Whittington Health NHS

TRUST BOARD

14.00 – 16.30

Wednesday 3 March 2016

Whittington Education Centre Room 7

Whittington Health NHS

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Meeting	**Trust Board – Public**
Date & time	**2 March 2016 1400hrs – 1700hrs**
Venue	**WEC 7**

AGENDA

Steve Hitchins, Chair Anita Charlesworth, Non-Executive Director Paul Lowenberg, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive (extended leave) Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Dr Greg Battle, Medical Director (Integrated Care) (on sabattical) 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
16/029	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*		*Declare* *1420hrs*
16/030	**Apologies & Welcome** *Steve Hitchins, Chair*		*Note* 1425hrs
16/031	**Minutes, Action Log and Matters Arising February** *Steve Hitchins, Chair*	**1**	*Approve* 1430hrs
16/032	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
16/033	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Note* 1445hrs
Patient Safety & Quality			
16/034	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**3**	*Note* 1455hrs
16/035	**Safe Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Note* 1505hrs

Performance			
16/036	**Financial Performance Month 10** *Stephen Bloomer, Chief Finance Officer*	**5**	*Note* 1515hrs
16/037	**Performance Dashboard Month 10** *Carol Gillen, Acting Chief Operating Officer*	**6**	*Note* 1525hrs
Governance			
16/038	**Local Supervising Authority (LSA) Annual Audit Report - Monitoring the Standards of Supervision & Midwifery** *Philippa Davies, Director of Nursing & Patient Experience*	**7**	*Note* 1535hrs
16/039	**Nursing Establishment Review** *Philippa Davies, Director of Nursing & Patient Experience*	**8**	*Note* 1545hrs
16/040	**Finance & Business Development Committee update** *Tony Rice, NED Chair*	9 **Verbal**	*Note* 1555hrs
16/041	**Audit & Risk Committee update** *David Holt, NED Chair*	**10**	*Note* 1605hrs
16/042	**Quality Committee Draft Minutes January 2016** *Anu Singh, NED Chair*	**11**	*Note* 1615hrs
16/043	**Standards of Business Conduct 2016/17** *Lynne Spencer, Director of Communications & Corporate Affairs*	**12**	*Note* 1625hrs
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meeting			
	06 April 2016 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:
Doc: 16/031

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 3rd February 2016 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Anita Charlesworth	Non-Executive Director
	Philippa Davies	Director of Nursing and Patient Experience
	Norma French	Director of Workforce
	Carol Gillen	Acting Chief Operating Officer
	Siobhan Harrington	Director of Strategy/Deputy CEO
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Paul Lowenberg	Non-Executive Director
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
In attendance:	Kate Green	Minute Taker
	Nicola Nagler	Head of Communications
	Lynne Spencer	Director of Communications & Corporate Affairs

16/012 Declaration of Conflicts of Interest

12.01 David Holt informed Board colleagues that he was currently a Non-Executive Director on the Board of the Planning Inspectorate. He felt it necessary to raise this in light of the agenda item on the Trust's estates strategy.

16/013 Apologies and welcome

13.01 Apologies for absence had been received from Greg Battle and Paul Convery. Steve Hitchins apologised for the slightly late start to the meeting, also for the cancellation of the day's patient story, due to the illness of the patient who remained keen to speak at a future Board meeting. Siobhan Harrington, Phil Ient and Sophie Harrison attended for item 16/020 only.

16/014 Minutes, Action Log and Matters Arising

14.01 Richard Jennings requested a minor amendment to minute 06.03, and would provide Kate Green with his preferred wording. Other than this, the minutes of the Trust Board meeting held on 6th January were approved.

Actions

14.02 105.08 Lynne Spencer to ask Stephen Bloomer to confirm the date for when the external IT review recommendations would be brought to the Board.

154.05:The draft Estates Strategy was scheduled for discussion on that day's agenda, this item could therefore be removed.

160.06 The second quarterly patient safety report was scheduled for discussion on that day's agenda, this item could therefore be removed.

160.09 Lynne Spencer would consult Carol Gillen to agree a date for when the review of the contents of the performance dashboard would be brought back to the Board.

160.11 The paper on the NHS Constitution had been agreed by the January Board, the only remaining action was the formal appointment of the 'right to speak up' champion.

16/015 Chairman's Report

15.01 Steve Hitchins began his report by expressing his congratulations on behalf of the Board on Islington's achievement of the UNICEF Baby Friendly accreditation, the culmination of several years' partnership working between health visiting and children's centre teams. The award was to be presented at the Trust by a UNICEF representative the following Monday, 8th February.

15.02 Local MP Catherine West had attended the Simmons House adolescent unit for the formal opening of two additional places, and the event had been covered by the Ham & High local newspaper.

15.03 Steve was pleased to inform the Board that Non-Executive Director Tony Rice had been re-appointed for a further three years. Given Tony's role as Chair of the Charitable Funds Committee, he added that the annual Rotary Club Quiz Night was to take place the following evening and he hoped to see fellow Board members there.

16/016 Chief Executive's Report

16.01 Simon Pleydell began by informing the Board that the Trust remained on track for its performance in relation to C. Difficile, having reported no new cases since his last report. There had been just the one case of MRSA; this had been thoroughly investigated using the Root Cause Analysis (RCA) methodology, and the cause deemed non-attributable to the Trust. Take-up of the 'flu vaccination had now risen to 61%, which was good when compared to some other parts of London although not as good as the previous year's performance. Efforts were still being made to increase the uptake during the remaining few weeks of the campaign.

16.02 Simon was pleased to announce the appointment of two new Associate Medical Directors; Rob Sherwin, obstetrics & gynaecology consultant was to lead on revalidation issues, and Julie Andrews, consultant microbiologist, on patient safety. Siobhan Harrington was taking a period of extended leave for three to four months, and Simon would be bringing in some temporary staff to cover some aspects of her responsibilities such as estates, value based commissioning and primary care development. The Trust had also gone out to advertisement for a new Chief Operating Officer with an interview date of 15th March. It was noted that Siobhan will attend the meeting for the Estate Strategy item today.

16.03 Simon reported that the Emergency Department was facing significant pressures, and it had been difficult to meet the ED target that month due in part to a significant rise in attendances, with the number exceeding 300 on four days the previous week. Efforts were being made to ensure no delays in patient flows, length of stay and discharge of patients but the Trust's top priority remained the safety and care of patients. It was noted that all surrounding units were facing similar problems. Simon highlighted to the Board the pressure on staff, and recorded his thanks, on behalf of the Board, for all their work.

16.04 Performance reviews for all the ICSUs had taken place the previous week, and Simon had stressed the importance of meeting financial targets as it was essential the Trust closed the financial year meeting its agreed deficit of £15m.

16.05 There was to be further industrial action by the junior doctors on 10th February, and this would be similar to that taken on 12th January, i.e. not an all-out strike but one which ensured cover

for urgent and emergency care pathways. It was important to support the junior doctors, remain aware of the effect ongoing negotiations had on morale, and urge those concerned not to make hasty decisions which could have an adverse effect on their future career prospects.

16.06 Simon continued to hold staff engagement sessions on strategy and financial sustainability but increasingly felt there was a need to look at different ways of communicating with community staff. He had asked Lynne Spencer to give this her consideration.

16/017 Serious Incident Report

17.01 Seven serious incidents (SIs) had been declared during December, bringing the total to forty-four since 1st April. Referring to ongoing investigations, Philippa Davies informed the Board that she had made it an issue of good practice to negotiate with the Commissioning Support Unit (CSU) any requests for extensions to the 60 day standard for completion of reports. This was the case for two existing investigations, one concerning a medication incident, the other concerning a delayed diagnosis and treatment of colorectal cancer, and both had been delayed due both to their complexity and the need to seek external review.

17.02 The seven incidents declared during December were as follows:

- the unexpected death of a patient re-admitted to hospital with sepsis
- a medication incident concerning controlled drugs
- two delayed diagnoses
- two cases of sub-optimal care of a deteriorating patient
- a patient who died following a fall on an escalator.

On the last, it was noted that the Health & Safety Executive had investigated and found there to be no issues of concern with the escalator or Trust health and safety arrangements – the incident had been deeply sad and a tragic accident. The Trust Board recorded their formal condolences to the family of the patient.

17.03 In answer to a question from David Holt about how lessons learned from SIs were included on ICSU risk registers, Richard replied that this happened in a variety of ways, primarily through recommendations arising from SI panels, but also through the ICSUs' own quality meetings and the patient safety meeting. The Trust's Quality Committee have the ultimate monitoring role which provided assurance to the Trust Board.

16/018 Safe Staffing Report

18.01 Philippa Davies informed the Board that there had been increases in the demand for specials during December which linked to an increase in agency spend. There had however been only two shifts which had triggered red during the month. Considerable work was going into the implementation of the new Allocate system; this would provide additional useful information on staffing including the reasons behind the need to bring in specials.

18.02 In answer to a question from Anita Charlesworth about the apparent increase in mental health patients, Carol Gillen explained that she had scrutinised the data. The need for specials tended to be relatively rare on care of the elderly wards, where the need was more acute was for patients with psychotic episodes, dementia or delirium – often waiting for a transfer to a mental health ward. Camden & Islington Mental Health Trust was noted as having capacity issues.

16/019 Preparation of Quality Account 2016/17

19.01 Richard Jennings said that the paper circulated provided a detailed timetable including Board approval dates. The previous year they had taken the view that areas listed for improvement should be clearly measurable, and also that they should be consistent with the pledges made

in the Trust's Sign up to Safety commitment. The Board would be updated on these pledges at its March meeting.

19.02 Steve Hitchins enquired whether it was possible to examine the direction of travel over a given timescale and in doing so ascertain the lessons learned during the course of that period, and Richard confirmed this was the case. It was also stressed that for the pledges there should be a proper balance between acute and community priorities, and Richard replied that three related to both hospital and community, two were more hospital focused. He added that local priorities also featured and that Whittington Health was the only Trust to commit to a pledge around learning disability.

19.03 Paul Lowenberg requested a quarterly update on how the Trust was performing against the objectives it had set itself in 2016/17. Simon Pleydell agreed, but emphasised that such an update should be incorporated into the quarterly patient safety report not the performance dashboard. Paul also suggested that learning from the CQC report, once available, should be incorporated, and Simon added that useful learning also came from national audits which will be included in the safety report.

16/020 <u>Draft Estates Strategy</u>

20.01 Siobhan Harrington highlighted the significant work that had been carried out over the previous year in preparation for the publication of the draft estates strategy. The aim was to maximise the use of the Trust's estate, and this includes ensuring good environments for staff to work from, recognising this was an important factor in recruiting and retaining staff. The strategy was about building for the future of the Trust, aligning it with future commissioning plans, and where strategically appropriate sharing accommodation, and where possible generating income.

20.02 The team had actively engaged the local community, patients and staff; for several months weekly meetings had been held in the hospital atrium, and meetings had also been held with community staff, local groups, MPs and voluntary organisations. In all over 120 responses were included in the engagement report and the resounding consensus was that above all else stakeholders valued openness and transparency.

20.03 The Trust held a diverse estates portfolio, much of it ageing, and some of it costly. The priorities for the future needed to centre on ease of access, enabling care closer to home, maximising the use of existing assets (including reviewing opening times) and flexibility. Principles included capacity, compliance, sustainability, partnerships and engagement. Success would be measured against how the Trust was operating in five years' time with flexible and improved facilities for patients and staff. The Trust will look for opportunities for partnership arrangements approval was requested from the Board to establish a 'partnership delivery vehicle'. Steve Hitchins suggested there was a need to create a delivery structure within the Trust, but it was for the executive team to consider what form this should take. Jill Moulton had been engaged to carry out an initial piece of scoping work and would be visiting the Trust the following day. She would be working alongside Phil Ient and Sophie Harrison in the estate team.

20.04 The next phase of this work would be to look at the Trust's estate in the context of its position within the local boroughs, alongside other health premises. Some parts of the area covered by Whittington Health offered significant opportunities for regeneration, and Siobhan had already held conversations with both local authorities. During discussion the following points were raised:

- the need to become actively involved in local consultation exercises on a one by one basis for different and relevant parts of the estates
- whether the Trust could expect to receive any financial support from partners
- the need to understand the current changing economic climate both within and externally to the health economy

- for criteria to be developed for what might be considered an acceptable use of sites.

20.05 Siobhan confirmed that there would be wider engagement and communication with stakeholders as plans were developed. In time if proposals involved any significant change of use there would be a formal (statutory) consultation exercise. It was noted that Defend the Whittington had fed back that the document required more clarity on future staff facilities and environments. They were keen to understand the Trust's future plans for working with the private sector and SP confirmed that he will continue to liaise with the group.

20.06 Paul Lowenberg stated that the next phase of this work was the development of a strategic programme plan with key milestones against which progress could be measured, which would ensure that both pace and direction were maintained. Graham Hart commented on the distribution and differential aspects of the site, wondering whether there might be a phasing of the scheme through which lessons might be learned, and Richard Jennings stressed the need for a strong patient experience and clinical focus.

20.07 The Board approved the strategy and endorsed the principles of the document. They expressed their thanks to Siobhan, Phil and Sophie for their considerable hard work on development the direction of travel strategy.

16/021 Quarterly Patient Safety Report

21.01 Richard Jennings introduced the second of his quarterly patient safety reports, saying that it followed a similar format to the first. He was pleased to note that the Trust continued to maintain its low mortality rate; infection control compliance was extremely positive.

21.02 Richard highlighted the second of the Trust's Sign up to Safety pledges, which was to reduce the number of falls resulting in severe harm. Although the results of the Royal College of Physicians' audit indicates that Whittington Health is performing well, if one scrutinised run charts over a long period of time and compared self with self, it showed that the amount of falls sustained in hospital has risen. There appeared to be a direct correlation between the amount of falls on a ward and the lack of substantively appointed nursing staff. Carol Gillen added that some of the ward environments required improvement for patients suffering from dementia. Graham Hart enquired whether the Trust had good information on dementia statistics to assist with planning, and Richard replied that the data available was adequate. Philippa Davies added that the new Allocate system will support improvements in reporting.

21.03 The Board discussed the target which had been set (to reduce falls by 50%) and whether it had been a realistic one. It was also noted that a gentle lowering of a patient to the floor due to loss of balance was classified as a 'fall', hence the focus on falls where patients had suffered serious harm.

21.04 Richard confirmed that the two new Associate Medical Directors will greatly assist with continuous improvement work for patient safety.

16/022 Mortality Review Process

22.01 Richard Jennings informed the Board that there was an aspiration, nationally, that Trusts should improve their recording not only of mortality data but of those deaths that were avoidable, and there was a national move towards standardising how this was done. In due course Trusts would be asked to produce and publish these statistics, and the paper circulated gave an example of a national tool.

22.02 Anita Charlesworth said that it would be important to include figures for patients who had died within thirty days of discharge. Referring to Appendix 1 which gave an example of how membership of a mortality surveillance might look, she wondered whether any consideration had been given to representatives of different Trusts sitting on one another's panels. Richard

undertook to discuss it with other Medical Directors. He would also seek clarification from the centre on what was meant by 'governance representation'.

16/023 Financial Report

23.01 Stephen Bloomer introduced the financial report for Month 9. At the end of December there had been a deficit of £11.9m, £1.6m off plan from the forecast position. The Trust remained committed to reaching a year end position of £15m deficit, however Stephen acknowledged this became more challenging each month, with the most critical risk was income. The Trust has now triggered the contractual cap for four of five of its CCG commissioners and escalated discussions are ongoing.

23.02 Turning to expenditure, the Trust was overspent on pay at Month 9, with an increase in temporary staffing and a breach of the 6% ceiling for agency nursing. Discussions have taken place with all the ICSUs and the position of each addressed during the previous week's performance review meetings. Finance colleagues were working closely with the ICSUs to help them to reach their forecast outturns.

23.03 On cash, Stephen reported that at the end of December the Trust had a higher cash balance than planned, in part due to the collection of some outstanding debts. Currently the Trust awaited a decision from the TDA and Department of Health (DH) on its request for £18.3m cash support (of which £15m had been utilised so far).

23.04 In December the Trust achieved 62% of its CIP target, giving a year to date position of 79% of its planned savings, or £9m. It was acknowledged that performance across the ICSUs was not consistent, with some having performed particularly well. Carol Gillen would be taking the lead on performance in this area through the Programme Management Office. The coding work was also progressing well; this had contributed to the improved information on falls and mortality referred to earlier in the meeting as well as strengthening the Trust's position in relation to negotiating on income.

23.05 Philippa Davies was clear that the Trust's position on agency nursing expenditure was not acceptable, stating that her team understood the complex underlying causes, which included the vacancy rates and requirement for additional beds. She added that good progress was being made on moving back onto the framework, which in turn meant that costs will reduce.

16/024 Performance Dashboard

24.01 Carol Gillen reported that progress had exceeded expectation on access performance, and that DNA numbers had improved. Theatre utilisation had improved and had been set as part of the Trust's CIP plans for 2016.17. Cancer performance had improved, both in the 62 day target and more generally out-patient appointments, and further improvements were expected when community services were linked to RIO in June.

24.02 MSK services were not achieving the 6 week target, there was a significant issue concerning demand over capacity, and this was to be discussed with commissioners going forward. There had been an improvement in waiting times for community rehabilitation, but there remained significant delays in Islington, where it had been necessary to employ additional staff in order to bring waiting lists down.

24.03 ED remained challenging in for both patient flow and discharge planning. Philippa Davies and Richard Jennings had provided considerable support to the service, making regular visits to in-patient wards in order to improve these areas. Meetings had taken place with social services and GP colleagues.

24.04 Philippa Davies confirmed for pressure ulcers that the main challenge for the Trust was within community services, and if those were removed from reporting with the hospital data sets, delivery of harm free care targets would be achieved each and every month. Moving to

theatre utilisation, Carol Gillen said that job planning was key and that Nick Harper and Fiona Isacsson had conducted a review and were making some changes accordingly. Simon Pleydell added that Boston Consulting had also given advice on this, the aim being to try to achieve an income stream through relevant areas.

24.05 Paul Lowenberg enquired about the apparent downward trend in face to face contacts as illustrated by the graph on page 8, and Carol Gillen replied that there remained some issues around reporting, as well as the usual seasonal 'dip' in activity over the Christmas and New Year period. This was in any case one of the areas to be considered as part of the overall review of the dashboard.

16/025 TDA Oversight Statements

25.01 The TDA oversight statements were approved by the Board.

16/026 Workforce Assurance Committee Terms of Reference

26.01 Norma French had prepared draft terms of reference for the Workforce Assurance Committee, due to hold its first meeting in April. Steve Hitchins suggested the insertion of 'retention'; Graham Hart offered to review the document and feed comments back to Norma outside the meeting.

16/027 Quality Committee minutes

27.01 Quality Committee Chair Anu Singh requested that in future the most recent committee minutes be circulated (given the committee only met every two months) in order to avoid time lags between meetings and assurance of committee work to the Board. It was agreed that draft minutes from all the Board committees will be presented to the Board once they had been signed off by the committee chair.

16/028 Patient & Public Involvement Policy

28.01 The Board had approved an engagement strategy at a previous meeting and this policy added detail and was designed to help those involved in service changes to think through how they best involved patients and the public in any such proposed changes. The paper will be advertised on the website for consultation with further consideration by the patient experience committee in February. The Board approved the policy.

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Action Notes Summary

14.02	SB to confirm the date for when the external IT review recommendations would be brought to the Board	TBC
160.09	CG to agree a date for when the review of the contents of the performance dashboard would be brought back to the Board	Developments in progress with draft metrics presented to February Board Seminar
160.11	NHS Constitution agreed by the January Board, the only remaining action was the formal appointment of the 'right to speak up' champion	TBC
19.01	The Board would be updated on sign up to safety pledges at its March meeting with safety report	On Agenda March Board

Whittington Health Trust Board

3 March 2015

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/0**	**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:	25 February 2016		

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

MRSA Bacteremia

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. During this reporting year the Trust has had one MRSA breach which occurred in January 2016.

Clostridium Difficile

The Trust reported no new cases of Clostridium Difficile and our total is six cases for the year to date. The target is for no more than 17 cases in each year. The Trust continues with regular awareness raising initiatives on the importance of adhering to infection control procedures to maintain a strong focus on patient safety as our top priority.

Cancer Waiting Time Targets

The Trust met four of the six national cancer targets demonstrating a slight improvement to last month which achieved three of the targets. The targets achieved are:

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 96%
- 31 days to subsequent treatment (drugs)100% against a target of 98%
- 62 days from referral to treatment 91.7% against a target of 85%

The Trust has robust plans in place to meet the following two targets which reported:

- 14 days cancer to be first seen 88.0% against a target of 93%
- 14 days to be first seen for breast symptomatic 90.8% against a target of 93%

Community Access Targets

MSK appointments are under target and the Trust is implementing new initiatives to improve performance in the longer term to address the current risks of capacity and demand. The targets this month reported:

- MSK waiting time – non consultant led patients seen in month – 51.0% against a target of 95%
- MSK waits – consultant led patients seen in month – 100% the target 95%
- IAPT – patients moving to recovery – reported 49.4% against the target of 50%

Flu campaign

Whittington Health has a good track record of delivering a high rate of flu vaccinations and our uptake for this winter closed at 62.06% of staff vaccinated against a target 75%. We remain amongst the top quartile in London NHS Trusts for take up of the flu vaccination.

Care Quality Commission (CQC)

Following the Trust's formal visit by the CQC in December 2015, publication of the draft report with recommendations was expected for mid-March. This will now be slightly delayed for publication and meanwhile the Trust will continue to implement the quality and safety Improvement Action Plan.

2. EXECUTIVE DIRECTOR

The chief operating officer post has been advertised and interviews will take place this month with an aim to recruit by the end of March. Carol Gillen continues to act into the post to ensure strong leadership for our operational teams.

3. OPERATIONAL

Junior Doctors

The BMA has launched a judicial review regarding the NHS employers' decision to impose a new contract on junior doctors in England. There will be three further dates of industrial action:

- 0800hrs on Wednesday 9 March to 0800hrs on Friday 11 March
- 0800hrs on Wednesday 6 April to 0800hrs on Friday 8 April
- 0800hrs on Tuesday 26 April to 0800hrs on Thursday 28 April

Over each of these 48-hour periods, junior doctors will offer emergency care only. The Trust will continue to manage services in line with its contingency arrangements.

Emergency Department (ED)

Pressures within the emergency care pathway continue which has affected our performance for the month. The main cause for the dip in performance against the ED standard relates to bed capacity issues and demand.

The North Central London sector is experiencing the same severe pressures during this busy winter period. January ED performance reported 84.6% against a target of 95% and year to date performance is 92.90%. During January over half of the hospital breaches were directly attributed to the lack of available in-patient beds which highlights some of the challenges the Trust is experiencing to bring performance back on track. In addition, the ED has seen over 100 patients per hour attending during peak periods.

The Integrated Clinical Service Units and operational teams are developing a revised action plan to improve our patient flow in the Emergency Department. We are focussing on key areas that include increasing the number of pre 1100hrs discharges, reducing our patients' length of stay, improving discharge planning with a rigorous back to basics approach and making sure we fully utilise our ambulatory care and community services.

Mandatory Training and Appraisal

To date our appraisal performance is 74% which has slightly decreased this period against a target of 90%. Our mandatory training performance is 83% against a target of 90%.

4. FINANCE MONTH 10

At the end of January, the Trust reported a year to date deficit of £12.5m which is £ 646k off our planned position. The Trust continues to trigger the contractual income cap for all north central London CCGs except Islington and is seeking to agree a contract settlement for 2015/16 to address the funding gap in commissioner payment for north central London patients (excluding Islington).

Within expenditure, pay costs exceeded the budgeted level by £307k during January, totalling £865k YTD with temporary staffing driving this cost pressure. In order to deliver

the forecast full-year income and expenditure deficit (£15m), the Trust will manage agency expenditure in line with the cap of 6% and the agreed ICSU forecast positions.

The Trust continues to manage capital expenditure and working capital position, to ensure sufficient cash balances are available to support payroll and high priority creditor commitments. The Trust has also agreed a £18.3m cash support facility with the Department of Health.

At an aggregate level the Trust reported income position is £482k better than plan which is predominantly due to the additional income collected for non-patient care services such as education. NHS patient care income is c.£1.4m less than the planned position. In broad terms income over-performance for medical specialties is mitigating below planned levels of income for surgical care. The Trust is reporting income over-performance in areas such as CAMHS, Local Authorities and Integrated Community services.

All Integrated Clinical Service Units and corporate executive director portfolios have agreed a forecast trajectory to ensure agreed improvement actions are completed to achieve the Trust's financial plan for 2015/16.

5. DIABETES TOP TEAM

Congratulations to our outstanding diabetes team who ranked top of all NHS trusts in England and Wales for our diabetes care processes in a recent national audit. Over 95 per cent of our patients are being treated with high quality standards compared with a national average of 59 per cent of patients. Well done to the team who are commended for their fantastic collective achievement.

6. WORLD CANCER DAY

To mark World Cancer day during this month, our team of specialist cancer nurses held our first ever Cancer Care Conference. This event was designed to help those affected by cancer to live longer, healthier lives. The event brought together over 50 patients and their families to help them find out more about the support and information available from our Trust following a cancer diagnosis. Thank you to the staff that arranged and managed this excellent conference which has received very positive feedback.

7. PAEDIATRIC TEAM AWARD

Congratulations to Dr Hannah Jacob and her research supervisor Dr Caroline Fertleman, from our paediatric team, for being highly commended at the Health Education North Central and East London (HENCEL) quality awards. The team were commended by the judges for their project to develop a national child health curriculum for medical students.

Simon Pleydell
Chief Executive Office

Whittington Health NHS

Nursing and Patient Experience
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Magdala Avenue
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Whittington Health Trust Board

2 March 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**16/034**	**Paper**	**03**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of January 2016. 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. • National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations. A Standard Operating Procedure has been developed to ensure learning from SIs at all clinical levels: nursing staff, junior doctors, consultants and admin staff.		
Date paper completed:	19/02/2016		

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		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incidents Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of January 2016.

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 recurrences.

2. Background

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet 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 has declared 4 serious incidents during January 2016 bringing the total to 48 since 1st April 2015. This includes 2 incidents that were later downgraded (de-escalated).

The Trust has 2 investigations with extended deadlines agreed;

a). Medication Incident (Nitrofurantoin) –an extension has been requested and approved for further 60 days due to the complexities surrounding this incident..

b). Delayed Diagnosis and treatment of Colorectal cancer –an extension has been requested and approved for further 60 days due to the requirement for an independent investigator and external expert being appointed.

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

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

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

Category	Month Declared	Summary
Delayed Diagnosis (Ref Oct DD) (2015.33113)	Oct 15	Delayed diagnosis and treatment of colo-rectal cancer
Medication Incident (Ref; Oct MI) (2015.33733)	Oct 15	Patient sustained long term harm from prolonged treatment with oral antimicrobials
Maternity/Obstetric incident Ref 818 (2015.36818)	Nov 15	Unexpected stillbirth at 29 weeks gestation.
Unexpected death Ref 590	Dec 15	Unexpected death of a patient re-admitted to hospital with sepsis and bleeding following ERCP (Endoscopic Retrograde Cholangio Pancreatogram).

Medication Incident Ref 614	Dec 15	Discrepancy and possible theft of controlled drugs from a ward.
Maternity/Obstetric incident Ref 438	Dec 15	Delayed Diagnosis (Appendix removed and Gall Bladder Trauma)
Sub optimal care of deteriorating patient Ref 657	Dec 15	Sub optimal care of debridement of pressure ulcer procedure carried out.
Sub optimal care of deteriorating patient Ref 650	Dec 15	Unexpected death in the community following issues around nutrition and safeguarding.
Delayed diagnosis Ref 620	Dec 15	Delayed Diagnosis, sepsis pathway was not followed.
Slip/Trips Falls Ref 604	Dec 15	Patient suffered a subdural haematoma following a fall on an escalator.
Pressure Ulcer meeting SI Criteria- (2016.2612)	Jan 16	Pressure Ulcer Cluster. 5 separate patients acquired Grade 3 pressure on the same ward between 20/01/2016-26/01/2016.
Maternity/Obstetric incident (2016.1302)	Jan 16	Unexpected admission to NICU, baby sustained shoulder dystocia
Maternity/Obstetric incident (2016.835)	Jan 16	Unexpected maternal death following delivery related to pre existing medical condition
Delayed Diagnosis (2016.732)	Jan 16	Delayed diagnosis - failure to screen appropriately for haemoglobinopathy.

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported 4 serious incidents in January 2016

STEIS 2015-16Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 2016	total
Child protection	0	0	0	1	0	0	0	0	0	0	1
Communication issue	1	0	0	0	0	0	0	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	0	0	1	2	1	0	0	0	7
Diagnostic Incident including delay	0	2	0	1	0	0	1	0	1	1	6
Drug incident	0	0	0	0	1	0	1	1	1	0	4
Failure to obtain appropriate bed for child who needed it	0	0	0	0	0	0	0	1	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus/neonate/infant)	0	1	0	1	0	1	0	1	1	2	7
Pressure ulcer grade 3 (including cluster)	5	1	0	0	0	0	0	0	0	1	7
Screening Issues	0	0	0	1	0	0	0	0	0	0	1
Slips/Trips/Falls	1	0	0	0	0	0	0	3	1	0	5
Suboptimal care of deteriorating patient	0	1	0	2	0	0	1	0	2	0	6
Medical equipment/ devices/disposables incident	0	0	0	0	0	1	0	0	0	0	1
Unexpected death	0	0	0	0	0	0	0	0	1	0	1
Total	8	7	0	6	2	4	4	6	7	4	**48**

4. Submission of SI reports

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

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations, 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 receive a final outcome letter highlighting the key findings of the investigation, actions taken to improve services and learn from mistakes. A 'being open' meeting is offered in line with duty of candour recommendations.

The Trust has executed its responsabilities under the Duty of Candour for the investigation completed and submitted in January 2016.

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 1 report to NELCSU in January 2016.

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

Summary	**Actions taken as result of lessons learnt**
• **Loss of Patient Data (Ref; Oct Lopd)**	**Loss of dental service records due to a corruption of the (SQL) service database.** • A Review the contractual and technical support arrangements for the SOEL (Software of Excellence) database solution (Microsoft SQL) has resulted in the a number of recommendations being made to improve the operational running of the SOEL database and several IT staff now have advanced SQL skills to assist with support if required. • Several technical changes have been implemented to both the server hardware and the SOEL software to reduce the likelihood of a future database corruption and improve its operational running and maintenance and are currently configuring the database mail so that daily reports of maintenance plan are provided. • A review of the IT service desk escalation procedures has been undertaken and all Acute and Community IT service desk staff have now been cross trained so they understand the priority of each IT system running in both the Acute and Community setting and know how to escalate appropriately to senior technical support staff and managers in the technical services

Summary	Actions taken as result of lessons learnt
	team.
	Notable practice • Letters were sent out to all affected patients explaining the incident, apologising and confirming that there had not been a breach of confidentiality. • As soon as the problem was detected all patients affected by this incident had their treatment plans reviewed and patients were informed and a record noted.

5.0 Sharing Learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies.

6.0 Falls Trend Analysis

Following discussion at a previous Board meeting this report contains a further analysis of falls data.
A total of 481 falls have been reported on Datix for the period 1st January 2015 to 31st January 2016. These include slides on to the floor and assisted 'controlled' falls in addition to falls both witnessed and unwitnessed that resulted in low, moderate or severe harm.

Top 5 areas reporting incidents of falls were:

- Victoria Ward 73 falls (gastro oncology ward with 33 beds)
- Cloudesley Ward 48 falls (care of older people ward with 25 beds)
- Meyrick Ward 41 falls (care of older people ward with 25 beds)
- Coyle Ward 35 falls (orthopaedic ward with 24 beds)
- Mary Seacole South 32 falls (acute assessment ward with 18 beds)

Although, the number of falls on Victoria ward is significantly higher than other wards it should be noted that the bed base on Victoria ward is greater and the acuity of patients significantly more dependant. A tabular timeline trend analysis has not identified any obvious patterns in terms of day shifts / night shifts or week days versus weekends. Victoria Ward is now under new ward managerment arrangements and systems and processes have been reviewed and revised. It is anticipated that there will be a decline in incidents of falls going forward.

In 6 out of 481 falls incidents, patients sustained fractures. These incidents were declared Serious Incidents via Steis and have been reported externally to Health and Safety Executive as RIDDOR. These incidents occurred in the following areas;

- 1 on Cloudesley Ward;
- 1 on Victoria Ward
- 2 on Meyrick Ward
- 2 on Coyle Ward.

7.0 Summary

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

Whittington Health Trust Board

2 March 2016

Title:	Safe Staffing (Nursing and Midwifery) for January 2016		
Agenda item:	**16/035**	**Paper**	**4**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in January 2016. 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 the increase in beds to accommodate patients as well as an increase in those requiring special care on a 1:1 basis. • The number of shifts required for 'specialling' purposes decreased in January compared to December • Only 1 shift triggered 'Red' in January.		
Summary of recommendations:	Trust Board members are asked to note the January UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care, Francis Report recommendations, Cummings recommendations and NICE recommendations.		
Reference to related / other documents:	Fits with clinical strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	February 2016		

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing & Patient Experience**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC	**1 Mar**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Safe Nurse Staffing Levels

1.0 Purpose

To provide the Board with an overview of nursing and midwifery staffing levels in terms of 'actual' versus 'planned' hours on our wards in January 2016 and an assurance that these levels are monitored and managed daily.

2.0 Background

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

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st January 2016 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

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

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in January 2016. The average fill rate was 100.7 % for registered staff and 115.1 % or care staff during the day and 97.8 % for registered staff and 112.6 % for care staff during the night.

Five 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 eight areas where nurses were required to care for patients who needed 1:1 care due to high dependency or acuity needs of those patients with mental health needs.

3.1 Additional Staff (Specials 1:1)

When comparing January's requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease level of need. January saw 95 requests for 1:1 specials compared to 133 requests in December. 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 to care for patients with a mental health condition decreased in January (41) compared to December (84).

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 January only 1/1488 (0.07%) shift triggered 'red'. This was lower than previous months.

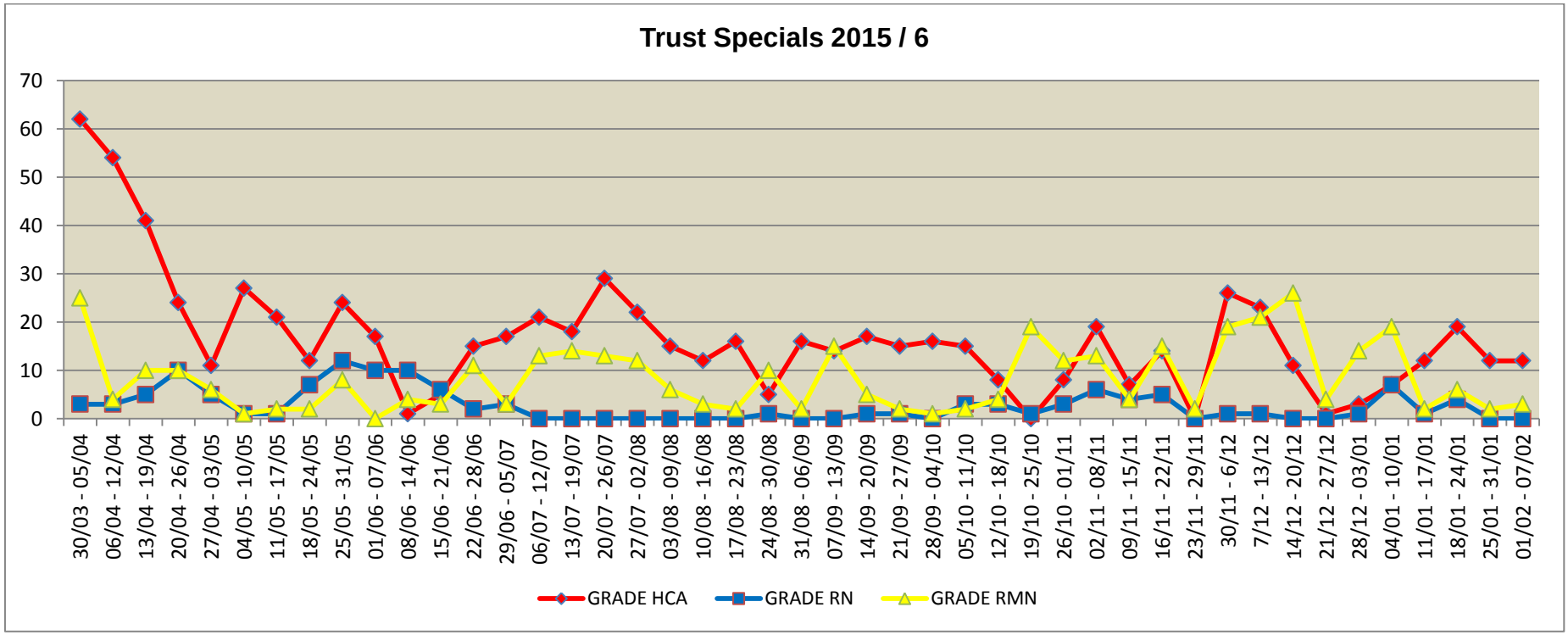
5.0 Conclusion

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

Fill rate data - summary
January 2015

Day				**Night**				**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				
Hours 35507	Hours 35740	Hours 11496	Hours 13237	Hours 28444	Hours 27824	Hours 8225	Hours 9262	100.7 %	115.1%	97.8%	112.6%

January 2016



Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board – Finance Report

02 March 2016

Title:	Month 10 2015/16 - Financial Performance		
Agenda item:	16/036	**Paper**	05
Action requested:	Consider the report and endorse actions taken to date to mitigate financial risk, and support the ICSUs to deliver the required actions to secure the year end position		
Executive Summary:	The paper analyses the financial performance of the Trust covering clinical division and corporate performance, cash, CIPs and capital.		
Summary of recommendations:	To note the financial results relating to January 2016		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers (Trust Board: March, April and May 2014). Board Assurance Framework (Section 3).		
Date paper completed:	21 February 2016		

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 | Financial performance summary

As at month 10 the organisation reported a £12.5m year to date (YTD) deficit (c.5% as a proportion of turnover), this is £647k worse than the planned position. The organisation continues to forecast the achievement of the full year planned deficit of £15m. Achievement of the forecast is dependent on robust expenditure controls for cost risk areas, and an appropriate full year income settlement for care services provided; both of which are covered more fully in this report.

The table below provides a summary of the key finance metrics (£k) and actual performance against plan both for the January monthly position (in-month) and cumulative year to date (YTD)

Indicator	Measure	In-Month Plan	In-Month Actual	YTD Plan	YTD Actual
Monitor COSR	score	-	-	1	1
EBITDA margin	%	-1.27%	2.55%	0.53%	0.33%
EBITDA achieved	£000s	-313	641	1,274	799
Adjusted net deficit margin	%	-6.64%	-2.64%	-4.94%	-5.20%
Adjusted net deficit achieved	£000s	-1,641	-662	-11,897	-12,544
Liquidity ratio	days	-	-	-20	-20
Capital Servicing Capacity	times	-	-	-0.34	0.02
Income	£000s	24,703	25,103	240,677	241,159
Pay	£000s	17,608	17,914	176,911	177,776
Non-Pay	£000s	7,408	6,547	62,492	62,585
CIPs	£000s	1,178	1,156	13,174	10,212

Finance overview | Statement of comprehensive income

At the end of January, the Trust posted a cumulative deficit of £12.5m, which is £646k worse than the planned position.

