Whittington Health NHS

TRUST BOARD

14.00 – 17.00
Wednesday 4 November 2015

Whittington Education Centre Room 7

Whittington Health NHS

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Meeting	**Trust Board – Public**
Date & time	**4 November 2015 at 1400hrs – 1630hrs**
Venue	**WEC 7**

AGENDA

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

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

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

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Verbal*	*Note* 1400hrs
15/132	**Declaration of Conflicts of Interests** *Anita Charlesworth, Acting Chair*		*Declare* 1420hrs
15/133	**Apologies & Welcome** *Anita Charlesworth, Acting Chair*		*Note* 1425hrs
15/134	**Minutes, Action Log and Matters Arising 7 October** *Anita Charlesworth, Acting Chair*	**1**	*Approve* 1430hrs
15/135	**Chairman's Report** *Anita Charlesworth, Acting Chair*	*Verbal*	*Note* 1435hrs
15/136	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Note* 1440hrs
Patient Safety & Quality			
15/137	**Trust Board Safety Report** *Richard Jennings, Medical Director*	**3**	*Note* 1445hrs
15/138	**Safe Staffing Report & New measures, workforce challenges** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Note* 1455hrs

15/139	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**5**	*Note* 1505hrs
Strategy			
15/140	**Trust Risk Management Strategy** *Philippa Davies, Director of Nursing & Patient Experience*	**6**	*Note* 1515hrs
15/141	**System Resilience Winter Plan** *Carol Gillen, Acting Chief Operating Officer*	**7**	*Note* 1525hrs
15/142	**Capital Plan** *Siobhan Harrington, Director Strategy & Deputy Chief Executive*	**8**	*Note* 1535hrs
Performance and Delivery			
15/143	**Financial Performance Month 6** *Stephen Bloomer, Chief Finance Officer*	**9**	*Note* 1545hrs
15/144	**Performance Dashboard Month 6** *Carol Gillen, Acting Chief Operating Officer*	**10**	*Note* 1555hrs
15/145	**Workforce KPIs Month 6** *Norma French, Director of Workforce*	**11**	*Note* 1605hrs
Governance and Regulatory			
15/146	**TDA Oversight Statements** *Siobhan Harrington, Director Strategy & Deputy Chief Executive*	**12**	*Note* 1615hrs
15/147	**Trust Board Corporate Risk Register** *Philippa Davies, Director of Nursing & Patient Experience*	**13**	*Note* 1620hrs
15/148	**Audit & Risk Committee Terms of Reference** *David Holt, Non-Executive Director / Chair Audit & Risk*	**14**	*Note* 1630hrs
15/149	**Medical Revaluation Annual Report 2014/15** *Richard Jennings, Medical Director*	**15**	*Note* *1640hrs*
Any other urgent business and questions from the public			
	No items notified to the Chairman		
Date of next Trust Board Meeting			
	02 December 2015 Whittington Education Centre, Room 7		

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

Whittington Health NHS

ITEM:15/134
Doc: 1

The minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 7th October 2015 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Anita Charlesworth	Non-Executive Director (in the Chair)
	Philippa Davies	Director of Nursing and Patient Experience
	Norma French	Director of Workforce
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Paul Lowenberg	Non-Executive Director
	Lee Martin	Chief Operating Officer
	Simon Pleydell	Chief Executive
	Graham Hart	Non-Executive Director
	Paul Convery	London Borough of Islington
In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Golde, present to recount the story of her son Tobi's patient experience at the Whittington hospital over a period of several years. Tobi had suffered from sickle cell anaemia from babyhood, had been treated at the Whittington until the age of seven, then at another hospital before returning at the age of 15 (he is now 25). Golde recounted episodes of treatment where she felt improvements to the attitude of some staff would be helpful to improve the patient experience. She described the anxiety she had felt when Tobi had been admitted on different occasions, and that improvements were required with responsiveness of treatments such as oxygen and pain relief.

Mattie the nurse, our specialist sickle cell nurse, described some of the recent improvements made as a result of the feedback. The introduction of a rapid assessment team to ED meant that patients such as Tobi who were in severe pain and known to be suffering from a serious long-term condition could be seen and assessed more quickly. There had been some staff training on the care of sickle cell patients and there were to be more sessions which would include input from expert patients. A recent training day on sickle cell was well attended by staff, and for the first time a sickle cell clinical nurse specialist for the hospital was to be appointed.

Both Philippa Davies and Richard Jennings expressed their sincere apologies to Golde and to her son, and Simon Pleydell asked Mattie whether she felt there was sufficient awareness amongst staff of sickle cell anaemia and its treatment – Mattie replied that she felt awareness was growing. In answer to a question about her level of satisfaction with the haematology team, Golde said that she was extremely impressed by Dr Davis and his colleagues, describing them as 'superb'. Philippa Davies said that an action plan would be developed and taken to the Trust's Quality Committee on care of sickle cell patients, and she undertook to share this with Golde.

15/115 Declaration of Conflicts of Interest

115.01 Paul Lowenberg said that he was currently carrying out some consultancy work for the Peabody Trust, who were involved in redeveloping a site in Archway. .

15/116 Apologies and welcome

116.01 Anita Charlesworth had agreed to chair the Board meeting in Steve Hitchins' absence. Steve had submitted his apologies, as had Tony Rice and Anu Singh.

15/117 Minutes of the previous meeting, action log and matters arising

117.01 Referring to minute 113.02, Philippa Davies reported that she had spoken to Kate Green earlier and clarified the minute relating to nursing and midwifery revalidation.

Action log

117.02 (94.04) The cancer services strategy would now be presented to the Board in December. The items on End of Life Care had been included on the cycle of business and could therefore be removed from the action log.

117.03 (109.05) Lee Martin informed the Board that there were now very few complaints within the Women & Family ICSU, and the two outstanding had been delayed in part due to their complexity but also because there were legal issues involved. Amanda Hallums continued to monitor performance.

15/118 Chairman's Report

118.01 Anita Charlesworth reported that since the last Board meeting Steve Hitchins had attended the CCG AGMs in Camden, Islington and Haringey. He had also mentioned the very successful annual Whittington Oration, at which Professor Sir Mike Richards had spoken, saying that Mike had demonstrated clearly that the CQC was raising the bar on quality standards.

118.02 There had been a useful meeting with the Governors the previous week. Amongst the subjects discussed had been the forthcoming CQC inspection, Trust values, the estates strategy, issues around tackling bullying and harassment and care on the wards.

118.03 Anita was sorry to report that Lee Martin was leaving the Trust having been appointed to a new role at London North West Hospitals NHS Trust. She extended a huge thank you to him on behalf of the Board for everything he had contributed to the success of the Trust.

15/119 Chief Executive's Report

119.01 Simon Pleydell also thanked Lee and wished him much success in his new role. Simon will confirm acting up arrangements for the chief operating officer role in the next week and this would be particularly important as winter approached to maintain the Trust's high performance standards. At a TDA meeting the previous day they had confirmed the Trust's recent ED performance as the best of any non-FT in London.

119.02 Another high priority is the Trust financial planning for next year in order to ensure a sustainable position. The Trust was currently working with Boston Consulting, whose unique selling point (USP) was the way they worked with clinicians - as well as non-clinical senior management. This approach focused on a better use of resources and in-depth analysis of data. The first phase of the work had now concluded, and Boston Consulting had presented the findings to the Trust Management Group (TMG) the previous day. Clinical leaders were actively involved to manage the saving themes being identified.

119.03 Simon was sorry to report that since the last meeting there had been a never event and all the staff involved had expressed their regret to the patient and family. The incident had involved a wrongly placed nasogastric tube, and Simon added that this particular type of incident is amongst the most frequently reported never events. The patient had recovered

from the immediate impact of that event, but remained in hospital for the original health care condition. The event has been reported and is being investigated in line with policy.

119.04 Murray Ward had been formally opened by actress Tameka Empson, and all concerned were delighted with the improvements made. Moving on to the maternity business case, Simon reported that a further meeting had been held with the TDA and they remained supportive of the Trust business case there was a wider issue of access to capital for the NHS. The team will continue working with the TDA and other relevant departments to gain the required support for this important strategic area of development.

119.05 Performance against targets continued to improve with action plans in place for areas that required further improvements. The Whistleblowing Policy was being promoted and named leads had been advertised internally for staff to refer issues of concern. Work continued on the estates review and engagement with staff and community stakeholders was ongoing to ensure feedback informed the future strategy. The estates strategy will be key to supporting the implementation of the Trust's clinical strategy. Siobhan Harrington added that there had already been a great deal of internal engagement via the new weekly drop-in sessions at the hospital where the executive team were informally meeting staff and the public for their views and ideas. There were plans to meet with the Rotary Club later that week and a calendar of community meetings had been produced for the executive team to attend local meetings across both boroughs.

119.06 Anita Charlesworth was pleased to note that Whittington Health had been named in the Observer as one of the first hospitals in the UK to welcome carers to stay with patients suffering from dementia at all times throughout their treatment in hospital, including overnight where this was required. This initiative was brought about through working with the national charity John's Campaign. Anita also drew attention to the relaunching of the new staff awards process.

119.07 Noting the section of the report on infection prevention and control, Graham Hart paid tribute to the work of Julie Andrews and her team in all their efforts to prevent infection – a particularly impressive feat given that nationally Clostridium Difficile infection rates were rising. David Holt asked whether the Trust knew what it was doing differently so that it might share the learning with others, and Philippa Davies replied that Whittington Health did pride itself on being extremely proactive and was also extremely careful to guard, as far as possible, against any source of hospital-acquired infection. Anita added that the importance of having a stable team under good leadership could not be underestimated. Richard Jennings mentioned the forthcoming retirement of Gretta O'Toole, a member of that team, who had given many years dedicated service to Whittington Health.

15/120 Safer Staffing Report

120.01 Philippa Davies introduced the August safer staffing report which highlighted that three wards had fallen below 95% that month and she gave assurance that all areas had been safely managed by working flexibly with staff. During August 14 shifts had triggered red, and the report provided a breakdown of the areas where this had occurred, and this was lower than previous months. The report was noted by the Board.

15/121 Serious Incident Report

121.01 Philippa Davies informed Board colleagues that two serious incidents had been declared during August, one of which related to wrong route administration of medicine and which had actually been a near miss but was still under investigation. The second, verbally reported to the Board at its last meeting, concerned the loss of usage of major IT outages which had resulted in the temporary non-availability of EPR and PACS.

121.02 Paul Lowenberg pointed out that although two serious incidents were recorded within this report, the performance data was at odds with this, appearing to state that no incidents had been declared during August. Lee Martin replied that this was due to the timing of the

report's production, but assured the Board he would look into it for future reports. Paul reported that he found it difficult to relate the comments in the tables on pages 4 and 5 to the incidents as he was unclear whether they related to July or August. Philippa replied that the panel had debated whether or not to include the incident's STEIS number, but had decided against it for reasons of confidentiality. Paul asked about the timing of the incident on page 5, and Richard undertook to check and let him know, adding that all action plans had dates clearly set out against actions.

15/122 Trust Response to Morecambe Bay Investigation (Kirkup Report)

122.01 Philippa Davies said that the Kirkup report had been published in March following an independent investigation into maternity and neonatal services provided by the University Hospitals of Morecambe Bay NHS Foundation Trust. The investigation had identified some serious failings within the services, grouped broadly into five main areas:

- clinical competence
- working relationships
- overzealous pursuit of natural childbirth
- failure to risk assess
- deficient response from clinicians to serious incidents.

122.02 Amanda Hallums, Director of Operations for Women & Family Services, informed the Board that the report had been reviewed by the ICSU, and the view was that Whittington Health complied with the majority of the recommendations. A task and finish group had been convened to ensure that all actions points had been addressed in order to provide assurance to the Board that a 'Morecambe Bay situation' could not happen within Whittington Health. She mentioned in particular the fact that the midwifery team and the consultant body had the highest of respect for one another, that there were strict protocols in place for the birthing centre which were clear and available to all staff, that performance was rated 'green' in most areas and that there was a strong safety culture. Regular review meetings were held and adherence to training was robust, although it was hoped to increase the number of GPs and staff from other departments attending PROMPT skills and drills training.

122.03 Anita Charlesworth enquired whether the ICSU was confident that all areas shown as amber in the action plan would have moved to green by the end of the year, and Amanda replied that she hoped this would be the case. It was therefore agreed that a progress report would be taken to the Quality Committee in January.

122.04 In answer to a question about the extent to which serious incidents are checked against one another to ensure they are not identifying systemic failures, Richard Jennings replied that this was a valuable question and one to which there could be no absolute guarantee. What was important, though, was to maintain some degree of continuity, and within Whittington Health this was achieved through consistency of membership of the SI Panel. When panel members felt they had seen a similar incident before, it could be built into the terms of reference to check what points of similarity existed and whether an incident was in fact the same, or had the same root causes. Finally, systems of monitoring trends were used, and Richard gave an example of one trend that had previously been identified, i.e. a disproportionate amount of incidents concerned patients with learning difficulties. This meant that each incident was now checked to see whether any patients with learning disabilities were involved, and services for this client group had also been highlighted as one of the Trust's 'Sign up to Safety' pledges.

122.05 David Holt commented on the comprehensive nature of the document, but stressed that one thing underlying the Trust's response must be the duty of candour. Amanda replied that this was strongly embraced within the ICSU, and that all clinical staff were aware and

trained. David asked about near misses, and Amanda assured him that these were picked up through the incident reporting system, which was reviewed on a monthly basis. Near misses were also reviewed with the families concerned. She added that reports were taken to the ICSU Board. Richard Jennings reminded Board colleagues there were issues within both systems and culture, and there were additional forums where learning could be shared, including the morning report (for doctors in medicine) and the patient safety forum chaired by Julie Andrews. He also made a link with the paper on tackling bullying and harassment to be discussed later in the meeting.

15/123 Trust Draft Research Strategy

123.01 Director for Research & Innovation Rob Sherwin introduced this item, saying that the strategy had been brought to the Board for information, feedback and approval. It was based on the Trust's clinical strategy, and as well as having received feedback from staff on its content, had been through many forums including the Quality Committee and Trust Management Group. The focus of the strategy was around investigation of optimal integrated care, and Rob hoped to launch it at a symposium to be held on 19th November.

123.02 Graham Hart expressed congratulations to Rob and his colleagues both for creating this strategy and for aligning it so closely with the clinical strategy. He also paid tribute to the contribution to the research agenda of Monica Lakhanpaul, now leader of his faculty, and Ruth Law, who had been to see him to discuss how best to embed research within clinical practice. Graham also informed the Board that one of the clinicians working at the highly successful TB hub was proposing an ambitious model of research. He further noted that since he had been supporting Rob in this work there had been a real cultural change from the old trials model to the ICO concept, and he felt that one of Whittington Health's USPs would be as a research Trust.

123.03 Paul Lowenberg enquired whether, if Whittington Health was to undertake Value Based Commissioning projects from next April, these should have an explicit research content built in. Richard Jennings replied that he agreed with the principle of this, and that in fact whenever the Trust embarked on any such new venture research should be an intrinsic part of the plan in order to ensure opportunities were not lost. He also spoke of the importance of the research strategy being aligned to the education strategy.

123.04 Greg Battle spoke of the importance of linking with the Trust's commissioners and seeing them as partners in any such developments. Stephen Bloomer asked for some measures of success to be built into the final version of the strategy, and Simon Pleydell felt there should be a range of metrics against which it should be possible to track progress against the operational plan. Graham Hart suggested these could be brought to a future Quality Committee. Anita Charlesworth said that trial numbers should be included within the Quality Account.

123.05 The Board approved the strategy and reiterated the point about inclusion of quantifiable metrics. The strategy overall was described as 'fantastic', and Board members were truly appreciative of the efforts of its authors.

15/124 Financial Report

124.01 Stephen Bloomer said that the report included the revised plan which had been submitted to the TDA and which gave the Trust's new stretch target of £15m deficit rather than the originally submitted £19.5m. From next month the Trust's financial performance would be measured against the new target. The key risks were highlighted in point 3.5 of the submission, also shown (at 3.6) was the continued request for support for the maternity business case. The Board agreed the submission and noted the revised financial statements attached at Annex B.

124.02 The report showing the Month 5 financial position had not been circulated and it was agreed this item to be circulated after the meeting.

124.03 Stephen Bloomer gave a verbal report of the Month 5 financial position. At the end of August the Trust had declared a deficit of £6.5m, £750k worse than the planned position. This was primarily due to income, however it was noted that August was traditionally a 'lean' month. The position on CIP had improved and now stood at 82%; this included a number of non-recurrent schemes. The cash position had also improved, largely due to success in collecting some long-standing debts. There were however some residual risks around some of the CIP schemes, contracting, and winter pressures.

124.04 Anita Charlesworth suggested that given the current position a more detailed discussion would be required at the Finance & Business Development meeting the following day, and Simon Pleydell added that the Boston Consulting proposals could be built into this. Paul Lowenberg had noted the significant escalation of CIP savings, but remained concerned at the amount of substitution and non-recurrent schemes that had contributed to this. It was generally agreed that next year's savings needed to be planned using robust analysis and a project based approach.

15/125 <u>Performance Dashboard</u>

125.01 The dashboard showing the Trust's performance for the month of August was introduced by Lee Martin, who reported that the Trust had met all three indicators for RTT that month, and for September he was ensuring sustainability was maintained for all three through monitoring at the acute waiting list meeting. The Trust was performing well against its cancer targets and maintaining sustainability, demonstrating the hard work carried out by the team. There had been a small dip on ED performance a few weeks ago, but they were now back on track. There was some risk as winter set in, and the department had already seen its first 300+ attendance (the winter 'norm').

125.02 The Trust was below target on its 6 week waits for MSK, there had been a backlog of patients caused by clinics being moved and for specialist clinics there was reduced capacity at present. Lee explained that because treatment was prioritised on clinical need figures would look less favourable temporarily but he expected an improvement by the end of November.

125.03 Anita Charlesworth asked for a formal update on winter planning to be provided for the November Board meeting. She also asked for increased narrative within the dashboard on DNA rates, which remained 'stubbornly red'. Finally, she thanked Lee for ensuring that waiting times for IAPT were included in the dashboard. Paul Convery asked for an explanation of the variance on waiting times, and Lee explained that the main issues were staff vacancies and staff changes, and every effort was being made to recruit more staff. There had also been the usual changeover of junior doctors on rotation, and some staff sickness.

125.04 Paul Lowenberg spoke of the importance of retaining the improvements that had been made. He then enquired about the percentage of district nursing outcomes that were unrecorded. Lee Martin explained that this was a matter of timing – medical records were updated but sometimes retained in case they were needed for a patient visit the following day therefore they were not always immediately reported centrally. Paul asked performance measures for district nursing and asked when these will be included within the report. Lee replied that the team had been looking at how the dashboard best reflected integration over the summer and he would shortly be presenting the product of this work to Simon Pleydell and then to the Trust Management Group. The revised dashboard would then come to the Trust Board. Simon Pleydell reported that it would show the Board the extent to which the Trust had progressed in its journey towards integration.

125.05 The Board discussed the Trust's level of performance and activity set against what it was commissioned to do, and Lee Martin said that this was routinely raised at the contract review meeting. Siobhan Harrington added that this linked with much of the work currently being undertaken on community services within the contract monitoring group which would taken forward by building it into the work of the Finance & Business Development Committee.

125.06 Paul Lowenberg asked about the MSK waits and Lee explained the position was different to last year as previous waits had concerned MSK services across the Board and this reported waits for purely specialist clinics. He added that this had been the subject of much discussion in PTL meetings, and there had been a significant amount of learning from these discussions. Paul would be keen to understand the lessons so the Trust would be in a good position to manage demand and capacity going forward.

15/126 Workforce KPIs

126.01 Norma French informed Board colleagues that this was the first report that, as newly-appointed Workforce Director she had been able to influence directly. Norma had endeavoured to make the information more meaningful and accessible, and for the first time vacancy rates could be seen by ICSU, and it will be possible to drill down still further in order to identify the 'hot spots'.

126.02 The sickness figures were largely self-explanatory, and Norma suspected reporting rates had risen. Moving on to areas of concern, Norma listed three – appraisal, mandatory training, and understanding the detail behind vacancy factors. From this month onwards she would be attending the ICSU performance meetings which would clarify some of these issues. She hoped that appraisal rates would begin to improve from September. Appendix 5 set out benchmarking data gathered as a product of the London Streamlining Project.

126.03 In answer to a question from Anita Charlesworth about the workforce plan, Norma replied that this was in her annual objectives. There is already a working draft of an organisational development plan, and she hoped that by the end of the calendar year there would also be an outline draft of a workforce strategy. Siobhan Harrington supported the timing of this in terms of other developments.

15/127 Annual Report on Partnership Working with the London Borough of Islington

127.01 Carol Gillen introduced Carol McGregor, who was appointed jointly by Whittington Health and the London Borough of Islington. She said that this was now the third year of the Section 75 partnership agreement with the local authority, and the annual report was also received by Islington's executive team. Key achievements included:

- developing integrated locality team working
- maintaining independence at home
- enhanced and mainstream reablement
- care closer to home.

127.02 Carol spoke about the success of the N19 pilot, which informed the integrated locality team working model now in place, and Islington's success in maintaining a low number of delayed transfers of care. The latter had been achieved through the intervention of the reablement service, regular use of teleconferencing and prompt access to equipment.

127.03 Going forward, the aim was to continue to embed community locality teams, develop the locality-base model with local GPs, utilise the pooled budget for intermediate care, regular medication checks and outreach from community therapy services.

127.04 Paul Convery passed on apologies from Cllr Janet Burgess, and on behalf of the Council said how pleased Islington was with the progress of the Section 75 partnership working, which was particularly important for them both in terms of the service provided to local residents and also in releasing costs. Anita Charlesworth replied that Whittington Health was grateful for the commitment both parties had shown to joint working.

127.05 Richard Jennings said that the report described a great many impressive initiatives, but he wished to highlight the Integrated Community Ageing Team (ICAT) as having made a significant difference in a relatively short period of time, and he extended congratulations to Ruth Law and her colleagues for their achievement. Carol Gillen added that the trend continued, and commissioners had committed to significant future investment.

127.06 Lee Martin added his congratulations, saying that he saw evidence of the success of this partnership on a daily basis, the work was renowned across London, and the Trust had received 11 visits in 8 weeks from other organisations wishing to learn from it.

127.08 In answer to a question about the position with the London Borough of Haringey, Carol replied that although joint working was not as far developed as with Islington, the relationship was a positive one, a Section 75 agreement was in place, Haringey regularly attended weekly 'long waits meetings', and some very good work was being undertaken around the locality teams.

15/128 Tackling bullying and harassment

128.01 Norma French informed Board colleagues she had agreed to pull together all work carried out in this area over the last twelve months, and at the same time set out some proposals for how the Trust might wish to move forward. Her paper therefore set out the context and described progress to date, with the exception of the equality scheme. The paper had been discussed at the Trust Management Team, and Norma had agreed to work up some of the areas including the possible introduction of a harassment adviser role.

128.02 Anita Charlesworth enquired how the Board should best maintain an understanding of progress in this area, as well as monitoring quality of care. It was noted that the workforce paper was to be submitted to Quality Committee. Norma added that this year's staff survey had just opened, and Simon Pleydell mentioned the GMC survey for junior doctors and the staff Friends & Family test. He asked for this agenda item to come back to the Board in due course, but only once some firm trends and data were available. The CQC inspection would also be a source of information. It was agreed that it was right to have a repertoire of methods for dealing with bullying and harassment as no single method dealt will all forms.

15/129 TDA Oversight Statements

129.01 Anita Charlesworth enquired whether there had been any material changes to the TDA statements since the previous month. Siobhan Harrington replied that the only change worthy of note was the inclusion of the risk management strategy, which would be coming to next month's Board meeting. The statements were approved by the Board.

15/130 Working Capital Facility – Updated Signatories

130.01 The Board formally approved the paper which proposed making Stephen Bloomer as Chief Finance Officer a signatory to the current revolving loan facility

15/131 Board Assurance Framework

131.01 Siobhan Harrington introduced the Board Assurance Framework (BAF), saying that two risks had been given a higher rating than had previously been the case and four new ones had been added. The BAF had been through the Executive Team and Trust Management Group and was to be presented to the Audit & Risk Committee later that month. She thanked Paul Lowenberg for submitting some detailed comments.

131.02 Paul Lowenberg queried the reference to KPIs, saying these were not yet seen by the Board, and Siobhan replied that these were referenced in the action plan part of the BAF and were being developed. He also noted there was no reference to RIO, which he was aware was a cause for concern in some quarters, and he sought clarification over the reference to the phrase 'capacity to deliver' in the gap in controls section of Risk 18 (CQC Inspection).

131.02 In response, Siobhan said that RIO had successfully gone live the previous weekend, with no issues. On Risk 18, the phrase used had reflected the issues the executive team raised when this version of the BAF was drafted, and these concerns had reduced considerably since then. These concerns had centred around submission of the required data, since this accounted for 47% of the final outcome score. Detail of the BAF would be scrutinised by the Audit & Risk Committee. The Board approved the BAF.

Action Notes Summary

Patient Story	Action plan to be developed and taken to the Trust's Quality Committee around sickle cell, and she undertook to share this with Golde.	On Quality Committee workplan	PD
103/02	Cancer services strategy due for presentation at the Board	Moved to January	CG
115/01	Paul Lowenberg said that he was currently carrying out some consultancy work for the Peabody Trust.	Add to Register of Interest form, sign and return to CEO office	LS/ PL
15/121	Paul asked about the timing of the serious incident on page 5, and Richard undertook to check and let him know		RJ
122/03	Trust Response to Morecombe Bay Investigation - A progress report to the Quality Committee in January.	January Quality Committee	PD
123/04	Measures of success to be built into the final version of the research strategy	On Quality Committee workplan	SMH /RS
124/02	Month 5 financial position to be circulated and published on website.	Completed	SB
125/03	Anita Charlesworth asked for a formal update on winter planning to be provided for the November Board meeting.	November	CG
125/04	Performance measures for district nursing to be included with the report and the revised dashboard to future Trust Board.	tbc	CG
125/05	Community disaggregration work to be discussed at a future Finance & Business Development Committee.	FBD committee workplan	SMH /SB
126/03	By the end of the calendar year there would be an outline draft of a workforce strategy and plan.	March 16	NF
105.08	External review of the resilience of the Trust's IT	tbc	GW
108.02	Board challenge business planning session with executives and the 7 ICSU's	1 December	ALL
109.05	Complaints responses performance had dropped within Women & Family services - it was agreed that Amanda Hallums would look into this and provide the Board with a response	Completed	AH
109.06	LM informed the Board that there would be a detailed look at theatre utilisation	Date tbc	CG

Whittington Health NHS

Whittington Health Trust Board

4 November 2015

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**15/136**	**Paper**	**02**
Action requested:	For discussion and information.		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust.		
Summary of recommendations:	To note the report.		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent.		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework.		
Date paper completed:	29 October 2015		

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

Chief Executive Officer Report

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

1. QUALITY AND PATIENT SAFETY

Care Quality Commission (CQC)

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

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

A full mock inspection took place on 29 October. Many thanks to all who took part. There will be a verbal update at Trust Board.

MRSA Bacteremia

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

Clostridium Difficile

The Trust reported that it has had 1 new case of Clostridium Difficile reported during September. This brings the Trust total to 5 cases for the year to date. The target is for no more than 17 cases in each year. The Trust has reminded colleagues to be extra vigilant with regular awareness raising initiatives on the importance of adhering to infection control procedures to maintain a strong focus on patient safety as the top priority.

Cancer Waiting Time Targets

The Trust continues to perform well overall for its national cancer targets. The Trust achieved 7 of the 8 national cancer waiting time targets for the latest reporting period up to end of August 2015. The cancer targets include important patient safety areas such as two weeks from referral to first appointment, 31 days from decision to treatment and 62 days from referral to treatment waits. The one area where there was a dip to 91.3% against a target of 93% was in regard to breast cancer 14 days to be seen.

National audit of inpatient falls 2015

The Royal College of Physicians report has been published. As a Trust, in comparison to other Trusts, we have a good record with 3.23 falls per 1,000 bed days. This is the second lowest rate of falls across all Trusts in London. We continue to work with all our clinicians and staff to reduce falls across the Trust.

Staff survey 2015/16

The annual NHS Staff Survey was launched at the end of September and closes at the end of November. This will gather important views to enable the Trust Management Group to inform their business plans with work priorities that tackle the issues staff raise as areas for improvement.

Flu campaign

The Trust continues to vaccinate staff against flu. Whittington Health has a track record of delivering a high rate of flu vaccinations and we are currently at 33% of staff having been vaccinated which is in line with what we did last year at this time of year. We are encouraging all staff to ensure they are vaccinated in order to protect our patients at this time of year.

2. FINANCE MONTH 6

At the end of September, the Trust is reporting a year to date deficit of £6.3m which is £303k better than its planned position.

In month the Trust made one-off gains in commercial negotiations which improved CIP delivery and reduced non-pay spend. As a result the Trust achieved £2.7m (216%) of the planned savings in September and £5.8m (96%) year to date. The second half of the financial year requires a greater level of cost improvement and has a larger number of planned schemes.

Whilst the Trust is forecasting to meet its planned 15/16 deficit of £15m it continues to face a very challenging financial position and focus needs to continue on:

- Reducing flexible staffing spend particularly agency which was higher in September than expected;
- Delivering agreed cost improvements;
- Managing within agreed budgeted levels;
- Delivery of agreed activity levels with a particular focus in spinal and maternity activity;
- Ensuring that all activity is counted and coded and entered within the patient notes quickly to enable a full collection of clinical income.

3. Estate strategy

The Trust is currently developing an Estates Strategy that will enable the Clinical Strategy 2015-2020 to be delivered. The work is well underway with engagement of staff and stakeholders in considering the environment required to deliver care for our local population over the next five years. We are engaging with our local community in a number of ways; attending local meetings, meeting with local groups and having informal events across the Trust. We want to continue this active engagement through November and December and so the final strategy will now come to January Trust Board.

Simon Pleydell
Chief Executive Office

Whittington Health NHS

Whittington Health

Trust Board

4th November 2015

The Whittington Hospital NHS Trust

Magdala Avenue
Dr Richard Jennings

Direct Line: 020 7288 5906

Title:	**Quarterly Safety and Quality Board Report (November 2015)**		
Agenda item:	**15/137**		**3**
Action requested:	For the board to note, discuss and make any additional recommendations		
Executive Summary:	This is the first of what will from now on be quarterly papers for the trust board giving an overview of safety and quality in the organisation. This new arrangement reflects the overall intention to significantly strengthen a safety culture that is already good (as evidenced by much of the data provided in this paper). At an organisational level, the trust has underlined this intention through its commitment to the national Sign up to Safety initiative. As part of a new emphasis on evidence based measurement of safety performance, the trust's Sign up to Safety goals, which are also reiterated in the trust's quality account, are clear, measurable and time bound. It is intended that this quarterly report and other reports and dashboards within the trust will develop a degree of consistency in the representation of quality and safety data, with an emphasis on run charts that clearly highlight trends over appropriately significant periods of time.		
Summary of recommendations:	It is recommended that the contents are noted and approved as the trust's approach to overseeing and strengthening safety and quality		
Fit with WH strategy:	To deliver consistent high quality, safe services.		
Reference to related / other documents:	Quality Account 2014-15 Sign up to Safety Priorities		
Date paper completed:	30th October 2015		

Author name and title:		**Richard Jennings, Executive Medical Director**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment**	**NA**	**Risk assessment**	**NA**	**Legal advice received?**	**NA**

		complete?		**undertaken ?**			

1) Executive Summary

This is the first of what will from now on be quarterly papers for the trust board giving an overview of safety and quality in the organisation. This new arrangement reflects the overall intention to significantly strengthen a safety culture that is already good (as evidenced by much of the data provided in this paper).

At an organisational level, the trust has underlined this intention through its commitment to the national Sign up to Safety initiative. As part of a new emphasis on evidence based measurement of safety performance, the trust's Sign up to Safety goals, which are also reiterated in the trust's quality account, are clear, measurable and time bound.

It is intended that this quarterly report and other reports and dashboards within the trust will develop a degree of consistency in the representation of quality and safety data, with an emphasis on run charts that clearly highlight trends over appropriately significant periods of time.

The recent organisational structure change from three divisions to seven integrated clinical service units (ICSUs) reflects an intention to devolve initiatives on patient safety to empowered clinicians and departments, while maintaining and improving corporate support in key areas, such as organisational safety strategy, dissemination of learning, information support and safety governance.

The trust aims to achieve a major strengthening in learning from patient safety incidents, and this change will include a renewed emphasis on sharing and celebrating achievements and best practice. The organisational change to this approach is described in this report.

Further improvements and initiatives that are planned for this financial year include:

- The on-going use of an external safety assurance tool, Copeland's Risk Adjusted Barometer (CRAB).
- The further development of trust-wide tools and corporate support for the sharing of learning, including training in quality improvement methodology.
- The establishment of a trust-wide process for the review of all inpatient deaths, to augment and complement the many existing examples of departmental good practice in morbidity and mortality audit.
- The planning of a patient safety week in 2015/16 to further raise the profile of patient safety and to raise best practice.

2) Contents

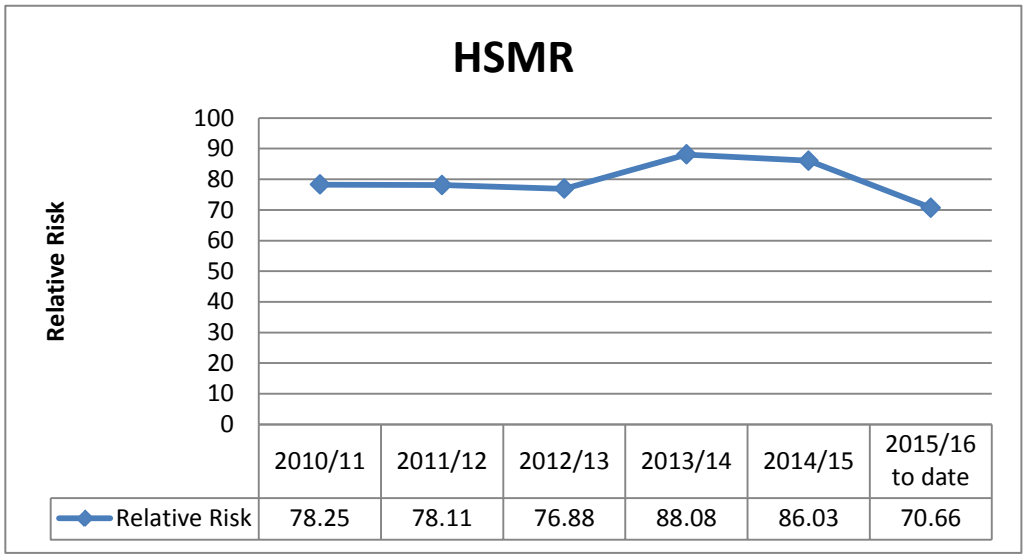
3) Mortality

This trust's HSMR and SHMI have both been 'lower than expected' since 2005/06. Since 2010/11 Whittington Health has had the lowest SHMI in the country. With regard to weekend mortality, the HSMR for patients who are admitted on Saturdays and Sundays is 'lower than expected' when compared to HSMR nationally and is also not statistically significantly different to the HSMR of patients admitted Monday - Friday. This data provides the trust board with positive assurance on the issue of weekend mortality in the Whittington Hospital. While the trust encourages celebration of positive achievements in patient safety there has been a deliberate attempt by the executive to encourage a focus on the on-going reduction of instances of avoidable harm rather than placing undue emphasis on our consistently positive mortality data. There is a current strong emphasis on improving our care for patients with sepsis and acute kidney injury, as described in our Sign up to Safety commitments and in our Quality Account for 2015/16. Achieving our goals in these areas may have a further positive impact on our mortality indicators. We are also developing a trust-wide approach to the review of all inpatient deaths, the learning from which will be collated and shared widely - this too may contribute positively to maintaining and improving mortality.

a. HSMR

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

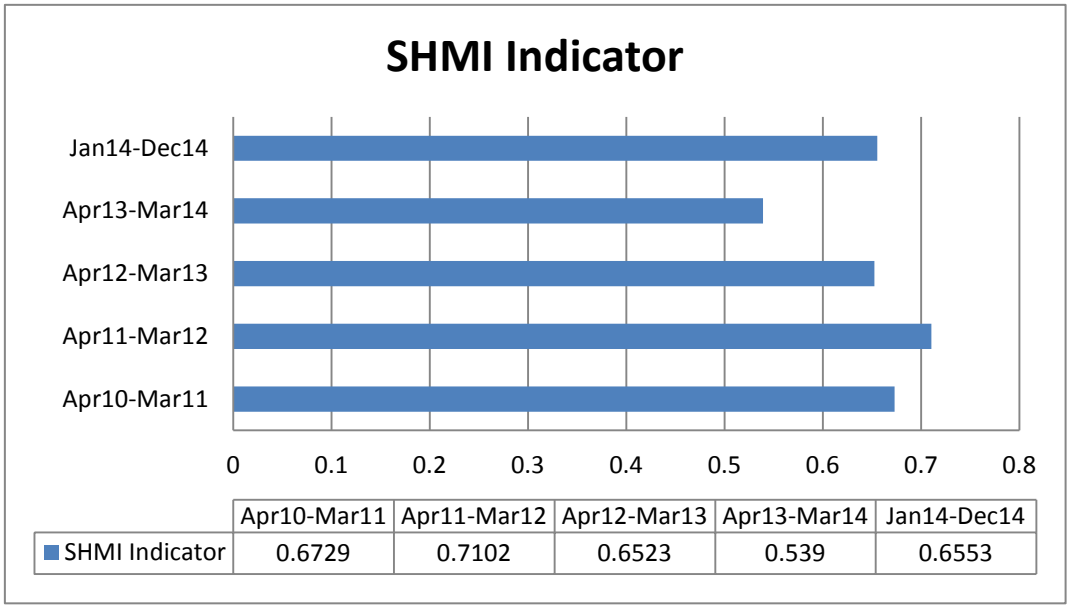
Chart 1: Whittington Health Hospital Standardised Mortality Ration (HSMR) by financial year April 2010 – October 2015



b) Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.
National guidance emphases that SHMI is not a measure of quality of care, but is meant as an indicator for further investigation.
SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.
The trust's SHMI has been 'lower than expected' since 2005/06. In 2014 the trust was one of 17 trusts in the country with a SHMI that was 'lower than expected'. There were 109 trusts with SHMIs 'as expected' and 11 trusts with SHMIs 'higher than expected'.

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) by financial year April 2010 – December 2014



	Apr10-Mar11	Apr11-Mar12	Apr12-Mar13	Apr13-Mar14	Jan14-Dec14
SHMI Indicator	0.6729	0.7102	0.6523	0.539	0.6553

4) Infection control report

a) MRSA Bacteraemia

To date, there have been no trust-attributable cases of MRSA bacteraemia in this financial year.

