Whittington Health NHS

TRUST BOARD

14.00 – 17.00
Wednesday 1 June 2016

Whittington Education Centre Room 7

Whittington Health NHS

Meeting	**Trust Board – Public**
Date & time	**1 June 2016 1400hrs – 1700hrs**
Venue	**WEC 7**

AGENDA

Members – Non-Executive Directors Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yuahaw Yoe, Non-Executive Director	**Members – Executive Directors** Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Philippa Davies, Director of Nursing and Patient Experience Carol Gillen, Chief Operating Officer

Attendees – Associate Directors
Dr Greg Battle, Medical Director (Integrated Care)
Norma French, Director of Workforce
Lynne Spencer, Director of Communications & Corporate Affairs
Secretariat
Kate Green, Minute Taker

Contact for this meeting:lynne.spencer1@nhs.net or 07733 393 178

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Verbal*	*Note* 1400hrs
16/078	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*		*Declare* *1420hrs*
16/079	**Apologies & Welcome** *Steve Hitchins, Chair*		*Note* 1425hrs
16/080	**Minutes, Action Log and Matters Arising 4 May** *Steve Hitchins, Chair*	**1**	*Approve* 1430hrs
16/081	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
16/082	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Approve* 1440hrs
Patient Safety & Quality			
16/083	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**3**	*Approve* 1450hrs
16/084	**Safer Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Approve* 1500hrs

16/085	**Quarterly Safety & Quality Report & Sign up to Safety Plan 2015/16 Review** *Richard Jennings, Medical Director*	**5**	*Approve* 1505hrs
16/086	**Quality Account 2015/16 Review and draft Quality Account 2016/17** *Richard Jennings, Medical Director*	**6**	*Approve* 1515hrs
Performance			
16/087	**Financial Performance Month 01** *Stephen Bloomer, Chief Finance Officer*	**7**	*Approve* 1525hrs
16/088	**Performance Dashboard Month 01** *Carol Gillen, Chief Operating Officer*	**8**	*Approve* 1535hrs
Strategy			
16/089	**Strategic Estates Partnership** *Simon Pleydell, Chief Executive*	**9**	*Approve* 1545hrs
16/090	**Clinical Collaboration** *Simon Pleydell, Chief Executive*	**10**	*Approve* 1555hrs
16/091	**Sustainability and Transformation** *Simon Pleydell, Chief Executive*	**11**	*Approve* 1605hrs
Governance			
16/092	**Audit Committee Meeting 1 June – assurance that the Trust Board can formally minute approval of the audited end of year returns for the Chief Executive to sign off the:** • **Annual Financial Accounts 2015/16** • **Annual Governance Statement 2015/16** • **Annual Report 2015/16** *David Holt, Audit Committee Chair*	*Verbal*	*Approve* 1615hrs
16/093	**Emergency Department Business Case** *Siobhan Harrington, Deputy Chief Executive/Dir. Strategy*	**12**	*Approve* 1625hrs
16/094	**Quality Committee 11 May 2016 Draft Minutes** *Anu Singh, NED*	**13**	*Approve* 1635hrs
16/095	**Bribery Act 2010 & Board declaration** *Lynne Spencer, Director of Communications & Corporate Affairs*	**14**	*Approve* 1645hrs
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meetings & 2015/16 AGM			
	06 July at 1400hrs Whittington Education Centre, Room 7 *August the Trust Board does not meet* 07 September at 1400hrs followed at 1730hrs for Trust Annual General Meeting to present the 2015/16 Annual Financial Accounts and 2015/16 Annual Report		

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: 16/080
Doc: 01

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 4th May 2016 in the Whittington Education Centre

Present:

Stephen Bloomer	Chief Finance Officer
Philippa Davies	Director of Nursing and Patient Experience
Carol Gillen	Acting Chief Operating Officer
Deborah Harris-Ugbomah	Non-Executive Director
Steve Hitchins	Chairman
David Holt	Non-Executive Director
Dr Richard Jennings	Medical Director
Simon Pleydell	Chief Executive
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Yua Haw Yoe	Non-Executive Director

In attendance:	Dr Greg Battle	Medical Director, Integrated Care
	Cllr. Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Isobel Spencer, in attendance at the Board to express her thanks to the Trust for caring for her late mother during her last few months up until her death at the end of last year. She had written to the Trust because she had been so impressed by the care her mother had been given, and she singled out Kayleigh Palmer from the Islington Continuing Healthcare Team for dealing with what she referred to as 'the enormous challenge of that level of complex care in the community'.

Central to Isobel's mother's care had been the need for someone to co-ordinate the wide variety of health and social care interventions required to help maintain her independence, and Isobel herself had taken on that role, with Kayleigh assessing options, researching, arranging the necessary funding and generally supporting the family throughout the entire process. Isobel said that Kayleigh had been 'the first person to make their lives easier', and approached the whole process by looking at what the family needed rather than what the services might have to offer.

The Board was then given a presentation by the Team's lead nurse, which focused on the structure of the team (based at Hornsey Rise Health Centre), its objectives, the criteria used for funding, noting that in order to receive the full continuing healthcare package the patient needed to have a primary health need. Isobel concluded the presentation by speaking of the sheer reliability of the service, and Janet Burgess added that the family of a friend of hers who had died recently had been so impressed by the care given by Trust staff that they had chosen to request donations to the service in her memory rather than flowers.

16/59 Declaration of Conflicts of Interest

59.01 Tony Rice informed Board colleagues that he had recently been appointed as Chairman of a pharmaceutical company concerned with animal medicines; the company had no

dealings with the NHS. Newly appointed Non-Executive Director Deborah Harris-Ugbomah said that she served as a Non-Executive Director on the Board of Moorfields Eye Hospital NHS Foundation Trust.

16/60 Apologies and welcome

60.01 Steve Hitchins welcomed everyone to the meeting and invited Deborah Harris-Ugbomah to say a few words about her background. In addition to her position on the Board at Moorfields, Deborah was an active member of the Institute of Chartered Accountants. Apologies for absence were received from Siobhan Harrington and Graham Hart.

16/61 Minutes, Action Log and Matters Arising

61.01 Carol Gillen requested an amendment to minute 46.02, to reflect the fact that the meeting held on 14th April had been to discuss the review of the performance dashboard rather than to launch it. Other than this, the minutes of the Trust Board meeting held on Wednesday 6th April were approved. There were no matters arising other than those already scheduled for discussion.

Actions

61.02 105.08 IT Reviews: Stephen Bloomer confirmed the report of this review would come to the June Board meeting.

160.09 Dashboard: Initial discussions about the format of the new dashboard were being held, and the dashboard was due to be discussed at a Board seminar.

160.11 Speak up Champion: Norma French informed the Board that Trusts were expected to have a local Champion in place by next April. The Trust already had lead Executive and Non-Executive Directors whistleblowing champions. In answer to a question from Deborah Harris-Ugbomah on assurance, Norma replied that all organisations have a policy covering the raising of concerns, and these were regularly reviewed to ensure they complied with current national policies and legislation.

61.03 All of the remaining actions on the log had either been completed or were scheduled for discussion later in the meeting.