At an aggregate level the Trust reported income position is £482k better than plan; however this is predominantly due to the additional income collected for non-patient care services (e.g. education) and masks the cumulative income shortfalls for patient care services. Reported NHS patient care income is c.£1.4m worse than the planned position. In broad terms income over-performance for medical specialties is mitigating below planned levels of income for surgical care. The Trust is reporting income over-performance in areas such as CAMHS, Local Authorities and Integrated Community services.

As reported at month 9, the Trust continues to forecast triggering the contractual income cap for all north central London CCGs except Islington. The Trust is seeking to agree an appropriate contract settlement for 2015/16 as in practice care is being delivered without commissioner payment for north central London patients (excluding Islington).

Within expenditure, Pay costs exceeded the budgeted level by £307k during January and £865k on a cumulative basis, the premium costs of temporary staffing reliance is driving this cost pressure. There continues to be close scrutiny applied to temporary staffing expenditure across the Trust. The non-pay position was broadly in line with plan on a cumulative basis.

In order to deliver the forecast full-year income and expenditure deficit (£15m), the Trust needs to curtail the agency expenditure reported since the start of 2016, deliver financial control in-line with the agreed ICSU forecast positions and achieve a satisfactory income settlement from north central London commissioners.

The Trust continues to restrict capital expenditure and closely manage the working capital position, to ensure sufficient cash balances are available to support payroll and high priority creditor commitments. The Trust has also agreed a £18.3m cash support facility with the Department of Health, this covered in more detail in this report.

The table below is a statement of comprehensive income for the period up to month 10 for the Trust

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	20,659	20,734	75	203,345	201,958	-1,387	243,894
Non-Nhs Clinical Income	1,982	2,232	250	16,321	17,000	679	20,284
Other Non-Patient Income	2,062	2,136	74	21,011	22,202	1,190	25,997
Total Income	**24,703**	**25,103**	**400**	**240,677**	**241,159**	**482**	**-290,176**
Non-Pay	7,408	6,547	861	62,492	62,585	-93	77,258
Pay	17,608	17,914	-307	176,911	177,776	-865	211,890
Total Operating Expenditure	**25,016**	**24,461**	**555**	**239,403**	**240,361**	**-957**	**289,148**
EBITDA	**-313**	**641**	**954**	**1,274**	**799**	**-475**	**1,028**
Depreciation	699	672	28	6,765	6,718	47	9,663
Dividends Payable	375	410	-35	4,000	4,101	-101	4,750
Interest Payable	260	228	31	2,473	2,567	-95	3,231
Interest Receivable	1	2	1	8	25	16	10
Other Finance Costs	0	0	0	0	28	-28	0
Total	**1,333**	**1,308**	**25**	**13,230**	**13,390**	**-160**	**17,634**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-1,646**	**-667**	**979**	**-11,956**	**-12,591**	**-635**	**-16,606**
Add back impairments and adjust for IFRS & Donate	5	5	0	59	48	-10	1,569
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-1,641**	**-662**	**979**	**-11,897**	**-12,544**	**-646**	**-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.

Property, Plant & Equipment: The variance of £11.9m for property, plant and equipment is predominantly explained by the underspend against plan for the largest scheme in the Trust capital programme, the Maternity and Neonatal scheme with c.£7.6m cumulative scheme slippage; the Trust does not to date have approval to proceed with this externally funded investment . Overall the Trust continues to slow down the capital programme to ensure sufficient cash balances are available to support operations. In total the capital programme is c.£9m underspent YTD, excluding the Maternity and Neonatal scheme (external funding source), the balance of c.1.3 million slippage is attributable to backlog and equipment investment schemes.

Trade Receivables: Continue to be higher than planned. This is mainly be due to the month 9 agreement of balances as NHS organisations tend to reduce payment of invoices while they run through the exercise; additionally the Trust is experiencing slow payment by Local Authorities for services received and an old contractual dispute with Islington CCG.

Cash: The annual cash plan assumed the Trust would have received £23.9m cash support from the Department of Health. Due to the constrained national finance position the final application for cash support agreed with the Department of Health was for £18.3m, the Trust expects to access this funding around mid-March. The cash variance to date is explained by the shortfall in central cash support accessed versus the original (higher) planned cash support requested from the Department of Health. The cash management plan includes robust collection of outstanding debt, targeted management and prioritisation of creditor settlements (to minimise disruption to care delivery) and controlled slippage of the capital programme.

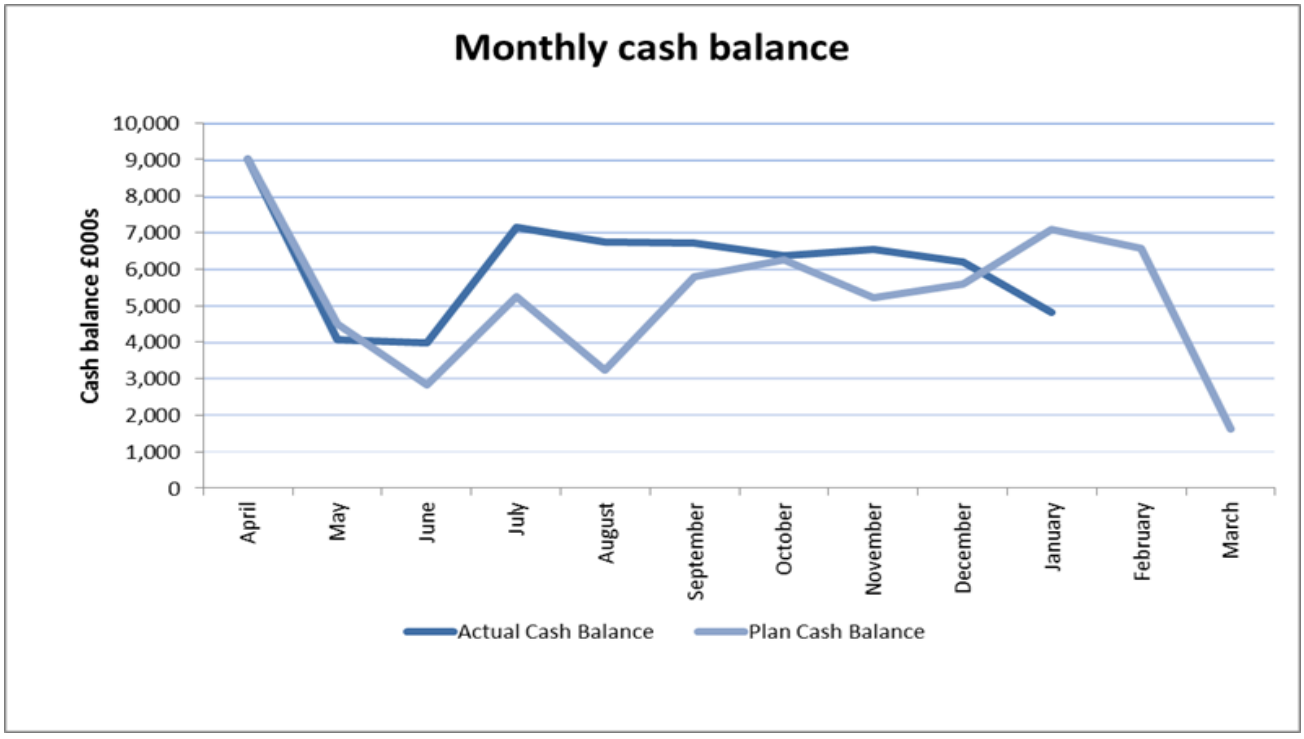
Payables: Delays in receiving cash support and increase in debtors (see above) have impacted adversely on creditors. Other increases are due to the month 9 agreement of balances exercise which tends to distort the underlying creditors. This is because the exercise to validate existing invoices and add missing invoices delays payment of NHS invoices.

Borrowings: Borrowings are £4.6m greater than planned due to a combination of factors; the working capital support accessed to date of £15m compensated by £8.3m relating to the maternity project not yet accessed. The working capital support was expected to be paid off by PDC funding which would be assessed on application, which is why PDC year to date is lower than planned. We have been instructed that planned support will no longer be repaid via PDC but will be available via a loan product. This means that PDC and borrowing will be at variance to the plan for this financial year.

The table below is the statement of financial position for the period up to month 10

			Year to Date	Year to Date
	As at 1 April 2015 £000	Plan 31 March 2015 £000	Plan YTD 31 Jan 2016 £000	As at 31 Jan 2016 £000	Variance YTD 31 Jan 2016 £000
Property, plant and equipment	194,918	211,762	203,547	191,698	11,849
Intangible assets	4,481	2,891	3,168	4,238	(1,070)
Trade and other receivables	757	533	755	775	(20)
Total Non Current Assets	**200,156**	**215,186**	**207,470**	**196,711**	**10,759**
Inventories	1,427	1,356	1,456	1,699	(243)
Trade and other receivables	19,223	22,224	19,185	22,371	(3,186)
Cash and cash equivalents	1,347	1,619	7,098	4,801	2,297
Total Current Assets	**21,997**	**25,199**	**27,739**	**28,871**	**(1,132)**
Total Assets	**222,153**	**240,385**	**235,209**	**225,582**	**9,627**
Trade and other payables	38,847	39,551	33,077	42,250	(9,173)
Borrowings	1,809	255	355	82	273
Provisions	1,380	723	422	869	(447)
Total Current Liabilities	**42,036**	**40,529**	**33,854**	**43,201**	**(9,347)**
Net Current Assets (Liabilities)	**(20,039)**	**(15,330)**	**34,276**	**44,070**	**(9,794)**
Total Assets less Current Liabilities	**180,117**	**199,856**	**201,355**	**182,381**	**18,974**
Borrowings	34,950	43,993	44,247	49,848	(5,601)
Provisions	1,952	1,697	1,952	1,908	44
Total Non Current Liabilities	**36,902**	**45,690**	**46,199**	**51,756**	**(5,557)**
Total Assets Employed	**143,215**	**154,166**	**155,156**	**130,625**	**24,531**
Public dividend capital	62,377	86,277	86,277	62,377	23,900
Retained earnings	6,187	(10,120)	(5,523)	(6,150)	627
Revaluation reserve	74,651	78,009	74,402	74,398	4
Total Taxpayers' Equity	**143,215**	**154,166**	**155,156**	**130,625**	**24,531**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	

The graph below illustrates the cash trajectory for 2015/16 and accounts for the receipt of deficit loan support



Finance overview | Cost improvement programmes

In month 10 savings amounting to £1.16m (65%) were delivered against the plan of £1.8m. Year to date, £10.2m (78%) has been achieved.

January's CIP performance was 65%, £1.16m delivered against a plan of £1.78m. YTD, the Trust has delivered 78% of its planned savings (£9m).

Against savings schemes allocated to ICSUs and divisions (PMO schemes), January's performance was 95% and YTD it is 109%. £659k under performance in ICSUs is offset by £1.4m over performance derived by a one off Estates benefit in Month 6 which resulted in reduced expenditure.

The Women's Services ICSU achieved just 59% of it planned January saving due to excessive temporary staffing expenditure within midwifery. The Clinical Support Services ICSU's accumulated slippage has grown to £232k.

The Trust delivered £200k of its planned £673k central savings which are aimed at reducing temporary staffing expenditure across the organisation, and recovering from accumulated over-spends.

Financial control across most ICSU areas was robust during month 10 with a collective expenditure reduction of c.£500k compared to month 9. However, Surgery and Women's Services ICSUs overspent against their allocated budgets in January and the Trust again failed to achieve its 6% registered nursing agency target.

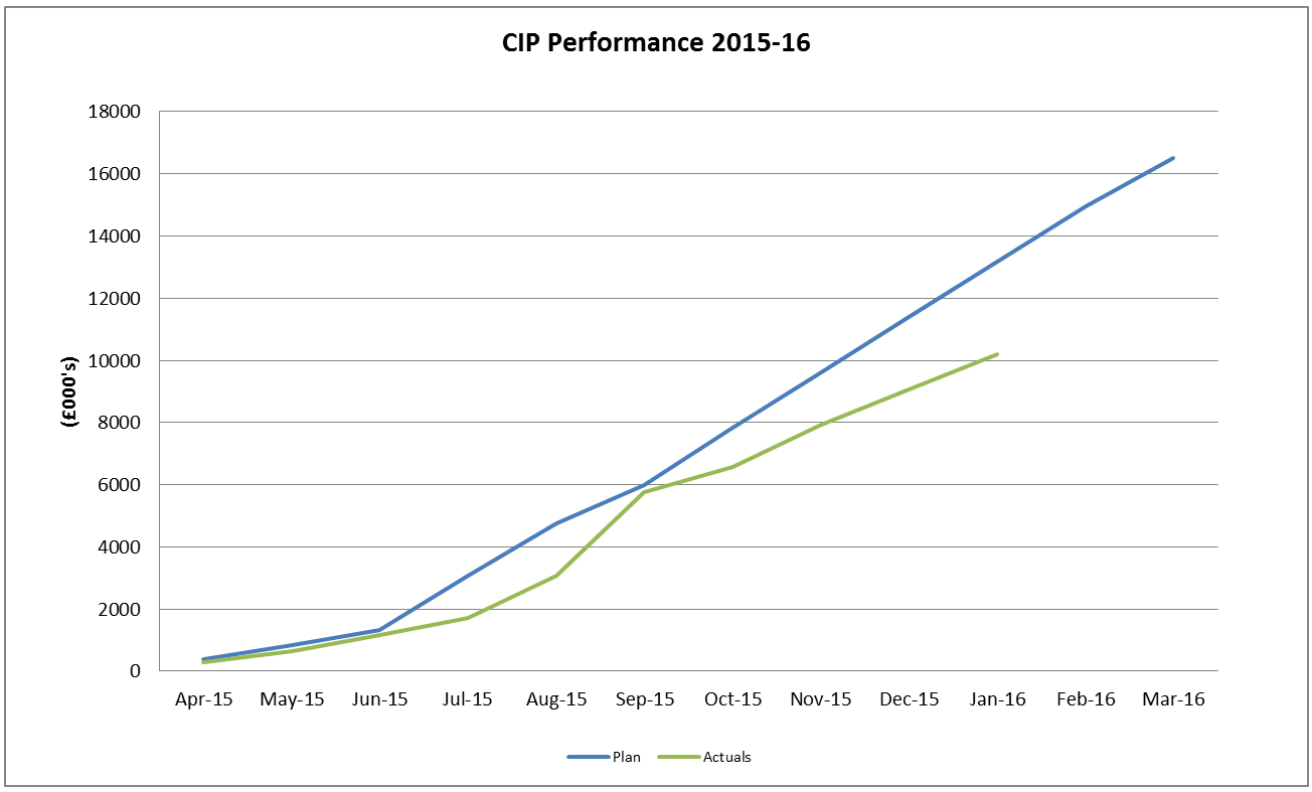
Procurement related savings of £32k were recognised in Month 10 and it is more than likely that the annual target will not be achieved.

The Trust CIP plan assumed savings of £3.3m would be delivered in February and March 2016 to support achievement of the income and expenditure plan. In order to meet the planned deficit, the Trust must:

- continue delivering existing saving schemes - at least matching the current CIP run rate;
- minimise additional budgetary overspends;
- control 'influenceable' spend for areas such as temporary staff usage

Below is the summary CIP performance table and graphic up to month 10

	Annual	January				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	1,413	132	203	154%	71	1,148	1,056	92%	(92)
Surgical Services	1,557	144	130	90%	(14)	1,269	1,173	92%	(96)
Emergency and Urgent Care	490	43	34	80%	(9)	404	306	76%	(98)
Women's Services	995	107	64	59%	(44)	780	622	80%	(159)
Children's Services	1,362	128	128	99%	(1)	1,105	1,092	99%	(14)
Clinical Support Services	635	52	29	55%	(24)	530	298	56%	(232)
OP and Long Term Conditions Services	673	88	88	100%	(0)	496	528	106%	32
Corporate Services	2,891	277	249	90%	(27)	2,237	3,587	160%	1,350
Peformance against PMO schemes	**10,016**	**972**	**924**	**95%**	**(48)**	**7,970**	**8,661**	**109%**	**691**
Trust-wide Schemes									
Procurement	935	134	32	24%	(102)	668	318	48%	(350)
Trust-wide Schemes	5,550	673	200	30%	(473)	4,537	1,233	27%	(3,304)
Performance against Operating Plan	**16,500**	**1,778**	**1,156**	**65%**	**(622)**	**13,174**	**10,212**	**78%**	**(2,962)**


CIP Performance 2015-16
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
(£000's)
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Plan
Actuals

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

Whittington Health Trust Board
2nd March 2016

Title:	Trust Board Report March 2016 (January 16 data)		
Agenda item:	**16/037**	**Paper**	**6**
Action requested:	To note performance of the Trust for January 2016		
Executive Summary:	**PATIENT SAFETY AND EXPERIENCE** The response to complaints within 25 days has improved slightly to 78%. There were no new bacteraemia identified during this period. **ACCESS** Achieved the target for Incomplete Referral to Treatment. Within the hospital, clinic cancellations for first appointments and follow up appointments achieved target. Overall Did Not Attend figures continue to improve to enable achieving our target. Theatre Utilisation is improving and an extensive plan is in place to continue to improvements. The cancer targets for 14 days and breast symptomatic are under achieving. The overall 14 days target plan is to achieve all standards for the year to date and this remains on track to deliver. In the community, overall service cancellations and DNAs continue to achieve their target. Appointments with no outcomes have gone up slightly to 1.9% The MSK service is under achieving against its target as demand for the service continues to increase. Discussions are taking place on how to continue service delivery within the existing specifications Islington Intermediate Care Services are under achieving and the implementation of a programme to reduce long waiters is underway which is improving performance. The plan that was agreed with commissioners to achieve targets in April 2016 is on track to deliver. GUM targets have been achieved for the last 2 months. The Podiatry Service has reduced 25% of staff in the last few months		

	due to natural progression of career development. A recruitment and retention drive is in progress and new staff are expected to be in place by May 2016 which will improve performance in 2016/17 **EMERGENCY AND URGENT CARE** Whittington Health and Islington CCG have agreed an action plan and improvement trajectory to address the causes of recent under performance. The actions outlined below will deliver a steady and sustainable recovery, reaching the required 95% standard at the end of April 2016.
Summary of recommendations:	That the board notes the performance.
Fit with WH strategy:	All five strategic aims
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	25th February 2016

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Acting Chief Operating Officer**	
Date paper seen by EC	**1 Mar**	**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Mar 2015 Trust Board Report (Jan data)

Whittington Health NHS

Quality	Threshold	Nov-15	Dec-15	Jan-16
Number of Inpatient Deaths	-	34	35	39
NHS number completion in SUS (OP & IP)	99%	98.8%	98.4%	arrears
NHS number completion in A&E data set	95%	94.7%	93.4%	arrears

Quality (Mortality index)	Threshold	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15
SHMI	-	0.66	0.67	0.66

Quality (Mortality index)	Threshold	Aug-15	Sep-15	Oct-15
Hospital Standardised Mortality Ratio (HSMR)	<100	80.4	84.0	72.7
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	146.9	14.9	55.8
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	58.7	103.1	78.2

Patient Safety	Threshold	Nov-15	Dec-15	Jan-16
Harm Free Care	95%	93.2%	93.2%	93.7%
VTE Risk assessment	95%	95.5%	94.6%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	35.0%	38.1%	46.7%
Serious Incident reports	-	6	7	4

Access Standards

Referral to Treatment (in arrears)	Threshold	Oct-15	Nov-15	Dec-15
Diagnostic Waits	99%	99.6%	99.6%	98.4%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Nov-15	Dec-15	Jan-16
Service Cancellations - Community	8%	6.5%	6.6%	7.0%
DNA Rates - Community	10%	6.3%	6.4%	6.3%
Community Face to Face Contacts	-	60,139	54,482	58,882
Community Appts with no outcome	0.5%	1.5%	0.7%	1.9%

Community Access Standards	Threshold	Nov-15	Dec-15	Jan-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	59.5%	61.4%	51.0%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	98.4%	100.0%	arrears
IAPT - patients moving to recovery	50%	49.5%	49.4%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	92.6%	94.9%	arrears
GUM - Appointment within 2 days	100%	85.9%	85.9%	98.1%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Nov-15	Dec-15	Jan-16
First:Follow-up ratio - acute	2.31	1.45	1.44	1.56
Theatre Utilisation	92%	82.2%	79.5%	81.9%
Hospital Cancellations - acute - First Appointments	8%	5.3%	5.9%	5.8%
Hospital Cancellations - acute - Follow-up Appointments	8%	7.7%	8.3%	7.9%
DNA rates - acute - First appointments	10%	12.7%	11.5%	11.9%
DNA rates - acute - Follow-up appts	10%	14.1%	13.3%	12.0%
Hospital Cancelled Operations	0	1	1	16
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	1	0

Meeting threshold

Failed threshold

Mar 2015 Trust Board Report (Jan data)

Whittington Health NHS

Patient Experience	Threshold	Nov-15	Dec-15	Jan-16
Patient Satisfaction - Inpatient FFT (% recommendation)	-	96%	96%	96%
Patient Satisfaction - ED FFT (% recommendation)	-	95%	93%	94%
Patient Satisfaction - Maternity FFT (% recommendation)	-	95%	94%	95%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	22	22	23
Complaints responded to within 25 working day	80%	63%	78%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Emergency and Urgent Care	Threshold	Nov-15	Dec-15	Jan-16
Emergency Department waits (4 hrs wait)	95%	92.5%	91.5%	84.6%
ED Indicator - median wait for treatment (minutes)	<60	73	81	84
30 day Emergency readmissions	-	187	172	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	2.3%	2.7%	2.8%
Ambulance Handover (within 30 minutes)	0	3	5	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Nov-15	Dec-15	Jan-16
Hospital acquired MRSA infection	0	0	0	0
Hospital acquired *C difficile* Infections	17 (15/16)	0	1	0
Hospital acquired *E. coli* Infections	-	0	0	0
Hospital acquired MSSA Infections	-	0	3	0
Ward Cleanliness	-	98%	98%	99%

Cancer Access Standards (in arrears)	Threshold	Oct-15	Nov-15	Dec-15
Cancer - 14 days to first seen	93%	91.4%	89.9%	88.0%
Cancer - 14 days to first seen - breast symptomatic	93%	90.1%	87.4%	90.8%
Cancer - 31 days to first treatment	96%	100.0%	96.8%	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%	80.6%	88.4%	91.7%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Nov-15	Dec-15	Jan-16
Referral to Treatment 18 weeks - Admitted	90%	77.6%	84.2%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	91.6%	92.4%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	92.3%	92.1%	arrears

Maternity	Threshold	Nov-15	Dec-15	Jan-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.5%	81.9%	81.9%
New Birth Visits - Haringey	95%	84.7%	80.8%	arrears
New Birth Visits - Islington	95%	95.0%	91.5%	arrears
Elective Caesarean Section rate	14.8%	10.2%	11.9%	12.0%
Breastfeeding initiated	90%	90.1%	86.8%	92.9%
Smoking at Delivery	<6%	4.0%	5.9%	3.0%

Meeting threshold

Failed threshold

	Threshold	Trust Actual		
		Nov-15	Dec-15	Jan-16
Number of Inpatient Deaths	-	34	35	39
Completion of a valid NHS number in SUS (OP & IP)	99%	98.8%	98.4%	arrears
Completion of a valid NHS number in A&E data sets	95%	94.7%	93.4%	arrears

	Standardised National Average	Trust		
		Aug-15	Sep-15	Oct-15
Hospital Standardised Mortality Ratio	<100	80.4	84.0	72.7
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	146.9	14.9	55.8
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	58.7	103.1	78.2

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Jul 2014 - Jun 2015	0.89	1.12	0.66
	Apr 2014 - Mar 2015	0.89	1.12	0.67
	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

Commentary

Completion of NHS number A&E data set

Issue: Below target

Action: Data audits have found a large number of non-registered and overseas patients in the November and December 2015 data. We are pro-actively working on sending out information to all non-registered patients on now 'How to register with their local GPs' and to update us once this information is available to them.

Timeframe: Current validation on track and should be achieving target for February data.

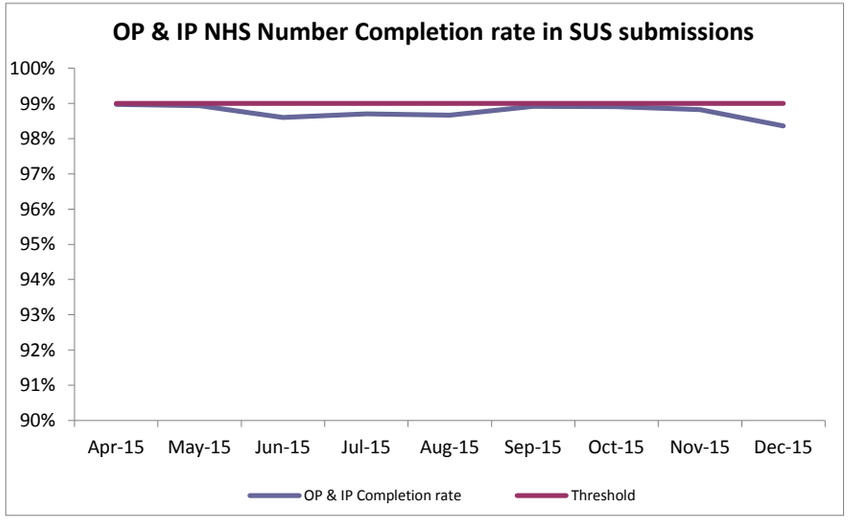
SHMI and HMSR

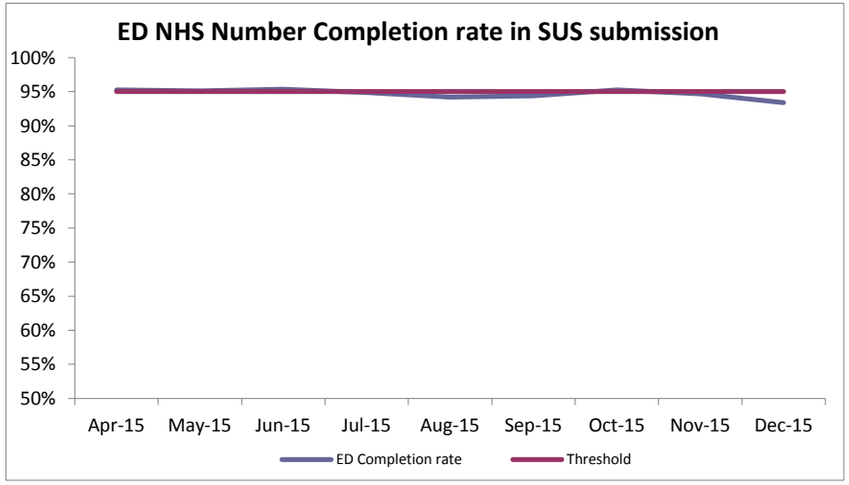
The above metrics are a ration of observed to expected death

Whittington Health mortality is consistently below the level that is expected for the hospital.

The two different metric employ slightly different methodologies, so result in different values.

Weekend vs weekend mortality rate show extreme variability, because on a monthly basis the numbers are low. No inference can be made from this data.



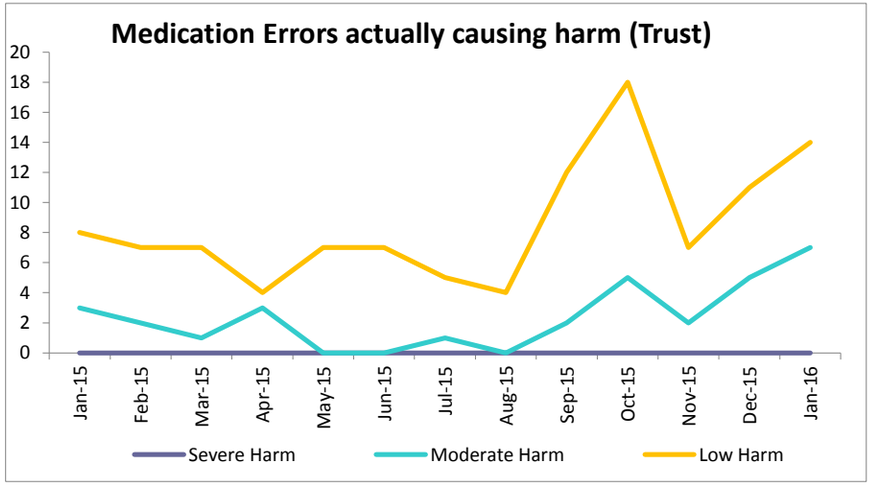


Patient Safety

Whittington Health NHS

Data extracted on 09/02/2016

	Threshold	Trust Actual Oct-15	Nov-15	Dec-15	Jan-15	Trend
Harm Free Care	95%	94.7%	93.2%	93.2%	93.7%	
Pressure Ulcers (prevalence)	-	4.65%	5.78%	5.65%	5.64%	
Falls (audit)	-	0.19%	0.56%	0.88%	0.18%	
VTE Risk assessment	95%	95.7%	95.5%	94.6%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	5	2	5	7	
Medication Errors actually causing **Low** Harm	-	18	7	11	14	
Never Events	0	0	0	0	0	
Open CAS Alerts (Central Alerting System)	-	0	0	0	0	
Proportion of reported patient safety incidents that are harmful	-	40.6%	35.0%	38.1%	46.7%	
Serious Incidents (Trust Total)	-	4	6	7	4	



ICSU	Number of SI's reported
WFS	3
MFNS	1

Commentary

Harm Free Care and Pressure Ulcer prevalence

Harm Free Care and the figure for prevalence of pressure ulcers include non-avoidable pressure ulcers. It remains just below target at 93%.

Falls (audit)

Issue: Falls are increasing with most falls within the Care of the Elderly Services. A cluster of falls on the wards have been identified and are investigated using the Serious Incidence framework.
Action: The Falls Group has been tasked to over arching issues and learning to be shared within the trust.
Timescale: Feedback in March 15

VTE

Issue: VTE under target and underachieving areas identified by ICSU and ward. Both Surgery and EUC ICSU score below target for the overall ICUS score.
Action: VTE assessment completion is monitored for all areas.

Medication errors causing harm in December 2015

The number of medication incidents reported for January (57) remains high, compared with early 2015 - 1st quarter mean = 36.
There are no incidents recorded as causing high harm, seven recorded as causing moderate harm and 14 low harm. Sixteen (28%) incidents were reported by community staff. Ten (18%) incidents were reported by medical staff. The ICSU with the highest number of reports was Emergency and Urgent Care (E&UC) - who reported 18 (32%) medication incidents. All the medication incidents reported by MF&NS occurred on Victoria ward.

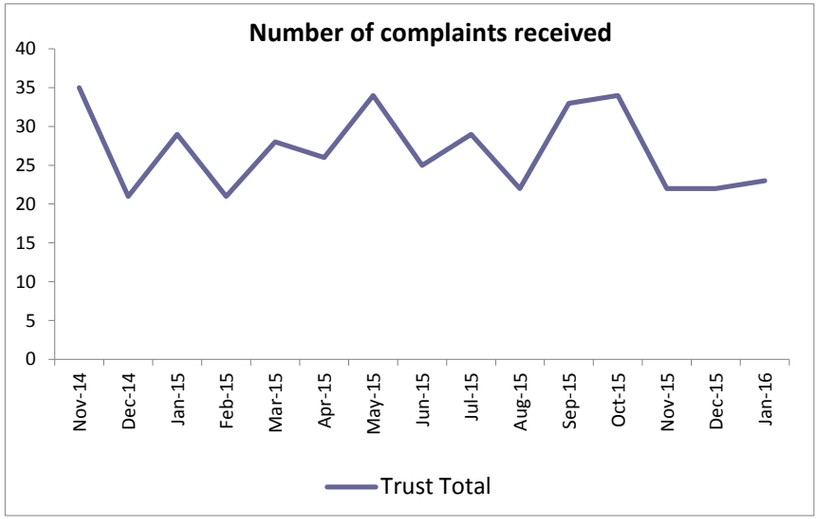
Serious Incidents

Whittington Health declared 4 SIs in January 2016. Including, pressure ulcers cluster on Victoria Ward, delayed diagnosis, maternal death and an unexpected admission to NICU. All identified learning form these incidents has been shared with the Services.

Patient Experience

Whittington Health NHS

	Threshold	Trust Actual Oct-15	Nov-15	Dec-15	Jan-16	Trend
Patient Satisfaction - Inpatient FFT (% recommendation)	-	96%	96%	96%	96%	
Patient Satisfaction - Emergency Department FFT (% recommendation)	-	93%	95%	93%	94%	
Patient Satisfaction - Maternity FFT (% recommendation)	-	96%	95%	94%	95%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	34	22	22	23	
Complaints responded to within 25 working day	80%	66%	63%	78%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	



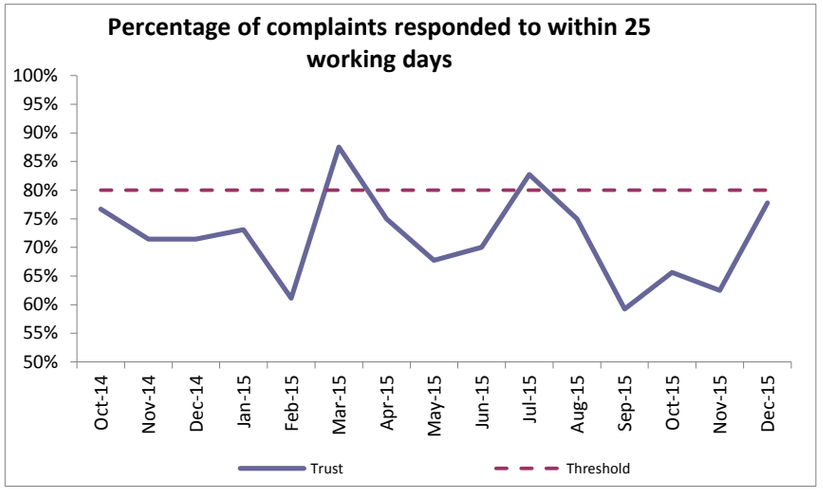
Commentary

Patient Satisfaction - a local standard of 90% has been agreed, overall standard achieved.
Action: continue to raise awareness and role out into community and OPD . Under achieving areas now identified through the Meridian system.
Timescale: On-going

Mixed Sex Accommodation
Achieved

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.
Timescale: Stepped improvement expected over the next months

ICSU	Number of complaints	Percentage completed in 25 days
WHS	0	100%
OPTLC	2	100%
Surgery	5	75%
EUC	6	75%
CS	1	0%
MFNS	4	75%
CSS	0	100%



Infection Prevention

Whittington Health NHS

	Threshold	Trust Actual Oct-15	Nov-15	Dec-15	Jan-16	Trend
MRSA	0	0	0	0	0	
E. coli Infections*	-	0	0	0	0	
MSSA Infections	-	0	0	3	0	

	Threshold	Oct 15	Nov 15	Dec 15	Jan 16	2015/16 Trust YTD
C difficile Infections	17 (Year)	1	0	1	0	7

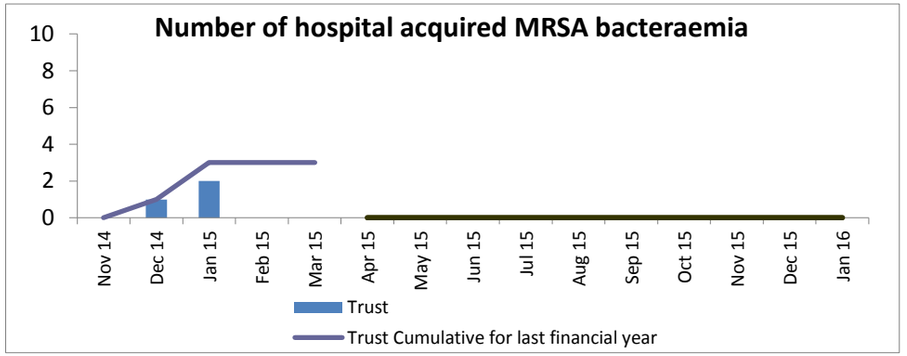
* E. coli infections are not specified by ward or division

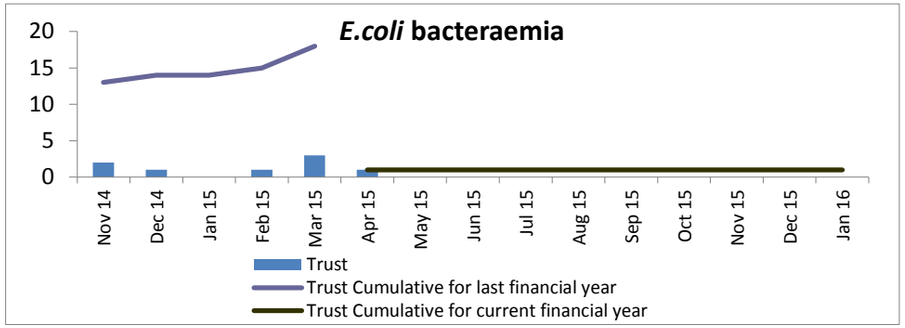
Ward Cleanliness

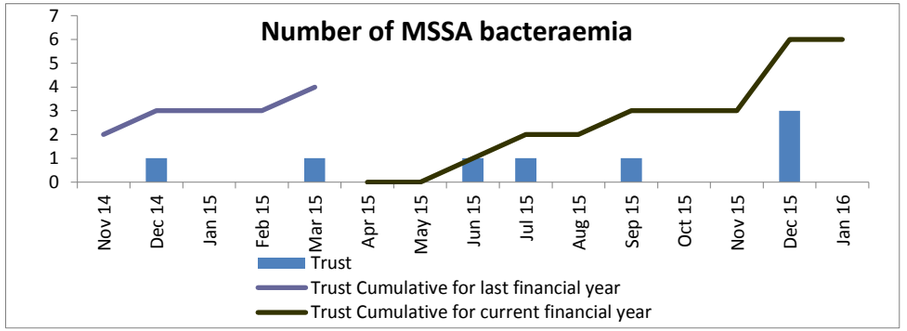
Audit period	Trust 14/04/15 to 01/05/15	15/06/15 to 10/07/15	01/09/15 to 30/09/15	05/10/15 to 03/11/15	22/12/15 to 31/01/15	Trend
Trust %	98.4%	97.9%	97.7%	97.8%	98.6%	

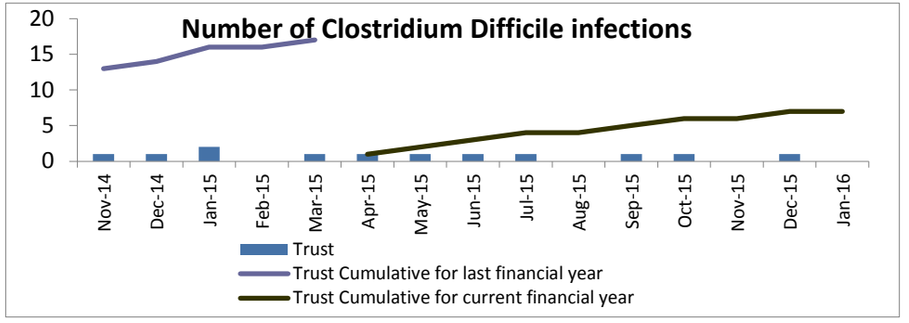
Commentary

No new bacteraemia





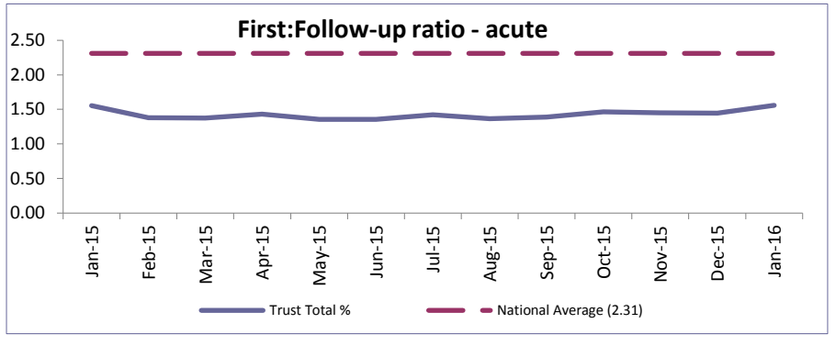


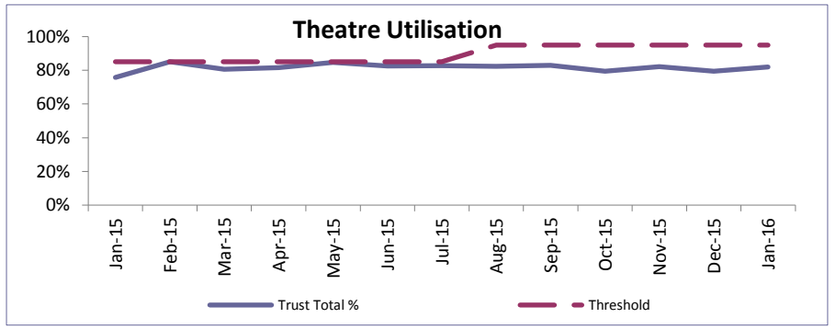


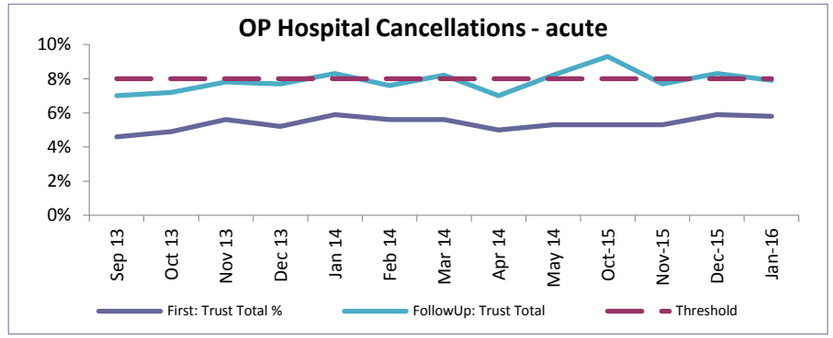
Efficiency and productivity - acute

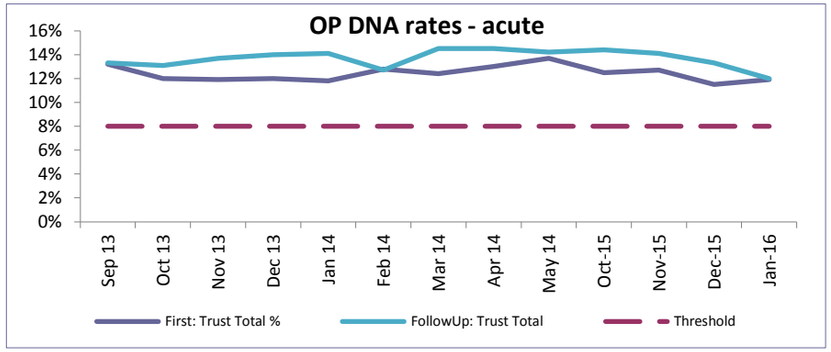
Whittington Health NHS

	Trust						
	Threshold	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Trend
First:Follow-up ratio - acute	2.31	1.39	1.46	1.45	1.44	1.56	
Theatre Utilisation	92%	82.9%	79.5%	82.2%	79.5%	81.9%	
Hospital Cancellations - acute - First Appointments	<8%	5.3%	5.3%	5.3%	5.9%	5.8%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	8.2%	9.3%	7.7%	8.3%	7.9%	
DNA rates - acute - First appointments	10%	13.7%	12.5%	12.7%	11.5%	11.9%	
DNA rates - acute - Follow-up appointments	10%	14.2%	14.4%	14.1%	13.3%	12.0%	
Hospital Cancelled Operations	0	16	6	1	1	16	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	4	3	0	1	0	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	









Commentary

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

Theatre Utilisation Check after Surgery meeting
Issue : stretch threshold of 95% has not been achieved. Slightly improvement.
Action: Ongoing work to improve utility

Hospital Cancellations - acute
Overall achieved for first appointments and just above target for follow up appointments.

