seeing a large number of elderly people with chest conditions, but several weeks ago there had been an increase in the number of young people attending. Richard Jennings, who had been on call the previous weekend, said that of 61 people he had seen, 31 had been suffering from respiratory conditions, and they had been quite seriously ill.

05.07 Anita Charlesworth asked about the impact of the ambulatory care centre. Lee Martin confirmed that projections had been largely accurate, adding that services would have struggled to manage in its absence. One positive aspect was that it had been able to take the more complex patients out of the in-patient units, it had also made it possible for sick children to remain at home with their families. Much of the increase demand was connected to winter. Lee added that the aim now was to increase the opening hours of the ambulatory care centre.

15/006 <u>Quality Committee Report</u>

06.01 Anu Singh introduced the report of the Quality Committee held on 26th November, saying that the meeting had begun with a discussion about the ownership of the quality agenda and progress made in this area. Also featuring in discussions was the extent to which learning became embedded into practice change. It had been agreed to revisit the terms of reference of the committee, and it was also noted that for the second time the meeting had not been quorate and this warranted consideration.

06.02 Steve Hitchins enquired about learning and whether appropriate checks were in place to ensure learning was properly embedded and shortcomings identified as a result of serious incidents were not repeated. Anu was confident the requisite systems were in place to ensure this, adding that assurances were also built into the templates for the routine divisional reports.

06.03 Congratulations were expressed to Julie Andrews and her team for their sterling work on infection control.

06.04 In answer to a question from Rob Whiteman about safeguarding training, Philippa Davies replied that there were two issues of note here, one being straightforward capacity, the second being the type of training offered. In regard to the latter, trainers were looking at different ways of offering training in ways which best suited the staff

groups requiring it, and the effects of this were already being felt, with a notable improvement in take-up rates.

15/007 Strategy Development Update

07.01 Introducing this item, Siobhan Harrington informed Board members that there was now a first draft of the Trust's strategy; however she felt that more clinical input was needed. To this end she had enlisted the help of a team of clinicians and there was also now a clinical editorial board. The main themes of the document were prevention, intermediate care, safety and quality and patient empowerment. The stakeholder engagement piece outlined the stage the Trust was at and what progress was being made.

07.02 Work was ongoing to look at the business plans which had been produced by the divisions in December. The Integrated Business Plan (IBP) will be developed following completion of the clinical strategy, and the Long Term Financial Model (LTFM) was also in progress. There was to be an extraordinary Trust Board meeting the following week to look at the maternity and neonatal services Full Business Case (FBC).

07.03 It was noted that a submission on the operational plan for 2015/16 needed to be sent to the TDA next Tuesday. Also taking place that day was the first of the contract meetings with the commissioners. Steve Hitchins informed the Board that he had seen Haringey Council's five year plan, and it fitted well with the Trust's strategy. Anita Charlesworth invited colleagues to consider the plan in the context of the Trust's participation in the Integrated Care Pioneers initiative. Rob Whiteman praised the quality of the document, pointing out that March appeared to be particularly pertinent in terms of the completion of one stage of the work, and querying what followed on from this. Siobhan Harrington replied that work had been ongoing since last summer to introduce a more robust planning structure. The clinical strategy would be complete by the end of March, and work was in hand to ensure that operations colleagues were fully involved in the development of the workforce, financial and contractual processes.

07.04 Tony Rice mentioned the requirements necessary for the Care Quality Commission (CQC) inspection, and Simon Pleydell replied that the key deliverable was to have a plan for 2015/16 that the Board was fully commensurate with and could be tracked back to the business plans developed during the year.

15/008 Performance Report

08.01 Lee Martin began his report by reminding colleagues that the dashboard presented was based on November data. He added that Board colleagues had requested updates on certain specific areas, and to this end he had invited operations colleagues to provide presentations.

08.02 Returning to the dashboard, Lee was pleased to report that the Trust had met the Referral to Treatment (RTT) national target in November, and projections were positive looking forward to December and January. On cancer targets, there had previously been some issues raised around choice, however, in November all targets had been met, and again, projections appeared positive for December and January. Steve Hitchins congratulated the team on these achievements, which he was aware had taken considerable effort. Paul Lowenberg raised a query about the Hospital

Standardised Mortality Ratio (HSMR) figure, and Lee replied that he too had queried this and would discuss it with Paul once he had received an update.

08.03 Paul also asked when the Board might receive details of patient satisfaction surveys from outpatients and community services. Lee replied that this data was now been collected and was being checked, and he hoped that the Board would be able to receive it in February or March. Paul added that he hoped information would be provided by percentage of respondents in order to be able to see a meaningful representation. He also hoped that the Board would soon see a KPI on ambulatory care, and Lee replied that this might be provided in shadow form in March with 'real' information coming in April.

08.04 Phillipa Marszall pointed out that the complaints figure on page 2 should read 79%.

08.05 <u>MSK Services</u>

08.05.01 Beverleigh Senior began her presentation by speaking about the work that had been undertaken to improve access rates. The service had been especially busy and there was little set pattern to rates of demand, but the aim was to see all patients within six weeks of referral, both RTT and non-RTT. Work had been carried out on demand and capacity. There had been a backlog of clients waiting for treatment but this had now been cleared. Much time had been spent validating data. An access policy had also been implemented, and Did Not Attend (DNA) rates had reduced from in the high 20% to below 10%. Beverleigh proceeded to show a graph illustrating waiting times, saying that efforts made had greatly contributed towards an improved working environment for the team. It was noted that the team also now had a qualified prescriber, which was an innovative (and fairly unusual) development.

08.05.02 Paul Lowenberg felt there was a discrepancy between the data presented by Beverleigh and that contained within the performance dashboard. It was noted, however, that the two services highlighted were not comparable.

08.05.03 Finally, Beverleigh showed the Board the front page of the new website which had been developed, and in particular the encouragement given to patients to self-manage their condition, including apps linked to relevant web pages. Lee Martin praised to work of the team, saying that GPs had noted and fed back the differences made to the service as a whole.

08.06 <u>District Nursing</u>

08.06.01 Sarah Hayes introduced her presentation by informing the Board that there had been a 30% increase in demand for services over the past couple of years. Recruitment and retention had therefore been key priorities, as had effective communication. The vacancy rate had now reduced to 5%. The structure of the team had now been altered and was now a better match with the integrated care teams and social services, although a slightly different approach was being taken by the two boroughs of Islington and Haringey.

08.06.02 Further work on integration of the service was to be progressed through the integration steering group, and the Board would receive details of the timetable for this in due course. It was noted, however, that Islington hoped to have its new localities fully functioning by the start of the next financial year, and Haringey was speeding up its

timetable. Much work was being undertaken on continuity of services (end of life care was cited as a particular example).

08.06.03 Sarah showed the Board an illustration of the realigned model for the night service. She also drew attention to new ways of working within the service that had led to increased productivity, including the use of cars and iPADs, the latter meaning that morning handover was now done virtually. As well as increasing productivity, these changes were contributing to staff retention, and improved work/life balance.

08.07 Health Visiting

08.07.01 Lynda Rowlinson reminded Board members that the Health Visiting Call to Action had been launched in 2011, with the aim of increasing the number of health visitors nationally to 4,500 by 2015. This had, she said, been particularly challenging in London. Good progress had however been made – in 2011 the Trust had employed 67.4 whole time equivalent (WTE) health visitors, and there were now 97, an approximate growth of 10 per year. Overall though, there was a shortfall of 57.5 against the agreed trajectory with NHS England. This was a challenge, but there was a cohort of students about to qualify which would increase numbers.

08.07.02 Anita Charlesworth enquired whether or not the Trust was also considering alternative service models, given that the target should be one based around service consequences rather than staff group numbers. This view was wholly endorsed by the Board, whilst they recognised that the increase in health visitor numbers was a national and non-negotiable requirement. Lee Martin said that this point was being addressed through the regular telephone conferences held with NHS England – it was recognised this was a national requirement – and, therefore, one which needed to be reported to the Board - but the Trust continued to push back, recognising the absolute importance of providing the right service rather than a prescribed number of bodies.

08.08 Workforce

08.08.01 Introducing this item, Chris Goulding informed the Board that some of the slides here presented were in an iterative state and should be viewed as work in progress. He said that from October there had been an increase in the overall number of staff of 31 WTE due to winter pressures and the need to open additional beds. Looking at turnover, the main area of interest was the Integrated Care and Acute Medicine (ICAM) division, and Carol Gillen was looking at recruitment and retention in that division. Sickness was now below the threshold, although there was concern at high Bradford scores in some areas. The overtime expenditure within Facilities raised at the previous Board had now steadied, and director Phil Ient was carrying out a benchmarking exercise with other trusts.

08.08.02 Bank and agency spending had reduced, and all efforts were being made to converting posts into fixed term contracts. There were plans to carry out a review of the new appraisal system shortly.

08.08.03 Referring to page 5 of the report, Paul Lowenberg enquired why the Trust appeared to be above establishment on administrative staff. He was reminded that the term was misleading since it included health care assistants and technical staff. Lee Martin would also check since he was sure there was a low proportion of administrative staff within the care divisions. Paul also enquired whether the additional staff employed to

put into place winter pressures measures would not have been included in the original workforce plan, and was told they would not since at the time the plan had been written precise requirements would not have been known. Consideration would however be given to how this might be presented the following year, perhaps with a baseline figure then an additional line built in on top.

15/009 Financial Report

09.01 Ursula Grueger reported that the report for Month 8 showed a deficit of £380k, bringing the year to date deficit position to £6.7m. This continued to be attributable to a combination of underperformance on income and pressures on expenditure, with CIP continuing as previous trends. The capital programme was on track and being carefully managed. The Trust is now declaring a £7.4m deficit at the year end. Work was therefore in hand to bring the position back to balance and moreover to move towards achieving a surplus. It was noted that the £7.4m position was a 'worst case scenario', and that there was an absolute focus in the final quarter to reduce non-essential spend. It would also be important to look at planning for next year, starting the process far earlier and involving more people.

09.02 Rob Whiteman pointed out that the start of the new financial year was now only two and a half months away and, this being the case, wondered whether the Trust would begin by overspending from the beginning of the year. Ursula acknowledged that was every likelihood of this, although every effort would be made to improving the position month by month. She added that the team was also working to make the process itself simpler and more inclusive, i.e. devolving to more people.

09.03 Anita Charlesworth said that a high proportion of the Trust's expenditure was attributable to pay costs. She found it difficult to reconcile the high level of expenditure on bank and agency staff within midwifery with the reduction in service provision and loss of market share. It was noted that head of midwifery Jenny Cleary was looking into this, but there were vacancies in that area. In answer to a question from Paul Lowenberg about a drop in activity to 15% below plan, Siobhan Harrington replied that ED services were 'flatlining' during that period, as were non-elective services; and that activity in surgical lines had grown; it should also be noted that the plan was inflated by 5%. It was agreed to try to insert a more detailed narrative into next month's report.

09.04 In summary, it was agreed that the most important point moving forward was for the Trust to work closely with its commissioners to improve the position for the following financial year.

15/010 TDA Board Statements

10.01 Given the TDA statements had been discussed in detail at the previous meeting, Steve Hitchins asked whether there were any changes of significance, and Simon Pleydell replied that the only change of note was to the financial position, and this had been discussed in full detail with the TDA.

15/011 Register of Interests

11.01 The register of board members' interests, current guidance and sample template form were noted.

15/012 Safe Staffing Report

12.01 Philippa Davies introduced the safe staffing report for nursing and midwifery for the month of November. The Trust continued to operate at safe staffing levels throughout the Trust, and there had been a reduction in the number of HCA 'specials' (set out in Appendix 2).

Questions and comments from the floor

Ron Jacob enquired whether the Trust had any remaining financial reserves, and was told by Simon Pleydell it did not. He also queried the categorisation of the Hanley Road practice – it was explained this was a CQC requirement.

Ron also raised the issue of the fairly high level of DNAs referred to in the performance report and the cost to the Trust of these. Lee Martin replied that the Trust had carried out two audits and implemented five improvements and more recently asked the Intensive Support Team (IST) for advice. He would be presenting the results of this at the next meeting. Lee added that Maureen Blunden was undertaking a pilot on patients' preferred methods of communication. Simon Pleydell pointed out there was, however, little scope for savings since the clinics remained and had to be staffed.

Finally, Ron asked whether the Trust had failed to meet its CIP target because the targets themselves had been unrealistic or there had been a failure to achieve realistic targets. Simon Pleydell replied that each year the Trust was set 'efficiency targets' which involved real money being removed from the system. He acknowledged that some areas had not been successful, saying there was a need to be more realistic and clearer about the delivery of plans.

Helena Kania raised the issue of the PALS office being closed at 3.00pm daily, saying this was not a positive way to encourage feedback from patients. Philippa Davies replied that she was undertaking a review of the service, and there were plans both to increase opening hours and to make the environment more welcoming. Helena also asked about physiotherapy waiting times, saying that six weeks was a long time to wait following an operation. It was clarified that this was a different service, and Lee Martin undertook to provide Helena with more detail. Helena also queried the use of the word 'challenge' in the district nursing presentation. She also expressed disappointment at the lack of detail in the Quality Committee Report, stressing that the real test was whether concerns were adequately flagged to the Board.

Margot Dunn spoke about the Trust's work with Islington and Haringey local authorities, and expressed disappointment commissioning varied so much between the two. It was clarified that commissioning was the responsibility of the CCGs rather than local authorities, and Siobhan Harrington added that the Trust was frequently in discussion with CCG colleagues to address any imbalance within the system and some very real improvements had been brought about through this process. She also made reference to working with CCG and the local authorities over the Better Care Fund.

David Emmett spoke of the possible benefits to Whittington Health as others considered moving to the ICO model. He also wondered whether a decrease in activity might herald an increase in health. Anita Charlesworth mentioned the decrease in admissions brought about through ambulatory care, adding that the Trust needed to ensure this service was properly funded.

Valerie Lang suggested talking to some of the local GP practices to see how they best dealt with DNA problems. She also spoke about non-payment for services, and Siobhan Harrington explained that the block contract system currently in place meant an increase in numbers did not bring with it additional income.

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Action Notes Summary 2014-15

This summary lists actions arising from meetings held July 2014 to December 2014 and lists new actions arising from the Board meeting held on 7th January 2015.

Ref.	Decision/Action	Timescale	Lead
100.03	Nursing establishment – final report would be coming to the Board in February	February	PD
143.01	Cancer services improvement plan – to address specific question on integrated care and to check timing for Board	February	LM
173.04	Benchmarking data on the composition and percentage of different staff groups to be made available to the Board	February	CG
173.04	Change to the layout of tables required plus supporting narrative to accompany them	February	CG
174.06	Finance and Business Development Committee to review the business plan produced for the outsourcing of the catering service	February	UG
06.01	Board to consider revised terms of reference for the Quality Committee and discuss the need for quoracy	March	AS/PD
08.02	To review the HSMR figure in the performance dashboard and feed back to Paul Lowenberg	February	LM
08.03	Key performance indicators on ambulatory care to be incorporated in the dashboard	April	LM
08.08.03	To check the figures relating to administrative staff contained within the workforce report	February	CG
09.03	To increase the narrative relating to the section of the financial report relating to activity	February	UG

Whittington Health NHS

ITEM: 15/018
Doc: 2.1

The minutes of the extraordinary meeting of the Trust Board of Whittington Health held at 11.00pm on Wednesday 14th January 2015 in the Whittington Education Centre

Present:	Philippa Davies	Interim Director of Nursing and Patient Experience
	Ursula Grueger	Deputy Director of Finance (Acting as Director of Finance)
	Chris Goulding	Acting Director of Human Resources
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Steve Hitchins	Chairman
	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:	Friedericke Eben	Medical Programme Director
	Kate Green	Trust Board Secretary
	Sophie Harrison	Assistant Director, Estates
	Phil Ient	Director of Estates & Facilities
	Caroline Thomsett	Director of Communications

1. Apologies for absence

1.1 Apologies were received from Anita Charlesworth, Graham Hart and Rob Whiteman.

2. Maternity and Neonatal Redevelopment Full Business Case

2.1 Chairman Steve Hitchins welcomed all present to this extraordinary meeting of the Whittington Health Trust Board. He explained that the timing of the meeting had been governed by the deadline for submission of the Full Business Case (FBC) to the Trust Development Authority (TDA), which was 16th January. Steve went on to thank everyone involved in the development of the FBC – there were too many to name individually, but he was well aware that staff had been working nights, weekends etc to produce a thorough creditable document. The FBC had been discussed in the Board Seminar held immediately prior to this meeting, and Siobhan Harrington as lead for the development of the FBC was recommending Board approval. The team had, she said, been amazing. The plan for this meeting was that the team would present the FBC, there would then be opportunity for questions from the Board, and finally they would take questions from any members of the public present.

2.2 Friedericke Eben said that since 1995 one of the main aims of the Trust had been to have a new maternity and neonatal unit. Whittington Health as an ICO had received good reviews and a survey carried out in 2013 showed that women liked coming to the hospital. Giving some of the history, Friedericke said that in 1983 the City of London Maternity Hospital had been incorporated into the Whittington Hospital maternity services.

2.3 Friedericke Eben explained that the maternity and neonatal services received extremely positive reviews, especially the new birthing centre. This included positive reviews for the

high risk elements of obstetrics. The unit also provided excellent education opportunities for junior doctors. Friedericke went on to describe recent developments in service provision, including the joining of health visiting with midwifery, the practice of partners being given the opportunity to stay overnight, the weight and nutrition clinic and EPR. New pathways had also been created.

2.4 Friedericke then took Board members through the feedback from the consultation exercise that had been undertaken, and highlighted some of the key responses which raised the question of the current environment. She had also held discussions with local GPs, had recently interviewed five practices, and she mentioned the lack of available information about the service in central and south Islington practices. In summary, then, the service provision is good, but in an environment which is 'poor and unacceptable'.

2.5 The aspiration was to have the maternity and neonatal redevelopment completed by September 2016. Friedericke took the Board through figures from the last ten years, including noting the reduction of deliveries, stressing that new delivery facilities do make a difference. In developing the FBC consideration had been given to eight different options. The implications of each were detailed, starting with the risks inherent in doing nothing. She then took the Board through the preferred option, which was Option 3A – strategic investment with marketing growth. This option contained the following elements:

- Marketing growth assumed
- Activity level increases; by 18/19 deliveries increase to 4,700 and neonatal cots increase from 23 to 27
- Workforce increase in line with increased activity
- Capital investment of £12M.

2.6 The Board was then shown the plans, including the new theatre facilities and neonatal care unit, and it was explained that the design allowed the option for further expansion at a later date. This could be done using a 'drop in' method which would minimise disruption.

2.7 Friedericke Eben described the process behind the financial modelling. She was aware that the preferred option contained an ambitious growth target the Trust needed to deliver on. She added that there had been a rise in costs between the development of the OBC and FBC, works and other costs had risen from £10m to £12m, one million of which was inflationary pressures. In terms of how the redevelopment would affect finances as a whole, the first two years there would be a negative impact, but after this the position would rapidly become positive. To do nothing would result in financial cost to the Trust.

2.8 The next stage was to gain approval from the TDA, and it was hoped that if this was forthcoming work on the redevelopment could begin in the summer 2015. Friedericke Eben thanked everyone for their support, including the many contributors who were not employed by the Trust.

2.9 Paul Lowenberg posed two questions:

- looking at past concerns women had raised, what increase in privacy and reduction in noise would the redevelopment bring
- referring to the letter of support the Trust had received from the CCGs, would the service meet national standards in relation to consultant cover

In answer to the first question Friedericke replied that the new neonatal unit would be much bigger, allowing more space between beds, and with improved facilities for parents. There would also be two single rooms adjacent to the obstetric theatre, in addition to a new 4 bed bay for recovery/high dependency care. Two new delivery rooms would be provided with en-suite facilities. In the interim, Murray ward was being refurbished, and this would contain more single rooms.

Turning to Paul's second question, at the moment the unit has consultant cover of some 80 hours per week, 08.00am – 10.00pm Mondays to Fridays, and five to six hours every Saturday and Sunday. This is in line with current guidelines for the number of deliveries we cover.

2.10 Paul also enquired whether the neonatal service should not be aspiring to be a Level 3 rather than Level 2 service. Friedericke explained the commissioning approach to neonatal units and the neonatal network which means that we should be aspiring to be an excellent Level 2 service, which also fits with the clinical strategy of the organisation as an integrated care organisation.

2.11 Richard Jennings said that he was confident staffing levels were safe and consistent with Royal College guidelines. He invited Friedericke to highlight patient safety advantages of the redevelopment, and she replied that those requiring an emergency caesarean section would no longer have to be moved to main theatres as the new second obstetric theatre would be on hand. She also said that the neonatal unit was not fit for purpose in terms of infection control etc.

2.12 Siobhan Harrington said that the business case was predicated on growth; however activity in the last year had gone down. She emphasised however that the Trust had never marketed the service, but plans were in place to do so now. A detailed plan had also been drawn up on how to regain market share. If the FBC was approved there would be considerable monitoring of activity levels. In addition, the information on the Trust website had been considerably improved including contributions from midwives, obstetricians and other colleagues across the Trust.

2.13 Steve Hitchins emphasised the importance of this development on the Trust's status as an ICO, and the advantages this could offer to patients. The Trust had never before had to market its services, but it was now required to do so. Caroline Thomsett added that work had already begun on marketing, with the approach being that the ICO offered care 'every step of the way'. This was seen as a positive approach by GPs.

2.14 Paul asked for executive colleagues to expand on the key risks. Siobhan replied that a great deal of work had been done. in this area including through the service transformation group. The Trust had the support of its main commissioners, and was expecting anticipating receiving formal support from NHS England later in the day. Siobhan outlined the five key risks as being:

- activity growth assumptions which have already been discussed and are being mitigated through the delivery of the marketing strategy

- the timeline on Town Planning – and we continue to work with colleagues in LBI to mitigate this risk

- increase in capital costs from OBC to FBC, and this has been discussed in detail with the TDA who explained that they would be pragmatic in their consideration of this

- delivery of CIPs which as a Trust we are very focused on and developing realistic detailed plans

- TDA approval of the FBC in the context of our LTFM, and the key mitigation is that we believe the evidence shows that this improves our LTFM.

Finally the NHSE letter of support which we are expecting imminently.

This was echoed by Ursula Grueger, who said that the Board had been provided with the details of the financial analysis of the risk, and she agreed that the greatest concern was that of any possible delay to the scheme. In answer to a question from Paul Lowenberg about capital costs, Sophie Harrison replied that the Trust had used a P21 procurement route, and there was a 'not to be exceeded maximum price' provided works kept to timetable.

2.15 Steve Hitchins asked about lessons learned from the process, and it was agreed that one problem had been the delay between the OBC and FBC. The TDA was now far more closely involved, and the scheme was within their planning pipeline.

2.16 In summary, Simon Pleydell said that the scheme was not without its risks, and there was a clear need to increase the number of births. To do nothing, however, was not acceptable, and the service would gradually become unsustainable without investment. Steve Hitchins asked those in favour of the FBC to indicate their support, and the recommended option was agreed unanimously.

Whittington Health NHS

The Whittington Hospital NHS Trust
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Whittington Health Trust Board

4 February 2015

Title:	Chief Executive's Report to the Board		
Agenda item:	**15/020**	**Paper**	**3**
Action requested:	For discussion and information		
Executive Summary:	Headlines: 1. Care Quality Commission (CQC) preparation 2. Flu campaign 2014/15 – trust target reached 3. Second MRSA bacteraemia 4. Emergency Department performance 5. Referral to Treatment waiting times 6. Cancer standards 7. Impact on Musculoskeletal (MSK) and District Nursing 8. Financial position at month nine (December) 9. Whittington Health – the next five years 10. Barbara Windsor MBE opens MacMillan Cancer Centre 11. Female Genital Mutilation (FGM) trial 12. Further industrial action 29 January 13. New Wi-Fi service 14. Apprentice success at HENCEL awards 15. Kings Fund Quarterly Report 16. Ambulance reports times		
Summary of recommendations:	The Board is recommended to discuss the report.		
Fit with WH strategy:	This report provides and update on key issues that could affect Whittington Health's strategy.		
Reference to related / other documents:	n/a		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	n/a		
Date paper completed:	27 January 2015		

Author name and title:		**Simon Pleydell, Chief Executive**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
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**

The purpose of this report is to update the Board on local, regional and national policy changes that will affect the organisation and set out the key issues facing the Trust.

Quality

1. Care Quality Commission (CQC) preparation

We are beginning to prepare for a full CQC inspection, which is likely to happen in the second quarter of the next financial year. It will be an opportunity to showcase our good work and improvements we've made. The inspection will also enable us to demonstrate that we know our improvement areas and what we are going to do about them. We will be able to show how we gain feedback on the care we provide, learn from our mistakes and share lessons to make changes. All colleagues will be supported to prepare for the inspection as well as offered best practice points for life beyond the CQC visit. We are holding a series of briefing meetings on the expected inspection for all clinical colleagues and everyone who works in patient areas.

2. Flu campaign 2014/15 – trust target reached

The Trust has not only reached the 75 per cent target but its own stretch target of vaccinating 80 per cent of colleagues this winter. Thanks to the efforts of everyone involved, particularly our flu champions, the Trust is again the top trust in London for vaccination rates. Public Health England reported in January that more than 506,000 frontline staff (52.6 per cent) were vaccinated between 1 September and 31 December 2014.

3. Second MRSA bacteraemia

After being MRSA bacteraemia free for a year, we have now had two patients with trust acquired blood stream infections within four weeks. Post infection reviews have been undertaken. Colleagues are being urged to be extra vigilant and reminded of the importance of our infection control procedures.

Performance

4. Emergency Department performance

Our Emergency Department (ED) and subsequent services have seen an increase in demand, particularly the acuity and complexity of the patients. Despite the continued pressure, our performance against the four hour standard improved in December to 0.1 per cent below 95 per cent. Assurance and planning meetings have been held with the NHS Trust Development Authority (TDA) and Islington Clinical Commissioning Group (CCG) to ensure that all possible assistance is being given and patients do not experience delays in their care pathways.

5. Referral-to-Treatment waiting times

In November and December, we met our national standard for patients waiting for planned care. A large amount of coordination and planning went into the drive to reduce the long waiting patients. There is still work to be done and further patients will be treated in February and March.

6. Cancer standards

We met our national standards, and the tumour streams now have processes and systems in place to enable sustained compliance with these strict timescales.

7. Impact on Musculoskeletal (MSK) and District Nursing

Additional demand has not only been placed on the Emergency Department and inpatients beds, we have also seen a large increase in referrals to MSK and to District Nursing. Both teams have been moving colleagues around our locations to ensure that patients receive timely treatment.

Finance

8. Financial position at month nine (December).

There has been a slight improvement in our financial position. Our in-month position at the end of December was a £480k surplus bringing our year-to-date position to a £6.2m deficit. The financial position overall is a combination of income underperformance and expenditure pressures. The favourable position in month is driven by an over performance in NHS clinical income. This reflects the £2m contract variation, £1.2m resilience support and higher than run rate NHS England performance which is paid on Payment by Results (PbR). We continue to exploit additional income opportunities. The main expenditure challenges remain in our Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostic (SCD) divisions. Our improved expenditure compared to month eight is largely due to the corporate division both pay and non-pay position. We continue to forecast a year-end deficit of £7.4m and endeavour to make every effort to reduce our discretionary expenditure. Discussions with our commissioners continue with the aim of improving our year end position.

Other key updates

9. Whittington Health – the next five years

There has been further clinical and public engagement in January with three more trust workshops and three health conversations in Islington, Tottenham and at The Whittington Hospital. There is support for the new mission and vision that has been developed and agreement on the strategic themes. The full clinical strategy is expected to be completed for the next Trust Board in March.

10. Barbara Windsor MBE opens MacMillan Cancer Centre

Barbara Windsor officially opened our Macmillan Cancer Information and Support Centre at The Whittington Hospital in January. The opening included a moving account from Lucy, a Whittington Health patient on the need for a support network when facing cancer. The centre provides information and emotional support to people with or affected by cancer including their carers and families. Cancer patients can be referred from the oncology team, from GPs working in the community or patients can drop in Monday to Friday from 10am to 4pm.

11. Female Genital Mutilation (FGM) trial

The first FGM court case in England and Wales began on 19 January at Southwark Crown Court involving one of our doctors. A second person is accused of aiding and abetting the doctor. Both deny the charges. The alleged incident happened in

November 2012 following a patient giving birth in our maternity unit. The charges and the current trial have had a major impact on colleagues. We have been providing support to everyone concerned, as far as we are able to do so. The trial is expected to last three weeks. We will issue a statement at the end of the case.

12. Further industrial action 29 January

A number of unions were due to escalate their industrial action on Thursday 29 January in response to the Government's decision on the 2014/15 pay award. Unison, Unite and GMB were calling on their NHS members in England to take strike action for 12 hours between 9am and 9pm. The GMB was also asking its members in the ambulance service to take part in a 24 hour strike from midnight on 29 January, while Unison members in the ambulance service were due to strike from noon to midnight. This will potentially have a widespread effect on the ambulance service and NHS England has declared a London-wide major incident. Other unions involved include the Royal College of Midwives (strike action between 1-3pm). This is a national dispute between the Government and national unions, and not between local unions and employers. A further strike is planned on Wednesday 25 February.

13. New Wi-Fi service

Wi-Fi is now available at The Whittington Hospital for all patients, carers, colleagues and students. This is a free service and a very welcome addition for patients and their families. The service is externally managed by Wi-Fi Spark.

14. Apprentice success at HENCEL awards

Congratulations to two of our apprentices who received acclaim at the Health Education North Central and East London (HENCEL) annual Quality Awards in December. Duncan Matthews won apprentice of the year and Sophie Thompson from Improving Access to Psychological Therapies (IAPT) was highly commended. Both are studying Business and Administration at City and Islington College. More than 120 nominations were received for the awards and 24 shortlisted.

15. Kings Fund Quarterly Report

The King's Fund's latest quarterly monitoring which examines the views of finance directors shows that waiting times for treatment and other key performance indicators are worsening, as the NHS faces increasing demand for services and an unprecedented financial squeeze. The report confirms that NHS finances remain under intense pressure, with more than 40 per cent of directors surveyed for the report forecasting that their trust will end the year in deficit. However, over three quarters reported that their organisation is planning to increase the number of permanent nursing staff it employs over the next six months as care is prioritised.

16. Ambulance reports times

London Ambulance Service NHS Trust has been announced as one of two new pilot sites that aim to reduce wasted ambulance journeys and improve the quality of care for all patients contacting 999. For the most serious calls, where every second counts, ambulances will continue to be dispatched immediately. A number of conditions will be upgraded from "Red 2" to "Red 1" to receive a faster response, and no conditions will be moved in the other direction to a lower priority classification. The call handling time will also be extended by 120 seconds for non-life threatening calls to reduce the number of double dispatches, freeing up more ambulances to respond to more patients, and allow the 999 response to be more accurately targeted to patient need. The first pilot is expected to start in February.

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Whittington Health Trust Board
4th February 2015

Title:	Quality Committee Report - 15th January 2015		
Agenda item:	15/021	Paper	4
Action requested:	For noting and approval		
Executive Summary:	This summary report details outcomes from the Quality Committee meeting of 14 January 2015 when the following reports were considered: • Divisional Risk and Quality Reports • Serious Incident Report • Quality Performance Report • Infection Control Update • Patient Safety Committee Report • Safeguarding Adults Report (quarter three) • Research and Innovation Report • Emergency Preparedness Report • Supervision of Midwives Report • Care Quality Commission (CQC) Inspection Preparation (verbal update) • Quality Standards (verbal update) • Update on Policy Reviews		
Summary of recommendations:	The Trust Board is asked to receive the report and comment on revised format and content.		
Fit with WH strategy:	The Quality Committee, a sub-committee of the Trust Board, considers issues relating to quality, patient safety and governance.		
Reference to related / other documents:			
Date paper completed:	January 2015		

Author name and title:		**Philippa Davies, Director of Nursing**		**Director name and title:**		**Philippa Davies, Director of Nursing**	
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

QUALITY COMMITTEE – MEETING HELD ON 15th January 2014

SUMMARY REPORT TO BOARD – 19th January 2014

The following Non-Executive Directors were present:

Anu Singh (Chair), Anita Charlesworth, Professor Graham Hart

The following Executive Directors were present:

Philippa Davies, Richard Jennings

Decisions made under delegated authority:

The Quality Committee made no delegated decisions on behalf of the Trust, under the authority delegated to it within its terms of reference.

Outcomes:

Terms of Reference

The Committee agreed the revised Terms of Reference subject to some minor amendments. The final version will be presented to the Trust Board in March for ratification.

Divisional Presentations –

Integrated Care and Acute Medicine (ICAM)

The committee received a clear comprehensive presentation from the Divisional Director of Operations. The presentation highlighted the achievement in complaints handling and improvements in staff appraisal rates. In addition, the division has maintained compliance with the same sex accommodation standard since 1st August 2014.

The committee requested that future reports highlight where there may be risks to quality. The committee recognised the hard work and achievements of the team recognising the recent significant pressures in the Emergency Department.

Surgery Cancer and Diagnostics (SCD)

The committee received a clear comprehensive presentation from the Head of Nursing and the Divisional Director of Operations. The committee discussed the impact current levels of admissions were having on elective cases and were pleased to note the cancellation of elective patients had been minimal. The committee were informed that cancellation was risk assessed and the small number of patients who had been cancelled were sent personal letters of apology from the Divisional Director of Operations. The committee agreed that this was very good practice.

The Trust's Summary Hospital-level Mortality Indicator (SHMI) position was discussed and the Medical Director informed the committee that the recent data was currently being reviewed and that the previous figure had been given a caveat due to the recent problems with Electronic Patient Record (EPR) data.

Women, Children and Families (WCF)

The committee received a presentation from the Head of Midwifery and highlighted the need for a more comprehensive report going forward. A discussion ensued around the importance of having sound governance processes in place.

Mandatory training and appraisal

The committee discussed mandatory training and staff appraisal performance and agreed that compliance remains a concern and that further work is required. The committee requested assurance that there was a robust plan in place to address these issues and as such would like to see a paper brought to the next committee for consideration.

Care Quality Commission – inspection preparation

The committee did not feel assured that each division had a holistic view of their compliance against the CQC standards and agreed that future divisional quality reports needed to provide this assurance.

Performance report

The committee discussed performance with regard to Referral-to-Treatment Times (RTT) and the invitation issued to support other Trusts if capacity allows.

Complaints handling has improved significantly both in terms of response times and quality of responses sent. The committee were assured that the Chief Executive personally reads and signs every response.

The committee discussed the continued inefficiency of the Electronic Staff Record (ESR) and current reporting system and the requirement for issues to be addressed as a priority.

Other matters:

The committee considered the following reports:

1. **Serious Incident (SI) Report –** The committee was informed there were six serious incidents declared in November taking the total to 102 since January 2014. Further assurance was given that a process is now in place for addressing the backlog of SI reports and that lessons learnt were being discussed across divisions.

2. **Infection, Prevention and Control Report –** The committee was informed that the Trust has declared its first hospital acquired MRSA bacteraemia case in 13 months. Lessons learnt have been shared across the organisation.

3. **Safeguarding Adults Report – Q3.** An improvement in Safeguarding Level 2 training was noted.

4. **Research and Innovation Report –** The committee reviewed the report detailing recruitment figures for the adopted studies in the National Institute of Health Research portfolio and welcomed the current research strategy review.

5. **Emergency Preparedness Report –** The committee received assurance that enhanced business continuity plans are in place in addition to effective command and control arrangements.

6. **Supervision of Midwives Report –** The committee was presented with a report highlighting the range of work undertaken by the midwifery supervision team in 2014. The Committee congratulated the team on receiving a successful Local Supervisory Authority (LSA) report in November 2014.

Anu Singh
Non Executive Director
19th January 2015

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The Whittington Hospital NHS Trust
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Whittington Health Trust Board

4th February 2015

Title:	Update on the Trust's clinical strategy development		
Agenda item:	**15/022**	**Paper**	**5**
Action requested:	For discussion and comment		
Executive Summary:	This paper updates the Board on the development of the Trust's clinical strategy for the next five years. It outlines our ongoing engagement process with clinicians, members of the public and other stakeholders. The paper also details our current strategic framework including the mission, vision and strategic themes. The final narrative will be presented to the Trust Board in March.		
Summary of recommendations:	The Board is asked: - To agree the mission, vision and strategic themes for the organisation - To note the ongoing engagement process for the clinical strategy.		
Fit with WH strategy:	This paper centres on the development of the Whittington Health strategy and outlines current and future plans.		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	22nd January 2015		

Author name and title:		**Hannah Finney Strategy and Planning Manager**		**Director name and title:**		**Siobhan Harrington, Director of Strategy and Deputy Chief Executive**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1. Introduction

This paper updates the Board on the development of the Trust's clinical strategy for the next five years.

There has been good engagement to date in developing the strategy, however, over Christmas it was decided to strengthen the clinical engagement. There is support for the mission and vision that has been developed and agreement on the strategic themes. The detail on the narrative is still being completed. It is expected that the full clinical strategy will be completed in time for the March Trust Board.

2. Engagement

Further engagement has been taking place to ensure that the development of the strategy is clinically led and has input from all stakeholders.

2.1. Clinical engagement

There were three clinical engagement workshops through November and December. These were attended by clinicians, operational staff as well as colleagues from Islington and Haringey Clinical Commissioning Groups (CCGs) and local authorities.

To ensure further clinical ownership of the plans, three more workshops have occurred in January and February. These workshops were well-attended and have provided insight that is being incorporated into the final version of the strategy.

Furthermore, a small group of clinicians volunteered to be part of an email conversation providing in-depth feedback on the current strategic framework and any further suggestions. The feedback received from those who responded was detailed and is also being incorporated into the final document. There will be a number of case studies of how care pathways will be improved during the implementation of the strategy.