Chart 3: Whittington Health attributable cases of MRSA bacteraemia by month (April 2011 – March 2015)

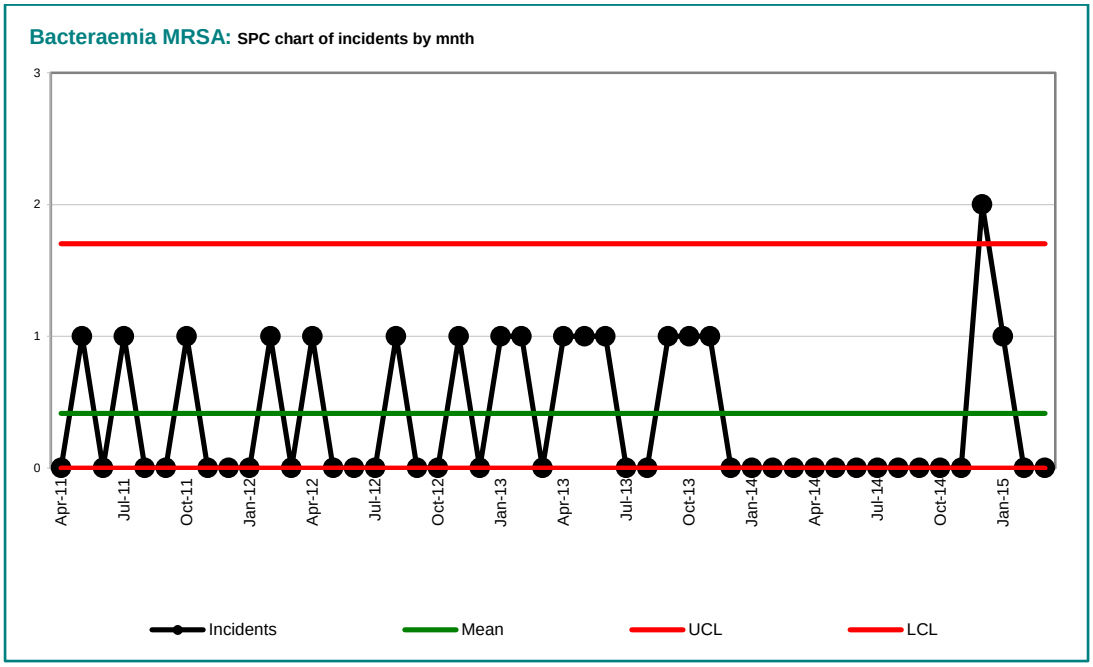
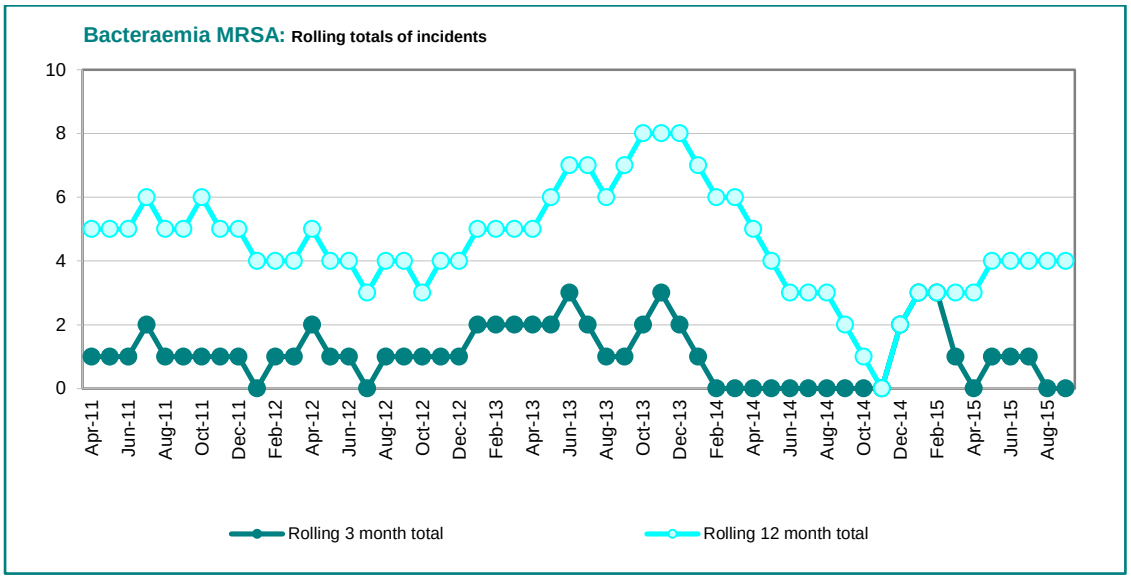


Chart 4: Whittington Health rolling totals of attributable cases of MRSA bacteraemia by month (April 2011 – September 2015)



b) *Clostridium difficile*–associated diarrhoea

In this financial year we have had five cases of *Clostridium difficile*-associated diarrhoea. The most recent case occurred in September 2015 in the Medicine, Frailty & Networked Service ICSU. We have had no cases in this financial year in the Surgery& Cancer ICSU. Consultant led post infection reviews (PIR) have been held on all cases and the reports disseminated to relevant parties both internally and externally. Our agreed objective for 2015/2016 has been set to not exceed a threshold of 17 cases and we are currently under this number, and the trust is currently on a trajectory not to exceed this threshold.
The trust is introducing single use equipment for isolation rooms, and isolation trolleys for bed bays. This should contribute to maintaining current performance and further reducing cases of *Clostridium difficile*-associated diarrhoea.

Chart 5: Whittington Health attributable cases of *Clostridium difficile*–associated diarrhoea by month (April 2011 – September 2015)

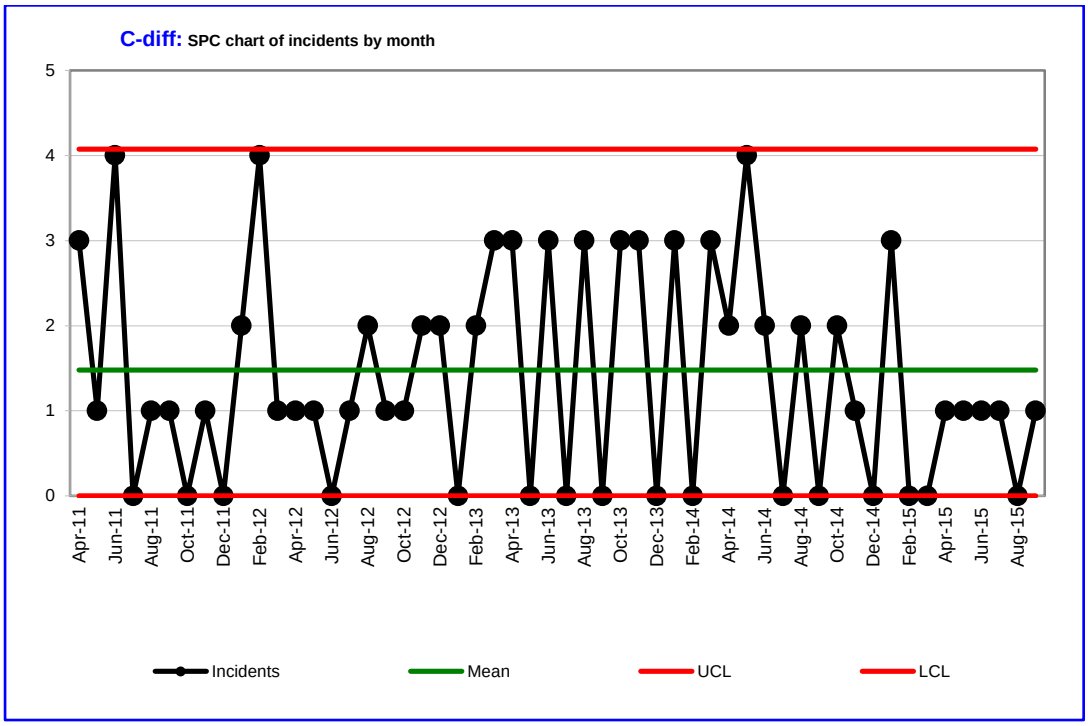
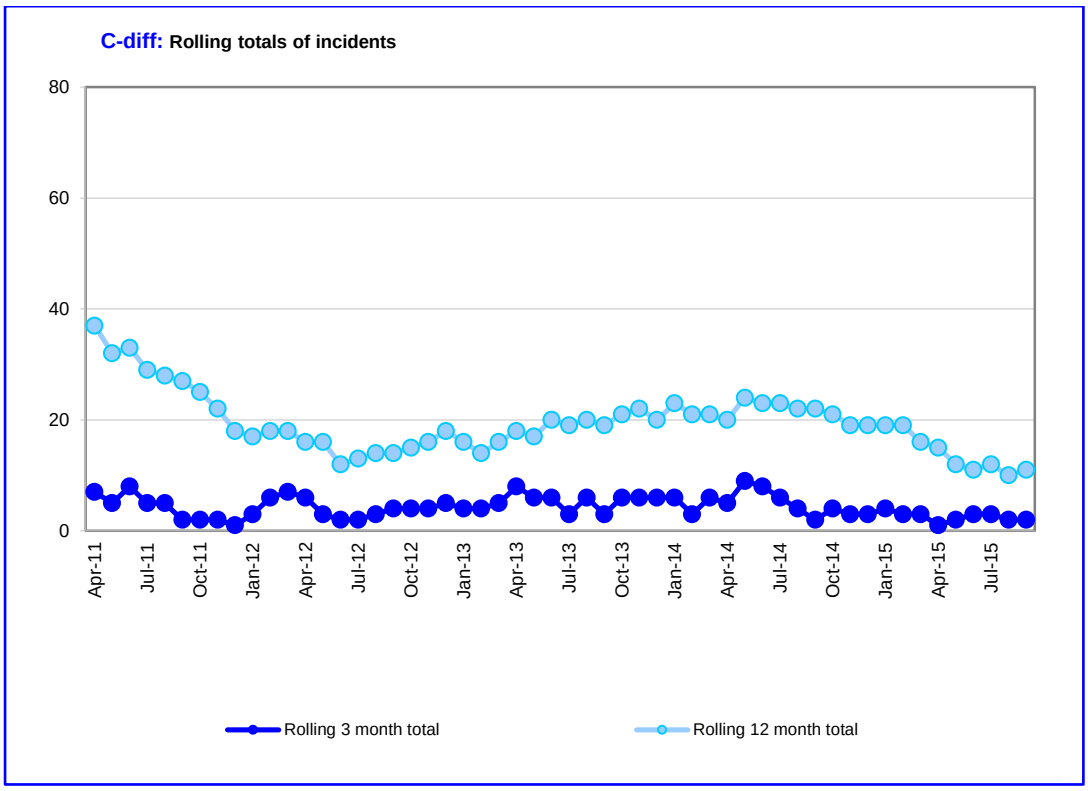


Chart 6: Whittington Health rolling totals of attributable cases of *Clostridium difficile*–associated diarrhoea by month (April 2011 – September 2015)



c) MSSA/ *E.coli* Bacteraemia Episodes

From 1 April 2015 to 25 August 2015 there have been 2 trust attributable MSSA bacteraemia episodes and 7 trust attributable *E.coli* bacteraemia episodes. There are no set objectives for these organisms. Each episode is investigated to see if any interventions (such as urinary catheterisation or peripheral line cannulation) have occurred and whether all correct procedures were followed.

d) Other Relevant Healthcare Associated Infection (HCAI) Issues

Public Health England (PHE) issued guidance on the identification and control of Carbapenamase producing Enterobacteriaceae CPE's (highly resistant Gram-negative bacteria). An action plan was formulated and is monitored through the IPCC; all actions to date have been completed. We have updated our infection control training to include information on this area. We have processes in place to deal with single cases and a completed policy which is available on the Trust's intranet. CPE inpatient screening was further enhanced on 1 October 2014 to include screening of patients who have received in-patient treatment in another London hospital. There have been a total of 4 hospital cases of CPE so far in this financial year.

e) Influenza and Para-Influenza

No outbreaks of Influenza A and B have been identified in the hospital in this financial year, since the seasonal outbreaks during the last winter.

The annual influenza vaccination campaign was a huge success last year with over 80% of staff vaccinated. This placed us at the top of the leader board for London, being the first Trust to achieve this.

The trust is now entering into this year's annual staff vaccination campaign. Influenza screening is likely to commence week commencing 2nd of November 2015.

5) Sign up to Safety

'Sign up to Safety' is a national patient safety initiative led by Sir David Dalton, partly in response to the Francis and Berwick Reports. Its aim is to reduce avoidable harm across the country by half in three years**.** Our own local trust Sign Up to Safety priorities have been chosen to provide a strong foundation for the Trust to continually promote quality across the organisation.

Whittington Health's safety priorities focus on pressure ulcers, falls, sepsis & acute kidney injury and learning disabilities.

Every quarter, the quarterly trust board paper on safety and quality will discuss one of these areas in detail. This paper explores pressure ulcers in detail.

The measurable improvement targets that we have set ourselves in our Sign up to Safety priorities are as follow;

1) Pressure Ulcers

We will have no avoidable grade 4 pressure ulcers.
We will reduce the number of avoidable grade 3 pressure ulcers in the acute setting by 50%.
We will reduce the number of avoidable grade 3 pressure ulcers in the community by 30%.

2) Falls

We will reduce the number of inpatient falls that result in serious harm by 50%.

3) Sepsis and Acute Kidney Injury (AKI)

We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis.
In addition we will effectively record our performance in delivering the sepsis 6 care bundle for all patients.
We will improve our performance by 50% in the course of the year.
We will achieve all our outcome measures associated with our AKI CQUIN in 2015/16.

4) Learning Disabilities

In Q4 90%of inpatients with learning disabilities (LD) will meet the LD specialist nurse during their admission, be clearly identified on the electronic patient record, and have a personalised care plan (Purple Folder).
In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with LD.

Quarterly Sign up to Safety focussed report; Pressure Ulcers

Whittington Health has zero tolerance to pressure ulcer development and is working across the organisation to reduce pressure ulcers within our care and local community. The Tissue Viability service is the lead for reduction in pressure ulcers across primary and secondary care.

Pressure ulcer incidence has been collated since the inception of the Integrated Care Organisation (ICO) in 2011. It is only since 2012, however, that we can be confident in the reliability and validity of all the data.

When a pressure ulcer is reported as a clinical incident a 72 hour investigation is undertaken. The investigation is reviewed by Tissue Viability lead, the Head of Nursing for the ICSU and a decision on avoidable is made using the Department of Health definition.

A pressure ulcer is deemed avoidable if the person receiving care developed a pressure ulcer and the provider of care did not do one of the following:

- evaluate the person's clinical condition and pressure ulcer risk factors
- plan and implement interventions that are consistent with the persons needs and goals,
- monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

<u>Pressure ulcer reduction strategy:</u>

- A 'React to red skin' campaign is being launched in November 2015. This is a raising awareness campaign aimed at health professionals, carers, patients and family members and the wider community about the importance of checking your skin for red areas, which is one of the first signs of pressure damage. This campaign also highlights the importance of early escalation.

- As part of the campaign a poster and logo has been developed to be distributed within the wider community.

- As part of the Sign up to Safety programme over the next 3 years we aim to develop combined package for community patients & carers so both health and social care staff work more closely together and documentation is not disjointed.

- We are developing a quick access protocol and pathway for those who identify 'red' skin.

- Education and training: A review of the way training and education is given has been undertaken and a new training package is being put in place.

- Safety and quality huddles are being commenced within the hospital, identifying patients with any redness or changes in risk at the earliest opportunity, and making sure that all the team are aware of the change in risk, and that the prevention plans are changed appropriately and promptly.

- An emergency department initiative, *Stop Them At The Door*, has been introduced. This involves the provision where necessary of specific dynamic air mattress for trolleys, heel protectors and education specific to ED. There will be a bundle of care

for ED, including any changes arising from a review of the current documentation regarding pressure ulcers prevention and assessment.

- A quarterly key tips and awareness sheet is now disseminated so that everyone is aware of any new areas which need addressing.

Chart 7: All reported trust attributed pressure ulcers from both community and acute (April 2012 – September 2015)

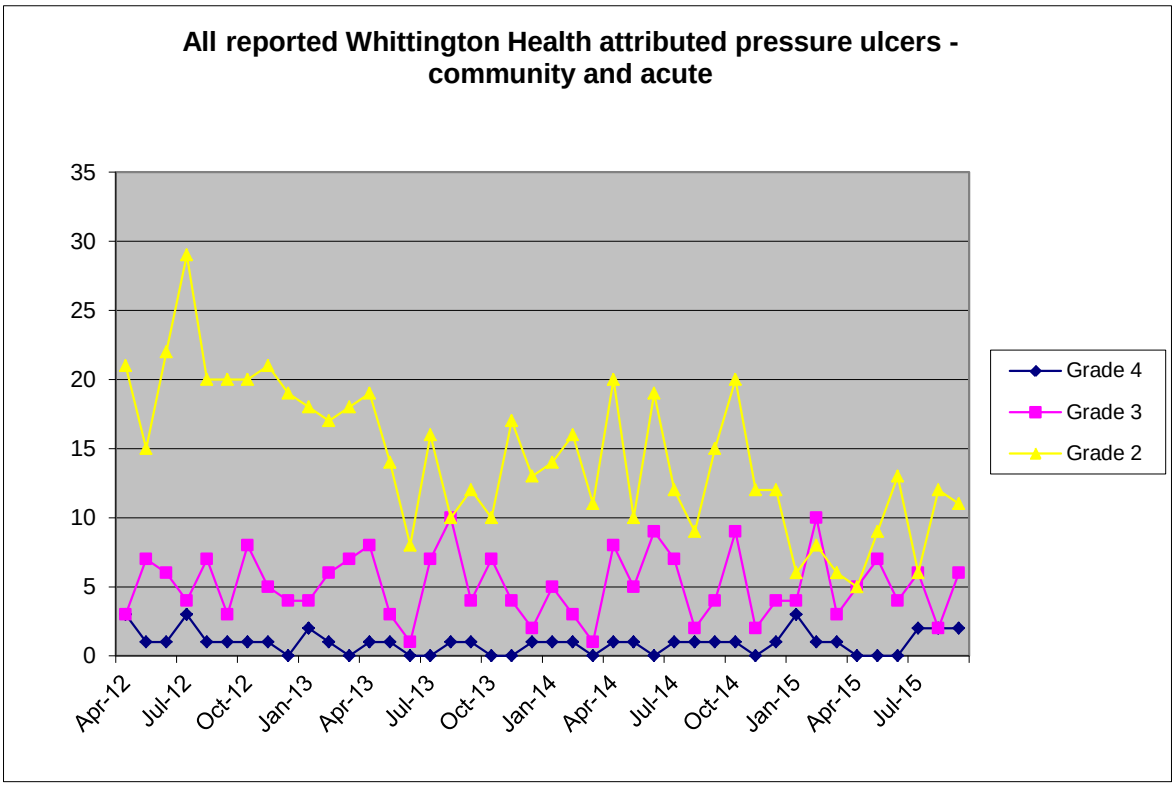


Chart 8: All reported trust attributed pressure ulcers from community (April 2012 – September 2015)

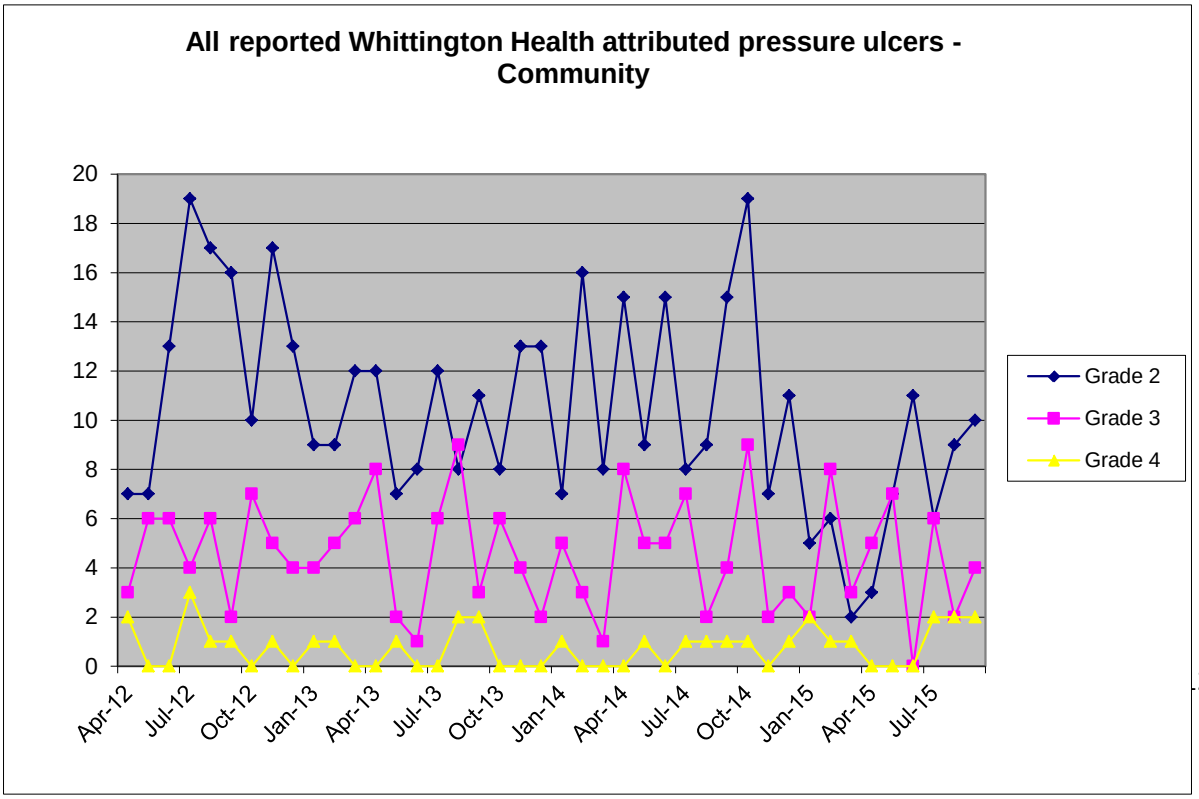
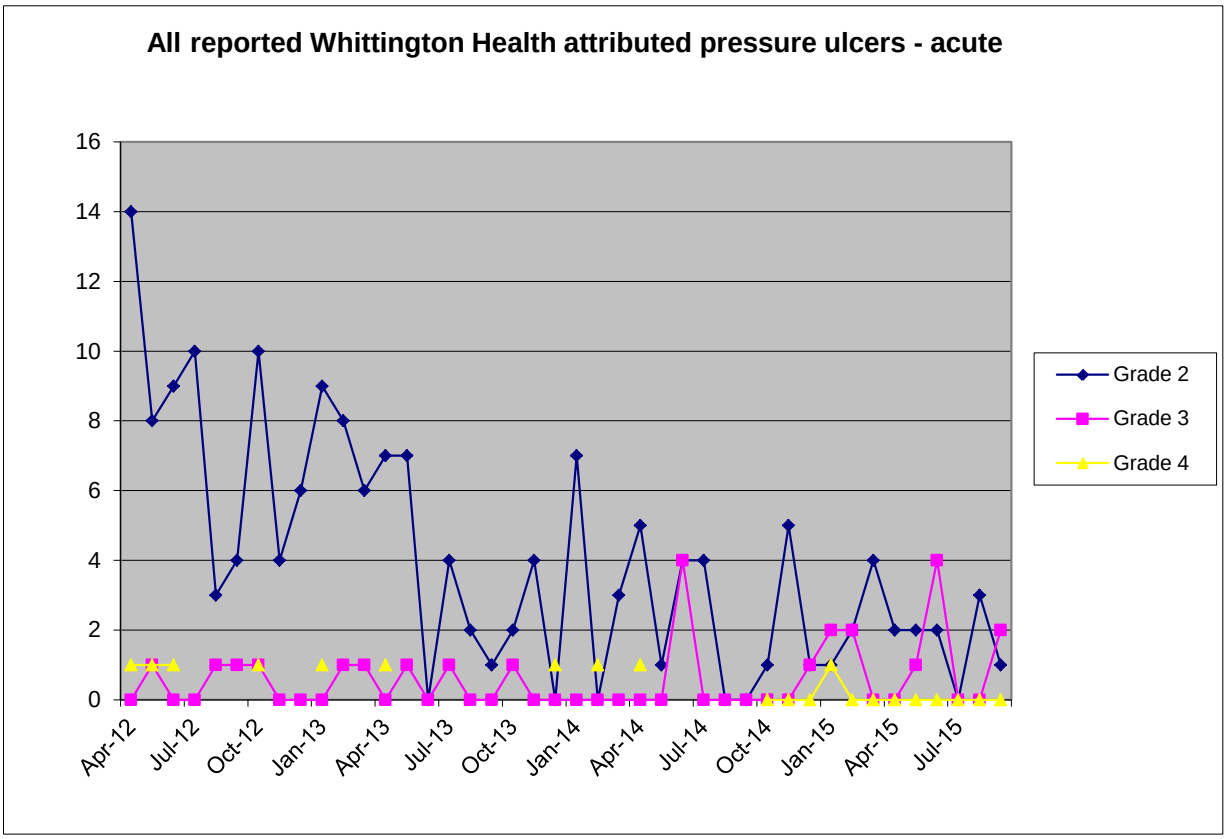


Chart 9: All reported trust attributed pressure ulcers from acute (April 2012 – September 2015)



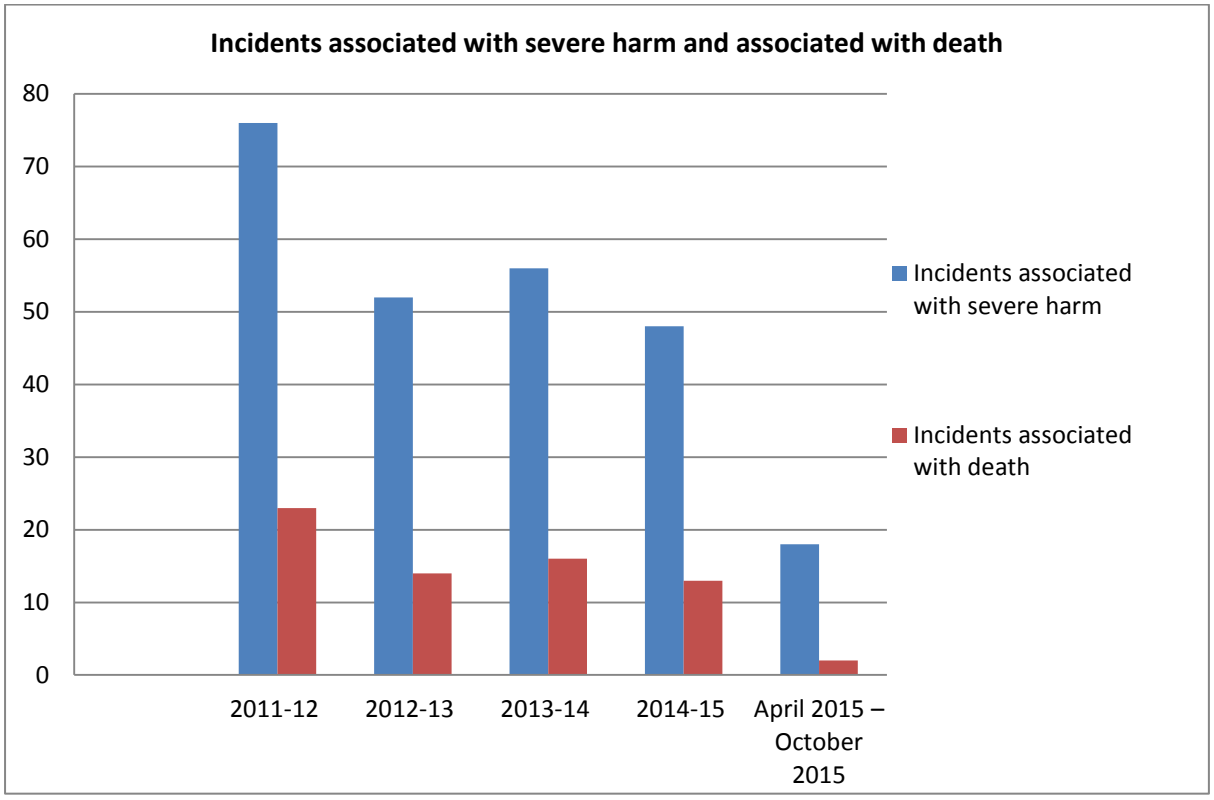
6) Clinical incidents associated with harm

Clinical incidents are contemporaneously reported on Datix, the trust's electronic incident reporting system. All incidents are graded according to whether they have caused no harm, low harm, moderate harm or severe harm. The total number of reported incidents is generally recognised to rise as a good reporting culture develops, and so the total number of reported incidents should not be considered as a quality or safety indicator in itself. It is generally accepted that a better marker of improving safety is a fall in the number of reported incidents associated with severe harm as a proportion/percentage of the number of the total number of incidents reported. It is recognised that all acute trusts will have reported incidents that have occurred in the context of a patient death; it is not necessarily the case that in all such instances the care and service delivery problems have actually contributed to or caused the death, but incidents associated with death remains a recognised important safety marker.

Table 1: The table below details four years of data associated with severe harm and associated with death since the inception of Whittington Health as an ICO.

Year	Incidents associated with severe harm	As a % of all incidents reported to the NRLS	Incidents associated with death	As a % of all incidents reported to the NRLS %
2011-12	76	2.22%	23	0.67%
2012-13	52	1.96%	14	0.53%
2013-14	56	1.55%	16	0.44%
2014-15	48	1.36%	13	0.37%
April 2015 – October 2015	18	1.15%	2	0.13%

Chart 10: Trust incidents associated with severe harm and associated with death (April 2012 – October 2015)



7) Dissemination of learning from Serious Incidents, near misses, inquests, complaints and claims

A key feature of a strong organisational safety culture is the ability to collect and disseminate learning from patient safety incidents, near misses, inquests, claims and complaints, and to share and embed this learning in such a way as that quality improvements are made and sustained.

The following examples give an overview of the way in which the trust's learning culture is currently being supported and developed.

- **Serious Incident process**
  The trust has strengthened its Serious Incident process to now ensure that every action plan includes a clear description of the way in which the learning from the incident will be shared and disseminated, both with the individuals involved and with the wider departments and services. These improvements are being embedded in the new ICSUs so that they become standard practice. The recent clearing of the backlog of Serious Incident investigations and the current maintenance of timely processes has greatly assisted with this change.

- **Junior doctor safety forum**
  Trainee doctors are recognised as a key staff group in the identification and dissemination of safety improvements and learning a monthly junior doctor safety forum is chaired by Dr Julie Andrews, Director of Infection Prevention and Control. This forum has been extremely successful and has been highlighted externally as an example of good practice in safety learning.

- **Medicines safety**
  The trust has a process initiated by the pharmacy department, and greatly strengthened by the introduction of electronic prescribing, to identify learning from drugs errors and to support a formative reflection and discussion between clinicians and their educational supervisors.

- **Lesson of the week**
  As a local example of best practice, the maternity department disseminates a patient safety lesson of the week, every week, and this is highly valued by all the staff in the department and is a practice that is now spreading to other parts of the trust.

- **Intranet page on learning from incidents**
  A new intranet site is being set up and every Serious Incident from now on will generate a summary with key learning points to be shared with all staff, which will appear on a specific intranet site. It is anticipated that as this resource grows it will become increasingly used by staff, clinical and non-clinical, and play an important role in strengthening the trust's safety culture.

- **Associate Medical Director for Patient Safety**
  A new post of Associate Medical Director for Patient Safety is being created and will be advertised in November. The appointee will play an essential role in collaboration with the Medical Director and Director of Nursing, in promoting and improving patient safety within the organisation.

- **Medical appraisal**
  A robust system of medical appraisal is in place and engagement with this is good. The Associate Medical Director will play a key role in strengthening the links between the oversight of learning from safety incidents and the ensuring of reflective discussions and learning at individual medical appraisal.

- **Educational supervision**
  The trust has a very strong culture of education and learning and almost all the consultants are also accredited and active educational supervisors.

- **Medical grand rounds**
  Every month the medical grand round, which is widely attended, focusses on a morbidity and mortality meeting at which learning from complex cases, and from patient deaths, is identified and disseminated.

- **Emergency department '10 at 10' initiative**
  As an example of a local safety initiative, the Emergency Department has just started the '10 at 10' initiative, whereby at 10am every morning clinical staff gather for 10 minutes to discuss safety issues and learning from the previous day.

- **Schwartz Rounds**
  The trust is resuming the holding of Schwartz rounds, at which all trust staff are invited to a multi-disciplinary discussion of complex or difficult clinical experiences from which valuable learning can be obtained, according to a well-defined internationally recognised approach.

8) External assurance; Copeland's Risk Adjusted Barometer (CRAB) report

Earlier this year, the trust commissioned an initial external safety and quality review from CRAB clinical informatics. A CRAB review takes data from a variety of sources and provides a detailed picture of the quality of care across the organisation, benchmarked against the largest database of clinical outcomes of its kind in the world.

The review found that the Trust has been providing good care overall. Risk adjusted mortality rates in operative surgery are low, and risk adjusted complications in most high volume specialties are also good. Trigger rates on the whole also appear to reflect the specialist case-mix of patients treated.

Ward-based care of surgical patients (operative and non-operative) has been consistently good.

The trust will now make arrangements to receive a regular on-going safety and quality report from the Copeland's Risk Adjusted Barometer Clinical Informatics. Data from this will be included in the next Quarterly Safety and Quality Board Report.

9) National Clinical Audit

Whittington Health participation in national clinical audits remains excellent. During the last Governance year, 96% (n=46) of Trust relevant national projects were submitted to, including 100% of national confidential enquiries. A further 15 additional national audit projects were undertaken.

Examples of high impact national audits include:

- Falls and Fragility Fractures (Royal College of Physicians)
- National Emergency Laparotomy audit (Royal College of Anaesthetists)
- National Chronic Pulmonary Disease Audit (Royal College of Physicians)
- National Audit of Diabetes (Paediatrics)
- Acute Coronary Syndrome or Acute Myocardial Infarction (National Institute for Cardiovascular Outcomes Research)

Continuous learning from the results of these audits is routine and embedded throughout the organisation.

Examples of post-audit improvements to patient care:

1) <u>Falls and Fragility Fractures:</u>

- There has been continued Orthogeriatric input to maintain reduced length of stay and delays to surgery.
- We have instituted Orthogeriatric leadership to ensure and maintain the early completion of falls and bone health assessments.
- Multidisciplinary working with Emergency Department clinical teams on initial assessment of patients has improved pain control and led to a significant reduction of ward transfer delays and admission delays.

2) <u>National Audit of Diabetes (Paediatrics)</u>

- A more effective system of chasing results of retinopathy screening has been implemented.
- There is now an improved process of enquiry in relation to social deprivation (an important factor in non-achievement of diabetic control), supported by the new hospital 'Twinkle' database.
- The smoking cessation team is now invited to adolescent clinics and education sessions.
- All newly diagnosed diabetic children now meet with our Consultant Child and Adolescent Psychiatrist on the paediatric ward.

- Planning has taken place to ensure more individualised age appropriate education. Group education programmes for newly diagnosed and pre-existing patients have also been initiated.

Local audits are aligned with the organisational strategy and priorities. Capacity is channelled away from small ad-hoc audits to major audits vital to safety without losing flexibility or suppressing good local ideas. Some examples may be found in our most recent Quality Account.

Since the formation of Whittington Health as an integrated care organisation in April 2011, both community and acute audits have been collated to produce the individual ICSU Clinical Audit Programmes. These programmes comply with the recommendations of the Care Quality Commission domains and NHS Litigation Authority (CNST) Standards. Furthermore, local recommendations from RSM Tenon (external auditor) have also been included and each clinical audit is now mapped to a quality driver with the source of each project clearly identified.

A number of successive audits (all of which have demonstrated continual improvement to patient care post ICO formation) are listed below;

- Case Mix programmes for Critical Care.
- National Heart Failure Audit.
- Community acquired pneumonia care bundle national audit.
- National Joint Registry audit.
- National Audit of Intermediate Care.

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London N19 5NF

Whittington Health Trust Board

4 November 2015

Title:	Safe Staffing (Nursing and Midwifery)		
Agenda item:	**15/138**	**Paper**	**4**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in September 2015. Key issues to note include: • The majority of areas reported greater than 95 per cent 'actual' versus 'planned' staffing levels. • A number of areas reported 'actual hours worked' over and above those 'planned' which was attributed in the main to the provision of extra support required due to extra beds on wards with more highly dependent patients. • The number of requests for 1:1 specials remains stable this month compared to last.		
Summary of recommendations:	Trust Board members are asked to note the September 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:	October 2015		

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

Safe Nurse Staffing Levels

1.0 Purpose

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

2.0 Background

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

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 30th September 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 September 2015. The average fill rate was 100.5 % for registered staff and 102.9 % for care staff during the day and 100.2 % for registered staff and 108.5 % for care staff during the night.

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

3.1 Additional Staff (Specials 1:1)

When comparing September's requirement for 1:1 'specials' with previous months, the figures continue to demonstrate a low level of need. There was little variation with regard to 1:1 requests in September (105) compared to the previous month (104). The requests made for this level of care are to ensure the safe management of particularly vulnerable groups of patients including elderly patients at risk of falls due to severe confusion, agitation and those patients detoxifying from drugs or alcohol. The number of RMN 'specials' required caring for patients under a mental health section or for patients with dementia continue to fluctuate.

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

Safe staffing levels are reviewed and managed on a daily basis. At the daily 08.30am bed meeting, the Director of Nursing/Deputy Director of Nursing in conjunction with matrons, site managers and other senior staff review all registered and unregistered workforce numbers by ward. Consideration is given to bed capacity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure that all areas are made safe.
Ward shifts are rated 'red' 'amber' or 'green' according to numbers of staff on duty, taking into account patient numbers, acuity and dependency.

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

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

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

In summary, in September a total of 21/1350 (1.5 %) shifts triggered 'red' which was higher than previous months. Of these, 4/360 (1.1%) occurred in the Surgical Integrated Care Service Unit, 1/90 (1.2%) in the Women's ISCU and 15/540 (2.8%) shifts were reported to have triggered 'red' in the Medicine and Frailty & Networked Service ISCU). In addition 1/180 (0.6%) triggered red in the Emergency and Urgent Care ISCU.

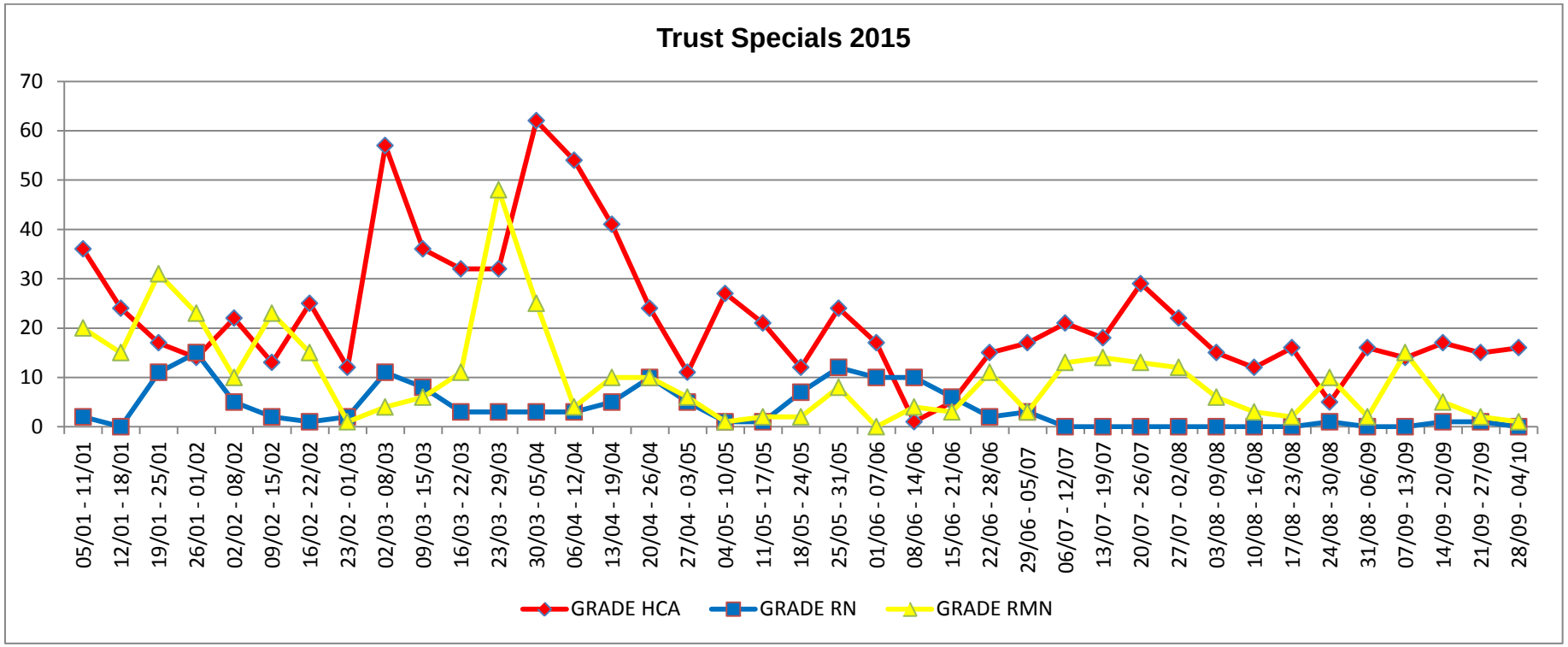
5.0 Conclusion

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

Fill rate data - summary
September 2015

Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual				
29494 hours	29647 hours	13117 hours	13495 hours	20275 hours	20324 hours	6060 hours	6576 hours	100.5%	102.9%	100.2%	108.5%

Appendix 2


Trust Specials 2015
70
60
50
40
30
20
10
0
05/01 - 11/01
12/01 - 18/01
19/01 - 25/01
26/01 - 01/02
02/02 - 08/02
09/02 - 15/02
16/02 - 22/02
23/02 - 01/03
02/03 - 08/03
09/03 - 15/03
16/03 - 22/03
23/03 - 29/03
30/03 - 05/04
06/04 - 12/04
13/04 - 19/04
20/04 - 26/04
27/04 - 03/05
04/05 - 10/05
11/05 - 17/05
18/05 - 24/05
25/05 - 31/05
01/06 - 07/06
08/06 - 14/06
15/06 - 21/06
22/06 - 28/06
29/06 - 05/07
06/07 - 12/07
13/07 - 19/07
20/07 - 26/07
27/07 - 02/08
03/08 - 09/08
10/08 - 16/08
17/08 - 23/08
24/08 - 30/08
31/08 - 06/09
07/09 - 13/09
14/09 - 20/09
21/09 - 27/09
28/09 - 04/10
GRADE HCA
GRADE RN
GRADE RMN

Whittington Health NHS

Whittington Health NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

November 2015

Title:	Safe Staffing and Efficiency		
Agenda item:		**Paper**	4a
Action requested:	To note the paper and discuss the implications		
Executive Summary:	The attached letter offers clarity with regard to Trust responsibilities in terms of safe staffing and efficiency. The letter provides guidance with regard to looking at staffing in a flexible way which is focussed on quality of care, patient safety and efficiency rather than numbers and ratios of staff. In light of the mandatory use of approved frameworks for procuring nursing agency staff coming into effect from 19 October the letter reiterates Trusts responsibilities in relation to ensuring that they get the balance right and neither understaff nor over spend and secure the right compliment of clinical staff to meet local patient need and circumstances.		
Summary of recommendations:			
Fit with WH strategy:			
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	18th October 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?**	

To: NHS foundation trust and NHS trust Chief Executives
Cc: NHS foundation trust and NHS trust Nurse Directors, Medical Directors, Finance Directors and Operations Directors

13 October 2015

Dear colleague

Safe staffing and efficiency

We know that many organisations have taken a systematic and thoughtful approach to staffing wards and services safely over the past two years, by responding positively to the guidance issued by the National Quality Board and by NICE, embracing transparency about their planned versus actual staffing, and focusing on how to make services as safe as possible within available resources. We are also aware that recent messages to the system on safe staffing and on the need to intensify efforts to meet the financial challenge have been seen as contradictory. We recognise that it is important to offer clarity to the system as we work together to close the gaps in health and wellbeing, care and quality, and funding and efficiency identified in the Five Year Forward View.

