

Whittington Health 

TRUST BOARD

14.00 – 17.00

Wednesday 04 March 2015

Whittington Education Centre Room 7



Meeting	Trust Board
Date & time	4 March 2015 at 2.00pm – 5.00pm
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
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Attendees

Chris Goulding, Deputy Director, HR
 Lynne Spencer, Director of Communications & Corporate Affairs
 Kate Green, Minute Taker

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

Agenda Item		paper	Action timing
15/031	Patient Story <i>Philippa Davies, Director of Nursing & Patient Experience</i>	1	Receive (20)
15/032	Declaration of Interests	<i>Verbal</i>	
15/033	Apologies	<i>Verbal</i>	
15/034	Minutes, action notes and matters arising To approve the minutes of the previous meeting held on 4 February 2015	2	Approve (10)
15/035	Chairman's Report <i>Steve Hitchins, Chairman</i>	<i>Verbal</i>	Receive (10)
15/036	Chief Executive's Report <i>Simon Pleydell, Chief Executive</i>	3	Receive (10)
Quality			
15/037	'Sign up to safety' <i>Richard Jennings, Medical Director</i> <i>Philippa Davies, Director of Nursing and Patient Experience</i>	4	Receive (10)

Strategy and Policy			
15/038	Our Clinical Strategy 2015-2020 <i>Siobhan Harrington, Director of Strategy & Deputy CEO</i> <i>Greg Battle, Medical Director</i>	5	Receive (15)
Performance and Delivery			
15/039	Monthly Performance Dashboard and Workforce Report <i>Lee Martin, Chief Operating Officer</i>	6	Discussion (20)
15/040	Monthly Financial Performance Report <i>Ursula Grueger, Acting Director of Finance</i>	7	Receive (20)
15/041	TDA Board Statements <i>Simon Pleydell, Chief Executive</i>	8	Approval (5)
Governance & Regulatory			
15/042	Corporate Risk Register <i>Philippa Davies, Director of Nursing and Patient Experience</i>	9	Approval (20)
Workforce: staffing and Agency			
15/043	Nursing Establishment Review <i>Philippa Davies, Director of Nursing and Patient Experience</i>	10	Receive (15)
15/044	Safe Staffing Report <i>Phillipa Davies, Director of Nursing and Patient Experience</i>	11	Receive (10)
Any other urgent business and Questions from the public			
Date of next meeting:			
15/045	1 April 2015 Whittington Education Centre, Room 7		
Register of Interests: The register of members' interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF.			



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 Anu Singh, Non-Executive Director
 Prof Graham Hart, Non-Executive Director

Simon Pleydell, Chief Executive
 Siobhan Harrington, Director of Strategy & Deputy CEO
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The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00pm on Wednesday 4th February 2015 in the Whittington Education Centre

Present:	Simon Pleydell	Chief Executive
	Greg Battle	Medical Director, Integrated Care
	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
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Rob Whiteman	Non-Executive Director

In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs
	Helen Taylor	Chief Pharmacist

15/014 Petition from members of the public

14.01 Steve Hitchins explained that whilst public board meetings generally began with an account of a patient story about treatment at Whittington Health, on this occasion the Trust had been approached by a group of 'concerned residents of North London' who had written to him setting out some specific questions around the Transforming Patient Experience' project and future plans for the hospital. Therefore, the Board had decided to allow the group a brief period of time at the start of the meeting to introduce their issues.

14.02 Steve Hitchins reminded all those present that the monthly Trust Board meeting was a meeting held in public rather than a public meeting, and as such, members of the public did not have an automatic right to place items on the agenda for discussion.

14.03 Speaking on behalf of the group described as 'concerned residents of North London', Sam Rae took Board members through the list of questions set out in the group's petition. It was noted that Siobhan Harrington had already provided a written response to these questions. Simon Pleydell added that he had been in regular contact with the 'Defend the Whittington Hospital Coalition' since his appointment as Chief Executive, and there was an open invitation in place for the group to meet with him to discuss any issues.

15/015 Patient Story

15.01 Philippa Davies introduced a carer who had kindly agreed to attend the meeting to share a patient story regarding his mother's patient experience by the district nursing service. The Board listened carefully to the story and noted the important

lessons which had been highlighted. Philippa Davies agreed to take forward the learning and ensure that improvements continue to be embedded in the District Nursing Service.

15/016 Declaration of Interests

16.01 No Board members present had any interests in any part of that day's Board proceedings to declare.

15/017 Apologies for absence

17.01 Apologies were received from Anita Charlesworth.

15/018 Minutes of the previous meeting

18.01 Under minute 8.4 Philippa Davies pointed out that this remark should be attributed to her rather than Philippa Marszall. Under 08.05.02 Paul Lowenberg felt this minute needed rephrasing and he agreed to contact Kate Green to suggest an alternative from of words.

18.02 Other than these amendments the minutes of the meeting held on 7th January were approved.

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

18.04 Action notes

100.03 - This report on nursing establishment was scheduled for March Board.

143.01 – The cancer services strategy will be added to the Board cycle for future agreement.

173.04 – Benchmarking data was now included within the workforce performance report - this item could therefore be removed from the schedule. It was noted that the tables had also been changed as requested.

174.06 - The Finance & Business Development Committee had not met since the last Board meeting.

06.01 – Terms of reference were scheduled for the discussion later on the agenda.

08.02 – To read 'MSK' rather than 'HSMR'.

08.03 - This item was not due for review until the April Board meeting.

08.08. – Administrative staff figures had now been incorporated in the workforce report, this could now be removed from the tracker.

09.03 – the narrative had now been increased and could therefore be removed from the tracker.

15/019 Chairman's Report

19.01 The Chairman began his report by welcoming Lynne Spencer, newly-appointed Communications & Corporate Affairs Director.

19.02 The Prime Minister's special advisor Nick Seddon had visited the Trust the previous Friday, Steve and Richard Jennings had accompanied him on a visit to several of the Trust's sites, both within the hospital and the community.

19.03 The current programme of public engagement had now been completed. A successful meeting had been held with local voluntary organisations, who had shown great commitment to and support of Whittington health.

- 19.04 On Sunday 1st March the annual walk by all London mayors from the Whittington Cat to Mansion House was scheduled to take place.
- 19.05 Steve had recently visited Lordship Lane, and said that he had been privileged to meet Valentina Treskavica, the first practitioner within the Trust to qualify as a prescribing physiotherapist. He expressed congratulations to her on behalf of the Board on this achievement.
- 19.06 Following recent meetings of sub-committees, Steve proposed that terms of reference were reviewed and amended by LS to ensure quoracy of meetings.
- 19.07 Referring back to the extraordinary Board meeting held on 14th January, Paul Lowenberg enquired whether the Trust had received the letter of support for the maternity and neonatal Full Business Case (FBC) from NHS England. Siobhan Harrington replied that the Trust had received this letter and a TDA meeting was being arranged where the FBC would be presented. The TDA had congratulated Trust staff on both the quality of the FBC and the quantity of work they could see had gone into its preparation.
- 19.08 The notes of the extraordinary Board meeting convened on 14th January to discuss the Maternity and Neonatal FBC were approved.
- 15/20 Chief Executive's Report
- 20.01 Simon Pleydell began his report by informing the Board that the percentage of staff members who had received the flu vaccination had reached 81%, an even higher figure than the previous year. This showed how seriously staff took both the safety of the patients they care for and their own health, and Simon expressed his gratitude to the infection prevention and control team for the immense amount of proactive work they had carried out to achieve this number of vaccinations, thought to be the highest percentage in London.
- 20.02 The Trust had just declared its second MRSA bacteremia; a RCA investigation was being conducted and the case was being reviewed to see what lessons might be learned.
- 20.03 Simon was pleased to inform the Board that the Trust was performing well in relation to national cancer standards. He also mentioned the excellent opening, performed by Barbara Windsor, of the MacMillan Cancer Information Hub on 8 January, describing it as a tremendous facility for patients and families alike. The Trust's financial position had also improved slightly within the last month, and efforts made to reduce spending on agency staff had also proved more successful of late.
- 20.04 The FGM case was expected to conclude later that day.
- 20.05 The day of industrial action planned for 25 February had been called off as an agreement with the unions had now been reached. It was now necessary for the Trust to consider the financial implication of the agreement.
- 20.06 The Trust had recently installed a new free Wi-Fi service for patients, carers, colleagues and students, and had received a great many positive comments on this. Paul Lowenberg stressed the importance of publicising such initiatives. Graham Hart added that this also afforded good opportunities for contacts. Another cause for celebration was the winning of a HENCEL award by two of the Trust's apprentices.

15/21 Quality Committee Report

- 21.01 Anu Singh introduced the report of the Quality Committee meeting held on 15 January, drawing attention to the new format of the report. She reported that there remained some differences to the approaches taken by the three divisional quality working groups although improvements continue to be accomplished. Further improvements will be required to ensure timely papers for each meeting. Each division will need to work coherently and have a holistic view of CQC preparedness against the standards.
- 21.02 There had not been a significant amount of progress made on mandatory training since the last meeting, although improvement could be seen in some areas. Approximately 18 months ago the Board had held a major focus on mandatory training, with some degree of success, and managers had received a regular bulletin providing a detailed picture of staff whose training was overdue; it was suggested this exercise be repeated. Richard Jennings commended the methodology used for Information Governance (IG) training, whereby he had received a pop-up message on his computer informing him that his training was due and that he could complete the module immediately (log-on details were provided) in less than twenty minutes. Anu questioned whether the Trust was taking a sufficiently robust approach to risk and Rob Whiteman, Chair of the Audit & Risk Committee, reported that the Audit & Risk Committee had carried out a deep dive exercise into this area which provided assurance that there had been improvements within the last year.

15/22 Clinical Strategy

- 22.01 Greg Battle informed colleagues that the intention for this meeting was not to produce the final strategy but to have an interim position. Three multi-disciplinary meetings had taken place since Christmas, as well as a governance meeting, and the products of these have contributed to the mission, vision and themes for the strategy. There will be other 'enabling' strategies to support the clinical strategy, including estates and finance. The mission statement had been locally agreed as 'helping local people live longer healthier lives', and the next stage of the process was to move to the 'how'. Safety and quality remained key themes, with the strategy combining the provision of high quality services whilst managing within existing resources. Greg and Siobhan would present the next iteration of this work at the March Board.
- 22.02 Tony Rice commended the strategy as 'brief and clear', but said that what he felt was missing was the detail of the patient experience, and it should be possible to frame the strategy so that this was better emphasised. The next phase of the strategy development was to turn the themes of the strategy into achievable measurable goals. The King's Fund had also agreed to look at the strategy, which was to contain some patient scenarios. Links were also being made with the Local authority prevention strategies. Graham Hart stressed the need for education and research to be included in the cross-cutting themes. Simon Pleydell reinforced this point, highlighting that a range of enablers are being developed.
- 22.03 The Board agreed the mission and vision statement and expressed strong support for the strategy whilst recognising the need for further development. This will include introducing stakeholders to the concept of requiring fewer beds, as the Trust's focus on preventing unnecessary hospital admissions was successful. This will also be reflected in the submission expressing interest in the Vanguard initiative put forward in NHS England's five year plan.

15/023 Cancer Strategy 2015/16

23.01 Discussion of the Cancer Strategy for 2015/16 was postponed until further details were included and after the Clinical Strategy had been completed

15/024 Performance Report

24.01 Lee Martin informed the Board that the Trust had made significant progress in achieving national performance targets during November and December, and it seemed likely that January figures would be equally positive. There had been an increase in older people presenting with complex needs, and this was placing additional strain on all the Trust's services. There had also been high rates of admission to the HDUU and ITU.

24.02 Lee reported that the Trust had met all national cancer targets, and was now undergoing a review to assess whether or not this position was sustainable in the longer term.

24.03 It was noted that the Trust had now declared two MRSA bacteraemia during 2014/15. Rob Whiteman asked about the apparent downward trend in elective theatre utilisation, and Lee replied that this was in part due to increased emergency care but also some cancellations of lists due to sickness of medical staff. He added that there had been some improvement in the cancellations the Trust controlled. The team was however still working on getting the measures correct, and from April 2015 counting would be done in a different way.

24.04 Graham Hart commented on the high staff sickness rate within maternity services. Lee explained that that this was due to some serious illnesses (heart disease, cancer) resulting in staff being absent from work for some considerable time. Chris Goulding assured the Board that affected staff were being offered appropriate support. In answer to a question about whether this situation was affecting new birth visits, Greg Battle reminded Board colleagues that this service was provided by the health visiting teams in the community, and said that Haringey in particular had made great progress towards improving its visiting times.

24.05 Paul Lowenberg highlighted the 6 week wait for MSK services, enquiring when the Trust was likely to see further improvement. He had also observed that indicators on HSMR trends appeared to be slipping, and asked that these be looked at in more detail in the next report. Paul also requested more detail on the indicators for ambulatory care. Lee Martin replied that meetings had been taking place to discuss ambulatory care performance and targets. Later in February the building work would be complete and patients would be able to move directly from triage to ambulatory care. Simon Pleydell added that reporting the mortality data in its current form was not necessarily helpful to the Board, and he would prefer to see a more detailed commentary. It was also noted that there is generally a rise in death rates around this time of year (winter), and that the Board would find it helpful to know how the Trust's death rates compared to peer groups.

24.06 Introducing the workforce section of the dashboard, Chris Goulding announced that for the first time he was able to provide benchmarked data, however this was very much work in progress and he hoped to be able to finesse data as a result of having recently joined the benchmarking club. Chris was able to report, however, that the number of whole time equivalent (w.t.e.) staff employed by the Trust had reduced since his last report, and spending on agency staff had also reduced. The high turnover of staff in the ICAM division was noted, and there was to be a 'deep

dive' into corporate staffing. Mandatory training had been discussed under the Quality Committee report item, and appraisal rates had levelled out.

15/025 Financial Report

25.01 Ursula Grueger informed the Board that this month she was able to report a £480k surplus, a very positive step, and one which meant that the Trust's forecast as reported to the Trust Development Authority (TDA) was on track. She explained that the improvement had been caused by two main factors, one being income received from a contract variation, the other some income received from PbR. There had been a reduction in spending on agency staff within the pay budget, and in non-pay, supplies and contract spending. Moving on to CIPs, Ursula said that the main focus now was ensuring that the Trust had a fully worked out plan for 2015/16, backed up by detailed financial projections. Nick Dawe would be leading on this work, and Simon emphasised that there would be better control and better planning. Tony Rice congratulated the finance team on their achievements.

25.02 It was noted that this was Ursula's last Board meeting as acting CFO, and the Board thanked her for her hard work and all that she had achieved during her period of tenure.

15/026 TDA Board Statements

26.01 The Board noted that little had changed since the previous month's report, although the appointment of the new CFO would be key. Paul Lowenberg raised the question of the trust's completing its 95% target on Level 2 Information Governance compliance training, and SMH explained that this had been flagged on the TDA statement as a risk. The statements were noted.

15/027 Audit & Risk Committee Report

27.01 Introducing this item, Rob Whiteman informed Board colleagues that the Audit & Risk sub-committee of the Board had been working to test the control environment and to conduct deep dives into areas where it felt warranted further scrutiny. In this the committee was advised not only by officials but also by internal and external audit representatives. In terms of routine matters, the committee had continued to look at levels of risk, and Rob reminded the Board that a year previously they had discussed the fact that over 70% of Trust spending was on workforce, and for this reason the committee had taken a particular interest in workforce planning, feeling that this did constitute a risk.

27.02 A VFM statement was due to be provided by the Trust's external auditors KPMG, this was to be presented to the Board by either Stephen Bloomer or Ursula Grueger in due course. Rob also informed the Board that the committee felt the Trust should have a policy on overseas patients.

27.03 In summary, then, the committee had felt that the Trust's position on risk had improved, although it would be reconsidered in the context of medium-term planning. Siobhan Harrington added that the challenge brought by the committee was welcome, and as a team the executive directors were aware of the need to continue to develop a robust approach to managing control of finance, workforce plans, strategic planning etc.

15/028 Safe Staffing Report

- 28.01 Philippa Davies introduced her monthly safe staffing report, which showed the position of staffing on the wards for December. She informed Board colleagues that she would be bringing a paper on the establishment by ward to the March Trust Board meeting.
- 15/029 Whistleblowing Policy
- 29.01 Chris Goulding explained that the new whistleblowing policy had been developed in the spirit of openness and transparency advocated by the Trust and taking into account recent legislation. Operation of the policy would be monitored through the Audit & Risk Committee. It was noted that extensive consultation had been undertaken with staff side, and that key findings from the 'freedom to speak up' review had also been taken into account. Once the policy was agreed by the Board the next stage of the process was for it to be disseminated and publicised.
- 29.02 Steve Hitchins felt that the tone of the policy was correct, adding that he had learned from his time at CQC that one important aspect of implementing this policy was how what came in was recorded. Additionally, people needed encouragement if they were to feel confident in speaking out. Referring to the flowchart, Paul Convery asked for clarification on what was meant by a 'body'. It was agreed Chris would append a list to the final version. Paul Lowenberg urged the Board to consider how best to handle implications for patients should these arise, and Steve asked Chris to think further about this. Tony Rice reminded Board colleagues of the responsibilities they jointly bore as a Board, citing as an example events at Mid Staffordshire. Chris to clarify who will be the lead for this area and to update the next Board following publication of the report.
- 29/03 It was agreed that reports on whistleblowing issues should come to the Board periodically. Gratitude was expressed to staff side representatives for their engagement and productivity throughout the development of this policy.

Questions and comments from the floor

Helena Kania asked for action points arising from questions or comments from the public be incorporated into the action tracker. Steve Hitchins agreed to give this his consideration. Helena also thanked Anu Singh and Philippa Davies for what she felt to be a much improved quality committee report. Helena's final question concerned mortality and whether there was a place for comparison of our position with that of other European countries. Considering this, Richard Jennings replied that the answer depended to some extent on what was to be done with the comparison, but he agreed with Helena that there were certainly areas where learning could be gleaned from other places' achievements, and felt patient safety might well be one such example.

Ron Jacob enquired about benchmarking and whether there was much opportunity to benchmark like for like. Ursula Grueger replied that there were plentiful opportunities to benchmark acute services, but for community services it was hard to find a comparator.

Referring back to the clinical strategy, Tony Rice stressed the importance of having a focus on patient experience and outcomes. There was a need to consider research and development within a strategic context, but there should also be a clear delineation between themes and outcomes. Siobhan Harrington would work on this.

Action Notes Summary 2014-15

This summary lists actions arising from meetings held September 2014 to January 2015 and lists new actions arising from the Board meeting held on 4th February 2015.

Ref.	Decision/Action	Timescale	Lead
15/015	District Nursing Service – to take forward and embed the patient story lessons	Ongoing	PD
100.03	Nursing establishment – final report to the Board in March	March	PD
143.01	Cancer services strategy to be aligned to the clinical strategy – to address specific question on integrated care and to present to a future board	On Board Cycle	LM
174.06	Finance and Business Development Committee to review the business plan produced for the outsourcing of the catering service	February	UG
19.06	Terms of reference to be reviewed and amended by LS to ensure quoracy of meetings	March	LS
08.02	To review the MSK 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
27.02	Consideration to be given to the development of a policy for overseas patients	On Board Cycle	LM
29.02	Chris to make minor amendments to the whistleblowing policy prior to its dissemination and report back to the Board to clarify who will be the lead following the publication of the Francis report later this week	March	CG

Whittington Health Trust Board

4 March 2015

Title:		Chief Executive Officer’s Report to the Board					
Agenda item:		15/036		Paper		3	
Action requested:		For discussion and information					
Executive Summary:		The purpose of this report is to update the Board on local, regional and national key issues facing the Trust.					
Summary of recommendations:		To note the report.					
Fit with WH strategy:		This report provides an update on key issues for Whittington Health’s strategic intent.					
Reference to related / other documents:		Whittington Health’s regulatory framework, strategies and policies.					
Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risks captured in risk registers.					
Date paper completed:		26 February 2015					
Author name and title:		Simon Pleydell, Chief Executive		Director name and title:		Simon Pleydell, Chief Executive	
Date paper seen by EC n/a	n/a	Equality Impact Assessment complete?	n/a	Quality Impact Assessment complete?	n/a	Financial Impact Assessment complete?	n/a



Chief Executive Officer Report

The purpose of this report is to update the Board on local, regional and national key issues facing the Trust.

QUALITY

Care Quality Commission (CQC) preparation

We continue to make good progress to prepare for a full CQC inspection; likely to happen between July and September. The inspection will identify best practice, as well as highlighting areas which may need improvement. Clinical colleagues and staff who work in patient areas have been attending our CQC briefing meetings to ensure everyone is well prepared and supported for the inspection.

MRSA bacteremia

The Trust has a zero tolerance approach to MRSA bacteremia breaches. In January there was one reported incident of MRSA bacteremia which now means we have two cases reported for 2014/15 which is very disappointing after reporting the previous months at year to date zero. Colleagues are being urged to be extra vigilant and reminded of the importance of adhering to our infection control procedures.

Joint Advisory Group (JAG)

The Joint Advisory Group on Gastrointestinal Endoscopy has given the Trust a national accreditation. This is really good news for patients of Whittington Health. Well done to all the staff that have helped secure this important milestone for our endoscopy unit.

Female Genital Mutilation (FGM)

The Trust held a learning forum in February to identify important lessons to take forward regarding the recent FGM case reported in the media involving one of Whittington Health doctors who was cleared of any charges or wrongdoing. The lessons learned and action plan from this topic will continue to be a high priority area for the Trust and one first step will be reviewing our multi-agency communications with other agencies and being clear about our processes and procedures. We remain committed to providing the very best care and support for girls and women living with the consequences of FGM.

Compassionate Care Conference – *how to support and enhance it*

This pioneering conference will build on innovative work that we have already carried out in developing our compassion model by showcasing evidence-based methods of supporting and enhancing the quality and level of compassion in healthcare staff. The conference is fully booked with 135 delegates.

Patient Safety Week 16 to 20 March

This important initiative is reported to today's Board Agenda and I would like to thank staff for their enthusiasm and hard work in planning this exciting week. I look forward to welcoming Sir David Dalton, Chief Executive at Salford Royal and National lead for the Sign up to Safety Campaign. David will be sharing his views on patient safety at our Trust on the last day of the Safety Week, Friday 20 March.

PERFORMANCE

Emergency Department (ED)

Our ED and subsequent services have seen an increase in demand, particularly the acuity and complexity of the patients. The high demand for inpatient and complex care planning continued into January as reported in December performance report. This demand remained for older people with complex cases and paediatrics. Increased focus occurred on our community teams in order to meet the demand for early discharge and increased referrals from neighbouring trusts. Despite the continued pressure, our performance against the four hour standard for January was 0.5 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 that patients do not experience delays in their care pathways.

Referral to treatment (RTT) waiting times

We have continued delivering the national standards for our planned care patients. This is the third consecutive month that we have achieved the target. These improvements have now been embedded and we are now looking at sustaining these throughout the year.

Cancer standards

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

Finance

There has been a slight improvement in our financial position with our month-in position at end of January at £0.3m surplus. The favourable position in month is driven by an over performance in NHS clinical income. However, we still have a deficit overall, which stands at just under £6m year to date; mainly a result of expenditure pressures. The principal challenges remain in our integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostic (SCD) Divisions.

We are continuing to forecast a year end deficit of £7.4m which continues to be a major problem for the Trust in the forthcoming months. Discussions with our commissioners continue with the aim of improving our year end position.

NHS staff survey 2014

The NHS Staff Survey was published on 24 February 2015. The survey collects the experiences and opinions of NHS staff on a range of matters including job satisfaction, staff wellbeing and raising concerns. Questionnaires were sent to all permanent colleagues and our response rate was 39.2 per cent. The full results of the NHS staff survey and an action plan based on the results will go to Trust Board in May

Simon Pleydell
Chief Executive Officer

Whittington Health Trust Board

4th March 2015

Title:		Sign up to Safety - Listen, Learn, Act					
Agenda item:		15/037		Paper		4	
Action requested:		For Approval					
Executive Summary:		<p>Listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patients' safety is a key aim of our Trust. By Signing up to Safety, we share an ambition of halving avoidable harm in the NHS over the next three years.</p> <p>This paper sets out what we will do to strengthen patient safety by proposing five safety pledges. It describes the areas of improvement we would like to take forward to continuously improve patient safety.</p> <p>This is a Secretary of State for Health, national campaign for NHS Trusts which is being managed in parallel with the NHS LA.</p>					
Summary of recommendations:		The Board to agree Whittington Health Sign up to Safety and the five safety pledges.					
Fit with WH strategy:		Fully aligns to Whittington Health strategic intent.					
Reference to related / other documents:		Quality framework for Whittington Health.					
Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risks captured on Trust risk registers. Supports the Trust NHS LA membership requirements of the Clinical Negligence Scheme for Trusts.					
Date paper completed:		25 February 2015					
Author name and title:		Philippa Davies, Director of Nursing & Patient Safety & Richard Jennings, Medical Director		Director name and title:		Philippa Davies, Director of Nursing & Patient Safety, Richard Jennings, Medical Director	
Date paper seen by EC	n/a	Equality Impact Assessment complete?	n/a	Risk assessment undertaken?	n/a	Legal advice received?	n/a





SIGN UP PACK

Welcome to Sign up to Safety - Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to strengthen patient safety by

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 and 4) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a safety improvement plan which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your safety improvement plan you will be asked to identify the patient safety improvement areas you will focus on. You will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from your own local priorities.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net or post to Sign up to Safety, Skipton House, Area 2B, 80 London Road, London SE1 6LH



SIGN UP PACK

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Organisation name:

Whittington Health

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges.
- Committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community.
- Make public our plan and update regularly on our progress against it.

Chief Executive Sponsor:

Simon Pleydell

11-Feb-2015

Name

Signature

Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Dr	First name:	Richard	Last name:	Jennings
Email:	richard.jennings@nhs.net			Job title:	Medical Director



SIGN UP PACK

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

Building on improvements we have already made, we will work with our patients and partners to develop a quality improvement programme that prioritises reducing avoidable harm in key areas.

We will focus our efforts on the most vulnerable patients in our community and link our safety initiatives with related strategies such as our deteriorating patient's strategy.

Pressure Care

- Eliminate avoidable grade 3 and 4 pressure ulcers within our integrated care organisation. With an increasing number of elderly patients with complex care needs this is an important area of improvement for us. If we can eliminate the most severe pressure ulcers we can reduce the level of medical interventions our patients need, and we can work with our community teams to extend independent living for our patients.

Falls

- Reduce the number of in-patient falls that result in serious harm.
- Ensure that every patient is assessed for risk of falling and that this risk is re-assessed in line with the patients' clinical needs.

This will be supported by the development of a 'falls care bundle' for use in all acute clinical areas. This 'falls care bundle' will be applied to all high risk patients, with the aim of eliminating falls which result in serious avoidable harm.

Sepsis and Acute Kidney Injury

- All cases of severe sepsis to be recognised and treated according to the "sepsis six" care bundle early interventions within the first hour.
- All cases of Acute Kidney Injury to be promptly recognised and appropriately treated.

Medicines Management

- Reduce the number of incidents which result in serious harm from drug errors, in particular those errors related to insulin, anticoagulants, opiates and injectable sedatives.



SIGN UP PACK

Reducing Suboptimal care in people with Learning Disability

- Reduce avoidable harm and avoidable poor patient experience in patients with Learning Disability by putting in place recognised improvement initiatives to make our care more responsive to the individual needs of each patient.

Missed fractures in the Emergency Department

- Reduce the number of missed fractures in the Emergency Department by 50% over a three year period.

Intrapartum fetal wellbeing assessment

- Introduce intrapartum fetal well-being assessments and management in high risk pregnancies with the aim of reducing avoidable harm by up to 50% of the total number of claims brought forward each year.

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

- Continue to develop our use of internal and external information including from our key performance indicators, incidents and serious incidents, complaints, safety thermometer, our own clinical audit programme and national audits to ensure that we are aware of and develop appropriate action plans and quality improvement projects targeted to our concerns. We will disseminate the outcomes through our staff briefings, walkabouts, and website and present them at divisional and Trust wide quality meetings.
- Develop our quality improvement projects with patients and share the improvement outcome with them through our stakeholder initiatives.
- Ensure there is team and personal learning from adverse events, through the sharing of Root Cause Analysis (RCA) investigation reports and delivery of the subsequent post incident action plans.
- Ensure that there is organisational wide learning from incidents, SIs and complaints through existing communications methodology to improve patient safety and experience, as well as drive down the number of claims.
- Ensure that we continually learn from all claims and Coroners' inquests, using this intelligence to identify further quality improvement projects.



SIGN UP PACK

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3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- Implement the Duty of Candour and work with staff to build our skills in disclosure. We will aim to increase our levels of reporting incidents and ensure that the Duty of Candour process is applied within the required timescales for any incidents which result in moderate harm or above.
- Ensure that we continually develop our culture of open and honest conversations with patients and families when things do go wrong and when care has fallen below expected standards, and we will support staff to do this.
- Seek out patient and carer involvement in our investigative processes and discuss the findings of our investigation and actions with them once complete.
- Publish progress with our quality improvement initiatives and the impact of these on patient safety.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- Whittington Health will be an active participator in our regional Patient Safety Collaborative and actively engage with safety initiatives across the local health and social care system. We will work with our university colleagues on developing quality improvement expertise.
- Continue to work closely with the Academic Health Science Network and UCLP Quality Forums including the
- Medical Director's Forum, Community Education Provider Network to develop education in patient safety, leadership development in improvement methodology and trainee education in improvement methodology.



SIGN UP PACK

5. Support. Help people understand why things go wrong and how to put them right and give staff the time and support to improve and celebrate the progress.

- Implement a process of written reflection as part of our Serious Incident process for all staff involved in incidents and develop our debriefing process following adverse events ensuring that appropriate feedback is given to staff where ever appropriate when harm or incidents have occurred.
- Develop processes that enable our patients and partners to understand our systems and how they can help be involved to help us improve.
- Celebrate our success by holding events to share them with our staff and others but also to champion individuals and teams who have done great work. We will use our excellence awards schemes to celebrate achievements.
- Ensure that staff can quickly and easily access our Employee Assistance Programme where additional emotional support may be required following involvement in an incident or complaint.
- Ensure that professional supervision structure is used effectively to help staff develop and improve individually and celebrate successes.



FREQUENTLY ASKED QUESTIONS

1. What is Sign up to Safety?

Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

2. What does Sign up to Safety mean?

This campaign and its mission are bigger and much more important than any individual's or organisations' programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that organisations currently own and aligning them with this single common purpose.

3. What is different about Sign up to Safety from previous campaigns?

What is unique and fundamentally different is that this campaign is for everyone. It transcends organisational boundaries and will align the whole system to achieving our shared ambition. There will be no targets or 'performance management' from the centre – the energy, ideas and expertise will be found deep inside the NHS and within your organisation. The Chief Executives of NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA) have all signed up to align their work with this campaign.

The idea is to harness the talent and enthusiasm within organisations and connect this to others in our National Health Service.

4. Who can sign up to the campaign?

Sign up to Safety is for everyone, everywhere. Whether you work in primary, secondary, or tertiary care; whether you work in acute, mental health, learning disabilities, ambulance, or community care settings; whether you work in a national body or a general practice, Sign up to Safety applies to you.

How is the campaign being organised and supported?

A National Co-ordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organisations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.
- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

5. What support is available to organisations who sign up to the campaign?

The National partners will work together with improvement experts to establish what a good improvement plan looks like and to support organisations to learn from each other in drawing up and delivering theirs. It is crucial that the leadership of the campaign is exercised locally but equally that this work is completely aligned with and mutually supportive of the work that is already underway or planned in relation to patient safety improvement. In this first phase, an 'Alliance of Improvement Experts' will be asked to come together and offer provider organisations who sign up the opportunity to have improvement support and advice.

The Improvement Alliance will also combine their sign up coaching with supporting the local patient safety collaborative to help enhance and align the activities of both. The level of advice and support will depend on what local organisations ask for, but the Improvement Alliance will act to bolster the development of these linked initiatives where they can, transferring skills to

collaboratives and provider organisations, as well as supporting the development of the Patient Safety Fellows Programme.

Over time we expect that the Campaign will be self-supporting as capacity is created locally to harness enthusiasm and develop capability, not least through the developing patient safety collaboratives. At the outset of the campaign a National Co-ordinating and Support Group will be established chaired by Sir David Dalton, with NHS England leadership provided by Dr Mike Durkin. The CQC, Monitor, the NHS LA and TDA will be part of the Group alongside representation from professional bodies, patient groups and improvement experts.

The Group will encourage organisations to commit to the campaign and will listen to what they need for support. The Group will also work to ensure the alignment with and support the establishment of related system activities including the patient safety collaborative programme, the Patient Safety Fellows Programme and the core development and support activity of the Trust development Authority and Monitor already in place. It is crucial that this campaign is seen as bringing the activity of the whole system together with a common and urgent single purpose.

6. How should organisations get patients, families and carers involved in Sign up to Safety

We strongly encourage organisations that sign up to be actively engaging with patients in a meaningful and productive way. Patients, their families and carers have a vital role in patient safety and their perception of safety and opinions on where improvement can be made should form part of the development of the improvement plans.

Their opinions are one of the most powerful influencers of other people and their choices and their voice a powerful force for change if listened to and learned from. This could be through a patient suggestion scheme, inviting patient representatives to be part of committees or forums to develop the plans, holding consultation events etc. More suggestions on including patients in the campaign are available on the website and case studies will be added as more and more organisations sign up to the campaign.

7. How does Sign up to Safety align with other patient safety programmes and initiatives?

The following linked initiatives to improve patient safety will be aligned with the campaign so that the whole system supports involvement. *Patient Safety collaboratives* – These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. They will begin their work later in the year. Organisations that sign up to safety can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Patient safety Fellows – work is underway to create a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety. The group will launch later this year and organisations who participate in Sign up to Safety are involved in the collaboratives will benefit from the expertise of the fellows and can also support their own staff to become fellows.

New National Reporting and Learning System (NRLS) – work is underway to review and re-commission the NRLS. We already have the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team – A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care. SAFE will be piloted later this year and could help support signed up organisations, and others, who require additional help.

Safety website – A new set of hospital patient safety data is now available on NHS Choices enabling trusts to be compared against each indicator. Putting key safety information into the public domain supporting transparency and helping patients to make informed choices about their care and exercise their right to challenge their local healthcare providers on safety issues. Organisations that have signed up to safety can use this public data to inform their plans and conversations with their local communities.

Whittington Health Trust Board

4th March 2015

Title:		Clinical Strategy					
Agenda item:		15/038		Paper		5	
Action requested:		<i>For approval</i>					
Executive Summary:		Our clinical strategy has been developed with staff and stakeholders to meet the challenges our community and local health economy face over next five years. It outlines our ambition as an integrated care provider, a 21 st century provider of innovative community and hospital services. Over next five years we will continue to strengthen our partnerships with mental health, social care and primary care services, alongside our multi agency partners to deliver our mission and vision and improve the health and outcomes for our local community. Our mission, vision and strategic themes were agreed by the Board in February 2015.					
Summary of recommendations:		To approve the clinical strategy for Whittington Health.					
Fit with WH strategy:		This paper outlines the strategic intent of Whittington Health and aligns with government policy.					
Reference to related / other documents:		IBP & LTFM					
Reference risk and corporate risks on the Board Assurance Framework:		Risk captured on risk registers					
Date paper completed:		24 February 2015					
Author name and title:		Siobhan Harrington, Director of Strategy/Deputy Chief Executive		Director name and title:		Siobhan Harrington, Director of Strategy / Deputy Chief Executive & Greg Battle, Medical Director Integrated Care	
Date paper seen by EC	18 & 24 Feb 2015	Equality Impact Assessment complete?	Ongoing	Quality Impact Assessment complete?	Ongoing	Financial Impact Assessment complete?	Ongoing



Our Clinical Strategy 2015-2020

‘Helping local people live longer, healthier lives’

1. OUR STRATEGY

Our clinical strategy provides a framework and direction for the organisation to be a national leader in delivering safe, integrated care to our local community.

The strategy has been developed with staff and stakeholders to meet the challenges our community and the local health economy face over the next five years. It outlines our ambition as an integrated care provider, a 21st century provider of innovative community and hospital services.

Whittington Health has an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. Our clinicians are encouraged to continuously evaluate their services and to adopt new ways of working across established boundaries in pursuit of improved outcomes.

Our relationship with our community and local partners is important to us. Whittington Health is a community asset. We are a key part of our community as they are to us; not only as a local health provider but also as an employer.

Over the next five years we will continue to strengthen **our partnerships with mental health, social care and primary care services, alongside our other multi agency partners** to deliver our mission and vision and improve the health and outcomes for our local community.

This document provides the detailed thinking underpinning our mission and our vision, followed by six strategic goals. A number of principles are outlined which will support delivery of the goals. Our approach to delivering care focused on five population groups is described.

2. OUR MISSION

“Helping local people live longer, healthier lives”

Our mission recognises that there are many determinants of health, not all of them in our remit to deliver. However, for us to support people to achieve this goal, we all agree that the most successful model will be local partnership working, with a range of agencies.

Our locality has a long and strong history of joint working, which we will continue to develop. We recognise a need for a greater emphasis on prevention which will require a change of focus towards promoting health and wellbeing.

With the requirement to become a leader in prevention as well as treatment, we will need to look beyond traditional pathways of delivering care.

3. OUR VISION

“Provide safe, personal, co-ordinated care for the community we serve”

The Mission Statement describes the 'What', the Vision is the 'How'. Each word of our vision has been carefully chosen.

'Provide' distinguishes us as a provider first and foremost. However we may also commission services from others. We will ensure that relationships with local providers are strengthened to deliver improved patient experience and outcomes, for example, working with GP providers in our urgent care model.

'Safe' care requires constant attention and re-emphasis. The best health care organisations recognise the importance of an explicit safety agenda and we will ensure safety is a priority in every encounter we have.

'Personal' - keeps the individual as a unique whole in our minds, and reminds clinicians that while guidelines and patient pathways are aids to care they are *not* the rationale of care. In our personal encounters, we must allow compassion and judgement their proper place.

'Personal' also encompasses the opportunity to encourage supported self-management and to be sensitive to the new ways people increasingly want to engage, for example via technological advancements.

'Co-ordinated care' restates a key element of integrated care. We face multi-morbidity in a population with increasingly complex needs. People require help in navigating the system. We will ensure their care is co-ordinated and not fragmented. The emphasis on health and well-being means that we will actively engage with all key providers involved in the care of our population.

'Communities we serve' - Whittington Health's acute patients come in large part (85%) from the boroughs of Islington and Haringey. Most of our community based services are provided to these two boroughs, with some covering the boroughs of Camden, Hackney and Enfield. These communities are vibrant, complex and multi-ethnic, and include considerable wealth and deprivation side by side. They provide the sorts of challenges that attract our staff.

As an organisation, we have opportunities to work in a wider geographical area where this makes sense for our communities and clinical pathways. We are deeply rooted in these communities as provider and employer. We have established and developing relationships with public, private and voluntary sector partners, and building long term relationships has been, and is, key to our strategy.

Our mission and vision will remain relevant, we believe, for the next 5 years and beyond.

4. STRATEGIC GOALS

Our clinical strategy will be delivered through achieving six key strategic goals.

4.1 To secure the best possible health and wellbeing for all our community.

We will ensure that everyone who has contact with our services will receive holistic care. Our focus will be on treatment of illness, and also prevention and health promotion. We will develop a health promoting menu for all our staff to use in contact with service users, incorporating guidance and information that supports patient empowerment.

We will continue to work closely with our local authorities in both Haringey and Islington to respond to the joint strategic needs assessments. In particular this will involve closer working with public health.

Local voluntary organisations have a great role to play in contributing to health and wellbeing and preventing illness. We already engage with voluntary sector providers for certain care pathways and over the next five years our intention is to further develop these relationships. We will encourage clinical teams to build relationships with relevant voluntary sector organisations as part of integrating care.

To maximise the combined impact of integrated care on health and wellbeing we will become system leaders with our partners.

Each department and team will consider its role in preventing or reducing smoking, alcohol, obesity and mental illness. Teams will focus on prevention in their specific area, for example, district nursing and prevention of pressure ulcers; orthopaedic team and prevention of accidents or falls; and midwives and health visitors and the prevention of perinatal mental illness.

4.2 To integrate/co-ordinate care in person-centred teams

Within the organisation we will foster greater multidisciplinary team (MDT) working around the needs of the patients/clients we serve.

We will further refine patient pathways to minimise duplication and fragmentation. Our infrastructure and administration systems will need to be aligned to enable MDTs to deliver patient centred care.

Across Haringey and Islington there are eight localities within which we will work as part of MDTs; with GPs, social care, mental health services, the voluntary sector, and other secondary care providers. We will share our approach to risk assessment, case management and care coordination. We will use technologies to support the development of new models of care.

We recognise that primary care has a unique role to play in integrated care. General practitioners are rooted in their communities, have a defined population to whom they offer continuity, and are usually patients' first contact with health services.

We will support our local GP practices to provide the best integrated care, by directly providing primary care through our Hanley Road practice; working as partners in localities, and offering support and advice to individual and local groups of practices on a tailored basis.

Where there is a direct interface with GPs we will provide a named lead clinician who will act as a contact for support, advice and navigation for each of the localities in which we provide services. This will enable us to strengthen the relationship within each locality.

4.3 To deliver consistent high quality, safe services

We will build on our record of providing high quality and safe care. All clinicians strive to deliver the safest care of the highest quality; 'right first time, every time', and a patient experience that exceeds expectations.

These key themes will continue to run throughout all our work. Moreover, the quality agenda must become embedded in the culture of every intervention both individually and within all clinical pathways.

We recognise that quality incorporates three key elements, clinical effectiveness, patient safety and patient experience.

- Clinical effectiveness can be defined as the extent to which specific clinical interventions achieve what they are intended to achieve. Decisions to develop and provide services should be driven by evidence of both clinical and cost effectiveness. In practice, clinical effectiveness is about developing and delivering high quality care. Ideally, this should involve using the best available research evidence, together with clinical expertise and patient involvement. Where there is a limited evidence base, clinical effectiveness can be achieved through benchmarking, audit, and continuous improvement based on identifying and sharing good practice.
- Regarding patient safety, our ambition is to deliver *Zero Avoidable Harm*. We will be at the forefront of the national Patient Safety Initiative 'Sign up to Safety'. We will reaffirm our commitment to patient safety and aspire to be among the safest organisations in the NHS.
- We will continuously improve patient experience. We will continue to refine our methods of obtaining feedback from patients and carers, shadow governors and others. We will seek to learn from that feedback. This will directly influence our plans for quality improvement and service development.

In driving improvements in quality we will continue to improve service delivery in the five core domains identified by the Care Quality Commission. We will ensure that our services are safe, effective, caring, responsive and well led.

4.4 To support our patients /Users in being active partners in their care

"Patients want to be listened to, to get good explanations from professionals, to get their questions answered, to share in decisions and to be treated with empathy and compassion." **National Voices' (2011) 'What patients want from integration'.**

Whittington Health has been a leader in developing patient centred approaches to care through our initial engagement in 'co-creating health' in adult services, self-management programmes and approaches to patient and clinician activation. We have been part of the '*Better Conversations*' initiative in our children's services. We will continue to embed these approaches in all our care pathways and take this to the next level by supporting all our users to be active partners in their care and in optimising their health and wellbeing. This will involve patients and clinicians in a culture change that will mean that every contact will equip people to play a greater role in managing their health and illness.

The evidence is increasing that '*supported self-management*' is important in preventing deterioration in long term conditions and improving patient empowerment.

Whittington Health has been a national leader in this area and we will include the full range of patient centred approaches such as shared decision making and health literacy.

4.5 To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research.

Our ambition is to build on decades of leadership and excellence in this area at undergraduate and postgraduate level. As a key campus for UCL and Middlesex Universities we are well placed to train health care professionals of the future. We are a partner within University College London Partners (UCLP). This will enable us to deliver our vision and mission and engage and attract staff.

We have an established education strategy that has been clinically led, supported by UCLP which describes how we will deliver educational opportunities across multi professional groups.

We are the host of the local '*Community Provider Education Network*' and are currently developing education and training across disciplines to reflect the requirements of our Clinical Strategy. The success of this network has prompted a further expansion across a wider geography.

Our clinical strategy will be supported and enriched by a research strategy. Whittington Health is in a strong position to draw in research expertise and funds to lead in integrated care research. This will also improve staff engagement, contribute to ongoing debates about patient pathways and leverage academic interest and resources to deliver our mission.

4.6 To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

As an organisation, we have proved we innovate and constantly review and evaluate our services to meet our population's changing needs. Our organisation will need to adapt and change. Innovation will continue to be an essential part of how we develop and evolve services and our workforce.

In order to innovate successfully, quality improvement methodologies need to be key a skillset of all people delivering care.

There is an increased focus on demonstrating improved outcomes that are both patient reported and also more quantitative clinical outcomes. We will continue to work with our commissioners as partners and respond innovatively to their outcome objectives. Initially we will work with partners to deliver improved outcomes to frail elderly people and people with long term conditions.

5. PRINCIPLES

To deliver the strategic goals of the organisation there are several principles that will help clinical teams develop their plans.

- Communication of who we are and what we do is important. We need to understand the needs of the local population. As clinical teams, especially where patients have on going care needs, we need to maintain registers that enable the coordination and management of care.
- We will further develop care planning across all clinical pathways, building on our work of enhanced recovery models and end of life care.
- Teams will need to ensure that that incorporate patient activation /empowerment/co-production in service development.

- Prevention and health promotion at every contact.
- We will deliver care in the most appropriate setting. This will allow us to be innovative in delivering patient centred working. Examples include locality working, virtual wards, multidisciplinary teams, conference calling, care at home, care in the hospital and ambulatory care.
- Clinical teams will reflect on the need to work with more specialist partners to ensure best outcomes for patients. This will continue to require close working with London wide and national networks.
- Primary care as a partner. Clinical teams will ensure that the advice and support to general practise is readily accessible.
- Delivering high value services. Value in health care is delivering the best outcomes efficiently and effective within available resources.

6. POPULATION FOCUS ON DELIVERING NEW MODELS OF CARE

We have held several workshops to consider how care will evolve over the next five years. Using a segmentation model developed by the Kings Fund, the workshops focused on care of older people, people with long term conditions, and people with unplanned care needs, people with planned care needs, and women, children and families. The following section reflects the discussions of the workshops and emergent themes and priorities. This is demonstrative of the engagement to date in considering the clinical strategy. It is in no means a complete and comprehensive detail of how our strategy will be delivered. Many clinical teams and departments are not mentioned in the following five sections. Every clinical team will need to develop plans in response to the mission, vision and strategic goals.

6.1 OLDER PEOPLE

Older people are a key part of our local community whose numbers are set to increase. People over 65 currently make up about one in 10 of the population of Islington and Haringey.

There is a strong commitment to deliver a care model for older people that delivers improved outcomes and better patient experience.

An increasingly aging population often brings more complex clinical requirements, especially around managing discharges from hospital and community services. We will strengthen our discharge planning pathways across Whittington Health to ensure that discharges are well co-ordinated, with excellent, integrated planning around the needs of the individual.

We have a clear vision of supporting patients and their carers to be active participants in their care and self-management. We will ensure that every interaction will receive support and intervention around prevention and self –management. Anticipatory care (proactive care that anticipates the needs of patients) is a key component in helping to support people to remain independent, to avoid hospital admission, and to return to an active life after illness.

IT systems will enable access all relevant data, enhancing all patient care, improving safety and reducing duplication.

To ensure that older people are managed in the best setting, we will deliver integrated care that is coordinated across the whole pathway.

We will continue to develop clinical models around rapid response and Intermediate care for older people. We have learnt that joint working between health and social care (e.g. our N19 project) offers considerable advantages to older people and staff. This improves the amount of time people spend supported in their homes and reduces their length of stay in hospital. We intend to extend this way of working.

Our ambulatory care centre offering rapid intervention and has supported quicker access to care for the older population, thereby avoiding some unnecessary hospital admissions. This model will need to be extended to ensure that urgent and emergency responses to the needs of the older people is fully integrated.

The virtual ward model compliments ambulatory care by delivering fully supported specialist care in older people's homes. We intend to continuously improve and extend this model.

We are delivering an integrated community assessment team to nursing homes in Islington, advanced care planning with community geriatricians and local GPs.

When hospital admission is necessary, we will strive to provide the best possible care on our 'care of the elderly' wards.

Rehabilitation is a critical part of recovery and we will increase our rehabilitation capacity.

One of the key places to integrate care for older people will be within locality based teams. We are working closely with mental health services and social care in both acute and community settings to ensure better integration of care.

Work will continue to be undertaken with advanced care planning, treatment escalation planning, working with all the relevant agencies and multidisciplinary teams, supporting the patient and their families to have the best end of life care possible.

Older people have often been prescribed multiple medications. Effective Medicines Management is an essential part of providing high quality integrated care. We need to continue to work closely with GPs, community pharmacists and hospital pharmacists and other clinicians.

6.2 PEOPLE WITH LONG TERM CONDITIONS

Many people across Haringey and Islington live with one or more long term condition, such as diabetes, '*chronic obstructive pulmonary disease*' (COPD) or heart failure. The number of people with one or more '*long term conditions*' (LTC) are predicted to rise in both boroughs.

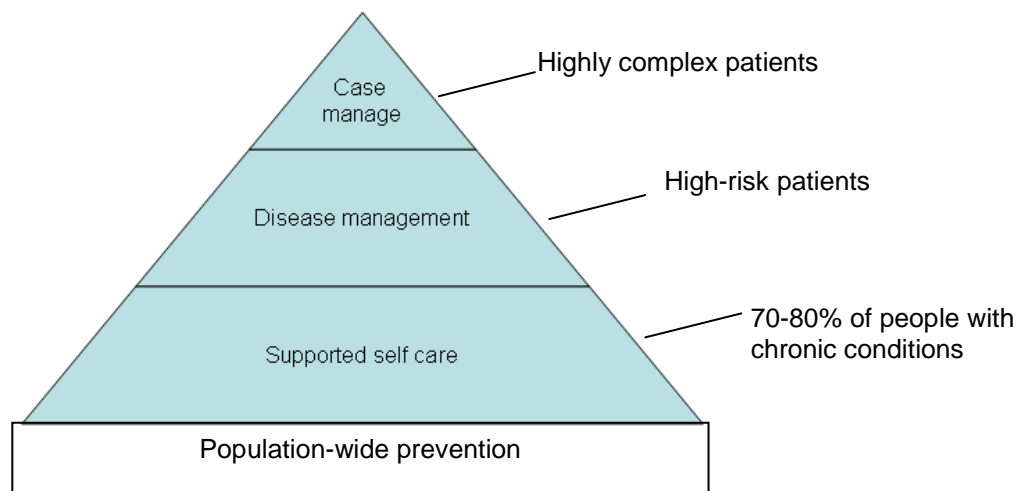
Our clinicians have been at the forefront of developing innovative and best practice models of care for this group, with work recognised nationally and across London.

We have developed a care co-ordination and case management approach with integrated pathways with local primary care. Some of our models use peer review and support to primary care in complex case review and clear care planning. We will continue to embed

these approaches across our medical specialities with the further development of multi-disciplinary teams and new roles.

As the prevalence and complexity of patients with LTCs continues to grow, it will become increasingly necessary to ensure that the right clinician is engaged in delivering the appropriate care to the patient. Following the Kaiser model (see below), our specialists will continue to deliver specialist services to highly complex patients with LTCs, while also working with the wider team of professionals to promote health and wellbeing.

The 'Kaiser Triangle' illustrating different levels of chronic care



To ensure a truly seamless and integrated model of care for people with LTCs, our locality based teams will need to include GPs, psychology services, social care and access to other services such as nutrition and dietetics and speech and language therapy.

We recognise the importance of supported self-management and we will ensure that every interaction with patients with LTCs will receive support and intervention regarding relapse prevention and self-management strategies.

6.3 PLANNED CARE

We will continue to strive to be the 'provider of choice' for local people for planned care.

We will ensure that it meets quality and safety standards. We will continue to streamline our pathways, coordinate care, and use the latest technology to improve access to care. We will continue to benchmark the care we provide.

Pathways will further build on our work to enhance recovery and prepare people for surgical procedures with a focus on optimising health and wellbeing before surgery. Patients will be supported to have care as day case or ambulatory care where possible. When a hospital stay is required, we will do our best to ensure it is for the appropriate duration. We will ensure that when people leave hospital there will be appropriate care in place to support them at home. We will evolve our models of virtual working, with support and supervision for patients being cared for in the community.

Planned care will be delivered using 'one stop' arrangements where possible, where patients will receive diagnosis and treatment in one visit.

We will build on the models of care we have in community urology and community gynaecology, where people can be seen by specialists in community facilities closer to where they live.

We will expand our day case work in all specialties to deliver excellent care in an efficient and effective way. We will continue to develop 'straight to test' for example our endoscopy service, to improve the early detection of cancer.

We have a unique contribution to make in delivering a multidisciplinary approach across the whole obesity pathway from home to hospital and delivery of preventative services as well as intermediate care and specialist surgery.

To respond to the needs of our local population we will focus our orthopaedic services on delivering exceptional joint replacement and repair. Orthopaedics also has a critical role to play in managing acute and chronic back pain. Our orthopaedic team will deliver high quality and safe surgery where needed, with a focus on prevention and supporting people to manage their condition.

Following a diagnosis of cancer, integrated care planning is essential. We will work closely with our partners in London Cancer to support patients at every step of the pathway. We have been nationally recognised for our work in acute oncology and will continue to strive for excellence.

By demonstrating the high value of our planned surgical pathways, we intend to grow our share of surgical work.

6.4 UNPLANNED CARE

To meet the continuing demand for unplanned care will require ever closer working between providers locally and nationally. To do this we will continue to provide the current range of emergency services and intensive care on the Whittington Hospital site.

We will guarantee high quality and safe services 24 hours a day, 7 days a week. We will respond in a timely way to individual needs and have an infrastructure that copes with peaks in demand.

We will ensure that people understand how to access our services and will work with partners to make care seamless and efficient. We will build health promotion and illness prevention into our unplanned care pathways. We will deliver innovative models of care to meet the continued rise in local demand.

Our community nursing models will need to respond to unplanned care developments in localities.

Where care requires more specialist input we will transfer patients in a timely and safe manner to a more specialist centre.

6.5 WOMEN, CHILDREN AND FAMILIES

Whittington Health offers a wide range of services to women, children and families. We will continue to develop and integrate the excellent clinical services offered to our population.

Our maternity and neonatal services: A core value of the maternity services within Whittington Health is to support people to have normal births where possible and to receive high quality care throughout pregnancy. We aim to provide a range of options for local women to deliver their babies either in their own home, in our midwifery led birthing unit or on a consultant led labour ward.

We will build on our reputation of having caring, professional and friendly staff and will see a significant redevelopment of our maternity and neonatal services. We have good team working and midwives who work both in the community and hospital setting. Increasingly we are building integrated working with community midwives and health visitors, alongside the family nurse partnership and PIPS (parent infant psychology) service. We plan to develop an integrated perinatal service. We will also continue our provision of complementary therapies to support pregnant women and women in labour.

Our neonatal unit is a level 2 unit which provides quality and safe care to premature babies that may have been delivered at the Whittington, or who may have been cared for elsewhere and require repatriation .

Our children's services: Our community and hospital services include some specialist community services for example child and adolescent mental health services, speech and language therapy and children looked after services. We also provide universal services to all children, for example health visiting and school nursing.

We are committed to continue to provide a full range of children's' services. This includes everything from care at home to our inpatient ward. We aim to put the child at the centre of everything we do. We are developing new models of care such as our Hospital at Home Service, to increase specialist support for children and families in their homes.

We recognise that children and families need timely and responsive services. There is a need for greater co-ordination between out of hours care, general practise, ambulatory care and acute services. We aim to be a system leader in improving urgent care and unplanned care for children.

The inpatient and outpatient services delivered to children will continue to include cancer care, acute care and care of children with long term conditions. The service also includes a fully integrated co-located paediatric mental health team, attending both to a rising trend in emergency admissions of suicidal teenage patients and also to complex/ medically unexplained presentations in children of all ages. This service will continue to develop to meet rising demand.

Children's services will work closely with general practise to offer advice and support and easy to access to services. We will improve co-ordination of information technology.

There will be further embedding of preventative work that focuses on health and wellbeing especially breastfeeding support, parenting skills, allergy management and childhood obesity. We will further develop our approach to engage children fully in their care, building on the 'Better Conversations' work.

Our mental health services including '*Parent Infant Psychology Service*' (PIPS), '*Child and Adolescent Mental Health Services*' (CAMHS), and Simmons House adolescent inpatient unit, will all be involved in increasing our psychological support and also preventing mental illness or the ongoing long term impact of mental illness for children.

As medical advances continue, there will be a small but growing group of infants and children with complex long term conditions and learning difficulties who require ongoing multidisciplinary input from our teams.

We recognise the critical importance of transitional services for children and adolescents with long term conditions. We will improve the quality of the experience for children undergoing this transition. Getting this right is difficult and will require close working with adult services.

7. CONCLUSION

This clinical strategy demonstrates the wide range of clinical services already provided by Whittington Health, an integrated care organisation (ICO) focused on the care of our local population. Over the next five years we intend to continue to grow and improve the care we provide across our community and hospital settings.

The strategy lays out a clear mission and vision. The strategic goals will enable the vision and mission to be achieved. The principles will guide clinical teams to formulate detailed plans which will be annually reviewed over the time period of the strategy.

Our mission is clear ***'helping local people live longer healthier lives'***.

The increasing complexity of the delivery of this mission requires an integrated approach that will require innovative thinking and behaviour change at all levels. A partnership between patient, carer, community, commissioners and providers that is stronger than what has been to date.

To quote the NHS Five Year Forward view (NHS England 2014) *'there is now quite a broad consensus on what a better future should be'*. Our clinical strategy is a reflection of that broad consensus and we are now in a position at Whittington Health to be a leader in making that *'better future'* real for our local population.

Siobhan Harrington
Director of Strategy/Deputy Chief Executive

Greg Battle
Medical Director Integrated Care

Whittington Health Trust Board

4 March 2015

Title:	Trust Board Report March 2015																		
Agenda item:	15/039	Paper	6																
Action requested:	For discussion and agreement of areas of focus.																		
Executive Summary:	<p>The following is the Performance and Quality report for January 2015; a number of highlights and areas for focus are identified.</p> <p><u>National Indicators</u></p> <p>Referral for Treatment (RTT): Achieved 3rd consecutive month.</p> <table border="1"> <thead> <tr> <th>Target</th><th>Nov-14</th><th>Dec-14</th><th>Jan-15</th></tr> </thead> <tbody> <tr> <td>Admitted 90%</td><td style="text-align: center;">90.7%</td><td style="text-align: center;">92.8%</td><td style="text-align: center;">91.3%</td></tr> <tr> <td>Non-Admitted 95%</td><td style="text-align: center;">95.0%</td><td style="text-align: center;">96.1%</td><td style="text-align: center;">95.0%</td></tr> <tr> <td>Incomplete 92%</td><td style="text-align: center;">92.2%</td><td style="text-align: center;">92.3%</td><td style="text-align: center;">92.96%</td></tr> </tbody> </table> <p>Having successfully met the back log reduction plan we are now working on sustaining the national access standards and reducing the overall waiting list to the level set in November 2014. This measure is the over 18 weeks waiting patients do not exceed 1047 by the end of March 2015.</p> <p>All units are on track, and capacity and demand reviews are underway across surgical specialities. A benchmarking exercise was completed during December and January with the aim of cross checking effective and efficient usage of our operating theatres. Feedback has been received and confirmation that the redesign work has delivered significant improvement in theatre productivity. Waiting times per speciality are listed in the overall document. Due to the high demand for emergency inpatient beds and emergency theatre capacity, the admitted RTT capacity was reduced for two weeks. This has affected the theatre utilisation for planned care patients.</p> <p>Emergency Care:</p> <p>The high demand for inpatient and complex care planning continued into January as reported in December performance report. This demand remained for older people with complex cases and paediatrics. Increased focus occurred on our community teams in order to meet the demand for early discharge and increased referrals from neighbouring trusts.</p> <p>The system resilience health economy board met and has provided</p>			Target	Nov-14	Dec-14	Jan-15	Admitted 90%	90.7%	92.8%	91.3%	Non-Admitted 95%	95.0%	96.1%	95.0%	Incomplete 92%	92.2%	92.3%	92.96%
Target	Nov-14	Dec-14	Jan-15																
Admitted 90%	90.7%	92.8%	91.3%																
Non-Admitted 95%	95.0%	96.1%	95.0%																
Incomplete 92%	92.2%	92.3%	92.96%																

close monitoring across different providers. Agreement was made to increase the capacity in district nursing to assist with these demands. Partnership working with LAS and Mental Health continues to be strong and direct involvement in management patient flow is seen on a daily basis.

Ambulatory care has continued to support demands for emergency flow, the stretch target of 5% is below due to the final stage of building work in the front entrance of ED. This will allow the senior clinical decision makers to assess and review at the point of arrival.

Cancer targets: All the national access standards for cancer have been met for QRT 3 and maintained in January and February. The redesign of patient pathways and capacity and demand work has delivered a significant improvement in the management of cancer patients. The clinical leadership of each pathway has maintained the focus and monitoring of patient access, achieved 3rd consecutive month. All referrals from other organisation completed and no further referrals are expected.

Dental Capacity: we will be refurbishing Enfield Dental Practice following a successful bid, this will provide additional capacity for routine patients.

Areas to note

Complaints: All support for divisions is now in place and improvement is expected in February through to April 15.

Infection Control: a second case, not related to the case in December 14, of MRSA has been reported. The review meeting took place on 27th January and Enhanced IPC environmental audit and management of isolated patients' audits have been completed. Both were found to be compliant. An audit of mobile x-ray machines was also completed.

Did not attend, in acute setting: All services now consistently using patient choice at point of booking and reminder calls at 7 days and 1 day before the appointment.

Maternity: Increase of 300 self-referrals received in maternity.

Summary of report:

QUALITY

- Inpatient deaths: the number of inpatients deaths has increased. Analysis finds a continued high proportion of deaths related to winter related illnesses.
- Completion of valid NHS number: Continues to improve despite increased demand on A&E.
- SHMI: Whittington Hospital mortality rate remains lower than expected for the Trust.

	<ul style="list-style-type: none"> • HSMR: Whittington Hospital score has returned to expected level, below the national average. <p>PATIENT SAFETY</p> <ul style="list-style-type: none"> • Harm Free Care: Achieved • VTE assessment: Achieved • Pressure Ulcers: Increase in prevalence on the wards, reduction plan in place. • Medication errors causing moderate/low harm: Action plans in place with close monitoring. • Never events: none • CAS alerts: none • Serious incidents reported: all incidents are fully investigated and learning is shared. <p>PATIENT EXPERIENCE</p> <ul style="list-style-type: none"> • Family and Friend Test: achieved • Mixed sex Accommodation: no breaches • Patient admission to adult facilities for under 16 years of age: no breaches <p>INFECTION PREVENTION</p> <ul style="list-style-type: none"> • Hospital acquired C Difficile infection: 2 in January 2015. A review has taken place and the action progressed, increased communication has been provided. • Hospital acquired E.coli infections: none • Ward Cleanliness: remains at 98% <p>ACCESS</p> <ul style="list-style-type: none"> • First to follow-up: acute ratio remains below the national benchmark. • Hospital cancellations: continued focus on improving cancellation rate. • Diagnostic waits: Achieved • 52 weeks wait: none • Community access: Podiatry, Intermediate Care and Community Rehabilitation added to this month's dashboard. Further services to be added to the dashboard over the coming months. <p>Presentation: Endoscopy project</p>
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:		19 th February 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?	



March Trust Board Report (January data)

Quality	Threshold	Nov-14	Dec-14	Jan-15
Number of Inpatient Deaths	-	27	54	50
NHS number completion in SUS (OP & IP)	99%	98.5%	98.6%	arrears
NHS number completion in A&E data set	95%	91.8%	94.3%	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	Jul-14	Aug-14	Sep-14
Hospital Standardised Mortality Ratio (HSMR)	<100	94.99	105.18	79.98
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	89.7	110.7	58.2
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	98.4	104.5	88.4

Patient Safety	Threshold	Nov-14	Dec-14	Jan-15
Harm Free Care	95%	94.5%	95.4%	95.2%
VTE Risk assessment	95%	95.1%	95.4%	arrears
Medication Errors actually causing Serious/Severe Harm	-	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	1	0	0
Proportion of reported patient safety incidents that are harmful	-	44.4%	35.2%	42.4%
Serious Incident reports	-	6	8	11

Access Standards

Referral to Treatment (in arrears)	Threshold	Oct-14	Nov-14	Dec-14
Diagnostic Waits	99%	100%	99.8%	99.7%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

		Meeting threshold		
Patient Experience	Threshold	Nov-14	Dec-14	Jan-15
Patient Satisfaction - Inpatient FFT (% recommendation)	-	88%	94%	94%

Efficiency and productivity - Community	Threshold	Nov-14	Dec-14	Jan-15
Service Cancellations - Community	2%	7.70%	7.70%	7.90%
DNA Rates - Community	10%	7.6%	6.9%	6.5%
Community Face to Face Contacts	-	63,382	58,199	62,496
Community Appts with no outcome	0.5%	3.4%	1.0%	1.6%

Community Access Standards	Threshold	Nov-14	Dec-14	Jan-15
Community Dental - Patient Involvement	90%	99.0%	98.0%	97.0%
Community Dental - Patient Experience	90%	99.0%	100.0%	100.0%
MSK Waits - Non-Consultant led still waiting at month end (% < 6 weeks)	100%	85.1%	83.5%	97.2%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	89.1%	99.3%	arrears
IAPT - patients moving to recovery	50%	47.0%	45.0%	arrears
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Nov-14	Dec-14	Jan-15
First:Follow-up ratio - acute	2.31	1.63	1.66	1.64
Theatre Utilisation	95%	82.9%	79.7%	75.3%
Hospital Cancellations - acute - First Appointments	<2%	6.0%	5.4%	4.6%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.6%	6.7%	7.0%
DNA rates - acute - First appointments	8%	12.8%	14.1%	14.2%
DNA rates - acute - Follow-up appts	8%	14.0%	13.8%	13.6%
Hospital Cancelled Operations	0	15	2	3
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	0

Additional capacity funding		Failed threshold		
Emergency and Urgent Care	Threshold	Nov-14	Dec-14	Jan-15
Emergency Department waits (4 hrs wait)	95%	92.4%	94.9%	94.5%

March Trust Board Report (January data)

Patient Satisfaction - ED FFT (% recommendation)	-	88%	87%	91%
Patient Satisfaction - Maternity FFT (% recommendation)	-	91%	87%	95%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	35	21	34
Complaints responded to within 25 working day	80%	71%	71%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Infection Prevention	Threshold	Nov-14	Dec-14	Jan-15
Hospital acquired MRSA infection	0	0	1	1
Hospital acquired <i>C difficile</i> Infections	19 YTD	1	1	2
Hospital acquired <i>E. coli</i> Infections	-	2	1	0
Hospital acquired MSSA Infections	-	0	1	0
Ward Cleanliness	-	98.2%	98.1%	-

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold		Oct-14	Nov-14	Dec-14
Referral to Treatment 18 weeks - Admitted	90%	Projected	84%	-	-
		Actual	83.3%	90.7%	92.8%
Referral to Treatment 18 weeks - Non-admitted	95%	Projected	72%	-	-
		Actual	89.9%	95.0%	96.1%
Referral to Treatment 18 weeks - Incomplete	92%	Projected	80%	-	-
		Actual	84.9%	92.2%	92.4%

ED Indicator - median wait for treatment (minutes)	60	85	70	69
30 day Emergency readmissions	-	240	269	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	2.7%	2.7%	2.8%
Ambulance Handover (within 30 minutes)	0	4	16	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Cancer Access Standards (in arrears)	Threshold	Oct-14	Nov-14	Dec-14
Cancer - 14 days to first seen	93%	94.9%	93.2%	93.7%
Cancer - 14 days to first seen - breast symptomatic	93%	97.1%	93.5%	94.4%
Cancer - 31 days to first treatment	96%	96.1%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	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%	94.7%	87.5%	88.2%

Maternity	Threshold	Nov-14	Dec-14	Jan-15
Women seen by HCP or midwife within 12 weeks and 6 days	90%	92.4%	85.7%	80.7%
New Birth Visits - Haringey	95%	85.0%	83.5%	arrears
New Birth Visits - Islington	95%	91.4%	88.7%	arrears
Elective Caesarean Section rate	14.80%	13.7%	12.9%	15.2%
Breastfeeding initiated	90%	88.7%	92.2%	88.6%
Smoking at Delivery	<6%	4.9%	4.9%	5.4%

Meeting threshold

Additional capacity funding

Additional capacity funding

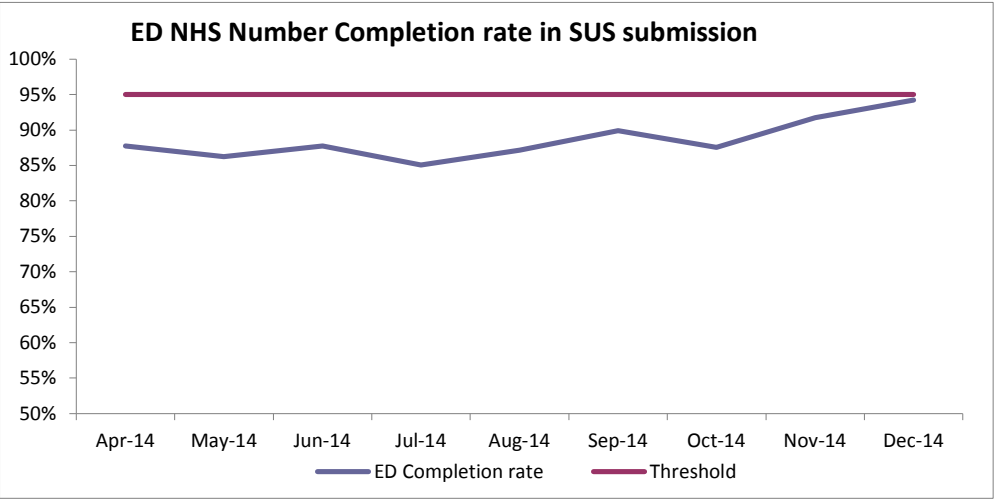
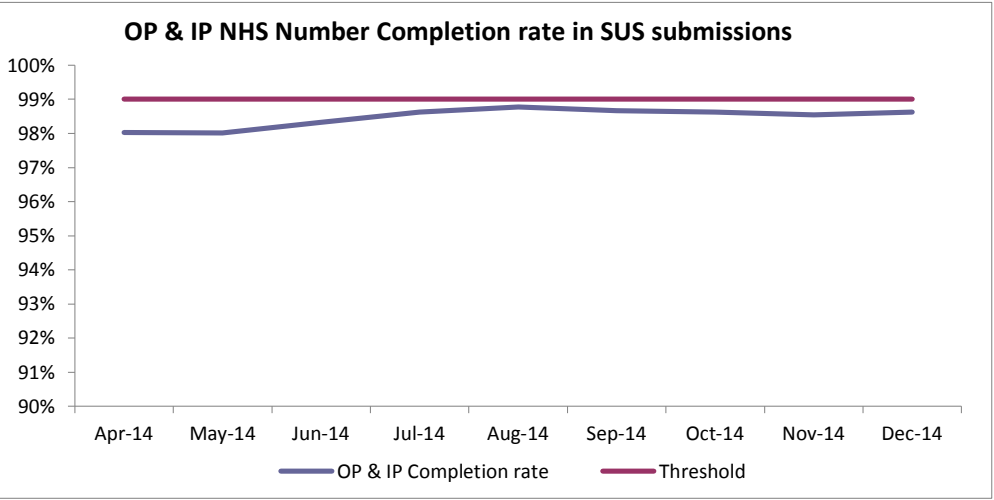
Failed threshold

	Threshold	Trust Actual		
		Nov-14	Dec-14	Jan-15
Number of Inpatient Deaths	-	27	54	50
Completion of a valid NHS number in SUS (OP & IP)	99%	98.5%	98.6%	arrears
Completion of a valid NHS number in A&E data sets	95%	91.8%	94.3%	arrears

		Lower Limit	Upper Limit	RKE SHMI 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 has increased in January 2015, this is being monitored and is a seasonal trend during winter.
as part of our aim to review mortality we have commenced the Jasmine Project, named after Jasmine Rodgers who died a few months after her birth. The Jasmine Project is our name for implementing the GAP/GROW project which started in the Midland to help increase the identification of small babies (IUGR babies) and help reduce the incident of stillbirth in London. We are part of a wider Pan London Strategic Maternity network plan to reduce the stillbirth rate. Staff will be trained on how to use individualised growth charts devised by the Perinatal institute to help monitor women so if there is concern about the growth of their baby they are referred for additional serial scans and possible early induction. We are launching this project at the next audit day in March and Jasmine's parents will be there for the launch
Action: Analysis of data shows a high number of winter related illnesses.
Timescale: On-going
Completion of valid NHS number
Issue: A steady improvement is observed in both the SUS and A&E dataset, despite the winter pressures.
Action: The ED department has access to a dataset, updated daily, identifying missing NHS numbers. Policies are re-enforce and procedures on completing NHS number in EPR are in place.
Timescale: Expected to be compliant in April 2015
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
The standardised mortality rate returns to expected level for Whittington Hospital, which means the balance between elective admissions and non-elective admissions are back at expected levels. Number of deaths recorded, 31, in September 2014 was the same as in August.