2.2. Public engagement

There were 'health conversations' conducted with the local community to influence the development of the strategy. Three more have been conducted in January and an online feedback process launched via the Trust's website. Once more, attendees were invited to give their health priorities, concerns and suggestions regarding the future of Whittington Health.

There are a number of local people who are also very interested to become 'patient champions'.

Feedback from these sessions will enable us to ensure that through our strategy we respond to areas of concern from local people.

Communication with the local community regarding the development of the Trust's clinical strategy has also been via the Trust's website, social media, and updates on stakeholder and community websites.

2.3. Engagement with CCGs and Local Authorities

Colleagues from Haringey and Islington CCGs and local authorities attended both sets of clinical engagement workshops.

2.4. Communications strategy

Strategy developments have been communicated through the aforementioned engagement events, through the Trust's intranet and social media, and the Chief Executive's monthly briefing to Trust staff.

Following approval of the Trust's mission and vision, we plan to have a comprehensive communications strategy in place to communicate these across the organisation as a whole.

3. Current strategic framework

There has been broad agreement from stakeholders regarding the 'mission', 'vision' and strategic themes in the Trust's draft strategic framework (see diagram below).

The mission is:

'Helping local people live longer, healthier lives.'

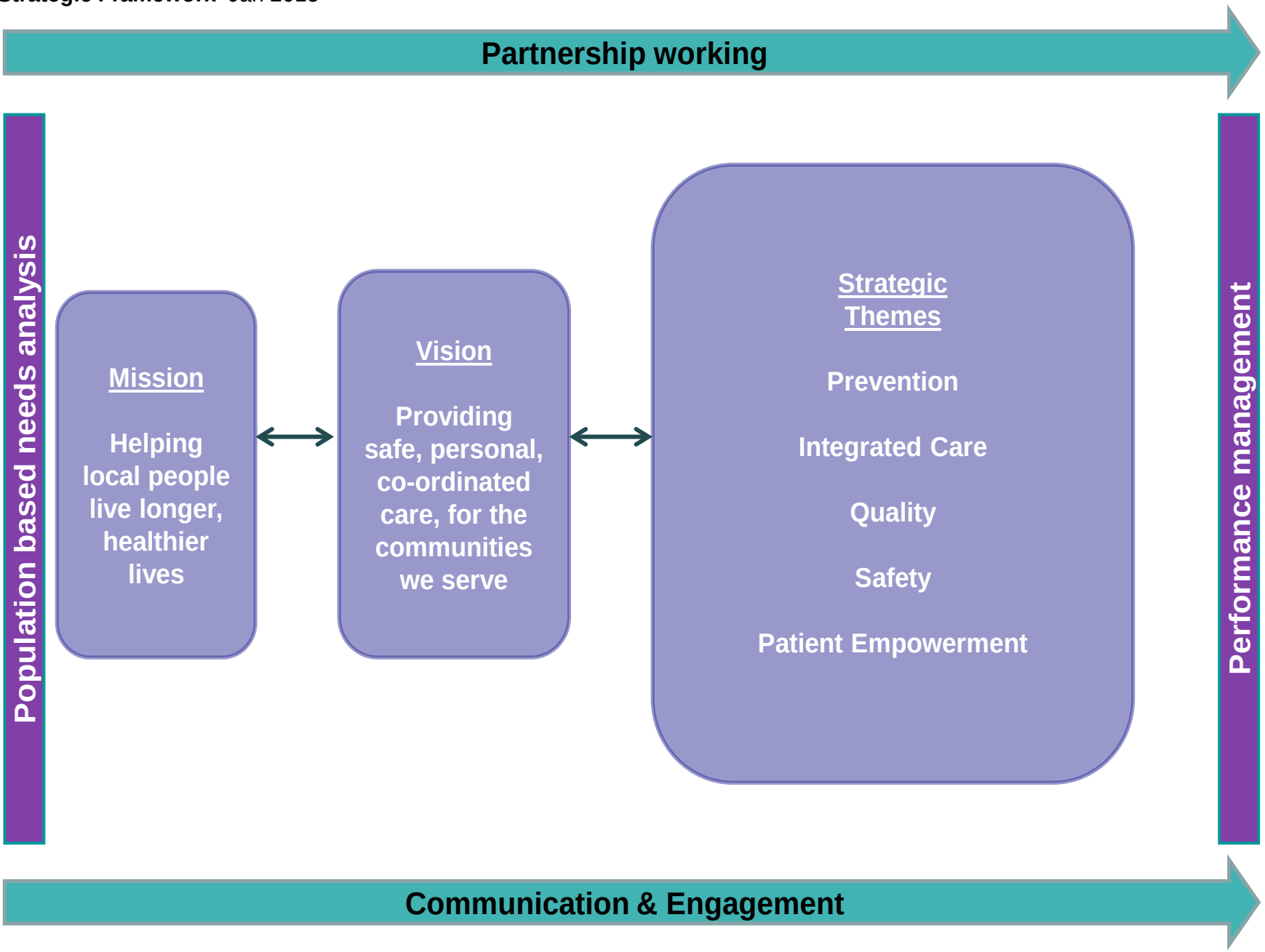
The focus is on prevention and on our local communities.

The vision is:

'Providing safe, personal, co-ordinated care, for the communities we serve.'

Through engaging with our colleagues, there was strong support for this vision encapsulating what we mean by 'integrated care' and that the coordination of care for people will be important over the next five years.

There has been much discussion and debate regarding the strategic themes and these are currently 'prevention', 'integrated care', 'quality', 'safety' and 'patient empowerment'. These will be developed into goals for the organisation and will help inform the corporate objectives in the year ahead.


Partnership working
Population based needs analysis
Mission
Helping local people live longer, healthier lives
Vision
Providing safe, personal, co-ordinated care, for the communities we serve
Strategic Themes
Prevention
Integrated Care
Quality
Safety
Patient Empowerment
Performance management
Communication & Engagement

5. Actions

The Board is asked to:

- To agree the mission, vision and strategic themes for the organisation
- To note the ongoing engagement process for the development of the clinical strategy.

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Whittington Health Trust Board

Title:	Whittington Health Cancer Strategy 2015/16		
Agenda item:	**15/023**	**Paper**	**6**
Action requested:	For discussion		
Executive Summary:	This Paper outlines the Whittington Health Cancer Strategy for 2015/2016		
Summary of recommendations:	To note		
Fit with WH strategy:	**Integrated Care -** Provides a full range of services for cancer patients with excellent integrated care across Whittington Health **No Decision Without Me** - We will transform the way we work by ensuring people and services work together to design and deliver the best care pathways and the best patient experience. **Efficient and Effective Care** - To deliver efficient, effective services that improve outcomes for patients and service users, while providing value for money. **Improving Population Health** - Treating and preventing cancer is a critical part of improving population health. **Culture of Improvement and Innovation -** The service will endeavour to deliver services through a more diverse workforce undertaking different roles and responsibilities.		
Reference to related / other documents:	Cancer Services Business Plan 2015/16		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	23rd January 2015		

Author name and title:		**Pauline Leonard Lead Cancer Clinician & Consultant Medical Oncologist**		**Director name and title:**		**Fiona Isacsson Director of Ops SCD**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

WHITTINGTON HEALTH CANCER STRATEGY 2015/16

Introduction

This paper describes the Cancer Strategy for Whittington Health 2015/2016. This has been produced in collaboration with each Tumour Group. Please find our objective below:

1. Our overarching principle is to deliver patient focussed, clinically effective, safe care locally which provide better value pound for pound by an engaged and healthy workforce. We want to further improve pathways of care to enable faster diagnosis, better tailored treatments with support along the whole patient journey to ensure an excellent experience of care that promotes confidence for self-management and emotionally supported survivorship.

2. To deliver on these principles we need to promote a range of diagnostic tests, which can be accessed directly by primary care within one week of request. In addition to full concise reports within 24 hours of completion of the test, we will add a recommended fast track access clinic to the report for the GP to refer their informed patient for further assessment and investigation.

3. We will provide better cancer prevention strategies and plan to offer a suite of healthy lifestyle choices including smoking cessation support for all patients referred to the Trust on a two week wait investigation of a suspected cancer. Our data show that, overall, 78 per cent of patients referred do not have an underlying suspected cancer. This large cohort of patients in addition to being reassured there is no malignancy will be provided with healthy living information and strategies to reduce their future cancer risk.

4. We are extending our screening programme by offering colorectal screening in addition to our breast screening programme. We need to solidify pathways of care from the screening centres to ensure our patients who are found to have a suspected cancer in the community have their definitive treatment repatriated to Whittington Health.

5. We want to provide faster diagnosis by promoting our drop in centre for a chest x-ray in high risk patients with persistent cough. We want to build on our excellent ambulatory care model by offering primary care an alternative route for senior clinical review and investigation of a suspected cancer avoiding admission via the emergency route.

6. We plan to embed a clinical frailty assessment working in tandem with the care of the elderly physicians to ensure there is equity of services to our patients over 75 years.

7. We want to implement Somerset software (a speciality patient management administration system) by April 2015 to ensure accurate data is collected on all our diagnosed patients not only contributing to the national cancer outcomes and service dataset (COSD) but embed a culture of regular interrogation of our datasets against national benchmarks to ensure there is no variation in providing the best evidenced based care for all our patients with a diagnosis of breast, colorectal, lung and prostate cancer.

8. We will continue to collaborate with our neighbouring specialised centres to provide seamless pathways of care to ensure our local patients who require specialist services have their care transferred in timely way.

9. We want to build networks of supporting services to ensure care is delivered as close to home as possible. In addition to our excellent ambulatory chemotherapy service which provides all chemotherapy including the administering of complex regimens to all patients with breast, colon, lung, upper gastrointestinal and hepato-biliary cancers, we plan to provide chemotherapy in the community and patient homes for those who request it and the governance structures are in place to safely deliver it. We have further developed our malignant haematology service by proving a range of evidence systemic regimens for our local patients. This practice is shared with University College London Hospitals NHS Foundation Trust (UCLH).

10. We are implementing the cancer recovery care package to ensure care is co-ordinated between primary and acute care so that patients are appropriately followed up and timely access back into the acute sector when needed. This includes stratified pathways for follow-up, initially with breast, colorectal and prostate cancers.

11. The opening of our Macmillan Cancer Information and Support Centre has improved further our patient and carer experience. Expanding the team of volunteers and incorporating other specialists who provide complimentary therapies, we will provide patients and their families with the emotional support to enjoy their survivorship.

12. We will further develop our research trials portfolio and apply to join the Clinical Practice Research Datalink, which supports the use of observational studies and lower cost randomised control studies to embed within every day practice as an integrated care organisation.

13. With our history and committed clinicians who have embraced and disseminated the learning from new models of care to drive efficiency and productivity, we wish to develop further this work to provide seamless care without walls. We will encourage our clinical teams to apply to be pilot sites for NHS England supported projects.

14. To achieve our aspirations to provide world-class cancer care for our local population, we need to invest in our workforce. We need to ensure the clinical leadership is engaged and committed to a culture of innovation and improvement. We need to ensure they have the skills and time built into their job plan to enable our strategy to be delivered.

15. We must work with our commissioners to share our vision and plans for future development so novel services which avoid costly secondary care can be reimbursed at a competitive tariff.

16. We will invest any efficiency savings back into the service to develop further innovation and expansion of successful services, which report an excellent patient experience and demonstrate improved clinical outcomes whilst being cost efficient.

17. All of the above is within our reach in the next year. Our major challenge for local cancer care is the quality of care of our admitted in-patients. We need to look at the current pathways and staff skill mix and work across the disciplines to ensure our patients with cancer who are admitted with an emergency related to their disease are managed by a group of staff who have the skills and compassion to address their holistic as well as medical needs.

Recommendation

The Cancer Team ask that the Board note these proposals and feedback with comments.

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Whittington Health Trust Board

4 February 2015

Title:	Trust Board Report February 2015 (December 2014 data)		
Agenda item:	**15/024**	**Paper**	**7**
Action requested:	For discussion and agreement of areas of focus.		

Executive Summary:

The following is the Performance and Quality Report for December 2014; a number of highlights and areas for focus are identified.

National Indicators

Referral-for-Treatment (RTT): During the last six months, a national programme has been underway to reduce the back log of long waiting patients. Whittington Health agreed a trajectory with the NHS Trust Development Authority (TDA) and Islington Clinical Commissioning Group (CCG), lead commissioner. The trajectory was to reduce time waiting for the RTT pathway, time waiting for outpatient appointments and potential subsequent elective surgery. A plan was developed and implemented with achievement of the national standards at the end of November, and continuation into December. Due to the available capacity within elective surgery, we have also been requested to assist other providers and to increase elective patients treated by the end of the financial year.

Target	November 2014	December 2014
Admitted 90%	90.7%	92.8%
Non-Admitted 95%	95.0%	96.1%
Incomplete 92%	92.2%	92.3%

Emergency Care: A resilience plan was agreed with Islington CCG back in the summer of 2014, this was reviewed and a full assurance rating was agreed by NHS England (NHSE) and the TDA. During November and December, significant demand was placed on the emergency care pathway. This was seen in several ways, increased acuity and complexity in older people presenting to the Emergency Department (ED) and also needing subsequent acute admission, an increase in paediatric presentations to ED, increased need for community services provided by our colleagues in mental health, social care and our services in the community.
Increased demand on intensive care and high dependency beds

	was also seen due to the acuity of the presenting patients. Further planning was completed in November and December with Islington CCG and further funding was released to assist with staffing for ED, bed capacity and also community services. Internal assurance meetings have been held each week and assurance meetings have been held with the TDA and NHSE. A significant rise in patients with mental health conditions was also seen and delays experienced with a demand for mental health beds. There was also the need to pause admissions to two wards due to Influenza A, this was for a limited number of days and only reduced the capacity for seven beds for five days. This is standard practice during the winter period and coordinated by the infection control team and access team. Due to the demand on the emergency care pathway, the planned reductions in surgical bed capacity over the Christmas period could not be undertaken to the full plan. The London Ambulance Service (LAS) target was also of concern due to the demands on LAS. An additional staff member was available to assist with ambulance handovers to ensure no delays in the process of transferring patients into ED. A significant rise has also been seen for district nursing teams as providers discharge patients into the care of community teams, these have been from Whittington Health, UCLH, and North Middlesex. It is worth noting that the 14 improvement schemes, including ambulatory care, have made a significant effect on managing the winter demand and reducing the activity to the emergency department. All additional staffing shifts within the resilience plan (winter) have been filled by firstly overtime, then bank, and finally agency to avoid additional cost pressures. All operational senior staff has been 'back to the floor' to assist with the increases in demand, ensure safety and quality, assist with sickness cover and maintain staff morale. Despite the continued pressure the ED four hour standard has improved to 0.1% below 95%. **Cancer targets:** the cancer board has been implementing a cancer improvement plan over the last twelve months and significant improvements have been made. This has been in care delivery, access to services and also in alignment of staffing resource. The continued improvement in performance has been seen in December by the achievement of all the national standards achieved for the second consecutive month. Additional capacity was provided to other providers in November and December and all these patients have been offered appointments.

Areas to note

Proportion of reported patient safety incidents that are harmful: this measure is being reviewed as a new data capture form was introduced in December 2014. The new reporting with be validated and in place by April 2015.

Complaints: Continued support for divisions to improve response rate has been provided. Due to recruitment of a Quality Officer for Surgery, Cancer and Diagnostics (SCD), the trajectory is that this division will improve in January through April.

Infection Control: one incident of MRSA bacteraemia has been reported in December. A review meeting has been held with the frontline staff involved, the governance team and SCD Divisional Director, Head of Nursing, and Director of Operations. The action plan from the meeting has been put in place including reminders for management of venous site, hand hygiene and communication with the patient. The communication of learning form this meeting will also be spread across the organisation.

Summary of report:

QUALITY

- Inpatient deaths: there has been a rise in the number of patients who have died; the main group being older people with respiratory disease.
- Completion of valid NHS number: Improved despite increased continued demand on ED which affects compliance as it is an extra step in the processes, Inpatient and Outpatient Department (OPD) NHS number completion is being led by the Assistant Director for Cancer and Outpatients.
- Summary Hospital-level Mortality Indicator (SHMI): Whittington Hospital mortality rate remains lower than expected for the Trust.
- Hospital Standardised Mortality Ratio (HSMR): the information department are contacting Dr Foster as we believe that a change has occurred in the rebasing the standard factors which changes the relative risk rate. The Board will be updated on this at the meeting.

PATIENT SAFETY

- Harm Free Care: Achieved
- VTE assessment: Achieved
- Medication errors causing moderate/low harm: Action plans in place with close monitoring.
- Never events: none
- Central Alerting System (CAS) alerts: none
- Serious incidents reported: all incidents are fully

investigated and learning is shared.

PATIENT EXPERIENCE

- Friends and Family Test (FFT): the performance has achieved and use of 'you said, we did' displays are in inpatient wards, and will be introduced into OPD
- Mixed Sex Accommodation: no breaches
- Patient admission to adult facilities for under 16 years of age: no breaches

INFECTION PREVENTION

- Hospital acquired C Difficile infection: 1 in December 2014. A review has taken place and the action progressed, increased communication has been provided.
- Hospital acquired E.coli infections: none
- Hospital acquired MSSA infections: 1 in December 2014. The patient was treated following the guidance procedure and was discharged home following treatment.
- Ward Cleanliness: remains at 98%

ACCESS

- Diagnostic waits: Achieved
- 52 weeks wait: none
- Community access: District Nursing and Musculoskeletal (MSK) referrals increasing, plans in place.
- Genito-urinary Medicine (GUM): Change in reporting covering Haringey residents only from December 2014.

November Board – two specific questions had been asked at the November Board meeting. These are detailed below.

<u>MSK Service - Difference between the MSK metrics</u>

There are different metrics with different definitions:

1. The Board metric is based on a count of the number of clock stops (**patients treated**) within the month - the prescribed performance indicator

2. The MSK waiting list charts in the presentation are a count of patients **still waiting to be seen** taken from each of the weekly patient tracking list (PTL) reports (a series of snapshots) – this looks at the size and shape of the waiting list.

<u>Maternity Staffing and costs</u>

Staffing is the biggest cost for a maternity services and we currently have the following staff;

- 9.4 whole time equivalent (WTE) midwives on long term sick leave
- 4.47 staff on maternity / accrued annual leave

	• 5.53 staff have departed maternity in December (left or joined the Health Visiting course) This is **13.6%** of the total number of midwives. We have recruited nine WTE more band six midwives who will be starting to work for the Trust from the 2nd February and the staff returning from maternity leave will be back at work in February. Bookings and birth figures are reviewed and staffing levels adjusted to the presenting demands. **Presentation:** The Access Centre will be providing a project update.
Summary of recommendations:	That the Board notes the performance.
Fit with WH strategy:	All five strategic aims.
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	21st January 2015

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

February Trust Board Report (December data)

Whittington Health NHS

Quality	Threshold	Oct-14	Nov-14	Dec-14
Number of Inpatient Deaths	-	24	27	54
NHS number completion in SUS (OP & IP)	99%	98.6%	98.3%	arrears
NHS number completion in A&E data set	95%	87.5%	91.3%	arrears

Quality (Mortality index)	Threshold	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
SHMI	-	0.63	0.54	0.54

Quality (Mortality index)	Threshold	Jun-14	Jul-14	Aug-14
Hospital Standardised Mortality Ratio (HSMR)	<100	60.56	85.91	101.94
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	17.0	63.3	111.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	71.9	95.7	100.5

Patient Safety	Threshold	Oct-14	Nov-14	Dec-14
Harm Free Care	95%	93.7%	94.4%	95.4%
VTE Risk assessment	95%	95.1%	95.1%	arrears
Medication Errors actually causing Serious/Severe Harm	-	0	0	1
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	1	0
Proportion of reported patient safety incidents that are harmful	-	52.5%	44.4%	arrears
Serious Incident reports	-	7	6	8

Access Standards

Referral to Treatment (in arrears)	Threshold	Sep-14	Oct-14	Nov-14
Diagnostic Waits	99%	100%	99.6%	99.8%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Meeting threshold

Patient Experience	Threshold	Oct-14	Nov-14	Dec-14
Patient Satisfaction - Inpatient FFT (% recommendation)	-	89%	88%	94%

Efficiency and productivity - Community	Threshold	Oct-14	Nov-14	Dec-14
Service Cancellations - Community	2%	7.70%	7.70%	7.70%
DNA Rates - Community	10%	7.9%	7.6%	6.9%
Community Face to Face Contacts	-	68,463	63,382	58,199
Community Appts with no outcome	0.5%	1.2%	3.4%	1.0%

Community Access Standards	Threshold	Oct-14	Nov-14	Dec-14
Community Dental - Patient Involvement	90%	95.0%	99.0%	98.0%
Community Dental - Patient Experience	90%	99.0%	99.0%	100.0%
MSK Waiting Times - % waiting less than 6 weeks when seen that month	100%	93.4%	85.1%	83.5%
MSK Waiting Times - Consultant led (<18 weeks)	95%	80.0%	89.1%	arrears
IAPT - patients moving to recovery	50%	45.0%	47.0%	arrears
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Oct-14	Nov-14	Dec-14
First:Follow-up ratio - acute	2.31	1.63	1.63	1.66
Theatre Utilisation	95%	81.9%	82.9%	79.0%
Hospital Cancellations - acute - First Appointments	<2%	6.6%	6.0%	5.4%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.5%	7.6%	6.7%
DNA rates - acute - First appointments	8%	12.3%	12.8%	14.1%
DNA rates - acute - Follow-up appts	8%	13.3%	14.0%	13.8%
Hospital Cancelled Operations	0	7	15	2
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	0

Failed threshold

Emergency and Urgent Care	Threshold	Oct-14	Nov-14	Dec-14
Emergency Department waits (4 hrs wait)	95%	93.4%	92.4%	94.9%

February Trust Board Report (December data)

Whittington Health NHS

Patient Satisfaction - ED FFT (% recommendation)	-	89%	88%	87%
Patient Satisfaction - Maternity FFT (% recommendation)	-	92%	91%	n/a
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	30	35	26
Complaints responded to within 25 working day	80%	76.67%	71.43%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

ED Indicator - median wait for treatment (minutes)	60	78	85	70
30 day Emergency readmissions	-	270	240	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	2.8%	2.7%	2.7%
Ambulance Handover (within 30 minutes)	0	6	4	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Oct-14	Nov-14	Dec-14
Hospital acquired MRSA infection	0	0	0	1
Hospital acquired *C difficile* Infections	19 YTD	1	1	1
Hospital acquired *E. coli* Infections	-	2	2	0
Hospital acquired MSSA Infections	-	0	0	1
Ward Cleanliness	-	98.2%	98.1%	-

Cancer Access Standards (in arrears)	Threshold	Sep-14	Oct-14	Nov-14
Cancer - 14 days to first seen	93%	91.6%	94.9%	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	90.8%	97.1%	93.5%
Cancer - 31 days to first treatment	96%	100.0%	97.9%	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%	91.1%	98.0%	88.0%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold		Sep-14	Oct-14	Nov-14
Referral to Treatment 18 weeks - Admitted	90%	Projected	84%	84%	90.7%
		Actual	75.6%	83.3%	
Referral to Treatment 18 weeks - Non-admitted	95%	Projected	72%	72%	95.0%
		Actual	91.5%	89.9%	
Referral to Treatment 18 weeks - Incomplete	92%	Projected	80%	80%	92.2%
		Actual	85.7%	84.9%	

Maternity	Threshold	Oct-14	Nov-14	Dec-14
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.9%	92.4%	85.7%
New Birth Visits - Haringey	95%	85.4%	85.0%	arrears
New Birth Visits - Islington	95%	89.8%	91.4%	arrears
Elective Caesarean Section rate	14.80%	12.0%	13.7%	12.9%
Breastfeeding initiated	90%	89.1%	88.7%	92.2%
Smoking at Delivery	<6%	5.4%	4.9%	4.9%

Meeting threshold Additional capacity funding Failed threshold

	Threshold	Trust Actual		
		Oct-14	Nov-14	Dec-14
Number of Inpatient Deaths	-	24	27	54
Completion of a valid NHS number in SUS (OP & IP)	99%	98.6%	98.3%	arrears
Completion of a valid NHS number in A&E data sets	95%	87.5%	91.3%	arrears

	Standardised National Average	Jun-14	Jul-14	Aug-14
Hospital Standardised Mortality Ratio	<100	60.56	85.91	101.94
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	17.0	63.3	111.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	71.9	95.7	100.5

		Lower Limit	Upper Limit	RKE SHMI Indicator
Summary Hospital Mortality Indicator (SHMI)	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: Number of inpatient deaths increased in December.

Action: Analysis of data including age has been done and the increase is seen in respiratory illnesses in older people.

Timescale:

Completion of valid NHS number

Issue: Improving, although continuing demands on A&E affects compliance.

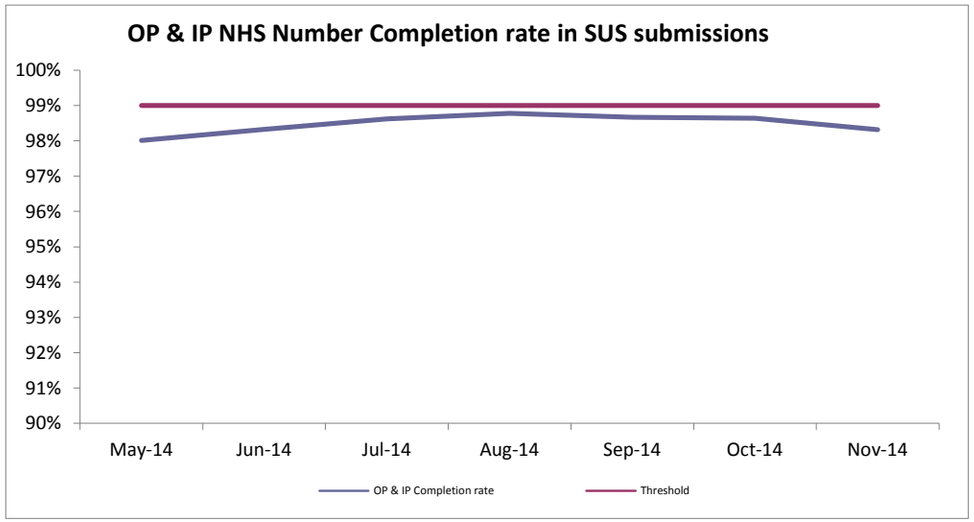
Action: Policies are re-enforce and procedures on completing NHS number in EPR are in place.

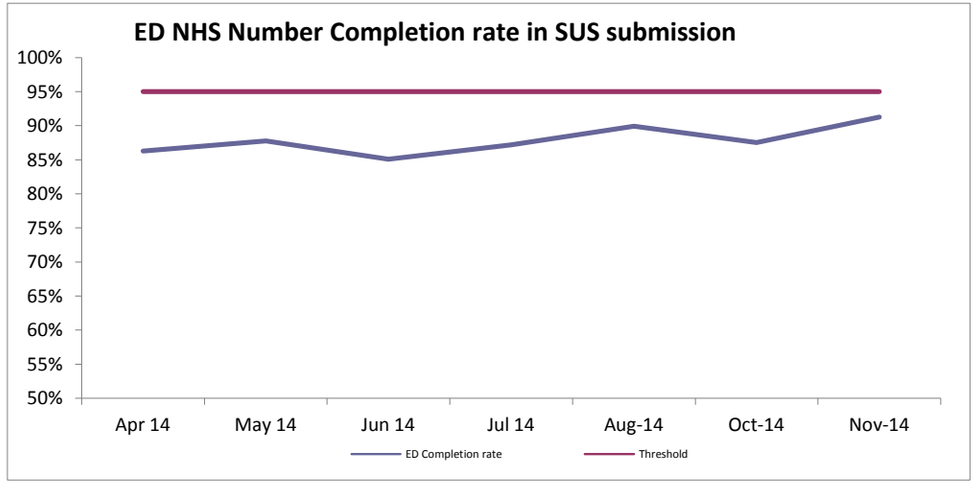
SHMI

WH score remains below the lower limit which therefore, indicates that the mortality rate remains lower than expected at our Trust. The continued improvement appears to be related to an increase in hospital spells whilst inpatient deaths remain constant.

HSMR

Issue: investigating with Dr Foster re change to relative risk index.



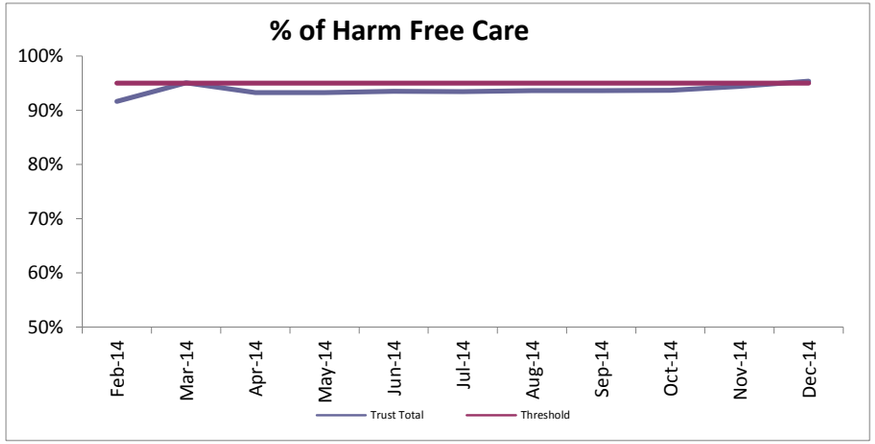


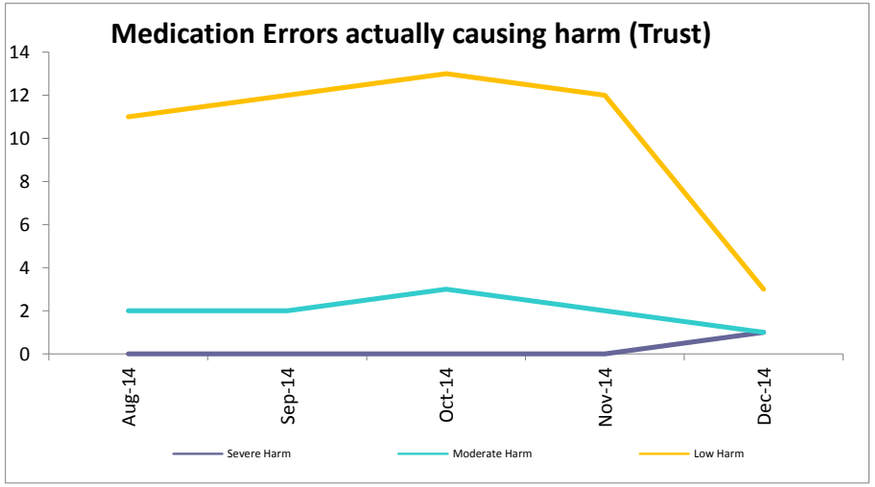
Patient Safety

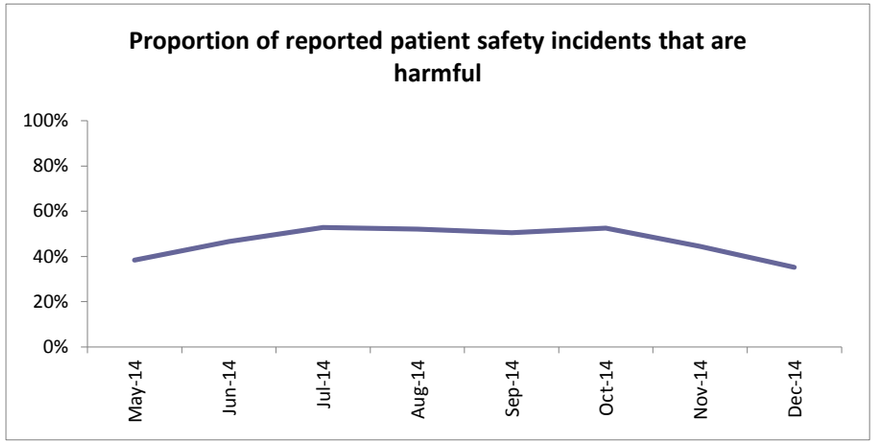
Whittington Health NHS

Data extracted on 13/01/2015

	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	Dec-14 ICAM	Dec-14 SCD	Dec-14 WCF
Harm Free Care	95%	94.4%	95.4%	94.3%	98.8%	100.0%
Pressure Ulcers (prevalence)	-	5.34%	3.88%	4.80%	1.25%	0.00%
Falls (audit)	-	0.18%	0.27%	0.35%	0.00%	0.00%
VTE Risk assessment	95%	95.1%	arrears	Reported one month in arrears		
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	1	1	0	0
Medication Errors actually causing **Moderate** Harm	-	2	1	0	1	0
Medication Errors actually causing **Low** Harm	-	12	3	1	2	0
Never Events	0	0	0	0	0	0
Open CAS Alerts (Central Alerting System)	-	1	0	-	-	-
Proportion of reported patient safety incidents that are harmful	-	44.4%	arrears	arrears	arrears	arrears
Serious Incidents (Trust Total)	-	6	8	8	0	0







Commentary

Harm Free Care

Issue: Achieved target.

Action: Continued HFC monitoring and learning from reviews is in place. Thematic Action plan in community in place to reduce the number of pressure ulcers acquired by patients under the care of Whittington Health by addressing issues identified in the investigation of pressure ulcer incidents.

Timescale: On-going

Medication Errors actually causing harm

Issue: the reported Serious medication error has been reviewed and did not occur whilst under the care of Whittington Health. The moderate error relates to prescribed specialist food not being available and a substitute prescribed. Low harm incidents are related to procedural and medical devise errors.

Action: The Serious harm error has now been re-graded to moderate harm. LAS has been informed of the incident to investigate.

Timescale: completed

Proportion of reported patient safety incidents that are harmful

Issue: In arrears due to reporting issues.

Action: The change to the incident form implemented in December 2014 has shown to affect data reporting. Incident reporting form and all incidents reported in December and January to be reviewed and corrected.

Timescale: immediately

Serious Incidents

Issues: 5 out of the 8 SI reported in December 13 were Pressure Ulcers

Action: All serious incidents are investigated and subsequently discussed at divisional level (Divisional Quality Committee), Trust Operational Board, Trust Quality Quality Committee and Commissioning Quality Review Group. After the investigations recommendations are made, notible practice observed, lessons learned shared and an action plan is put in place.

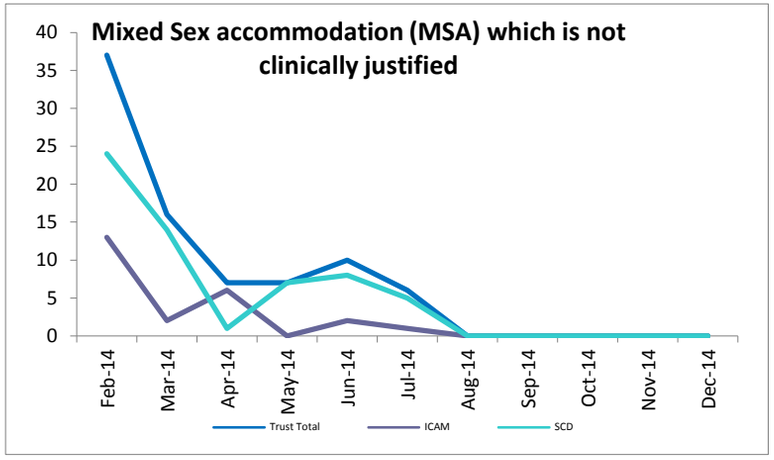
Patient Experience

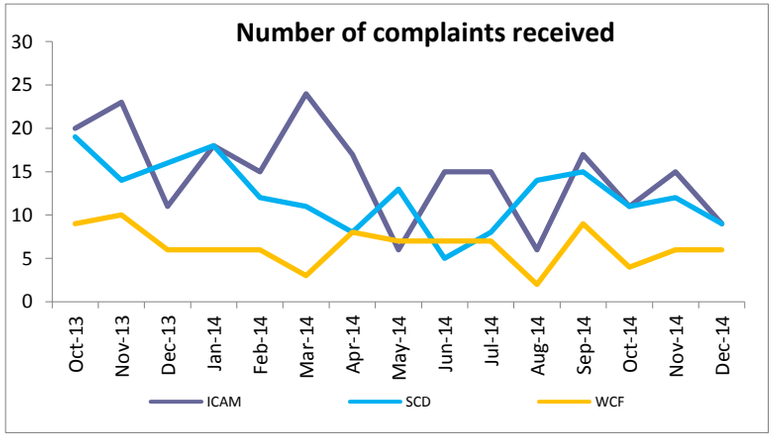
Whittington Health NHS

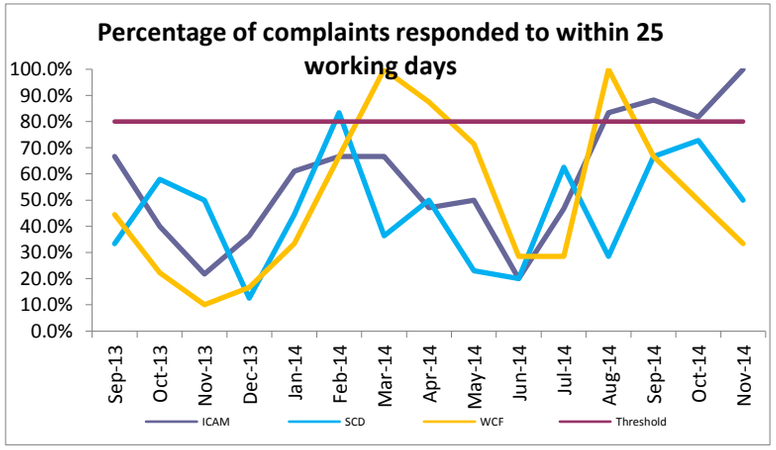
	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	Dec-14 ICAM	Dec-14 SCD	Dec-14 WCF
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	87.5%	93.8%	97.3%	88.0%	100.0%
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	87.9%	87.0%	87.0%	-	-
Patient Satisfaction - Maternity FFT (% recommendation) **	-	90.5%	87.2%	-	-	87.2%
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	0
Complaints (**incl Corporate**)	-	35	26	9	9	6
Complaints responded to within 25 working day	80%	71.43%	arrears	100.0% *	50.0% *	33.3% *
Patient admission to adult facilities for under 16 years of age	-	0	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

The nationally mandated scoring method for FFT has changed to make it simpler and more suitable for NHS Hospital Trusts. It shows percentage of patients satisfied. There are currently no targets set.