Did not attend
Issue: Overall 'Did not attend ' shows improvement.
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment. EPR now aligned with the service Netcall and set up to identify underperforming areas, including missing telephone numbers.
Timescale: Stepped improvement to be seen over the next coming months.

Hospital Cancelled Operations
Issue: There were 16 reportable cancelled operation. Six because overrunning of the list, 4 cancellation by surgeon, 3 because there was no bed available, 2 incorrect patient bookings and 1 equipment not available.
Action: The Surgical board monitor cancellations.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Trend
Service Cancellations - Community	8%	7.7%	6.5%	6.6%	7.0%	
DNA Rates - Community	10%	6.1%	6.3%	6.4%	6.3%	
Community Face to Face Contacts	-	58,863	60,139	54,482	58,882	
Community Appointment with no outcome	0.5%	5.8%	1.5%	0.7%	1.9%	

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

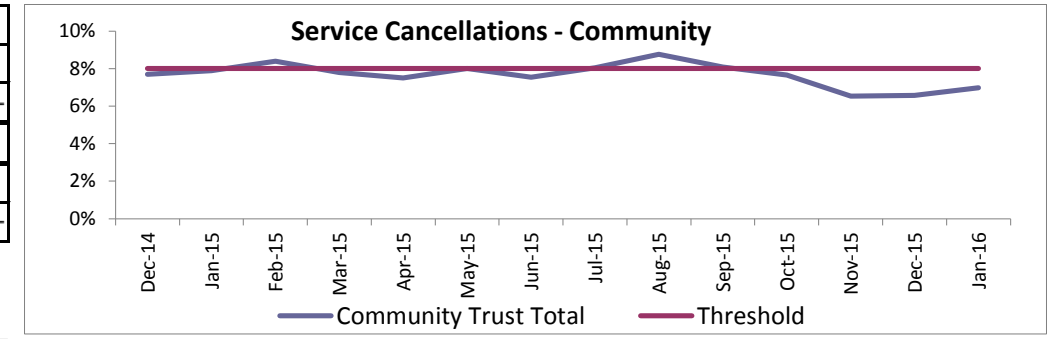
Commentary

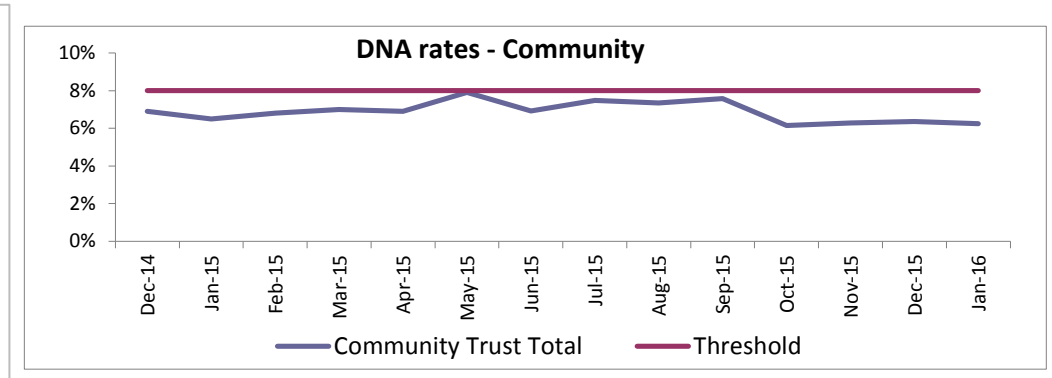
Service Cancellations - Community
Achieved

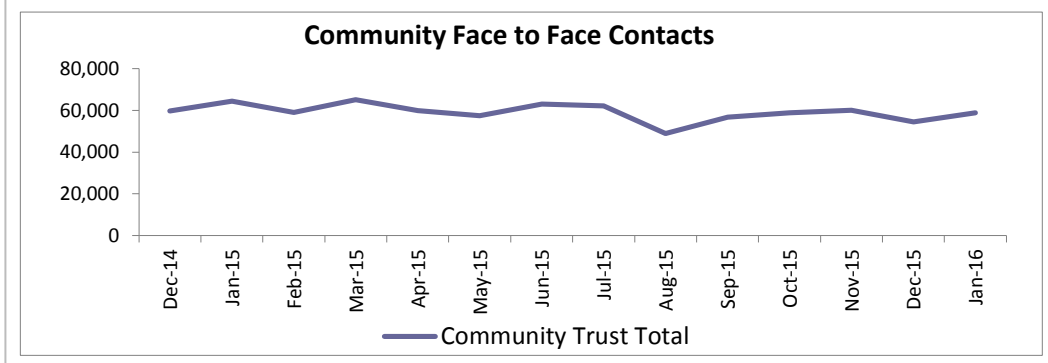
DNA Rates - Community
Achieved.

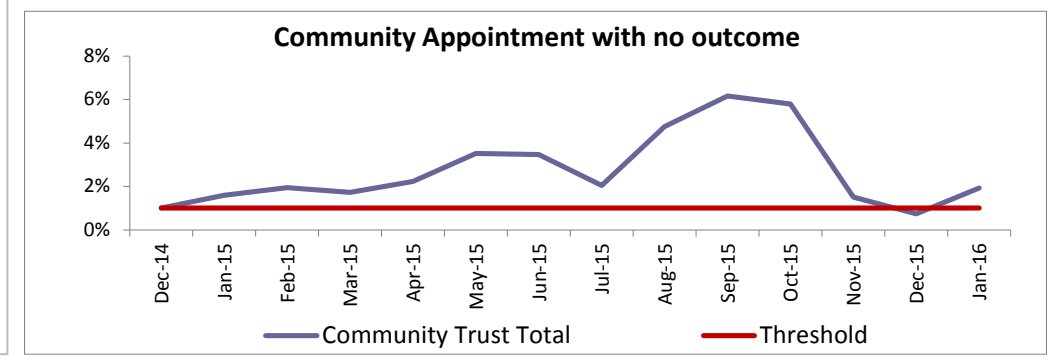
Community Face to Face Contacts
All services are monitored against activity targets.

Community Appointment with no outcome
Action: Monitor to ensure the new processes are embedded.
Timescale: Immediately.

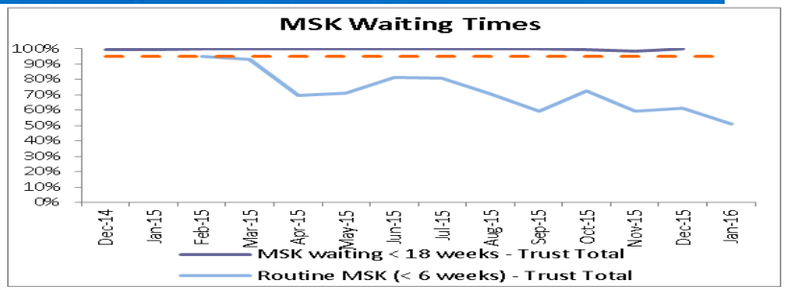








	Threshold	Trust Actual Nov-15	Trust Actual Dec-15	Trust Actual Jan-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	61.1%	75.0%	80.0%	66.7%
District Nursing Wait Time - 2hrs assess (Haringey)	-	85.7%	83.3%	93.3%	86.7%
District Nursing Wait Time - 48hrs for visit (Islington)	-	97.5%	96.3%	96.4%	95.3%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	98.6%	95.4%	97.7%	96.2%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	59.5%	61.4%	51.0%	67.9%
MSK Waiting Times - Consultant led (<18 weeks)	95%	98.4%	100.0%	arrears	99.8%
IAPT - patients moving to recovery	50%	49.5%	49.4%	arrears	51.0%
GUM - Appointment within 2 days	98%	96.8%	99.0%	98.1%	96.4%
Haringey Adults Community Rehabilitation (<6weeks)	85%	89.7%	89.1%	84.2%	80.8%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	73.1%	70.2%	51.6%	68.4%
Islington Community Rehabilitation (<12 weeks)	-	87.3%	78.6%	78.2%	82.0%
Islington Intermediate Care (<6 weeks)	85%	57.6%	50.3%	50.2%	56.5%
Islington Podiatry (Foot Health) (<6 weeks)	-	87.7%	83.2%	66.6%	72.2%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	92.6%	96.0%	arrears	94.0%
Death in place of choice	90%	73%	59%	61%	
Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams)	8	8	8	8	
Number of DN teams completing a monthly caseload review of timely discharge (eight teams)	8	8	8	8	



Commentary

District Nursing

Improvement seen in both 2 and 48 hours targets. The data above shown is un-triaged referrals.

Issue: Continued manual triaging of urgency for 2hr referrals and true urgent referrals are still phoned through to the Service and seen within 2 hours.

Action: The RiO report capturing this data is monitored and will be reviewed.

Timescale: Improvements seen and expected to continue.

Death in place of choice

Issue: Most patients on the DN caseload die within the preferred place. Data is complicated to capture correctly as patient might change their mind towards the end of life.

Action: working with the Palliative Care service to capture data correctly from the paper notes.

Timescale: ongoing

Podiatry

Issue: The podiatry Service has lost 25% of the staff in the last months. It is due to natural progression of career development.

Action: A recruitment drive is in progress.

Timescale: New staff to be in place in May 2016 and targets expected to improve from then.

GUM

Achieved target. Last months' figure corrected.

IAPT

IAPT scores just below target.

Issue: January result for Whittington health IAPT = 50%.

However Haringey borough wide % reported to NHS England for January = 47.2 % due to low recovery rate from another provider commissioned by CCG (Nafsiyat Intercultural Therapy Centre).

Action: Whittington IAPT and the CCG will be working with these providers to improve their outcomes to the standard of Whittington Team.

Timescale: Working with the CCG over the coming year to improve target.

MSK

Issue: Capacity and demand. The percentage is expected to continue to decrease. Whilst new initiatives and quick fixes continue to be used they are short term remedies.

Action: Increased funding to meet the demand or a review and possible reduction in service provision and the acceptance criteria, including self-referrals.

The service remains on the risk register

Timescale: Continues review to maximise efficiency and piloting new initiatives.

Islington Intermediate Care

Issue: Significant capacity issues identified. A large scale clear up of long delays in preparation for winter in place and this has impacted on the 6 week target. Gaps in rotation , sickness and vacancy which has also impacted on performance.

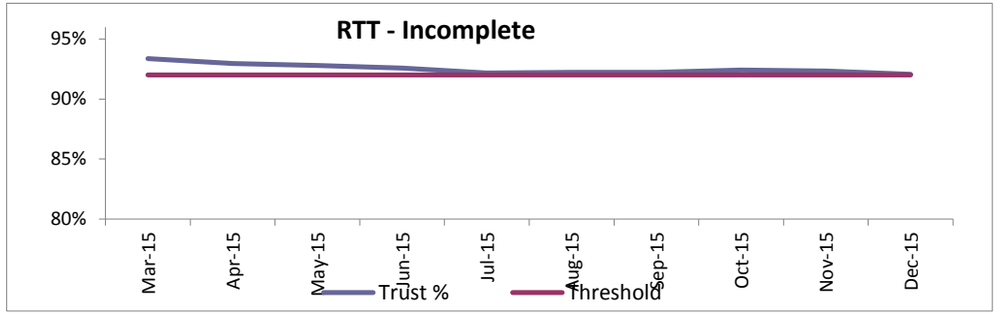
Action: Capacity issue being resolved. Commissioners have agreed to fund extra resource to improve overall capacity with an expectation of being compliant with KPI from April 2016. Additional staff have started in January.

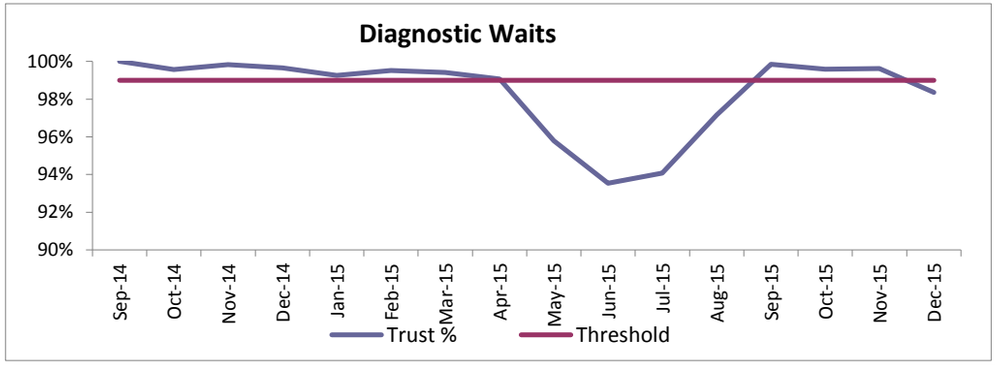
Timescale: On plan for January 16. Compliant from April 2016

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

	Trust				
	Threshold	Oct-15	Nov-15	Dec-15	Trend
Referral to Treatment 18 weeks - Admitted	90%	76.6%	77.6%	84.2%	
Referral to Treatment 18 weeks - Non-admitted	95%	92.8%	91.6%	92.4%	
Referral to Treatment 18 weeks - Incomplete	92%	92.4%	92.3%	92.1%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	99.6%	99.6%	98.4%	





Commentary

RTT
National KPI for 18 weeks incomplete achieved.
Issues: 18 weeks admitted and non-admitted data reported above is un-validated.
Action: Focus on Incomplete RTT data will improve the Admitted and non-Admitted targets.
Timescale: Stepped improvement to be seen in the next months.

Diagnostic Waits
Just below target.
Issue: Audiology capacity due to sickness within the staff at St Ann's resulted in not achieving the target.
Action: This is now resolved
Timescale: Immediate and expected to be within target next month.

Waiting times - OPD appointment
Cardiology 10 Weeks, Dermatology 13 Weeks , Endocrine 9 Weeks, ENT 12 Weeks, Gastroenterology 10 Weeks, General Surgery 10 Weeks , Gynaecology 9 Weeks, Neurology 13 Weeks, Pain 24 Weeks, Rheumatology 8 Weeks, Thoracic Medicine 10 Weeks, T&O 9 weeks, Vascular 19 Weeks, Ophthalmology 9 weeks.

Diagnostic waiting times (radiology) all under 6 weeks (42 days) waiting time standard
See table to the right.

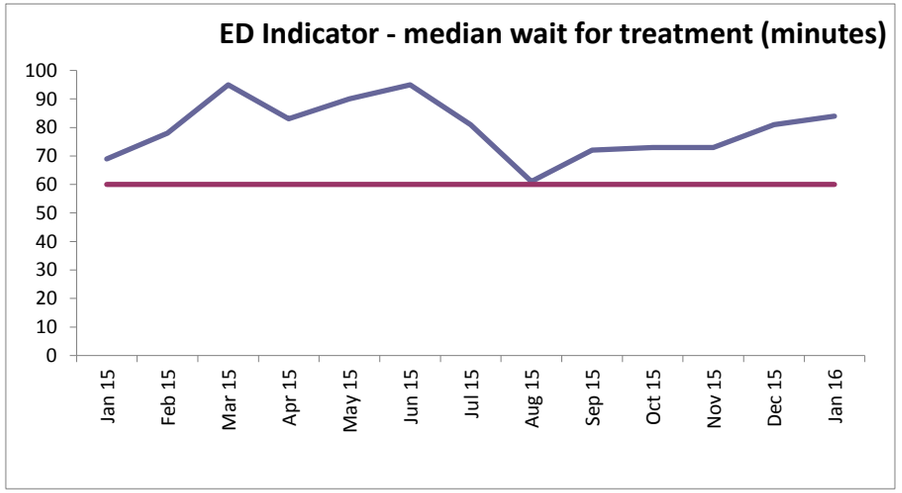
Imaging Waiting Times as of 12 January 2016

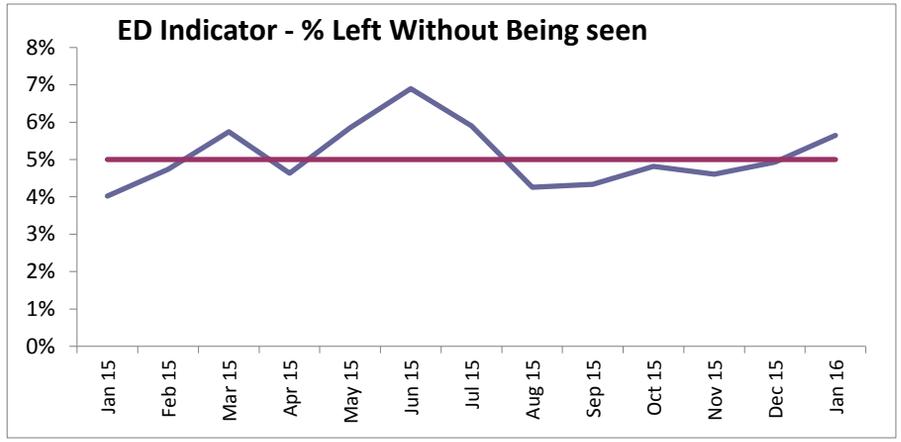
Modality	Today booking into	Waiting Time in Days
CT	26 January 2016	14
DEXA	27 January 2016	15
Fluoroscopy	09 February 2016	28
Mammography	29 January 2016	17
MRI	15 February 2016	34
Nuclear Medicine	18 January 2016	6
Ultrasound - Abdomen & Gynae at Hornsey	20 January 2016	8
Ultrasound - Dating - ANC	30 January 2016	18
Ultrasound - General (Radiologist Lead)	28 January 2016	16
Ultrasound - Gynae	19 January 2016	7
Ultrasound - Hernias	03 February 2016	22
Ultrasound - MSKs	02 February 2016	21
Ultrasound - Obstetrics - Anomaly	23 January 2016	11
Ultrasound - Obstetrics - Growth	26 January 2016	14
Ultrasound - Paediatrics	09 February 2016	28

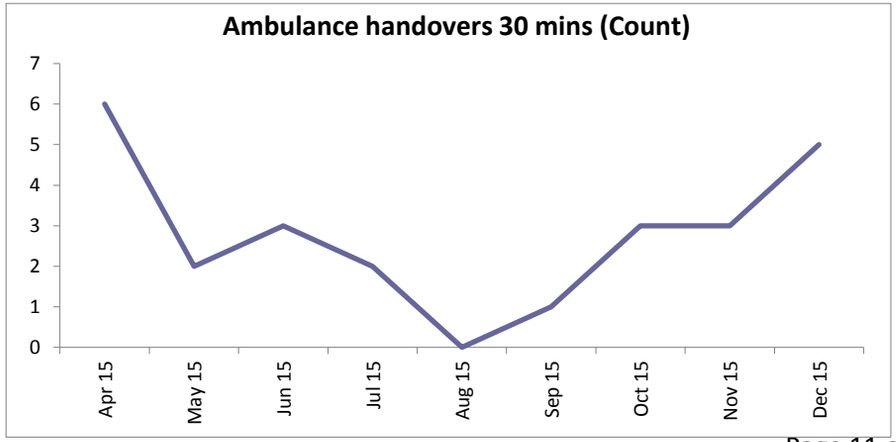
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Dec-15	Trust Actual Jan-16	2015/16 Trust YTD
Emergency Department waits (4 hrs wait)	95%	91.5%	84.6%	92.9%
Emergency Department waits (4 hrs wait) Paeds only	95%	95.6%	95.3%	96.7%
Wait for assessment (minutes - 95th percentile)	<=15	14	16	14
ED Indicator - median wait for treatment (minutes)	60	81	84	79
Total Time in ED (minutes - 95th percentile)	<=240	360	554	347
ED Indicator - % Left Without Being seen	<=5%	4.9%	5.7%	5.2%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	5	arrears	25
Ambulance handovers exceeding 60 minutes	0	0	arrears	0
Ambulatory Care (% diverted)	>5%	2.7%	2.8%	







Commentary

Whittington Health and Islington CCG have agreed an action plan and improvement trajectory to address the causes of recent poor performance. The action plan has immediate and short term actions.

Breach analysis indicates that bed availability (causing exit block) is the attributable to over half of reported four hour breaches. Additionally there are times when the department is unable to respond to surges in activity due to a lack of available decision makers at key times (late afternoon).

A self-assessment against the ECIST (emergency Care Intensive Support Team) best practice guide has been undertaken.

Progress against the plan will be monitored by the acting COO each week. Additionally progress against the plan will be discussed at the weekly teleconference with Islington CCG and monthly at the Islington System Resilience Group.

There is an expectation that the actions outlined below will assist the Whittington Health to deliver a steady and sustainable recovery, reaching the required 95% standard at the end of April 2016.

Cancer

Whittington Health NHS

	Threshold	Trust Oct-15	Trust Nov-15	Trust Dec-15	Trend	2015/16 Trust Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	91.4%	89.9%	88.0%		93.2%	92.5%	89.7%	-	91.7%
Cancer - 14 days to first seen - breast symptomatic	93%	90.1%	87.4%	90.8%		93.6%	91.7%	89.4%	-	91.6%
Cancer - 31 days to first treatment	96%	100.0%	96.8%	100.0%		100.0%	100.0%	99.0%	-	99.6%
Cancer - 31 days to subsequent treatment - surgery	94%	-	100.0%	100.0%		100.0%	100.0%	100.0%	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	-	100.0%
Cancer - 62 days from referral to treatment	85%	80.6%	88.4%	91.7%		93.2%	85.5%	87.8%	-	89.3%
Cancer - 62 days from consultant upgrade	-	50%	-	100%		92.9%	83.3%	60.0%	-	87.2%

Commentary

Please note Cancer data is always one month in areas

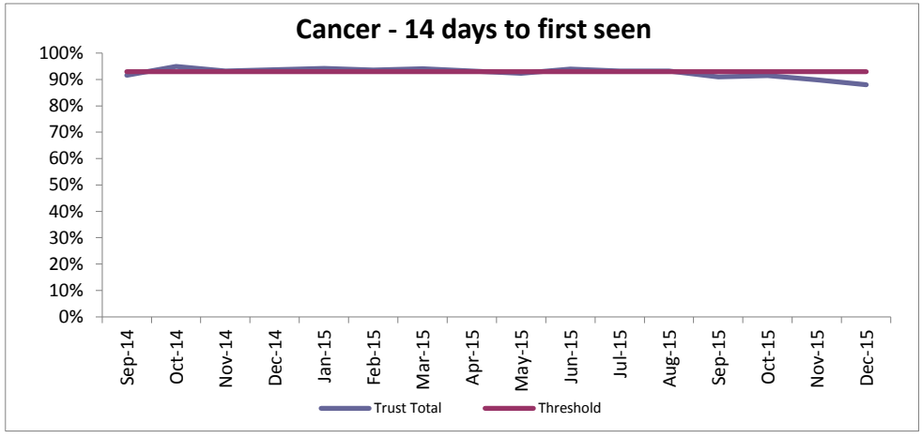
62 Day Target achieved for November and December (Dec Breaches 2.5 patients in Urology)

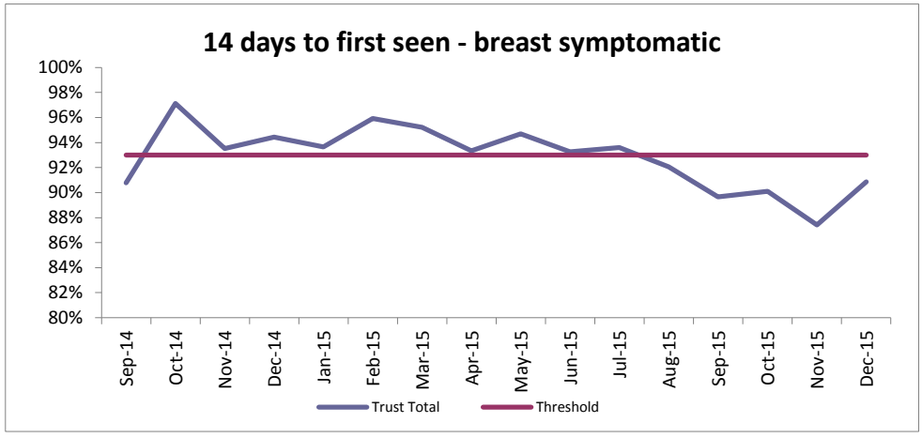
31 Day also achieved, error in Royal Free uploading a patient in November has been corrected - now compliant for Quarter 3

Cancer 14 days to first seen / Breast Symptomatic
Issue: Upper Gastro (21 out of 65 patients were not seen in time) and lower GI (16 out of 116) , Gynaecology (6 out of 80), Breast (9 out of 105), Breast Symptomatic (15 out of 155), Lung (1 out of 7), Skin (9 out of 142) and Urology 9 out of 62) did not meet the target of 93%.

Action: All waiting lists are scrutinised daily and staff have been retrained on Cancer access policy / Procedure
Twice weekly Cancer PTl meetings
MDT - issues highlighted weekly

Timescale: Forecasting to improve and meet target next month.

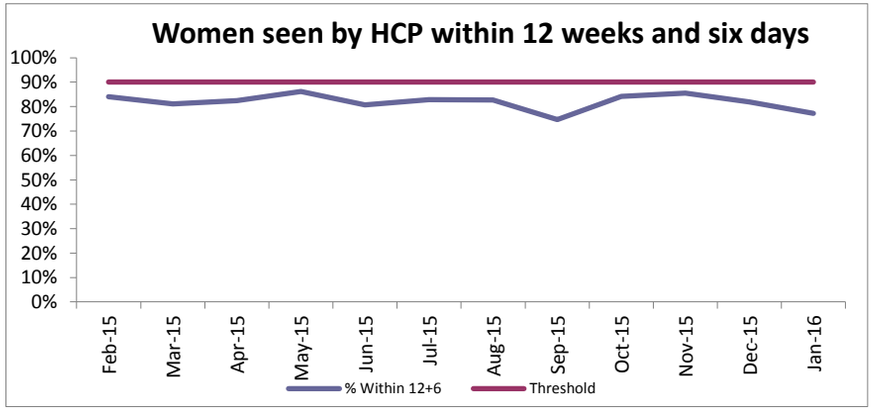


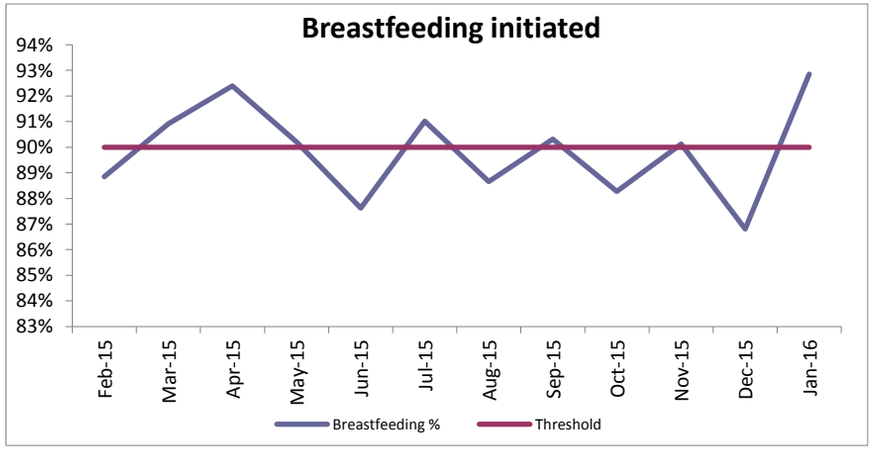


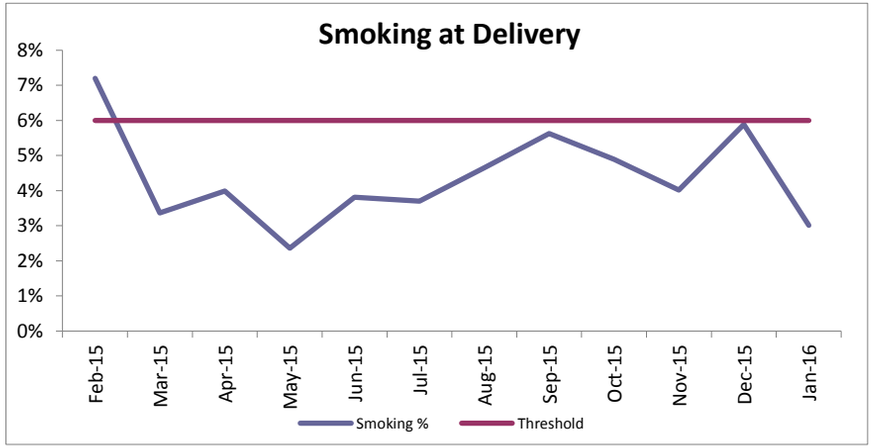
Maternity

Whittington Health NHS

	Threshold	Trust Actual Nov-15	Trust Actual Dec-15	Trust Actual Jan-16	2015/16 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	85.5%	81.9%	81.9%	82.3%
New Birth Visits - Haringey	95%	84.7%	80.8%	Arrears	87.5%
New Birth Visits - Islington	95%	95.0%	91.5%	Arrears	91.8%
Elective Caesarean Section rate	14.8%	10.2%	11.9%	12.0%	12.4%
Emergency Caesarean Section rate	-	21.0%	20.0%	20.0%	19.0%
Breastfeeding initiated	90%	90.1%	86.8%	92.9%	89.5%
Smoking at Delivery	<6%	4.0%	5.9%	3.0%	4.7%







Commentary

12+6
Issue: Remains just below target.
Action: Continued phoning of women who DNA appointments.
Timescale: Ongoing

New birth visits
Issue: Both below target
Action: Workforce plan in place to mitigate: HVs now receiving RRP - 4 HV candidates offered posts; skill mix recruitment almost completed - 12 nursery nurses and 10 staff nurses in process of starting.
Timescale: Ongoing

Elective Caesarean Section rate
Target achieved

Breast feeding initiated
Target achieved

Smoking at Delivery
Target achieved

Executive Offices
Direct Line: 020 7288 3939/5959
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

2 March 2016

Title:	**Local Supervising Authority (LSA) Annual Audit Report – Monitoring the Standards of Supervision and Midwifery**		
Agenda item:	**16/038**	**Paper**	**7**
Action requested:	The Trust Board is asked to note this report for assurance		
Executive Summary:	The London Local Supervising Authority conducted its annual audit of midwifery supervision in October 2015. The aim of the audit is to ensure that the supervisors of midwives at Whittington Health are fulfilling their role to protect the public ensuring that care provision is safe and evidence based. Overall the audit was successful achieving full compliance with two of the four required domains. An action plan has been developed in order to achieve full compliance. Progress against the action plan will be monitored through the supervisors and the Women's Health Service Clinical Governance Committee		
Summary of recommendations:	The recommendations are set out in the attached report and action plan. There is a particular recommendation with respect to increasing the home birth rate.		
Fit with WH strategy:	4.1 To secure the best possible health and wellbeing for all our community 4.3 To deliver consistently high quality services 4.4 To support our patients / users in being active partners in their care		
Reference to related / other documents:	Aligns with clinical strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers relevant to risk scoring		
Date paper completed:	January 2016		

Author name and title:		**Manjit Roseghini Head of Midwifery and Women`s Health / Supervisor of Midwives**		**Director name and title:**		**Philippa Davies – Director of Nursing**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice receive?**	

Whittington Health NHS

Report to Whittington Health Trust Board : Women's Children's and Families – 21st January 2016

Introduction:

The London Local Supervising Authority (LSA) conducted its annual audit of Supervision domains in 27th October 2015 at Whittington Health. The main responsibility of the LSA is to protect the public by monitoring the quality of midwifery practice through the mechanism of Statutory Supervision of Midwives. The aim of the audit is to ensure that Supervisors of Midwives are fulfilling their roles in meeting the domains required by the LSA to protect the public, ensuring that care provision is evidence based and safe.

In brief the four domains are:

Domain 1: Interface of Statutory Supervision of Midwives with Clinical Governance

Domain 2: The profile and effectiveness of Statutory Supervision

Domain 3: Teamwork, Leadership and development

Domain 4: Interface of Supervision with Service Users

Summary of feedback

The supervisory team at Whittington Health demonstrated great leadership and championed for women centred care by ensuring that maternity services met the needs of the women and proactively using range of methods and tailored their services to meet their identified needs. They have also maintained their extremely positive profile with the midwives of the service developing skills and offering support, which will again prove to beneficial to the women and families coming to Whittington Health. On the Audit day, Midwives, Student Midwives and users were verbally spoken to and very positive report from users because of the maternity services excellent.

Overall, the SoM team have had a very successful 2015 LSA audit, two of these Domains fully met and two that required improvement.

A full report has been circulated to the SOM team and also attached to this report. The SOM has set a date for the 20th April as an Away day to review the Audit cycle and to address and action as appropriate the Audit Recommendations. There is work in progress on the recommendations (see below).

A recommendation for all SOM teams in 2014 - 15:

Work with the LSA to “future proof” the leadership, support and advocacy elements of Supervision into the new model following legislative change.

Our Plan for 2015

The team has got a busy year ahead as usual to continue to continue positively to the overall care and safety of women and their families.

- Continuous commitment to women focused care
- Succession planning in meeting the NMC standard 1:15 SoM /Midwife ratio
- To work on reducing C/S rate, the team is fully engaged and working in progress
- Continue to involve in raising the profile in the Children’s centre
- Set a day for roadshow
- To support midwives in adapting to the concept of Revalidation
-

Report by :- Arinola Erinle Contact supervisor of midwives

Recommendation	Key Action(s)	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation
To demonstrate a robust structure for identifying and monitoring investigation Further development of the existing spreadsheet	Create a folder on the I drive under investigations for Decision trees for all SOM's to complete and file complete	April 2016 Dec. 2015	Therese Lawton Logan Van Lessen	Monthly review. Actions on LSAdb. Monthly review	Evidence on the I Drive Minutes of meetings Evidence on the I Drive
Meeting the NMC standard of 1:15 SoM/Midwife ratio	Succession planning Exploring course at st Georges and Kings for two students 2 students qualifying in April 16	Sept 2016 July 2016	Arinola Erinle Sinead Farrell	Presentation on nomination and selection 11/1/16	Minutes of January 2016 meeting
To incorporate the role of a full time SOM	HOM aware of recommendation		Manjit Roseghini		
To have a structured meeting Agenda SOM as a standing Agenda on the Clinical Governance meeting	complete	November 17th 2015	Arinola Erinle	Ongoing every month	Minutes of the meeting since Nov.2015
Team to consider strategies for improving homebirth rate	To be concluded as part of the Away Day – topic to be discuss	April 2016	SOM Team		
To undertake further evaluate of the effectiveness of the VBAC workshop and cervical sweep to assess impact on LSCS rate	To be included as part of the Away Day To be looked at as part of Normality meeting		SOM Team Logan Van Lessen		
To further raise the profile of supervision with service users	Walking the patch and SOM rounds	Ongoing	SOM Team		

Local Supervising Authority

Annual Audit Report
Monitoring the Standards of Supervision & Midwifery Practice

Whittington Hospital

Date 27th October 2015

On 1st January 2013 the Nursing and Midwifery Council launched a revised edition of the midwives rules and standards. These standards form the basis against which statutory supervision of midwives is audited.

Introduction to the Local Supervising Authority Annual Audit

The LSA annual audit was undertaken by Bernie Nipper LSA Support Midwife, Jessica Read LSA Midwifery Officer, Maria Mills-Shaw Supervisor of Midwives, Helen McCrann Supervisors of Midwives, Monica Franklin, Student Supervisor of midwives and Gamu Mudungwe LSA Lay Auditor. The audit team was made to feel very welcome and appreciated the hospitality shown.