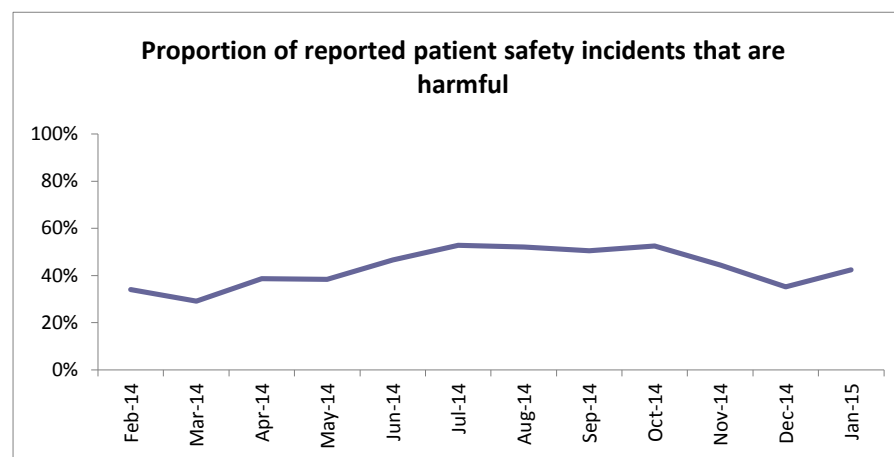
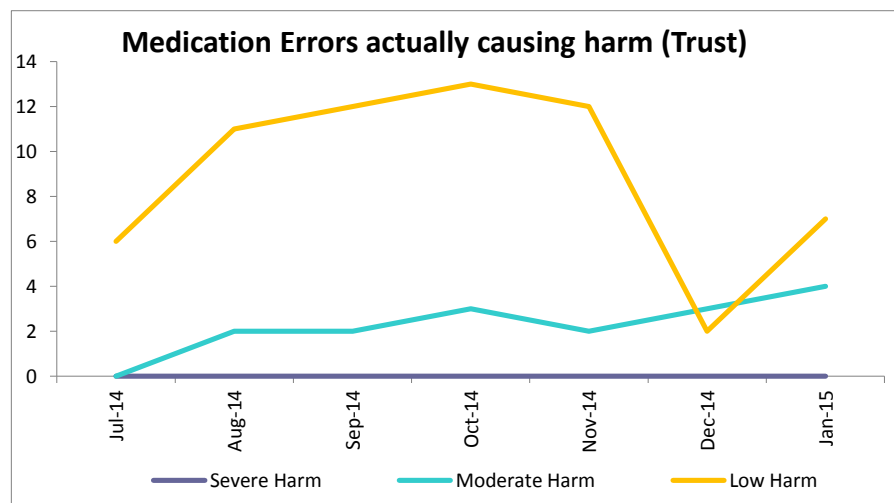
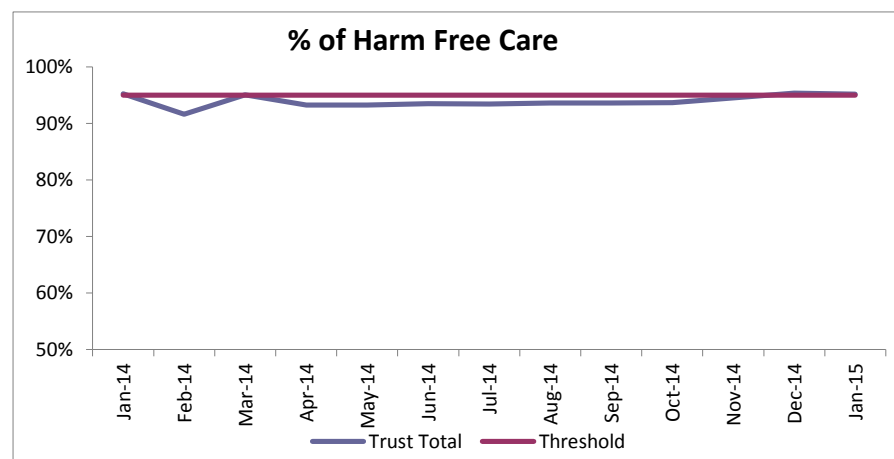
	Standardised National Average	Jul-14	Aug-14	Sep-14
Hospital Standardised Mortality Ratio	<100	94.99	105.18	79.98
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	89.7	110.7	58.2
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	98.4	104.5	88.4



Data extracted on 09/02/2015

	Threshold	Trust Actual	
		Dec-14	Jan-15
Harm Free Care	95%	95.4%	95.2%
Pressure Ulcers (prevalence)	-	3.90%	4.25%
Falls (audit)	-	0.27%	0.09%
VTE Risk assessment	95%	95.4%	arrears
Medication Errors actually causing Serious or Severe Harm	0	0	0
Medication Errors actually causing Moderate Harm	-	3	4
Medication Errors actually causing Low Harm	-	2	7
Never Events	0	0	0
Open CAS Alerts (Central Alerting System)	-	0	0
Proportion of reported patient safety incidents that are harmful	-	35.2%	42.4%
Serious Incidents (Trust Total)	-	8	11

Jan-15		
ICAM	SCD	WCF
94.1%	97.8%	100.0%
5.30%	1.07%	0.00%
0.11%	0.00%	0.00%
Reported one month in arrears		
0	0	0
3	1	0
3	1	3
0	0	0
-	-	-
42.6%	28.3%	48.8%
11	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

Timescale: Plan by end of March

Pressure Ulcer prevalence

Issue: There was a reduction in the number of pressure ulcers in the community but an increase on the wards.

Action: The Tissue Viability nurse has met with the Director of Nursing and is working with the Head of Nursing and Deputy Director of Nursing to implement a reduction plan.

Timescale: Immediate

Medication Errors actually causing harm

Issue: No Serious medication error have been reported in January. The moderate errors relates to process errors in prescribing (no end date, delay in medication order and prescription on paper but not JAC). The low harm incidents related to incorrect procedures being followed (incorrect prescription frequency and delay in medication order).

Action: All errors are investigated and appropriate action taken.

Timescale: completed

CAS alerts: The trust has no overdue CAS alerts. All alerts were actioned as appropriate.

Proportion of reported patient safety incidents that are harmful

Issue: Datix reporting has been fixed, but data in this dashboard might still be affected.

Action: Divisional reports and data between December 14 and January 2015 are being validated.

Timescale: March 2015

Serious Incidents

Issues: Out of the 11 SI reported in January 2015. Six pressure ulcers, four grade 3 and two grade 4. The five other SI included 2 patients who died as a result of influenza related illness, one patients died unexpectedly due to PE, one incident related to incorrect insulin administration and one patient sustained head injury due to self harm in ED.

Action: All incidents have been investigated. All reports are due in March 15. One grade 4 ulcers is investigated for de-escalation. Maternity are reviewing SI in the last years to identify themes in incidents and action plans. Learning of this will be shared.

Timescale: March 2015

	Threshold	Trust Actual		Jan-15		
		Dec-14	Jan-15	ICAM	SCD	WCF
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	93.8%	93.6%	96.4%	90.1%	100.0%
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	87.0%	91.4%	91.4%	-	-
Patient Satisfaction - Maternity FFT (% recommendation) **	-	87.2%	94.9%	-	-	94.9%
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	0
Complaints (incl Corporate)	-	21	34	17	8	8
Complaints responded to within 25 working day	80%	71.43%	arrears	100.0% *	57.1% *	25.0% *
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: The in patient score remains around 93%. The Maternity FFT score has improved, but is still manually collated.

Action: Maternity FFT Electronic device has not yet been repaired and the feedback is still collated manually. Friend and Family Tests are now becoming embedded. 'You said we did' is being spread across all services.

Timescale: On-going

Examples of 'You said, we did'

Life Force (paediatric palliative care team)

We asked "If we could offer more flexibility from the respite sessions, with regards to day and hours, what would be beneficial to you as a family"

The following responses were received: "2.30 - 6pm would be useful as it helps bed time and supper; after 5pm in the week would be good; weekends would be good; later starts in the morning would be good"

We did: "changed the hours of working and now the service runs from 8am - 8pm Monday - Friday"

If for ward

You said: Families complained that there were no play specialists working at the weekends and therefore no appropriate toys available.

We did: As a result each Friday afternoon the play specialist identifies which children will be an in-patient on the ward and will create a play programme and provide a play box of toys for each specific child.

Mixed Sex Accommodation

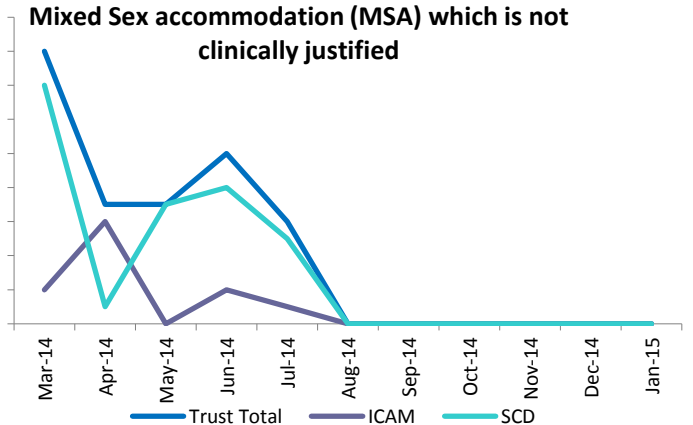
A policy and processes embedded in the services and no breaches for 6 consecutive months.

Complaints

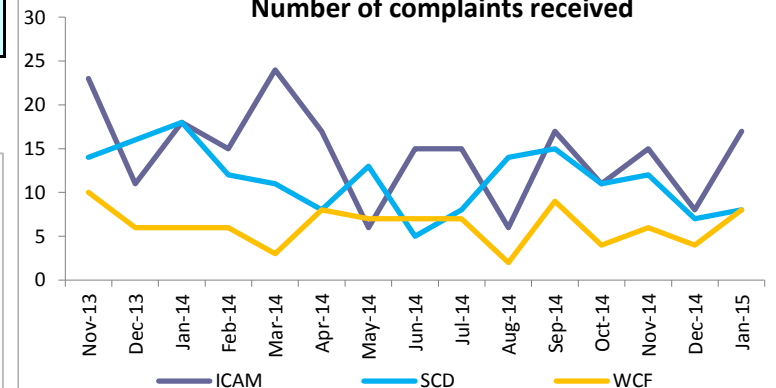
Issue: Below threshold remaining around 71%. The Integrated Care and Acute Medicine has score 100% in the last 2 months.

Action: Action plan embedded, key themes analysed. WCF now have support in place and backlog is being addressed.

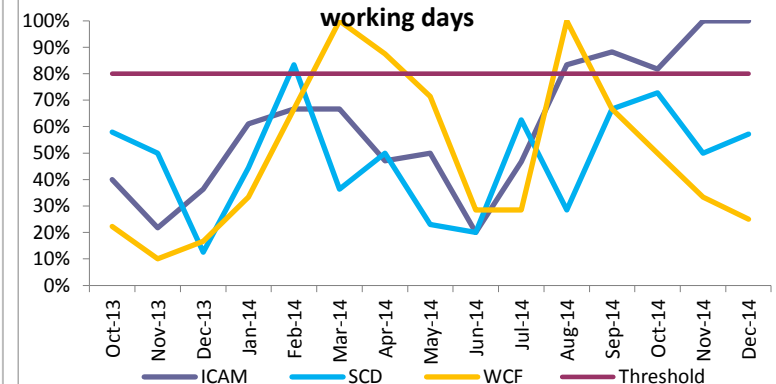
Mixed Sex accommodation (MSA) which is not clinically justified



Number of complaints received



Percentage of complaints responded to within 25 working days



		Trust Actual	
	Threshold	Dec-14	Jan-15
MRSA	0	1	1
E. coli Infections*	-	1	0
MSSA Infections	-	1	0

	Threshold	Jan 15	YTD
C difficile Infections	19 (Year)	2	16

Jan-15		
ICAM	SCD	WCF
0	1	0
-	-	-
0	0	0

ICAM	SCD	WCF
2	0	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: 1 new MRSA bacteraemia was diagnosed on ITU on the 16th of January 2015. (Two cases for the year to date both in SCD)

The PIR meeting took place on 27/01/15. The issues identified were the patient acquired MRSA bacteraemia on the unit. the review showed that the patient had 10 negative screens and then was transferred for a day procedure to an other provider and on the 11 screening had acquired MRSA Bacteraemia

Action: Enhanced IPC environmental audit and management of isolated patients audits have been completed. Both were found to be compliant. An audit of mobile x-ray machines was also completed, improvements to be made by radiology

Timescale: On-going for review in 4 weeks. All above actions completed, for monitoring at ICC.

E.coli Infection and MSSA

No new E. coli infections or MSSA identified in January 2015.

C Difficile

Issue: 16 cases ytd, from consultation with other hospital it is understood we all are in a similar position.

Action: all cases are investigated and action plans put in place including: training for wards, SOP for terminal cleaning, Alerts on EPR and JAC. A business case is being drafted to fund single use of access in side rooms on all wards, after a successful pilot on Meyrick ward.

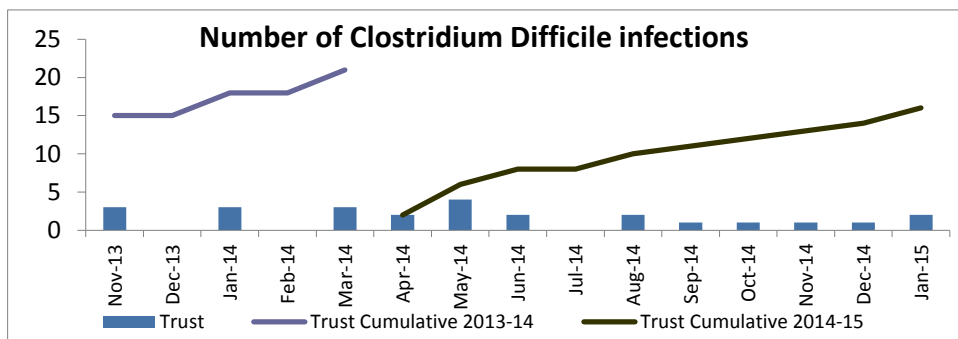
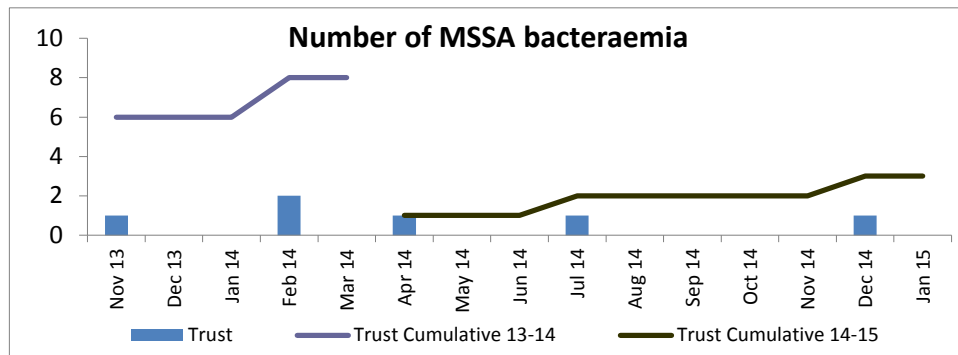
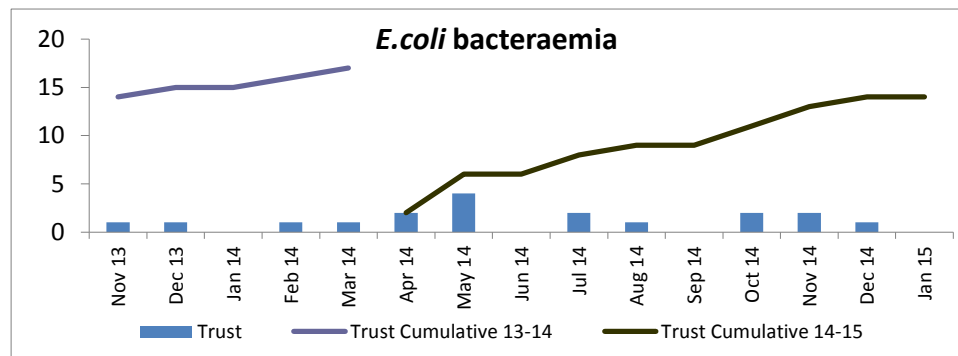
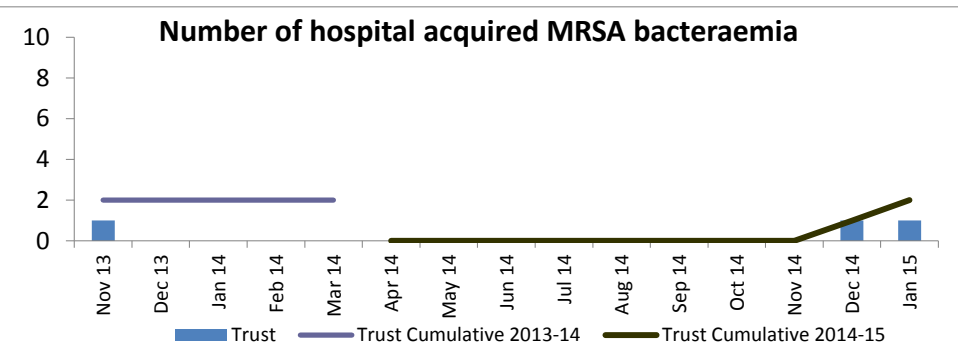
Timescale: On-going

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.



	Jan-15				
	Threshold	Trust Actual	ICAM	SCD	WCF
First:Follow-up ratio - acute	2.31	1.64	2.03	1.72	1.03
Theatre Utilisation	95%	75.3%	84.7%	74.7%	78.0%
Hospital Cancellations - acute - First Appointments	<2%	4.6%	5.5%	5.4%	2.9%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.0%	7.8%	8.7%	4.1%
DNA rates - acute - First appointments	8%	14.2%	18.6%	14.3%	10.6%
DNA rates - acute - Follow-up appointments	8%	13.6%	16.0%	14.6%	10.1%
Hospital Cancelled Operations	0	3	0	2	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 has dropped by 4%. WCF have transferred Gynea patients out to the community showing a drop in percentage. ICAM has investigated their utilisation of theatres for Pain patients and plans are in place showing a increase in percentage.

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.

Timescale: Immediate

Hospital Cancellations - acute

Issue: Cancellations for first appointment are steadily coming down, but follow -up appointments remain around 7%. Booking Team continue to identifying any unused clinic slots to pull patient appointments forward, this affects the percentage.

Action: Consultant leave is monitored closely.

Timescale: on-going

Did not attend

Issue: Overall 'Did not attend ' remains between 12 and 15%.

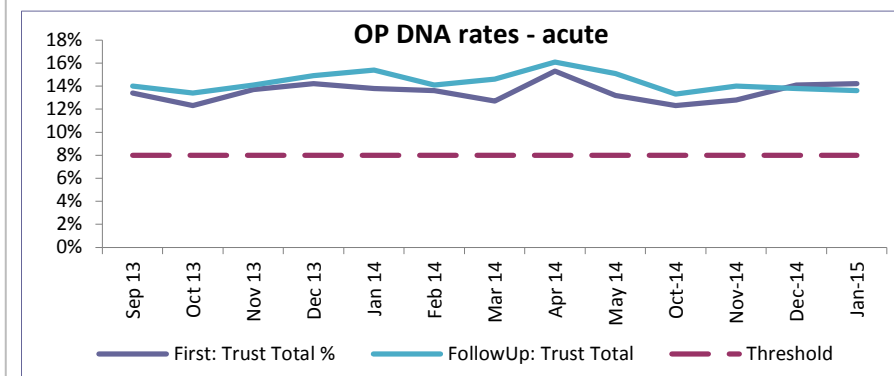
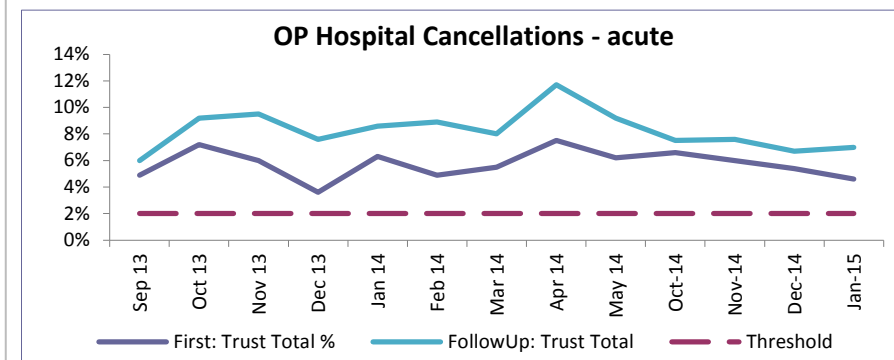
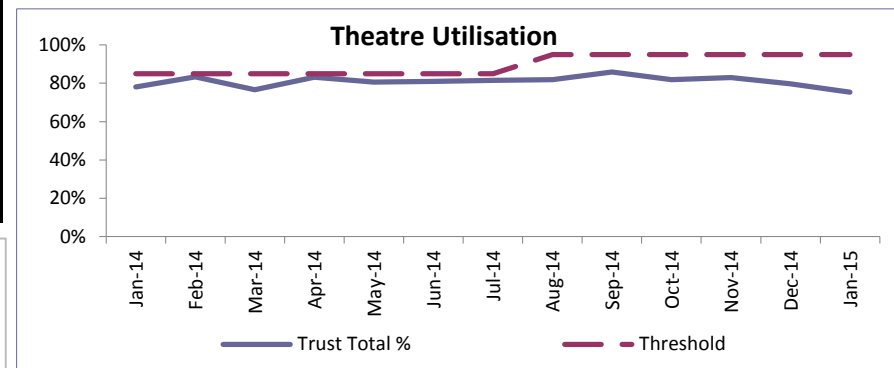
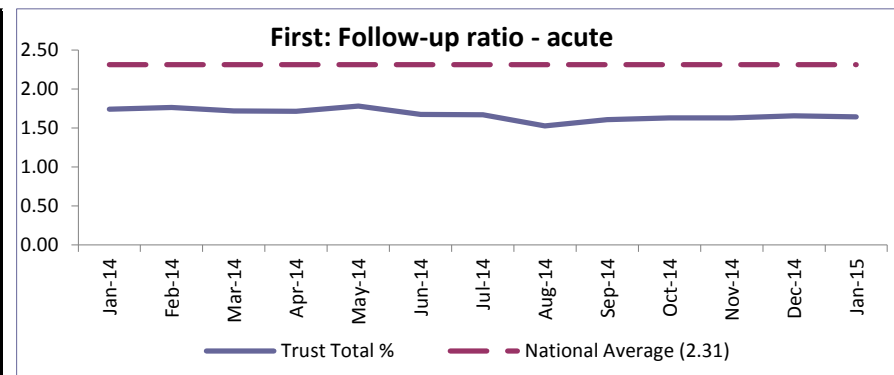
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment.

Timescale: Further reduction of DNA expected March 2015

Hospital Cancelled Operations

Issue: There were three cancellations in January due to non-clinical reasons, all patients were clinically categorised as routine. One was due to incomplete preparation of patient, one due to ward bed not available on ITU and one due to the surgeon being called to an emergency operation. All have been rebooked within the 28 day period.

Action: The Surgical board monitor cancellations.



	Jan-15				
	Threshold	Trust Actual	ICAM	SCD	WCF
Service Cancellations - Community	2%	7.9%	8.9%	6.0%	5.4%
DNA Rates - Community	10%	6.5%	6.4%	16.0%	6.9%
Community Face to Face Contacts	-	62,496	42,729	1,733	18,034
Community Appointment with no outcome	0.5%	1.6%	1.5%	0.0%	2.1%

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

Commentary

Service Cancellations - Community

Issue: Community service cancellation remain between 7 and 8% as work on the community waiting list continues.

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 March 2015.

DNA Rates - Community

Community clinics - Achieved.

Community Dental DNA's is increasing . 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 decrease by 2.8 %, compared to the same month last year.

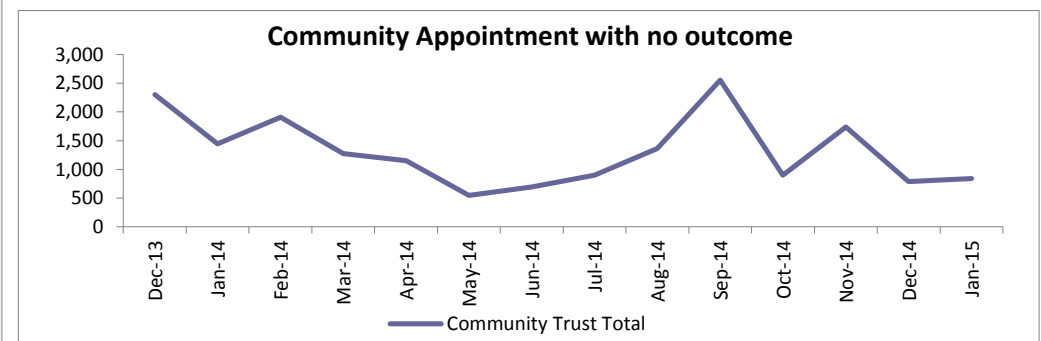
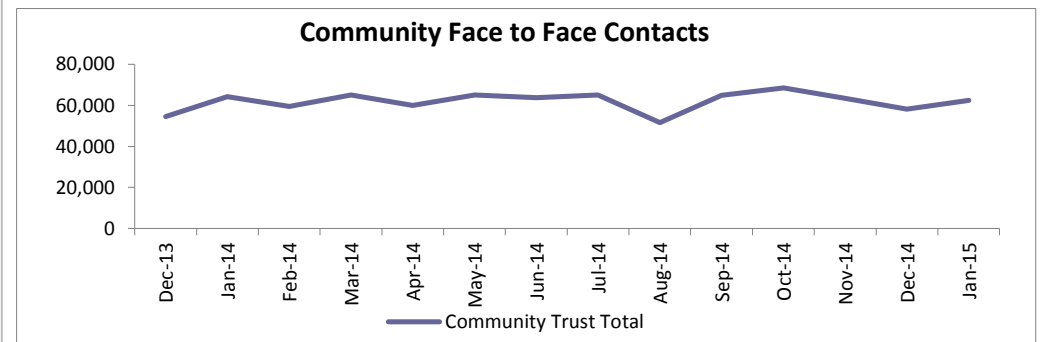
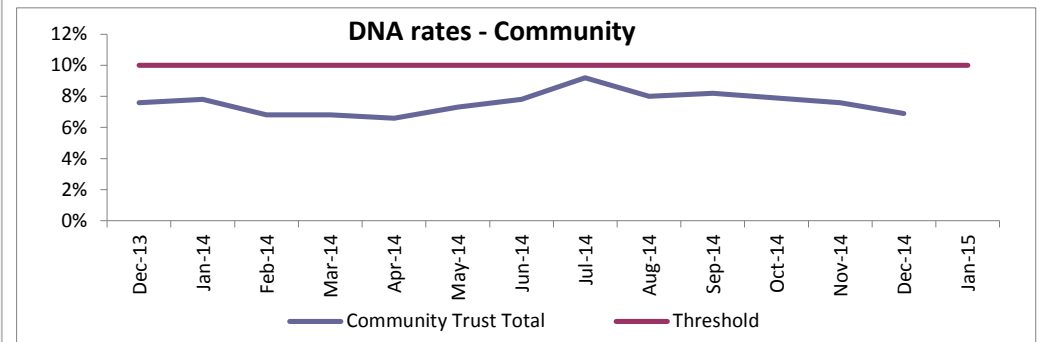
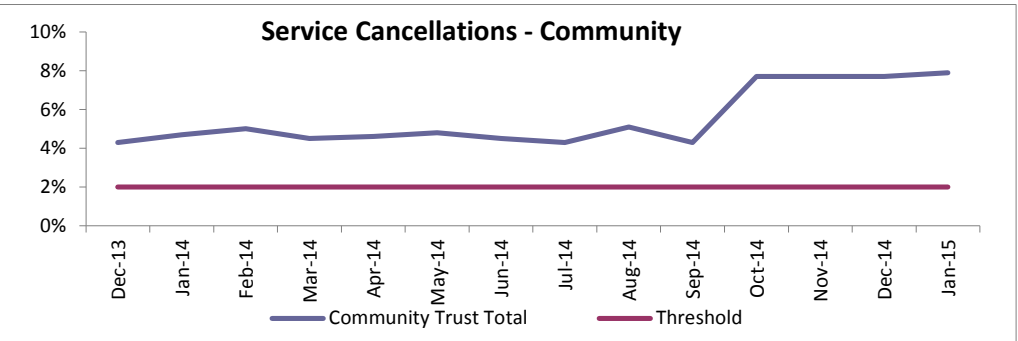
Community Appointment with no outcome

December data submission was completed before the final submission to the Secondary Uses Service (SUS). This is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Issue: Above the threshold. There is a delay in outcoming appointments but all are done by final SUS submission.

Action: Teams with high levels of un-outcomed appointments identified and processes to outcome appointments within 48 hours re-enforced. SUS submission discussed weekly at Patient Tracker List meeting.

Timescale: immediately



	Threshold	Trust Actual			YTD
		Nov-14	Dec-14	Jan-15	
Community Dental - Patient Involvement	90%	99.0%	98.0%	97.0%	n/a
Community Dental - Patient Experience	90%	99.0%	100.0%	100.0%	n/a
District Nursing Waiting Times - 2hrs assessment	-	100%	-	-	TBC
District Nursing Waiting Times - 48 hrs for visit	-	100%	-	-	TBC
MSK Waiting Times - Routine MSK (<6 weeks)	100%	85.1%	83.5%	97.2%	-
MSK Waiting Times - Consultant led (<18 weeks)	95%	89.1%	99.3%	arrears	90.6%
IAPT - patients moving to recovery	50%	47.0%	45.0%	arrears	-
GUM - Appointment within 2 days	100%	100.0%	100.0%	arrears	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: December and January data is being processed and is estimated to be 100%. Electronic process has been developed and are being tested.

Action: New process to be signed off by division.

Timescale: March 2015

MSK

Issue: Validating work is now completed and 18 weeks target is achieved. 6 weeks target for routine MSK appointments has also improved and is now within reach of achieving the target.

Action: Continued work on waiting list.

Timescale: Completed

IAPT

Issue: Under performing and the clinical measure of reliable recovery has gone down by 1% to 54%.

Action: An improvement plan is in place, closely monitored jointly with CCG Haringey including: Wait to first appointment on target, waiting list tails being successfully reduced through use of Crisis Concordant money, tight case management and clinical supervision, telephone consultations to increase patient engagement and creating a monthly performance report for Therapists, starting in February 2015

Timescale: Immediately

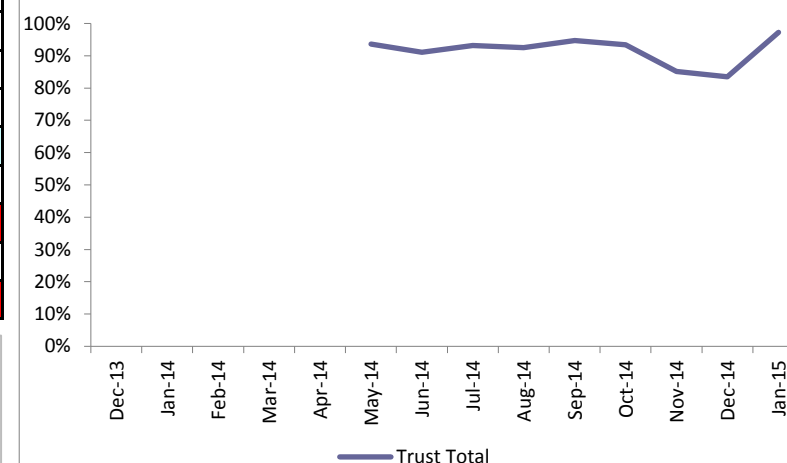
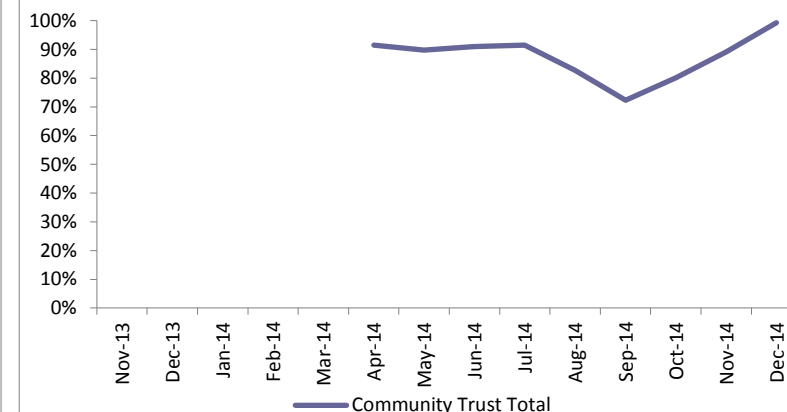
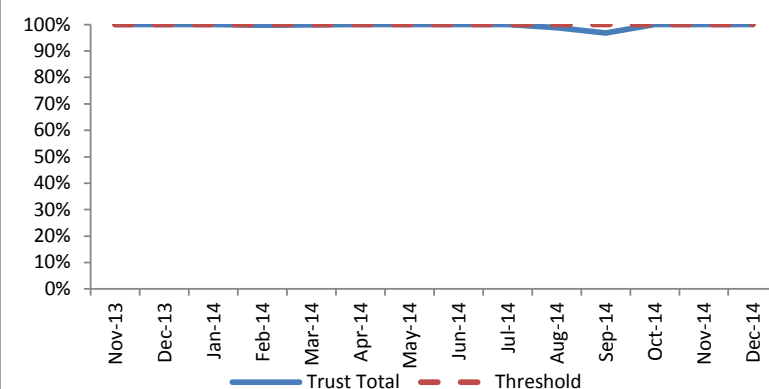
GUM

Achieved.

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

Over the last 6 months we have been increasing the number of community services reported in the dash board, by the end of March we hope to have all 12 services reported. the next services we are working on are listed below.

		Nov 14	Dec 14	Jan 15
Threshold		n/a		
Integrated Care and Acute Medicine	Haringey Adults Community Rehabilitation	54%	71%	61%
	Haringey Adults Podiatry (Foot Health)	57%	74%	64%
	Haringey Adults Tissue Viability Service	100%	100%	93%
	Islington Community Rehabilitation	93%	89%	85%
	Islington Intermediate Care	71%	66%	45%
	Islington Podiatry (Foot Health)	71%	64%	82%

Routine MSK (<6 week)**MSK waiting < 18 weeks****GUM - Appointment within 2 days**

	Dec-14 (arrears)				
	Threshold	Trust Actual	ICAM	SCD	WCF
Referral to Treatment 18 weeks - Admitted	90%	92.8%	-	92.0%	96.8%
Referral to Treatment 18 weeks - Non-admitted	95%	96.1%	97.2%	93.7%	98.6%
Referral to Treatment 18 weeks - Incomplete	92%	92.4%	93.5%	89.9%	99.4%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0
Diagnostic Waits	99%	99.7%	97.8%	99.2%	98.97%

Commentary

RTT

Achieved second consecutive month.

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 during January, February and March to decrease further waiting for patients.

Under performing areas monitored weekly in Patient Tracker List meeting. Weekly reporting to TDA also continues.

Diagnostic Waits

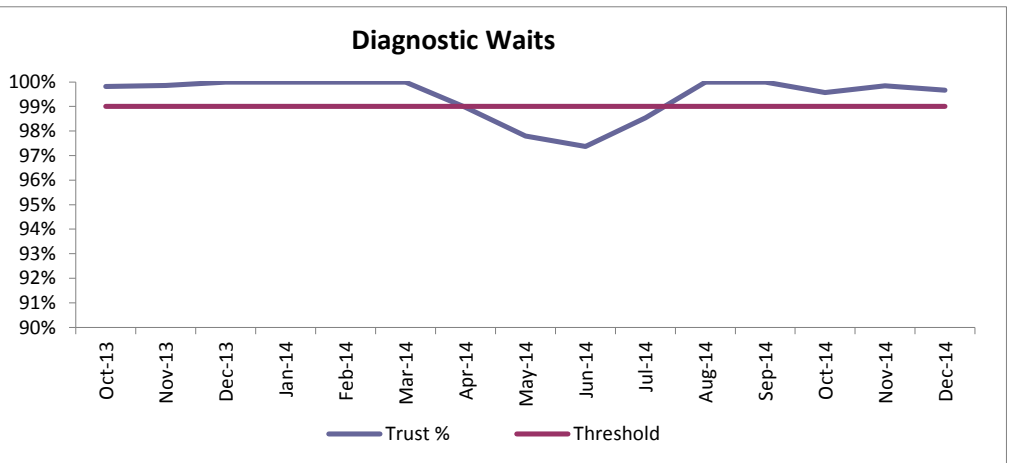
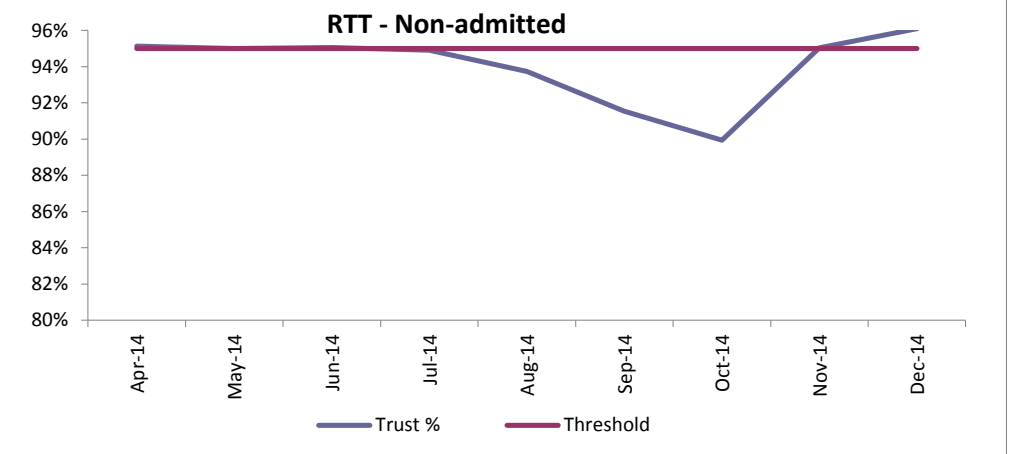
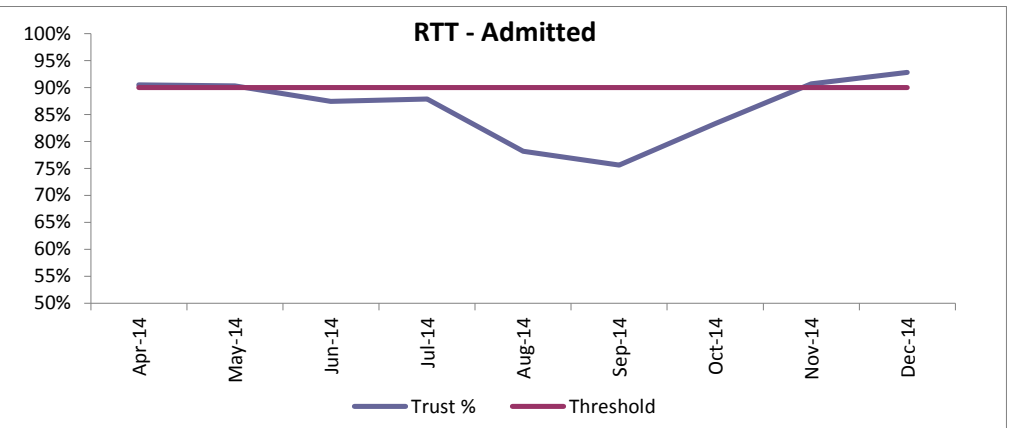
Target achieved. This included Audiology, Imaging, Neurophysiology and in/out patients.

Waiting times - OPD appointment

Cardiology 8 Weeks, Dermatology 12 Weeks , Endocrine 10 Weeks, ENT 7 Weeks, Gastroenterology 9 Weeks, General Surgery 7 Weeks , Gynaecology 10 Weeks, Neurology 10 Weeks, Pain 13 Weeks , Rheumatology 6 Weeks, Thoracic Medicine 12 Weeks, Urology 6 Weeks, Vascular 12 Weeks, Ophthalmology 5 Weeks

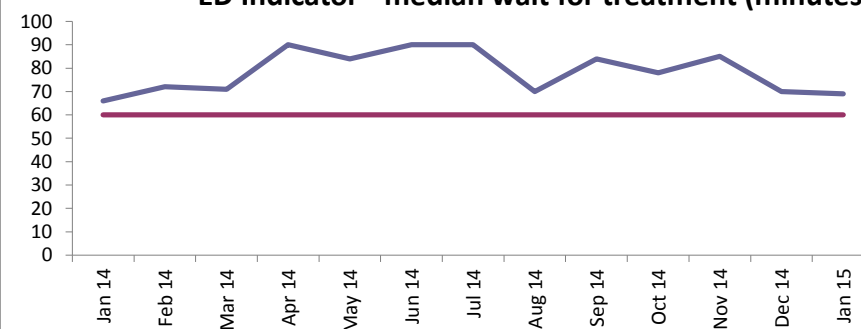
Diagnostic waiting times (radiology) all under 6 weeks (42 days) waiting time standard

CT 18 days, MRI 19 days, Nuclear Medicine 18 days, DEXA 13 days, Fluoroscopy 25 days, Ultrasound (Gynae) 18days, Ultrasound General (Radiologist Lead) 14 days, Ultrasound Paediatrics 39 days, Ultrasound MSKs 33 days, Ultrasound Hernias 40 days, Ultrasound Obstetrics 29 days, Ultrasound Abdomen & Gynae at Hornsey General 20 days.



	Threshold	Trust Actual		YTD
		Dec-14	Jan-15	
Emergency Department waits (4 hrs wait)	95%	94.9%	94.5%	94.96%
Wait for assessment (minutes - 95th percentile)	<=15	17	15	15
ED Indicator - median wait for treatment (minutes)	60	70	69	80
Total Time in ED (minutes - 95th percentile)	<=240	265	307	255
ED Indicator - % Left Without Being seen	<=5%	3.9%	4.0%	5.4%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	16	7	57
Ambulance handovers exceeding 60 minutes	0	0	0	0

ED Indicator - median wait for treatment (minutes)



Commentary

The high pressure for inpatient care as stated in December continued into January, this affected the flow within ED. However the initial assessment time and time to treatment indicators both improved in January. the additional capacity to support emergency and urgent care where all in place and included; additional inpatient beds, evening GP, extended hours of consultant cover, increased district nursing, additional middle grade medical staff and increased staffing in the access team.

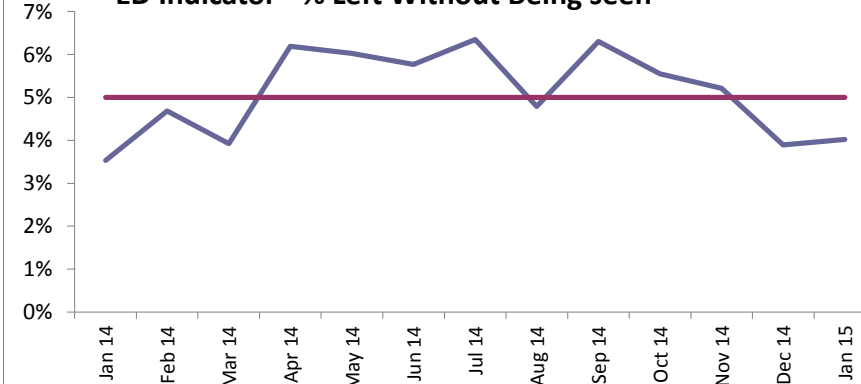
All procedures for maintaining quality on going care for patients within the ED have been followed including pressure care, nutrition etc.

The data for London emergency and urgent care services shows that the Whittington has remained in the upper quartile high performing Trusts.

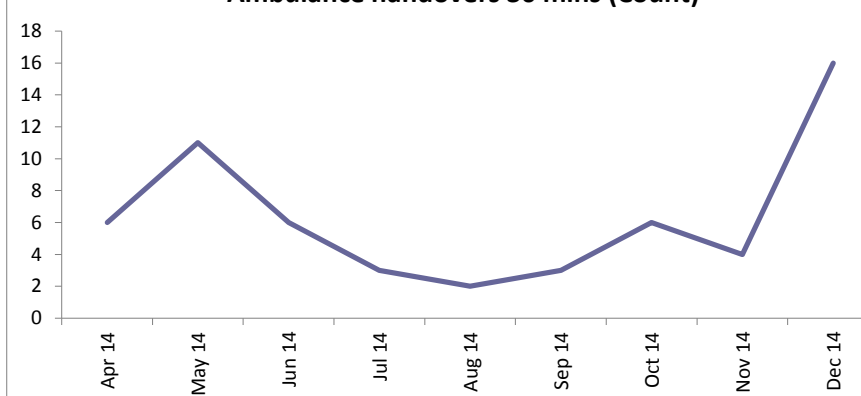
Monitoring of the ED Paediatrics flows has also shown that improvements have been seen in December and January. this was due to agreed investment in paediatric medical staffing each evening.

	Threshold	WCF			
		Nov-14	Dec-14	Jan-15	YTD
Emergency Department waits (4 hrs wait) Paeds only	95%	93.0%	96.4%	98.1%	96.4%

ED Indicator - % Left Without Being seen



Ambulance handovers 30 mins (Count)



	Threshold	Trust Actual	Dec-14			2014/15				
			ICAM	SCD	WCF	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.7%	83.3%	94.6%	100.0%	89.3%	89.4%	93.9%		90.6%
Cancer - 14 days to first seen - breast symptomatic	93%	94.4%	-	94.4%	-	83.7%	93.1%	95.2%		89.8%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%	-	100.0%	100.0%	98.6%		99.7%
Cancer - 31 days to subsequent treatment - surgery	94%	-	-	-	-	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%	88.2%	75.0%	96.0%	-	91.5%	88.9%	90.6%		90.9%
Cancer - 62 days from consultant upgrade	-	100%	-	-	100%	75%	73%	33%		69%

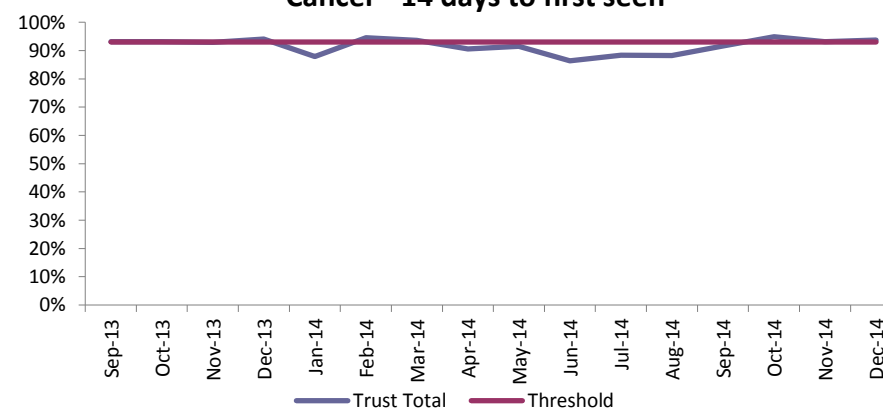
Commentary

All cancer targets were achieved this month and QRT 3 standards all achieved.

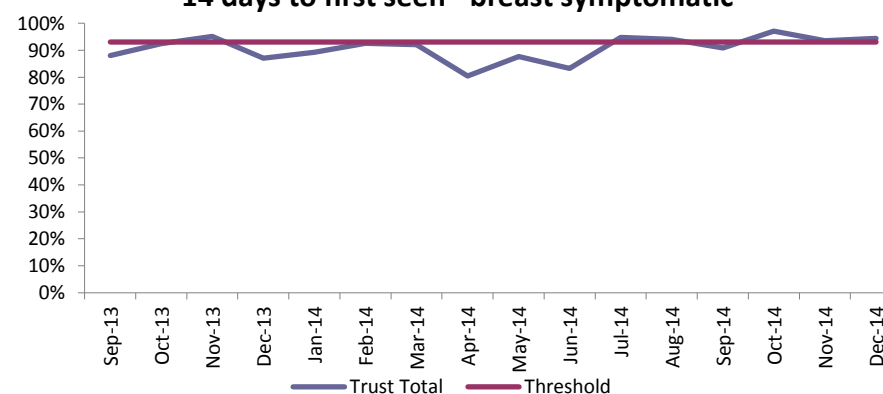
The Cancer Patients tracking list is monitored daily and discussed in the weekly

Whittington Health also proved support to other trust who needed additional capacity. All these patients have been treated and no further patients have been transferred.

Cancer - 14 days to first seen



14 days to first seen - breast symptomatic



	Threshold	Trust Actual			YTD
		Nov-14	Dec-14	Jan-15	
Women seen by HCP or midwife within 12 weeks and 6 days	90%	92.4%	85.7%	80.7%	86.7%
New Birth Visits - Haringey	95%	85.0%	83.5%	Arrears	88.2%
New Birth Visits - Islington	95%	91.4%	88.7%	Arrears	91.1%
Elective Caesarean Section rate	14.80%	13.7%	12.9%	15.2%	11.4%
Emergency Caesarean Section rate	-	17.5%	16.9%	15.9%	19%
Breastfeeding initiated	90%	88.7%	92.2%	88.6%	90.5%
Smoking at Delivery	<6%	4.9%	4.9%	5.4%	5.2%

Commentary

Women seen by HCP or midwife within 12 weeks and 6 days

Whittington Hospital Maternity department received 300+ additional self-referrals in January and so far 150 for February. Not all woman were at an early stage of pregnancy.

Issue: The additional referrals have placed additional demand on Midwives, the overall performance of 12+6 as not all woman eligible could be accommodated within this time. This has also placed high demand on sonography department i- additional capacity is being planned.

Action: All woman were called by a qualified midwife to arrange an appointment and any issues with the pregnancies were discussed. Further information about our services, for example our website and the Women's Diagnostic Unit (WDU) facilities were given.

Timescale: Feedback March 2015

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 which aims to 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: Under target. A number of women choose not to breastfeed.

Action: All breastfeeding support is in place on the wards. Work towards Level 3 Unicef Breastfeeding initiative now started.

Timescale: On-going

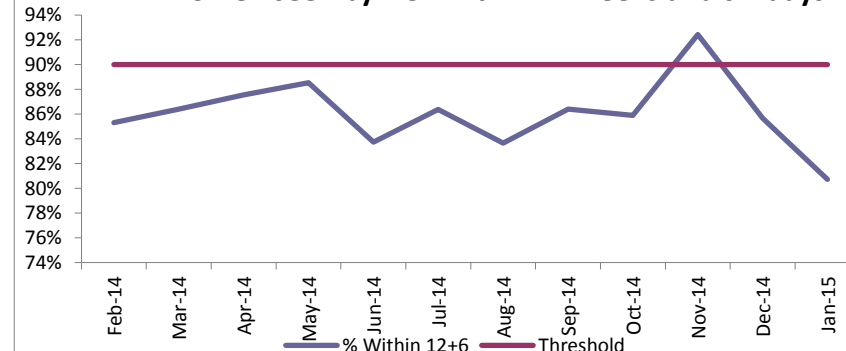
Smoking:

Achieved

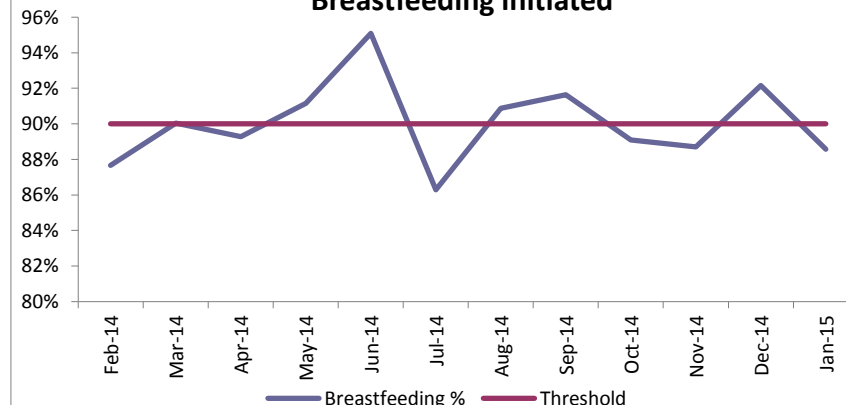
Action: Funding for carbon monoxide screening during antenatal period has been secured.

Timescale: On-going

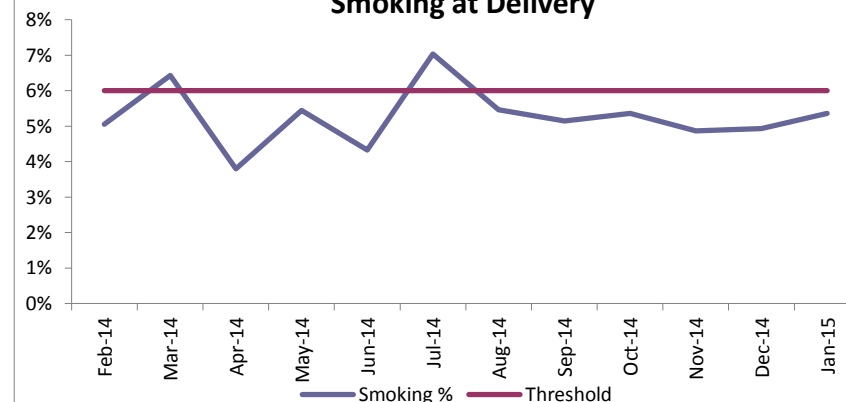
Women seen by HCP within 12 weeks and six days



Breastfeeding initiated



Smoking at Delivery



Whittington Health Trust Board

March 4th 2015

Title:	Dashboard Performance Workforce report January 2015.
Action requested:	For noting.
Executive Summary:	<p>Background The monthly dashboard as it refers to the workforce KPI's is a standard report and part of the Performance Dashboard report.</p> <p>Highlights this month:</p> <p>Headcount In total, actual worked whole time equivalent posts has increased by 29 from 4,388 in December to 4,417 in January 2015.</p> <p>Turnover Turnover figures this month are marginally lower than the previous month. In particular the figure for ICAM has decreased as a result of interventions by the management team to address staff retention.</p> <p>Vacancy rates Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis and posts that remain vacant are being scrutinised to assess whether they can be permanently deleted from the establishment.</p> <p>Sickness Sickness rates are at 2.8% 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 relative high Bradford scores. The Trust Management Group has agreed to assign a bespoke resource in the Facilities Directorate. In conjunction with HR the resource over 12 months will support managers in delivering better performance which will reduce the overall sickness rates and tackle the highest Bradford scores. In turn this will reduce occupational sick pay, overtime expenditure and bank and agency usage. If successful this resource will be targeted at other services where sickness rates are high.</p> <p>Overtime Overtime figures have increased on last month in Corporate</p>

	<p>services but decreased in SCD and WCF.</p> <p>Bank and Agency This month, the bank and agency project tables (consisting of 4 work streams) are included up to month 9. This shows the direction of travel to reduce agency usage to fill vacancies with substantive employees and to use the bank flexibly. Despite an increase in agency expenditure on last month, the average agency expenditure for the last 3 months is £1.096m (November to December 2014). This is £45k lower than the 3 month average (October to December 2014), of £1.141m.</p> <p>Appraisal The appraisal figures show no change from last month. At 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 % increases and review the position month by month. This is a key priority for SCD in particular.</p> <p>Mandatory Training There is a 2% 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 and in particular by quarter two. Notwithstanding that, the Audit and Risk Committee were informed at their last meeting that the Executive will be redoubling their efforts through corporate initiatives and setting up a steering and working group to give senior management direction. The Audit and Risk Committee have requested a further report at the March meeting.</p> <p>Benchmark Comparisons It was reported at the last Trust Board that steps had been taken to join a benchmark network and the report in January included initial comparisons with other Trusts on staffing levels. As a result of our work, the London HR network are surveying all Trusts in the network which represents the majority of London Trusts to benchmark standard KPI's namely sickness, turnover, mandatory training and appraisal rates etc. Once those results are available they will be reported to the Trust Board. Benchmarking with other Trusts outside London will be our next priority.</p>
Summary of recommendations:	To note the report and the progress being made in key areas to increase compliance rates and benchmark with other Trusts.
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:		25 February 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?	



Workforce	Trust									
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Starting Point for Workforce 14/15	4,403	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)	(126)
Contract Additions	4	15	12	17	22	34	46	54	58	65
Total	4	(3)	(34)	(45)	(52)	(31)	(65)	(65)	(61)	(62)
Revised Workforce Plan	4,407	4,399	4,369	4,358	4,351	4,372	4,338	4,338	4,342	4,342
Headcount wte Total	4,404	4,397	4,366	4,398	4,429	4,374	4,383	4,414	4,388	4,417
Variance to Revised Plan	3	3	2	(41)	(78)	(2)	(45)	(76)	(46)	(69)

The actual whole time equivalent posts have increased by 29 (from 4,388 in December to 4,417 in January).

The key movements in staffing levels are in Nursing and Midwifery which has increased over this period, due to the exceptional demands placed on front line services as experienced by most Trusts. The figures include additional winter planning staff to cover resilience one, two and three plans as a result of the impact of winter pressures as at January 2015. The work on vacancies management (please refer to the section on vacancies) and the robust review of all vacant posts for advert through the vacancy scrutiny panel continues with non clinical posts in particular being held.

Management of the workforce	Threshold	Trust								
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Dec-14	Jan-15
Trust Turnover Rate	<13%	15.1%	14.1%	14.0%	13.9%	13.7%	13.4%	13.8%	13.9%	13.4%
Total trust vacancy rate	<13%	13.4%	14.2%	14.3%	14.1%	14.1%	13.2%	13.3%	13.2%	11.1%
Sickness rates	<3%	2.7%	2.6%	2.8%	2.8%	2.8%	2.6%	3.2%	2.9%	2.8%
Overtime wte	75	123	118	113	94	113	99.66	92.05	85.34	88.99
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	51,754.53
Bank Hours expenditure	-	1,523	1,580	1,519	1,402	1,602	1,472	1,546	1,437	1,478
Agency Hours expenditure *	1m	1,426	1,184	1,491	1,457	1,200	1,210	1,254	1,007	1,155

*bank expenditure will fluctuate as agency expenditure reduces

Development of the workforce	Threshold	Trust								
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Dec-14	Jan-15
Appraisal	90%	43%	40%	39%	45%	51%	55%	58%	60%	60%
Mandatory Training	90%	75%	77%	76%	76%	75%	73%	66%	66%	68%

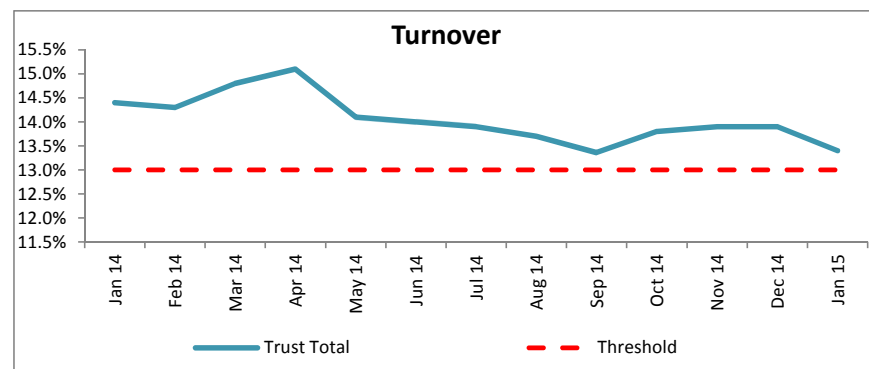
Staff FFT Results		Trust	
		Q1	Q2
Staff who would recommend the trust as a place to work	-	62%	59%
Staff who would recommend the trust as a place for treatment	-	74%	74%

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

	January 2015					
	Threshold	Trust	ICAM	SCD	WCF	CORP
Trust Turnover Rate	<13%	13.4%	17.8%	9.9%	12.0%	11.6%
Total trust vacancy rate	<13%	11.1%	5.2%	8.8%	5.6%	13.0%
Trust level total sickness rate	<3%	2.8%	2.5%	2.9%	2.5%	4.0%

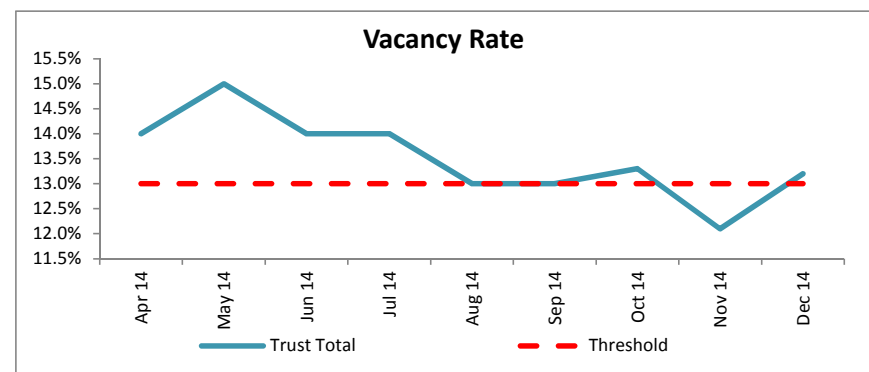
Turnover rate

ICAM figures remain high but this month is showing a decrease of up to 2% . The Director of ICAM is now implementing a retention plan to address high turnover.



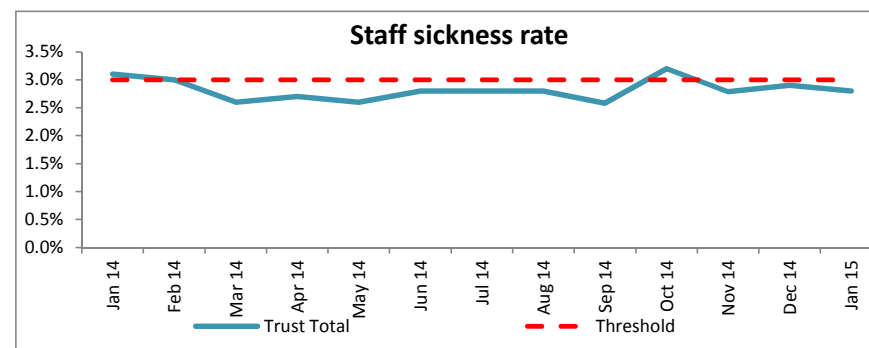
Vacancy Rates

Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis and posts that remain vacant for 6 months are being scrutinised to assess whether they can be permanently deleted from the establishment.



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.



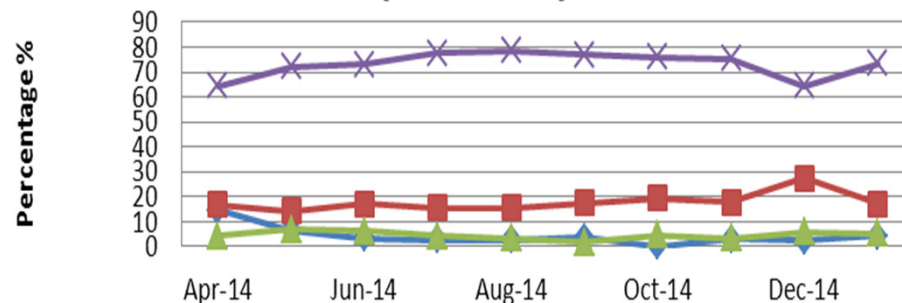
Overtime expenditure

	January 2015					
	Trust		ICAM	SCD	WCF	CORP
Overtime cost	£51,754.53		£2,147.72	£8,935.64	£2,728.05	£37,943.12

Overtime

For the month of January there was a decrease in SCD and WCF expenditure, however ICAM and Corporate both had an increase. The increase in overtime in the Facilities service is mostly attributable to the provision of the Estates out of hours service (24/7 on site service). This service has recently undergone a review, with TMG agreeing that the current model should remain 'as is' as the benefit of providing such service outweighed the costs.