The current safe staffing guidance has been designed to support decision makers at the ward/service level and at the Board to get the best possible outcomes for patients within available resources. The guidance supports - but does not replace - the judgements made by experienced professionals at the front line. The responsibility for both safe staffing and efficiency rests, as it has always done, with provider Boards.

As set out in the guidance, it is important for providers to take a rounded view of staffing. Providers should be able to demonstrate that they are able to ensure safe, quality care for patients and that they are making the best use of resources. This should take account of patient acuity and dependency, time of day and local factors, such as line of sight for those caring for patients. In some cases, these factors will mean a higher number of nurses per patient, and in other cases it will mean a lower number or different configuration of staff can be justified. Some trusts have taken innovative approaches whereby Allied Health Professionals are included in their ward based teams, and this can have a positive impact on patient outcomes. We support this approach where appropriately implemented.

It is therefore important to look at staffing in a flexible way which is focused on the quality of care, patient safety and efficiency rather than just numbers and ratios of

staff. We would stress that a 1:8 ratio is a guide not a requirement. It should not be unthinkingly adhered to: achieving the right number and balance of clinical and support staff to deliver quality care based on patient needs in an efficient way that makes the best possible use of available resources is the key issue for provider Boards. Where trusts are able to maximise the proportion of time spent by clinical staff focusing on care that contributes most directly to patient outcomes (including through the use of innovation and technology) there are likely to be benefits for both patient care and for efficiency.

Trusts are responsible for ensuring that they get the balance right by neither under-staffing nor over-spending, and are able to secure the right complement of clinical staff to meet local patient need and circumstances.

CQC always assesses staffing levels as part of rating a service on safety in its programme of comprehensive inspections. These assessments include observation of care delivery, listening to staff and patients, assessing outcomes of care and discussions with nurse managers about assessment of acuity levels and achievement of planned staffing levels. Staffing ratios are never the sole determinant of a rating.

We will continue to work with and support trusts to secure both safe staffing and greater efficiency. This will include:

- further progress on the Model Hospital led by Lord Carter, who will be working with providers to develop a way to use data on the nursing and care hours per patient, so that staffing arrangements remain safe across a range of different times and situations. Lord Carter's team will be working closely with front-line staff to put in place a more sophisticated approach to measurement of nursing time and its connections with outcomes, costs and other critical measures; and

- development of further safe staffing guidance. We are currently reviewing the responses we had to the letter dated 4 August 2015 and will confirm further details on the development of the guidance and timescales in due course.

In order to support your efforts to manage your agency staffing costs, the mandatory use of approved frameworks for procuring nursing agency staff will come into effect from 19 October. Further work is being taken forward at pace by Monitor and the NHS TDA to introduce a national rate-cap for all agency staff, to include medical and other agency staff later this autumn.

As we collectively work on both the efficiency and the safe staffing agendas, we recognise the need for clarity and consistency across the work of all teams in the arm's length bodies in this area. We will be working hard across the national organisations and in close partnership with providers and all clinicians to ensure these are delivered in the next phase of work.

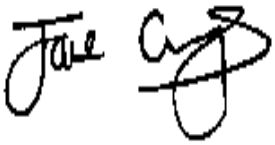
The financial and quality challenges that you are grappling with are unprecedented, and we thank you for all you are doing for patients and their families.

Yours sincerely

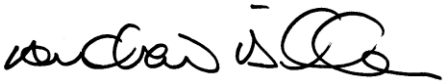
Ed Smith, Chairman-Designate NHS Improvement

Sir Mike Richards, Chief Inspector of Hospitals

Dr Mike Durkin, National Director of Patient Safety, NHS England



Jane Cummings, Chief Nursing Officer for England



Sir Andrew Dillon,
Chief Executive, National Institute for Health and Care Excellence

Whittington Health NHS

Whittington Health Trust Board

November 2015

Title:	New measures to support trusts and foundation trusts in managing workforce challenges		
Agenda item:		**Paper**	4b
Action requested:	To note the paper and discuss the implications		
Executive Summary:	The attached letter details new measures to support trusts and foundation trusts in managing workforce challenges and links to the joint letter from Sir Mike Richards, Mike Durkin, Jane Cummings, Sir Andrew Dillon and Ed Smith setting out their shared view on how providers should approach the need to ensure safe, quality care for patients on a sustained, financially stable basis. The letter proposes the introduction of hourly price caps for all agency staff across all staff groups, the introduction of which is currently subject to consultation but if approved will take place from 23rd November 2015. The Trust is expected to comply fully with measures proposed and limit and overtime, reduce spend on agency staff. The TDA and Monitor have limited levels of agency use and will monitor use across the sector as measures are implemented.		
Summary of recommendations:			
Fit with WH strategy:			
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	18th October 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?**	

To: NHS foundation trust and NHS trust chief executive officers
Cc: NHS foundation trust and NHS trust nurse directors, medical directors, finance directors and operations directors

15 October 2015

Dear colleague,

New measures to support trusts and foundation trusts in managing workforce challenges

Last week's data on Q1 trust and foundation trust financial performance highlighted the need for concerted further action in 2015/16, specifically to address some immediate workforce challenges, including the rapid growth of spending on agencies and the need for a rounded approach to staffing decisions.

We are writing to inform you of two important steps being taken – with the support of the national system leaders – which we hope will help you meet these challenges.

Safe staffing and efficiency

You will have received on Tuesday 13 October a joint letter from Sir Mike Richards, Mike Durkin, Jane Cummings, Sir Andrew Dillon and Ed Smith, setting out our shared view on how providers should approach the need to ensure safe, quality care for patients on a sustained, financially stable basis, and reinforcing the need to use guidance and best practice to support but not replace local judgement about the best use of resources.

National price caps for agency staff

We have been strongly pressed by a large number of providers to take urgent national measures to cap the rates paid for agency staff and to encourage workers back into substantive and bank roles. We have therefore accelerated our timescale for making this happen.

Subject to consultation, we propose to introduce hourly price caps for all agency staff across all staff groups – doctors, nurses and all other clinical and non-clinical staff. The intention would be to have these in place from 23 November 2015. The consultation is being published today, along with detail of the proposed caps, the proposed rules and an impact assessment.

Subject to the consultation process, the price caps would ratchet down in two further stages so that from 1 April 2016, agency staff would not be paid any more than the equivalent substantive worker. It is proposed that the caps would also apply to bank rates.

Full compliance would be essential for these measures to work. All trusts would be expected to limit and reduce their spending on agency staff over time, and we would continue to work

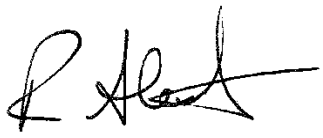
closely with all trusts to monitor and limit levels of agency use across the sector as the measures are implemented. The maximum rates would apply to all NHS trusts, NHS foundation trusts receiving interim support from the Department of Health and NHS foundation trusts in breach of their licence for financial reasons. All other NHS foundation trusts would be very strongly encouraged to comply[1] and all trusts would be required to report shift-level detail when they exceed the price caps and the reason for doing so in their reporting to Monitor/TDA. Ambulance trusts and ambulance foundation trusts would initially be exempt,[2] but there would be no other up-front exemptions, either for individual trusts or specialties.

We recognise that adhering to price caps would not always be without challenge and that the effect on staffing supply, though difficult to predict, could be significant, particularly in the short term and for some trusts and specialties. Where appropiate, national bodies will work together to support trusts in meeting the price controls and other agency rules.

The proposed price caps have been developed with, and are fully supported by, clinical leaders in Monitor, TDA, Care Quality Commission (CQC) and NHS England, but trusts would nevertheless need to ensure they maintain patient safety at all times. We propose a 'break glass' provision for trusts that need to override the caps on exceptional safety grounds. Any overrides would be scrutinised by Monitor and TDA and inappropriate use would be subject to regulatory action as appropriate. We would also monitor closely the overall impact of the policy to ensure patient safety concerns are being managed appropriately. In addition, it is proposed that pay for interim very senior managers paid on an agency basis would be subject to the Monitor/TDA consultancy approvals process. NHS England would take an equivalent approach with respect to clinical commissioning groups.

We very much hope that you will find these steps helpful and a positive response to some of the staffing issues you have highlighted – and we can assure you that the national system leaders remain focused on the wider set of workforce challenges.

Yours sincerely,



Robert Alexander
Chief Executive
NHS Trust Development Authority

Stephen Hay
Managing Director Provider Regulation
Monitor

[1] The new value for money risk assessment trigger means that Monitor will take into account inefficient or uneconomic spending practices when considering the need for regulatory action concerning any potential breaches of governance licence conditions

[2] We are considering how to introduce equivalent measures for ambulance trusts in the near future and will gather views through the consultation process.

Nursing and Patient Experience
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The Whittington Hospital NHS Trust
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Whittington Health Trust Board

4 November 2015

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**15/139**	**Paper**	**5**
Action requested:	For Information		
Executive Summary:	The purpose of this report is to provide an overview of the reporting and management of Serious Incidents (SI) via StEIS (Strategic Executive Information System) as of the end of September 2015. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). Ensuring that health service bodies are open and transparent with the relevant person/s. NELCSU. SI Reporting. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, Whittington Health Serious Incident policy.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 179**- Risk has been mitigated and closed on Datix. Currently, there are no gaps in assurance with regard to Serious Incidents performance.		
Date paper completed:	19/10/2015		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Philippa Davies, Director of Nursing and Patient Experience**	
Date paper seen by EC	**22/09**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incident Monthly Report

1. Introduction

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

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

2. Background

The Serious Incident Executive Approval Group (SIEAG) — comprising the Executive Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer and the Head of Integrated Risk Management meets weekly to review Serious Incident investigation reports in addition to investigations into high severity incidents to ascertain whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework (March 2015).

3. Serious Incidents

3.1 The Trust declared 4 serious incidents during September 2015 bringing the total to 27 since 1st April 2015. This includes 1 incident that was later downgraded (de-escalated).

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

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

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

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

Category	Month Declared	Summary
Diagnostic incident including delay (Ref:July15-Diag/01)	July 15	Delay in a number of referred patients being seen in a timely manner.
Wrong route administration (Ref:Aug15 WRA)	Aug 15	Epidural procedure – near miss
Loss of usage of major outages relating to hospital services. (Ref:Aug15 IT)	Aug 15	Loss of ability to access the electronic patient record and PACS.
Medical equipment/ devices incident. (Never Event) (Ref:Sept15 NE)	Sept 15	Misplaced Naso Gastric tube
Maternity/Obstetric incident (Ref:Sept15 M/O)	Sept 15	Unexpected Admission to NICU
Information Governance Breach	Sept 15	Inappropriate access to staff records

(Ref:Sept15IGSR)		
Information Governance Breach (Ref:Sept15IGF)	Sept 15	Faxes sent to Incorrect address

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported 4 serious incidents in September 2015

STEIS 2015-16 Category	April	May	Jun	Jul	Aug	Sept
Child protection	0	0	0	1	0	0
Communication issue	1	0	0	0	0	0
Confidential information leak/Information governance breach	1	2	0	0	1	2
Diagnostic Incident including delay	0	2	0	1	0	0
Drug incident	0	0	0	0	1	0
Maternity/Obstetric incident mother and baby (includes foetus, neonate and infant)	0	1	0	1	0	1
Pressure ulcer grade 3	5	1	0	0	0	0
Screening Issues	0	0	0	1	0	0
Slips/Trips/Falls	1	0	0	0	0	0
Suboptimal care of deteriorating patient	0	1	0	2	0	0
Medical equipment/ devices/disposables incident	0	0	0	0	0	1
Total	8	7	0	6	2	4

4. Submission of SI reports

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

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

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

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

4.1 The Trust submitted 2 reports to NELCSU in September 2015. Currently the Trust has 1 overdue incident report awaiting submission relating to 'delayed diagnosis'.

4.2. The table below provides a brief summary of individual completed serious incident investigations submitted in Septembers and a selection of actions taken as a result of the lessons learnt.

Summary	Actions taken as result of lessons learnt
• Suboptimal care of deteriorating Patient Patient admitted following a significant upper gastrointestinal haemorrhage. Gastroscopy performed and patient transferred to a ward following period in the Intensive Care Unit.	The Duty Medical Registrars (DMR) induction material has been updated to include a case study of this incident to ensure wider learning. The case study will be used in ward staff training re; the deteriorating patient, which is delivered by Practice Development Nurses. Learning from this incident is being disseminated to all medical and surgical clinical teams.
• Screening Issues Delayed referral to antenatal specialist services. Sickle Cell and Thalassemia Centre Screening	All healthcare professionals who see women for antenatal related check-ups to ensure specialist referrals (where appropriate) have been made. In conjunction with the Sickle Cell and Thalassemia Centre, laboratory and midwifery services a review is being undertaken to agree an appropriate patient pathway. The Antenatal Screening Policy is being reviewed and updated. Referrals for screening to now be made via Anglia ICE.

5. Summary

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

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

Whittington Health Trust Board

4"' November 2015

Title:	Risk Management Strategy October 2015 - 2018		
Agenda item:	**15/140**	**Paper**	**6**
Action requested:	For agreement		
Executive Summary:	The Risk Management Strategy has been revised in line with the Trust annual review process and the 2015/18 strategy now aligns with the new Integrated Clinical Service Units.		
Summary of recommendations:	For discussion and approval		
Fit with WH strategy:	Aligns to good governance and SOs and SFIs		
Reference to related / other documents:	Aligns to trust strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	This is the Trust risk management strategy		
Date paper completed:	30th October 2015		

Author name and title:		**Philippa Davies Director of Nursing & Patient Experience & Lynne Spencer Director of Communications & Corporate Affairs**		**Director name and title:**		**Philippa Davies Director of Nursing & Patient Experience**	
Date paper seen by EC	**3 Nov**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Whittington Health NHS

Risk Management Strategy

October 2015-2018

CONTENTS

1. Overview

The Trust vision is to 'help local people live longer healthier lives' and ensuring sound governance and risk management is fundamental to this ambition. Governance and risk and its management are an integral part of everyone's role. The Trust is committed to ensuring the environment and culture enables people to identify and respond to risk and improve quality. This is supported by the Trust values, strategic goals and corporate objectives.

The Trust Values are

I Innovative
C Compassionate
A Accountable
R Respectful
E Excellence

The Trust strategic goals and corporate objectives are set out in the annual Operating Plan and the Trust clinical strategy. The strategic goals are:

1. To deliver a consistent high quality safe service
2. To secure the best possible health and wellbeing for our community
3. To innovate and continuously improve the quality of our services and to deliver the best outcomes for our patients
4. To integrate care in patient centred teams
5. To support patients to be active partners in their care
6. To be a leader of medical, multi-professional education and population based clinical research

The Board will consider strategic risks >15 (greater than) facing the Trust in the coming year and will develop its processes and management of risks within its Board Development Programme which are held in regular seminar sessions and this will inform future strategies and policies of the Trust. This three year Risk Management Strategy is an integral part of the Trust's integrated approach to governance. It replaces the previous versions of the Risk Management Strategy and has been refined to enable better understanding across the organisation. It is a high level Strategy and does not cover in detail, management of specific risk and quality improvement. This detailed information is set out in relevant strategies and policies (see appendices).

2. Introduction

All actions contain inherent risks. Risk management is central to the effective running of any organisation and the Trust's vision 'helping local people live longer healthier lives'. Whittington Health will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks and quality improvements.

The diagram overleaf sets out the core elements of the Risk Management Strategy. This framework supports the delivery of the Trust's strategy, strategic goals and corporate objectives as defined in the annual Operating Plan and our Clinical Strategy.

Core Elements of the Strategy:

Regulation and Assurance	Patient Safety	Patient Experience	Clinical Outcomes and Effectiveness
RISK MANAGEMENT			
INTEGRATED GOVERNANCE Compliance with standards & statutory obligations Continuous assurance and improvement in quality			

The Trust Board needs to be confident that the systems, policies and people it has put in place are operating in a way that is effective, focused on key risks, and is driving the delivery of the Trust's goals and objectives. The Trust Board needs to demonstrate that it has been properly informed, (through evidence from the Board Assurance Framework and Corporate Risk Register), that it is aware of the totality of the risks facing the organisation, and that it has made effective decisions on the management of risk based on the available evidence.

The Trust recognises that quality and risk management must be embedded in order for the organisation to function safely and effectively. The Trust Board is therefore committed to ensuring that integrated risk management forms an integral part of the organisation's philosophy, practices, activity and planning, and should not be viewed as a separate programme of work at any level within the organisation. All stakeholders, internal and external, must be considered.

This Strategy will be reviewed by the Trust Board annually and updated in line with current best practice and/or any change in legislation.

Definitions

- Integrated Governance

  Integrated governance is the combination of structures and processes at and below Board level to lead on Trust-wide quality and safety performance including:

  - Ensuring required standards are achieved
  - Investigating and taking action on sub-standard performance
  - Planning and driving continuous improvement
  - Identifying, sharing and ensuring delivery of best practice
  - Identifying and managing risks to quality of care

  The Trust considers integrated governance under the domains of patient safety, clinical outcomes and effectiveness and patient experience (these are in line with the three domains identified in High Quality Care for All - Measuring Quality Improvement) and regulation and compliance.

- Risk management

  Risk management is defined as uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance (HM Treasury Orange Book).

  Risk management is a systematic process of risk identification, analysis and evaluation and correction of potential and actual risks to a patient, visitor or member of staff.

3. Aims and Objectives

The aims of this Strategy are to:

- Support the delivery of the Trust's vision, values and strategic goals and annual objectives
- Provide a framework to support the Trust to take responsibility for the appropriate and effective management of its risks, in such a way that informed business decisions are taken to improve safety and quality
- Have a clear operational and corporate structure which enables responsive and effective management and provides for appropriate escalation and delegation
- Provide a framework to support a consistent approach to integrated governance and risk management
- Provide an open culture and proactive culture rather than reactive approach to integrated governance and risk management, thus supporting a learning organisation
- Have a Board Assurance Framework (BAF) and Corporate Risk Register that is truly reflective of the risks faced
- Support compliance with regulatory bodies including, registration with the Care Quality Commission, Monitor (on gaining Foundation Trust Status), and Health and Safety Executive
- Maintaining and achieving year on year improvement in compliance with national standards, regulation requirements and accreditation schemes
- Provide and maintain a safe, high quality and secure environment for patients, staff and visitors
- Encourage and support innovation and service developments within a framework for risk management
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination, or transfer of risk. Otherwise ensure the organisation openly accepts the remaining risks.

In summary: 1) no surprises 2) have contingency plans 3) manage continuity

The objectives of this Strategy are:

- To achieve the Trust's strategic goals and operational objectives as defined in the Annual Operating Plan and Clinical Strategy
- To maintain registration with the CQC without compliance conditions
- To strengthen compliance with the Board Assurance Framework and annual Internal Audit recommendations

4. Duties and Accountabilities

The Chief Executive is the Accountable Officer and has overall accountability and responsibility for governance and risk management within the Trust. Following the implementation of a system of Director line-accountability, he has delegated responsibility for providing assurance on all areas of governance and risk to individual Executive Directors.

The Executive Directors are held to account for progress with mitigating identified risks by the Trust Board. The Audit and Risk Committee commission 'deep dives' into areas which require detailed scrutiny in order to provide assurance to the Board on the overall process for identification, assessment and management of risk.

The key areas that each Executive Director has accountability for are defined on the Board level and Director Accountability Structure **Appendix 4**. Each Director has clear assurance systems and structures in place to support the delivery of their areas of responsibility which includes line management structures and supporting working groups, forums and/or committees. The Executive Team and each Director is accountable to the Board through the Board Committee structure. Each Integrated Clinical Service Unit (ICSU) will be accountable through the ICSU performance structures, including the quarterly quality and performance challenge days, and to the Executive Directors.

Commitment to integrated governance and risk management is a non-negotiable requirement at all levels of the organisation. All staff throughout the Trust, including contractors and temporary staff are expected to participate in risk management processes. Specific duties and accountabilities are outlined at **Appendix 2.**

The designated Assurance Committees of the Trust Board are the Quality Committee, the Finance and Business Development Committee, the Audit and Risk Committee and the Remuneration Committee. They are supported by the Trust Management Group and ICSU forums. A brief summary of the purpose of these committees is outlined below and the Terms of Reference for these Board Committees are provided at **Appendix 3.**

The purpose of the Audit and Risk Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

The purpose of the Quality Committee is to ensure that the Board has a sound assessment of risk and quality and that the Trust has adequate plans, processes and systems in place. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, clinical audit,

research governance, health & safety, staff governance (including statutory and mandatory training) and patient and public safety.

The Committee will ensure that the Trust has an effective management and clinical governance framework which includes the assessment and monitoring of quality indicators which drive forward the development of quality of services and care, patient safety, patient experience and clinical outcomes and effectiveness.

The purpose of the Finance and Business Development Committee is to support the further development of the financial and business development strategies of the Trust, to review the strategies as appropriate and monitor progress against them to ensure the achievement of financial targets and business objectives and the financial sustainability and stability of the Trust. This includes:

- overseeing the development and maintenance of the Trust's medium and long term financial strategy
- reviewing and monitoring financial plans and their link to operational performance
- overseeing financial risk management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Trust's Finance and Business Development Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality or safety identified; in these circumstances the Quality Committee will provide scrutiny and assurance.

This Committee also oversees aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T Strategy for the Trust. It will ensure the Trust is prepared for any forthcoming major changes.

5. Integrated Governance

Integrated Governance is everyone's responsibility and will be delivered through all staff. It is an integral part of all Trust business; finance, performance, human resources, governance and quality are not mutually exclusive.

The Trust will:

- Continue to strengthen the Board Assurance Framework and Governance Framework and this will be a focus of the Board Development in Seminars
- Use internal and external learning to ensure continuous quality improvement
- Continue to review and adapt systems and practices to meet the needs of regulatory and legislative changes and developments and self-regulation

- Review the Director and ICSU accountability structures annually to ensure they continue to support the delivery of the Risk Management Strategy

Meeting Regulatory Requirements

- Oversight of NHS Trusts

  Oversight includes clinical quality, finance, service performance, governance and the delivery of the Trust Annual Operating Plan. It is reflective of NTDA assurance framework and reporting requirements. The Trust will continue to review and adapt systems and practices to meet the needs of the Annual Operating Plan and report to the Board and its Committees on compliance and exceptions.

- Care Quality Commission

  Under the system of regulation, effective 1st April 2010, NHS provider organisations are required to register with the Care Quality Commission (CQC) and declare compliance with the essential standards of quality and safety. Annual declarations of compliance are no longer required as CQC expects that organisations will monitor compliance on an ongoing basis and notify them of any changes to compliance.

- NHS Litigation Authority Risk Management Standards and CNST (Maternity Risk Management Standards) levels 1 to 3

  These have been abolished for a new pricing methodology based upon a Trust's safety record and claims history. The Trust will remain a member of this scheme to ensure indemnity cover is adequate.

- Information Governance Toolkit

  The Deputy Chief Executive/Director of Strategy is the lead for ensuring the Executive Directors deliver the standards and this work is reported to the Information Governance Committee. The Assistant Director of Information Governance Manager will maintain core evidence logs, identifying and escalating areas of risk of non-compliance and implementing action identified. A review of compliance is undertaken twice a year in line with the requirements of the IG Toolkit submission and this is reported to the Audit & Risk Committee.

- Medical Revalidation

  The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012 came into force 3 December 2012 and requires revalidation for doctors within the UK. Medical revalidation is the process by which all doctors with a license to practice in the UK will need to satisfy the GMC at regular intervals that they are fit to practice and should retain that license. The Trust's Responsible officer is the Medical Director who is accountable to the Board through the Quality Committee.

The Board level and Director accountability structure is shown on **Appendix 4.**

Responding to external agency visits and inspections

The Trust is subject to a number of announced and unannounced inspections and accreditation visits from external agencies. The planning and outcomes from such events are a core part of the Trust's integrated governance and assurance arrangements. These events are reported to the Board Committee relevant to the subject matter and reported to the Board.

6. Local Management of Risk

Through a process of risk identification, assessment, learning and control the organisation will maintain a dynamic Corporate Risk Register that will inform the Board Assurance Framework and thereby provide assurance to both the Board and the community. Risk is comprised of two key elements: the likelihood that a hazard will actually cause injury, illness, harm, loss or disruption to services and the severity of the consequence of that harm. The hazard may be the same but the risk can change depending upon the circumstances and/or the environment.

Categories of risk

The Trust is committed to ensuring the safety of patients, staff and the public through an integrated approach to managing risk, regardless of whether the risk is clinical, corporate or financial and has broadly defined risks into corporate risk categories:

- Patient Safety
- Quality
- Financial

It is recognised that the boundaries between these categories are not always clear, and that some risks may fall into more than one category.

To promote a consistent approach the Trust will ensure that risk management is supported by the development of formal mechanisms to assess risk and to measure the effectiveness of risk management, plans and processes. In particular:

- Having clear arrangements for monitoring the Board Assurance Framework
- Providing training and support to managers and identified risk leads to enable them to manage risk as part of role and/or line management responsibilities
- Risk management will be supported by accurate, timely and effective incident reporting, including categorising the consequences of risk and investigating system failures
- Safe systems of work will be in place to protect patients, visitors and staff
- Risk management processes will be in place for all clinical and non-clinical Integrated Clinical Service Units and Directorates, including risk registers with all risks linked to a corporate risk category and owned by the appropriate Executive Director
- There will be a process of challenge at Performance Review meetings by the Executive in relation to assumptions underpinning risk scores and plans
- Evidence will be maintained to demonstrate that recommendations and action plans have

been developed and changes implemented accordingly to mitigate risk

- Use information from risk assessments, incidents, complaints, audit, claims and other relevant internal and external sources to improve safety and facilitate organisational learning

- Risk assessments will be undertaken for strategic policy decisions and documents relating to new projects

- Risk assessments will be undertaken for all cost improvement programmes which includes a review of quality impact

Each ICSU will continue to develop and maintain a comprehensive risk register, which will be formally reviewed as part of the ICSU quarterly Performance Review process. At these meetings the ICSUs will be expected to report on their top risks rated >15, and present action plans for minimising and managing these risks and escalate to the Quality Committee and Trust Management Group for review and agreement.

Each Corporate Directorate will continue to develop and maintain a comprehensive risk register, which will be formally reviewed as part of the CEO Executive Director Performance Review process. At these meetings the Directors will be expected to report on their top risks rated > 15 and present action plans for minimising and managing these risks and escalate to the relevant Board Committee and Trust Management Group for review and agreement.

All ICSUs/Directorates/Board Committees are responsible for ensuring there are clear risk management structures and processes in their areas, including the regular review of all their risks from a specialty to ICSU/Directorate/Board Committee level. These risk registers will be collated with the risks identified within each area of responsibility and the risks measuring >15 will be escalated to the Head of Integrated Risk Management who will maintain the Corporate Risk Register and DATIX records.

The Corporate Risk Register will be subjected to review and challenge by the Trust Management Group and Executive Team at least quarterly.

The Audit and Risk Committee will review the Corporate Risk Register at least annually.

The Trust Board will review the Corporate Risk Register at least twice a year.

Risk Appetite and Risk Management options

The aim of the Risk Management Strategy is not to remove all risk but to recognise that some level of risk will always exist. It is recognised that taking risks in a controlled manner is fundamental to innovation and developing a positive culture. Risk appetite is the amount of exposure to risk the organisation is prepared to accept or tolerate should the exposure become a reality.

- Risk Management Options

Whittington Health will provide safe and effective care to patients by identifying risks relevant to the organisation and to take the appropriate action to address them. This will typically be to either eliminate the risk entirely, or to reduce it to an acceptable level. All options of risk management are:

- Risk Avoidance

Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place the Trust Board will consider whether the service should continue in the Trust. This may also be applied in the consideration of providing new service developments. The decision on Risk Avoidance may only be made by the Trust Executive Team who must consult with the Chief Executive for final agreement who will report to the Trust Board and relevant stakeholders as appropriate.

- Risk Transfer

Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place the Trust Executive Team will consider whether the activity should continue and they will report to the Board. An example of such a risk transfer measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.

- Risk Mitigation

Where a risk is identified that cannot be avoided the Trust must consider whether there are suitable and sufficient control measures in place. If there are not, then the Trust must consider how better control measures may be applied in order to reduce the risk. Making and carrying out risk reduction action plans is the responsibility of a line manager and /or risk lead.

- Risk Acceptance

When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes. This level of risk must be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent. The financial consequences of clinical risk acceptance will be managed through indemnity schemes and other forms of insurance.

The operational management of risk is supported by the Trust's Risk Register Policy, which sets out the process for undertaking, approving and managing risk. This includes a clear matrix, and processes for the assessment and escalation of risk which conforms to the NPSA good practice guidance for risk management.

- Risk Opportunity

This option is not an alternative to those above; rather it is an option which should be considered whenever tolerating, transferring or treating a risk. There are two aspects to this. The first is whether or not at the same time as mitigating threats, an opportunity arises to exploit positive impact. For example, if a large sum of capital funding is to be put at risk in a major project, are the relevant controls judged to be good enough to justify increasing the sum of money at stake to gain even greater advantages? The second is whether or not circumstances arise which, whilst not generating threats, offer positive opportunities. For example, a service redesign may free up resources which can be re-deployed into other service developments.

Appendix 5 sets out the Trust scoring criteria which has been adopted from the National Patient Safety guidance which the majority of NHS Trusts adopt as best practice to risk management.

Interpretation is crucial and final scoring should be the subject of debate at the local level, although final accountability for the risk assessment rests with the local approver.

The risk matrix can also be used to determine who has the appropriate level of authority to authorise that a risk is accepted in relation to risk appetite. If the residual risk is:

- Scored 10 or below: the Approving Manager may accept the risk.
- Scored 12 moderate/high: the risk owner or Approving Manager must refer and discuss with their Line Manager or equivalent for corporate departments for a risk acceptance decision to be taken.
- Scored 15> or above: the risk must be referred to the Trust Management Group and considered at the next ICSU/Directorate Performance Management Meeting for consideration.
- Scored 20> the Executive Team and/or relevant Board Committee should assess the risk and recommend decision for risk acceptance to the Trust Board for consideration and decision.

The following prompts can be used in assessing and determining risk acceptance:

- Can we tolerate the possibility of the risk actually happening?
- If not, can we do more?
- Will the cost of managing the risk outweigh the benefit?
- It the risk outside of the control of the organisation?

Documentation

All decisions will be documented against the individual risk on the Risk Register or Board Assurance Framework.

The electronic risk register on Datix will remain the system where all risks are electronically recorded including actions and reviews.

In addition: when discussing and reviewing risks at Board level, ICSU and Directorate Performance Reviews and specialty meetings, this must be clearly recorded in the minutes.

7. Linking the Board Assurance Framework and the Corporate Risk Register

The Board Assurance Framework (BAF) provides the Trust with a comprehensive method for the effective and focused management of risk to the Trust's strategic goals and corporate annual objectives. Through this Framework the Board gains assurance from the appropriate Executive Director that risks are being appropriately and effectively managed throughout the organisation.

Risks to the Trust's strategic goals and corporate annual objectives are managed through the BAF.

The Board and its Committees review the progress in controlling risks to these important priorities, the levels of assurance, and plans to mitigate the impact of the actual or potential risk on the Trust. This allows the Board to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care and ensure that goals and objectives are being delivered. All the principle risks that are identified in achieving the Trust's strategic goals or corporate annual objectives will be recorded on the BAF and reported to the Board.

The Trust's Corporate Risk Register provides a record of all identified risks to the organisation. Each risk is aligned with a corporate risk category and can be linked to a Trust objective to facilitate a straightforward means of assessing compliance. The Board Committees and Trust Management Group, with additional oversight provided by the Audit and Risk Committee, determines whether or not any risks from the Corporate Risk Register should be transferred to the Board Assurance Framework; this would occur when the risk is considered to have a potential impact on the Trust's strategic goals and/or corporate annual objectives.

At least annually the Audit and Risk Committee will review risks scoring 15 or above from the ICSUs and/or Corporate Directorates. ICSU and Corporate Directorates should review all their risks scoring >15 at their quarterly Performance meetings.

The Corporate Risk Register is populated with risks arising from sources throughout the organisation, specifically:

- Business and Service Delivery Plans – i.e. principal risks to the Trust achieving key performance standards or safe service delivery

- Adverse Incident Forms – if it is apparent from an adverse event form, or subsequent investigation into the adverse event, that there is a significant risk then it will be transferred to the risk register

- Health & Safety Risk Assessments – Health and Safety risk assessments are a legal obligation for the Trust, and managers are responsible for ensuring these assessments are undertaken. Any risk identified from these assessments will be included on the Risk Register

- Local Risk Assessments – where local assessments have identified risks

- External Assessment / Audit – significant risks identified by any internal / external audit e.g., Care Quality Commission, Local Counter Fraud, NHS Litigation Authority, H&SE notices, will be placed on the Risk Register

- External Guidance / Alerts – NICE, Quality Strategies, etc that are not yet implemented

- Results of Feedback – Learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices etc.

8. Training and Support

At the heart of this Strategy is the desire to learn from events and situations in order to continuously improve management processes. All members of staff have an important role to play in identifying, assessing, reviewing and managing risk. The Trust will develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role and provide information, training and support to achieve this. The Trust will:

- ensure all staff have access to a copy of this Risk Management Strategy via the Trust's Intranet
- communicate with staff actions to be taken with respect to assurance, quality and risk issues e.g., via the Trust weekly e-noticeboard
- develop policies, procedures and guidelines based on the results of assessments, investigations and all identified risks
- ensure that training programmes raise and sustain awareness of the importance of identifying and managing risk
- ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with this Strategy
- facilitate specific risk management training for Board Members, Executives and Senior Managers, as specified.

9. Communication with stakeholders and staff

Systems of communication with stakeholders that contribute to minimising risk and improving quality are in place. These systems include high level meetings with key stakeholders by the Trust Executive team, the Trust website, the communications and engagement activities, patient and staff surveys, consultation publications, the annual general meeting, and Public Board Meetings.

Communication with staff is mainly via line management at team meetings, the Chief Executive's briefing, the Trust Bulletin, the Intranet or Trust-wide emails.

10. Monitoring the Effectiveness of the Strategy

This Strategy will be reviewed on an annual basis by the Trust Board.

The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed through the following:

- The Annual Governance Statement and the Board Assurance Framework
- Achievement of the Trust's strategic goals and annual corporate objectives
- Achievement of the ICSU business plans
- Compliance with National Standards, e.g. Care Quality Commission
- Monitoring of key performance indicators via the Trust and ICSU-level performance

dashboards

- Receiving assurance from internal and external audit reports that the Trusts risk management and governance processes are being implemented
- External reporting is undertaken in accordance with reporting requirements and timescales
- Reports relating to risk management and integrated governance will be presented to the Quality Committee with deep dives commissioned by the Audit and Risk Committees, and on a regular basis to the Trust Board in line with the reporting cycle
- Record of meetings and actions from Trust Board Committees, TMG and ICSU meetings

The Head of Integrated Governance will be responsible for ensuring systems and processes are in place to monitor the effectiveness of the Risk Management Strategy at least quarterly and report through to the Quality and Audit and Risk Committees who report to the Board.

11. Equality Impact Assessment

This Strategy and its impact on equality have been reviewed in line with the Trust's Equality Scheme and no detriment was identified.

Appendix 1 – Key Trust Strategies and Policies

Strategy / Policy	Executive Lead
Annual Operating Plan	Director of Strategy/Deputy Chief Executive
Quality Account	Medical Director
Risk Register Policy	Director of Nursing & Patient Experience
Health & Safety Policy	Director of Nursing & Patient Experience
Infection Control Policies	Director of Nursing & Patient Experience
Adverse Incident Reporting and Investigation Policy	Director of Nursing & Patient Experience
Research & Education Strategy	Medical Director
Major Incident Plan	Chief Operating Officer
Business Continuity Plan	Chief Operating Officer
Safeguarding Children Policy	Director of Nursing & Patient Experience
Safeguarding Adult Policy	Director of Nursing & Patient Experience
Being Open Policy	Medical Director
Raising Concerns (Whistleblowing) Policy	Director of Workforce
People and Workforce Development Strategy	Director of Workforce
Appraisal Policy (Medical Staff)	Medical Director

Appendix 2 – Duties and Accountabilities

Chief Executive and Directors

The Chief Executive is ultimately accountable for ensuring that there is a comprehensive risk management system in place and maintained in accordance with this strategy. The Chief Executive has delegated responsibility for all areas of risk to individual Executive Directors (areas of accountability are reflected in the Corporate Governance Map, Corporate Risk Register and Board Assurance Framework).

Accountable Executive Director for the Risk Management Strategy and risk management processes

The Director of Nursing and Patient Experience is the accountable Director for the Trust Risk Management Strategy, policies and procedures and the Corporate Risk Register.

Accountable Executive Director for the Board Assurance Framework

The Deputy Chief Executive/Director of Strategy is the accountable Director for the Trust Board Assurance Framework.

Accountable Executive Director for the Senior Information Risk Owner role (SIRO)

The Deputy Chief Executive/Director of Strategy is the accountable Director for the Trust Board Senior Information Risk Owner.

Local Security Services Management

The Deputy Chief Executive/Director of Strategy is the accountable Director for the Trust Board Local Security Services Management.