16/62 Chairman's Report

62.01 Steve Hitchins was pleased to announce the appointment of Dr Peter Christian as Chair of Haringey CCG.

62.02 Informing the Board of meetings he had recently attended, Steve expressed his gratitude to the local Rotary Club, who had handed him a generous donation to Whittington Health's Charitable Funds following their very successful quiz night at the hospital. He had also attended the first of a series of seminars entitled 'Learning together from patient stories'.

62.03 On behalf of the Board, Steve congratulated Miss Friedericke Eben on her forthcoming retirement; she had given Whittington Health many years of dedicated service and would be very much missed. He also informed the Board that because NHS Improvement was now moving away from the requirement for all organisations to achieve Foundation Trust status and work towards 'earned autonomy' and it had been decided the role of shadow governors had now concluded. The appointments had been for a three year term from 2008 and the tenures had clearly expired. He thanked all the shadow governors for the time and commitment they had shown and hoped they would continue to come to future

events and meetings. The Trust will now consider how to best engage with a wider and more diverse group to reflect the population it serves.

16/63 Chief Executive's Report

63.01 Simon Pleydell began his report by reminding the Board that the Trust faced an extremely busy quarter, with current workstreams including the development and implementation of both the Sustainability & Transformation Plan and the Health & Wellbeing Partnership. Both, he said, were key elements of the overall planning and improvement process. He was currently engaged in setting objectives for 2016/17 both for Executive Directors and each of the ICSU Clinical Directors.

63.02 Simon was pleased to report that good progress had been made in respect of the cancer targets throughout the month; more generally most performance targets had been met. The exceptions to this were some of the community access targets and in particular MSK, which the Trust had held discussions with commissioners about regarding capacity and demand.

63.03 Simon confirmed that the Trust was currently exploring the development of a strategic estates partnership and was working towards having a soft market launch towards the end of May. A report would be brought to the June Board meeting to agree the next steps.

63.04 On behalf of the Board, Simon praised staff throughout the organisation for the way they had responded to the junior doctors' strike, ensuring a safe service was maintained, that every effort was made to avoid disruption. The situation had been approached with great team spirit and camaraderie and he had written to staff to thank them for their professionalism and commitment to patient care. To date there had been no change in the national position and no indication that negotiations would resume, so the Trust was preparing for the implementation of the new contract. There was a requirement to appoint a nominated Guardian who would have responsibility for ensuring the safety of rotas.

63.05 ED performance had reached 98.2% the previous Monday, but for month the organisation had failed to meet the 4 hour ED target of 95%. The Trust is not an outlier and the majority of acute Trusts were facing similar pressures. Discussions were ongoing with commissioners and regulators to understand the continuing rise in attendances at EDs across NCL. A whole system approach will be considered and Trusts will need to work together to support improvements to patient pathways in both community and hospital settings.

63.06 The Trust's financial position at end of year reported a deficit of £14.8m against a planned deficit of £15m. The Trust had agreed a financial plan for the future which will enable financial sustainability within two years.

63.07 A number of staff had completed the London Marathon and raised money for Whittington Health's charitable funds. Simon's report congratulated the achievements of community nurse Aleksandra Dackiewicz and health visitor Audrey Martin, who had been named Community Nurse of the Year and Universal Health Visitor of the year respectively at the Annual Community Practitioners and Health Visitors Awards.

63.08 Simon informed the Board that the Trust had started the process of recruiting to fifteen bullying and harassment advisor posts. These appointments were being made in response to findings from the staff survey. It was agreed the key to the success of this initiative was to ensure accessibility to the advisors for staff.

16/64 Serious Incident Report

64.01 Philippa Davies informed the Board that two serious incidents (SIs) had been declared in March, bringing the total for the year to 58 since 1st April 2015. The two new SIs declared were as follows:

- An unexpected admission to NICU, and
- A case of sub-optimal care related to sepsis

64.02 The team was currently engaged in a 'look back' exercise into SIs declared over the year, with significant time spent in discussion of this at the Patient Safety Committee and plans for further debate at Quality Committee. Work was in hand to see how numbers compared with other Trusts, and Richard Jennings would soon be able to benchmark numbers of 'avoidable deaths'.

64.03 Philippa informed the Board that she had observed a heightened readiness to learn across the organisation. Also worthy of note was the work on patient safety Julie Andrews carried out with the junior doctors.

16/65 Safe Staffing Report

65.01 The safe staffing report covered the position for nursing and midwifery on the wards during March, and Philippa reported that the number of shifts triggering 'red' had decreased from the previous month, although there had been an increase in the requirement for specials, linked to the increase in ED attendance.

65.02 From May, the Trust had been asked by NHS England to carry out a count of patients on the wards at midnight and to upload this information on a daily basis onto the Unify system. The safe staffing report was approved by the Board.

16/66 Quarterly Safety & Quality Report and Sign up to Safety Plan Review

66.01 This item was deferred to the June Board meeting.

16/67 Quality Account 2015/16 and Draft Quality Account 2016/17

67.01 This item was deferred to the June Board meeting

16/68 Financial Report

68.01 Stephen Bloomer introduced the financial report for Month 12. He began by saying that the Trust had posted a deficit of £14.8m at year end, slightly better than the predicted forecast. This achievement had been made possible by a combination of additional income for non-patient care services and the successful negotiation of the annual income settlement with commissioners.

68.02 Stephen was clear that moving forward there was a greater need for improved financial control throughout the organisation.

68.03 Steve Hitchins congratulated Stephen and the Executive team for achieving the year-end planned target.

68.04 Simon Pleydell reported that a considerable amount of time had been spent in developing cost improvement plans for 2016/17, and there was a significant number of 'road maps' in place which set out the detail of these plans. The Trust was in the process of recruiting to

the Programme Management Office, and was also meeting each of the ICSUs to discuss their business plans for the coming year. The work carried out by Boston Consulting had helped to identify potential for savings and productivity schemes which were both ambitious and challenging.

68.05 In answer to a question from David Holt about the quality and safety implications of some of the savings proposed, Carol Gillen replied that all potential schemes are subject to a quality impact assessment. There was a regular meeting to review schemes and to ensure that both Richard Jennings and Philippa Davies could be satisfied that there would be no negative impact on the quality and safety of services. Richard Jennings added that this exercise was a detailed and sophisticated process, and David suggested that this might be an area where the Speak Up Champion could add value. Richard assured the Board that every proposal received detailed attention and appropriate changes were frequently made to schemes where concerns had been expressed.

16/69 Performance Dashboard

69.01 Carol Gillen began her report by informing the Board that complaints response times remained at 90% for March, with only one ICSU scoring below 80%. Moving on to access, she said that a considerable amount of work had been done to clear the RTT backlog, and the target for this had now been achieved. There had been a reduction in theatre utilisation during March, but Carol assured the Board that plans were in hand to address this through the Surgery & Cancer ICSU's improvement plan. Good progress had been achieved on cancer targets, and Carol was confident that the Trust would be fully compliant by May.

69.02 There continued to be challenges within the MSK service due to capacity and demand issues, however a positive meeting had been held with the commissioners to explore the position in more detail and some benchmarking work had been undertaken which had shown that Whittington Health was not an outlier. Carol was pleased to report that there had been success in recruiting to podiatry posts.

69.03 It was noted that the figure on Bank & Agency usage in the report represented hours rather than full time equivalent staff.