Overtime spend % by Div Jan15



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
ICAM	14.45	6.63	3.39	2.81	2.82	3.79	0.12	3.15	2.42	4.15
SCD	16.92	14.25	17.04	15.44	15.44	17.60	19.26	17.88	27.4	17.26
WCF	4.31	6.96	6.34	4.30	3.17	1.78	4.56	3.45	5.74	5.27
CORP	64.32	72.16	73.23	77.45	78.57	76.83	76.06	75.51	64.4	73.31

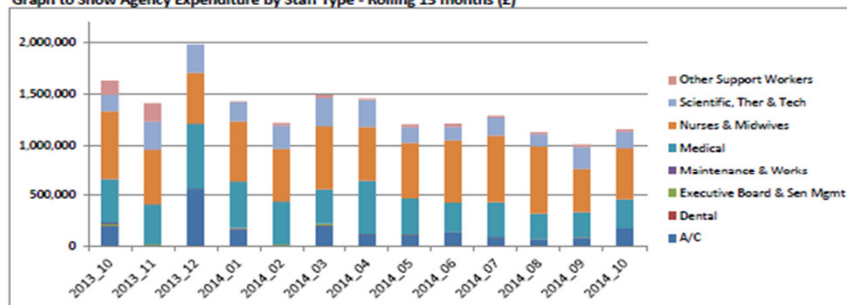
Bank and Agency wte usage and expenditure

Trust Overall Agency Report - Month 10

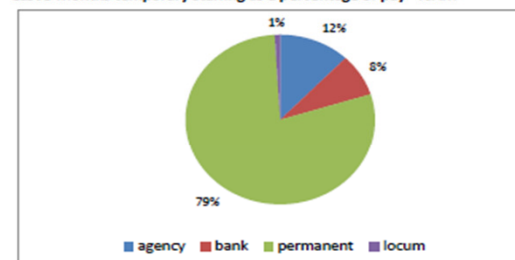
Table to Show Agency Expenditure by Division - Rolling 13 months

Month	ICAM	SCD	WCF	Corporate	Grand Total
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	£2,158,212
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
2014_10	£679,535	£105,499	£175,028	£195,275	£1,155,337
Grand Total	£10,618,467	£1,846,814	£2,770,614	£1,233,269	£16,469,164
Last 12 Months	£9,775,323	£1,649,435	£2,521,718	£892,010	£14,838,487

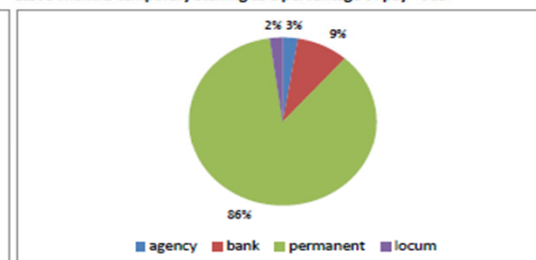
Graph to Show Agency Expenditure by Staff Type - Rolling 13 months (£)



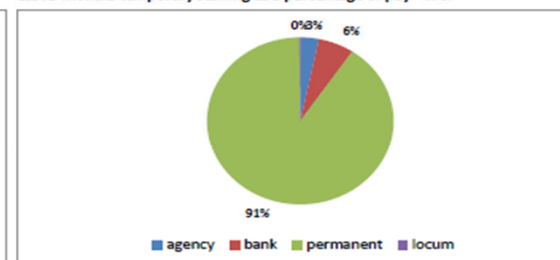
Last 3 Months temporary staffing as a percentage of pay - ICAM



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



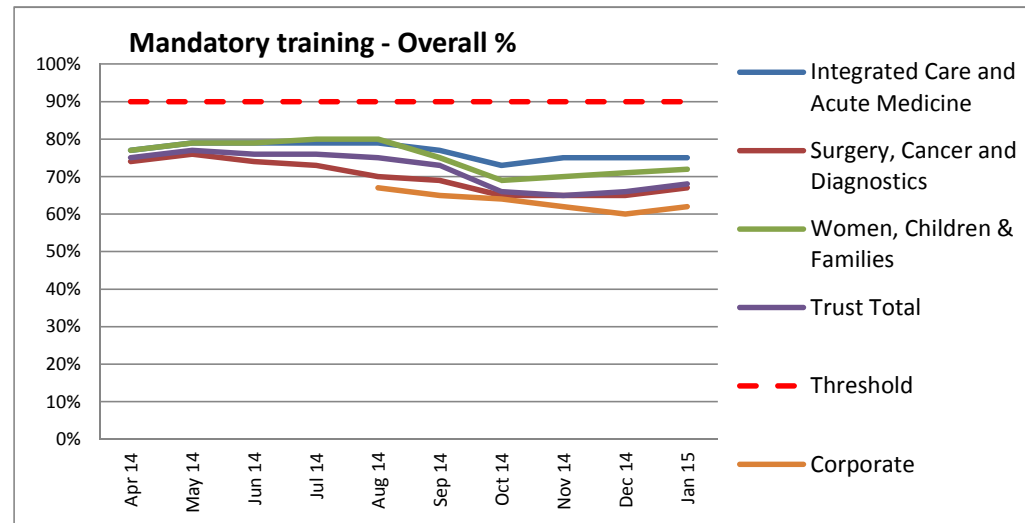
Last 3 Months temporary staffing as a percentage of pay - WCF



	January 2015					
	Threshold	Trust Actual	ICAM	SCD	WCF	CORP
Percentage of staff with mandatory training compliance	90%	68%	75%	67%	72%	62%
Percentage of staff with annual appraisal	90%	60%	71%	40%	63%	58%

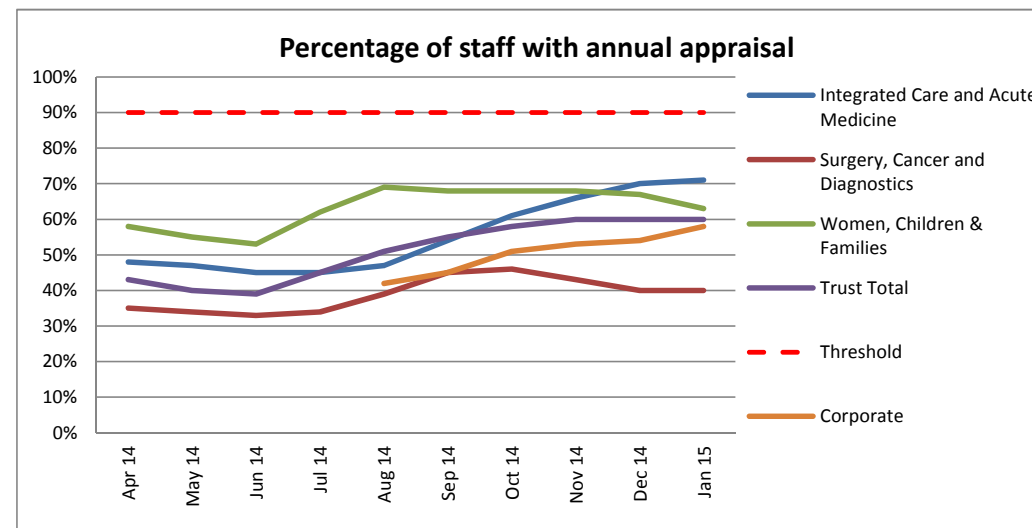
Mandatory training

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 TMG has received a report at its last meeting recommending further action to improve compliance rates. As a result, each Director has been tasked with forecasting significant improvements in compliance rates by quarter two.



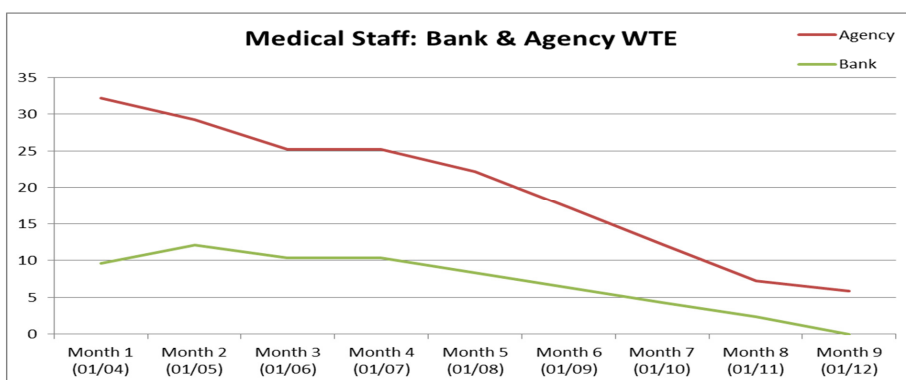
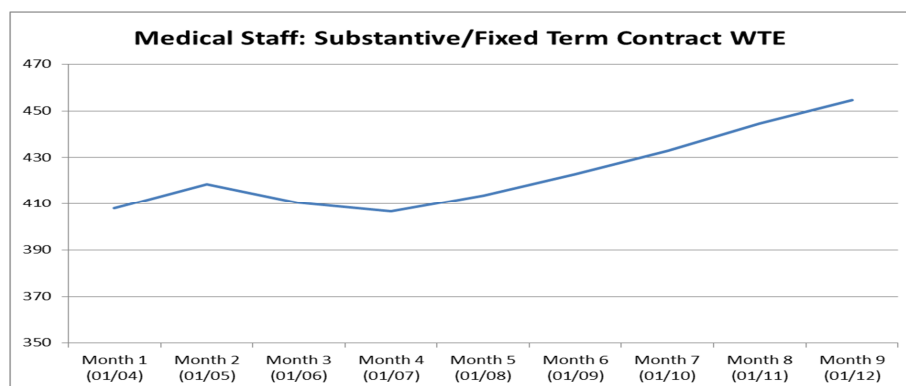
Appraisal

The overall rate remains the same as last month. The implementation of action plans for both Corporate and the divisions remains a priority.

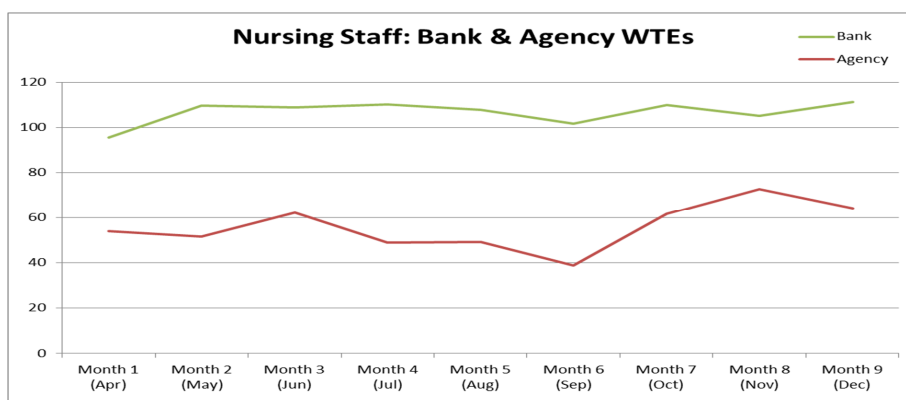
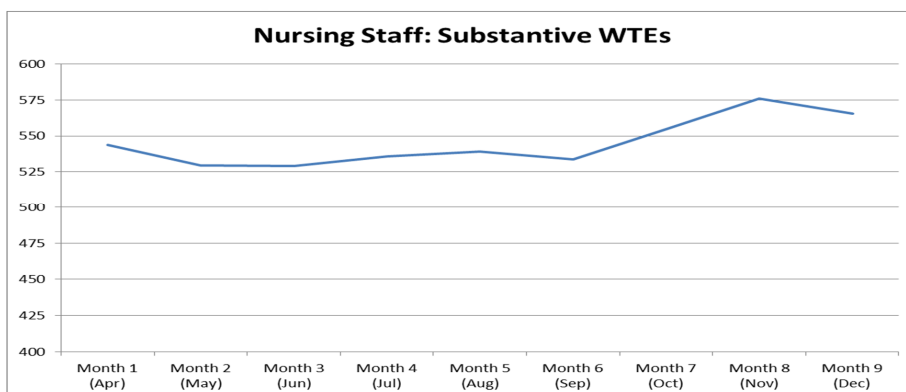


Bank & Agency Project

A. Medical Staff

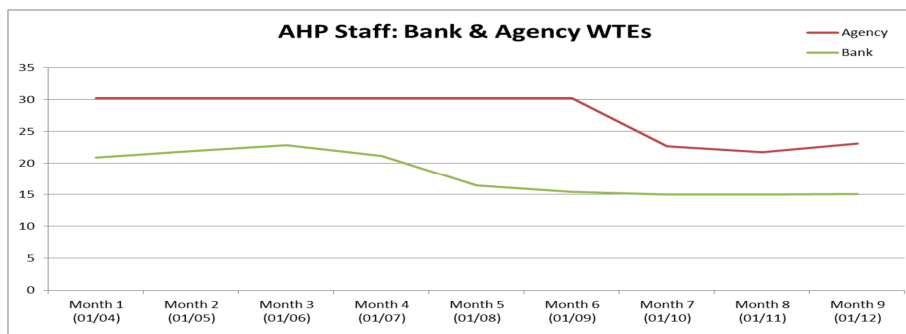
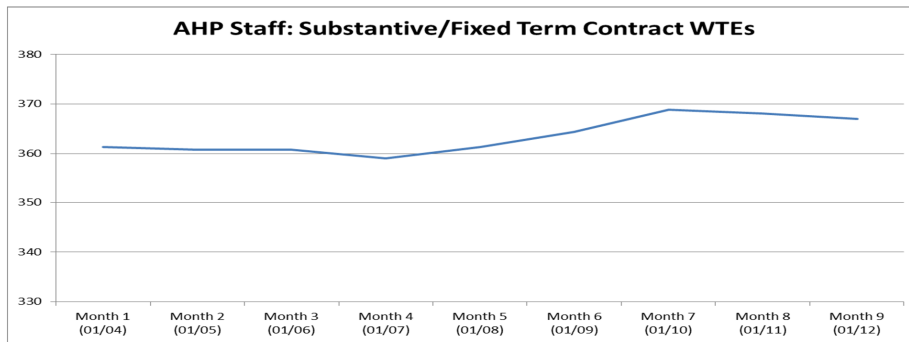


B. Nursing Staff

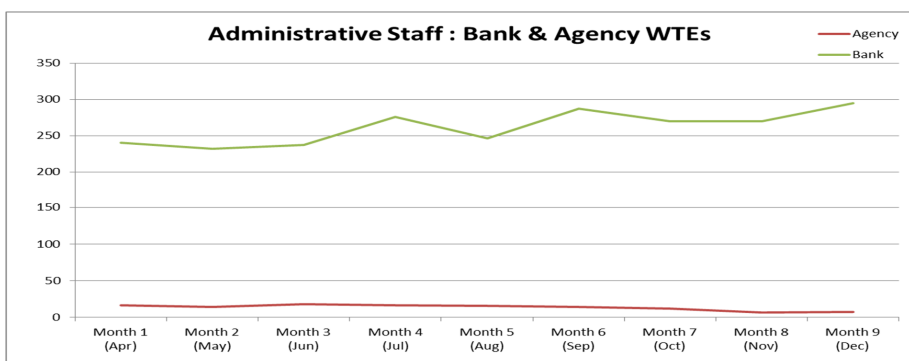
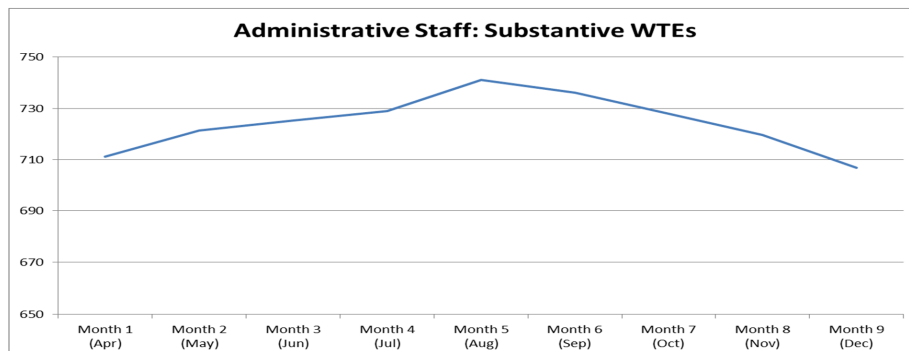


Note: The winter establishment for nursing is an extra 32 WTE.

C. AHP Staff



D. Administrative Staff



Trust Board
04th March 2015

Title:	2014/15 Finance Report - December (Month 10)					
Agenda item:	15/040		Paper		7	
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 January 2015.					
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:	19th February 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 10 Finance Report - Executive Summary

The in-month position is a £0.3m surplus against a planned surplus of £0.2k, a favourable variance of £0.1m. The year to date (YTD) position is a £5.83m deficit against a planned deficit of £0.06m, an adverse variance of £5.77m. The adverse variance is driven by expenditure pressures, mainly in pay.

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

Income

The income position is £1.4m favourable in month and £1.7m favourable YTD. The favourable position in month is driven by an additional £2m CCG income (£4m contract variation in total). This second tranche is phased over the last 3 months of the financial year and it is this income that drives the in month over performance.

The Trust is continues to seek 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 £1.7m adverse in month and £7.1m adverse YTD. The major expenditure challenges remain in the Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostics (SCD) Divisions.

Pay is £0.7m adverse in month and £3.7m adverse YTD. This is partly driven by additional activity, but nursing and medical overspends continue in ICAM largely due to high agency spend. Non Pay is £0.3m adverse in month and £1.9m adverse YTD. This is mainly activity related.

Further expenditure reductions are being developed.

The monthly position has resulted in the EBITDA margin of 6.6%, which is below the target of 6.78%. 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 £7.1m against a plan of £11.9m (60%). There are plans to deliver £9.1m in total for 2014/15 (60% of the target for the year). The divisions continue to look for further opportunities to close the gap to plan.

Cash and Capital

Cash increased by in month to £7.0m in anticipation of the repayment of temporary PDC in February. The Trust needs to ensure that the CIP plan is achieved and produces cash releasing savings and also that activity is efficiently coded and counted in order to ensure all activity is paid for. The capital programme is on track.

Statement of Comprehensive Income	Full Year	January			YTD		
	Budget (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)
Nhs Clinical Income	246,955	20,613	21,312	699	205,780	205,345	(434)
Non-Nhs Clinical Income	16,332	1,380	1,500	120	13,639	14,415	775
Other Non-Patient Income	26,176	2,217	2,769	552	21,657	22,954	1,316
Total Income	289,464	24,210	25,581	1,371	241,076	242,714	1,657
Non-Pay	69,880	5,849	6,136	(287)	58,110	60,011	(1,901)
Pay	206,047	17,008	17,754	(746)	171,956	175,628	(3,672)
Savings	(3,303)	(275)	0	(275)	(2,752)	0	(2,752)
Total Expenditure	272,624	22,582	23,890	(1,308)	227,314	235,639	(8,325)
EBITDA	16,840	1,628	1,691	63	13,762	7,075	(6,688)
EBITDA %	5.82%	6.72%	6.61%	-0.11%	5.71%	2.91%	-2.79%
Interest Payable	2,820	235	240	(5)	2,350	2,376	(26)
Interest Receivable	30	3	1	(2)	25	20	(5)
Depreciation	9,724	810	628	182	8,103	8,244	(140)
Dividends Payable	4,326	361	488	(127)	3,605	3,620	(15)
Donated Asset Additions	0	0	0	0	0	19	19
Net Surplus / (Deficit) - before IFRIC 12 adjustments	(0)	225	336	111	(271)	(7,126)	(6,855)
Add back impairments and adjust for IFRS & donated assets	285	24	7	(17)	214	1,295	1,081
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	285	248	343	94	(57)	(5,831)	(5,774)
<i>Previous Month</i> : adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	285	617	480	(137)	(282)	(6,173)	(5,892)
Movement from Month 9 to Month 10 (+ve(Green) is Favourable)	0	(369)	(138)	231	225	343	118

Whittington Health Cost Improvement Programme Report - Month 10

	Annual Plan £'000	January				YTD				Forecast			
		Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Fcst £'000	% achieved	Var £'000
ICAM	1,768	166	441	265%	275	1,435	913	64%	(523)	1,768	1,330	75%	(438)
SCD	1,179	113	60	53%	(53)	959	482	50%	(477)	1,179	623	53%	(556)
WCF	1,299	108	36	33%	(72)	1,082	374	35%	(709)	1,299	498	38%	(801)
Corporate	1,519	132	154	117%	22	1,256	1,170	93%	(86)	1,519	1,570	103%	51
Total Divisional Schemes	5,764	519	691	133%	172	4,732	2,938	62%	(1,794)	5,764	4,021	70%	(1,743)
Productivity & Efficiency	5,347	469	388	83%	(82)	4,409	1,171	27%	(3,238)	5,347	1,599	30%	(3,748)
VIPs	3,388	510	33	6%	(477)	2,368	169	7%	(2,199)	3,388	313	9%	(3,075)
Total Productivity & Efficiency and Transformational Schemes	8,735	979	420	43%	(559)	6,776	1,339	20%	(5,437)	8,735	1,912	22%	(6,823)
Non Recurrent Benefits	500	42	42	100%	0	417	417	100%	0	500	500	100%	0
Non Recurrent Under Spends	0	0	138		138	0	2,430		2,430	0	2,630		2,630
Total Non Recurrent Items	500	42	179		138	417	2,847		2,430	500	3,130		2,630
Total delivery against planned schemes	15,000	1,540	1,291	84%	(249)	11,925	7,124	60%	(4,801)	15,000	9,064	60%	(5,936)

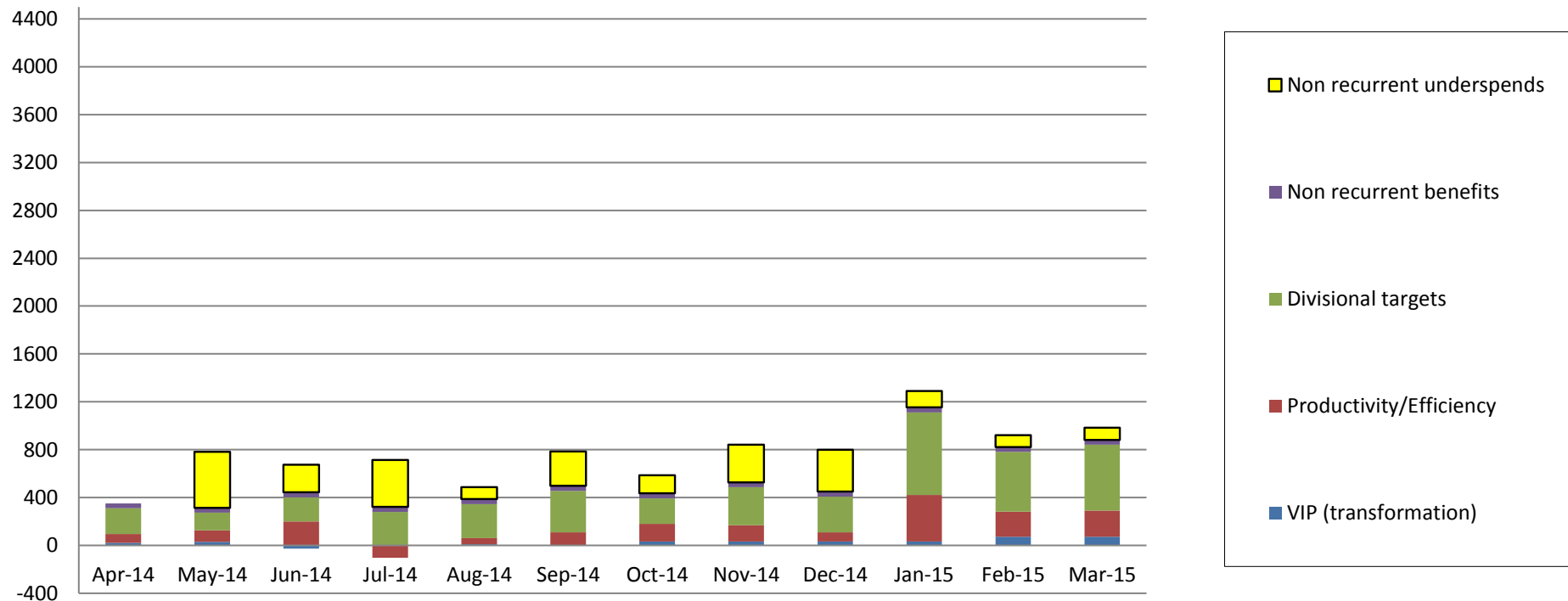
Month 10 CIP Summary

The CIP delivery underperformance YTD has continued into month 10.

In month 10 £1,291k (84%) CIP delivery was achieved compared to a plan of £1,540k. This includes a benefit from non recurrent underspends of £138k. The month position was improved with the TB income of £369k.

YTD delivery is £7,124k (60%) compared to a YTD target of £11,925k. YTD delivery includes a benefit from non recurrent underspends of £2,430k.

CIP performance to January, Forecast February - March



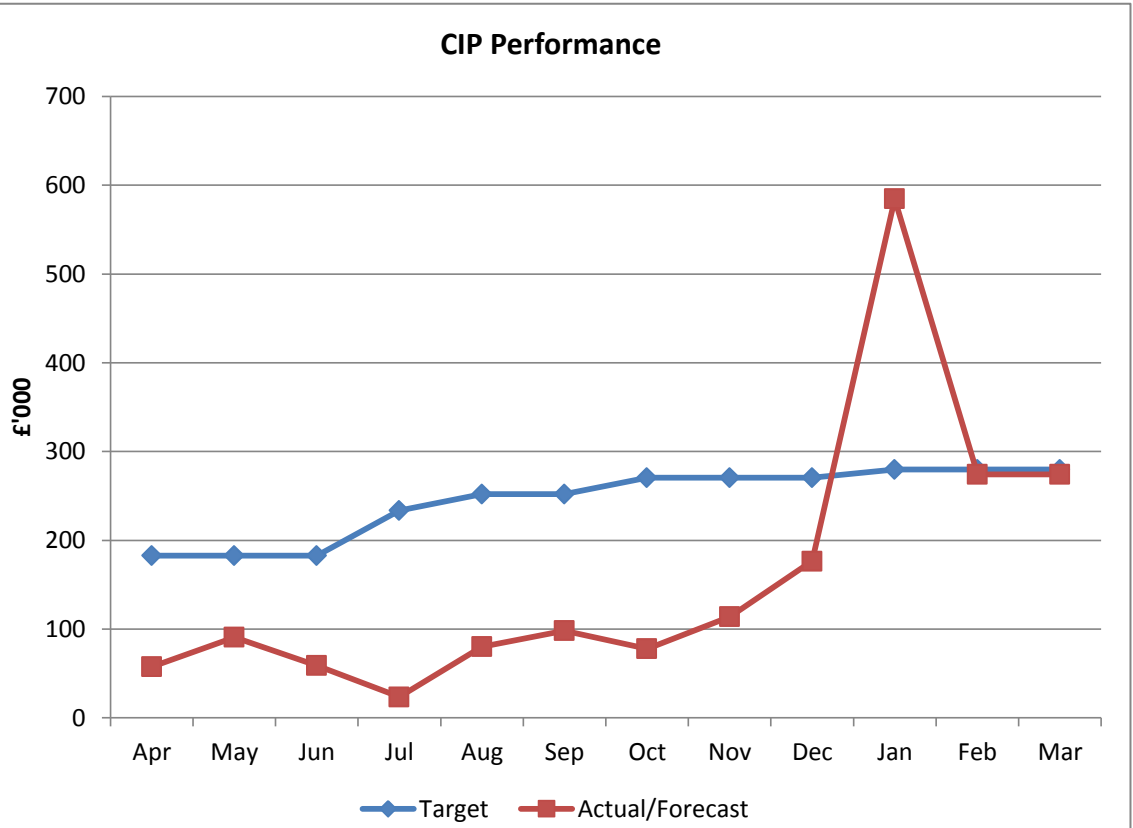
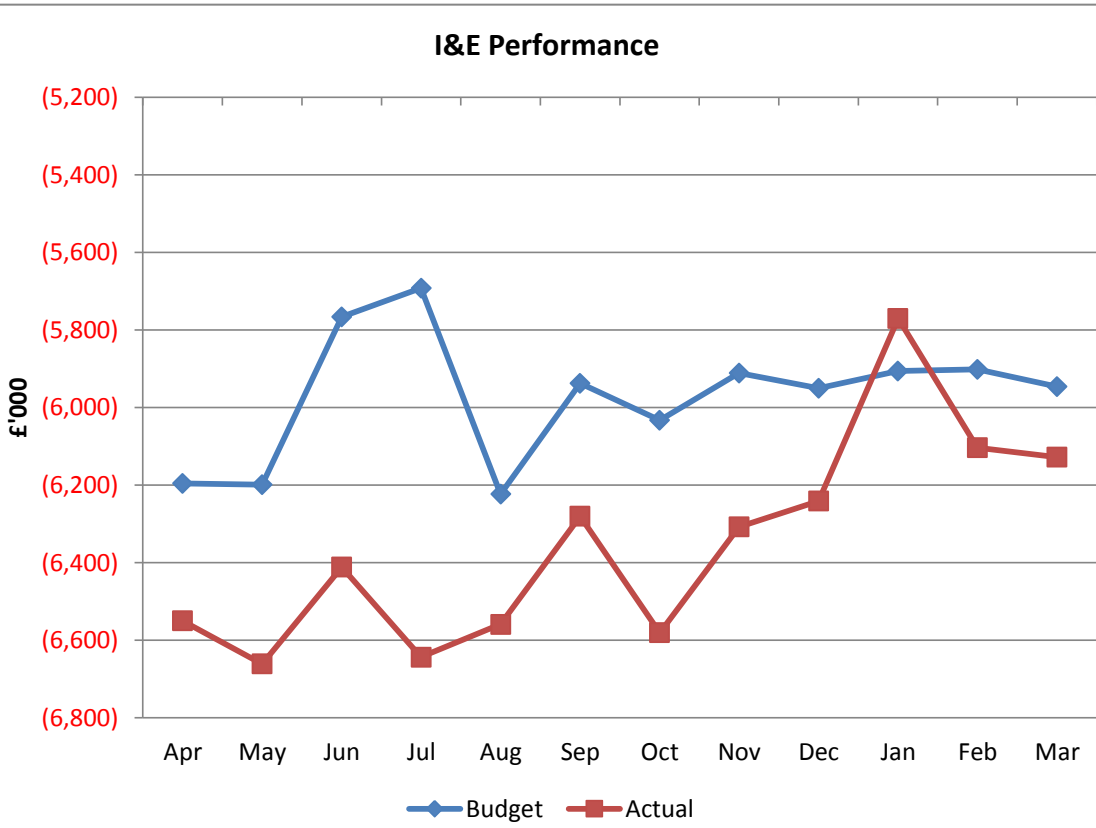
The divisional schemes are forecasting £4,021k delivery (70%) against the target of £5,764k.

The productivity & efficiency schemes are forecasting £1,599k delivery (30%) against a target of £5,347k.

The VIP transformational schemes are forecasting £313k delivery (9%) against the target of £3,388k.

ICAM Divisional Position - Month 10 (January 15)

Income & Expenditure	Ann Plan £'000	In Month			Year To Date		
		Plan £'000	Act £'000	Var £'000	Plan £'000	Act £'000	Var £'000
Nhs Clinical Income	7,776	648	1,534	886	6,480	8,525	2,045
Other Income For Pat Care	2,127	177	205	28	1,773	1,790	17
Other Non-Patient-Devolved	682	60	65	4	583	492	(90)
Other_Non-Patient_Non-Dev	0	0	10	10	0	10	10
Income	10,585	886	1,814	929	8,835	10,818	1,982
A/C	5,243	433	479	(46)	4,378	4,848	(470)
Executive Board & Sen Mgmt	486	40	32	8	405	400	5
Medical	13,400	1,095	1,296	(201)	11,232	12,634	(1,402)
Nurses & Midwives	28,694	2,371	2,728	(356)	23,951	25,895	(1,944)
Other Support Workers	199	17	(15)	32	166	308	(142)
Scientific, Ther & Tech	17,412	1,450	1,522	(71)	14,512	15,099	(587)
Pay Reserve	(1,638)	(145)	0	(145)	(1,340)	0	(1,340)
Pay	63,795	5,261	6,041	(780)	53,303	59,184	(5,881)
Establishment	462	39	51	(13)	384	498	(114)
Ext Cont Staffing & Cons	115	6	9	(3)	58	418	(360)
Healthcare From Non Nhs	548	46	49	(3)	456	75	382
Miscellaneous	364	30	30	0	303	296	7
Non-Pay Reserve	(253)	(21)	0	(21)	(211)	0	(211)
Premises & Fixed Plant	392	33	50	(17)	327	572	(245)
Supplies & Servs - Clin	16,450	1,368	1,238	130	13,715	13,328	386
Supplies & Servs - Gen	373	31	117	(86)	312	443	(131)
Non Pay	18,450	1,530	1,544	(13)	15,345	15,631	(286)
Income Less Direct Costs	(71,660)	(5,906)	(5,771)	135	(59,813)	(63,997)	(4,184)



Income and Expenditure Commentary

The position at month 10 is £135k favourable in month and £4,184k adverse YTD.

NHS Clinical Income is £366k favourable in month due to TB income now accounted for within ICAM. In addition to this funding for additional beds on Cavell Ward and Enhanced Virtual Ward income has now been accounted for. YTD the position is £1,982k favourable due to prison income recognised in month 1 (£0.5m), additional CCG investments and RTT and winter resilience funding.

Pay is £780k adverse in month and £5,881k adverse YTD.

Nursing is £356k adverse in month and £1,944k 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. ED nursing spend has been partly offset by Winter Resilience income received.

Medical is £201k adverse in month and £1,402k 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 consultants increased spend is offset by Enhanced Virtual Ward income.

Unallocated CIP and VIP is leading to a £145k adverse variance in month and £1,340k adverse YTD.

Non-Pay - YTD Adverse £286K; £13k adverse in month. YTD adverse; £286k 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.

In month 10, the division delivered £507k against a plan of £462k. Year to date the division has delivered £1,285k against a plan of £2,724k.

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 has now 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 2 months of the year based on significant recruitment, challenging targets set for district nursing and ward specialing expenditure improvement and additional TB income.

ED - Nursing vacancies are set to be filled by trust wide nursing recruitment drives. Winter resilience is currently funding additional medical and nursing shifts.

District Nursing - Phased recruitment plan in place to reduce agency spend. New nurses have started in November to 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.

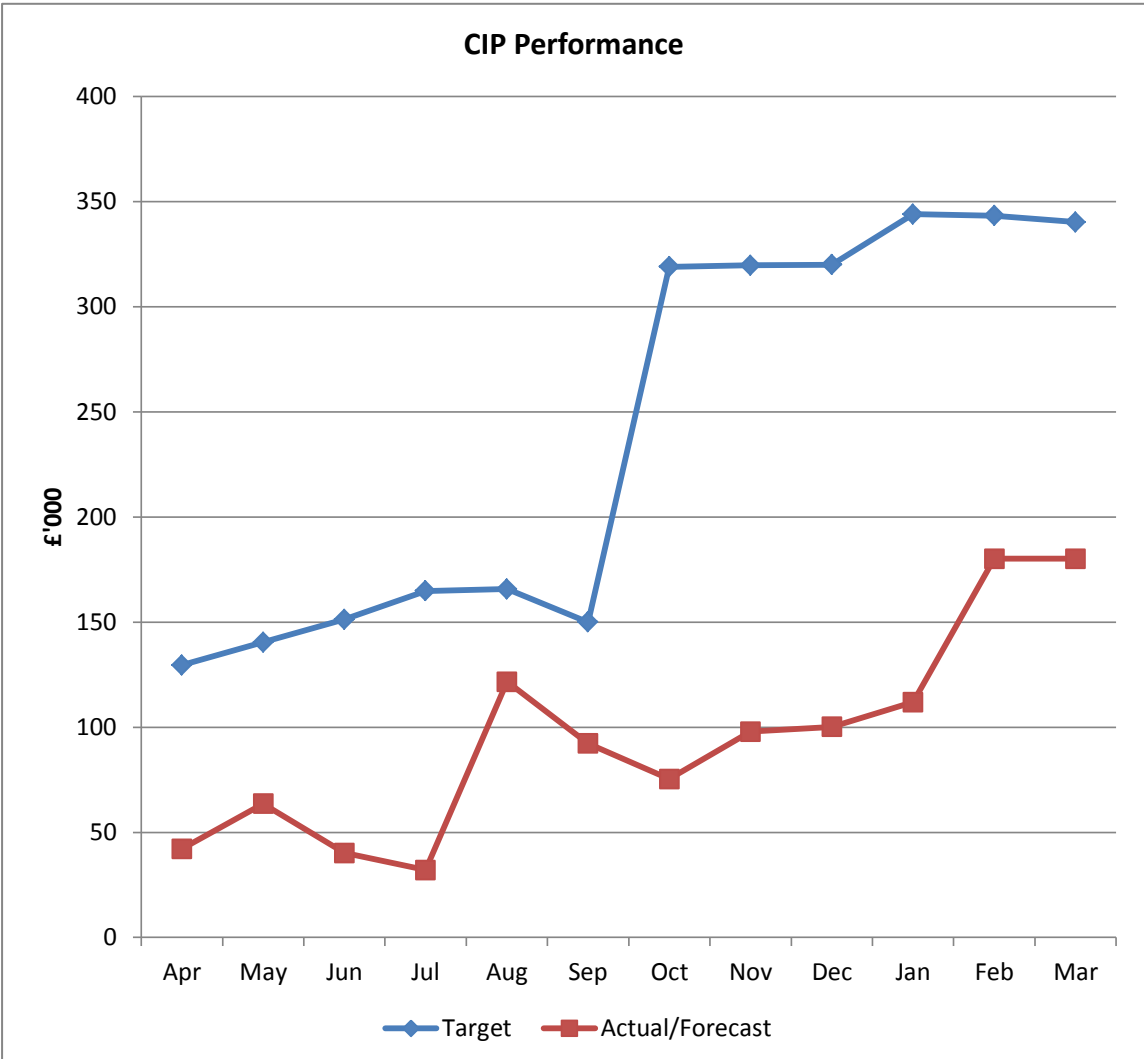
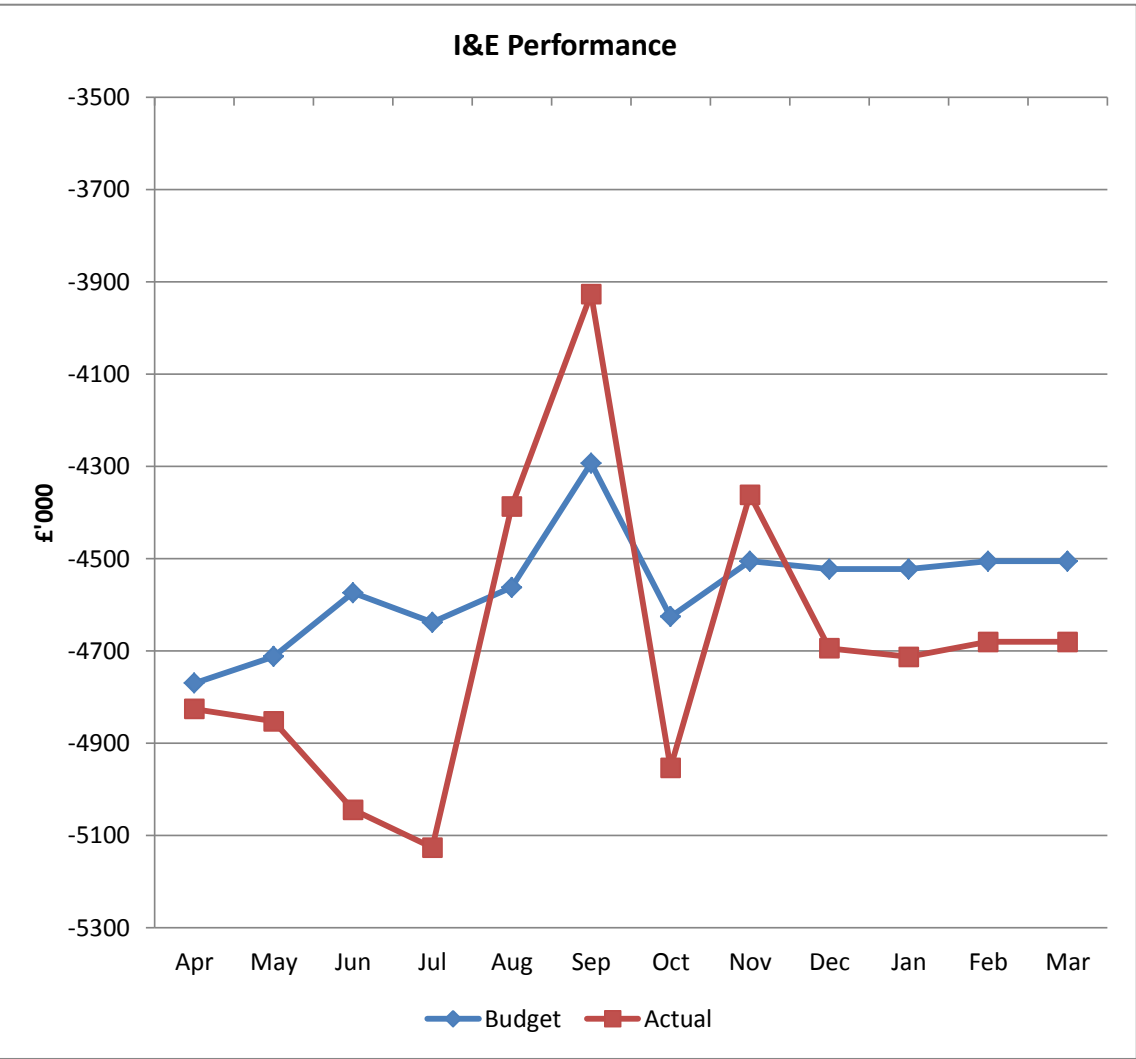
Ward Nursing - Corporate Nursing to look into required budget for specialing and what processes are required to control the spend.

Consultant Agency - 1 x Gastroenterology post offer accepted. 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 - 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 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Actuals			Actuals		
		Plan £'000	£'000	Var £'000	Plan £'000	£'000	Var £'000
Nhs Clinical Income	819	68	131	63	683	2,534	1,851
Other Income For Pat Care	1,028	87	140	53	855	1,173	319
Other Non-Patient-Devolved	719	33	41	8	610	534	(76)
Other_Non-Patient_Non-Dev	640	53	80	27	533	573	39
Income	3,206	242	392	150	2,680	4,814	2,133
A/C	4,040	311	413	(102)	3,418	4,304	(887)
Dental	2,344	195	194	1	1,954	1,936	18
Executive Board & Sen Mgmt	611	85	74	11	509	393	116
Medical	16,161	1,337	1,328	10	13,478	13,586	(109)
Nurses & Midwives	15,024	1,237	1,238	(1)	12,483	12,574	(90)
Other Support Workers	376	31	30	2	313	291	22
Scientific, Ther & Tech	8,356	700	699	1	6,956	7,197	(241)
Pay Reserve	(1,640)	(194)	0	(194)	(1,251)	0	(1,251)
Pay	45,273	3,703	3,976	(273)	37,859	40,282	(2,423)
Establishment	280	23	31	(7)	233	362	(128)
Ext Cont Staffing & Cons	176	15	15	(1)	147	124	22
Miscellaneous	334	28	38	(10)	278	433	(155)
Non-Pay Reserve	(65)	(11)	0	(11)	(44)	0	(44)
Premises & Fixed Plant	591	49	61	(12)	492	590	(98)
Supplies & Servs - Clin	10,799	910	952	(42)	8,979	9,468	(489)
Supplies & Servs - Gen	554	47	32	15	460	438	23
Non Pay	12,669	1,061	1,129	(68)	10,546	11,415	(868)
Income Less Direct Costs	54,735	4,522	4,713	(190)	45,725	46,883	(1,158)



Income and Expenditure Commentary

The position at month 10 is £190k adverse in month and £1,158k adverse YTD. Against forecast for the month the Division over-performed by £106k.

Income is £150k favourable in month and £2,133k favourable YTD driven by £1,348k of RTT income recognised YTD along with income from Dental OOH service. Additionally, Resilience 2 funding of £35k was also accounted for in-month along with pathology prison and RFH ophthalmology over-runs.

Pay is £273k adverse in month and £2,423k adverse YTD. Against the average runrate of last 9 months the cost of pay continues to remain lower by £50K in-month.

Nurses & Midwives is £1k adverse in month and £90K adverse YTD. This is largely due to the escalation bed budget in Coyle. However ITU ward overspend by £64K in-month due to higher levels of activity and bed occupancy.

Admin and clerical is £102k adverse in month and £887k 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 £1,251k adverse YTD. This is because the Planned Activity VIP target was phased from M07.

Non Pay is £68k adverse in month and £868k adverse YTD. This is largely due to costs within theatres (due to electives) and pathology on clinical consumables, prosthetics and reagents.

CIP Commentary -

In month 10 the division delivered £112k against a plan of £344k

Year to date the division has delivered £777k against a plan of £2,203k.

2 % schemes - the division under-performed by £18K after taking into account the non-recurrent schemes. However it continues to deliver 74% of the schemes YTD.

Productivity Target - This is under-performing in-month. However it is forecasted to improve through increase in referrals from Moorfield & UCLH activities to the financial year end.

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 performance for Theatres have remained constant since December, however performance has fallen back to 50% achievement due to increase in orthopaedic prosthetics spend.

Divisional Actions

Imaging

- The constant budget review continues to reduce spend.
- An alternative to existing additional Radiology reporting spend has been identified and is being implemented.
- There is a plan to reduce spend for A&C till financial year end
- Cross charging to RFH and UCLH is of concern and is being checked.

Theatres

- It is expected that theatres will be fully staffed by end of financial year 2014/15, agency & bank spend continues to reduce.
- Non pay spend is linked to activity. All non pay spend is scrutinised through a control process to keep costs to a minimum.

Admin & clerical Staffing

- Most staff are now in new roles.
- A review has been undertaken to make sure that all staff are accounted for in the correct positions. This has raised some concerns which are being addressed in February 2015.

Surgery

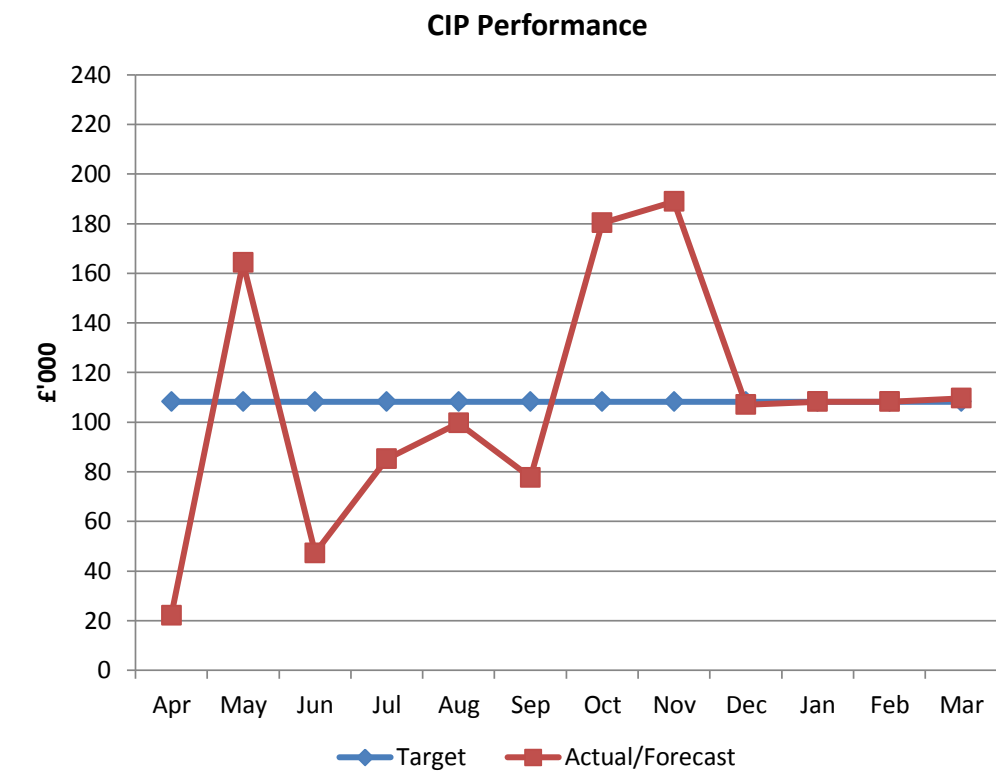
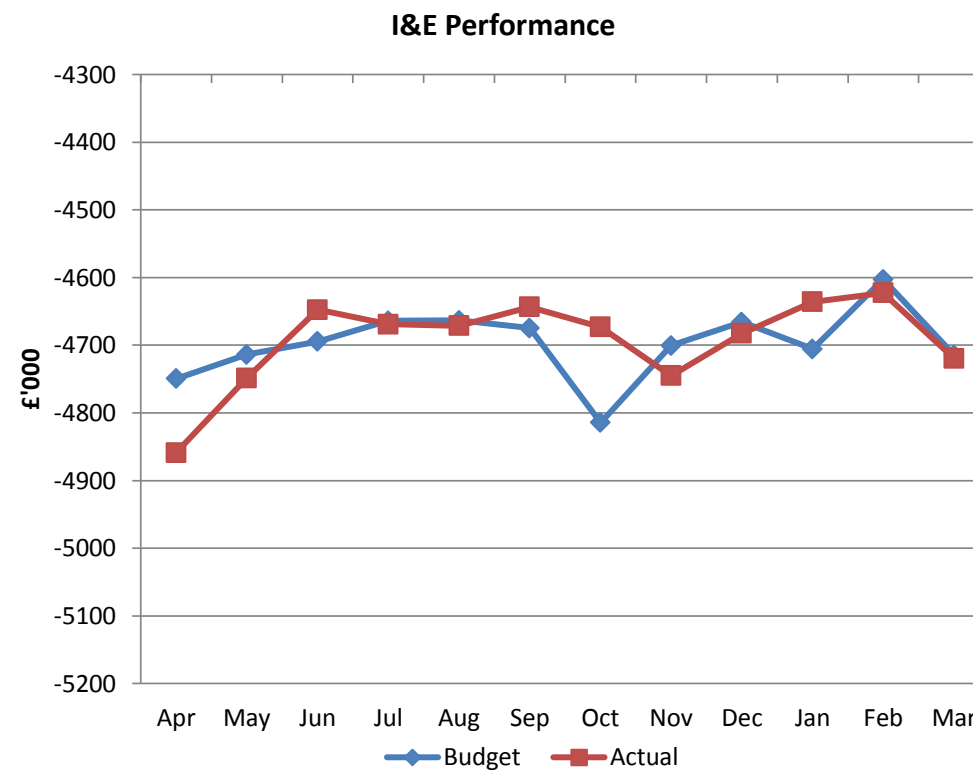
- The Orthotics service as a managed service is an opportunity and work continues to reclaim VAT for 2014/15.

WLI

- The division continues to pursue the possibility of work from other organisations, Moorfields contract will start in March 2015, and we will

WCF Divisional Position - Month 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Nhs Clinical Income	940	79	148	68	781	1,218	437
Other Income For Pat Care	6,958	595	597	2	5,808	6,152	344
Other Non-Patient-Devolved	393	106	121	15	358	446	88
Other_Non-Patient_Non-Dev	0	0	41	41	0	82	82
Income	8,291	781	906	125	6,946	7,897	951
A/C	4,575	383	403	(20)	3,811	4,015	(204)
Executive Board & Sen Mgmt	666	53	38	15	560	418	141
Medical	11,418	1,029	1,003	26	9,545	9,756	(211)
Nurses & Midwives	31,296	2,625	2,631	(6)	26,169	25,998	171
Other Support Workers	39	3	17	(14)	33	116	(83)
Scientific, Ther & Tech	12,758	1,050	1,074	(24)	10,658	10,740	(81)
Pay Reserve	(347)	(9)	0	(9)	(289)	0	(289)
Pay	60,406	5,134	5,166	(32)	50,487	51,043	(556)
Establishment	477	40	34	6	398	505	(107)
Ext Cont Staffing & Cons	78	7	2	5	65	69	(3)
Miscellaneous	291	21	57	(36)	210	355	(145)
Non-Pay Reserve	1	0	0	0	0	0	0
Premises & Fixed Plant	548	47	46	0	455	486	(31)
Supplies & Servs - Clin	2,507	209	215	(6)	2,088	2,195	(106)
Supplies & Servs - Gen	345	29	21	7	288	221	67
Non Pay	4,247	352	375	(23)	3,505	3,829	(325)
Income Less Direct Costs	(56,363)	(4,706)	(4,636)	70	(47,046)	(46,975)	71



Income and Expenditure Commentary

The WCF position at month 10 is £70k favourable in month and £71k favourable YTD.

Patient Care Income is £70k favourable in month and £781k 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 £56k favourable in month and £170k favourable. The in-month position is mainly driven by a provision for additional student midwifery funding of £33k. The YTD position is driven by additional education and training and schools income.

Pay is £32k adverse in month and £556k adverse YTD.

A&C is £20k adverse in the month and £204k adverse YTD. The in-month position is largely driven by an overspend in LAC and School Nursing for which there is corresponding income. The YTD variance relates to LAC and School Nursing, maternity admin, which is due to long-term sickness and agency cover and paediatric integrated care.

Medical is £26k favourable in month and £211k adverse YTD. The favourable in-month position is driven by additional £91k flexi trainee funding, which relates to M1-10. This is partly offset by junior doctor agency expenditure in Obstetrics and Gynaecology, unfunded maternity and sick leave cover, and the appointment of an additional paediatric consultant to cover 7 day working. The YTD adverse variance is largely driven by junior doctor agency expenditure in Obstetrics and Gynaecology which has reduced over the past three months.

Scientific, Ther & Tech is £24k adverse in month and £81k adverse YTD. Of the in-month variance £23k 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 £23k adverse in month which is driven by professional services in central management and teaching and training expenditure in CAMHS which is offset by income. The adverse YTD position of £325k is driven by additional equipment requirements and increased activity in special schools, professional services for the preparation of tenders and the cost of setting up new services.

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 10, the division delivered the monthly CIP plan of £108k in full.

Year to date the division has delivered CIPs of £1,081k against the YTD plan of £1,082k.

Of the £1081k delivered YTD, £376k is recurrent and £705k 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 is required in managing the reduction in bank, agency and locum spend, which in turn will ensure the currently reported financial position is maintained or improved.

Recruitment to vacancies are continuing in areas where agency staffing is currently used and to specific posts relating to new investments.

The pan London ban to stop using agency Health Visitors is now in place.

Recent nurse recruitment into NICU has been successful and a small reduction in bank and agency expenditure can be seen in January.

Income

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

Corporate Divisional Position - Month 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Organisational Development	2,163	177	161	17	1,812	2,090	(279)
ICT	6,642	553	565	(12)	5,536	5,631	(95)
Finance	4,052	338	332	7	3,375	3,497	(122)
Trust Secretariat	1,695	137	119	18	1,422	1,579	(157)
Chief Operating Officer	1,187	40	113	(73)	1,107	1,433	(326)
Nursing & Patient Experience	9,508	804	812	(8)	7,900	7,927	(27)
Procurement	789	66	102	(36)	658	639	19
Medical Director	1,053	88	81	7	878	657	221
Facilities	28,314	2,378	2,136	242	23,569	22,765	805
Total	55,402	4,580	4,420	160	46,257	46,217	40

ICT Breakdown

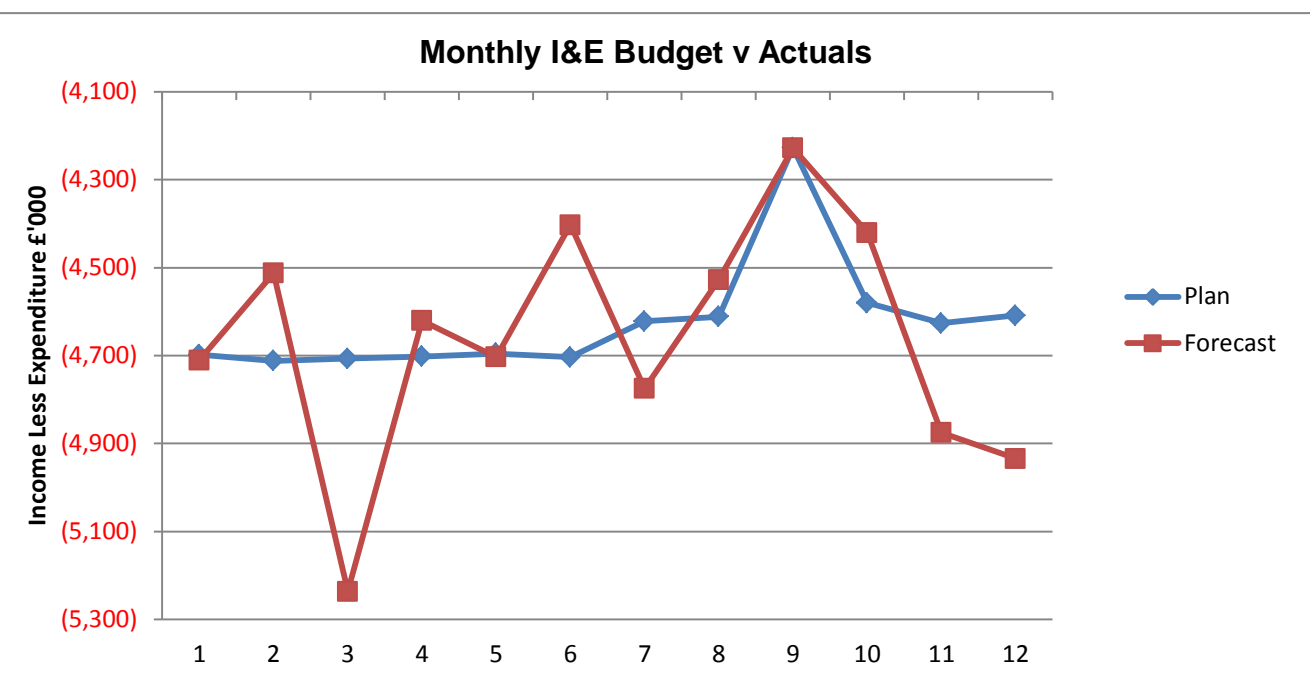
Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Income	(22)	(2)	(9)	8	(19)	(29)	10
Pay	2,977	247	280	(32)	2,482	2,751	(269)
Non-Pay	3,688	307	295	13	3,073	2,909	164
Total	6,642	553	565	(12)	5,536	5,631	(95)

Facilities Breakdown

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Income	(1,841)	(133)	(198)	65	(1,576)	(1,772)	196
Pay	11,178	900	792	108	9,377	8,286	1,091
Non-Pay	18,978	1,610	1,542	68	15,768	16,251	(483)
Total	28,314	2,378	2,136	242	23,569	22,765	805

Nursing & Patient Experience Breakdown

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Non-Pay	6,075	507	526	(19)	5,062	5,184	(123)
Non-Nhs Clinical Income	0	0	(5)	5	0	(34)	34
Other Non-Patient Income	(3)	(0)	(6)	5	(2)	(83)	81
Pay	3,435	297	296	2	2,841	2,860	(19)
Total	9,508	804	812	(8)	7,900	7,927	(27)



Commentary

The corporate position at month 10 is £84k favourable in month and £119k adverse YTD.

COO - The forecast position now includes the transfer of a CIP target of £710k (Locality based VIP) from ICAM to COO.

Facilities - The favourable variance in M10 was better than trend due to revisions to catering contract expenditure (£40k reduction ytd based on invoiced amounts) and adjustments to Medical Physics expenditure (£63k reduction ytd following budget holder review of contracts in M10).

ICT - A schedule of annual expenditure and agency 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 £95k YTD adverse variance.

Organisational Development - YTD adverse position driven by underperformance against the Occupational Health income target and staffing CIPs. The in month improvement is due to the receipt of education funding in M10 for apprentice programme ytd expenditure (£53k).

Finance - YTD adverse position improved in Jan due to ongoing vacancies and education funding received for financial planning costs incurred in earlier months.

Trust Secretariat – YTD adverse position driven by a number of posts being covered by interim staff. Position improved in recent months due to vacancy gaps and transfer of temporary staff to permanent contracts.

Procurement - The M10 variance was due to revised interim staff costs following review of contract schedule. The forecast position at year end remains favourable.

Acute Activity Analysis

Activity by PoD Type

PoD Group	Annual Plan	January			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Adult Critical Care	7,745	645	497	(148)	6,454	5,939	(515)
Block Contract/Adjustments	0	0	0	0	0	0	0
Day Cases	19,179	1,598	1,384	(214)	15,982	16,737	755
Direct Access	1,014,339	84,528	67,535	(16,993)	845,283	809,089	(36,194)
ED Attendances	104,069	8,672	7,208	(1,464)	86,724	76,854	(9,870)
Elective Inpatients	2,752	229	218	(11)	2,293	2,316	23
Excess Beddays	7,301	608	1,423	815	6,084	6,636	552
Maternity Pathway	8,943	745	655	(90)	7,452	6,577	(875)
NICU High Dependency Beddays	1,942	162	122	(40)	1,619	1,609	(10)
NICU Intensive Care Beddays	880	73	35	(38)	734	467	(267)
NICU Special Care Beddays	5,171	431	335	(96)	4,309	3,337	(972)
NICU Transitional Care Beddays	6,350	529	232	(297)	5,292	4,257	(1,035)
Non-Elective Inpatients	29,445	2,454	1,917	(537)	24,538	23,040	(1,498)
Other Activity	69,572	5,798	1,706	(4,092)	57,977	44,268	(13,709)
Outpatient 1st Attends	61,195	5,100	3,087	(2,013)	50,996	48,094	(2,902)
Outpatient Diagnostic Imaging	23,529	1,961	1,876	(85)	19,608	18,481	(1,127)
Outpatient Follow Ups	152,207	12,684	6,321	(6,363)	126,839	112,507	(14,332)
Outpatient Procedures	21,099	1,758	820	(938)	17,582	11,678	(5,904)
Paediatrics High Dependency	256	21	0	(21)	214	395	181
TOTAL	1,535,974	127,998	95,371	(32,627)	1,279,978	1,192,281	(87,697)

Commentary
Critical care activity has decreased by 209 (30%) compared to December 2014, but the data is still ongoing up to the freeze date.
Day case activity is 112 below the Month 10 plan of 1,598. NB This line also includes the additional RTT activity (national).
Direct access activity has reduced in month by 510 (1%) compared to December 2014 and 4% below plan YTD. 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. However, patients show high acuity and are complex.
Elective inpatient activity is below plan, with this line in YTD terms including the additional national RTT work.
Maternity actuals have decreased by 37 (5%), compared to December 2014. Actual activity has been lower than plan for the first few months of the year. NICU activity is below December level by 87 days and 2,284 below the YTD plan.
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

Commissioner	Annual Plan	January			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
NHS England	17,697	1,475	730	(745)	14,747	12,623	(1,704)
NHS Islington CCG	842,508	70,209	52,003	(18,206)	702,090	655,084	(47,144)
NHS Haringey CCG	521,106	43,425	33,614	(9,811)	434,255	408,134	(26,315)
NHS Camden CCG	30,086	2,507	1,766	(741)	25,071	21,063	(4,025)
NHS City and Hackney CCG	19,066	1,589	824	(765)	15,888	11,975	(3,924)
NHS Enfield CCG	11,822	985	918	(67)	9,851	11,192	1,328
NHS Barnet CCG	69,945	5,829	4,102	(1,727)	58,288	51,353	(6,967)
Other CCG	23,745	1,979	1,414	(565)	19,787	20,857	1,055
TOTAL	1,535,974	127,998	95,371	(32,627)	1,279,978	1,192,281	(87,697)

Commentary
The NHS England variance due to critical care activity and time lag in coding of High cost drugs
The majority of activity under performance for Islington CCG is from OP Pods which are 15,968 attendances below the YTD plan and Direct Access Pathology by 20,408.
A significant proportion of activity under performance for Haringey CCG is also from OP Pods which are below plan by 6,158 attendances and DA Pathology by 12,779 YTD.

Acute Income Analysis

Income Analysis

PoD Group	Annual Plan £'000	January			YTD		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Adult Critical Care	£ 10,160	£ 847	£ 652	-£ 195	£ 8,467	£ 7,737	-£ 729
Block Contract/Adjustments	£ 10,997	£ 916	£ 1,018	£ 101	£ 9,164	£ 10,094	£ 930
Day Cases	£ 11,899	£ 992	£ 975	-£ 17	£ 9,916	£ 10,667	£ 752
Direct Access	£ 10,965	£ 914	£ 877	-£ 37	£ 9,138	£ 9,774	£ 636
ED Attendances	£ 11,434	£ 953	£ 818	-£ 135	£ 9,529	£ 8,591	-£ 938
Elective Inpatients	£ 9,142	£ 762	£ 601	-£ 160	£ 7,618	£ 7,222	-£ 396
Excess Beddays	£ 2,140	£ 178	£ 189	£ 11	£ 1,783	£ 1,633	-£ 150
Maternity Pathway	£ 9,945	£ 829	£ 674	-£ 154	£ 8,287	£ 7,345	-£ 942
NICU High Dependency Beddays	£ 1,717	£ 143	£ 108	-£ 35	£ 1,431	£ 1,422	-£ 9
NICU Intensive Care Beddays	£ 1,012	£ 84	£ 40	-£ 44	£ 843	£ 537	-£ 307
NICU Special Care Beddays	£ 1,974	£ 165	£ 128	-£ 37	£ 1,645	£ 1,274	-£ 371
NICU Transitional Care Beddays	£ 2,425	£ 202	£ 89	-£ 113	£ 2,020	£ 1,625	-£ 395
Non-Elective Inpatients	£ 42,876	£ 3,573	£ 3,371	-£ 202	£ 35,730	£ 33,227	-£ 2,503
Other Activity	£ 2,010	£ 167	£ 97	-£ 71	£ 1,675	£ 1,171	-£ 504
Outpatient 1st Attends	£ 8,916	£ 743	£ 549	-£ 194	£ 7,430	£ 7,176	-£ 254
Outpatient Diagnostic Imaging	£ 2,655	£ 221	£ 218	-£ 3	£ 2,213	£ 2,058	-£ 155
Outpatient Follow Ups	£ 11,631	£ 969	£ 627	-£ 342	£ 9,693	£ 8,910	-£ 782
Outpatient Procedures	£ 3,596	£ 300	£ 145	-£ 155	£ 2,997	£ 2,099	-£ 898
Paediatrics High Dependency	£ 263	£ 22	£ -	-£ 22	£ 219	£ 405	£ 186
TOTAL	£ 155,757	£ 12,980	£ 11,174	-£ 1,806	£ 129,797	£ 122,967	-£ 6,830

Income by Commissioner - £000's

NHS England	£ 13,942	£ 1,162	£ 770	-£ 392	£ 11,618	£ 9,844	-£ 1,774
NHS Islington CCG	£ 64,371	£ 5,364	£ 4,370	-£ 994	£ 53,642	£ 50,151	-£ 3,491
NHS Haringey CCG	£ 49,898	£ 4,158	£ 3,857	-£ 301	£ 41,582	£ 40,640	-£ 942
NHS Camden CCG	£ 5,280	£ 440	£ 355	-£ 85	£ 4,400	£ 3,442	-£ 958
NHS City and Hackney CCG	£ 4,776	£ 398	£ 276	-£ 122	£ 3,980	£ 3,489	-£ 491
NHS Enfield CCG	£ 2,892	£ 241	£ 279	£ 38	£ 2,410	£ 2,694	£ 284
NHS Barnet CCG	£ 9,056	£ 755	£ 833	£ 78	£ 7,547	£ 7,488	-£ 59
Other CCG	£ 5,541	£ 462	£ 434	-£ 27	£ 4,617	£ 5,218	£ 601
TOTAL	£ 155,757	£ 12,980	£ 11,174	-£ 1,806	£ 129,797	£ 122,967	-£ 6,830

Commentary

In month 10 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 10 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 £1.8m in month and an *under performance* of £6.8m 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.