Local Counter Fraud

The Chief Finance Officer is the accountable Director of management of the Local Counter Fraud services and reporting mechanisms.

Internal and External Audit

The Chief Finance Officer is the accountable Director of management of the Trust internal and external audit plans and reporting.

Integrated Risk Management

The Head of Integrated Risk Management is accountable to the Director of Nursing and Patient Safety who reports to the Board for ensuring systems and processes are in place to monitor the effectiveness of the Risk Management Strategy and further development of the Trust's integrated governance and risk management processes. The Head of Quality and Integrated Risk Management is also responsible for overseeing the day to day management/coordination of risks across the organisation. The role is an expert resource for all clinical and non-clinical risk related issues, professional advice and support to senior managers and leads risk triangulation and reporting

through the interrogation and trend analysis of incident data held on Datix.

Integrated Clinical Service Unit Clinical Directors and Directors of Operations

Integrated Clinical Service Unit Clinical Directors and Directors of Operations are responsible for ensuring that effective integrated governance and risk management processes, as described within this strategy, are in place and implemented within their ICSUs and are responsible for leading and monitoring clinical governance issues with relevant staff.

All Managers (medical, clinical and non-clinical)

All managers are accountable for the day-to-day identification and management of all risks within their area of responsibility. They must ensure that risk registers / logs are maintained; that risk assessments are undertaken and preventive action is carried out where necessary or escalation of the risk where required.

Safety and Security Advisor

The Safety and Security Advisor is responsible for overseeing the day-to-day management/coordination of non-clinical risks throughout the organisation in conjunction with other non-clinical risk management specialist who are responsible for their respective areas.

All Staff (inc. contract staff and agency staff)

Management of risk is a fundamental duty of all staff. All staff must follow Trust policies and procedures; ensure that identified risks and incidents are dealt with swiftly and effectively; report all incidents and near misses on Datix; and undertake mandatory training.

Commitment to risk management is a non-negotiable requirement at all levels of the organisation. All staff throughout the Trust, including contractors and temporary staff, are expected to participate in risk management processes.

All staff, including locums, agency and honorary contracted staff have a personal and professional responsibility to be familiar with the Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce risk (see the Trust's Adverse Incident Reporting and Investigation Policy).

Appendix 3 – Trust Board Committees – Terms of Reference

AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 The Audit & Risk Committee will be appointed by the Board of Directors.

2.2 All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.

2.3 The Committee shall consist of at least three members.

2.4 The Board should appoint the Chair of the Audit & Risk Committee from amongst its independent Non-Executive Directors.

2.5 At least one member of the Audit & Risk Committee should have recent and relevant financial experience.

3. Attendance

3.1 The Chief Finance Officer and appropriate External and Internal Audit and LCFS representatives shall normally attend meetings.

3.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.

3.3 The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.

3.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement.

3.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

4. Quorum

4.1 This shall be at least two members.

5. Frequency of meetings

5.1 The Committee shall meet at least four times per year.

5.2 The external or internal auditor may request a meeting when they consider it necessary.

6. Secretary

6.1 A Secretary shall be appointed for the Audit & Risk Committee.

7. Agenda & Papers

7.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

7.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

8. Minutes of the Meeting

8.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

8.2 Approved minutes will be forwarded to the Board of Directors for noting.

8.3 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

9. Authority

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

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

10. Duties

10.1 Governance, Risk Management and Internal Control

10.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

10.1.2 In particular, the Committee will review the adequacy of:

10.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

10.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

10.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

10.1.2.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

10.1.2.5 the financial systems

10.1.2.6 the Internal and External Audit services, and counter fraud services

10.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

10.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

- the process for the completion and up-dating of the Assurance Framework;
- the relevance and quality of the assurances received;
- whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
- Whether the Assurance Framework remains relevant and effective for the organisation.

10.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

10.1.5 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10.1.6 The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.

10.1.7 The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

10.2 Internal Audit

10.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

10.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

10.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

10.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

10.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

10.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

10.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

10.3 External Audit

10.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Trust Board, and consider the implications and management's responses to their work. This will be achieved by:

10.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

10.3.1.2 consideration of recommendations to the Trust Board relating to the appointment and performance of the External Auditor

10.3.1.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

10.3.1.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

10.3.1.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

10.4 Other Assurance Functions

10.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

10.4.2 These will include, but will not be limited to, any reviews by Monitor, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

10.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality, Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

10.4.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

10.4.5 The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

10.4.6 The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports.

10.4.7 The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports

10.5 Management

10.5.1 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

10.5.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

10.6 Financial Reporting

10.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

10.6.1.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

10.6.1.2 changes in, and compliance with, accounting policies and practices

10.6.1.3 unadjusted mis-statements in the financial statements

10.6.1.4 major judgemental areas

10.6.1.5 significant adjustments resulting from the audit

10.6.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

10.7 Appointment, reappointment, and removal of external auditors

10.7.1 The Committee shall make recommendations to the Board of Directors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors

10.7.2 The Committee shall make recommendations to the Board of Directors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Board of Directors with information on the performance of the External Auditor

10.7.3 The Committee shall approve the remuneration and terms of engagement of the External Auditors

11. Other Matters

11.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

11.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

12. Sources of Information

12.1 The Committee will receive and consider minutes from the other Committees when requested. The Committee will receive and consider other sources of information from the Chief Finance Officer

13. Reporting

13.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit & Risk Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

13.2 The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

13.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities

QUALITY COMMITTEE TERMS OF REFERENCE

1. Authority & Scope

1.1 The Quality Committee is constituted as a standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Trust Board.

1.2 The Quality Committee shall meet formally no fewer than 6 times per year.

1.3 The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality for all services provided by the Integrated Care Organisation. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the ICO and escalate findings as necessary to the Trust Board.

1.4.1 Subject to the conditions set out in the Trust's Standing Orders, the Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the organisation with relevant experience and expertise if the committee feels this is necessary to exercise its functions and discharge its duties, in the course of appointing external representation the committee will notify the Trust Board.

1.4.2 The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties.

2. Membership

2.1 The Committee will be chaired by a Non-executive Director of the Trust and administered by the Trust Board Secretariat or its nominated officer.

2.2 The Quality Committee will comprise at least two non-executive members of the Trust Board. Appendix 1 outlines membership as at January 2015

2.3 In the absence of the Chair, any Non-executive Director present at a meeting may be asked to act as Vice-chair for the duration of that meeting.

2.4 All Trust Board members may attend the Quality Committee as ex-officio members.

2.5 The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and any two executive directors, one of whom should have a clinical background.

2.6 Members are required to attend a minimum of four meetings per year a record of attendance will be recorded at each meeting and monitored throughout the year to ensure compliance with the minimum attendance level. In the event of any executive member being unavailable, a nominated deputy should attend in their place, and such deputies should be recorded in the minutes as having been in attendance.

3. Purpose and role:

3.1 The purpose of the Committee is to focus on service quality and improvement through the following the three NHS defined components:

- Patient Safety, Clinical Risk
- Effectiveness, and
- Patient Experience.

3.2 The role of the Committee is to obtain assurance that high standards of care are provided by the ICO and in particular that adequate and appropriate governance structures, processes and controls are in place.

This can be defined as being:

- To provide assurance to the Trust Board that the Trust has adequate systems and processes in place to ensure and continuously improve patient safety and management of risk

- To provide assurance to the Trust Board that the Trust has effective structures in place to measure and continuously strive to improve the effectiveness of care

- To provide assurance to the Trust Board that the Trust is responding to patients' feedback about their experiences and taking action appropriately.

4. Duties

4.1 Members of the committee are required to read and interrogate all monitoring reports presented in order to identify issues/deficiencies and act upon them as appropriate. Required actions will be recorded and completed within a specified timeframe and monitored at each meeting through the use of an action log. All agreed actions pertaining to the above will also be recorded within the minutes of the Quality Committee.

4.2 The Committee will receive bi monthly divisional reports which will consist of the following:

Section 1: Clinical Risk Register and Risk Profile
Section 2: Actions and mitigations to risks identified, areas of concern
Section 3: .Synopsis of innovations and improvement occurring within the divisions

4.3 The Committee will also receive reports from each division with a focus on areas within the integrated dashboard which are below target and which identifies actions being implemented and expected timescales to return the performance to the expected target levels.

4.4 The Committee will review, approve and monitor implementation of the Trust's Quality Strategy and Quality Account.

4.5 Where performance in respect of quality and patient safety is proven to have fallen short of agreed standards, the Committee will request evidence that all concerns have been investigated, corrective action has been taken and lessons have been learned.

4.6 The committee will receive workforce information concerning, Mandatory Training, Turnover, Sickness Absence, Vacancy Rates and Bank/Agency Usage and any other aspects of workforce monitoring where this impacts on quality for the organisation or regulatory compliance.

4.7 Outside of the formal committee meetings a program of divisional quality visits and patient safety walkabouts will be completed by a combination of executives and non executives who will report back their findings to the committee following the visits.

4.8 The committee will review and seek assurance on external reviews/ national inquiries to ensure that the organisation is able internally assess and implement actions resulting from such reviews.

4.9 To approve the terms of reference of its reporting sub committees and oversee the work of those sub committees, receiving reports from them as specified by the committee approved annual work plan.

4.10 To consider matters referred to the Quality Committee by the Trust Board and agree appropriate courses of action, ensure these are monitored and report back once implemented.

4.11 To consider matters referred by its sub committees and agree appropriate courses of action, ensure these are monitored and implemented.

4.12 To have overview responsibility for the monitoring of organisational compliance against the CQC Essential Standards of Quality and Safety.

4.13 To seek assurance on compliance with Infection Control through its sub committees and reporting arrangements.

4.14 To promote a culture of openness and honest reporting in accordance with our policies.

4.15 To seek assurance that the organisation is compliant with any licences relevant to clinical activity e.g. Human Tissue Authority, through the reporting of compliance through its sub committee structures.

4.16 To seek assurance that risks to patients are minimised through the application of a comprehensive risk management system.

4.17 To contribute the ongoing review of the Trusts Risk Management Strategy.

4.18 To seek assurance that there are robust arrangements in place for the management of safeguarding adults and children.

4.19 To escalate to the Trust Board and or Executive Committee and identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the organisation.

4.20 To seek assurance from its sub committees that there is an appropriate and effective process to monitor compliance against clinical standards and guidelines (NICE/IRMER).

4.21 To seek assurance from its sub committees that the research program and associated governance frameworks is implemented and appropriately monitored.

4.22 To seek assurance from its sub committees that appropriate mechanisms are in place to take action in response to adverse clinical audits or the recommendations of any relevance external reports.

4.23 To seek assurance from its sub committees that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.

4.24 To promote where there is practice of high quality that this practice is recognised and shared across the organisation.

5. Reporting Structure:

5.1 The following groups / committees will report to the Quality Committee:

- Patient Safety Committee
- Patient Experience Committee
- Clinical Audit Improvement Group
- Serious Incident Group
- Nutrition Falls Group
- Pressure Ulcer Group
- Resuscitation Group
- Medical Exposure Group
- Research Executive Group
- PALS and Complaints Group
- End of Life Group
- Safeguarding Group
- Organ Donations Group
- Medical Devices Group
- Drugs and Therapeutics Group
- Blood Transfusion Group
- Clinical Ethics Group
- Trauma
- Policy Approval Group

5.2 The minutes of all meetings shall be formally recorded and approved at the subsequent meeting. The minutes of the meeting and/or assurance report with key headlines will be submitted to the Trust Board, thus enabling the Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.

6. Review

6.1 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually, and will be amended to reflect any change in organisational structure or legal status.

6.2 The next review date will be January 2016 or earlier in the event of change as above.

Monitoring:

Activity	Frequency	Dates next due:
Terms of reference review	Annual	January 2016
Membership Attendance	• Monitored at each committee • Annual review summarising committee year position	January 2016
Reports to Trust Board	After each committee, monthly.	Bi - monthly return
Submissions of papers/information sources as identified in committee work plan.	Monthly/Quarterly/Bi Annual.	Ongoing review

Membership

Non-Executive Director (Chair)
Non-Executive Director (Deputy Chair) Non-Executive Director
Medical Directors
Director of Nursing & Patient Experience
Chief Operating Officer
Shadow Governor
Shadow Governor

In attendance

Deputy Director of Nursing & Patient Experience Head of Patient Experience
Director of Communications & Corporate Affairs
Head of Integrated Governance and Risk Management
Director of Research, Innovation and Quality
Director of Improvement, Performance and Information
Minute Taker

ICSU Representatives
Director of Operations X 7
Clinical Directors X 7
Heads of Nursing
Head of Midwifery

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Constitution of the Committee

The Whittington Hospital NHS Trust was appointed as corporate trustee of the charitable funds by virtue of SI2002 (2271) and that its Board serves as its agent in the administration of the charitable funds held by the Trust.
The Charitable Funds Committee (CFC) has been formally constituted by the Board in accordance with its standing orders, with delegated responsibility to make and monitor arrangements for the control and management of the trust's charitable funds and will report through to the Trust Board.

2. Membership of the Committee

At least one non-Exec Director (committee to be chaired by a non-Exec)
At least 2 Executive Directors (one of whom must be the Director of Finance),
At least one Governor
All appointments to the Charitable Funds Committee should be approved by the Board.
Executive Directors should nominate a deputy to attend meetings if they cannot be present themselves
The tenure of the Chairman of the Committee should be reviewed every three years.

3. Form of Meetings of the Committee

The meetings will be considered as public meetings and as such details will be published of meetings four weeks in advance of their date.
The Charitable Funds Committee can declare part of the meeting to be closed, if this is a formally recorded decision and the business under consideration warrants this decision, i.e. if it relates to named individuals or matters of commercial interest and sensitivity.
Agendas and papers for meetings will be published two weeks in advance of the notified meeting date.
The standard items of business to be considered by the Committee at each and every meeting will include, declarations of interest, minutes, action tracker, fund raising report and financial report.

4. Frequency of meetings

The CFC shall be held not less than two times per year.

5. Attendance at meetings by non-Committee members

The CFC may require the attendance for advice, support and information routinely at meetings from:
Communications Manager/ Press Manager
Appeal Manager
Assistant Director of Finance/ Finance Manager
Investment Fund Manager
Individual managers representing bids to the Committee

6. Decision Making

Decision making must be made in accordance with the scheme of delegation and all relevant standing orders and standing financial instructions of the Trust.

The meeting will only be considered quorate if one non-executive director and two executive directors, one of whom must be the Director of Finance – or a senior finance officer deputising for them - are present.

7. Overview
The CFC has been established by the Board to make and monitor arrangements for the control and management of the Trust's charitable funds.

8. Scope and Duties
To apply the charitable funds in accordance with their respective governing documents, within the budget, priorities and spending criteria determined by the Trust as corporate trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts).

To ensure that the Trust policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with The Trustee Act 2000, The Charities Acts 1993 and 2006 and the terms of the fund's governing document.

To receive at least two times per year reports for ratification from the Director of Finance or Finance Manager on investment decisions and action taken through delegated powers.

To oversee and monitor the functions performed by the Director of Finance as defined in the NHS Trust's Standing Financial Instructions.

To monitor the progress of the current Appeal Fund. To receive reports from the Appeal Board and the Donor management system.

To consider recommendations for new major appeals to be taken to the Trust Board

To approve the scheme of delegation from the Trustees to the directors, clinicians and managers who act as fund-holders for the operational management of the departmental funds. The scheme of delegation is set out in the Fund Management Handbook, which is approved by the Trust Board, and the schedule of authorised signatories. To determine the appropriate level of application of the general purpose funds, (including the major bequest funds), taking account of the need to strike a balance between ensuring that the funds are applied to meet the objects of the charity and ensuring that sufficient capital sums are maintained for future use, as far as possible.

To evaluate, prioritise and authorise proposals for the non-recurrent application of the general purpose and bequest funds

To review and where appropriate rationalise the departmental funds list, taking account of the size and turnover of each fund.

To approve all individual charitable fund expenditure items in excess of £25,000.

Expenditure items over £100,000 must have in addition formal Trust Board approval.

9. Delegated Powers and Duties of the Director of Finance
The Director of Finance has prime responsibility for the Trust's charitable funds as defined in the Trust's standing financial instructions. The specific powers, duties and responsibilities delegated to the Director of Finance are

To administer and account for all existing charitable funds

To identify any new charity that may be created (of which the Trust is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity

To provide guidelines with respect to donations, legacies and bequests, fundraising and trading income

Responsibility for the management of investment of funds held on trust

To ensure appropriate banking services are available to the Trust. The banking arrangements for the charitable funds should be kept entirely distinct from the Trust's NHS funds

To prepare reports to the Trust Board including the annual accounts

10. Investments

The CFC is empowered with the responsibility for

Management of the investments of the charitable funds in accordance with the investment strategy set down by the Trust Board

Appointment of an investment manager to advise on investment matters. Day-to-day management of some or all of the investments may be delegated to that investment manager. In exercising this power the CFC must ensure that

the scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it and in particular

That there are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently

That performance is regularly reviewed

That the investment manager is regulated under the Financial Services Act 1986

That acquisitions or disposals of a material nature must always have written authority of the Director of Finance in conjunction with the CFC Chairman.

Ensuring that the amounts to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments

Proposing to the Trust Board the basis for applying accrued income to individual funds within the investment pool

Regularly reviewing investments to see if other opportunities or investment managers offer a better return.

11. Reporting

The minutes of the Charitable Funds Committee will be submitted to the next available Trust Board meeting.

The Charitable Funds Committee will be responsible for producing an annual report of its activities alongside the accounts in line with Charity Commissioner Guidance.

12. Review

These terms of reference to be reviewed annually in March.

FINANCE & BUSINESS DEVELOPMENT COMMITTEE
TERMS OF REFERENCE

1. Authority

1.1 The Finance and Business Development Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

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

1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The Finance and Business Development Committee shall review financial performance, business development and investment decisions of the Trust. The Committee will focus on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee will seek assurances, mitigations and recovery action plans where appropriate.

2.2 The Committee will work with the CEO and Executive Management to ensure the organisation has the structure, resources and capacity to develop and grow third party business without any impact on its core operation of fully servicing the primary and social needs of the local community.

2.3 The Board may request that the Committee reviews specific aspects of finance and/or business development matters where the Board requires additional scrutiny and assurance.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and be composed of:

- Three Non Executive Directors appointed by the Board
- Chief Executive Officer
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy

3.2 One Non Executive member of the Board will be appointed as the Chair of the Committee by the Trust Board.

3.3 A quorum shall be three members, at least two of whom should be Non Executive

members of the Trust Board.

3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two scheduled meetings in a calendar year. In this event, the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. Attendance

4.1 All other Non Executive Directors shall be welcome to attend. Executive Directors shall be invited to attend for specific agenda items as appropriate.

4.2 The following members of staff will also attend the Finance and Business Development Committee: Director of Contracts and Business Development, Deputy Director of Finance.

4.3 The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.

4.4 The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.

5. Frequency of meetings

5.1 Meetings will normally be held every 8 weeks. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

6. Reporting

6.1 The Chair of the Finance and Business Development Committee will provide a written summary to the Trust Board after each meeting, highlighting key issues arising from the monthly finance report for discussion and any other items requiring decision. The approved minutes of the Committee's meetings will be available to all Trust Board members on request. The Chair of the Committee will draw to the attention of the Board any issues that require disclosure to the full Board, including those that are considered to affect the financial standing of the Trust or require executive action.

7. Review

7.1 The terms of reference shall be reviewed by the Finance and Business Development Committee and approved by the Trust Board at least annually.

8. Duties

Finance

8.1 Oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan (IBP), incorporating a review of the risks and opportunities.

8.2 Gain assurance that an appropriate performance management process is in place to allow the executive to identify the need for corrective action and identify emerging risks.

8.3 Review the Trust's annual financial plans: revenue (OpEx), capital (CapEx), working capital, investments, borrowing and key performance targets; ensuring these are consistent with operational plans and risk assessed. Financial Plans should also be assessed against regulatory requirements and demonstrate appropriate consultation with key stakeholders, as appropriate.

8.4 Review and maintain an overview of the Trust's contract and service delivery agreements (>£5m pa) and material supplier agreements (>£1m pa) and ensure an adequate assessment of delivery risk. The Committee may wish to conduct a review of any new and innovative contract structures below the figures above. To conduct post implementation reviews of major contracts.

8.5 Review the Trust's Estates Strategy to ensure consistency with overall Trust Strategy assess for acceptable risk (delivery risk and residual risks). Any disposal plans should be assessed for political and reputational risks.

8.6 Review major investment plans (business cases) as defined by:

- Capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years
- All proposed asset disposals where the value of the asset exceeds £1 million.

8.7 Review Trust performance against in-year delivery of the financial plan (income, expenditure, capital, cash, working capital and regulatory requirements), including delivery of the Trusts improvement programme supporting the financial plan; while recognising that the primary ownership and accountability for the Trust's financial performance rests with the full Trust Board.

8.8 Request, review and monitor any corrective action against financial plans.

8.9 Oversee the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting.

8.10 To Oversee the development and application of Service Line Reporting and Reference Costs to support operational improvement and strategic decision making.

8.11 Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

8.12 Request and receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources.

8.13 Address any specific requests by the Trust Board in relation to finance matters.

Business Development

8.14 Oversee and evaluate the development of the Trust's Business Development Strategy to deliver its integrated business plan (IBP), incorporating a review of consistency with Trust Strategy, risks (business, delivery and reputational) and market conditions.

8.15 Approve the resource structure, operating policies and procedures for the preparation of business development bids.

8.16 Receive, review and recommend to the Board proposals for new business development and existing major contracts due for renewal: market development, acquisitions, potential investments and disinvestments in order to recommend options to the Board.

8.17 Review the case for, and make recommendation to the Trust Board for, the establishment of any subsidiary bodies, joint ventures, strategic partnerships or other commercial partnerships (within the Trust's delegated authority under the Health and Social Care Act 2012) having regard to the risk profile and adequacy of investment requirements.

8.18 Review and support the development of the Whittington Charitable Trust to maximise the income from such activities available for investment in supplementing the core infrastructure and services capability of the Trust.

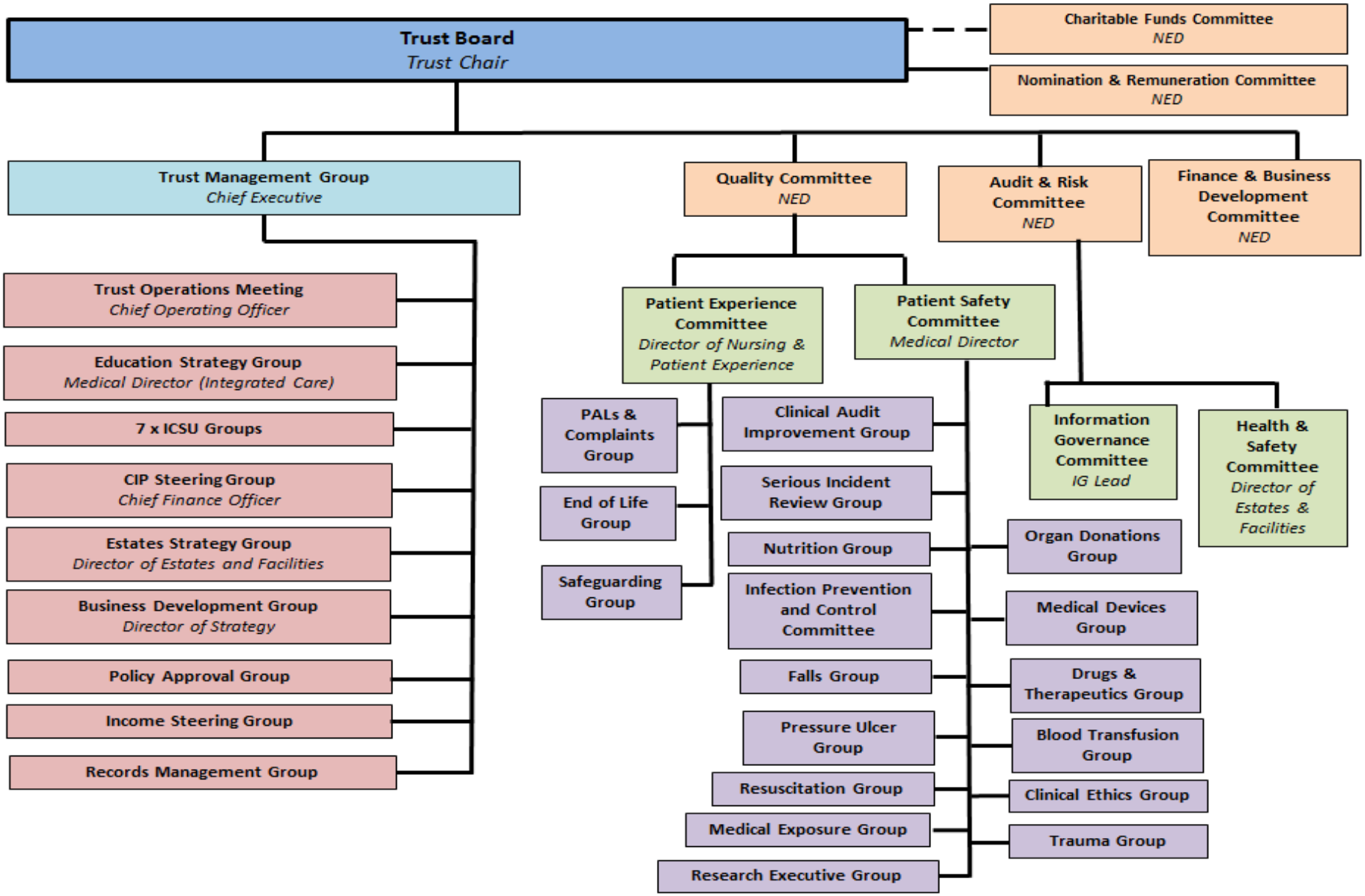
8.19 Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of startup companies.

8.20 Monitor the outcomes of business development initiatives. Receive regular reports and updates from management regarding progress in the achievement of the business development elements of the Strategic Plan.

8.21 Examine any matter referred to the Committee by the Trust Board.

Appendix 4 – BOARD LEVEL AND DIRECTOR ACCOUNTABILITY STRUCTURE

BOARD COMMITTEE STRUCTURE



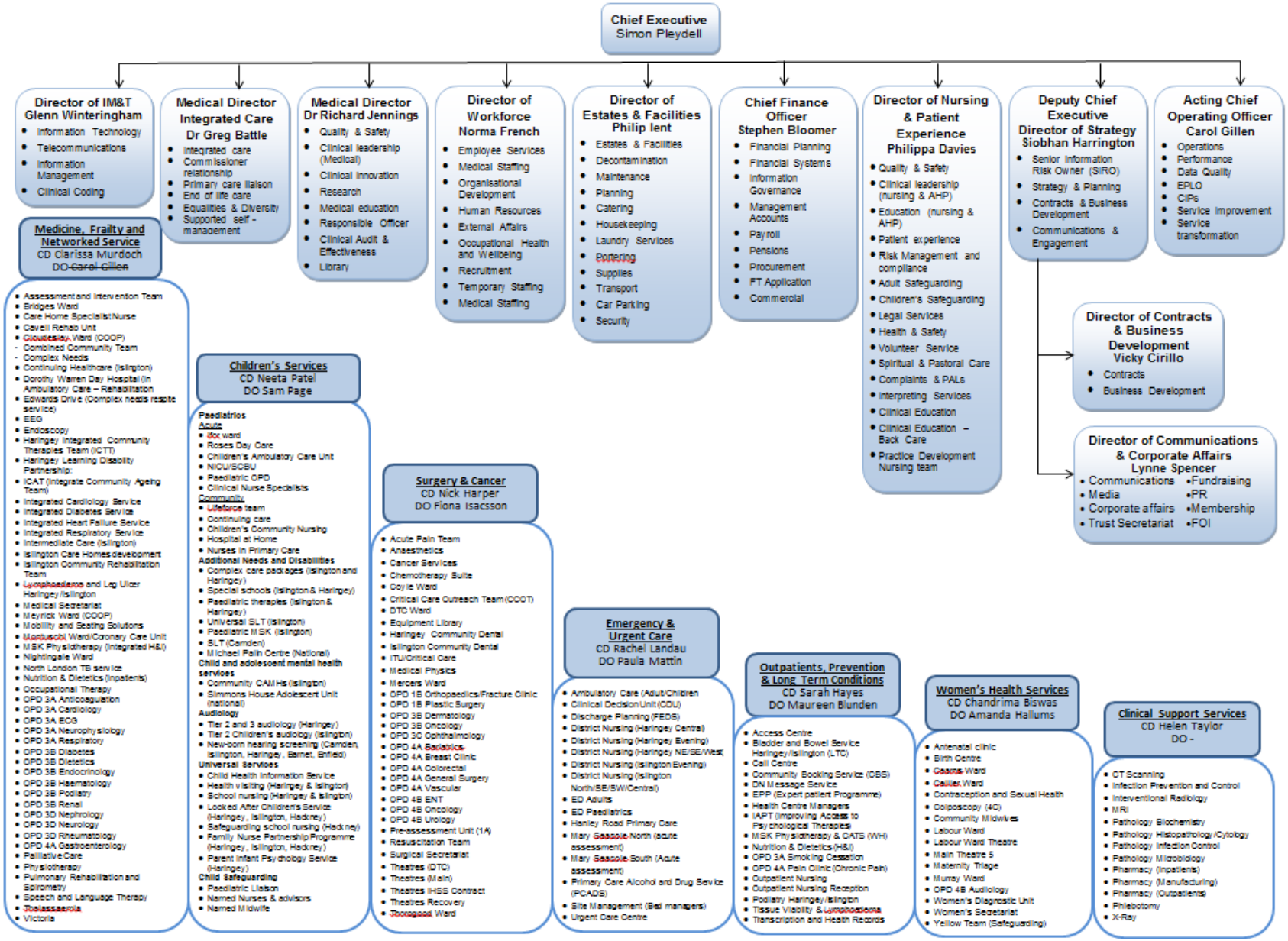

Chief Executive
Simon Pleydell
Director of IM&T
Glenn Winteringham
Information Technology
Telecommunications
Information Management
Clinical Coding
Medical Director
Integrated Care
Dr Greg Battle
Integrated care
Commissioner relationship
Primary care liaison
End of life care
Equalities & Diversity
Supported self - management
Medical Director
Dr Richard Jennings
Quality & Safety
Clinical leadership (Medical)
Clinical Innovation
Research
Medical education
Responsible Officer
Clinical Audit & Effectiveness
Library
Director of Workforce
Norma French
Employee Services
Medical Staffing
Organisational Development
Human Resources
External Affairs
Occupational Health and Wellbeing
Recruitment
Temporary Staffing
Medical Staffing
Director of Estates & Facilities
Philip Ient
Estates & Facilities
Decontamination
Maintenance
Planning
Catering
Housekeeping
Laundry Services
Portering
Supplies
Transport
Car Parking
Security
Chief Finance Officer
Stephen Bloomer
Financial Planning
Financial Systems
Information Governance
Management Accounts
Payroll
Pensions
Procurement
FT Application
Commercial
Director of Nursing & Patient Experience
Philippa Davies
Quality & Safety
Clinical leadership (nursing & AHP)
Education (nursing & AHP)
Patient experience
Risk Management and compliance
Adult Safeguarding
Children's Safeguarding
Legal Services
Health & Safety
Volunteer Service
Spiritual & Pastoral Care
Complaints & PALs
Interpreting Services
Clinical Education
Clinical Education – Back Care
Practice Development Nursing team
Deputy Chief Executive
Director of Strategy
Siobhan Harrington
Senior Information Risk Owner (SIRO)
Strategy & Planning
Contracts & Business Development
Communications & Engagement
Acting Chief Operating Officer
Carol Gillen
Operations
Performance
Data Quality
EPLO
CIPs
Service improvement
Service transformation
Director of Contracts & Business Development
Vicky Cirillo
Contracts
Business Development
Director of Communications & Corporate Affairs
Lynne Spencer
Communications
Media
Corporate affairs
Trust Secretariat
Fundraising
PR
Membership
FOI
Medicine, Frailty and Networked Service
CD Clarissa Murdoch
DO Carol Gillen
Assessment and Intervention Team
Bridges Ward
Care Home Specialist Nurse
Cavell Rehab Unit
Gloucester Ward (COOP)
Combined Community Team
Complex Needs
Continuing Healthcare (Islington)
Dorothy Warren Day Hospital (In Ambulatory Care – Rehabilitation
Edwards Drive (Complex needs respite service)
EEG
Endoscopy
Haringey Integrated Community Therapies Team (ICTT)
Haringey Learning Disability Partnership:
ICAT (Integrate Community Ageing Team)
Integrated Cardiology Service
Integrated Diabetes Service
Integrated Heart Failure Service
Integrated Respiratory Service
Intermediate Care (Islington)
Islington Care Homes development
Islington Community Rehabilitation Team
Lymphoedema and Leg Ulcer Haringey/Islington
Medical Secretariat
Meyrick Ward (COOP)
Mobility and Seating Solutions
Montuscobi Ward/Coronary Care Unit
MSK Physiotherapy (Integrated H&I)
Nightingale Ward
North London TB service
Nutrition & Dietetics (Inpatients)
Occupational Therapy
OPD 3A Anticoagulation
OPD 3A Cardiology
OPD 3A ECG
OPD 3A Neurophysiology
OPD 3A Respiratory
OPD 3B Diabetes
OPD 3B Dietetics
OPD 3B Endocrinology
OPD 3B Haematology
OPD 3B Podiatry
OPD 3B Renal
OPD 3D Nephrology
OPD 3D Neurology
OPD 3D Rheumatology
OPD 4A Gastroenterology
Palliative Care
Physiotherapy
Pulmonary Rehabilitation and Spirometry
Speech and Language Therapy
Thalassaemia
Victoria
Children's Services
CD Neeta Patel
DO Sam Page
Paediatrics
Acute
Ilex ward
Roses Day Care
Children's Ambulatory Care Unit
NICU/SCBU
Paediatric OPD
Clinical Nurse Specialists
Community
Lifeforce team
Continuing care
Children's Community Nursing
Hospital at Home
Nurses in Primary Care
Additional Needs and Disabilities
Complex care packages (Islington and Haringey)
Special schools (Islington & Haringey)
Paediatric therapies (Islington & Haringey)
Universal SLT (Islington)
Paediatric MSK (Islington)
SLT (Camden)
Michael Palin Centre (National)
Child and adolescent mental health services
Community CAMHs (Islington)
Simmons House Adolescent Unit (national)
Audiology
Tier 2 and 3 audiology (Haringey)
Tier 2 Children's audiology (Islington)
New-born hearing screening (Camden, Islington, Haringey, Barnet, Enfield)
Universal Services
Child Health Information Service
Health visiting (Haringey & Islington)
School nursing (Haringey & Islington)
Looked After Children's Service (Haringey, Islington, Hackney)
Safeguarding school nursing (Hackney)
Family Nurse Partnership Programme (Haringey, Islington, Hackney)
Parent Infant Psychology Service (Haringey)
Child Safeguarding
Paediatric Liaison
Named Nurses & advisors
Named Midwife
Surgery & Cancer
CD Nick Harper
DO Fiona Isacsson
Acute Pain Team
Anaesthetics
Cancer Services
Chemotherapy Suite
Coyle Ward
Critical Care Outreach Team (COOT)
DTC Ward
Equipment Library
Haringey Community Dental
Islington Community Dental
ITU/Critical Care
Medical Physics
Mercers Ward
OPD 1B Orthopaedics/Fracture Clinic
OPD 1B Plastic Surgery
OPD 3B Dermatology
OPD 3B Oncology
OPD 3C Ophthalmology
OPD 4A Bariatrics
OPD 4A Breast Clinic
OPD 4A Colorectal
OPD 4A General Surgery
OPD 4A Vascular
OPD 4B ENT
OPD 4B Oncology
OPD 4B Urology
Pre-assessment Unit (1A)
Resuscitation Team
Surgical Secretariat
Theatres (DTC)
Theatres (Main)
Theatres IHSS Contract
Theatres Recovery
Tocolgood Ward
Emergency & Urgent Care
CD Rachel Landau
DO Paula Mattin
Ambulatory Care (Adult/Children
Clinical Decision Unit (CDU)
Discharge Planning (FEDS)
District Nursing (Haringey Central)
District Nursing (Haringey Evening)
District Nursing (Haringey NE/SE/West)
District Nursing (Islington Evening)
District Nursing (Islington North/SE/SW/Central)
ED Adults
ED Paediatrics
Hanley Road Primary Care
Mary Seacole North (acute assessment)
Mary Seacole South (Acute assessment)
Primary Care Alcohol and Drug Service (PCADS)
Site Management (Bed managers)
Urgent Care Centre
Outpatients, Prevention & Long Term Conditions
CD Sarah Hayes
DO Maureen Blunden
Access Centre
Bladder and Bowel Service Haringey/Islington (LTC)
Call Centre
Community Booking Service (CBS)
DN Message Service
EPP (Expert patient Programme)
Health Centre Managers
IAPT (Improving Access to Psychological Therapies)
MSK Physiotherapy & CATS (WH)
Nutrition & Dietetics (H&I)
OPD 3A Smoking Cessation
OPD 4A Pain Clinic (Chronic Pain)
Outpatient Nursing
Outpatient Nursing Reception
Podiatry Haringey/Islington
Tissue Viability & Lymphoedema
Transcription and Health Records
Women's Health Services
CD Chandrima Biswas
DO Amanda Hallums
Antenatal clinic
Birth Centre
Gaskin Ward
Galileo Ward
Contraception and Sexual Health
Colposcopy (4C)
Community Midwives
Labour Ward
Labour Ward Theatre
Main Theatre 5
Maternity Triage
Murray Ward
OPD 4B Audiology
Women's Diagnostic Unit
Women's Secretariat
Yellow Team (Safeguarding)
Clinical Support Services
CD Helen Taylor
DO -
CT Scanning
Infection Prevention and Control
Interventional Radiology
MRI
Pathology Biochemistry
Pathology Histopathology/Cytology
Pathology Infection Control
Pathology Microbiology
Pharmacy (Inpatients)
Pharmacy (Manufacturing)
Pharmacy (Outpatients)
Phlebotomy
X-Ray

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4- 14 days Increase in length of hospital stay by 4-15 days RIDDOR/agenc y reportable incident	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanageme nt of patient care with long-	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			An event which impacts on a small number of patients	term effects	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational	Short-term low staffing level that temporarily reduces service	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of	Non-delivery of key objective/service due to lack of

developmen t/staffing/ competence	quality (< 1 day)		Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendatio ns/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non- compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1– 0.25 per cent of budget Claim less than £10,000	Loss of 0.25– 0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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

Trust Board
04 November 2015

Title:	Resilience Planning (Winter15/16)		
Agenda item:	**15/141**	**Paper**	**7**
Action requested:	To note the winter resilience plan, the work completed to date, areas for concern, risks, and proposed mitigations.		
Executive Summary:	Winter planning during 14/15 has moved to a system wide approach as opposed to a series of isolated individual organisational plans. Previous plans have been reviewed and used to inform the winter plan for 15/16. This paper highlights investments and schemes planned for this year, comparing them to the previous year. The risks faced by the organisation are clearly highlighted.		
Summary of recommendations:	To agree the bed plan Eddington Ward to be prepared in case of surge and used if further funding becomes available Mitigations are in place to ensure quality and safety Communication plan for all staff re winter plan		
Fit with WH strategy:	Aligns with clinical strategy		
Reference to related / other documents:	Resilience plans and business continuity		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Capture on RR or BAF		
Date paper completed:	09 October 2015		

Author name and title:		**Lee Martin Chief Operating Officer**		**Director name and title:**		**Carol Gillen, Acting Chief Operating Officer**	
Date paper seen by EC	**20 Oct**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	

Background

Winter planning within the NHS changed during 2014-15 to a system resilience plan as opposed to an individual organisation plan. Within this change each lead CCG was asked to develop a System Resilience Group (SRG). Membership of the group includes, Acute Trusts, Mental Health providers, LAS, Primary Care, Social Care and Health Watch representation.

Whittington Health is a member of Islington SRG and also attends Haringey SRG as community services provider supporting the North Middlesex Hospital and Haringey GPs.
Whittington Health is represented at the Islington SRG by the COO and DOO for Emergency and Urgent Care. The DCOO and relevant service leads attend Haringey SRG.