The Supervisors of Midwives (SoM) presentations were introduced by the contact Supervisor of midwives to a number of invited guests including Amanda Hallums, Director of operations, Lisa Smith, Assistant Director of Nurse Education and workforce, Julie Juliff, maternity commissioner, Manjit Roseghini, Head of Midwifery, Clare Maher, LME Middlesex University Friedericke Eben, Consultant Obstetrician and Meg Wilson, Consultant obstetrician. This representation by senior members of the multidisciplinary team demonstrates the high profile and visibility the team of supervisors have achieved within the Trust.

The Theme of the audit presentations was “Business as usual”. The first presentation gave a brief background of Whittington Health including demographics followed by an update on the team’s progress in achieving the recommendations from 2014 LSA audit. It was clear from this presentation that the birth rate of just less than 3700 for 2014/ 2015 has decreased on previous year’s figures; however the team envisage this improving as the trend for bookings this year has increased. The team demonstrated they had met 4 out of the 6 actions from last year’s audit with the exception of recruiting a full time SoM and providing water birth training for midwives to support their normalising birth agenda. The latter is in the process of being planned.

In addition, the team presented the various innovations and audits they have been involved in focusing mainly on normalising birth; these included a cervical sweep audit and an evaluation of their vaginal births after caesarean section (VBAC) workshops. These pieces of work were undertaken by the team in response to the increased lower segment caesarean section (LSCS) rate which is currently 30.2% and as a result of complaints from service users. Results were encouraging although the number of audit participants was small. Cervical sweeps are now embedded in practice as are the VBAC workshops for service users. The SoM team plan to undertake a further evaluation of the effectiveness of these innovations using a larger sample group. The team are positive a reduction in the LSCS rate will be achieved.

The final presentation was from the Head of Midwifery Manjit Roseghini who spoke of the challenges and the recent changes in the management and clinical leadership structure. The Whittington has had an unsettled year in relation to their management and clinical leadership structure. The newly formed Integrated Clinical support Unit officially came into effect on 1st July 2015 resulting in recruitment to the post of the Head of Midwifery, Director of Operations and a new Clinical Director for women’s services. The Trust has also recently invested a substantial amount of capital to improve the physical environment of the unit, resulting in improvements being made to the Antenatal ward, maternity Diagnostic Unit and the Triage department. There are further plans to refurbish and improve other areas of maternity. Manjit also discussed the key achievements in Obstetric, Maternity and Gynaecology during 2015/2016 e.g. establishment of a birth reflections clinic and the VBAC workshops, she completed her presentation by highlighting the Trusts future plans to improve both client and staff experiences.

The Context

The Nursing and Midwifery Council (NMC) sets the rules and standards for the function of the Local Supervising Authorities (LSAs) and the supervision of midwives. The Local Supervising Authority Midwifery Officer (LSAMO) is professionally accountable to the Nursing and Midwifery Council. The function of the LSAMO is to ensure that statutory supervision of midwives is in place to ensure that safe and high quality midwifery care is provided to women.

Supervisors of Midwives are appointed by the LSA and the LSA function sits within NHS England. The main responsibility of the LSA is to protect the public by monitoring the quality of midwifery practice through the mechanism of statutory supervision for midwives. The SHA will appoint a LSAMO to carry out the functions of the LSA, which may include visits and inspections of places of midwifery work. This will provide a structured means to oversee the practice and supervision of midwives within London LSA, to ensure the requirements of the NMC are being met (Rule 11, NMC 2012). The audit is carried out to inform the Local Supervising Authority annual report to the NMC (Rule 13, NMC 2012).

All practising midwives in the United Kingdom are required to have a named Supervisor of Midwives. A Supervisor of Midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 8, NMC 2012). Each supervisor oversees approximately 15 midwives and is someone that midwives may go to for advice, guidance and support. The Supervisor of Midwives will monitor care by meeting with each midwife annually, (Rule 9, NMC 2012) auditing the midwives' record keeping and investigating any reports of problems/concerns in practice. They are also responsible for investigating any serious incidents and reporting them to the LSAMO (Rule 10, NMC 2012).

The Standards for Supervision

The Standards for Supervision incorporate the following broad principles: The Midwives Rules and Standards, NMC (2012)

1. Supervisors of Midwives are available to offer guidance and support to women accessing a maternity service that is evidence based in the provision of women centred care.

2. Supervisors of Midwives are directly accountable to the Local Supervising Authority for all matters relating to the statutory supervision of midwives and a local framework exists to support the statutory function.

3. Supervisors of Midwives provide professional leadership and nurture potential leaders.

4. Supervisors of Midwives are approachable and accessible to midwives to support them in their practice.

5. Supervisors of Midwives support midwives in providing a safe environment for the practice of evidence based midwifery.

LSA Audit Aims

The aims of the audit are:-

- To review the evidence demonstrating that the standards for supervision are being met.
- To ensure that there are relevant systems and processes in place for the safety of mothers and babies.
- To review the impact of supervision on midwifery practice
- To ensure that midwifery practice is evidence based and responsive to the needs of women.

Methodology

The process for the audit of the LSA standards continues to be a self/peer review approach with verification of evidence by the LSA audit team employing a targeted sampling technique. Self/peer review is recognised as a powerful tool that stimulates professional development and decentralises power creating awareness of personal accountability.

A profile of the maternity service and the completed assessment tool listing the supporting evidence and any comments and recommendations the supervisors wished to make was sent to the LSA office two working weeks prior to the audit.

On the Audit day the LSA meets with student midwives, midwives and service users to triangulate the evidence provided.

Formal LSA Audit Processes

- Programme for Audit visit
  The programme was sent in advance to the audit team.

- Self-audit tool
  The tool was completed before the audit and sent to the LSAMO.

- Evidence
  The supervisors had prepared evidence for each standard similar to a CNST audit. Where possible evidence was sent electronically to the LSA in advance of the formal audit.

Assessment of the LSA Standards for the Supervision of Midwifery

The LSA Standards for the Supervision of Midwives are incorporated into four domains for auditing purposes; each domain is underpinned by the Standards and Guidance set by the NMC for registrants and for Statutory Supervision, including:

The Midwives rules and standards NMC (2012)
The Code: Standards of Professional Standards of practice and behaviour for nurses and midwives, NMC (2015)
Standards for Medicines Management, NMC (2007)
Record keeping: Guidance for nurses and midwives, NMC (2009)
Quality Governance in the NHS – A guide for provider boards, DH (2011)

Domain 1: The Interface of Statutory Supervision of Midwives with Clinical Governance

The team presented evidence showing they are involved in clinical governance activity in the unit. They attend a range of meetings including labour ward forum, Maternity Service Liaison Committee (MSLC) and clinical governance meetings. The minutes presented as evidence highlight that Supervisors of Midwives (SoMs) attend meetings as a SoM and not in their substantive roles and it is clear they contribute effectively to discussions. The team interact well with the risk management team by attending weekly maternity case reviews and capture all information on a very clear and concise template. Following last year's audit the team was to consider becoming a standing item on the agenda of a range of meetings including clinical governance. Although they attend these meetings they are not a standing agenda item and would benefit by instigating this as it will help to raise the profile of supervision and enable the team to feedback on the innovations and activities they are undertaking to improve the care provided to service users.

The Supervisor of Midwives (SoM) strategy outlines the team's achievements and challenges for 2014/2015.The recommendations from last year's audit are listed in bullet point form. When the strategy is updated it would benefit from having a structured action plan which details the team's intentions on achieving their set goals, identifies leads for different objectives and indicates any progress on achieving the set objectives.

Due to the structural realignment at the trust the Risk management Strategy is currently under review however the draft version provided as evidence contained a number of pertinent references to supervision.

The SoM team demonstrated evidence that they are involved in record keeping audits annually and they undertake controlled drug (CD) audits on a monthly basis in different clinical areas. They have also been instrumental in initiating a number of audits as a result of their concerns about the high Lower Segment Caesarean Section (LSCS) rate and in response to complaints from service users e.g. cervical sweep audit & vaginal birth after caesarean section (VBAC) workshop audit.
The team presented guideline group minutes as evidence indicating their involvement in the development and dissemination of guidelines however it was not always clear from these if the SoM team had developed any guidelines, this could have been strengthened by including examples of guidelines showing SoM involvement.

The team demonstrated how they have escalated concerns to the senior leadership team in the trust in relation to staffing resources within the clinical governance team. The numerous

correspondences' resulted in a positive outcome and the team should be proud of this achievement.

There have been no supervisory investigations since October 2014 and only one decision tool (May 2015) was seen by the audit team. The team do have an investigation spreadsheet which did not appear to be updated regularly and contained sections which were incomplete. This could be developed further to demonstrate a robust process for the identification of midwifery practice concerns and monitoring investigations and recommendations made from investigations.

Domain 1: Improvement required - to demonstrate a robust process for identifying and monitoring investigations and recommendations made.

Domain 2: The profile and effectiveness of Statutory Supervision of Midwives.

The current midwife to SoM ratio is 1:17. The appointment of a newly qualified SoM to the team will mitigate this and two students will qualify as SoMs in June 2016.The team have not moved forward with the recommendation to consider a full time SoM which is disappointing, particularly as the ratio is no longer meeting the NMC standard and the team struggled to complete 100% of annual reviews prior to the audit this year.

At the time of writing this report the range of completed annual reviews was 93% - 100% with an overall average of 99 % completed. This showed a significant improvement from the average of 88% viewed prior to the audit. Only two midwives had never had an annual review and they were new to the trust and had dates set for their annual review. All midwives working at Whittington had submitted an ITP for this practice year and thus meeting the standard.

All student cohorts have a named SoM and those student midwives who met with the audit team knew who their named SoM was.
It was clear from the evidence presented that the SoM team work well with the LSA and networking with the sector teams of SoMs in their area.

There are currently no managers on call at the Trust and it was evident that the majority of calls go via the SoM on call this was backed up by an audit undertaken by the team in June – August 2015 where the team highlighted the main reason for being called was to address staffing and capacity issues in the unit. The trust has a site manager on call but the feeling was that midwives are not aware of their role or when to call them. The SoM team would benefit from raising the profile of the role of the site manager and their own role as this may go some way to ensure they are getting called appropriately.

Feedback from Midwives and Student Midwives

Meeting with Midwives

The LSA team met with two midwives both band 6 community midwives with experience ranging from 18 months – 5 years. This is a low number and it is unfortunate that more midwives were not made available. Both midwives present were aware who their named SoM was and were aware of the supervisory role and when to call a SoM, they were also clear on the process to follow if they wished to change their named SoM.

Both midwives reported having had an annual review which they found informative and beneficial. They rated their annual reviews with a score of 5 (where a score of 1 is poor and 5 excellent).The midwives described the team as assessable as both had experience of SoMs responding to incidents by coming into the unit where there were staffing issues.

The midwives liked the supportive nature of the SoM newsletter and felt that women using The maternity services knew how to contact a SoM as there were posters visible in the unit and the SoM business cards were in the women's maternity records. They commented on the positive impact of some of the SoM initiative particularly the "partner staying overnight" and the "VBAC clinic".
Both midwives present said they would not consider undertaking the Supervisors course mainly due to the uncertainty of supervision in the future.

Feedback from the midwives confirmed a positive, transparent culture at Whittington with the multidisciplinary team working well together. The midwives expressed their concerns about the loss of the homebirth team and the occasional closure of the birth centre. It was clear from the presentations that the current homebirth rate is 1%, the SoM team where not aware of a strategy being in place to address this and may wish to consider having discussions with senior management team to look at ways to improve the homebirth rate.

Meeting the students midwives

The LSA team met with 4 student midwives two were third year students and two were 3 weeks into their 18 months training.
All four students were aware of whom their named SoM was and the two 18 month students had already met with their named SoM.
The third year students had reported working with their mentors 100% of the time in their community placement and in the other clinical areas it ranged from 70 – 95% of the time. The students reported the main reason for not being able to work with their mentor was because they had been allocated the coordinator as a mentor. The two 18 month's students have been allocated mentors and have worked with them so far. All the students gave very positive feedback about mentorship and found the mentors and staff in general to be supportive and willing to teach, these included doctors. The students did report having had some negative experiences during their placements particularly in NICU and when they were in theatre and on occasions they felt they were ignored and treated like "they knew nothing". Despite this they felt extremely supported by the staff and the clinical placement facilitator (CPF) when they escalated any concerns and they felt listened to.

The students reported their perception of the skill mix in the unit was generally good. They indicated that the SoMs were very visible in the clinical areas and found it helpful that the clinical areas had SoMs who were clinical midwives. All four students would work as midwives in the trust given the opportunity.

When asked about the women's experience the students reported that there was often issues with staff shortage on the postnatal ward and at times there were a lot of agency midwives, however they felt this did not impact on the women's care of safety and the women in general were happy with the care they had received.

Domain 2: Improvement required: With regards to meeting the NMC required standard of 1:15 (SoM: Midwife). The appointment of a Full time Supervisor of Midwives is recommended.

Domain 3: Team working, Leadership and development.

The SoMs team attendance at meetings this year was presented in a table format and showed improvement on last year's figures with the team achieving the 75% target set out in their terms of reference. The teams caseload currently range from 13 – 20, however the appointment of as new SoM to the team and two students SoMs in training will create more equity in the future.

The team have devised clear terms of reference for their team meetings. The meetings would benefit by having a more structured approach to their agenda, this could include having set sections for feedback from management, clinical governance etc. Inviting guests on a regular basis to their meetings e.g. Chief executive (CEO) and Chief Nurse (twice a year) would raise their profile further at Trust level ensuring supervision is in the forefront prior to the transition period. Evidence was seen of the presentation of the annual report by the team to the Trust board in January 2014 and further dates have been arranged for the team to attend these meetings before the end of this year.

Evidence in the form of the investigation spreadsheet was presented indicating equity in investigation allocation. However it was difficult to identify if this was a true reflection as the team have had no investigations to undertake since October 2014. The investigation spread sheet and the team shared drive need to be utilised, maintained and updated regularly by all members of the team to enable effective monitoring and tracking of investigations and recommendations made as a result of investigations.

The team are involved in a number of initiatives to raise the profile of supervision in the unit as well as facilitating the "back to basics" session at mandatory training and having ad hoc sessions used to identify and encourage midwives to undertake the SoM course. The initiatives have been highlighted previously in the report and include embedding cervical sweeps into practice and facilitating VBAC workshops. The team have been instrumental in setting up group reflective sessions for midwives and student midwives which are held each month before their SoM meeting showing they are engaged in support strategies. It was evident that they are currently experiencing difficulties with the implementation of the Jasmine project (Growth Assessment project (GAP)) mainly due to issues out of their control however as leaders it is key the GAP team keep the momentum going to enhance the care provided to their service users and in light of the Pan London maternity SCN work on GAP. The team should also be commended for the 2015 RCM (Royal College of Midwives) award for their partners staying overnight project.

Evidence of multidisciplinary working and networking within the sector was seen. The team are well represented at their local sector meetings and LSA meetings and events and have a good interface with Middlesex University as they attend the midwifery education group meetings and have a very clear presentation on supervision for teaching student midwives.

The evidence presented to the audit team demonstrates that the SoM team does display leadership, effective team working and development.

Supervisors Professional Development Plans

SoMs	LSA Audit	SoM PREP
ABDULLAHI MOHAMED AHMED, Shamsa	LOA	NA
BASRI, Rosalind	√	√
BRENNAN, Louise	LOA	NA
CATHCART, Hazel M	√	√
DANLARDY, Constance	√	X
DAVIDSON, Jacqueline	√	√
ERINLE, Arinola O	√	√
FARRELL, S M	√	√
HAMMOND-NORRIS, Nuala	√	√
IGUNNUBOLE, C I	√	√
LAWTON, Therese E	√	√
LEYDEN, M F	√	√
OKONKWO, Chika Charity	X	X
PADMORE-WOOD, Jane Esi	√	√
VAN LESSEN, Gnanambikai	√	√
Alvaro Baeza – Nonez (Student SoM)	√	NA
Tenu Harding (Student SoM)	√	NA

Domain 3: Met

Domain 4: Supervision of Midwives and interface with service users.

The Lay auditor Gamu Mudungwe spoke to the Contact SoM and maternity service users and below is a summary of her report. The full report can be found in the appendices.

Gamu was impressed with her visit to the Whittington where she gained insight into the trust and the work being undertaken by the SoM team from their presentations, a tour of the unit, and through discussions with service users. Gamu thanked the team for their hospitality and for all the hard work they are carrying out in engaging service users and providing women with an excellent maternity service. Gamu felt the team demonstrated enthusiasm, innovativeness and adaptability in responding to their service user's needs. Gamu commented on the fact that woman's centred care is evident throughout the maternity service and the SoMs team's commitment to providing an exceptional service to all its service users is exemplary.

Information on Statutory Supervision is available on the Trust website and efforts have been made to raise the profile of supervision. Posters were visible on noticeboards throughout the hospital, however on speaking to service users on the day it was evident that the women were not familiar with the role of the Supervisor of Midwives.

The lay auditor reported that the SOM team at Whittington Hospital demonstrated great leadership and championed for women entered care by ensuring that the maternity services met the needs of the women and proactively sought their; views using a range of methods,

and tailored their services to meet the identified needs. Efforts were also made to engage service users in hard to reach communities to ensure that their views were taken into consideration and that they were involved in shaping the maternity services provided at Whittington Hospital.

Domain 4: Met

Recommendations

1) To demonstrate a robust process for identifying and monitoring investigations and recommendations made. This should be undertaken by further development of the existing spreadsheet and shared drive ensuring both are utilised by all members of the team and updated on a regular basis.
2) To incorporate the role of the full time supervisor of midwives into their team
3) To have a structured meeting agenda this could include feedback from management, clinical governance and invited visitors as set agenda items.
4) Team to consider strategies for improving home birth rate
5) To undertake further evaluation of the effectiveness of the VBAC workshops and cervical sweeps to assess impact on LSCS rate.
6) To further raise the profile of supervision with service users

A recommendation for all SoM teams in 2014 - 15:

Work with the LSA to “future proof” the leadership, support and advocacy elements of Supervision into the new model following legislative change.

Summary

The SoM team at the Whittington have demonstrated good team work and have engaged in a number of projects which have directly impacted on improving the quality of care for woman. It was clear that the team felt they were strong together and were happy to keep going as they are however it is important not to become complacent and remember that it is not just about meeting the ratio standard it is also about the quality of supervision. The Full Time SoM role brings quality into the function and is an excellent means of ensuring the NMC ratio is met whilst consolidating the statutory function. This will be particularly important in ensuring midwives and SoMs are fully prepared for revalidation.
The head of midwifery and the Director of operations demonstrated ambition to support the supervisory team through the transition to a system of supportive supervision following legislative change. It is important for the SoM team to work with management to ensure that a model of the non – statutory elements of supervision is retained post legislative change.

A copy of this report will be sent to NHS England London Region and will available on the London LSA website: http://www.londonlsa.org.uk/

Following publication of the audit outcome report the supervisory team should review the strategy for supervision and develop a new action plan, thus completing the cycle.

APPENDIX 1 – AGENDA FOR AUDIT DAY

London LSA Programme for annual LSA audits of Maternity Services

Date: 27 October 2015 **WHITTINGTON HEALTH**

Time	Activity	People
09:00	LSA audit team meet at front entrance of the Hospital	LSA Audit team
09:15	Coffee and welcome with the SoM team	LSA audit team/SoM team
09:30	Presentations to the LSA audit team and invited guests to include: • Actions taken from previous years LSA audit recommendations • SoM team innovations • Other selected applicable topics	SoM team LSA audit team Invited guests
10:30	Questions and discussions	All
10:45	Coffee	All
11:00	LSAMO or representative commences SoM 1-1s	LSAMO or LSA rep SoM team
11:00	LSA audit team meets with midwives and students	LSA audit team Midwives and students
11:00	LSA Lay auditor to meet service users (for contact SOM to have pre-arranged this)	LSA Lay auditor Service Users
12:00	Tour of the unit for the LSA audit team	LSA audit team
12:45	Lunch	All
13:30	Review any outstanding evidence, discussion with SoM team regarding evidence submitted	LSA audit team SoM team
14:30	Meeting with SoM team	LSA audit team SoM team
15.00	Meeting with LSAMO & Head of Midwifery	LSAMO
15:30	Close of the day	

APPENDIX 2 – LAY AUDITORS FULL REPORT

WHITTINGTON HOSPITAL

LSA AUDIT 27 October 2015

Written by: Gamuchirai Mudungwe (Lay Auditor)

Domain 4: Supervision of Midwives and Interface with Users

Supervisors of Midwives are available to offer guidance and support to women accessing a midwifery service that is evidence based in the provision of women centred care

Overview

The report presents the observations, conclusions and recommendations relating to Standard 1 of the LSA Audit framework and represents a “user’s perspective” of the maternity service. As part of the audit, I reviewed information provided by the team of Supervisors of Midwives (SOMs) relating to Domain 4, I then explored the methods used by the hospital to gather user feedback and how that impacts on the activities of the SOMs. I also spoke to a range of service users on the audit day, and this provided me with an insight on the views of women past and present at Whittington Hospital. I concluded my observation by taking a tour of the hospital’s maternity unit.

I would like to thank the entire team of SOMs for all of the hard work that they are carrying out at Whittington hospital in engaging service users and providing women with an excellent maternity service. The team demonstrated enthusiasm, innovativeness and adaptability in responding to their service users’ needs.

Report

The SOM team at Whittington Hospital demonstrated great leadership and championed for women entered care by ensuring that the maternity services met the needs of the women and proactively sought their; views using a range of methods, and tailored their services to meet the identified needs. Efforts were also made to engage service users in hard to reach communities to ensure that their views were taken into consideration and that they were involved in shaping the maternity services provided at Whittington Hospital.

The team of SOMs utilises a range of methods to engage service users at different stages of the service users’ journey through the maternity services. During the first stage in this journey, service users are issued with SOM business cards with details on how to contact the SOM team. Furthermore, the SOMs also have a visible presence in the community holding roadshows which aim to promote the role of supervision and evidence was also given of a children's centre open day attended by the SOMs. The purpose of these days is to give families an opportunity to find out about more about midwifery supervision, promote natural birth and information on what is available to service users to promote this. The SOM team reported that the feedback from the events was positive, and it gave women an insight into the services available at the hospital and encouraged women to book at the hospital for their care.

The SOMs also use a range of methods to collect user feedback including surveys, patient tracker experience, complaints, follow-up calls and through the Birth Reflection clinic; and the results of the feedback have been the drive behind a number of the team’s initiatives

such as the Partners staying overnight programme which has been running successfully at Whittington for some time now.

Information on supervision as well as advice and guidance is available to women on the hospital's website and on notice boards throughout the maternity unit. This increases the accessibility of SOMs to service users. The SOMs also offer a birth reflection clinic which offers women an opportunity to debrief with a SOM. This offers women an opportunity to talk through their birth experience and ask any questions on their birth experience. This is a very unique and effective service, especially for users who have had a difficult birth and gives women reassurance and a clinical insight into the birth experience.

The team of SOMs demonstrated a willingness to engage service users through their active participation in the Maternity Service Liaison Committee (MSLC). The SOMs played an active role in working with service users in improving information available to women for example, in response to the LSA lay auditor's recommendation from last year's audit. However, the MSLC was not currently in operation at the time of the audit and a chair had recently been appointed, with the first meeting expected to be held on 5th November 2015.This meeting will coincide with the maternity review being undertaken by Baroness Cumberlege. The team demonstrated a keenness to have an MSLC at the hospital and I am confident that when the MSLC is re-launched, the SOMs will continue to work alongside service users through the MSLC in delivering a woman focused maternity service at Whittington hospital.

The team informed that they have initiatives in place such as the cervical sweep audits and VBAC workshops in an attempt to address the high C-section rate. This shows the team's efforts to champion normality. The hospital is also currently considering plans to introduce complimentary therapies as part of their plans to further normalise birth.

Information on statutory supervision of midwives is available on hospital's website and efforts have been made to raise the profile of SOMs and posters were displayed on notice boards throughout the hospital, however, on speaking to the service users on the audit day, women were not familiar with the role of Supervision of Midwives. However, they all commended the staff for the high quality of care that they had received from the staff and stated that they did not feel the need to seek further advice or support beyond what they given by their respective midwives.

Conclusion

The SOMs have demonstrated a commitment to delivering high a quality maternity service that is responsive to the needs of the service users. The emphasis on woman-focused care is evident throughout the maternity service at Whittington hospital. Service users described the care they received as 'excellent' and the SOM team's commitment to providing an exceptional service to all its service users is exemplary.

APPENDIX 3 – RAG RATING SUMMARY

LONDON LOCAL SUPERVISING AUTHORITY AUDIT

SUMMARY DASHBOARD

FOR: Whittington Hospital

DATE: 27th October 2015

ITEM	RATING
Domain 1 -The Interface of Statutory Supervision of Midwives with Clinical Governance **Met** **Improvement Required** **Not Met**	
Domain 2 - The profile and effectiveness of Statutory Supervision of Midwives **Met** **Improvement Required** **Not Met**	
Domain 3 - Team working, Leadership and development **Met** **Improvement Required** **Not Met**	
Domain 4 -Supervision of Midwives and interface with service users. **Met** **Improvement Required** **Not Met**	
SoM Ratio **<1:15** **1:15 – 1:19** **1:20**	1:17
MW to Birth Ratio **<1:30** **1:30 – 1:32** **>1:32**	1:28
Vacancy **0-4.9%** **5-10%** **> 10.0%**	3%

The rag rating will inform London Local Supervising Authority and NHS England London Region Maternity Services data collection.

Executive Offices
Direct Line: 020 7288 3939/5959
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

March 2016

Title:	A review of nursing establishments relating to wards areas, the Emergency Department, Maternity, theatres and the Intensive Care Unit (this report excludes community services)		
Agenda item:	**16/039**	**Paper**	**8**
Action requested:	For Information		
Executive Summary:	1. In line with National Quality Board guidance this report provides an update to the Trust Board on the current ward nursing and midwifery staffing position. 2. The review is underpinned by monthly safer staffing reports which detail staffing on a shift-by-shift 'planned' versus 'actual' basis at ward level. 3. This review includes for the first time an establishment review within the Emergency Department, Maternity Unit, Theatre and Intensive Care Unit using appropriate methodology for these complex clinical areas. 4. The Trust has recently introduced an electronic-rostering tool (Allocate) which incorporates a 'Safer Care' Module. This supports Lord Carters recent recommendations in his Report on Productivity in the NHS		
Summary of recommendations:	1. Review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure wards, Emergency Department, ITU and Maternity Unit are safely staffed 2. To note the recommendation to support the current staffing arrangement on Victoria Ward to ensure patient safety 3. To note the future workforce challenges 4. To note that the implementation and roll out of the Allocate electronic rostering tool will afford an opportunity to ensure standardization and implementation of good quality rostering practice		
Fit with WH strategy:	Efficient and effective care.		
Reference to related / other documents:	Francis Report recommendations Cummings recommendations		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	February 2016		

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing/Lisa Smith AD Nurse Education**		**Director name and title:**		**Philippa Davies Director of Nursing**	
Date paper seen by EC		**Equality Impact Assessment completes?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment ?**	

Bi-annual Update on the Nursing and Midwifery workforce

1.0 Introduction

This paper provides an update on current ward nursing and midwifery staffing levels following a review of ward establishment undertaken in October 2015. This paper should be considered alongside the information shared each month in the Nursing and Midwifery Safer Staffing Reports.

2.0 Background

2.1 The impact of nurse staffing levels on the quality of care experienced by patients, patient outcomes and experience is well documented. Many studies link low staffing levels to poorer patient outcomes and increased mortality rates (Berwick 2013, Cavendish 2013, Francis 2013, Keogh 2013, DH. 2014, NICE. 2014).

2.2 The National Quality Board (NQB) publication How to ensure the right people, with the right skills in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability (National Quality Board 2013) requires hospitals to review nurse staffing levels every six months using validated methods. The NQB sets out ten expectations for NHS Providers and Commissioners to enable right decisions about staffing needs. This report meets NQB expectations:

1 – Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.

3 – Evidence based tools are used to inform nursing, midwifery and care staffing capacity and capability.

5 – A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.

3.0 Our approach to ensuring safe staffing levels

3.1 Ward nursing establishments are formally reviewed bi-annually to ensure the ward based nursing workforce meets the demands of clinical care provision and delivers safe care with a positive patient experience.

3.2 For the purpose of this review two national acuity based tools, Shelford Safer Nursing Care Tool (Shelford Group 2012) and Nursing Hours per Patient Day (Twigg 2011) were used to measure patient acuity, nurse staffing levels and activity, in addition to the professional judgment model.

3.3 For the Ward establishment reviews, data was collected at 15.00 hours on 20 consecutive days between 5th October and 24th October 2015. Data collection was undertaken by Ward Managers. Matrons conducted validity checks with regard to data accuracy. The Assistant Director of Nurse Education and Workforce reviewed all data submitted and conducted ward visits to further check and verify any outstanding or unusual data.

3.4 The 'Nursing Hours per Patient' Day model NHpPD (Twigg 2011) was applied to this review. The tool was developed in Western Australia and has been endorsed by the Australian Department of Health. It consists of seven categories of complexity of nursing tasks within a ward based on specialty case mix to determine the average value of nursing hours required. This, together with the number of beds is formulated with a resultant staff required recommendation. As with all establishment a 22% uplift was applied to this result for each ward to cover sickness absence, study, annual and maternity leave

3.5 Professional judgment of senior nurses from each clinical area is an essential part of each staffing review. This ensures not only accurate data interpretation, but also a sense check of the exact staffing requirements based on professional knowledge of the specialty.

4.0 Lord Caters Report on Productivity in the NHS

4.1 Lord Caters final report (Carter 2015) makes it clear that there is more Trusts can do to manage their workforce more productively. It states 'unwarranted variation' highlighting examples such as sickness and absence between 2.7% to 5.8%.

4.2 The report fully recommends the use of e-Rostering to meet the workforce productivity challenge and it outlines an opportunity for Trust's to mature their use of both e-Rostering and Job Planning**.** It also identifies a benefit for Trusts to better deployment the Allied Health Professional (AHPs) workforce.

4.3 The Trust introduced Allocate E-Rostering system in August 2015 and is currently rolling out the e-rostering tool across the acute wards, with an intended completion date of May 2016. Running alongside the e-roster is the SaferCare Module which allows for real time acuity and dependency modelling of patients. This will provide up-to-date information on which to make safe staffing decisions.

4.4 The Carter report also introduces a new metric called Care Hours per Patient Day (CHPPD). This metric is closely related to Nursing Hours per Patient Day which formed part of the NICE guideline on staffing in acute wards. This metric is already available to the Trust as a user of the SafeCare Module. This is expected to become a key performance reporting metric for all Trusts.

5.0 Royal College of Nursing and specialist guidance

5.1 The RCN recommend that the skill mix (the ratio of registered to unregistered staff) for general adult inpatient areas should as a minimum be 65/35, although this may be higher in specialist areas and lower in slower stream/rehab type settings. The additional tools and guidance applied in the establishment review is set out in Table 1. The Actual Ward ratios can be found in Appendix 1.

Area	Methodology
Wards	The Shelford Tool
Neonatal Unit	BAPM guidelines
Intensive, Coronary & High Dependency Care Units (including outreach	BACCN/RCN critical care forum/ICS guidelines
Theatres	Association for Perioperative Practitioners (AfPP)
Emergency Department	Professional Judgment methodology - Activity & Acuity/dependency - Appendix 1
Hyper-Acute Stroke Unit (HASU)	NHS London guidance
Maternity services	Birthrate+
Paediatrics	RCN guidelines

Table 1

6.0 Supervisory allowance for the sister/charge nurse to be "in-charge"

6.1 The importance of providing ward sisters with sufficient time to fulfil their duties was first highlighted in "Breaking Down Barriers, Driving up Standards" (Royal College of Nursing 2009) and "Making the business case for ward sisters/team leaders to be supervisory to practice" (Royal College of Nursing 2010) and has subsequently been endorsed by the Francis enquiry and the National Quality Board.

6.2 Common sense would suggest that having an empowered leader who is "in-charge" and overseeing, coordinating and assuring the ward operates effectively is essential. Evidence also backs this - University of Southampton Hospital for example was able to demonstrate a reduction in staff sickness from 5% to 1.8% and reduced incidence of falls, pressure ulcers and complaints.

7.0 Vacancy levels:

7.1 There has been an increase in vacancy levels between April 2015 (12.5 %) and October 2015 (15.27%). The most recent study by NHS Employers (2014) highlighted the overall vacancy rate across organisations within the UK that provided their nurse staffing establishment data was calculated at 10 per cent (12,566.35 FTE) i.e. posts not permanently occupied.

7.2 A recent Royal College of Nursing report (Royal College of Nursing 2016) identified the vacancy rate for nurses in London is now 17%, up from 14% last year and 11% the year before. It is estimated that there are more than 10,000 nurse vacancies in the capital.

7.3 The challenge and risk for the organisation will be ensuring our nursing and midwifery vacancy levels do not significantly rise above current levels.

7.4 Retention: Turnover of Nurses and Midwives leaving the organisation is currently at 18.57%. This is accepted nationally as being poor. Retention and growing our own talented staff within the organisation is a key area of focus over the next year. This will assist with stabilising and retaining our existing workforce.

7.5 Temporary staffing reliance has remained fairly stable over the year. In 2016 there will be a key drive to reduce the reliance on temporary staff alongside the vacancy levels across the Organisation.

7.6 Over the last six months it has become evident that the lack of availability of nurses within the UK poses a recruitment risk. This is not just an issue for Whittington Health; nationally there is a shortage of experienced nurses in many specialty areas including Emergency Department, Paediatric, Theatre and Intensive Care trained nurses.

7.7 Nursing and Midwifery Council (NMC) changes in relation to how overseas candidates from Non EU countries can join the UK nursing register have had a significant impact nationally on the availability and speed of recruiting abroad (Nursing & Midwifery Council 2014). The time from initial sourcing of nurses from non EU countries to confirmation of NMC registration can now take up to 9-12 months. Recruiting nurses from Non-EU countries is not a viable short term recruitment plan but one Whittington Health will consider within the long term recruitment plan.

8.0 Fill Rates

8.1 In line with national guidelines, the Trust publishes a monthly 'Safe Staffing' report detailing staff fill rate data by ward in terms of 'planned' hours versus 'actual' hours worked. This report is also discussed at Trust Board and details the process for managing safe staffing levels in the organization.

8.2 The Trust has maintained fill rate levels above 90% on the majority of its wards since reporting commenced.

9.0 Analysis of current review

9.1 During the review period there were high occupancy levels on the medical and assessment and general surgical wards. Nightingale ward consistently reported a 100% bed occupancy rate.

9.2 When comparing the current review with the review undertaken October 2014, there is a decrease in skill mix ratios of registered nurses (RN) to health care assistants (HCA) on the medical and assessment wards, with RN skill mix ratios from 75:25 to 71:29. The surgical wards overall report a skill mix ratio of 76:24 – the same as in October 2014 (Pg. 7)

9.3 The staff to bed ratio (RN & HCA: Bed) remains largely unchanged since October 2014 and is an average of 1.32 for medical and assessment wards and 1.36 for surgical wards.

9.4 The nurse to patient ratio for all wards reviewed falls within the range of 1:3.2 - 1:7 Nurses to Patient. The highest Nurse to Patient ratio of 1:3.2 was identified on Mercers Ward. This ward is small in comparison to many other hospital wards as contains only 16 beds.

9.5 The lowest Nurse to Patient ratio (1:7, RN: Pt) was identified on Cavell Ward. This ward is our rehabilitation ward and dependency and acuity of these patients is relatively low when compared to many of our acute wards (Pg. 7)

9.6 The findings of both validated tools indicate small variations to the current ward establishments. The tools have identified potential small increases or decreases on a number of wards. It is recommended that these establishments remain unchanged until establishments and budgets have been reviewed and realigned with the implementation of e-Roster.

9.7 Quality outcomes remain within accepted limits with one case of acquired MRSA bacteraemia in January 2016 and C. Difficile rates remaining low at 7 reported cases.

9.8 The focus around pressure ulcer prevention remains high in line with our Sign up to Safety pledge to reduce avoidable acquired pressure ulcers by 50%. The tissue viability team work closely with wards to share learning and embed practice through the use of the SSKIN bundle.

9.9 The number of inpatient falls remains low and the Trust continues to deliver a target of less than five inpatient falls per 1000 bed days. The Trust was part of the first national inpatient falls audit undertaken by the Royal College of Physicians (Royal College of Physicians 2015) and results demonstrated the second lowest falls rate across all London hospitals.

10.0 Maternity

10.1 Maternity Department staffing is calculated using the Royal College of Midwives / Department of Health staffing tool Birthrate Plus (Ball 2007) . Since 2006, detailed results from 120 studies involving Birthrate Plus® (BR+) in England have been compiled in a database. The results are based on a total (over four years) of 385,490 hospital and 8500 home births, and cover 87 DGH's and 9 Tertiary services.

10.2 The ratio for national planning cited, produced by Birthrate Plus in 2003/2007 is usually quoted as 28 births per wte midwife for hospital births and all related community care. The ratio for home births is 35 births per wte Midwife.

10.3 A recent review of Whittington Health Midwifery Service identified a higher than average number of mothers fell in to the highly complex categories and BR+ recommended a ratio of 1 midwife to 25 births. The current ratio is 1:22 midwife to birth ratio which the Head of Midwifery will continue to review.

11.0 Emergency Department

11.1 Over 14 million people attended Emergency Departments in England last year and in 2014/15 96,000 patients visited the Whittington Emergency Department. Nursing staff are often among the first to see patients and the care they provide is essential for successful treatment of every patient.

Ensuring there are enough available nursing staff, with the right skills, helps to make sure people in need of immediate medical help, will get safe care, whatever the time of day or night.

11.2 A nurse staffing guideline for Emergency Departments was commissioned by the Department of Health and NHS England in November 2013 from the National Institute for Health and Care Excellence (NICE. 2015).

11.3 The new draft recommendations set out the responsibilities of senior nurses and hospital managers, and the actions organisations can take, to ensure there are enough registered nurses and non-registered nursing staff to provide safe care at all times to patients attending A&E. This includes making sure that the department has the capacity to provide all necessary emergency care, as well as specialist input for children, older people or those with mental health needs.

11.4 The draft guideline includes recommendations for minimum ratios which can be considered by organisations when planning the establishment or they can also be used on a shift-by-shift basis to help work out what services can be made available at that time. These are based on the seriousness of a person's condition and the level of care they need.

11.5 The Emergency Department has sufficient staff numbers when compared to the draft NICE guideline. The review would suggest that the establishment is higher than required and a further review will take place following implementation of the Allocate e-Rostering system.

12.0 Recommendation

12.1 The review would suggest two wards and one department have higher establishments than required (Mercers, Mary Seacole North and the Emergency Department). It is proposed that these staffing establishments remain unchanged, but are reviewed on implementation of the new Allocate E-roster system. This system enables a detail view of shifts which may be over or under resourced.

12.2 The establishment of Victoria Ward of 33 beds should be reviewed in the next six months to clearly identify if the temporary uplift initiated by the ICSU would need to be maintained to further ensure patient safety due to high acuity and dependency requirements of the patient group.

13.0 The Trust Board is asked to:

- Review and be satisfied that the appropriate level of detail and assessment has been undertaken to assure itself the wards, Emergency Department, ITU and Maternity unit are safely staffed
- To note the recommendation to review the current staffing arrangement on Victoria Ward to ensure patient safety.
- To note the continued workforce challenges
- To note that the implementation and roll out of the Allocate electronic rostering tool will afford an opportunity to ensure standardization and implementation of good quality rostering practice and standards.