Issue: Overall score improved, Maternity FFT manually collated.

Action: Maternity FFT Electronically devise to collate feedback has broken down and feedback is now collated manually. Friend and Family Tests are now becoming embedded. 'You said we did' is being spread across all services. Examples:

Coyle Ward

'You said': Friendly staff who keep you informed, very honest and open. All working very hard around the clock.

'We did': We have shared your feedback with our staff who were pleased to hear our patients had a positive experience. We will continue to remind staff each day as a way of maintaining good practice.

Maternity

'You said': Noisy ward at night'

'We did': Reminding staff and patients to keep noise down at night, turning lights down and reminding people about use of mobile phones '

Timescale: monthly updated with comments follow FFT reports.

Mixed Sex Accommodation

A policy and processes embedded in the services and no breaches for 5 consecutive months.

Complaints

Issue: Overall score fallen by 5%

Action: Action plan embedded, key themes analysed. Report to Quality Committee in January 2015 identified clinical care and communication as the highest categories. Extra support is in place for 2 of 3 divisions.

Timescale: Expectation to be compliant when all divisions have support in place.

Infection Prevention

Whittington Health NHS

	Trust Actual		Dec-14		
	Threshold	Nov-14	Dec-14	ICAM	SCD	WCF
MRSA	0	0	1	0	1	0
E. coli Infections*	-	2	0	-	-	-
MSSA Infections	-	0	1	0	0	0

	Threshold	Dec 14	YTD	ICAM	SCD	WCF
C difficile Infections	19 (Year)	1	14	0	1	0

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

Ward Cleanliness

Audit period

	01/02/14 to 09/04/14	04/03/14 to 03/04/14	09/05/14 to 12/06/14	01/07/14 to 15/08/15	01/09/14 to 02/10/14	06/11/14 to 16/12/14
Trust %	97.5%	97.6%	97.9%	97.7%	98.2%	98.1%

Commentary

MRSA

Issue: The Trust's first patient in 14 months with MRSA bacteraemia was diagnosed on Coyle ward on 19th December. The PIR meeting took place on 6/1/15. The issues identified were compliance with checking and removal of peripheral cannulae and hand hygiene compliance.
Action: Review completed and action plan in place.
Reminder sent to all staff regarding compliance with hand hygiene policy and cannula care.
Ward sister and matron reviewing all patients with cannula daily to monitor compliance with policy.
Timescale: On-going-for review in 4 weeks.

E.coli Infection and MSSA

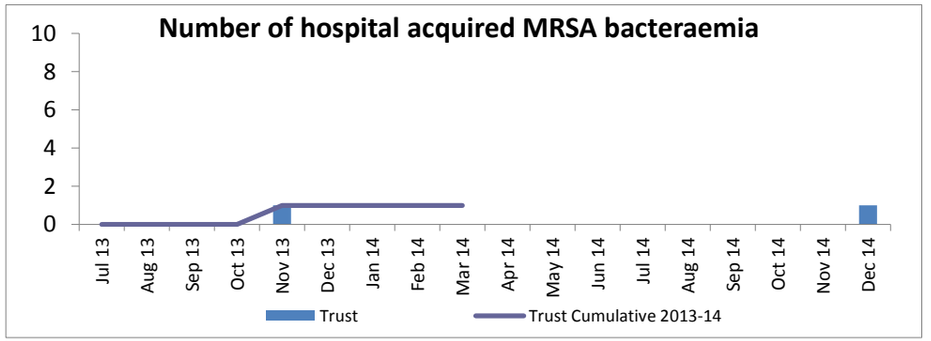
Issue: No new E. coli infections in December. One MSSA identified in December 14.
Action: Action plan in place. Patient placed in side room as per protocol.
Timescale: Immediate

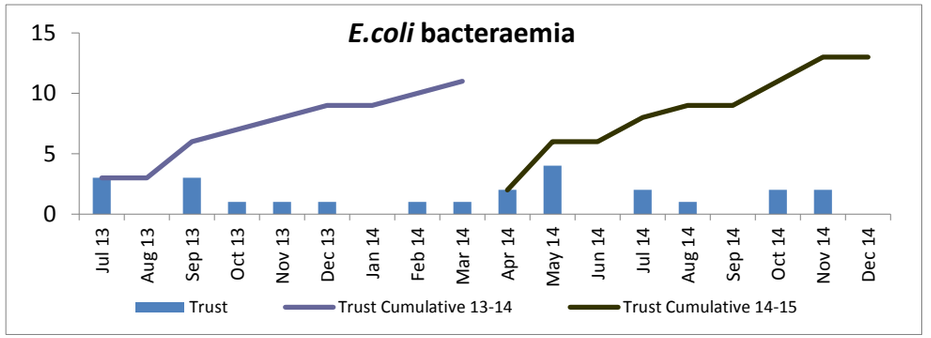
C Difficile

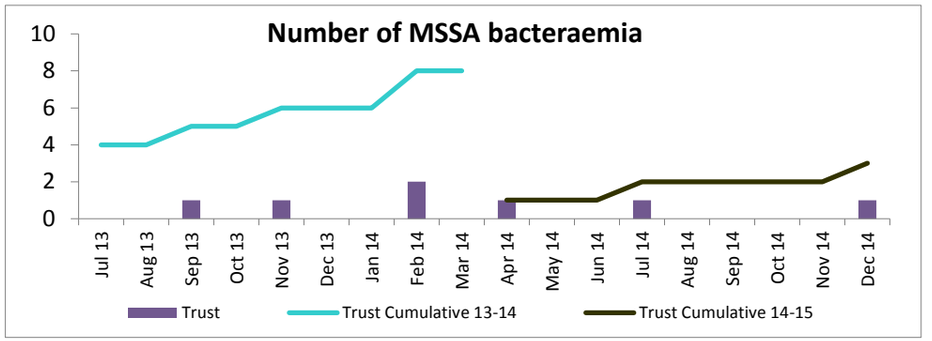
Issue: 14 cases ytd
Action: Plans in place following RCA findings. Meeting held with the infection control nurse, matron and nursing staff to share learning outcomes and provisions that will be put in place.
Timescale: February 2015

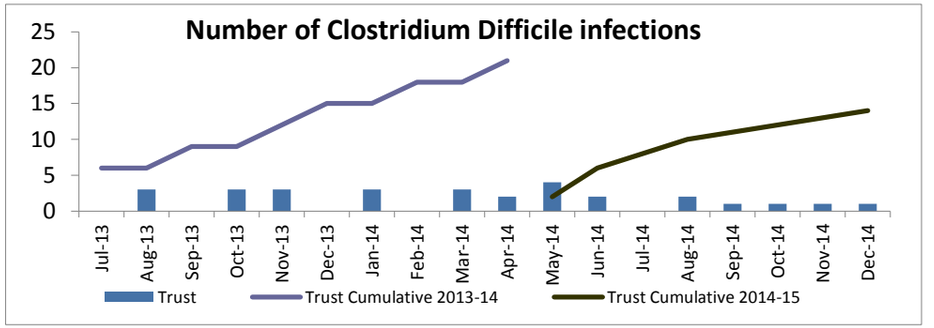
Ward Cleanliness

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.





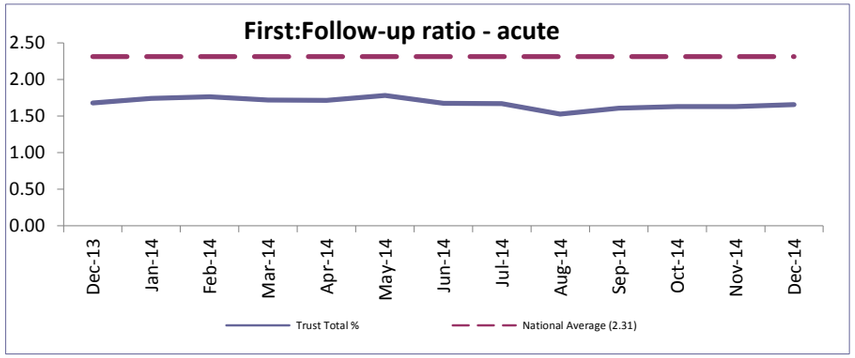


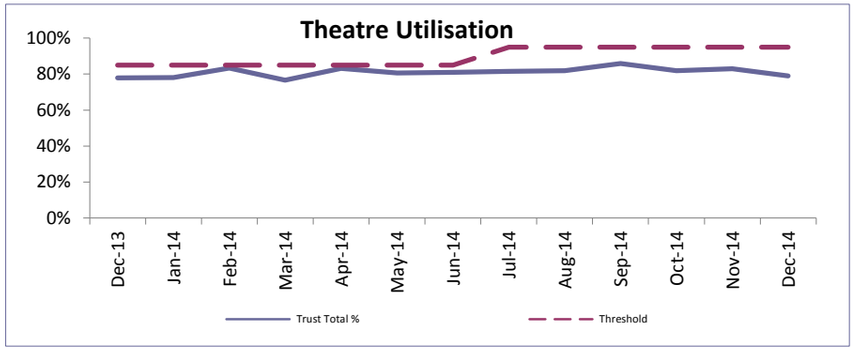


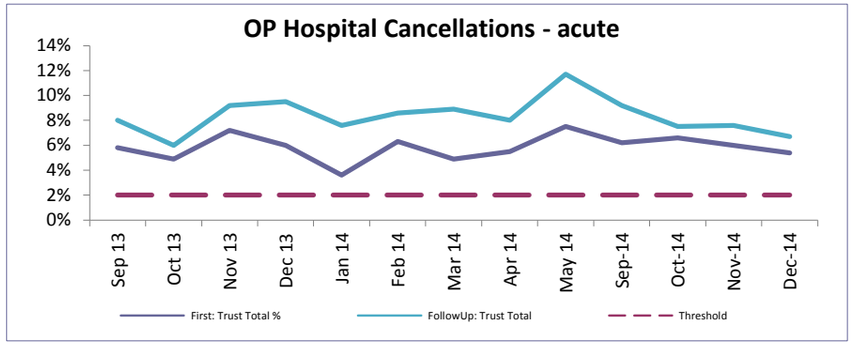
Efficiency and productivity - acute

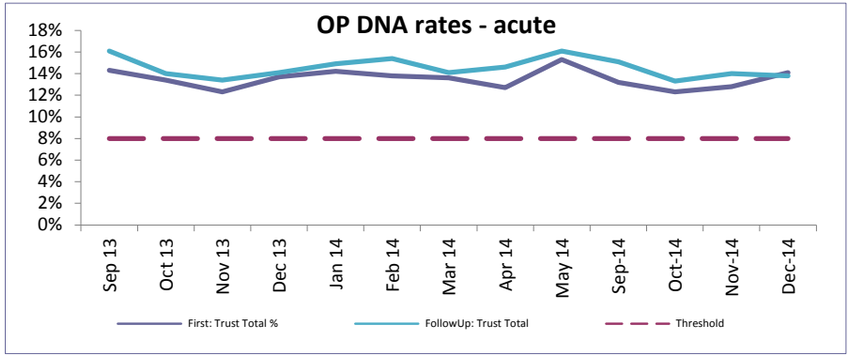
Whittington Health NHS

	Dec-14				
	Threshold	Trust Actual	ICAM	SCD	WCF
First:Follow-up ratio - acute	2.31	1.66	1.94	1.74	1.13
Theatre Utilisation	95%	79.0%	51.2%	77.9%	87.6%
Hospital Cancellations - acute - First Appointments	<2%	5.4%	6.2%	8.1%	2.0%
Hospital Cancellations - acute - Follow-up Appointments	<2%	6.7%	9.2%	7.5%	3.5%
DNA rates - acute - First appointments	8%	14.1%	17.7%	14.7%	10.6%
DNA rates - acute - Follow-up appointments	8%	13.8%	9.2%	15.3%	11.2%
Hospital Cancelled Operations	0	2	0	1	1
Cancelled ops not rebooked < 28 days	0	0	0	0	0
Urgent Procedures cancelled	0	0	0	0	0
Urgent Procedures cancelled (of these how many cancelled 2nd time)	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. The Value Improvement Program for Out Patients will continue to monitor and improve new to follow up ratios by unit.

Theatre Utilisation
Issue : Theatre utilisation fluctuating between 80 and 85% utilisation.
Action : Weekly theatre meetings in place. New activity tracking system is now in place and also there are theatre leaders on the ground every morning to make sure lists start on time. Fluctuation in results within ICAM being investigated.
Timescale: Feedback in March board meeting.

Hospital Cancellations - acute
Issue: Fewer patients are now being moved into earlier appointments and the number of hospital cancellation has come down. Booking Team are continuing to identifying any unused clinic slots to pull patient appointments forward.
Action: Tracking and cancelling at Consultant level are being address.
Timescale: Additional capacity work has now been completed and steady improvement is now expected.

Did not attend
Issue: a slight increase is noted over the festive period.
Action: DNA rates by specialty are being monitored. Learning from Paediatric pilot have been shared.
Timescale: Further reduction of DNA expected after learning is embedded completion January 2015

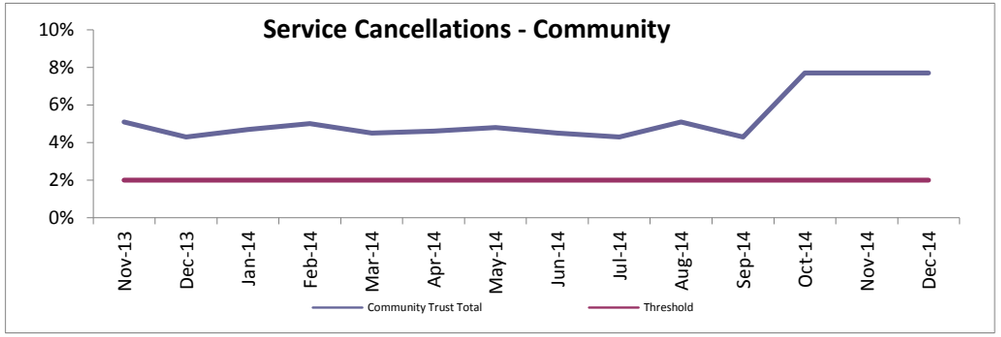
Hospital Cancelled Operations
Issue: There were two cancellations in December due to non-clinical reasons, both patients were clinically categorised as routine. One due to list overrun (complications with earlier patients) and the other due to surgical team not ordering specialist equipment. Both have been rebooked within the 28 day period.

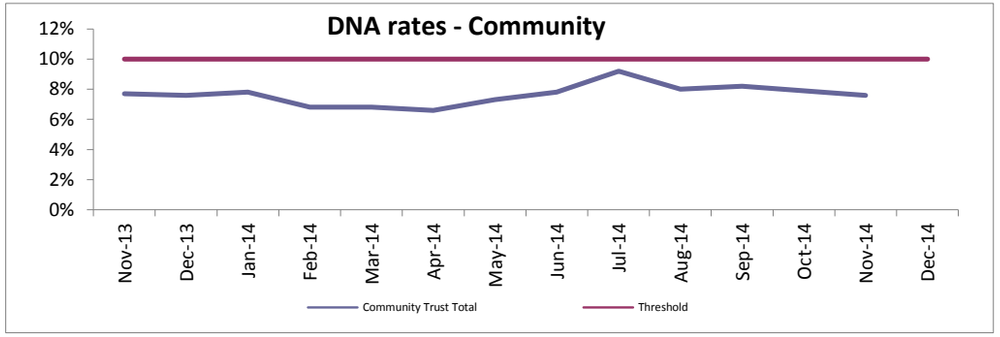
Efficiency and productivity - Community

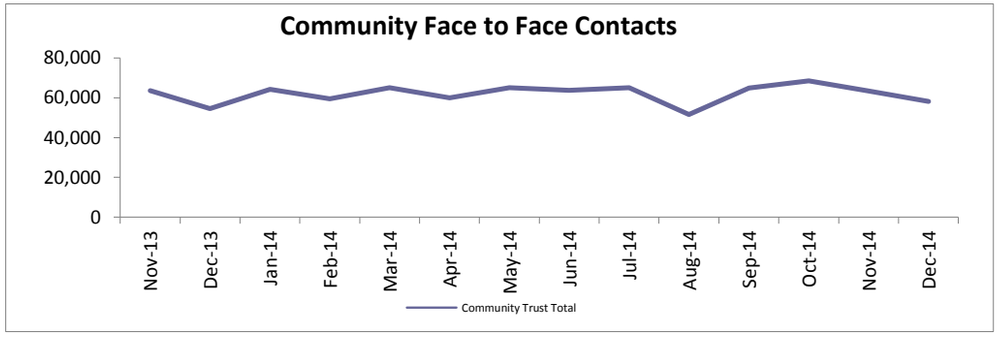
Whittington Health NHS

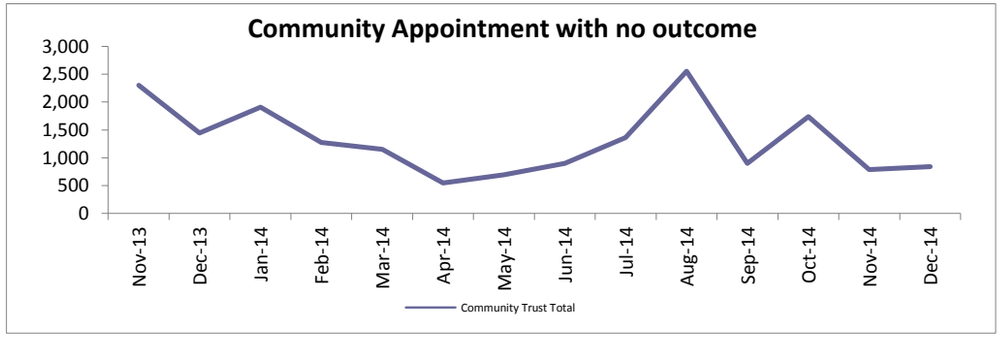
	Dec-14				
	Threshold	Trust Actual	ICAM	SCD	WCF
Service Cancellations - Community	2%	7.7%	7.8%	5.0%	7.6%
DNA Rates - Community	10%	6.9%	6.6%	14.2%	7.6%
Community Face to Face Contacts	-	58,199	41,822	1,406	14,971
Community Appointment with no outcome	0.5%	1.0%	0.8%	0.0%	1.8%

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









Commentary

Service Cancellations - Community
Issue: Community service cancellation remains at 7.7%
Action: The improvement plan for waiting list management in the community continues and includes review of all templates and increase in filling unfilled late cancelations by patients.
Timescale: The threshold to be achieved after completion of additional capacity work in January 2015.

DNA Rates - Community
Community clinics - Achieved.
Community Dental DNA's is increasing slightly from 13 to 14.2%. Actions are being taken to remind patients regarding their appointments including text and phone call reminders.

Community Face to Face Contacts
Face to face contacts have increase by 6%, compared to the same month last year.

Community Appointment with no outcome
November data submission was completed before the final data submission deadline (freeze date)
Issue: Above the threshold, but overall reduced compared to last month.
Action: Teams with high levels of un-outcomed appointments identified and processes to outcome appointments within 48 hours re-enforced.
Timescale: immediately

	Threshold	Trust Actual Oct-14	Nov-14	Dec-14	YTD
Community Dental - Patient Involvement	90%	95.0%	99.0%	98.0%	n/a
Community Dental - Patient Experience	90%	99.0%	99.0%	100.0%	n/a
District Nursing Waiting Times - 2hrs assessment	-	100%	100%	100%	TBC
District Nursing Waiting Times - 48 hrs for visit	-	100%	100.0%	100.0%	TBC
MSK Waiting Times - Routine MSK (<6 weeks)	100%	93.4%	85.1%	83.5%	-
MSK Waiting Times - Consultant led (<18 weeks)	95%	80.0%	89.1%	arrears	90.6%
IAPT - patients moving to recovery	50%	45.0%	47.0%	arrears	-
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%	99.8%

Commentary

Dental

Patient Involvement and Experience consistently score above threshold.

District Nursing

The two response times for District Nursing being 2 hours for assessment and 48 hours are being met. **Issue:** Data collection for both targets is manual. RiO is not able to collate this electronically.
Action: Manual collection of data in place and electronic process being commenced.
Timescale: NHS Elect are supporting capacity and demand modelling in District Nursing.

MSK

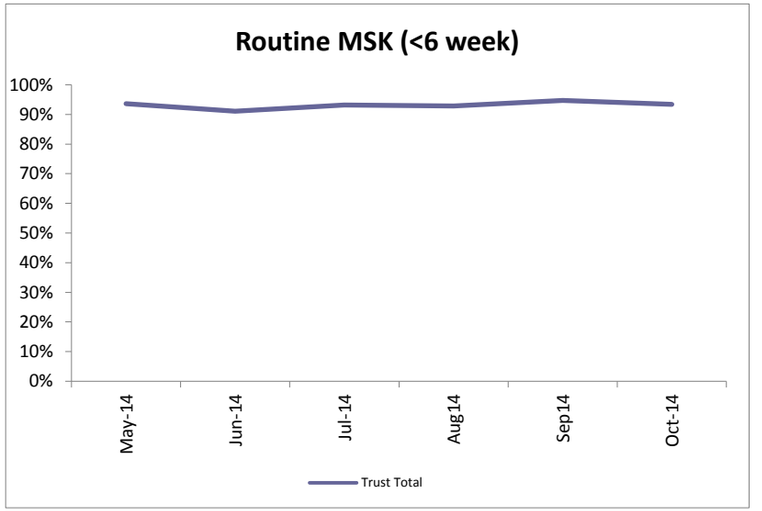
Issue: The 6 weeks and 18 weeks are performing under target, this is mainly due to the increase in demand on the service. Additional staff and also moving clinics to locations with high demand have been undertaken. Upgrade of Patient Record system in November 2014 also changed parameters of reporting which may be affecting the performance figures, however manual checks are being carried out to ensure booking of patients.
Action: Validating work is underway in conjunction with the Information Team.
Timescale: To complete in January 2015.

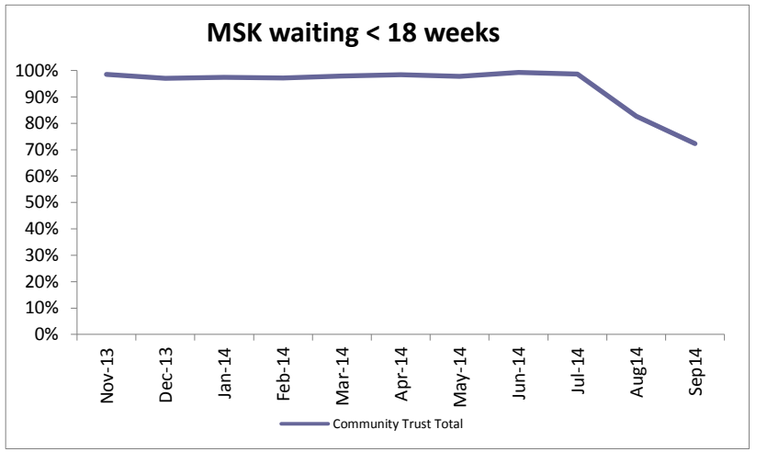
IAPT

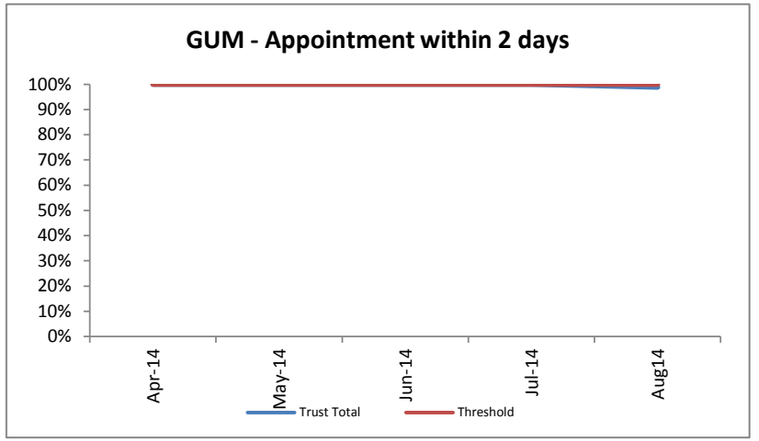
The national measure is improving month on month . An improvement plan is in place, closely monitored jointly with CCG Haringey.
A clinical measure of reliable recovery remains at 55%.

GUM

Please note: Change in reporting for Sexual Health Service Haringey. As of December 2014 only Haringey residents will be included in the figures.







	Nov-14 (arrears)					
	Threshold		Trust Actual	ICAM	SCD	WCF
Referral to Treatment 18 weeks - Admitted	90%	Trust Actual	90.7%	71.4%	90.1%	95.1%
Referral to Treatment 18 weeks - Non-admitted	95%	Trust Actual	95.0%	94.1%	94.1%	98.2%
Referral to Treatment 18 weeks - Incomplete	92%	Trust Actual	92.2%	95.0%	89.3%	98.0%
Referral to Treatment 18 weeks - 52 Week Waits	0		0	0	0	0
Diagnostic Waits	99%		99.8%	100.0%	97.8%	99.2%

Commentary

RTT

Following a 6 months of planned reduction in long waiting patients the RTT targets have been achieved as per trajectory. Additional activity is being planned duruing January, February and March to decrease further waiting for patients.

Diagnostic Waits

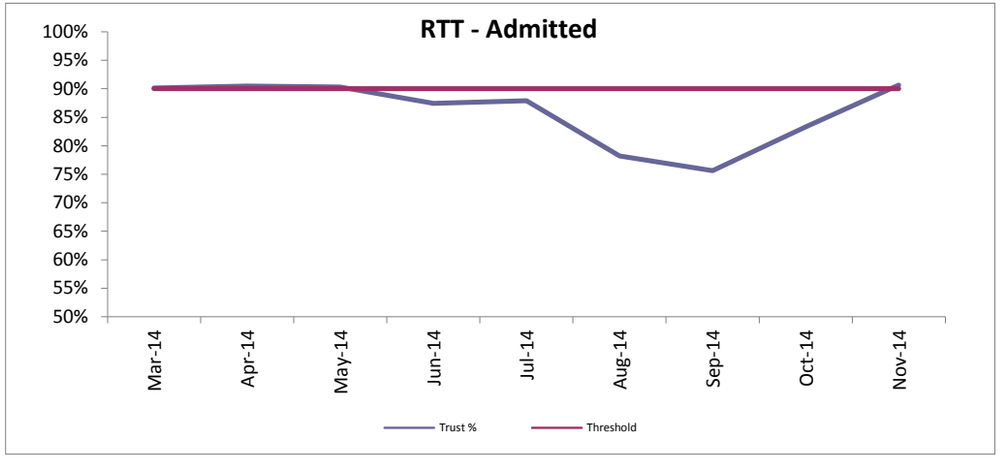
Target achieved.

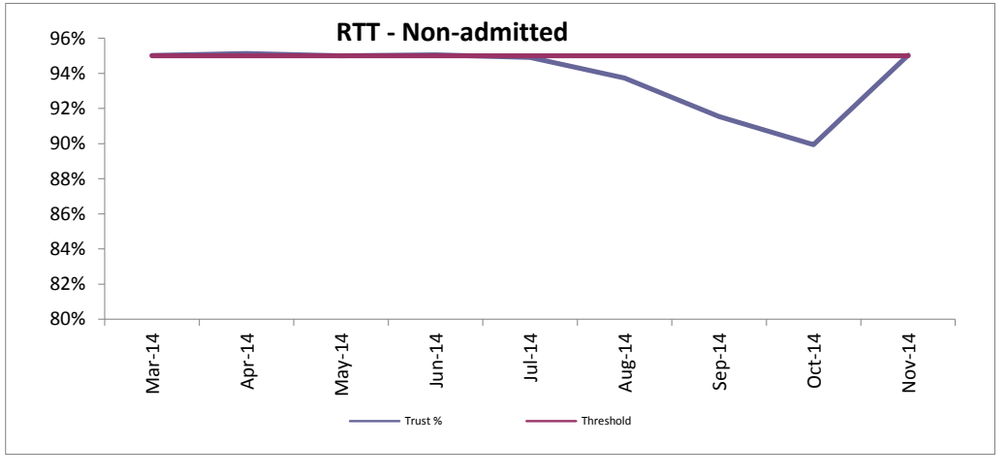
A weekly PTL meeting (waiting list meeting) is chaired with the COO and each waiting list is cross checked and capacity and demand discussed. The current waiting times for first consultant routine appointment within specialisties are below;

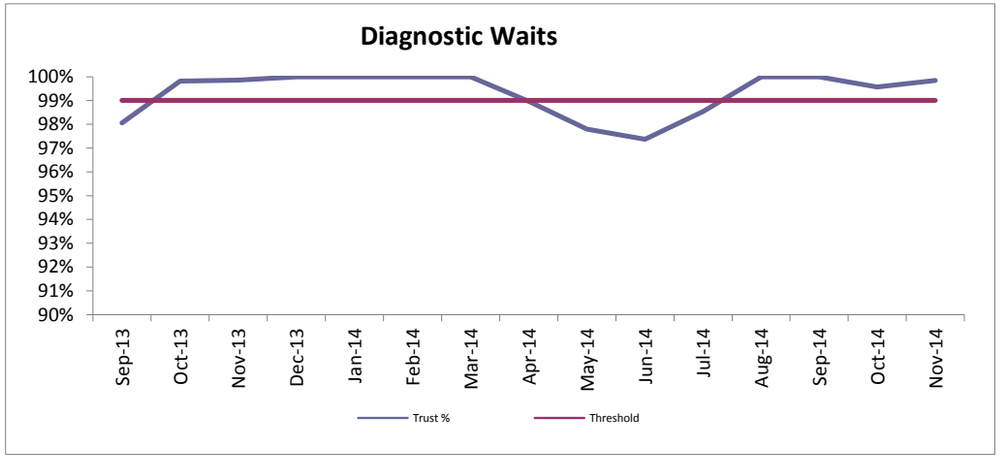
Cardiology 8 Weeks, Dermatology 7 Weeks, Endocrine 10 Weeks, ENT 6 Weeks, Gastroenterology 7 Weeks, General Surgery 7 Weeks, Gynaecology 6 Weeks, Neurology 11 Weeks, Pain 13 Weeks, Rheumatology 6 Weeks, Thoracic Medicine 11 Weeks, Urology 7 Weeks, Vascular 11 Weeks.

Diagnostic RTT (Radiology) waiting times are also below;

CT 4 weeks , MRI 2 weeks , Nuclear Medicine 2 weeks, DEXA 3-4 weeks , Fluoroscopy 2 weeks, Ultrasound (Gynae) 2 weeks , Ultrasound General (Radiologist Lead) 3-4 weeks , Ultrasound Abdomen & Gynae at Hornsey General 2 weeks .



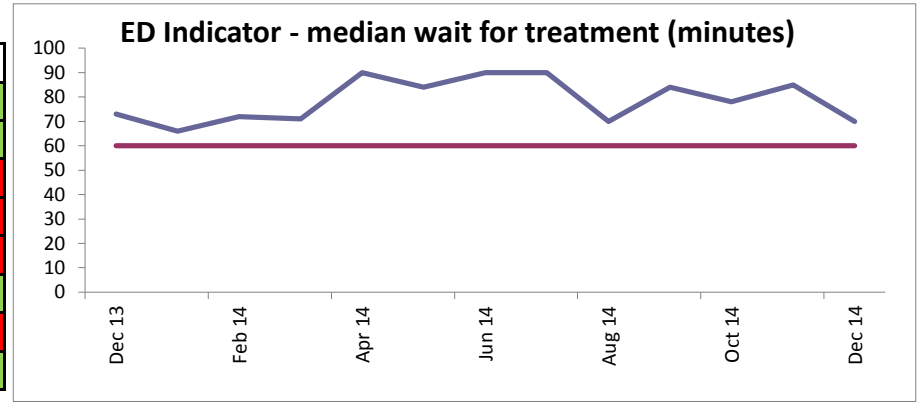




Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Nov-14	Trust Actual Dec-14	YTD
Emergency Department waits (4 hrs wait)	95%	92.4%	94.9%	95.2%
Wait for assessment (minutes - 95th percentile)	<=15	14	17	15
ED Indicator - median wait for treatment (minutes)	60	85	70	84
Total Time in ED (minutes - 95th percentile)	<=240	360	265	476
ED Indicator - % Left Without Being seen	<=5%	5.2%	3.9%	5.8%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	4	arrears	31
Ambulance handovers exceeding 60 minutes	0	0	arrears	0



Commentary

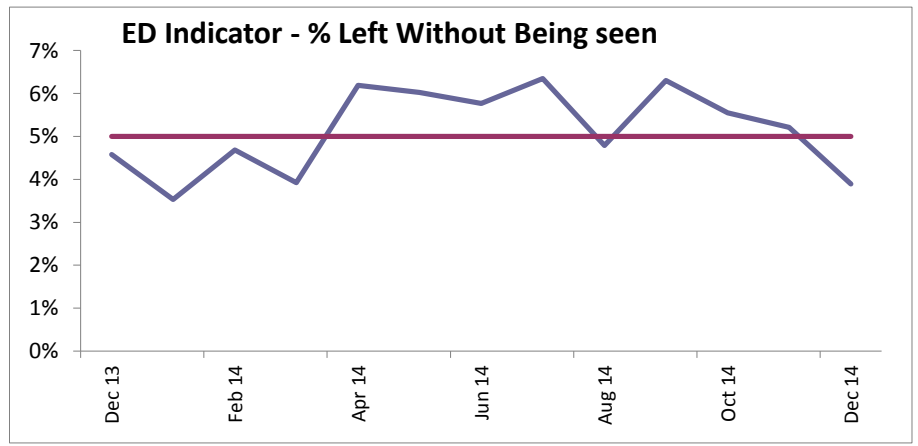
Further increased activity has been seen in A&E in November and December. The Emergency Department standard is 0.1% below target for December 2014. The mean average time from arrival to departure for admitted patients was 272 minutes. Bed pressures were further indicated by an average in patient length of stay of 5.2 days whereas the Q3 average is 4.6 days.

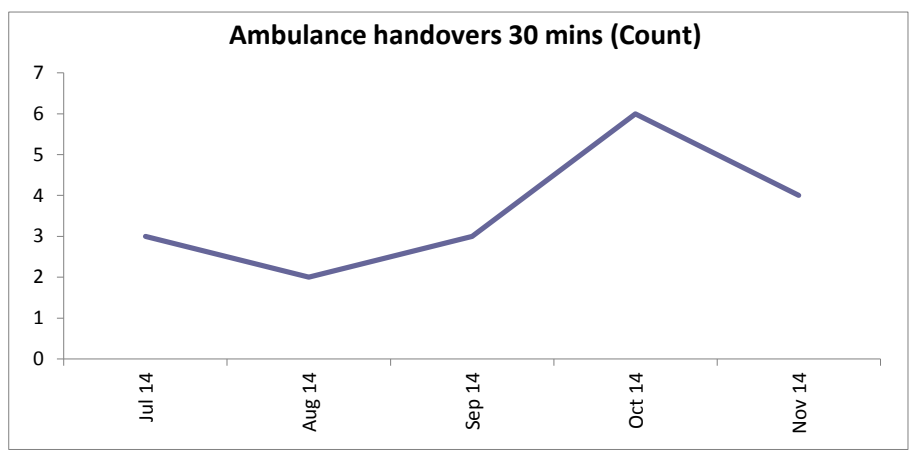
The system resilience group has agreed and gained assurance that the resilience plan (winter plan) was aligned to demand. Further plans have been agree to support emergency care patients and achievement of the national standard.

All additional resources are in place for the first stage plan (resilience 1) and all additional resources will be in place (resilience 2) by the middle of November, and further resources in December (resilience 3).

Whittington Health is working with all providers to ensure patient flow, senior staff have also been asked to support inpatient wards, and access centre to ensure any delays in patient flow are progressed asap. Strong working relationships are being seen with Social Care, London Ambulance Service (LAS), other hospitals and voluntary sector.

Ensuring patient flow has been a essential to allow LAS to hand over patients and return to meet LAS demand.