Each SRG is tasked with developing annual plans to deliver emergency and planned care capacity to maintain national access standards as set out in the NHS constitution commencing 1st April through until the end of March.

Resilience plan for 2014/15

A 'mop up' winter review was completed nationally, the 'mop up' templates reviewed capacity and demand with a focus on admission and discharge patterns and use of acute beds. This was then cross checked against performance. Despite the national challenges Whittington Health achieved ED performance of 94.73% with no LAS black breach (60 mins wait) or redirection of LAS to other providers. All RTT indicators were achieved.

The SRG was asked to review all schemes to identify those offering the best value and effectiveness. The review was used to inform planning for 2015-16.

The 2014-15 winter resilience plans contained the following increased capacity;

- Escalation beds
- Additional ED staff medical, nursing and admin
- Primary care capacity
- Weekend discharge support
- Increase therapy/pharmacy support
- Extended ambulatory care
- Increased district nursing and domiciliary capacity
- Discharge lounge open

The total additional funding was 2.7m

The 5 most effective schemes were identified as;

- Escalation beds
- Additional staff within the emergency department
- Domiciliary care capacity/additional district nursing capacity
- Additional community mental health rapid response and escalation beds
- Additional crisis intervention staff to support ED and inpatient units

Resign and improvement projects were also part of the plan and included;

- Establishing an access centre with clear set of business processes
- Redesign roles of patient flow and access team

- Better discharge planning and change of roles
- Length of stay rounds introduced and other improvement methodologies to optimise LOS
- Additional Quality checks for ED bedded patients including nutrition, hydration, pressure care, and communication.
- Integrated service manual provided to all areas with training
- Buddying of senior managers and clinicians to review wards enabling fast resolution of delays
- Development of internal local authority escalation framework
- Review of demand escalation and training to manage surge in patient flow
- Training for gold, silver and bronze groups in patient flow management and surge

Also lessons learnt where identified, these being;

- Capacity plans developed in the first stage of the winter plan showed need for additional acute bed capacity; this was not agreed until half way through winter when the flu increase occurred.
- Bed plans should be agreed at the earliest point in winter planning.
- Funding was allocated in tranches, this made it difficult to plan ahead which affected the developed of care pathways as these became rushed to get in place and also increased staffing costs due to high use of agency staff.
- Major increase in external reporting requirements taking senior and front line leaders away from managing patient care.
- Need to improve collaboration with 3rd party providers
- Set up and have ready inpatient capacity in case of extreme demand
- Increased communication with the local population to prevent winter illness
- Prepare for opening additional in patient capacity by preparing, staffing and signing off Eddington Ward in advance

Resilience plan 2015/16

Due to sustained pressure of the first quarter a national decision was made that all winter capacity should be maintained in April and May supported by SRGs. Significant national negative media attention and implementation of emergency plans had been seen across the country. WH maintained a positive approach and experienced positive media coverage during the challenges.

During June the formal planning commenced for 2015/16. Whittington Health requested and hosted an extended SRG to consider and reflect on the demands placed on services, staff morale and to ensure early preparation for winter 15/16.

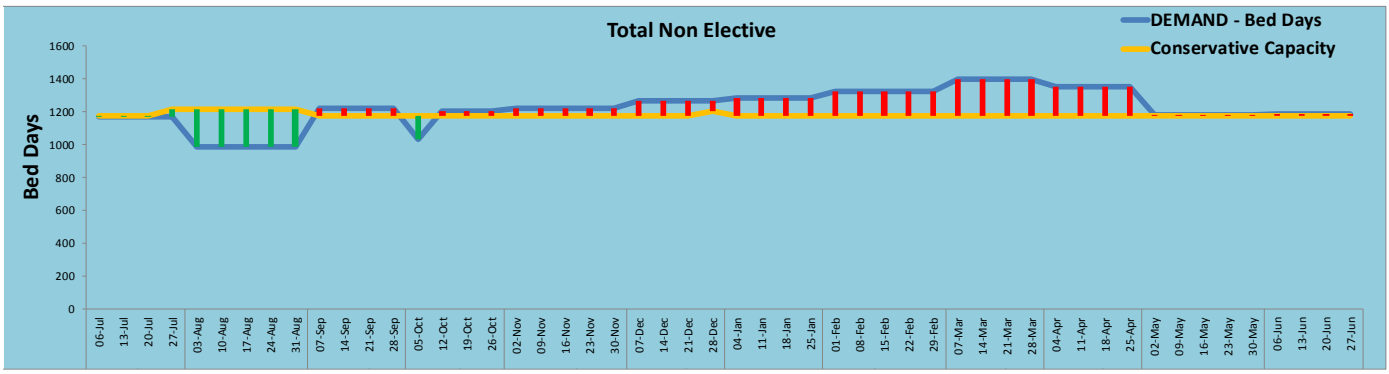
This workshop was called reflecting, learning and working together for 15/16 winter.

Formal documentation from the national team has been completed and includes the following;

- Capacity and demand analysis
- Review of the eight high impact changes
- 2014/15 mop up template
- Winter review Tripartite template
- SRH review template
- Bed capacity plan
- Surge team SYSTON escalation framework

Analysis

A number of capacity and demand templates have been submitted, the chart below show the predicted demand for admissions against bed capacity. It clearly illustrates that unless we agree additional capacity above that already agreed our service will be compromised.



Proposed funding to support winter capacity

The SRG has agreed funding for 1.7m for winter schemes in total; this covers;

- ED staffing and Bed capacity for April and May 2015, cost 600K
- Bed capacity November to March 2016 costing 1.1m This includes mobilisation of Bridges ward (19 beds) additional flex beds on Victoria ward (7) and Cavell (5). In extreme demand additional capacity could be opened on Coyle (6) and Eddington (16).
- The additional beds on Coyle and Eddington will be authorised by the CEO

Risks

Clinical area	Additional capacity in 2014-15	Additional capacity in 2015-16	Risks to patients	Mitigations
Community	Increased district nursing and domiciliary care staffing	-	Not being seen within correct clinical timescale, increase number of unallocated visits, limited capacity to take same day discharges from acute beds	- Clinical triage at 8am - Daily workload review - Coordination via access centre - Risk plans per patient
Emergency department	Increased Medical, nursing and admin staff within adult stream		Overcrowded ED Increased time to treatment Deterioration of ED QIs	- increase in ENP establishment - refreshed escalation framework - training for floor coordination and site, silver and gold

				- refreshment emergency management plans
	Increased Medical staffing for PAEDS stream		Prolonged waits for children in the evenings during Nov-Feb	Agree consultant escalation and also back fill if working time directive breach
	Increased primary care capacity in urgent care centre		Prolong waits in evening and weekends, within disruption to other streams in ED Potential junior Drs needing to review pts and increasing investigations due to limited primary care knowledge	Islington IHUB pathway to be confirmed Robust redirection to primary care facilities Website messages to patients re attending GPS
Access team	Additional discharge and patient flow RN and Medical staff at weekends		Increased LOS and poor discharges Overcrowding due to bed demand	Criteria led discharges by clinical nurse specialist and ward senior nurses
Inpatient care	Additional acute beds x 50	Additional acute beds x 32 beds	Increased total time in ED Potential 12 hour trolley waits Non-compliance with national 4 hour standard Adverse clinical outcomes due to overcrowding Complications associated with increased LOS LAS cannot off load due to cubicles being occupied by inpatient transfers	Increase use of ambulatory care Senior nursing rostered into evenings and weekends Buddy ward rounds to resolve delays LAS early escalation and joint working to assist LAS optimise their turnaround times
Mental Health capacity	Additional crisis intervention staff and support to wards (ILAT)		Long waits in ED Overcrowding of patients within MH conditions Potential blocking hand	

			over of LAS and Police	
Secondary implications for above issues				
Work force			Decreased moral, increase sickness and poor retention due to winter pressures work load Deterioration of staff survey	Managers briefing re care for staff HR staff support – open surgery's Rotational opportunities Increase team meetings and team work Training for gold, silver and bronze in surge management
Media			Decreased public confidence in WH Adverse press stories re winter pressure Reduced friends and family test scores	Media plan to be formed Regular comms to staff and patients

Quality and safety checks

Each day a number of processes are carried out to check quality and safety of patient potentially experiencing delays in patient flow. These are;

The Access Matron or site practitioner will;

- check ICU discharges each day and this will be the first item on the access meeting process each morning, this is recorded on the white board and also in the daily diary.
- check at 3pm each day outliers and form a plan to repatriate to the home ward.
- ensure that patient who are end of life have appropriate standards of care and families are well informed.

The ED Matron will;

- carry out a safety and quality check at 8am each day for all patient who may have been bedded in ED
- monitoring escalation and delay tracking ensuring that floor coordinators are utilising escalation and delay tracking plans

Summary

There are a number of risks to managing demand during winter; the winter action plan is in place and being monitored at the SRG.

Due to the significant reduced funding additional capacity will only be opened when a corporate instruction is provided in relation to funding allocation.

Throughout the winter plan we have stated that quality and safety of patient will be the first priority and during times of surge national access targets maybe compromised.

Recommendations

To agree the bed plan

Eddington Ward to be prepared in case of surge and used if further funding becomes available

Mitigations are in place to ensure quality and safety

Communication plan for all staff re winter plan

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4 November 2015

Title:	Capital Plan update 2015/16		
Agenda item:	**15/142**	**Paper**	**8**
Action requested:	For agreement		
Executive Summary:	There has been a material deterioration to the reported financial position of the NHS provider sector in 2015/16, with significant sector deficit performance forecast for the year end. As a result of this financial position, central Department of Health capital funding constraints have been put in place with increased scrutiny applied to the affordability of capital investments. In response to the constrained capital position the Trust has undertaken a review of all investment decisions. The purpose of this paper therefore is to: ▪ Update the Trust Board on the capital plan position for 2015/16. ▪ Update the Trust Board on the current position for the Maternity and Neonatal Redevelopment Full Business Case.		
Summary of recommendations:	The Trust Board is asked to: • Note the current capital plan position • Note the business cases requiring capital and yet to be approved • Note the position with regards to Maternity and Neonatal Redevelopment • Note and confirm the next steps proposed.		
Fit with WH strategy:	The capital plan is an enabler to the delivery of the clinical		

	strategy
Reference to related / other documents:	Capital plan Trust Operational Plan Maternity & Neonatal Full Business Case
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF risk 9 and risk 14
Date paper completed:	29 October 2015

Author name and title:		**Philip Ient Director of Estates and Facilities**		**Director name and title:**		**Siobhan Harrington Director of Strategy**	
Date paper seen by EC	**25 Oct**	**Equality Impact Assessment complete?**	**N**	**Quality Impact Assessment complete?**	**N**	**Financial Impact Assessment complete?**	**Y**

Trust Board – 4 November 2015

Update on 2015-16 Capital Plan

Introduction and Purpose

There has been a material deterioration to the reported financial position of the NHS provider sector in 2015/16, with significant sector deficit performance forecast for the year end. As a result of this financial position, central Department of Health capital funding constraints have been put in place with increased scrutiny applied to the affordability of capital investments. In response to the constrained capital position the Trust has undertaken a review of all investment decisions. The purpose of this paper therefore is to:

- Update the Trust Board on the capital plan position for 2015/16.
- Update the Trust Board on the current position for the Maternity and Neonatal Redevelopment Full Business Case.

1. Capital Plan 2015/16

Earlier this year all Trusts were asked by the NHS TDA/Monitor to review all investment decisions. Alongside this with the Trust's projected financial deficit position for 2015/16 and subsequent impact on cash availability a review of 2015/16 capital spend has been undertaken. This review tested the effect of reducing the overall capital spend, delaying full programme implementation and the risks associated with that delay, if accepted.

The review focused on the three sections of the plan dealing with buildings, medical equipment and Information Technology (IT).

Programme managers subjected their plans to review by a panel of directors which included The Chief Operating Officer, the Chief Finance Officer and the Deputy Chief Executive. Each element of the schemes was tested for risk, immediate impact and effect on subsequent years. The net result was a reduction across all backlog and equipment replacement categories.

In addition the panel requested that business cases be submitted to the TMG (and Trust Board where required) for review, after financial checks had been completed on each.

Following consideration of the outcome of the review in the private section of the Trust Board in October, the capital plan for 2015/16 is as follows (see table 1):

- a minimum capital requirement of £5,172,061 (for backlog works, legal and statutory works, medical devices, IT schemes, capitalisation of leases).
- a potential capital requirement of £2,021,000, for business cases still to be approved.

Table 1

	2015/16	2016/17	Comments and Actions
Capital Allocation	**£ 8,100,000**		Annual allocation £1m less than 14/15 due to estate revaluation
Total Capital committed for: - Backlog works - Legal and Statutory works - Medical devices - IT schemes - Capitalisation of leases	£ 5,172,061		As described in October 2015 Trust Board Paper
Balance	**£ 2,927,939**		

Additional spend identified but not yet approved				
1	**Business Case;** Yr2/3 Maternity Infrastructure Scheme (Project 2)	£ 1,200,000	£ 1,266,000	Scheme developed through P21+ process. Requires TB approval.
2	**Business Case;** Endoscopy/Decontamination washer equipment replacement	£ 100,000	£ 1,900,000	Requires TB approval Business case to be reviewed internally and brought to TB.
3	**Business Case;** Bowel Screening expansion	£ 250,000		Requires TMG approval
4	**Business Case (IT)** Community IT Infrastructure EPR EDMS	£ 281,000		Requires TMG approval
5	**Business Case (IT)** NHS Number - spine project	£ 100,000		Requires TMG approval
6	**Business Case;** Patient self service check-in	£ 90,000		Requires TMG approval
Total of schemes subject to business case approval		**£ 2,021,000**	**£ 3,166,000**	

2. Maternity and Neonatal Redevelopment

2.1 Background

The Trust developed and approved an Outline Business Case for the redevelopment of Maternity and Neonatal services in February 2014. Following conditional approval by the NHS TDA in

September 2014, the Trust adopted the P21+ Procurement process to develop the Full Business Case.

Integrated Health Projects (IHP) were appointed through the P21+ procurement framework as the Trust's Principle Supply Chain Partner (PSCP) for the re-development of Maternity & Neonatal services and formally entered the P21 Stage 3 process (FBC and approval to proceed) on 24th October 2014. The Stage 3 has been undertaken at a cost to the Trust of circa £1m.

IHP were required to confirm the design and build costs for the scheme by the 19th December 2014 in order to inform the FBC due for submission in Jan 2015. Phase 1 of the Stage 3 programme was achieved with the submission of a not-to-exceed cost plan on the 19th December 2014. The Full Business Case was approved by the Trust Board in January 2015 and submitted to the NHS TDA for approval.

The 2nd phase of the Stage 3 programme required IHP to continue working on the project during the NHS TDA review period in order to progress the development of the design in accordance with the established Affordability Limit, and in so doing firm up the price through market testing, improve cost certainty and drive out risk. This phase was originally programmed to complete in May 2015, with the submission of a Guaranteed Maximum Price (GMP) timed to coincide with the TDA's approval of the business case and the Local Planning Authorities consent to the planning application. The target start date for the commencement of Stage 4 – Construction, was originally set for June 2015.

2.2 Current Position

The Trust is facing two major challenges in progressing the Maternity and Neonatal Redevelopment Full Business Case.

i) Availability of capital funding within the NHS: access to capital across the NHS has deteriorated significantly in this financial year (2015/16). The Trust has been advised that Public Dividend Capital is unlikely to be available, and access to interest bearing loans is also proving challenging.

   The Trust is continuing discussions with the NHS TDA focussed on demonstrating the robustness of the affordability of the investment, in order to achieve formal approval for the Full Business Case to enable an application for a loan to be progressed.

ii) Concluding stage 3 (FBC and approval to proceed): There has been a delay in completing the stage 3 programme for a number of reasons:
   - Extended design development programme
   - Delay in submission of planning application
   - Extended timetable for securing planning consent (principally affected by prolonged S106 negotiations)
   - Extended period for procurement and development of the GMP

   Following completion of the design development and the conclusion of the planning application, current activity is focused on reaching a value-for-money GMP. The Trust is currently engaged in a review of the IHP GMP submitted on 15th October 2015, the conclusions of which are informing further work with IHP to ensure that value for money is achieved. The detail of the maternity infrastructure scheme is being revisited and the Trust will continue to work to identify best value from the whole redevelopment.

3.0 Next Steps

A number of detailed next steps have been identified:

i) Capital business cases to be reviewed by Finance and taken to TMG (and Trust Board where required) for approval

ii) Trust to continue to work with the TDA on approval and funding for the Full Business Case

iii) Trust to develop the Estates Strategy to set the context and framework for future developments

4.0 Recommendations

The Trust Board is asked to:

- Note the current capital plan position
- Note the business cases requiring capital and yet to be approved
- Note the position with regards to Maternity and Neonatal Redevelopment
- Note and confirm the next steps proposed.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

04th November 2015

Title:	Month 6 2015/16 - Financial Performance		
Agenda item:	15/143	**Paper**	9
Action requested:	For noting		
Executive Summary:	The paper analyses the financial performance of the Trust covering overall, clinical division and corporate performance, cash and capital.		
Summary of recommendations:	To note the financial results relating to September 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:	16th October 2015		

Author name and title:		**Stephen Bloomer, Chief Financial Officer**		**Director name and title:**		**Stephen Bloomer, Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Finance overview | Position Summary

Indicator	Measure	In-Month Plan	In-Month Actual	YTD Plan	YTD Actual
Monitor COSR	score	-	-	1	1
EBITDA margin	%	1.55%	6.73%	0.98%	1.23%
EBITDA achieved	£000s	364	1,601	1,397	1,758
Adjusted net deficit margin	%	-3.43%	1.16%	-4.55%	-4.33%
Adjusted net deficit achieved	£000s	-805	275	-6,509	-6,205
Liquidity ratio	days	-	-	-21	-15
Capital Servicing Capacity	times	-	-	-0.30	0.40
Income	£000s	23,473	23,801	143,075	143,388
Pay	£000s	19,096	17,744	106,611	106,257
Non-Pay	£000s	4,013	4,456	35,067	35,373
CIPs	£000s	1,234	2,666	5,995	5,756

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

Year to date EBITDA performance improved in September due to a contract benefit in Facilities. This is a one off item and has also affected CIPs.

Finance overview | Statement of comprehensive income

At the end of September, the Trust posted a YTD deficit of £6.2m which is £303k better than its planned position.

The Trust is now monitoring against the revised plan submitted to NTDA with a revised deficit target of £15m. As part of the submission the trust took the opportunity to revise timings and classification of some expenditure items given greater certainty five months in to the year.

The overall Trust income position is above plan by £0.3m at M6 YTD. This is partly due to increase in funding relating to Non-devolved Education and Training funding above plan. Other areas of over performance include provider to provider SLAs and flexible trainee income. Income relating to NCL contract is above plan at M6 (£637k) before adjusting for the contract cap and collar. The over performance is due to increased demand in areas where reductions were made to the baseline plan for CCG QIPP plans which suggest they are not delivering as planned and a significant over performance in Outpatient care.

Expenditure is £0.9m ahead of plan in month and broadly on plan YTD. The better than planned expenditure variance in month is largely due to a one off contract benefit in Facilities of which 70% was a prior year benefit.

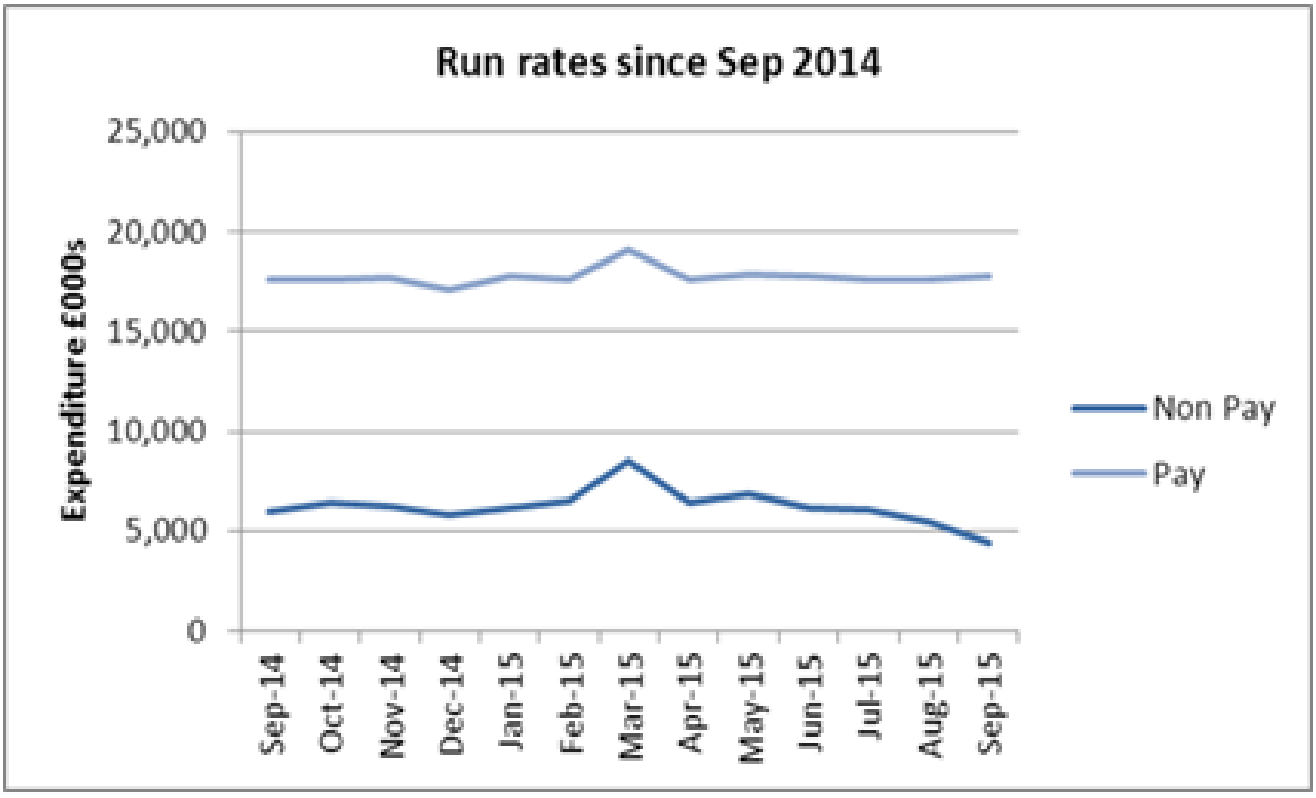
The Trust achieved £2.7m (216%) of its planned savings in September and £5.8m (96%) YTD. This was helped by the above contractual settlement.

The Trust ended the month with a cash balance of £6.7m, which is £0.9m more than it had planned. This was due to the successful collection of large outstanding debts, a reduction in capital spend which is being actively managed to support the trust's deficit reduction plan and the withholding of payments during commercial negotiation. Following the successful completion of those discussions the Trust has instructed payment so cash balances will reduce in October.

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

- underachievement of CIP delivery (£2m) as there are a number of local schemes with Q4 forecast delivery and these have already slipped. Further slippage will cause an under delivery;
- poor management of expenditure budgets (£1m). At the recent Q2 ICSU performance meeting ICSU forecasts included assumptions which were felt to be challenging and areas will therefore need increased support to hit their budgeted targets;
- failure to achieve the income targets set within its major CCG contract (£2m). These relate in particular to spinal activity (£1.3m) and maternity (£0.7m) which despite improvement is unlikely to catch back to original planned levels;
- write-off of capital setup costs should the maternity business case not materialise (£1.2m);
- overspend against resilience funding as CCGs are not funding expenditure incurred in quarter 1 and plans which currently exceed the funded levels proposed by CCGs (£0.5m)
- poor record keeping of temporary staff bookings on Health Roster and subsequent control (£0.5m). There are already significant prior year values within this year's position and accuracy of input remains of concern.

in £000	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Nhs Clinical Income	19,421	20,273	852	122,106	121,934	-172	243,894
Non-Nhs Clinical Income	1,252	1,471	220	8,394	8,490	96	20,284
Other Non-Patient Income	2,801	2,056	-744	12,575	12,964	388	25,997
Total Income	**23,473**	**23,801**	**327**	**143,075**	**143,388**	**313**	**-290,176**
Non-Pay	4,013	4,456	-444	35,067	35,373	-307	77,308
Pay	19,096	17,744	1,352	106,611	106,257	354	211,839
Total Operating Expenditure	**23,109**	**22,200**	**909**	**141,678**	**141,630**	**48**	**289,148**
EBITDA	**364**	**1,600**	**1,236**	**1,397**	**1,757**	**360**	**1,028**
Depreciation	573	665	-92	4,025	4,028	-3	9,663
Dividends Payable	429	410	19	2,479	2,461	19	4,750
Interest Payable	171	259	-88	1,446	1,518	-72	3,231
Interest Receivable	1	3	3	5	15	10	10
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-808**	**270**	**1,078**	**-6,549**	**-6,235**	**314**	**-16,606**
Add back impairments and adjust for IFRS & Donate	3	5	1	39	29	-10	1,569
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-804**	**274**	**1,078**	**-6,510**	**-6,207**	**303**	**-15,037**



Finance overview | Statement of financial position

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

Trade Receivables: The Trust has made significant progress in collecting a number of long outstanding debts and more efforts are being put in place to collect more.

Cash: The cash position was better than planned mainly due to the collection of large outstanding debts.

Payables: Significant progress has also been made in this regard however we are disputing a few invoices, which need to be resolved so that the outstanding amounts can be paid. This is being followed up.

Borrowings: Borrowings are greater than planned as the working capital support is yet to be paid off by PDC funding. Equally, PDC is lower than planned for the same reason. The Trust is engaging with the TDA on the application process.

			Year to Date		Year to Date
	As at 1 April 2015 £000	Plan 31 March 2015 £000	Plan YTD 30 Sep 2015 £000	As at 30 Sep 2015 £000	Variance YTD 30 Sep 2015 £000
Property, plant and equipment	194,918	211,762	201,132	192,389	(8,743)
Intangible assets	4,481	2,891	4,754	4,805	51
Trade and other receivables	757	533	755	749	(6)
Total Non Current Assets	**200,156**	**215,186**	**206,641**	**197,943**	**(8,698)**
Inventories	1,427	1,356	1,456	1,715	259
Trade and other receivables	19,223	22,224	17,443	16,991	(452)
Cash and cash equivalents	1,347	1,619	5,793	6,723	930
Total Current Assets	**21,997**	**25,199**	**24,692**	**25,429**	**737**
Total Assets	**222,153**	**240,385**	**231,333**	**223,372**	**(7,961)**
Trade and other payables	38,847	39,551	36,976	33,892	(3,084)
Borrowings	1,809	255	903	694	(209)
Provisions	1,380	723	1,040	1,002	(38)
Total Current Liabilities	**42,036**	**40,529**	**38,919**	**35,588**	**(3,331)**
Net Current Assets (Liabilities)	**(20,039)**	**(15,330)**	**(14,227)**	**(10,159)**	**4,068**
Total Assets less Current Liabilities	**180,117**	**199,856**	**192,414**	**187,784**	**(12,766)**
Borrowings	34,950	43,993	43,257	48,848	5,591
Provisions	1,952	1,697	1,952	1,946	(6)
Total Non Current Liabilities	**36,902**	**45,690**	**45,209**	**50,794**	**5,585**
Total Assets Employed	**143,215**	**154,166**	**147,205**	**136,990**	**10,215**
Public dividend capital	62,377	86,277	72,914	62,377	(10,537)
Retained earnings	6,187	(10,120)	(211)	114	325
Revaluation reserve	74,651	78,009	74,502	74,499	(3)
Total Taxpayers' Equity	**143,215**	**154,166**	**147,205**	**136,990**	**(10,215)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	

Finance overview | Cost improvement programmes

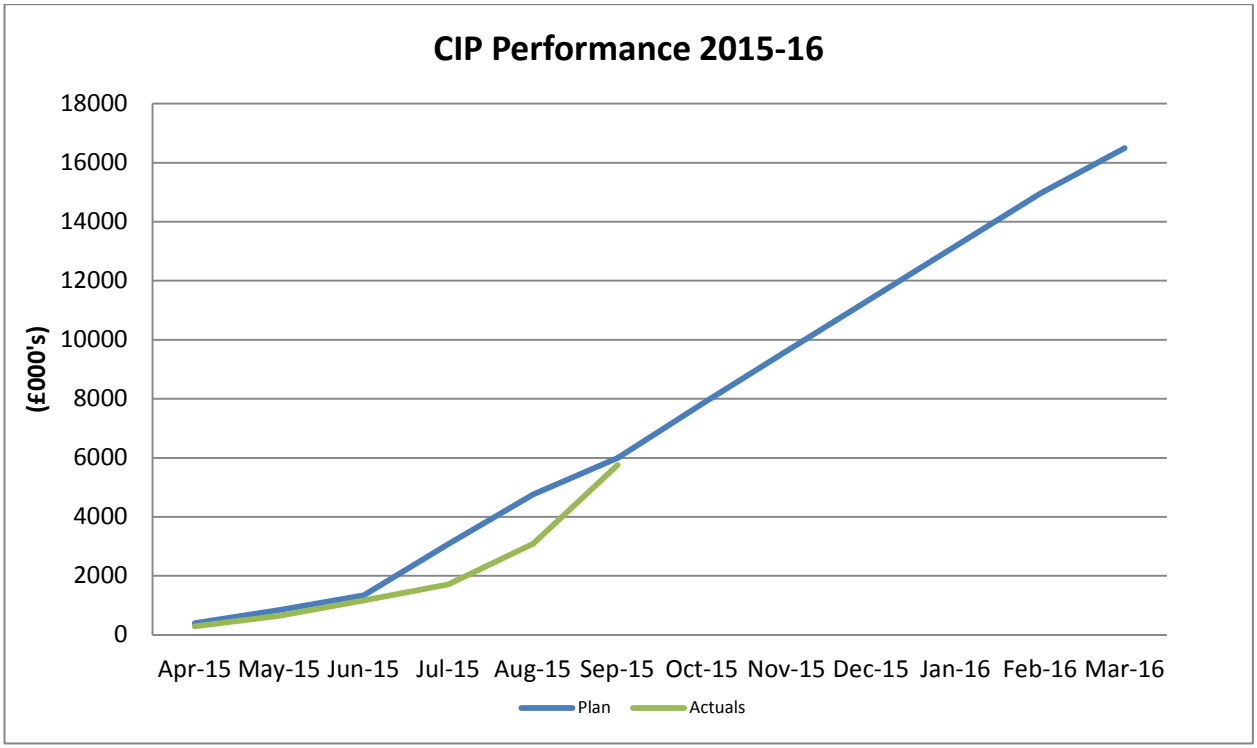
In month 6 savings amounting to £2.67m (216%) were delivered against the TDA operating plan of £1.23m. Year to date, £5.76m (96%) has been achieved.

Against savings schemes allocated to ICSUs (PMO schemes), September's performance was 249% and YTD it was 124%. This was mainly driven by a one off benefit in Facilities where a long standing contract dispute was resolved, resulting in a lower contract cost to the Trust.

ICSUs continued to reduce their CIP gaps by delivering savings to replace the income schemes voided in July along with other challenged schemes. Some of these savings are non-recurrent. Monthly clinical agency expenditure across Nursing and Medical staffing groups increased in September and did not yield the savings recognised in August.

Trust-wide schemes of £4.6m must be delivered in the last 6 months to ensure the Trust meets its planned deficit. These schemes include procurement efficiencies, reductions in temporary staffing and postponing expenditure on a non-recurrent basis.

	Annual	September				YTD			
	Plan	Plan	Act	%	Var	Plan	Act	%	Var
Integrated Clinical Service Units	£'000	£'000	£'000	achieved	£'000	£'000	£'000	achieved	£'000
Medicine Frailty and Network Services	1,332	94	59	63%	(35)	570	413	72%	(157)
Surgical Services	1,557	125	137	110%	12	670	612	91%	(59)
Emergency and Urgent Care	490	43	27	62%	(16)	232	183	79%	(49)
Women's Services	995	39	131	338%	92	351	348	99%	(3)
Children's Services	1,362	92	147	161%	56	590	595	101%	5
Clinical Support Services	635	56	32	58%	(24)	317	180	57%	(137)
OP and Long Term Conditions Services	753	82	124	152%	43	196	205	104%	8
Corporate Services	2,891	542	2,008	371%	1,466	1,205	2,595	215%	1,390
Peformance against PMO schemes	**10,016**	**1,072**	**2,666**	**249%**	**1,594**	**4,133**	**5,132**	**124%**	**999**
Trust-wide Schemes	6,485	162	0	0%	(162)	1,862	624	34%	(1,238)
Performance against Operating Plan	**16,500**	**1,234**	**2,666**	**216%**	**1,432**	**5,995**	**5,756**	**96%**	**(239)**



Whittington Health NHS

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

Whittington Health Trust Board
4th November 2015

Title:	Trust Board Performance Dashboard Report (September 15 data)		
Agenda item:	**15/144**	**Paper**	**10**
Action requested:	For discussion and decision making		
Executive Summary:	The following is the Performance and Quality report for November 2015; a number of highlights and areas for focus are identified. <u>Summary of report:</u> **QUALITY** • **Inpatient deaths** remain as expected. • **Completion of valid NHS number**: Remain just below the standard of 95% for SUS submission. • **SHMI:** Whittington Hospital mortality rate remains lower than expected for the Trust. • **HSMR:** Continuing to perform better than expected for the national standard. **PATIENT SAFETY** • **Harm Free Care:** Below target due to pressure ulcers, action plan in place with community teams. • **Falls (audit):** Remains at 0.00%, which means no falls resulting in harm were recorded in the snapshot audits this month. • **VTE assessment:** Achieved standard. • **Medication errors causing severe/moderate/low harm:** No severe medication errors in September 15. There were 2 moderate medication errors and 12 low medication errors ranging from delays in medication given to doses being missed. • **Never events:** One never event was recorded in September 2015. Missed Place Naso gastric Tube - NEVER EVENT Naso-gastric tube inserted at 17:30 pm on 18/09/2015 and a pH of 4.5 was obtained. Tube length was documented as 56 cm and it was anticipated that a feed would have been commenced at that point. However, the feed was not commenced. As there was a prolonged delay in starting the feed there would have been an expectation to check the pH before commencing the first feed, this did not happen. The patient may have displaced the tube in the period of time between tube insertion. Subsequently, the patient became unwell the following morning. • **CAS alerts:** None outstanding.		

- **Serious incidents**: Two new SI's were recorded in September 2015. One unexpected admission to NICU. A baby born in poor condition. Baby was later found to be tachypnoeic, grey, in respiratory distress and X-ray showed bilateral pneumothoraces in addition to the hypoglycaemia. The second one is an Information Governance Breach inappropriate access of staff members personal records.

PATIENT EXPERIENCE

- **Family and Friend Test:** Achieves standard.
- **Mixed sex Accommodation:** No breaches.
- **Patient admission to adult facilities for under 16 years of age:** No breaches.
- **Complaints:** Below target for 3 of the now 7 ICSU's reported. Focus on internal processes.
- **Patient admission to adult ward for under 16 years of age:** None.

INFECTION PREVENTION

- **MRSA:** No new cases
- **E.coli:** No new cases
- **MSSA:** One new infection, all protocols in place.
- **C Difficile:** One new infection, all protocols in place.
- **Ward Cleanliness:** Overall cleanliness rate at 97.7%.