Specialty	Ward	beds	RN(Est)	RN / Day Shift	Ratio RN: Patient
Care of Older People	Cloudesley	25	20.38	4	1:6
	Meyrick	25	19.98	4	1:6
	Cavell	14	13.3	2	1:7
Respiratory	Nightingale	21	25.17	4	1:5
Cardiology	Montouchi	16	20.24	3	1:5
Gastro-Oncology	Victoria	26	25.03	5	1:5
Acute	MSN	16	21.14	3	1:5
	MSS	18	24.37	4	1:4.5
Orthopaedics	Coyle	24	25.08	6	1:4
	Thorogood	10	11.0	2	1:5
General Surgery	Mercers	16	20.2	5	1:3
Critical Care	ITU	15	77	16	1:1
Women and Children	Ifor	23	31.66	4	N/A
Paediatrics	NICU	23	52.52	8	N/A

Ratio of RN: Patient

Specialty	Ward	RCN recommended Registered Nurse %	RCN recommended Unregistered Nurse %	Actual Registered Nurse %	Actual Unregistered Nurse %
Care of Older People	Cloudesley	60	40	60	40
	Meyrick	60	40	60	40
	Cavell	60	40	67	33
Respiratory	Nightingale	75	25	80	20
Cardiology	Montouchi	60	40	80	20
Gastro-Oncology	Victoria	60	40	69	31
Acute	MSN	60	40	81	19
	MSS	60	40	69	31
Orthopaedics	Coyle	65	35	67	33
	Thorogood	65	35	78	22
General Surgery	Mercers	65	35	82	18
Critical Care	ITU	90	10	100	0
Women and Children	Ifor	70	30	91	9
Paediatrics	NICU			87	13

Staff skill mix RN: HCA

Coyle Ward

Ward Summary

Coyle Ward is a 24 bed non-elective orthopaedic surgery/ trauma ward. Patients admitted to this ward have a range of orthopaedic injuries which require surgery. Occasionally, care is provided for spinal patients prior to transfer to a specialist centre. Patients are admitted directly to Coyle ward from the Emergency Department.

The ward layout consists of four side rooms and five four bedded bays. The ward can support extra escalation beds during times of high capacity need. These extra beds create three bays of five beds and two bays of six beds.

The trust employs nine orthopaedic Consultant surgeons and two spinal Consultant surgeons.

The ward manager has an administrative management day one day per week.

The ward has a phlebotomist who works 0.5wte shared with the other surgical wards. There are 3wte physiotherapists, 1wte physiotherapist assistant and 2wte Occupational Therapists providing therapy cover seven days a week. Additional staff includes a dedicated ward pharmacist and ward clerk who assists with phlebotomy duties when required.

The sickness rate in October 2015 was 1.15%.

The ward had 13.88 wte vacancies at time of review.

Coyle was funded for 31 beds during October, but for much of the time was operating with 20 beds as the ward was temporarily relocated for refurbishment.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 25.08 HCA 12.0 RN/HCA 37.08	RN 15.0 HCA 8.22 RN/HCA 23.22	Direct Nursing WTE 37.08 Recommended WTE 24.13 Variance -12.70	Direct Nursing WTE 37.08 Recommended WTE 36.31 Variance -0.52

Staff to bed ratio:	**NICE**	**Current Planned Staffing levels**	**Bed Occupancy**
1.19	RN WTE 24.83 RN(1:8) 19.86 Variance -4.97	Day: 5+2 (6+3 with escalation beds) Night: 3+2 (4+2 with escalation beds) Weekend Day: 4+2 (5+3 with escalation beds) Night: 3+2 (4+2 with escalation beds)	2014: 96.7% 2015: 89.4% Variance: -7.3%

Activity during reference period;

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
69	90	2	7	0	0	0	1

Quality Indicators

There were 12 recorded complaints over the 12 month period. Patient falls declined from a peak of five in May 2015 to one in October 2015. One case of MSSA bacteraemia was identified and attributed to Barnet CCG. There was a small cluster of pressure ulcers during the spring. There were no reported cases during the period June – October 2015. There was one medication error in July 2015 and one in October 15.

Current challenges

Of the total ward establishment eight nurses are newly qualified or on the overseas nursing programme.

The ward manager is newly appointed and has been without a band 6 deputy for several months due to difficulties in recruiting a suitable candidate. For much of the past year, the ward has flexed capacity and had seven additional beds. Safe staffing levels were assessed by the Head of Nursing and additional bank and agency staff booked accordingly. There were four incidents recorded on Datix which relate to nurse staffing levels over the 12 month period.

Recommendations

There is adequate provision in the establishment for the planned staffing model. Assessing staff numbers using NHPPD suggests correct establishment however the SNCT recommendations appear to suggest that the ward is over resourced, despite an adjustment made for the high flow of patients.

When taking into account the average bed numbers for the period, the extrapolated establishment would be 34.9wte, making the variance considerably less at 2.18wte.

There will be a review of the establishment later in the year following the implementation of Allocate E-Roster.

The Safe Staffing 'live' facility will enable acuity and dependency of patients to be reviewed against planned and actual staffing levels in addition to competencies of staff on duty.

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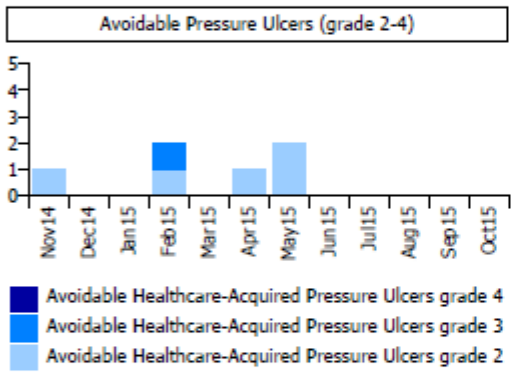
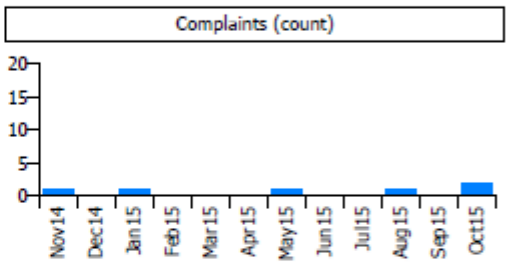
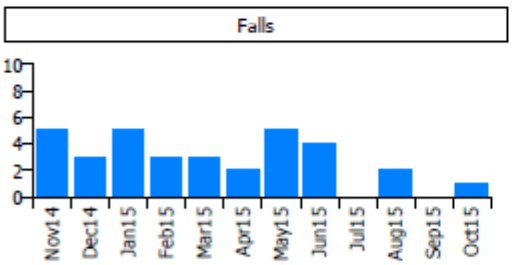
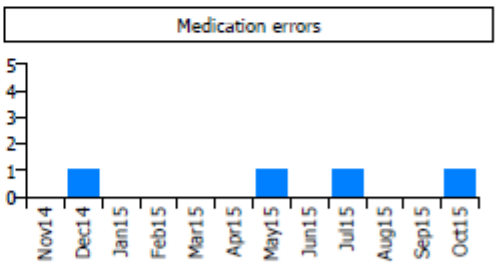
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

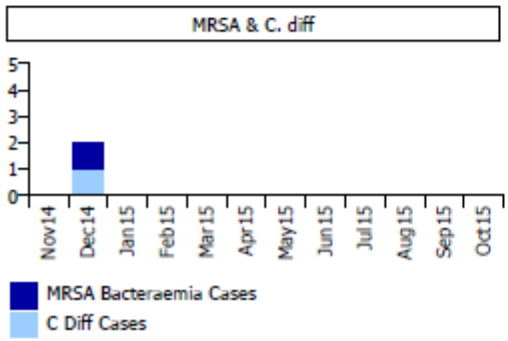
Coyle	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	1	0	0	1	0	1	2	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	1	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	1	0	0	0	0	0	0	0	0	0	0
Inpatient falls	5	3	5	3	3	2	5	4	0	2	0	1
Medication errors reported	0	1	0	0	0	0	1	0	1	0	0	1
MRSA Bacteraemia Cases	0	1	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	1	0	0	0	1	0	0	1	0	2
Safety Thermometer Patients with no acquired harm	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	97%	100%	97%	97%	100%	100%	100%	100%	100%	94.7%

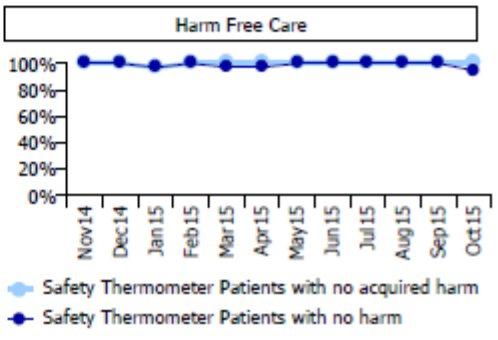












Ward Summary

Thorogood is a ten bed 'clean' orthopaedic ward. Patients are admitted for elective orthopaedic surgery. The ward has two four bedded bays and two side rooms.

The ward has a dedicated ward pharmacist and ward clerk. There are eleven orthopaedic consultants who work within this speciality. The ward manager works 13 'long day' shifts a month and spends 34.5- 46 hrs per month on 'administrative management' dependent on staffing. The ward shares a phlebotomist with the other surgical wards. There are 2wte physiotherapists and 1wte physiotherapist assistant who provide therapy cover seven days a week.

The sickness rate during the review period was 0.81%

The ward had 1.74 wte vacancies at time of review.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 11.0 HCA 4.0 RN/NA 15.0	RN 9.0 NA 4.0 RN/NA 13.0	Direct Nursing WTE 13.8 Recommended WTE 7.16 Variance -6.64	Direct Nursing WTE 13.8 Recommended WTE 7.23 Variance -6.57
Staff to bed ratio:	**NICE**	**Current Planned Staffing levels**	**Bed Occupancy**
Whitt: 1.38	RN WTE 10.8 RN(1:8) 6.41 Variance -4.39	Day: 2+1 Night: 2+0	2014: 77.5% 2015: 63.5% Variance: -14.0%

Activity during reference period;

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
41	31	2	2	0	0	0	1

Quality Indicators

There have been no cases of MRSA bacteraemia or C. Difficile over the 12 month period. Two medication errors were reported during the recording period. Complaints occurred in July 2015 and October 2015. One pressure ulcer was reported in August 2015. This one pressure ulcer accounts for the drop in harm free care. As the ward is small, any one incident will have an exaggerated effect statistically on the percentage of harm free care. Falls incidents remain low.
There was one hip implant surgical site infection reported for the period 1 April 2015- 30 June 2015. This is below the national trajectory.

Current challenges

Retirement/attrition of experienced nurses is an ongoing challenge. There are peaks and troughs in elective admissions which make bed planning and staffing of the ward challenging.

There were two incidents recorded on Datix that relate to nurse staffing levels between November 14 and October 15.

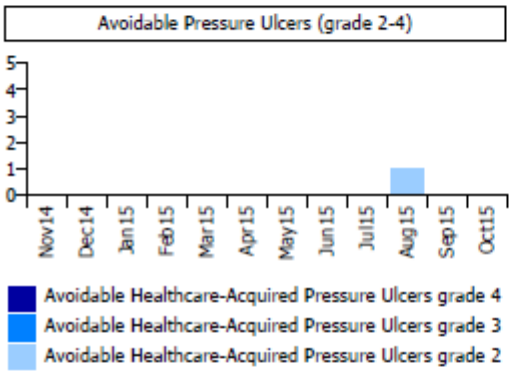
Recommendations

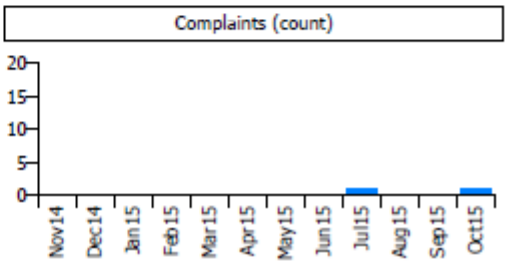
All measures suggest that the ward is over resourced, however the bed base is small and there is a requirement to have at least two RNs on duty at all times to ensure safe care. The minimum establishment would therefore be: 10.68wte.
A healthcare assistant supports the RNs during the day.

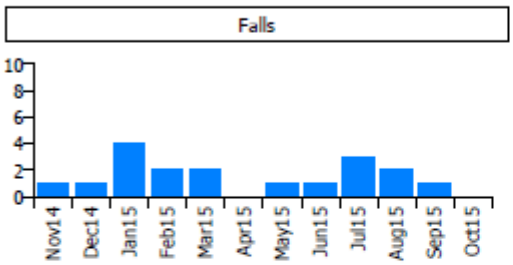
There is adequate provision in the establishment for a 2+1 day and 2+0 night staffing model.

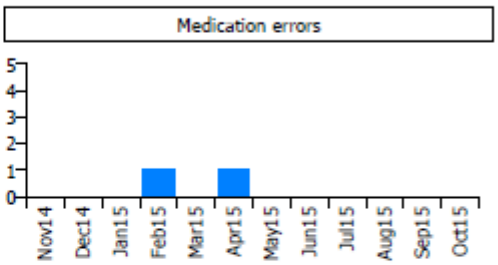
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

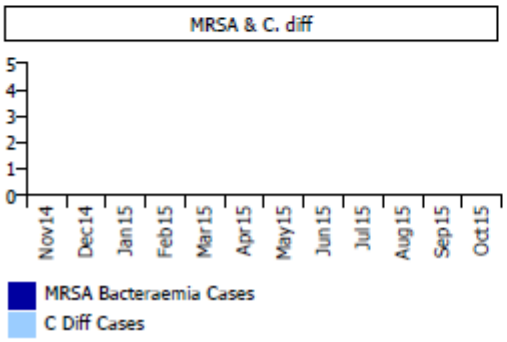
Thorogood	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	O
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	1	0	
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	
Inpatient falls	1	1	4	2	2	0	1	1	3	2	1	
Medication errors reported	0	0	0	1	0	1	0	0	0	0	0	
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	
No.of Complaints	0	0	0	0	0	0	0	0	1	0	0	
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	85.7%	100%	50.0%	100%	1
Safety Thermometer Patients with no harm	100%	100%	93%	100%	100%	100%	100%	85.7%	100%	50.0%	100%	1

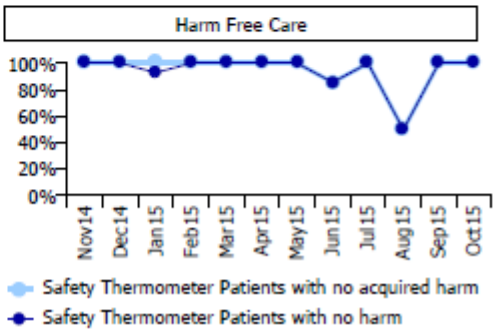












Mercers Ward

Ward Summary

Mercers Ward is a 16 bed general surgical ward, of which six beds accommodate high dependency surgical patients.
The ward recently relocated from Victoria Ward premises. Complex surgical patients are admitted to this ward.
The ward layout consists of eight side rooms and two four bedded bays. Six of these beds are used to care for high dependency surgical patients.
The ward has a dedicated ward pharmacist and ward clerk and shares a phlebotomist with the other surgical wards.
The Consultant responsible for patient care will vary according to the type of surgery.
The ward has a Physiotherapist and Occupational therapist with a shared therapies technician.
The ward manager has an 'administrative management' day 1 day per week.

The sickness rate in October was 0.56%.

The ward had 9.22wte vacancies during the review period.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 20.2 NA 5.24 RN/NA 25.44	RN 14.61 NA 1.61 RN/NA 16.22	Direct Nursing WTE 24.24 Recommended WTE 16.85 Variance -7.59	Direct Nursing WTE 24.24 Recommended WTE 22.88 Variance -1.36
Staff to bed ratio: Whitt: 1.52	**NICE** RN WTE 20.0 RN(1:8/1:2) 17.94 Variance -2.06	**Current Planned Staffing levels** Day: 5+1 Night: 3+1 Weekend Day: 4+1 Night: 3+1	**Bed Occupancy** 2014: 93.9% 2015: 98.1% Variance: 4.2%

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
20	45	44	10	0	0	1	0

Quality Indicators

There were no reported cases of MRSA bacteraemia and one case of C. Difficile reported over the 12 month period. No reported acquired pressure ulcers since March 2015, with a variable falls rate, with a peak in January 2015 of ten. All falls were assessed as no harm or minimal harm. A number of medication errors were reported throughout the year with a peak of 4 in February 2015, all of which were assessed as no harm or low harm. There are low numbers of complaints received.

Current challenges

The staff attrition rate has been high over the 12 month period and a number of experienced nurses have been replaced with newly qualified and overseas nurses.

There were three incidents recorded on Datix which relate to nurse staffing levels over the 12 month period.

One complaint relating to staffing levels was received during the 12 month period.

Recommendations

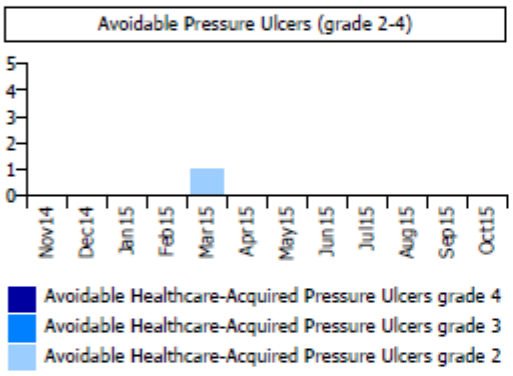
This ward must be able to take high dependency patients at any time and the high number of side rooms impacts on the number of staff required.

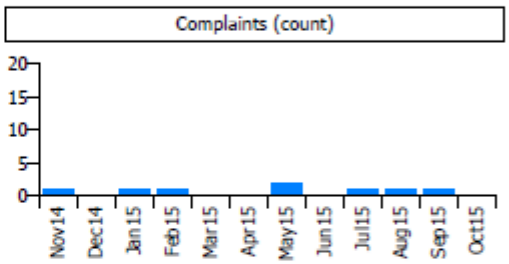
The recommendation is to further review the establishment later in the year following the implementation of Allocate E-Roster.

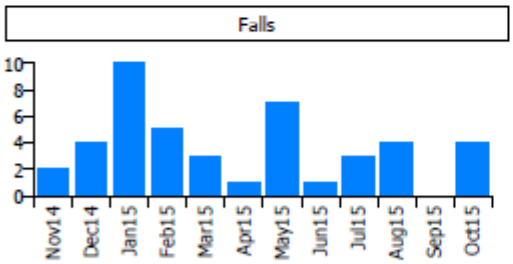
The Safe Staffing 'live' facility will enable acuity and dependency of patients to be reviewed against planned and actual staffing levels in addition to competencies of staff on duty.

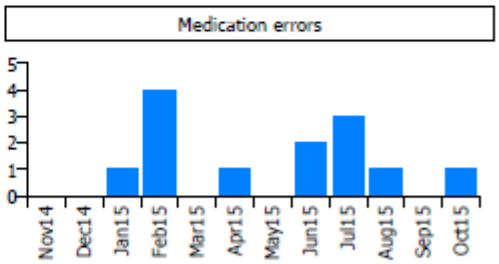
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

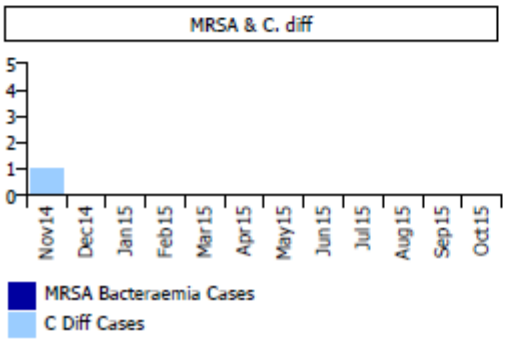
Mercers	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	1	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	1	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	2	4	10	5	3	1	7	1	3	4	0	4
Medication errors reported	0	0	1	4	0	1	0	2	3	1	0	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	1	1	0	0	2	0	1	1	1	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	97%	100%	96.8%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	97%	88%	96.8%	100%	90.6%	93.8%	100%	100%

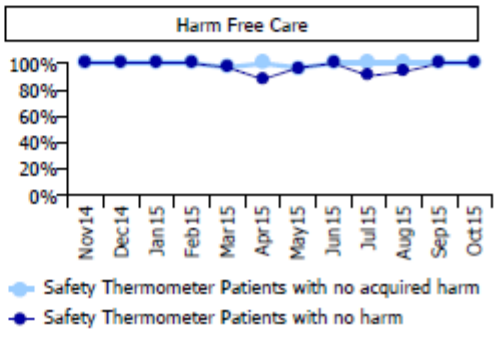












Cloudesley ward

Ward Summary

Cloudesley is a 25 bed care of older people ward. Patients admitted have varying conditions, including dementia and multiple co-morbidities. These patients require constant supervision and many have mobility problems requiring two staff to help them to mobilise and complete their activities of daily living. Their discharge is often complex requiring liaison with multiple agencies within the community. Patients are admitted directly from the Emergency Department, or one of the assessment wards.
The ward has three five bedded bays, one six bedded bay and four side rooms.
The ward manager is completely supervisory and in addition, has one management day per week. During the week when the ward manager is not on duty there is a supervisory shift leader. The nurses are supported by a housekeeper, a ward clerk and 0.26wte phlebotomist. The ward has access to 2wte dedicated Physiotherapists; share a senior physiotherapist with Meyrick ward, 2wte Occupational therapists, and a therapies technician. The ward has a dedicated pharmacist.

There is no sickness recorded during the review period.

The ward had 3wte vacancies during the period reviewed.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 20.38 NA 12.1 RN/NA 32.48	RN 17.98 NA 11.3 RN/NA 29.28	Direct Nursing WTE 30.41 Recommended WTE 31.27 Variance 0.86	Funded WTE 30.41 Recommended WTE 32.61 Variance 2.20
Staff to bed ratio:	**NICE**	**Current Planned Staffing levels**	**Bed Occupancy**
Whitt: 1.22	RN WTE 17.48 RN(1:8) 15.88 Variance -1.60	Day : 4+3 Night: 3+2	2014: 99.8% 2015: 99.6% Variance: -0.2%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
40	27	1	7	0	0	3	0

Quality Indicators

There were no reported cases of MRSA or C. Difficile in the past year. One reported complaint in August 2015. There were two avoidable pressure ulcers, one was a grade three. This was sustained on the heel of a patient who was admitted with cellulitis and who refused to mobilise.
There continue to be a number of falls each month. Ten falls were recorded in December 2014 and 6 falls in September 2015; none of the falls resulted in serious harm. Two of the patients who fell in December had previously fallen and all the patients who fell were suffering from delirium or dementia. There have been a small number of medication errors, none causing harm. A reduction in harm free care was reported in October; this was due to the admission of five patients with old pressure ulcers.

Current challenges

The ward is seeing an increasing number of patients with high levels of acuity and dependency, many of whom require services of the mental health team. One incident was recorded on Datix which relate to nurse staffing levels between November 2014 and October 2015.

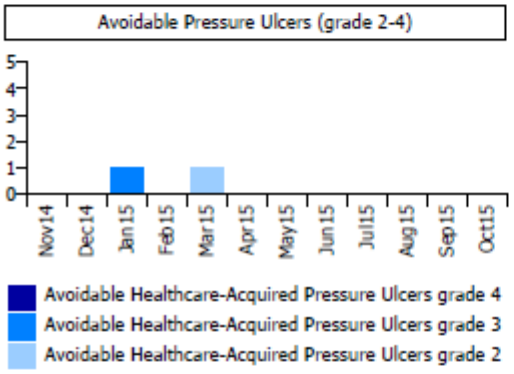
Recommendations

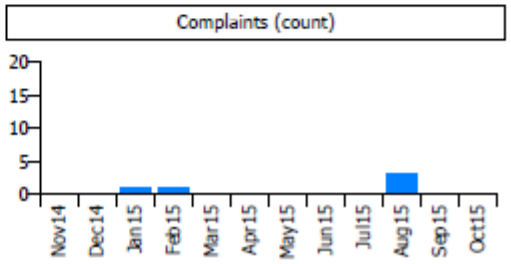
There is little variance between the recommendation for the establishment for either the safer nursing care tool or NHPPD. It is therefore recommended that there are no changes to the establishment.

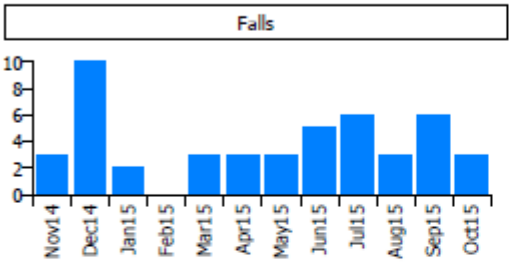
There is provision in the establishment for a 4+3 day and 3+2 staffing model with the ward manager supervisory. The ward establishment will be reviewed following implementation of the Allocate E-roster system to identify if there is sufficient staff to have a shift leader completely supervisory on days.

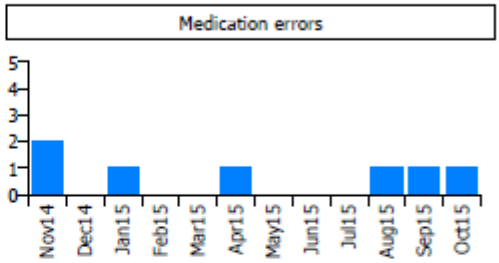
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

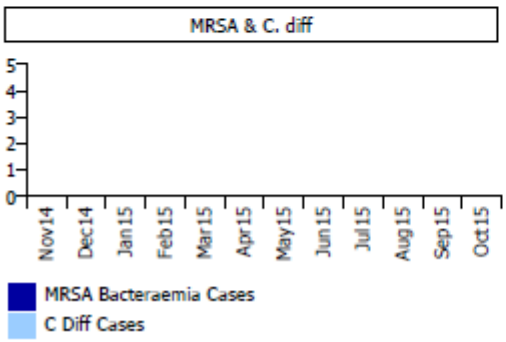
Cloudesley	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	1	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	1	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	3	10	2	0	3	3	3	5	6	3	6	3
Medication errors reported	2	0	1	0	0	1	0	0	0	1	1	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	1	1	0	0	0	0	0	3	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	96%	100%	92%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	87%	84%	90%	88%	84.0%	100%	96.0%	100%	96.0%	80.0%

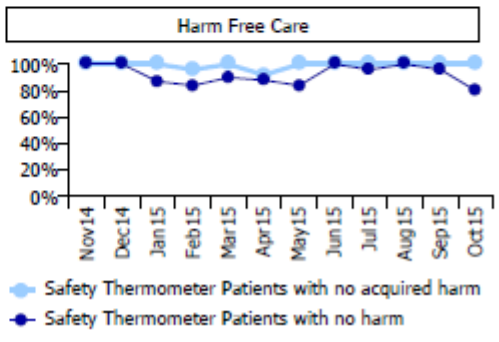












Ward Summary

Meyrick is a 25 bed ward providing care for older people. Patients admitted to this ward are generally over the age of 65 and have varying conditions, including dementia. They often have co-morbidities and complex social problems. Their discharge is often complex requiring liaison with multiple agencies within the community. Patients are often confused and require constant supervision; many have mobility problems and require two staff to help them to mobilise and to complete their activities of daily living. Patients are admitted directly from the Emergency Department, or one of the assessment wards.
The ward has three five bedded bays and one six bedded bay in addition to four side rooms.
The ward manager is completely supervisory and undertakes 'administrative management' duties one day per week. During the week when the ward manager is not on duty there is a supervisory shift leader. The nurses are supported by a housekeeper, a ward clerk, and 0.26wte phlebotomist with a dedicated Pharmacist.
Patients have access to a dedicated Physiotherapist, share an additional senior physiotherapist, two Occupational therapists and a therapies assistant

The sickness rate was zero during the review period.

The ward had 2wte vacancies during the review period.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 19.98 HCA 12.1 RN/HCA 32.08	RN 17.98 HCA 12.1 RN/HCA 30.08	Direct Nursing WTE 30.41 Recommended WTE 31.27 Variance 0.86	Direct Nursing WTE 30.41 Recommended WTE 32.61 Variance 2.20
Staff to bed ratio:	**NICE**	**Current Planned Staffing levels**	**Bed Occupancy**
Whitt: 1.22	RN WTE 17.91 RN(1:8) 15.88 Variance -2.03	Early: 4+3 Late: 4+3 Night: 3+2	2014: 99.6% 2015: 99.4% Variance: -0.2%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
19	25	3	3	0	0	2	0

Quality Indicators

No reported cases of MRSA over the 12 month period. One pressure ulcer was reported and three cases of C. Difficile (one case was trust attributable). Three medication errors were reported during the year all resulting in low harm. There were a number of reported falls, five falls occurring in October but none resulted in serious harm. It is not clear why there were five in the month, but the Matron considered this was due to high patient dependency. There was a reduction in harm free care in May, July and September 2015, all as a result of patients admitted with old pressure ulcers.

Current challenges

The ward clerk took on maternity leave and then resigned her post. This resulted in nurses needing to undertake extra administration duties. This post has now been recruited to.
There were two incidents recorded on Datix which relate to nurse staffing levels between November 2014 and October 2015.

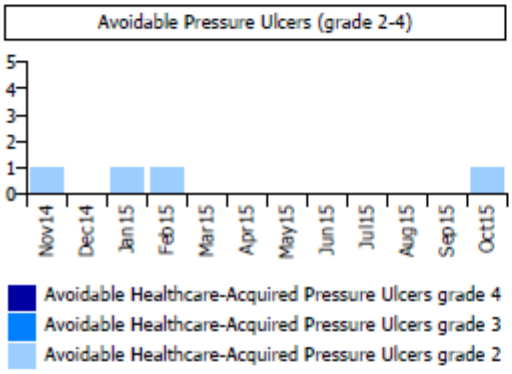
Recommendations

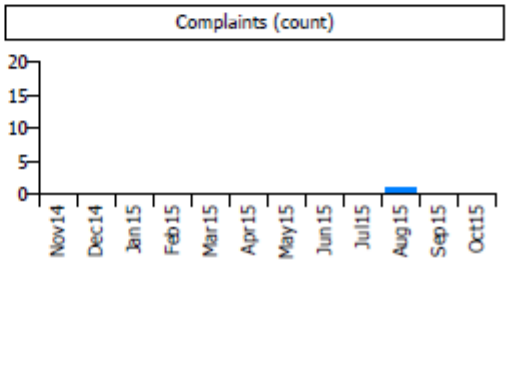
There is little variance between the recommendation for the establishment for either the safer nursing care tool or NHPPD. It is therefore recommended that there are no changes to the establishment.

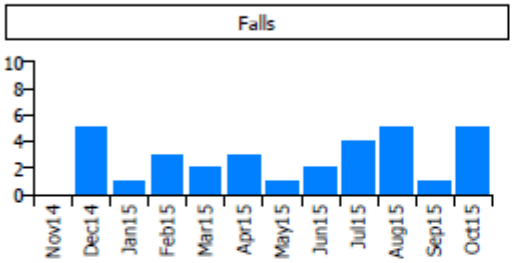
There is provision in the establishment for a 4+3 and 3+2 night staffing model. The establishment will be reviewed following implementation of the Allocate E-roster system.

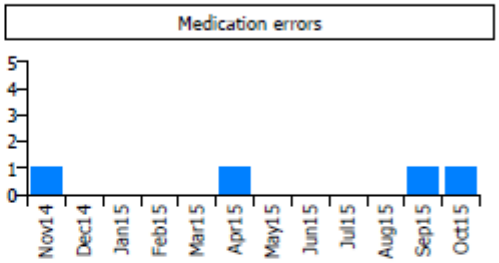
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

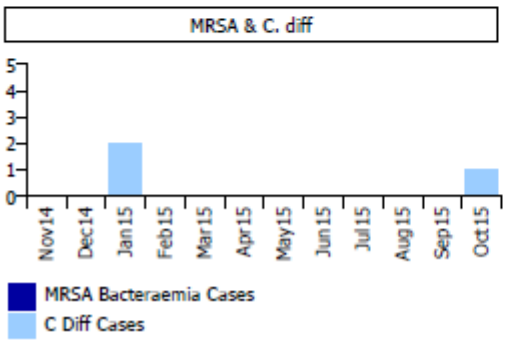
Meyrick	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	1	0	1	1	0	0	0	0	0	0	0	1
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	2	0	0	0	0	0	0	0	0	1
Inpatient falls	0	5	1	3	2	3	1	2	4	5	1	5
Medication errors reported	1	0	0	0	0	1	0	0	0	0	1	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	0	0	0	0	0	0	0	1	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	96%	100%	100%	95.5%	96.0%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	88%	100%	91%	76%	80%	83%	72.7%	80.0%	72.0%	84.0%	72.0%	96.0%

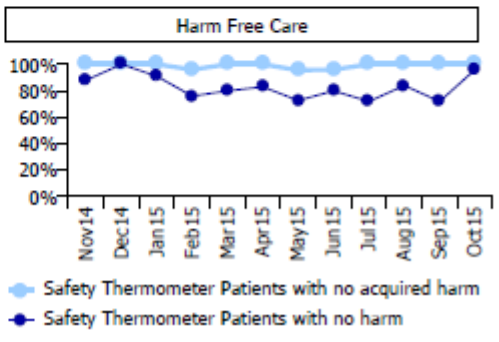












Cavell ward

Ward Summary

Cavell is a 14 bed elderly rehabilitation ward. It is managed by a ward manager who reports to a unit coordinator who is a Senior Physiotherapist. There are a range of therapists and therapies assistants working with the nursing team to provide care.

The ward has three side rooms, one five bedded bay and one six bedded bay. The ward has a rehabilitation gym and on occasion, additional bed capacity is provided in the day area. Patients on this ward require regular physiotherapy and occupational therapy treatments to prepare them for discharge.

The ward accepts referrals from wards within Whittington Health and externally from other hospitals. Admissions are 'nurse led' and the discharges 'therapies led'.

The unit is funded, commissioned and contracted by Haringey CCG to have a minimum of 12 beds with 90% occupancy, with the ability to increase up to 14 beds during periods of high demand. Staffing levels are set by the Trust. In addition to clinical staff there is a ward clerk and dedicated pharmacist. The ward manager is completely supervisory with one management day a week. During the week when the ward manager is not on duty there is a supervisory shift leader.

The sickness rate during the review period was 4.42%.

The ward had 1.13 vacancies over this period.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 13.3 NA 6.0 RN/NA 19.3	RN 11.61 NA 6.92 RN/NA 17.61	Direct Nursing WTE 17.23 Recommended WTE 14.17 Variance -3.06	Direct Nursing WTE 17.23 Recommended WTE 14.35 Variance -2.88
Staff to bed ratio:	**NICE**	**Current Planned Staffing levels**	**Bed Occupancy**
1: 1.23	RN WTE 11.48 RN(1:8) 8.89 Variance -2.59	Day: 2+2 Night: 2+1	2014: 90.9% 2015: 90% Variance: -0.9%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
7	6	0	0	0	0	0	0

Quality Indicators

The ward received no complaints during the past 12 month period. There was one case of C. Difficile reported in September 2015 and one medication error in October 2015. Falls incidents are low for this client group. A grade 3 avoidable pressure ulcer occurred in September 2015. The patient was admitted with oedematous legs, and staff did not recognise a lesion on the patient's heel was a leg ulcer. Further training was provided. There was a reduction in harm free care in April and May primarily as a result of patients being admitted with old pressure ulcers.

Current challenges

The bed base is the main challenge for this ward with the resultant inefficiency in terms of nurse staffing.

There was one incident recorded on Datix that related to nurse staffing levels between November 2014 and October 2015.

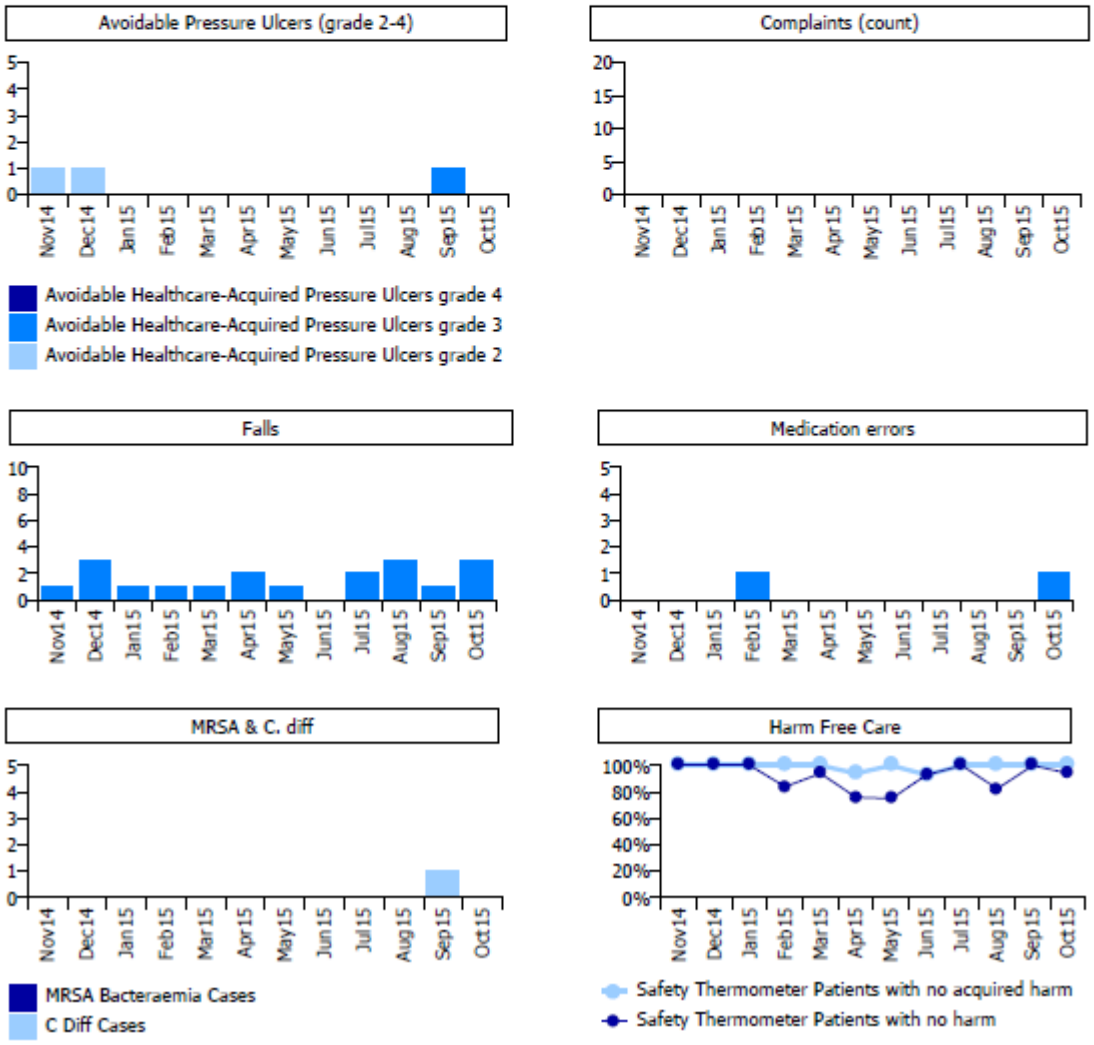
Recommendations

The data indicates the ward is slightly over resourced according to the NHPPD, SNCT and NICE recommendations. The ward is small and nurse staffing would be more efficient on a larger ward. In order to maintain safe care levels a minimum of two RN's per shift must be maintained; this equates to 10.48 wte.