Cancer

Whittington Health NHS

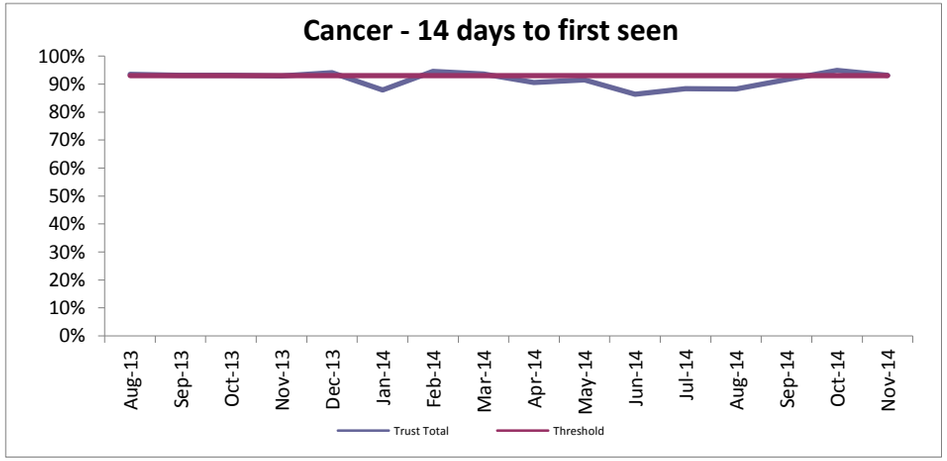
	Threshold	Nov-14 Trust Actual	ICAM	SCD	WCF	2014/15 Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.2%	87.8%	95.1%	89.3%	89.3%	88.9%	94.9%		90.2%
Cancer - 14 days to first seen - breast symptomatic	93%	93.5%	-	93.5%	-	83.7%	93.4%	97.1%		89.3%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%		99.6%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	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%		100.0%
Cancer - 62 days from referral to treatment	85%	88.0%	69.2%	100.0%	-	91.5%	89.6%	98.1%		91.4%
Cancer - 62 days from consultant upgrade	-	0%	-	0%	-	75.0%	100%	-		73.3%

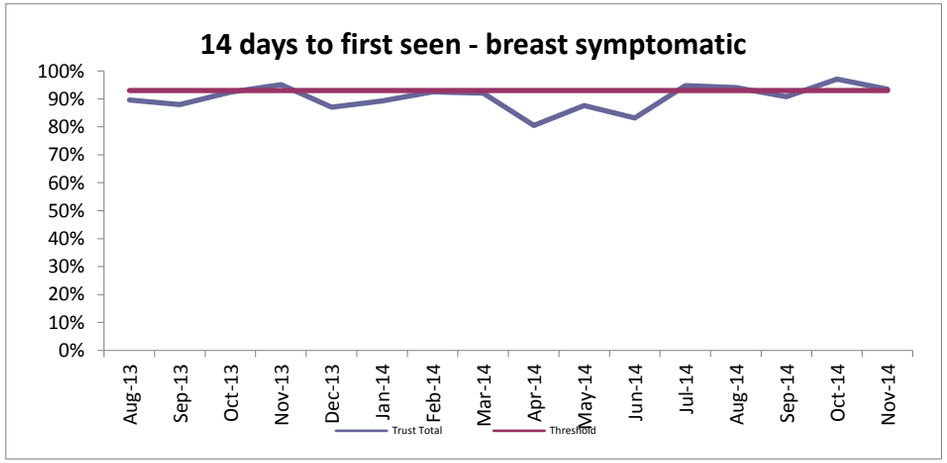
Commentary

Overall all cancer targets were achieved this month.

The Cancer Patients tracker list is monitored daily and discussed in the weekly operational meeting with review at monthly performance meeitngs and quarterly at the cancer board.

Whittington Health also provided support to other trusts who needed additional capacity, all these patients have been treated or offered appointment.





	Threshold	Trust Actual Oct-14	Nov-14	Dec-14	YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.9%	92.4%	85.7%	86.0%
New Birth Visits - Haringey	95%	85.4%	85.0%	Arrears	89.2%
New Birth Visits - Islington	95%	89.8%	91.4%	Arrears	91.2%
Elective Caesarean Section rate	14.80%	12.0%	13.7%	12.9%	10.7%
Emergency Caesarean Section rate	-	19.3%	17.5%	16.9%	19%
Breastfeeding initiated	90%	89.1%	88.7%	92.2%	90.3%
Smoking at Delivery	<6%	5.4%	4.9%	4.9%	5.2%

Commentary

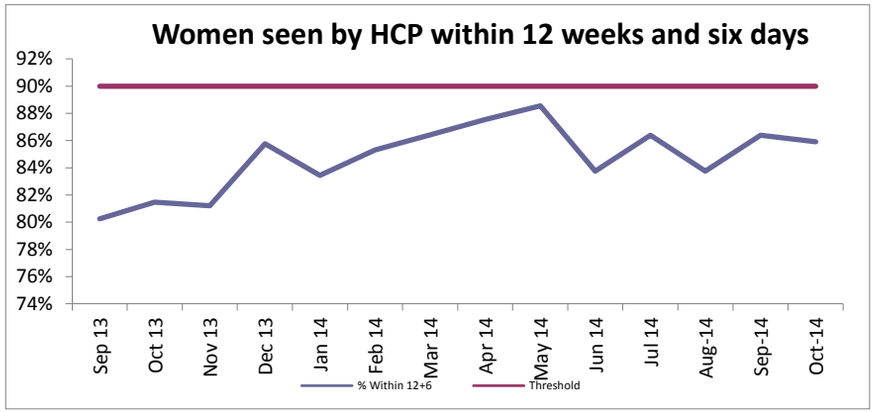
Women seen by HCP or midwife within 12 weeks and 6 days
Issue: Overall performance continues to be below the 90% threshold due to patients choice. Maternity is working on one named Midwife throughout the pregnancy to give continuity of carer.
Action: PAN London Maternity network discussion on-going regarding this measurement.
Timescale: On-going

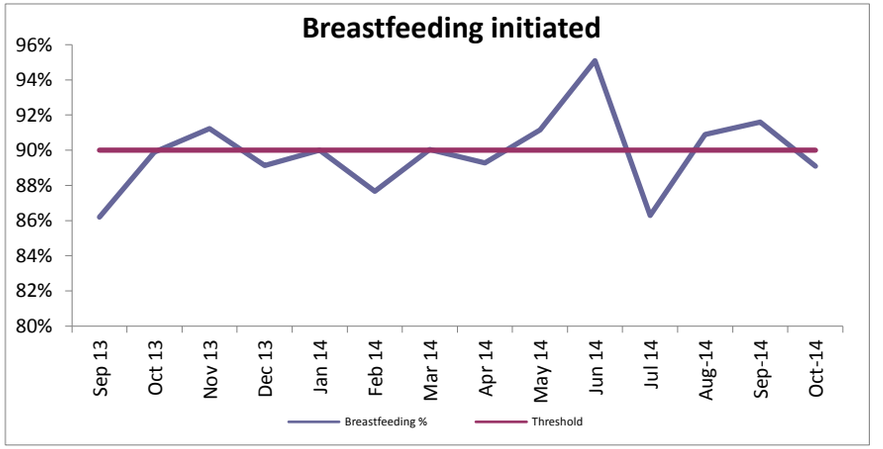
New Birth Visits
Issue: Rates remain around 90% YTD across both boroughs.
Action: Fortnightly conference calls with NHSE from January 2015 until April to update on 'Call to Action' programme increasing levels of HV's. Bespoke work pilot with Haringey Public Health has commenced in Tottenham where deprivation is high and staff numbers are low.
Timescale: On-going

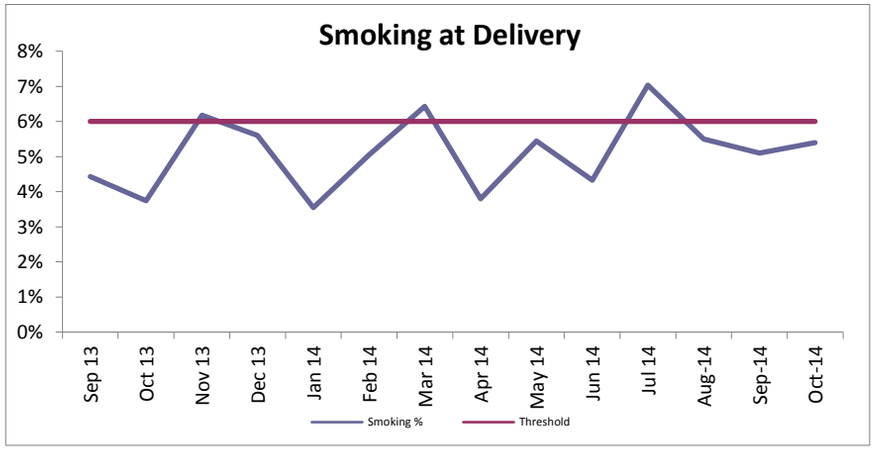
Caesarean Section rates
Issue: The elective C-section rate continues to be below the national average.
Action: Multiple work streams are in place to help reduce rates including improved education for women and a VBAC clinic (Vaginal birth after C-section Clinics).
Timescale: On-going

Breastfeeding
Issue: Achieved
Action: Work completed on the Level 2 Unicef Breastfeeding initiative. Awaiting confirmation to start working towards level 3.
Timescale: Due in December, but no feedback received yet.

Smoking:
Issue: Smoking at time of delivery remains at a compliant position.
Action: Public Health Midwife in discussion with Public Health to secure funding for carbon monoxide screening during antenatal period.
Timescale: On-going







Dashboard Definition page

	Definition	targets or benchmarks
First: Follow-up ratio - acute	Ratio comparing the number of follow-up appointments seen in comparison to first appointments.	National Average - April to September 2013 - is 2.31 Source: Health and Social Care Information Centre.
Theatre Utilisation	Theatre Utilisation is based on total time spent within the scheduled theatre session for each individual patient divided by the available session time. For example, during week ending 30/06/2013, 175 hours out of 233 hours scheduled time in theatres was utilised.	The target threshold rose to 95% from April 2014 but previously it was 85%
Hospital Cancellations - acute - First Appointments	Percentage of total first and follow up outpatient appointments that the hospital cancels and the rebooked appointment results in a delay to the patient.	<2% (Locally defined)
Hospital Cancellations - acute - Follow-up Appointments	As above	As above
DNA rates - acute - First appointments	Percentage of outpatient appointments where the patient does not attend without contacting the trust to cancel the appointment before the appointment time.	8% (Locally defined) - National Average April to September 2013: 8.1% Source: Health and Social Care Information Centre
DNA rates - acute - Follow-up appointments	As above	As above
Hospital Cancelled Operations	Hospital initiated cancellations on day of operation	<0.8% (Locally defined)
Cancelled ops not rebooked < 28 days	The total number of cancelled operations where the national standard (treatment within 28 days following an operation cancellation by the hospital) has been breached.	
Urgent procedures cancelled	Count all urgent operations that are cancelled by the trust for non-medical reasons	

Urgent Procedures cancelled (of these how many cancelled 2nd time)	A count of those urgent operations that have already been cancelled on one or more occasions before	
Cancer - 14 days to first seen	14 day targets relate to patients referred from GP to hospital on a suspected cancer pathway excluding breast patients where cancer not initially suspected. For the purpose of calculating performance in relation to waiting times for suspected cancer patients 'two weeks' is always taken to be 14 calendar days, with the date of receipt of referral being 'day zero'.	National Operational Standard - 93%
Cancer - 14 days to first seen - breast symptomatic	14 day targets relate to patients referred from GP to hospital on a pathway for breast patients where cancer not initially suspected. For the purpose of calculating performance in relation to waiting times is always taken to be 14 calendar days, with the date of receipt of referral being 'day zero'.	National Operational Standard - 93%
Cancer - 31 days to first treatment	This standard covers patients starting a first definitive treatment for a new primary cancer. Patients should be seen within 31 days of the decision to treat to first definitive treatment.	National Operational Standard - 96
Cancer - 31 days to subsequent treatment - surgery	This standard covers patients starting a subsequent treatment. 31 days is measured from decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is surgery, drug treatment or radiotherapy.	National Operational Standard: Surgery - 94% Drug Treatment - 98% Radiotherapy - 94%
Cancer - 31 days to subsequent treatment - drugs	As above - "Cancer - 31 days to subsequent treatment - surgery"	As above - "Cancer - 31 days to subsequent treatment - surgery"
Cancer - 62 days from referral to treatment	This standard covers patients starting a first definitive treatment for a new primary cancer following a target GP referral for suspected cancer.	National Operational Standard - 85%

Cancer - 62 days from consultant upgrade	This standard covers patients who received a first treatment for cancer within 62 days following a consultant decision to upgrade their priority.	No Operational Standard as yet
Referral to Treatment 18 weeks - Admitted	Waiting times for referrals to consultant led services, timed from receipt of referral to treatment or discharge.	90%
Referral to Treatment 18 weeks - Non-admitted	Waiting times for referrals to consultant led services, timed from receipt of referral to treatment or discharge.	95%
Referral to Treatment 18 weeks - Incomplete	Waiting times for referrals to consultant led services, timed from receipt of referral	92%
Referral to Treatment 18 weeks - 52 Week Waits	Count of pathways Waiting times over 52 weeks for referrals to consultant led services, timed from receipt of referral to treatment or discharge	0
Diagnostic Waits	Percentage of patients waiting for a diagnostic test who are seen within six weeks. There are 15 diagnostic tests in this cohort including endoscopy and imaging . Excludes laboratory tests (pathology).	99%
Service Cancellations - Community	The proportion of outpatient appointments that are cancelled by the Trust. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.	
DNA Rates - Community	The proportion of outpatient appointments that result in a DNA or UTA. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.	
Community Face to Face Contacts	The number of attended 'Face to Face' Contacts that have taken place during the month indicated.	
Community Appointment with no outcome	Appointments that do not have an outcome entered by the data entry deadline of the 3rd working day of the month following.	

Women seen by HCP or midwife within 12 weeks and 6 days	Percentage of pregnant women referred before 12 weeks 6 days of pregnancy who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days	90%
New Birth Visits - Haringey	The proportion of new mothers and their babies visited by health visiting services between 10 and 14 days inclusive after birth in accordance with recommended best practice.	
New Birth Visits - Islington	The proportion of new mothers and their babies visited by health visiting services between 10 and 14 days inclusive after birth in accordance with recommended best practice.	
Elective Caesarean Section rate	Women who deliver by elective caesarean section as a percentage of all deliveries	14.8%
Emergency Caesarean Section rate	Women who deliver by emergency caesarean section as a percentage of all deliveries	No target set
Breastfeeding initiated	Breastfeeding initiated before discharge as a percentage of all deliveries	90%
Smoking at Delivery	Women who smoke at delivery against total known to be smoking or not smoking.	<6%
% Harm Free Care	Data is sourced from the Safety Thermometer, a snapshot of the condition of a large number of patients, reporting on falls, catheter UTI and VTE. Pressure ulcer figure comes from incidence data	95%
VTE Risk assessment	Percentage of patients assessed for VTE/ Admissions	Target is 95% and over Monthly

Medication Errors causing actual Harm	Medication Errors recorded on Datix graded by risk. Information is submitted to National Reporting and Learning Service and the trust is ranked as a medium Acute Trust with a median percentage of medication errors of all incidents	There should be zero medication errors causing actual and serious harm but no thresholds currently set for the other grades
Never Events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The incidence of never events may indicate unsafe care. In the unlikely event of such an event occurring, it is reported to STEIS and investigated internally.	There should be zero never events although the CQC guidance states that there is an elevated risk associated with an increase in **estimated total person bed day**s
Open CAS Alerts (Central Alerting System)	Issued alerts include safety alerts, and Medical Device Alerts issued on behalf of the Medicines and Healthcare products Regulatory Agency, the NHS England, and the Department of Health. When an alert is issued we have a deadline in which to respond to confirm whether the alert is applicable to our Trust or to confirm that the recommendations have been implemented. This measure counts the number of issued alerts that remain open in a given month which have not been responded to.	There should not be any CAS alerts that remain open.
Proportion of reported patient safety incidents that are harmful	A high proportion of harmful patient safety incidents may indicate potential safety risks in trusts whose patients are experiencing more harm. Alternatively, it may also highlight trusts with a poorly developed reporting culture, who may tend to report fewer 'no harm' incidents, driving up their proportion of harmful incidents.	No threshold currently set but CQC guidance suggests a statistical method to determine the risk

Serious Incidents	Number of Serious Incidents (SIs) using national framework for reporting agreed by executive directors. The count includes pressure ulcer incidents and the month an incident is reported on STEIS is not necessarily the month the incident took place.	No threshold currently set
Community Dental - Patient Involvement	Based on a Patient rating on whether they were involved as much as they wanted to be in decisions about their care. It is a real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "yes definitely"	Internally set deadlines
Community Dental - Patient Experience	Based on a Patient rating on how they would you rate their overall care. It is a real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "excellent or good"	Internally set deadlines
District Nursing Waiting Times - % waiting less than 6 weeks	The percentage of patients that have waited less then 6 weeks for their initial 'Face to Face' contact following a referral to the District Nursing the Service.	
MSK Waiting Times - % waiting less than 6 weeks when seen that month	Percentage of patients waiting less than 6 weeks for their first attended appointment	100%
MSK Waiting Times - Consultant led (<18 weeks)	Waiting times for referrals to MSK consultant led services, timed from receipt of referral to treatment or discharge.	95%
IAPT - patients moving to recovery	IAPT services conduct routine clinical outcome monitoring to monitor the effectiveness of psychological therapies NICE guidance indicates the delivery of evidence based psychological therapies or depression and anxiety disorders should support recovery for at least 50% of patients completing treatment.	
Mixed Sex Accommodation	Clinically unjustified mixing of genders (i.e. breaches) in sleeping accommodation	Target of 100% single sex accommodation

Complaints	Formal complaints made about Trust services.	No threshold set
Complaints responded to within 25 working day	This measure is reported a month in arrears	The standard response time is 80% within 25 working days
Patient admission to adult facilities for under 16 years of age	A count of inpatient under 16 years staying on specific adult acute wards	No threshold currently set
Number of Inpatient Deaths	Includes all types of admission Patient death defined as discharge method = died	No threshold set
NHS number completion in SUS (OP & IP)	NHS completion rate is calculated against our SUS extracts and is a month in arrears however, the latest month reported represents a flex position so still gives time for improvement (the next month previous represents a freeze position though)	A 99% threshold is set for CCG contract monitoring
NHS number completion in A&E data set	As above	A 95% threshold is set for CCG contract monitoring
SHMI	SHMI is Summary Hospital-level Mortality Indicator and measures whether deaths are higher or lower than expected. Methodology varies from HSMR.	If our score is below the lower limit, our mortality index is banded as 'lower than expected'; if our score falls between the low and high values, our mortality index is 'as expected'; if our score is higher than the upper limit, our mortality index is 'higher than expected'
Hospital Standardised Mortality Ratio (HSMR)	Sourced from DrFoster Healthcare intelligence. Standardises all mortality across the NHS and allows trusts to compare mortalities against an 'expected' figure. This figure is adjusted for variations in hospital case mix.	The standardised expected rate is 100 - trusts below/above this potentially have fewer/more mortality outcomes than expected, based on national data.
Hospital Standardised Mortality Ratio (HSMR) - weekend	As above, but specifically for weekend non-elective admissions. This attempts to identify whether the non-elective admission process during the weekend may produce more mortality outcomes than expected.	as above

Hospital Standardised Mortality Ratio (HSMR) - weekday	As above, but specifically for weekday non-elective admissions. This attempts to identify whether the non-elective admission process on a weekday may produce more mortality outcomes than expected.	as above
Patient Satisfaction - Inpatient FFT (% recommendation)	FFT responded to by patients discharged from acute wards. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Patient Satisfaction - ED FFT (% recommendation)	FFT responded to by patients discharged from ED. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Patient Satisfaction - Maternity FFT (% recommendation)	FFT responded to by patients at 4 points in the maternity pathway. % recommendation is calculated: 'extremely likely' + 'likely' responses divided by total responses.	None
Hospital acquired MRSA infection	Number of MRSA bacteraemia (bacteria in the blood)	Zero MRSA cases permitted throughout the entire financial year
Hospital acquired *C difficile* Infections	Number of Clostridium Difficile infections (bacterial infection affecting the digestive system)	19 C diff cases permitted throughout the entire financial year
Hospital acquired *E. coli* Infections	Numbers of E.coli bacteraemia cases (presence of bacteria in the blood)	No threshold set
Hospital acquired MSSA Infections	Numbers of MSSA bacteraemia cases (presence of bacteria in the blood)	No threshold set
Ward Cleanliness	The results of on-going facilities cleanliness audits. Results are tallied approximately every 6 weeks, and show the proportion all ward areas examined that passed inspection for cleanliness	Currently no target set
GUM - Appointment within 2 days	The percentage of patients offered an appointment within 2 days	100% should be offered an appropriate appointment
Emergency Department waits (4 hrs wait)	Proportion of all emergency department arrivals that do not wait longer than 4 hours from arrival to departure from the department (excludes planned arrivals)	95% of patients should not wait more than 4 hours
Wait for assessment (minutes - 95th percentile)	The wait from arrival to triage (in minutes) for the patient with the 95th percentile longest wait	The 95th percentile longest waiter should not wait more than 15 minutes

ED Indicator - median wait for treatment (minutes)	The median wait (in minutes) from arrival to time first seen by a 'treating' clinician.	The median wait for treatment should not be more than 60 minutes
Total Time in ED (minutes - 95th percentile)	The wait from arrival to departure from the department (in minutes) for the patient with the 95th percentile longest wait	The 95th percentile longest waiter should not wait more than 240 minutes
ED Indicator - % Left Without Being seen	The proportion of patients arriving in the department that leave of their own accord before they are seen by a 'treating' clinician	Fewer than 5% of patients should leave before being seen
12 hour trolley waits in A&E	The number of patients that wait 12 hours or more from the time a decision is made to admit the patient, to the time the patient is admitted	0 patients should wait longer than 12 hours
Ambulance handovers 30 minutes	The number of patients that wait for 30 minutes or more from the time an ambulance arrives to the time that responsibility for the patient is handed over to a member of our emergency team	0 patients should wait longer than 30 minutes
Ambulance handovers exceeding 60 minutes	The number of patients that wait for 60 minutes or more from the time an ambulance arrives to the time that responsibility for the patient is handed over to a member of our emergency team	0 patients should wait longer than 60 minutes
Ambulatory Care (% diverted)		>5% referrals should be going to ambulatory care

Executive Offices
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Magdala Avenue
London N19 5NF

Whittington Health Trust Board

February 4th 2015

Title:	Monthly Performance Dashboard – Workforce Report (December data)		
Agenda item:	**15/024**	**Paper**	**7.1**
Action requested:	For noting.		
Executive Summary:	**Background** The monthly dashboard as it refers to the workforce Key Performance Indicators (KPIs) is a standard report and part of the Performance Report. **Bank and Agency tables** The Board is asked to note that the tables which refer to bank and agency performance have been modified to show bank and agency expenditure broken down by division/corporate departments. **Benchmark comparisons – work in progress** Benchmark comparisons with other trusts in relation to staffing levels and occupational groups also appear this month. The Board is asked to note that this is work in progress. The comparisons selected were from trusts with hospital and community provision. The relative staffing numbers between trusts was an additional factor used. Further work is needed to identify a benchmarking network and the relevant family of comparable trusts to widen the scope to enable more meaningful conclusions to be reached about Whittington Health staffing levels to that of other trusts. A similar exercise to identify a benchmarking network is being developed by finance. **Highlights this month:** **Headcount** The workforce summary table shows actual worked WTE has decreased in December 2014 by 26 (from 4,414 in November to 4,388). **Turnover** The report outline demonstrates that this is a welcome sign and is in line with the strategic direction of travel to reduce agency usage.		

	Integrated Care and Acute Medicine (ICAM) figures are high and in the recent quarterly performance meetings chaired by the Chief Executive, the Director presented an outline retention plan. With a robust recruitment strategy in place and an effective campaign recruiting nurses from overseas, the focus now is on retention. **Vacancy rates** Despite the sharp fall last month, the vacancy rate has returned to 13.2% (Trust threshold 13%). Corporate services have a high vacancy rate which is subject to further analysis. **Sickness** Sickness rates are at 2.9% below the Trust threshold of 3%. From the analysis of absence management across the Trust, the specific priorities are to tackle short term absence and relatively high Bradford scores. The Executive is considering assigning a bespoke resource in conjunction with Human Resources (HR) to support managers to deliver better performance which will reduce occupational sick pay and the use of overtime and bank and agency cover. **Overtime** Both in terms of expenditure and WTE, performance is very positive and a downward trend shows that the focus on reducing overtime is working. **Bank and Agency** Agency figures are down on last month and back on track. **Appraisal** The appraisal figures show no change from last month. The recent quarterly performance meetings, the Chief Executive has emphasised that appraisal rates need to be more of a priority. Despite action plans being in place, Directors will work on incremental percentage increases and review the position by quarter two. This is a key priority for Surgery Cancer and Diagnostics (SCD). **Mandatory Training** There is a 1% increase in the performance on mandatory training compliance rates. Mandatory training compliance was also a key concern at the quarterly performance meetings and each Director has an action plan to increase compliance rates by the year end. Notwithstanding that, the Audit and Risk Committee were informed at their last meeting that the Executive will be redoubling their efforts through corporate initiatives to support the work that Directors are implementing. The Audit and Risk Committee have requested a further report at the March meeting.
Summary of recommendations:	To note the report and the progress in key areas and action to increase compliance rates in other areas.
Fit with WH strategy:	
Reference to related / other documents:	N/A

Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A						
Date paper completed:	21 January 2015						
Author name and title:	**Various Managers who source the workforce data**		**Director name and title:**		**Chris Goulding Acting Director HR**		
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Trust Board Report - Workforce (December data)

Whittington Health NHS

Workforce		Trust							
Headcount	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**
Starting Point for Workforce 14/15	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403
Planned Changes (reductions)	0	(18)	(46)	(63)	(74)	(66)	(111)	(119)	(119)
Contract Additions	4	15	12	17	22	34	46	54	58
Total	**4**	**(3)**	**(34)**	**(45)**	**(52)**	**(31)**	**(65)**	**(65)**	**(61)**
Revised Workforce Plan	4,407	4,399	4,369	4,358	4,351	4,372	4,338	4,338	4,342
Headcount wte Total	4,404	4,397	4,366	4,398	4,429	4,374	4,383	4,414	4,388
Variance to Revised Plan	3	2	3	(40)	(78)	(2)	(45)	(76)	(46)

In total, the number of whole time equivalent staff (WTE) has decreased in December 2014 by 26 (from 4,414 in November to 4,388 in December), with this increase further broken down by staffing type as follows: agency: increase of 6 WTE, bank: decrease 31 WTE, locum: unchanged from last month and substantive: an increase of 1 WTE.

In financial terms, after non recurrent adjustments, actual pay costs for December were £564k higher than plan, compared to £797k higher in November.

In comparison to the revised Workforce Plan for December of 4,342 WTE, the WTE of 4,388 is 46 WTE higher, compared to November, which was 76 WTE higher.

		Trust								
Management of the workforce	**Threshold**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**
Trust Turnover Rate	<13%	15.1%	14.1%	14.0%	13.9%	13.7%	13.4%	13.8%	13.9%	13.90%
Total trust vacancy rate	<13%	13.4%	14.2%	14.3%	14.1%	14.1%	13.2%	13.3%	12.1%	13.20%
Sickness rates	<3%	2.7%	2.6%	2.8%	2.8%	2.8%	2.6%	3.2%	2.8%	2.90%
Overtime wte	75	123	118	113	94	113	99.66	92.05	113.06	85.34%
Overtime expenditure		70459.7	69704.27	63236.55	51535.17	61,751.31	56431.72	51716.56	63456.99	46,129.40
Bank Hours expenditure	-	1,523	1,580	1,519	1,402	1,602	1,472	1,546	1,506	1,437
Agency Hours expenditure *	1m	1,426	1,184	1,491	1,457	1,200	1,210	1,254	1,125	1,007

*bank expenditure will fluctuate as agency expenditure reduces

		Trust								
Development of the workforce	**Threshold**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**
Appraisal	90%	43%	40%	39%	45%	51%	55%	58%	60%	60%
Mandatory Training	90%	75%	77%	76%	76%	75%	73%	66%	65%	66%

		Trust	
Staff FFT Results		**Q1**	**Q2**
Staff who would recommend the trust as a place to work	-	62%	59%
Staff who would recommend the trust as a place for treatment	-	74%	74%

Staff FFT Results for Q3 and Q4 will not be available until April 2015

Management of the Workforce - Turnover, vacancy and sickness

Whittington Health NHS

	December 2014					
	Threshold	Trust Actual	ICAM	SCD	WCF	CORP
Trust Turnover Rate	<13%	13.9%	19.1%	9.5%	12.6%	11.8%
Total trust vacancy rate	<13%	13.2%	10.1%	10.4%	4.9%	22.9%
Trust level total sickness rate	<3%	2.9%	2.7%	2.4%	3.3%	3.5%

Turnover rate

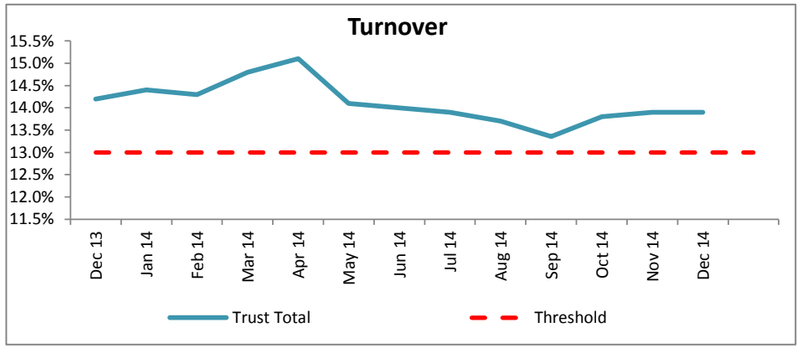
ICAM figures are high and in the recent quarterly performance meetings chaired by the Chief Executive, the Director presented an outline retention plan. With a robust recruitment strategy in place and an effectice campaign recruiting nurses from overseas, the focus now is on retention.

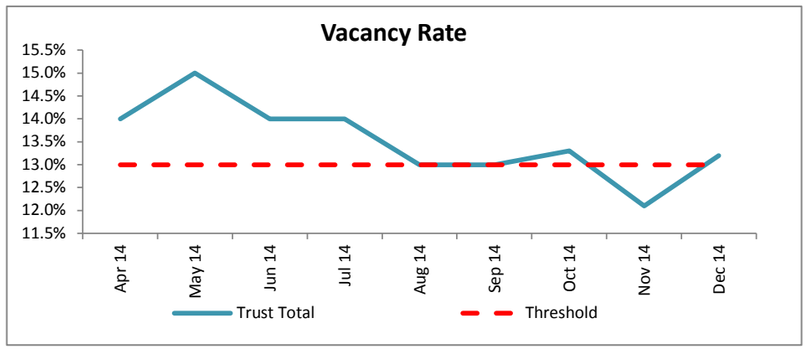
Vacancy Rates

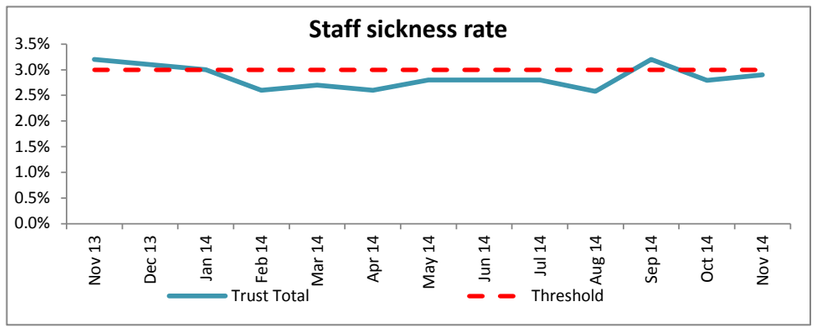
Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis. A verbal update will be available at the Trust Board if the root causes can be identified.

Trust Level Sickness rates

Levels for sickness rates are below the threshold and action plans have been developed by each Division/Corporate services to reduce short term sickness absence and to tackle high Bradford scores.





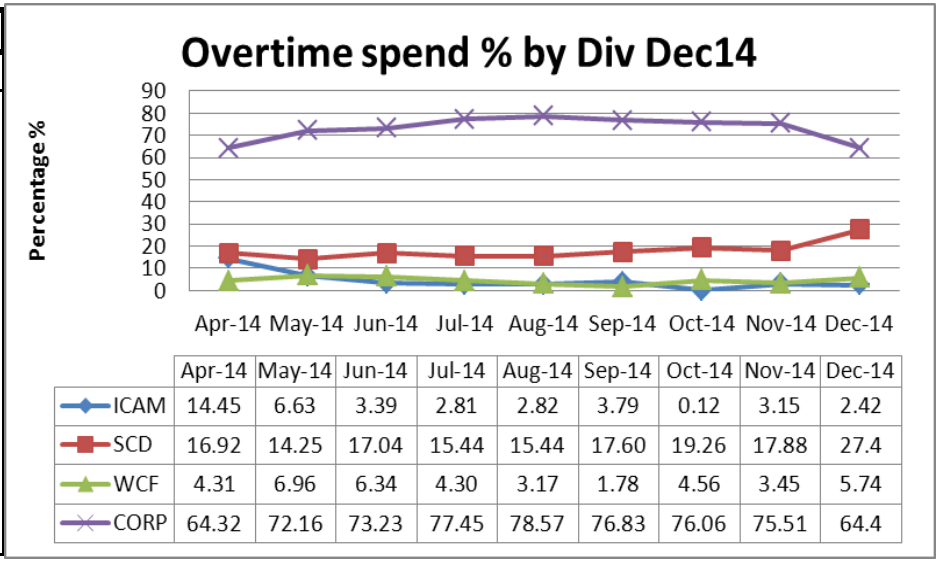


Management of the Workforce - Overtime, Bank & Agency

Whittington Health NHS

Overtime expenditure

	December 2014					
	Trust		ICAM	SCD	WCF	CORP
Overtime cost	£46,129.40		£1,117.07	12637.56	£2,649.22	£29,725.55

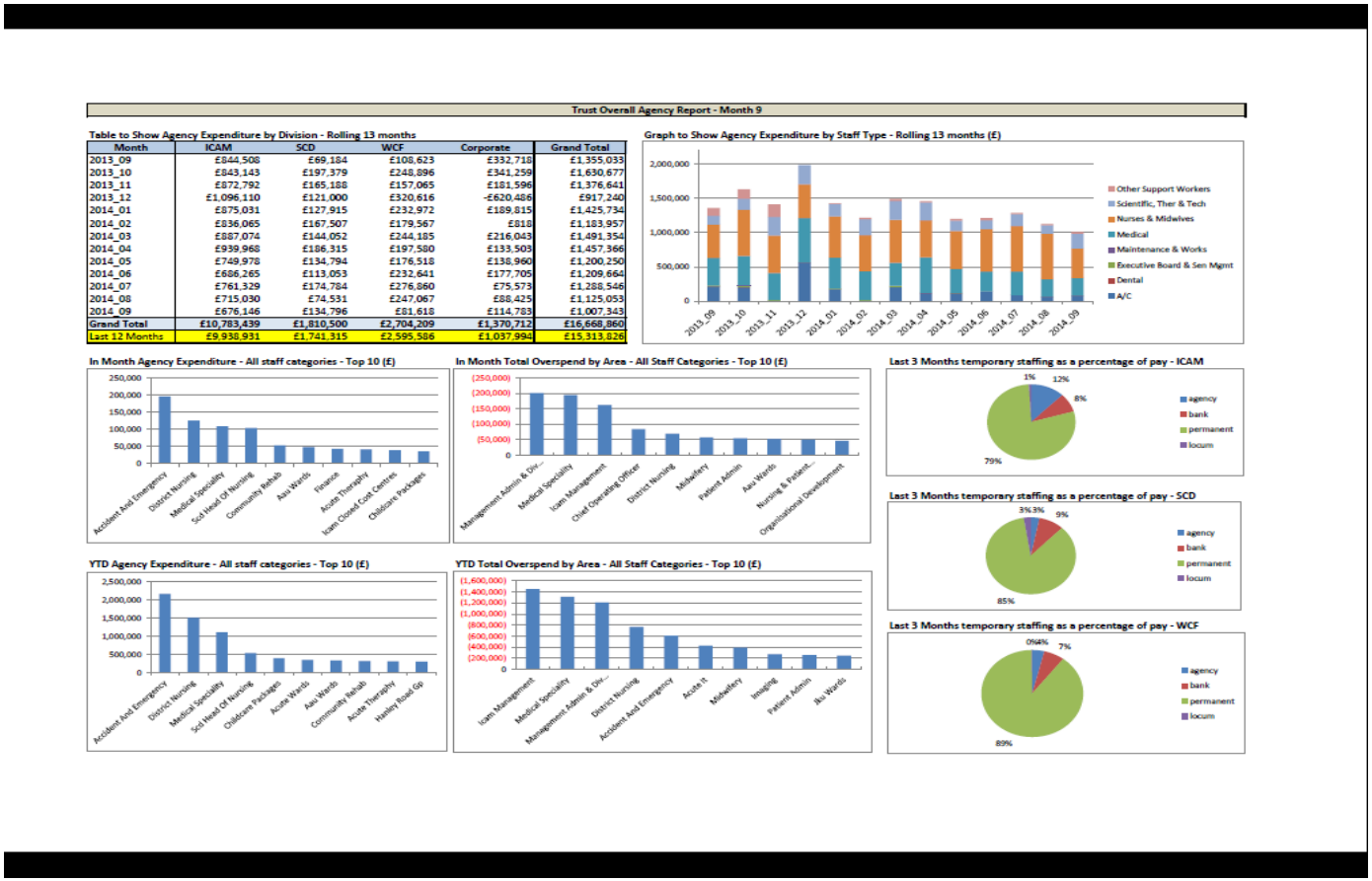


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
ICAM	14.45	6.63	3.39	2.81	2.82	3.79	0.12	3.15	2.42
SCD	16.92	14.25	17.04	15.44	15.44	17.60	19.26	17.88	27.4
WCF	4.31	6.96	6.34	4.30	3.17	1.78	4.56	3.45	5.74
CORP	64.32	72.16	73.23	77.45	78.57	76.83	76.06	75.51	64.4

Overtime

Both in terms of expenditure and WTE, performance is very positive and a downward trend shows that the focus on reducing overtime is working.