Statement of Financial Position

	As at 1st April 2014 £000	As at 31st January 2015 £000	Forecast 31st March 2015 £000	Plan 31st March 2015 £000	Commentary
<u>Non Current Assets</u>					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.
Property, plant and equipment	179,975	183,586	187,317	180,105	
Intangible assets	5,428	4,350	4,023	4,295	
Trade and other receivables	702	995	533	610	
Total Non Current Assets	186,105	188,931	191,873	185,010	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.
<u>Current Assets</u>					
Inventories	1,295	1,578	1,456	1,290	
Trade and other receivables	17,527	17,003	14,994	6,930	
Cash and cash equivalents	5,123	7,013	1,002	3,976	Cash increased by £4.8m during the month. This was due to the expected requirement to repay the temporary public dividend capital of £5.6m, with a corresponding reduction in taxpayer's equity. It is now expected that the advance will be made permanent and used to reduce payables. In accordance with the expected permanent PDC arrangement, the cash forecast has been reduced to a more realistic £1m. Cash is subject to various additional risks, mainly involving receivables, payables and CIP delivery.
Total Current Assets	23,945	25,594	17,452	12,196	
Total Assets	210,050	214,525	209,325	197,206	
<u>Current Liabilities (amounts due in less than one year)</u>					
Trade and other payables	36,010	39,795	34,993	27,154	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.
Borrowings	1,377	1,361	2,344	2,542	
Provisions	1,238	390	417	198	
Total Current Liabilities	38,625	41,546	37,754	29,894	
Net Current Assets (Liabilities)	(14,680)	(15,952)	(20,302)	(17,698)	
Total Assets less Current Liabilities	200,785	204,883	212,175	202,708	
<u>Non Current Liabilities (amounts due greater than one year)</u>					
Borrowings	36,758	34,603	34,419	34,028	
Provisions	2,015	1,863	1,915	2,190	
Total Non Current Liabilities	38,773	36,466	36,334	36,218	
Total Assets Employed	132,652	136,513	135,237	131,094	
<u>Taxpayers' Equity</u>					
Public dividend capital	56,461	62,111	62,321	56,671	
Retained earnings	15,277	8,345	6,788	18,918	
Revaluation reserve	60,914	66,057	66,128	55,505	
Total Taxpayers' Equity	132,652	136,513	135,237	131,094	
Capital cost absorption rate	3.5%	3.5%	3.5%	3.5%	

Month 10 (January) Aged Debtors Analysis
Period End Date: 28/01/2015

£	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	2,716,726.67	50,513.52	11,415.82	225,111.58	28,074.79	253,186	3,031,842
2	NHS HARINGEY CCG	65,084.91	962,426.00	18,271.00	41,922.45	6,302.25	48,225	1,094,007
3	THE ROYAL FREE LONDON NHS FT	191,741.29	69,257.71	6,466.10	117,952.19	39,712.87	157,665	425,130
4	NHS CITY & HACKNEY CCG	0.00	0.00	-74,753.84	464,127.03	0.00	464,127	389,373
5	THE UCL HOSPITALS NHS FOUNDATION TRUST	26,076.87	42,631.89	5,346.81	57,408.76	85,787.60	143,196	217,252
6	CNWL NHS FOUNDATION TRUST	46,168.50	19,736.33	18,485.66	100,185.49	0.00	100,185	184,576
7	NHS ENFIELD CCG	32,952.25	0.00	0.00	151,026.45	0.00	151,026	183,979
8	NHS BRENT CCG	30,112.04	2,887.04	125,707.21	6,228.01	0.00	6,228	164,934
9	NORTH MIDDLESEX HOSPITAL NHS TRUST	109,184.21	4,524.56	3,710.00	11,041.45	6,045.10	17,087	134,505
10	ROYAL FREE LONDON NHS FT	77,389.11	6,205.00	24,744.00	22,384.50	0.00	22,385	130,723
Top 10 NHS Total:		3,295,436	1,158,182	139,393	1,197,388	165,923	1,363,311	5,956,321
All Other NHS Total:		691,165.49	148,130.78	-107,122.36	-183,826.81	97,280.09	(86,547)	645,627
NHS Total:		3,986,601	1,306,313	32,270	1,013,561	263,203	1,276,764	6,601,948

NHS Total Previous Month	4,500,112	375,891	(127,510)	1,805,519	120,345	1,925,864	6,674,357
NHS Total Movement (Month 9 to Month 10)	(513,510)	930,422	159,780	(791,958)	142,858	(649,100)	(72,409)

£	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	253,253.73	172,974.73	119,860.71	722,776.26	-4,324.52	718,452	1,264,541
2	LONDON BOROUGH OF ISLINGTON	284,321.24	37,169.10	0.00	7,933.20	25.65	7,959	329,449
3	OVERSEAS VISITOR (SH)	48,794.00	39,350.00	58,238.00	159,026.00	0.00	159,026	305,408
4	THE HIGH ROAD SURGERY	0.00	0.00	0.00	159,613.26	0.00	159,613	159,613
5	HIGHBURY GRANGE HC	11,084.19	11,084.19	0.00	75,305.58	0.00	75,306	97,474
6	VODAFONE LIMITED	92,390.40	0.00	0.00	0.00	0.00	0	92,390
7	RIVER PLACE GROUP PRACTICE	22,961.44	7,247.25	0.00	46,869.72	0.00	46,870	77,078
8	LONDON BOROUGH OF ENFIELD	64,288.31	0.00	0.00	480.00	9,421.32	9,901	74,190
9	THE RISE PRACTICE	10,916.46	10,916.46	0.00	49,356.20	0.00	49,356	71,189
10	LONDON BOROUGH OF CAMDEN	61,922.30	0.00	2,400.00	2,226.51	0.00	2,227	66,549
Top 10 Non NHS Total:		849,932	278,742	180,499	1,223,587	5,122	1,228,709	2,537,882
All other Non NHS Total:		339,870.55	134,333.75	65,325.37	359,269.73	234,967.33	594,237	1,133,767
Non NHS Total:		1,189,803	413,075	245,824	1,582,856	240,090	1,822,946	3,671,648

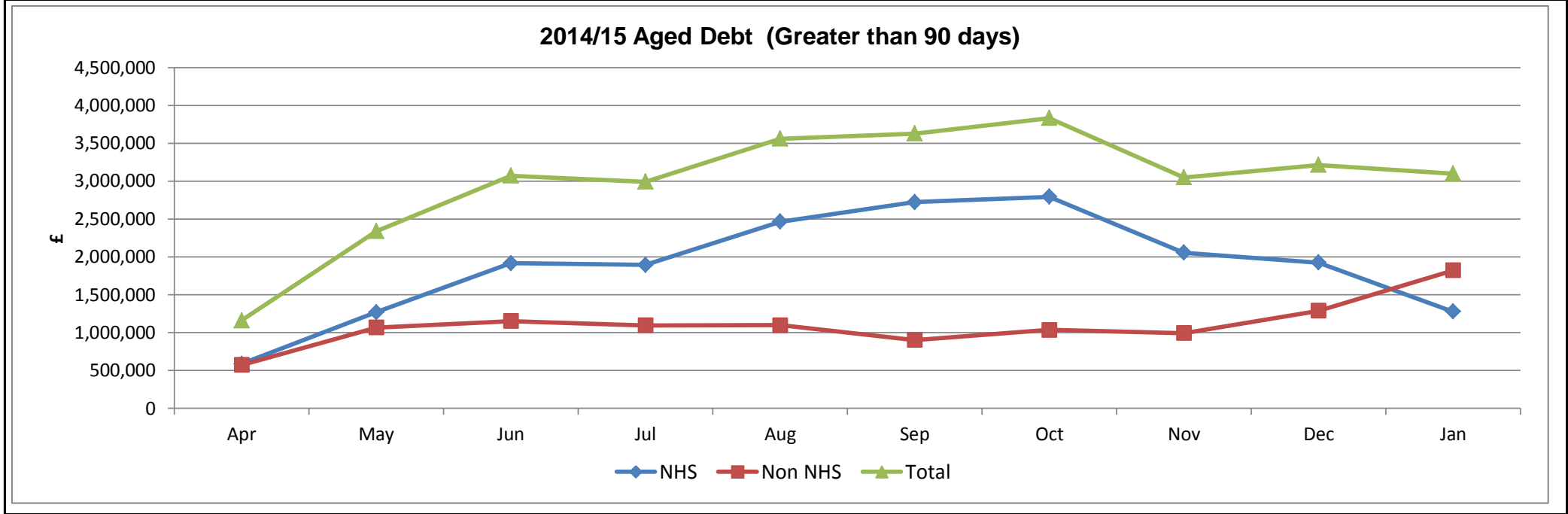
Non NHS Total Previous Month	1,377,737	387,577	691,278	1,048,252	241,841	1,290,093	3,746,685
Non NHS Total Movement (Month 9 to Month 10)	(187,935)	25,499	(445,454)	534,604	(1,751)	532,853	(75,036)

Grand Total	5,176,404	1,719,388	278,094	2,596,418	503,292	3,099,710	10,273,597
Grand Total Previous Month	5,877,849	763,468	563,768	2,853,772	362,186	3,215,957	10,421,042
Grand Total Movement	(701,445)	955,920	(285,673)	(257,354)	141,107	(116,247)	(147,445)

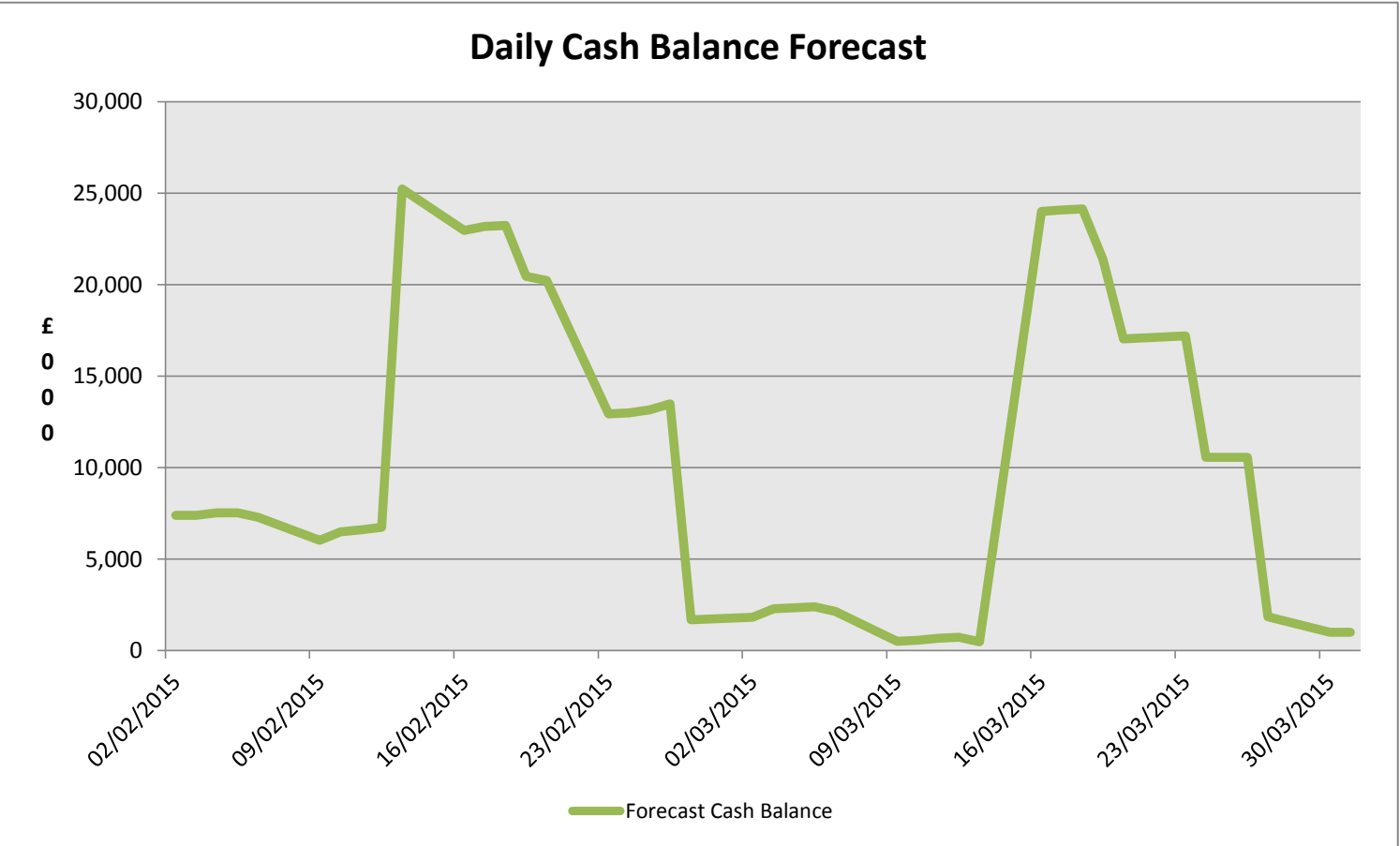
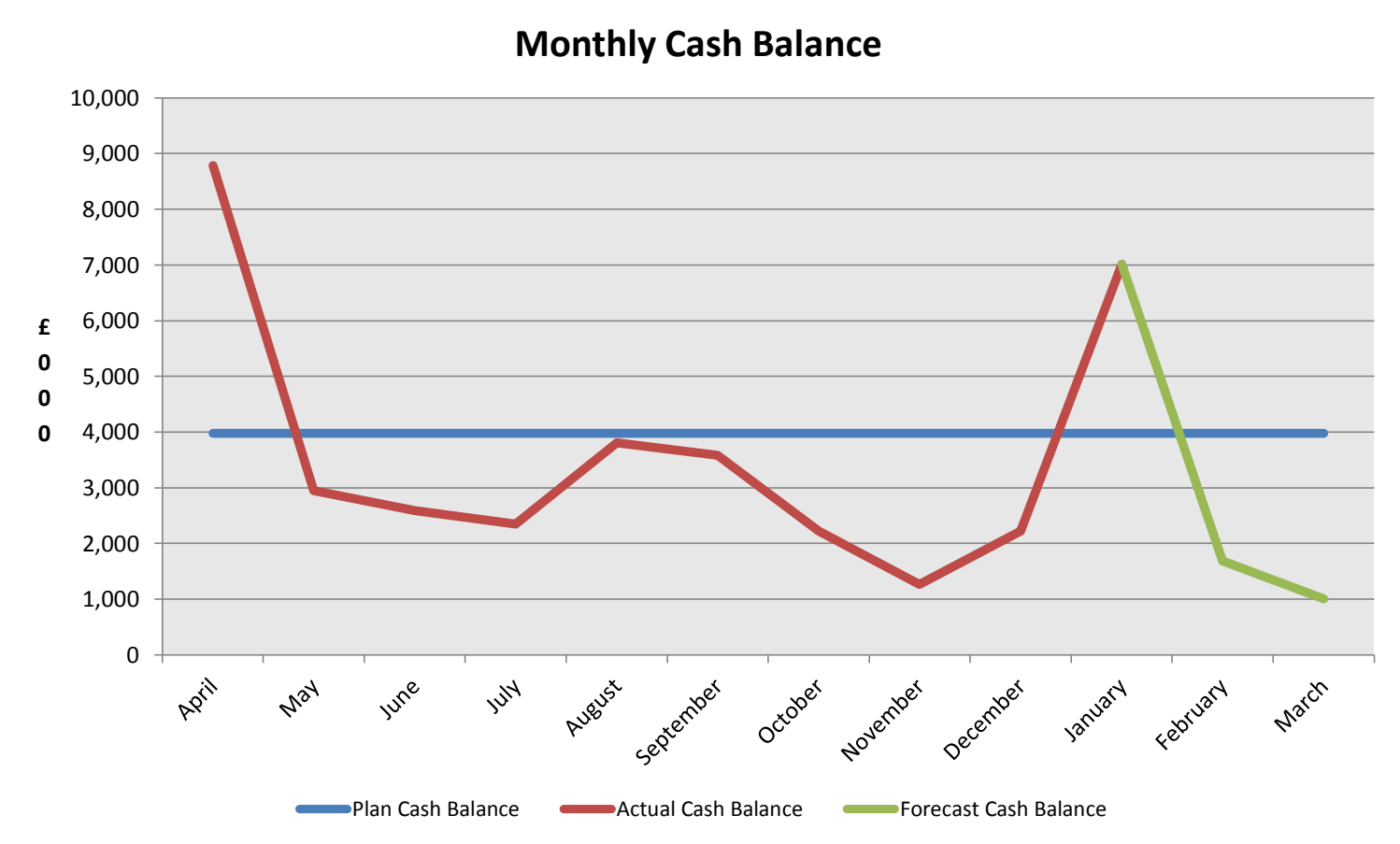
Commentary

Aged Debt '*Greater than 90 days*' has reduced by £0.1m to £3.1m in Month 10. **Material aged debt over 90 days includes:**
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 totals **£540k** and while our lead commissioners Islington and Haringey have paid their bills, other CCGs are yet to follow.

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 over £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 everything due.

In December, the Trust received a £5.6m cash loan, in the form of temporary PDC. This was expected to be repaid in January but this remains under negotiation and therefore held in the month end balance. It is now assumed that the advance will be made permanent and used to pay creditors, with no net impact on the cash outturn.

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. Failure to meet any of these conditions may compromise the statutory duty to operate within the EFL. In accordance with the expected outcome of the PDC negotiations, the forecast cash balance has been reduced to £1m, with a corresponding adjustment to the EFL.

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

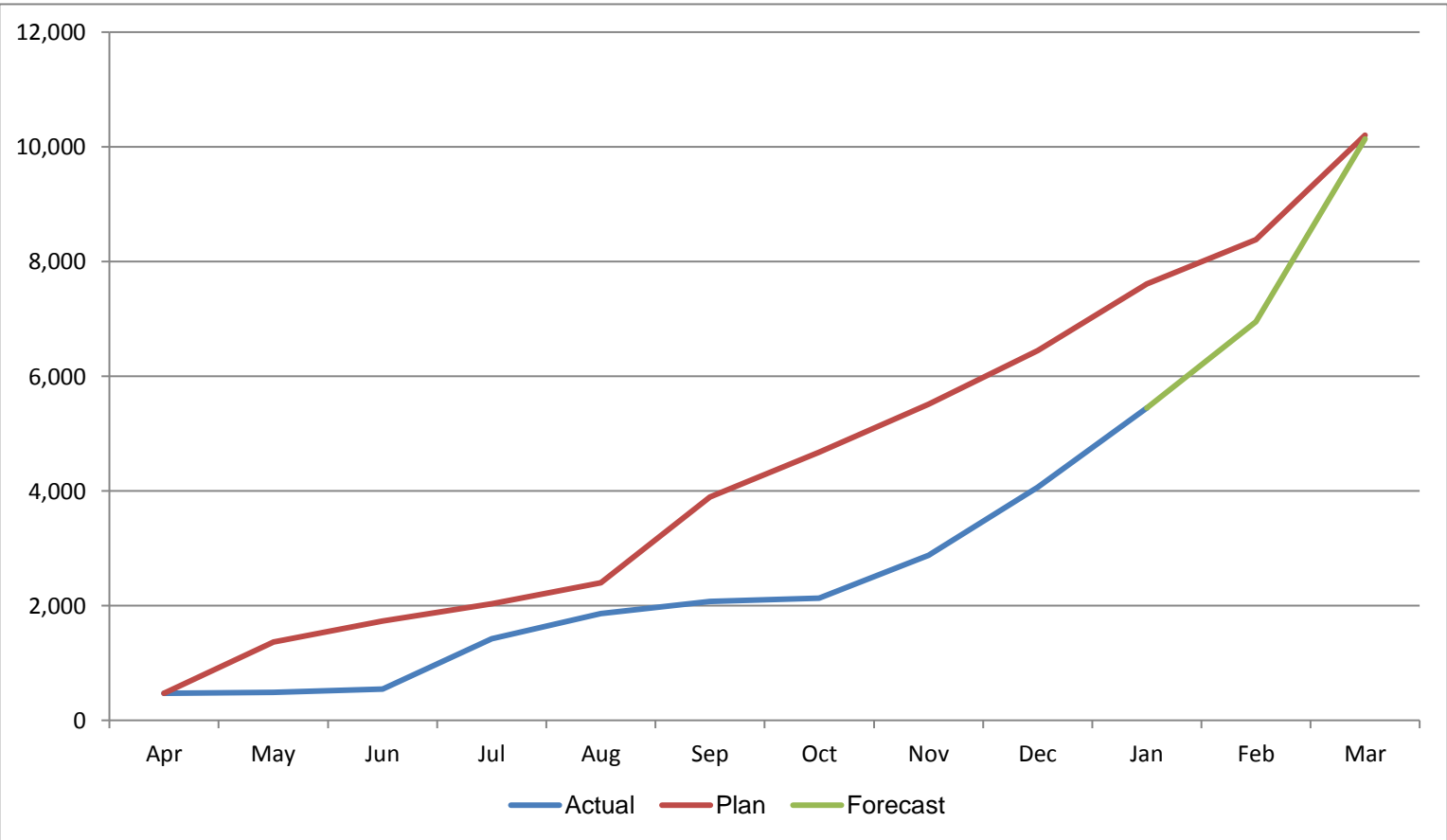
Action needed to meet the cash target and associated EFL comprises ensuring that all income is invoiced as soon as possible, and reducing expenditure in line with the CIP.

Capital Spend Performance and Forecast

	Annual Plan £'000	Current Month			YTD			Forecast Outturn		
		Plan £'000	Act £'000	Var £'000	Plan £'000	Act £'000	Var £'000	Plan £'000	Forecast £'000	Var £'000
Estates	5,618	990	767	223	4,167	2,869	1,298	5,618	5,618	-
IT	810	70	472	-402	415	1,722	-1,307	810	810	-
Equipment	1,514	100	139	-39	1,429	449	980	1,514	1,514	-
Business Cases	336	0	0	0	0	0	0	336	336	-
Leases	1,922	0	0	0	1,598	403	1,195	1,922	1,922	-
Total	10,200	1,160	1,378	-218	7,609	5,444	2,165	10,200	10,200	-

CRL	10,200
Variance	0

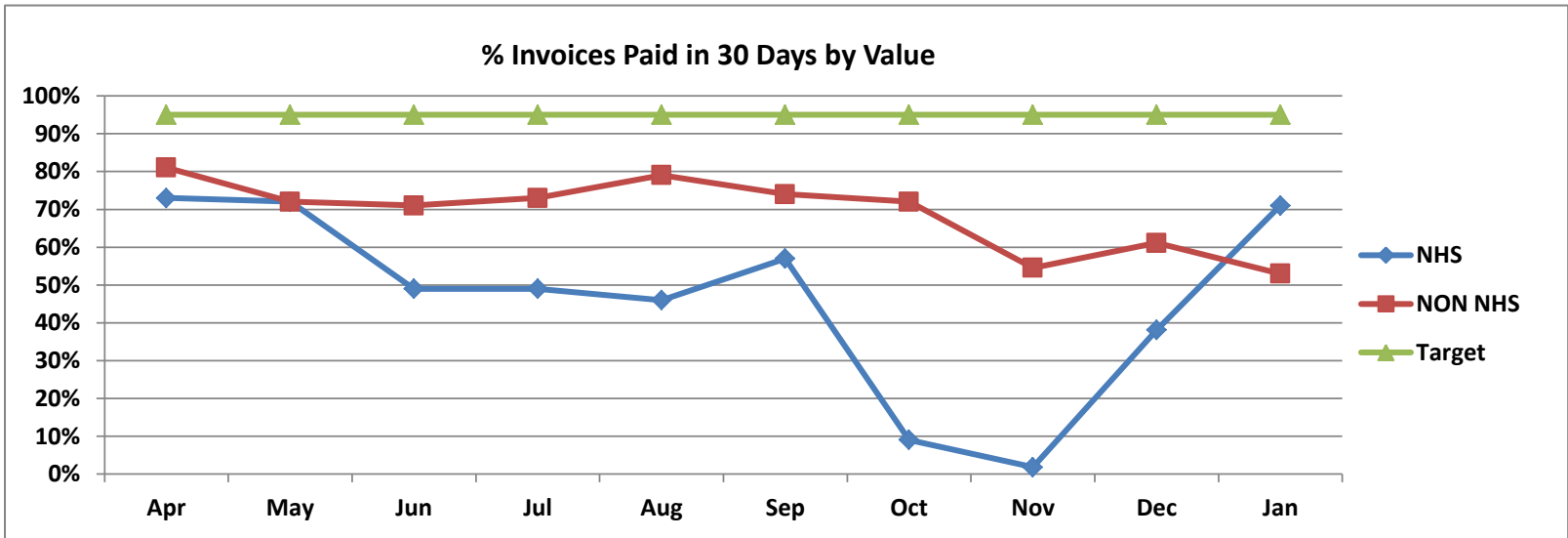
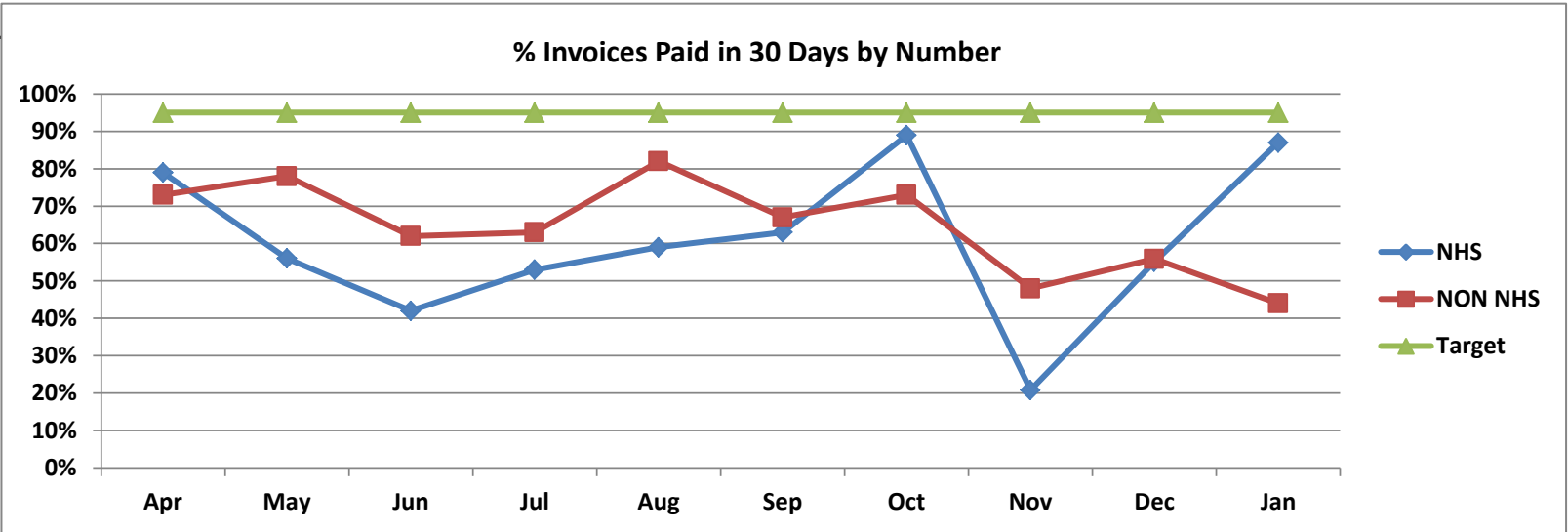
Spend against Capital Programme



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
<p>The Trust is currently falling short against its requirement of paying 95% of invoices within 30 days.</p> <p>Part of the reason for the poor performance is active management of working capital, which is planned to continue during the remainder of the 2014/15 financial year.</p> <p>In December, the Trust applied for and received a £5.6m cash loan in temporary PDC, which was used to clear a backlog of payments.</p> <p>Performance against the BPPC improved in January for NHS invoices, with a slight deterioration for non-NHS invoices. The latter was due to the requirement to retain the £5.6m PDC in anticipation of repaying it.</p>

Continuity of Services Risk Rating (COSR)

Metric		Definition		Parameters				Actual YTD	Forecast Outturn	Plan Outturn
				1	2	3	4			
Working Capital Balance (£'000) (+/-)								(17,530)	(20,106)	(18,988)
Annual Operating Expenses (£'000) (+)								235,668	280,024	271,133
Liquidity Ratio (Days)								(22)	(22)	(25)
Liquidity Rating	$\frac{\text{Working Capital Balance} \times 360}{\text{Annual Operating Expenses}}$	<-14	-14	-7	0			1	1	1
Revenue Available for Debt Service (£'000) (+)								7,095	9,440	16,786
Annual Debt Service (£'000) (+)								8,456	10,422	10,358
Capital Servicing Capacity (Times)								0.8	0.9	1.6
Capital Servicing Capacity Rating	$\frac{\text{Revenue Available for Debt Service}}{\text{Annual Debt Service}}$	<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.

Whittington Health Trust Board

4th March 2015

Title:		NHS Trust Development Authority (TDA) – Self-Certification					
Agenda item:		15/041		Paper		8	
Action requested:		<i>For approval</i>					
Executive Summary:		The NHS 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 January 2015, which was submitted to the TDA on 23 February 2015 and agree the status for the February 2015 return. The Trust Board is also asked to discuss and agree any reporting issues in anticipation of the February 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:		18 February 2015					
Author name and title:		Ursula Grueger DDOF		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



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

CONTACT INFORMATION:



Enter Your Name:

Enter Your Email Address

Full Telephone Number:

Tel Extension:

SELF-CERTIFICATION DETAILS:



Select Your Trust:

Submission Date:

Reporting Year:

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.

Timescale for compliance:

2. Condition G5

Having regard to monitor Guidance.

Timescale for compliance:

3. Condition G7

Registration with the Care Quality Commission.

Timescale for compliance:

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

4. Condition G8

Patient eligibility and selection criteria.

Timescale for compliance:

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

5. Condition P1
Recording of information.

Timescale for compliance:

6. Condition P2
Provision of information.

Timescale for compliance:

7. Condition P3
Assurance report on
submissions to Monitor.

Timescale for compliance:

8. Condition P4
Compliance with the
National Tariff.

Timescale for compliance:

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

9. Condition P5
Constructive engagement
concerning local tariff
modifications.

Timescale for compliance:

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

10. Condition C1

The right of patients to
make choices.

Timescale for compliance:

11. Condition C2

Competition oversight.

Timescale for compliance:

12. Condition IC1

Provision of integrated
care.

Timescale for compliance:

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

CONTACT INFORMATION:



Enter Your Name:

Enter Your Email Address

Full Telephone Number:

Tel Extension:

SELF-CERTIFICATION DETAILS:



Select Your Trust:

Submission Date:

Reporting Year:

Select the Month

April

May

June

July

August

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October

November

December

January

February

March

BOARD STATEMENTS:



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.

Timescale for compliance:

RESPONSE:

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

Whittington Health Trust Board

4th March 2015

Title:		Corporate Risk Register Annual Review					
Agenda item:		15/042		Paper		9	
Action requested:		For Approval					
Executive Summary:		<p>This paper sets out an annual summary of the Trust corporate risk register.</p> <p>All risks have been reviewed to establish a profile of the current risks. This provides assurance that risks will be mitigated by scrutinising documented actions and target ratings. The extreme (red risks scoring 15-25) are outlined and an overview provided of the assurances from the reporting cycle.</p> <p>Appendices: Appendix 1 corporate risk register Appendix 2 triangulated risk management</p>					
Summary of recommendations:		Members of the Trust Board are asked to approve the corporate risk register and take assurance that risks are being managed appropriately.					
Fit with WH strategy:		Sound risk management and internal controls which align to Whittington Health Risk Management Strategy.					
Reference to related / other documents:		Annual governance statement Board assurance framework Annual audit plan					
Date paper completed:		16 February 2015					
Author name and title:		Pauline Frost, Interim Director of Risk & Lynne Spencer, Director of Communications & Corporate Affairs		Director name and title:		Philippa Davies Director of Nursing and Patient Experience	
Date paper seen by TMG	17/02/15	Equality Impact Assessment complete?	n/a	Risk assessment undertaken?		Legal advice received?	n/a



Corporate Risk Register Annual Review

1. Purpose

This report provides a summary of the corporate risk register. All risks have been reviewed to establish a profile of the current risks. This provides assurance that risks will be mitigated by scrutinising documented actions and target ratings. The extreme (red risks scoring 15-25) are outlined below and an overview provided of the assurances from the reporting cycle.

2. Background

The trust has a risk management strategy that sets out the process for managing all risks. This aligns with NHS requirements for management and handling of risks. The data and information used to produce this report was extracted from the Datix risk management database February 2015.

Extreme risks are escalated from other risk registers onto the corporate risk register. (Appendix 2 shows the escalation process). An ongoing programme of work will strengthen the controls required by the risk owners to mitigate risks, alongside actions and links to known future sources of internal and independent assurance.

The risks on the corporate risk register will continue to be reviewed and updated at least monthly at their respective divisional level and monthly on an aggregated basis through the trust management group (TMG). The director of communications and corporate affairs will retain core oversight of the document.

3. Risks and objectives

As an NHS Trust one of our core functions is to provide high quality services whilst achieving financial break-even. The corporate risk register identify risks to achieving financial break-even. Risks to achieving financial break-even are also being identified at an operational level and escalated to the corporate risk register where mitigating actions are not sufficient to control the risk. This demonstrates that risks are identified at all levels throughout the organisation from strategic to an operational level.

There are a number of extreme rated risks which relate directly to the financial, agency spend and cost improvement plans. Further review of the risk scoring and will be undertaken during March 2015 in order to streamline and simplify the process of risk management. The financial risks have materialised and the trust has put into place a plan to mitigate the consequences of the financial overspend within an agreed timescale.

4. Quality assuring divisional and directorate risk registers

The purpose of risk quality reviews is to ensure:

- risks are described and graded appropriately;
- mitigating actions are sufficient to manage the risk;
- controls and assurances are clear, accurate and up- to-date.

To ensure this programme of work is conducted efficiently, discussions are required between the risk owner and the central governance and risk team who report to the Director of Nursing and Patient Experience. This will enable appropriate review and challenge to the extreme (red) and high (amber) risks recorded within their respective division.

5. Total number of risks

There was a 54% increase in the number of risks identified on the trust wide risk registers in 2014. This positive increase in the number of risks identified and recorded was expected with the appointment of a dedicated risk manager for Integrated Care and Acute Medicine (ICAM). In addition, a member of the corporate governance team has been assisting Surgery, Cancer and Diagnostics (SDC) to identify and record risks on divisional risk registers.

This demonstrates a significant improvement in the risk aware culture of the organisation over the past year.

6. Extreme risks (score of 15 – 25)

There are currently seven risks rated as extreme on the corporate risk register. The majority of risks are currently rated as high (amber score of 12 to 14) and these will undergo further review and evaluation using the National Patient Safety Agency (January 2008) Risk Matrix for Risk Managers. This matrix scoring methodology is recommended by NHS England as a best practice tool.

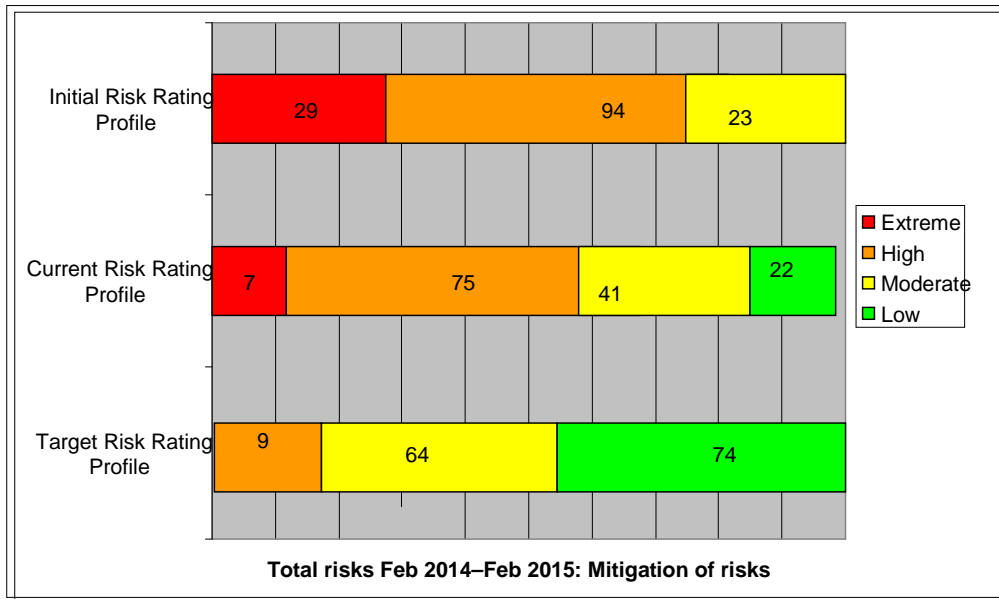
Table 1: Number of extreme risks

Current Risks by grading	No
25	1
20	1
16	4
15	1

7. Mitigation status

Progress against approved risk actions has been demonstrated by review of how the risks had been addressed, what actions were taken to mitigate the risks and how confident the division were in actions resulting in required improvements to achieve the tolerance level of risk control. **Chart 2** below demonstrates the transfer that has already taken place to reduce the initial extreme risk rating profile to the current risk profile. This provides a trajectory of what the target risk rating profile will look like once mitigating actions continue to be implemented.

There has been a significant shift from the initial extreme risk rated risks from 29 down to 7 over the previous twelve months which demonstrates a robust approach to the management of risks during 2014/15.

Chart 2: Annual status of risks transferred from initial to current risk status

8. Risk management continuous improvement journey

There will be a targeted review of high (scores of 8–12 amber) category rated risks during the first quarter of 2015/16, moderate risks in the second quarter and low risks in the third quarter. This will provide a sound approach to the assurance report detailing the annual review presented to the Board in April 2016 for 2015/16. The objective and independent scrutiny will take place by a newly formed 'Quality Risk Watch' working group led by the Director of Communications and Corporate Affairs.

The trust auditors have commented that risk registers will become an even more useful and informative risk management tool if they include perceived prospective risks. This is now in place as each division has reviewed their 2015/16 business plans and identified areas where there may be threats to achieving their objectives.

In future, new extreme risks on the corporate risk register will have an associated action plan which will be implemented to mitigate the risk to a level which is considered to be an acceptable tolerance rating. This evolving proactive approach to managing risks in a structured and systematic manner will enable the trust to tackle risks in a timely and considered manner before they materialise.

9. Recommendations

Members of the Trust Board are asked to approve the corporate risk register and take assurance that risks are being managed appropriately.

Philippa Davies
Director of Nursing and Patient Experience

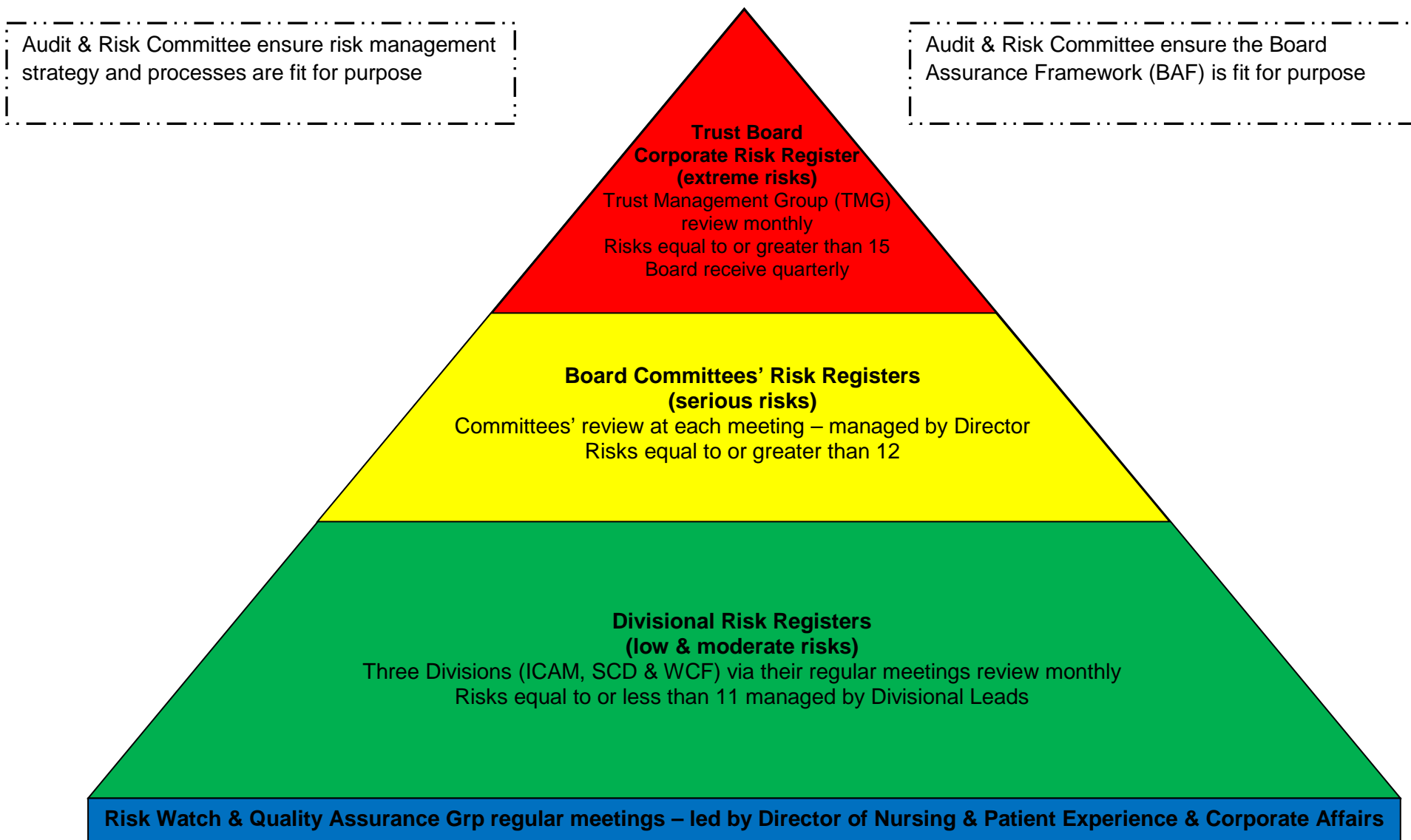
Appendices:

Appendix 1 Corporate risk register **Appendix 2** Triangulated risk management

ID	Directorate	Department	Staff Lead	Description	Controls in Place	Gaps In Controls	Risk level (current)	Assurance	Gaps in Assurances	Progress Notes / Overall Risk Update	Review date	Target Date
Department:												
	Nursing and Patient Experience	Organisation	Ms Alison Kett	* High levels of agency staff will result in high costs which will impact on the Trust meeting its financial targets	Agency usage group Monthly monitoring of agency spend Agency usage controls in place at all levels for management approval - shift by shift review Establishment review of adult wards, agreed higher level of staffing in budget Monthly recruitment drives Designated post in place for recruitment of nursing positions	Recruitment to substantive posts which are currently vacant Recruitment strategy to be ratified	Extreme 16 ▶	Bank and agency reduction group monitoring spend on a monthly basis Meeting weekly to progress 10 workstreams to manage spend Vacancies to reduce on a monthly basis.	Continued to have high spend in nursing bank and agency	16.1.15 - high use of agency over the last 4 weeks due to winter pressures to keep patients safe but continue to monitor closely	#####	28/02/2014
540	SCD	SCD	Mrs Fiona Isaacsson	* Division will not meet financial balance at the end of the year as the cost improvement and value improvement plans have not all delivered planned savings	Regular review of CIP plans to continue delivery of successful initiatives 14/15 Plans in place to ensure schemes get back on track for 2015/16 There are strong controls around spend across the division so that actual spend is reduced as much as possible to improve the Divisional forecast	Demand on beds, in particular medical, has resulted in slippage of planned savings for Victoria ward (pay & non pay) Traction across radiology spend difficult due to significant increase in demand. Smallo increase in income to facilitate economic staffing models Controls requesting both radiology and pathology are not as high as they could be as no consequence currently to continue to request tests as there is no cross charge to referrers' budgets The gaps in the savings plan have not	Extreme 16 ▼	Divisional CIP demonstrates CIP recurrent position is improving month on month 2014/15 forecast sheet describes actions in place and forecasts the year end position which is currently at £2m overspend. Tracking of forecast position is undertaken weekly to ensure this is maintained as a maximum position but with any improvements documented to reduce to year end 29.01.15 update shows CIP schemes are now delivering although VIP ones are not		Weekly review from now to end of year to reduce forecast position down to the minimum	#####	31/03/2015
491	Integrated Care and Acute Medicine	ICAM	Ms Carol Gillen	* Forecast year end overspend of £2.5M (excluding CIPs/VIPs) and main areas are: ED (£600K), Wards (£600K Specialing), District Nursing (£350K)	Action plan in place: Each of the three highlighted areas have a recruitment plan being monitored against actual recruitment International recruitment, recruitment for Europe and UK Planned recruitment events in 2015 £2.5M is the forecast based on month 4 outturn, the controls are in place to contain spending to this level	Budget for specialings not included in the revised ward establishment budget. To be a separate piece of work by corporate for focus and grip. Specific process in place for approving specialing and monitored daily Expanded mental health liaison team reviewing need for RMN specialing on daily basis Inconsistency in Extra dependency patients recording so new process will capture patients who are high dependency to enable compensation	Extreme 25 ▲	Financial reporting. Monitoring activity, daily capacity report. Action plan for each of the areas, with named budget holders held to account	Focus has been on nursing so now will scrutinise other professional groups eg admin and AHPs	January 2015 - Forecast overspend to end of financial year. Recovery plan in place, and current full year forecast overspend is £3.2m (excluding CIP and VIP). The forecast includes significant run rate reduction in Q4	#####	31/03/2015
492	Integrated Care and Acute Medicine	ICAM	Ms Carol Gillen	* Failure to deliver against CIP and VIP financial targets, forecast at £1.1M	CIP and VIP group meetings, regular updates to CIP project manager	Whole system approach scrutiny has not occurred	Extreme 20 ▶	CIPs monitoring on a weekly basis with a named manager held to account. Weekly meetings, regular reporting, discussed and monitored at Trust Operational Board	None within the division. There has been further slippage due to demand on beds and in ED, which has resulted in the twilight shift still being in use in ED and ISIS remaining open	Division forecasting underachievement against 2014/15 CIP and VIP targets. Forecast underperformance at £1m. due to twilight shift still being used in ED, and delay to close ISIS. Pharmacy has some of their target unidentified. Resilience money planned to offset under-performance against the twilight shift saving non recurrently	#####	31/03/2015

Department: General Surgery												
402	Surgery, Cancer and Diagnostics	General Surgery	Ms Deborah Clatworthy	* If additional beds remain open on Coyle and Victoria wards there will continue to be use of temporary nursing staff which may impact on quality and finance	Daily monitoring staffing levels and quality indicators Visibility of Matron and Head Of Nursing Use of bank and pool nurses where possible	Progress in agreement to recruit more permanent staff but the vacancies have not all been filled and at times the temporary staff office are unable to fill requests for bank/agency staff	Extreme 16 ►	Additional funding identified to increase the overall substantive nursing numbers. Some nurses commenced and others have been recruited awaiting start date. Monitoring of safety standards Monitoring of bed use collected daily so that financial impact can be calculated	Continues to be high number of medical patients on Victoria ward so dual usage. Ward rounds and the appropriate support requires strengthening. Junior medical and consultant medical staff extended ward rounds which impacts frequency of visits	Additional beds are still open due to winter pressures and 65% - 70% of ward has medical outliers. Nursing establishment to be rectified so currently use temporary staff	#####	01/03/2015
Department: People (Human Resources)												
97	People (Human Resources)	People (Human Resources)	Mr Chris Goulding	* Workforce plan presented to Trust Board seminar March 2014 with £15M CIP and estimated £11M of transformational programmes were identified. Gap to be closed from agency reductions and other initiatives. £4M offplan CIP target if workforce plan not met	Two year TDA submission on the Operational Financial Plan endorsed by the Trust Board in April 2014, included workforce implications and targets	Workforce reporting and monitoring	Extreme 15 ►	Reports to Trust Management Group Reports to Trust Board		Audit and Risk Committee received assurance report July meeting and further discussed September Committee. Workforce monitoring now in place and HR metrics reported to Executive and Trust Operational Board. Committee received report January 2015 for assurance	#####	31/03/2015
Department: Imaging												
444	Surgery, Cancer and Diagnostics	Imaging	Mr Robert Katz(*)	* Radiology examinations that show a significant finding must be communicated to referring clinician in a timely manner, or potential risk that a patient may not receive appropriate and timely treatment	Imaging results reviewed by consultant radiologists and reports placed on anglia ice. Alert flags raised against high risk reports Patients referred with a high suspicion of cancer have their pathways tracked closely and adverse results highlighted by MDT or co-ordinator for prompt action	Alert flags and review of reports on anglia ice requires regular review to ensure ward or clinical teams systematically check flags Consistent best practice by radiologists required to support referring clinicians	Extreme15 ►	Referred to Medical Director for action Standard Operating Procedure drafted and shared for implementation	Trust standard operating procedure to be agreed for OP and IP Implement process and monitor for compliance	Medical Director disseminated SOP for alerting and checking Radiology and histopathology output. ED reports sent to Dr Jennings mid August. SOP cascaded to Divisional leads September.	#####	31/12/2014
Department: Safeguarding Adults												
176	Nursing and Patient Experience	Safeguarding Adults	Ms Alison Kett	* If insufficient robust governance arrangements (including compliance with all levels of training) there is risk to protect vulnerable adults from harm and escalation of adult safeguarding concerns and issues to internal and external authorities	Adult Safeguarding Policy Dedicated Adult Safeguarding Lead Nurse Close monitoring of compliance with mandatory training External review of adult safeguarding to commence	Staff trained in Level 2 Safeguarding Deprivation of Liberty Safeguards Prevent (Radicalisation of Individuals) Domestic Violence Mental Capacity Act Some staff not routinely escalating concerns to safeguarding lead Policies are not embedded within practice Organisational capability and competence within acute setting regarding Adult Safeguarding and MCA/DOLS Engagement of patients and carers in	Extreme-16 ►	Quality Committee and reporting Monitoring shows evidence staff are engaging and informing the adult safeguarding lead when safeguarding concerns are raised both by and against the organisation	Visible leadership internal MCA audit identified a lack of understanding of MCA/DOLS Lack of data of numbers of safeguarding alerts raised against and by the organisation Low numbers of Deprivation of Liberty authorisation as compared with peer Acute organisations	7.1.15 - Level 2 training compliance at 27%. Trajectory to reach 90% in September 2015. Additional face to face training, raising awareness of areas for non compliance, all new starters to receive Adult Safeguarding training at Level 1/2. Dols training complete resulting in an increase in Dols (6 authorisations in Dec) Offered to New Adult Safeguarding postholder 6.1.15 External review completed.	#####	29/10/2014

Whittington Health Triangulated Risk Management in Action



Whittington Health Trust Board

4th March 2015

Title:		Nursing and Midwifery Ward Establishment Review – October 2014					
Agenda item:		15/043		Paper		10	
Action requested:		For Approval					
Executive Summary:		<p>This paper sets out the ward establishment review undertaken in October 2014 and makes recommendations related to nurse staffing levels on the acute adult wards.</p> <ul style="list-style-type: none">• Ward staffing levels in October 2014 were reviewed using Nursing Hours Per Patient Day (NHPPD), Safer Nursing Care Tool (SNCT) and Professional Judgement models. Benchmarking was also undertaken.• Following the last review the Board approved £1.9m investment in nursing establishments. This paper details where this investment was made.					
Summary of recommendations:		Members of the Trust Board are asked to consider proposals detailed.					
Fit with WH strategy:		Efficient and effective care. Francis Report recommendations Cummings recommendations					
Reference to related / other documents:							
Date paper completed:		16 th February 2015					
Author name and title:		Philippa Davies 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?	



Nursing and Midwifery Ward Establishment Review

Purpose:

This Nursing and Midwifery ward establishment review follows that which was undertaken in 2013. The Trust Board considered a paper presented in June 2014 and approved the recommendation which was uplift in nursing establishment and pay budget.

This establishment review was undertaken to:

- Provide an assurance both internally and externally that ward establishments are safe and that staff are able to provide appropriate levels of care to patients and levels of care that reflect the Trust values and the 6 C's of the national nursing strategy (2012). This is particularly important in light of key recommendations made in the Francis Report (2013), the Berwick Report (2013) and following the National Quality Board publication; "How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*, and the recently published NHS England document; 'Safe Staffing – A guide to care contact time'.
- Comply with CQC and NHS England 'Hard Truths Commitments Regarding the Publishing of Staffing Data'
- To provide establishment data that will inform the Trust Workforce Strategy, and the 2015- 2016 Cost Improvement Plan (CIP) programme.
- To conform to Care Quality Commission requirements under the Essential Standards of Quality & Safety, including outcomes 13 (staffing) and 14 (supporting staff).

Background:

The Trust has a duty to ensure that ward staffing levels are adequate and that patients are cared for by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013), and the Health and Social Care Act (2012).

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, all of which align with the Trust priorities and objectives which include:

- Improvement in patient experience
- Reducing failure to rescue
- Improving pressure ulcer incidence
- Reducing adverse incidents, particularly related to medication errors and falls

Summary of key actions implemented following the last establishment review:

Following recommendations made in the 2013 establishment review, a £1,990,713 (full year effect) investment was committed which equated to an increase in 38.85 WTE staff of which 8.64 WTE posts were in the division of Surgery Cancer and Diagnostics (SCD) and 30.21 WTE posts in the division of Integrated Care and Medicine (ICAM). In addition, within the £1,990,713 investment, 'headroom' increased by 5% from 17% to 22% at a cost of £544K.

Headroom is made up of the following;

Annual leave 15%
Maternity Leave 3%
Sickness 2%
Development 2%

Recognising the requirement to fund additional 'escalation' beds particularly in the winter months, the budget was further increased by £643K to fund an increase in temporary staff which equated to an additional £138,784 in ICAM and £504,220 in SCD. For the purpose of this review, the additional escalation beds staffed by temporary staff on Coyle ward and Victoria ward were excluded from the review.

Methodology for 2014 establishment review:

A literature review was undertaken prior to commencement of the establishment review in order to incorporate the latest evidence to inform the methodology and the recommendations.

In addition:

- Establishments were compared to 2013
- A benchmarking exercise was undertaken with 4 other anonymised Trusts using data for all comparable wards
- Three nursing establishment models were utilised to assess for variances, which comprised of the Safer Nursing Care Tool (SNCT), Nursing Hours per Patient Day (NHPPD) and Professional Judgement model, as per national guidance
- National standards for specialty areas were used e.g. critical care 'step down' and acute respiratory beds.
- Registered to unregistered ratios were reviewed
- Staff to bed ratios were reviewed in line with national guidance
- Number of beds and bed occupancy was used
- The nursing quality indicators and key safety and outcome measures were reviewed.

The review includes band 2 – 4 health care assistants who are categorised as 'unregistered' staff, in addition to band 5 – 7 nurses who are categorised as 'registered' staff. The review covers the wards in The Whittington Hospital. A summary of the detail by ward is included within this report and the whole analysis can be reviewed by contacting the Director of Nursing.

Nursing Hours Per Patient Day (NHPPD) Benchmark Review:

NHPPD is a systematic nursing workload monitoring and measuring system that provides a guide to the number of nurses required for service provision within a specific clinical area. The NHPPD model is not designed as a rigid, mandatory determinant of staffing but relies on clinical judgement to assess adequate staffing to deliver care on a daily basis. The model is used to calculate the number of direct nursing hours required to provide patient care and as a framework to establish a nursing roster. This establishment review took this model into account to inform findings.

Key Quality and Outcome Measures:

A comprehensive Nursing Quality Indicator Report is produced monthly and presented and discussed at ward and committee level. This report details key nurse sensitive quality indicators by ward, directorate and community team. The Trust Board receive monthly information in relation to Infection Prevention and Control, Patient Experience and Patient Safety within a performance pack. The Patient Experience report and Complaints, Litigation and PALs report are presented quarterly to the Quality Committee, a sub-committee of the Trust Board. Staff experience and satisfaction metrics are presented by the Deputy Director of Human Resources.

All of the above metrics are taken into consideration at the time of the establishment review and when making recommendations. The recommendations for the establishment review were discussed with senior nursing and midwifery colleagues within the Trust and at the Nursing and Midwifery Executive Committee prior to seeking approval of the recommendations by the Trust Management Group.

Key Findings

1. Funded changes since the 2013 establishment review:

The funded establishments in ICAM have increased in total by 30.21 WTE; this is accounted for by the implementation of the establishment review recommendations in 2013 for Cloudesley, Mayrick, Cavell, Nightingale, Montushi, and Mercers wards in addition to an increase in establishments in Mary Seacole North and Mary Seacole South assessment wards.

The funded establishments in SCD have increased by 8.64 WTE, accounted for by increases in establishment in Coyle, Thorogood and Victoria wards.

The funded establishments in the Women Children and Families (WCF) division remained unchanged.

2. Current registered to unregistered staff ratios

In 2006, the Royal Collage of Nursing recommended the use of a 65:35 skill mix on acute general and surgical wards in England where 65% of staff should be registered

nursing staff. A national review in 2009 indicated an average of 62% of registered staff which increased to 64% of registered staff in 2011.

Current ratios on our wards are detailed in the table below;

Ward		% Registered nurses	% Health Care Assistants	Nurse to bed ratio
Cloudesley	Care of the elderly	63	37	1.30 nurses to each bed
Meyrick		63	37	1.30
Cavell		70	30	1.69
Nightingale	Respiratory	82	18	1.46
Montouschi	Cardiology	87	13	1.36
Mercers	Gastro/oncology	86	14	1.25
Mary Seacole South	Acute Assessment	82	18	1.65
Mary Seacole North		82	18	1.86
Coyle	Orthopaedic	66	34	1.43
Thorogood	Elective Orthopaedic	80	20	1.52
Victoria	General surgery	74	26	1.39

3. Nurse to bed ratios

While there is no national standard for nurse to bed ratios there is national guidance based on patient safety and outcome measures which recommend a nurse to bed ratio of 1.2:1. As can be seen in the table above, the Trust does not have any wards that do not meet this standard.

4. Supervisory ward managers

One of the Francis Report (2013) recommendations was that Trusts should make all ward managers supervisory, this means supplementary to the rostered work force. This review has highlighted that there is variation in the number of days worked per week by the ward manager i.e. not all ward managers are rostered to work Monday to Friday. There is also variation in the number of hours per week the Band 6 Junior Sister/Charge Nurse undertakes management duties (non-clinical duties). One of the recommendations implemented following the last establishment review was all ward managers would have one management day per week. It is unclear at this stage how many hours per week are spent on management (non-clinical duties) and the impact of vacancies and operational pressures on this protected time. As such, one of the recommendations from this review will be to undertake a comprehensive diary exercise of ward manager activity over a two week period to assess the current supervisory allocation. The diary exercise will highlight any variation by ward in the supervisory allowance and highlight activities that registered nurses are currently routinely undertaking that could be undertaken by an alternative health professional or support worker.

5. Changes to establishments following the 2013 review;

5.1 *Cloudesley Ward*

The funded establishment on this ward increased by 2.46 WTE and the ratio of registered to unregistered nurses increased from 58% to 63%. The staff to bed ratio increased from 1.20:1 to 1.30:1

5.2 *Meyrick Ward*

The funded establishment on this ward increased by 2.46 WTE and the ratio of registered to unregistered nurses remains unchanged. The staff to bed ratio increased from 1.20:1 to 1.30:1

5.3 *Cavell Ward*

The funded establishment on this ward increased by 1.13 WTE and the ratio of registered to unregistered nurses decreased by 1%. The staff to bed ratio increased from 1.60:1 to 1.69:1

5.4 *Nightingale Ward*

The funded establishment on this ward increased by 5.47 WTE and the ratio of registered to unregistered nurses increased from 80% to 82%. The staff to bed ratio increased from 1.20:1 to 1.46:1. This ward has 4 high dependency beds which require 1 registered nurse to 2 patients.

5.5 *Montouchi Ward*

The funded establishment on this ward increased by 2.51 WTE and the ratio of registered to unregistered nurses increased from 78% to 87%. The staff to bed ratio increased from 1.20:1 to 1.36:1. This ward has 4 high dependency beds which require 1 registered nurse to 2 patients.

5.6 *Mercers Ward*

The funded establishment on this ward increased by 0.77 WTE and the ratio of registered to unregistered nurses increased from 70% to 86%. The staff to bed ratio increased from 1.20:1 to 1.25:1

5.7 *Mary Seacole South Assessment Unit*

The funded establishment on this ward increased by 5.31 WTE and the ratio of registered to unregistered nurses increased from 80% to 82%. The staff to bed ratio increased from 1.36:1 to 1.65:1

5.8 *Mary Seacole North Assessment Unit*

The funded establishment on this ward increased by 6.91 WTE and the ratio of registered to unregistered nurses increased from 79% to 82%. The staff to bed ratio increased from 1.43:1 to 1.86:1

5.9 *Coyle ward*

The funded establishment on this ward has increased by 1.74 WTE and the ratio of registered to unregistered nurses increased from 61% to 66%. The staff to bed ratio increased from 1.36:1 to 1.46:1

5.10 *Thorogood ward*

The funded establishment on this ward has increased by 3.73 WTE and the ratio of registered to unregistered nurses decreased from 83% to 80%. The staff to bed ratio increased from 1.15:1 to 1.52:1

5.11 *Victoria ward*

This ward has 4 beds allocated to high dependency patients and the funded establishment on this ward has increased by 3.51 WTE and the ratio of registered to unregistered nurses increased from 70% to 74%. The staff to bed ratio increased from 1.31:1 to 1.47:1

5.12 *Ifor ward*

The funded establishment on this ward has decreased by 1.71 WTE and the ratio of registered to unregistered nurses decreased from 88% to 89%. The staff to bed ratio decreased from 1.62:1 to 1.54:1

5.13 *Neonatal Intensive Care Unit*

The funded establishment on this ward has decreased by 0.70 WTE and the ratio of registered to unregistered nurses remained unchanged at 94%. The staff to bed ratio decreased from 2.72:1 to 2.68:1

6. *Staffing in the Emergency Department (ED)*

The nurse staffing levels in the ED were not included in this review but have been assessed using the Baseline Emergency Staffing Tool - BEST. This is yet to be fully validated; however it is the only tool currently endorsed for use by the Chief Nursing Officer. Whittington Health was one of the organisations elected to pilot this tool for the RCN in 2013. This involved hourly assessments of all the patients in the department over the period of one week. NICE have been reviewing nurse staffing in Emergency Departments and are due to publish recommendations in May 2015.

A consultation document was published by NICE in January 2015, making recommendations for 'Safe Staffing in Emergency Departments', the final document will be published in May 2015.

7. Staffing in the Maternity Dept

The staffing levels in the maternity unit were not included in this review but have been assessed using 'Birthrate Plus'. This is the only research based, nationally acknowledged method for recommending staffing levels in maternity units and has been endorsed by the Chief Nursing Officer. An independent assessor was commissioned by the Trust in November 2013. Women are classified into five different categories according to the amount of care time required. These categories are weighted, and from this, the establishment can be calculated. The independent assessor reported that Whittington Health had a higher than average number of women who required a high number of midwifery hours per person. All calculations were based on the assumption of 3985 births annually.

8. Summary

The Whittington Health establishment review of October 2014 used a combination of SNCT, NHPPD and Professional Judgement models in addition to consideration of evidence in the latest literature. It considered a number of Francis recommendations, including staffing ratios and skill mix.

The findings of this review indicate that there are a number of opportunities to be explored in terms of increasing the number of 'supervisory' hours of ward managers, reviewing registered to unregistered nurse ratios and reviewing care contact time.

9. Recommendations

- 9.1** To procure an electronic staff rostering system which will include a 'safe staffing' function. This will allow skill mix and staff numbers to be aligned with patient acuity.
- 9.2** To review and agree percentage of 'headroom' allocation.
- 9.3** To undertake a ward manager diary exercise to understand care contact time, supervisory time and time spent on 'other' activities.
- 9.4** To review percentage of registered to unregistered nurses.
- 9.5** To review nurse structure by ward.

Philippa Davies
Director of Nursing and Patient Experience

Whittington Health Trust Board

4th March 2015

Title:		Safe Staffing (Nursing and Midwifery)					
Agenda item:		15/044		Paper		11	
Action requested:		For information					
Executive Summary:		<p>This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in January 2015. Key issues to note include:</p> <ul style="list-style-type: none">• The majority of areas reported greater than 95 per cent ‘actual’ versus ‘planned’ staffing levels• A number of areas reported ‘actual hours worked’ over and above those ‘planned’ which was attributed in the main to the provision of RMNs/RGN’s/HCA’s to support patients under a Mental Health Section, patients with increased dependency and 1:1 ‘specialing’ of some of our most vulnerable patients.• In the Emergency Department 14 shifts ‘triggered’ red in January, 10 of which related paediatric nursing hours. 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 January 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:		February 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 Nurse Staffing Levels January 2015

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 January 2015 and an assurance that these levels are monitored and managed daily.

2.0 Background

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

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st January 2015 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

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

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in January 2015. Average fill rate was 103.3% for registered staff and 114% for care staff during the day and 100.4% for registered staff and 125.1% for care staff during the night.

Two wards fell below average fill rates for qualified nurses but were managed safely using newly qualified nurses who were waiting for their Nursing and Midwifery Council (NMC) personal identification number (PIN) working as HCAs and by moving staff from other green ragged rated areas. Above average fill rate occurred on one ward where an additional RMN nurse was required to care for patients subject to a Mental Health Section. Above average fill rates in excess of 100% for HCA's continues on wards where vulnerable patients require 1:1 care. 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. In January 2015 between 14 and 36 HCA 'specials' were required, under a

quarter of the number in August. The number of RMN 'specials' required to care for patients under a mental health section continues at a rate of between 15 and 30 shifts per week.

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 January can be seen in Appendix 3. In summary, in January a total of 40/1488 (2.69%) shifts triggered 'red' which is fractionally higher than previous months but continues to be low. Of these, 22/837 (2.63%) occurred in the division of Integrated Care and Acute Medicine (ICAM), 2/279 (0.72%) in the Women's, Children and Families (WCF) division and 16/372 (4.3%) 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, 10 were in the paediatric emergency department due to paediatric nursing vacancies. ICAM covered rotas with support from paediatric in-patient and ambulatory care services. Additional paediatric nurses have been recruited and are in the recruitment process.

Of all shifts that initially triggered 'red', 14 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 January can be attributed to the following:

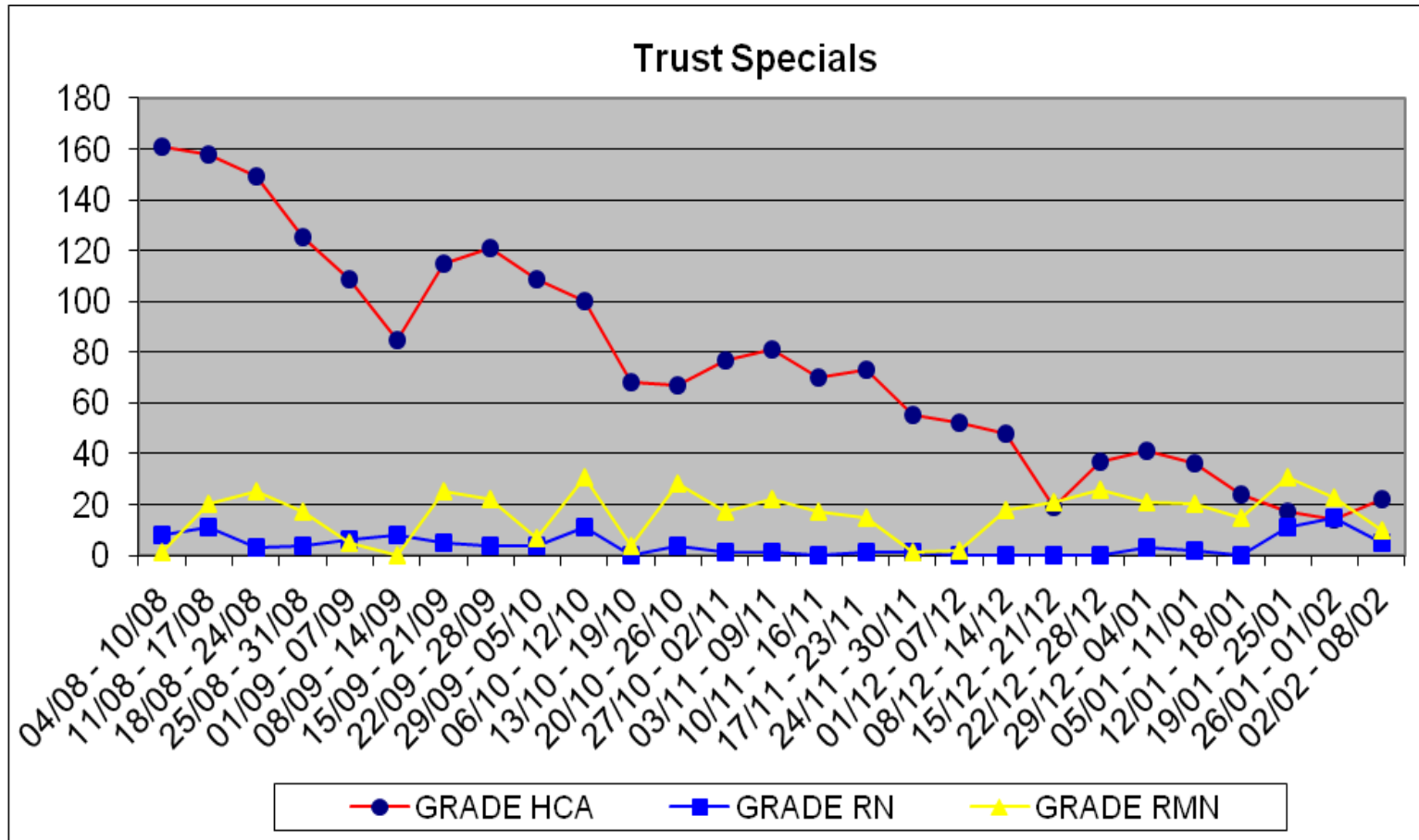
- Nursing vacancy rates in the Paediatric Emergency Department which are reducing as a result of local and overseas recruitment.
- Patients requiring 1:1 care by an RMN.
- Continued demand for staff to provide 1:1 care for our vulnerable patients, particularly on three wards.