ACCESS

Acute

- **First to follow-up:** Whittington Health performance better than the National Standard.
- **Theatre Utilisation:** Focus is now on smaller services provided by other organisations.
- **Hospital cancellations:** Achieved for first appointment and just below target for follow up appointment.
- **Patient DNA:** Remain underachieving around 12% for first appointment and 14% for follow up appointment.
- **Hospital cancelled operations:** 16 patients cancelled in August of which 3 were target patients and 1 was urgent. The target patients had not had the pre-operative scan. The urgent patient's notes were not available. Other operations were cancelled because of list overrunning or the surgeon not being available.
- **Cancelled ops not rebooked within 28 days:** none
- **RTT 52 week wait:** No patients waited over 52 weeks for first appointment.
- **RTT 18 weeks Admitted Target 90%:** Overall achieved
- **RTT 18 weeks non-Admitted Target 95%:** Overall achieved

	• **RTT 18 weeks incomplete Target 92%:** Overall Achieved. • **Diagnostic waits Target 99%:** Under performance standard due to endoscopy, flexi sigmoidoscopy, gastroscopy and colonoscopy all performed below 99%. • **Cancer:** Overall achieved, except for Breast 14 days, due to staffing. **Community** • **Service cancellations:** Just above target in September 2015. Due to recording issues within RiO of cancellations of clinics. • **Patient DNA:** Achieved standard. • **Face to Face contacts:** Monitoring in place and reviewed for contract performance. • **Appointments with no outcome:** Above target and monitored within services. • **MSK wait 6 week (non-consultant led):** Below target due to reduced capacity, action plan in place and paper written. • **MSK 18 weeks:** Achieved. • **IAPT:** Achieved. • **GUM:** below target due to reduced capacity, action plan in place. **EMERGENCY AND URGENT CARE** • **Emergency Department standard:** Achieved **MATERNITY** • **Woman seen by HCP or midwife within 12 weeks and 6 days:** below target action plan in place targeting DNA and EPR recording issues. • **New birth visits within 14 days:** Improved performance, action being monitored. • **Elective C-section rate:** elective above standard, extensive action plan in place. Emergency achieved standard, • **Breastfeeding initiated:** Achieved. • **Smoking at delivery:** Achieved.
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	N/A

risks on the Board Assurance Framework:							
Date paper completed:		19th October 2015					
Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Acting Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Nov 2015 Trust Board Report (Sept data)

Whittington Health NHS

Quality	Threshold	Jul-15	Aug-15	Sep-15
Number of Inpatient Deaths	-	25	29	35
NHS number completion in SUS (OP & IP)	99%	98.7%	98.6%	arrears
NHS number completion in A&E data set	95%	94.9%	94.2%	arrears

Quality (Mortality index)	Threshold	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
SHMI	-	0.54	0.60	0.66

Quality (Mortality index)	Threshold	Apr-15	May-15	Jun-15
Hospital Standardised Mortality Ratio (HSMR)	<100	73.2	67.2	69.5
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	62.2	116.9	81.3
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	77.3	44.4	67.6

Patient Safety	Threshold	Jul-15	Aug-15	Sep-15
Harm Free Care	95%	94.7%	94.0%	94.3%
VTE Risk assessment	95%	95.3%	96.2%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	1
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	40.7%	37.0%	38.1%
Serious Incident reports	-	6	0	3

Access Standards

Referral to Treatment (in arrears)	Threshold	Jun-15	Jul-15	Aug-15
Diagnostic Waits	99%	93.5%	94.1%	97.2%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Jul-15	Aug-15	Sep-15
Service Cancellations - Community	8%	8.0%	8.8%	8.1%
DNA Rates - Community	10%	7.5%	7.3%	7.6%
Community Face to Face Contacts	-	62,279	48,937	56,834
Community Appts with no outcome	1.0%	2.0%	4.8%	6.2%

Community Access Standards	Threshold	Jul-15	Aug-15	Sep-15
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	80.9%	70.5%	59.4%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	100.0%	100.0%	arrears
IAPT - patients moving to recovery	50%	50.9%	51.0%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	93.6%	94.5%	arrears
GUM - Appointment within 2 days	100%	95.6%	95.6%	92.3%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Jul-15	Aug-15	Sep-15
First:Follow-up ratio - acute	2.31	1.42	1.37	1.39
Theatre Utilisation	92%	82.1%	82.0%	81.1%
Hospital Cancellations - acute - First Appointments	8%	5.6%	5.0%	5.3%
Hospital Cancellations - acute - Follow-up Appointments	8%	8.2%	7.0%	8.2%
DNA rates - acute - First appointments	10%	12.4%	13.0%	13.7%
DNA rates - acute - Follow-up appts	10%	14.5%	14.5%	14.2%
Hospital Cancelled Operations	0	3	5	16
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	4

Meeting threshold

Failed threshold

Nov 2015 Trust Board Report (Sept data)

Whittington Health NHS

Patient Experience	Threshold	Jul-15	Aug-15	Sep-15
Patient Satisfaction - Inpatient FFT (% recommendation)	-	95%	95%	94%
Patient Satisfaction - ED FFT (% recommendation)	-	91%	94%	96%
Patient Satisfaction - Maternity FFT (% recommendation)	-	93%	93%	91%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	29	22	34
Complaints responded to within 25 working day	80%	83%	75%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

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

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Jul-15	Aug-15	Sep-15
Referral to Treatment 18 weeks - Admitted	90%	90.8%	90.6%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	95.0%	95.1%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	92.2%	92.2%	arrears

Meeting threshold
Failed threshold

Emergency and Urgent Care	Threshold	Jul-15	Aug-15	Sep-15
Emergency Department waits (4 hrs wait)	95%	95.1%	95.8%	95.0%
ED Indicator - median wait for treatment (minutes)	<60	81	61	72
30 day Emergency readmissions	-	246	213	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	3.0%	3.2%	2.8%
Ambulance Handover (within 30 minutes)	0	2	0	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

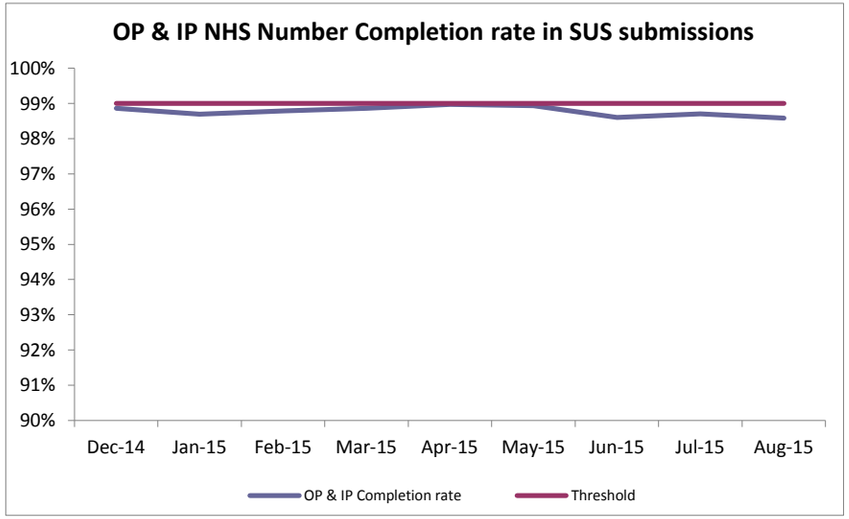
Cancer Access Standards (in arrears)	Threshold	Jun-15	Jul-15	Aug-15
Cancer - 14 days to first seen	93%	93.9%	93.2%	93.0%
Cancer - 14 days to first seen - breast symptomatic	93%	93.3%	93.6%	91.3%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%
Cancer - 62 days from referral to treatment	85%	90.0%	89.3%	90.0%

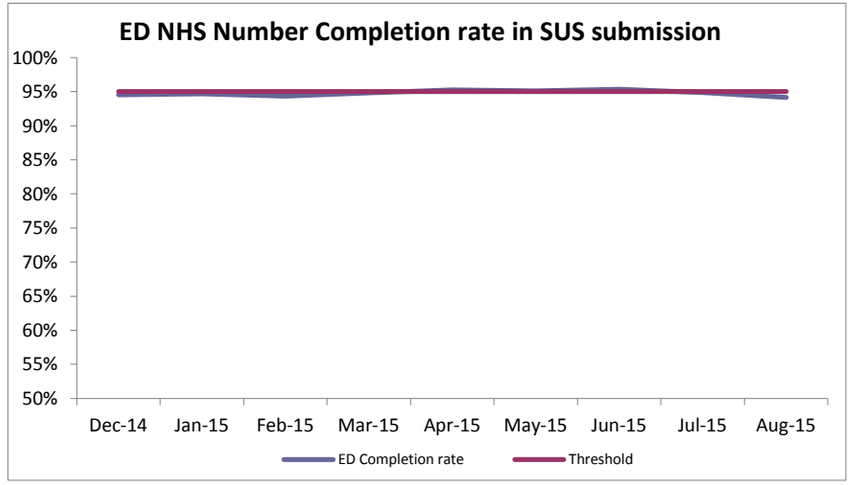
Maternity	Threshold	Jul-15	Aug-15	Sep-15
Women seen by HCP or midwife within 12 weeks and 6 days	90%	82.8%	82.7%	74.7%
New Birth Visits - Haringey	95%	93.3%	88.8%	arrears
New Birth Visits - Islington	95%	92.7%	95.0%	arrears
Elective Caesarean Section rate	14.8%	17.8%	9.1%	15.2%
Breastfeeding initiated	90%	91.0%	88.7%	90.3%
Smoking at Delivery	<6%	3.7%	4.7%	5.6%

	Threshold	Trust Actual		
		Jul-15	Aug-15	Sep-15
Number of Inpatient Deaths	-	25	29	35
Completion of a valid NHS number in SUS (OP & IP)	99%	98.7%	98.6%	arrears
Completion of a valid NHS number in A&E data sets	95%	94.9%	94.2%	arrears

	Standardised National Average	Trust		
		Apr-15	May-15	Jun-15
Hospital Standardised Mortality Ratio	<100	73.2	67.2	69.5
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	62.2	116.9	81.3
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	77.3	44.4	67.6

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54
	Apr 2013 - Mar 2014	0.87	1.15	0.54
	Jan 2013 - Dec 2013	0.88	1.14	0.62
	Oct 2012 - Sep 2013	0.89	1.13	0.63
	Jul 2012 - Jun 2013	0.88	1.13	0.63





Commentary

Inpatient Deaths
Issue: The number of in-patient death remain at expected level. September 2014 31 inpatients death were reported.
Action: Audits are discussed in the ICSU Quality Committee meetings monthly and feedback is provided to the Trust quality committee from the Audit Committee.
Timescale: completed

Completion of valid NHS number
Issue: NHS number completion in SUS dataset remains just under target.
Action: Reports to support the process are in place.
Timescale: Expected to be compliant in October 2015 due to training schedule and new staff commencing.

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

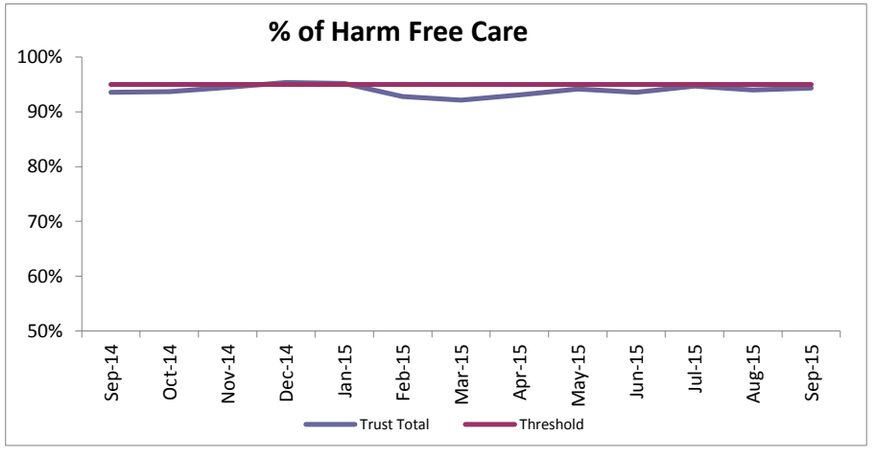
HSMR
In June 2015 Whittington Health reported 25 in-patient deaths. The overall standardised mortality rate has remained expected level for Whittington Hospital, which means the balance between elective admissions and non-elective admissions are back at expected levels.

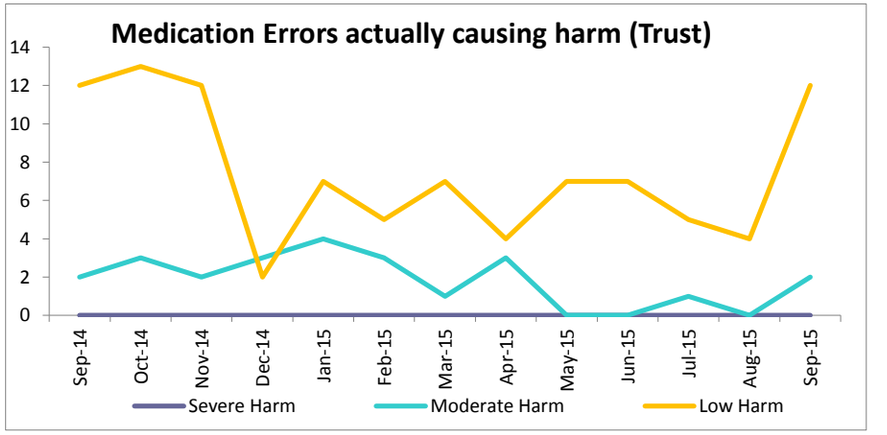
Patient Safety

Whittington Health NHS

Data extracted on 08/10/2015

	Threshold	Trust Actual Jun-15	Jul-15	Aug-15	Sep-15	Trend
Harm Free Care	95%	93.6%	94.7%	94.0%	94.3%	
Pressure Ulcers (prevalence)	-	5.72%	4.21%	5.68%	4.79%	
Falls (audit)	-	0.29%	0.40%	0.00%	0.00%	
VTE Risk assessment	95%	95.1%	95.3%	96.2%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	0	1	0	2	
Medication Errors actually causing **Low** Harm	-	7	5	4	12	
Never Events	0	0	0	0	1	
Open CAS Alerts (Central Alerting System)	-	0	0	0	0	
Proportion of reported patient safety incidents that are harmful	-	36.1%	40.7%	37.0%	38.1%	
Serious Incidents (Trust Total)	-	0	6	0	3	





Commentary

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

Pressure Ulcer prevalence
Issue: Prevalence remains around 5%.
Action: The improvements put in place in the community have identifying the need for education to families around pressure ulcers. This is ongoing work.
Timescale: On-going

Medication Errors actually causing harm
Issue: No Serious medication error have been reported in 2015 . Two moderate harm medication errors are an allergic reaction to antibiotics given during day surgery and antibiotics stopped for two day unintentionally. The 12 low medication errors include , 2 patients with delay in their dose of medication. Two medication orders were not done causing delay in medication given at home and delay in discharge from hospital for one night. Two patients received the incorrect dose and for two patients there was confusion over what dose was even. One patient received the medication of another patient. One patient missed a medication dose and 2 received the dose twice by mistake.
Action: All errors are investigated and appropriate action taken.
Timescale: completed

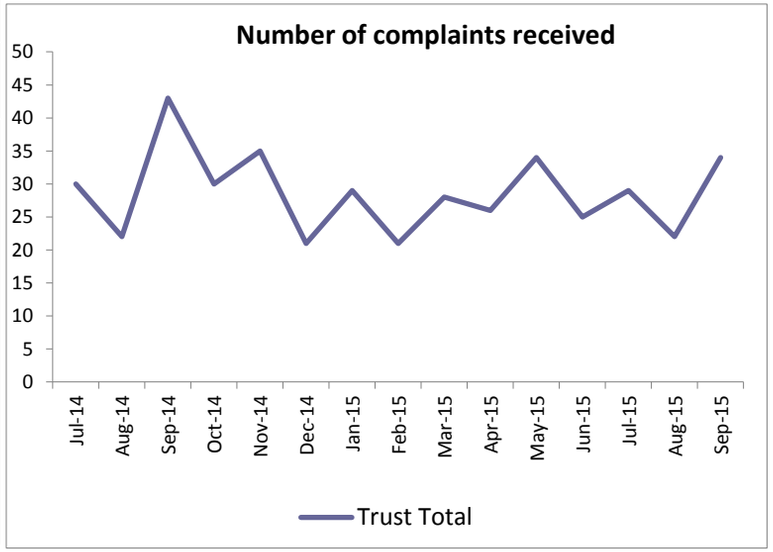
Falls Audit
In the last 2 consecutive months no fall that are harmful were recorded in the falls audit.

Continued commentary

Never Event
Missed Place Naso gastric Tube - NEVER EVENT
Naso-gastric tube inserted at 17:30 pm on 18/09/2015 and a pH of 4.5 was obtained. Tube length was documented as 56 cm and it was anticipated that a feed would have been commenced at that point. However, the feed was not commenced . As there was a prolonged delay in starting the feed there would have been an expectation to check the pH before commencing the first feed. This did not happen. The patient may have displaced the tube in the period of time between tube insertion. Subsequently, the patient became unwell the following morning.

Serious Incidents
Two further SI were identified. One unexpected admission to NICU. A baby born in poor condition. Baby was later found to be tachypnoeic, grey, in respiratory distress and X-ray showed bilateral pneumothoraces in addition to the hypoglycaemia. The second one is an Information Governance Breach

	Threshold	Trust Actual Jun-15	Jul-15	Aug-15	Sep-15	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	93%	95%	95%	94%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	89%	91%	94%	96%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	81%	93%	93%	91%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	25	29	22	34	
Complaints responded to within 25 working day	80%	70.0%	82.8%	75.0%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	



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

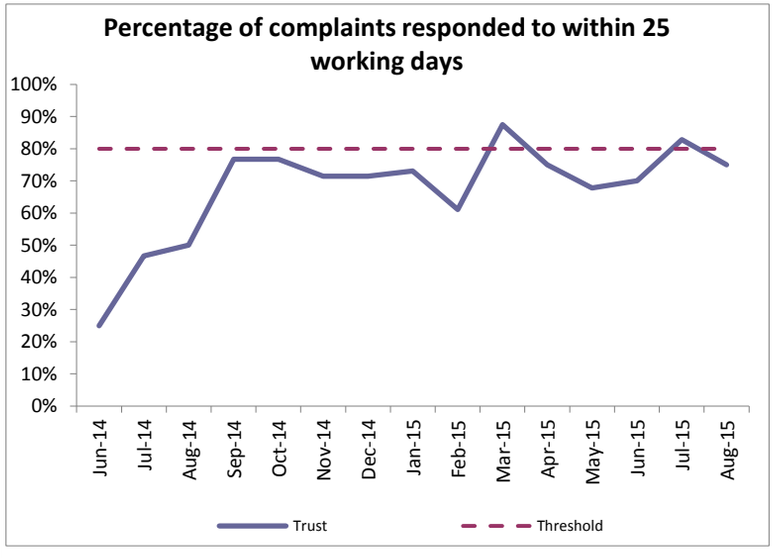
Commentary

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

Mixed Sex Accommodation
A policy and processes embedded in the services and no breaches for 12 consecutive months.

Complaints
The complaints compliance figure includes all services within the Trust. The operational services score as shown in the table within the commentary section.
Action: All complaints are monitored weekly within the ICSU's.
New training being developed by corporate team for Complaints handling and ongoing recruitment for the vacant post supporting the ICSU's.
Timescale: Stepped improvement expected over the next months.

ICSU	Number of complaints	Compliance score
MFNS	6	80%
EUC	4	100%
CS	3	67%
WFS	1	0%
OP	1	100%
Surgery	4	50%
SS	1	100%



Infection Prevention

Whittington Health NHS

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

	Threshold	Jun 15	Jul 15	Aug 15	Sep 15	2015/16 Trust YTD
C difficile Infections	17 (Year)	1	1	0	1	5

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

Ward Cleanliness

Audit period	Trust 06/11/14 to 16/12/14	19/01/15 to 17/02/15	14/04/15 to 01/05/15	15/06/15 to 10/07/15	01/09/15 to 30/09/15	Trend
Trust %	98.1%	98.3%	98.4%	97.9%	97.7%	

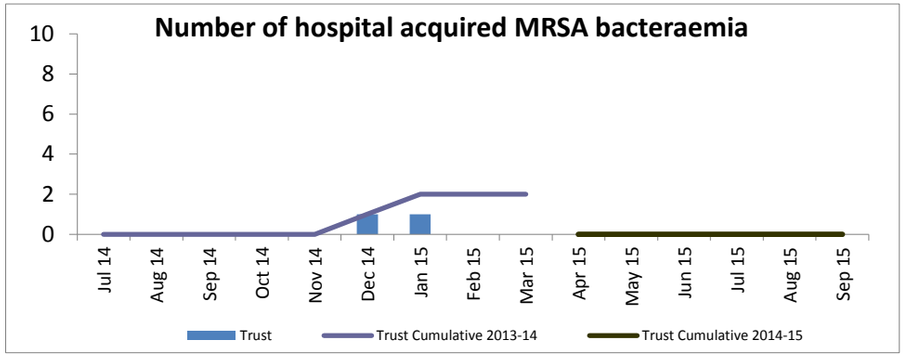
Commentary

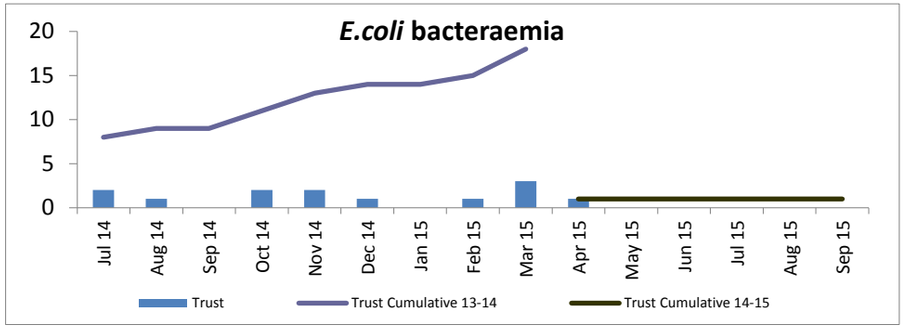
MSRA and E.coli
No new infections

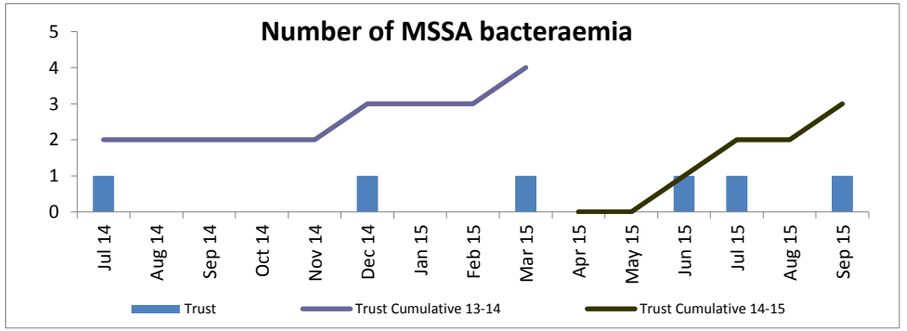
MSSA
One new infection and all protocols implemented.

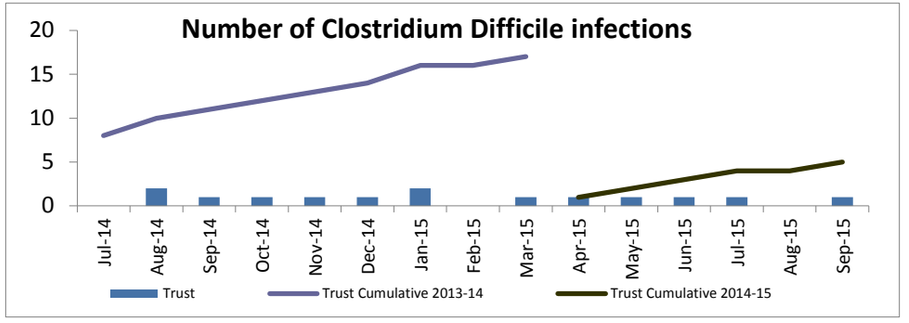
C difficile
One new infection and all protocols implemented.

Ward Cleanliness
Issue: Ward Cleanliness figures for September remained between 97 and 98%. **Action:** A detailed action plan is in place for infection prevention, cleaning standards and audits are being carried out by Estates and matrons to ensure standards are maintained.
Timescale: In place.





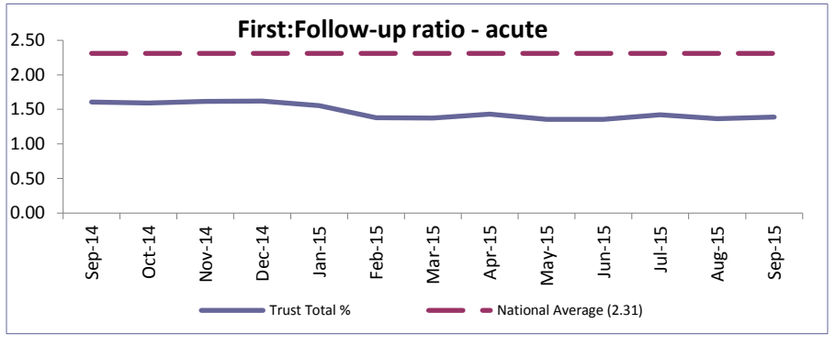


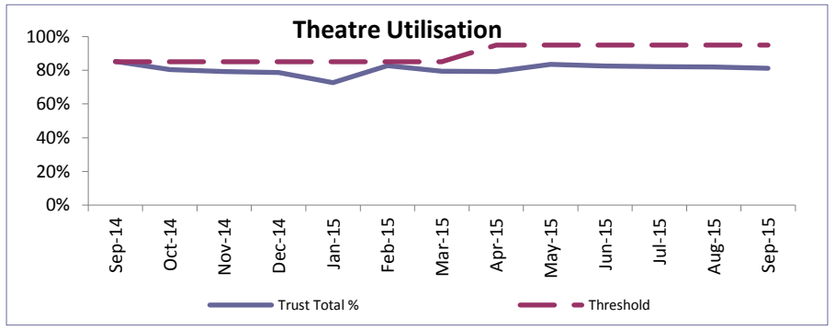


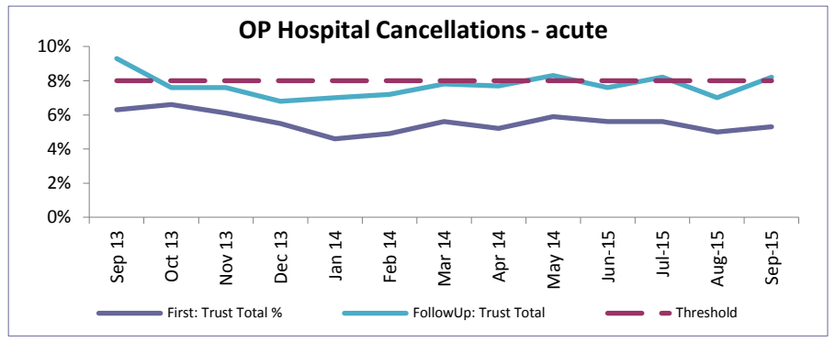
Efficiency and productivity - acute

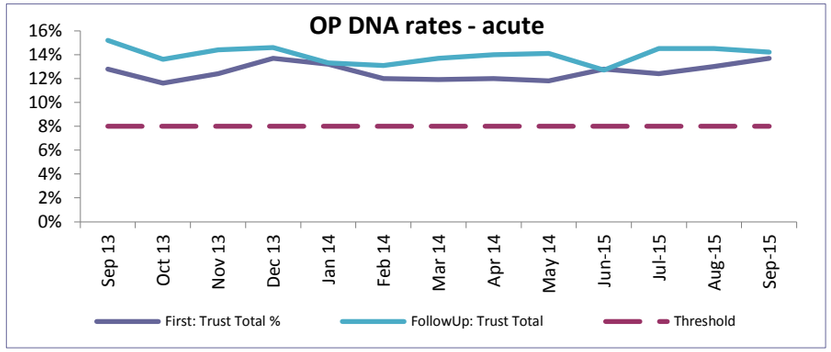
Whittington Health NHS

	Trust						
	Threshold	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Trend
First:Follow-up ratio - acute	2.31	1.35	1.35	1.42	1.37	1.39	
Theatre Utilisation	92%	83.5%	82.5%	82.1%	82.0%	81.1%	
Hospital Cancellations - acute - First Appointments	<8%	5.9%	5.6%	5.6%	5.0%	5.3%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	8.3%	7.6%	8.2%	7.0%	8.2%	
DNA rates - acute - First appointments	10%	11.8%	12.8%	12.4%	13.0%	13.7%	
DNA rates - acute - Follow-up appointments	10%	14.1%	12.7%	14.5%	14.5%	14.2%	
Hospital Cancelled Operations	0	4	6	3	5	16	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	1	1	0	0	4	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	









Commentary

First: Follow-up ratio - acute
The new to follow up rate is continuing to be is under the national benchmark of 2.31.

Theatre Utilisation
Issue : utilisation continues to be below the stretch target of 95%, and particularly low for one or two specialities. T&O, general surgery and gynaecology are high performers while urology, breast and ENT are low performers
Action : Urology services to improve start time , lead nurse to start earlier; more patients to be booked to their lists to increase capacity; weekly checking of lists by DOps & Divisional Director. Urology job planning, DRAFT job plans have been produced to be discussed with Lead Clinician for Urology this week.
ENT and Breast numbers are so small impact is minimal.
T&O work, waiting list shared with clinical lead to flex clinicians to increase productivity, waiting list reviewed weekly to check hips and knees are dated ASAP, spinal work, we have more capacity now to do complex work so this continues to increase.
Timescale : continued monitoring

Hospital Cancellations - acute
Achieved for first appointments and just over the target of 8% for follow up appointments.

Did not attend
Issue: Overall 'Did not attend ' remained around the same.
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment. EPR is in the process of being re-aligned with the service Netcall, with text reminding being rolled out to all out patient clinics. Paper is taken to the senior management group to extend the use of Netcall dashboards within services.
Timescale: Improvement to be seen in November dashboard.

Hospital Cancelled Operations
Issue: There were 16 operation cancelled by the hospital in August due to non-clinical reasons, 12patients were clinically categorised as routine. Four were categorised as urgent. All have been rebooked within the 28 day period. Urology cancelled the four urgent patients of which 3 were targets patients. For this patient the notes were not found. The other 3 patients were not scanned before the operation and therefore needed to be cancelled. In ENT 4 operations and General Surgery 2 operations were cancelled because the surgeon was not available. The other 6 operations were cancelled in Orthopaedics because the list overran.
Action: The Surgical board monitor cancellations.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Jun-15	Jul-15	Aug-15	Sep-15	Trend
Service Cancellations - Community	8%	7.5%	8.0%	8.8%	8.1%	
DNA Rates - Community	10%	6.9%	7.5%	7.3%	7.6%	
Community Face to Face Contacts	-	63,131	62,279	48,937	56,834	
Community Appointment with no outcome	1.0%	3.5%	2.0%	4.8%	6.2%	

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

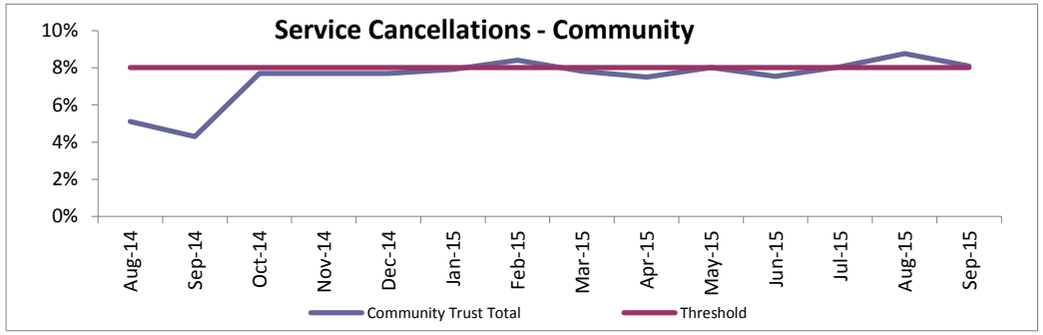
Commentary

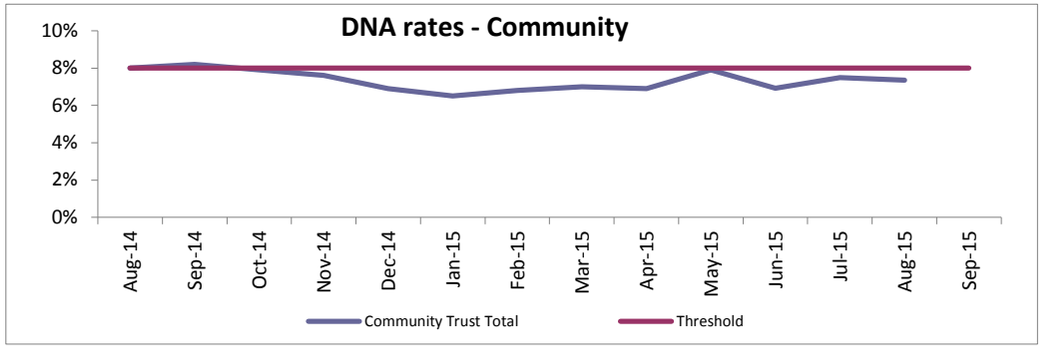
Service Cancellations - Community
Issue: Just above target
Action: The new version Open Rio will be able to reflect service cancellation more accurately. This is being implemented during October 2015.
Timescale: Role out in October 2015 started.

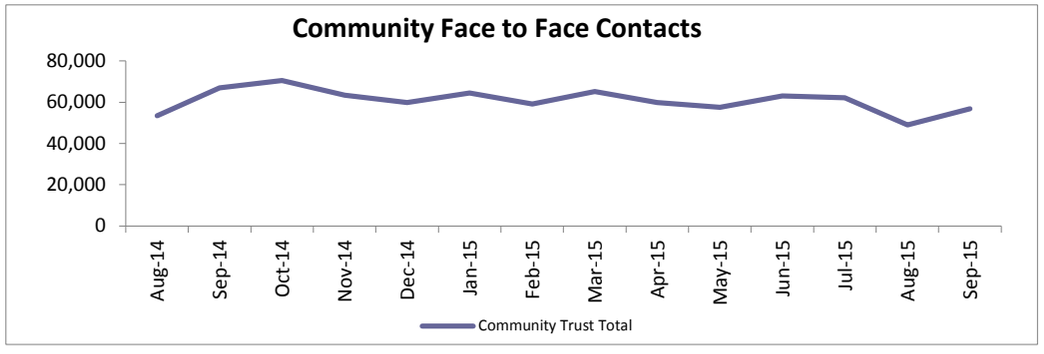
DNA Rates - Community
Community clinics - Achieved.

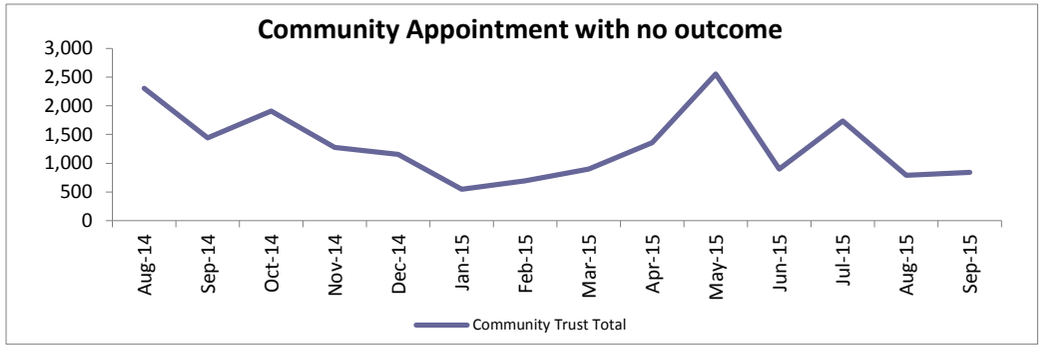
Community Face to Face Contacts
All services are monitored against activity targets.

Community Appointment with no outcome
A process is in place to complete all outcomes of appointment within the same timelines as the acute services. This process has been standardised and training provided. The high volume service District Nursing have most un-outcomed appointments, a improvement plan is lead by the Operational director of Emergency and Urgent Care ICSU.
Unoutcomed appointments are reported to the commissioners and a monthly reminder check is in place to make sure all appointments are outcomed before final submission.
Action: Monitor to ensure the new processes are embedded.
Timescale: Immediately.

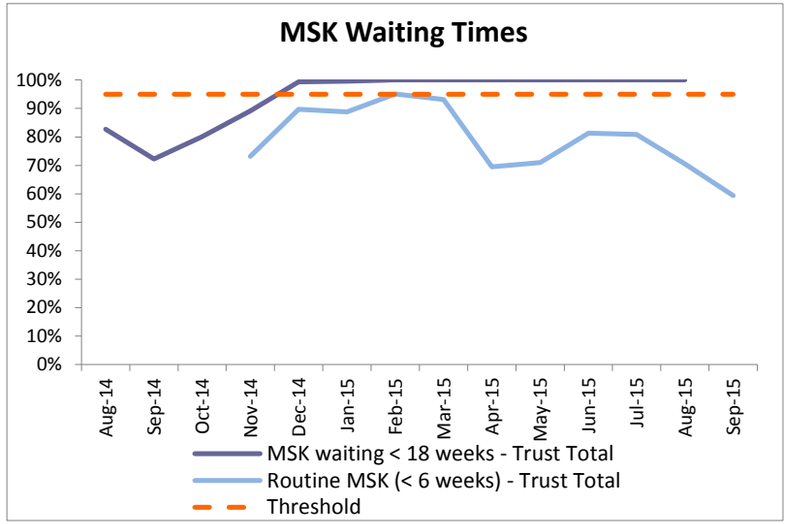








	Threshold	Trust Actual Jul-15	Trust Actual Aug-15	Trust Actual Sep-15	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	71.4%	66.7%	66.7%	62.1%
District Nursing Wait Time - 2hrs assess (Haringey)	-	91.9%	88.9%	90.0%	86.1%
District Nursing Wait Time - 48hrs for visit (Islington)	-	97.1%	96.3%	95.6%	94.0%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	98.4%	91.5%	90.7%	95.6%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	80.9%	70.5%	59.4%	77.3%
MSK Waiting Times - Consultant led (<18 weeks)	95%	100.0%	100.0%	arrears	100.0%
IAPT - patients moving to recovery	50%	50.9%	51.0%	arrears	51.0%
GUM - Appointment within 2 days	100%	96.0%	95.6%	92.3%	96.8%
Haringey Adults Community Rehabilitation (<6weeks)	85%	76.0%	78.0%	66.4%	74.0%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	69.0%	73.0%	51.7%	68.4%
Islington Community Rehabilitation (<12 weeks)	-	97.9%	93.0%	84.1%	93.2%
Islington Intermediate Care (<6 weeks)	85%	63.0%	70.0%	54.0%	59.2%
Islington Podiatry (Foot Health) (<6 weeks)	-	70.0%	69.0%	57.9%	67.0%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	93.6%	94.5%	arrears	93.6%



Commentary

District Nursing
The two response times for District Nursing are now reported electronically.
Issue: Referrals for DN are processed in the Central Referral Team and Urgency is taken from the referral form, filled in by the referrer. The referral is then triaged by the District Nursing Triage Nurse and the Urgency might be changed, hence the lower scores than previously reported. The true Urgent referrals are mostly phoned through to the Service and are always seen within 2 hours. Examples of urgent referrals are 'End of Life Care change' and 'Blocked catheters'.
Action: Process from Central Referral Team to triaging to be reviewed. Further actions include meeting with the messaging service, agree plans / revised SLA for DN. Addressing incomplete and inappropriate referrals, to be visible on the system. Addressing the triage nurse training needs for 8 new nurses into roles that will be used to cover the Triage rota.
Timescale: Action to be put in place in October and November 2015 with improvement being see in early 2016.

MSK
MSK Waiting Times - Routine MSK (<6 weeks):
Issue: Ongoing increased demand. The main issue is the capacity for specialist community clinics.
Action: An extensive action plan has been completed following review of the total waiting list and realignment of capacity. A paper has been shared with the Clinical Director of OPLC.
Timescale: Ongoing.
MSK Waiting Times - Consultant led (<18 weeks): Standard is being met.

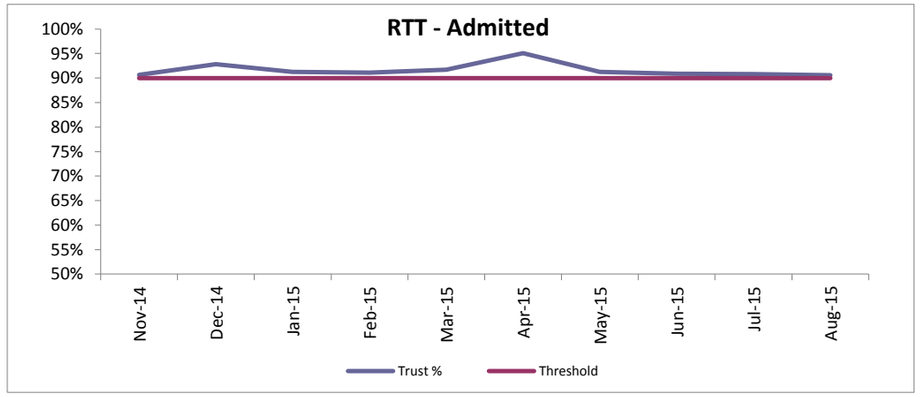
IAPT
Achieved. IAPT waiting times have been added and are preforming above the threshold of seeing 75% of all patients within 6 weeks. The threshold of 18 weeks is 95%.

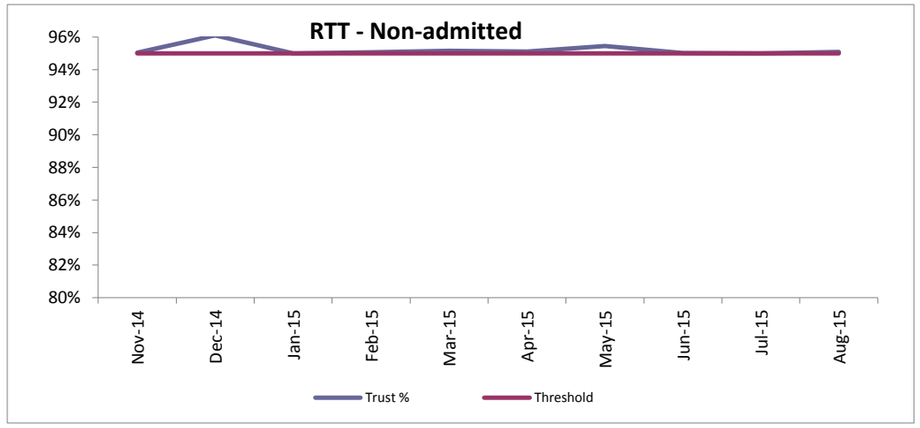
GUM
Issue: Staffing reduction due to vacancies .

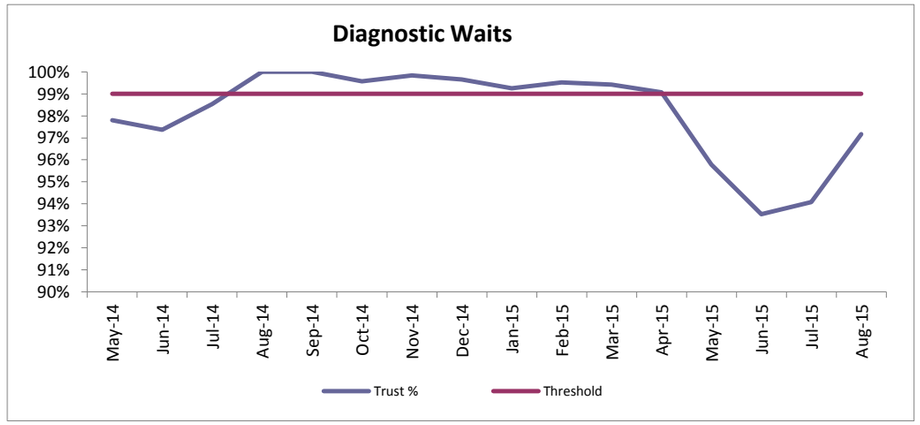
Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

	Trust (arrears)				
	Threshold	Jun-15	Jul-15	Aug-15	Trend
Referral to Treatment 18 weeks - Admitted	90%	90.9%	90.8%	90.6%	
Referral to Treatment 18 weeks - Non-admitted	95%	95.0%	95.0%	95.1%	
Referral to Treatment 18 weeks - Incomplete	92%	92.6%	92.2%	92.2%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	93.5%	94.1%	97.2%	







Commentary

RTT

Achieve standard

Diagnostic Waits

Issues: Endoscopy demand has exceeded capacity and a backlog has built. Flexi sigmoidoscopy, gastroscopy and colonoscopy all performed below 99%.