16/70 North Central London Sustainability & Transformation Plan

70.01 Item deferred.

16/71 Wellbeing Programme Islington & Haringey

71.01 Simon Pleydell explained that the Wellbeing Partnership enabled joint working across NCL of local NHS organisations and local authorities to support delivery of the Trust's Clinical Strategy and to address population health needs. There were four priority areas that the Partnership will be working together to address:

- MSK
- Learning Disabilities
- Diabetes & CVD
- Older people.

71.02 Anni Hartley-Walder, Programme Director, has produced a resource plan to support the development of new models of care for the above priorities. Simon reported that there would be visible results in the coming year which will support population based healthcare.

71.03 In answer to a question from Yua Haw Yoe about how results would be monitored, Simon replied that the team would be working with UCL Partners who had an evaluation arm, and that the process for measuring outcomes would be included within the overall project plan.

16/72 Annual Operating Plan 2016/17

72.01 Helen Taylor informed the Board that the Operating Plan for 2016/17 had been submitted in April to NHSI. It was a high level plan which brought together all the planning work carried out to date by the team including:

- activity and quality planning
- sign up to safety
- shared learning and how results could be used to improve services
- ED and patient flow throughout the organisation
- workforce plans, including the work being carried out on recruitment and retention and the plans to reduce agency spend
- the approach to financial planning,
- the link to the Sustainability & Transformation Plan.

72.02 In answer to a question about engagement, Helen replied that the Operating Plan had been developed using the ICSU plans and through close working with the Operations Team and was very much the result of a 'bottom up' approach. David Holt said that the plan was obviously the culmination of a great deal of work and read very well, and asked how it was to be used. Helen replied that the next stage of the process was to identify some key success criteria and develop a communication plan to share with our stakeholders and patients.

16/73 Workforce Strategy 2016-21

73.01 Norma French reminded Board members that it had been some time since the Trust had had a workforce strategy, and she outlined the process for its development, reporting the sign off process by TMG, ICSU Boards, staff and the Partnership Group prior to being agreed by the Workforce Assurance Committee on 7th April.

73.02 The Board formally agreed adoption of the Workforce Strategy, and agreed that monitoring of its implementation be delegated to the Workforce Assurance Committee. In answer to a question from Deborah Harris-Ugbomah about whether the Trust conducted exit interviews, Norma replied that these had recently been re-introduced and the first report of had just been produced.

16/74 Draft minutes of the Workforce Assurance Committee

74.01 Steve Hitchins reported that the inaugural meeting of the Workforce Assurance Committee held on 7th April had gone well and papers for it had been produced to a high standard. The draft minutes of that meeting were noted by the Board.

16/75 Nursing and Midwifery Revalidation

75.01 Philippa Davies informed the Board that the requirement for nurses and midwives to be revalidated had been introduced on 1st April 2016, and the process was proceeding smoothly. All affected staff had received a personal letter from Philippa, and seminars and training sessions had been arranged for all those approaching their due date.

16/76 Register of Deed of Execution

76.01 The Register of Deed of Execution covering the period from 26th March 2015 through to 31st March 2016 was formally approved by the Board.

16/77 Any other business

77.01 Philippa Davies reported to the Board that 12th May was International Nurses' Day, and there would be a Midwifery and Nursing Conference, including speakers and the presentation of awards, at Alexandra Place. All were welcome to attend. Steve Hitchins commended Philippa and her team for arranging this important event and he would attend with Simon Pleydell.

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Action Notes Summary

105.08	IT Reviews: Stephen Bloomer confirmed this report would be brought to the June Board meeting.	June Board – deferred to July	SB
160.09	Dashboard: To be launched at a meeting on 14th April and would come to a Board seminar after that.	Seminar September	CG
160.11	Speak up Champion: Trusts expected to be able to demonstrate processes for appointment by September.	September	PD
160/66 66.01	Quarterly Safety & Quality Report and Sign up to Safety Plan Review	June Board **On Agenda**	RJ
67.01	Quality Account 2015/16 and Draft Quality Account 2016/17	June Board **On Agenda**	RJ
48.04 (63.03)	Proposals for next stage of work on the Estates Strategy to come to the June Board meeting	June Board **On Agenda**	PI
53.04	A report on progress achieved on the staff survey action plan to come back to the Board in six months' time	October Board	NF
63.04	Junior Doctors contract – to appoint a Guardian who would be responsible for ensuring the safety of rotas	July	RJ
70.01	NC London Sustainability & Transformation Plan to be placed on the agenda for a future Board meeting	June Board **On Agenda**	SP

Whittington Health NHS

Whittington Health Trust Board

1 June 2016

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/082**	**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:	27 May 2016		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**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 and key priorities 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. The Trust reported zero MRSA breaches throughout this reporting period.

Clostridium Difficile

The Trust continues to maintain the high standards it has achieved during 2015/16 and reported no new cases of Clostridium Difficile during this period. The target is for no more than 17 cases in each year. The Trust will promote regular awareness raising initiatives on the importance of adhering to infection control procedures to sustain our focus on patient safety as our top priority.

Cancer Waiting Time Targets

The Trust met all six national cancer targets for the reporting month of April. *The Trust reports in arrears in line with the national cancer data validation process*.

- 31 days to first treatment 97.7% 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 88.5% against a target of 85%
- 14 days cancer to be first seen 98.8% against a target of 93%
- 14 days to be first seen for breast symptomatic 99.4% against a target of 93%

Community Access Targets

MSK appointments remain under target which has triggered a performance notice of six months. The Trust is liaising with commissioners to consider the capacity and demand issues and to agree an improvement options paper. This will include areas such as recruitment, retention and training for junior staff. The key targets and performance for the month are:

- MSK waiting time – non consultant led patients seen in month – 41.5% against the target 95%
- MSK waits – consultant led patients seen in month – 82.2% against the target 95%
- IAPT – patients moving to recovery – reported 46.6% against the target 50%

Care Quality Commission (CQC)

Following the Trust's formal visit by the CQC in December 2015, publication of the initial draft report with recommendations is expected to be received during this month which will trigger a process to enable the Board to potentially receive a final report in late Summer or early Autumn 2016.

2. STRATEGIC

There are a number of important strategic reports on the Agenda of the Board today. The Trust welcomes the opportunity of playing a key role in the Islington and Haringey Wellbeing Sponsorship Board and continuing to work more closely with our valued colleagues at University College London Hospitals NHS Foundation Trust. In addition, the opportunity which our current estates work programme presents is very exciting and the paper outlines different options to ensure we achieve financial sustainability in the future years whilst keeping quality and safety as our top priorities.

3. GP FORWARD VIEW

NHS England published a 'General Practice Forward View' last month. NHS England have set out a commitment to increasing the share of spend to General Practice from by £2.4 billion (14% increase) by 2020/21. The Forward View mandates 'legally' the way we interact with primary care with standards for inpatient and outpatient communications. It is explicit about the need for our staff to follow up results and organise pathways which are patient centred. It asserts the need for easier access to secondary care consultants and specialist advice. There are opportunities with £1billion available for, up to a hundred percent reimbursement of premises costs and it refers to supporting GP Federations to develop new models of care specifically 'integrated primary and community health services'.

4. OPERATIONAL

Emergency Department (ED)

Pressures within the emergency care pathway continue and the ED 4 hour performance result for April was 84.1% against a target of 95%.