The establishment will be reviewed following implementation of the Allocate E- roster system

INPATIENT WARDS: Safe Staffing Review - Quality Indicators

Cavell Rehab	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	1	1	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	1	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	1	0
Inpatient falls	1	3	1	1	1	2	1	0	2	3	1	3
Medication errors reported	0	0	0	1	0	0	0	0	0	0	0	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	0	0	0	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	94%	100%	92.9%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	84%	94%	76%	75.0%	92.9%	100%	82.4%	100%	94.1%



Nightingale ward

Ward Summary

Nightingale is a 21 bed respiratory ward, four beds of which are high dependency beds. Patients admitted to this ward typically suffer from acute respiratory failure or an exacerbation of a chronic respiratory illness. Patients may require non-invasive ventilation (Continuous Positive Airway Pressure or Bi-level Positive Airway Pressure) or have a tracheostomy. Patients are admitted directly from the Emergency Department or one of the assessment wards. The ward has three four bedded bays and nine side rooms.
The nurses are assisted by a ward clerk and have a dedicated ward Pharmacist, Physiotherapist and Occupational therapist.
The lead consultant is supported by three others. The ward manager is completely supervisory and in addition, has one 'administrative management' day per week. When the ward manager is not on duty there is a supervisory shift leader during the day. The sickness rate during the review period was 1.63%

The ward had 2.83wte vacancies during the review period.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 25.17 NA 5.51 RN/NA 30.68	RN 23.87 NA 3.98 RN/NA 27.85	Direct Nursing WTE 27.86 Recommended WTE 31.12 Variance 3.26	Direct Nursing WTE 27.86 Recommended WTE 30.13 Variance 2.27
Staff to bed ratio: Whitt: 1.33	**NICE** RN WTE 22.35 RN(1:8) 21.13 Variance -1.22	**Current Planned Staffing levels** Day: 4+1 Night: 4+1	**Bed Occupancy** 2014: 100% 2015: 100% Variance: 0%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
8	10	1	0	1	0	0	0

Quality Indicators

No reported cases of MRSA during the 12 month period. There was one medication error reported and one case of C. Difficile. There have been a number of falls which increased to five in October 2015. Three of these related to slips in the bathroom and one to a confused patient who attempted to strike a member of the nursing staff with their walking frame. None of the falls in October resulted in serious harm. There have been occasional complaints reported. There were reductions in harm free care during July and September. The July figure was primarily due to two patients developing a pulmonary embolus, and September due two patients with pressure ulcers – one old and one acquired. There was an acquired pressure ulcer in June 2015.

Current challenges

Currently three nurses recruited from overseas programme are awaiting their PIN's from the NMC. These qualified nurses cannot be included in RN numbers. This placed extra pressure on those registered nurses on shift.

There were three incidents recorded on Datix that relate to nurse staffing levels recorded between November 2014 and October 2015.

Recommendations

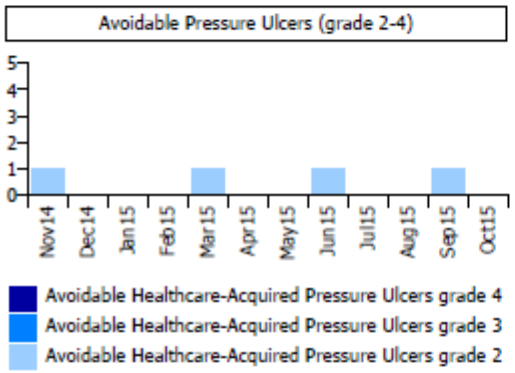
The safer nursing care tool and the NHPPD recommendations are close to the establishment, therefore it is recommended that there are no changes to the establishment on this ward.

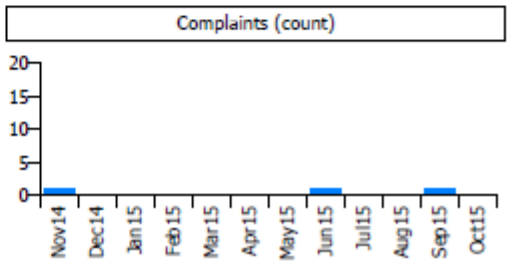
There is adequate provision in the establishment for a 4+1 staffing model with the ward manager supervisory and the shift leader supervisory on days.

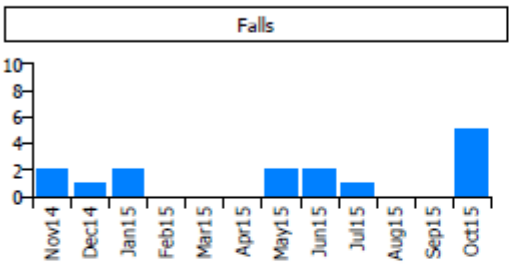
The establishment will be reviewed again following the implementation of the Allocate E- roster system

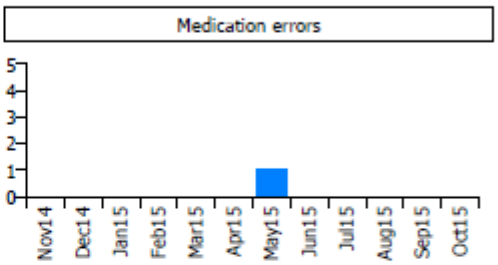
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

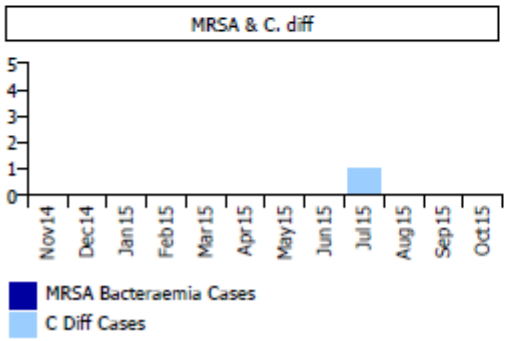
Nightingale	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	1	0	0	0	1	0	0	1	0	0	1	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	1	0	0	0
Inpatient falls	2	1	2	0	0	0	2	2	1	0	0	5
Medication errors reported	0	0	0	0	0	0	1	0	0	0	0	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	0	0	0	0	0	1	0	0	1	0
Safety Thermometer Patients with no acquired harm	95%	100%	100%	95%	95%	95%	95.0%	100%	89.5%	100%	90.5%	100%
Safety Thermometer Patients with no harm	86%	100%	100%	95%	80%	95%	95.0%	100%	84.2%	100%	85.7%	100%

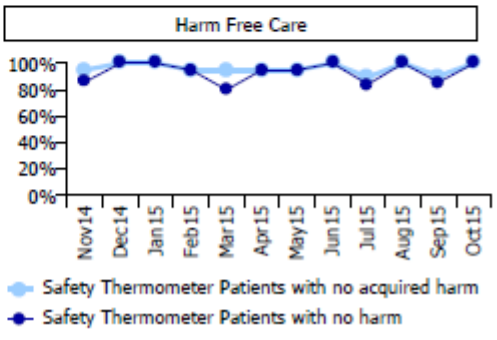












Ward Summary

Montuschi is a 16 bed cardiology ward providing 4 coronary care beds. Patients who require interventional cardiology are transferred to a specialist centre. Patients admitted to this ward suffer from angina, heart failure or rhythm disturbances and may have a tracheostomy. They may be on complex intravenous drug regimens including inotropic support and increased level of observation is required. Patients are admitted direct from the Emergency Department, or one of the assessment wards.
The ward has two four bedded bays, one six bedded bay and two side rooms. There are a number of cardiologists who care for patients on this ward. The patients have access to a dedicated Physiotherapist and Occupational therapist. The ward manager is wholly supervisory and in addition, has one management day a week. When the ward manager is off duty, the shift leader on days is supervisory. There is a dedicated ward pharmacist and ward clerk.

The sickness rate during the review period was zero.

During the review period, the ward had 0.6wte vacancies.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 20.24 HCA 4.2 RN/HCA 24.44	RN 19.64 HCA 4.2 RN/HCA 23.84	Direct Nursing WTE 21.62 Recommended WTE 19.7 Variance -1.92	Direct Nursing WTE 21.62 Recommended WTE 23.25 Variance 1.63
Staff to bed ratio: Whitt: 1.35	**NICE** RN WTE 17.42 RN(1:8) 17.94 Variance 0.52	**Current Planned Staffing levels** Day: 3+1 Night: 3+0	**Bed Occupancy** 2014: 98.4 2015: 99.7% Variance: 1.3%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
14	23	17	4	0	0	0	0

Quality indicators

There have been no complaints, cases of MRSA or C. difficile relating to Montuschi this year. There were two medication errors during the period considered.
There was one pressure ulcer in October 2015. This resulted in a reduction in the percentage of harm free care due to the ward size. Low levels of patient falls occurred sporadically throughout the year.

Current challenges

Staff may be moved from Montuschi in order to make other ward areas safe. There were four incidents recorded on Datix which relate to nurse staffing levels between November 2014 and October 2015.

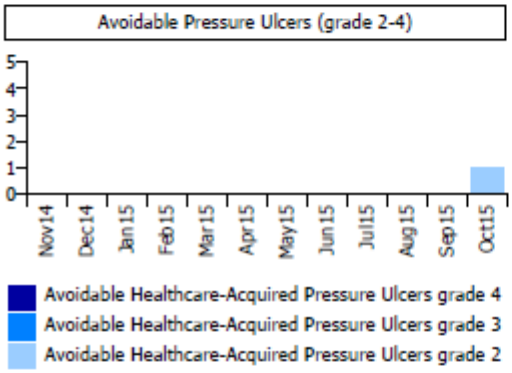
Recommendations

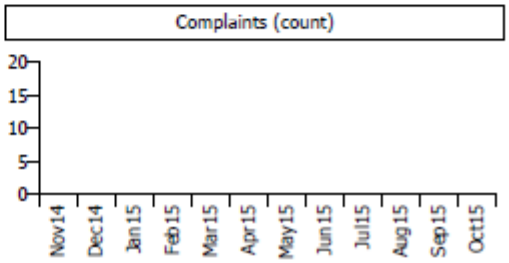
All measures suggest the nursing establishment is at the correct level. The recommendation is for the establishment to remain unchanged.

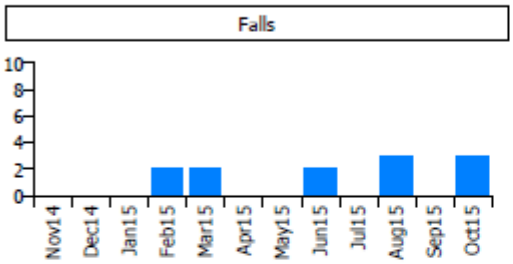
There adequate provision in the establishment for a 3+1 day and 3+0 staffing model with the ward manager wholly supervisory.

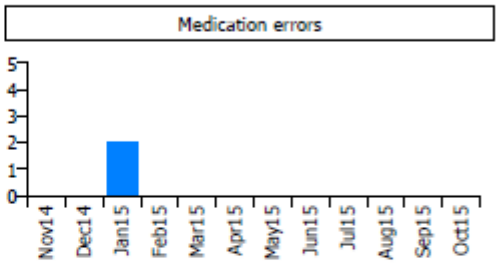
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

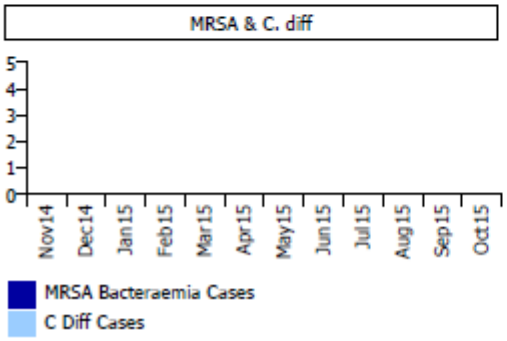
Montuschi	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	1
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	2	2	0	0	2	0	3	0	3
Medication errors reported	0	0	2	0	0	0	0	0	0	0	0	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	0	0	0	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92.9%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	88%	100%	88%	100%	100%	100%	100%	92.9%	81.3%

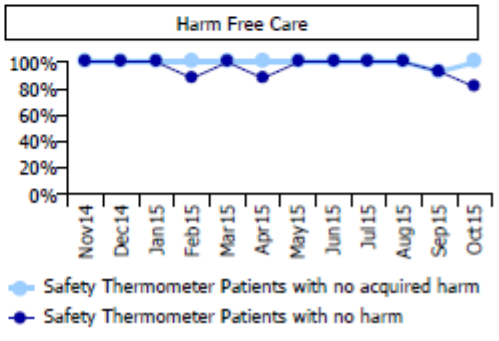












Victoria ward

Ward Summary

Victoria is a 26 bed medical ward with seven additional 'escalation' beds which were opened to create additional capacity. These were in use during the review period. Mercers ward transferred to the larger Victoria ward facility in August 2015, increasing the bed base for medical patients from 16 to 26 (+seven 'flex' beds providing additional capacity). Patients admitted to this ward have a range of medical conditions including sickle cell, alcohol withdrawal and gastro-intestinal conditions. Many have high acuity and dependency needs. Patients are admitted either direct from the Emergency Department or from one of the assessment wards.

The ward has two six bedded bays and three five bedded bays. In addition, the ward has six side rooms. The ward staff are currently in the early stages of building relationships and working together as a team. There are a number of consultants who are responsible for patients in this ward. The ward manager is totally supervisory and has one day a week performing 'administrative management' duties. When she is not on duty there is a shift leader who is supervisory. The ward has a dedicated Pharmacist, ward clerk and a 0.7wte phlebotomist along with a housekeeper. The sickness rate at time of review was 1% and the ward reported 12.3wte vacancies.

During the review period an additional seven 'flex capacity' beds were open and in use. Staffing levels for escalation beds were agreed by the Head of Nursing and the shortfall was found through the use of bank and agency staff.

WTE (33 beds)	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 25.03 HCA 10.5 RN/HCA 35.51	RN 17.23 HCA 6.0 RN/HCA 23.23	Direct Nursing WTE 33.44 Recommended WTE 40.36 Variance 6.92	Direct Nursing WTE 33.44 Recommended WTE 42.88 Variance 9.44
Staff to bed ratio: Whitt: 1.01	**NICE** RN WTE 22.96 RN(1:8) 21.14 Variance -1.82	**Current Planned Staffing levels** Early: 5+2 Late: 5+2 Night: 4+2	**Bed Occupancy** 2014: 98.1% 2015: 99.2% Variance: 1.1%

Activity during reference period;

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
84	90	2	3	0	1	2	0

Quality Indicators

There have been no cases of MRSA and no acquired pressure ulcers. Two cases of C Difficile have been reported. There is an increasing number of falls, though this is comparatively low for the client group. Falls peaked at 8 in September but none of these resulted in serious harm. No themes were identified, three were patients who were confused and one patient did not use their walking aids to mobilise. An increase in the number of medication errors have been reported since the move to larger ward footprint in August. Errors related to the administration of controlled drugs. One of these incidents resulted in moderate harm. A training programme was put in place to support the nursing staff. There were very few complaints. In May 2015, there was a reduction in harm free care due to a patient admitted with a pressure ulcer.

Current challenges

A move to a larger ward footprint and the opening of escalation beds. A junior sister post was introduced to help strengthen nurse leadership. A large proportion of the RN posts are filled by newly qualified nurses. Complaints received relate mainly to staff attitude. There were 22 incidents recorded on Datix which relate to nurse staffing levels in November 2014 – October 2015.

Recommendations

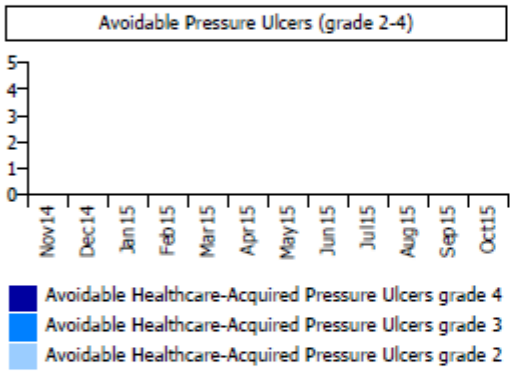
The safer nursing care tool and NHPPD suggests that the establishment should be increased to accommodate 33 beds. (The SNCT recommendations were adjusted to take into account high patient flow.) The NICE recommendations suggest a small decrease in the nursing establishment. In view of the nurse sensitive indicators, it is recommended that the establishment of HCAs is increased by 5.24wte when 33 beds are open. This would allow one additional HCA on duty at any one time. Following this review and in agreement with the Chief Operating Officer, the Head of Nursing initiated these changes to minimise risk and ensure patient safety.

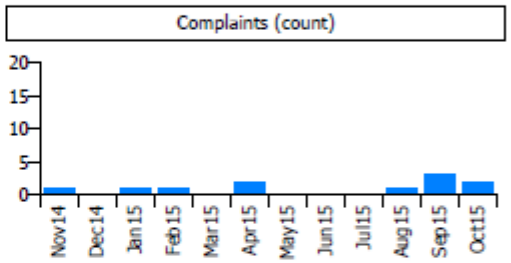
Establishment levels will be reviewed later this year following the implementation of Allocate E-Roster.

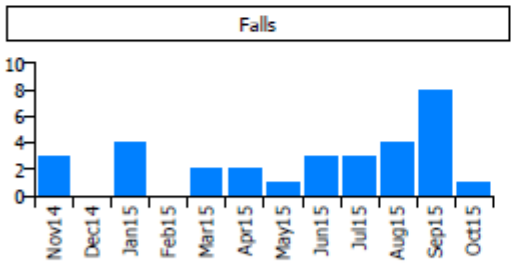
The Safe Staffing 'live' facility will enable acuity and dependency of patients to be reviewed against planned and actual staffing levels in addition to competencies of staff on duty.

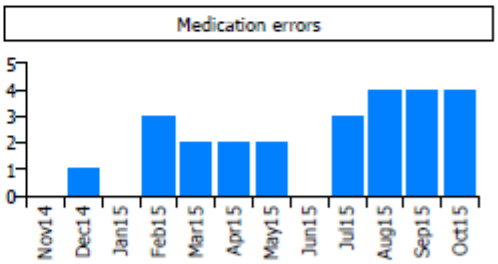
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

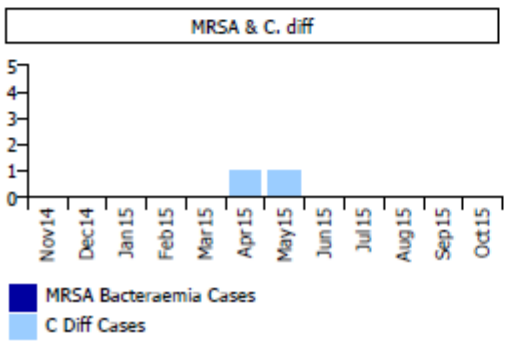
Victoria	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	1	1	0	0	0	0	0
Inpatient falls	3	0	4	0	2	2	1	3	3	4	8	1
Medication errors reported	0	1	0	3	2	2	2	0	3	4	4	4
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	1	1	0	2	0	0	0	1	3	2
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	92.9%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	88%	88%	100%	88%	100%	100%	80.0%	85.7%	100%	92.9%	97.0%	93.5%

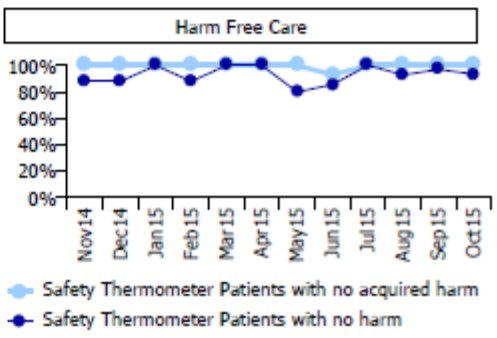












Ward Summary

Mary Seacole North is an acute assessment unit consisting of 16 beds. Patients are admitted from the Emergency Department to this unit and may present with a range of acute medical issues which require assessment and treatment prior to discharge home or transfer to another ward.

The ward has two five bedded bays and six side rooms. Transfers generally take place to the wards between 6am and 9 pm. There is 1 Facilities Service Assistant (FSA) who undertakes portering duties and assists with other activities such as meal service, a dedicated pharmacist and ward clerk who assists with administration. The Facilitated Early Discharge Service (FEDS) provide Occupational Therapy and Physiotherapy input to patients on this ward, and is shared with Mary Seacole South, Ambulatory Care and ED.

The ward manager is totally supervisory and in addition, has one 'administrative management' day per week. When the ward manager is not on duty there is a supervisory shift leader during the day.

There are six Consultants who work across the two assessment units.

Sickness rate was above trust average at time of review at 7.86%.

There were 2.8 wte vacancies during the review period.

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 21.14 HCA 9 RN/HCA 30.14	RN 16.43 HCA 10.39 RN/HCA 26.82	Direct Nursing WTE 27.32 Recommended WTE 23.54 Variance -3.78	Direct Nursing WTE 27.32 Recommended WTE 21.59 Variance -5.73
Staff to bed ratio: Whitt: 1.71	**NICE** RN WTE 18.32 RN(1:8/1:2) 10.25 Variance -8.07	**Current Planned Staffing levels** Day: 3+2 Night: 3+2	**Bed Occupancy** 2014: 97.2% 2015: 98.8% Variance: 1.6%

Activity during reference period;

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
140	56	1	46	1	2	1	0

Quality Indicators

No reported cases of MRSA or C Difficile on Mary Seacole North this year and no acquired pressure ulcers. There was a reduction in harm free care in April as one patient was admitted with on old pressure ulcer. There are low numbers of complaints. The falls rates are also low, with none in October 2015.

Current challenges

The high turnover of patients and relatively high number of admissions of people with mental health diagnoses places extra burden on the staffing resource. There were two incidents recorded on Datix relating to nurse staffing levels during the 12 month period.

Recommendations

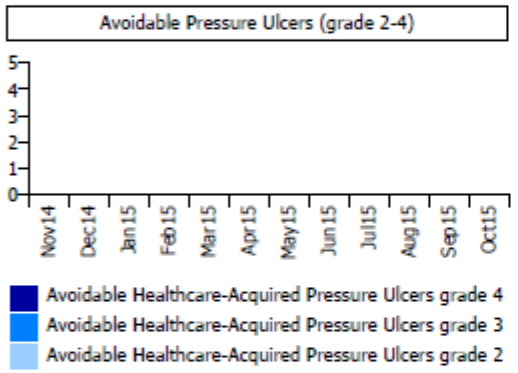
There is adequate provision in the establishment for a 3+2 staffing model with the ward manager totally supervisory. An adjustment was made to the SNCT recommended wte to take into account the high patient flow.

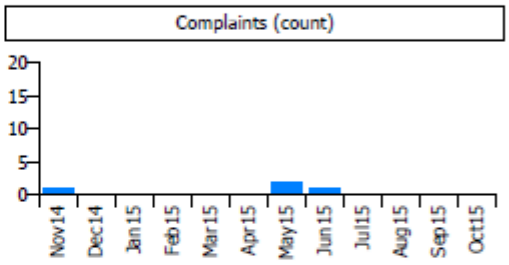
Establishment levels will be reviewed later this year following the implementation of Allocate E-Roster.
The Safe Staffing 'live' facility will enable acuity and dependency of patients to be reviewed against planned and actual staffing levels in addition to competencies of staff on duty.

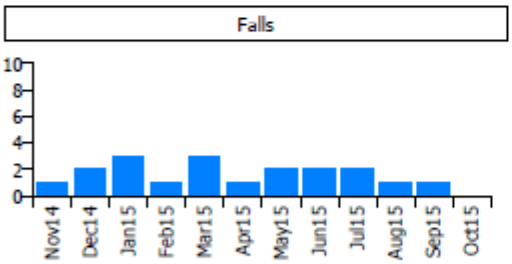
In discussion with the Head of Nursing, it is proposed that there is further review of the role of the band 5 nurses in this area, and the potential to introduce Assistant Practitioners (band 4).

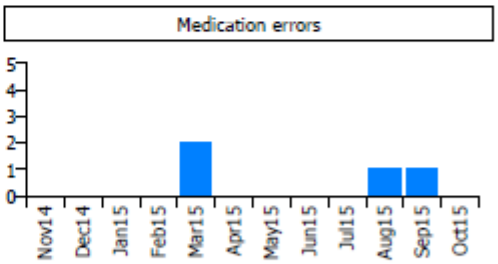
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

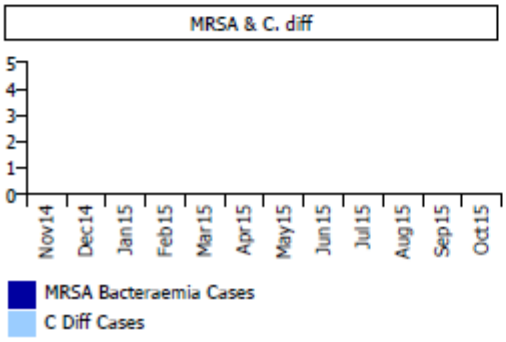
Mary Seacole North	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	1	2	3	1	3	1	2	2	2	1	1	0
Medication errors reported	0	0	0	0	2	0	0	0	0	1	1	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	0	0	0	0	2	1	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	88%	100%	93.8%	100%	100%	93.8%	100%

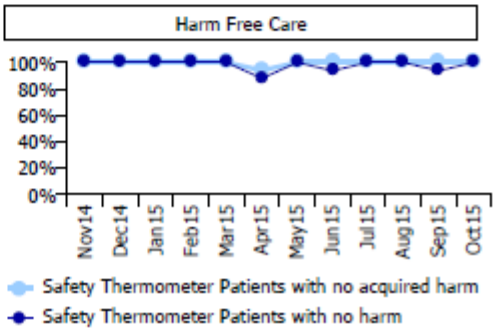












Ward Summary

Mary Seacole South is an acute assessment unit consisting of 18 beds, six of which can accommodate high dependency patients. Patients are admitted direct from the Emergency Department to this unit and may present with a range of acute surgical or medical issues that require assessment and treatment prior to discharge home or transfer to another ward. A number of patients on this unit will be highly dependent and on complex drug regimens. Increased levels of observation are frequently required including cardiac monitoring. The ward is L shaped, with the six monitored beds opposite the nurses' station, four side rooms and two four bedded bays. Nurses are assisted by 1 Facilities Services Assistant (FSA) who undertakes portering duties, a part time ward clerk and a dedicated ward Pharmacist. Six consultants and their teams cover Mary Seacole South. The Facilitated Early Discharge Service (FEDS) provides Occupational Therapy and Physiotherapy input on this ward, which is shared with Mary Seacole North, Ambulatory Care and the Emergency Department.
The ward manager is totally supervisory providing shift coordination and has one 'administrative management' day per week. When the ward manager is not on duty there is a shift leader who is supervisory and provides shift coordination. The SNCT recommended WTE below was adjusted to include provision for high patient flow.

Sickness rates at time of review was 8.55%

Vacancy rate at time of review was 0.06wte

Funded WTE	**Actual WTE**	**Safer Nursing Care Tool WTE**	**NHPPD**
RN 24.37 HCA 5.35 RN/HCA 29.72	RN 20.34 HCA 9.32 RN/HCA 29.66	Direct Nursing WTE 26.90 Recommended WTE 24.97 Variance -1.70	Direct Nursing WTE 26.90 Recommended WTE 25.98 Variance -0.92
Staff to bed ratio: Whitt: 1.49	**NICE** RN WTE 21.55 RN(1:8/1:2) 16.65 Variance -4.90	**Current Planned Staffing levels** Day: 4+1 Night: 4+1	**Bed Occupancy** 2014: 96.9% 2015: 97.5% Variance: 0.6%

Activity during reference period;

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
89	62	4	53	0	0	0	0

Quality Indicators

There have been no cases of MRSA bacteraemia or C Difficile on Mary Seacole South over the 12 month period. There was one acquired grade 3 pressure ulcer in June 2015. There was one medication error in August 2015 and complaints are at low levels. The falls rate is variable. There was a reduction in performance in harm free care in May and September. The May and October figures were as a result of two patients admitted who had old pressure ulcers and old urinary tract infections (UTI). These were counted in Safety Thermometer on the day of audit, but are not counted in the graph of new avoidable pressure ulcers.

Current challenges

High turnover of patients and relatively high number of admissions of patients with mental health conditions impacts on staffing resources.

Recommendations

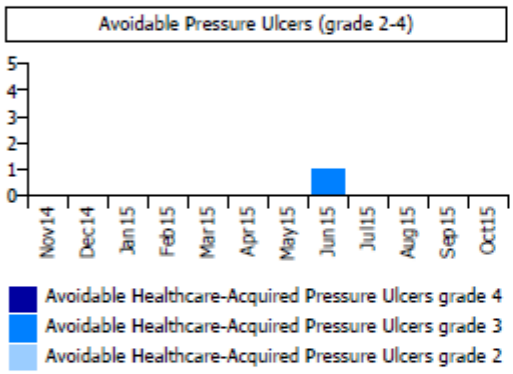
In discussion with the Head of Nursing, it is proposed that there is further review of the role of the band 5 nurses in this area, and the potential to introduce Assistant Practitioners (band 4).

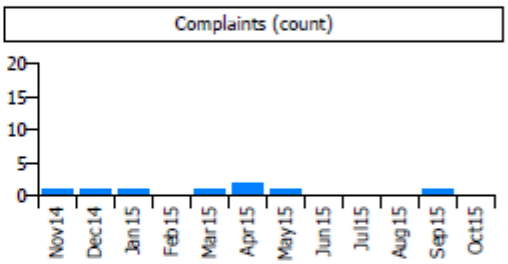
Establishment levels will be further reviewed later this year following the implementation of Allocate E-Roster.
The Safe Staffing 'live' facility will enable acuity and dependency of patients to be reviewed against planned and actual staffing levels in addition to competencies of staff on duty.

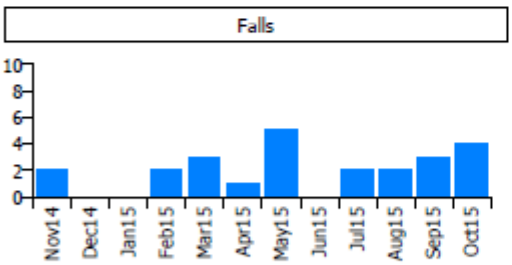
There is adequate provision in the establishment for a 4+1 staffing model with the ward manager/shift leader being supervisory. The original funded establishment was agreed on the basis of a 5+1 and 4+1 model. There are currently a number of nurses awaiting their PIN and so the actual wte for HCAs is higher than the funded establishment and there is a corresponding decrease in the number of actual RNs. The model has been adjusted accordingly and is considered safe.

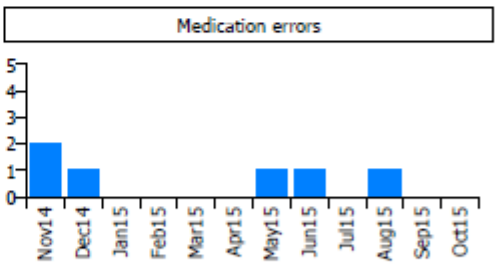
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

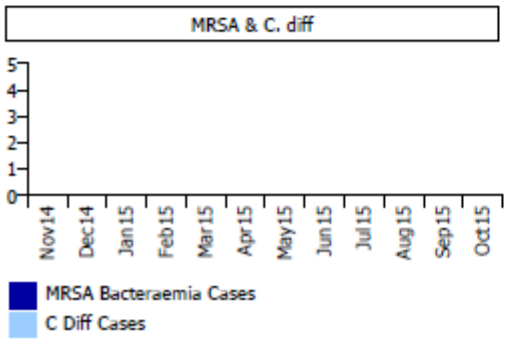
Mary Seacole South	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	1	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	2	0	0	2	3	1	5	0	2	2	3	4
Medication errors reported	2	1	0	0	0	0	1	1	0	1	0	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	1	1	0	1	2	1	0	0	0	1	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	83%	100%	100%	94%	100%	75.0%	100%	100%	100%	76.5%	100%

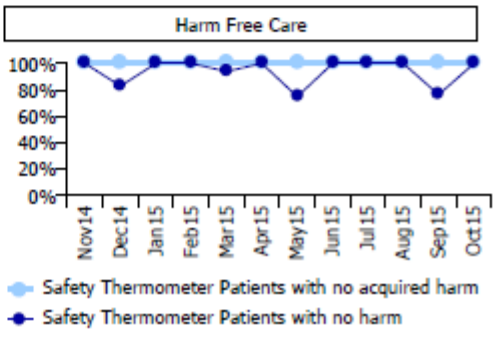












Ward Summary

The Emergency Department (ED) contains both an adult and a paediatric area.
There are four beds within the resuscitation area, 13 cubicles in the 'Majors' area, two mental health cubicles, three cubicles in the 'rapid assessment' area, eight beds in the clinical decision unit, four cubicles in urgent care. The paediatric area accommodates five cubicles and one high dependency bed.
There is a plaster room, a suture room and an eye room within the ED.
There are two Matrons, a practice development nurse (PDN), a lead nurse for Urgent Care and a lead nurse for paediatric ED all of whom are totally supernumerary. There is also an administrator and young people have access to a play specialist. One of the senior nurses acts as shift leader and oversees ambulance admissions in addition to managing flow within the department. Patients seen here have a range of conditions, including injuries relating to trauma. Patients requiring specialist trauma care are seen at the Royal London Hospital. Patients with major burns are transferred to the Chelsea and Westminster specialist unit. The condition of patients can be highly changeable. There is a high demand for 1-1 Registered Mental Health nurses to provide close supervision for patients with mental health conditions.

During the review period there were 10.28wte RN vacancies and a sickness rate of 4.34%.

Funded WTE	**Actual WTE**	**NICE Draft Guidance:**	**NICE Establishment Recommendations:**
RN 92.88 HCA 8.89 RN/HCA 101.77	RN 77.3 HCA 9.61 RN/HCA 86.91	Majors/minors 1:4 RN to patient In the event of a cardiac arrest: 2:1 RN to patient	Adult: 47.14 wte RN Resus: 10.48 wte RN Paed ED: 15.71 wte RN Total : 73.33 wte RN
Variance NICE WTE:	**EDSNCT Pilot**	**Current Planned Staffing levels**	**Attendance:**
Funded: 92.88 NICE: 73.33 Variance: 19.55	RN: 60.48 Variance RN: 32.40 HCA: 7.76 Variance HCA: 1.13	Day: 17 Night: 14	96000 per annum

Quality Indicators

There have been no cases of MRSA bacteraemia, C Difficile or pressure ulcers attributed to care in ED over the 12 month period. There was a cluster of falls over the summer but this has reduced to zero. There were two medication errors reported in September 2015. The number of complaints is reducing. The key theme about complaints received in ED relates to medical care and missed diagnosis.

Current challenges

Increasing numbers of patients are expected to attend over the winter period with the annual attendance higher than that of the Royal Free Hospital.
Challenges with the fabric of the department include only one toilet in majors and a very small sluice. It is acknowledged that the layout is challenging. The rooms for mental health patients have been put on the risk register as they require refurbishment. In addition it is recognised that patients with mental health conditions who require a specialist bed in a specialist facility are spending an unacceptably long time within the department. There were 16 incidents recorded on Datix that relate to nurse staffing levels between November 14 and October 15.

Recommendations

The Emergency Department has sufficient numbers of staff according to the draft NICE guidance and the pilot of the yet to be validated prototype of the ED Safer Nursing Care Tool.

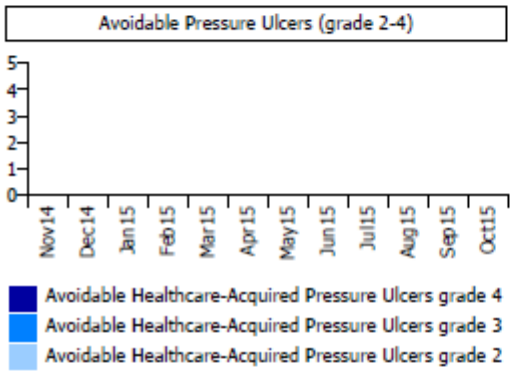
The Trust took part in the national pilot of the BEST tool (An acuity tool developed for ED nurse staffing) in 2013. It recommended that the RN and the HCA establishment each were increased by 11wte. This tool is yet to be fully validated and is not currently in use in North Central East London.

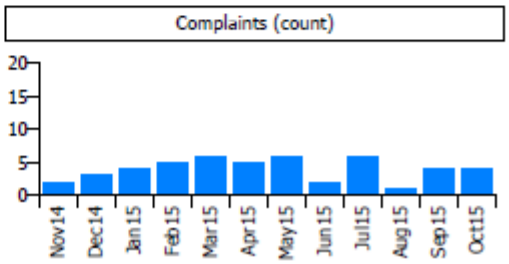
In the absence of a fully validated tool, the professional judgement of the Matron is that the current model of staffing is adequate.

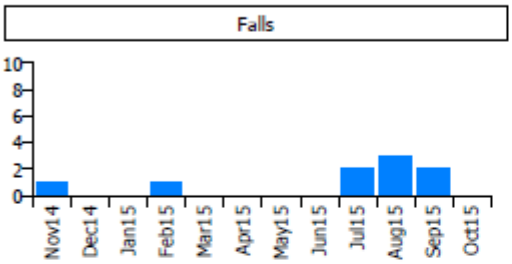
The NICE draft guidance model suggests that ED is over established, however staffing will be further reviewed after implementation of the Allocate E-roster system. There is adequate in the establishment for the current staffing model with the shift leader being supernumerary.

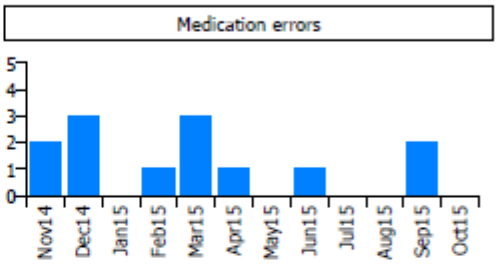
Emergency Department: Safe Staffing Review - Quality Indicators

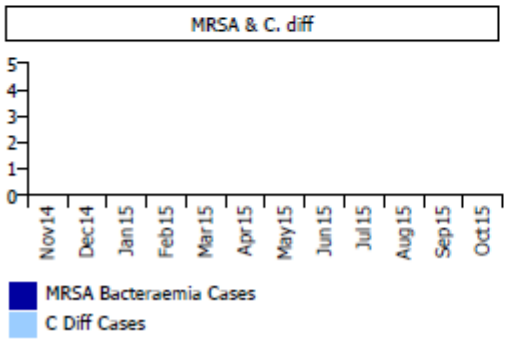
Emergency Department	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	1	0	0	1	0	0	0	0	2	3	2	0
Medication errors reported	2	3	0	1	3	1	0	1	0	0	2	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	2	3	4	5	6	5	6	2	6	1	4	4











Theatres

Ward Summary

Theatres includes a Day Treatment Centre (DTC) for day- case patients, a recovery unit, ten theatres and four procedure rooms in addition to a pre-assessment clinic. Theatres are arranged along a corridor and each theatre has an anaesthetic room. DTC opens at 07:00 and the first patient is in the anaesthetic room at 08:15 with the exception of Thursday when theatres open at 9:00 due to staff training and/or a multidisciplinary team meeting. There is a trauma meeting on a daily basis and at this meeting emergency cases that arrived overnight are given a place on the operating list. There is an emergency theatre available 24 hours a day. Nurse staffing start times are staggered throughout the day, with some staff being on call till midnight, with skeleton staff overnight. Each theatre operates two four hour sessions each day. At the end of the day, one theatre is prepared for use in the event of an emergency. Some theatres/theatre sessions are leased by other organisations, including Moorfields, and the Royal Free. These are either staffed with their own staff or Whittington Trust staff.
There is a Matron responsible for theatres operates in a totally supervisory capacity.

The sickness rate during the review period was 1.86%

There were 18.63 vacancies noted during the review period.

Funded WTE	**Actual WTE**	**AfPP Recommendation:**
RN 92.66 NA 26.0 RN/NA 118.66	RN 76.05 NA 23.98 RN/NA 86.91	RN 103.8 wte HCA 6.18wte Total Variance: -8.68wte

Quality Indicators

There are no specific nurse sensitive indicators for theatres, but surgical site infection rates are reported nationally and are below national benchmark levels. The data is reported at the Infection Control Committee and is on the Trust dashboard. The latest report from Public Health England is available on request. There are no concerns about our infection rates. There is an annual audit programme of performance against the Association for Perioperative Practice (AfPP) standards. The latest quarterly audit is available on request.