5.0 Conclusion

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

**Fill rate data - summary
January 2015**

Day				Night				<u>Average</u> fill rate data- Day		<u>Average</u> 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	103.3%	114%	100.4%	125.1%
34,282 hours	29,057 hours	10,424 hours	11,887 hours	28,450 hours	28,572 hours	6,566 hours	8,211 hours				



January – 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	Elderly Care	Meyrick		93	1	0	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	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
		Cavell		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
		Bridges		93	1	1	1	3	3.23		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	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
	Respiratory	Nightingale		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
	Gastro/Haem/Onc	Mercers		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
	MAU	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
		MSN		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
	Emergency	ED		93	4	0	10	14	15.05		Staffing levels proved challenging, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
TOTAL				837	6	3	13	22	2.63		
SCD	ITU	ITU		93	2	2	0	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
	Surgical	Victoria		93	4	4	0	8	8.6		Staffing levels proved challenging, 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	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
	Ortho (planned)	Thorogood		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
TOTAL				372	8	8	0	16	4.3		
WCF	Paediatrics	IFOR		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
	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	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
TOTAL				279	1	1	0	2	0.72		
TRUST TOTAL				1,488	15	12	13	40	2.69		

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00pm on Wednesday 4th February 2015 in the Whittington Education Centre

Present:	Simon Pleydell	Chief Executive
	Greg Battle	Medical Director, Integrated Care
	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
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Rob Whiteman	Non-Executive Director

In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs
	Helen Taylor	Chief Pharmacist

15/014 Petition from members of the public

14.01 Steve Hitchins explained that whilst public board meetings generally began with an account of a patient story about treatment at Whittington Health, on this occasion the Trust had been approached by a group of 'concerned residents of North London' who had written to him setting out some specific questions around the Transforming Patient Experience' project and future plans for the hospital. Therefore, the Board had decided to allow the group a brief period of time at the start of the meeting to introduce their issues.

14.02 Steve Hitchins reminded all those present that the monthly Trust Board meeting was a meeting held in public rather than a public meeting, and as such, members of the public did not have an automatic right to place items on the agenda for discussion.

14.03 Speaking on behalf of the group described as 'concerned residents of North London', Sam Rae took Board members through the list of questions set out in the group's petition. It was noted that Siobhan Harrington had already provided a written response to these questions. Simon Pleydell added that he had been in regular contact with the 'Defend the Whittington Hospital Coalition' since his appointment as Chief Executive, and there was an open invitation in place for the group to meet with him to discuss any issues.

15/015 Patient Story

15.01 Philippa Davies introduced a carer who had kindly agreed to attend the meeting to share a patient story regarding his mother's patient experience by the district nursing service. The Board listened carefully to the story and noted the important

lessons which had been highlighted. Philippa Davies agreed to take forward the learning and ensure that improvements continue to be embedded in the District Nursing Service.

15/016 Declaration of Interests

16.01 No Board members present had any interests in any part of that day's Board proceedings to declare.

15/017 Apologies for absence

17.01 Apologies were received from Anita Charlesworth.

15/018 Minutes of the previous meeting

18.01 Under minute 8.4 Philippa Davies pointed out that this remark should be attributed to her rather than Philippa Marszall. Under 08.05.02 Paul Lowenberg felt this minute needed rephrasing and he agreed to contact Kate Green to suggest an alternative from of words.

18.02 Other than these amendments the minutes of the meeting held on 7th January were approved.

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

18.04 Action notes

100.03 - This report on nursing establishment was scheduled for March Board.

143.01 – The cancer services strategy will be added to the Board cycle for future agreement.

173.04 – Benchmarking data was now included within the workforce performance report - this item could therefore be removed from the schedule. It was noted that the tables had also been changed as requested.

174.06 - The Finance & Business Development Committee had not met since the last Board meeting.

06.01 – Terms of reference were scheduled for the discussion later on the agenda.

08.02 – To read 'MSK' rather than 'HSMR'.

08.03 - This item was not due for review until the April Board meeting.

08.08. – Administrative staff figures had now been incorporated in the workforce report, this could now be removed from the tracker.

09.03 – the narrative had now been increased and could therefore be removed from the tracker.

15/019 Chairman's Report

19.01 The Chairman began his report by welcoming Lynne Spencer, newly-appointed Communications & Corporate Affairs Director.

19.02 The Prime Minister's special advisor Nick Seddon had visited the Trust the previous Friday, Steve and Richard Jennings had accompanied him on a visit to several of the Trust's sites, both within the hospital and the community.

19.03 The current programme of public engagement had now been completed. A successful meeting had been held with local voluntary organisations, who had shown great commitment to and support of Whittington health.

- 19.04 On Sunday 1st March the annual walk by all London mayors from the Whittington Cat to Mansion House was scheduled to take place.
- 19.05 Steve had recently visited Lordship Lane, and said that he had been privileged to meet Valentina Treskavica, the first practitioner within the Trust to qualify as a prescribing physiotherapist. He expressed congratulations to her on behalf of the Board on this achievement.
- 19.06 Following recent meetings of sub-committees, Steve proposed that terms of reference were reviewed and amended by LS to ensure quoracy of meetings.
- 19.07 Referring back to the extraordinary Board meeting held on 14th January, Paul Lowenberg enquired whether the Trust had received the letter of support for the maternity and neonatal Full Business Case (FBC) from NHS England. Siobhan Harrington replied that the Trust had received this letter and a TDA meeting was being arranged where the FBC would be presented. The TDA had congratulated Trust staff on both the quality of the FBC and the quantity of work they could see had gone into its preparation.
- 19.08 The notes of the extraordinary Board meeting convened on 14th January to discuss the Maternity and Neonatal FBC were approved.
- 15/20 Chief Executive's Report
- 20.01 Simon Pleydell began his report by informing the Board that the percentage of staff members who had received the flu vaccination had reached 81%, an even higher figure than the previous year. This showed how seriously staff took both the safety of the patients they care for and their own health, and Simon expressed his gratitude to the infection prevention and control team for the immense amount of proactive work they had carried out to achieve this number of vaccinations, thought to be the highest percentage in London.
- 20.02 The Trust had just declared its second MRSA bacteremia; a RCA investigation was being conducted and the case was being reviewed to see what lessons might be learned.
- 20.03 Simon was pleased to inform the Board that the Trust was performing well in relation to national cancer standards. He also mentioned the excellent opening, performed by Barbara Windsor, of the MacMillan Cancer Information Hub on 8 January, describing it as a tremendous facility for patients and families alike. The Trust's financial position had also improved slightly within the last month, and efforts made to reduce spending on agency staff had also proved more successful of late.
- 20.04 The FGM case was expected to conclude later that day.
- 20.05 The day of industrial action planned for 25 February had been called off as an agreement with the unions had now been reached. It was now necessary for the Trust to consider the financial implication of the agreement.
- 20.06 The Trust had recently installed a new free Wi-Fi service for patients, carers, colleagues and students, and had received a great many positive comments on this. Paul Lowenberg stressed the importance of publicising such initiatives. Graham Hart added that this also afforded good opportunities for contacts. Another cause for celebration was the winning of a HENCEL award by two of the Trust's apprentices.

15/21 Quality Committee Report

- 21.01 Anu Singh introduced the report of the Quality Committee meeting held on 15 January, drawing attention to the new format of the report. She reported that there remained some differences to the approaches taken by the three divisional quality working groups although improvements continue to be accomplished. Further improvements will be required to ensure timely papers for each meeting. Each division will need to work coherently and have a holistic view of CQC preparedness against the standards.
- 21.02 There had not been a significant amount of progress made on mandatory training since the last meeting, although improvement could be seen in some areas. Approximately 18 months ago the Board had held a major focus on mandatory training, with some degree of success, and managers had received a regular bulletin providing a detailed picture of staff whose training was overdue; it was suggested this exercise be repeated. Richard Jennings commended the methodology used for Information Governance (IG) training, whereby he had received a pop-up message on his computer informing him that his training was due and that he could complete the module immediately (log-on details were provided) in less than twenty minutes. Anu questioned whether the Trust was taking a sufficiently robust approach to risk and Rob Whiteman, Chair of the Audit & Risk Committee, reported that the Audit & Risk Committee had carried out a deep dive exercise into this area which provided assurance that there had been improvements within the last year.

15/22 Clinical Strategy

- 22.01 Greg Battle informed colleagues that the intention for this meeting was not to produce the final strategy but to have an interim position. Three multi-disciplinary meetings had taken place since Christmas, as well as a governance meeting, and the products of these have contributed to the mission, vision and themes for the strategy. There will be other 'enabling' strategies to support the clinical strategy, including estates and finance. The mission statement had been locally agreed as 'helping local people live longer healthier lives', and the next stage of the process was to move to the 'how'. Safety and quality remained key themes, with the strategy combining the provision of high quality services whilst managing within existing resources. Greg and Siobhan would present the next iteration of this work at the March Board.
- 22.02 Tony Rice commended the strategy as 'brief and clear', but said that what he felt was missing was the detail of the patient experience, and it should be possible to frame the strategy so that this was better emphasised. The next phase of the strategy development was to turn the themes of the strategy into achievable measurable goals. The King's Fund had also agreed to look at the strategy, which was to contain some patient scenarios. Links were also being made with the Local authority prevention strategies. Graham Hart stressed the need for education and research to be included in the cross-cutting themes. Simon Pleydell reinforced this point, highlighting that a range of enablers are being developed.
- 22.03 The Board agreed the mission and vision statement and expressed strong support for the strategy whilst recognising the need for further development. This will include introducing stakeholders to the concept of requiring fewer beds, as the Trust's focus on preventing unnecessary hospital admissions was successful. This will also be reflected in the submission expressing interest in the Vanguard initiative put forward in NHS England's five year plan.

15/023 Cancer Strategy 2015/16

23.01 Discussion of the Cancer Strategy for 2015/16 was postponed until further details were included and after the Clinical Strategy had been completed

15/024 Performance Report

24.01 Lee Martin informed the Board that the Trust had made significant progress in achieving national performance targets during November and December, and it seemed likely that January figures would be equally positive. There had been an increase in older people presenting with complex needs, and this was placing additional strain on all the Trust's services. There had also been high rates of admission to the HDUU and ITU.

24.02 Lee reported that the Trust had met all national cancer targets, and was now undergoing a review to assess whether or not this position was sustainable in the longer term.

24.03 It was noted that the Trust had now declared two MRSA bacteraemia during 2014/15. Rob Whiteman asked about the apparent downward trend in elective theatre utilisation, and Lee replied that this was in part due to increased emergency care but also some cancellations of lists due to sickness of medical staff. He added that there had been some improvement in the cancellations the Trust controlled. The team was however still working on getting the measures correct, and from April 2015 counting would be done in a different way.

24.04 Graham Hart commented on the high staff sickness rate within maternity services. Lee explained that that this was due to some serious illnesses (heart disease, cancer) resulting in staff being absent from work for some considerable time. Chris Goulding assured the Board that affected staff were being offered appropriate support. In answer to a question about whether this situation was affecting new birth visits, Greg Battle reminded Board colleagues that this service was provided by the health visiting teams in the community, and said that Haringey in particular had made great progress towards improving its visiting times.

24.05 Paul Lowenberg highlighted the 6 week wait for MSK services, enquiring when the Trust was likely to see further improvement. He had also observed that indicators on HSMR trends appeared to be slipping, and asked that these be looked at in more detail in the next report. Paul also requested more detail on the indicators for ambulatory care. Lee Martin replied that meetings had been taking place to discuss ambulatory care performance and targets. Later in February the building work would be complete and patients would be able to move directly from triage to ambulatory care. Simon Pleydell added that reporting the mortality data in its current form was not necessarily helpful to the Board, and he would prefer to see a more detailed commentary. It was also noted that there is generally a rise in death rates around this time of year (winter), and that the Board would find it helpful to know how the Trust's death rates compared to peer groups.

24.06 Introducing the workforce section of the dashboard, Chris Goulding announced that for the first time he was able to provide benchmarked data, however this was very much work in progress and he hoped to be able to finesse data as a result of having recently joined the benchmarking club. Chris was able to report, however, that the number of whole time equivalent (w.t.e.) staff employed by the Trust had reduced since his last report, and spending on agency staff had also reduced. The high turnover of staff in the ICAM division was noted, and there was to be a 'deep

dive' into corporate staffing. Mandatory training had been discussed under the Quality Committee report item, and appraisal rates had levelled out.

15/025 Financial Report

25.01 Ursula Grueger informed the Board that this month she was able to report a £480k surplus, a very positive step, and one which meant that the Trust's forecast as reported to the Trust Development Authority (TDA) was on track. She explained that the improvement had been caused by two main factors, one being income received from a contract variation, the other some income received from PbR. There had been a reduction in spending on agency staff within the pay budget, and in non-pay, supplies and contract spending. Moving on to CIPs, Ursula said that the main focus now was ensuring that the Trust had a fully worked out plan for 2015/16, backed up by detailed financial projections. Nick Dawe would be leading on this work, and Simon emphasised that there would be better control and better planning. Tony Rice congratulated the finance team on their achievements.

25.02 It was noted that this was Ursula's last Board meeting as acting CFO, and the Board thanked her for her hard work and all that she had achieved during her period of tenure.

15/026 TDA Board Statements

26.01 The Board noted that little had changed since the previous month's report, although the appointment of the new CFO would be key. Paul Lowenberg raised the question of the trust's completing its 95% target on Level 2 Information Governance compliance training, and SMH explained that this had been flagged on the TDA statement as a risk. The statements were noted.

15/027 Audit & Risk Committee Report

27.01 Introducing this item, Rob Whiteman informed Board colleagues that the Audit & Risk sub-committee of the Board had been working to test the control environment and to conduct deep dives into areas where it felt warranted further scrutiny. In this the committee was advised not only by officials but also by internal and external audit representatives. In terms of routine matters, the committee had continued to look at levels of risk, and Rob reminded the Board that a year previously they had discussed the fact that over 70% of Trust spending was on workforce, and for this reason the committee had taken a particular interest in workforce planning, feeling that this did constitute a risk.

27.02 A VFM statement was due to be provided by the Trust's external auditors KPMG, this was to be presented to the Board by either Stephen Bloomer or Ursula Grueger in due course. Rob also informed the Board that the committee felt the Trust should have a policy on overseas patients.

27.03 In summary, then, the committee had felt that the Trust's position on risk had improved, although it would be reconsidered in the context of medium-term planning. Siobhan Harrington added that the challenge brought by the committee was welcome, and as a team the executive directors were aware of the need to continue to develop a robust approach to managing control of finance, workforce plans, strategic planning etc.

15/028 Safe Staffing Report

- 28.01 Philippa Davies introduced her monthly safe staffing report, which showed the position of staffing on the wards for December. She informed Board colleagues that she would be bringing a paper on the establishment by ward to the March Trust Board meeting.
- 15/029 Whistleblowing Policy
- 29.01 Chris Goulding explained that the new whistleblowing policy had been developed in the spirit of openness and transparency advocated by the Trust and taking into account recent legislation. Operation of the policy would be monitored through the Audit & Risk Committee. It was noted that extensive consultation had been undertaken with staff side, and that key findings from the 'freedom to speak up' review had also been taken into account. Once the policy was agreed by the Board the next stage of the process was for it to be disseminated and publicised.
- 29.02 Steve Hitchins felt that the tone of the policy was correct, adding that he had learned from his time at CQC that one important aspect of implementing this policy was how what came in was recorded. Additionally, people needed encouragement if they were to feel confident in speaking out. Referring to the flowchart, Paul Convery asked for clarification on what was meant by a 'body'. It was agreed Chris would append a list to the final version. Paul Lowenberg urged the Board to consider how best to handle implications for patients should these arise, and Steve asked Chris to think further about this. Tony Rice reminded Board colleagues of the responsibilities they jointly bore as a Board, citing as an example events at Mid Staffordshire. Chris to clarify who will be the lead for this area and to update the next Board following publication of the report.
- 29/03 It was agreed that reports on whistleblowing issues should come to the Board periodically. Gratitude was expressed to staff side representatives for their engagement and productivity throughout the development of this policy.

Questions and comments from the floor

Helena Kania asked for action points arising from questions or comments from the public be incorporated into the action tracker. Steve Hitchins agreed to give this his consideration. Helena also thanked Anu Singh and Philippa Davies for what she felt to be a much improved quality committee report. Helena's final question concerned mortality and whether there was a place for comparison of our position with that of other European countries. Considering this, Richard Jennings replied that the answer depended to some extent on what was to be done with the comparison, but he agreed with Helena that there were certainly areas where learning could be gleaned from other places' achievements, and felt patient safety might well be one such example.

Ron Jacob enquired about benchmarking and whether there was much opportunity to benchmark like for like. Ursula Grueger replied that there were plentiful opportunities to benchmark acute services, but for community services it was hard to find a comparator.

Referring back to the clinical strategy, Tony Rice stressed the importance of having a focus on patient experience and outcomes. There was a need to consider research and development within a strategic context, but there should also be a clear delineation between themes and outcomes. Siobhan Harrington would work on this.

Action Notes Summary 2014-15

This summary lists actions arising from meetings held September 2014 to January 2015 and lists new actions arising from the Board meeting held on 4th February 2015.

Ref.	Decision/Action	Timescale	Lead
15/015	District Nursing Service – to take forward and embed the patient story lessons	Ongoing	PD
100.03	Nursing establishment – final report to the Board in March	March	PD
143.01	Cancer services strategy to be aligned to the clinical strategy – to address specific question on integrated care and to present to a future board	On Board Cycle	LM
174.06	Finance and Business Development Committee to review the business plan produced for the outsourcing of the catering service	February	UG
19.06	Terms of reference to be reviewed and amended by LS to ensure quoracy of meetings	March	LS
08.02	To review the MSK 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
27.02	Consideration to be given to the development of a policy for overseas patients	On Board Cycle	LM
29.02	Chris to make minor amendments to the whistleblowing policy prior to its dissemination and report back to the Board to clarify who will be the lead following the publication of the Francis report later this week	March	CG

Whittington Health Trust Board

4 March 2015

Title:		Chief Executive Officer’s Report to the Board					
Agenda item:		15/036		Paper		3	
Action requested:		For discussion and information					
Executive Summary:		The purpose of this report is to update the Board on local, regional and national key issues facing the Trust.					
Summary of recommendations:		To note the report.					
Fit with WH strategy:		This report provides an update on key issues for Whittington Health’s strategic intent.					
Reference to related / other documents:		Whittington Health’s regulatory framework, strategies and policies.					
Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risks captured in risk registers.					
Date paper completed:		26 February 2015					
Author name and title:		Simon Pleydell, Chief Executive		Director name and title:		Simon Pleydell, Chief Executive	
Date paper seen by EC n/a	n/a	Equality Impact Assessment complete?	n/a	Quality Impact Assessment complete?	n/a	Financial Impact Assessment complete?	n/a



Chief Executive Officer Report

The purpose of this report is to update the Board on local, regional and national key issues facing the Trust.

QUALITY

Care Quality Commission (CQC) preparation

We continue to make good progress to prepare for a full CQC inspection; likely to happen between July and September. The inspection will identify best practice, as well as highlighting areas which may need improvement. Clinical colleagues and staff who work in patient areas have been attending our CQC briefing meetings to ensure everyone is well prepared and supported for the inspection.

MRSA bacteremia

The Trust has a zero tolerance approach to MRSA bacteremia breaches. In January there was one reported incident of MRSA bacteremia which now means we have two cases reported for 2014/15 which is very disappointing after reporting the previous months at year to date zero. Colleagues are being urged to be extra vigilant and reminded of the importance of adhering to our infection control procedures.

Joint Advisory Group (JAG)

The Joint Advisory Group on Gastrointestinal Endoscopy has given the Trust a national accreditation. This is really good news for patients of Whittington Health. Well done to all the staff that have helped secure this important milestone for our endoscopy unit.

Female Genital Mutilation (FGM)

The Trust held a learning forum in February to identify important lessons to take forward regarding the recent FGM case reported in the media involving one of Whittington Health doctors who was cleared of any charges or wrongdoing. The lessons learned and action plan from this topic will continue to be a high priority area for the Trust and one first step will be reviewing our multi-agency communications with other agencies and being clear about our processes and procedures. We remain committed to providing the very best care and support for girls and women living with the consequences of FGM.

Compassionate Care Conference – *how to support and enhance it*

This pioneering conference will build on innovative work that we have already carried out in developing our compassion model by showcasing evidence-based methods of supporting and enhancing the quality and level of compassion in healthcare staff. The conference is fully booked with 135 delegates.

Patient Safety Week 16 to 20 March

This important initiative is reported to today's Board Agenda and I would like to thank staff for their enthusiasm and hard work in planning this exciting week. I look forward to welcoming Sir David Dalton, Chief Executive at Salford Royal and National lead for the Sign up to Safety Campaign. David will be sharing his views on patient safety at our Trust on the last day of the Safety Week, Friday 20 March.

PERFORMANCE

Emergency Department (ED)

Our ED and subsequent services have seen an increase in demand, particularly the acuity and complexity of the patients. The high demand for inpatient and complex care planning continued into January as reported in December performance report. This demand remained for older people with complex cases and paediatrics. Increased focus occurred on our community teams in order to meet the demand for early discharge and increased referrals from neighbouring trusts. Despite the continued pressure, our performance against the four hour standard for January was 0.5 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 that patients do not experience delays in their care pathways.

Referral to treatment (RTT) waiting times

We have continued delivering the national standards for our planned care patients. This is the third consecutive month that we have achieved the target. These improvements have now been embedded and we are now looking at sustaining these throughout the year.

Cancer standards

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

Finance

There has been a slight improvement in our financial position with our month-in position at end of January at £0.3m surplus. The favourable position in month is driven by an over performance in NHS clinical income. However, we still have a deficit overall, which stands at just under £6m year to date; mainly a result of expenditure pressures. The principal challenges remain in our integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostic (SCD) Divisions.

We are continuing to forecast a year end deficit of £7.4m which continues to be a major problem for the Trust in the forthcoming months. Discussions with our commissioners continue with the aim of improving our year end position.

NHS staff survey 2014

The NHS Staff Survey was published on 24 February 2015. The survey collects the experiences and opinions of NHS staff on a range of matters including job satisfaction, staff wellbeing and raising concerns. Questionnaires were sent to all permanent colleagues and our response rate was 39.2 per cent. The full results of the NHS staff survey and an action plan based on the results will go to Trust Board in May

Simon Pleydell
Chief Executive Officer

Whittington Health Trust Board

4th March 2015

Title:		Sign up to Safety - Listen, Learn, Act					
Agenda item:		15/037		Paper		4	
Action requested:		For Approval					
Executive Summary:		<p>Listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patients' safety is a key aim of our Trust. By Signing up to Safety, we share an ambition of halving avoidable harm in the NHS over the next three years.</p> <p>This paper sets out what we will do to strengthen patient safety by proposing five safety pledges. It describes the areas of improvement we would like to take forward to continuously improve patient safety.</p> <p>This is a Secretary of State for Health, national campaign for NHS Trusts which is being managed in parallel with the NHS LA.</p>					
Summary of recommendations:		The Board to agree Whittington Health Sign up to Safety and the five safety pledges.					
Fit with WH strategy:		Fully aligns to Whittington Health strategic intent.					
Reference to related / other documents:		Quality framework for Whittington Health.					
Reference to areas of risk and corporate risks on the Board Assurance Framework:		Risks captured on Trust risk registers. Supports the Trust NHS LA membership requirements of the Clinical Negligence Scheme for Trusts.					
Date paper completed:		25 February 2015					
Author name and title:		Philippa Davies, Director of Nursing & Patient Safety & Richard Jennings, Medical Director		Director name and title:		Philippa Davies, Director of Nursing & Patient Safety, Richard Jennings, Medical Director	
Date paper seen by EC	n/a	Equality Impact Assessment complete?	n/a	Risk assessment undertaken?	n/a	Legal advice received?	n/a





SIGN UP PACK

Welcome to Sign up to Safety - Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to strengthen patient safety by

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 and 4) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a safety improvement plan which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your safety improvement plan you will be asked to identify the patient safety improvement areas you will focus on. You will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from your own local priorities.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net or post to Sign up to Safety, Skipton House, Area 2B, 80 London Road, London SE1 6LH



SIGN UP PACK

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Organisation name:

Whittington Health

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges.
- Committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community.
- Make public our plan and update regularly on our progress against it.

Chief Executive Sponsor:

Simon Pleydell

11-Feb-2015

Name

Signature

Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Dr	First name:	Richard	Last name:	Jennings
Email:	richard.jennings@nhs.net			Job title:	Medical Director



SIGN UP PACK

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

Building on improvements we have already made, we will work with our patients and partners to develop a quality improvement programme that prioritises reducing avoidable harm in key areas.

We will focus our efforts on the most vulnerable patients in our community and link our safety initiatives with related strategies such as our deteriorating patient's strategy.

Pressure Care

- Eliminate avoidable grade 3 and 4 pressure ulcers within our integrated care organisation. With an increasing number of elderly patients with complex care needs this is an important area of improvement for us. If we can eliminate the most severe pressure ulcers we can reduce the level of medical interventions our patients need, and we can work with our community teams to extend independent living for our patients.

Falls

- Reduce the number of in-patient falls that result in serious harm.
- Ensure that every patient is assessed for risk of falling and that this risk is re-assessed in line with the patients' clinical needs.

This will be supported by the development of a 'falls care bundle' for use in all acute clinical areas. This 'falls care bundle' will be applied to all high risk patients, with the aim of eliminating falls which result in serious avoidable harm.

Sepsis and Acute Kidney Injury

- All cases of severe sepsis to be recognised and treated according to the "sepsis six" care bundle early interventions within the first hour.
- All cases of Acute Kidney Injury to be promptly recognised and appropriately treated.

Medicines Management

- Reduce the number of incidents which result in serious harm from drug errors, in particular those errors related to insulin, anticoagulants, opiates and injectable sedatives.



SIGN UP PACK

Reducing Suboptimal care in people with Learning Disability

- Reduce avoidable harm and avoidable poor patient experience in patients with Learning Disability by putting in place recognised improvement initiatives to make our care more responsive to the individual needs of each patient.

Missed fractures in the Emergency Department

- Reduce the number of missed fractures in the Emergency Department by 50% over a three year period.

Intrapartum fetal wellbeing assessment

- Introduce intrapartum fetal well-being assessments and management in high risk pregnancies with the aim of reducing avoidable harm by up to 50% of the total number of claims brought forward each year.

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

- Continue to develop our use of internal and external information including from our key performance indicators, incidents and serious incidents, complaints, safety thermometer, our own clinical audit programme and national audits to ensure that we are aware of and develop appropriate action plans and quality improvement projects targeted to our concerns. We will disseminate the outcomes through our staff briefings, walkabouts, and website and present them at divisional and Trust wide quality meetings.
- Develop our quality improvement projects with patients and share the improvement outcome with them through our stakeholder initiatives.
- Ensure there is team and personal learning from adverse events, through the sharing of Root Cause Analysis (RCA) investigation reports and delivery of the subsequent post incident action plans.
- Ensure that there is organisational wide learning from incidents, SIs and complaints through existing communications methodology to improve patient safety and experience, as well as drive down the number of claims.
- Ensure that we continually learn from all claims and Coroners' inquests, using this intelligence to identify further quality improvement projects.



SIGN UP PACK

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3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- Implement the Duty of Candour and work with staff to build our skills in disclosure. We will aim to increase our levels of reporting incidents and ensure that the Duty of Candour process is applied within the required timescales for any incidents which result in moderate harm or above.
- Ensure that we continually develop our culture of open and honest conversations with patients and families when things do go wrong and when care has fallen below expected standards, and we will support staff to do this.
- Seek out patient and carer involvement in our investigative processes and discuss the findings of our investigation and actions with them once complete.
- Publish progress with our quality improvement initiatives and the impact of these on patient safety.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- Whittington Health will be an active participator in our regional Patient Safety Collaborative and actively engage with safety initiatives across the local health and social care system. We will work with our university colleagues on developing quality improvement expertise.
- Continue to work closely with the Academic Health Science Network and UCLP Quality Forums including the
- Medical Director's Forum, Community Education Provider Network to develop education in patient safety, leadership development in improvement methodology and trainee education in improvement methodology.



SIGN UP PACK

5. Support. Help people understand why things go wrong and how to put them right and give staff the time and support to improve and celebrate the progress.

- Implement a process of written reflection as part of our Serious Incident process for all staff involved in incidents and develop our debriefing process following adverse events ensuring that appropriate feedback is given to staff where ever appropriate when harm or incidents have occurred.
- Develop processes that enable our patients and partners to understand our systems and how they can help be involved to help us improve.
- Celebrate our success by holding events to share them with our staff and others but also to champion individuals and teams who have done great work. We will use our excellence awards schemes to celebrate achievements.
- Ensure that staff can quickly and easily access our Employee Assistance Programme where additional emotional support may be required following involvement in an incident or complaint.
- Ensure that professional supervision structure is used effectively to help staff develop and improve individually and celebrate successes.



FREQUENTLY ASKED QUESTIONS

1. What is Sign up to Safety?

Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

2. What does Sign up to Safety mean?

This campaign and its mission are bigger and much more important than any individual's or organisations' programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that organisations currently own and aligning them with this single common purpose.

3. What is different about Sign up to Safety from previous campaigns?

What is unique and fundamentally different is that this campaign is for everyone. It transcends organisational boundaries and will align the whole system to achieving our shared ambition. There will be no targets or 'performance management' from the centre – the energy, ideas and expertise will be found deep inside the NHS and within your organisation. The Chief Executives of NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA) have all signed up to align their work with this campaign.

The idea is to harness the talent and enthusiasm within organisations and connect this to others in our National Health Service.

4. Who can sign up to the campaign?

Sign up to Safety is for everyone, everywhere. Whether you work in primary, secondary, or tertiary care; whether you work in acute, mental health, learning disabilities, ambulance, or community care settings; whether you work in a national body or a general practice, Sign up to Safety applies to you.

How is the campaign being organised and supported?

A National Co-ordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organisations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.
- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

5. What support is available to organisations who sign up to the campaign?

The National partners will work together with improvement experts to establish what a good improvement plan looks like and to support organisations to learn from each other in drawing up and delivering theirs. It is crucial that the leadership of the campaign is exercised locally but equally that this work is completely aligned with and mutually supportive of the work that is already underway or planned in relation to patient safety improvement. In this first phase, an 'Alliance of Improvement Experts' will be asked to come together and offer provider organisations who sign up the opportunity to have improvement support and advice.

The Improvement Alliance will also combine their sign up coaching with supporting the local patient safety collaborative to help enhance and align the activities of both. The level of advice and support will depend on what local organisations ask for, but the Improvement Alliance will act to bolster the development of these linked initiatives where they can, transferring skills to

collaboratives and provider organisations, as well as supporting the development of the Patient Safety Fellows Programme.

Over time we expect that the Campaign will be self-supporting as capacity is created locally to harness enthusiasm and develop capability, not least through the developing patient safety collaboratives. At the outset of the campaign a National Co-ordinating and Support Group will be established chaired by Sir David Dalton, with NHS England leadership provided by Dr Mike Durkin. The CQC, Monitor, the NHS LA and TDA will be part of the Group alongside representation from professional bodies, patient groups and improvement experts.

The Group will encourage organisations to commit to the campaign and will listen to what they need for support. The Group will also work to ensure the alignment with and support the establishment of related system activities including the patient safety collaborative programme, the Patient Safety Fellows Programme and the core development and support activity of the Trust development Authority and Monitor already in place. It is crucial that this campaign is seen as bringing the activity of the whole system together with a common and urgent single purpose.

6. How should organisations get patients, families and carers involved in Sign up to Safety

We strongly encourage organisations that sign up to be actively engaging with patients in a meaningful and productive way. Patients, their families and carers have a vital role in patient safety and their perception of safety and opinions on where improvement can be made should form part of the development of the improvement plans.

Their opinions are one of the most powerful influencers of other people and their choices and their voice a powerful force for change if listened to and learned from. This could be through a patient suggestion scheme, inviting patient representatives to be part of committees or forums to develop the plans, holding consultation events etc. More suggestions on including patients in the campaign are available on the website and case studies will be added as more and more organisations sign up to the campaign.

7. How does Sign up to Safety align with other patient safety programmes and initiatives?

The following linked initiatives to improve patient safety will be aligned with the campaign so that the whole system supports involvement. *Patient Safety collaboratives* – These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. They will begin their work later in the year. Organisations that sign up to safety can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Patient safety Fellows – work is underway to create a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety. The group will launch later this year and organisations who participate in Sign up to Safety are involved in the collaboratives will benefit from the expertise of the fellows and can also support their own staff to become fellows.

New National Reporting and Learning System (NRLS) – work is underway to review and re-commission the NRLS. We already have the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team – A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care. SAFE will be piloted later this year and could help support signed up organisations, and others, who require additional help.

Safety website – A new set of hospital patient safety data is now available on NHS Choices enabling trusts to be compared against each indicator. Putting key safety information into the public domain supporting transparency and helping patients to make informed choices about their care and exercise their right to challenge their local healthcare providers on safety issues. Organisations that have signed up to safety can use this public data to inform their plans and conversations with their local communities.

Whittington Health Trust Board

4th March 2015

Title:		Clinical Strategy					
Agenda item:		15/038		Paper		5	
Action requested:		<i>For approval</i>					
Executive Summary:		Our clinical strategy has been developed with staff and stakeholders to meet the challenges our community and local health economy face over next five years. It outlines our ambition as an integrated care provider, a 21 st century provider of innovative community and hospital services. Over next five years we will continue to strengthen our partnerships with mental health, social care and primary care services, alongside our multi agency partners to deliver our mission and vision and improve the health and outcomes for our local community. Our mission, vision and strategic themes were agreed by the Board in February 2015.					
Summary of recommendations:		To approve the clinical strategy for Whittington Health.					
Fit with WH strategy:		This paper outlines the strategic intent of Whittington Health and aligns with government policy.					
Reference to related / other documents:		IBP & LTFM					
Reference risk and corporate risks on the Board Assurance Framework:		Risk captured on risk registers					
Date paper completed:		24 February 2015					
Author name and title:		Siobhan Harrington, Director of Strategy/Deputy Chief Executive		Director name and title:		Siobhan Harrington, Director of Strategy / Deputy Chief Executive & Greg Battle, Medical Director Integrated Care	
Date paper seen by EC	18 & 24 Feb 2015	Equality Impact Assessment complete?	Ongoing	Quality Impact Assessment complete?	Ongoing	Financial Impact Assessment complete?	Ongoing



Our Clinical Strategy 2015-2020

‘Helping local people live longer, healthier lives’

1. OUR STRATEGY

Our clinical strategy provides a framework and direction for the organisation to be a national leader in delivering safe, integrated care to our local community.

The strategy has been developed with staff and stakeholders to meet the challenges our community and the local health economy face over the next five years. It outlines our ambition as an integrated care provider, a 21st century provider of innovative community and hospital services.

Whittington Health has an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. Our clinicians are encouraged to continuously evaluate their services and to adopt new ways of working across established boundaries in pursuit of improved outcomes.

Our relationship with our community and local partners is important to us. Whittington Health is a community asset. We are a key part of our community as they are to us; not only as a local health provider but also as an employer.

Over the next five years we will continue to strengthen **our partnerships with mental health, social care and primary care services, alongside our other multi agency partners** to deliver our mission and vision and improve the health and outcomes for our local community.

This document provides the detailed thinking underpinning our mission and our vision, followed by six strategic goals. A number of principles are outlined which will support delivery of the goals. Our approach to delivering care focused on five population groups is described.

2. OUR MISSION

“Helping local people live longer, healthier lives”

Our mission recognises that there are many determinants of health, not all of them in our remit to deliver. However, for us to support people to achieve this goal, we all agree that the most successful model will be local partnership working, with a range of agencies.

Our locality has a long and strong history of joint working, which we will continue to develop. We recognise a need for a greater emphasis on prevention which will require a change of focus towards promoting health and wellbeing.

With the requirement to become a leader in prevention as well as treatment, we will need to look beyond traditional pathways of delivering care.

3. OUR VISION

“Provide safe, personal, co-ordinated care for the community we serve”

The Mission Statement describes the 'What', the Vision is the 'How'. Each word of our vision has been carefully chosen.

'Provide' distinguishes us as a provider first and foremost. However we may also commission services from others. We will ensure that relationships with local providers are strengthened to deliver improved patient experience and outcomes, for example, working with GP providers in our urgent care model.

'Safe' care requires constant attention and re-emphasis. The best health care organisations recognise the importance of an explicit safety agenda and we will ensure safety is a priority in every encounter we have.

'Personal' - keeps the individual as a unique whole in our minds, and reminds clinicians that while guidelines and patient pathways are aids to care they are *not* the rationale of care. In our personal encounters, we must allow compassion and judgement their proper place.

'Personal' also encompasses the opportunity to encourage supported self-management and to be sensitive to the new ways people increasingly want to engage, for example via technological advancements.

'Co-ordinated care' restates a key element of integrated care. We face multi-morbidity in a population with increasingly complex needs. People require help in navigating the system. We will ensure their care is co-ordinated and not fragmented. The emphasis on health and well-being means that we will actively engage with all key providers involved in the care of our population.

'Communities we serve' - Whittington Health's acute patients come in large part (85%) from the boroughs of Islington and Haringey. Most of our community based services are provided to these two boroughs, with some covering the boroughs of Camden, Hackney and Enfield. These communities are vibrant, complex and multi-ethnic, and include considerable wealth and deprivation side by side. They provide the sorts of challenges that attract our staff.

As an organisation, we have opportunities to work in a wider geographical area where this makes sense for our communities and clinical pathways. We are deeply rooted in these communities as provider and employer. We have established and developing relationships with public, private and voluntary sector partners, and building long term relationships has been, and is, key to our strategy.

Our mission and vision will remain relevant, we believe, for the next 5 years and beyond.

4. STRATEGIC GOALS

Our clinical strategy will be delivered through achieving six key strategic goals.

4.1 To secure the best possible health and wellbeing for all our community.

We will ensure that everyone who has contact with our services will receive holistic care. Our focus will be on treatment of illness, and also prevention and health promotion. We will develop a health promoting menu for all our staff to use in contact with service users, incorporating guidance and information that supports patient empowerment.

We will continue to work closely with our local authorities in both Haringey and Islington to respond to the joint strategic needs assessments. In particular this will involve closer working with public health.

Local voluntary organisations have a great role to play in contributing to health and wellbeing and preventing illness. We already engage with voluntary sector providers for certain care pathways and over the next five years our intention is to further develop these relationships. We will encourage clinical teams to build relationships with relevant voluntary sector organisations as part of integrating care.

To maximise the combined impact of integrated care on health and wellbeing we will become system leaders with our partners.

Each department and team will consider its role in preventing or reducing smoking, alcohol, obesity and mental illness. Teams will focus on prevention in their specific area, for example, district nursing and prevention of pressure ulcers; orthopaedic team and prevention of accidents or falls; and midwives and health visitors and the prevention of perinatal mental illness.

4.2 To integrate/co-ordinate care in person-centred teams

Within the organisation we will foster greater multidisciplinary team (MDT) working around the needs of the patients/clients we serve.

We will further refine patient pathways to minimise duplication and fragmentation. Our infrastructure and administration systems will need to be aligned to enable MDTs to deliver patient centred care.

Across Haringey and Islington there are eight localities within which we will work as part of MDTs; with GPs, social care, mental health services, the voluntary sector, and other secondary care providers. We will share our approach to risk assessment, case management and care coordination. We will use technologies to support the development of new models of care.

We recognise that primary care has a unique role to play in integrated care. General practitioners are rooted in their communities, have a defined population to whom they offer continuity, and are usually patients' first contact with health services.

We will support our local GP practices to provide the best integrated care, by directly providing primary care through our Hanley Road practice; working as partners in localities, and offering support and advice to individual and local groups of practices on a tailored basis.

Where there is a direct interface with GPs we will provide a named lead clinician who will act as a contact for support, advice and navigation for each of the localities in which we provide services. This will enable us to strengthen the relationship within each locality.

4.3 To deliver consistent high quality, safe services

We will build on our record of providing high quality and safe care. All clinicians strive to deliver the safest care of the highest quality; 'right first time, every time', and a patient experience that exceeds expectations.

These key themes will continue to run throughout all our work. Moreover, the quality agenda must become embedded in the culture of every intervention both individually and within all clinical pathways.

We recognise that quality incorporates three key elements, clinical effectiveness, patient safety and patient experience.

- Clinical effectiveness can be defined as the extent to which specific clinical interventions achieve what they are intended to achieve. Decisions to develop and provide services should be driven by evidence of both clinical and cost effectiveness. In practice, clinical effectiveness is about developing and delivering high quality care. Ideally, this should involve using the best available research evidence, together with clinical expertise and patient involvement. Where there is a limited evidence base, clinical effectiveness can be achieved through benchmarking, audit, and continuous improvement based on identifying and sharing good practice.
- Regarding patient safety, our ambition is to deliver *Zero Avoidable Harm*. We will be at the forefront of the national Patient Safety Initiative 'Sign up to Safety'. We will reaffirm our commitment to patient safety and aspire to be among the safest organisations in the NHS.
- We will continuously improve patient experience. We will continue to refine our methods of obtaining feedback from patients and carers, shadow governors and others. We will seek to learn from that feedback. This will directly influence our plans for quality improvement and service development.

In driving improvements in quality we will continue to improve service delivery in the five core domains identified by the Care Quality Commission. We will ensure that our services are safe, effective, caring, responsive and well led.

4.4 To support our patients /Users in being active partners in their care

"Patients want to be listened to, to get good explanations from professionals, to get their questions answered, to share in decisions and to be treated with empathy and compassion." **National Voices' (2011) 'What patients want from integration'.**

Whittington Health has been a leader in developing patient centred approaches to care through our initial engagement in 'co-creating health' in adult services, self-management programmes and approaches to patient and clinician activation. We have been part of the '*Better Conversations*' initiative in our children's services. We will continue to embed these approaches in all our care pathways and take this to the next level by supporting all our users to be active partners in their care and in optimising their health and wellbeing. This will involve patients and clinicians in a culture change that will mean that every contact will equip people to play a greater role in managing their health and illness.

The evidence is increasing that '*supported self-management*' is important in preventing deterioration in long term conditions and improving patient empowerment.

Whittington Health has been a national leader in this area and we will include the full range of patient centred approaches such as shared decision making and health literacy.

4.5 To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research.

Our ambition is to build on decades of leadership and excellence in this area at under graduate and postgraduate level. As a key campus for UCL and Middlesex Universities we are well placed to train health care professionals of the future. We are a partner within University College London Partners (UCLP). This will enable us to deliver our vision and mission and engage and attract staff.

We have an established education strategy that has been clinically led, supported by UCLP which describes how we will deliver educational opportunities across multi professional groups.

We are the host of the local '*Community Provider Education Network*' and are currently developing education and training across disciplines to reflect the requirements of our Clinical Strategy. The success of this network has prompted a further expansion across a wider geography.

Our clinical strategy will be supported and enriched by a research strategy. Whittington Health is in a strong position to draw in research expertise and funds to lead in integrated care research. This will also improve staff engagement, contribute to ongoing debates about patient pathways and leverage academic interest and resources to deliver our mission.

4.6 To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

As an organisation, we have proved we innovate and constantly review and evaluate our services to meet our population's changing needs. Our organisation will need to adapt and change. Innovation will continue to be an essential part of how we develop and evolve services and our workforce.

In order to innovate successfully, quality improvement methodologies need to be key a skillset of all people delivering care.

There is an increased focus on demonstrating improved outcomes that are both patient reported and also more quantitative clinical outcomes. We will continue to work with our commissioners as partners and respond innovatively to their outcome objectives. Initially we will work with partners to deliver improved outcomes to frail elderly people and people with long term conditions.

5. PRINCIPLES

To deliver the strategic goals of the organisation there are several principles that will help clinical teams develop their plans.

- Communication of who we are and what we do is important. We need to understand the needs of the local population. As clinical teams, especially where patients have on going care needs, we need to maintain registers that enable the coordination and management of care.
- We will further develop care planning across all clinical pathways, building on our work of enhanced recovery models and end of life care.
- Teams will need to ensure that that incorporate patient activation /empowerment/co-production in service development.

- Prevention and health promotion at every contact.
- We will deliver care in the most appropriate setting. This will allow us to be innovative in delivering patient centred working. Examples include locality working, virtual wards, multidisciplinary teams, conference calling, care at home, care in the hospital and ambulatory care.
- Clinical teams will reflect on the need to work with more specialist partners to ensure best outcomes for patients. This will continue to require close working with London wide and national networks.
- Primary care as a partner. Clinical teams will ensure that the advice and support to general practise is readily accessible.
- Delivering high value services. Value in health care is delivering the best outcomes efficiently and effective within available resources.

6. POPULATION FOCUS ON DELIVERING NEW MODELS OF CARE

We have held several workshops to consider how care will evolve over the next five years. Using a segmentation model developed by the Kings Fund, the workshops focused on care of older people, people with long term conditions, and people with unplanned care needs, people with planned care needs, and women, children and families. The following section reflects the discussions of the workshops and emergent themes and priorities. This is demonstrative of the engagement to date in considering the clinical strategy. It is in no means a complete and comprehensive detail of how our strategy will be delivered. Many clinical teams and departments are not mentioned in the following five sections. Every clinical team will need to develop plans in response to the mission, vision and strategic goals.

6.1 OLDER PEOPLE

Older people are a key part of our local community whose numbers are set to increase. People over 65 currently make up about one in 10 of the population of Islington and Haringey.

There is a strong commitment to deliver a care model for older people that delivers improved outcomes and better patient experience.

An increasingly aging population often brings more complex clinical requirements, especially around managing discharges from hospital and community services. We will strengthen our discharge planning pathways across Whittington Health to ensure that discharges are well co-ordinated, with excellent, integrated planning around the needs of the individual.

We have a clear vision of supporting patients and their carers to be active participants in their care and self-management. We will ensure that every interaction will receive support and intervention around prevention and self –management. Anticipatory care (proactive care that anticipates the needs of patients) is a key component in helping to support people to remain independent, to avoid hospital admission, and to return to an active life after illness.

IT systems will enable access all relevant data, enhancing all patient care, improving safety and reducing duplication.

To ensure that older people are managed in the best setting, we will deliver integrated care that is coordinated across the whole pathway.

We will continue to develop clinical models around rapid response and Intermediate care for older people. We have learnt that joint working between health and social care (e.g. our N19 project) offers considerable advantages to older people and staff. This improves the amount of time people spend supported in their homes and reduces their length of stay in hospital. We intend to extend this way of working.

Our ambulatory care centre offering rapid intervention and has supported quicker access to care for the older population, thereby avoiding some unnecessary hospital admissions. This model will need to be extended to ensure that urgent and emergency responses to the needs of the older people is fully integrated.

The virtual ward model compliments ambulatory care by delivering fully supported specialist care in older people's homes. We intend to continuously improve and extend this model.

We are delivering an integrated community assessment team to nursing homes in Islington, advanced care planning with community geriatricians and local GPs.

When hospital admission is necessary, we will strive to provide the best possible care on our 'care of the elderly' wards.

Rehabilitation is a critical part of recovery and we will increase our rehabilitation capacity.

One of the key places to integrate care for older people will be within locality based teams. We are working closely with mental health services and social care in both acute and community settings to ensure better integration of care.

Work will continue to be undertaken with advanced care planning, treatment escalation planning, working with all the relevant agencies and multidisciplinary teams, supporting the patient and their families to have the best end of life care possible.

Older people have often been prescribed multiple medications. Effective Medicines Management is an essential part of providing high quality integrated care. We need to continue to work closely with GPs, community pharmacists and hospital pharmacists and other clinicians.

6.2 PEOPLE WITH LONG TERM CONDITIONS

Many people across Haringey and Islington live with one or more long term condition, such as diabetes, '*chronic obstructive pulmonary disease*' (COPD) or heart failure. The number of people with one or more '*long term conditions*' (LTC) are predicted to rise in both boroughs.

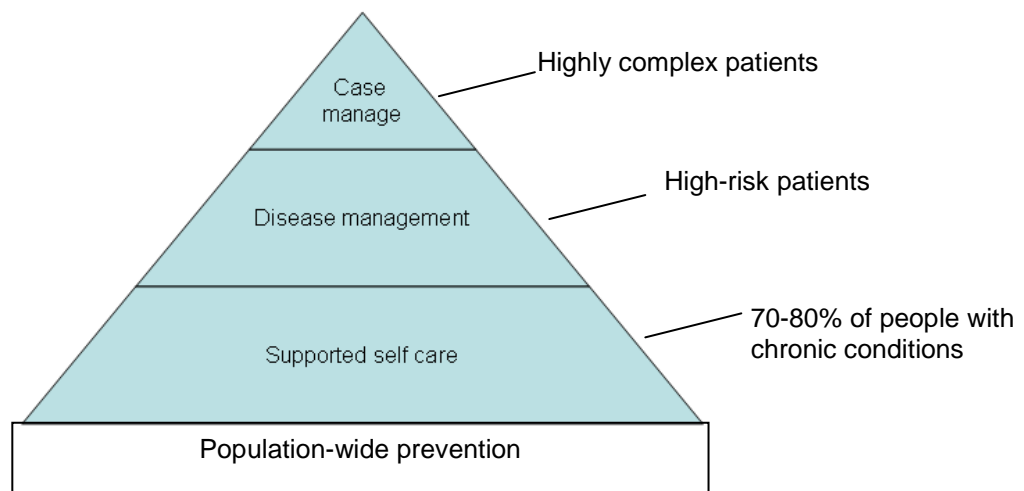
Our clinicians have been at the forefront of developing innovative and best practice models of care for this group, with work recognised nationally and across London.

We have developed a care co-ordination and case management approach with integrated pathways with local primary care. Some of our models use peer review and support to primary care in complex case review and clear care planning. We will continue to embed

these approaches across our medical specialities with the further development of multi-disciplinary teams and new roles.

As the prevalence and complexity of patients with LTCs continues to grow, it will become increasingly necessary to ensure that the right clinician is engaged in delivering the appropriate care to the patient. Following the Kaiser model (see below), our specialists will continue to deliver specialist services to highly complex patients with LTCs, while also working with the wider team of professionals to promote health and wellbeing.

The 'Kaiser Triangle' illustrating different levels of chronic care



To ensure a truly seamless and integrated model of care for people with LTCs, our locality based teams will need to include GPs, psychology services, social care and access to other services such as nutrition and dietetics and speech and language therapy.

We recognise the importance of supported self-management and we will ensure that every interaction with patients with LTCs will receive support and intervention regarding relapse prevention and self-management strategies.

6.3 PLANNED CARE

We will continue to strive to be the 'provider of choice' for local people for planned care.

We will ensure that it meets quality and safety standards. We will continue to streamline our pathways, coordinate care, and use the latest technology to improve access to care. We will continue to benchmark the care we provide.

Pathways will further build on our work to enhance recovery and prepare people for surgical procedures with a focus on optimising health and wellbeing before surgery. Patients will be supported to have care as day case or ambulatory care where possible. When a hospital stay is required, we will do our best to ensure it is for the appropriate duration. We will ensure that when people leave hospital there will be appropriate care in place to support them at home. We will evolve our models of virtual working, with support and supervision for patients being cared for in the community.

Planned care will be delivered using 'one stop' arrangements where possible, where patients will receive diagnosis and treatment in one visit.

We will build on the models of care we have in community urology and community gynaecology, where people can be seen by specialists in community facilities closer to where they live.

We will expand our day case work in all specialties to deliver excellent care in an efficient and effective way. We will continue to develop 'straight to test' for example our endoscopy service, to improve the early detection of cancer.

We have a unique contribution to make in delivering a multidisciplinary approach across the whole obesity pathway from home to hospital and delivery of preventative services as well as intermediate care and specialist surgery.

To respond to the needs of our local population we will focus our orthopaedic services on delivering exceptional joint replacement and repair. Orthopaedics also has a critical role to play in managing acute and chronic back pain. Our orthopaedic team will deliver high quality and safe surgery where needed, with a focus on prevention and supporting people to manage their condition.

Following a diagnosis of cancer, integrated care planning is essential. We will work closely with our partners in London Cancer to support patients at every step of the pathway. We have been nationally recognised for our work in acute oncology and will continue to strive for excellence.

By demonstrating the high value of our planned surgical pathways, we intend to grow our share of surgical work.

6.4 UNPLANNED CARE

To meet the continuing demand for unplanned care will require ever closer working between providers locally and nationally. To do this we will continue to provide the current range of emergency services and intensive care on the Whittington Hospital site.

We will guarantee high quality and safe services 24 hours a day, 7 days a week. We will respond in a timely way to individual needs and have an infrastructure that copes with peaks in demand.

We will ensure that people understand how to access our services and will work with partners to make care seamless and efficient. We will build health promotion and illness prevention into our unplanned care pathways. We will deliver innovative models of care to meet the continued rise in local demand.

Our community nursing models will need to respond to unplanned care developments in localities.

Where care requires more specialist input we will transfer patients in a timely and safe manner to a more specialist centre.

6.5 WOMEN, CHILDREN AND FAMILIES

Whittington Health offers a wide range of services to women, children and families. We will continue to develop and integrate the excellent clinical services offered to our population.

Our maternity and neonatal services: A core value of the maternity services within Whittington Health is to support people to have normal births where possible and to receive high quality care throughout pregnancy. We aim to provide a range of options for local women to deliver their babies either in their own home, in our midwifery led birthing unit or on a consultant led labour ward.

We will build on our reputation of having caring, professional and friendly staff and will see a significant redevelopment of our maternity and neonatal services. We have good team working and midwives who work both in the community and hospital setting. Increasingly we are building integrated working with community midwives and health visitors, alongside the family nurse partnership and PIPS (parent infant psychology) service. We plan to develop an integrated perinatal service. We will also continue our provision of complementary therapies to support pregnant women and women in labour.

Our neonatal unit is a level 2 unit which provides quality and safe care to premature babies that may have been delivered at the Whittington, or who may have been cared for elsewhere and require repatriation .

Our children's services: Our community and hospital services include some specialist community services for example child and adolescent mental health services, speech and language therapy and children looked after services. We also provide universal services to all children, for example health visiting and school nursing.

We are committed to continue to provide a full range of children's' services. This includes everything from care at home to our inpatient ward. We aim to put the child at the centre of everything we do. We are developing new models of care such as our Hospital at Home Service, to increase specialist support for children and families in their homes.

We recognise that children and families need timely and responsive services. There is a need for greater co-ordination between out of hours care, general practise, ambulatory care and acute services. We aim to be a system leader in improving urgent care and unplanned care for children.

The inpatient and outpatient services delivered to children will continue to include cancer care, acute care and care of children with long term conditions. The service also includes a fully integrated co-located paediatric mental health team, attending both to a rising trend in emergency admissions of suicidal teenage patients and also to complex/ medically unexplained presentations in children of all ages. This service will continue to develop to meet rising demand.

Children's services will work closely with general practise to offer advice and support and easy to access to services. We will improve co-ordination of information technology.

There will be further embedding of preventative work that focuses on health and wellbeing especially breastfeeding support, parenting skills, allergy management and childhood obesity. We will further develop our approach to engage children fully in their care, building on the 'Better Conversations' work.

Our mental health services including '*Parent Infant Psychology Service*' (PIPS), '*Child and Adolescent Mental Health Services*' (CAMHS), and Simmons House adolescent inpatient unit, will all be involved in increasing our psychological support and also preventing mental illness or the ongoing long term impact of mental illness for children.

As medical advances continue, there will be a small but growing group of infants and children with complex long term conditions and learning difficulties who require ongoing multidisciplinary input from our teams.

We recognise the critical importance of transitional services for children and adolescents with long term conditions. We will improve the quality of the experience for children undergoing this transition. Getting this right is difficult and will require close working with adult services.

7. CONCLUSION

This clinical strategy demonstrates the wide range of clinical services already provided by Whittington Health, an integrated care organisation (ICO) focused on the care of our local population. Over the next five years we intend to continue to grow and improve the care we provide across our community and hospital settings.

The strategy lays out a clear mission and vision. The strategic goals will enable the vision and mission to be achieved. The principles will guide clinical teams to formulate detailed plans which will be annually reviewed over the time period of the strategy.

Our mission is clear ***'helping local people live longer healthier lives'***.

The increasing complexity of the delivery of this mission requires an integrated approach that will require innovative thinking and behaviour change at all levels. A partnership between patient, carer, community, commissioners and providers that is stronger than what has been to date.

To quote the NHS Five Year Forward view (NHS England 2014) *'there is now quite a broad consensus on what a better future should be'*. Our clinical strategy is a reflection of that broad consensus and we are now in a position at Whittington Health to be a leader in making that *'better future'* real for our local population.

Siobhan Harrington
Director of Strategy/Deputy Chief Executive

Greg Battle
Medical Director Integrated Care

Whittington Health Trust Board

4 March 2015

Title:	Trust Board Report March 2015																		
Agenda item:	15/039	Paper	6																
Action requested:	For discussion and agreement of areas of focus.																		
Executive Summary:	<p>The following is the Performance and Quality report for January 2015; a number of highlights and areas for focus are identified.</p> <p><u>National Indicators</u></p> <p>Referral for Treatment (RTT): Achieved 3rd consecutive month.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #d9e1f2;">Target</th><th style="background-color: #d9e1f2;">Nov-14</th><th style="background-color: #d9e1f2;">Dec-14</th><th style="background-color: #d9e1f2;">Jan-15</th></tr> </thead> <tbody> <tr> <td>Admitted 90%</td><td style="background-color: #c6e0b4;">90.7%</td><td style="background-color: #c6e0b4;">92.8%</td><td style="background-color: #c6e0b4;">91.3%</td></tr> <tr> <td>Non-Admitted 95%</td><td style="background-color: #c6e0b4;">95.0%</td><td style="background-color: #c6e0b4;">96.1%</td><td style="background-color: #c6e0b4;">95.0%</td></tr> <tr> <td>Incomplete 92%</td><td style="background-color: #c6e0b4;">92.2%</td><td style="background-color: #c6e0b4;">92.3%</td><td style="background-color: #c6e0b4;">92.96%</td></tr> </tbody> </table> <p>Having successfully met the back log reduction plan we are now working on sustaining the national access standards and reducing the overall waiting list to the level set in November 2014. This measure is the over 18 weeks waiting patients do not exceed 1047 by the end of March 2015.</p> <p>All units are on track, and capacity and demand reviews are underway across surgical specialities. A benchmarking exercise was completed during December and January with the aim of cross checking effective and efficient usage of our operating theatres. Feedback has been received and confirmation that the redesign work has delivered significant improvement in theatre productivity. Waiting times per speciality are listed in the overall document. Due to the high demand for emergency inpatient beds and emergency theatre capacity, the admitted RTT capacity was reduced for two weeks. This has affected the theatre utilisation for planned care patients.</p> <p>Emergency Care:</p> <p>The high demand for inpatient and complex care planning continued into January as reported in December performance report. This demand remained for older people with complex cases and paediatrics. Increased focus occurred on our community teams in order to meet the demand for early discharge and increased referrals from neighbouring trusts.</p> <p>The system resilience health economy board met and has provided</p>			Target	Nov-14	Dec-14	Jan-15	Admitted 90%	90.7%	92.8%	91.3%	Non-Admitted 95%	95.0%	96.1%	95.0%	Incomplete 92%	92.2%	92.3%	92.96%
Target	Nov-14	Dec-14	Jan-15																
Admitted 90%	90.7%	92.8%	91.3%																
Non-Admitted 95%	95.0%	96.1%	95.0%																
Incomplete 92%	92.2%	92.3%	92.96%																

close monitoring across different providers. Agreement was made to increase the capacity in district nursing to assist with these demands. Partnership working with LAS and Mental Health continues to be strong and direct involvement in management patient flow is seen on a daily basis.

Ambulatory care has continued to support demands for emergency flow, the stretch target of 5% is below due to the final stage of building work in the front entrance of ED. This will allow the senior clinical decision makers to assess and review at the point of arrival.

Cancer targets: All the national access standards for cancer have been met for QRT 3 and maintained in January and February. The redesign of patient pathways and capacity and demand work has delivered a significant improvement in the management of cancer patients. The clinical leadership of each pathway has maintained the focus and monitoring of patient access, achieved 3rd consecutive month. All referrals from other organisation completed and no further referrals are expected.

Dental Capacity: we will be refurbishing Enfield Dental Practice following a successful bid, this will provide additional capacity for routine patients.

Areas to note

Complaints: All support for divisions is now in place and improvement is expected in February through to April 15.

Infection Control: a second case, not related to the case in December 14, of MRSA has been reported. The review meeting took place on 27th January and Enhanced IPC environmental audit and management of isolated patients' audits have been completed. Both were found to be compliant. An audit of mobile x-ray machines was also completed.

Did not attend, in acute setting: All services now consistently using patient choice at point of booking and reminder calls at 7 days and 1 day before the appointment.

Maternity: Increase of 300 self-referrals received in maternity.

Summary of report:

QUALITY

- Inpatient deaths: the number of inpatients deaths has increased. Analysis finds a continued high proportion of deaths related to winter related illnesses.
- Completion of valid NHS number: Continues to improve despite increased demand on A&E.
- SHMI: Whittington Hospital mortality rate remains lower than expected for the Trust.

	<ul style="list-style-type: none"> • HSMR: Whittington Hospital score has returned to expected level, below the national average. <p>PATIENT SAFETY</p> <ul style="list-style-type: none"> • Harm Free Care: Achieved • VTE assessment: Achieved • Pressure Ulcers: Increase in prevalence on the wards, reduction plan in place. • Medication errors causing moderate/low harm: Action plans in place with close monitoring. • Never events: none • CAS alerts: none • Serious incidents reported: all incidents are fully investigated and learning is shared. <p>PATIENT EXPERIENCE</p> <ul style="list-style-type: none"> • Family and Friend Test: achieved • Mixed sex Accommodation: no breaches • Patient admission to adult facilities for under 16 years of age: no breaches <p>INFECTION PREVENTION</p> <ul style="list-style-type: none"> • Hospital acquired C Difficile infection: 2 in January 2015. A review has taken place and the action progressed, increased communication has been provided. • Hospital acquired E.coli infections: none • Ward Cleanliness: remains at 98% <p>ACCESS</p> <ul style="list-style-type: none"> • First to follow-up: acute ratio remains below the national benchmark. • Hospital cancellations: continued focus on improving cancellation rate. • Diagnostic waits: Achieved • 52 weeks wait: none • Community access: Podiatry, Intermediate Care and Community Rehabilitation added to this month's dashboard. Further services to be added to the dashboard over the coming months. <p>Presentation: Endoscopy project</p>
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:		19 th February 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?	



March Trust Board Report (January data)

Quality	Threshold	Nov-14	Dec-14	Jan-15
Number of Inpatient Deaths	-	27	54	50
NHS number completion in SUS (OP & IP)	99%	98.5%	98.6%	arrears
NHS number completion in A&E data set	95%	91.8%	94.3%	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	Jul-14	Aug-14	Sep-14
Hospital Standardised Mortality Ratio (HSMR)	<100	94.99	105.18	79.98
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	89.7	110.7	58.2
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	98.4	104.5	88.4

Patient Safety	Threshold	Nov-14	Dec-14	Jan-15
Harm Free Care	95%	94.5%	95.4%	95.2%
VTE Risk assessment	95%	95.1%	95.4%	arrears
Medication Errors actually causing Serious/Severe Harm	-	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	1	0	0
Proportion of reported patient safety incidents that are harmful	-	44.4%	35.2%	42.4%
Serious Incident reports	-	6	8	11

Access Standards

Referral to Treatment (in arrears)	Threshold	Oct-14	Nov-14	Dec-14
Diagnostic Waits	99%	100%	99.8%	99.7%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

		Meeting threshold		
Patient Experience	Threshold	Nov-14	Dec-14	Jan-15
Patient Satisfaction - Inpatient FFT (% recommendation)	-	88%	94%	94%

Efficiency and productivity - Community	Threshold	Nov-14	Dec-14	Jan-15
Service Cancellations - Community	2%	7.70%	7.70%	7.90%
DNA Rates - Community	10%	7.6%	6.9%	6.5%
Community Face to Face Contacts	-	63,382	58,199	62,496
Community Appts with no outcome	0.5%	3.4%	1.0%	1.6%

Community Access Standards	Threshold	Nov-14	Dec-14	Jan-15
Community Dental - Patient Involvement	90%	99.0%	98.0%	97.0%
Community Dental - Patient Experience	90%	99.0%	100.0%	100.0%
MSK Waits - Non-Consultant led still waiting at month end (% < 6 weeks)	100%	85.1%	83.5%	97.2%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	89.1%	99.3%	arrears
IAPT - patients moving to recovery	50%	47.0%	45.0%	arrears
GUM - Appointment within 2 days	100%	100.0%	100.0%	100.0%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Nov-14	Dec-14	Jan-15
First:Follow-up ratio - acute	2.31	1.63	1.66	1.64
Theatre Utilisation	95%	82.9%	79.7%	75.3%
Hospital Cancellations - acute - First Appointments	<2%	6.0%	5.4%	4.6%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.6%	6.7%	7.0%
DNA rates - acute - First appointments	8%	12.8%	14.1%	14.2%
DNA rates - acute - Follow-up appts	8%	14.0%	13.8%	13.6%
Hospital Cancelled Operations	0	15	2	3
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	0

Additional capacity funding		Failed threshold		
Emergency and Urgent Care	Threshold	Nov-14	Dec-14	Jan-15
Emergency Department waits (4 hrs wait)	95%	92.4%	94.9%	94.5%

March Trust Board Report (January data)

Patient Satisfaction - ED FFT (% recommendation)	-	88%	87%	91%
Patient Satisfaction - Maternity FFT (% recommendation)	-	91%	87%	95%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	35	21	34
Complaints responded to within 25 working day	80%	71%	71%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Infection Prevention	Threshold	Nov-14	Dec-14	Jan-15
Hospital acquired MRSA infection	0	0	1	1
Hospital acquired <i>C difficile</i> Infections	19 YTD	1	1	2
Hospital acquired <i>E. coli</i> Infections	-	2	1	0
Hospital acquired MSSA Infections	-	0	1	0
Ward Cleanliness	-	98.2%	98.1%	-

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold		Oct-14	Nov-14	Dec-14
Referral to Treatment 18 weeks - Admitted	90%	Projected	84%	-	-
		Actual	83.3%	90.7%	92.8%
Referral to Treatment 18 weeks - Non-admitted	95%	Projected	72%	-	-
		Actual	89.9%	95.0%	96.1%
Referral to Treatment 18 weeks - Incomplete	92%	Projected	80%	-	-
		Actual	84.9%	92.2%	92.4%

ED Indicator - median wait for treatment (minutes)	60	85	70	69
30 day Emergency readmissions	-	240	269	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	2.7%	2.7%	2.8%
Ambulance Handover (within 30 minutes)	0	4	16	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Cancer Access Standards (in arrears)	Threshold	Oct-14	Nov-14	Dec-14
Cancer - 14 days to first seen	93%	94.9%	93.2%	93.7%
Cancer - 14 days to first seen - breast symptomatic	93%	97.1%	93.5%	94.4%
Cancer - 31 days to first treatment	96%	96.1%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	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%	94.7%	87.5%	88.2%

Maternity	Threshold	Nov-14	Dec-14	Jan-15
Women seen by HCP or midwife within 12 weeks and 6 days	90%	92.4%	85.7%	80.7%
New Birth Visits - Haringey	95%	85.0%	83.5%	arrears
New Birth Visits - Islington	95%	91.4%	88.7%	arrears
Elective Caesarean Section rate	14.80%	13.7%	12.9%	15.2%
Breastfeeding initiated	90%	88.7%	92.2%	88.6%
Smoking at Delivery	<6%	4.9%	4.9%	5.4%

 Meeting threshold

 Additional capacity funding

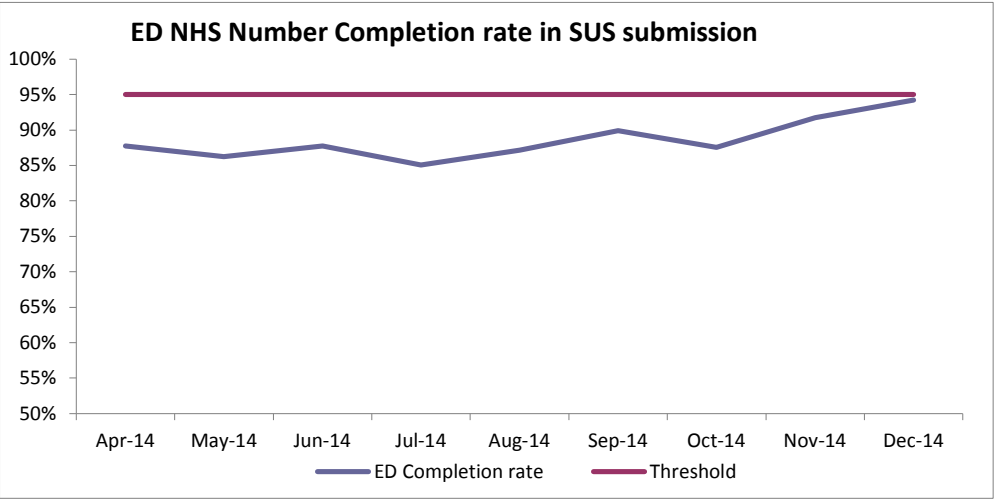
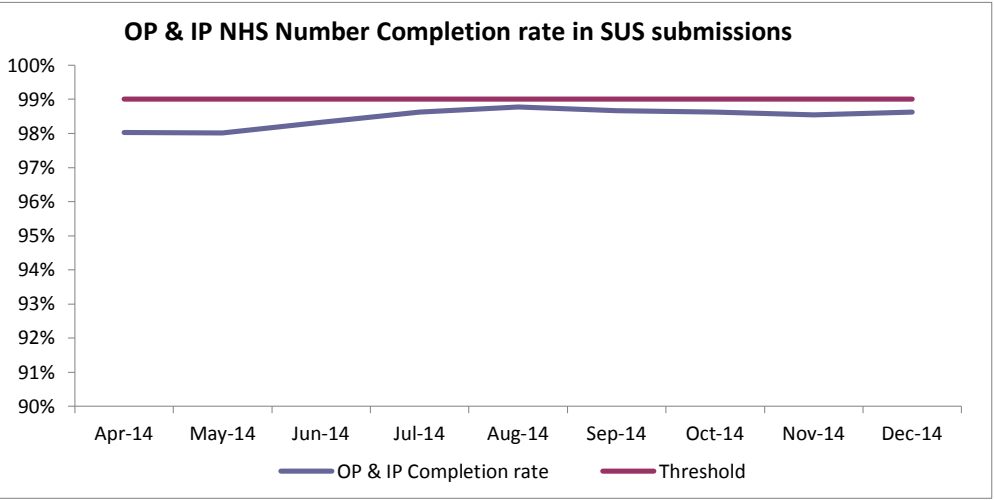
 Failed threshold

	Threshold	Trust Actual		
		Nov-14	Dec-14	Jan-15
Number of Inpatient Deaths	-	27	54	50
Completion of a valid NHS number in SUS (OP & IP)	99%	98.5%	98.6%	arrears
Completion of a valid NHS number in A&E data sets	95%	91.8%	94.3%	arrears

		Lower Limit	Upper Limit	RKE SHMI 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 has increased in January 2015, this is being monitored and is a seasonal trend during winter.
as part of our aim to review mortality we have commenced the Jasmine Project, named after Jasmine Rodgers who died a few months after her birth. The Jasmine Project is our name for implementing the GAP/GROW project which started in the Midland to help increase the identification of small babies (IUGR babies) and help reduce the incident of stillbirth in London. We are part of a wider Pan London Strategic Maternity network plan to reduce the stillbirth rate. Staff will be trained on how to use individualised growth charts devised by the Perinatal institute to help monitor women so if there is concern about the growth of their baby they are referred for additional serial scans and possible early induction. We are launching this project at the next audit day in March and Jasmine's parents will be there for the launch
Action: Analysis of data shows a high number of winter related illnesses.
Timescale: On-going
Completion of valid NHS number
Issue: A steady improvement is observed in both the SUS and A&E dataset, despite the winter pressures.
Action: The ED department has access to a dataset, updated daily, identifying missing NHS numbers. Policies are re-enforce and procedures on completing NHS number in EPR are in place.
Timescale: Expected to be compliant in April 2015
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
The standardised mortality rate returns to expected level for Whittington Hospital, which means the balance between elective admissions and non-elective admissions are back at expected levels. Number of deaths recorded, 31, in September 2014 was the same as in August.