During May the clinical and operational teams convened an in-depth planning meeting to consider how best to create a robust plan for how the Trust manages the emergency pathway differently in 2016/17. This has resulted in a comprehensive improvement action plan that will create the required interventions and changes to get the Trust back on track for meeting the 4 hour performance target every month. This will include a focus on key areas such as increasing the number of pre 1100hrs discharges, reducing patient length of stay, improving discharge planning via a rigorous back to basics approach and fully utilising the ambulatory care centre and community services.

5. FINANCE MONTH 1

The Trust reported a deficit of £1m which is £228k adverse to the forecast £774k. This was a disappointing start to the year but an early reminder of the importance the Trust will need to put into place on introducing more stringent financial controls.

Historically the Trust has not met its targets for reducing agency and temporary staff. National benchmarking ranks the Trust 78 out of 90 with spending on average £15m pa for the past four years. The new national agency cap is £9.6m for 2016/17 and this allows for an average spend of £0.8m per month. For Month 1 the expenditure was reported at £1.4m. The Trust must change its approach to managing the pay bill in order to meet the exacting target.

To support the required changes, stricter financial controls will be introduced and the first step has been the establishment of a central programme management office. The new team will support the Integrated Clinical Service Units to deliver at pace their ambitious cost improvement targets and transition plans for reduction of agency and temporary staff.

The Executive team will also be providing extensive support throughout the coming year to the Integrated Clinical Service Units who will be changing the way they work and reducing their cost base to ensure we deliver value for money services.

6. CHKS AWARD

The Trust was named as one of the best performing Trusts in the UK by CHKS, alongside 40 other Hospitals in the UK. This prestigious award was based on 22 indicators which included clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

7. NURSING AND MIDWIFERY EXCELLENCE AWARDS

Held on International Nurses Day, as part of our Annual Nursing and Midwifery Conference, the Trust celebrated the work of nurses and midwives and awarded the below Nursing and Midwifery Excellence Awards. The awards were a celebration of the dedication, compassion and commitment of our teams to deliver excellent patient care. Congratulations to

Marion Coyle	Healthcare Assistant Ifor Ward
Orla Hillary	Student Nurse, Intensive Care Unit
Ilana-Pizer Mason	Student Midwife
Linda Greaves	Midwife
Kelly Collins	Mary Seacole, South
Anna Sweeney	Emergency Department
Jane Laking	Midwife
Team of the year acute	Emergency Department
Team of the year community	Nurses from Life Force Team

8. STAFF AWARDS

Congratulations to our **Diabetes Team** who won the March staff award. The diabetes service was rated first of all NHS trusts in England and Wales in the national audit which looked at 8 care processes for people with the diabetes. Over 95% of our patients are treated with all eight standards, compared with a national average of 59%.

Congratulations to April's winner, **Collette Datt, Paediatric Nurse Consultant** for training nurses to keep up to date with clinical practice and for working proactively with children and young people in the management of their care. She recently helped to develop the national asthma toolkit with the Healthy London Partnership and this initiative supports clinicians and schools to provide better care for children and young people asthma.

Simon Pleydell
Chief Executive

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

1 June 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**16/083**	**Paper**	**03**
Action requested:	For Approval		
Executive Summary:	This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of April 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:	To approve the report		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Duty of Candour • 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 Se 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.		
Date paper completed:	23/05/2016		

Author name and title:		**Daniela Petre Head of Integrated Risk Management**		**Director name and title:**		**Philippa Davies, Director of Nursing and Patient Experience**	
Date paper seen by EC	**31/5**	**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 April 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 April 2016.

In addition 4 investigations have extended deadlines agreed;

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

2) 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.

3) Catastrophic subdural haematoma following fall from first step of an escalator – a second extension has been requested due to an independent external Trauma Centre Neurosurgical Consultant being commissioned to review the incident.

4) Unexpected maternal death following delivery of probably cardio myopathy related to sickle cell disease.

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:33113	Oct 15	Delayed diagnosis and treatment of colorectal cancer.
Medication Incident Ref:33733	Oct 15	Patient sustained long term harm from prolonged treatment with oral antimicrobials
Slip/Trips Ref: 604	Dec 15	Patient suffered a subdural haematoma following a fall on an escalator.
Maternity / Obstetric Incident Ref: 835	Jan 16	Unexpected maternal death following delivery of probably cardio myopathy related to sickle cell disease.
Diagnostic incident (including failure to act on test results) Ref:4127	Feb16	Musculoskeletal Imaging waiting time breach: appointment / referrals not followed.
Maternity Birth Centre Closure Ref:5557	Feb16	Maternity Birth Centre closure due to capacity and demand issues.
Unexpected Admission to NICU- Baby Ref:5552	Feb16	Baby born in poor condition, requiring resuscitation.
Slips/trips/falls meeting SI criteria Ref:5535	Feb16	Patient sustained a fractured neck of femur following an unwitnessed fall.
Unexpected Admission to NICU– Baby Ref 7570	Mar 16	Baby born in poor condition transferred to NICU and then UCLH for total body cooling
Delayed Diagnosis Ref 10345	Apr 16	Delay in diagnosis resulting in delayed intervention.
Delayed Diagnosis Ref 11071	Apr 16	Chest X-ray results not followed-up and later found to be abnormal.
Information Governance Breach Ref 9747	Apr 16	Two reports inadvertently placed in incorrectly labelled envelopes.
Intrauterine Death Ref: 11789	Apr 16	Patient presented at 30 weeks gestation with history of no fetal movements. Intrauterine death diagnosed by ultrasound scan.

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

STEIS 2016-17 Category	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2017	Feb	Mar	total
Information Governance Breach	1												
Delayed diagnosis	2												
Unexpected still birth	1												
Total	4												

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. Trust has executed its duties under the Duty of Candour for investigations completed and submitted in April 2016.

Lessons learnt following each investigation are shared with all staff and departments involved in the patient's care through various means including the 'Big 4' in theatres and 'message of the week' in Maternity, Obstetrics and other departments. In addition, learning from identified incidents is published on the Trust Intranet ensuring it is available to all staff.

4.1 The Trust submitted 2 reports to NELCSU in April 2016.

4.2. The table below provides a brief summary of a selection of actions taken as a result of the lessons learnt.

Summary	Actions taken as result of lessons learnt
• **Ref 1302**	**Unexpected admission of a term infant to the Neonatal Intensive Care Unit (NICU) – the baby was born in poor condition and was transferred to a tertiary unit for total body cooling.** • Birth Centre to launch a "fresh eyes" approach to reviewing care plans. • Staff involved undertaking reflection with supervisors and taking part in a documentation audit.
• **Ref:732**	**Delayed Haemoglobinopathy Screening** • All midwives to follow-up blood results for their own department on a daily basis until a failsafe process is implemented to ensure that all women booked have been offered sickle cell testing, results are available and at risk women are referred timely for sickle cell counselling. • All healthcare professionals who see women for antenatal related check-ups are aware of appropriate time scales for follow-up appointments. • The Department to explore employing a screening failsafe officer responsible for the production and upkeep of a failsafe database.

5.0 Summary

The Trust Board is asked to approve the content of this report which aims to provide assurance that the serious incident process is managed effectively, that there are good levels of openness and transparency within the organisation and that lessons learnt as a result of serious incident investigations are widely shared.