Bank and Agency wte usage and expenditure



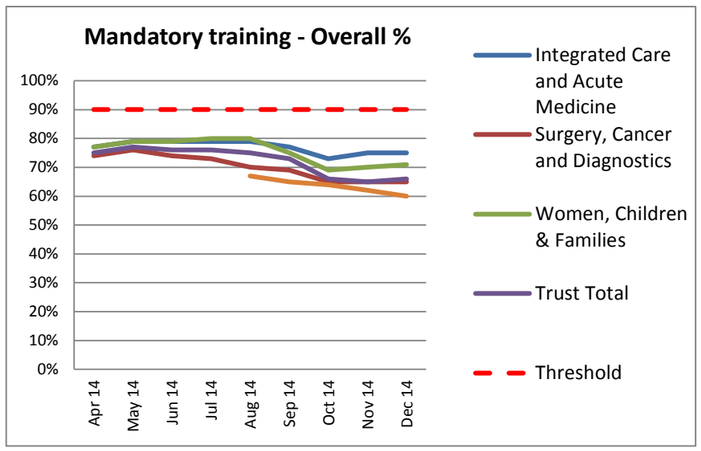
Development of workforce

Whittington Health NHS

	December 2014						
	Threshold	Trust Actual		ICAM	SCD	WCF	CORP
Percentage of staff with mandatory training compliance	90%	66%		75%	65%	71%	60%
Percentage of staff with annual appraisal	90%	60%		70%	40%	67%	54%

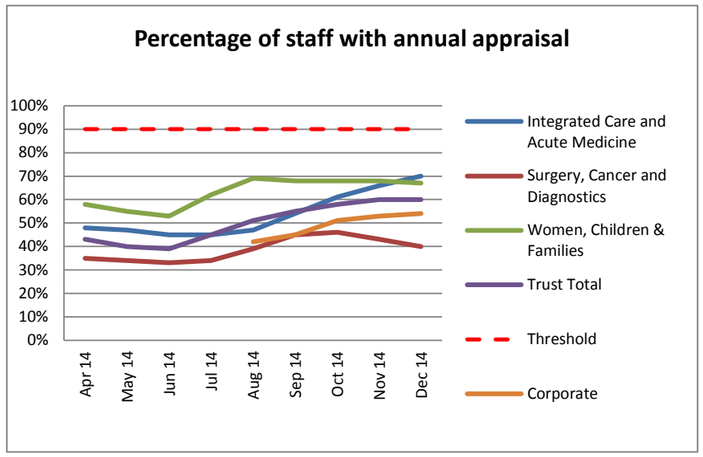
Mandatory training

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. The Trust Management Group (TMG) has received a report at its last meeting recommending further action to improve compliance rates.



Appraisal

There has been a marginal increase in the compliance rate for appraisal. The implementation of action plans for both corporate and the divisions remains a priority.



Benchmarking data on the composition and % of different staff groups by banding and FTE

Whittington Health NHS

The data reported below has been extracted from the HSCIC reporting tool NHS Iview and is based on NHS Workforce information, extracted directly from the Electronic Staff Record unless stated; data was extracted in December 2014 with the most recent month being October 2014.
Unless otherwise stated, the month referred to is October 2014.

The NHS organisations selected as comparators for benchmarking against Whittington Health are Croydon Services, Homerton University Hospital, Lewisham and Greenwich NHS. These organisations are broadly comparable in terms of size and provision of services:

Croydon Health Services - Croydon Health Services provide acute and community healthcare services across the borough of Croydon either in patient's own homes or from clinics and specialist centres, including Croydon University Hospital and Purley War Memorial Hospital in Purley, which recently underwent an £11 million refurbishment and re-opened in the summer of 2013.Around 3,500 staff provide services for a population of over 360,000 people who are relatively young with a high level of ethnic diversity. Reference costs100.8.

Homerton University Hospital - Homerton employs over 3500 staff and provides hospital and community services to Hackney and the City of London. Specialist care includes: obstetrics, neonatology, fetal medicine, fertility, neurorehabilitation, bariatric surgery, and asthma and allergy treatments for patients throughout east London and beyond. The hospital has over 450 inpatient beds, an A&E department, an intensive care unit, state-of-the-art imaging and x-ray facilities, a modern sexual health treatment centre, diabetes centre and eye screening service. Homerton provides a wide range of adult and children's community health services across Hackney and the City, with staff working out of 75 different sites.
Reference costs 87.1

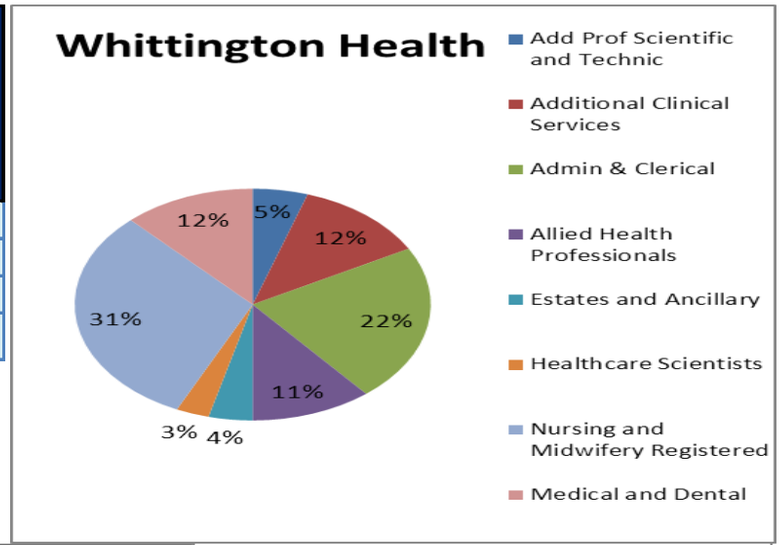
Lewisham and Greenwich NHS - provides NHS services for local people in Lewisham, Greenwich, Bexley and other parts of South East London.
They are responsible for NHS services at: Lewisham Hospital, Queen Elizabeth Hospital in Greenwich, and 11 different health centres in Lewisham.
In addition they provide some services at Queen Mary's Hospital in Sidcup. Reference costs 100.2.

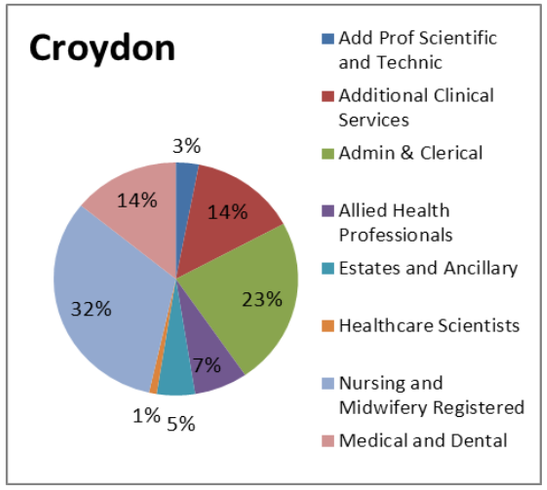
Benchmarking data on the composition and % of different staff groups by banding and FTE

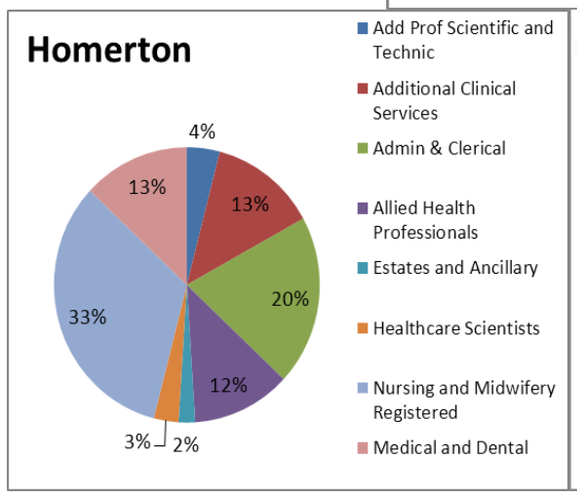
Whittington Health NHS

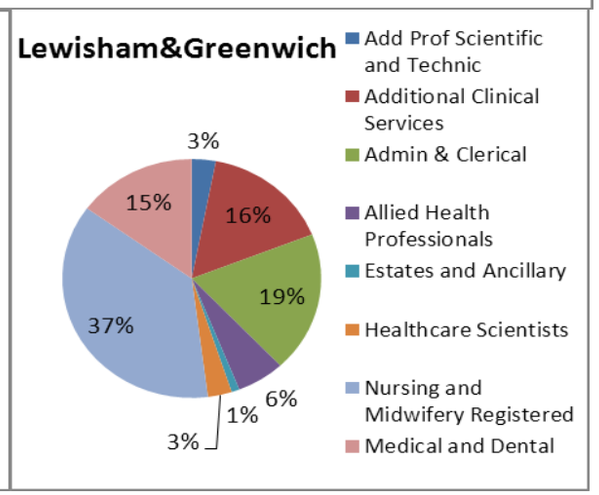
The following table shows FTE figures by staff group for each organisation as well as total FTE. The accompanying pie charts show the actual percentage of staff by staff group.

NHS Organisations	Add Prof Scientific and Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Nursing and Midwifery Registered	Medical and Dental	Total FTE
Croydon	95	435	750	240	145	20	1020	455	**3205**
Homerton	120	435	665	385	55	90	1110	445	**3330**
Lewisham and Greenwich	145	875	1020	340	30	150	1970	800	**5335**
Whittington Health	185	450	815	400	160	105	1175	455	**3780**





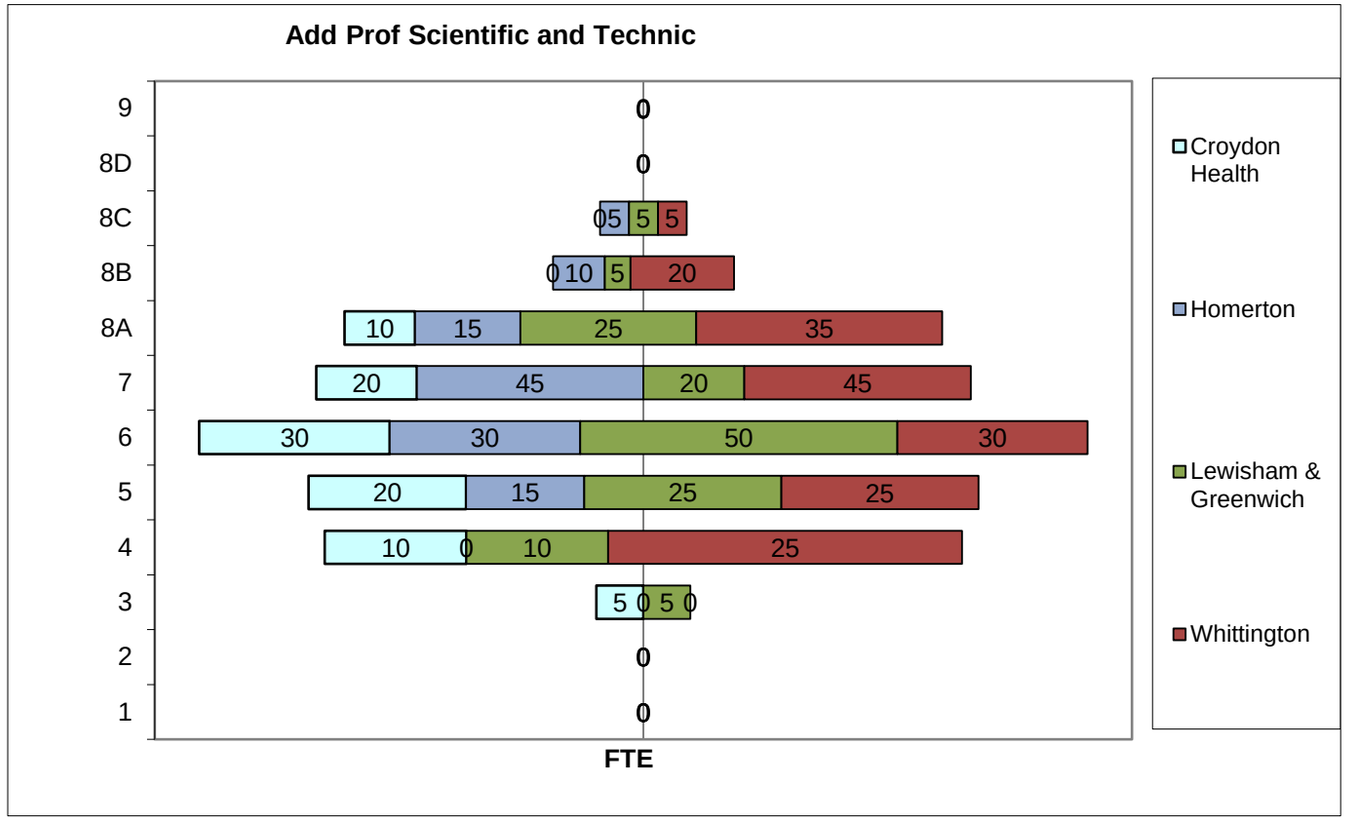




ADD PROF SCIENTIFIC & TECHNIC A4C banding profile by FTE (October 2014)

Roles: Chaplain, Clinical Director, Clinical Psychologist, (Qualified and Trainee) Psychotherapist, Social Worker, Technician, Osteopath, Pharmacist, Physician asst Psychological Therapist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3	5		5	
4	10		10	25
5	20	15	25	25
6	30	30	50	30
7	20	45	20	45
8A	10	15	25	35
8B		10	5	20
8C		5	5	5
8D				
9				
Total FTE	95	120	145	185

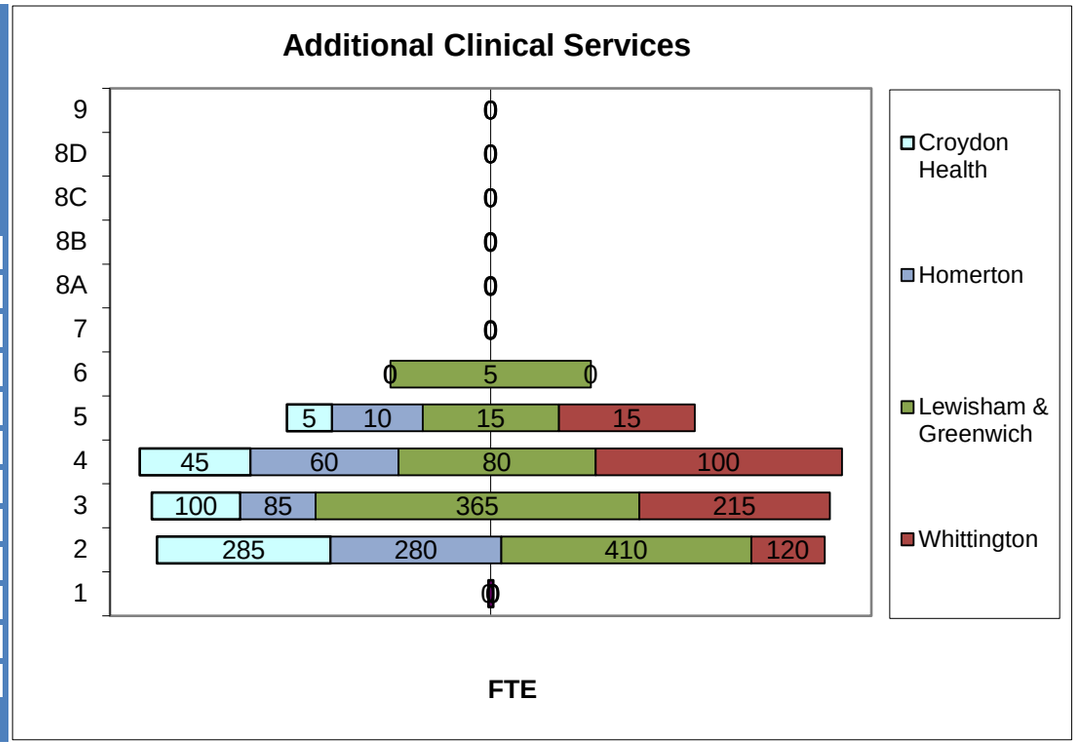


Whittington Health has a much lower proportion of the workforce at Band 6, with them making up 16% within this professional group against 34% at Lewisham & Greenwich, 30% at Croydon Health and 25%.

ADDITIONAL CLINICAL SERVICES A4C banding profile by FTE (October 2014)

Role: Assistant Psychologist, Assistant/Associate Practitioner, Counsellor, HCS worker HCA, Helper/Assistant, Med Laboratory Assistant, Nursery Nurse, Play Specialist Pre-Reg Pharmacist, Technical Instructor, Technician, Trainee Scientist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2	285	280	410	120
3	100	85	365	215
4	45	60	80	100
5	5	10	15	15
6			5	
7				
8A				
8B				
8C				
8D				
9				
Total FTE	435	435	875	450

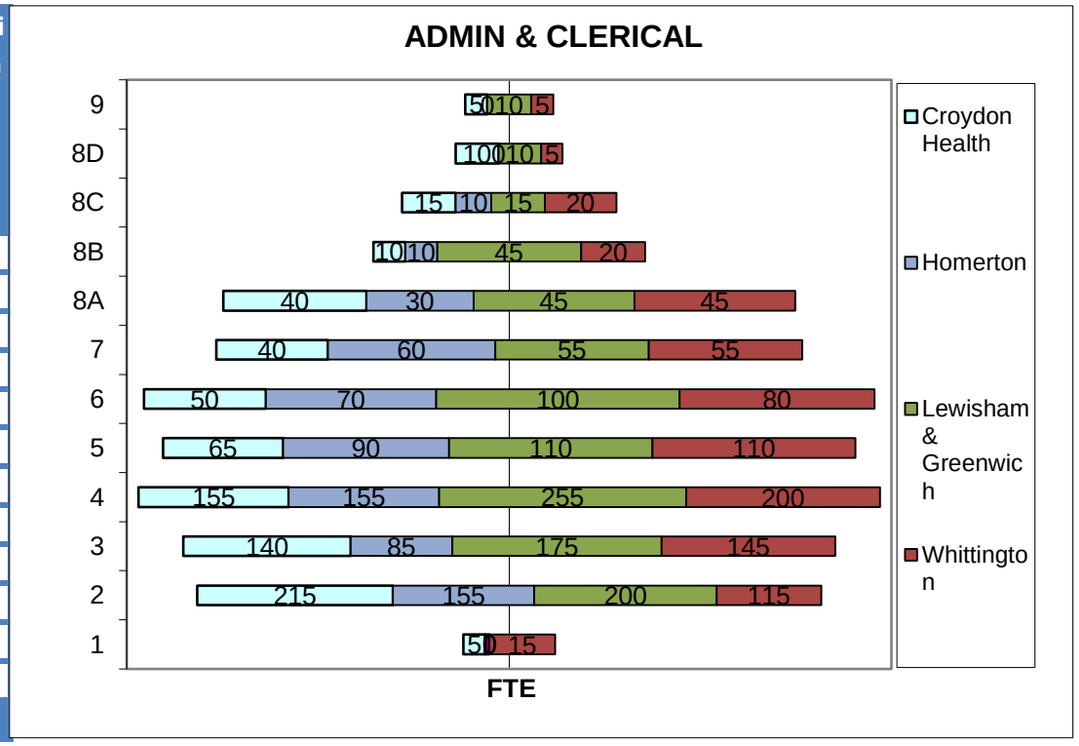


Whittington Health has fewer Band 2 roles in this professional Band 2s but more staff at Band 3 and 4.

ADMIN & CLERICAL A4C banding profile by FTE (October 2014)

Role: Accountant, Adviser, Chair, Clerical Worker, Interpreter, Manager, Medical Secretary Officer, Other Exec Dir, Personal Assistant, Receptionist, Researcher, Secretary, Snr Mgr Technician

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	5			15
2	215	155	200	115
3	140	85	175	145
4	155	155	255	200
5	65	90	110	110
6	50	70	100	80
7	40	60	55	55
8A	40	30	45	45
8B	10	10	45	20
8C	15	10	15	20
8D	10		10	5
9	5		10	5
Total FTE	750	665	1020	815

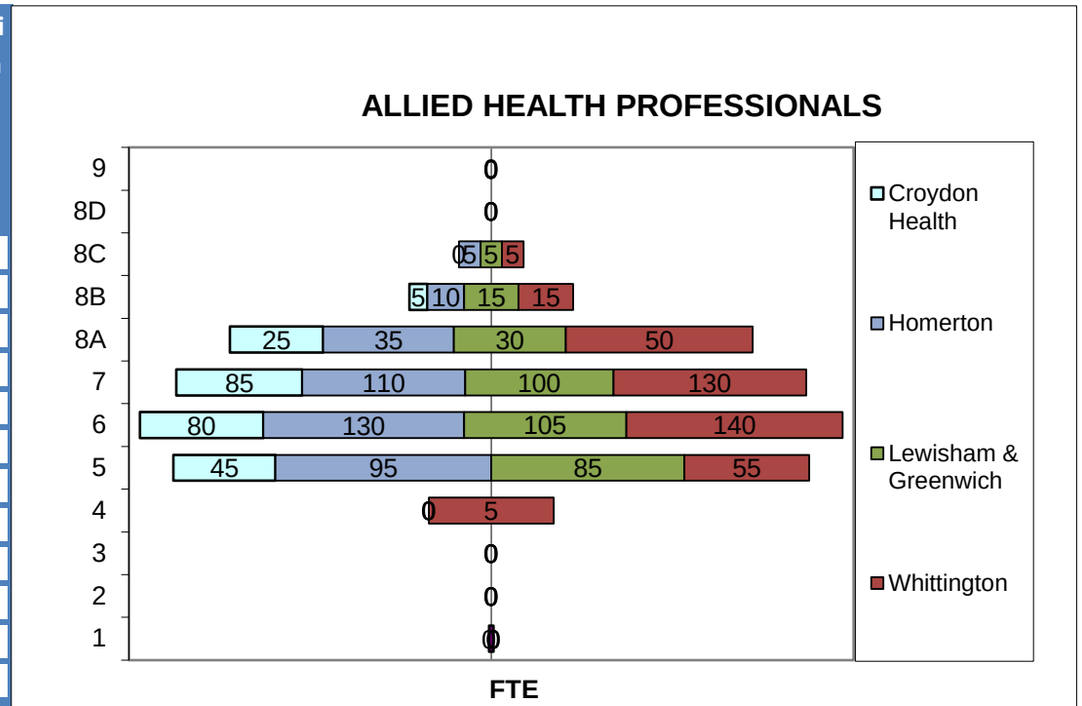


Whittington has fewer Band 2 staff in this professional group at 14% compared with 28% at Croydon Health, 23% at the Homerton and 20% in Lewisham & Greenwich.

ALLIED HEALTH PROFESSIONALS A4C banding profile by FTE (October 2014)

Role: Chiropodist/Podiatrist, Dietitian, Dietician Mgr, Occ Therapist, Occ Therapist Mgr Orthoptist, Physio, Physio Mgr, Physio Specialist Practitioner, Radiographer - Diagnostics Radiographer Diagnostic Mgr, SLT, SLT Mgr.

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3				
4				5
5	45	95	85	55
6	80	130	105	140
7	85	110	100	130
8A	25	35	30	50
8B	5	10	15	15
8C		5	5	5
8D				
9				
Total FTE	240	385	340	400

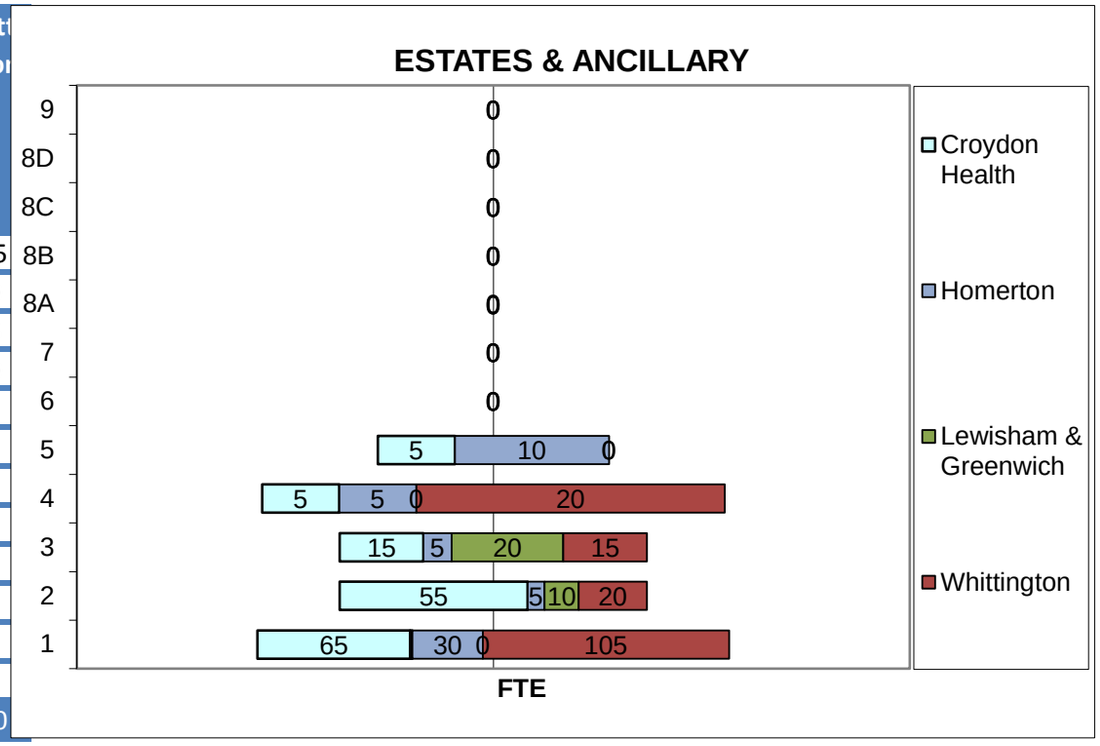


Whittington Health has a much lower proportion of staff in this professional group at Band 5: 14% compared with 25% at the Homerton and Lewisham and Greenwich and 19% at Croydon.

ESTATES AND ANCILLARY A4C banding profile by FTE (October 2014)

Role: Assistant, Chargehand, Gardener/Groundsperson, Porter, Supervisor, Support Worker Technician

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	65	30		105
2	55	5	10	20
3	15	5	20	15
4	5	5		20
5	5	10		
6				
7				
8A				
8B				
8C				
8D				
9				
Total FTE	145	55	30	160



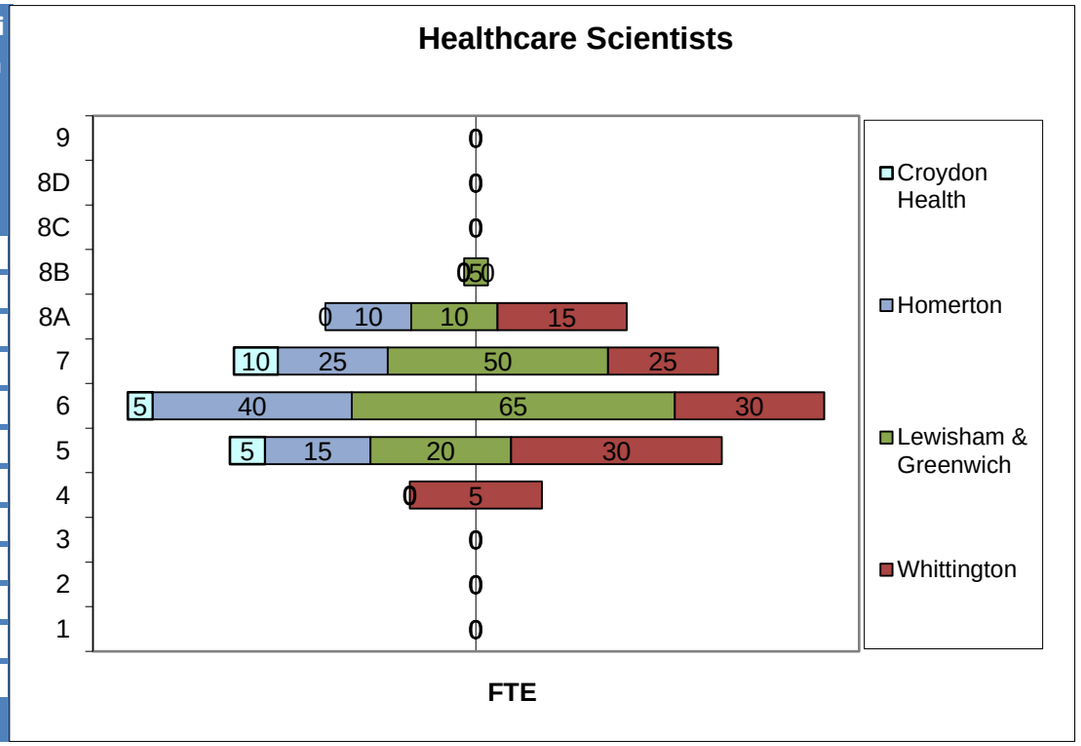
Whittington Health has significantly fewer staff at a high grade for this professional group compared with Croydon and the Homerton.

HEALTHCARE SCIENTISTS A4C banding profile by FTE (October 2014)

Role: Biomedical Scientist, Healthcare Scientist, Manager, Specialist Healthcare Scientist

Associate Specialist

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1				
2				
3				
4				5
5	5	15	20	30
6	5	40	65	30
7	10	25	50	25
8A		10	10	15
8B			5	
8C				
8D				
9				
Total FTE	20	90	150	105

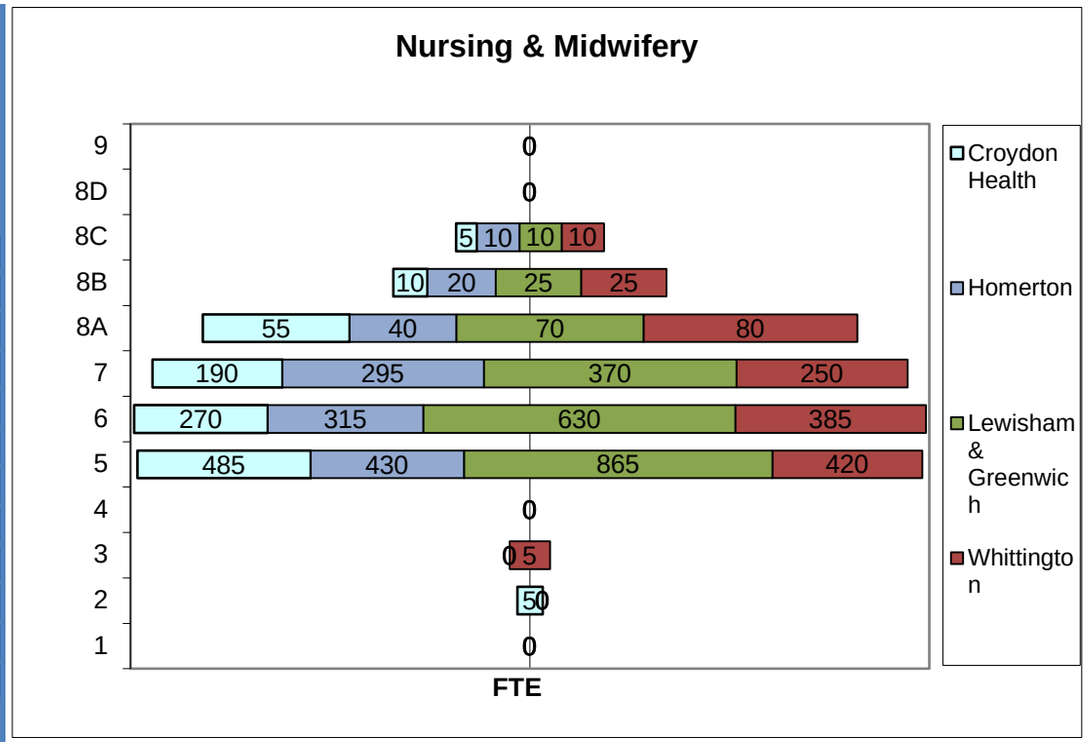


Whittington Health has a much greater proportion at a lower grade than Homerton

NURSING & MIDWIFERY A4C banding profile by FTE (October 2014)

Role: Community Nurse, Community Practitioner, Enrolled Nurse, Midwife, Midwife Mgr,
Midwife Specialist Practitioner, Modern Matron, Nurse Consultant, Nurse Mgr
Sister/Charge Nurse, Specialist Nurse Practitioner, Staff Nurse

A4C Band	Croydon Health	Homerton	Lewisham & Greenwich	Whittington
1	5			
2				5
3				
4	485	430	865	420
5	270	315	630	385
6	190	295	370	250
7	55	40	70	80
8A	10	20	25	25
8B	5	10	10	10
8C				
8D				
9				
Total FTE	1020	1110	1970	1175

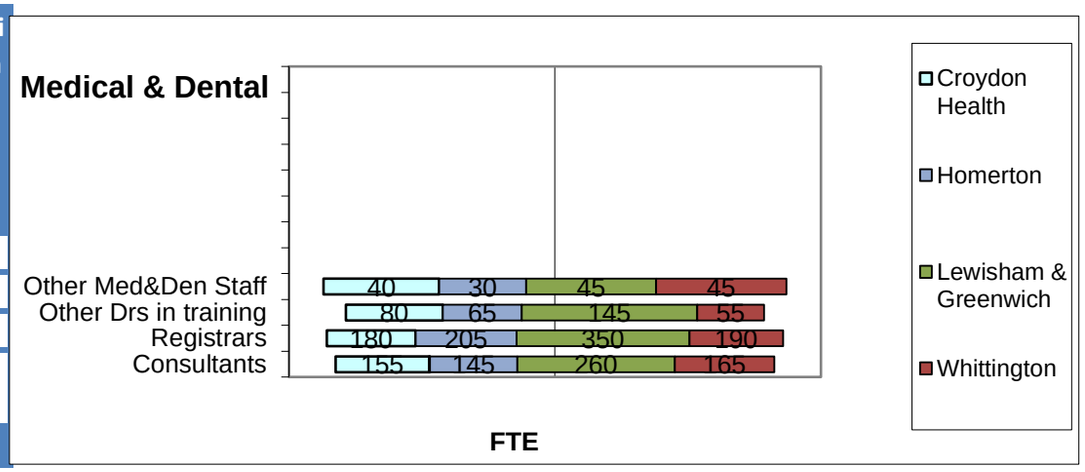


There would appear to be different uses for the coding in ESR across the comparator organisations with HCAs coded to "Additional Clinical Services" making comparisons difficult. For the qualified nursing workforce Whittington Health has a higher proportion at

Band 7: 7% compared with 3.5% at Lewisham&Greenwich, 3.6% at the Homerton and 5.4% at Croydon.

MEDICAL & DENTAL Job role profile by FTE (October 2014)

Job Roles	Croydon Health	Homerton Uni F	Lewisham & Greenwich	Whittington
Consultants	155	145	260	165
Registrars	180	205	350	190
Other Doctors in Training	80	65	145	55
Other Medical and Dental Staff	40	30	45	45
Total FTE	455	445	800	455



Whittington Health has the highest proportion of medical & dental at Consultant: 36% compared with 33% at Homerton and Lewisham & Greenwich and 34% at Croydon. Whittington Health has the lowest proportion of “Other Doctors in Training” at 12% compared with 18% at Croydonand Lewisham & Greenwich and 15% at the Homerton.

Whittington Health NHS

Trust Board
4 February 2015

Title:	**2014/15 Finance Report - December (Month 9)**					
Agenda item:	15/025		**Paper**	8		
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 in month and for the YTD to December 2014.**					
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:	**23rd January 2015**					
Author name and title:		**Ursula Grueger, Deputy Director of Finance**	**Director name and title:**		**Simon Pleydell, CEO**	
Date paper seen by EC ?		**Equality Impact Assessment complete?**	**Risk Assessment undertaken ?**	**N\A**	**Legal advice received ?**	**N\A**

Month 9 Finance Report - Executive Summary

The in-month position is a £480k surplus against a planned surplus of £617k, an adverse variance of £137k. The year to date (YTD) position is a £6.2m deficit against a planned deficit of £0.3m, an adverse variance of £5.9m. The adverse variance is a combination of income underperformance and expenditure pressures.

This financial position represents significant deviation from plan at the start of the year. The Trust is currently forecasting a £7.4m deficit at year end.

Income

The income position is £0.5m favourable in month and £0.3m favourable YTD. The favourable position in month is driven by an overperformance in NHS clinical income. This reflects the contract variation of £2m, resilence support of £1.2m (both phased in over the last five months of the year) as well as higher than runrate NHS England performance, which is paid on PbR. The income position continues to reflect the Trust operating against a block contract arrangement with its main CCGs, which has now been agreed to continue to the end of the 2014/15 financial year.

Where possible the Trust is seeking to exploit other means of securing income such as looking to support other Trusts in addressing their RTT and capacity challenges. RTT Income of £1.6m is reflected in the YTD position.

Non NHS Clinical income is above plan YTD due to road traffic accident, overseas visitors and local authority commissioned sexual health and higher dental activity. Other non patient income is above plan YTD due to mainly additional education and training income as well as some additional research income which is offset with costs.

Expenditure

The expenditure position is £0.8m adverse in month and £7.0m adverse YTD. The major expenditure challenges remain in the Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostics (SCD) Divisions. The improvement in the expenditure position compared to month 8 is largely due to improvements in the corpporate divisions in both pay and non pay.

Pay is £0.5m adverse in month and £2.9m adverse YTD. Key drivers of the in month pay variance include ICAM £480k adverse and SCD £252k adverse.

Non Pay is £0.2m adverse in month and £1.6m adverse YTD. Key drivers of the *in month* are the Corporate divisions (£95k) and SCD (£52k).

Further expenditure reductions are being developed.

The monthly position has resulted in the EBITDA margin of 6.82%, which is below the target of 8.27%. EBITDA stands for earnings before interest, taxation, depreciation and amortisation and is a measure of our ability to generate cash from our operations. It is vital to maintain a healthy cash balance to service our liabilities and finance the Trust's capital programme.

Cost Improvement Plans (CIPs)

The Trust has delivered YTD savings of £5.7m against a plan of £10.4m (55%). There are plans to deliver £9.1m in total for 2014/15 of a target of £15m (61%) and the divisions are working on back up plans to deliver the gap.

Cash and Capital

Cash increased by £1.3m in the month to £2.2m. The capital programme is on track.