Current challenges

Overall theatre utilisation is 85-87%. Work is in progress to increase the rates in specialities that fall below this. Some theatre lists also overrun consistently. There are high rates of sickness, although rates during the review period were low. There is a business opportunity for theatres to gain contracts from external companies.

Recommendations

The Association for Perioperative Practice (AfPP) review was undertaken in 2015, and suggested that the nurse staffing establishment is sufficient to meet the needs of the service. This is also the professional judgement of the departmental manager. Though there seems to be more healthcare assistants than required, theatres is a difficult to recruit to area and so additional healthcare assistants have been built into the establishment. This together with the opportunity to bid for contracts in the future that might require an increase in nursing staff leads to the conclusion that staffing should remain unchanged.

Common Quality Indicators not appropriate Theatres

Ward Summary

Critical care is a 15 bed unit which cares for ventilated and high dependency patients. There is no separate or designated high dependency area and patients are admitted to beds which are available when required. Four beds are in isolation cubicles situated away from the main area. There is a Matron and staff also have access to a Lecturer Practitioner and a Practice Development Nurse. There is an administrator and data entry administrator. The Matron and the shift leader are both supernumerary as recommended by the British Association of Critical Care Nurses (BACCN). There are three 'runners' on each shift, two for the side rooms and one for the main area. They assist nurses who have been assigned a patient with activities that require an additional nurse such as turning a patient. Staffing flexes up and down as required. Patients seen here have a range of acute medical and surgical conditions, with a high number of these being in respiratory distress. The HDU patients though not ventilated may require haemo-filtration and other invasive support which means greater dependency and need for nursing care There are a low number of trauma cases here as these are normally transferred to the Royal London. Burns patients are not cared for in the unit and are normally transferred to Chelsea and Westminster Hospital for specialist care. By the nature of the environment, the condition of patients can be highly changeable and all require close supervision and high levels of care. The team of seven consultant intensivists is led by Chris Hargreaves. The unit has a dedicated physiotherapist, and shares a senior physiotherapist with the surgical wards, another physiotherapist with Victoria ward and a therapies technician with Mercers ward.

The sickness rate during the review period was 1.88%

There were 14 band 5 and 8 band 6 vacancies in October.

There were 60 inpatient stays in October with a total of 324 days spent in critical care.

Funded WTE	**Actual WTE**	**BACCN Guidance:**	**BACCN Establishment Recommendations:**
RN 77 HCA 0 RN/HCA 77	RN 56.36 HCA 0 RN/HCA 56.36	Ventilated : 1:1 RN to patient HDU: 1:2 RN to patient	Ventilated: 57.62 wte RN HDU: 10.48 wte RN Total: 68.10 wte RN Runners: 15.71 wte RN Nurse In Charge: 5.24 wte RN

Variance BACCN WTE:	**BACCN Recommendations (runners and charge nurse) vs % occupancy WTE**	**Current Planned Staffing levels**
Funded: 77 BACCN: 68.10 Variance: 8.9	70%: 62.34 75%: 66.79 80%: 71.24 85%: 75.69	Day: 16 Night: 16 **Bed Occupancy** October 2015: 78.3% Average for 2014-15: 76.9%

Quality Indicators

No cases of C. Difficile or acquired pressure ulcers over the period measured. There was one MRSA bacteraemia in January 2015 that was Trust attributable for which a root cause analysis as part of an SI investigation was undertaken. No obvious cause was found. The patient had multiple co-morbidities and active treatment had been withdrawn. Complaints are rare. There was a small number of falls and medication errors in the reference period. There was a reduction in harm free care in July. This was because there were two patients admitted with old pressure ulcers.

Current challenges

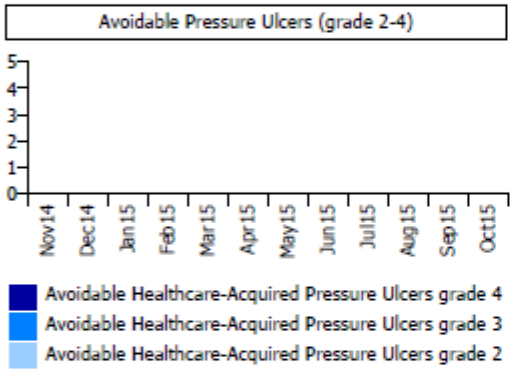
Recruiting staff to this area is a constant challenge and turnover amongst these staff is high. There are few opportunities for promotion in the unit as there are proportionately less band 6s than 5s. Staff often need to leave to gain promotion. There was one incident recorded on Datix related to nurse staffing levels in November 2014 – October 2015.

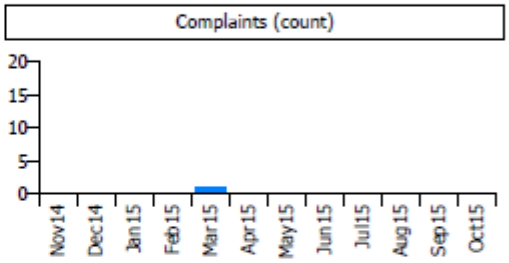
Recommendations

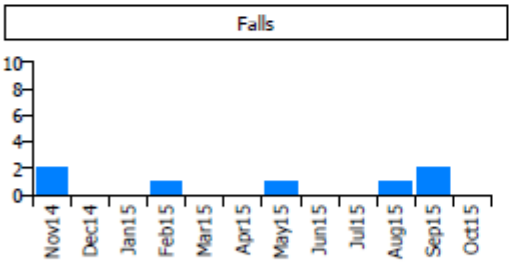
If the unit was 100% occupied, the BACCN guidelines suggest that the area is understaffed. However, when considering the average occupancy, the compliment of registered nurses is adequate, with a 5% confidence interval. Therefore it is recommended that the nurse staffing establishment remain unchanged.

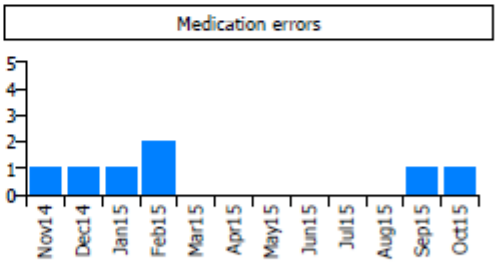
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

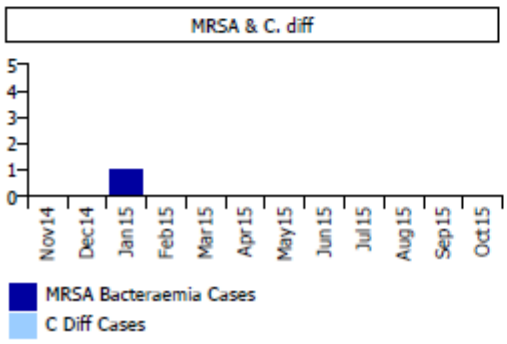
ITU	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	2	0	0	1	0	0	1	0	0	1	2	0
Medication errors reported	1	1	1	2	0	0	0	0	0	0	1	1
MRSA Bacteraemia Cases	0	0	1	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	0	0	1	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	92.3%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	92%	100%	100%	100%	100%	100%	84.6%	77.8%	100%	100%	100%

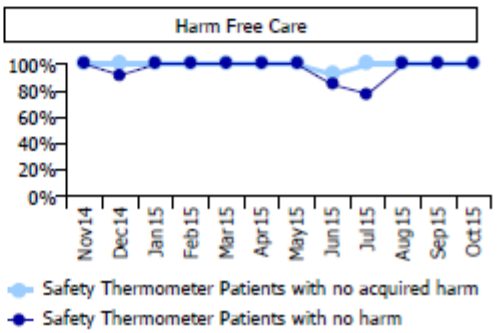












Ifor Ward

Ward Summary

Ifor is a 23 bed paediatric ward which includes two paediatric critical care level 2 beds, one six bedded bay, one five bedded bay and ten side rooms. Young people between the ages of 0-17 are admitted here through the emergency department with a range of acute medical and surgical conditions. There is no paediatric ITU on site, and young people whose condition deteriorates and require ventilation are transferred to a specialist centre. Young people with mental health issues are assessed by a specialist psychiatrist and they advise on whether the young person requires specialist monitoring. There is a dedicated ward pharmacist and ward clerk who assists nurses with administration, Monday to Friday. There are three play specialists who are shared with other departments in the Trust. The ward has a part time housekeeper. There is a Consultant on site Monday to Friday until 10pm. There is an on-call registrar available overnight and the service is supported by a range of other medical staff of differing levels of training. There are three Physiotherapists that work between Ifor and the outpatient clinics. The ward manager is totally supervisory and works alongside staff clinically.

The sickness rate during the review period was 4.59%.

The ward has 4wte vacancies during that period.

There were 215 inpatient stays in October 2015. This is a high number of admissions, which would take additional nursing time.

Funded WTE	**Actual WTE**	**Occupancy Split**	**RCN Guidance:**
RN 31.66 NA 4.54 RN/NA 36.2	RN 29.66 NA 2.54 RN/NA 32.2	Under 2: 41.34% Over 2: 58.66%	Under 2: 1:3 RN to child Over 2: 1:4 RN to child HDU: 1:2 RN to child
Staff to bed ratio: Whitt: 1.5	**RCN Guidance:** RN WTE: 29.66 RN (1:2,3,4)WTE: 36.67 Variance: 7.01 WTE adjusted for Occupancy: 65%: 23.84 70%: 25.67 75%: 27.50 80%: 29.34	**Current Planned Staffing levels** Day: 4+1 Night: 4+1	**Bed Occupancy** October 2015: 78.3% Average for 2014-15: 64.6%

Quality Indicators

No cases of MRSA, C Difficile falls or acquired pressure ulcers on Ifor this year. There has been the occasional medication error and complaint. There are no clear themes from the complaints received. The ICSU is considering implementing the paediatric safety thermometer later this year (Measurements include the early warning score and action, pain assessment and action, pressure ulcers and moisture lesions and extravasation.) Ifor achieved 100% harm free care in the year from November 14 – October 15.

Current challenges

New national guidance for paediatric high dependency care was published in 2014 which relates to operational standards. Compliance with these standards will be assessed at the next peer review, which is scheduled to be next year. The Head of Nursing is confident that we meet these already. Pressure for level three (ventilated) beds is high, and the expansion of critical care beds is in the ICSU strategy for 2015/16. There are also plans to reconfigure the ward to include an adolescent bay. Planned staffing levels for paediatric critical care as well as the general ward need to be separate to comply with the new national standards and peer review requirements. There was one incident recorded on Datix that related to nurse staffing levels in November 2014 – October 2015.

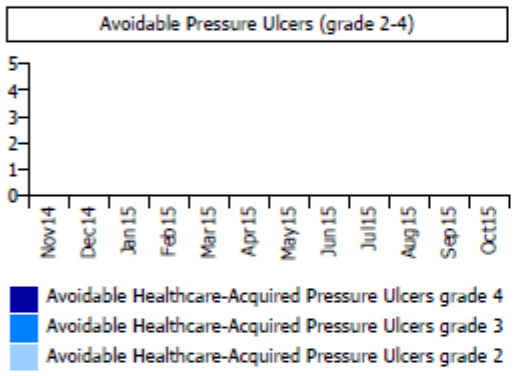
Recommendations

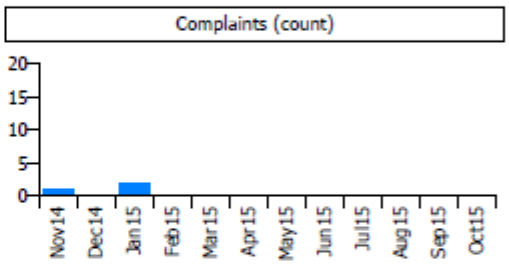
According to RCN guidelines, the staffing establishment for registered nurses would not be sufficient if the ward was fully occupied. The funded wte above also includes the ward manager and other staff who are not counted in the numbers. However, when looking at the average occupancy levels and specifically occupancy in the month of October when the review took place, there would appear to be adequate numbers of registered nurses. The NHPPD tool determined an establishment of 20.75wte based on activity undertaken in October.

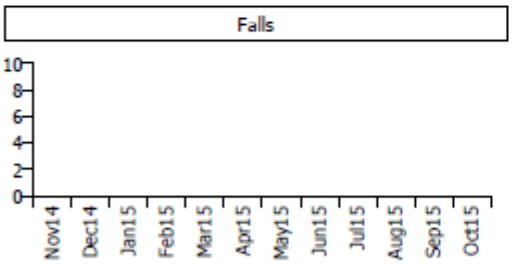
The recommendation is for the establishment to remain unchanged but reviewed on implementation of the Allocate E-roster system later this year.

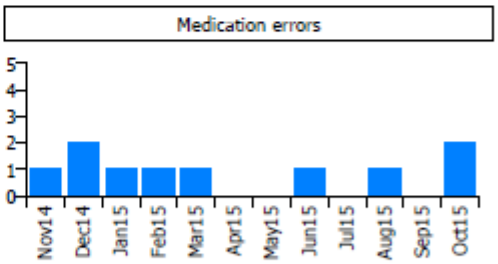
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

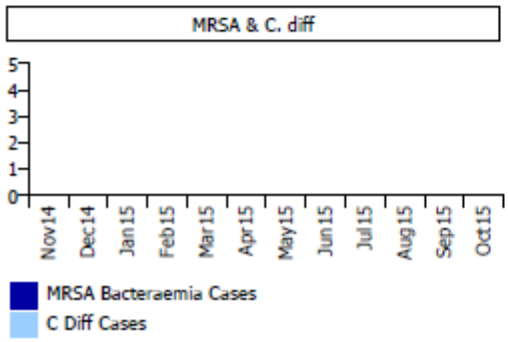
Ifor	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	0	0	0	0	0	0	0	0	0
Medication errors reported	1	2	1	1	1	0	0	1	0	1	0	2
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	2	0	0	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

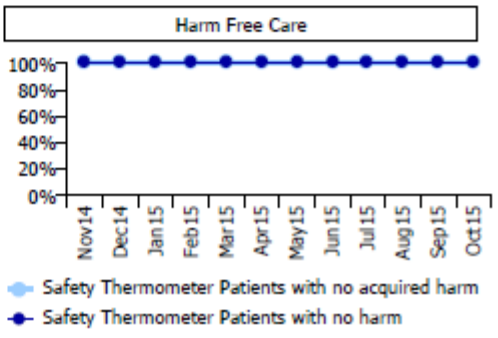












Ward Summary

NICU has six intensive care cots, six high dependency cots, eleven special care cots and four isolation cots. The special care baby unit is housed on the floor directly above NICU and accommodates less dependent babies who do not require ventilation. This area is staffed by nursery nurses under the supervision of a registered nurse. Babies are generally admitted to the neonatal unit directly from the labour suite and may have a range of acute conditions such as respiratory distress.

As a level 2 unit, acute referrals are received from local level 1 units (the Royal Free) A level 2 unit is a unit that accepts babies born at gestation equal to or greater than 32 weeks and at a weight of greater than 1.5 kg. These babies require a higher level of nursing care in comparison to a level 1 unit. Level 1 units are for babies that are stable but require more support than a fully healthy new-born. Since the Royal Free merged with Barnet Hospital which has a level 2 unit, the number of transfers from the Royal Free has reduced. However a new contract has been agreed with Great Ormond Street to repatriate neonatal post-surgical babies, both Whittington and non- Whittington. This will increase the number of admissions. Babies with more serious conditions requiring surgery and who are extremely premature (less than 28 weeks gestation) may be transferred to a specialist level three unit such as UCLH. There is a dedicated ward Pharmacist and a ward clerk who assists nurses with administration Monday – Friday. Babies have access to a play specialist from Ifor if their condition allows. The Matron for the area is totally supervisory and a day is not allocated for administrative management. There isn't a dedicated physiotherapist for the unit.

The sickness rate during the review period was 8.04%

The ward has 14.16wte vacancies at time of review.

Funded WTE	**Actual WTE**	**RCN Guidance:**	**RCN Establishment Recommendations:**
RN 52.52 NN 7 RN/NN 59.52	RN 39.83 NN 5.53 RN/NN 45.36	Ventilated : 1:1 RN to baby HDU: 1:2 RN to child Special care: 1:4 RN to baby	ITU: 31.43 wte RN HDU: 15.71 wte RN Special Care: 14.40 wte RN Total: 61.54 wte RN
Variance RN WTE: Funded: 52.52 RCN: 61.54 Variance:-9.02	**RCN Recommendations vs % occupancy WTE** 70%: 43.08 75%: 46.16 80%: 49.23 85%: 52.31	**Current Planned Staffing levels** Day: 8+2 Night: 9+1	**Bed Occupancy** October 2015: 79.3% Average for 2014-15: 76.6%

Activity during reference period:

Admissions	Discharges	Transfers In	Transfers Out	Escorts on site	Escorts off site	Deaths	Ward attenders
43	47	4	2	0	0	0	0

Quality Indicators

No cases of MRSA, C Difficile, pressure ulcers or complaints on NICU over the reference period. There were four medication errors in December 2015, which were not linked. There was 100% harm free care in the past year.

Current challenges

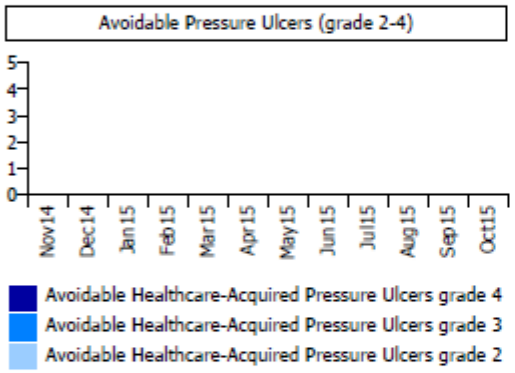
There continue to be a number of vacancies, which reflects the national position of neonatal nurses being the only nursing specialism on the government's shortage occupation list. There are national and local projects that are working to address this issue including an accelerated band 5 postgraduate programme. The occupancy rate of the unit reflects the activity through maternity which has recently increased and is set to increase further if expansion plans go ahead. The plan is to increase the Advanced Neonatal Nurse Practitioner (ANNP) workforce to meet future skill mix and workforce requirements. There were two incidents recorded on Datix that relate to nurse staffing levels in November 2014 – October 2015.

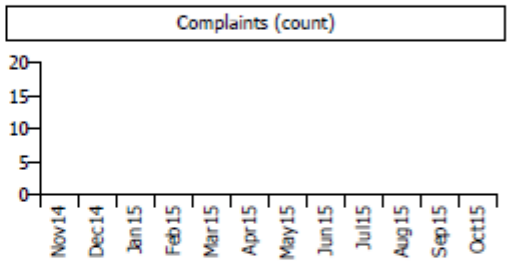
Recommendations

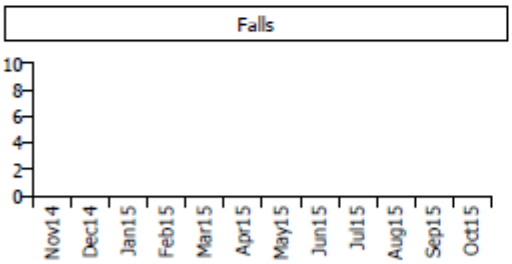
NICU would appear to be under staffed according to the RCN guidance; however, when looking at the average occupancy, the funded establishment for RNs is sufficient, with a 5% confidence interval. However, the funded establishment includes staff that are not counted in the numbers such as the Matron and PDN. On discussion with the Matron, he feels that staffing levels are safe with the current proposed staffing model. Therefore it is recommended that there is no change to the current establishment outside of the planned strategy.

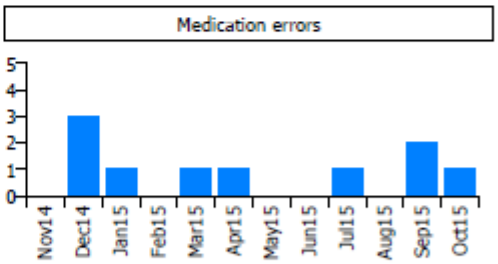
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

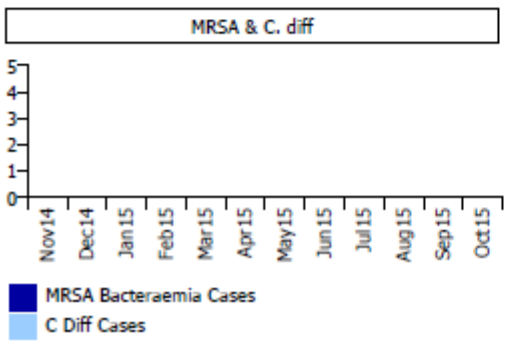
NICU	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	0	0	0	0	0	0	0	0	0
Medication errors reported	0	3	1	0	1	1	0	0	1	0	2	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	0	0	0	0	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

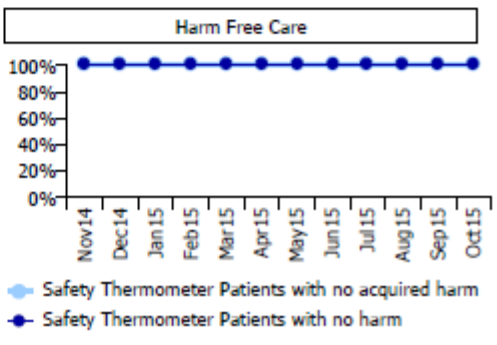












Department Summary

The maternity department consists of a Labour Ward (12 beds), Birth Centre (five beds), Cellier (postnatal ward and transitional care - 25 beds) and Murray Ward (antenatal ward and inductions of labour - 18 beds) and Cearns (triage of ante and postnatal mothers and babies - 3 beds).
A maternity triage service is provided. The maternity unit is located in a Victorian section of the hospital. Midwives are supported by 17.28wte administrative staff. There is a housekeeper shared between Cellier and Labour ward. The last full Birthrate Plus assessment was reported in November 2013. This is a system endorsed by the Royal College of Midwives and Department of Health for determining safe staffing and is a framework which recommends an establishment and skill mix based on the complexity of the mothers that present to us. The assessment found that there was a higher than average number of mothers that fell into the highly complex categories and recommended a ratio of 1 midwife to 25 births. This latest update report is available on request. The current ratio is 1:22 which the Head of Midwifery confirms is a safe ratio for the current client group, based on 4,000 births per year. This is the lowest midwife to birth ratio in London and corresponds to the recommendations from Birth-rate Plus after a further review at the end of last year. There is a bleep holder during the day that supports midwives with management issues. The Hospital site manager provides management support out of hours. There are currently 13 Supervisors of Midwives and an additional two currently in training.

The sickness rate during the reference period was 2.87%

The department reported 3.89wte vacancies during the period reviewed.

Funded WTE		**Actual WTE**		**Birthrate Plus WTE**		**Staffing Model**
RM	166.9	RM	151.5	Funded WTE	202.15	Day: 16+6
MSW	35.25	MSW	30	Recommended WTE	202.15	Night: 16+6
Band 4	16.72	Band 4	16.72	Variance	0	
RM/RN/MSW/Band 4:	202.15	RM/RN/MSW/Band 4:	198.26			

Quality Indicators

No cases of MRSA or C Difficile, pressure ulcers or falls over the 12 month reference period. Complaint numbers are declining. There was a spike of complaints received relating to the Labour ward in May 2015. The subjects of these complaints were different and did not relate to care received from midwives. There are no apparent themes for complaints received about maternity as a whole. There was a spike of four medication errors on Cellier in June 2015 and Labour ward in March 2015. There were no themes identified. There was 100% harm free care across all areas of maternity during November 2014 – October 2015.

There were 138 incidents reported on Datix relating to Midwife staffing levels between November 2014 and October 2015. However, only one complaint relating to staffing levels was received during this time. There were eight serious incidents in the past year for which there were no apparent trends or themes.

Current challenges

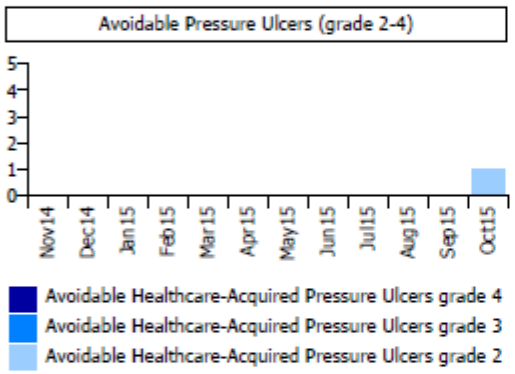
A multi million pound business case has been proposed to allow for upgrading and expansion of the current unit.

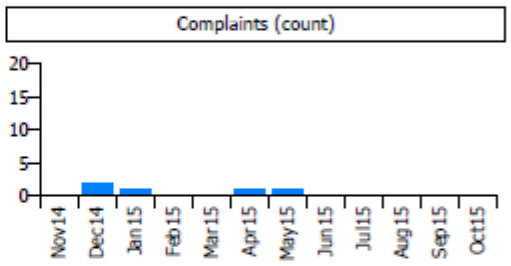
Recommendations

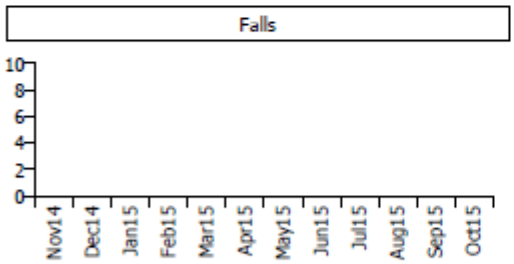
There is sufficient in the establishment to cover the current staffing model. It is recommended that there are no reductions to the staffing levels while there are plans to expand the service.

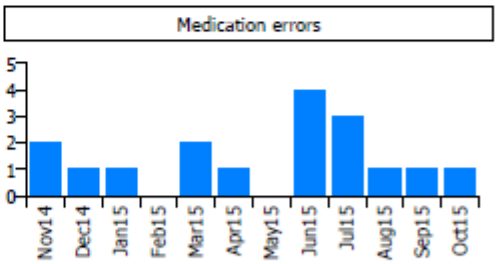
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

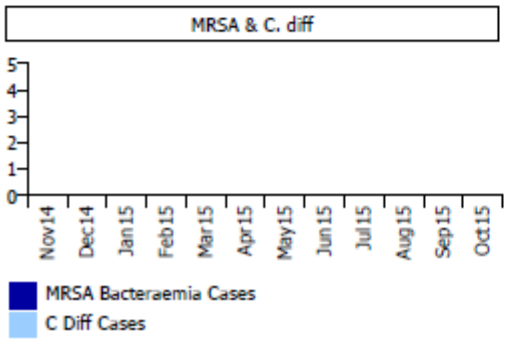
Cellier	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	1
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	0	0	0	0	0	0	0	0	0
Medication errors reported	2	1	1	0	2	1	0	4	3	1	1	1
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	0	2	1	0	0	1	1	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

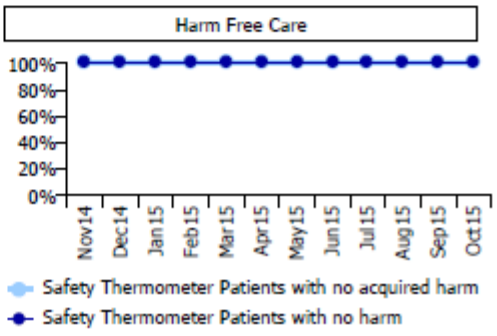






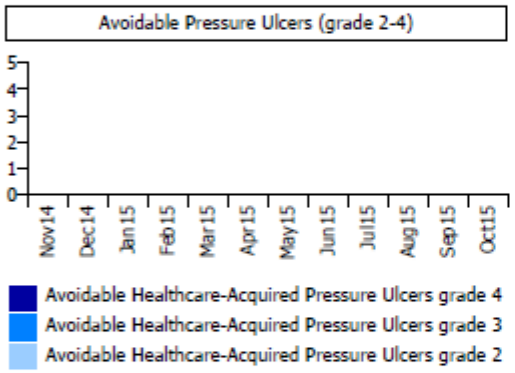


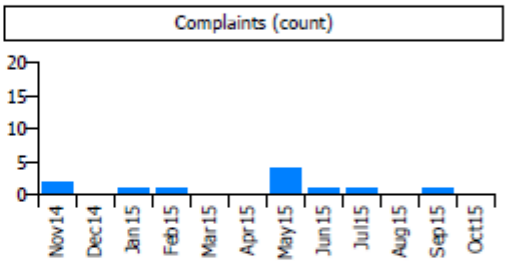


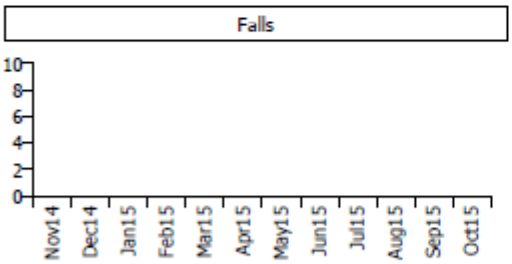


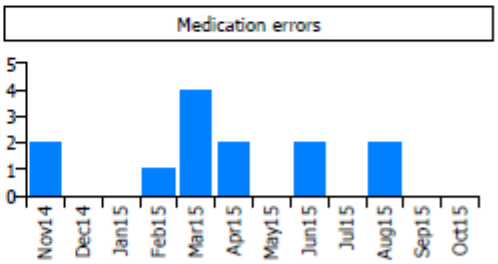
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

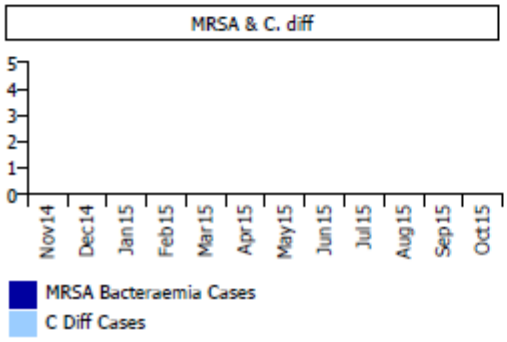
Labour Ward	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	0	0	0	0	0	0	0	0	0
Medication errors reported	2	0	0	1	4	2	0	2	0	2	0	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	2	0	1	1	0	0	4	1	1	0	1	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

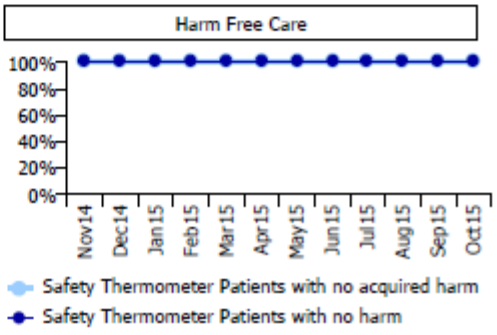






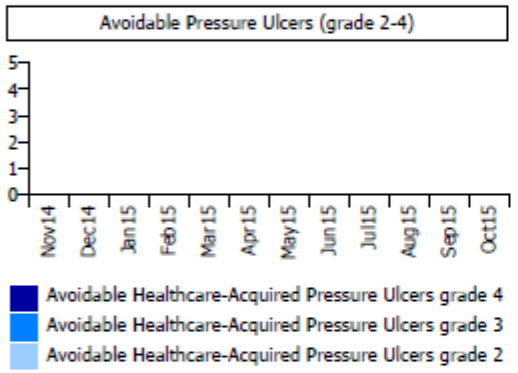


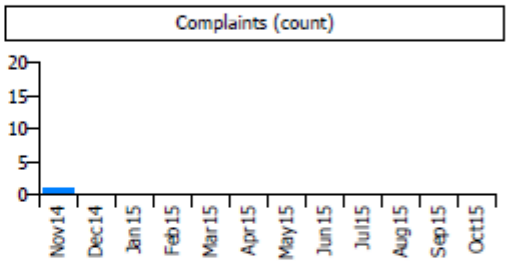


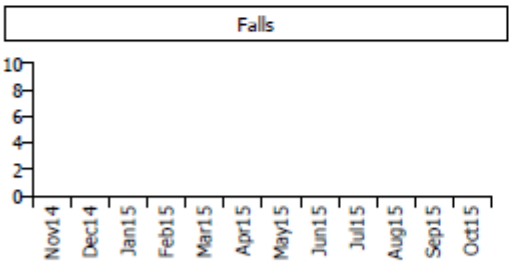


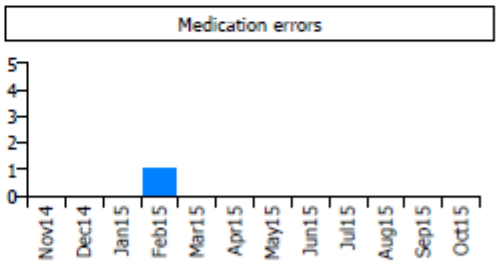
INPATIENT WARDS: Safe Staffing Review - Quality Indicators

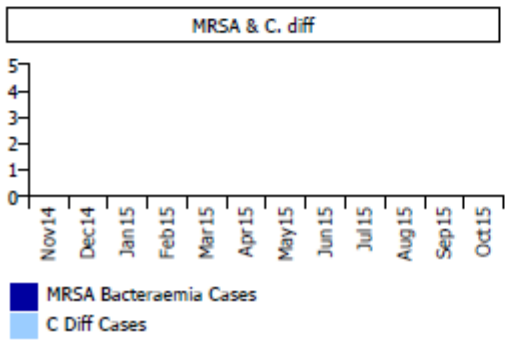
Murray	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	0	0	0	0	0	0	0	0	0	0	0	0
C Diff Cases	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient falls	0	0	0	0	0	0	0	0	0	0	0	0
Medication errors reported	0	0	0	1	0	0	0	0	0	0	0	0
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0	0
No.of Complaints	1	0	0	0	0	0	0	0	0	0	0	0
Safety Thermometer Patients with no acquired harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safety Thermometer Patients with no harm	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

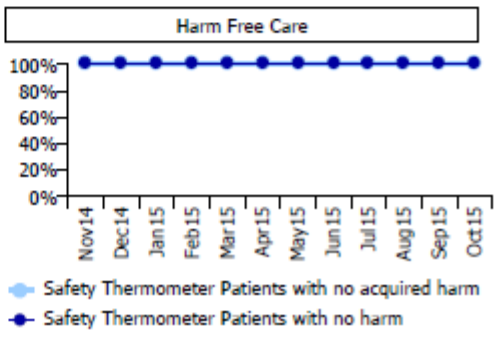












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Whittington Health NHS

Trust Board
2 March 2016

Title:	Quality Committee Meeting 13 January 2016						
Agenda item:	**16/042**		**Paper**		**11**		
Action requested:	For the Board to note the business of the 13 January Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper is the draft January Quality Committee minutes						
Summary of recommendations:	The Trust Board is asked to take assurance that the Quality Committee is compliant with its terms of reference and delegated authority						
Fit with WH strategy:	The Committee, a sub-committee of the Trust Board, considers business relating to quality and safety of services						
Reference to related / other documents:	SO's. SFI's and Scheme of Delegation						
Date paper completed:	22 February 2016						
Author name and title:	**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Anu Singh, Non-Executive Chair**		
Date paper seen by EC	**Mar 2016**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

DRAFT Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 13th January 2016 2:00pm – 4:00pm
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS) Non-Executive Director (Chair)
Members Present:	Philippa Davies (PD), Director of Nursing and Patient Experience Mary Slow (MS), Shadow Governor Graham Hart (GH), Non-Executive Director Carol Gillen (CG), Acting Chief Executive Officer
In attendance	Lynne Spencer (LS), Director of Communications Daniela Petre (DP), Head of Risk Emmeline Closier (EC), PDN Surgery Fiona Isacsson (FI), Director of Operations, Surgery and Cancer Amanda Hallums (AH), Director of Operations, WFS Manjit Roseghini (MR), Head of Midwifery Doug Charlton (DC), Deputy Director of nursing & Patient Experience Steve Hitchin (SH), Chairman Clarissa Murdoch (SM), Clinical Director MFNS Alison Kett (AK), Head of Nursing MFNS Charlotte Johnson (CJ), Equality and Diversity Lead Trish Folan (TF), Matron Infection Control Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes)
Apologies:	Richard Jennings (RJ), Clinical Director Anita Charlesworth (AC), Non-Executive Director Helena Kania (HK), Shadow Governor

Agenda items

1.	**Welcome & Apologies**	AS
1.1	AS welcomed everyone to the meeting and apologies were received and noted. AS highlighted the need to ensure appropriate attendance in future as the Committee developed to enable good discussions from all areas. There were no declarations of conflicts of interest. AS formally thanked Kate Green for her work in taking minutes at previous Quality	

	Committee meetings and welcome Gillian Lewis as the new Committee Administrator.	
Actions	**Deadline**	**Owner**
Review Terms of Reference and membership to ensure appropriate attendance 2016/17	9 March 2016	LS/PD

2.	**Minutes of the previous meeting (18th November 2015)**	MM
2.1	The minutes of the last meeting were approved as a correct record	
Actions	**Deadline**	**Owner**
Minutes to be included in the next Trust Board public meeting for assurance to the Board.	6 January 2016	AS/LS

3.	**Action Log**	AS
3.1	The Action Log was reviewed and updates recorded.	
Actions	**Deadline**	**Owner**
See Action Log	On Log	On Log

4.	**CQC Update**	AS
4.1	PD provided an update on the CQC inspection process. The Trust expects to receive the draft report in early February. The Quality Summit is scheduled for the end of February, and the expected publication date of the final report is 9th March 2016. The Committee acknowledged the work of all staff during the CQC inspection.	
Actions	**Deadline**	**Owner**
Update the Committee on progress of the report and confirm dates	Ongoing	PD

5. **5.1** **5.2**	**Quality Performance Reports** **Women's Health Services, including Local Supervising Authority Annual Audit Report** **Medicine, Frailty and Networked Service**	**ICSU Leads**
5.1	**Trust Quality Performance report and National Maternity Survey Report** received and noted. Key points were highlighted as follows: • Overall performance was good. • Improvements noted in the complaints response rate and appraisal completion	

	rate. • Friends and Family Test (FFT) response rates were discussed. MR noted that there was a change in the FFT system in October which contributed to a drop in response rates. However response rates are now above the national average (18%, national average 15%). Under the new system matrons have easy access to the data and are able to feedback to staff in real time. MR provided an example of improvements made in discharge planning as a result of FFT comments. • An action plan has been developed to address areas of non-compliance in the National Maternity Survey report. MR provided a summary of the maternity patient story which was presented to Trust Board. GH asked if providing tongue tie services at the Trust was an option in the future. MR responded that as this was not a routine service for Whittington Health, patient experience and safety would be better serviced from the North London specialist service. MR provided an update on the recent maternal death. MR noted the huge impact the death had had on staff; counselling services were being offered to staff involved and the family. MR noted that the consultants involved in this patient's care were meeting with the family on 14th January 2016. PD added that the incident had been reported to CQC, TDA and commissioners, and there was likely to be an external investigation.
5.2	**MFNS Quality Report November 2015** received and noted. Key points were highlighted as follows: • Complaints response rates are below the Trust average. AK noted an influx in complaints on Victoria ward. • The Committee discussed the challenges on Victoria ward and the actions currently in place to address these. AK highlighted staffing as the biggest risk; the Band 7 ward manager post was currently being advertised internally but there had been no interest to date. CM and AK noted the significant progress made on Victoria ward but emphasised that work was ongoing to improve practice. • AK praised the leadership on the Winter Pressure Ward • Mandatory training and appraisal compliance rates were improving, but ongoing work required Deprivation of Liberty (DoLs) monitoring was identified as an area for improvement. DC assured the Committee that the process had been reviewed and that an administrative post had been re-deployed to support the maintenance of a central DoLs database. DC added that there was a national consultation to change the current DoLs process anticipated in summer 2016.