Trust Board – 1 June 2016

Title:	Safe Staffing - Nursing and Midwifery – April 2016 data		
Agenda item:	**16/084**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in April 2016. Key issues to note include: • All areas reported greater than 90 per cent 'actual' versus 'planned' staffing levels except Coyle, Mary Seacole North and Nightingale Wards • Nine ward areas reported Registered Nurse '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 'specialing' purposes increased in April compared to March due to the high number of vulnerable patients requiring specialist care, especially the therapeutic care of patients with mental health disorders • 1 shift initially triggered 'Red' in April following which remedial action was immediately taken		
Summary of recommendations:	Trust Board members are asked to note the April 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:	Compliant with regulatory framework		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	May 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	**31/5**	**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 April 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 – 30th April 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 are moved from other clinical areas to ensure safe staffing levels across our hospital. Staff are 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 April 2016. The average fill rate was 97.7 % for registered staff and 106.0 % for care staff during the day and 101.7% for registered staff and 106.1 % for care staff during the night.

Seven 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. Where clinical areas have one Healthcare Assistant on duty and there is reported sickness this significantly alters the percentage calculation this can be seen in both areas reporting low HCA numbers on days. Above 100% fill rates occurred in eleven 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 April's requirement for 1:1 'specials' with previous month, the figures demonstrate a high level of need (Appendix 2). April saw 100 requests for 1:1 HCA specials compared to 99 requests in March. 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 were much higher in April (160) compared to March (63).The reason behind this large increase in temporary RMN usage is due to the significant increase in patients with mental health disorders requiring therapeutic interventions across are admission wards including the Emergency Department, Mary Seacoles North and South and Victoria ward.

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 April a total of 1/1395 (0.1%) shifts triggered 'red' which was lower than the 18 shifts in the previous month. Of these, 1/372 (0.3%) occurred in the Surgical Integrated Care Service Unit, 0/93 (0%) in the Women's ICSU and 0/651 (0%) shifts were reported to have triggered 'red' in the Medicine and Frailty & Networked Service ICSU). In addition 0/279 (0.0%) triggered red in the Emergency and Urgent Care ISCU and 0/93 (0.0%) in Children's ICSU.

5.0 New Requirements

New requirements for reporting have been requested from NHS Improvement. As set out in Lord Carter's final report *'Operational productivity and performance in English acute hospitals: Unwarranted variations*'. The report recommended that Care Hours per Patient Day (CHPPD) be collected monthly. This will become the principle measure of nursing and healthcare support worker deployment. This new measure requires the organisation to collect the total number of patients on inpatient wards at midnight and to upload this on a daily basis to the UNIFY system

The new field – Patient count at midnight – is the total number of patients on the ward at 23.59. CHPPD will automatically be calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. This new field will be included from the May collection.

5.0 Conclusion

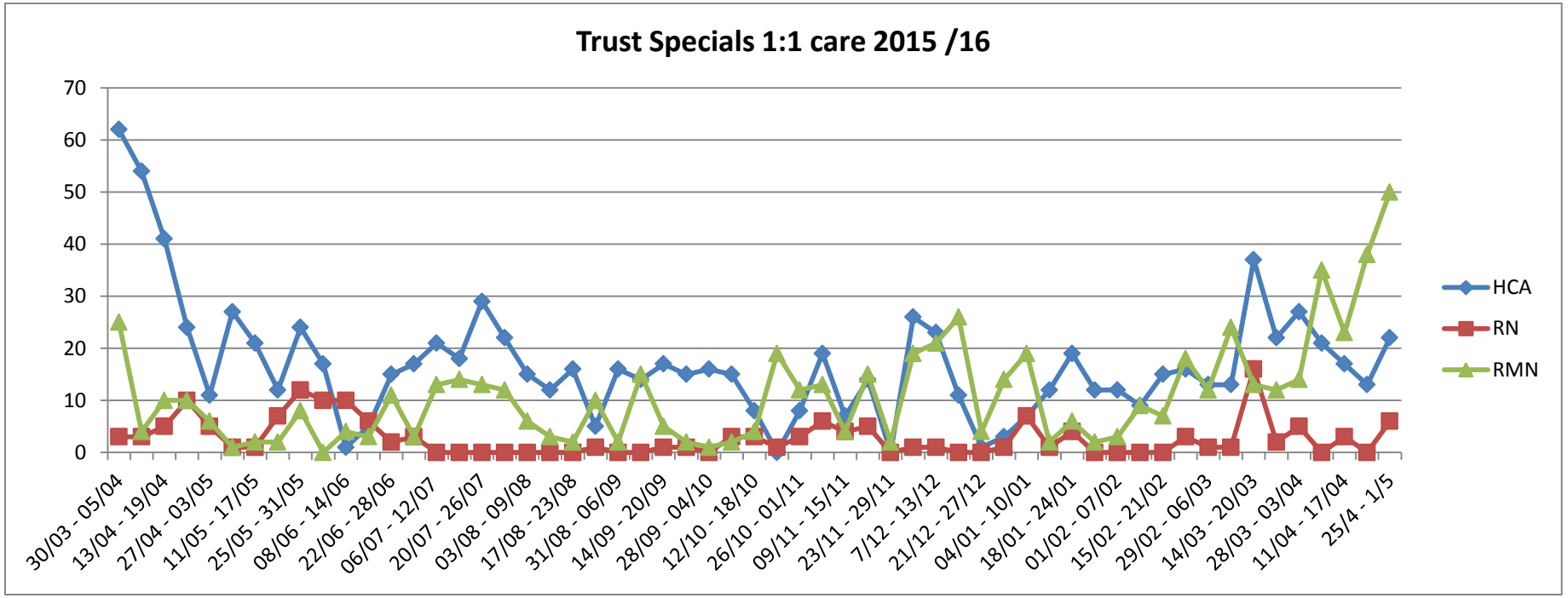
Trust Board members are asked to note the April UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Fill rate data - summary
April 2016

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				
33714 Hours	33714 Hours	9494 Hours	10066 Hours	27512 Hours	27987 Hours	7695 Hours	8164 Hours	97.7%	106.0%	101.7%	106.1%

Appendix 2

April 2016



Whittington Health

Trust Board

1st June 2016

Title:	**Quarterly Safety and Quality Board Report**						
Agenda item:	**16/085**		**05**				
Action requested:	For the Board to note, discuss and make any additional recommendations						
Executive Summary:	This is the third quarterly paper for the Trust Board giving an overview of safety and quality in the organisation.						
Summary of recommendations:	It is recommended that the contents are noted and discussed						
Fit with WH strategy:	To deliver consistent high quality, safe services.						
Reference to related / other documents:	Quality Account 2014-15 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards						
Date paper completed:	31st May 2016						
Author name and title:	**Richard Jennings, Executive Medical Director**		**Director name and title:**		**Richard Jennings, Executive Medical Director**		
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

1) Executive Summary

This is the third quarterly paper for the Trust Board giving an overview of safety and quality in the organisation.

This report provides an update on mortality, and the Trust's HSMR and SHMI figures remain assuring.

This report also summarises the Trust's progress in the last year with its Sign up to Safety pledges. The Sign up to Safety programme involves Trusts identifying key safety areas in which the pledge to make measurable and sustained quality improvements over a period of three years. The b original pledges were first highlighted as areas for improvement in the Trust's 2014/15 Quality Account, and this review of progress forms part of the Trust's 2015/16 Quality Account, which is about to be published, and are being retained, as was always planned, as on-going priorities for next year.