Statement of Comprehensive Income	Full Year	December			YTD		
	Budget (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)
Nhs Clinical Income	246,955	20,613	21,118	504	185,166	184,033	(1,133)
Non-Nhs Clinical Income	16,332	1,358	1,273	(85)	12,260	12,915	655
Other Non-Patient Income	26,176	2,164	2,269	105	19,440	20,185	763
Total Income	**289,464**	**24,135**	**24,660**	**525**	**216,866**	**217,133**	**285**
Non-Pay	69,880	5,592	5,829	(237)	52,262	53,875	(1,614)
Pay	206,047	16,618	17,150	(532)	154,947	157,874	(2,926)
Savings	(3,303)	(72)	0	(72)	(2,477)	0	(2,477)
Total Expenditure	**272,624**	**22,138**	**22,979**	**(841)**	**204,732**	**211,749**	**(7,017)**
EBITDA	**16,840**	**1,997**	**1,681**	**(316)**	**12,134**	**5,384**	**(6,751)**
EBITDA %	**5.82%**	**8.27%**	**6.82%**	**-1.46%**	**5.60%**	**2.48%**	**-3.12%**
Interest Payable	2,820	235	241	(6)	2,115	2,136	(21)
Interest Receivable	30	3	2	(1)	23	19	(4)
Depreciation	9,724	810	720	90	7,293	7,616	(322)
Dividends Payable	4,326	361	248	113	3,245	3,132	113
Donated Asset Additions	0	0	0	0	0	19	19
Net Surplus / (Deficit) - before IFRIC 12 adjustments	(0)	594	474	(119)	(496)	(7,461)	(6,966)
Add back impairments and adjust for IFRS & donated assets	285	24	6	(18)	214	1,288	1,074
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**285**	**617**	**480**	**(137)**	**(282)**	**(6,173)**	**(5,892)**
Previous Month : adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**285**	**137**	**(380)**	**(517)**	**(899)**	**(6,654)**	**(5,754)**
Movement from Month 7 to Month 8 (+ve(Green) is Favourable)	**(0)**	**480**	**860**	**380**	**617**	**480**	**(137)**

Whittington Health Cost Improvement Programme Report - Month 9

	Annual	November				YTD				Forecast			
	Plan £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Fcst £'000	% achieved	Var £'000
ICAM	1,768	157	72	46%	(85)	1,269	471	37%	(797)	1,768	1,408	80%	(360)
SCD	1,179	89	60	67%	(29)	847	422	50%	(424)	1,179	636	54%	(544)
WCF	1,299	108	43	40%	(65)	974	337	35%	(637)	1,299	534	41%	(765)
Corporate	1,519	132	123	94%	(8)	1,124	1,016	90%	(109)	1,519	1,612	106%	93
Total Divisional Schemes	**5,764**	**485**	**298**	**61%**	**(187)**	**4,214**	**2,247**	**53%**	**(1,967)**	**5,764**	**4,189**	**73%**	**(1,576)**
Productivity & Efficiency	5,347	469	76	16%	(393)	3,939	783	20%	(3,157)	5,347	1,382	26%	(3,965)
VIPs	3,388	427	33	8%	(394)	1,857	136	7%	(1,722)	3,388	353	10%	(3,035)
Total Productivity & Efficiency and Transformational Schemes	**8,735**	**896**	**109**	**12%**	**(787)**	**5,797**	**919**	**16%**	**(4,878)**	**8,735**	**1,735**	**20%**	**(7,000)**
Non Recurrent Benefits	500	42	42	100%	0	375	375	100%	0	500	500	100%	0
Non Recurrent Under Spends	0	0	350		350	0	2,193		2,193	0	2,653		2,653
Total Non Recurrent Items	**500**	**42**	**391**		**350**	**375**	**2,568**		**2,193**	**500**	**3,153**		**2,653**
Total delivery against planned schemes	**15,000**	**1,423**	**798**	**56%**	**(625)**	**10,386**	**5,734**	**55%**	**(4,652)**	**15,000**	**9,077**	**61%**	**(5,923)**
Unidentified Schemes	0	0	0		0	0	0		0	0	5,923		5,923
Trust Total	**15,000**	**1,423**	**798**	**56%**	**(625)**	**10,386**	**5,734**	**55%**	**(4,652)**	**15,000**	**15,000**	**100%**	**0**

Month 9 CIP Summary

The CIP delivery underperformance YTD has continued into month 9.

In month 9 £798k (56%) CIP delivery was achieved compared to a plan of £1,423k. This includes a benefit from non recurrent underspends of £350k.

YTD delivery is £5,734k (55%) compared to a YTD target of £10,424k. YTD delivery includes a benefit from non recurrent underspends of £2,193k.

The divisional schemes are forecasting £4,189k delivery (73%) against the target of £5,764k.

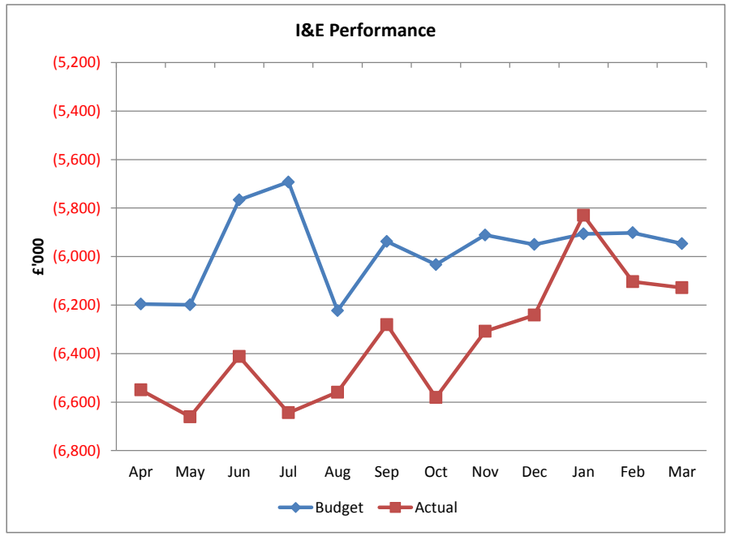
The productivity & efficiency schemes are forecasting £1,382k delivery (26%) against a target of £5,347k.

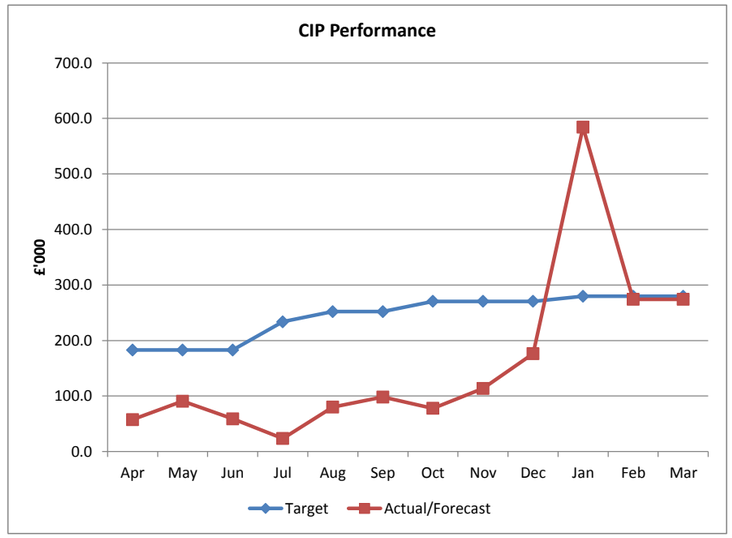
The VIP transformational schemes are forecasting £353k delivery (10%) against the target of £3,388k.

The £5,923k gap has been phased to deliver over the last 3 months of the financial year.

ICAM Divisional Position - Month 9 (December 14)

Income & Expenditure	Ann Plan £'000	In Month Plan £'000	In Month Act £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Act £'000	Year To Date Var £'000
Nhs Clinical Income	7,674	640	827	188	5,756	6,914	1,159
Other Income For Pat Care	1,783	149	147	(2)	1,337	1,314	(23)
Other Non-Patient-Devolved	671	58	58	(0)	522	443	(79)
Other_Non-Patient_Non-Dev	0	0	(34)	(34)	0	0	0
Income	10,128	846	997	151	7,615	8,671	1,057
A/C	5,243	433	484	(52)	3,945	4,369	(424)
Executive Board & Sen Mgmt	486	71	65	6	364	368	(3)
Medical	13,389	1,092	1,251	(159)	10,137	11,338	(1,201)
Nurses & Midwives	28,694	2,380	2,480	(100)	21,580	23,168	(1,588)
Other Support Workers	199	17	36	(20)	150	323	(174)
Scientific, Ther & Tech	16,975	1,412	1,429	(17)	12,733	13,243	(509)
Pay Reserve	(1,638)	(139)	0	(139)	(1,195)	0	(1,195)
Pay	63,347	5,267	5,746	(480)	47,714	52,808	(5,094)
Establishment	458	38	40	(1)	343	459	(116)
Ext Cont Staffing & Cons	115	6	8	(3)	52	409	(357)
Healthcare From Non Nhs	548	46	29	17	411	26	385
Miscellaneous	362	30	33	(2)	271	265	6
Non-Pay Reserve	(253)	(21)	0	(21)	(190)	0	(190)
Premises & Fixed Plant	392	33	49	(17)	294	522	(228)
Supplies & Servs - Clin	16,450	1,368	1,396	(29)	12,347	12,091	256
Supplies & Servs - Gen	373	31	(63)	94	281	326	(45)
Non Pay	18,445	1,530	1,492	38	13,810	14,099	(289)
Income Less Direct Costs	(71,664)	(5,950)	(6,241)	(291)	(53,909)	(58,236)	(4,327)





Income and Expenditure Commentary

The position at month 9 is £291k adverse in month and £4,329k adverse YTD.

NHS Clinical Income is £188k favourable in month due to Winter Resilience income within the position. YTD the position is £1,159k favourable due to prison income recognised in month 1 (£0.5m), additional CCG investments and RTT and winter resilience funding.

Other Income is £36k adverse in month due to IAPT training income now help centrally, with expenditure budget given to division. £102k adverse YTD due to lower than budgeted income for flexible trainees.

Pay is £480k adverse in month and £5,094k adverse YTD.

Nursing is £100k adverse in month and £1,588k YTD due to high agency spend within ED, District Nursing and in Acute Wards. This is high due to vacancies, specialing and high dependency patients on the wards. This variance is offset in part (£54k) with winter resilience income.

Medical is £159k adverse in month and £1,201k adverse YTD. This is due to 3 x agency consultants within medical specialties (gastroenterology x2 and rheumatology) covering vacancies, long term sick leave and maternity. In addition, agency spend on middle grade doctors in ED is higher than planned due to vacancies, high activity, and extra winter staffing. ED overspend (£35k) is offset with winter resilience income.

Unallocated CIP and VIP is leading to a £139k adverse variance in month and £1,195k adverse YTD.

Non-Pay - YTD Adverse £289K; £38k favourable in month due to low spend in wheelchairs (big order in M8). YTD adverse; £341k due to Prison expenditure accounted for in month 1, with no budget (service now decommissioned). This is partially offset by Pharmacy drugs underspend.

CIP Commentary

CIP figures below include Divisional Schemes, Divisional VIP & P&E and N\R Underspend. This will therefore make it difficult to compare to the Trust CIP performance report, with VIP, P&E & N\R not being broken down by division.

In month 9, the division delivered £176k against a plan of £271k. Year to date the division has delivered £772k against a plan of £2,098k.

In month commentary:

ED Nursing - Only additional nursing spend is now offset by winter resilience income.

District Nursing - Cohort of new nurses have started in November and December. This has helped reduce DN run rate, but as yet run rate hasn't been reduced sufficiently to achieve CIP.

Ward Nursing - Saving no longer achievable due to new nursing model

TB - TB income is due to come into the ICAM budget in M10-M12, therefore achieving the CIP for TB in full.

VIP - Emergency Care and Ambulatory Care VIPs not yet delivering. Locality based teams VIP moved to COO cost centre. Emergency care VIP is non-recurrently achieved through winter pressure money funding the twilight shift.

Divisional Actions

Forecast I&E improvement in final 3 months of the year based on significant recruitment, challenging targets set for district nursing and ward specialing expenditure improvement and additional TB income.

ED - 2 x middle grade doctors are due to start date of January. Nursing vacancies are set to be filled by trust wide nursing recruitment drives. Winter resilience is currently funding additional medical and nursing shifts. In month 9 ED was on budget.

District Nursing - Phased recruitment plan in place to reduce agency spend. New nurses have started in November and December, with more expected in January. Savings are delayed due to double running costs for 2 week induction for new starters. Weekly teleconference with Finance lead looking at spend & capacity. Activity levels continue to increase, so savings due to productivity and efficiency have not materialised. Discussions with commissioners to be had regarding reimbursement for this.

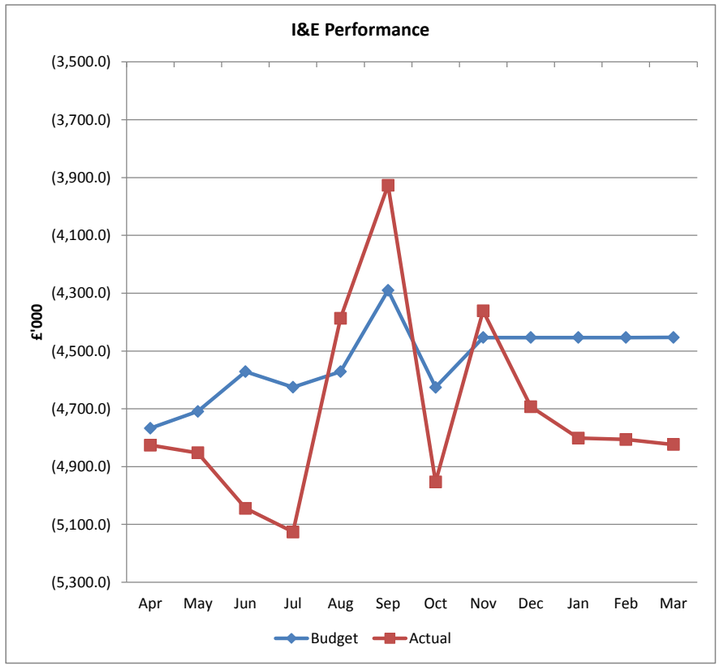
Ward Nursing - Corporate Nursing to look into required budget for specialing and what processes are required to control the spend. Higher scrutiny of agency spend has lead to reduced run rate in M9, with this set to continue for the remainder of the year.

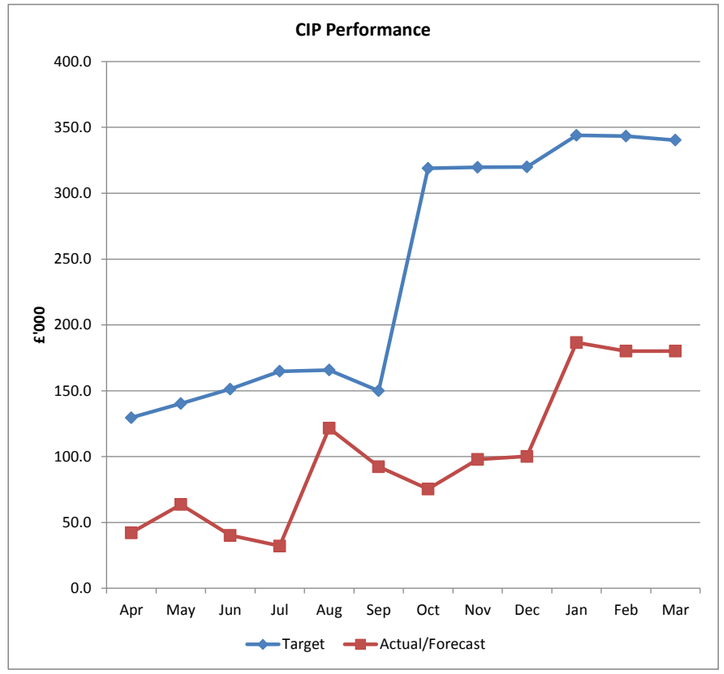
Consultant Agency - 1 x Gastroenterology post offer accepted. Expected to be in post by end of January. 1 x post going out to advert fixed term, expected to be recruited into post by April. 1 x agency consultant has finished in August. Additional activity of UCLH work set to offset overspend in Q4.

Underachieved CIPs - Additional income expected from TB activity, and recruitment of consultant to permanent posts in Gastroenterology, with income from UCLH activity offsetting remaining overspend. All non-essential vacancies to continue to be held vacant where possible.

SCD Divisional Position - Month 9 (December 14)

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Nhs Clinical Income	819	68	153	84	614	2,403	1,789
Other Income For Pat Care	1,028	87	118	31	768	1,034	266
Other Non-Patient-Devolved	740	34	38	4	577	492	(84)
Other_Non-Patient_Non-Dev	640	53	66	13	480	493	13
Income	3,227	242	374	132	2,439	4,422	1,983
A/C	4,040	311	406	(95)	3,106	3,891	(785)
Dental	2,344	195	192	3	1,758	1,742	16
Executive Board & Sen Mgmt	566	47	47	1	425	319	105
Medical	16,165	1,375	1,322	53	12,141	12,259	(118)
Nurses & Midwives	15,069	1,274	1,267	8	11,246	11,335	(89)
Other Support Workers	376	31	27	4	282	261	21
Scientific, Ther & Tech	8,356	700	732	(32)	6,256	6,498	(243)
Pay Reserve	(1,640)	(194)	0	(194)	(1,057)	0	(1,057)
Pay	45,277	3,740	3,992	(252)	34,156	36,306	(2,150)
Establishment	280	23	30	(6)	210	331	(121)
Ext Cont Staffing & Cons	176	(22)	12	(34)	132	109	23
Miscellaneous	334	28	41	(13)	250	395	(145)
Non-Pay Reserve	(65)	(11)	0	(11)	(33)	0	(33)
Premises & Fixed Plant	591	49	66	(16)	443	529	(86)
Supplies & Servs - Clin	10,799	910	881	29	8,069	8,515	(446)
Supplies & Servs - Gen	554	47	47	(0)	414	406	7
Non Pay	12,669	1,024	1,076	(52)	9,485	10,286	(800)
Income Less Direct Costs	(54,719)	(4,522)	(4,694)	(172)	(41,203)	(42,170)	(967)





Income and Expenditure Commentary

The position at month 9 is £172k adverse in month and £967k adverse YTD. Against forecast for the month the Division over-performed by £165k.

Income is £132k favourable in month and £1,983k favourable YTD driven by £1,348k of RTT income recognised YTD along with income from Dental Out of Hours service. Additionally, Resilence 2 funding of £35k was also accounted for in-month as well as income from UCH of £5.4k in-month.

Pay is £252k adverse in month and £2,149k adverse YTD. Against the average runrate of last 8 months the cost of pay in M09 improved by £48k.

Nurses & Midwives is £8k favourable in month and £89K adverse YTD. The improvement is largely due to the escalation bed budget in Coyle and reduction of temporary staffing usage in Theatres by £49K.

Admin and clerical is £95k adverse in month and £785k adverse YTD. This is driven largely by the delayed implementation of TPE (bank admin) and bank spend within Imaging.

Unallocated CIP and VIP is leading to a £194k adverse variance in month and £1,057k adverse YTD. This is because the Planned Activity VIP target was phased from M07.

Non Pay is £52k adverse in month and £800k adverse YTD. This is largely due to costs within theatres (due to RTT activities) and pathology on clinical consumables, prosthetics and reagents.

CIP Commentary -

In month 9 the division delivered £100k against a plan of £320k

Year to date the division has delivered £666k against a plan of £1,860k.

2 % schemes - the division continues to breakeven against the in-month target of £88K since Nov. This includes the non-recurrent schemes. Delivered 73% of the schemes YTD.

Productivity Target - This is under-performing in-month. However it is forecasted to improve through increase in referrals from UCLH for breast and spinal work.

VIP - Transformation stretch target in Diagnostics and parts of Outpatient pathway target have been profiled from Q1 & Q2 which remains un-identified and therefore unachieved. Planned Activity VIP was profiled from M07 which is also unachieved. There are further financial pressures due to extra beds in wards.

Imaging - WLI payments plus bank & agency spend to cover vacancies remains high. Non pay continues to increase.

Theatres schemes - CIP schemes for Theatres are significantly improving by delivering 73% of the schemes as opposed to 23% on average in previous months.

Divisional Actions

Imaging
- A full budget review continues to reduce spend.
- Non Pay is also projected to reduce from Nov 14 when CT injectors scheme is implemented.

Theatres
- Recruitment continues for theatres and reliance on bank and agency spend has reduced.
- We cotinue to work to achieve the final 25% of CIP for theatres.
- Non pay spend is linked to activity. A solution to materials management has been proposed to help with stock control.

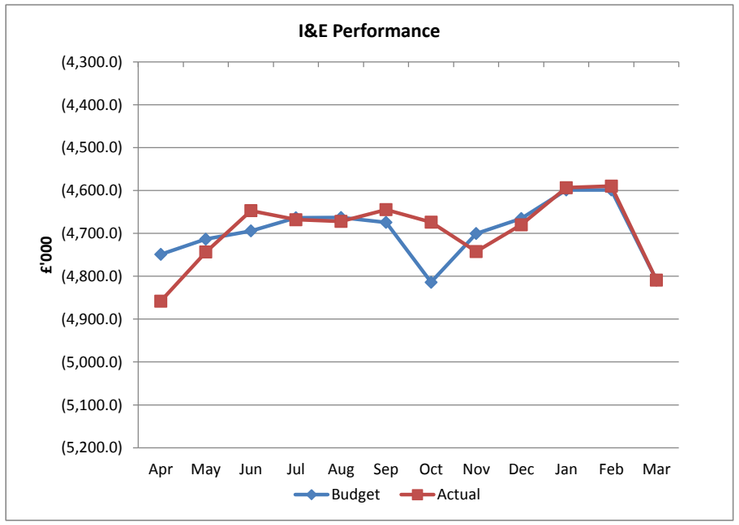
Outpatient Staffing
- Most staff should be in new roles from Q4 onwards.

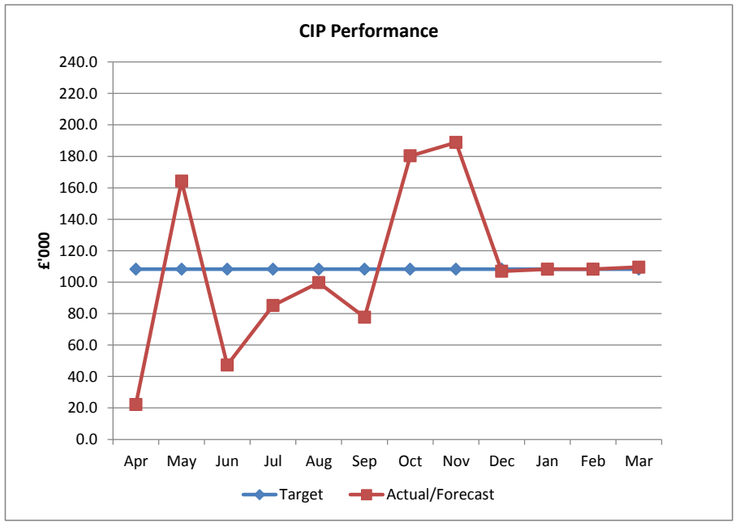
WLI
- The division is constantly engaging with other NHS organisations to bringing in more referrals especially for T&O, spinal and General Surgery services improving utilisation and productivity, building relationships and commercially increasing contribution.

The division is continuously reviewing its financial position and focusing on improving the forecast position for the year.

WCF Divisional Position - Month 9 (December 14)

Income & Expenditure	Ann Plan £'000	In Month Plan £'000	In Month Act £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Act £'000	Year To Date Var £'000
Nhs Clinical Income	1,042	88	151	63	778	1,147	369
Other Income For Pat Care	7,276	602	622	20	5,471	5,826	355
Other Non-Patient-Devolved	304	27	33	7	251	325	73
Other_Non-Patient_Non-Dev	0	0	7	7	0	41	41
Income	8,622	717	814	96	6,500	7,339	839
A/C	4,575	383	411	(27)	3,428	3,612	(184)
Executive Board & Sen Mgmt	666	53	36	17	507	381	126
Medical	11,314	947	1,000	(53)	8,517	8,753	(236)
Nurses & Midwives	31,296	2,579	2,573	5	23,544	23,366	178
Other Support Workers	39	3	11	(8)	30	99	(69)
Scientific, Ther & Tech	13,196	1,096	1,140	(44)	9,936	10,000	(63)
Pay Reserve	(373)	(31)	0	(31)	(280)	0	(280)
Pay	60,714	5,030	5,171	(141)	45,681	46,210	(530)
Establishment	481	39	50	(11)	361	474	(113)
Ext Cont Staffing & Cons	78	7	10	(3)	59	67	(8)
Miscellaneous	293	23	34	(11)	190	298	(108)
Non-Pay Reserve	1	0	0	0	0	0	0
Premises & Fixed Plant	548	47	42	4	408	439	(31)
Supplies & Servs - Clin	2,507	209	163	46	1,879	1,980	(100)
Supplies & Servs - Gen	345	29	24	5	259	200	59
Non Pay	4,253	352	322	31	3,157	3,457	(301)
Income Less Direct Costs	(56,344)	(4,666)	(4,680)	(14)	(42,338)	(42,329)	8





Income and Expenditure Commentary

The WCF position at month 9 is £14k adverse in month and £8k favourable YTD.

Patient Care Income is £83k favourable in month and £724k favourable YTD, which relates to income for new investments where budgets are not yet set, higher GUM activity, new born screening income and YTD RTT funding of £121k.

Other Income is £14k favourable in month and £114k favourable YTD driven by additional education and training and schools income.

Pay is £141k adverse in month and £530k adverse YTD.

Medical is £53k adverse in month and £236k adverse YTD. Of the in-month variance £9k relates to a backdated incremental payment, the balance relates to junior doctor agency expenditure in Obstetrics and Gynaecology and unfunded maternity and sick leave cover. The YTD adverse variance is largely driven by junior doctor agency expenditure in Obstetrics and Gynaecology which has reduced over the past two months. Community paediatrics is also adverse due to part time junior doctors on the rota.

Scientific, Ther & Tech is £44k adverse in month and £63k adverse YTD. Of the in-month variance £9k relates to a new investment within Community CAMHS for which there is corresponding income. The balance relates to therapy services across Paediatric Integrated Care.

Non Pay is £31k favourable in month which is driven by a reduction in spend on clinical supplies and services predominantly on the labour ward and in sexual health. The adverse YTD position of £301k is driven by additional equipment requirements as well as increased activity in special schools, professional services for the preparation of tenders and the costs of setting up new services.

CIP Commentary

CIP figures below include Divisional Schemes, Divisional VIP & P&E and non recurrent underspend. This will therefore make it difficult to compare to the Trust CIP performance report, with VIP, productivity & non recurrent savings not being broken down by division.

In month 9, the division delivered £107k against a plan of £108k.

Year to date the division has delivered CIPs of £973k against the YTD plan of £974k.

Of the £973k delivered YTD, £337k is recurrent and £636k is non-recurrent.

The Division is forecasting that the 2014-15 CIP plan will be achieved in full through recurrent and non-recurrent CIPs.

Although most areas have identified recurrent CIPs, Obstetrics and Gynaecology is an area where this has proved difficult to do.

There are no VIP schemes to report on within WCF.

Divisional Actions

Agency reduction

Close management of sickness levels and vacancies will be key in managing and reducing the bank, agency and locum spend in the coming months.

Recruitment to vacancies are continuing in areas where agency staffing is currently used.

Newly qualified health visiting and midwifery students have taken up their positions, with reductions in agency spend already partly reflected in December, which will continue over the next couple of months.

Obs and Gynae had a gap of 2 WTE in junior doctor rota but one post has now been recruited to and a further post is being recruited to.

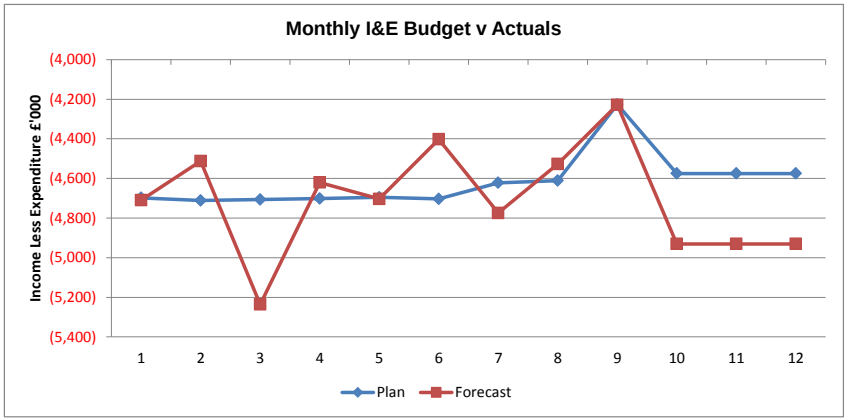
Recent recruitment into NICU has been successful which should result in a reduction in bank agency expenditure from January, when staff have undergone the necessary training.

Income

Ensure all income due is invoiced appropriately for existing contracts and new investments.

Corporate Divisional Position - Month 9 (December 14)

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Organisational Development	2,163	190	224	(34)	1,635	1,929	(294)
Ict	6,642	197	211	(14)	4,983	5,066	(83)
Finance	4,052	338	341	(3)	3,037	3,166	(128)
Trust Secretariat	1,695	137	148	(12)	1,285	1,460	(175)
Chief Operating Officer	1,187	40	119	(79)	1,067	1,321	(253)
Nursing & Patient Experience	9,508	804	796	8	7,097	7,115	(19)
Procurement	789	66	47	19	592	537	55
Medical Director	1,053	88	17	71	790	576	214
Facilities	28,314	2,369	2,325	44	21,191	20,629	563
Total	**55,402**	**4,227**	**4,228**	**(1)**	**41,678**	**41,798**	**(120)**



ICT Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Income	22	2	3	1	17	20	3
Pay	2,977	(109)	(84)	(25)	2,234	2,471	(237)
Non-Pay	3,688	307	298	9	2,766	2,614	152
Total	**(6,642)**	**(197)**	**(211)**	**(14)**	**(4,983)**	**(5,066)**	**(83)**

Facilities Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Income	1,841	133	127	(6)	1,443	1,574	130
Pay	11,178	900	784	117	8,477	7,493	983
Non-Pay	18,978	1,601	1,668	(67)	14,158	14,709	(551)
Total	**(28,314)**	**(2,369)**	**(2,325)**	**44**	**(21,191)**	**(20,629)**	**563**

Nursing & Patient Experience Breakdown

Income & Expenditure	Annual Plan £'000	In Month Plan £'000	In Month Actuals £'000	In Month Var £'000	Year To Date Plan £'000	Year To Date Actuals £'000	Year To Date Var £'000
Non-Pay	6,075	499	465	34	4,555	4,658	(103)
Non-Nhs Clinical Income	0	0	(10)	10	0	(29)	29
Other Non-Patient Income	(3)	(0)	(15)	14	(2)	(77)	75
Pay	3,435	305	355	(51)	2,543	2,564	(20)
Total	**2,642**	**804**	**796**	**8**	**7,097**	**7,115**	**(19)**

Commentary

The corporate position at month 9 is £1k adverse in month and £120k adverse YTD.

COO - £79k adverse in month and £253k adverse YTD. As reported in month 8, the **forecast position** at year end worsened due to the transfer of a CIP target of £710k (Locality based VIP) from ICAM to COO. There has been no progress to date in achievement of this VIP.

Facilities - The forecast for Estates remains favourable to the end of the year. The £44k favourable variance in M9 is largely driven by reduced expenditure on Communty Estates.

ICT - A schedule of annual non pay expenditure contracts has been agreed with ICT for 2014/15. The YTD ICT bottom line reflects the agreed schedule and is a key driver for the £14k YTD adverse variance, which is an improvement of £54k on the previous month. The adverse YTD position is expected to improve during the remaining months of 2014/15.

Organisational Development - YTD adverse position driven by underperformance against the Occupational Health income target and staffing CIPs.

Finance - YTD adverse position has marginally detriorated by £3k in December. Agency staff continue to be replaced with permanent staff and posts have been held vacant when staff have been transferred to other divisions.

Trust Secretariat – YTD adverse position driven by a number of posts being covered by interim staff. The in month £12k adverse variance continues to be an improvement, compared to the in the average YTD monthly adverse variance of 19k.

Acute Activity Analysis

Activity by PoD Type

		December			YTD		
PoD Group	**Annual Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Adult Critical Care	7,745	645	706	61	5,808	5,438	(370)
Block Contract/Adjustments	0	0	0	0	0	0	0
Day Cases	19,179	1,598	1,496	(102)	14,384	15,219	835
Direct Access	1,014,339	84,528	67,025	(17,503)	760,755	739,835	(20,920)
ED Attendances	104,069	8,672	7,604	(1,068)	78,052	69,516	(8,536)
Elective Inpatients	2,752	229	170	(59)	2,064	2,102	38
Excess Beddays	7,301	608	1,559	951	5,475	6,155	680
Maternity Pathway	8,943	745	692	(53)	6,707	5,923	(784)
NICU High Dependancy Beddays	1,942	162	281	119	1,457	1,481	24
NICU Intensive Care Beddays	880	73	46	(27)	660	427	(233)
NICU Special Care Beddays	5,171	431	308	(123)	3,878	2,964	(914)
NICU Transitional Care Beddays	6,350	529	176	(353)	4,763	3,629	(1,134)
Non-Elective Inpatients	29,445	2,454	2,132	(322)	22,084	20,877	(1,207)
Other Activity	69,572	5,798	1,852	(3,946)	52,179	39,654	(12,525)
Outpatient 1st Attends	61,195	5,100	3,549	(1,551)	45,896	43,941	(1,955)
Outpatient Diagnostic Imaging	23,529	1,961	1,786	(175)	17,647	16,606	(1,041)
Outpatient Follow Ups	152,207	12,684	7,761	(4,923)	114,155	101,865	(12,290)
Outpatient Procedures	21,099	1,758	1,235	(523)	15,824	10,859	(4,965)
Paediatrics High Dependency	256	21	0	(21)	192	315	123
TOTAL	**1,535,974**	**127,998**	**98,378**	**(29,620)**	**1,151,980**	**1,086,806**	**(65,174)**

Commentary

Critical care activity has increased by 231 (49%) compared to November 2014, as a result of improved data capture.

Day case activity is 102 below the Month 9 target of 1,598. NB This line also includes the additional RTT activity (national).

Direct access 'actual' activity has reduced in month by 10,412 (13%) as compared to November 2014. An investigation is on-going to understand this trend, to determine if this is 'seasonality' driven or other.

ED attendance, non elective inpatients and some of 'other' activity are all part of the emergency care pathway. This is reduced due to the impact of admission avoidance schemes and ambulatory care centre.

Elective inpatient activity is below plan, with this line in YTD terms including the additional national RTT work.

Maternity actuals have increased by 17 (3%), compared to November 2014. Actual activity has been lower than plan for the first few months of the year. NICU activity has also been lower the first quarter of the year and continues to increase, with December activity higher than November, by 294 in total for all NICU lines..

OPD activity continues to be below plan due to catch up of data recording, for example in anticoagulation. OPD is also impacted by CQUIN and QIPP schemes.

Outpatient procedures are expected to increase in future months, as the pathways are now in place and data recording is being monitored.

Activity By Commissioner

		December			YTD		
Commissioner	**Annual Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS England	17,697	1,475	1,216	(259)	13,273	11,554	(1,240)
NHS Islington CCG	842,508	70,209	54,907	(15,302)	631,881	599,637	(32,433)
NHS Haringey CCG	521,106	43,425	33,074	(10,351)	390,829	370,383	(20,637)
NHS Camden CCG	30,086	2,507	1,839	(668)	22,564	18,958	(3,625)
NHS City and Hackney CCG	19,066	1,589	754	(835)	14,299	10,782	(3,525)
NHS Enfield CCG	11,822	985	943	(42)	8,866	9,970	1,088
NHS Barnet CCG	69,945	5,829	3,963	(1,866)	52,459	46,634	(5,858)
Other CCG	23,745	1,979	1,682	(297)	17,808	18,888	1,055
TOTAL	**1,535,974**	**127,998**	**98,378**	**(29,620)**	**1,151,980**	**1,086,806**	**(65,174)**

Commentary

The NHS England variance due to critical care activity and time lag in payment of high cost drugs.