Action: Endoscopy action plan in place to increase the capacity for patient bookings.

Timescale: Compliance with the standard by September 2015 (October 2015 dashboard)

Waiting times - OPD appointment (No update since last month)

Cardiology 7 Weeks, Dermatology 11 Weeks , Endocrine 7 Weeks, ENT 9 Weeks, Gastroenterology 8 Weeks, General Surgery 5 Weeks , Gynaecology 6 Weeks, Neurology 9 Weeks, Pain 11 Weeks , Rheumatology 4 Weeks, Thoracic Medicine 6 Weeks, Urology 3 Weeks, Vascular 11 Weeks, Ophthalmology 5 Weeks, Trauma and Orthopaedic 6 weeks.

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

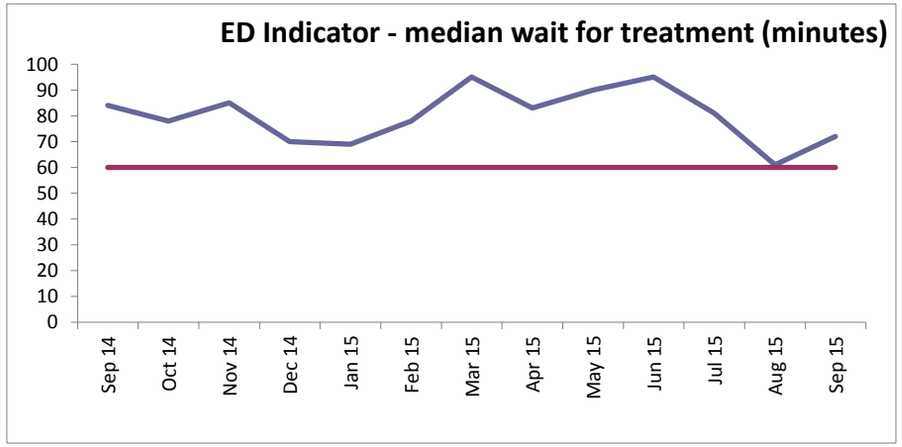
Imaging Modality wait in days: CT 29 days, MRI 35 days, Nuclear Medicine 16 days, DEXA 36 days, Fluoroscopy 22 days, Mammography 12, Ultrasound (Gynae) 10 days, Ultrasound General (Radiologist Lead) 24 days, Ultrasound Paediatrics 36 days, Ultrasound MSKs 42 days, Ultrasound Hernias 30 days, Ultrasound Obstetrics Anomaly 32 days, Ultrasound Obstetrics Growth 46 days, Ultrasound Abdomen & Gynae at Hornsey General 14 days.

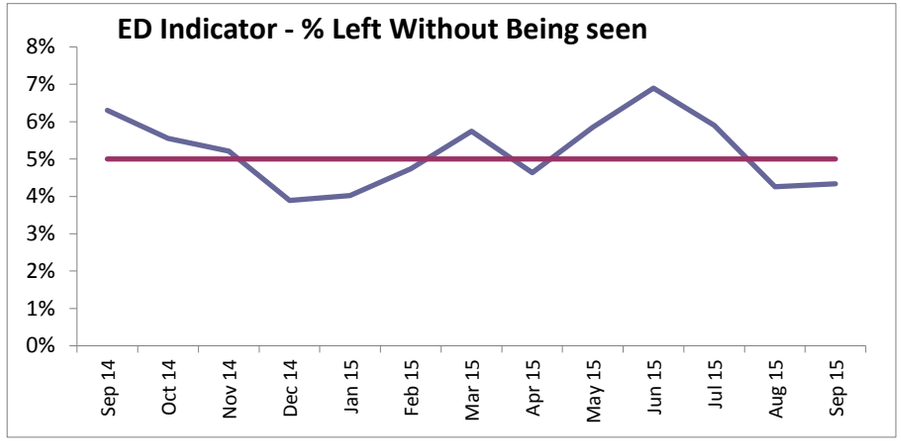
Flexi sigmoidoscopy

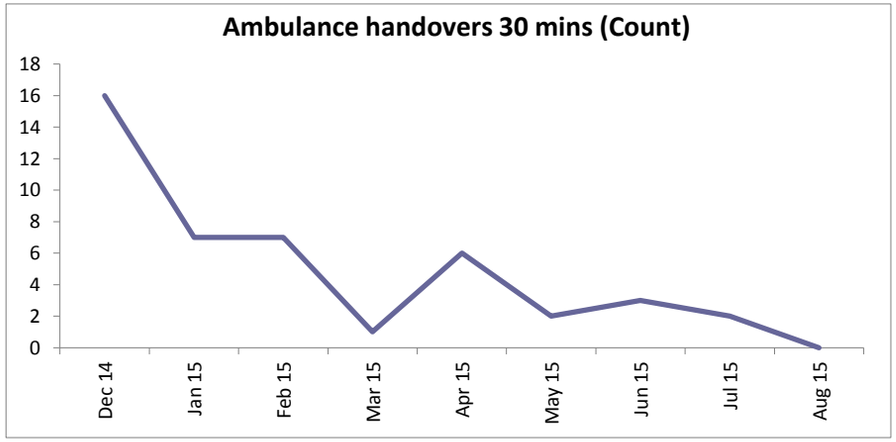
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Aug-15	Trust Actual Sep-15	2015/16 Trust YTD
Emergency Department waits (4 hrs wait)	95%	95.8%	95.0%	94.8%
Emergency Department waits (4 hrs wait) Paeds only	95%	98.4%	97.1%	97.2%
Wait for assessment (minutes - 95th percentile)	<=15	12	13	14
ED Indicator - median wait for treatment (minutes)	60	61	72	81
Total Time in ED (minutes - 95th percentile)	<=240	240	240	275
ED Indicator - % Left Without Being seen	<=5%	4.3%	4.3%	5.3%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	0	arrears	13
Ambulance handovers exceeding 60 minutes	0	0	arrears	0







Commentary

The Trust achieved the standard again in September. However, performance was fragile during the latter part of the month due to an increase in complexity of patients and associated reduced number of anticipated discharges.

A review of escalation triggers and actions for wards and in-patient teams is underway. Although the median time to treatment increased last month it remains below year to date figure.

Left without being seen remains below the required 5% .

A 'deep dive' review of ED performance has been undertaken in partnership with NELCSU and will be used to inform future action plans.

The department continues to perform well in relation to ambulance handovers.

Cancer

Whittington Health NHS

	Threshold	Trust Jun-15	Trust Jul-15	Trust Aug-15	Trend	2015/16 Trust Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.9%	93.2%	93.0%		93.2%	93.1%	-	-	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	93.3%	93.6%	91.3%		93.6%	92.4%	-	-	93.2%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	90.0%	89.3%	90.0%		93.2%	89.6%	-	-	92.2%
Cancer - 62 days from consultant upgrade	-	83%	67%	100%		92.9%	75.0%	-	-	90.6%

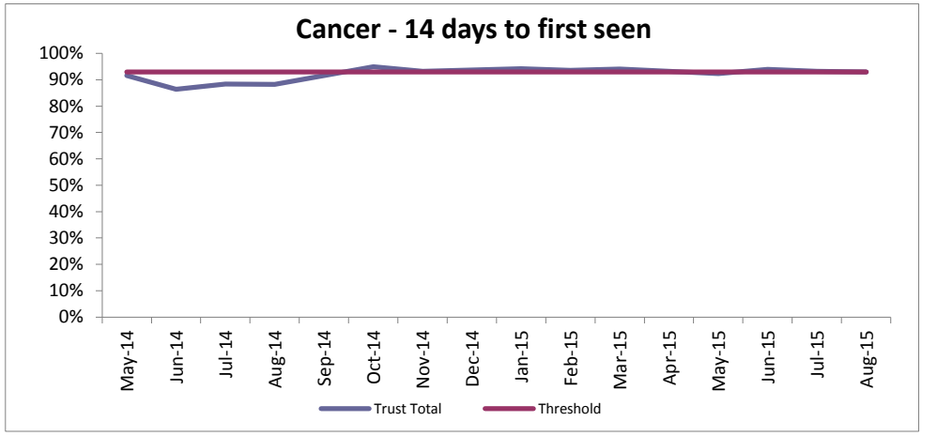
Commentary

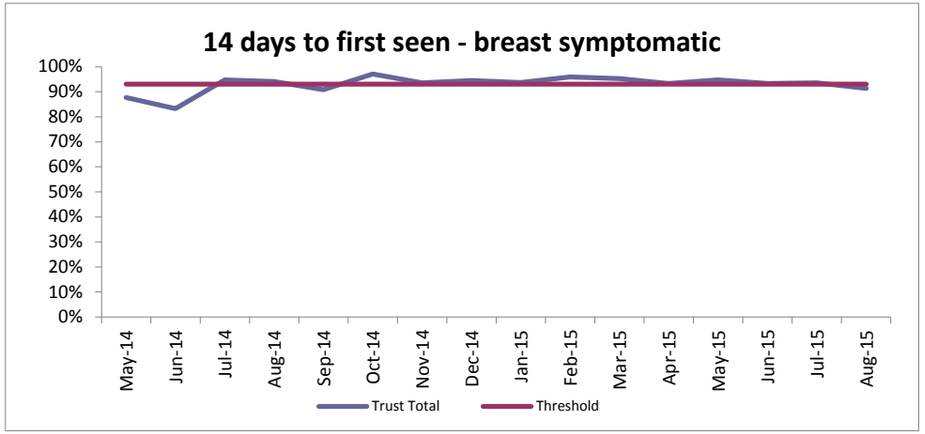
Cancer - 14 days to first seen - breast symptomatic
Issue : This standard was not achieved in August 2015, due to a junior doctor not turning up for a whole day clinic, although this had been booked. As many patients as possible were seen to reduce impact on patients. This effect coupled with the reduced number of patients in August 2015, due to holidays resulted in non compliance.
Action : a sustainable position is now in place where there is adequate cover for breast clinics as a junior doctor has been appointed. **Timescale** : doctor has already started

All other cancer targets were met.

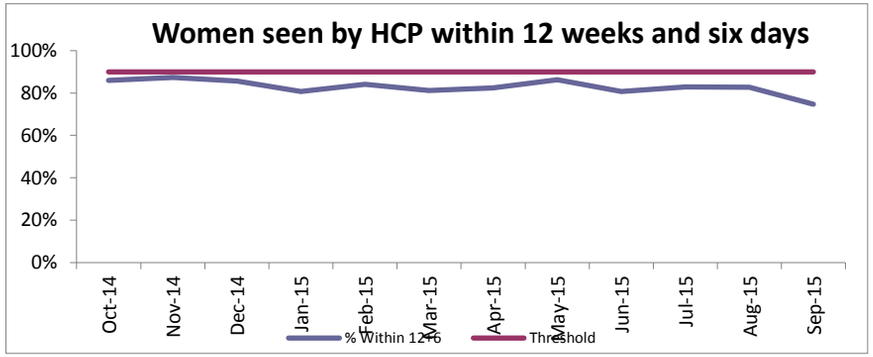
The Cancer Patients tracking list is monitored daily and discussed in the weekly PTL meeting.

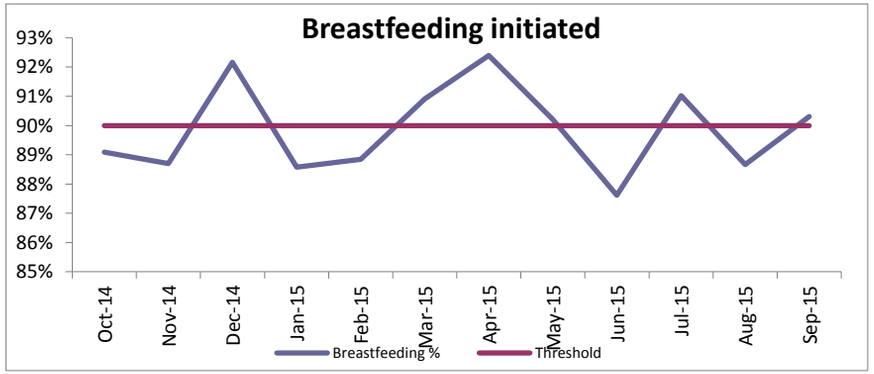
The 'dash' in July 15 for 31 days to subsequent treatment - surgery indicates that there were no patients for this month.





	Threshold	Trust Actual Jul-15	Aug-15	Sep-15	2015/16 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	82.8%	82.7%	74.7%	81.4%
New Birth Visits - Haringey	95%	93.3%	88.8%	Arrears	86.1%
New Birth Visits - Islington	95%	92.7%	95.0%	Arrears	91.4%
Elective Caesarean Section rate	14.8%	17.8%	9.1%	15.2%	12.7%
Emergency Caesarean Section rate	-	17.8%	18.9%	16.8%	18.0%
Breastfeeding initiated	90%	91.0%	88.7%	90.3%	90.0%
Smoking at Delivery	<6%	3.7%	4.7%	5.6%	4.4%





Commentary

12+6

Issue: The 12+6 target continues to be a challenging across the sector and London.

DNA first appointment continues to be a main concern where women are choosing not to attend appointments offered within the time scale. There were 77 (20%) out 388 completed bookings in September who were all offered appointment within the time scale but chose not to attend and arranged appointments outside of the 12+6. Not all women call advance to cancel or change appointments. These women represent a wide cross section of the population. We attempted to contact all women who DNA in August to ascertain reasons for DNA, and had difficulty with contact information due to the highly mobile nature of the population.

Action: To work closely with Public health strategist in Haringey and Islington to increase knowledge about referring early in pregnancy

Timescale: 31st October 2015

Issue: Reporting errors. The report for September includes information on women who were booked into maternity prior to September. This is due to staff inputting data incorrectly and also as a result to staff appropriately changing clinical data.

Action: IT midwife to work with IT to ensure that the reports are pulled from the appropriate fields and take into account clinically necessary data changes.

Timescale: 31st October 2015

New Birth Visits

Issue: Both boroughs improved.

Action: Action plan continue to be monitored. Targeted recruitment to vulnerable teams.

NBV results reflect where each borough is in terms of HV recruitment and retention. This is the first time Islington have reached the target and is due to the service being well into the HV C2A growth; conversely, Haringey saw further HVs leave or retire. In order to support the Haringey HV workforce we have:

- recruited 2x NQHVs and 3x HVs since August
- agreed a premia for HVs
- a FTC for a HCP Development Lead out to advert
- increased the skill mix - 11 nursery nurses and 3 staff nurses recruited

Timescale: Ongoing

Caesarean Section rate

Issue: WH elective C-section rate remains red in rag rating. This rate is similar to North Central London sector (NCL)

Action: Normalising birth campaign has been launched with the introduction of VBAC workshops and birth reflections clinic which aim at targeting those women who have had previous C-section or have had a traumatic experience which may influence their decision to have a vaginal birth. Audit: NCL have requested an audit of maternal request CS pathway. A local audit will allow us to understand the numbers of maternal request C-sections and ensure standard compliance. Audit of ECV - external cephalic version. This data will help us understand the number of women who are offered and have successful version of their babies from the breech to cephalic position. This will be used for service improvement in terms of a dedicated ECV clinic. Data collection: Maternal request C-sections data will be included on maternity's monthly dashboard

Timeframe: December 2015.

Breastfeeding
Achieved

Smoking
Achieved

Whittington Health NHS

Operations Directorate
Direct Line: 020 7288 5440
www.whittington.nhs.uk

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

Trust Board

04 November 2015

Title:	**Corporate Workforce KPIs – September 2015**		
Agenda item:	**15/145**	**Paper**	**11**
Paper from	**Director of Workforce**		

1.0 Introduction

This report gives details of the Trust workforce key performance indicators (KPIs) as at 30th September 2015. This report continues to be developed and will evolve over the coming months as resources become available

Workforce information continues to be a priority objective for the directorate. The Chief Finance Officer and Director of Workforce have instructed the commencement of an important piece of work to harmonise workforce information across the general ledger and the electronic staff record (ESR). The key to this is updating establishment information within ESR. This will result in more accurate vacancy, statutory and mandatory training and appraisal data as staff are correctly assigned on the ESR establishment, including workforce equality data covering some of the protected characteristics which will contribute to meeting the Workforce Race Equality Standard (WRES) requirements

2.0 ICSU and Directorate Workforce Information

The Performance Review Meetings with each of the ICSUs took place in October. From a workforce perspective there was focus and discussion on: long term sickness; vacancy rates (and accompanying recruitment strategies), progress with staff survey action plans, compliance with statutory and mandatory training and appraisal rates.

3.0 Vacancy Rate

Table 1 below and Graph 1.1 of Appendix 1 give details of the vacancy rate as at 30th September 2015. The vacancy rate for the Trust dropped in September to 10.7%

TABLE 1 – Workforce KPIs

		Trust					
Management of the workforce	**Threshold**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**
Trust Turnover Rate	<13%	14.1%	14.4%	14.2%	14.8%	14.4%	14.6%
Total trust vacancy rate	<13%	12.5%	14.2%	13.5%	13.7%	14.6%	10.7%
Sickness rates	<3%	2.8%	2.5%	2.9%	3.0%	2.9%	2.9%

Table 2 shows the analysis by ICSU/Department of vacancy rates. As previously reported our vision for this would be to better identify trends and patterns in vacancy rates, to analyse the reasons for vacancies remaining unfilled, to anticipate risks and opportunities for the Trust in developing our practice to reduce vacancies, and to set clear actions and monitor progress delivered against them. As a first step we would wish

to review the information by ICSU and staff group, however the resources to manipulate to this level continue to be limited.

TABLE 2 – Vacancy Rate by ICSU/Directorate

Division	Sum of Budget (WTE)	Staff in Post (WTE)	Vacancy (WTE)	Vacancy % (WTE)
Children's Services	916.6	833.3	83.3	9.1
Clinical Support Services	274.7	244.5	30.2	11.0
Corporate Services	593.2	563.1	30.1	5.1
Emergency & Urgent Care	486.5	402.9	83.6	17.2
Med, Frailty & Networked	604.6	588.1	16.5	2.7
Outpatient, Prevention LTS	304.1	252.6	51.4	16.9
Surgery	648.4	559.4	89.0	13.7
Women & Family Services	387.3	320.5	66.8	17.2
Grand Total	**4215.4**	**3764.5**	**450.9**	**10.7**

Table 3 indicates the vacancy rate across all medical and nursing and midwifery staff (AfC band 5 and above). This month we have excluded "pay reserves" on the budgeted wte. These are unidentified savings targets at cost centre level and the reason for excluding them is that their inclusion was leading to negative budgeted wte for some cost centres. This explains the slight increase in some areas, notably nursing and midwifery. As we progress the establishment reconciliation work there may be some other similar adjustments to improve the accuracy of the data. There are 70 nursing and midwifery posts currently out to advert. There are a further 110 staff in the offer stage of their appointment. In addition, 45 staff commenced in October with a further 29 due to commence in November.

TABLE 3 – Vacancy Rate by Professional Group

Staff Group	WTE Vacant	Vacancy Rate
Medical and Dental	25.3	5.3%
Nursing and Midwifery	214.4	15.4%

4.0 Sickness Absence Rate

Table 1 above and Graph 1.2 of Appendix 1 give details of the sickness absence rate at 30th September 2015. The level for sickness rates in September remains below the Trust target at 2.9% and below the national target of 3.5%. Each ICSU receives a monthly report on long term absence, along with short term sickness trigger reports to enable appropriate case management by line managers. The Performance Review Meetings have provided an opportunity to seek assurance that all staff who hit the trigger within the Sickness Absence Policy are being managed appropriately through that process.

In September Facilities had the highest sickness rate (6%) although this is due to a few staff being on long term sickness. Within the ICSUs:

- Emergency & Urgent Care had a rate of 4.8% (HCAs and Community Nursing had the highest rate, with 5.3% and 5% respectively);
- Women & Family Services 4.7% (by staff group Admin and Clerical had the highest rate, 11.6%, followed by Additional Clinical Services with 6.6%);
- Outpatient Prevention & LTC 4.2% (Admin and Clerical had the highest rate with 9.5 %, AHPs 2% and no sickness in the nursing staff group);
- The sickness rate for the remaining ICSUs was below the 3% threshold.

The average sickness absence rate for the NHS in England was 4.4% in July 2015. North East and Central London has the lowest average at 3.61%.

5.0 Turnover

Table 1 above and Graph 1.3 of Appendix 1 give details of the turnover rate as at 30th September 2015. Turnover is the percentage of employees that leave the trust over the past year. Turnover rate in September was 14.6%. It is however in establishing the reasons for staff leaving that we can inform and improve our employment practice to retain staff. The revised exit interview scheme was launched in October and publicised to staff. It is intended that details of exit interviews are reported to TMG on a regular basis as soon as the data becomes meaningful.

Turnover in Corporate Services remains high: Nursing and Patient Experience (29.2%), Workforce (24.3%) and Finance (20.6%)

Overall turnover by staff group indicates that nursing and midwifery had the highest rate at 19% with AHPs at 17% (turnover excludes staff on fixed term contracts, therefore AHPs on rotations are excluded from the turnover calculation).

6.0 Appraisals

The overall rate increased by 8% through September and early October. While there has been an improvement it is essential that we continue to improve the trajectory of appraisal activity to achieve the Trust's compliance rate of 90% by December. A continuous concerted focus on this indicator is needed to maintain this positive impact in the forthcoming weeks. Table 4 below details the monthly rate since April 2015. Compliance rates for appraisals continue to be reviewed on a regular basis within management teams. The implementation of action plans and the development of trajectories for improvement remains a priority for the ICSUs.

As with Statutory and Mandatory training, appraisal rates are a priority for the Executive Team with regular feedback to directors and ICSUs of performance in their area of responsibility.

TABLE 4 – Appraisal and Stat/Man Training Rates

		Trust					
Development of the workforce	**Threshold**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**
Appraisal	90%	58%	56%	56%	54%	52%	60%
Mandatory Training	90%	73%	76%	77%	78%	78%	77%

7.0 Statutory and Mandatory Training

Table 2 above along with the graph in Appendix 4 gives details of the rates since April 2015. The latest report in September no change since August. 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 ICSUs and corporate areas. Each Director has been tasked with forecasting when significant improvements will be made in compliance rates for their staff.

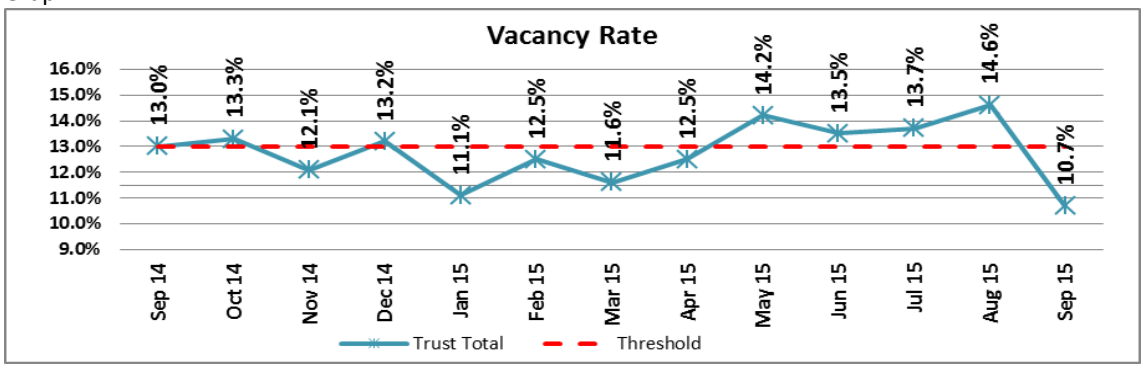
Appendix 5 gives a breakdown of compliance rates by subject matter. This shows that none of the subject matter are above the target of 90%. Managers have been asked to urgently review staff who are not compliant and arrange for them to complete training using the different mode of training where available..

8.0 Recommendations

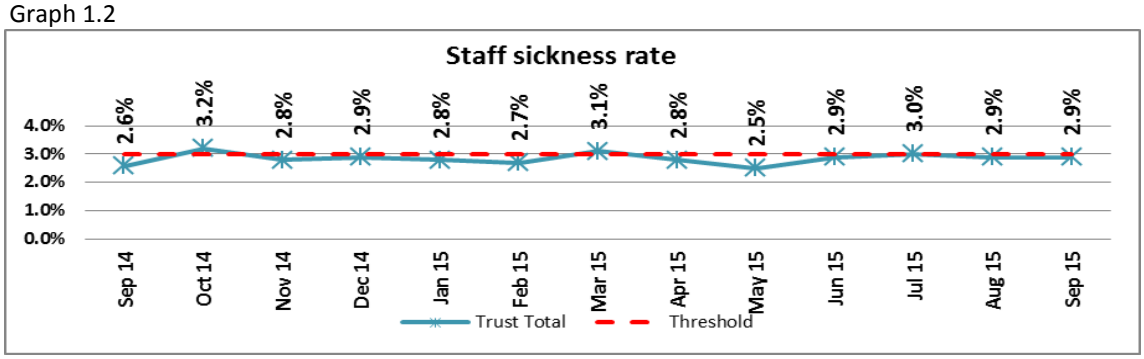
Trust Management Group and TMG are asked to note the content of this report and support the Workforce Directorate as we improve the quality of workforce information that can be provided. In addition staff with management responsibilities are request to give attention to the workforce key performance indicators they are responsible for within their area.

APPENDIX 1

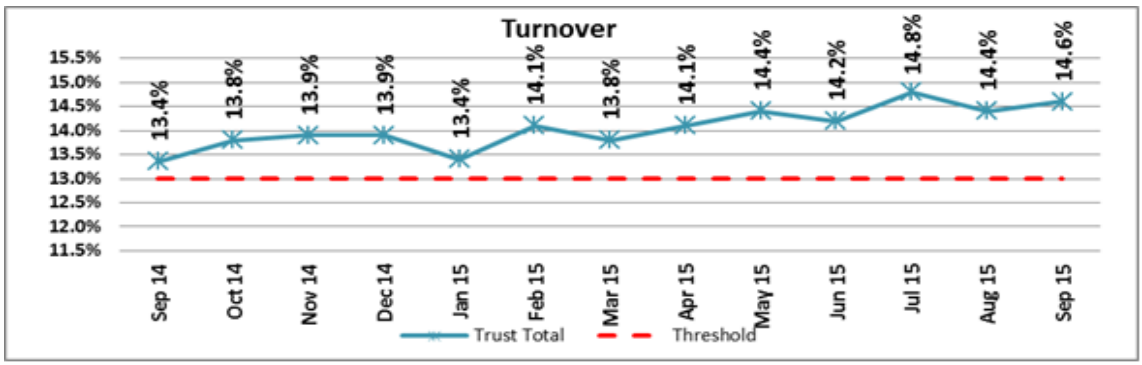
Graph 1.1



Graph 1.2

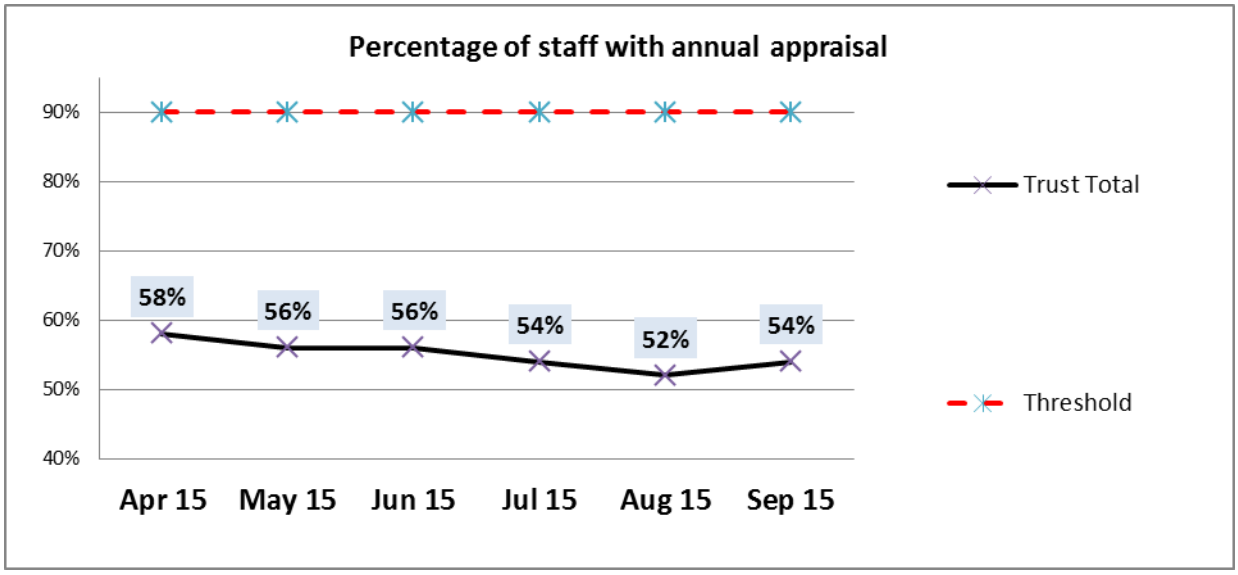


Graph 1.3



APPENDIX 2

Graph 2.1



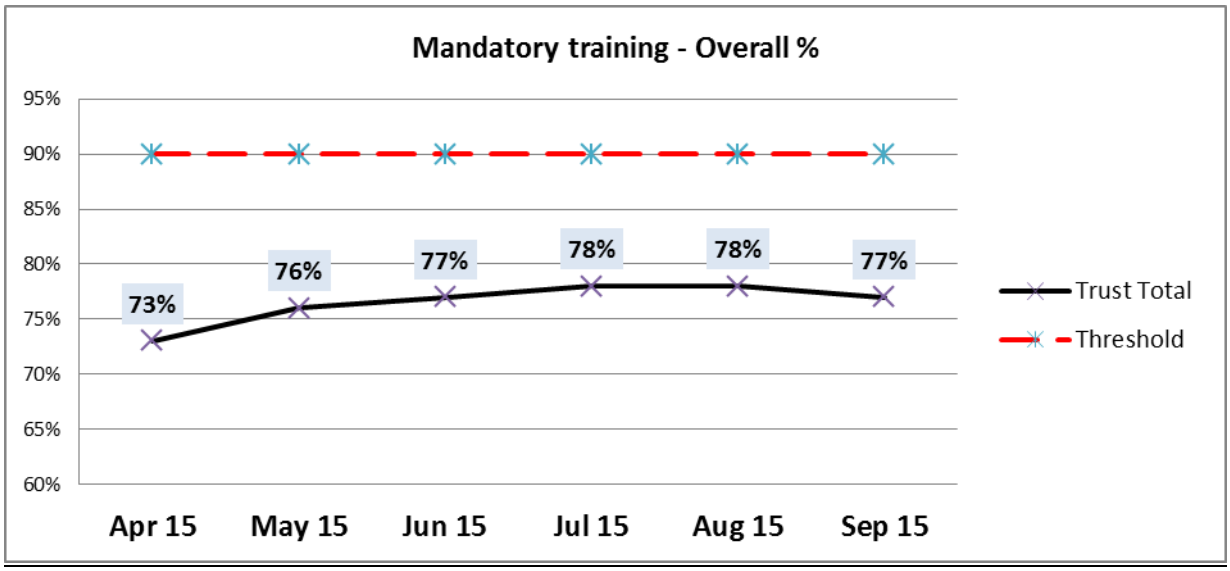
APPENDIX 3

APPRAISAL RATE BY ICSU/DIRECTORATE AT 22nd October 2015

Divisions	Staff Nos:	Q 1	July %age	August %age	Sept %age	In month diff	Comment
Integrated Care & Acute Medicine	1,339						
Surgery Cancer & Diagnostics	792						
Women Children & Families	1,283						
Medicine, Frailty & Networked Service	674	70	72	68	76	+6	
Emergency & Urgent Care	348	65	64	66	65	-1	
Clinical Support Services	263	60	58	52	81	+29	
Outpatient, Prevention & Long Term	249	56	60	64	53	-11	
Children's Services	893	49	51	50	63	+13	
Women & Family Services	370	35	35	36	37	+1	
Surgery	567	51	49	51	61	+10	
Workforce	46	84	85	79	88	+9	
Nursing &Patient Experience	58	60	60	73	64	-11	
Facilities	258	59	43	26	24	-2	Urgent action required
Medical Director	17	44	38	54	86	+32	
Finance	53	42	51	50	84	+34	
Procurement	98	36	20	16	46	+30	
Chief Operating Officer	6	30	17	20	60	+40	
Trust Secretariat	20	28	60	75	82	+7	
Information Technology	61	96	53	48	60	+12	
Total	**3891**	**57**	**54**	**52**	**60**	**+8**	

NB: Data included in above table excludes staff who have joined Whittington Health within the past 12 months; on maternity and adoption leave; career break; external secondment and bank staff.

APPENDIX 4


Mandatory training - Overall %
95%
90%
85%
80%
75%
70%
65%
60%
73%
76%
77%
78%
78%
77%
Apr 15
May 15
Jun 15
Jul 15
Aug 15
Sep 15
Trust Total
Threshold

Subject	Frequency	Total Staff	Trained (Sept)	Quarter 2	Difference since last month	Gap % to Achieve Compliance	Outstanding
Child Protection Level 1	3 years	995	848	**83%**	2%	5%	147
Child Protection Level 2	3 years	1868	1300	**72%**	-2%	20%	568
Child Protection Level 3	3 years	1115	811	**72%**	No change	17%	304
Equality & Diversity	3 years	3978	3396	**85%**	No change	5%	582
Fire Safety	2 years	3978	3038	**76%**	No change	14%	940
Health & Safety	2 years	3978	3066	**75%**	3%	13%	912
Infection Prevention & Control	2 years	3978	3356	**83%**	1%	6%	622
Information Governance	Annual	3978	3032	**76%**	1%	14%	946
Moving & Handling	2 years	3978	3144	**78%**	2%	11%	834
Resuscitation	2 years	2891	2326	**80%**	No change	10%	565
Safeguarding Adults Level 1	3 years	995	869	**85%**	3%	3%	126
Safeguarding Adults level 2	3 years	2983	2387	**79%**	1%	10%	596
Conflict	3 years	2878	1949	**70%**	-2%	22%	929
Risk Management/ Duty of Candour	Under review	3978	2595	**68%**	No change	22%	1383
Overall %				**78%**	-1%	13%	622

APPENDIX 5 – Mandatory Training Activity at September 2015

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

Whittington Health Trust Board

4th November 2015

Title:	TDA oversight and self-certification report		
Agenda item:	**15/146**	**Paper**	**12**
Action requested:	Approve the self-certification for board governance to report to the TDA for submission of the monthly oversight report.		
Executive Summary:	The Trust is required to produce monthly self-certification statements for board governance. The report provides the details for October 2015. The Trust will declare compliance with its board governance statements except the IG Toolkit level 2. The Trust has a plan in place to achieve IG Toolkit level 2 in 2015/16.		
Summary of recommendations:	The Board are asked to approve the compliance statements and identify any gaps or concerns.		
Fit with WH strategy:	Alignment with financial and clinical strategies. It is also a mandatory requirement placed on us by our regulator.		
Reference to related / other documents:	Complies with SFI's, SOs and NHS reporting requirements		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks are documented and captured on the Trust Datix risk management software system and/or the corporate risk register and BAF		
Date paper completed:	21st October 2015		

Author name and title:		**Hannah Finney Strategy and Planning Manager**		**Director name and title:**		**Siobhan Harrington Director of Strategy and Deputy Chief Executive**	
Date paper seen by EC	**21st October 2015**	**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

NHS Trust Development Authority oversight report for October 2015

1. Introduction

This report is used as the basis for the Trust's response to the TDA monthly oversight reporting requirements. This template replaces the former statements reported to the Board. The Trust is required to confirm compliance with a set of Board self-certificated statements.
These compliance statements should be discussed and approved by the Trust Board with the discussion minuted. The Board should have or request access to assurance in relation to the accuracy of the reports and any associated actions.

2. Monitor compliance statements

		Compliant (Yes/risk/no)	Issue	Action plan
1.	**Condition G4:** Fit and proper persons as Governors and Directors	Yes	n/a	n/a
2.	**Condition G5:** Having regard to Monitor Guidance	Yes	n/a	n/a
3.	**Condition G7:** Registration with the Care Quality Commission	Yes	n/a	n/a
4.	**Condition G8:** Patient eligibility and selection criteria	Yes	n/a	n/a
5.	**Condition P1:** Recording of information	Yes	n/a	n/a
6.	**Condition P2:** Provision of information	Yes	n/a	n/a
7.	**Condition P3:** Assurance report on submissions to Monitor	Yes	n/a	n/a
8.	**Condition P4:** Compliance with the National Tariff	Yes	n/a	n/a
9.	**Condition P5:** Constructive engagement concerning local tariff modifications	Yes	n/a	n/a
10.	**Condition C1:** The right of patients to make choices	Yes	n/a	n/a

11.	**Condition C2:** Competition oversight	Yes	n/a	n/a
12.	**Condition IC1:** Provision of integrated care	Yes	n/a	n/a

3. Board assurance statements

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

3.	The Board is satisfied that process 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.	Executive Medical Director	Yes	n/a	n/a	n/a
For FINANCE, that:						
4.	The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.	Chief Financial Officer	Yes	For 2014/15 the Trust reported a deficit of £7.3m. The Trust financial position has been affected by historic underachievement of CIP, income, activity, coding and budgetary controls.	In June external auditors judged the Trust as a going concern. The Trust is working with commissioners to ensure contracts and payments recognise the actual work done. The Trust has developed a more comprehensive CIP governance structure with detailed tracking including accountability and exception reporting. A CIP PMO has been established which reports to a Steering Group. A Quality Impact Group is in place to ensure a robust process for identifying quality impact scores and validating schemes to protect patient safety and quality am is chaired by the Medical Director or Director of Nursing and Patient Experience. The Trust continues to work with external support to identify further schemes and ensure there are detailed plans for 2016/17 so that the Trust achieves financial balance in the future.	31/03/16

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.	Director of Comms & Corporate Affairs	Yes	n/a	The Trust Board will receive a briefing paper on the NHS constitution. This national initiative has recently been amended and republished.	Dec 15
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.	Director of Nursing & Patient Experience	Yes	n/a	n/a	n/a
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.	Director of Nursing & Patient Experience	Yes	n/a	n/a	n/a
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.	Director of Strategy / Deputy Chief Executive	Yes	n/a	n/a	n/a
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.	Director of Strategy / Deputy Chief Executive	Yes	The Trust has delayed revision and sign off for the risk management strategy in order to realign with the new ICSUs.	The Board will receive a revised risk management strategy in November which aligns with the new ICSUs	Nov 15

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.	Chief Operating Officer	Yes	ED improvement plan in place Detailed winter planning has commenced	The Trust is committed to achievement against targets. Work continues supported by our CCG colleagues to drive improvements and compliance with the standards which are off target. These are documented within the Board monthly performance reports and reported to the TDA each month. Plans are in place to mitigate areas which are off trajectory.	n/a
11.	The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Director of Strategy / Deputy Chief Executive	No	Non-compliant	An improvement plan to achieve Level 2 has been agreed at the IG Committee. The improvement plan will be managed by the IG department and monitored by the IG Committee. An audit by the Information Commissioner's Office (ICO) reported a 'reasonable assurance' rating in July 2015.	31/03/16
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.	Chief Executive	Yes	n/a	Following the departure of the Trust's Chief Operating Officer, the Deputy COO will be acting COO from the 24th October. Recruitment will commence in the new year. There will be backfill arrangements for the Deputy COO's current responsibilities.	n/a

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.	Chief Executive	Yes	n/a	n/a	n/a
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.	Chief Executive	Yes	n/a	n/a	n/a

Whittington Health Trust Board
4 November 2015

Title:	Corporate Risk Register		
Agenda item:	14/147	**Paper**	13
Action requested:	For the Board to identify new significant risks and/or mitigating actions.		
Executive Summary:	The Trust Board's main focus is strategy. The Board must understand the strategic goals and corporate objectives and be able to identify the principal risks that may threaten the achievement of them. The Corporate Risk Register enables high visibility of significant risks to support the Board discharge its statutory and legal duties. The Trust has agreed 2015/20 Strategic Goals which are to: • Deliver consistent high quality, safe services • Secure best possible health & wellbeing for our community • Innovate and continuously improve the quality of our services to deliver the best outcomes for our local population • Integrate care in patient centred teams • Support patients to be active partners in their care • Leader of medical, multi professional education and population based clinical research The Trust annual 2015/16 Corporate Objectives are to: • Deliver quality, patient safety and patient experience • Develop and support our people and teams • Develop our business to ensure we are financially sustainable • Further develop and expand our partnerships and engagement This paper presents the revised and updated Corporate Risk Register (CRR) that was presented to the Executive on 26 October and to TMG on 3 November. The CRR brings together the significant risks scoring16> from the: • Trust Board Committees • Trust Management Group • 7 Integrated Clinical Service Units • Trust Projects and Working Groups This ensures a bottom up and top down approach to identifying and mitigating the Trust's risks from all levels across the integrated care		

		organisation. **Appendix 1** shows how the Trust manages the bottom up and top down risk management approach which is known as 'triangulation of risk management'.					
Summary of recommendations:		To approve the Corporate Register					
Fit with WH strategy:		Fits with the Trust Clinical Strategy					
Reference to related / other documents:		Aligns to the Trust Risk Management Strategy					
Reference to areas of risk and corporate risks on the Board Assurance Framework:		This is the Trust Corporate Risk Register which aligns and feeds into the BAF					
Date paper completed:		26 October 2015					
Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Philippa Davies, Director of Nursing & Patient Experience**	
Date paper seen by EC	**26 Oct**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Whittington Health NHS

Corporate Risk Register - Version 1 - October 2015

Key: Text highlighted blue indicates the changes that have been made to the Risk Register since it was last presented to any other forum.