This report also summaries the new developments in the Trust's disseminating of learning from incidents, near misses, inquests, complaints and claims that underpin our goal to be a genuinely learning organisation.

2) Contents

3. Mortality

This Trust's HSMR and SHMI have both been 'lower than expected' since 2005/06.

3.1 Hospital Standardised Mortality Ratio (HSMR)

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

Since the last quarterly safety and quality board report (February 2016) the HSMR figures for January and February 2016 have become available. These show an HSMR relative risk of 100.7 in January 2016 and 73.39 in February 2016, giving an average of 87.99 for the first two months of this calendar year.

3.2 Summary Hospital-level Mortality Indicator (SHMI)

Summary Hospital Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.

Nationally the data for the period October 2014 – September 2015 is as shown in the table below. Whittington Health was among the 15 Trusts graded as having a lower than expected number of mortalities.

15 Trusts were graded as having a lower than expected number of mortalities
18 Trusts were graded as having a higher than expected number of mortalities
103 remaining trusts were graded as showing a number of mortalities in line with expectations

Whittington Health continues to have the lowest SHMI score in England. We consider this data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal.

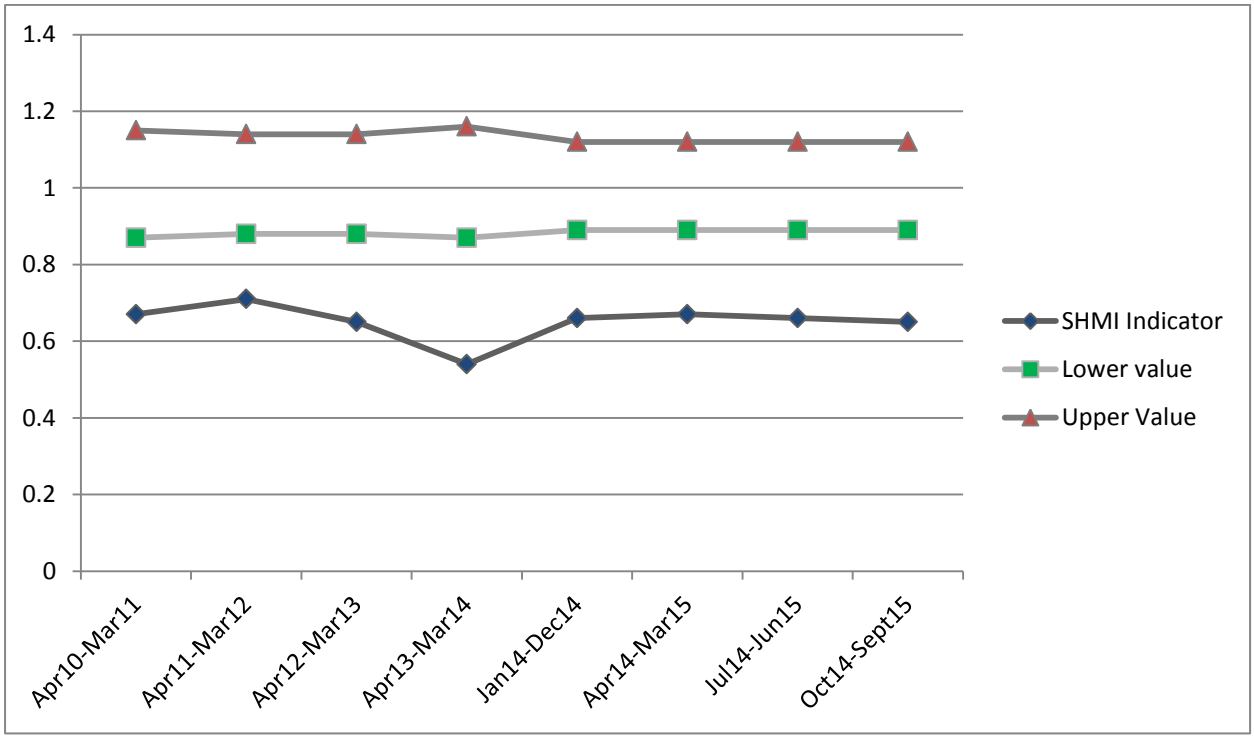
The most recent data available (released in March 2016) covers the period October 2014 to September 2015:

Whittington Health SHMI score	**0.6516**
National standard	**100**
Lowest national score	**0.6516 (Whittington Health)**
Highest national score	**1.198**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) by financial year April 2010 – June 2015

	SHMI Indicator	Lower value	Upper Value	National ranking
Apr10-Mar11	0.67	0.87	1.15	1
Apr11-Mar12	0.71	0.88	1.14	1
Apr12-Mar13	0.65	0.88	1.14	1
Apr13-Mar14	0.54	0.87	1.16	1
Jan14-Dec14	0.66	0.89	1.12	1
Apr14-Mar15	0.67	0.89	1.12	-
Jul14-Jun15	0.66	0.89	1.12	-
Oct14-Sept15	0.65	0.89	1.12	-

Chart 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) by financial year April 2010 – September 2015 (with lower and upper confidence intervals)



The lower value (green square) represents the lower 95% confidence limit from the national expected value. The upper value (orange triangle) represents the upper 95% confidence limit from the national expected value.

4. Infection control report

4.1 MRSA Bacteraemia

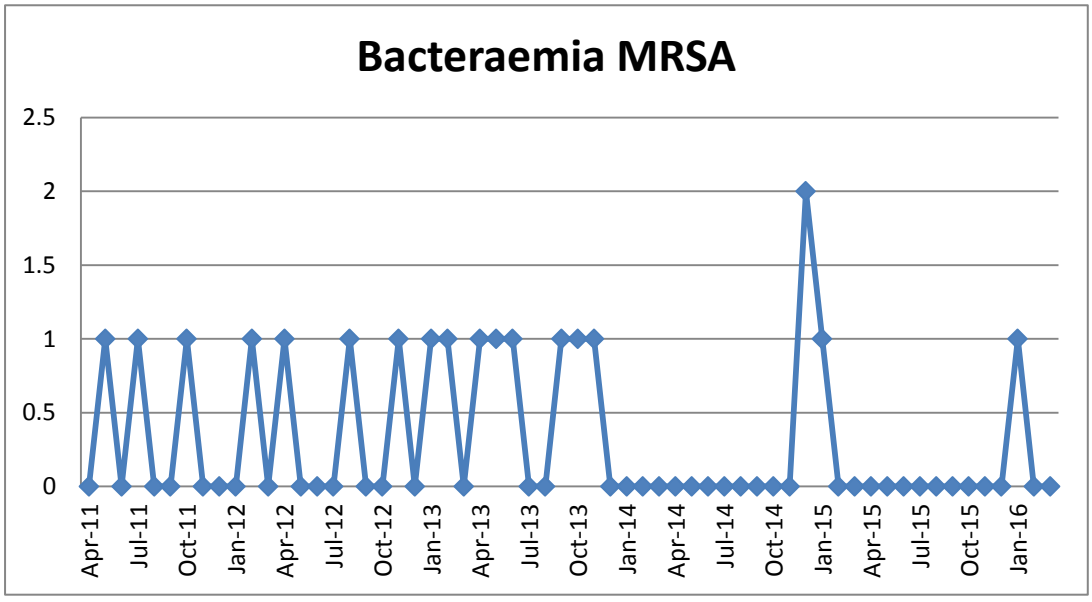
From 1st April 2015 – 31st March 2016 there was one Trust-attributable MRSA bacteraemia, in January 2016. Prior to this the Trust was MRSA bacteraemia free for 12 months. A full post infection review has been completed. The patient who developed a MRSA bacteraemia was on a medical ward, and had been an inpatient for over 100 days, and treatment had required multiple instances of venous, central venous and arterial cannulation. At some point during this admission the patient acquired an MRSA bacteraemia. The post infection review showed that overall the patient had been looked after well, but the key learning was that more attention is required in the absolutely regular documentation of the visual inspection of cannulation sites for signs of infection. Staff were also reminded, as they always are, that standards of hand hygiene need to be very high at all times to minimise the chances of MRSA transmission from patient to patient.