Acute Income Analysis

Income Analysis

PoD Group	Annual Plan £'000	December Plan £'000	December Actual £'000	December Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Adult Critical Care	£ 10,160	£ 847	£ 926	£ 80	£ 7,620	£ 7,083	-£ 537
Block Contract/Adjustments	£ 10,997	£ 916	£ 1,016	£ 100	£ 8,248	£ 9,127	£ 880
Day Cases	£ 11,899	£ 992	£ 963	-£ 28	£ 8,924	£ 9,644	£ 720
Direct Access	£ 10,965	£ 914	£ 845	-£ 68	£ 8,224	£ 8,868	£ 644
ED Attendances	£ 11,434	£ 953	£ 849	-£ 104	£ 8,576	£ 7,755	-£ 820
Elective Inpatients	£ 9,142	£ 762	£ 543	-£ 219	£ 6,856	£ 6,589	-£ 267
Excess Beddays	£ 2,140	£ 178	£ 194	£ 15	£ 1,605	£ 1,476	-£ 129
Maternity Pathway	£ 9,945	£ 829	£ 703	-£ 126	£ 7,459	£ 6,678	-£ 781
NICU High Dependancy Beddays	£ 1,717	£ 143	£ 248	£ 105	£ 1,288	£ 1,309	£ 21
NICU Intensive Care Beddays	£ 1,012	£ 84	£ 53	-£ 31	£ 759	£ 491	-£ 268
NICU Special Care Beddays	£ 1,974	£ 165	£ 118	-£ 47	£ 1,481	£ 1,132	-£ 349
NICU Transitional Care Beddays	£ 2,425	£ 202	£ 67	-£ 135	£ 1,818	£ 1,386	-£ 433
Non-Elective Inpatients	£ 42,876	£ 3,573	£ 3,563	-£ 10	£ 32,157	£ 29,813	-£ 2,344
Other Activity	£ 2,010	£ 167	£ 108	-£ 59	£ 1,507	£ 1,081	-£ 426
Outpatient 1st Attends	£ 8,916	£ 743	£ 655	-£ 88	£ 6,687	£ 6,600	-£ 87
Outpatient Diagnostic Imaging	£ 2,655	£ 221	£ 203	-£ 19	£ 1,991	£ 1,840	-£ 151
Outpatient Follow Ups	£ 11,631	£ 969	£ 808	-£ 162	£ 8,724	£ 8,188	-£ 535
Outpatient Procedures	£ 3,596	£ 300	£ 217	-£ 83	£ 2,697	£ 1,954	-£ 743
Paediatrics High Dependency	£ 263	£ 22	£ -	-£ 22	£ 197	£ 323	£ 126
TOTAL	**£ 155,757**	**£ 12,980**	**£ 12,078**	**-£ 902**	**£ 116,818**	**£ 111,338**	**-£ 5,480**

Income by Commissioner - £000's

NHS England	£ 13,942	£ 1,162	£ 953	-£ 209	£ 10,457	£ 8,880	-£ 1,577
NHS Islington CCG	£ 64,371	£ 5,364	£ 5,015	-£ 349	£ 48,278	£ 45,696	-£ 2,583
NHS Haringey CCG	£ 49,898	£ 4,158	£ 3,944	-£ 214	£ 37,424	£ 36,641	-£ 783
NHS Camden CCG	£ 5,280	£ 440	£ 389	-£ 51	£ 3,960	£ 3,079	-£ 881
NHS City and Hackney CCG	£ 4,776	£ 398	£ 259	-£ 140	£ 3,582	£ 3,213	-£ 369
NHS Enfield CCG	£ 2,892	£ 241	£ 333	£ 92	£ 2,169	£ 2,454	£ 285
NHS Barnet CCG	£ 9,056	£ 755	£ 683	-£ 72	£ 6,792	£ 6,642	-£ 151
Other CCG	£ 5,541	£ 462	£ 504	£ 42	£ 4,156	£ 4,733	£ 578
TOTAL	**£ 155,757**	**£ 12,980**	**£ 12,078**	**-£ 902**	**£ 116,818**	**£ 111,338**	**-£ 5,480**

Commentary

In month 9 the Trust financial position continues to show the acute income position to be reflected as though the Trust were under a block contract.

The tables presented on this page show the position for the first 9 months of the year as if the Trust were on a pure PbR acute contract and therefore this does not reflect the actual Trust income position. The position shows an *under performance* of £0.9m in month and an *under performance* of £5.5m YTD.

Actions taken to resolve data capture and coding issues are showing results. There will be continued focus on this. Income on our acute medical pathway continues to be below plan and there is work with commissioners on developing our approach to funding ambulatory care for 2015/16.

PoD Group	Annual Plan £'000	November Plan £'000	November Actual £'000	November Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	M9-M8 £	M9-M8 %
Adult Critical Care	£ 10,144	£ 845	£ 623	-£ 222	£ 6,763	£ 6,024	-£ 739	303,040	49%
Block Contract/Adjustments	£ 11,725	£ 977	£ 1,026	£ 48	£ 7,817	£ 8,208	£ 391	-9,520	-1%
Day Cases	£ 11,883	£ 990	£ 1,090	£ 100	£ 7,922	£ 8,645	£ 723	-126,526	-12%
Direct Access	£ 10,966	£ 914	£ 929	£ 15	£ 7,311	£ 7,985	£ 674	-83,844	-9%
ED Attendances	£ 11,412	£ 951	£ 861	-£ 90	£ 7,608	£ 6,906	-£ 702	-12,299	-1%
Elective Inpatients	£ 9,136	£ 761	£ 785	£ 23	£ 6,090	£ 5,999	-£ 91	-241,483	-31%
Excess Bed days	£ 2,136	£ 178	£ 147	-£ 31	£ 1,424	£ 1,317	-£ 107	46,113	31%
Maternity Pathway	£ 9,937	£ 828	£ 778	-£ 50	£ 6,624	£ 5,992	-£ 633	-74,831	-10%
NICU High Dependency Bed days	£ 1,717	£ 143	£ 179	£ 36	£ 1,145	£ 1,062	-£ 83	68,951	38%
NICU Intensive Care Bed days	£ 1,012	£ 84	£ 18	-£ 66	£ 675	£ 438	-£ 237	34,479	188%
NICU Special Care Bed days	£ 1,974	£ 165	£ 101	-£ 64	£ 1,316	£ 1,013	-£ 303	16,799	17%
NICU Transitional Care Bed days	£ 2,424	£ 202	£ 13	-£ 189	£ 1,616	£ 1,172	-£ 444	54,215	418%
Non-Elective Inpatients	£ 42,815	£ 3,568	£ 3,308	-£ 260	£ 28,543	£ 26,224	-£ 2,319	254,958	8%
Other Activity	£ 2,001	£ 167	£ 96	-£ 71	£ 1,334	£ 960	-£ 374	12,277	13%
Outpatient 1st Attends	£ 8,902	£ 742	£ 689	-£ 53	£ 5,934	£ 5,919	-£ 16	-34,106	-5%
Outpatient Diagnostic Imaging	£ 2,653	£ 221	£ 192	-£ 29	£ 1,769	£ 1,646	-£ 123	10,581	6%
Outpatient Follow Ups	£ 11,615	£ 968	£ 816	-£ 151	£ 7,743	£ 7,303	-£ 440	-8,744	-1%
Outpatient Procedures	£ 3,590	£ 299	£ 248	-£ 51	£ 2,393	£ 1,735	-£ 659	-31,144	-13%
Paediatrics High Dependency	£ 262	£ 22	£ -	-£ 22	£ 175	£ 255	£ 81	0	#DIV/0!
TOTAL	**£ 156,304**	**£ 13,025**	**£ 11,899**	**-£ 1,126**	**£ 104,203**	**£ 98,801**	**-£ 5,401**	178,916	2%

Income by Commissioner - £000's

NHS England	£ 14,654	£ 1,221	£ 892	-£ 329	£ 9,769	£ 7,759	-£ 2,010	60,663	7%
NHS Islington CCG	£ 64,425	£ 5,369	£ 4,973	-£ 396	£ 42,950	£ 40,609	-£ 2,342	41,672	1%
NHS Haringey CCG	£ 49,899	£ 4,158	£ 4,016	-£ 142	£ 33,266	£ 32,563	-£ 703	-71,448	-2%
NHS Camden CCG	£ 4,956	£ 413	£ 400	-£ 13	£ 3,304	£ 2,693	-£ 611	-11,293	-3%
NHS City and Hackney CCG	£ 4,768	£ 397	£ 268	-£ 130	£ 3,179	£ 2,940	-£ 239	-9,255	-3%
NHS Enfield CCG	£ 2,921	£ 243	£ 258	£ 15	£ 1,947	£ 2,100	£ 152	74,537	29%
NHS Barnet CCG	£ 9,097	£ 758	£ 635	-£ 123	£ 6,065	£ 5,939	-£ 126	47,155	7%
Other CCG	£ 5,584	£ 465	£ 457	-£ 8	£ 3,723	£ 4,200	£ 477	46,885	10%
TOTAL	**£ 156,304**	**£ 13,025**	**£ 11,899**	**-£ 1,126**	**£ 104,203**	**£ 98,801**	**-£ 5,401**	178,916	2%

Acute Activity and Income Variances by Division

In Month Activity Variance - December

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	0	0	61	0	**61**
Block Contract/Adjustments	0	0	0	0	**0**
Day Cases	0	-84	51	-69	**-102**
Direct Access	0	157	-17,660	0	**-17,503**
ED Attendances	0	-1,068	0	0	**-1,068**
Elective Inpatients	0	-10	-45	-4	**-59**
Excess Beddays	0	830	122	-0	**951**
Maternity Pathway	0	0	0	-53	**-53**
NICU High Dependancy Beddays	0	0	0	119	**119**
NICU Intensive Care Beddays	0	0	0	-27	**-27**
NICU Special Care Beddays	0	0	0	-123	**-123**
NICU Transitional Care Beddays	0	0	0	-353	**-353**
Non-Elective Inpatients	0	-16	-30	-276	**-322**
Other Activity	0	-988	16	-2,973	**-3,946**
Outpatient 1st Attends	0	-212	-472	-866	**-1,551**
Outpatient Diagnostic Imaging	0	-103	-59	-13	**-175**
Outpatient Follow Ups	0	-1,979	-167	-2,777	**-4,923**
Outpatient Procedures	0	-136	-113	-274	**-523**
Paediatrics High Dependency	0	0	0	-21	**-21**
TOTAL	**0**	**-3,611**	**-18,297**	**-7,712**	**-29,620**

In Month Price Variance £000's - December

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	£ -	£ -	£ 80	£ -	**£ 80**
Block Contract/Adjustments	£ 100	£ -	£ -	£ -	**£ 100**
Day Cases	£ -	-£ 48	£ 62	-£ 43	**-£ 28**
Direct Access	£ -	£ 137	-£ 205	£ -	**-£ 68**
ED Attendances	£ -	-£ 104	£ -	£ -	**-£ 104**
Elective Inpatients	£ -	-£ 10	-£ 204	-£ 4	**-£ 219**
Excess Beddays	£ -	£ 17	£ 18	-£ 19	**£ 15**
Maternity Pathway	£ -	£ -	£ -	-£ 126	**-£ 126**
NICU High Dependancy Beddays	£ -	£ -	£ -	£ 105	**£ 105**
NICU Intensive Care Beddays	£ -	£ -	£ -	-£ 31	**-£ 31**
NICU Special Care Beddays	£ -	£ -	£ -	-£ 47	**-£ 47**
NICU Transitional Care Beddays	£ -	£ -	£ -	-£ 135	**-£ 135**
Non-Elective Inpatients	£ -	£ 116	-£ 57	-£ 70	**-£ 10**
Other Activity	£ -	-£ 47	£ 0	-£ 13	**-£ 59**
Outpatient 1st Attends	£ -	-£ 34	-£ 68	£ 14	**-£ 88**
Outpatient Diagnostic Imaging	£ -	-£ 13	-£ 5	-£ 0	**-£ 19**
Outpatient Follow Ups	£ -	-£ 108	-£ 15	-£ 38	**-£ 162**
Outpatient Procedures	£ -	-£ 17	-£ 12	-£ 54	**-£ 83**
Paediatrics High Dependency	£ -	£ -	£ -	-£ 22	**-£ 22**
TOTAL	**£ 100**	**-£ 111**	**-£ 407**	**-£ 484**	**-£ 902**

YTD Activity Variance

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	0	0	-370	0	**-370**
Block Contract/Adjustments	0	0	0	0	**0**
Day Cases	0	448	657	-271	**835**
Direct Access	0	4,682	-25,602	0	**-20,920**
ED Attendances	0	-8,536	0	0	**-8,536**
Elective Inpatients	0	58	-74	55	**38**
Excess Beddays	0	678	-75	77	**680**
Maternity Pathway	0	0	0	-784	**-784**
NICU High Dependancy Beddays	0	0	0	24	**24**
NICU Intensive Care Beddays	0	0	0	-233	**-233**
NICU Special Care Beddays	0	0	0	-914	**-914**
NICU Transitional Care Beddays	0	0	0	-1,134	**-1,134**
Non-Elective Inpatients	0	-84	-308	-815	**-1,207**
Other Activity	0	-4,354	867	-9,038	**-12,525**
Outpatient 1st Attends	0	-295	-2,271	612	**-1,955**
Outpatient Diagnostic Imaging	0	-294	-542	-205	**-1,041**
Outpatient Follow Ups	0	-8,340	2,839	-6,789	**-12,290**
Outpatient Procedures	0	-1,190	-2,006	-1,769	**-4,965**
Paediatrics High Dependency	0	0	0	123	**123**
TOTAL	**0**	**-17,225**	**-26,888**	**-21,061**	**-65,174**

YTD Price Variance £000's

Board Report PoD Group	Trust Wide	Integrated Care & Acute Medicine	Surgery & Diagnostics	Women, Children & Families	TOTAL
Adult Critical Care	£ -	£ -	-£ 537	£ -	**-£ 537**
Block Contract/Adjustments	£ 1,480	-£ 600	£ -	£ -	**£ 880**
Day Cases	£ -	£ 240	£ 654	-£ 174	**£ 720**
Direct Access	£ -	£ 1,038	-£ 394	£ -	**£ 644**
ED Attendances	£ -	-£ 820	£ -	£ -	**-£ 820**
Elective Inpatients	£ -	£ 65	-£ 455	£ 123	**-£ 267**
Excess Beddays	£ -	-£ 19	-£ 46	-£ 64	**-£ 129**
Maternity Pathway	£ -	£ -	£ -	-£ 781	**-£ 781**
NICU High Dependancy Beddays	£ -	£ -	£ -	£ 21	**£ 21**
NICU Intensive Care Beddays	£ -	£ -	£ -	-£ 268	**-£ 268**
NICU Special Care Beddays	£ -	£ -	£ -	-£ 349	**-£ 349**
NICU Transitional Care Beddays	£ -	£ -	£ -	-£ 433	**-£ 433**
Non-Elective Inpatients	£ -	-£ 600	-£ 927	-£ 817	**-£ 2,344**
Other Activity	£ -	-£ 323	£ 1	-£ 105	**-£ 426**
Outpatient 1st Attends	£ -	£ 19	-£ 340	£ 234	**-£ 87**
Outpatient Diagnostic Imaging	£ -	-£ 73	-£ 66	-£ 12	**-£ 151**
Outpatient Follow Ups	£ -	-£ 592	£ 273	-£ 216	**-£ 535**
Outpatient Procedures	£ -	-£ 148	-£ 246	-£ 349	**-£ 743**
Paediatrics High Dependency	£ -	£ -	£ -	£ 126	**£ 126**
TOTAL	**£ 1,480**	**-£ 1,812**	**-£ 2,083**	**-£ 3,065**	**-£ 5,480**

Statement of Financial Position

	As at 1st April 2014	As at 31st December	Forecast 31st March 2015	Plan 31st March 2015
	£000	£000	£000	£000
Non Current Assets				
Property, plant and equipment	179,975	182,722	187,317	180,105
Intangible assets	5,428	4,464	4,023	4,295
Trade and other receivables	702	955	533	610
Total Non Current Assets	**186,105**	**188,141**	**191,873**	**185,010**
Current Assets				
Inventories	1,295	1,565	1,456	1,290
Trade and other receivables	17,527	19,309	14,994	6,930
Cash and cash equivalents	5,123	2,223	5,596	3,976
Total Current Assets	**23,945**	**23,097**	**22,046**	**12,196**
Total Assets	**210,050**	**211,238**	**213,919**	**197,206**
Current Liabilities (amounts due in less than one year)				
Trade and other payables	36,010	36,749	45,187	27,154
Borrowings	1,377	1,360	2,344	2,542
Provisions	1,238	375	417	198
Total Current Liabilities	**38,625**	**38,484**	**47,948**	**29,894**
Net Current Assets (Liabilities)	**(14,680)**	**(15,387)**	**(25,902)**	**(17,698)**
Total Assets less Current Liabilities	**200,785**	**203,528**	**217,775**	**202,708**
Non Current Liabilities (amounts due greater than one year)				
Borrowings	36,758	34,716	34,419	34,028
Provisions	2,015	1,863	1,915	2,190
Total Non Current Liabilities	**38,773**	**36,579**	**36,334**	**36,218**
Total Assets Employed	**132,652**	**136,175**	**129,637**	**131,094**
Taxpayers' Equity				
Public dividend capital	56,461	62,111	56,721	56,671
Retained earnings	15,277	7,989	6,788	18,918
Revaluation reserve	60,914	66,075	66,128	55,505
Total Taxpayers' Equity	**132,652**	**136,175**	**129,637**	**131,094**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**

Commentary

A revaluation of land and buildings took place earlier in the year which increased both property, plant and equipment (PPE) and the revaluation reserve by £5.3m. This was partially offset by impairments of £1.2m which reduced both PPE and retained earnings, but are excluded from the breakeven duty. A further revaluation is expected at the year end, which cannot yet be quantified.

The revaluation also increased asset lives, thereby reducing the depreciation charged to both PPE and retained earnings. PPE additions are below plan for the year to date, but forecast to meet the capital resource limit by the year end.

Cash increased during the month by £1m mainly due to the receipt of temporary public dividend capital of £5.6m, with a corresponding increase in taxpayer's equity. This receipt was partially offset by the clearance of a backlog of payments. Cash is subject to various risks, mainly involving receivables, payables and CIP delivery.

There has been a reduction over the year in retained earnings due to the impairment and the income and expenditure deficit. Recovery of the latter is dependent upon CIP delivery.

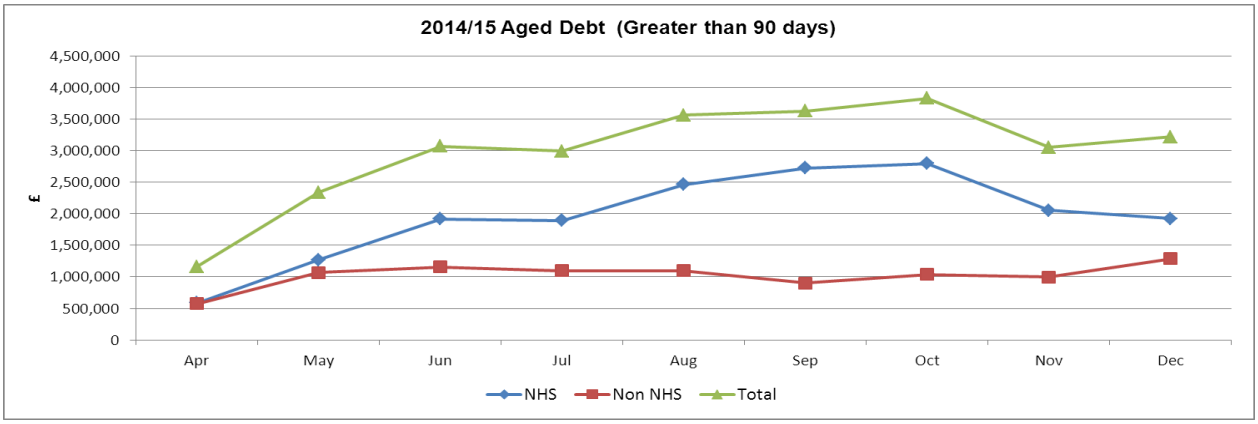
Month 9 (December) Aged Debtors Analysis
Period End Date: 23/12/2014

£	Sum of Outstanding debtors	Days Range						
	NHS	30 Days & Under	30 to 60 Days	60 to 90 Days	Over 90 Days	Over 365 Days	Greater than 90 Days	Grand Total
1	NHS ISLINGTON CCG	2,060,339	11,416	25,511	294,450	52,963	347,413	**2,444,678**
2	NHS HARINGEY CCG	971,649	18,271	12,435	37,262	7,837	45,099	**1,047,454**
3	THE ROYAL FREE LONDON NHS FT	292,663	181,972	15,710	111,514	0	111,514	**601,859**
4	NHS CITY & HACKNEY CCG	0	(74,754)	(18,665)	482,792	0	482,792	**389,373**
5	THE UCL HOSPITALS NHS FOUNDATION TRUST	65,153	19,239	29,090	122,778	24,278	147,056	**260,538**
6	NHS ENFIELD CCG	25,283	43,102	32,000	150,123	0	150,123	**250,508**
7	NHS BARNET CCG	7,355	0	0	203,072	0	203,072	**210,427**
8	CNWL NHS FOUNDATION TRUST	56,504	18,322	0	100,185	0	100,185	**175,011**
9	NHS BRENT CCG	2,887	125,707	(3,831)	10,059	0	10,059	**134,822**
10	ROYAL FREE LONDON NHS FT	77,926	24,744	3,523	22,385	0	22,385	**128,578**
Top 1	**Top 10 NHS Total:**	3,559,760	368,019	95,772	1,534,621	85,078	1,619,698	**5,643,249**
	All Other NHS Total:	940,352	7,873	(223,282)	270,898	35,267	306,166	**1,031,108**
	NHS Total	**4,500,112**	**375,891**	**(127,510)**	**1,805,519**	**120,345**	**1,925,864**	**6,674,357**
	NHS Total Previous Month	**1,860,443**	**(45,367)**	**364,631**	**1,907,757**	**147,448**	**2,055,204**	**4,234,911**
	NHS Total Movement (Month 8 to Month 9)	**2,639,668**	**421,258**	**(492,141)**	**(102,238)**	**(27,102)**	**(129,340)**	**2,439,446**

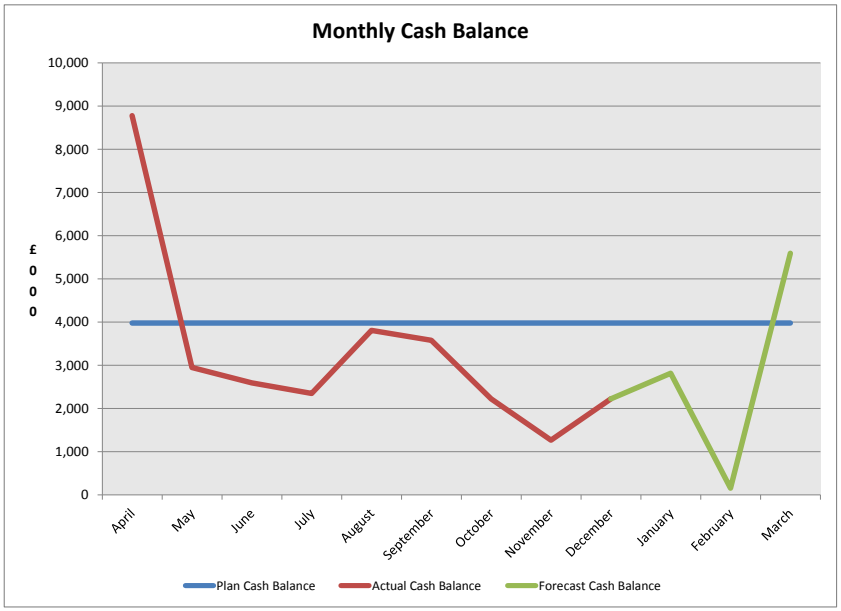
£	Non NHS	30 Days & Under	30 to 60 Days	60 to 90 Days	Over 90 Days	Over 365 Days	Greater than 90 Days	Grand Total
1	LONDON BOROUGH OF HARINGEY	607,873	256,795	501,258	221,519	(4,325)	217,194	**1,583,121**
2	OVERSEAS VISITOR (SH)	50,368	47,220	42,498	116,528	0	116,528	**256,614**
3	LONDON BOROUGH OF ISLINGTON	203,596	0	3,018	4,915	26	4,941	**211,555**
4	THE HIGH ROAD SURGERY	0	0	0	159,613	0	159,613	**159,613**
5	ACTION FOR STAMMERING CHILDREN	105,606	0	0	0	0	0	**105,606**
6	HIGHBURY GRANGE HC	11,084	0	0	75,306	0	75,306	**86,390**
7	LONDON BOROUGH OF CAMDEN	23,435	633	55,803	2,227	0	2,227	**82,097**
8	LONDON BOROUGH OF HACKNEY	9,106	0	38,021	428	31,760	32,187	**79,315**
9	RIVER PLACE GROUP PRACTICE	22,961	0	0	49,320	0	49,320	**72,282**
10	THE RISE PRACTICE	10,916	0	0	49,356	0	49,356	**60,273**
	Top 10 Non NHS Total:	1,044,948	304,648	640,598	679,211	27,461	706,672	**2,696,866**
	All other Non NHS Total:	332,790	82,929	50,680	369,041	214,380	583,421	**1,049,819**
	Non NHS Total:	**1,377,737**	**387,577**	**691,278**	**1,048,252**	**241,841**	**1,290,093**	**3,746,685**
	Non NHS Total Previous Month	**934,361**	**740,031**	**405,066**	**783,896**	**211,359**	**995,255**	**3,074,713**
	Non NHS Total Movement (Month 8 to Month 9)	**443,376**	**(352,454)**	**286,212**	**264,356**	**30,481**	**294,838**	**671,971**
	Grand Total	**5,877,849**	**763,468**	**563,768**	**2,853,772**	**362,186**	**3,215,957**	**10,421,042**
	Grand Total Previous Month	**2,794,804**	**694,664**	**769,697**	**2,691,653**	**358,807**	**3,050,459**	**7,309,624**
	Grand Total Movement	**3,083,045**	**68,804**	**(205,929)**	**162,119**	**3,379**	**165,498**	**3,111,418**

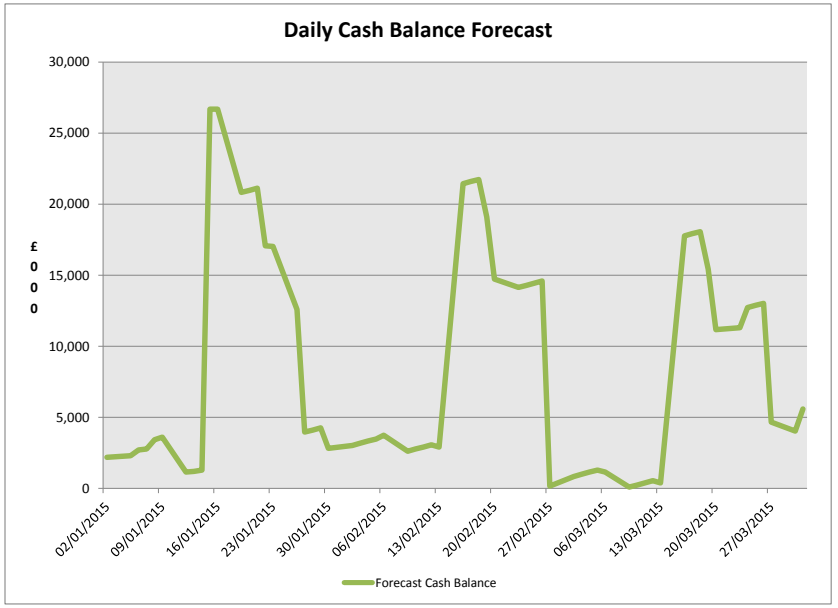
Commentary

Aged Debt 'Greater than 90 days' has increased by £0.2m to £3.2m in Month 9. Material aged debt over 90 days include:
Rent and Rates charges to L.B. Haringey, CNWL and various GP Surgeries(£714k). 2013/14 payments relating to changes in the way the Trust is paid for the maternity pathway total £540k and while our lead commissioners Islington and Haringey have paid their bills, other CCGs are yet to pay.
Outstanding debt of £400k relates to the NHSE Community Dental Contract which was transferred out of CCG contracts in 13/14. A swift resolution is required in order to also secure the correct contract value for 14/15.Other amounts include £305k of NCA (Non Contractual Activity), outstanding SLA performance debts(£392k) Debts with UCLH (£147K), Royal Free (£221k) and a number of other smaller debts including overseas patients.



Cash Forecast for the Trust





Commentary

The principal cash inflows are clinical SLA receipts, typically around £19m in the middle of the month. Cash decreases sharply in the latter part of the month due to income tax, NI and pension contributions totalling £7m and the monthly payroll of around £9.5m on the 27th of the month. Any cash available after allowing for these obligations is used to service the weekly payment of creditors. The underlying payment run is normally around £1m but there are numerous variables which can have a significant impact on the value. Major payments distorting these values are accounted for specifically in the forecast.

Income is invoiced as promptly as possible, and outstanding debts chased regularly. Prioritisation is on the basis of materiality, notably the clinical SLAs. Creditors are prioritised by due date, with payments being restricted if there is insufficient cash to pay eveyrything due.

The forecast shows what is necessary in order to meet the year end target and thereby meet the EFL. Major assumptions in this forecast comprise reduced payments from the CIP and below average payment runs. Failure to meet any of these conditions may compromise the statutory duty to operate within the EFL.

In December, the Trust received a £5.6m cash loan, in the form of temporary PDC. This is forecast to be repaid in January.

The most significant outstanding payments are to Community Health Partnerships. These payments are forecast in February, with a consequent dip in the cash balance.

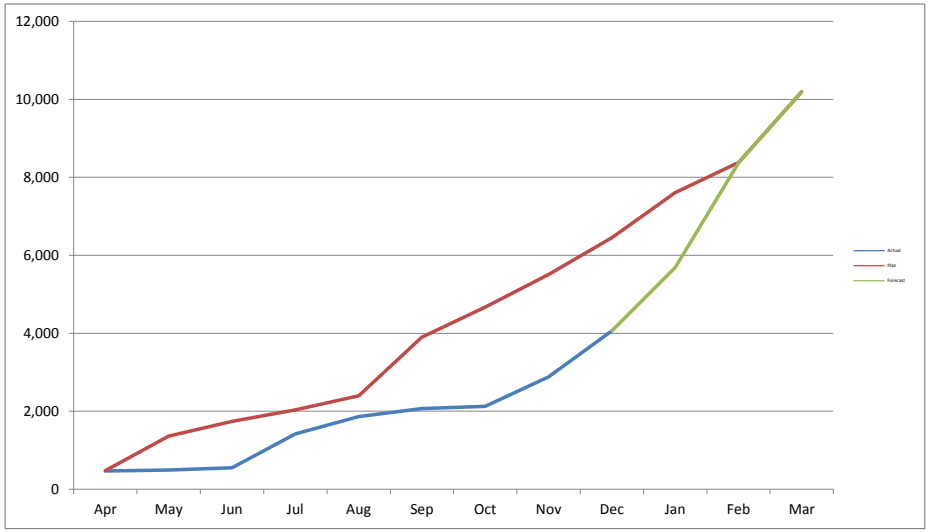
Action needed to meet the cash target and associated EFL comprises ensuring that all income is invoiced as soon as possible, and reducing expenditure in line with the CIP.

Capital Spend Performance and Forecast

	Annual	Current Month			YTD			Forecast Outturn		
	Plan	Plan	Act	Var	Plan	Act	Var	Plan	Forecast	Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates	5,618	695	636	59	3,177	2,102	1,075	5,618	5,618	-
IT	810	145	409	-264	345	1,250	-905	810	810	-
Equipment	1,514	100	0	100	1,329	310	1,019	1,514	1,514	-
Business Cases	336	0	0	0	0	0	0	336	336	-
Leases	1,922	0	143	-143	1,598	403	1,195	1,922	1,922	-
Total	**10,200**	**940**	**1,188**	**-248**	**6,449**	**4,065**	**2,384**	**10,200**	**10,200**	**-**

CRL	10,200
Variance	0

Spend against Capital Programme



Commentary

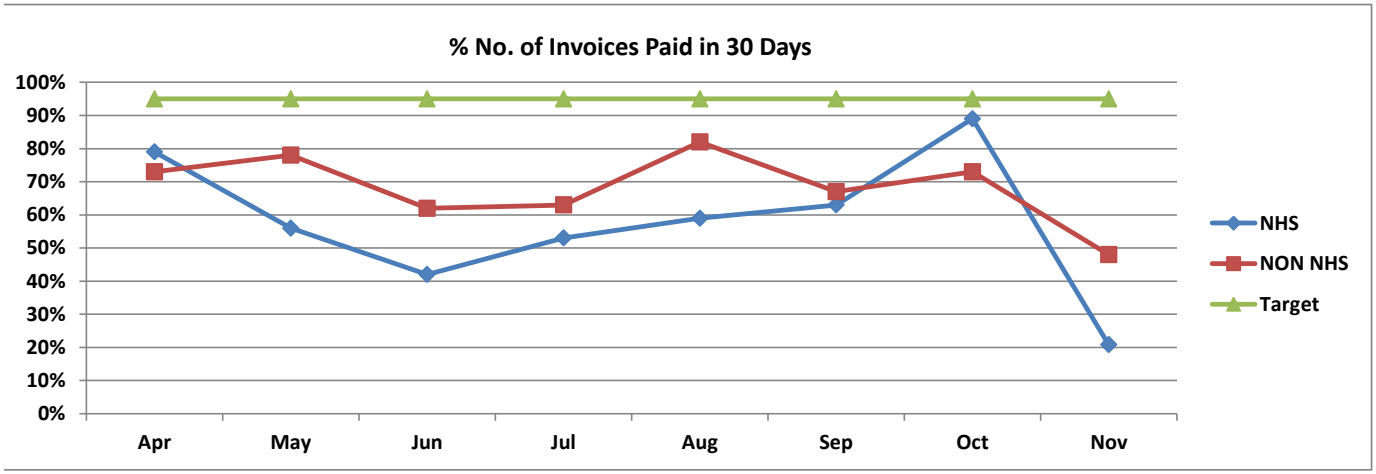
- The Capital Accountant meets regularly with project managers and monthly at the Capital Monitoring Group (CMG) to report progress against plan.

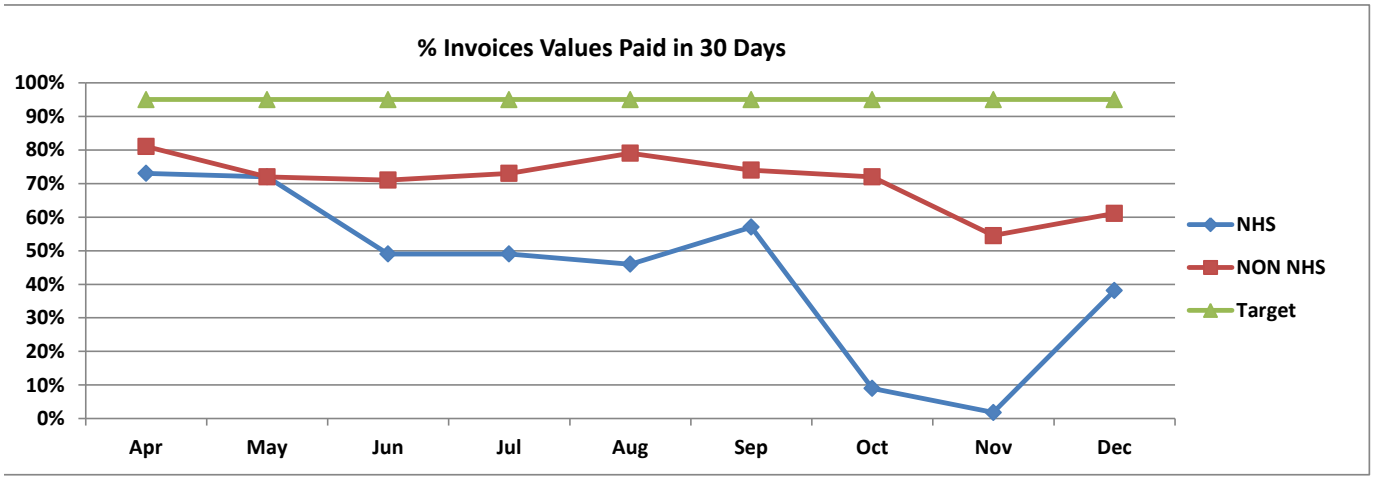
- The year to date actuals are showing an underspend against plan due to delays & changes to the capital programme to meet the Trust's priorities. The CMG is still forecasting to spend the £10.2m as planned.

- The in month variance is due to the IT month 1-9 capital project cost and the delayed leased ultrasound

- The Trust is expecting to spend up to it's Capital Resource Limit (CRL).

Best Practice Payment Code





Commentary

The Trust is currently falling short against its requirement of paying 95% of invoices within 30 days.

Part of the reason for the poor performance is due to active management of working capital, which is planned to continue during the remainder of the 2014\15 financial year.

Performance against the BPPC has improved in December, with backlog payments being made for invoices which are over the 30 day target.

In December, the Trust received applied for and received a £5.6m cash loan (temporary PDC), which has been used to clear backlog payments.

Continuity of Services Risk Rating (COSR)

Metric	Definition	Parameters 1	2	3	4	Actual YTD	Forecast Outturn	Plan Outturn
Working Capital Balance (£'000) (+/-)						(16,952)	(20,137)	(18,988)
Annual Operating Expenses (£'000) (+)						211,862	280,024	271,133
Liquidity Ratio (Days)						(22)	(19)	(25)
Liquidity Rating	Working Capital Balance x 360 / Annual Operating Expenses	**<-14**	**-14**	**-7**	**0**	**1**	**1**	**1**
Revenue Available for Debt Service (£'000) (+)						5,402	9,440	16,786
Annual Debt Service (£'000) (+)						7,617	10,422	10,358
Capital Servicing Capacity (Times)						0.7	0.9	1.6
Capital Servicing Capacity Rating	Revenue Available for Debt Service / Annual Debt Service	**<1.25**	**1.25**	**1.75**	**2.50**	**1**	**1**	**2**
Weighted:								
Liquidity Rating - 50%						**0.5**	**0.5**	**0.5**
Capital Servicing Capacity Rating - 50%						**0.5**	**0.5**	**1.0**
Overall Continuity of Services Risk Rating						**1**	**1**	**2**

The Continuity of Services Rating (COSR) represents the financial risk rating used by Monitor, where a score of "one" highlights an organisation as "high risk". The table shows that WH is in this high risk category

Whilst this demonstrates the need for improvement this should be assessed in light of two key factors. Firstly, our current financial performance is materially below plan and supports an assessment of high risk. Secondly, a strong COSR performance relies upon a strong working capital position and our balance sheet has been recognised as, historically, weak. We therefore find ourselves at a disadvantage under this measure, for example, compared to Foundation Trusts that have high cash balances from previous land and property sales even though they may also report an in year deficit.

Executive Offices
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Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4th February 2015

Title:	**NHS Trust Development Authority (TDA) – Self-Certification**		
Agenda item:	**15/026**	**Paper**	**9**
Action requested:	***For approval***		
Executive Summary:	The NHS Trust Development Authority (TDA) has published their Accountability Framework for NHS Trust Boards which details a clear set of rules and principles under which NHS Trusts should all operate. Within the framework, the NHS TDA describes their monthly self-certification process, which is based on compliance to a number of the conditions within Monitor's Provider Licence and a set of Board Statements.		
Summary of recommendations:	Under the NHS TDA assurance process, a self-certification submission is required each month. Therefore, the Board is asked to retrospectively sign-off the return for December 2014, which was submitted to the TDA on 21 January 2015 and agree the status for the January 2015 return. The Trust Board is also asked to discuss and agree any reporting issues in anticipation of the January 2015 and future returns.		
Fit with WH strategy:	n/a – regulatory requirement.		
Reference to related / other documents:	Self-certification is monthly.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	21 January 2015		

Author name and title:		**Ursula Grueger Deputy Director of Finance**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC	**-**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Ursula Grueger

Enter Your Email Address: Ursula.Grueger@nhs.net

Full Telephone Number: 020 72883844 Tel Extension: 3844

SELF-CERTIFICATION DETAILS:

Select Your Trust: The Whittington Hospital NHS Trust

Submission Date: 21/01/2015 Reporting Year: 2014/15

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

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 model (supported by 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.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE:	n/a
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance: 21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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 requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance: 21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework 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.

6. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE: Comment where non-compliant or at risk of non-compliance	n/a

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	21/01/2015
RESPONSE: Comment where non-compliant or at risk of non-compliance	Finance - forecast outturn position of £7.4m reported to TDA on 15/12/14. Work continues to improve the position in terms of both income and expenditure.

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Trust business planning process in place. Divisional business plans reviewed by Trust Board and Trust Management Group in December.

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Board Assurance Framework being updated with further work to refresh strategy of the organisation

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

18 weeks Performance for November - admitted adjusted 90.70%, non-admitted 95.04%, incomplete 92.24%

Performance was in line with agreed trajectory.

A and E 4 hour target for November:- 92.38%

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Risk

Timescale for compliance:

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

The Trust is working through its workplan to deliver Level 2 Compliance. Key challenge is delivering the 95% target for IG training.

BOARD STATEMENTS:

For GOVERNANCE, that

12. 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.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

31/12/2014

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Permanent CEO and CFO recruited.
All remaining Board positions are filled.

BOARD STATEMENTS:

For GOVERNANCE, that

13. 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.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

21/01/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

BOARD STATEMENTS:

For GOVERNANCE, that

14. 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.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance

n/a

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Ursula Grueger

Enter Your Email Address: Ursula.Grueger@nhs.net

Full Telephone Number: 020 72883844 Tel Extension: 3844

SELF-CERTIFICATION DETAILS:

Select Your Trust: The Whittington Hospital NHS Trust

Submission Date: 21/01/2015 Reporting Year: 2014/15

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	n/a
	Timescale for compliance:	21/01/2015
2. Condition G5 Having regard to monitor Guidance.	Yes	n/a
	Timescale for compliance:	21/01/2015
3. Condition G7 Registration with the Care Quality Commission.	Yes	n/a
	Timescale for compliance:	21/01/2015
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	n/a
	Timescale for compliance:	21/01/2015

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	n/a
Timescale for compliance:	21/01/2015	
6. Condition P2 Provision of information.	Yes	n/a
Timescale for compliance:	21/01/2015	
7. Condition P3 Assurance report on submissions to Monitor.	Yes	n/a
Timescale for compliance:	21/01/2015	
8. Condition P4 Compliance with the National Tariff.	Yes	n/a
Timescale for compliance:	21/01/2015	

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	n/a
Timescale for compliance:	21/01/2015	

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	n/a
Timescale for compliance:	21/01/2015	
11. Condition C2 Competition oversight.	Yes	n/a
Timescale for compliance:	21/01/2015	
12. Condition IC1 Provision of integrated care.	Yes	n/a
Timescale for compliance:	21/01/2015	

Submit

Whittington Health NHS

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4th February 2015

Title:	Audit and Risk Committee: Update to the Board		
Agenda item:	**15/027**	**Paper**	**10**
Action requested:	For information		
Executive Summary:	To update the Board on the work and recommendations conducted at the January 2015 Audit and Risk Committee.		
Summary of recommendations:	None		
Fit with WH strategy:	The Audit and Risk Committee is a sub-committee of the Board, established to provide the Board of Directors with a means of independent and objective review of financial and corporate governance and risk management. In addition the committee shall provide assurance of the independence of both external and internal audit.		
Reference to related / other documents:	Previous reports to the Trust Board.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Strategic Goal 3: Delivering efficient and effective services (ref 3.1 to 3.12).		
Date paper completed:	20th November 2014		

Author name and title:		**Ursula Grueger, Deputy Director of Finance**		**Director name and title:**		**Rob Whiteman 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**

Audit and Risk Committee Update to the Board

Meeting Date – 15th January 2015

1. The Audit and Risk Committee met on the 15th January 2015, chaired by Rob Whiteman, non-executive director (NED).

2. The chair asked for a joint update paper on the Data Quality Improvement Plan from Finance and Human Resources (HR).

3. The Workforce Plan will come to the May committee with assurance of work being undertaken.

4. External Audit (KPMG) presented a progress and technical update report. The committee agreed that the Use of Resources item presented should be discussed at a private meeting of the Trust Board. In addition, the Deputy Director of Finance would bring a paper on securing economy, efficiency and effectiveness.

5. Following discussion on Service-Line Reporting (SLR), the Chair requested a report on how the tools will be used.

6. There was a discussion on the future Information Governance Internal Audit Report and the possibility of the Internal Auditor attending the Trust Management Group twice a year.

7. The committee ratified the Counter Fraud and Corruption Policy.

8. The committee decided to look at the policy for obtaining upfront payment from Overseas Visitors and discuss in the summer.

9. The committee reviewed the list of bad debts for write off and tender waivers and it was agreed that the Deputy Director of Finance would discuss the Value for Money (VfM) rating with procurement and the Trust Management Group.

10. The Mandatory Training Report was discussed in detail. The Deputy Director of HR will bring back temporary staffing figures within a further review paper to the next committee meeting in March.

11. The committee reviewed the Board Assurance Framework (BAF) and the Corporate Risk Register in detail and welcomed the new Director of Risk and Governance to the committee. The committee discussed the failure to deliver on income targets in relation to Emergency Care and the increase in attendance. The committee was happy for the Corporate Risk Register to progress to the Trust Board for discussion.

12. The committee reviewed the Deep Dive Risk Management Report from the Women, Children and Families division and found it very helpful.

13. The committee agreed to tender for a new Internal Audit contract next year as TIAA's contract expires.

--end--

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Magdala Avenue
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Whittington Health Trust Board

4th February 2015

Title:	Safe Staffing (Nursing and Midwifery) Report		
Agenda item:	**15/028**	**Paper**	**11**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in December 2014. Key issues to note include: • Most areas had greater than 95 per cent 'actual' versus 'planned' staffing levels • One area fell below 95 per cent of planned Registered General Nurse (RGN) hours required but were covered by senior nursing staff (matrons, professional development nurses, specialist nurses) working to support as necessary. • A number of areas reported 'actual hours' worked over and above those 'planned' which was attributed in the main to the provision of Registered Mental Nurses (RMNs), RGNs or Healthcare Assistants (HCAs) to support patients under a Mental Health Section, increased dependency and 1:1 'specialing' of some of our vulnerable patients. • The Emergency Department triggered 15 red shifts in December, which related to a shortage of paediatric nurses. Shifts were supported by moving staff from paediatric in-patient and ambulatory care services.		
Summary of recommendations:	Trust Board members are asked to note the December 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:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	January 2015		

Author name and title:		**Alison Kett – Deputy Director of Nursing and Patient Experience**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Safe Staffing Report
December 2014

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 December 2014 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 General Nurses (RGNs), 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.

As of June 2014, all hospitals with in-patient beds were required to publish their staff fill rates (actual versus planned) in hours, taking into consideration day and night shifts and Registered and Un-registered staff. This fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st December 2014 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's 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. During December, bed numbers increased on the rehabilitation ward and a surgical ward to support further admissions due to 'winter pressures'. 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 December 2014. Average fill rate was 104.8% for registered staff and 131.3% for care staff during the day and 103% for registered staff and 114.2% for care staff during the night.

Above average fill rates in excess of 100% for qualified nurses occurred on two wards. One related to an additional RGN being booked to care for a patient subject to a mental health 'section' and the other related to an additional RGN for a number of patients requiring high dependency care. HCA fill rates in excess of 100% relate to the requirements of our vulnerable patients who, following risk assessment are judged to require 1:1 care where

care demand on a particular shift exceeds capacity. On wards where one HCA is planned, provision of an additional HCA raises the percentage to 200% for that shift.

In the first week of August 2014, the number of HCA 'specials' used for patients on our wards was 162. By the last week of December only 37 HCA 'specials' were required, under a quarter of the original number. There has been no increase in the number of patients sustaining falls or reported adverse incidents as a result of this decrease and senior staff on wards feel more empowered to manage their own requirements.

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.

Details of wards that initially triggered 'red' in December can be seen in Appendix 3. In summary, in December a total of 32/1488 (2.15%) shifts triggered 'red' which is fractionally higher than previous months but continues to be very low. Of these, 22/837 (2.63%) occurred in the division of Integrated Care and Acute Medicine (ICAM), 5/279 (1.8%) in the Women, Children and Families (WCF) division and 5/372 (1.34%) shifts were reported to have triggered 'red' in the division of Surgery, Cancer and Diagnostics (SCD).

Out of the 22 shifts which triggered red in ICAM, 15 were in the paediatric emergency department due to paediatric nursing vacancies. ICAM covered rotas with support from paediatric inpatient and ambulatory care services. Additional paediatric nurses have been recruited and are in the recruitment process.

Of all shifts that initially triggered 'red', 8 were related to 'early' duty shifts, 12 to 'late' duty shifts and 14 to 'night' duty shifts.
The challenges of ensuring adequate staffing levels on wards during December can be attributed to the following:

- Nursing vacancy rates in the Paediatric Emergency Department, which are reducing as a result of local and overseas recruitment.
- A patient requiring 1:1 care by a Registered Mental Nurse (RMN).
- Continued demand for staff to provide 1:1 care for our vulnerable patients, particularly on three wards.
- A high dependency patient on one ward.

5.0 Conclusion

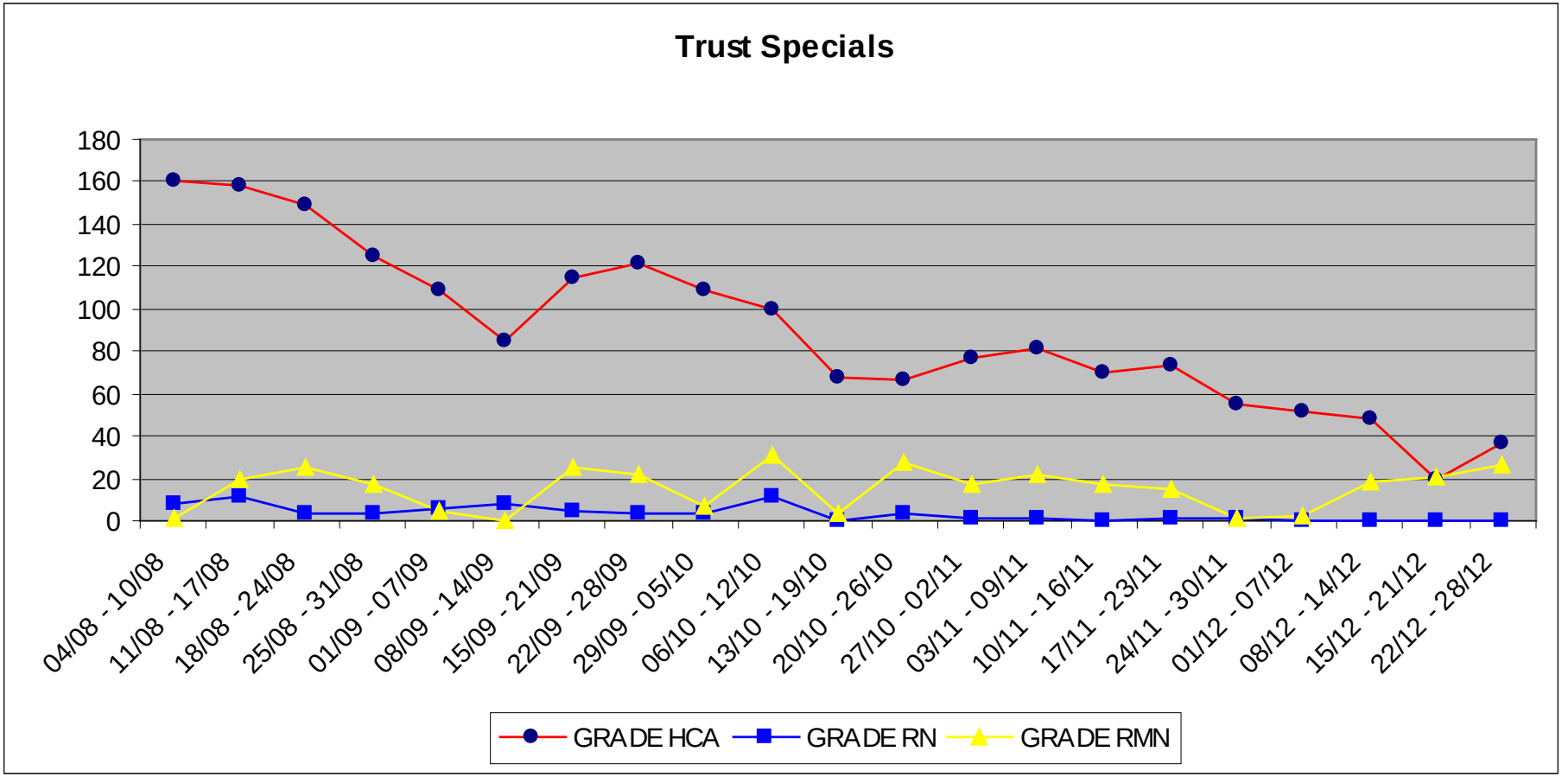
Trust Board members are asked to note the December UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Appendix 1

Fill rate data - summary
December 2014

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	104.8%	131.3%	103%	114.2%
34,639 hours	35,688 hours	10,378 hours	13,114 hours	28,776 hours	29,092 hours	6,819 hours	8,518 hours				

Appendix 2


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
15/12 - 21/12
22/12 - 28/12
GRADE HCA
GRADE RN
GRADE RMN

Appendix 3

				December – SHIFT DATA							
Division	Speciality	Ward		Total No. of shifts available	Early	Late	Night	Number of shifts where staffing fell below agreed staffing levels and triggered 'Red'	% of shifts where staffing fell below agreed staffing levels and triggered a 'Red' rating	RAG rating following action taken	DoN statement of actions taken to ensure safe staffing levels
ICAM		Meyrick		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		Cloudesley		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Elderly Care	Cavell		93	0	2	0	2	2.15		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Cardiology	Montuchi		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Respiratory	Nightingale		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Gastro/Haem/Onc	Mercers		93	0	1	0	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		MSS		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	MAU	MSN		93	1	1	0	2	2.15		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Emergency	ED		93	2	2	11	15	6.67		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		837	3	8	11	22	2.63		
SCD	ITU	ITU		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Surgical	Victoria		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Ortho (Trauma)	Coyle		93	2	3	0	5	5.38		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Ortho (planned)	Thorogood		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		372	2	3	0	5	1.34		
WCF	Paediatrics	IFOR		93	0	0	1	1	1.07		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Maternity	All mat wards		93	0	0	0	0	0		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
	Neonatal ITU	NICU/SCBU		93	1	1	2	4	4.3		Staffing sufficient, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
		TOTAL		279	1	1	3	5	1.8		
		TRUST TOTAL		1,488	6	12	14	32	2.15		

Whittington Health NHS

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The Whittington Hospital NHS Trust
Magdala Avenue
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Whittington Health Trust Board

4 February 2015

Title:	Whistleblowing Policy and Procedure		
Agenda item:	**15/029**	**Paper**	**12**
Action requested:	The Trust Board approves the revised Whistleblowing Policy.		
Executive Summary:	The Trust Board is asked to consider the updated Whistleblowing Policy and Procedure. The revised policy takes account of the changes in the relevant legislation, namely The Public Interest Disclosure Act (PIDA) 1998 (as amended by the Enterprise and Regulatory Reform Act 2013) and sets out the organisation's approach to openness and transparency so that workers are encouraged to speak up about genuine concerns. The procedure has been amended to set out more clearly, how and to whom individuals can raise concerns. It also explains the mechanism for how concerns will be investigated. Roles and responsibilities are, therefore, clearly identified. The revised policy states that human resources (HR) will hold a register of formal complaints, which will be monitored by the audit and risk committee every 12 months. The policy will be reviewed on a three yearly cycle in line with other HR policies. The policy has now been the subject of extensive consultation with staff-side and most of the proposed changes have been incorporated. These changes specifically related to procedure and the respective roles and responsibilities within the policy.		
Summary of recommendations:	The Trust Board is asked to approve: 1) the revised Whistleblowing Policy and Procedure 2) that the policy is implemented from 1 March 2015 3) that the Audit and Risk Committee will review the register of whistleblowing cases every 12 months 4) that the policy will be reviewed every three years in line with changes in legislation or other organisational changes.		

Fit with WH strategy:	Ensure the Trust has up-to-date and fit for purpose HR policies and procedures.
Reference to related / other documents:	The Trust's Disciplinary Policy and Procedure. Public Accounts Commons Committee ninth report of session 2014/15 as it refers to the NHS Whistleblowing guidance and recommendations HC 593.
Reference to areas of risk and corporate risks on the Board Assurance Framework:	The Trust requires an up-to-date and relevant Whistleblowing Policy and Procedure in order to comply with changes in relevant legislation.
Date paper completed:	20 January 2015

Author name and title:		**Jo Bronte HR Manager**		**Director name and title:**		**Chris Goulding DD, HR Operations**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Whistleblowing Policy and Procedure

Reference/Number	*To be supplied by Corporate Policy Officer*		
Version:	Two		
Ratified by:			
Ratification Date:			
Approval Committee			
Date Approved:			
Date Issued:			
Executive Owner:	Chris Goulding, Deputy Director HR		
Name of Author(s) and Job Title(s):	Jo Bronte, HR Manager		
Target Audience:	All staff		
Review date: 3 years after ratification date			
Procedural document linked to/Tagged:	**Tick as appropriate**	✓	
	Regulatory Compliance		
	Organisation-wide	✓	
	Directorate		
	Service		
	Shared document		

Dissemination and Implementation

Responsible person for coordinating dissemination and implementation		Jo Bronte, HR Manager	
Methods of dissemination	Intranet	Whittington Health Noticeboard	Email to key Stakeholders
(Delete as appropriate)	Yes	Yes	Yes

Consultation

List of those consulted	Staff-side sub group TMG
Period of consultation	November 2014 -

Version Control Summary

Version No	Description of change	Author	Date
One	Harmonisation of policies from predecessor organisations on formation of Whittington Health ICO (amended July 2013 to reflect legislative changes)	Unknown	*May 2012*
Two	Review to update policy and make the procedure clearer	Jo Bronte	

Contents

1.0 INTRODUCTION: POLICY STATEMENT

1.1 Whittington Health encourages a culture of openness and dialogue endorsed by positive working relationships. The Trust promotes an environment which enables everyone working for the Trust to raise concerns in a responsive way, without fear of victimisation, censorship or reprisals, which contributes to a safer and higher performing Trust for all.

1.2 The Public Interest Disclosure Act (PIDA)1998 (as amended by the Enterprise and Regulatory Reform Act 2013) provides a clear signal that it is safe and acceptable for all workers to raise any specific concerns they may have that they reasonably believe are in the public interest (often known as 'whistleblowing'). By providing strong protection for those who raise concerns, the legislation helps ensure that employers address the message and not the messenger. It is a safety net for the Trust, those who work for it and users of its services. The fundamental principle behind the legislation is to improve governance and accountability within organisations.

1.3 Essentially, under PIDA, workers who act honestly and reasonably are given automatic protection for raising a matter internally. Further information on the PIDA can be found at: http://www.pcaw.org.uk/

1.4 This document sets out the Trust's position and provides guidance on how people working for the Trust can raise their concerns whilst being fully protected. In doing this the procedure draws together the *NHS Constitution 2013* and the *Public Interest Disclosure Act 1998,* and is based on the British Standards Code of Practice July 2008 and illustrates how these should operate locally at Whittington Health.

1.5 Workers who raise concerns that they reasonably believe are in the public interest and do so not for personal gain will be protected under statute law from suffering detriment, recrimination, harassment and victimisation by the Trust, its workers and agents.

1.6 A whistleblowing concern is about a risk, malpractice or wrongdoing that affects others. It could be something which adversely affects patients, the public, other workers or the organisation itself. This is distinct from a grievance which is, by contrast, a dispute about an employee's own employment position and has no additional public interest dimension. A whistleblowing concern is where an individual raises information as a **witness**, whereas a grievance is where the individual is a complainant. If you are uncertain which policy should be used, please seek advice from Human Resources.

1.7 It is important that workers feel that they are able to raise genuine issues and to feel confident that their position will not be jeopardised or that harassment or bullying will not take place as a result of their actions. Disciplinary action will not be taken against the individual raising the concern as a direct result of raising a concern. The Trust regards the ability to raise issues of concern as very important, and is therefore anxious that staff feel able to do so, and will protect

staff from any form of victimisation, providing it is not a deliberately false or malicious allegation.

1.8 When raising a concern, it will be helpful to know how the worker thinks the matter might be best resolved. If the worker has any personal interest in the matter, they should inform the Trust at the outset. If the Trust considers that the concern falls more properly within the grievance (inc. bullying and harassment) procedure or other relevant procedures, it will inform the worker accordingly.

1.9 The Trust aims to promote the positive aspects of whistleblowing and in doing so move away from the negative perception of the word.

1.10 The Trust will not tolerate any detriment, reprisals, bullying, harassment or victimisation against any worker or other individual because he or she has raised a concern under this policy, and will treat any such instance as a disciplinary matter which may lead to dismissal of the perpetrators or sanctions against those acting as agents of the Trust.

1.11 The Trust has a Counter Fraud Policy and Response Plan which provides information on fraud reporting procedures. Further details are contained in Section 8 under the heading 'Fraud, Corruption and Bribery.'

1.12 In addition, this document complements professional or ethical rules and guidelines, such as for nurses in NMC Code of Practice (para 32 to 34) and for medical staff in Good Medical Practice on raising and escalating concerns.

2.0 PURPOSE

2.1 This Whistleblowing Policy and Procedure sets out the Trust's position and provides guidance on how people working for the Trust can raise their concerns whilst being fully protected.

3.0 SCOPE

3.1 This policy and procedure applies to all workers employed by the Trust, Executive and Non-Executive Directors, bank workers, agency workers, students, volunteers, contractors, secondees and those holding honorary contracts. Whittington Health views the contribution made to its services by all those who work for it as an essential element of caring for patients and values issues raised by workers, particularly relating to situations where there is the possibility of harm, danger or a breach of safety to patients in a clinical or research capacity.

3.2 Managers at the Trust will always take concerns seriously and give them due and sympathetic consideration. There may be occasions when they will wish to seek specialist advice from other health care professionals.

3.3 The Trust's view is that individual workers in the NHS have a right and a duty to raise any matters of concern they may have about health service issues related to

the delivery of care, research or services to a patient/s within the Trust, or any other matter that can be said to be in the public interest.

4.0 DEFINITIONS

4.1 Where concepts have a particular meaning for this procedure the definition is given within this document.

4.2 The term 'workers' will be used throughout this policy to refer to all those defined under section 3.1 of the policy.

5.0 DUTIES

5.1 Managers are responsible for:

5.1.1 Ensuring that all staff are familiar with and have access to this policy.
5.1.2 Complying with the Trust's procedures and principles as outlined.
5.1.3 Ensuring concerns raised are taken seriously and responding to concerns in a timely fashion.
5.1.4 Evaluating the basis of any claim brought to their attention and referring upwards to a more senior manager if appropriate.

5.2 Human Resources are responsible for:

5.2.1 Ensuring staff are made aware of this policy and how they can access it.
5.2.2 Advising managers and individuals in the application of the policy and procedure.
5.2.3 Monitoring the application of the policy to ensure it is applied in a fair and consistent way to each concern raised.
5.2.4 Keeping a register of formal Whistleblowing concerns, monitoring and auditing the number and nature of claims made, actions taken, and reporting this information to the Trust Board on a regular basis.

5.3 Employees are responsible for:

5.3.1 Raising the concern as soon as possible in an objective and factual way, using this policy and accompanying procedure.
5.3.2 Keeping records where possible of any incidents and potential witnesses.
5.3.3 Cooperating with any investigation, if appropriate, including being available for interview (notice will be given), providing a statement and/or documentation.
5.3.4 Maintaining confidentiality of patients and staff.

6.0 PROCEDURE FOR DEALING WITH WORKERS CONCERNS

6.1 Step One - Informal Stage

6.1.1 If a worker has a concern about risk, malpractice or wrongdoing at work, they should raise it first with their immediate manager, supervisor or lead clinician. If the

concern is about the worker's line manager then the individual should refer their concern to the director of a service or to their trade union representative as appropriate. The manager/clinician (or director) is responsible for meeting with the worker to understand the issues and seek to resolve the problem immediately or escalate for help.

For concerns about fraud, corruption and bribery, please refer to section 8.0 of the document.

6.1.2 Where a concern can be acted upon, action should be taken promptly and the individual notified quickly of the action taken insofar as this does not prejudice the Trust's legal obligations of confidentiality to its patients and other staff as per 6.2.12 below.

6.1.3 Individuals or representative organisations who raise a concern should receive feedback in writing as quickly as possible taking into account the seriousness of the concern but, in any event, within ten working days of the meeting with the manager/clinician confirming what action (if any) has been taken. Information provided in accordance with this paragraph shall be subject to the Trust's legal obligations of confidentiality to its patients and other staff as per 6.2.12 below.

6.1.4 If the person dealing with the concern decides that no action is warranted, they must discuss this with their respective manager/director prior to the decision being notified to the individual who has raised the concern or representative organisations. Where action is not considered appropriate, then the individual should be given a prompt and thorough explanation of the reasons for this. They should also be advised that they can raise this issue in accordance with Step Two, detailed below.

6.1.5 Workers must report their concerns without delay if they witness or suspect there is immediate risk.

6.2 Step Two - Formal Stage

6.2.1 This stage should be applied if having followed Step One, a worker is dissatisfied with the outcome. Step Two should also be followed if the worker feels unable to report matters to their line manager or director of service informally (e.g. if their line manager/ director of service is at the centre of the concern).

6.2.2 The concern should be in writing to the appropriate director. The director must seek advice from the HR Director/Deputy Director. The worker's concerns will be acknowledged normally within five working days.

6.2.3 The director who receives the concern will appoint a designated officer, normally a senior manager to investigate the concern. This may involve an informal review, an internal inquiry or a more formal investigation. The worker will be told the name of the person handling the matter, how they can contact them and what further assistance may be needed from them. The designated officer should not have been involved in the case previously, should have no conflict of interest and be impartial.

6.2.4 If the concern made is about an Executive Director the concern will be investigated by the Chief Executive or Chairman.

6.2.5 If the concern made is about the Chief Executive the concern will be investigated by the Non-Executive Director (Audit and Risk Committee Chair), or the Chairman.

6.2.6 If the concern raised is about a Non-Executive Director (including the Chairman) the concern will be investigated by the Non-Executive Director (Audit and Risk Committee Chair).

6.2.7 If the concern raised is about the Non-Executive Director (Audit and Risk Committee Chair) the concern will be investigated by the Chairman.

6.2.8 The outcome of the investigation will be reported back to the director usually within 28 working days to decide what action is required.

6.2.9 In exceptional circumstances, if the designated officer responsible for investigating the concern raised requires longer than 28 working days, the reason will be notified to the individual who has raised the concern with an expected date of completion.

6.2.10 The issue should however obviously be dealt with immediately if it has urgent patient care or other such serious implications.

6.2.11 Following consideration of the report by the appropriate director or Non-Executive Director a written response will be provided to the individual raising the concern usually within 10 working days, thereafter. The written response should contain details of what actions are to be taken together with a timetable or if no action, the reasons why.

6.2.12 The Trust will give as much feedback as it properly can, however it does have legal obligations of confidentiality to its patients and other staff. Therefore, the Trust may not be able to freely provide full feedback, taking into consideration the requirement for confidentiality in disciplinary and capability cases.

6.2.13 Any anonymous concerns should be raised with the relevant Executive Director. Concerns will be considered and may be investigated, but if the Trust does not know who has raised a specific concern, it will be more difficult to look into the matter, protect the individual and provide appropriate feedback. If an anonymous concern is raised and found to be deliberately false or malicious or then disciplinary action may be taken against the individual raising the concern if identified.

6.2.14 Workers making **deliberately false or malicious** allegations will be subject to disciplinary action in accordance with the Trust's disciplinary procedure. However, if the individual has a reasonable belief that the disclosure is made in the public interest (effectively this means acting honestly) it does not matter if they are mistaken or if there is an innocent explanation for their concerns. Disciplinary action would not be taken in these circumstances.

6.2.15 A central register of all formal concerns raised will be logged and maintained by the Director of HR. This will allow for the effective acknowledgement, monitoring and progress of reported disclosures. This log will be available to the Audit and Risk Committee.

7.0 REFERRAL TO A REGULATORY BODY

7.1 The Trust believes that this policy should enable almost all concerns to be raised internally and hopes that it provides workers the reassurance to do so. However, we recognise that there may be exceptional circumstances where the individual can properly report a concern to an outside body.

7.2 Before reporting concerns to a regulatory organisation, it is recommended that advice is sought (see section 11). The Trust should also be informed of the individual's actions.

7.3 In order for the concern to be investigated and for individual protection under current legislation, this should normally be with a recognised healthcare organisation that has the authority to investigate the issue. This could be the regulator of health and social care services or a regulator of health professionals.

8.0 FRAUD, CORRUPTION AND BRIBERY

8.1 All allegations of suspected fraud, bribery and corruption must be reported to either the Chief Finance Officer, the Trust's nominated Local Counter Fraud Specialist (LCFS), or by calling the NHS Fraud and Corruption Reporting Line. All reports will be assessed and, where necessary, investigated in accordance with the Trust's Counter Fraud Policy and Response Plan.

8.2 In addition, where allegations involve an Executive Director or Non-Executive Director (NED) the information can also be reported to the Audit and Risk Committee Chair.

8.3 The contact details for reporting fraud, corruption and bribery are as follows:

8.3.1 Chief Finance Officer on: 020 7288 3190

8.3.2 Local Counter Fraud Specialist (LCFS) on: 020 7953 8353

8.3.3 NHS Fraud and Corruption Reporting Line on: 08000 724 725.

9.0 CONFIDENTIALITY

9.1 It is recommended that concerns are raised openly, and that workers raising concerns identify themselves. This makes it easier for the concern to be investigated and is the best way for the individual to be protected under the Act. It is recognised that there may be circumstances when the individual raising a concern would like to keep his/her identity confidential. In such instances, the individual should say so at the outset. The individual should realise however that

there may be practical or legal limits to this confidentiality where the concern cannot be resolved without their identity being revealed, and the individual will be informed of this at the outset.

9.2 Whilst the Trust is committed to encouraging a policy of openness, workers are expected to respect this commitment by observing the appropriate procedures for raising concerns.

9.3 In particular, all workers have a duty of confidentiality to patients and any unauthorised disclosure of personal information identifiable to a specific patient could be regarded as a breach of duty and as such might result in disciplinary action being taken. This applies even where an individual believes that he or she is acting in the best interests of a patient or client, by disclosing personal information. It is strongly advised that individuals seek advice from Human Resources or their professional organisation before taking any such action

9.4 Consideration should be given to the stage at which the subject of any disclosure(s) is informed of the concern raised about them. The Trust will need to carefully balance the risks of when to do this at each stage.

9.5 Individuals who have a concern raised about them will have the right to know details of the concern and any possible consequences, the right to respond and the right of representation.

10.0 INDEPENDENT ADVICE AND SUPPORT

10.1 If individuals are unsure whether to use this procedure or want confidential independent advice at any stage, they should contact:

10.1.1 Their trade union or professional association.
10.1.2 The independent charity Public Concern at Work on 020 7404 6609 or helpline@pcaw.co.uk. Their legal advisors will give free confidential advice at any stage about how to raise a serious concern at work.
10.1.3 The NHS Whistleblowing helpline on 08000 724 725.

11.0 THE PUBLIC INTEREST DISCLOSURE ACT 1998

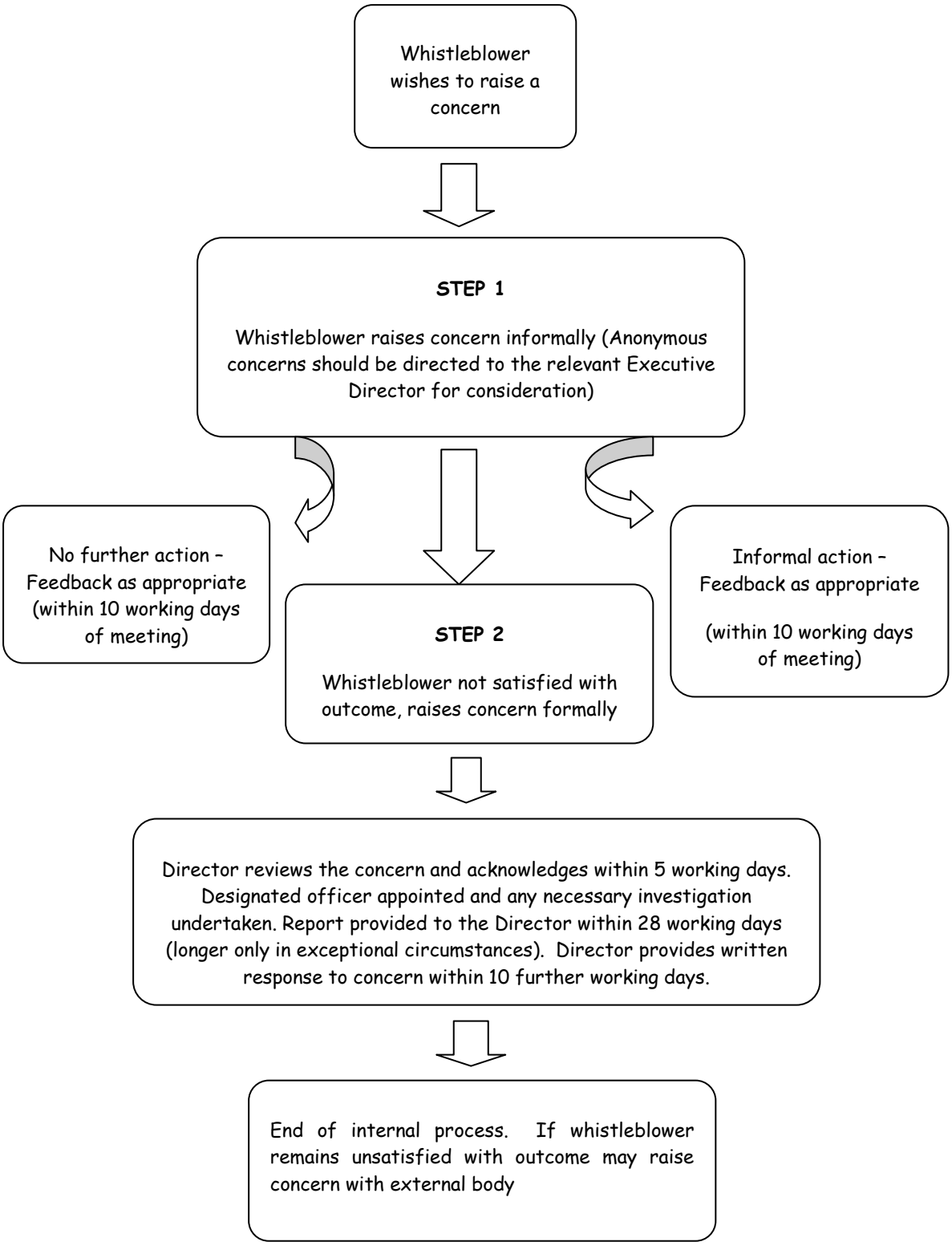
11.1 In addition to the local procedures, the Public Interest Disclosure Act 1998 provides specific rights for those who disclose information to a third party about an alleged wrongdoing.

11.2 If an individual has a concern, and wishes to consider seeking protection under the Public Interest Disclosure Act when raising it, they should seek advice from their trade union or an independent advisor.

12.0 MONITORING COMPLIANCE and EFFECTIVENESS

12.1 Whistleblowing cases will be monitored by the HR Directorate and reported to audit and risk committee. The Whistleblowing policy will be reviewed in line with the Trust's cycle of policy review, subject to consultation with staff representatives recognised for that purpose.

13.0 APPENDIX ONE – WHISTLEBLOWING FLOWCHART



14.0 APPENDIX TWO –
WHITTINGTON HEALTH EQUALITY IMPACT ASSESSMENT REPORT

1. Name of Policy or Service

Whistleblowing Policy and Procedure

2. Assessment Officer

Assessment undertaken by joint staff-side chair and Deputy Director of Human Resources

3. Officer responsible for policy implementation

All trust managers – policy is trust-wide

4. Date Equality Impact Assessment Completed

October 2014

5. Description and Aims of Policy/Service

Whittington Health is committed to encouraging a culture of openness and dialogue endorsed by positive working relationships. The Trust is keen to promote an environment, which enables staff everywhere to feel able to raise concerns in a responsible way without fear of victimisation or censorship.

6. Initial Screening

An initial assessment has been carried out to explore whether the Trust's staff raising healthcare concerns policy is likely to have a detrimental impact in terms of people included in one or more of the following equality categories:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion and belief
- Pregnancy and maternity
- Gender Reassignment

7. Outcome of initial screening

The policy was revised in partnership.

No direct adverse impact could be seen in terms of the protected groups.

The policy explicitly seeks to provide a fair and consistent process for staff raising healthcare concerns.

Assistance may be obtained from union representatives for employees for whom English is an additional language or who have difficulty expressing themselves on paper.

A full impact assessment was not necessary following initial review.

8. Monitoring and review

The policy will be reviewed` every third year.

9. Publication

This impact assessment will be scrutinised by the Trust's Equality Impact Assessment (EIA) group on behalf of the Trust Board, prior to publication through the hospital's website.