Actions	**Deadline**	**Owner**
None		

6.	**Director of Nursing Patient Safety Report**	DC
6.1	Patient Safety Report (October and November 2015 data) received and noted. Key issues were highlighted as follows; • Royal College of Physicians Inpatient Falls Audit published. There was an increase in falls from October to November, however the total numbers compare favourably nationally. • There were two Grade 3 and one Grade 2 pressure ulcers reported in November which were considered avoidable. The 50% increase on the comparable chart refers to 2 cases. • DC commented on the continuing improvement in Adult and Child Safeguarding training. • The new legislative process for Domestic Violence on coercive and controlling behaviour was released.	

Actions	**Deadline**	**Owner**
None		

7.	**Central Alerting System (CAS): Report on alerts received in 2015**	DP
7.1	CAS report received and noted. DP noted that the Trust had missed the target deadline for two alerts in 2015, relating to window restrictors and window blinds. DP explained that the alert was missed due to unexpected delays in assessing the community premises, particularly in liaising with landlords. The target for the hospital site was met. DP added that the Health and Safety team were undertaking an audit to provide assurance of compliance with the alert.	

Actions	**Deadline**	**Owner**
None		

8.	**Director of Nursing Patient Experience Report**	DC
8.1	Patient Experience report noted and received. Key issues were highlighted as follows; • DC highlighted an error on p2 of the report; the Adult Inpatient survey results are due in February 2016. • The Friends and Family Test response rate was low, but positive responses received. Further analysis required to identify if learning can be shared from areas of good reporting. • CG asked if the new FFT system, Meridian, had now been rolled out across the community. PD noted that there were still some ongoing IT issues, and an update on progress was due to go to the Audit and Risk Committee.	

	The Trust was piloting a new patient experience initiative called Therapaws, in which animals were brought into therapeutic environments to support patients. The Trust would pilot bringing dogs into specific clinical areas, which infection control had approved. DC added that the National Cancer Survey was in progress and initial analysis showed good response rates.

Actions	**Deadline**	**Owner**
DC to analyse the FFT data to identify areas with good response rates and share any positive practice across the Trust. Findings to be included in the next Patient Experience Report.		DC
Update report on Meridian community roll-out, due to be presented at Audit and Risk Committee, to be brought for information to the Quality Committee.		DC

9.	**Serious Incident Report**	PD
9.1	Serious Incident report received and noted. Key issues were highlighted as follows; • 6 serious incidents declared in November 2015 • There were 3 serious incidents in the category of slips, trips and falls. DP noted that no major failures had been identified in the initial investigation process. Following review of the 72 hour reports at the Serious Incident Review Panel, immediate action was taken to release staff to units affected at the weekends to support nursing staff to provide 1-to-1 care. DP updated the Committee on a serious incident on 24th December 2015, where a patient fell on the escalator in the main reception and tragically died. The Health Service Executive carried out an immediate assessment but no failures were identified and it had been confirmed this had been a very sad accident. The incident has been declared an SI and an independent investigator will be appointed in line with the Trust policy. The Committee discussed the possibility of including benchmarking date on future reports and the uptake of the patient safety learning examples on the intranet.	

Actions	**Deadline**	**Owner**
Benchmarking data on serious incident reporting to be provided in future Serious Incident Reports.	March 2016	DP
Statistics on the hits on the Patient Safety Learning section of		

the intranet to be gathered and fed back to the Committee at the next meeting.	March 2016	LS

10.	**Infection Control Quarterly Report**	TF
10.1	Infection Control Quarterly report received and noted. TF noted that since writing the report, the Trust had one attributable case of MRSA. The Post Infection Review was due on 12th January 2016 but was delayed due to the Junior Doctors Strike. The patient has since sadly passed away due to a cardiac arrest, not MRSA symptoms. Key issues were highlighted as follows; • 5 CPEs in the year, but these were not acquired in the Trust and did not spread to other patients. • 7 Trust attributable (post 48-hour) C.diff cases were diagnosed between 1st April 2015 to 25th December 2015. The objective for 2015/16 has been set at 17 cases. • 98% of Infection Prevention and Control Audits were completed, with an 82% compliance rate. This is an improvement from quarter 2. TF added that there were additional Infection Prevention and Control Audits carried out as part of CQC preparation which are not included in the totals. • TF highlighted to the Committee that Quarter 4 data for surgical site infection surveillance would not be completed due to a staff vacancy. This will be re-instated upon appointment.	

Actions	**Deadline**	**Owner**
None		

11.	**Safety Thermometer Paper December 2015**	**EC**
11.1	Safety Thermometer report received and noted. Key issues were highlighted as follows; • Harm free care was 93.2% in December. DC noted that old pressure ulcers counted towards the harm free care target, which brought down the average. • There was an increase in falls with harm in Haringey Community Services. CG asked if this was related to a particular team or was there a high period of unallocated visits.	

Actions	**Deadline**	**Owner**
EC to feedback on the analysis behind the falls in Haringey Community services, including reviewing if there was a high period of unallocated visits, or if the falls were specific to a particular team.	March 2016	EC

12.	Nursing Quality Indicators	DC
12.1	Nursing Quality Indicators report received and noted. Key issues were highlighted as follows; • Good completion of nutrition screening assessments, however the accuracy was low at 62% • The sickness rate was on target at 2.6% DC noted that the Nursing Quality Indicators were new and still under development. Indicators will be reviewed for relevance and accuracy for 2015/16. PD proposed including an amber rating so staff felt more encouraged at progress.	

Actions	Deadline	Owner
Nursing Quality Indicators to be reviewed in April 2016.	April 2016	DC

13.	Risk Register	DP
13.1	Risk Register received and noted. LS outlined the triangulated process for monitoring risks in the Trust which derived from bottom up and top down risk management. All ICSUs review risks regularly and attend the Quality Committee to provide assurance on mitigations. AS highlighted the low level of representation from ICSUs in terms of discussing risks across all the ICSUs and agreed to raise the concern at Trust Board. FI queried the scoring of the Risk Register, and the rationale for changing the scoring of the consequence. LS confirmed risk scorings were indicative from the risk teams/officers and the Committee should challenge or agree scores at each meeting. LS outlined the risks requiring review and approval from the Committee. Three risks were considered for removal due to mitigating actions taken; <u>Corporate Risk Register 001 (CRR001)</u> Failure to share and embed learning which could lead to repeated safety incidents. • DP outlined the actions taken by the Trust to improve Trust wide learning including updating the Trust intranet learning page, a new SOP on disseminating learning, amended SI action plan template to ensure feedback to reporter and closer working with legal on coroners inquests. At the time of the risk there were three outstanding Prevention of Future Death orders (PFDs) which now have action plans monitored by the SI Panel. • The Committee discussed the option of assigning risks to individual ICSUs instead of the Quality Committee Risk Register. CG responded that there was a risk of not sharing learning between ICSUs so it was appropriate to have as a Trust wide risk.	

	• LS confirmed each ICSU managed their own risk register and the Quality Committee Risk Register highlighted risks of >12 to enable good oversight and assurance of risks and their mitigating action plans. • AS highlighted the importance of disseminating and embedding learning as an ongoing issue. PD acknowledged the work completed to date, but noted that more work was required to ensure learning was embedded across the ICSUs. • Change not agreed for risk CR001, risk to remain on Risk Register. <u>Corporate Risk Register 0011 (CRR0011)</u> Failure to improve the efficiency and effectiveness of the e-procurement system, especially in regard to catalogue management, will result in impacting on service delivery. • PD noted that the Audit Committee had questioned the number of waivers which was connected to the procurement process. The Committee proposed transfering the risk to the Finance Risk Register and asked Finance to consider widening the risk to the whole procurement process, not only e-procurement. <u>Corporate Risk Register 0014 (CRR 0014)</u> 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 • DP outlined the progress made in reducing the backlog of overdue complaints, from 125 to approximately 25 policies currently overdue. • Committee approved removal of risk from Quality Risk Register Six risks were proposed for inclusion on the Quality Risk Register. All new risks were approved and added to the Quality Risk Register. • CRR0017 Failure to implement resilience plan to cover Junior Doctor strikes could impact on quality and safety. • CRR0018 Failure to establish action plans from complaints and monitor implementation will affect learning and not enable continuous improvement of service • CRR0019 Lack of provision to fund a new endoscopy and decontamination unit which will reduce the ability to service bowel screening and endoscopy procedures • CRR0020 Failure to meet the Institute of Health Records Guidance will result in patients not having appropriate treatment. • CRR0021 Inconsistency to identify patients who require Deprivation of Liberties (DoLs) – process not monitored – risk of unauthorised DoLs and failure to notify CQC or refer to coroner • CRR0022 Lack of resilience for bronchoscopy procedures could affect patient safety and inability to meet waiting time targets

Actions	**Deadline**	**Owner**
DP to review scoring on Risk Register for next Committee	March 2016	DP
Changes to the Risk Register: • CRR001- Change not agreed • CRR0011 – Transfer to Finance Risk Register, consider widening the risk to procurement process, not only e-procurement. • CRR0014 – Reduce risk, remove from Quality Risk register • New risks approved (CRR0017, CRR0018, CRR0019,	March 2016	DP

CRR0020, CRR0021, CRR0022) ICSU representation at the Quality Committee to be discussed at the next Trust Board	March 2016	AS

15.	**Legal Services Report**	**PD**
15.1	Legal Services report received and noted. PD presented the report, in the absence of the Head of Patient Experience. This was a new report designed to alert the Committee to clinical and non-clinical claims. FI asked if the information in the report was accurate, and suggested that trends may be emerging at local levels which are not reflected in the report. PD agreed to feedback these concerns to the Head of Patient Experience for review.	
Actions		**Deadline** / **Owner**
ICSU concerns regarding local trends not being reflected in Legal Services report to be fed back to the Legal Services Department.		March 2016 / PD

16.	**Trust Policies Update**	**DP**
16.1	List of Trust policies approved since the last meeting received and noted. PD queried if there was now a process for alerting policy authors before the review deadline. GL noted that policy authors would be contacted two to three months ahead of expiry dates, with frequent reminders and escalation if required.	
Actions		**Deadline** / **Owner**
None		

17.	**Equality and Diversity Bi-Annual Report**	**CJ**
17.1	Equality and Diversity Bi-Annual report received and noted. CJ presented the report and noted that the Trust had published its Workforce Race Equality Standard on the Trust website, in line with mandatory requirements. AS enquired about the CQC concerns raised around equality and bullying and harassment allegations. CJ noted that the equality issues picked up by CQC related to the Staff Survey and a detailed action plan has been developed to address this. The	

	full details of CQC queries would be published in their final report and the CQC action plan will be reviewed at the Quality Committee.

Actions	**Deadline**	**Owner**
Quality Committee to receive update on actions to address CQC concerns about equality & diversity, and bully & harassment allegations.	May 2016	CJ

18.	**Self-assessment of Committee**	**DC**
18.1	LS presented the Committee with the annual self-assessment questionnaire to enable an analysis of its activities against its Terms of Reference for 2015/16. All Committee members were asked to complete the questionnaire by end of January. PD proposed that any initial feedback should be sent to LS, and the questionnaire re-issued in two weeks for reporting to the Committee in March 2016. AS noted the need to consider membership and ICSU representation at the meeting.	

Actions	**Deadline**	**Owner**
Self-assessment questionnaire to be re-issued in two weeks, following initial feedback, and findings reported to the Quality Committee in March 2016.	March 2016	LS

12.	**AOB**	**Lead**
13.1	None	

Actions	**Deadline**	**Owner**
None		

Next meeting: Wednesday 9th March, 2:00pm, Room 6, Whittington Education Centre

Trust Board – 2 March 2016

Title:	Trust Standards of Business Conduct Policy 2016/17 Trust Board Register of Declaration of Interests 2016/17 Trust Register of Staff Declaration of Interests 2016/17 Trust Hospitality Register 2016/17		
Agenda item:	**16/043**	**Paper**	**12**
Action requested:	To review the Trust Standards of Business Conduct Policy which aligns to the Nolan Principles, the NHS Code of Governance and statutory requirements for NHS Trusts and Boards		
Executive Summary:	The Standards of Business Conduct Policy describes public service values which underpin the work of the NHS and align to the Nolan Principles. The revised policy reflects current guidance and best practice to which all individuals within Whittington Health must have regard in their work. The Trust aspires to the highest standards of corporate behaviour and responsibility and Whittington Health staff are required and expected to comply with this policy. The **Trust Board Register of Declaration of Interests** for 2016/17 is included within the policy review paper and this includes the newly formed Trust Management Group members' declarations of interests to ensure completeness and transparency. This aligns with a best practice approach for public accountability for public bodies and their staff.		
Summary of recommendations:	To approve the annual review and updating of the Trust Standards of Business Conduct Policy 2016/17 and to note the revised **Trust Board Register of Declaration of Interests 2016/17** which has been submitted by Board members		
Fit with WH strategy:	Complies with the Nolan Principles, the NHS Trust Board Code of Conduct and Code of Accountability in the NHS, the revised 2015 NHS Constitution, the Trust NHS Counter Fraud policy and relevant good governance principles		
Reference to related / other documents:	Trust Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SD)		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks are captured on the Trust Board Risk Registers and/or Board Assurance Framework (BAF) where relevant		
Date paper completed	February 2016		

Author name and title:		**Lynne Spencer, Director of Corporate Affairs and Communications**		**Director name and title:**		**Lynne Spencer, Director of Corporate Affairs and Communications**	
Date paper seen by EC	**1 March**	**Equality Impact Assessment complete?**	**Supports equality duties**	**Risk assess-ment?**	**Part of the governance review**	**Legal advice receive d?**	**Complies with statutory requirements**

Whittington Health NHS

Standards of Business Conduct

1. Introduction

1.1. This policy seeks to describe the public service values, which underpin the work of the NHS and to reflect current guidance and best practice to which all individuals within Whittington Health NHS Trust must have regard in their work for the Trust.

1.2. The Trust aspires to the highest standards of corporate behaviour and responsibility. All Whittington Health staff are required to comply with this policy.

1.3. The Code of Conduct and Code of Accountability in the NHS (second revision July 2004) **Appendix E** sets out the following three public service values which are central to the work of Whittington Health

- Accountability - everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct
- Probity - there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, officers and members and suppliers, and in the use of information acquired in the course of NHS duties
- Openness - there should be sufficient transparency about NHS activities to promote confidence between Whittington Health and its staff, patients and the public

1.4. In addition, all individuals within the Trust must abide by the Seven Principles of Public Life as set out by the Committee on Standards in Public Life and set out at **Appendix A** of this policy.

2. Scope of policy

2.1. This policy applies to:

- Executive, Non-Executive and Associate Directors
- Trust Board Committee members
- Trust Management Group members
- Employees (whether their remit is clinical or corporate)
- Third parties acting on behalf of the Trust under a contract
- Students, volunteers and trainees (including apprentices)
- Agency, bank, temporary staff and secondees

3. Prevention of corruption

3.1. Whittington Health has a responsibility to ensure that all Whittington Health staff are made aware of their duties and responsibilities arising from the Bribery Act 2010. Under this Act there are four offences:

- Bribing, or offering to bribe, another person (section 1)

- Requesting, agreeing to receive, or accepting a bribe (section 2)
- Bribing, or offering to bribe, a foreign public official (section 6)
- Failing to prevent bribery (section 7)

3.2. All Whittington Health staff are required to be aware of the Bribery Act 2010 and should also refer to paragraph seven below for further guidance in relation to this.

4. Raising concerns

4.1. It is the duty of every member of staff to speak up about genuine concerns in relation to criminal activity, breach of a legal obligation (including negligence, breach of contract or breach of administrative law), miscarriage of justice, danger to health and safety or the environment, and the cover up of any of these in the workplace. Whittington Health has a whistle-blowing policy to set out the arrangements for raising and handling staff concerns and this is published on the Trust intranet with regular promotion to staff. The procedure for reporting specific concerns relating to fraud are described in paragraph five below.

5. Counter fraud measures

5.1.1 All Whittington Health staff are required not to use their position to gain financial advantage. Whittington Health is keen to prevent fraud and encourages staff with concerns or reasonably held suspicions about potentially fraudulent activity or practice, to report these. Whittington Health staff should inform the Chief Financial Officer immediately, unless the Chief Finance Officer is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken.

5.1. Whittington Health staff can also call the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60. This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

5.2. Anonymous letters, telephone calls, etc are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously. The Chief Financial Officer will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised.

5.3. Whittington Health staff should not ignore their suspicions, investigate themselves or tell colleagues or others about their suspicions.

6. Standing orders (SOs), standing financial instructions (SFIs) and scheme of delegation (SD)

6.1.1 All Whittington Health staff must carry out their duties in accordance with the Whittington Health's SOs, SFIs and SD which out the statutory and governance framework in which Whittington Health operates. Whittington Health staff must at all times refer to and act in accordance with the SOs, SFIs and SD to ensure current

Whittington Health processes are followed. In the event of doubt, Whittington Health staff should seek advice from their line manager.

6.1.2 Whittington Health SOs, SFIs and SD will be reviewed for 2016/17 in line with the Trust annual review process for key statutory and governance documents.

7. Declaration of interests

7.1. Whittington Health needs to have in place principles and procedures for minimising, managing and registering potential conflicts of interests which could be deemed or assumed to affect the decisions made by those involved in the Whittington Health. These decisions could include awarding contracts, procurement, policy, employment and other decisions.

7.1.1. Whittington Health staff should not allow their judgement or integrity to be compromised. They should be, and be seen to be, honest and objective in the exercise of their duties and should understand fully their terms of appointment, duties and responsibilities.

7.2. This section describes the Whittington Health policy in relation to the identification and management of conflicts of interest for staff. Adherence to these provisions is mandatory in order to identify and manage current or potential conflicts which may arise between the interests of the Whittington Health and the personal interests, associations and relationships of its staff or representative family members.

7.3. Failure to adhere to these provisions relating to the declaration of interests may constitute the criminal offence of fraud, as an individual could be gaining unfair advantages or financial rewards for themselves or a family member/friend or associate. Any suspicion that a relevant personal interest may not have been declared should be reported to the Director of Corporate Affairs and Communications.

7.4. All Whittington Health staff must declare any interest, either on appointment or when the interest is acquired, which may directly or indirectly give rise to an actual or potential conflict of interest or duty. Such interests, and potential conflicts of interest, include personal and indirect interests, and may come about through

- financial interests (for example, where someone involved has significant shareholdings or voting rights in a company or partnership)
- decisions affecting individuals who share the interests of organisation staff – for example, family members or members of societies, clubs or other organisations
- acceptance of hospitality from current or prospective business contacts; and acceptance of gifts.

7.5. A family member may include

- a partner (someone who is married to, a civil partner or someone with whom the Whittington Health staff member lives in a similar capacity)
- a parent or parent in law
- a son or daughter or stepson or step daughter the child of a partner
- a brother or sister
- a brother or sister of the staff member's partner a grandparent and/ or a

grandchild
- an uncle or aunt
- a nephew or niece
- the partners of the above

7.6. Whittington Health is required to maintain a **Trust Board Register of Interests** to record formally declarations of interest of Whittington Health Board members. The declaration of interests form is set out at **Appendix B.** This form should be completed by Board members and sent to the Director of Corporate Affairs and Communications when members join, once a year on review and when members' interests change throughout each year.

7.7. The **Trust Board Register of Interests** will be presented annually to the Trust Board within a public meeting and published on the Trust website in line with NHS guidance and good governance. This will include senior staff that are members of the Trust Management Group as the most senior decision making group of the Trust to provide transparency and openness.

7.8. Whittington Health will also maintain other interests on the **Trust Register of Interests** declared by other Whittington Health staff. Whittington Health staff should complete the form set out at **Appendix B** to declare any relevant interests and send it to the Director of Corporate Affairs and Communications.

8. Personal conduct

8.1. Lending or borrowing

8.1.1. The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

8.1.2. It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

8.2. Gambling

8.2.1. No member of staff may bet or gamble when on duty or on Whittington Health premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

8.3. Trading on official premises

8.3.1. Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-Whittington Health interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff or for the Trust charitable funds.

8.4. Collection of money

8.4.1. Whittington Health Charitable collections and/or corporate sponsorship must be

authorised by the Director of Corporate Affairs and Communications. With line management agreement, small collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage or a new job.

8.5. Bankrupt or insolvent staff

8.5.1. Any member of staff who becomes bankrupt or insolvent must inform their line management and the Workforce and Human Resource Department as soon as possible. Staff who are declared bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the handling of money; for example an Executive Director.

8.6. Arrest or conviction

8.6.1. A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line management and the Workforce and Human Resource Department.

9. Gifts and hospitality

9.1. With the exception of items of small value (less than £25) such as diaries, calendars, flowers and small tokens of appreciation such as cakes/confectionary, which may be accepted, all offers of gifts should be declined. In cases of doubt, advice should be sought from your line manager.

9.2. Any personal gift of cash or cash equivalents (e.g. tokens) must be declined whatever its value.

9.3. Whittington Health staff should:

- Report immediately all offers of unreasonably generous gifts to the Director of Corporate Affairs and Communications
- Return promptly any unacceptable gifts, with a letter politely explaining the terms of this policy and stating that staff are not allowed to accept them

9.4. Whittington Health staff should exercise discretion in accepting offers of hospitality from contractors, other organisations or individuals concerned with the supply of goods or services. Modest hospitality provided in normal and reasonable circumstances during the course of working visits may be acceptable, although it should be on a similar scale to that which the Whittington Health might offer in similar circumstances, e.g. hospitality provided at meetings, events, seminars. In cases of doubt, advice should be sought from your line manager.

9.5. All hospitality or gifts accepted regardless of value should be recorded in the Hospitality Register held by the Director of Corporate Services and Communications set out at **Appendix D,** as soon as is reasonably practicable. It is not necessary to record refreshments such as tea, coffee etc, or for course participants to record meals provided during a training event or seminar.

9.6. Whittington Health staff should be especially cautious of accepting small items of

value, or hospitality over that afforded in a normal meeting environment (i.e. beverages such as tea or coffee) during a procurement process or from bidders/potential bidders. This avoids any potential claim of unfair influence, collusion or canvassing.

9.7. Care should be taken when providing hospitality. Avoid providing hospitality at non-business locations unless there is a clear need to do so – this should be agreed in advance by the responsible executive director. Any hospitality provided should be modest.

10. Political activities

10.1. Any political activity should not identify an individual as an employee of Whittington Health. Conferences or functions run by a party political organisation should not be attended in an official Whittington Health capacity, except with prior written permission from an executive director.

11. Suppliers and contractors

11.1. All Whittington Health staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the **Code of Ethics of the Chartered Institute of Purchasing and Supply (Appendix D).**

11.2. All Whittington Health staff must treat prospective contractors or suppliers of services to Whittington Health equally and in a non-discriminatory way and act in a transparent manner.

11.3. Whittington Health staff involved in the awarding of contracts and tender processes must take no part in a selection process if a personal interest or conflict of interest is known. Such an interest must be declared to the Director of Communications and Corporate Affairs using the **Declaration of Interests** form at **Appendix B** as soon as it becomes apparent. Whittington Health staff should not at any time seek to give undue advantage to any private business or other interests in the course of their duties.

11.4. Whittington Health has duties under European and UK procurement law and Whittington Health staff must comply with Whittington Health SOs, SFIs and SD in relation to all contract opportunities with Whittington Health.

11.5. Whittington Health staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of Whittington Health.

11.6. Whittington Health staff invited to visit organisations to inspect equipment (eg software or training aids) for the purpose of advising on its purchase will be reimbursed for their travelling expenses in accordance with the travel expenses policy laid down by Whittington Health. Such expenses should not be claimed from other organisations to avoid compromising the purchasing decisions of Whittington Health.

11.7. Every invitation to tender to a prospective bidder for Whittington Health business must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing Whittington Health, its employees or officers concerning the contract opportunity tendered.

13.8 Offers of pro bono work from prospective bidders for Whittington Health business should be politely refused.

12. Initiatives

12.1. As a general principle any financial gain resulting from external work where use of Whittington Health time or title is involved (speaking at training events/ conferences, writing articles etc) and/or which is connected with Whittington Health business will be forwarded to the Director of Corporate Affairs and Communications.

12.2. Any patents, designs, trademarks or copyright resulting from the work (eg, research) of an employee of Whittington Health carried out as part of their employment by Whittington Health shall be the Intellectual Property of Whittington Health.

12.3. Approval from the appropriate line manager should be sought prior to entering into an obligation to undertake external work connected with the business of Whittington Health such as writing articles for publication, speaking at conferences.

12.4. Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances Whittington Health's reputation or results in financial gain for Whittington Health, consideration will be given to rewarding employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

13. Confidentiality

Information concerning Whittington Health which is not in the public domain must not at any time be divulged to any unauthorised person. Similarly, patient data or personal data concerning staff must not be divulged, in line with the Data Protection Act, 1998. This duty of confidence remains after termination of employment and applies to all individuals working within Whittington Health. Care should be taken that confidentiality is not breached inadvertently by, for instance discussing confidential matters in public places, such as whilst travelling by train, or by leaving portable IT equipment containing confidential information where it might easily be stolen, such as on full view in a parked car. Data should only be distributed using mechanisms with an appropriate level of security.

13.1. Whittington Health staff must maintain confidentiality of information at all times, both commercial data and personal data, as defined by the Data Protection Act and set out in the Trust's Information Governance policies.

13.2. Whittington Health staff should guard against providing information on the operations

of Whittington Health which might provide a commercial advantage to any organisation (private or NHS) in a position to supply goods or services to Whittington Health.

14. Management arrangements

14.1. Whittington Health staff should be aware that a breach of this policy could render them liable to prosecution as well as leading to the termination of their employment or position with Whittington Health.

14.2. Whittington Health staff who fail to disclose any relevant interests, outside employment or receipt of gifts or hospitality as required by this policy or Whittington Health's SOs, SFIs and SD may be subject to disciplinary action which could, ultimately, result in the termination of their employment or position with Whittington Health.

14.3. The Director of Corporate Affairs and Communications will be responsible for maintaining the **Trust Registers of Interests**, holding the **Trust Hospitality Register** and reviewing the implementation of this policy.

15. Complaints

15.1. Whittington Health staff who wish to report suspected or known breaches of this policy should inform the Director of Corporate Affairs and Communications. All such notifications will be held in the strictest confidence and the person notifying the Director of Corporate Affairs and Communications can expect a full explanation of any decisions taken as a result of any investigation.

16. Further information

16.1. This policy is an interpretation of guidance and is based on examples of good practice. In addition to referring to Whittington Health SOs, SFIs and SDs staff should refer to

- National Health Service Act 2006 & the Health and Social Care Act 2008
- Code of Conduct for NHS Managers
- NHS Codes of Conduct and Accountability (NHS Appointments Commission & Department of Health – amended July 2004)
- Code of Practice on Openness in the NHS
- Duty of Candour
- NHS Constitution revised 2015
- Additional or successor guidance published by the Department of Health

16.2. Copies of these documents are available from the Director of Corporate Affairs and Communications.

16.3. This policy will be reviewed each year in accordance with

- NHS Code of Governance
- Whittington Health Board annual cycle of business
- Legislative and regulatory changes including good practice guidance
- Case law and/or significant incidents which highlight new vulnerabilities
- Changes to organisational infrastructure

Appendix A

The seven principles of public life set out by the Committee on standards in public life (the Nolan principles)

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for awards or benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Appendix B

Trust Board Declaration of Conflict of Interests Form

All Board members of Trusts are required by the NHS 'Code of Conduct, Code of Accountability in the NHS', to declare interests which are relevant and material to the NHS Board when they are appointed. Board members should inform the Director of Corporate Services and Communications of changes to their interests as and when they arise.

Trust Board agendas include a standing agenda item which prompts members to declare interests before each meeting to ensure up to date declarations are recorded.

If a member has no relevant interests a nil return should be recorded and the form signed and returned to the Director of Corporate Services and Communications.

Name ……

Post …… Date of Appointment ……

Positions on external bodies which might give rise to a conflict of interest	
Position	**Company / organisation and activity**
Relationship (family or friendship) which might give rise to a conflict of interest	
Relation	**Interest**

Signed ……..

Print Name …… **Date of signature ……..**

Notes

Declaring interests helps to avoid public concern that external links and relationships might unduly influence the work of the Whittington Health. It ensures that such interests are openly and publicly declared.

Declaring an interest would not necessarily preclude an individual from undertaking an external activity, whether Personal or Non-Personal, but it might mean that they would not be able to take part in certain parts of a process where there could be a conflict of interest. As a result, for example, an individual may be asked to leave the room during a decision making process.

Examples of particular interests that should be regarded as relevant are

Directorships, including Non-Executive Directorships held in private companies or PLCs

Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

Majority or controlling share holdings in organisations likely or possibly seeking to do business with Whittington Health

A position of authority in a charity or voluntary organisation in the field of health and social care or contracting for NHS services

Research funding/grants that may be received by an individual or his/her department

Appendix C
WHITTINGTON HEALTH hospitality register

NAME	POSITION	DATE & DETAILS OF GIFT OR HOSPITALITY RECEIVED	VALUE WHERE KNOWN (OR ESTIMATED VALUE) £	SUPPLIER	REASON FOR THE GIFT/HOSPITALITY

Appendix D

The chartered institute of purchasing and supply (CIPS) code of ethics

Use of the code

Members of CIPS are required to uphold this code and to seek commitment to it by all those with whom they engage in their professional practice. Members are expected to encourage their organisation to adopt an ethical purchasing policy based on the principles of this code and to raise any matter of concern relating to business ethics at an appropriate level. The Institute's Royal Charter sets out a disciplinary procedure which enables the CIPS Council to investigate complaints against any of our members and, if it is found that they have breached the code, to take appropriate action. Advice on any aspect of the code is available from the CIPS.

This code was approved by the CIPS Council on 11 March 2009.

As a member of The Chartered Institute of Purchasing & Supply, I will:

- Maintain the highest standard of integrity in all my business relationships
- Reject any business practice which might reasonably be deemed improper
- Never use my authority or position for my own personal gain
- Enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- Foster the highest standards of professional competence amongst those for whom I am responsible
- Optimise the use of resources which I have influence over for the benefit of my organisation
- Comply with both the letter and the intent of the law of countries in which I practice, agreed contractual obligations and CIPS guidance on professional practice
- Declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- Ensure that the information I give in the course of my work is accurate
- Respect the confidentiality of information I receive and never use it for personal gain
- Strive for genuine, fair and transparent competition
- Not accept inducements or gifts, other than items of small value such as business diaries or calendars
- Always to declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- Remain impartial in all business dealing and not be influenced by those with vested interests

Whittington Health NHS

Whittington Health Trust Board : Register of Interests (March 2016)

Non-Executive Directors

Steve Hitchins	Chairman (wef 01/01/14)	• Non Executive Director and Vice Chair, Newlon Housing Trust; (Registered social housing provider) • Non Executive Director, Euradia Registered Charity (fundraising & research for diabetes) • Director: Steve Hitchins Ltd (Consultancy) • Member: Liberal Democrats Conflicts of interests that may arise out of any known immediate family involvement • Wife : voting member of House of Lords who sits on Liberal Democrat benches
Anita Charlesworth	Non-Executive Director (wef 01/04/11)	• Chief Economist at Health Foundation • Trustee 'Tommy's' the baby charity Conflicts of interests that may arise out of any known immediate family involvement • Nil
Anu Singh	Non-Executive Director (wef 14/01/14)	• Director, Independent Futures; an all age service to help disabled people achieve an independent, active and enjoyable life for as long as possible Conflicts of interests that may arise out of any known immediate family involvement • Nil
David Holt	Non-Executive Director (wef 13/07/2015)	• NED/SID at Tavistock and Portman NHSFT • NED, Chair of Audit Committee, Hanover Housing Association • Deputy Chair, Chair of Audit Committee Ebbsfleet Development Corporation (DCLG) • NED and Chair of Audit Committee, Planning Inspectorate • Chair Merton Developments Limited (Part of Circle Housing Association) Conflicts of interests that may arise out of any known immediate family involvement • Wife Dr Kim Holt employed by Whittington Health
Paul Lowenberg	Non-Executive Director (wef 01/05/12)	• Director/Proprietor Paul Lowenberg Associates – Management Consultancy undertaking consultancy with Peabody Trust assisting them with asset management and maintenance (June 2015 – March 2016) • Chair – Ascham Homes – Housing Management and Homelessness Services • Trustee – LASA Advice services and support organisation Conflicts of interests that may arise out of any known immediate family involvement • Wife – Lay member, Islington CCG
Prof Graham Hart	Non-Executive Director (wef 01/09/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Tony Rice	Non-Executive Director (wef 01/03/14)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Executive Directors – voting rights

Simon Pleydell	Chief Executive (wef 01/04/14 on contract until 01/01/15)	• Lay Member of Council, Newcastle University Conflicts of interests that may arise out of any known immediate family involvement • Nil
Siobhan Harrington	Deputy Chief Executive Director of Strategy (wef 01/04/14)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Son, Whittington Health staff (Pharmacy Department) • Mother, Whittington Health shadow governor
Stephen Bloomer	Chief Finance Officer (wef 03/06/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Richard Jennings	Executive Medical Director (wef 01/06/14)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Wife Patient Experience Manager at Ealing Clinical Commissioning Group
Philippa Davies	Director of Nursing and Patient Experience (wef interim 01/08/14 and substantive 15/07/15)	• Director & Trustee Kissing it Better Charity no. 1148795 Conflicts of interests that may arise out of any known immediate family involvement • Nil
Carol Gillen	Acting Chief Operating Officer (wef 26/10/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Associate Directors – non voting rights

Greg Battle	Medical Director Integrated Care (wef 06/06/11)	• GP Partner Goodinge Group Practice : General Medical Services • GP Wish. GP service provision to Whittington Health UCC Conflicts of interests that may arise out of any known immediate family involvement • Nil
Glenn Winteringham	Director of IM&T (wef 01/10/11)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Lynne Spencer	Director of Communications & Corporate Affairs (wef 02/02/15) (Company Secretariat)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Son, Management Consultant at Brent, Harrow & Hillingdon Clinical Commissioning Group
Norma French	Director of Workforce (wef 23/06/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Husband, Consultant at UCLH, employed by Central and North West London NHS Foundation Trust
Phil Ient	Director of Estates & Facilities (wef 01/03/01)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Clinical Directors

Chandrima Biswas	Clinical Director Women's Health Services	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Clarissa Murdoch	Clinical Director Medicine, Frailty and Networked Services	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Helen Taylor	Clinical Director Clinical Support Services	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Neeta Patel	Clinical Director Children's Services	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Nick Harper	Clinical Director Surgery & Cancer	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Rachel Landau	Clinical Director Emergency & Urgent Care	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Sarah Hayes	Clinical Director Outpatients Prevention and Long Term Conditions	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc

Directors of Operations

Paul Attwal	**Director of Operations Medicine, Frailty and Networked Services**	• **Nil** **Conflicts of interests that may arise out of any known immediate family involvement** • **Nil**
Sam Page **(leaves 26/2/15)** **(Russell Nightingale starts 1/4/16)**	**Director of Operations Children's Services**	• **n/a** **Conflicts of interests that may arise out of any known immediate family involvement** • **n/a**
Fiona Isacsson	Director of Operations Surgery & Cancer	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Paula Mattin	Director of Operations Emergency & Urgent Care	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Beverleigh Senior **(wef 30/11/15)**	**Director of Operations Outpatients, Prevention & Long Term Conditions**	• **Nil** **Conflicts of interests that may arise out of any known immediate family involvement** • **Nil**
Amanda Hallums **(wef June 2015)**	**Director of Operations Women's Health Services**	• **Trustee – unremunerated, Haven House Children's Hospice, Woodford Green Essex** **Conflicts of interests that may arise out of any known immediate family involvement** • **Nil**
Danielle Morrell	Director of Operations Clinical Support services	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc

CODE OF CONDUCT

CODE OF ACCOUNTABILITY

for NHS BOARDS

CODE OF CONDUCT

Public Service Values

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CODE OF CONDUCT

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is funded from public money, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

There are three, crucial public service values that must underpin the work of the NHS.

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

General Principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that there is consultation on major changes before decisions are reached. Information supporting those decisions should be made available to the public in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As large employers in the local community, NHS organisations should forge open and positive relationships with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation's activities on the environment.

The confidentiality of personal and individual patient information must be respected at all times.

Public Service Values in Management

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all

times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports published in good time and made publically available, to allow full consideration by those wishing to attend public meetings on local health issues.

Public Business and Private Gain

Chairs and board directors should act impartially and not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

Relations with Suppliers

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship.

Staff

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- that gives a clear commitment that staff concerns will be taken seriously and investigated; and
- where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

Compliance

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All

board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

CODE OF ACCOUNTABILITY

This Code is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

Status

NHS trusts are established under statute as corporate bodies to ensure that they have separate legal personalities. Statutes and regulations prescribe the structure, functions and responsibilities of their boards and prescribe the way their chairs and directors are to be appointed.

Code of Conduct

All chairs and non-executive directors of NHS trusts are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct should be drawn to the attention of the NHS Trust Development Authority, (NHS TDA).

NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to him and to Parliament.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children) and must ensure that they are of high quality and accessible.

National standards of quality and safety

NHS trusts providing care in hospitals are required to register with the Care Quality Commission (CQC). It is a condition of registration that hospitals meet five national standards of quality and safety. They mean that patients can expect:

- to be respected, involved and told what's happening at every stage
- care, treatment and support that meet their needs
- to be safe
- to be cared for by staff with the right skills to do their job properly
- hospitals to routinely check the quality of its services

Boards are required to ensure that hospitals continue to meet these minimum standards.

Financial accountability

NHS trusts are subject to external audit by the Audit Commission. NHS boards must co-operate fully with the NHS TDA and the Audit Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/ Permanent

Secretary of the Department of Health, as Accounting Officer for the NHS, is accountable to Parliament.

The work of the Department of Health and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and the health service.

The Board of Directors

NHS boards comprise executive directors together with non-executive directors and a chair appointed by the NHS TDA on behalf of the Secretary of State for Health. Together they share corporate responsibility for all decisions of the board. The chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS TDA for the performance of the organisation.

Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health, through the NHS TDA, for the discharge of these responsibilities.

The NHS TDA provides the line of accountability from local NHS trusts to the Secretary of State for the performance of the organisation.

The duty of an NHS trust board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of an NHS board is to:

- be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs
- provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed
- set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

The Role of the Chair

The overarching role of the chair is one of enabling and leading, so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- ensuring the provision of accurate, timely and clear information to directors

- ensuring effective communication with staff, patients and the public
- arranging the regular evaluation of the performance of the board, its committees and individual directors and
- facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board.

Further information is available in *The Healthy NHS Board: Principles for Good Governance*

Non-Executive Directors

Non-executive directors are appointed by the NHS TDA on behalf of the Secretary of State for Health to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the NHS TDA to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy
- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance
- satisfy themselves that quality and financial information is accurate and that controls and systems of risk management are robust and defensible
- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning and
- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration and Terms of Service Committee, the Clinical Governance Committee and Risk Management Committee.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

Reporting and Controls

It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to:

- the Department of Health, on behalf of the Secretary of State
- the NHS Trust Development Authority
- the Audit Commission and its appointed auditors and
- the local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health must be observed. The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

Declaration of Interests

It is a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member's interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

Employee Relations

NHS boards must comply with legislation and guidance from the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of a remuneration and terms of service committee, that executive board directors' remuneration can be justified as reasonable. Board directors' remuneration for the NHS organisation should be published in its annual report.

Originally published April 1994
First revision April 2002
Second revision July 2004
Third revision April 2013