Since the start of the new financial year there have been no Trust-attributable MRSA bacteraemias.

Table 2: Whittington Health MRSA acquisition April 2015- March 2016 (one Trust-attributable case)

Number of patients with MRSA acquisition April 2015 to March 2016													
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
ITU	0	0	0	0	0	0	1	1	0	0	2	0	**4**
NICU	0	0	2	0	0	0	0	1	0	4	0	0	**7**
SCBU	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Meyrick	0	0	5	1	0	0	0	2	1	0	2	0	**11**
Cloudesley	3	0	0	0	0	0	0	4	2	0	1	0	**10**
Cavell	0	0	0	0	1	0	0	2	0	0	0	0	**3**
Coyle #NOF	0	0	0	0	0	0	0	2	0	0	1	1	**4**

Chart 2: Whittington Health attributable cases of MRSA bacteraemia by month (April 2011 – March 2016)



4.2 *Clostridium difficile*–associated diarrhoea

To 31st March 2016 we had 7 Trust-attributable *Clostridium difficile*–associated diarrhoea cases. Consultant led post infection reviews (PIR) were held on all cases and the reports disseminated to relevant parties both internally and externally. Our agreed objective for 2015/2016 was set at 17 cases and we came in well under trajectory. The cases are broken down as follows:

Table 3: Whittington Health *Clostridium difficile*–associated diarrhoea cases by ward

Date	No. of Cases	Ward
April 2015	1	Mercers
May 2015	1	Mercers (not same type as case in April)
June 2015	1	Bridges
July 2015	1	Nightingale
September 2015	1	Cavell
October 2015	1	Meyrick
December 2015	1	Victoria

Infection prevention control alerts are already placed on the Medway system for patients diagnosed with healthcare associated infections, but it is apparent that these are not always reviewed prior to bed placement. A further alert has been introduced to the JAC electronic prescribing system to improve staff awareness and aid the correct bed placement of the patient in order to reduce the risk of cross contamination. A meeting between the Infection Prevention and Control Team and Bed Management Team has been held to discuss recurrent placement issues and a new Bed Management Policy has been issued.

Education sessions on *Clostridium difficile* continue on all wards. An enhanced *Clostridium difficile* request form has been finalised on Sunquest ICE to reduce chances of staff incorrectly requesting tests.

4.3 MSSA/ *E.coli* Bacteraemia Episodes

From 1 April 2015 to 31 March 2016 there were 5 Trust-attributable MSSA bacteraemia episodes and 19 trust attributable *E.coli* bacteraemia episodes. There are no set thresholds for these bacteraemias. From 1st April 2016 to date we have had 0 trust attributable MSSA bacteraemias and 0 trust attributable *E.coli* bacteraemia episodes. Any such episode will be investigated to see if any interventions (such as urinary catheterisation or peripheral line cannulation) have occurred and whether all correct procedures were followed.

4.4 Other Relevant Healthcare Associated Infection (HCAI) Issues

Public Health England (PHE) issued guidance on the identification and control of Carbapenamase producing Enterobacteriaceae CPE's (highly resistant Gram negative bacteria). An action plan was formulated and is monitored through the IPCC; all actions to date have been completed. We have updated our talks to include information on this area. We have processes in place to deal with a single case and a completed policy which is available on the Trust's intranet. CPE inpatient screening was further enhanced on 1

October 2014 to include screening of patients who have received in-patient treatment in another London hospital. CPE training is ongoing.

Since the introduction of screening we have had a total of six confirmed CPE cases found within the labs at Whittington; one in the previous financial year and five for the period 1st April 2015 to 31st March 2016:

- Three were Klebsiella with NDM type
- One was *E. coli* with NDM type
- One was *E. coli* with OXA type. Ribotyping is awaited on the last case.

There is no evidence of cross infection of the Klebsiella NDM within Whittington Health. No cases of CPE were acquired at the Whittington.

Since 1st April 2016 there have been zero cases of CPE.

An infection control incident (datix reference W33781) occurred when a patient with Creutzfeldt-Jacob disease (CJD) was examined using a fibre-optic bronchoscope, which was then mistakenly decontaminated with other scopes in the normal way rather than being quarantined and taken out of use. This incident was fully investigated and the risk of infection transmission to other patients was judged to be exceedingly low, but the incident highlighted the need to disseminate learning concerning the decontamination of instruments that have been used to treat patients with CJD. Electronic alerts are now being placed on the patient records of known patients with CJD and clinical staff are being reminded to inform the Infection Prevention and Control Team whenever a patient with known CJD is admitted.

5. Sign up to Safety

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

5.1 Review of progress through 2015-16 on our Sign up to Safety pledges

The following information is also presented in the Trust Quality Account for 2015/16.

Priority one: Learning Disabilities (LD)
Improving care for people with a learning disability is one of our 4 key Sign up to Safety pledges; a three year campaign which will focus on providing individualised person-centred care. For 2015/16, we agreed two priorities as part of this three year project.

1. In quarter four, 90 percent of inpatients with learning disabilities will
    - be clearly identified on the electronic patient record
    - meet the Learning Disabilities Specialist Nurse during their admission
    - have a personalised care plan (Purple Folder)

2. In the Emergency Department (ED) 75 percent of all staff will have had specific training in the care of people with learning disabilities

Target one: In Q4, 90 percent of inpatients with learning disabilities will be clearly identified on the electronic patient record, meet the Learning Disabilities Specialist Nurse during their admission and have a personalised care plan ('my purple folder')

In Quarter four of 2015/16, every inpatient known to have a learning disability was clearly identified on the electronic patient record system (Medway) and for all of these patients an electronic flag was added to the system, to alert staff from the beginning of the patient's admission that the patient has a learning disability.

The Learning Disability Specialist Nurse is automatically alerted via Medway, when a patient with a learning disability is admitted as an inpatient. In cases where the patient's learning disability was not previously recorded on Medway, a referral should be made by the clinical staff to the Specialist Nurse. We have not yet met the target of 90 percent of patients with the learning disability meet the Specialist Nurse during their admission. The improvement plan for 2016/17 (listed below) should enable us to meet this target in 2016/17.

We have not jet met the target that 90 percent of patients with a learning disability should have a personalised care plan, but again, the improvement plan for 2016/17 (listed below) should enable us to meet this target in 2016/17.

Target two: In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with learning disabilities

The Emergency Department adopted a two-pronged approach to learning disability awareness training in 2015/16. In addition to the comprehensive training provided by the Learning Disability Specialist Nurse, learning disability awareness briefing sessions are run at team meetings. This ensures that all staff receives regular awareness training on how to support patients with learning disabilities in the Emergency Department.