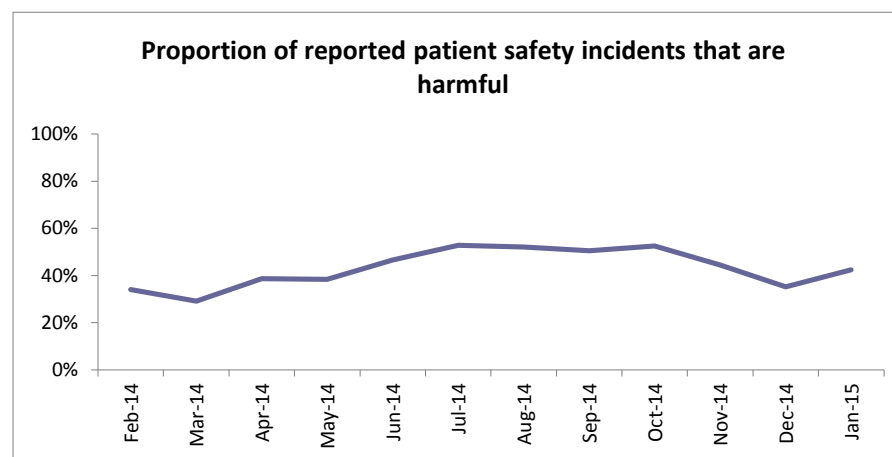
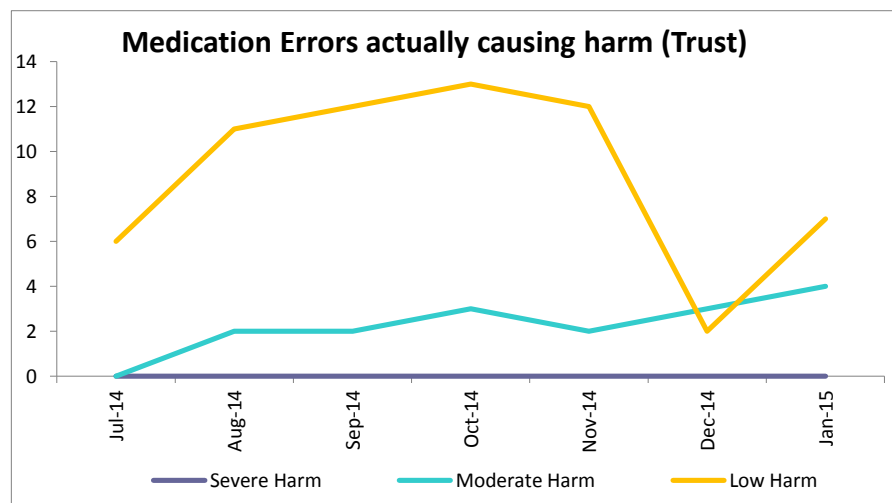
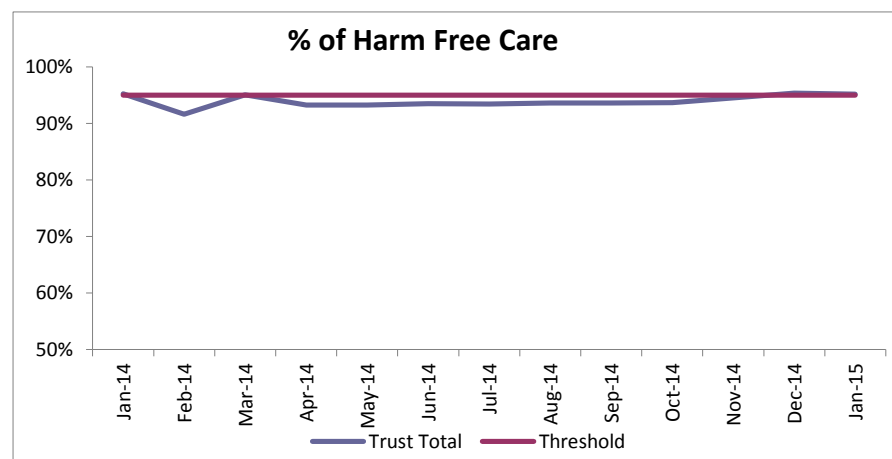
	Standardised National Average	Jul-14	Aug-14	Sep-14
Hospital Standardised Mortality Ratio	<100	94.99	105.18	79.98
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	89.7	110.7	58.2
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	98.4	104.5	88.4



Data extracted on 09/02/2015

	Threshold	Trust Actual	
		Dec-14	Jan-15
Harm Free Care	95%	95.4%	95.2%
Pressure Ulcers (prevalence)	-	3.90%	4.25%
Falls (audit)	-	0.27%	0.09%
VTE Risk assessment	95%	95.4%	arrears
Medication Errors actually causing Serious or Severe Harm	0	0	0
Medication Errors actually causing Moderate Harm	-	3	4
Medication Errors actually causing Low Harm	-	2	7
Never Events	0	0	0
Open CAS Alerts (Central Alerting System)	-	0	0
Proportion of reported patient safety incidents that are harmful	-	35.2%	42.4%
Serious Incidents (Trust Total)	-	8	11

Jan-15		
ICAM	SCD	WCF
94.1%	97.8%	100.0%
5.30%	1.07%	0.00%
0.11%	0.00%	0.00%
Reported one month in arrears		
0	0	0
3	1	0
3	1	3
0	0	0
-	-	-
42.6%	28.3%	48.8%
11	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

Timescale: Plan by end of March

Pressure Ulcer prevalence

Issue: There was a reduction in the number of pressure ulcers in the community but an increase on the wards.

Action: The Tissue Viability nurse has met with the Director of Nursing and is working with the Head of Nursing and Deputy Director of Nursing to implement a reduction plan.

Timescale: Immediate

Medication Errors actually causing harm

Issue: No Serious medication error have been reported in January. The moderate errors relates to process errors in prescribing (no end date, delay in medication order and prescription on paper but not JAC) The low harm incidents related to incorrect procedures being followed (incorrect prescription frequency and delay in medication order).

Action: All errors are investigated and appropriate action taken.

Timescale: completed

CAS alerts: The trust has no overdue CAS alerts. All alerts were actioned as appropriate.

Proportion of reported patient safety incidents that are harmful

Issue: Datix reporting has been fixed, but data in this dashboard might still be affected.

Action: Divisional reports and data between December 14 and January 2015 are being validated.

Timescale: March 2015

Serious Incidents

Issues: Out of the 11 SI reported in January 2015. Six pressure ulcers, four grade 3 and two grade 4. The five other SI included 2 patients who died as a result of influenza related illness, one patients died unexpectedly due to PE, one incident related to incorrect insulin administration and one patient sustained head injury due to self harm in ED.

Action: All incidents have been investigated. All reports are due in March 15. One grade 4 ulcers is investigated for de-escalation. Maternity are reviewing SI in the last years to identify themes in incidents and action plans. Learning of this will be shared.

Timescale: March 2015

	Threshold	Trust Actual		Jan-15		
		Dec-14	Jan-15	ICAM	SCD	WCF
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	93.8%	93.6%	96.4%	90.1%	100.0%
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	87.0%	91.4%	91.4%	-	-
Patient Satisfaction - Maternity FFT (% recommendation) **	-	87.2%	94.9%	-	-	94.9%
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	0
Complaints (incl Corporate)	-	21	34	17	8	8
Complaints responded to within 25 working day	80%	71.43%	arrears	100.0% *	57.1% *	25.0% *
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: The in patient score remains around 93%. The Maternity FFT score has improved, but is still manually collated.

Action: Maternity FFT Electronic device has not yet been repaired and the feedback is still collated manually. Friend and Family Tests are now becoming embedded. 'You said we did' is being spread across all services.

Timescale: On-going

Examples of 'You said, we did'

Life Force (paediatric palliative care team)

We asked "If we could offer more flexibility from the respite sessions, with regards to day and hours, what would be beneficial to you as a family"

The following responses were received: "2.30 - 6pm would be useful as it helps bed time and supper; after 5pm in the week would be good; weekends would be good; later starts in the morning would be good"

We did: "changed the hours of working and now the service runs from 8am - 8pm Monday - Friday"

If for ward

You said: Families complained that there were no play specialists working at the weekends and therefore no appropriate toys available.

We did: As a result each Friday afternoon the play specialist identifies which children will be an in-patient on the ward and will create a play programme and provide a play box of toys for each specific child.

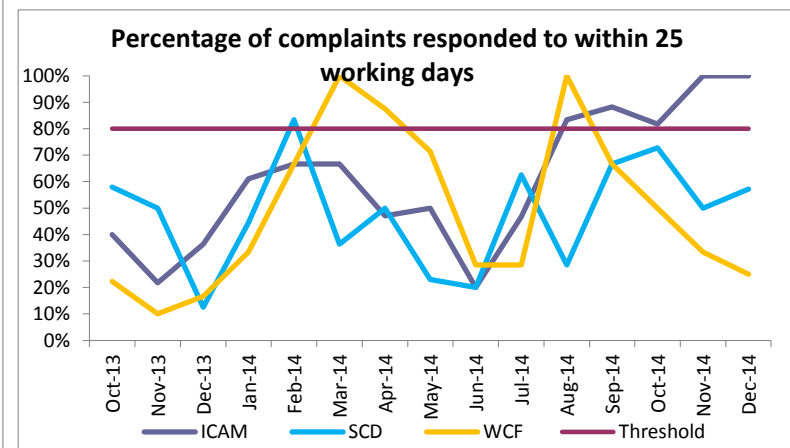
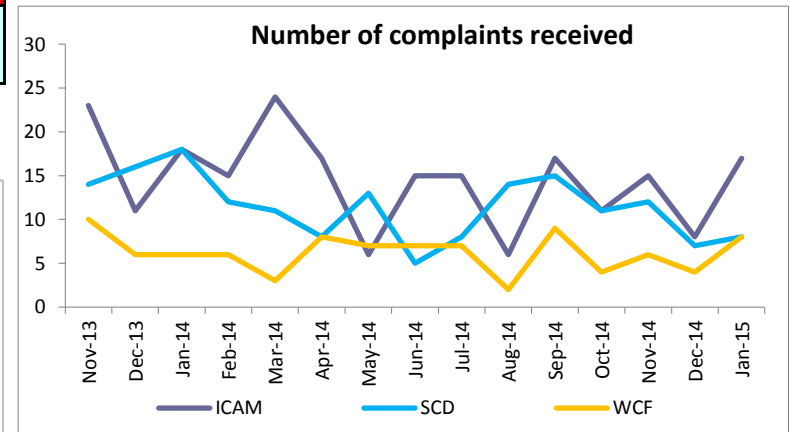
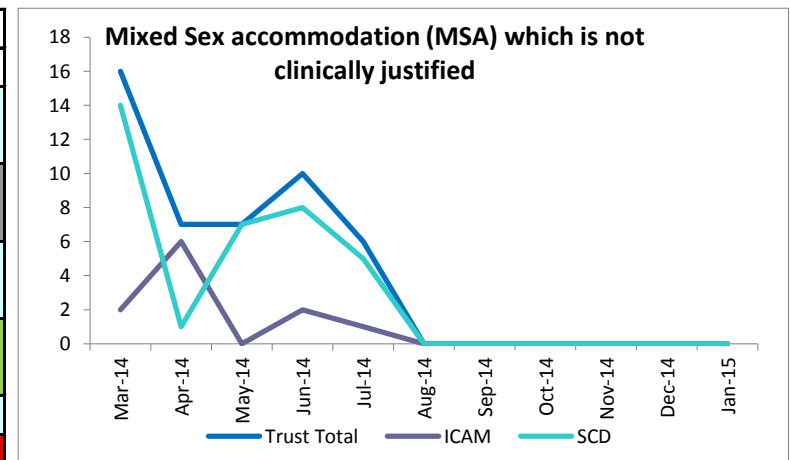
Mixed Sex Accommodation

A policy and processes embedded in the services and no breaches for 6 consecutive months.

Complaints

Issue: Below threshold remaining around 71%. The Integrated Care and Acute Medicine has score 100% in the last 2 months.

Action: Action plan embedded, key themes analysed. WCF now have support in place and backlog is being addressed.



		Trust Actual	
	Threshold	Dec-14	Jan-15
MRSA	0	1	1
E. coli Infections*	-	1	0
MSSA Infections	-	1	0

	Threshold	Jan 15	YTD
C difficile Infections	19 (Year)	2	16

Jan-15		
ICAM	SCD	WCF
0	1	0
-	-	-
0	0	0

ICAM	SCD	WCF
2	0	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: 1 new MRSA bacteraemia was diagnosed on ITU on the 16th of January 2015. (Two cases for the year to date both in SCD)

The PIR meeting took place on 27/01/15. The issues identified were the patient acquired MRSA bacteraemia on the unit. the review showed that the patient had 10 negative screens and then was transferred for a day procedure to an other provider and on the 11 screening had acquired MRSA Bacteraemia

Action: Enhanced IPC environmental audit and management of isolated patients audits have been completed. Both were found to be compliant. An audit of mobile x-ray machines was also completed, improvements to be made by radiology

Timescale: On-going for review in 4 weeks. All above actions completed, for monitoring at ICC.

E.coli Infection and MSSA

No new E. coli infections or MSSA identified in January 2015.

C Difficile

Issue: 16 cases ytd, from consultation with other hospital it is understood we all are in a similar position.

Action: all cases are investigated and action plans put in place including: training for wards, SOP for terminal cleaning, Alerts on EPR and JAC. A business case is being drafted to fund single use of access in side rooms on all wards, after a successful pilot on Meyrick ward.

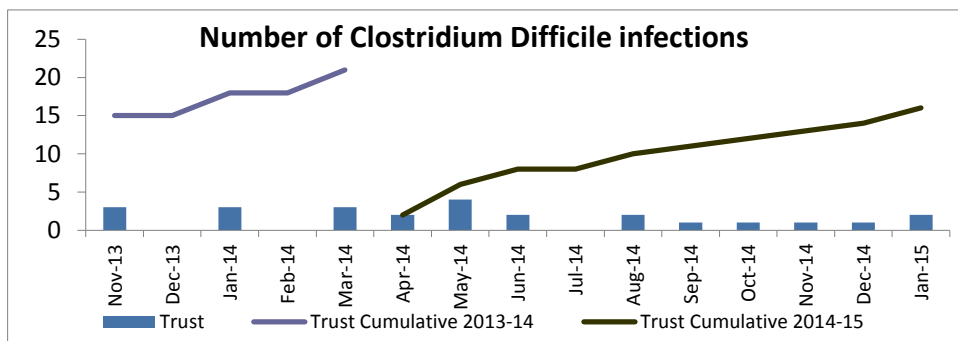
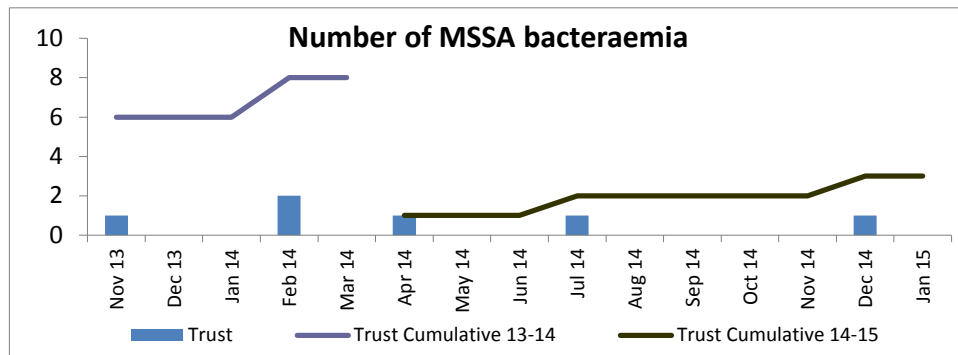
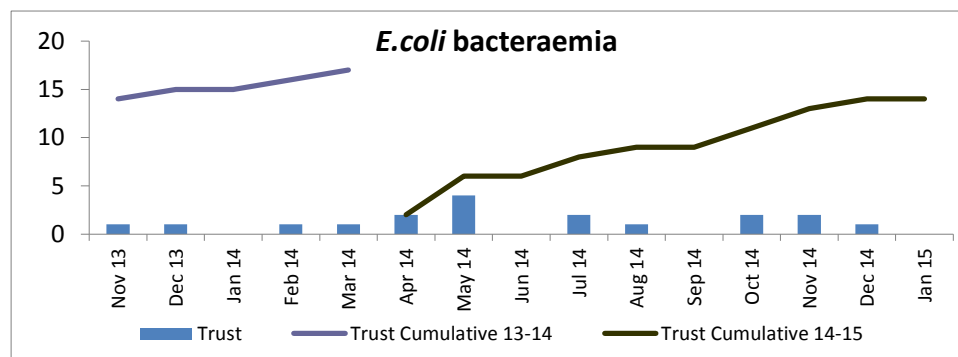
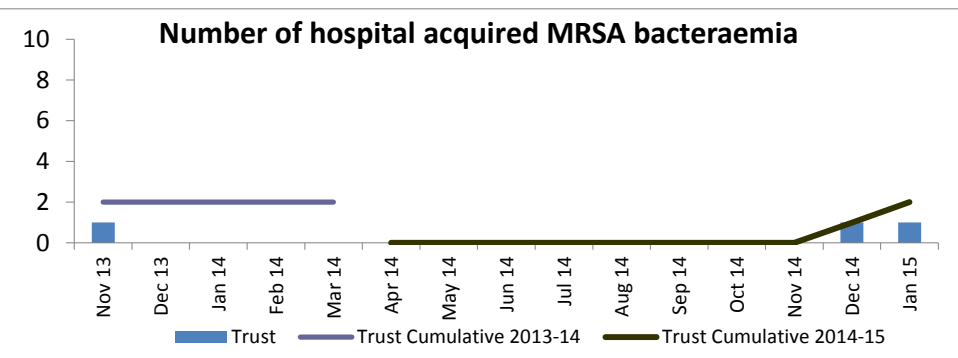
Timescale: On-going

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.



	Jan-15				
	Threshold	Trust Actual	ICAM	SCD	WCF
First:Follow-up ratio - acute	2.31	1.64	2.03	1.72	1.03
Theatre Utilisation	95%	75.3%	84.7%	74.7%	78.0%
Hospital Cancellations - acute - First Appointments	<2%	4.6%	5.5%	5.4%	2.9%
Hospital Cancellations - acute - Follow-up Appointments	<2%	7.0%	7.8%	8.7%	4.1%
DNA rates - acute - First appointments	8%	14.2%	18.6%	14.3%	10.6%
DNA rates - acute - Follow-up appointments	8%	13.6%	16.0%	14.6%	10.1%
Hospital Cancelled Operations	0	3	0	2	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 has dropped by 4%. WCF have transferred Gynea patients out to the community showing a drop in percentage. ICAM has investigated their utilisation of theatres for Pain patients and plans are in place showing a increase in percentage.

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.

Timescale: Immediate

Hospital Cancellations - acute

Issue: Cancellations for first appointment are steadily coming down, but follow -up appointments remain around 7%. Booking Team continue to identifying any unused clinic slots to pull patient appointments forward, this affects the percentage.

Action: Consultant leave is monitored closely.

Timescale: on-going

Did not attend

Issue: Overall 'Did not attend ' remains between 12 and 15%.

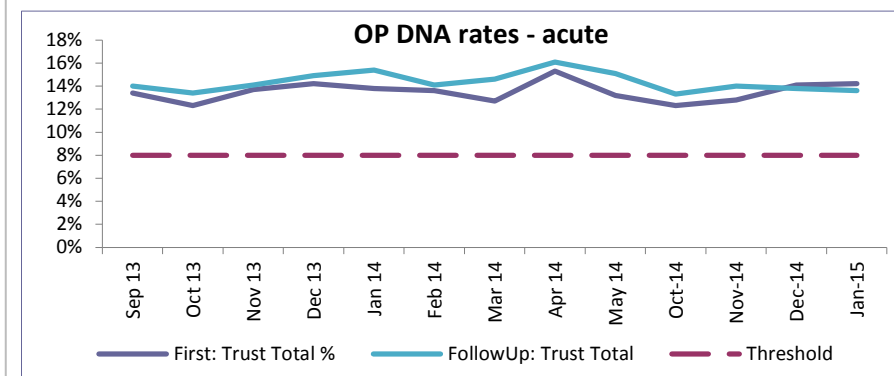
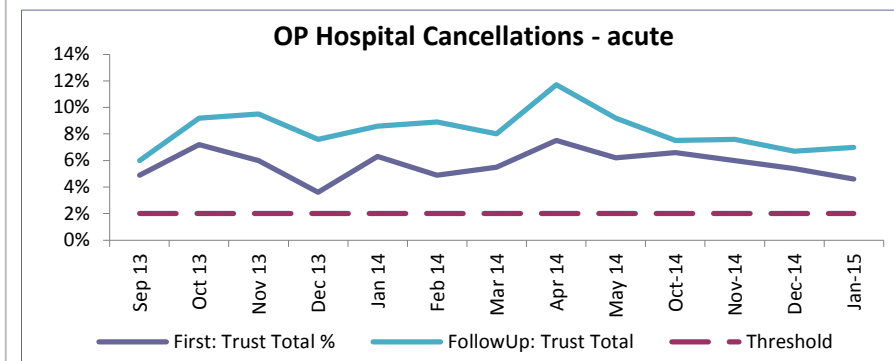
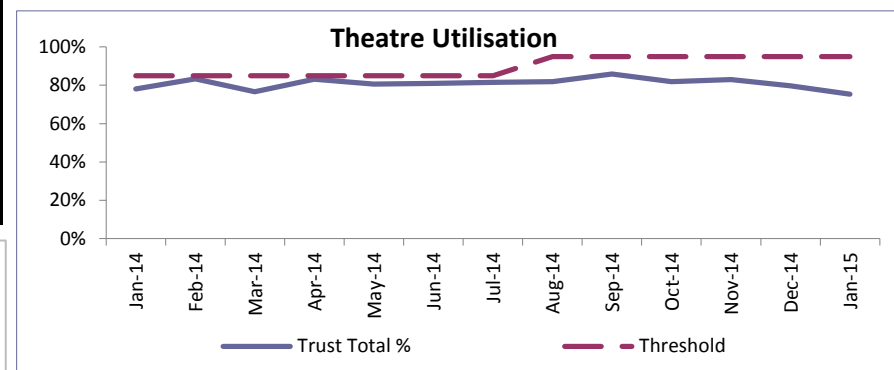
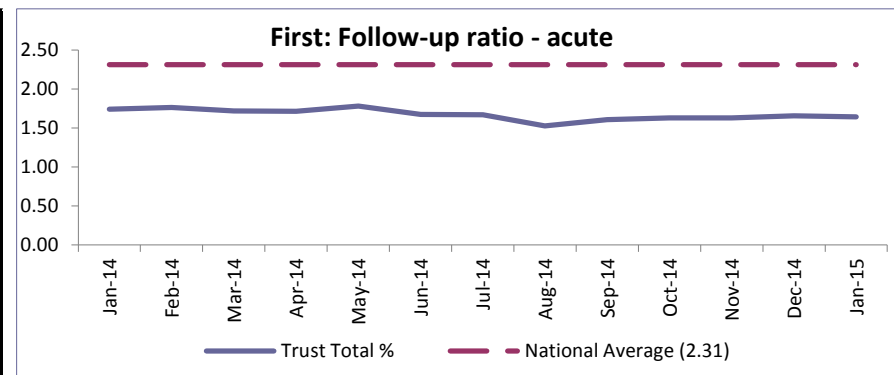
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment.

Timescale: Further reduction of DNA expected March 2015

Hospital Cancelled Operations

Issue: There were three cancellations in January due to non-clinical reasons, all patients were clinically categorised as routine. One was due to incomplete preparation of patient, one due to ward bed not available on ITU and one due to the surgeon being called to an emergency operation. All have been rebooked within the 28 day period.

Action: The Surgical board monitor cancellations.



	Jan-15				
	Threshold	Trust Actual	ICAM	SCD	WCF
Service Cancellations - Community	2%	7.9%	8.9%	6.0%	5.4%
DNA Rates - Community	10%	6.5%	6.4%	16.0%	6.9%
Community Face to Face Contacts	-	62,496	42,729	1,733	18,034
Community Appointment with no outcome	0.5%	1.6%	1.5%	0.0%	2.1%

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

Commentary

Service Cancellations - Community

Issue: Community service cancellation remain between 7 and 8% as work on the community waiting list continues.

Action: The improvement plan for waiting list management in the community continues and includes review of all templates and increase in filling unfilled late cancellations by patients.

Timescale: The threshold to be achieved after completion of additional capacity work in March 2015.

DNA Rates - Community

Community clinics - Achieved.

Community Dental DNA's is increasing . 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 decrease by 2.8 %, compared to the same month last year.

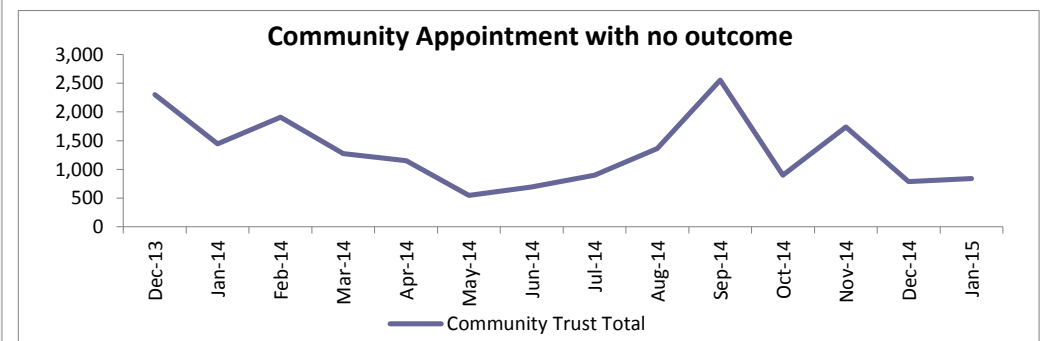
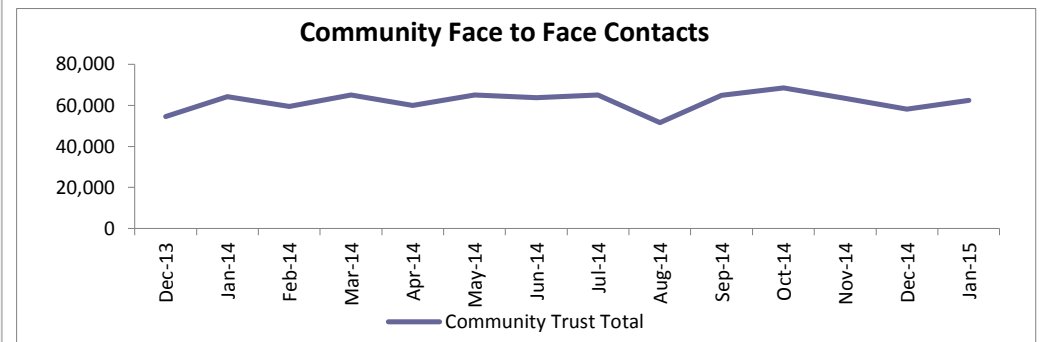
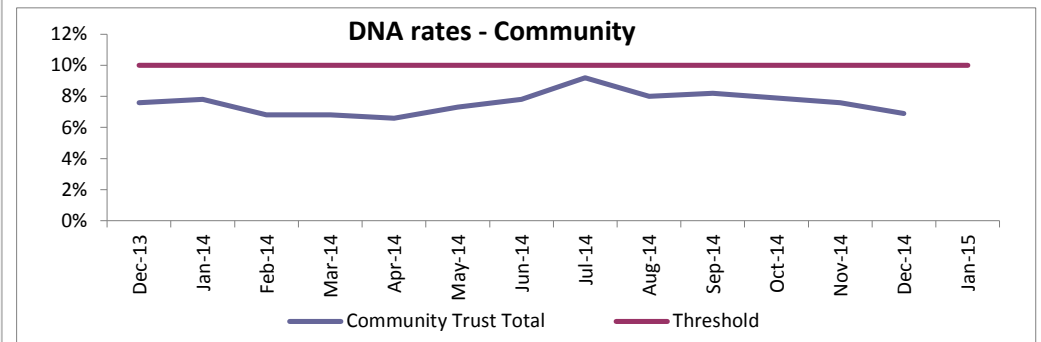
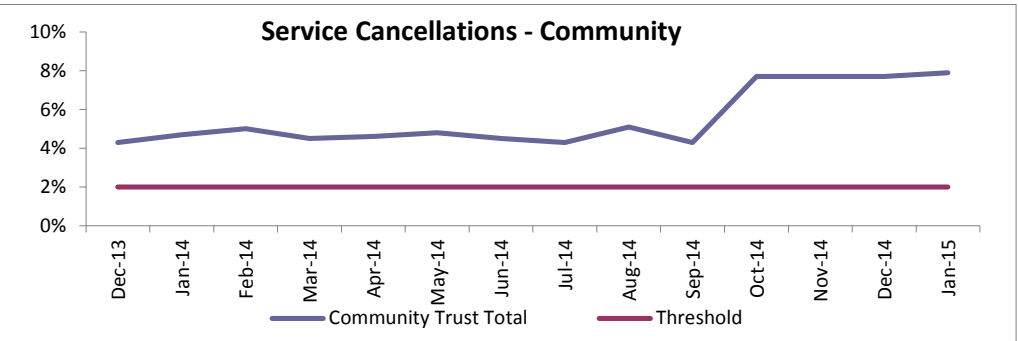
Community Appointment with no outcome

December data submission was completed before the final submission to the Secondary Uses Service (SUS). This is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Issue: Above the threshold. There is a delay in outcoming appointments but all are done by final SUS submission.

Action: Teams with high levels of un-outcomed appointments identified and processes to outcome appointments within 48 hours re-enforced. SUS submission discussed weekly at Patient Tracker List meeting.

Timescale: immediately



	Threshold	Trust Actual			YTD
		Nov-14	Dec-14	Jan-15	
Community Dental - Patient Involvement	90%	99.0%	98.0%	97.0%	n/a
Community Dental - Patient Experience	90%	99.0%	100.0%	100.0%	n/a
District Nursing Waiting Times - 2hrs assessment	-	100%	-	-	TBC
District Nursing Waiting Times - 48 hrs for visit	-	100%	-	-	TBC
MSK Waiting Times - Routine MSK (<6 weeks)	100%	85.1%	83.5%	97.2%	-
MSK Waiting Times - Consultant led (<18 weeks)	95%	89.1%	99.3%	arrears	90.6%
IAPT - patients moving to recovery	50%	47.0%	45.0%	arrears	-
GUM - Appointment within 2 days	100%	100.0%	100.0%	arrears	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: December and January data is being processed and is estimated to be 100%. Electronic process has been developed and are being tested.

Action: New process to be signed off by division.

Timescale: March 2015

MSK

Issue: Validating work is now completed and 18 weeks target is achieved. 6 weeks target for routine MSK appointments has also improved and is now within reach of achieving the target.

Action: Continued work on waiting list.

Timescale: Completed

IAPT

Issue: Under performing and the clinical measure of reliable recovery has gone down by 1% to 54%.

Action: An improvement plan is in place, closely monitored jointly with CCG Haringey including: Wait to first appointment on target, waiting list tails being successfully reduced through use of Crisis Concordant money, tight case management and clinical supervision, telephone consultations to increase patient engagement and creating a monthly performance report for Therapists, starting in February 2015

Timescale: Immediately

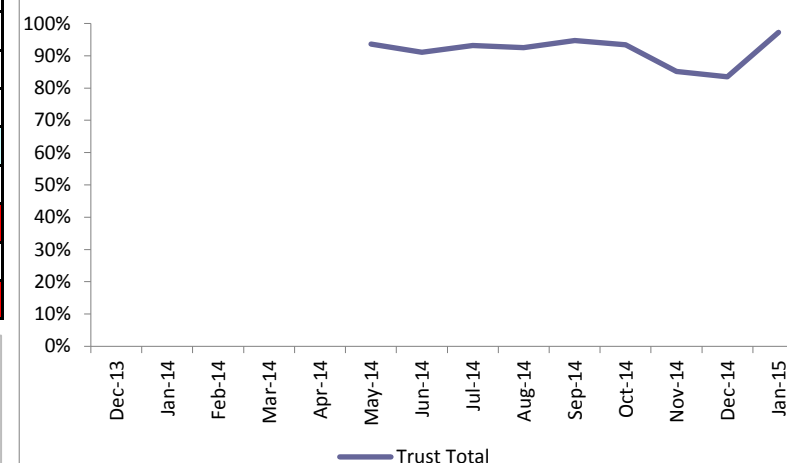
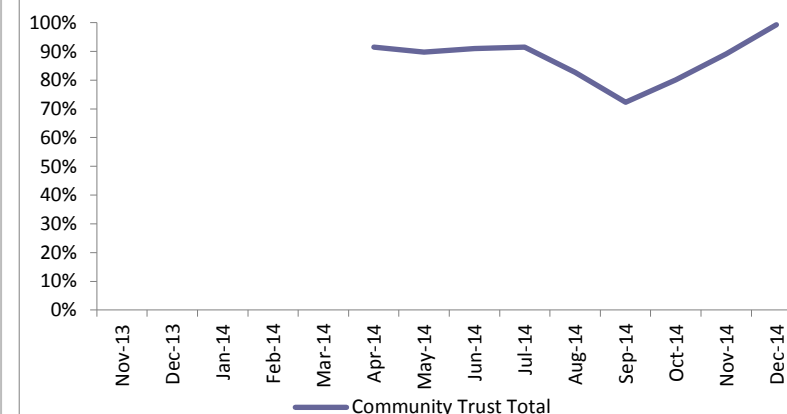
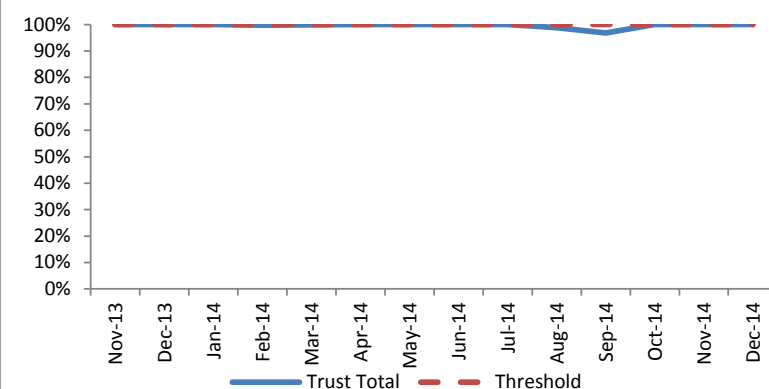
GUM

Achieved.

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

Over the last 6 months we have been increasing the number of community services reported in the dash board, by the end of March we hope to have all 12 services reported. the next services we are working on are listed below.

		Nov 14	Dec 14	Jan 15
Threshold		n/a		
Integrated Care and Acute Medicine	Haringey Adults Community Rehabilitation	54%	71%	61%
	Haringey Adults Podiatry (Foot Health)	57%	74%	64%
	Haringey Adults Tissue Viability Service	100%	100%	93%
	Islington Community Rehabilitation	93%	89%	85%
	Islington Intermediate Care	71%	66%	45%
	Islington Podiatry (Foot Health)	71%	64%	82%

Routine MSK (<6 week)**MSK waiting < 18 weeks****GUM - Appointment within 2 days**

	Dec-14 (arrears)				
	Threshold	Trust Actual	ICAM	SCD	WCF
Referral to Treatment 18 weeks - Admitted	90%	92.8%	-	92.0%	96.8%
Referral to Treatment 18 weeks - Non-admitted	95%	96.1%	97.2%	93.7%	98.6%
Referral to Treatment 18 weeks - Incomplete	92%	92.4%	93.5%	89.9%	99.4%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0
Diagnostic Waits	99%	99.7%	97.8%	99.2%	98.97%

Commentary

RTT

Achieved second consecutive month.

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 during January, February and March to decrease further waiting for patients.

Under performing areas monitored weekly in Patient Tracker List meeting. Weekly reporting to TDA also continues.

Diagnostic Waits

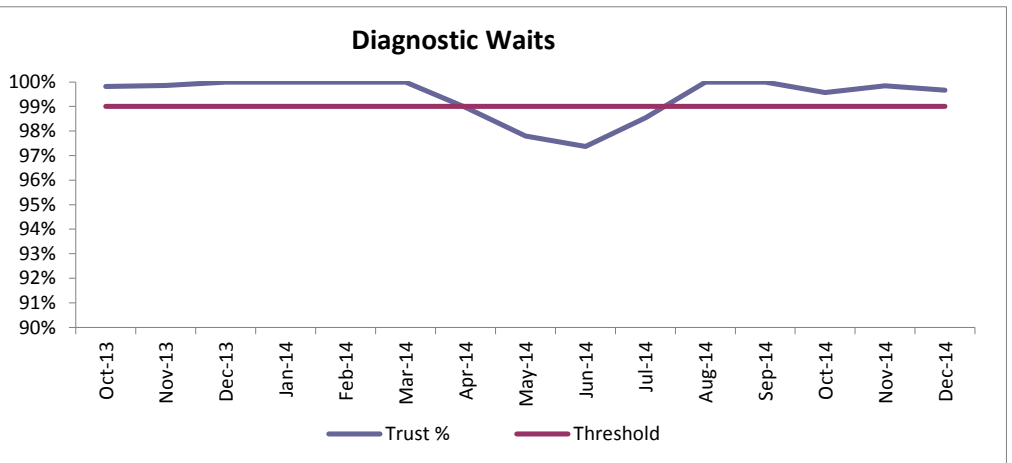
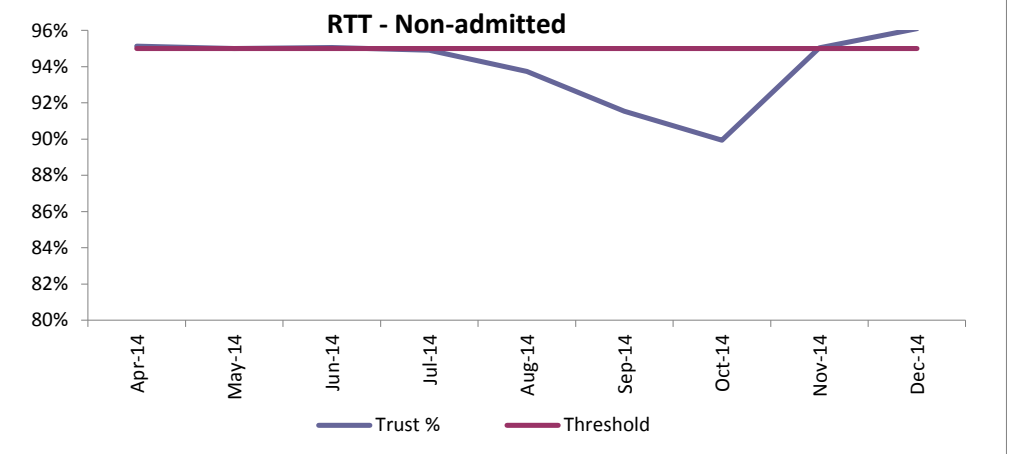
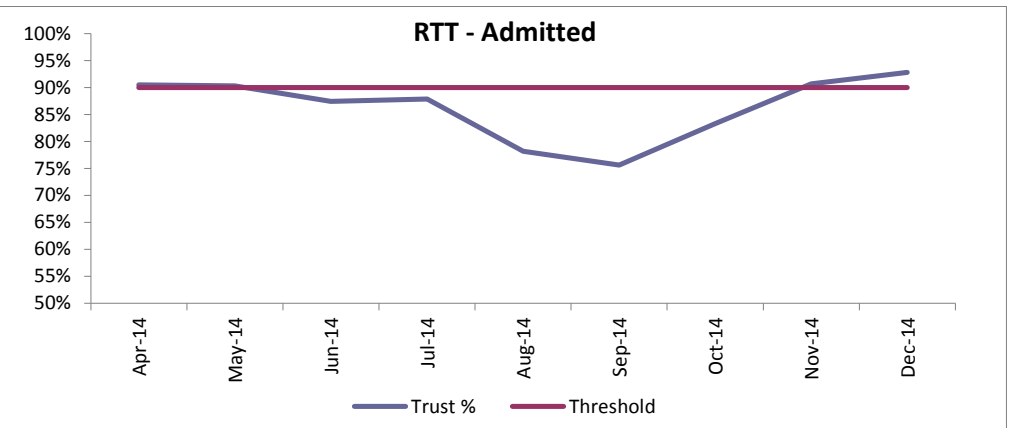
Target achieved. This included Audiology, Imaging, Neurophysiology and in/out patients.

Waiting times - OPD appointment

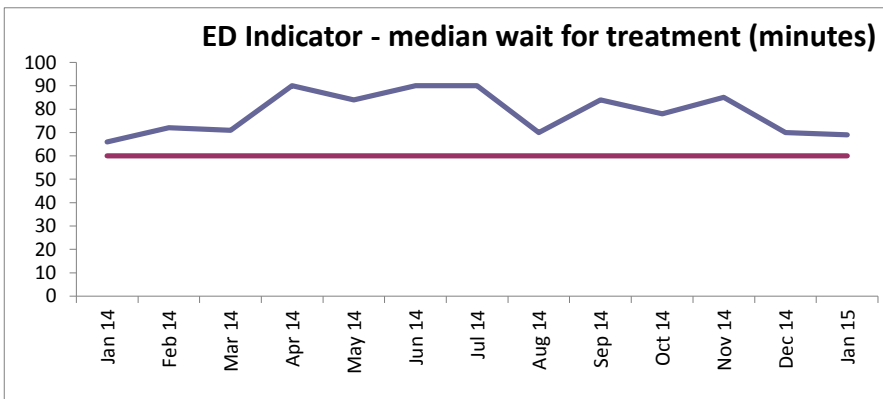
Cardiology 8 Weeks, Dermatology 12 Weeks , Endocrine 10 Weeks, ENT 7 Weeks, Gastroenterology 9 Weeks, General Surgery 7 Weeks , Gynaecology 10 Weeks, Neurology 10 Weeks, Pain 13 Weeks , Rheumatology 6 Weeks, Thoracic Medicine 12 Weeks, Urology 6 Weeks, Vascular 12 Weeks, Ophthalmology 5 Weeks

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

CT 18 days, MRI 19 days, Nuclear Medicine 18 days, DEXA 13 days, Fluoroscopy 25 days, Ultrasound (Gynae) 18days, Ultrasound General (Radiologist Lead) 14 days, Ultrasound Paediatrics 39 days, Ultrasound MSKs 33 days, Ultrasound Hernias 40 days, Ultrasound Obstetrics 29 days, Ultrasound Abdomen & Gynae at Hornsey General 20 days.



	Threshold	Trust Actual		YTD
		Dec-14	Jan-15	
Emergency Department waits (4 hrs wait)	95%	94.9%	94.5%	94.96%
Wait for assessment (minutes - 95th percentile)	<=15	17	15	15
ED Indicator - median wait for treatment (minutes)	60	70	69	80
Total Time in ED (minutes - 95th percentile)	<=240	265	307	255
ED Indicator - % Left Without Being seen	<=5%	3.9%	4.0%	5.4%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	16	7	57
Ambulance handovers exceeding 60 minutes	0	0	0	0



Commentary

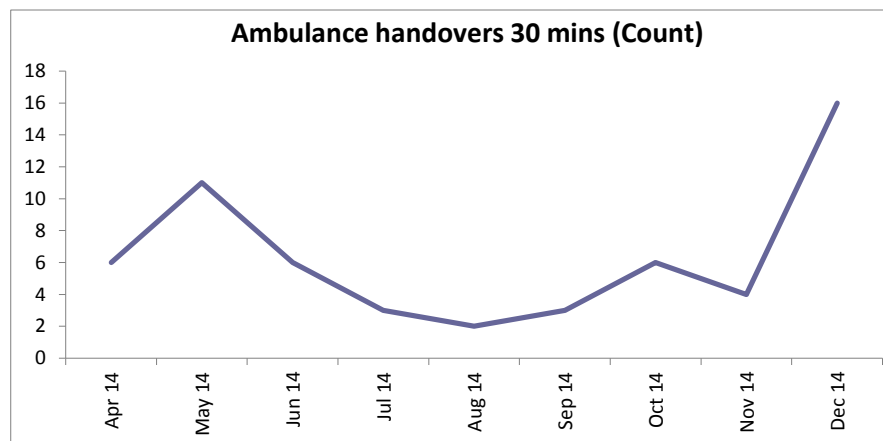
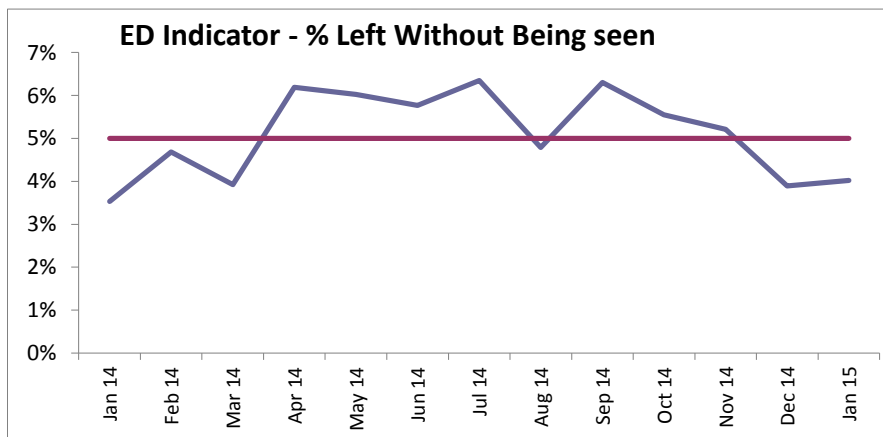
The high pressure for inpatient care as stated in December continued into January, this affected the flow within ED. However the initial assessment time and time to treatment indicators both improved in January. the additional capacity to support emergency and urgent care where all in place and included; additional inpatient beds, evening GP, extended hours of consultant cover, increased district nursing, additional middle grade medical staff and increased staffing in the access team.

All procedures for maintaining quality on going care for patients within the ED have been followed including pressure care, nutrition etc.

The data for London emergency and urgent care services shows that the Whittington has remained in the upper quartile high performing Trusts.

Monitoring of the ED Paediatrics flows has also shown that improvements have been seen in December and January. this was due to agreed investment in paediatric medical staffing each evening.

	Threshold	WCF			
		Nov-14	Dec-14	Jan-15	YTD
Emergency Department waits (4 hrs wait) Paeds only	95%	93.0%	96.4%	98.1%	96.4%



	Threshold	Trust Actual	Dec-14			2014/15				
			ICAM	SCD	WCF	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.7%	83.3%	94.6%	100.0%	89.3%	89.4%	93.9%		90.6%
Cancer - 14 days to first seen - breast symptomatic	93%	94.4%	-	94.4%	-	83.7%	93.1%	95.2%		89.8%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%	-	100.0%	100.0%	98.6%		99.7%
Cancer - 31 days to subsequent treatment - surgery	94%	-	-	-	-	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%	88.2%	75.0%	96.0%	-	91.5%	88.9%	90.6%		90.9%
Cancer - 62 days from consultant upgrade	-	100%	-	-	100%	75%	73%	33%		69%

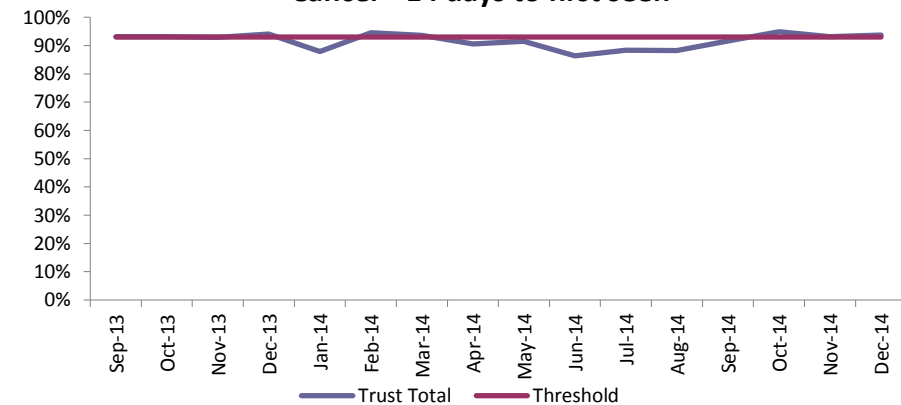
Commentary

All cancer targets were achieved this month and QRT 3 standards all achieved.

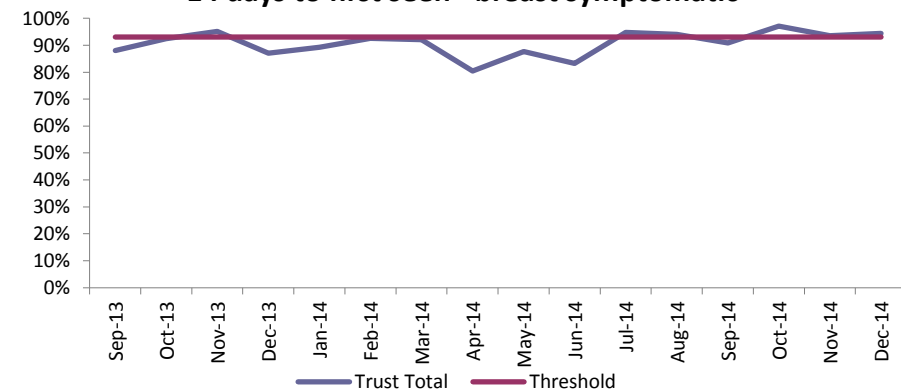
The Cancer Patients tracking list is monitored daily and discussed in the weekly

Whittington Health also proved support to other trust who needed additional capacity. All these patients have been treated and no further patients have been transferred.

Cancer - 14 days to first seen



14 days to first seen - breast symptomatic



	Threshold	Trust Actual			YTD
		Nov-14	Dec-14	Jan-15	
Women seen by HCP or midwife within 12 weeks and 6 days	90%	92.4%	85.7%	80.7%	86.7%
New Birth Visits - Haringey	95%	85.0%	83.5%	Arrears	88.2%
New Birth Visits - Islington	95%	91.4%	88.7%	Arrears	91.1%
Elective Caesarean Section rate	14.80%	13.7%	12.9%	15.2%	11.4%
Emergency Caesarean Section rate	-	17.5%	16.9%	15.9%	19%
Breastfeeding initiated	90%	88.7%	92.2%	88.6%	90.5%
Smoking at Delivery	<6%	4.9%	4.9%	5.4%	5.2%

Commentary

Women seen by HCP or midwife within 12 weeks and 6 days

Whittington Hospital Maternity department received 300+ additional self-referrals in January and so far 150 for February. Not all woman were at an early stage of pregnancy.

Issue: The additional referrals have placed additional demand on Midwives, the overall performance of 12+6 as not all woman eligible could be accommodated within this time. This has also placed high demand on sonography department i- additional capacity is being planned.

Action: All woman were called by a qualified midwife to arrange an appointment and any issues with the pregnancies were discussed. Further information about our services, for example our website and the Women's Diagnostic Unit (WDU) facilities were given.

Timescale: Feedback March 2015

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 which aims to 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: Under target. A number of women choose not to breastfeed.

Action: All breastfeeding support is in place on the wards. Work towards Level 3 Unicef Breastfeeding initiative now started.

Timescale: On-going

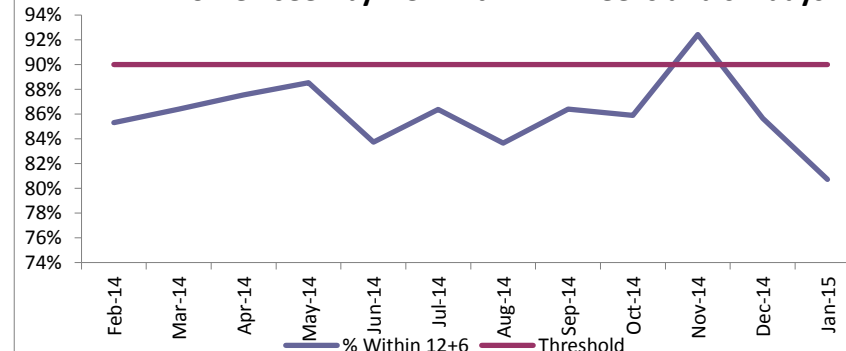
Smoking:

Achieved

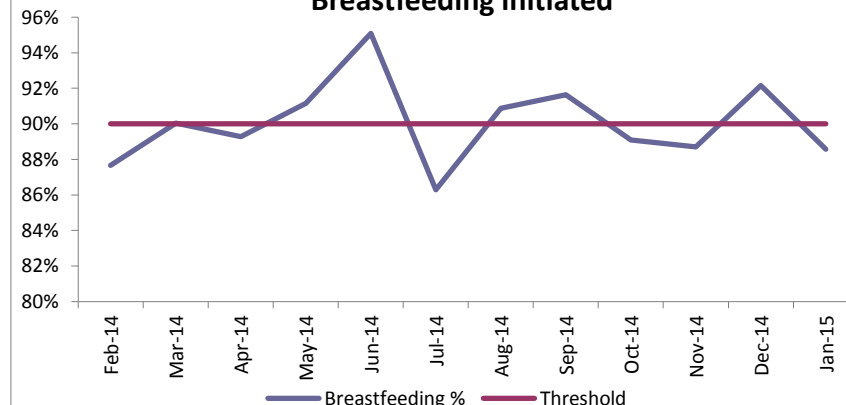
Action: Funding for carbon monoxide screening during antenatal period has been secured.

Timescale: On-going

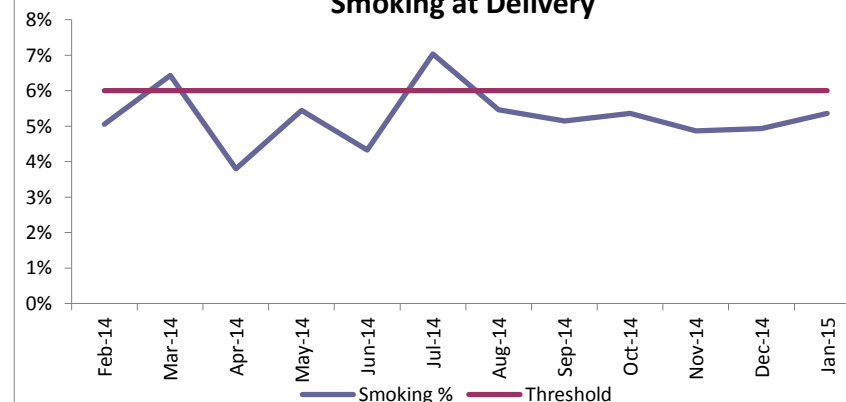
Women seen by HCP within 12 weeks and six days



Breastfeeding initiated



Smoking at Delivery



Whittington Health Trust Board

March 4th 2015

Title:	Dashboard Performance Workforce report January 2015.
Action requested:	For noting.
Executive Summary:	<p>Background The monthly dashboard as it refers to the workforce KPI's is a standard report and part of the Performance Dashboard report.</p> <p>Highlights this month:</p> <p>Headcount In total, actual worked whole time equivalent posts has increased by 29 from 4,388 in December to 4,417 in January 2015.</p> <p>Turnover Turnover figures this month are marginally lower than the previous month. In particular the figure for ICAM has decreased as a result of interventions by the management team to address staff retention.</p> <p>Vacancy rates Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis and posts that remain vacant are being scrutinised to assess whether they can be permanently deleted from the establishment.</p> <p>Sickness Sickness rates are at 2.8% 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 relative high Bradford scores. The Trust Management Group has agreed to assign a bespoke resource in the Facilities Directorate. In conjunction with HR the resource over 12 months will support managers in delivering better performance which will reduce the overall sickness rates and tackle the highest Bradford scores. In turn this will reduce occupational sick pay, overtime expenditure and bank and agency usage. If successful this resource will be targeted at other services where sickness rates are high.</p> <p>Overtime Overtime figures have increased on last month in Corporate</p>

	<p>services but decreased in SCD and WCF.</p> <p>Bank and Agency This month, the bank and agency project tables (consisting of 4 work streams) are included up to month 9. This shows the direction of travel to reduce agency usage to fill vacancies with substantive employees and to use the bank flexibly. Despite an increase in agency expenditure on last month, the average agency expenditure for the last 3 months is £1.096m (November to December 2014). This is £45k lower than the 3 month average (October to December 2014), of £1.141m.</p> <p>Appraisal The appraisal figures show no change from last month. At 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 % increases and review the position month by month. This is a key priority for SCD in particular.</p> <p>Mandatory Training There is a 2% 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 and in particular by quarter two. Notwithstanding that, the Audit and Risk Committee were informed at their last meeting that the Executive will be redoubling their efforts through corporate initiatives and setting up a steering and working group to give senior management direction. The Audit and Risk Committee have requested a further report at the March meeting.</p> <p>Benchmark Comparisons It was reported at the last Trust Board that steps had been taken to join a benchmark network and the report in January included initial comparisons with other Trusts on staffing levels. As a result of our work, the London HR network are surveying all Trusts in the network which represents the majority of London Trusts to benchmark standard KPI's namely sickness, turnover, mandatory training and appraisal rates etc. Once those results are available they will be reported to the Trust Board. Benchmarking with other Trusts outside London will be our next priority.</p>
Summary of recommendations:	To note the report and the progress being made in key areas to increase compliance rates and benchmark with other Trusts.
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:		25 February 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?	



Workforce	Trust									
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Starting Point for Workforce 14/15	4,403	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)	(126)
Contract Additions	4	15	12	17	22	34	46	54	58	65
Total	4	(3)	(34)	(45)	(52)	(31)	(65)	(65)	(61)	(62)
Revised Workforce Plan	4,407	4,399	4,369	4,358	4,351	4,372	4,338	4,338	4,342	4,342
Headcount wte Total	4,404	4,397	4,366	4,398	4,429	4,374	4,383	4,414	4,388	4,417
Variance to Revised Plan	3	3	2	(41)	(78)	(2)	(45)	(76)	(46)	(69)

The actual whole time equivalent posts have increased by 29 (from 4,388 in December to 4,417 in January).

The key movements in staffing levels are in Nursing and Midwifery which has increased over this period, due to the exceptional demands placed on front line services as experienced by most Trusts. The figures include additional winter planning staff to cover resilience one, two and three plans as a result of the impact of winter pressures as at January 2015. The work on vacancies management (please refer to the section on vacancies) and the robust review of all vacant posts for advert through the vacancy scrutiny panel continues with non clinical posts in particular being held.

Management of the workforce	Threshold	Trust								
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Dec-14	Jan-15
Trust Turnover Rate	<13%	15.1%	14.1%	14.0%	13.9%	13.7%	13.4%	13.8%	13.9%	13.4%
Total trust vacancy rate	<13%	13.4%	14.2%	14.3%	14.1%	14.1%	13.2%	13.3%	13.2%	11.1%
Sickness rates	<3%	2.7%	2.6%	2.8%	2.8%	2.8%	2.6%	3.2%	2.9%	2.8%
Overtime wte	75	123	118	113	94	113	99.66	92.05	85.34	88.99
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	51,754.53
Bank Hours expenditure	-	1,523	1,580	1,519	1,402	1,602	1,472	1,546	1,437	1,478
Agency Hours expenditure *	1m	1,426	1,184	1,491	1,457	1,200	1,210	1,254	1,007	1,155

*bank expenditure will fluctuate as agency expenditure reduces

Development of the workforce	Threshold	Trust								
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Dec-14	Jan-15
Appraisal	90%	43%	40%	39%	45%	51%	55%	58%	60%	60%
Mandatory Training	90%	75%	77%	76%	76%	75%	73%	66%	66%	68%

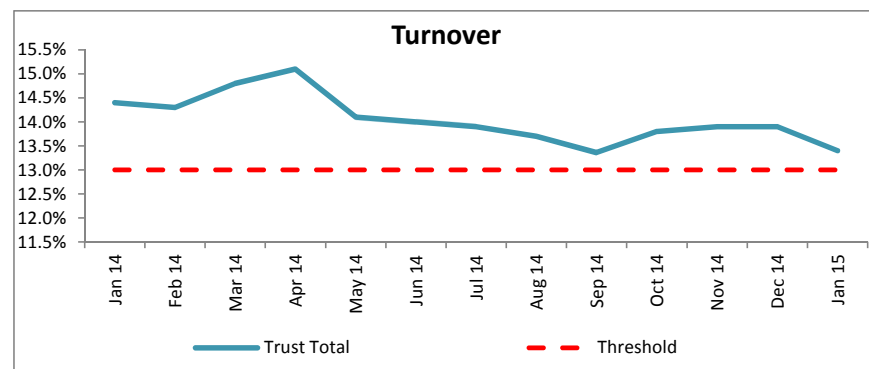
Staff FFT Results		Trust	
		Q1	Q2
Staff who would recommend the trust as a place to work	-	62%	59%
Staff who would recommend the trust as a place for treatment	-	74%	74%

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

	January 2015					
	Threshold	Trust	ICAM	SCD	WCF	CORP
Trust Turnover Rate	<13%	13.4%	17.8%	9.9%	12.0%	11.6%
Total trust vacancy rate	<13%	11.1%	5.2%	8.8%	5.6%	13.0%
Trust level total sickness rate	<3%	2.8%	2.5%	2.9%	2.5%	4.0%

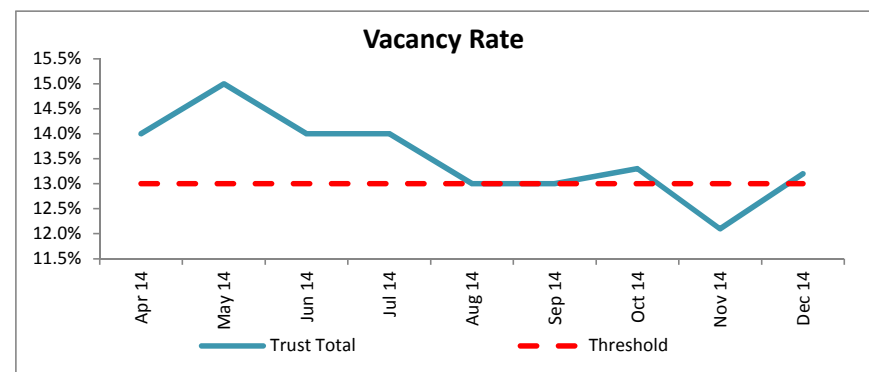
Turnover rate

ICAM figures remain high but this month is showing a decrease of up to 2% . The Director of ICAM is now implementing a retention plan to address high turnover.



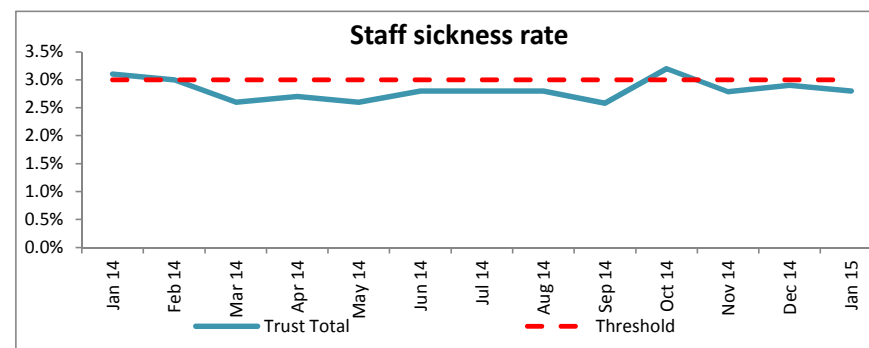
Vacancy Rates

Vacancy rates are linked to turnover and the high level of vacancies in Corporate Services is subject to a "deep dive" analysis and posts that remain vacant for 6 months are being scrutinised to assess whether they can be permanently deleted from the establishment.



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.



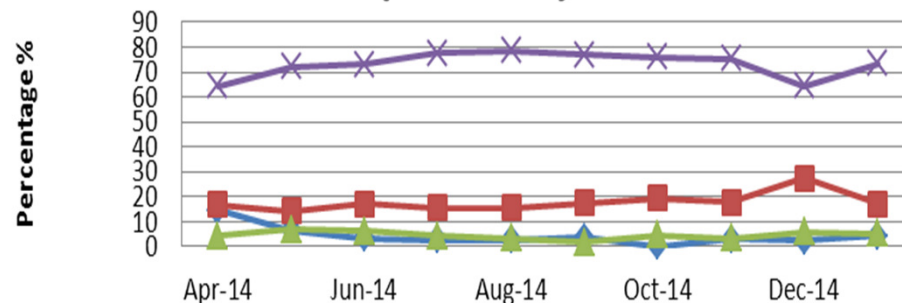
Overtime expenditure

	January 2015					
	Trust		ICAM	SCD	WCF	CORP
Overtime cost	£51,754.53		£2,147.72	£8,935.64	£2,728.05	£37,943.12

Overtime

For the month of January there was a decrease in SCD and WCF expenditure, however ICAM and Corporate both had an increase. The increase in overtime in the Facilities service is mostly attributable to the provision of the Estates out of hours service (24/7 on site service). This service has recently undergone a review, with TMG agreeing that the current model should remain 'as is' as the benefit of providing such service outweighed the costs.