2015/16 Corporate Objectives: CO1. Deliver quality, patient safety and patient experience. CO2. Develop and support our people and teams. CO3. Develop our business to ensure we are financially sustainable. CO4. Further develop and expand our partnerships and engagement.

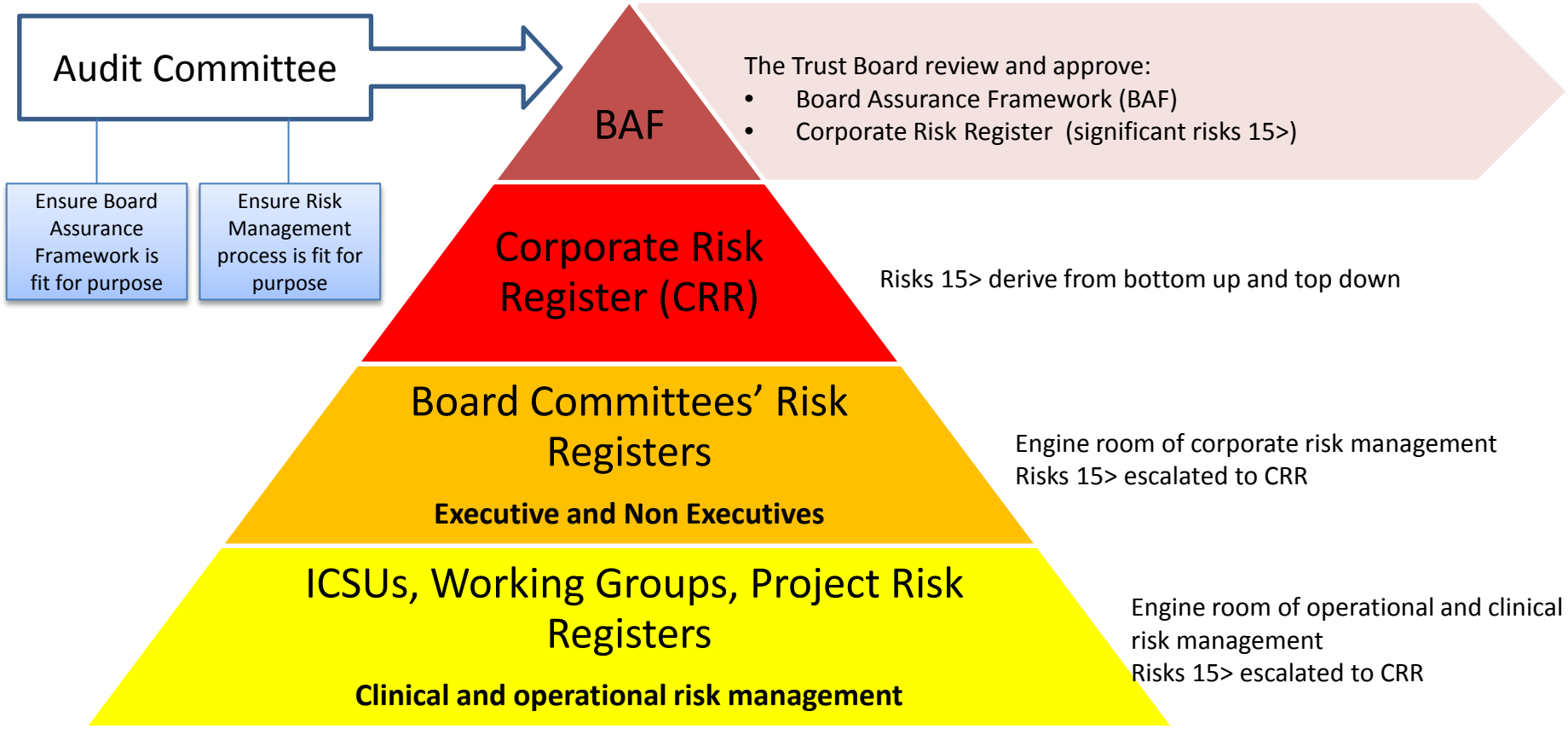
Risk Title	Risk Category	Risk Description	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Controls in Place	Current Risk Rating	Action Summary	Action Deadline	Forecast risk rating (post actions)	Corporate Objectives	Risk Source	Date added to register	Ref	Risk Rating Movement (since last update)
Embedding Learning	Patient Safety	• Failure to share and embed learning which could lead to repeated safety incidents	Medical Director/Director of Nursing & Patient Experience	SERIOUS (4)	ALMOST CERTAIN (5)	20	• SI Panel meeetings • SI reports now in public board meetings • TMG meetings • CEO Team briefing meetings • Executive Director Team meetings • Patient Safety Committee to monitor • Quality Committee to monitor • Audit & Risk Committee to monitor • Integrated clinical service units governance in place • Performance reviews quarterly with ICSUs • Patient safety huddles	**16**	• Share learning from SI Panel • TMG to add regular learning items to the cycle of business • CEO Team briefings to include regular learning items to enable cascade to teams • Share learning from local safeguarding board • ICSUs to share learning from departments • Executive Directors to share learning from portfolios eg IG incidents, H&S incidents, finance • Create a robust process to share learning to upload to new learning zone on intranet • Add learning to GP bulletin and CCG newsletters	Ongoing in year	12	CO3	Medical Director	Oct 15	CRR 001	↓
Maternity FBC	Quality	• Failure to access capital funding for maternity & neonatal redevelopment will delay the modernisation of the unit	Medical Director /Director of Nursing & Patient Experience	SERIOUS (4)	LIKELY (4)	16	• Regular strategic meetings with TDA • Finance and Business Development Committee • Maternity Steering Group and Transformation Board	**20**	• Continue to review capital plan to identify areas of funding for investment • Estates Strategy to January Board • Implement marketing plan • Update to Board November	Ongoing in year	16	CO1	Medical Director	July 2015	CRR 002	↑
CIPs	Quality	• Failure to identify quality impact from Cost Improvement Programmes	Medical Director /Director of Nursing & Patient Experience	V.SERIOUS (5)	LIKELY (4)	20	• CIP Quality Impact Group and CIP PMO team • TMG and reports • Quality Committee and reports • Boston consulting PMO and Programme Board • Clinical Quality Review Group • Safe staffing methodlogy and reporting to Board	**16**	• CIP work programme to be rolled out • Monitoring of quality impact • ICSUs business plans and risk management • ICSU governance and quality controls • Implement lessons learned from SIs and other incident reporting	Ongoing in year	12	CO1	TMG	July 2015	CRR 003	↓
Agency staffing	Financial & Quality	• Failure to meet nationally set agency spend targets	Directors of Workforce and Nursing and Patient Experience	V.SERIOUS (5)	LIKELY(4)	20	• Vacancy Panel meetings • Workforce KPIs reported to TMG & Board • Finance & Business Development Committee • Quality Committee	**15**	• Implement plan to reduce agency staffing • • Strengthen active performance management • Workforce strategy and plan to be drafted and agreed • ICSU business planning and performance meetings	Ongoing in year	12	CO3	CFO & F&BD	30 April 2015	CRR004	↓

Risk Title	Risk Category	Risk Description	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Controls in Place	Current Risk Rating	Action Summary	Action Deadline	Forecast risk rating (post actions)	Corporate Objectives	Risk Source	Date added to register	Ref	Risk Rating Movement (since last update)
Value Based Commissioning	Financial and Quality	• Failure to deliver viable lead provider model for diabetes and frail elderly services	Deputy CEO/Director of Strategy	SERIOUS (4)	LIKELY (4)	16	• TMG • Finance & Business Development Committee • Business Planning Group • Trust Board briefings • Risk sharing principle agreed with commissioners	**16**	• CCG & LA meetings • Lead clinicians input and joint working • Director of contracting supporting negoations • Contract to be agreed • Lead clinicians input and joint working • Business Planning Team & Deputy CEO workplans • Linking this work to strategic work across Haringey and Islington on population health and accountable care	Ongoing in year	12	CO3	TMG	May 2015	CRR005	↔
Operational Performance	Operations	• Failure to meet national and local operational targets which will affect delivery of high quality care and specifically A&E 4 hour target through winter	COO	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Trust Board performance report monthly • Trust Operational Management meetings monitor performance and corrective action plans • CCG monthly monitoring meetings • TDA monthly monitoring meetings	16	• Ongoing negotiation with commissioners re winter funding • Operational training completed • System Resilience Winter Plan to TB Nov 15 • Additional beds opened	Ongoing in year	12	CO1	COO	July 2015	CRR006	↓
Victoria Ward	Quality & Safety	• Failure to recruit and retain permanent nursing staff will lead to the inability to maintain high quality and safe services	Medicine, Frailty & Networked Services CD & DO	SERIOUS (4)	LIKELY (4)	16	• Trust Board safety/quality/safe staffing reports • Quality Committee safety/quality reports • TMG • Trust Operational Meeting • Workforce KPI reports • Rolling programme of recruitment days	16	• Action plan in place • Action plan updated weekly and monitored daily on the wards • Huddle check list from 18.09.15 • Executive safety hudles and walkabouts • Recruitment and retention strategy being developed as part of workforce strategy	Ongoing in year	12	CO2	Director of Nursing	Jul-15	CRR007	↔
Ophthalmology	Quality & Safety	• Failure to ensure dictate letter compliance of 100%	Surgery CD & DO	SERIOUS (4)	LIKELY (4)	16	• SLA in place with Royal Free for Opthalmology service • Operations Business meetings monitoring Dictate	16	• Performance manage SLA • Renew SLA • Dictate IT project 15/16	Ongoing in year	8	CO1	ICSU	Oct-15	CRR009	↔
Surgery	Quality & Safety	• Failure to effectively manage the maintenance of medical devices will lead to patient safety and quality risks materialising	Surgery CD & DO	SERIOUS (4)	LIKELY (4)	16	• Manager in place to lead department • Equipment library • New ICSU structures for stronger clinical leadership • Medical devices policy	16	• Review of team and resource • ICSU governance and forums reporting	Ongoing in year	8	CO1	ICSU	Oct	CRR010	↔

Risk Title	Risk Category	Risk Description	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Controls in Place	Current Risk Rating	Action Summary	Action Deadline	Forecast risk rating (post actions)	Corporate Objectives	Risk Source	Date added to register	Ref	Risk Rating Movement (since last update)
Finance	Quality & Safety	• Failure to improve the efficiency and effectiveness of the e-procurement system, especially in regard to catelogue management, will result in impacting on service delivery	Chief Finance Officer	SERIOUS (4)	SERIOUS (4)	16	• I&MT working group • New leadership by CFO of I&MT • TMG	16	• Manager in place to lead department • Work plans and actions • Training for staff	Ongoing in year	8	CO1	ICSU	Oct	CRR011	↓
Workforce	Quality & Safety	• Failure to achieve compliance with mandatory training target will result in staff that are not aware of policies and procedures which will impact on delivery of high quality and safe services	Director of Workforce	SERIOUS (4)	LIKELY (5)	20	• Director of Workforce • New Workforce report to TMG • New Workforce report to Trust Board • TDA reports to Trust Board monthly • Plans in place for all ICSUs and services to meet target	16	• New mandatory training workbook published and being used • Performance reviews with ICSUs • Awareness raising across the organisation • Inputting to ESR system in place	Ongoing in year	8	CO2	TMG	August 2015	Crr012	↓
Workforce	Quality & Safety	• Failure to achieve compliance with appraisal target will result in staff who may feel unsupported or clear in their objectives to delivery high quality care and support services	Director of Workforce	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Director of Workforce • New Workforce report to TMG • New Workforce report to Trust Board • Appraisal system simplified	16	•Performance reviews with ICSUs • Awareness raising across the organisation • Inputting to ESR system in place	Ongoing in year	8	CO2	TMG	August 2015	CRR013	↓
Workforce	Quality & Safety	• Failure to update legacy policies will result in staff not following the latest procedures and guidance which will impact on delivery of high quality and safe services	Director of Workforce	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Head of Integrated Risk Management recruited • New focus on refreshing policies • Policy working group • Staffside working group for policy sign off • TMG	16	• Policy update action plan • Manager in place to lead and monitor actions • New ICSU structures for clinical leadership	Ongoing in year	8	CO2	TMG	September 2015	CRR014	↓
Data Quality	Quality & Safety	• Failure to ensure high quality data will result in poor decision making that will impact on the Trust reputation, income and quality of services	Deputy Chief Executive/Director of Strategy	SERIOUS (4)	ALMOST CERTAIN (5)	20	• New leadership by Deputy CEO • New Data Quality Group • Internal audit report and external report completed • Income steering group in place • IG governance in place	16	• Implement Audit Recommendations • Training for staff to improve • data quality improvement plan required • clinical engagement through ICSUs	Dec-15	12	CO3	TMG	April 2015	CRR015	↓

Risk is Everybody's Business

Whittington Health NHS



Whittington Health Trust Board
November 2015

Title:	Audit and Risk Terms of Reference		
Agenda item:	15/148	**Paper**	14
Action requested:	To review the revised Terms of Reference		
Executive Summary:	The Audit and Risk Committee verifies internal controls and assesses efficacy of assurance processes for the Trust. The Committee met in October and reviewed its terms of reference to ensure they were fit for purpose and complied with best practice. The Committee agreed to recommend to the Board that the Terms of Reference are approved.		
Summary of recommendations:	To approve the revised Terms of Reference		
Fit with WH strategy:	Aligns with good governance and the Trust governance framework		
Reference to related / other documents:	SOs and SFIs, audit committee handbook		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on BAF and/or risk registers		
Date paper completed:	28 October 2015		

Author name and title:		**Audit & Risk Committee**		**Director name and title:**		**David Holt, Non-Executive Director**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Whittington Health NHS

Audit & Risk Committee

Terms of Reference

Audit and Risk Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 The Audit & Risk Committee will be appointed by the Board of Directors.

2.2 All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.

2.3 The Committee shall consist of at least three members.

2.4 The Board should appoint the Chair of the Audit & Risk Committee from amongst its independent Non-Executive Directors.

2.5 At least one member of the Audit & Risk Committee should have recent and relevant financial experience.

3. Attendance

3.1 The Chief Finance Officer and appropriate External and Internal Audit and LCFS representatives shall normally attend meetings.

3.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.

3.3 The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.

3.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement.

3.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

4. Quorum

4.1 This shall be at least two members.

5. Frequency of meetings

5.1 The Committee shall meet at least four times per year.

5.2 The external or internal auditor may request a meeting when they consider it necessary.

6. Secretary

6.1 A Secretary shall be appointed for the Audit & Risk Committee.

7. Agenda & Papers

7.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

7.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

8. Minutes of the Meeting

8.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

8.2 Approved minutes will be forwarded to the Board of Directors for noting.

8.3 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

9. Authority

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

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

10. Duties

10.1 Governance, Risk Management and Internal Control

10.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

10.1.2 In particular, the Committee will review the adequacy of:

10.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

10.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

10.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

10.1.2.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

10.1.2.5 the financial systems

10.1.2.6 the Internal and External Audit services, and counter fraud services

10.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

10.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

- the process for the completion and up-dating of the Assurance Framework;
- the relevance and quality of the assurances received;
- whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
- Whether the Assurance Framework remains relevant and effective for the organisation.

10.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

10.1.5 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10.1.6 The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.

10.1.7 The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

10.2 Internal Audit

10.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

10.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

10.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

10.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

10.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

10.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

10.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

10.3 External Audit

10.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Trust Board, and consider the implications and management's responses to their work. This will be achieved by:

10.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

10.3.1.2 consideration of recommendations to the Trust Board relating to the appointment and performance of the External Auditor

10.3.1.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

10.3.1.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

10.3.1.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

10.4 Other Assurance Functions

10.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

10.4.2 These will include, but will not be limited to, any reviews by Monitor, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

10.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality, Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

10.4.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

10.4.5 The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

10.4.6 The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports.

10.4.7 The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports

10.5 Management

10.5.1 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

10.5.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

10.6 Financial Reporting

10.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

10.6.1.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

10.6.1.2 changes in, and compliance with, accounting policies and practices

10.6.1.3 unadjusted mis-statements in the financial statements

10.6.1.4 major judgemental areas

10.6.1.5 significant adjustments resulting from the audit

10.6.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

10.7 Appointment, reappointment, and removal of external auditors

10.7.1 The Committee shall make recommendations to the Board of Directors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors

10.7.2 The Committee shall make recommendations to the Board of Directors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Board of Directors with information on the performance of the External Auditor

10.7.3 The Committee shall approve the remuneration and terms of engagement of the External Auditors

11. Other Matters

11.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

11.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

12. Sources of Information

12.1 The Committee will receive and consider minutes from the other Committees when requested. The Committee will receive and consider other sources of information from the Chief Finance Officer

13. Reporting

13.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit & Risk Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

13.2 The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

13.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

Whittington Health NHS

The Whittington Hospital NHS Trust

Magdala Avenue

Dr Richard Jennings

Direct Line: 020 7288 5906

Whittington Health

Trust Board

4 November 2015

Title:	Medical Appraisal and Revalidation: Annual Board Report		
Agenda item:	**15/149**	Paper	**15**
Action requested:	To approve		
Executive Summary:	This is the third annual Medical Appraisal Board Report in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation. The Board has previously received reports on medical appraisal and revalidation figures following each appraisal cycle, which for most doctors will occur between September and November every year. Medical revalidation went live in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical system. This report reviews appraisals completed and revalidation recommendations submitted in the financial year 2014/15.		
Summary of recommendations:	The Board is asked to approve this report.		
Fit with WH strategy:	This report is a requirement under NHS England Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). It is designed to provide the Board with oversight and assurance of its local medical appraisal and revalidation processes.		
Reference to related / other documents:	Medical Appraisal Policy Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff Remediation and Rehabilitation Policy Maintaining High Professional Standards in the Modern NHS Responsible Officer Regulations		
Date paper completed:	17th September 2015		

Author name and title:		**Ashleigh Soan Medical Director Portfolio Manager**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

Medical Appraisal and Revalidation: Annual Board Report

August 2015

1. Executive Summary and Background

This is the third of the Trust's Medical Appraisal Annual Board Reports in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation. The Board has previously received locally designed reports on medical appraisal and revalidation figures following each appraisal cycle, which for most doctors will occur between September and November every year.

Medical revalidation went live in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical profession.

All provider organisations known as designated bodies (see terminology section below) have a statutory obligation to support their Responsible Officer in fulfilling his or her duties under the Responsible Officer Regulations[1]. For this reason, this report has been designed to ensure that the Board has oversight of the following areas:

- monitoring the frequency and quality of medical appraisals within the Trust;
- checking there are effective systems in place for monitoring the conduct and performance of the Trust's doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for the Trust's doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work that they perform.

Dr Richard Jennings, the Trust's Executive Medical Director, was appointed to the role of Responsible Officer and has been in post since June 2014.

2. Terminology

'Revalidation': the process whereby the General Medical Council (GMC) renews a doctor's license to practise every five years, based on a recommendation from the doctor's Responsible Officer.

'Designated body': an organisation recognised by the GMC as responsible for submitting revalidation recommendations. Every designated body must have a Responsible Officer.

'Responsible Officer' (RO): a senior doctor, usually the Medical Director, who is responsible for medical appraisal and revalidation within the organisation and who makes recommendations to the GMC about doctors' fitness to practise. The revalidation recommendations submitted by the RO are considered by the GMC when they make the final decision with regards to a doctor's revalidation. The RO's responsibilities are laid out in the Responsible Officer Regulations, and in additional documents provided by the GMC such as the Responsible Officer Framework.

'Prescribed Connection': the term used to indicate the link with a doctor and their designated body. The prescribed connection is determined by law in the Responsible Officer Regulations and cannot be chosen, though it can be altered in exceptional circumstances. For doctors in a formal training programme, their prescribed connection is with the Local Education Training Board (LETB) that

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practise and Revalidation) Regulations Order of Council 2012'

administrates their course. All GPs on performers' lists have a prescribed connection to their Area Team for NHS England. Doctors who only work privately have a prescribed connection to the private organisation for which they do most work, and doctors employed only by an agency will usually have a prescribed connection to that agency. For all other doctors, including those with honorary contracts or on the bank, their prescribed connection is to the organisation for which they do most work, or, in the case of doctors who do an equal amount of work at two different NHS Trusts, to the organisation which is closest to their GMC registered address.

'Medical Appraisal': the evidence to inform revalidation recommendations is based on annual medical appraisals. Medical appraisals are performed by trained appraisers, and include a process whereby the doctor must provide a portfolio of evidence regarding their practice, including six kinds of information which are considered mandatory by the GMC. These should relate to:

1. Continuing Professional Development
2. Quality improvement activity
3. Significant events (including but not limited to Serious Incidents)
4. Colleague feedback (Completed through a formal 360)
5. Patient feedback (Completed through a formal 360)
6. Review of complaints and compliments

Revalidation recommendations

Responsible Officers are only able to submit one of three revalidation recommendations about a doctor to the GMC:

1. ***'Positive recommendation':*** a recommendation from the Responsible Officer to the GMC that in his/her opinion a doctor is up-to-date and fit to practise.

2. ***'Deferral request':*** a request from the Responsible Officer to the GMC to delay a doctor's revalidation submission date to allow for additional information to be considered (for example, if the doctor has not completed a 360 Multi-Source Feedback exercise, or if they are in a local HR process that has not yet come to a conclusion). Deferral of revalidation is neutral and has no impact on a doctor's practice; however, more than one request for deferral of revalidation date for an individual will lead to the GMC requesting further information as to the reasons for the deferral.

3. ***'Recommendation of non-engagement'***: a recommendation of non-engagement is made by the Responsible Officer to the GMC where a doctor is failing to engage with the processes that support revalidation (for example, where a doctor has repeatedly failed to complete an appraisal). A recommendation of non-engagement can be made at any point in the revalidation cycle.[2]

3. Prescribed connection and appraisal completion rate

It should be noted that due to the nature of the prescribed connection, which includes doctors on honorary contracts, as well as doctors on short term contracts and doctors employed via the Trust Bank if they have no other NHS employment, these figures frequently fluctuate. For this reason it is unusual for the appraisal completion rate to be 100%. At 1st April 2014, there were 226 doctors with a prescribed connection to Whittington Health.

Between 1st April 2014 and 31st March 2015 175 medical appraisals were completed, since the 31st March a further 22 doctors have completed a late 2014-15 medical appraisal. 12 doctors had an agreed postponement of appraisal with the RO, primarily due to long term leave (sickness, sabbatical, maternity). 17 doctors are now significantly past their appraisal due dates and these cases will be escalated by correspondence with the Responsible Officer and discussion with the GMC Employer Liaison Advisor (ELA) if necessary.

[2] Revalidation Statements, accessible at http://www.gmc-uk.org/doctors/revalidation/12394.asp

The remaining doctors who have not been appraised within the Trust due to having recently taken up employment here will be appraised in the coming appraisal cycle.

4. Governance Arrangements and Responsibilities

The Responsible Officer is supported by the Medical Director Portfolio Manager and the Revalidation Support Officer. Their responsibilities include:

- Maintaining the Trust's prescribed connection list on GMC Connect;
- Monitoring revalidation submission dates;
- Responding to revalidation information requests from other organisations on behalf of the Responsible Officer;
- Storing information relating to revalidation recommendations;
- Maintaining and monitoring the annual appraisal list, including providing reminders to doctors that their appraisals are due and escalating missed appraisals appropriately to Clinical Directors and the Responsible Officer;
- Supporting the Divisional Directors in allocating appraisers to the Trust's doctors, and keeping records of appraisal pairings in order to ensure that these are in line with the policy;
- Monitoring the Trust's online Revalidation Management System and liaising with the provider (Equiniti360Clinical) on improvements and development;
- Providing training for doctors with regard to using the online system, as well as more generally about the requirements of appraisal and revalidation;
- Providing refresher training to appraisers;
- Ensuring that Trust-held data on complaints, incidents and registered audit is entered onto the Revalidation Management System;
- Assisting the Directors of Medical Education with the completion of the Trainee Revalidation Portal;
- Monitoring new advice from the GMC and NHS England and providing advice on process to individual doctors and to the Responsible Officer as necessary;
- Reviewing and updating the Medical Appraisal Policy in line with new guidance as necessary;
- Managing appraisal reporting, including locally to the Responsible Officer, and the completion of quarterly reports to NHS England;
- Completing the Annual Organisational Audit;
- Completing first stage quality assurance audit of annual appraisals.

The monthly report for the Responsible Officer (Appendix F) has been designed to support the NHS England Quarterly Reports, which are presented to the RO prior to submission. The monthly reporting format provides granular oversight of appraisal completion rates against changing prescribed connection figures.

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports and updates provided by the recruitment team. However, this requires further work in order to ensure that trust grade doctors can be distinguished from junior doctors in training programmes.

a. Policy and Guidance

The Trust's Medical Appraisal Policy[3] was written in 2012 in line with NHS England guidance taken from the Organisational Readiness Self-Assessment questionnaires. It is currently being updated in order to reflect the new requirements in the Framework of Quality Assurance and the change in the trust's organisational structure.

5. Medical Appraisal

b. Appraisal and Revalidation Performance Data

As at 31st March 2015 175 appraisals had been completed, below is an activity level of appraisal completion rates by division:

Integrated Care and Acute Medicine

Number of doctors: 54

Number of completed appraisals: 52

Surgery, Cancer and Diagnostics

Number of doctors: 90

Number of completed appraisals: 57

Women, Children and Families

Number of doctors: 78

Number of completed appraisals: 66

The audit of missed or incomplete appraisals (Appendix A) provides detail on the reasons for those appraisals not completed in the window within which they were due.

c. Appraisers

The Trust had 58 active appraisers for the 2014-15 appraisal period (an active appraiser is defined as having performed at least one appraisal in the year). This represents approximately one quarter of the total number of doctors with a prescribed connection. All appraisers received revalidation-ready training from approved external providers. Additional refresher training for the 2015-16 appraisal period will be provided by the Medical Director Portfolio Manager, and will be tailored specifically to the organisation's local needs based on findings from the appraisal quality assurance audits. This training also includes a question and answer session and an opportunity for appraisers to discuss particular issues that they may have encountered in a confidential environment on an anonymous basis.

The Trust does not currently have an Appraisal Lead, but this would be incorporated into the role of an appointed Associate Medical Director.

[3] Medical Appraisal Policy, accessible at http://whittnet/default.asp?c=5917

d. Quality Assurance

Quality assurance of appraisals

Individual appraisal portfolios and output documents are reviewed at two stages. An audit is conducted by the RO's team on approximately one sixth of completed appraisals following the completion of the appraisal cycle. For the most recent cycle, the audit was conducted using a locally adapted form of the audit template created by NHS England. This includes a check that the appraisals forms have been correctly submitted by the individual doctor, and a check on appraisal output forms including the Personal Development Plan (PDP) and appraisal summary. The results of this audit are included in Appendix B.

An individual doctor's appraisal output documents and some key pieces of evidence from the appraisal portfolio are then reviewed again by the Responsible Officer and a member of his team prior to a revalidation recommendation being made.

Within 2015-16 to the Trust will work with two other NHS Trusts to complete an external review of our appraisal and revalidation processes.

Quality assurance for appraisers

All Trust appraisers have undertaken revalidation-ready training in order to provide a level of assurance that they have the skills and knowledge appropriate for the role. In addition, the Trust collects anonymous feedback on individual appraisers via the online Revalidation Management System; this feedback is collated by the RO's team and provided to individual appraisers so that they can reflect on it at their own appraisal. In cases where an appraiser consistently scores very low in a number of areas, where multiple doctors have requested not to be appraised by one individual, or where audits have identified substandard appraisals conducted by one appraiser, the RO's team will escalate this to the Responsible Officer and this appraiser may be asked to undertake further training. The Trust also keeps records of appraiser attendance at refresher training events which can be used in the appraiser's portfolio as evidence of ongoing professional development.

e. Access, security and confidentiality

In line with GMC requirements that all medical appraisals be performed electronically, the Trust uses the Revalidation Management System (RMS) provided by software company Equiniti. The system is part of the G-cloud programme, which provides a very high level of data security and assurance. A doctor's appraiser only has access to the appraiser's portfolio once it has been submitted to them, and loses access once the appraisal is signed off. The Responsible Officer has access to a doctor's information in order to be able to make revalidation recommendations, and the RO's team have administrative access in order to be able to provide IT and technical support, as well as conducting audits.

f. Clinical Governance Data

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and PALS;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

Complaints, PALS, claims, incidents and audit data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

6. Revalidation Recommendations

The audit of revalidation recommendations (Appendix C) details recommendations made for the year 1st April 2014 to 31st March 2015. Since revalidation went live in November 2012, the Trust has made 199 recommendations for doctors with a prescribed connection to the Whittington, of which 136 were positive recommendations, and 63 were requests for deferrals. So far there have not been any recommendations of non-engagement. Between the 1st April 2014 and 31st March 2015 the Trust has made 91 revalidation recommendations for doctors with a prescribed connection to the Whittington, of which 57 were positive recommendations, and 34 were requests for deferral. In this time period 7 recommendations were submitted later than the requested submission dates, these were due to administrative error. To prevent late submissions the Responsible Officer now reviews the required documentation for revalidation up to a month in advance of the planned submission dates.

7. Recruitment and engagement background checks

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- CRB checking and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK where this is necessary
- Verification of license to practise and other relevant qualifications
- Filing of references and CVs

The audit of recruitment and engagement background (Appendix E) provides some detail with regard to pre-employment checks for substantive staff.

Honorary contract holders have previously had their pre-employment checks performed by the RO's team but this is now performed by and administrator with the recruitment team. Where a doctor applies for an honorary contract with the Whittington, but also holds a substantive role at another organisation, the recruitment team seek confirmation of their employment checks from that organisation's HR department.

With regard to doctors working at the Trust via an agency, the Trust only uses agencies where reassurance is provided that all pre-employment checks have been performed.

Revalidation references

The ROs team is working to put in place a robust revalidation reference request process. The electronic recruitment system ('Health-jobs') has an integrated revalidation reference process that automatically sends revalidation reference requests to the doctor's previous Responsible Officer in the same way that other references are sent to referees. However, the response rate has always been extremely low and requires chasing by the ROs team. The updated Medical Appraisal Policy will include an escalation plan in case a revalidation reference is not received in a timely manner.

8. Responding to Concerns and Remediation

The Trust has a policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS'[4] and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

[4] Maintaining High Professional Standards in the Modern NHS, accessible at http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

10. Risk and Issues

The Board should note that licenses for the Trust's Revalidation Management System currently requires renewal and the Medical Director Portfolio Manager is working with the Trust's procurement team and Equiniti360Clinical to ensure that this is completed as quickly as possible.

12. Action Planning and Next Steps

The following actions will be incorporated into a formal action plan:

- Appointment of an Associate Medical Director for Patient Safety and Revalidation
- Reintroduction of the Revalidation Working Group
- Responsible Officer to have individual discussion with doctors who have outstanding appraisals
- Update of the Medical Appraisal Policy, to include:
    - Quality assurance details in line with the Framework of Quality Assurance
    - Clear escalation framework with timescales for missed appraisals
    - Further details on educational appraisal and the link between revalidation and educational supervisor accreditation
    - Stronger language on not uploading patient identifiable data to the appraisal portfolio
- Work with the recruitment team on collating and presenting data prospectively to meet NHS England audit template requirements
- Work on escalation plan for unanswered revalidation reference requests
- Additional training for doctors on writing reflective notes in their appraisal portfolios

13. Recommendations

The Board is asked to accept the report, which will be shared (along with the Annual Organisational Audit or AOA) with the higher level Responsible Officer, Dr Andy Mitchell.

The CEO is asked to approve the 'statement of compliance' (appendix G) confirming that the organisation, as a designated body, is in compliance with the regulations.

Audit of all missed or incomplete appraisals audit
Please note that this relates only to doctors due for an appraisal within the year 1st April 2014 – 31st March 2015

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	0
Exclusion during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	2
Postponed due to incomplete portfolio/insufficient supporting information	20
Appraisal outputs not signed off by doctor within 28 days	0
Doctor cited insufficient time and capacity*	16
Lack of engagement of doctor	0
Other doctor factors: Insufficient engagement of doctor not yet warranting recommendation of non-engagement	0
(describe)	0
Carers leave	1
Appraiser factors	
Unplanned absence of appraiser	2
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	4
Other appraiser factors (describe): Appraisal meeting occurred but documentation inadequate and then not revised	0
(describe)	
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	2
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

***Please note that of these doctors there have been no instances where it has been agreed formally that a doctor would not have to complete an appraisal. Where doctors cite this reason we work with individual doctors to ensure that they understand what is required for the medical appraisal and revalidation processes.**

Quality assurance audit of appraisal inputs and outputs
Please note that this relates only to doctors due for an appraisal within the year 1st April 2014 – 31st March 2015

Total number of appraisals completed: 175 **Number of appraisal portfolios sampled:** 20 (12%)		
Appraisal inputs	**Any evidence provided**	**Evidence considered of acceptable standard and includes reflective notes**
Scope of work: Has a full scope of practice been described?	20	20
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	18	18
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	19	18
Patient feedback exercise: Has a patient feedback exercise been completed?	16	15
Colleague feedback exercise: Has a colleague feedback exercise been completed?	17	17
Review of complaints: Have all complaints been included?	20	20
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	20	20
Is there sufficient supporting information from all the doctor's roles and places of work?	20	20
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	20	18
Appraisal Outputs		
Appraisal Summary	20	20
Appraiser Statements	20	20
PDP	20	20

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	84
Late recommendations (completed, but after the GMC recommendation window closed)	7
Missed recommendations (not completed)	0
TOTAL	**91**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	7
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	0
TOTAL [sum of (late) + (missed)]	**7**

Employment relation cases concerning the Trust's medical & dental staff for the period 1 February 2014 to 31 March 2015.

The purpose of this paper is to provide a numerical breakdown of the employment relations casework relating to the Trust's Medical & Dental staff. This is in accordance with the requirement under the NHS England Annual Organisational Audit and the Trust Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff, to provide this information to the Trust Board. Please note this information is based on all cases notified and managed by Medical HR.

1. **Number of formal cases by grade**

Grade	Numbers
Consultant	13
SASG*	3
GPs	0
Dentists	0
Trainee Doctors	2
Total	18

2. **Number of informal cases by grade**

Grade	Numbers
Consultant	8
SASG*	1
GPs	0
Dentists	1
Trainee Doctors	1
Total	11

3. **Number of medical & dental staff excluded by grade**

Grade	Numbers
Consultant	1
SASG*	1
GPs	0
Dentists	0
Trainee Doctors	0
Total	2

4. **Number of medical & dental staff restricted from practice by grade but not excluded from work.**

Grade	Numbers
Consultant	1
SASG*	1
GPs	0
Dentists	0
Trainee Doctors	1
Total	3

5. **Type of concerns by grade.**

Type of Concern	Consultant	SASG	GP	Dentists	Trainees
Conduct	11	1	0	0	1
Capability	2	0	0	1	1
Grievance	6	2	0	0	1

Bullying & Harassment	1	1	0	0	
Other (unfair dismissal claims)	1	0	0	0	
Total	21	4	0	1	3

*SASG: Includes all doctors in the following grades: Associate Specialist, Specialty Doctor, Staff Grade & Trust Grade

Author:

Shamima Chowdhury

Senior HR Manager (Medical HR)

14.08.15

Audit of recruitment and engagement background checks
Period covered is from April 2014 – March 2015

Please note that these figures include trainee doctors

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	79
Temporary employed doctors	1049

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	DBS (Disclosure and Barring Service) check	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check (GMC reg)	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	79	79	79	79	79	79	79	79	79	79	79	79	Not recorded by recruitment	Not recorded by recruitment	Not recorded by recruitment	79
Temporary employed doctors	976	976	976	976	976	976	976	976	976	976	976	976	Not recorded by recruitment	Not recorded by recruitment	Not recorded by recruitment	976
Locums brought into the designated body through a locum agency	13	13	13	13	13	13	13	13	13	13	13	13	Not recorded by recruitment	Not recorded by recruitment	Not recorded by recruitment	13
Locums brought into the designated body through 'staff bank' arrangements	60	60	60	60	60	60	60	60	60	60	60	60	Not recorded by recruitment	Not recorded by recruitment	Not recorded by recruitment	60
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	1128	1128	1128	1128	1128	1128	1128	1128	1128	1128	1128	1128	Not recorded by recruitment	Not recorded by recruitment	Not recorded by recruitment	1128

Locum use by specialty:	Consultant: overall number of locum hours used	SAS doctors: overall number of locum hours used	Trainees (all grades): overall number of locum hours used	Total overall number of locum hours used
Surgery	214 instances (2822 hours)	1 instance (13 hours)	489 instances (5321 hours)	8156
Medicine	1129 instances (8044 hours)	20 instances (163 hours)	1261 instances (12365 hours)	20572
Psychiatry	0	O	0	0
Obstetrics/Gynaecology	6 instances (44 hours)	0	568 instances (5820 hours)	5864
Accident and Emergency	188 instances (870 hours)	88 instances (748 hours)	2204 instances (19568 hours)	21186
Anaesthetics	7 instances (62 hours)	0	85 instances (1064 hours)	1126
Radiology	239 instances (1154 hours)	0	159 instances (671 hours)	1825
Pathology	96 instances (754 hours)	0	0	754
Other	0	0	0	0

Currently no exit reports are completed for locum staff (through bank and locum agencies), under current policy these are only applied to substantive staff.

Report for staff brought in by locum agencies is based on exception reporting if there is a concern about the doctor's practice.

Monthly Appraisal Report

April 2014

Prescribed Connections	**Month**	**Quarter**	**YTD**
Number of new prescribed connections			
Number of pre-employment checks performed			
Number of revalidation references received			
Status			

Medical Appraisals	**Month**	**Quarter**	**YTD**
Number of appraisals due			
Number of appraisals completed			
Status			

Revalidation Recommendations: Compliance	**Month**	**Quarter**	**YTD**
Number of appraisals due			
Number of appraisals completed			
Status			

Revalidation Recommendations: Type	**Month**	**Quarter**	**YTD**
Positive recommendations			
Deferrals			
Recommendations of non-engagement			
Status			

Date submitted to Responsible Officer:……..

Designated Body Statement of Compliance

The board/executive management team –[delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: New RO appointed in June 2014; booked for training in September sessions (earliest available)

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[5] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[5] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[6] have qualifications and experience appropriate to the work performed; and

Comments: These checks are performed but work is required to ensure that the checks are recorded centrally so that the data can be collected in real time

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: Signed: _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date:

[6] Doctors with a prescribed connection to the designated body on the date of reporting.