Overtime spend % by Div Jan15



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
ICAM	14.45	6.63	3.39	2.81	2.82	3.79	0.12	3.15	2.42	4.15
SCD	16.92	14.25	17.04	15.44	15.44	17.60	19.26	17.88	27.4	17.26
WCF	4.31	6.96	6.34	4.30	3.17	1.78	4.56	3.45	5.74	5.27
CORP	64.32	72.16	73.23	77.45	78.57	76.83	76.06	75.51	64.4	73.31

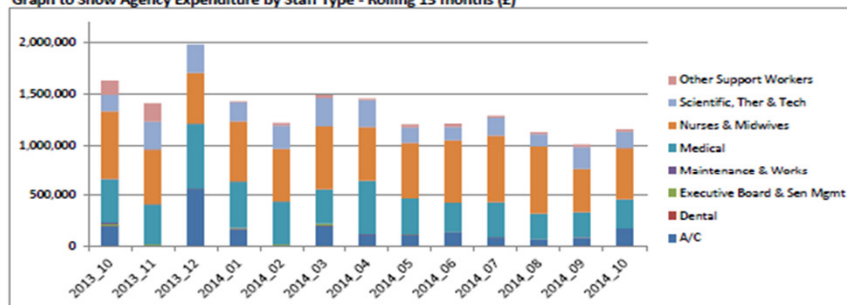
Bank and Agency wte usage and expenditure

Trust Overall Agency Report - Month 10

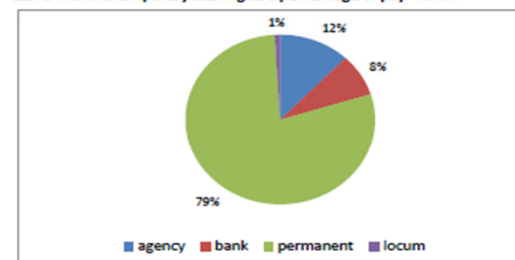
Table to Show Agency Expenditure by Division - Rolling 13 months

Month	ICAM	SCD	WCF	Corporate	Grand Total
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	£2,158,212
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
2014_10	£679,535	£105,499	£175,028	£195,275	£1,155,337
Grand Total	£10,618,467	£1,846,814	£2,770,614	£1,233,269	£16,469,164
Last 12 Months	£9,775,323	£1,649,435	£2,521,718	£892,010	£14,838,487

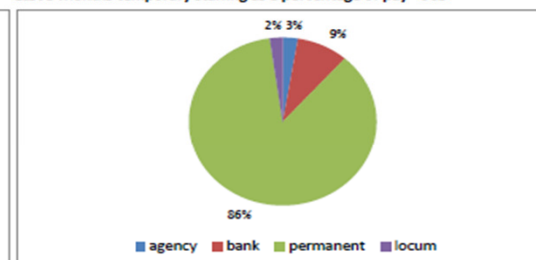
Graph to Show Agency Expenditure by Staff Type - Rolling 13 months (£)



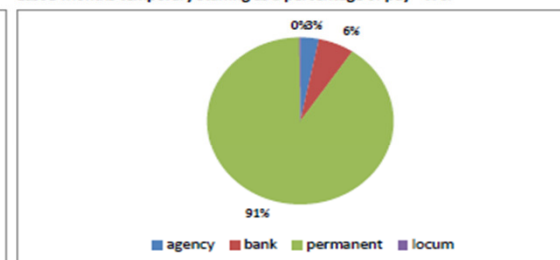
Last 3 Months temporary staffing as a percentage of pay - ICAM



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



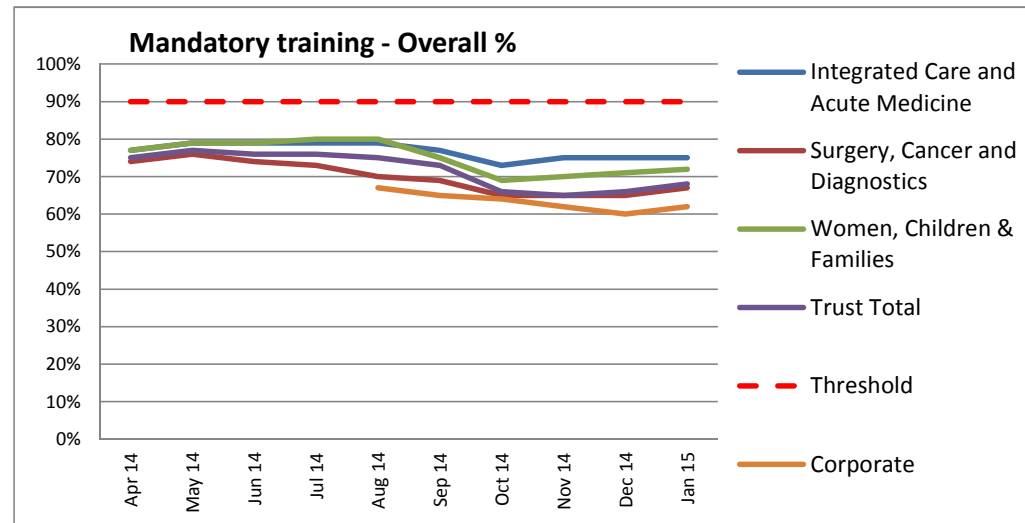
Last 3 Months temporary staffing as a percentage of pay - WCF



	January 2015					
	Threshold	Trust Actual	ICAM	SCD	WCF	CORP
Percentage of staff with mandatory training compliance	90%	68%	75%	67%	72%	62%
Percentage of staff with annual appraisal	90%	60%	71%	40%	63%	58%

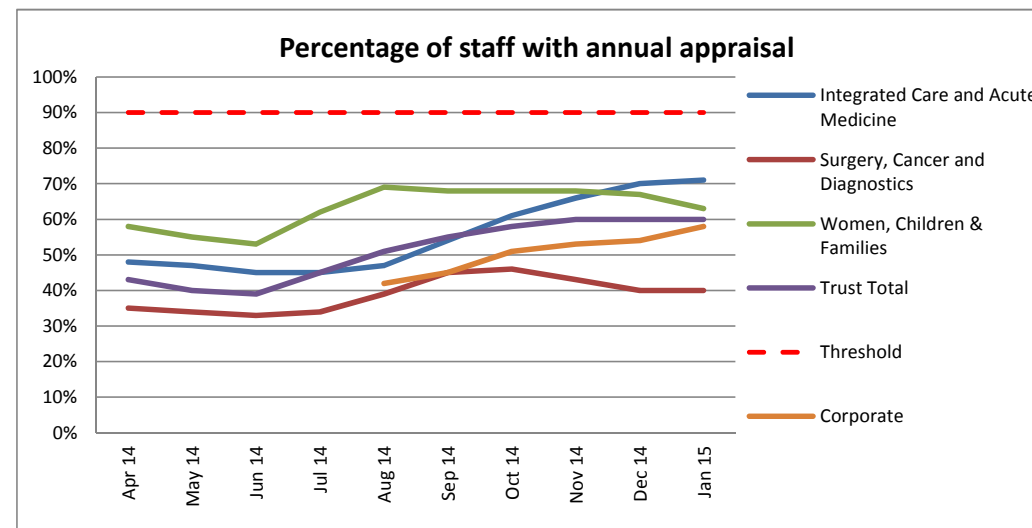
Mandatory training

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 TMG has received a report at its last meeting recommending further action to improve compliance rates. As a result, each Director has been tasked with forecasting significant improvements in compliance rates by quarter two.



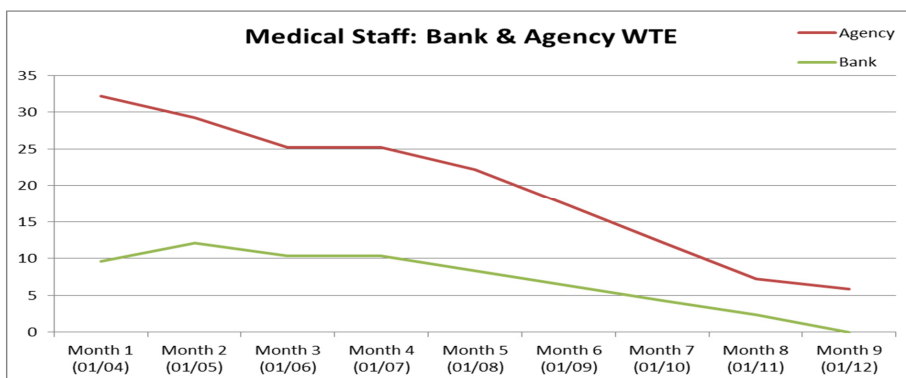
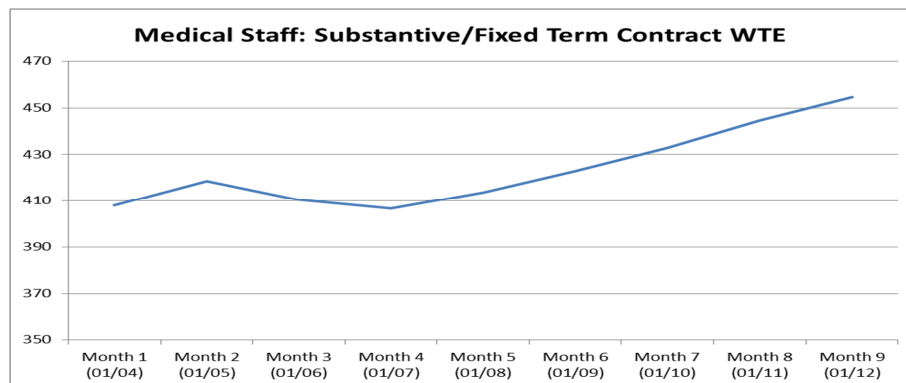
Appraisal

The overall rate remains the same as last month. The implementation of action plans for both Corporate and the divisions remains a priority.

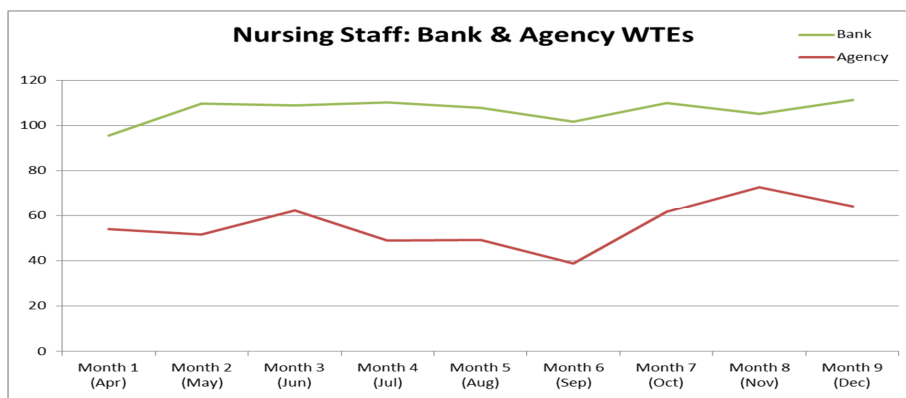
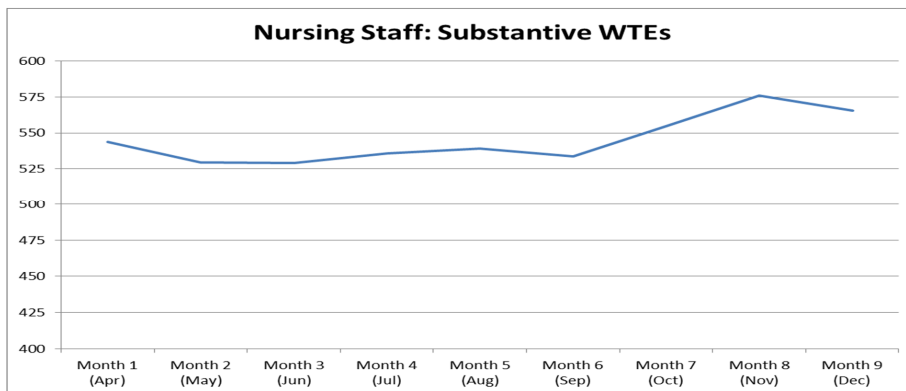


Bank & Agency Project

A. Medical Staff

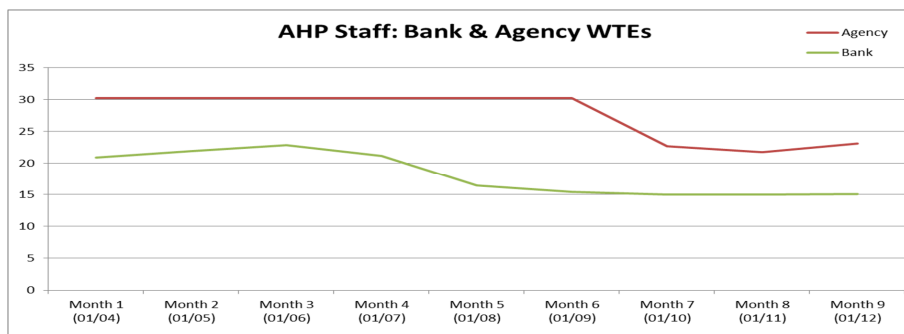
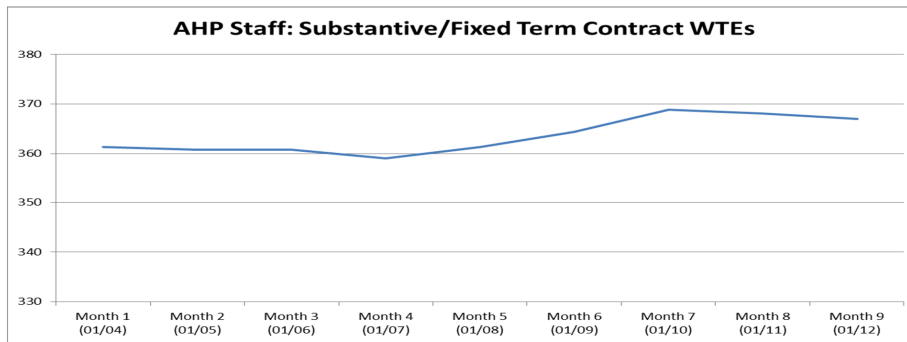


B. Nursing Staff

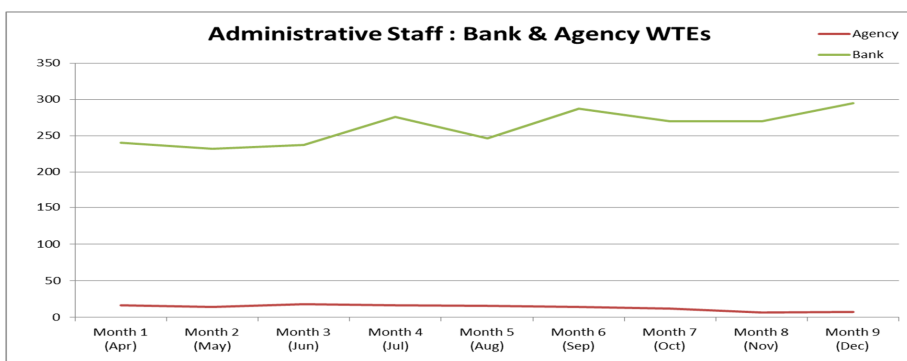
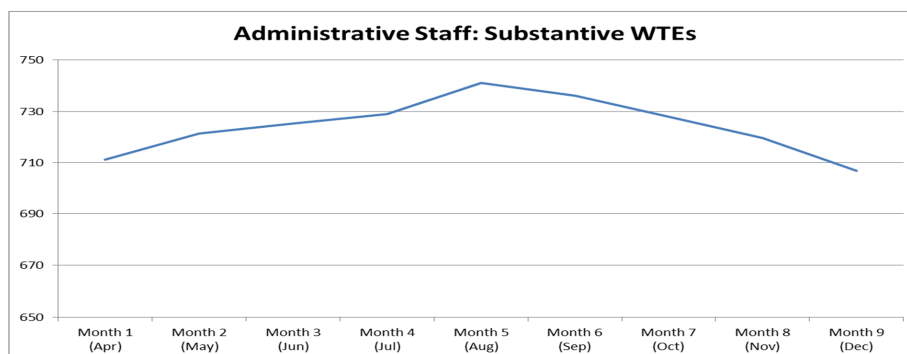


Note: The winter establishment for nursing is an extra 32 WTE.

C. AHP Staff



D. Administrative Staff



Trust Board
04th March 2015

Title:	2014/15 Finance Report - December (Month 10)					
Agenda item:	15/040		Paper		7	
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 January 2015.					
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:	19th February 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 10 Finance Report - Executive Summary

The in-month position is a £0.3m surplus against a planned surplus of £0.2k, a favourable variance of £0.1m. The year to date (YTD) position is a £5.83m deficit against a planned deficit of £0.06m, an adverse variance of £5.77m. The adverse variance is driven by expenditure pressures, mainly in pay.

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

Income

The income position is £1.4m favourable in month and £1.7m favourable YTD. The favourable position in month is driven by an additional £2m CCG income (£4m contract variation in total). This second tranche is phased over the last 3 months of the financial year and it is this income that drives the in month over performance.

The Trust is continues to seek 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 £1.7m adverse in month and £7.1m adverse YTD. The major expenditure challenges remain in the Integrated Care and Acute Medicine (ICAM) and Surgery, Cancer and Diagnostics (SCD) Divisions.

Pay is £0.7m adverse in month and £3.7m adverse YTD. This is partly driven by additional activity, but nursing and medical overspends continue in ICAM largely due to high agency spend. Non Pay is £0.3m adverse in month and £1.9m adverse YTD. This is mainly activity related.

Further expenditure reductions are being developed.

The monthly position has resulted in the EBITDA margin of 6.6%, which is below the target of 6.78%. 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 £7.1m against a plan of £11.9m (60%). There are plans to deliver £9.1m in total for 2014/15 (60% of the target for the year). The divisions continue to look for further opportunities to close the gap to plan.

Cash and Capital

Cash increased by in month to £7.0m in anticipation of the repayment of temporary PDC in February. The Trust needs to ensure that the CIP plan is achieved and produces cash releasing savings and also that activity is efficiently coded and counted in order to ensure all activity is paid for. The capital programme is on track.

Statement of Comprehensive Income	Full Year	January			YTD		
	Budget (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)	Budget (£'000)	Actuals (£'000)	Variance (£'000)
Nhs Clinical Income	246,955	20,613	21,312	699	205,780	205,345	(434)
Non-Nhs Clinical Income	16,332	1,380	1,500	120	13,639	14,415	775
Other Non-Patient Income	26,176	2,217	2,769	552	21,657	22,954	1,316
Total Income	289,464	24,210	25,581	1,371	241,076	242,714	1,657
Non-Pay	69,880	5,849	6,136	(287)	58,110	60,011	(1,901)
Pay	206,047	17,008	17,754	(746)	171,956	175,628	(3,672)
Savings	(3,303)	(275)	0	(275)	(2,752)	0	(2,752)
Total Expenditure	272,624	22,582	23,890	(1,308)	227,314	235,639	(8,325)
EBITDA	16,840	1,628	1,691	63	13,762	7,075	(6,688)
EBITDA %	5.82%	6.72%	6.61%	-0.11%	5.71%	2.91%	-2.79%
Interest Payable	2,820	235	240	(5)	2,350	2,376	(26)
Interest Receivable	30	3	1	(2)	25	20	(5)
Depreciation	9,724	810	628	182	8,103	8,244	(140)
Dividends Payable	4,326	361	488	(127)	3,605	3,620	(15)
Donated Asset Additions	0	0	0	0	0	19	19
Net Surplus / (Deficit) - before IFRIC 12 adjustments	(0)	225	336	111	(271)	(7,126)	(6,855)
Add back impairments and adjust for IFRS & donated assets	285	24	7	(17)	214	1,295	1,081
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	285	248	343	94	(57)	(5,831)	(5,774)
<i>Previous Month</i> : adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	285	617	480	(137)	(282)	(6,173)	(5,892)
Movement from Month 9 to Month 10 (+ve(Green) is Favourable)	0	(369)	(138)	231	225	343	118

Whittington Health Cost Improvement Programme Report - Month 10

	Annual Plan £'000	January				YTD				Forecast			
		Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Fcst £'000	% achieved	Var £'000
ICAM	1,768	166	441	265%	275	1,435	913	64%	(523)	1,768	1,330	75%	(438)
SCD	1,179	113	60	53%	(53)	959	482	50%	(477)	1,179	623	53%	(556)
WCF	1,299	108	36	33%	(72)	1,082	374	35%	(709)	1,299	498	38%	(801)
Corporate	1,519	132	154	117%	22	1,256	1,170	93%	(86)	1,519	1,570	103%	51
Total Divisional Schemes	5,764	519	691	133%	172	4,732	2,938	62%	(1,794)	5,764	4,021	70%	(1,743)
Productivity & Efficiency	5,347	469	388	83%	(82)	4,409	1,171	27%	(3,238)	5,347	1,599	30%	(3,748)
VIPs	3,388	510	33	6%	(477)	2,368	169	7%	(2,199)	3,388	313	9%	(3,075)
Total Productivity & Efficiency and Transformational Schemes	8,735	979	420	43%	(559)	6,776	1,339	20%	(5,437)	8,735	1,912	22%	(6,823)
Non Recurrent Benefits	500	42	42	100%	0	417	417	100%	0	500	500	100%	0
Non Recurrent Under Spends	0	0	138		138	0	2,430		2,430	0	2,630		2,630
Total Non Recurrent Items	500	42	179		138	417	2,847		2,430	500	3,130		2,630
Total delivery against planned schemes	15,000	1,540	1,291	84%	(249)	11,925	7,124	60%	(4,801)	15,000	9,064	60%	(5,936)

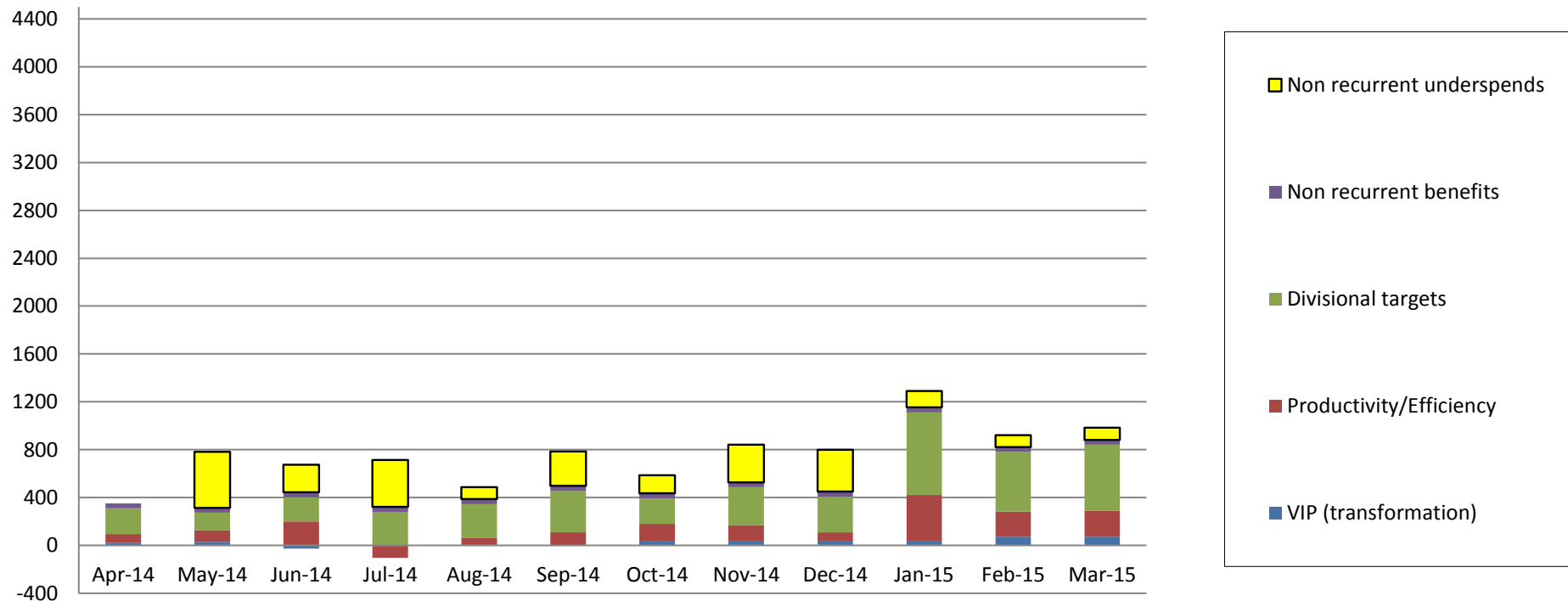
Month 10 CIP Summary

The CIP delivery underperformance YTD has continued into month 10.

In month 10 £1,291k (84%) CIP delivery was achieved compared to a plan of £1,540k. This includes a benefit from non recurrent underspends of £138k. The month position was improved with the TB income of £369k.

YTD delivery is £7,124k (60%) compared to a YTD target of £11,925k. YTD delivery includes a benefit from non recurrent underspends of £2,430k.

CIP performance to January, Forecast February - March



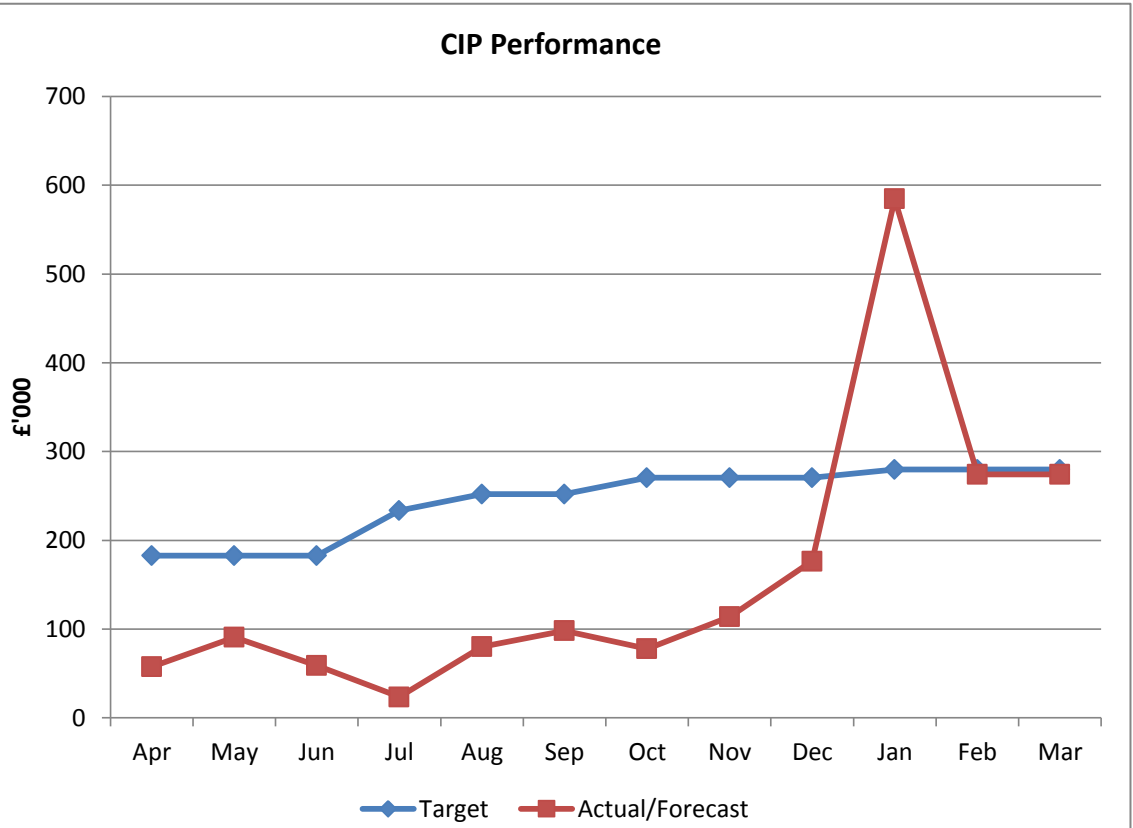
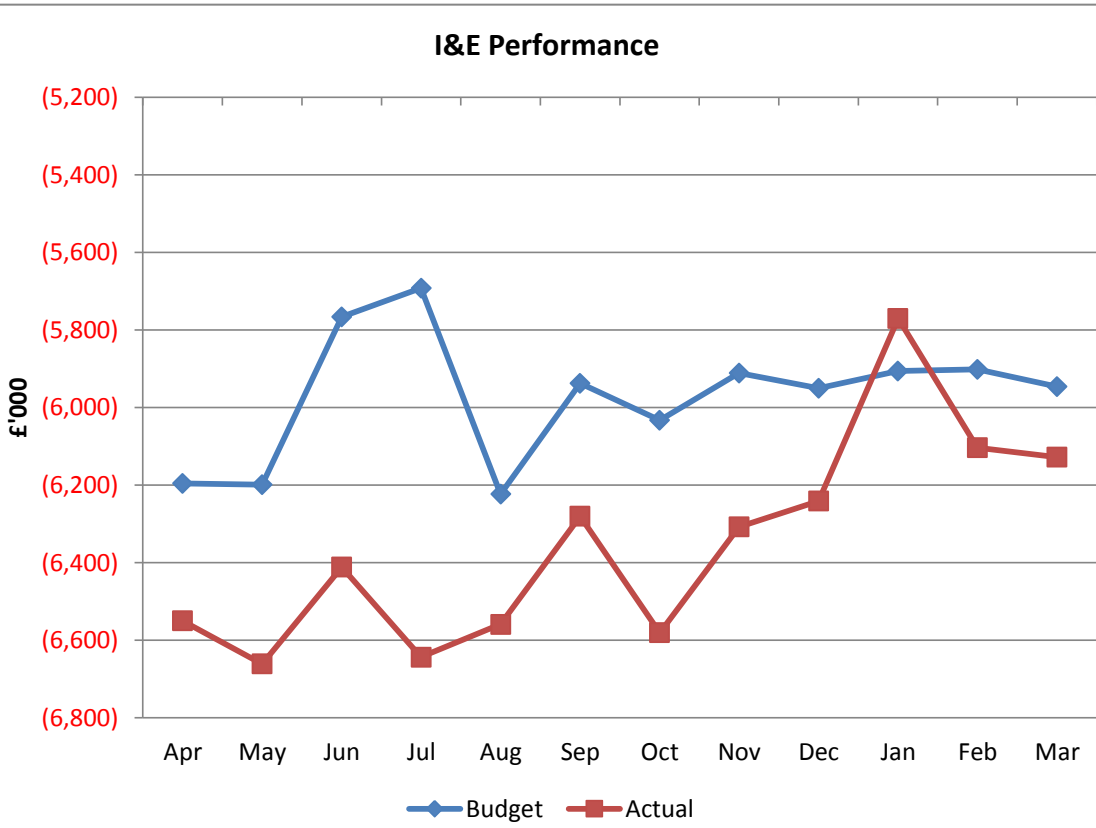
The divisional schemes are forecasting £4,021k delivery (70%) against the target of £5,764k.

The productivity & efficiency schemes are forecasting £1,599k delivery (30%) against a target of £5,347k.

The VIP transformational schemes are forecasting £313k delivery (9%) against the target of £3,388k.

ICAM Divisional Position - Month 10 (January 15)

Income & Expenditure	Ann Plan £'000	In Month			Year To Date		
		Plan £'000	Act £'000	Var £'000	Plan £'000	Act £'000	Var £'000
Nhs Clinical Income	7,776	648	1,534	886	6,480	8,525	2,045
Other Income For Pat Care	2,127	177	205	28	1,773	1,790	17
Other Non-Patient-Devolved	682	60	65	4	583	492	(90)
Other_Non-Patient_Non-Dev	0	0	10	10	0	10	10
Income	10,585	886	1,814	929	8,835	10,818	1,982
A/C	5,243	433	479	(46)	4,378	4,848	(470)
Executive Board & Sen Mgmt	486	40	32	8	405	400	5
Medical	13,400	1,095	1,296	(201)	11,232	12,634	(1,402)
Nurses & Midwives	28,694	2,371	2,728	(356)	23,951	25,895	(1,944)
Other Support Workers	199	17	(15)	32	166	308	(142)
Scientific, Ther & Tech	17,412	1,450	1,522	(71)	14,512	15,099	(587)
Pay Reserve	(1,638)	(145)	0	(145)	(1,340)	0	(1,340)
Pay	63,795	5,261	6,041	(780)	53,303	59,184	(5,881)
Establishment	462	39	51	(13)	384	498	(114)
Ext Cont Staffing & Cons	115	6	9	(3)	58	418	(360)
Healthcare From Non Nhs	548	46	49	(3)	456	75	382
Miscellaneous	364	30	30	0	303	296	7
Non-Pay Reserve	(253)	(21)	0	(21)	(211)	0	(211)
Premises & Fixed Plant	392	33	50	(17)	327	572	(245)
Supplies & Servs - Clin	16,450	1,368	1,238	130	13,715	13,328	386
Supplies & Servs - Gen	373	31	117	(86)	312	443	(131)
Non Pay	18,450	1,530	1,544	(13)	15,345	15,631	(286)
Income Less Direct Costs	(71,660)	(5,906)	(5,771)	135	(59,813)	(63,997)	(4,184)



Income and Expenditure Commentary

The position at month 10 is £135k favourable in month and £4,184k adverse YTD.

NHS Clinical Income is £366k favourable in month due to TB income now accounted for within ICAM. In addition to this funding for additional beds on Cavell Ward and Enhanced Virtual Ward income has now been accounted for. YTD the position is £1,982k favourable due to prison income recognised in month 1 (£0.5m), additional CCG investments and RTT and winter resilience funding.

Pay is £780k adverse in month and £5,881k adverse YTD.

Nursing is £356k adverse in month and £1,944k 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. ED nursing spend has been partly offset by Winter Resilience income received.

Medical is £201k adverse in month and £1,402k 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 consultants increased spend is offset by Enhanced Virtual Ward income.

Unallocated CIP and VIP is leading to a £145k adverse variance in month and £1,340k adverse YTD.

Non-Pay - YTD Adverse £286K; £13k adverse in month. YTD adverse; £286k 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.

In month 10, the division delivered £507k against a plan of £462k. Year to date the division has delivered £1,285k against a plan of £2,724k.

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 has now 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 2 months of the year based on significant recruitment, challenging targets set for district nursing and ward specialing expenditure improvement and additional TB income.

ED - Nursing vacancies are set to be filled by trust wide nursing recruitment drives. Winter resilience is currently funding additional medical and nursing shifts.

District Nursing - Phased recruitment plan in place to reduce agency spend. New nurses have started in November to 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.

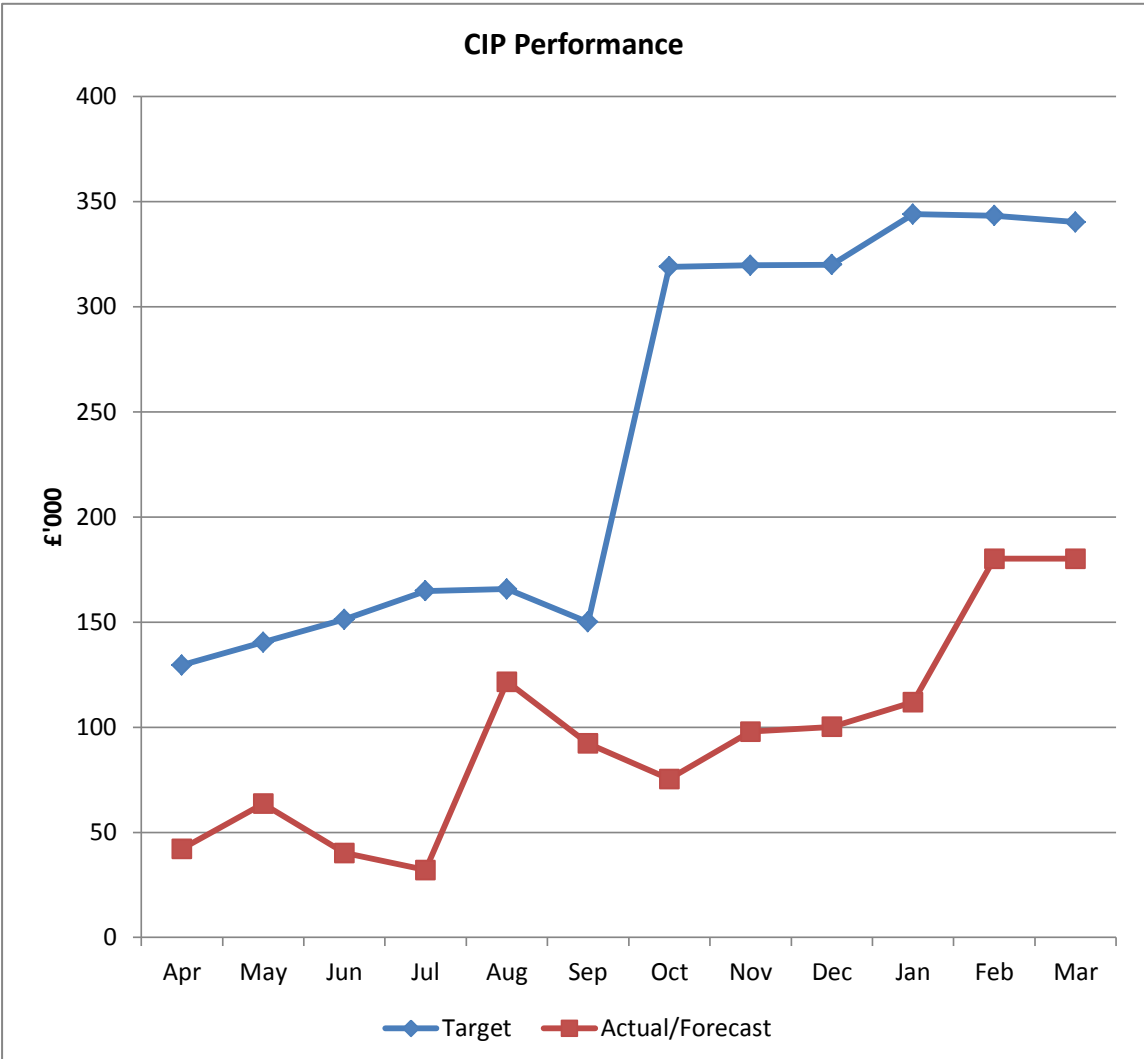
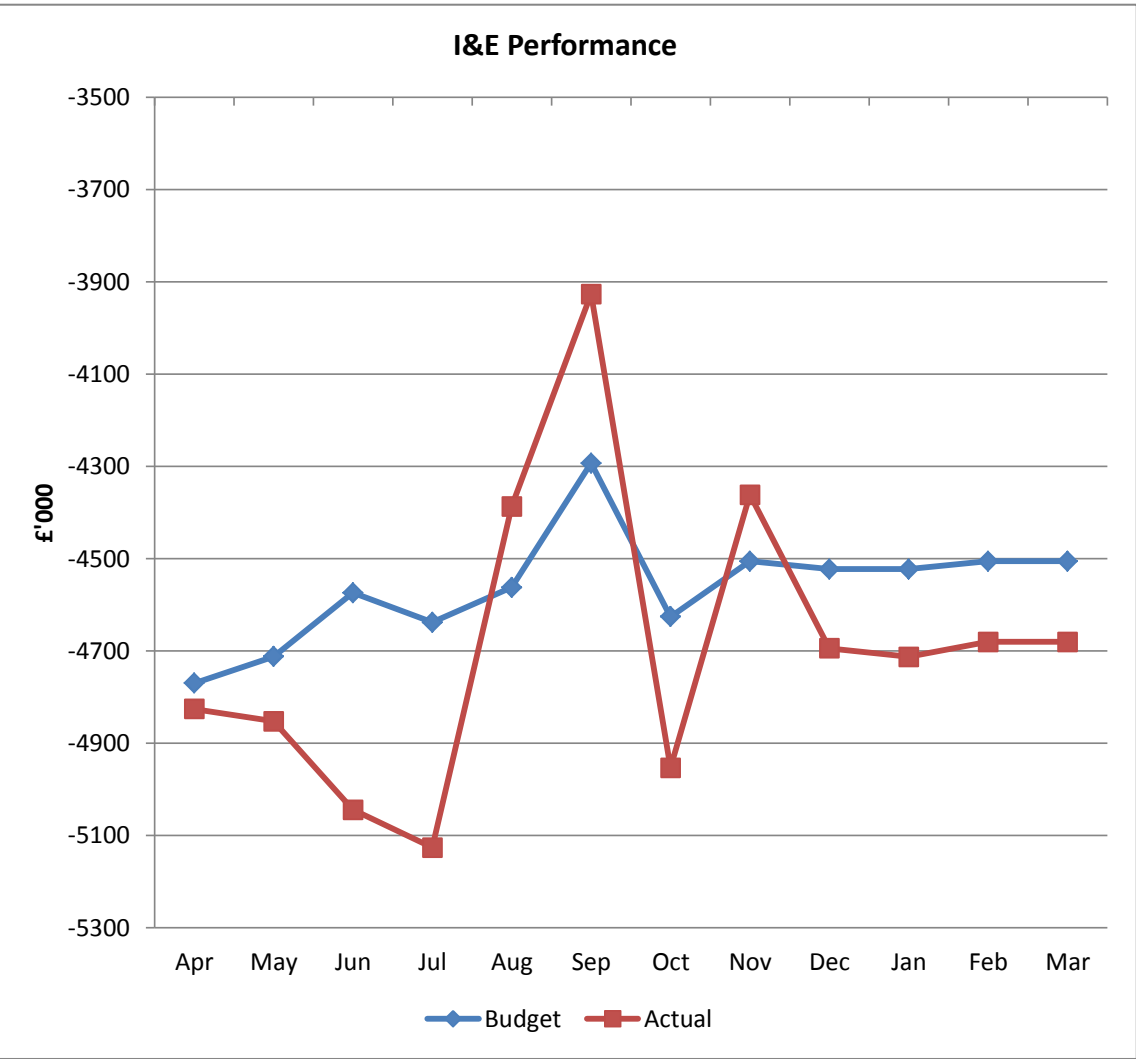
Ward Nursing - Corporate Nursing to look into required budget for specialing and what processes are required to control the spend.

Consultant Agency - 1 x Gastroenterology post offer accepted. 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 - 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 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Actuals			Actuals		
		Plan £'000	£'000	Var £'000	Plan £'000	£'000	Var £'000
Nhs Clinical Income	819	68	131	63	683	2,534	1,851
Other Income For Pat Care	1,028	87	140	53	855	1,173	319
Other Non-Patient-Devolved	719	33	41	8	610	534	(76)
Other_Non-Patient_Non-Dev	640	53	80	27	533	573	39
Income	3,206	242	392	150	2,680	4,814	2,133
A/C	4,040	311	413	(102)	3,418	4,304	(887)
Dental	2,344	195	194	1	1,954	1,936	18
Executive Board & Sen Mgmt	611	85	74	11	509	393	116
Medical	16,161	1,337	1,328	10	13,478	13,586	(109)
Nurses & Midwives	15,024	1,237	1,238	(1)	12,483	12,574	(90)
Other Support Workers	376	31	30	2	313	291	22
Scientific, Ther & Tech	8,356	700	699	1	6,956	7,197	(241)
Pay Reserve	(1,640)	(194)	0	(194)	(1,251)	0	(1,251)
Pay	45,273	3,703	3,976	(273)	37,859	40,282	(2,423)
Establishment	280	23	31	(7)	233	362	(128)
Ext Cont Staffing & Cons	176	15	15	(1)	147	124	22
Miscellaneous	334	28	38	(10)	278	433	(155)
Non-Pay Reserve	(65)	(11)	0	(11)	(44)	0	(44)
Premises & Fixed Plant	591	49	61	(12)	492	590	(98)
Supplies & Servs - Clin	10,799	910	952	(42)	8,979	9,468	(489)
Supplies & Servs - Gen	554	47	32	15	460	438	23
Non Pay	12,669	1,061	1,129	(68)	10,546	11,415	(868)
Income Less Direct Costs	54,735	4,522	4,713	(190)	45,725	46,883	(1,158)



Income and Expenditure Commentary

The position at month 10 is £190k adverse in month and £1,158k adverse YTD. Against forecast for the month the Division over-performed by £106k.

Income is £150k favourable in month and £2,133k favourable YTD driven by £1,348k of RTT income recognised YTD along with income from Dental OOH service. Additionally, Resilience 2 funding of £35k was also accounted for in-month along with pathology prison and RFH ophthalmology over-runs.

Pay is £273k adverse in month and £2,423k adverse YTD. Against the average runrate of last 9 months the cost of pay continues to remain lower by £50K in-month.

Nurses & Midwives is £1k adverse in month and £90K adverse YTD. This is largely due to the escalation bed budget in Coyle. However ITU ward overspend by £64K in-month due to higher levels of activity and bed occupancy.

Admin and clerical is £102k adverse in month and £887k 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 £1,251k adverse YTD. This is because the Planned Activity VIP target was phased from M07.

Non Pay is £68k adverse in month and £868k adverse YTD. This is largely due to costs within theatres (due to electives) and pathology on clinical consumables, prosthetics and reagents.

CIP Commentary -

In month 10 the division delivered £112k against a plan of £344k

Year to date the division has delivered £777k against a plan of £2,203k.

2 % schemes - the division under-performed by £18K after taking into account the non-recurrent schemes. However it continues to deliver 74% of the schemes YTD.

Productivity Target - This is under-performing in-month. However it is forecasted to improve through increase in referrals from Moorfield & UCLH activities to the financial year end.

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 performance for Theatres have remained constant since December, however performance has fallen back to 50% achievement due to increase in orthopaedic prosthetics spend.

Divisional Actions

Imaging

- The constant budget review continues to reduce spend.
- An alternative to existing additional Radiology reporting spend has been identified and is being implemented.
- There is a plan to reduce spend for A&C till financial year end
- Cross charging to RFH and UCLH is of concern and is being checked.

Theatres

- It is expected that theatres will be fully staffed by end of financial year 2014/15, agency & bank spend continues to reduce.
- Non pay spend is linked to activity. All non pay spend is scrutinised through a control process to keep costs to a minimum.

Admin & clerical Staffing

- Most staff are now in new roles.
- A review has been undertaken to make sure that all staff are accounted for in the correct positions. This has raised some concerns which are being addressed in February 2015.

Surgery

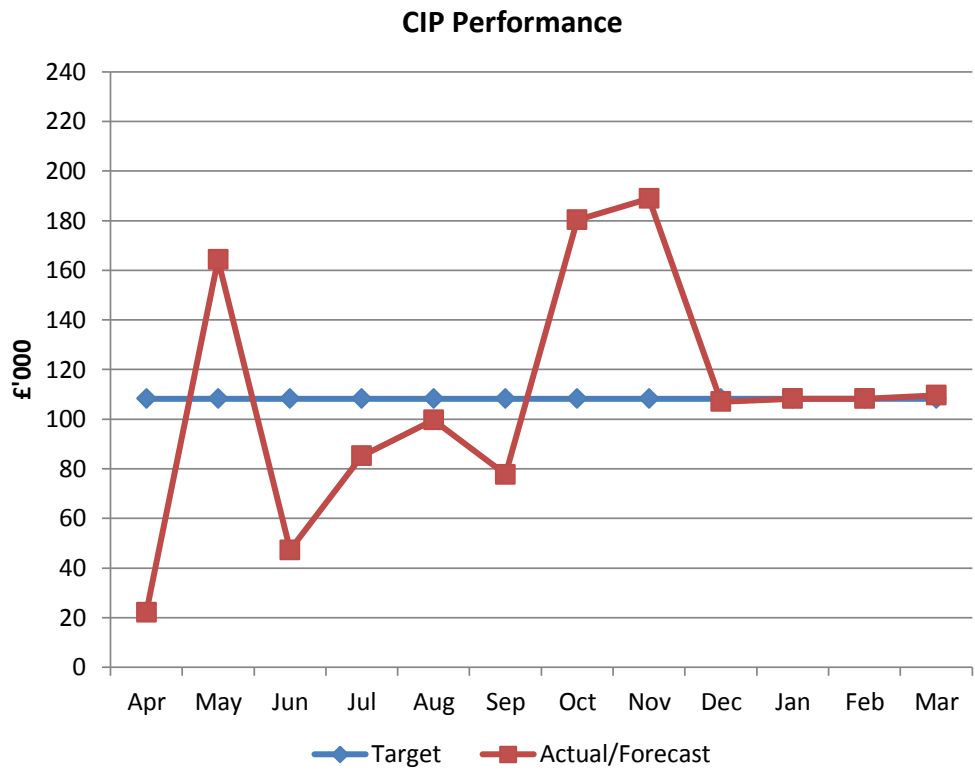
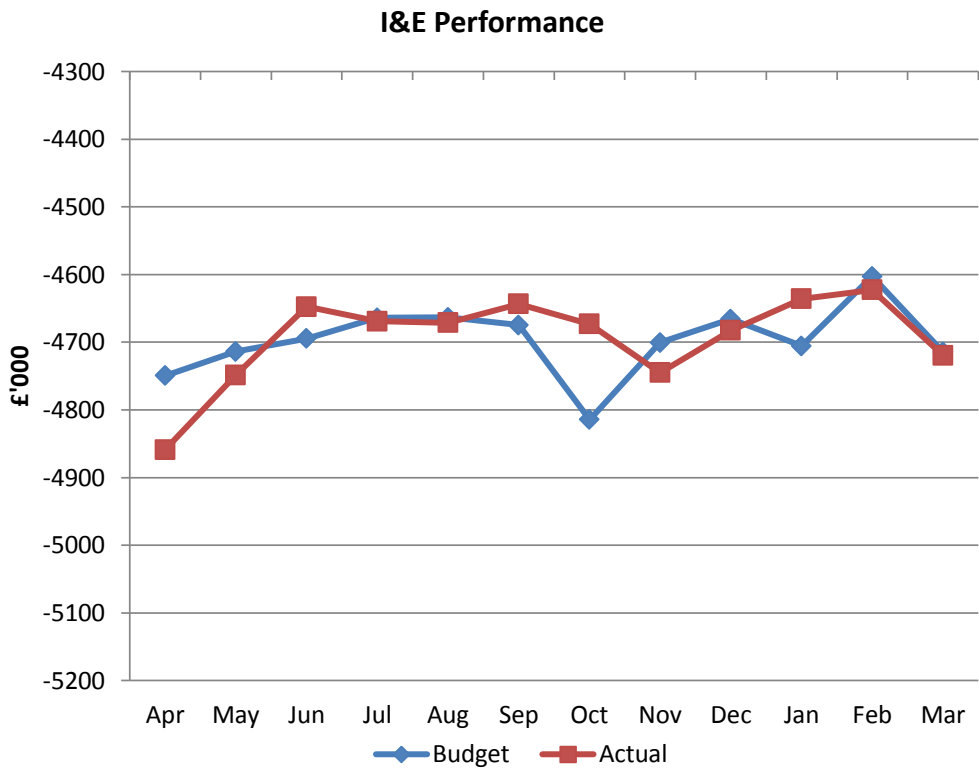
- The Orthotics service as a managed service is an opportunity and work continues to reclaim VAT for 2014/15.

WLI

- The division continues to pursue the possibility of work from other organisations, Moorfields contract will start in March 2015, and we will

WCF Divisional Position - Month 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Nhs Clinical Income	940	79	148	68	781	1,218	437
Other Income For Pat Care	6,958	595	597	2	5,808	6,152	344
Other Non-Patient-Devolved	393	106	121	15	358	446	88
Other_Non-Patient_Non-Dev	0	0	41	41	0	82	82
Income	8,291	781	906	125	6,946	7,897	951
A/C	4,575	383	403	(20)	3,811	4,015	(204)
Executive Board & Sen Mgmt	666	53	38	15	560	418	141
Medical	11,418	1,029	1,003	26	9,545	9,756	(211)
Nurses & Midwives	31,296	2,625	2,631	(6)	26,169	25,998	171
Other Support Workers	39	3	17	(14)	33	116	(83)
Scientific, Ther & Tech	12,758	1,050	1,074	(24)	10,658	10,740	(81)
Pay Reserve	(347)	(9)	0	(9)	(289)	0	(289)
Pay	60,406	5,134	5,166	(32)	50,487	51,043	(556)
Establishment	477	40	34	6	398	505	(107)
Ext Cont Staffing & Cons	78	7	2	5	65	69	(3)
Miscellaneous	291	21	57	(36)	210	355	(145)
Non-Pay Reserve	1	0	0	0	0	0	0
Premises & Fixed Plant	548	47	46	0	455	486	(31)
Supplies & Servs - Clin	2,507	209	215	(6)	2,088	2,195	(106)
Supplies & Servs - Gen	345	29	21	7	288	221	67
Non Pay	4,247	352	375	(23)	3,505	3,829	(325)
Income Less Direct Costs	(56,363)	(4,706)	(4,636)	70	(47,046)	(46,975)	71



Income and Expenditure Commentary

The WCF position at month 10 is £70k favourable in month and £71k favourable YTD.

Patient Care Income is £70k favourable in month and £781k 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 £56k favourable in month and £170k favourable. The in-month position is mainly driven by a provision for additional student midwifery funding of £33k. The YTD position is driven by additional education and training and schools income.

Pay is £32k adverse in month and £556k adverse YTD.

A&C is £20k adverse in the month and £204k adverse YTD. The in-month position is largely driven by an overspend in LAC and School Nursing for which there is corresponding income. The YTD variance relates to LAC and School Nursing, maternity admin, which is due to long-term sickness and agency cover and paediatric integrated care.

Medical is £26k favourable in month and £211k adverse YTD. The favourable in-month position is driven by additional £91k flexi trainee funding, which relates to M1-10. This is partly offset by junior doctor agency expenditure in Obstetrics and Gynaecology, unfunded maternity and sick leave cover, and the appointment of an additional paediatric consultant to cover 7 day working. The YTD adverse variance is largely driven by junior doctor agency expenditure in Obstetrics and Gynaecology which has reduced over the past three months.

Scientific, Ther & Tech is £24k adverse in month and £81k adverse YTD. Of the in-month variance £23k 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 £23k adverse in month which is driven by professional services in central management and teaching and training expenditure in CAMHS which is offset by income. The adverse YTD position of £325k is driven by additional equipment requirements and increased activity in special schools, professional services for the preparation of tenders and the cost of setting up new services.

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 10, the division delivered the monthly CIP plan of £108k in full.

Year to date the division has delivered CIPs of £1,081k against the YTD plan of £1,082k.

Of the £1081k delivered YTD, £376k is recurrent and £705k 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 is required in managing the reduction in bank, agency and locum spend, which in turn will ensure the currently reported financial position is maintained or improved.

Recruitment to vacancies are continuing in areas where agency staffing is currently used and to specific posts relating to new investments.

The pan London ban to stop using agency Health Visitors is now in place.

Recent nurse recruitment into NICU has been successful and a small reduction in bank and agency expenditure can be seen in January.

Income

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

Corporate Divisional Position - Month 10 (January 15)

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Organisational Development	2,163	177	161	17	1,812	2,090	(279)
Ict	6,642	553	565	(12)	5,536	5,631	(95)
Finance	4,052	338	332	7	3,375	3,497	(122)
Trust Secretariat	1,695	137	119	18	1,422	1,579	(157)
Chief Operating Officer	1,187	40	113	(73)	1,107	1,433	(326)
Nursing & Patient Experience	9,508	804	812	(8)	7,900	7,927	(27)
Procurement	789	66	102	(36)	658	639	19
Medical Director	1,053	88	81	7	878	657	221
Facilities	28,314	2,378	2,136	242	23,569	22,765	805
Total	55,402	4,580	4,420	160	46,257	46,217	40

ICT Breakdown

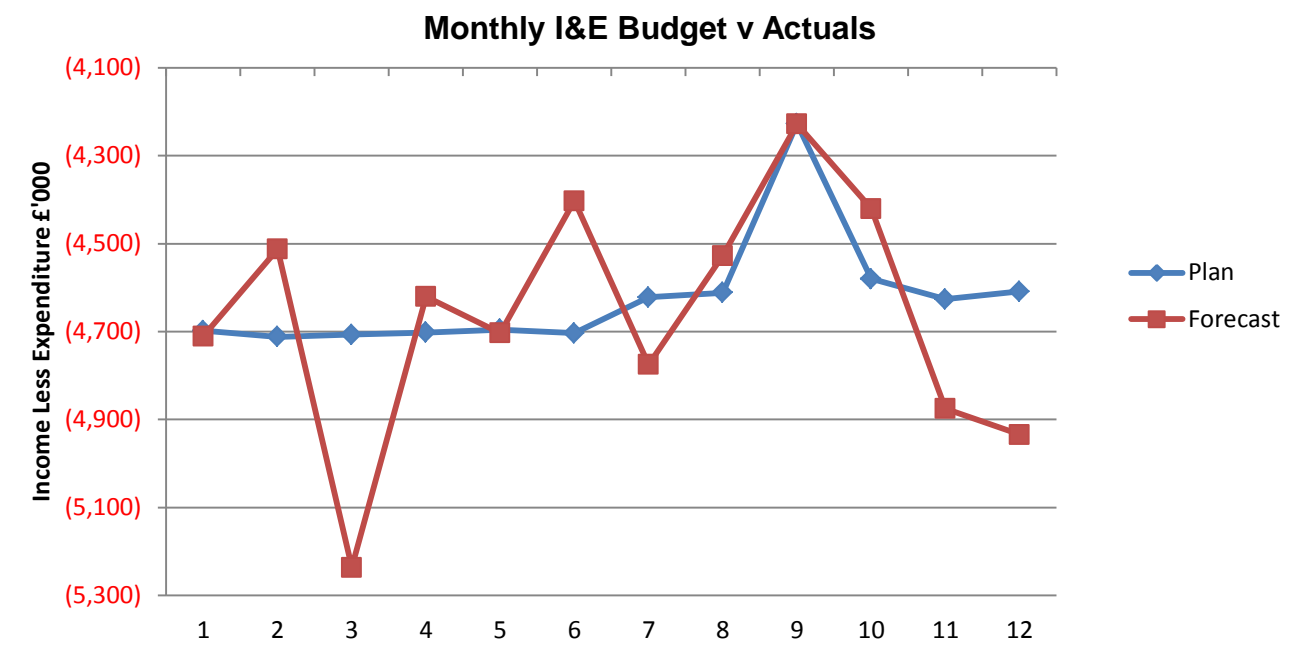
Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Income	(22)	(2)	(9)	8	(19)	(29)	10
Pay	2,977	247	280	(32)	2,482	2,751	(269)
Non-Pay	3,688	307	295	13	3,073	2,909	164
Total	6,642	553	565	(12)	5,536	5,631	(95)

Facilities Breakdown

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Income	(1,841)	(133)	(198)	65	(1,576)	(1,772)	196
Pay	11,178	900	792	108	9,377	8,286	1,091
Non-Pay	18,978	1,610	1,542	68	15,768	16,251	(483)
Total	28,314	2,378	2,136	242	23,569	22,765	805

Nursing & Patient Experience Breakdown

Income & Expenditure	Annual Plan £'000	In Month			Year To Date		
		Plan £'000	Actuals £'000	Var £'000	Plan £'000	Actuals £'000	Var £'000
Non-Pay	6,075	507	526	(19)	5,062	5,184	(123)
Non-Nhs Clinical Income	0	0	(5)	5	0	(34)	34
Other Non-Patient Income	(3)	(0)	(6)	5	(2)	(83)	81
Pay	3,435	297	296	2	2,841	2,860	(19)
Total	9,508	804	812	(8)	7,900	7,927	(27)



Commentary

The corporate position at month 10 is £84k favourable in month and £119k adverse YTD.

COO - The forecast position now includes the transfer of a CIP target of £710k (Locality based VIP) from ICAM to COO.

Facilities - The favourable variance in M10 was better than trend due to revisions to catering contract expenditure (£40k reduction ytd based on invoiced amounts) and adjustments to Medical Physics expenditure (£63k reduction ytd following budget holder review of contracts in M10).

ICT - A schedule of annual expenditure and agency 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 £95k YTD adverse variance.

Organisational Development - YTD adverse position driven by underperformance against the Occupational Health income target and staffing CIPs. The in month improvement is due to the receipt of education funding in M10 for apprentice programme ytd expenditure (£53k).

Finance - YTD adverse position improved in Jan due to ongoing vacancies and education funding received for financial planning costs incurred in earlier months.

Trust Secretariat – YTD adverse position driven by a number of posts being covered by interim staff. Position improved in recent months due to vacancy gaps and transfer of temporary staff to permanent contracts.

Procurement - The M10 variance was due to revised interim staff costs following review of contract schedule. The forecast position at year end remains favourable.

Acute Activity Analysis

Activity by PoD Type

PoD Group	Annual Plan	January			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Adult Critical Care	7,745	645	497	(148)	6,454	5,939	(515)
Block Contract/Adjustments	0	0	0	0	0	0	0
Day Cases	19,179	1,598	1,384	(214)	15,982	16,737	755
Direct Access	1,014,339	84,528	67,535	(16,993)	845,283	809,089	(36,194)
ED Attendances	104,069	8,672	7,208	(1,464)	86,724	76,854	(9,870)
Elective Inpatients	2,752	229	218	(11)	2,293	2,316	23
Excess Beddays	7,301	608	1,423	815	6,084	6,636	552
Maternity Pathway	8,943	745	655	(90)	7,452	6,577	(875)
NICU High Dependency Beddays	1,942	162	122	(40)	1,619	1,609	(10)
NICU Intensive Care Beddays	880	73	35	(38)	734	467	(267)
NICU Special Care Beddays	5,171	431	335	(96)	4,309	3,337	(972)
NICU Transitional Care Beddays	6,350	529	232	(297)	5,292	4,257	(1,035)
Non-Elective Inpatients	29,445	2,454	1,917	(537)	24,538	23,040	(1,498)
Other Activity	69,572	5,798	1,706	(4,092)	57,977	44,268	(13,709)
Outpatient 1st Attends	61,195	5,100	3,087	(2,013)	50,996	48,094	(2,902)
Outpatient Diagnostic Imaging	23,529	1,961	1,876	(85)	19,608	18,481	(1,127)
Outpatient Follow Ups	152,207	12,684	6,321	(6,363)	126,839	112,507	(14,332)
Outpatient Procedures	21,099	1,758	820	(938)	17,582	11,678	(5,904)
Paediatrics High Dependency	256	21	0	(21)	214	395	181
TOTAL	1,535,974	127,998	95,371	(32,627)	1,279,978	1,192,281	(87,697)

Commentary
Critical care activity has decreased by 209 (30%) compared to December 2014, but the data is still ongoing up to the freeze date.
Day case activity is 112 below the Month 10 plan of 1,598. NB This line also includes the additional RTT activity (national).
Direct access activity has reduced in month by 510 (1%) compared to December 2014 and 4% below plan YTD. 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. However, patients show high acuity and are complex.
Elective inpatient activity is below plan, with this line in YTD terms including the additional national RTT work.
Maternity actuals have decreased by 37 (5%), compared to December 2014. Actual activity has been lower than plan for the first few months of the year. NICU activity is below December level by 87 days and 2,284 below the YTD plan.
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

Commissioner	Annual Plan	January			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
NHS England	17,697	1,475	730	(745)	14,747	12,623	(1,704)
NHS Islington CCG	842,508	70,209	52,003	(18,206)	702,090	655,084	(47,144)
NHS Haringey CCG	521,106	43,425	33,614	(9,811)	434,255	408,134	(26,315)
NHS Camden CCG	30,086	2,507	1,766	(741)	25,071	21,063	(4,025)
NHS City and Hackney CCG	19,066	1,589	824	(765)	15,888	11,975	(3,924)
NHS Enfield CCG	11,822	985	918	(67)	9,851	11,192	1,328
NHS Barnet CCG	69,945	5,829	4,102	(1,727)	58,288	51,353	(6,967)
Other CCG	23,745	1,979	1,414	(565)	19,787	20,857	1,055
TOTAL	1,535,974	127,998	95,371	(32,627)	1,279,978	1,192,281	(87,697)

Commentary
The NHS England variance due to critical care activity and time lag in coding of High cost drugs
The majority of activity under performance for Islington CCG is from OP Pods which are 15,968 attendances below the YTD plan and Direct Access Pathology by 20,408.
A significant proportion of activity under performance for Haringey CCG is also from OP Pods which are below plan by 6,158 attendances and DA Pathology by 12,779 YTD.

Acute Income Analysis

Income Analysis

PoD Group	Annual Plan £'000	January			YTD		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Adult Critical Care	£ 10,160	£ 847	£ 652	-£ 195	£ 8,467	£ 7,737	-£ 729
Block Contract/Adjustments	£ 10,997	£ 916	£ 1,018	£ 101	£ 9,164	£ 10,094	£ 930
Day Cases	£ 11,899	£ 992	£ 975	-£ 17	£ 9,916	£ 10,667	£ 752
Direct Access	£ 10,965	£ 914	£ 877	-£ 37	£ 9,138	£ 9,774	£ 636
ED Attendances	£ 11,434	£ 953	£ 818	-£ 135	£ 9,529	£ 8,591	-£ 938
Elective Inpatients	£ 9,142	£ 762	£ 601	-£ 160	£ 7,618	£ 7,222	-£ 396
Excess Beddays	£ 2,140	£ 178	£ 189	£ 11	£ 1,783	£ 1,633	-£ 150
Maternity Pathway	£ 9,945	£ 829	£ 674	-£ 154	£ 8,287	£ 7,345	-£ 942
NICU High Dependency Beddays	£ 1,717	£ 143	£ 108	-£ 35	£ 1,431	£ 1,422	-£ 9
NICU Intensive Care Beddays	£ 1,012	£ 84	£ 40	-£ 44	£ 843	£ 537	-£ 307
NICU Special Care Beddays	£ 1,974	£ 165	£ 128	-£ 37	£ 1,645	£ 1,274	-£ 371
NICU Transitional Care Beddays	£ 2,425	£ 202	£ 89	-£ 113	£ 2,020	£ 1,625	-£ 395
Non-Elective Inpatients	£ 42,876	£ 3,573	£ 3,371	-£ 202	£ 35,730	£ 33,227	-£ 2,503
Other Activity	£ 2,010	£ 167	£ 97	-£ 71	£ 1,675	£ 1,171	-£ 504
Outpatient 1st Attends	£ 8,916	£ 743	£ 549	-£ 194	£ 7,430	£ 7,176	-£ 254
Outpatient Diagnostic Imaging	£ 2,655	£ 221	£ 218	-£ 3	£ 2,213	£ 2,058	-£ 155
Outpatient Follow Ups	£ 11,631	£ 969	£ 627	-£ 342	£ 9,693	£ 8,910	-£ 782
Outpatient Procedures	£ 3,596	£ 300	£ 145	-£ 155	£ 2,997	£ 2,099	-£ 898
Paediatrics High Dependency	£ 263	£ 22	£ -	-£ 22	£ 219	£ 405	£ 186
TOTAL	£ 155,757	£ 12,980	£ 11,174	-£ 1,806	£ 129,797	£ 122,967	-£ 6,830

Income by Commissioner - £000's

NHS England	£ 13,942	£ 1,162	£ 770	-£ 392	£ 11,618	£ 9,844	-£ 1,774
NHS Islington CCG	£ 64,371	£ 5,364	£ 4,370	-£ 994	£ 53,642	£ 50,151	-£ 3,491
NHS Haringey CCG	£ 49,898	£ 4,158	£ 3,857	-£ 301	£ 41,582	£ 40,640	-£ 942
NHS Camden CCG	£ 5,280	£ 440	£ 355	-£ 85	£ 4,400	£ 3,442	-£ 958
NHS City and Hackney CCG	£ 4,776	£ 398	£ 276	-£ 122	£ 3,980	£ 3,489	-£ 491
NHS Enfield CCG	£ 2,892	£ 241	£ 279	£ 38	£ 2,410	£ 2,694	£ 284
NHS Barnet CCG	£ 9,056	£ 755	£ 833	£ 78	£ 7,547	£ 7,488	-£ 59
Other CCG	£ 5,541	£ 462	£ 434	-£ 27	£ 4,617	£ 5,218	£ 601
TOTAL	£ 155,757	£ 12,980	£ 11,174	-£ 1,806	£ 129,797	£ 122,967	-£ 6,830

Commentary

In month 10 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 10 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 £1.8m in month and an *under performance* of £6.8m 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.

Statement of Financial Position

	As at 1st April 2014 £000	As at 31st January 2015 £000	Forecast 31st March 2015 £000	Plan 31st March 2015 £000	Commentary
<u>Non Current Assets</u>					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.
Property, plant and equipment	179,975	183,586	187,317	180,105	
Intangible assets	5,428	4,350	4,023	4,295	
Trade and other receivables	702	995	533	610	
Total Non Current Assets	186,105	188,931	191,873	185,010	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.
<u>Current Assets</u>					
Inventories	1,295	1,578	1,456	1,290	
Trade and other receivables	17,527	17,003	14,994	6,930	
Cash and cash equivalents	5,123	7,013	1,002	3,976	Cash increased by £4.8m during the month. This was due to the expected requirement to repay the temporary public dividend capital of £5.6m, with a corresponding reduction in taxpayer's equity. It is now expected that the advance will be made permanent and used to reduce payables. In accordance with the expected permanent PDC arrangement, the cash forecast has been reduced to a more realistic £1m. Cash is subject to various additional risks, mainly involving receivables, payables and CIP delivery.
Total Current Assets	23,945	25,594	17,452	12,196	
Total Assets	210,050	214,525	209,325	197,206	
<u>Current Liabilities (amounts due in less than one year)</u>					
Trade and other payables	36,010	39,795	34,993	27,154	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.
Borrowings	1,377	1,361	2,344	2,542	
Provisions	1,238	390	417	198	
Total Current Liabilities	38,625	41,546	37,754	29,894	
Net Current Assets (Liabilities)	(14,680)	(15,952)	(20,302)	(17,698)	
Total Assets less Current Liabilities	200,785	204,883	212,175	202,708	
<u>Non Current Liabilities (amounts due greater than one year)</u>					
Borrowings	36,758	34,603	34,419	34,028	
Provisions	2,015	1,863	1,915	2,190	
Total Non Current Liabilities	38,773	36,466	36,334	36,218	
Total Assets Employed	132,652	136,513	135,237	131,094	
<u>Taxpayers' Equity</u>					
Public dividend capital	56,461	62,111	62,321	56,671	
Retained earnings	15,277	8,345	6,788	18,918	
Revaluation reserve	60,914	66,057	66,128	55,505	
Total Taxpayers' Equity	132,652	136,513	135,237	131,094	
Capital cost absorption rate	3.5%	3.5%	3.5%	3.5%	

Month 10 (January) Aged Debtors Analysis
Period End Date: 28/01/2015

£	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	2,716,726.67	50,513.52	11,415.82	225,111.58	28,074.79	253,186	3,031,842
2	NHS HARINGEY CCG	65,084.91	962,426.00	18,271.00	41,922.45	6,302.25	48,225	1,094,007
3	THE ROYAL FREE LONDON NHS FT	191,741.29	69,257.71	6,466.10	117,952.19	39,712.87	157,665	425,130
4	NHS CITY & HACKNEY CCG	0.00	0.00	-74,753.84	464,127.03	0.00	464,127	389,373
5	THE UCL HOSPITALS NHS FOUNDATION TRUST	26,076.87	42,631.89	5,346.81	57,408.76	85,787.60	143,196	217,252
6	CNWL NHS FOUNDATION TRUST	46,168.50	19,736.33	18,485.66	100,185.49	0.00	100,185	184,576
7	NHS ENFIELD CCG	32,952.25	0.00	0.00	151,026.45	0.00	151,026	183,979
8	NHS BRENT CCG	30,112.04	2,887.04	125,707.21	6,228.01	0.00	6,228	164,934
9	NORTH MIDDLESEX HOSPITAL NHS TRUST	109,184.21	4,524.56	3,710.00	11,041.45	6,045.10	17,087	134,505
10	ROYAL FREE LONDON NHS FT	77,389.11	6,205.00	24,744.00	22,384.50	0.00	22,385	130,723
Top 10 NHS Total:		3,295,436	1,158,182	139,393	1,197,388	165,923	1,363,311	5,956,321
All Other NHS Total:		691,165.49	148,130.78	-107,122.36	-183,826.81	97,280.09	(86,547)	645,627
NHS Total:		3,986,601	1,306,313	32,270	1,013,561	263,203	1,276,764	6,601,948

NHS Total Previous Month	4,500,112	375,891	(127,510)	1,805,519	120,345	1,925,864	6,674,357
NHS Total Movement (Month 9 to Month 10)	(513,510)	930,422	159,780	(791,958)	142,858	(649,100)	(72,409)

£	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	253,253.73	172,974.73	119,860.71	722,776.26	-4,324.52	718,452	1,264,541
2	LONDON BOROUGH OF ISLINGTON	284,321.24	37,169.10	0.00	7,933.20	25.65	7,959	329,449
3	OVERSEAS VISITOR (SH)	48,794.00	39,350.00	58,238.00	159,026.00	0.00	159,026	305,408
4	THE HIGH ROAD SURGERY	0.00	0.00	0.00	159,613.26	0.00	159,613	159,613
5	HIGHBURY GRANGE HC	11,084.19	11,084.19	0.00	75,305.58	0.00	75,306	97,474
6	VODAFONE LIMITED	92,390.40	0.00	0.00	0.00	0.00	0	92,390
7	RIVER PLACE GROUP PRACTICE	22,961.44	7,247.25	0.00	46,869.72	0.00	46,870	77,078
8	LONDON BOROUGH OF ENFIELD	64,288.31	0.00	0.00	480.00	9,421.32	9,901	74,190
9	THE RISE PRACTICE	10,916.46	10,916.46	0.00	49,356.20	0.00	49,356	71,189
10	LONDON BOROUGH OF CAMDEN	61,922.30	0.00	2,400.00	2,226.51	0.00	2,227	66,549
Top 10 Non NHS Total:		849,932	278,742	180,499	1,223,587	5,122	1,228,709	2,537,882
All other Non NHS Total:		339,870.55	134,333.75	65,325.37	359,269.73	234,967.33	594,237	1,133,767
Non NHS Total:		1,189,803	413,075	245,824	1,582,856	240,090	1,822,946	3,671,648

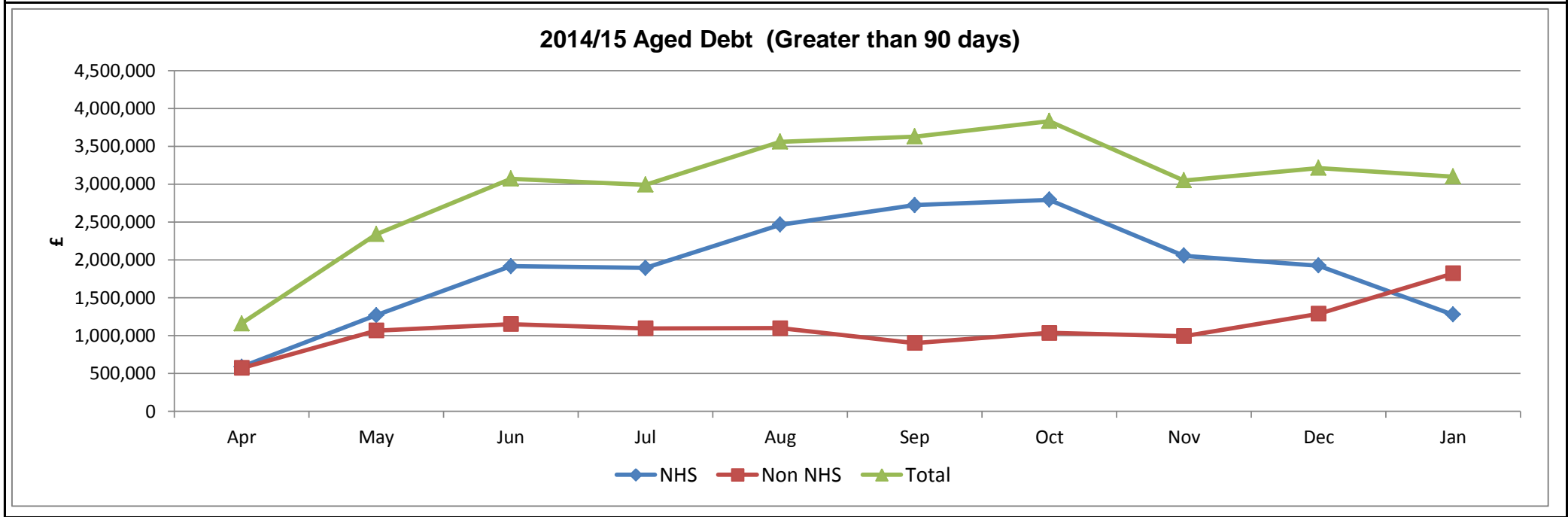
Non NHS Total Previous Month	1,377,737	387,577	691,278	1,048,252	241,841	1,290,093	3,746,685
Non NHS Total Movement (Month 9 to Month 10)	(187,935)	25,499	(445,454)	534,604	(1,751)	532,853	(75,036)

Grand Total	5,176,404	1,719,388	278,094	2,596,418	503,292	3,099,710	10,273,597
Grand Total Previous Month	5,877,849	763,468	563,768	2,853,772	362,186	3,215,957	10,421,042
Grand Total Movement	(701,445)	955,920	(285,673)	(257,354)	141,107	(116,247)	(147,445)

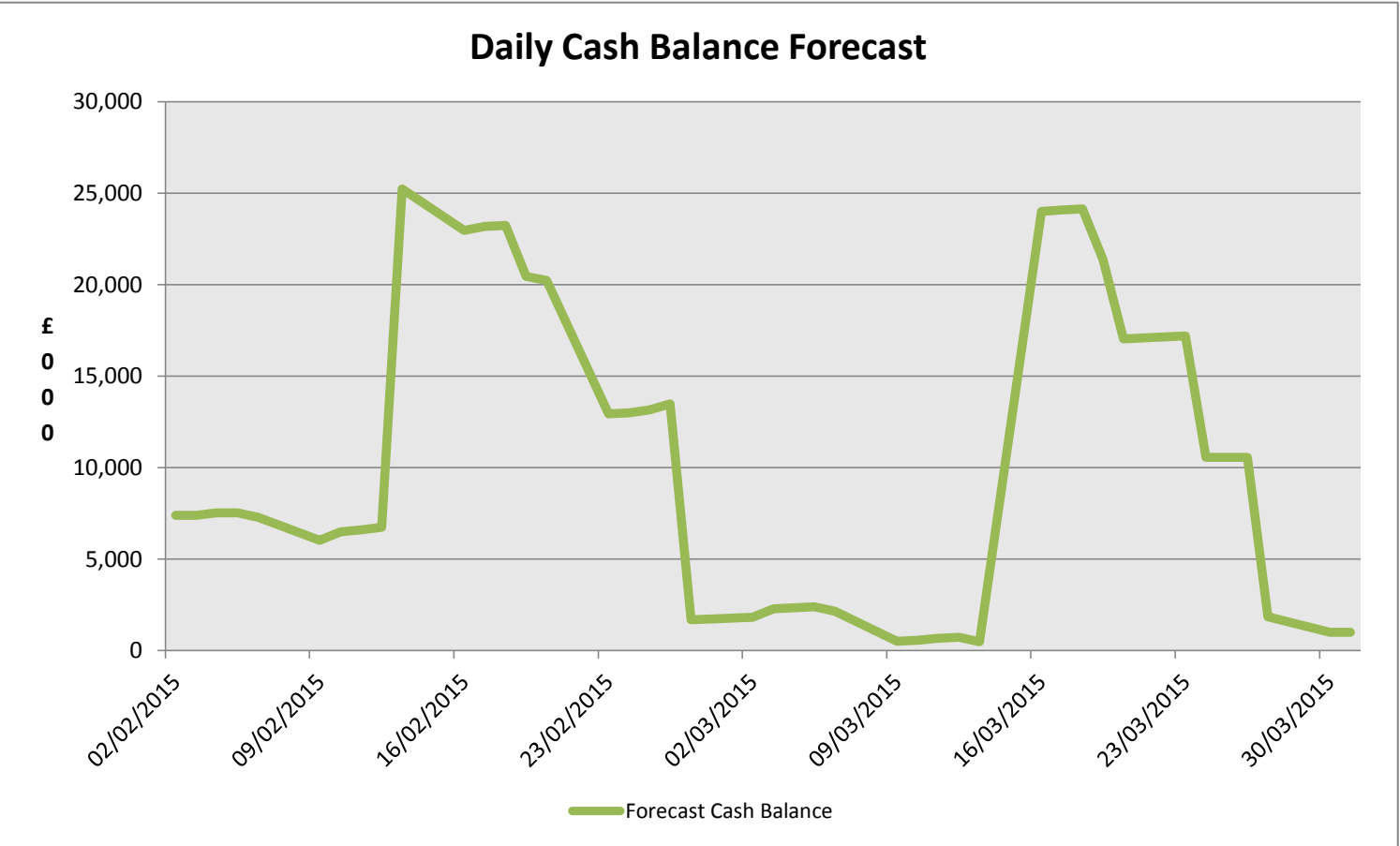
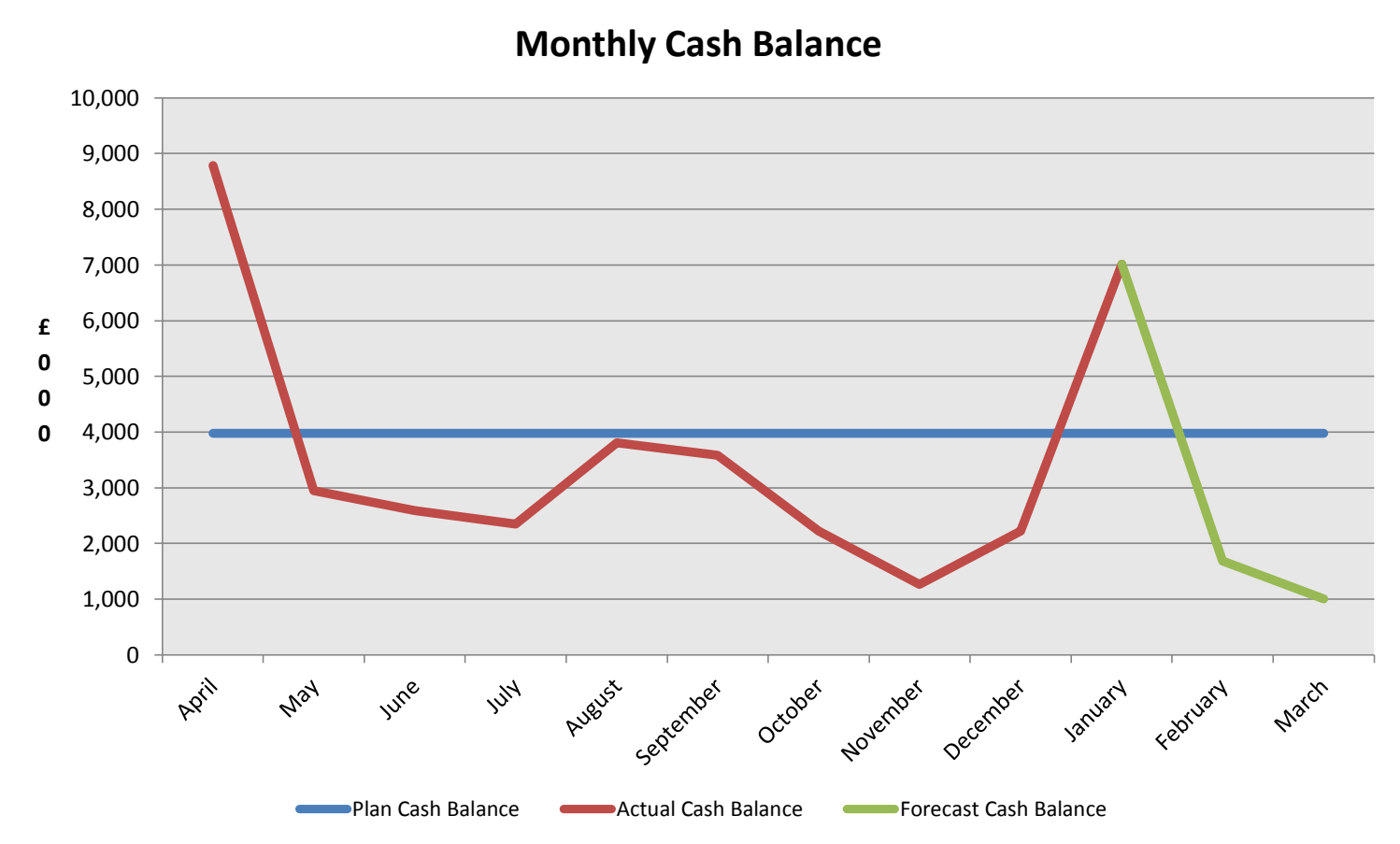
Commentary

Aged Debt '*Greater than 90 days*' has reduced by £0.1m to £3.1m in Month 10. **Material aged debt over 90 days includes:**
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 totals **£540k** and while our lead commissioners Islington and Haringey have paid their bills, other CCGs are yet to follow.

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 over £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 everything due.

In December, the Trust received a £5.6m cash loan, in the form of temporary PDC. This was expected to be repaid in January but this remains under negotiation and therefore held in the month end balance. It is now assumed that the advance will be made permanent and used to pay creditors, with no net impact on the cash outturn.

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. Failure to meet any of these conditions may compromise the statutory duty to operate within the EFL. In accordance with the expected outcome of the PDC negotiations, the forecast cash balance has been reduced to £1m, with a corresponding adjustment to the EFL.

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

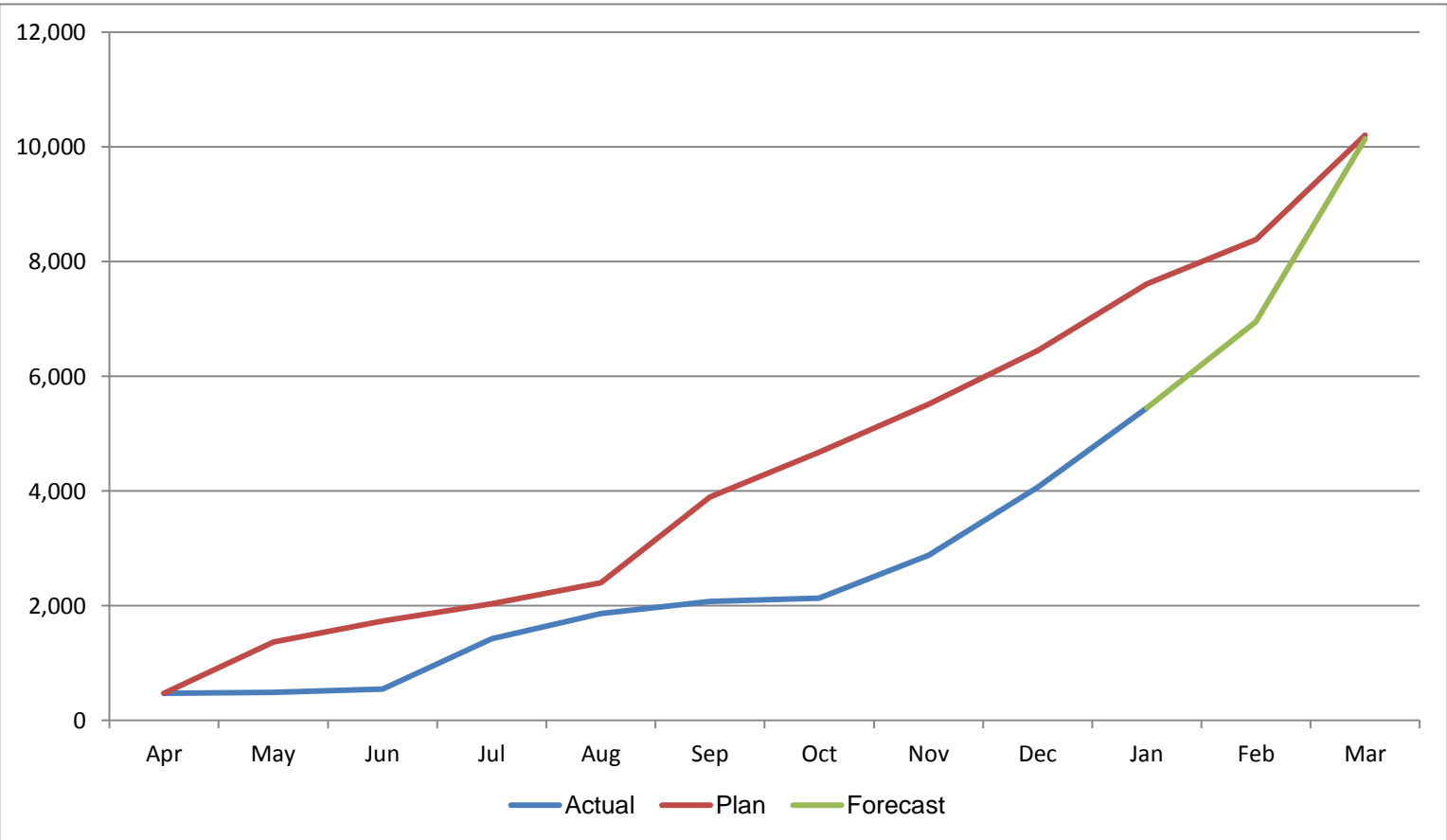
Action needed to meet the cash target and associated EFL comprises ensuring that all income is invoiced as soon as possible, and reducing expenditure in line with the CIP.

Capital Spend Performance and Forecast

	Annual Plan £'000	Current Month			YTD			Forecast Outturn		
		Plan £'000	Act £'000	Var £'000	Plan £'000	Act £'000	Var £'000	Plan £'000	Forecast £'000	Var £'000
Estates	5,618	990	767	223	4,167	2,869	1,298	5,618	5,618	-
IT	810	70	472	-402	415	1,722	-1,307	810	810	-
Equipment	1,514	100	139	-39	1,429	449	980	1,514	1,514	-
Business Cases	336	0	0	0	0	0	0	336	336	-
Leases	1,922	0	0	0	1,598	403	1,195	1,922	1,922	-
Total	10,200	1,160	1,378	-218	7,609	5,444	2,165	10,200	10,200	-

CRL	10,200
Variance	0

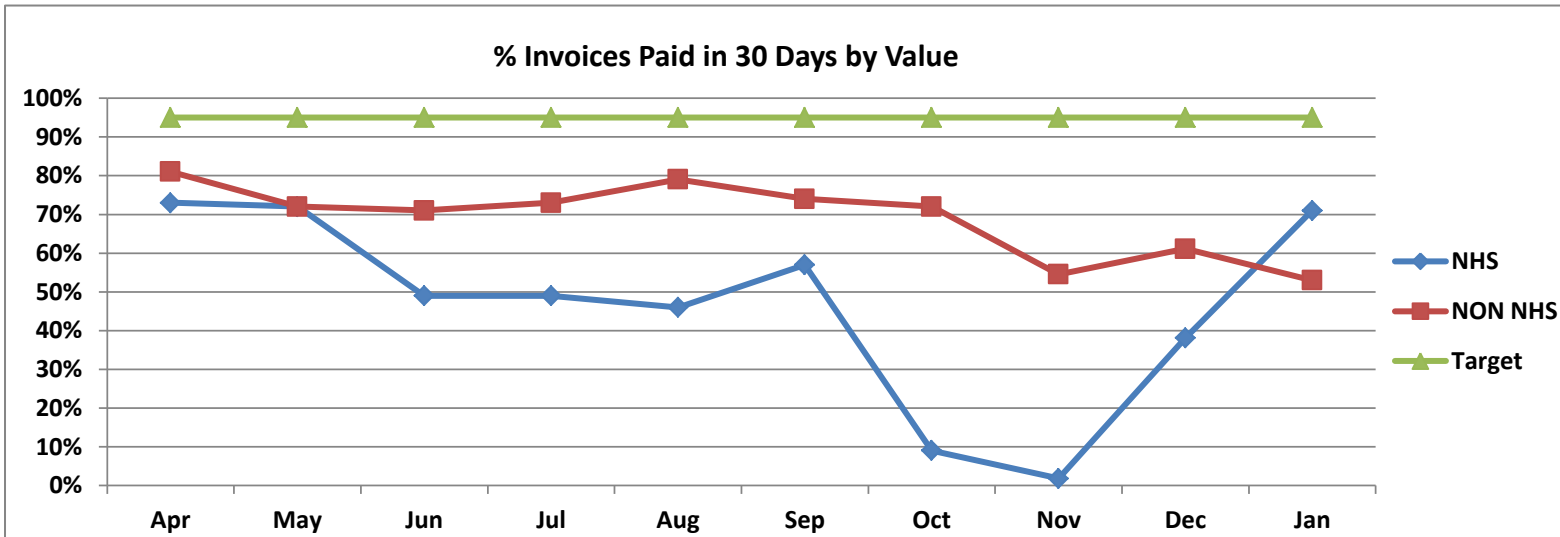
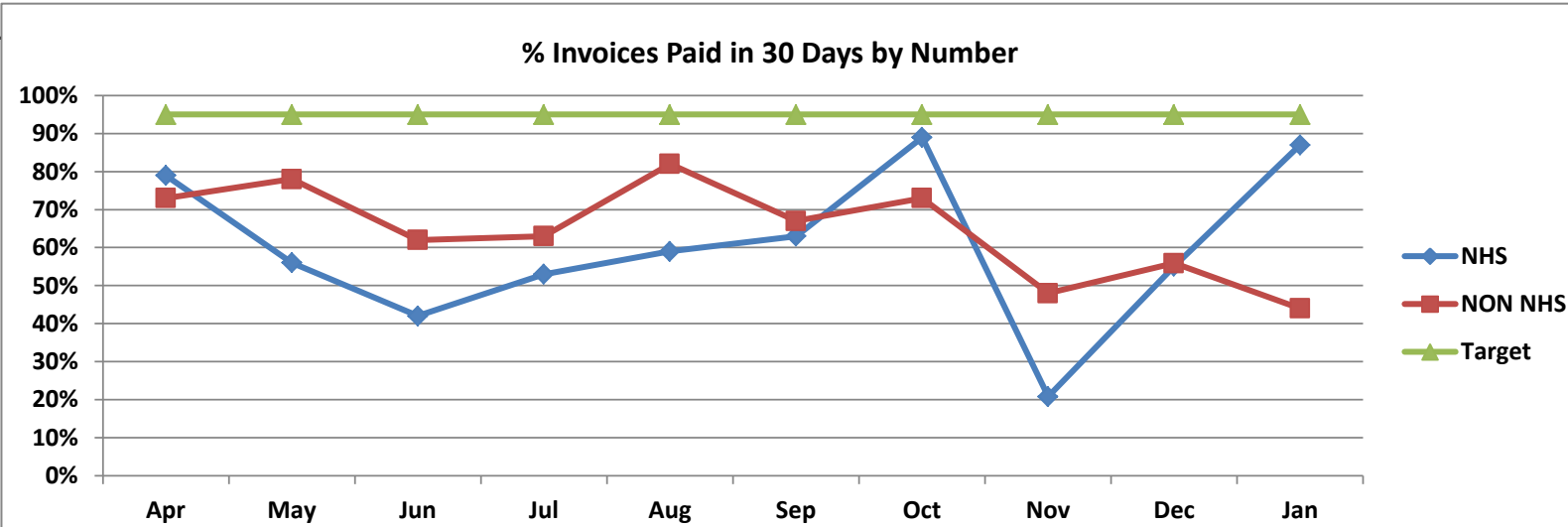
Spend against Capital Programme



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 active management of working capital, which is planned to continue during the remainder of the 2014/15 financial year.

In December, the Trust applied for and received a £5.6m cash loan in temporary PDC, which was used to clear a backlog of payments.

Performance against the BPPC improved in January for NHS invoices, with a slight deterioration for non-NHS invoices. The latter was due to the requirement to retain the £5.6m PDC in anticipation of repaying it.

Continuity of Services Risk Rating (COSR)

<u>Metric</u>		<u>Definition</u>		<u>Parameters</u>				Actual YTD	Forecast Outturn	Plan Outturn
				1	2	3	4			
Working Capital Balance (£'000) (+/-)								(17,530)	(20,106)	(18,988)
Annual Operating Expenses (£'000) (+)								235,668	280,024	271,133
Liquidity Ratio (Days)								(22)	(22)	(25)
Liquidity Rating	$\frac{\text{Working Capital Balance} \times 360}{\text{Annual Operating Expenses}}$		<-14	-14	-7	0	1	1	1	
Revenue Available for Debt Service (£'000) (+)								7,095	9,440	16,786
Annual Debt Service (£'000) (+)								8,456	10,422	10,358
Capital Servicing Capacity (Times)								0.8	0.9	1.6
Capital Servicing Capacity Rating	$\frac{\text{Revenue Available for Debt Service}}{\text{Annual Debt Service}}$		<1.25	1.25	1.75	2.50	1	1	2	
<u>Weighted:</u>										
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.

Whittington Health Trust Board

4th March 2015

Title:		NHS Trust Development Authority (TDA) – Self-Certification					
Agenda item:		15/041		Paper		8	
Action requested:		<i>For approval</i>					
Executive Summary:		The NHS 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 January 2015, which was submitted to the TDA on 23 February 2015 and agree the status for the February 2015 return. The Trust Board is also asked to discuss and agree any reporting issues in anticipation of the February 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:		18 February 2015					
Author name and title:		Ursula Grueger DDOF		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



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

CONTACT INFORMATION:



Enter Your Name:

Enter Your Email Address

Full Telephone Number:

Tel Extension:

SELF-CERTIFICATION DETAILS:



Select Your Trust:

Submission Date:

Reporting Year:

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.

Timescale for compliance:

2. Condition G5

Having regard to monitor Guidance.

Timescale for compliance:

3. Condition G7

Registration with the Care Quality Commission.

Timescale for compliance:

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

4. Condition G8

Patient eligibility and selection criteria.

Timescale for compliance:

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

5. Condition P1
Recording of information.

Timescale for compliance:

6. Condition P2
Provision of information.

Timescale for compliance:

7. Condition P3
Assurance report on
submissions to Monitor.

Timescale for compliance:

8. Condition P4
Compliance with the
National Tariff.

Timescale for compliance:

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

9. Condition P5
Constructive engagement
concerning local tariff
modifications.

Timescale for compliance:

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

10. Condition C1

The right of patients to
make choices.

Timescale for compliance:

11. Condition C2

Competition oversight.

Timescale for compliance:

12. Condition IC1

Provision of integrated
care.

Timescale for compliance:

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

CONTACT INFORMATION:



Enter Your Name:

Enter Your Email Address

Full Telephone Number:

Tel Extension:

SELF-CERTIFICATION DETAILS:



Select Your Trust:

Submission Date:

Reporting Year:

Select the Month

April

May

June

July

August

September

October

November

December

January

February

March

BOARD STATEMENTS:



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.

Timescale for compliance:

RESPONSE:

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

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.

Timescale for compliance:

RESPONSE:

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

Whittington Health Trust Board

4th March 2015

Title:		Corporate Risk Register Annual Review					
Agenda item:		15/042		Paper		9	
Action requested:		For Approval					
Executive Summary:		<p>This paper sets out an annual summary of the Trust corporate risk register.</p> <p>All risks have been reviewed to establish a profile of the current risks. This provides assurance that risks will be mitigated by scrutinising documented actions and target ratings. The extreme (red risks scoring 15-25) are outlined and an overview provided of the assurances from the reporting cycle.</p> <p>Appendices: Appendix 1 corporate risk register Appendix 2 triangulated risk management</p>					
Summary of recommendations:		Members of the Trust Board are asked to approve the corporate risk register and take assurance that risks are being managed appropriately.					
Fit with WH strategy:		Sound risk management and internal controls which align to Whittington Health Risk Management Strategy.					
Reference to related / other documents:		Annual governance statement Board assurance framework Annual audit plan					
Date paper completed:		16 February 2015					
Author name and title:		Pauline Frost, Interim Director of Risk & Lynne Spencer, Director of Communications & Corporate Affairs		Director name and title:		Philippa Davies Director of Nursing and Patient Experience	
Date paper seen by TMG	17/02/15	Equality Impact Assessment complete?	n/a	Risk assessment undertaken?		Legal advice received?	n/a



Corporate Risk Register Annual Review

1. Purpose

This report provides a summary of the corporate risk register. All risks have been reviewed to establish a profile of the current risks. This provides assurance that risks will be mitigated by scrutinising documented actions and target ratings. The extreme (red risks scoring 15-25) are outlined below and an overview provided of the assurances from the reporting cycle.

2. Background

The trust has a risk management strategy that sets out the process for managing all risks. This aligns with NHS requirements for management and handling of risks. The data and information used to produce this report was extracted from the Datix risk management database February 2015.

Extreme risks are escalated from other risk registers onto the corporate risk register. (Appendix 2 shows the escalation process). An ongoing programme of work will strengthen the controls required by the risk owners to mitigate risks, alongside actions and links to known future sources of internal and independent assurance.

The risks on the corporate risk register will continue to be reviewed and updated at least monthly at their respective divisional level and monthly on an aggregated basis through the trust management group (TMG). The director of communications and corporate affairs will retain core oversight of the document.

3. Risks and objectives

As an NHS Trust one of our core functions is to provide high quality services whilst achieving financial break-even. The corporate risk register identify risks to achieving financial break-even. Risks to achieving financial break-even are also being identified at an operational level and escalated to the corporate risk register where mitigating actions are not sufficient to control the risk. This demonstrates that risks are identified at all levels throughout the organisation from strategic to an operational level.

There are a number of extreme rated risks which relate directly to the financial, agency spend and cost improvement plans. Further review of the risk scoring and will be undertaken during March 2015 in order to streamline and simplify the process of risk management. The financial risks have materialised and the trust has put into place a plan to mitigate the consequences of the financial overspend within an agreed timescale.

4. Quality assuring divisional and directorate risk registers

The purpose of risk quality reviews is to ensure:

- risks are described and graded appropriately;
- mitigating actions are sufficient to manage the risk;
- controls and assurances are clear, accurate and up- to-date.

To ensure this programme of work is conducted efficiently, discussions are required between the risk owner and the central governance and risk team who report to the Director of Nursing and Patient Experience. This will enable appropriate review and challenge to the extreme (red) and high (amber) risks recorded within their respective division.

5. Total number of risks

There was a 54% increase in the number of risks identified on the trust wide risk registers in 2014. This positive increase in the number of risks identified and recorded was expected with the appointment of a dedicated risk manager for Integrated Care and Acute Medicine (ICAM). In addition, a member of the corporate governance team has been assisting Surgery, Cancer and Diagnostics (SDC) to identify and record risks on divisional risk registers.

This demonstrates a significant improvement in the risk aware culture of the organisation over the past year.

6. Extreme risks (score of 15 – 25)

There are currently seven risks rated as extreme on the corporate risk register. The majority of risks are currently rated as high (amber score of 12 to 14) and these will undergo further review and evaluation using the National Patient Safety Agency (January 2008) Risk Matrix for Risk Managers. This matrix scoring methodology is recommended by NHS England as a best practice tool.

Table 1: Number of extreme risks

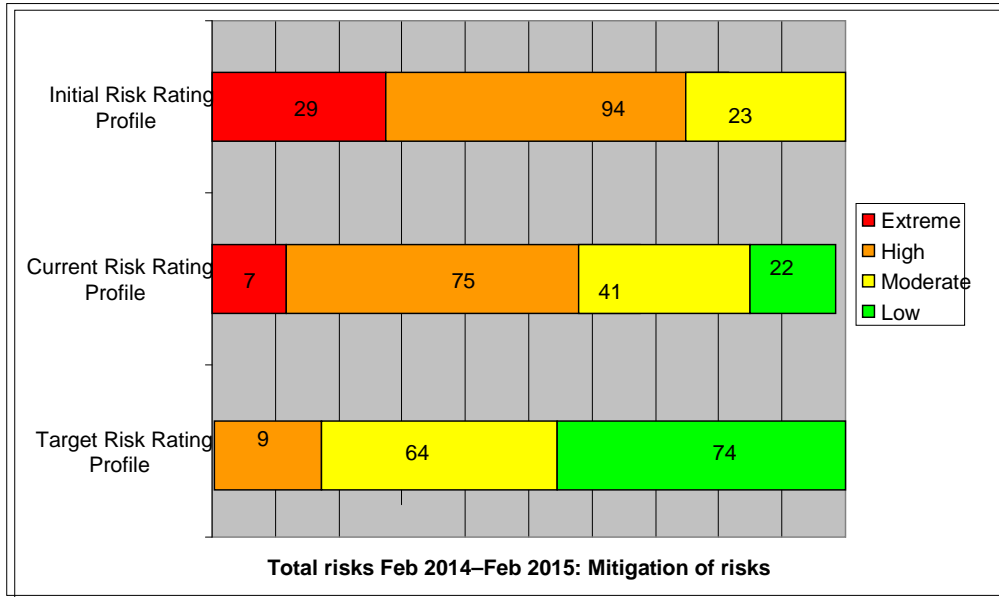
Current Risks by grading	No
25	1
20	1
16	4
15	1

7. Mitigation status

Progress against approved risk actions has been demonstrated by review of how the risks had been addressed, what actions were taken to mitigate the risks and how confident the division were in actions resulting in required improvements to achieve the tolerance level of risk control. **Chart 2** below demonstrates the transfer that has already taken place to reduce the initial extreme risk rating profile to the current risk profile. This provides a trajectory of what the target risk rating profile will look like once mitigating actions continue to be implemented.

There has been a significant shift from the initial extreme risk rated risks from 29 down to 7 over the previous twelve months which demonstrates a robust approach to the management of risks during 2014/15.

Chart 2: Annual status of risks transferred from initial to current risk status



8. Risk management continuous improvement journey

There will be a targeted review of high (scores of 8–12 amber) category rated risks during the first quarter of 2015/16, moderate risks in the second quarter and low risks in the third quarter. This will provide a sound approach to the assurance report detailing the annual review presented to the Board in April 2016 for 2015/16. The objective and independent scrutiny will take place by a newly formed 'Quality Risk Watch' working group led by the Director of Communications and Corporate Affairs.

The trust auditors have commented that risk registers will become an even more useful and informative risk management tool if they include perceived prospective risks. This is now in place as each division has reviewed their 2015/16 business plans and identified areas where there may be threats to achieving their objectives.

In future, new extreme risks on the corporate risk register will have an associated action plan which will be implemented to mitigate the risk to a level which is considered to be an acceptable tolerance rating. This evolving proactive approach to managing risks in a structured and systematic manner will enable the trust to tackle risks in a timely and considered manner before they materialise.

9. Recommendations

Members of the Trust Board are asked to approve the corporate risk register and take assurance that risks are being managed appropriately.

Philippa Davies
Director of Nursing and Patient Experience

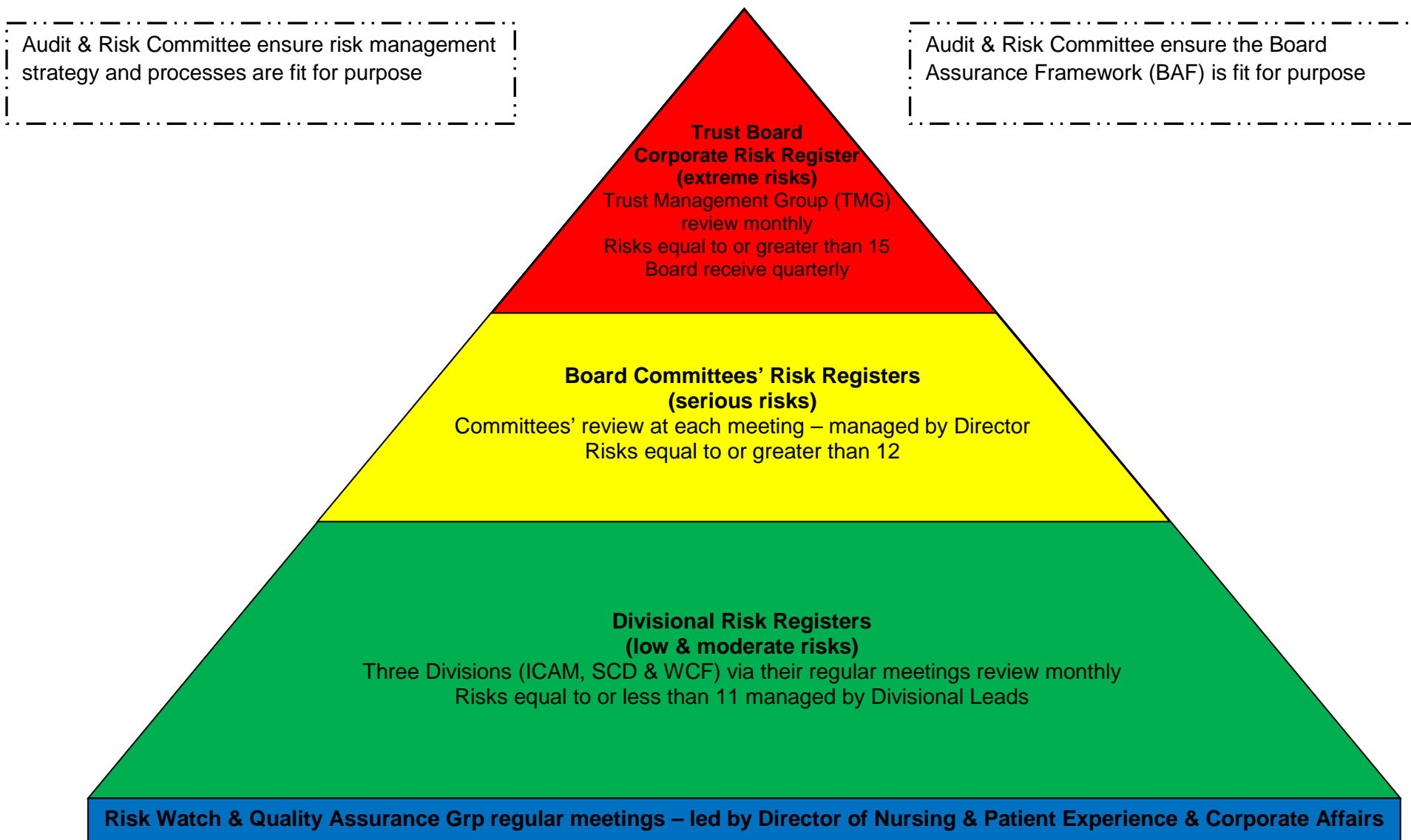
Appendices:

Appendix 1 Corporate risk register **Appendix 2** Triangulated risk management

ID	Directorate	Department	Staff Lead	Description	Controls in Place	Gaps In Controls	Risk level (current)	Assurance	Gaps in Assurances	Progress Notes / Overall Risk Update	Review date	Target Date
Department:												
	Nursing and Patient Experience	Organisation	Ms Alison Kett	* High levels of agency staff will result in high costs which will impact on the Trust meeting its financial targets	Agency usage group Monthly monitoring of agency spend Agency usage controls in place at all levels for management approval - shift by shift review Establishment review of adult wards, agreed higher level of staffing in budget Monthly recruitment drives Designated post in place for recruitment of nursing positions	Recruitment to substantive posts which are currently vacant Recruitment strategy to be ratified	Extreme 16 ▶	Bank and agency reduction group monitoring spend on a monthly basis Meeting weekly to progress 10 workstreams to manage spend Vacancies to reduce on a monthly basis.	Continued to have high spend in nursing bank and agency	16.1.15 - high use of agency over the last 4 weeks due to winter pressures to keep patients safe but continue to monitor closely	#####	28/02/2014
540	SCD	SCD	Mrs Fiona Isaacsson	* Division will not meet financial balance at the end of the year as the cost improvement and value improvement plans have not all delivered planned savings	Regular review of CIP plans to continue delivery of successful initiatives 14/15 Plans in place to ensure schemes get back on track for 2015/16 There are strong controls around spend across the division so that actual spend is reduced as much as possible to improve the Divisional forecast	Demand on beds, in particular medical, has resulted in slippage of planned savings for Victoria ward (pay & non pay) Traction across radiology spend difficult due to significant increase in demand. Smallo increase in income to facilitate economic staffing models Controls requesting both radiology and pathology are not as high as they could be as no consequence currently to continue to request tests as there is no cross charge to referrers' budgets The gaps in the savings plan have not	Extreme 16 ▼	Divisional CIP demonstrates CIP recurrent position is improving month on month 2014/15 forecast sheet describes actions in place and forecasts the year end position which is currently at £2m overspend. Tracking of forecast position is undertaken weekly to ensure this is maintained as a maximum position but with any improvements documented to reduce to year end 29.01.15 update shows CIP schemes are now delivering although VIP ones are not		Weekly review from now to end of year to reduce forecast position down to the minimum	#####	31/03/2015
491	Integrated Care and Acute Medicine	ICAM	Ms Carol Gillen	* Forecast year end overspend of £2.5M (excluding CIPs/VIPs) and main areas are: ED (£600K), Wards (£600K Specialing), District Nursing (£350K)	Action plan in place: Each of the three highlighted areas have a recruitment plan being monitored against actual recruitment International recruitment, recruitment for Europe and UK Planned recruitment events in 2015 £2.5M is the forecast based on month 4 outturn, the controls are in place to contain spending to this level	Budget for specialisms not included in the revised ward establishment budget. To be a separate piece of work by corporate for focus and grip. Specific process in place for approving specialising and monitored daily Expanded mental health liaison team reviewing need for RMN specialising on daily basis Inconsistency in Extra dependency patients recording so new process will capture patients who are high dependency to enable compensation	Extreme 25 ▲	Financial reporting. Monitoring activity, daily capacity report. Action plan for each of the areas, with named budget holders held to account	Focus has been on nursing so now will scrutinise other professional groups eg admin and AHPs	January 2015 - Forecast overspend to end of financial year. Recovery plan in place, and current full year forecast overspend is £3.2m (excluding CIP and VIP). The forecast includes significant run rate reduction in Q4	#####	31/03/2015
492	Integrated Care and Acute Medicine	ICAM	Ms Carol Gillen	* Failure to deliver against CIP and VIP financial targets, forecast at £1.1M	CIP and VIP group meetings, regular updates to CIP project manager	Whole system approach scrutiny has not occurred	Extreme 20 ▶	CIPs monitoring on a weekly basis with a named manager held to account. Weekly meetings, regular reporting, discussed and monitored at Trust Operational Board	None within the division. There has been further slippage due to demand on beds and in ED, which has resulted in the twilight shift still being in use in ED and ISIS remaining open	Division forecasting underachievement against 2014/15 CIP and VIP targets. Forecast underperformance at £1m. due to twilight shift still being used in ED, and delay to close ISIS. Pharmacy has some of their target unidentified. Resilience money planned to offset under-performance against the twilight shift saving non recurrently	#####	31/03/2015

Department: General Surgery												
402	Surgery, Cancer and Diagnostics	General Surgery	Ms Deborah Clatworthy	* If additional beds remain open on Coyle and Victoria wards there will continue to be use of temporary nursing staff which may impact on quality and finance	Daily monitoring staffing levels and quality indicators Visibility of Matron and Head Of Nursing Use of bank and pool nurses where possible	Progress in agreement to recruit more permanent staff but the vacancies have not all been filled and at times the temporary staff office are unable to fill requests for bank/agency staff	Extreme 16 ►	Additional funding identified to increase the overall substantive nursing numbers. Some nurses commenced and others have been recruited awaiting start date. Monitoring of safety standards Monitoring of bed use collected daily so that financial impact can be calculated	Continues to be high number of medical patients on Victoria ward so dual usage. Ward rounds and the appropriate support requires strengthening. Junior medical and consultant medical staff extended ward rounds which impacts frequency of visits	Additional beds are still open due to winter pressures and 65% - 70% of ward has medical outliers. Nursing establishment to be rectified so currently use temporary staff	#####	01/03/2015
Department: People (Human Resources)												
97	People (Human Resources)	People (Human Resources)	Mr Chris Goulding	* Workforce plan presented to Trust Board seminar March 2014 with £15M CIP and estimated £11M of transformational programmes were identified. Gap to be closed from agency reductions and other initiatives. £4M offplan CIP target if workforce plan not met	Two year TDA submission on the Operational Financial Plan endorsed by the Trust Board in April 2014, included workforce implications and targets	Workforce reporting and monitoring	Extreme 15 ►	Reports to Trust Management Group Reports to Trust Board		Audit and Risk Committee received assurance report July meeting and further discussed September Committee. Workforce monitoring now in place and HR metrics reported to Executive and Trust Operational Board. Committee received report January 2015 for assurance	#####	31/03/2015
Department: Imaging												
444	Surgery, Cancer and Diagnostics	Imaging	Mr Robert Katz(*)	* Radiology examinations that show a significant finding must be communicated to referring clinician in a timely manner, or potential risk that a patient may not receive appropriate and timely treatment	Imaging results reviewed by consultant radiologists and reports placed on anglia ice. Alert flags raised against high risk reports Patients referred with a high suspicion of cancer have their pathways tracked closely and adverse results highlighted by MDT or co-ordinator for prompt action	Alert flags and review of reports on anglia ice requires regular review to ensure ward or clinical teams systematically check flags Consistent best practice by radiologists required to support referring clinicians	Extreme15 ►	Referred to Medical Director for action Standard Operating Procedure drafted and shared for implementation	Trust standard operating procedure to be agreed for OP and IP Implement process and monitor for compliance	Medical Director disseminated SOP for alerting and checking Radiology and histopathology outpatient. ED reports sent to Dr Jennings mid August. SOP cascaded to Divisional leads September.	#####	31/12/2014
Department: Safeguarding Adults												
176	Nursing and Patient Experience	Safeguarding Adults	Ms Alison Kett	* If insufficient robust governance arrangements (including compliance with all levels of training) there is risk to protect vulnerable adults from harm and escalation of adult safeguarding concerns and issues to internal and external authorities	Adult Safeguarding Policy Dedicated Adult Safeguarding Lead Nurse Close monitoring of compliance with mandatory training External review of adult safeguarding to commence	Staff trained in Level 2 Safeguarding Deprivation of Liberty Safeguards Prevent (Radicalisation of Individuals) Domestic Violence Mental Capacity Act Some staff not routinely escalating concerns to safeguarding lead Policies are not embedded within practice Organisational capability and competence within acute setting regarding Adult Safeguarding and MCA/DOLS Engagement of patients and carers in	Extreme-16 ►	Quality Committee and reporting Monitoring shows evidence staff are engaging and informing the adult safeguarding lead when safeguarding concerns are raised both by and against the organisation	Visible leadership internal MCA audit identified a lack of understanding of MCA/DOLS Lack of data of numbers of safeguarding alerts raised against and by the organisation Low numbers of Deprivation of Liberty authorisation as compared with peer Acute organisations	7.1.15 - Level 2 training compliance at 27%. Trajectory to reach 90% in September 2015. Additional face to face training, raising awareness of areas for non compliance, all new starters to receive Adult Safeguarding training at Level 1/2. Dols training complete resulting in an increase in Dols (6 authorisations in Dec) Offered to New Adult Safeguarding postholder 6.1.15 External review completed.	#####	29/10/2014

Whittington Health Triangulated Risk Management in Action



Whittington Health Trust Board

4th March 2015

Title:		Nursing and Midwifery Ward Establishment Review – October 2014					
Agenda item:		15/043		Paper		10	
Action requested:		For Approval					
Executive Summary:		<p>This paper sets out the ward establishment review undertaken in October 2014 and makes recommendations related to nurse staffing levels on the acute adult wards.</p> <ul style="list-style-type: none">• Ward staffing levels in October 2014 were reviewed using Nursing Hours Per Patient Day (NHPPD), Safer Nursing Care Tool (SNCT) and Professional Judgement models. Benchmarking was also undertaken.• Following the last review the Board approved £1.9m investment in nursing establishments. This paper details where this investment was made.					
Summary of recommendations:		Members of the Trust Board are asked to consider proposals detailed.					
Fit with WH strategy:		Efficient and effective care. Francis Report recommendations Cummings recommendations					
Reference to related / other documents:							
Date paper completed:		16 th February 2015					
Author name and title:		Philippa Davies 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?	



Nursing and Midwifery Ward Establishment Review

Purpose:

This Nursing and Midwifery ward establishment review follows that which was undertaken in 2013. The Trust Board considered a paper presented in June 2014 and approved the recommendation which was uplift in nursing establishment and pay budget.

This establishment review was undertaken to:

- Provide an assurance both internally and externally that ward establishments are safe and that staff are able to provide appropriate levels of care to patients and levels of care that reflect the Trust values and the 6 C's of the national nursing strategy (2012). This is particularly important in light of key recommendations made in the Francis Report (2013), the Berwick Report (2013) and following the National Quality Board publication; "How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*, and the recently published NHS England document; 'Safe Staffing – A guide to care contact time'.
- Comply with CQC and NHS England 'Hard Truths Commitments Regarding the Publishing of Staffing Data'
- To provide establishment data that will inform the Trust Workforce Strategy, and the 2015- 2016 Cost Improvement Plan (CIP) programme.
- To conform to Care Quality Commission requirements under the Essential Standards of Quality & Safety, including outcomes 13 (staffing) and 14 (supporting staff).

Background:

The Trust has a duty to ensure that ward staffing levels are adequate and that patients are cared for by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013), and the Health and Social Care Act (2012).

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, all of which align with the Trust priorities and objectives which include:

- Improvement in patient experience
- Reducing failure to rescue
- Improving pressure ulcer incidence
- Reducing adverse incidents, particularly related to medication errors and falls

Summary of key actions implemented following the last establishment review:

Following recommendations made in the 2013 establishment review, a £1,990,713 (full year effect) investment was committed which equated to an increase in 38.85 WTE staff of which 8.64 WTE posts were in the division of Surgery Cancer and Diagnostics (SCD) and 30.21 WTE posts in the division of Integrated Care and Medicine (ICAM). In addition, within the £1,990,713 investment, 'headroom' increased by 5% from 17% to 22% at a cost of £544K.

Headroom is made up of the following;

Annual leave 15%
Maternity Leave 3%
Sickness 2%
Development 2%

Recognising the requirement to fund additional 'escalation' beds particularly in the winter months, the budget was further increased by £643K to fund an increase in temporary staff which equated to an additional £138,784 in ICAM and £504,220 in SCD. For the purpose of this review, the additional escalation beds staffed by temporary staff on Coyle ward and Victoria ward were excluded from the review.

Methodology for 2014 establishment review:

A literature review was undertaken prior to commencement of the establishment review in order to incorporate the latest evidence to inform the methodology and the recommendations.

In addition:

- Establishments were compared to 2013
- A benchmarking exercise was undertaken with 4 other anonymised Trusts using data for all comparable wards
- Three nursing establishment models were utilised to assess for variances, which comprised of the Safer Nursing Care Tool (SNCT), Nursing Hours per Patient Day (NHPPD) and Professional Judgement model, as per national guidance
- National standards for specialty areas were used e.g. critical care 'step down' and acute respiratory beds.
- Registered to unregistered ratios were reviewed
- Staff to bed ratios were reviewed in line with national guidance
- Number of beds and bed occupancy was used
- The nursing quality indicators and key safety and outcome measures were reviewed.

The review includes band 2 – 4 health care assistants who are categorised as 'unregistered' staff, in addition to band 5 – 7 nurses who are categorised as 'registered' staff. The review covers the wards in The Whittington Hospital. A summary of the detail by ward is included within this report and the whole analysis can be reviewed by contacting the Director of Nursing.

Nursing Hours Per Patient Day (NHPPD) Benchmark Review:

NHPPD is a systematic nursing workload monitoring and measuring system that provides a guide to the number of nurses required for service provision within a specific clinical area. The NHPPD model is not designed as a rigid, mandatory determinant of staffing but relies on clinical judgement to assess adequate staffing to deliver care on a daily basis. The model is used to calculate the number of direct nursing hours required to provide patient care and as a framework to establish a nursing roster. This establishment review took this model into account to inform findings.

Key Quality and Outcome Measures:

A comprehensive Nursing Quality Indicator Report is produced monthly and presented and discussed at ward and committee level. This report details key nurse sensitive quality indicators by ward, directorate and community team. The Trust Board receive monthly information in relation to Infection Prevention and Control, Patient Experience and Patient Safety within a performance pack. The Patient Experience report and Complaints, Litigation and PALs report are presented quarterly to the Quality Committee, a sub-committee of the Trust Board. Staff experience and satisfaction metrics are presented by the Deputy Director of Human Resources.

All of the above metrics are taken into consideration at the time of the establishment review and when making recommendations. The recommendations for the establishment review were discussed with senior nursing and midwifery colleagues within the Trust and at the Nursing and Midwifery Executive Committee prior to seeking approval of the recommendations by the Trust Management Group.

Key Findings

1. Funded changes since the 2013 establishment review:

The funded establishments in ICAM have increased in total by 30.21 WTE; this is accounted for by the implementation of the establishment review recommendations in 2013 for Cloudesley, Mayrick, Cavell, Nightingale, Montushi, and Mercers wards in addition to an increase in establishments in Mary Seacole North and Mary Seacole South assessment wards.

The funded establishments in SCD have increased by 8.64 WTE, accounted for by increases in establishment in Coyle, Thorogood and Victoria wards.

The funded establishments in the Women Children and Families (WCF) division remained unchanged.

2. Current registered to unregistered staff ratios

In 2006, the Royal Collage of Nursing recommended the use of a 65:35 skill mix on acute general and surgical wards in England where 65% of staff should be registered

nursing staff. A national review in 2009 indicated an average of 62% of registered staff which increased to 64% of registered staff in 2011.

Current ratios on our wards are detailed in the table below;

Ward		% Registered nurses	% Health Care Assistants	Nurse to bed ratio
Cloudesley	Care of the elderly	63	37	1.30 nurses to each bed
Meyrick		63	37	1.30
Cavell		70	30	1.69
Nightingale	Respiratory	82	18	1.46
Montouschi	Cardiology	87	13	1.36
Mercers	Gastro/oncology	86	14	1.25
Mary Seacole South	Acute Assessment	82	18	1.65
Mary Seacole North		82	18	1.86
Coyle	Orthopaedic	66	34	1.43
Thorogood	Elective Orthopaedic	80	20	1.52
Victoria	General surgery	74	26	1.39

3. Nurse to bed ratios

While there is no national standard for nurse to bed ratios there is national guidance based on patient safety and outcome measures which recommend a nurse to bed ratio of 1.2:1. As can be seen in the table above, the Trust does not have any wards that do not meet this standard.

4. Supervisory ward managers

One of the Francis Report (2013) recommendations was that Trusts should make all ward managers supervisory, this means supplementary to the rostered work force. This review has highlighted that there is variation in the number of days worked per week by the ward manager i.e. not all ward managers are rostered to work Monday to Friday. There is also variation in the number of hours per week the Band 6 Junior Sister/Charge Nurse undertakes management duties (non-clinical duties). One of the recommendations implemented following the last establishment review was all ward managers would have one management day per week. It is unclear at this stage how many hours per week are spent on management (non-clinical duties) and the impact of vacancies and operational pressures on this protected time. As such, one of the recommendations from this review will be to undertake a comprehensive diary exercise of ward manager activity over a two week period to assess the current supervisory allocation. The diary exercise will highlight any variation by ward in the supervisory allowance and highlight activities that registered nurses are currently routinely undertaking that could be undertaken by an alternative health professional or support worker.

5. Changes to establishments following the 2013 review;

5.1 *Cloudesley Ward*

The funded establishment on this ward increased by 2.46 WTE and the ratio of registered to unregistered nurses increased from 58% to 63%. The staff to bed ratio increased from 1.20:1 to 1.30:1

5.2 *Meyrick Ward*

The funded establishment on this ward increased by 2.46 WTE and the ratio of registered to unregistered nurses remains unchanged. The staff to bed ratio increased from 1.20:1 to 1.30:1

5.3 *Cavell Ward*

The funded establishment on this ward increased by 1.13 WTE and the ratio of registered to unregistered nurses decreased by 1%. The staff to bed ratio increased from 1.60:1 to 1.69:1

5.4 *Nightingale Ward*

The funded establishment on this ward increased by 5.47 WTE and the ratio of registered to unregistered nurses increased from 80% to 82%. The staff to bed ratio increased from 1.20:1 to 1.46:1. This ward has 4 high dependency beds which require 1 registered nurse to 2 patients.

5.5 *Montouchi Ward*

The funded establishment on this ward increased by 2.51 WTE and the ratio of registered to unregistered nurses increased from 78% to 87%. The staff to bed ratio increased from 1.20:1 to 1.36:1. This ward has 4 high dependency beds which require 1 registered nurse to 2 patients.

5.6 *Mercers Ward*

The funded establishment on this ward increased by 0.77 WTE and the ratio of registered to unregistered nurses increased from 70% to 86%. The staff to bed ratio increased from 1.20:1 to 1.25:1

5.7 *Mary Seacole South Assessment Unit*

The funded establishment on this ward increased by 5.31 WTE and the ratio of registered to unregistered nurses increased from 80% to 82%. The staff to bed ratio increased from 1.36:1 to 1.65:1

5.8 *Mary Seacole North Assessment Unit*

The funded establishment on this ward increased by 6.91 WTE and the ratio of registered to unregistered nurses increased from 79% to 82%. The staff to bed ratio increased from 1.43:1 to 1.86:1

5.9 *Coyle ward*

The funded establishment on this ward has increased by 1.74 WTE and the ratio of registered to unregistered nurses increased from 61% to 66%. The staff to bed ratio increased from 1.36:1 to 1.46:1

5.10 *Thorogood ward*

The funded establishment on this ward has increased by 3.73 WTE and the ratio of registered to unregistered nurses decreased from 83% to 80%. The staff to bed ratio increased from 1.15:1 to 1.52:1

5.11 *Victoria ward*

This ward has 4 beds allocated to high dependency patients and the funded establishment on this ward has increased by 3.51 WTE and the ratio of registered to unregistered nurses increased from 70% to 74%. The staff to bed ratio increased from 1.31:1 to 1.47:1

5.12 *Ifor ward*

The funded establishment on this ward has decreased by 1.71 WTE and the ratio of registered to unregistered nurses decreased from 88% to 89%. The staff to bed ratio decreased from 1.62:1 to 1.54:1

5.13 *Neonatal Intensive Care Unit*

The funded establishment on this ward has decreased by 0.70 WTE and the ratio of registered to unregistered nurses remained unchanged at 94%. The staff to bed ratio decreased from 2.72:1 to 2.68:1

6. *Staffing in the Emergency Department (ED)*

The nurse staffing levels in the ED were not included in this review but have been assessed using the Baseline Emergency Staffing Tool - BEST. This is yet to be fully validated; however it is the only tool currently endorsed for use by the Chief Nursing Officer. Whittington Health was one of the organisations elected to pilot this tool for the RCN in 2013. This involved hourly assessments of all the patients in the department over the period of one week. NICE have been reviewing nurse staffing in Emergency Departments and are due to publish recommendations in May 2015.

A consultation document was published by NICE in January 2015, making recommendations for 'Safe Staffing in Emergency Departments', the final document will be published in May 2015.

7. Staffing in the Maternity Dept

The staffing levels in the maternity unit were not included in this review but have been assessed using 'Birthrate Plus'. This is the only research based, nationally acknowledged method for recommending staffing levels in maternity units and has been endorsed by the Chief Nursing Officer. An independent assessor was commissioned by the Trust in November 2013. Women are classified into five different categories according to the amount of care time required. These categories are weighted, and from this, the establishment can be calculated. The independent assessor reported that Whittington Health had a higher than average number of women who required a high number of midwifery hours per person. All calculations were based on the assumption of 3985 births annually.

8. Summary

The Whittington Health establishment review of October 2014 used a combination of SNCT, NHPPD and Professional Judgement models in addition to consideration of evidence in the latest literature. It considered a number of Francis recommendations, including staffing ratios and skill mix.

The findings of this review indicate that there are a number of opportunities to be explored in terms of increasing the number of 'supervisory' hours of ward managers, reviewing registered to unregistered nurse ratios and reviewing care contact time.

9. Recommendations

- 9.1** To procure an electronic staff rostering system which will include a 'safe staffing' function. This will allow skill mix and staff numbers to be aligned with patient acuity.
- 9.2** To review and agree percentage of 'headroom' allocation.
- 9.3** To undertake a ward manager diary exercise to understand care contact time, supervisory time and time spent on 'other' activities.
- 9.4** To review percentage of registered to unregistered nurses.
- 9.5** To review nurse structure by ward.

Philippa Davies
Director of Nursing and Patient Experience

Whittington Health Trust Board

4th March 2015

Title:		Safe Staffing (Nursing and Midwifery)					
Agenda item:		15/044		Paper		11	
Action requested:		For information					
Executive Summary:		<p>This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in January 2015. Key issues to note include:</p> <ul style="list-style-type: none">• The majority of areas reported greater than 95 per cent ‘actual’ versus ‘planned’ staffing levels• A number of areas reported ‘actual hours worked’ over and above those ‘planned’ which was attributed in the main to the provision of RMNs/RGN’s/HCA’s to support patients under a Mental Health Section, patients with increased dependency and 1:1 ‘specialing’ of some of our most vulnerable patients.• In the Emergency Department 14 shifts ‘triggered’ red in January, 10 of which related paediatric nursing hours. 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 January 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:		February 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 Nurse Staffing Levels January 2015

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 January 2015 and an assurance that these levels are monitored and managed daily.

2.0 Background

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

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st January 2015 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

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

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in January 2015. Average fill rate was 103.3% for registered staff and 114% for care staff during the day and 100.4% for registered staff and 125.1% for care staff during the night.

Two wards fell below average fill rates for qualified nurses but were managed safely using newly qualified nurses who were waiting for their Nursing and Midwifery Council (NMC) personal identification number (PIN) working as HCAs and by moving staff from other green ragged rated areas. Above average fill rate occurred on one ward where an additional RMN nurse was required to care for patients subject to a Mental Health Section. Above average fill rates in excess of 100% for HCA's continues on wards where vulnerable patients require 1:1 care. 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. In January 2015 between 14 and 36 HCA 'specials' were required, under a

quarter of the number in August. The number of RMN 'specials' required to care for patients under a mental health section continues at a rate of between 15 and 30 shifts per week.

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 January can be seen in Appendix 3. In summary, in January a total of 40/1488 (2.69%) shifts triggered 'red' which is fractionally higher than previous months but continues to be low. Of these, 22/837 (2.63%) occurred in the division of Integrated Care and Acute Medicine (ICAM), 2/279 (0.72%) in the Women's, Children and Families (WCF) division and 16/372 (4.3%) 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, 10 were in the paediatric emergency department due to paediatric nursing vacancies. ICAM covered rotas with support from paediatric in-patient and ambulatory care services. Additional paediatric nurses have been recruited and are in the recruitment process.

Of all shifts that initially triggered 'red', 14 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 January can be attributed to the following:

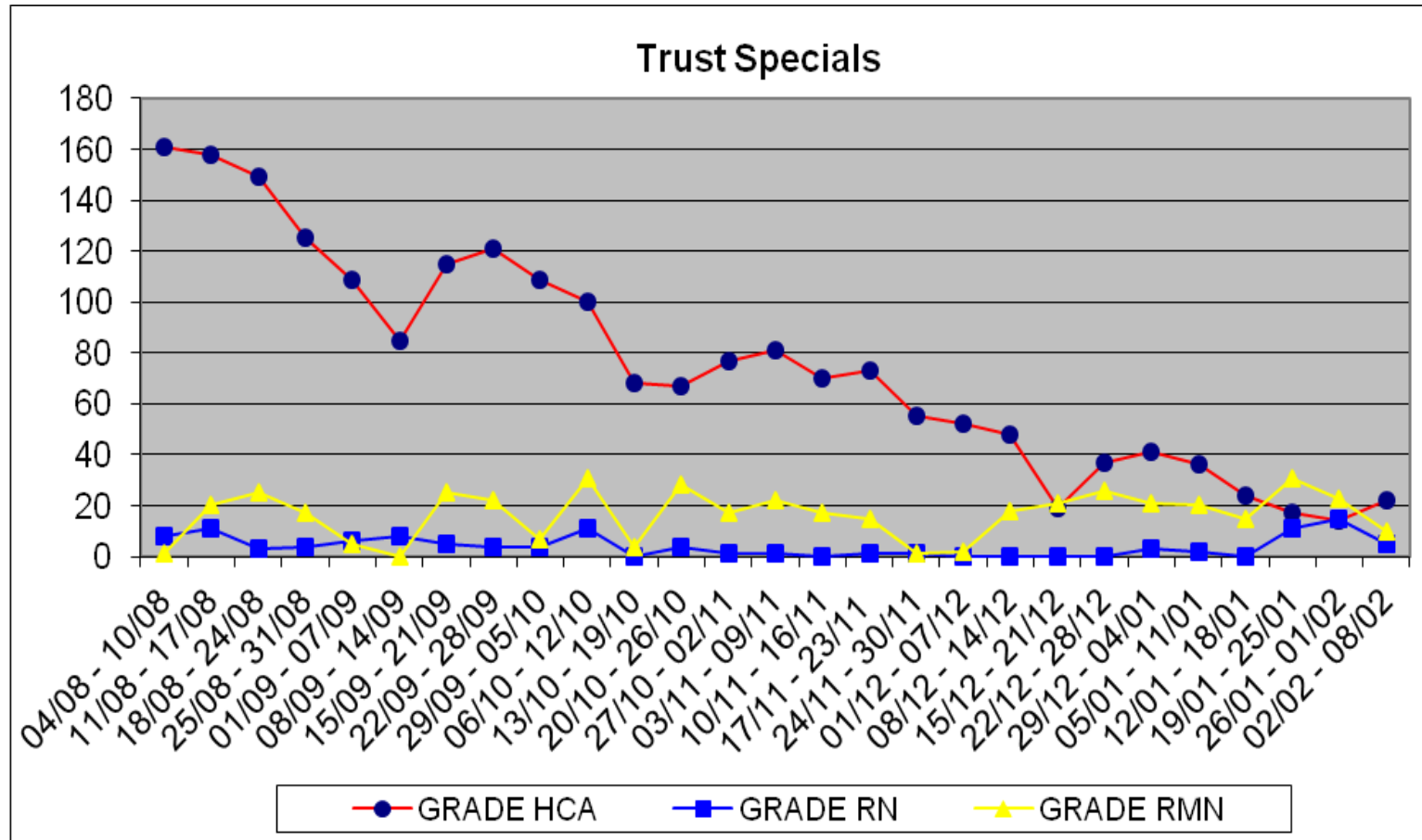
- Nursing vacancy rates in the Paediatric Emergency Department which are reducing as a result of local and overseas recruitment.
- Patients requiring 1:1 care by an RMN.
- Continued demand for staff to provide 1:1 care for our vulnerable patients, particularly on three wards.

5.0 Conclusion

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

**Fill rate data - summary
January 2015**

Day				Night				<u>Average</u> fill rate data- Day		<u>Average</u> 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	103.3%	114%	100.4%	125.1%
34,282 hours	29,057 hours	10,424 hours	11,887 hours	28,450 hours	28,572 hours	6,566 hours	8,211 hours				



January – 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	Elderly Care	Meyrick		93	1	0	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	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
		Cavell		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
		Bridges		93	1	1	1	3	3.23		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	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
	Respiratory	Nightingale		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
	Gastro/Haem/Onc	Mercers		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
	MAU	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
		MSN		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
	Emergency	ED		93	4	0	10	14	15.05		Staffing levels proved challenging, vacancies and sickness covered by bank or agency nurses or staff moved to provide cover to ensure patient safety not affected
TOTAL				837	6	3	13	22	2.63		
SCD	ITU	ITU		93	2	2	0	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
	Surgical	Victoria		93	4	4	0	8	8.6		Staffing levels proved challenging, 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	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
	Ortho (planned)	Thorogood		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
TOTAL				372	8	8	0	16	4.3		
WCF	Paediatrics	IFOR		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
	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	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
TOTAL				279	1	1	0	2	0.72		
TRUST TOTAL				1,488	15	12	13	40	2.69		