In Quarter four 2015/16 a trust wide electronic education platform, 'Moodle', was introduced to support the delivery and recording of learning and training throughout the trust. This is now being used to gather reliable data on learning disability training in the Emergency Department, and will enable us to demonstrate in 2016/17 that we have met our target of training at least 75 percent of relevant staff in the Emergency Department.

Learning disabilities: Quality Improvement priorities for 2016/17

Proposed plans for 2016/17 include:

- simplifying the existing paper-based tools for risk assessments, care plans and discharge planning for inclusion on Medway and Anglia ICE
- developing an electronic referral system for Anglia ICE to replace the existing paper-based system

Priority two: Falls

Every year, over 240,000 falls are reported in acute hospitals and mental health trusts in England and Wales. A fall in hospital can cause patients and their families to feel anxious and distressed. For frail patients even minor injuries caused by a fall can cause serious injury, permanent disability, or death.

Aside from the obvious impact on patient safety and patient experience, falls in hospital can also have an impact on the length of time a patient needs to stay in hospital and may require surgical or other major interventions, and potentially additional care after discharge from hospital.

Target: We will reduce the number of inpatient falls that result in moderate or severe harm by 50 percent.

In 2015/16 there were six falls resulting in significant harm (defined as diagnosed fractures or death). In the previous year, 2014/15, there were 11 falls resulting in significant harm (defined as diagnosed fractures or death). The total numbers are low but do show a reduction of almost 50 percent.

We did achieve good results when benchmarked against other trusts in the most recent National Audit of Inpatient Falls undertaken by the Royal College of Physicians. We had a low level of 3.23 falls per thousand occupied beds days (OBD's), which was the second best figure among the participating trusts in the London region.

Falls: Quality Improvement priorities for 2016/17

In 2016/17 we will introduce the new role of Specialist Nurse in falls and dementia care and re-vitalise some of the education and training around this topic. A high proportion of inpatient falls occur in elderly patients with dementia and/or delirium, and the introduction of this new specialist role will strengthen the training and learning for our staff in caring for this vulnerable group of patients. We anticipate this will enable us to reduce the number of falls resulting in significant harm (as defined above) in 2016/17.

Priority three: Sepsis and Acute Kidney Injury (AKI)

Sepsis and acute kidney injury are recognised nationally as leading causes of harm and death. Early recognition of patients with sepsis/AKI and rapid initiation of treatment plans will lead to improvements in both morbidity and mortality rates.

We are committed to improving our care of people with sepsis in line with emerging national best practice. There is a trust-wide multi-professional sepsis team that leads on developing and disseminating pathways for patients and ensuring widespread education and training for all relevant staff. We have recently appointed to the new post of Lead Sepsis Nurse Specialist which will be instrumental in delivering further improvements.

Target one: We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis (90 percent).

Despite clear improvements in the number of patients being given antibiotics within the first hour, we are disappointed to have not met this target. Of the 46 patients with severe sepsis

seen between January and March 2016, 36 received antibiotics within an hour of arrival to hospital, which equates **to** 78.2 percent (which is up from 67.4 percent between October and December 2015).

One of the key ways to ensure more patients with severe sepsis receive antimicrobials within an hour of arrival to hospital is by ensuring patients with sepsis arrive with a pre-hospital alert for sepsis and this has increased from 8% of patients (April 2015-June 2015) to 40% of patients (January 2016-March 2016).

Target two: We will effectively record our performance in delivering the sepsis six care bundles for all patients with sepsis. We will improve our performance by 50 percent in the course of the year.

We are pleased to have made clear progress in our ability to deliver all 6 aspects of the sepsis care bundle that includes interventions such as rapid intravenous fluids and antibiotics. In 2014 an audit demonstrated that we delivered sepsis 6 bundle to 42% of patients. The latest audit in January -March 2016 80% of patients with sepsis received all 6 aspects of the care bundle.

Target three: In more than 90% of patients with Acute kidney injury (stage 3) we will ensure correct documentation and assessment has occurred in line with the national AKI CQUIN.

Table 4: CQUIN AKI Audit Results

Quarter 1 – 15%	April 2015 – 7%	May 2015 – 15%	June 2015 – 23%
Quarter 2 – 14%	July 2015 – 11%	August 2015 – 19%	September 2015 – 11%
Quarter 3 – 39%	October 2015 – 29%	November 2015 – 38%	December 2015 – 49%
Quarter 4 – 60%	January 2016 – 56%	February 2016 – 56%	March 2016 – 68%

Whilst we have taken some key steps forward to improving the outcomes of patients with AKI, we have not met out target for 2015/16 of 90 percent although there has been steady improvement in the monthly figures.

Sepsis/AKI: Quality Improvement priorities 2016/17

Our sepsis CQUIN target for 2016/17 has been confirmed and now covers all emergency admissions with sepsis as well as patients who develop sepsis on the wards. We are committed to achieving this new target and will continue to focus our efforts, particularly on obstetric sepsis. We will also continue to strengthen our relationships with local GPs and other community teams to increase awareness of sepsis amongst health professionals before patients come to hospital.

The national AKI CQUIN has been dropped for 2016/17 but we will continue to work towards improving outcomes for patients with AKI in 2016/17, and have already introduced a number of important measures to help improve care, including:

- Increasing training and education for staff – particularly in amongst pharmacy and junior doctor teams
- Reviewing and refreshing the way clinical notes are managed for patients with AKI
- Including a specific AKI section in a patient discharge letter to ensure they receive the right care when back in the community.

Priority four: Pressure ulcers

We have a zero tolerance to our patients developing 'avoidable' pressure ulcers and are working closely with teams across the hospital and community to tackle this important issue.

Target one: We will have no avoidable grade four pressure ulcers

Target two: We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 50 percent and we will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent

Table 5: Grade 3 and Grade 4 pressure ulcers acquired in the community and acute

	Community (avoidable pressure ulcers)		Acute (avoidable pressure ulcers)		Total (avoidable pressure ulcers)	
	Grade 3	**Grade 4**	**Grade 3**	**Grade 4**	**Grade 3**	**Grade 4**
2014/15	58	10	4	2	62	12
2015/16	25	3	13	0	38	3
% change	- 59%	- 70%	+ 78%	- 100%	- 53%	- 75%

Overall, there has been a 75 percent reduction in the number of grade four pressure ulcers across Whittington Health. However, we have not met our target of no avoidable grade four pressure ulcers because we had three avoidable grade four pressure ulcers within the community in 2015/16.

We exceeded our target to reduce the number of avoidable grade three pressure ulcers in the community, but did not managed to reduce the number of avoidable grade three pressure ulcers acquired in the acute setting.

Key actions taken to reduce the number of avoidable pressure ulcers

We have undertaken a number of initiatives to help further reduce the number of avoidable pressure ulcers:

- We launched our ‘React to Red’ campaign, to increase awareness across our hospital and community sites.

- We developed a combined safe care and skin care bundle document which is in use across our inpatient wards. The care bundle has also been implemented in the Emergency Department for patients who are identified as being at high risk of skin damage.

- The ‘React to Red’ campaign was introduced during daily ‘safety huddles’. It is currently being trialled in selected wards and plans are in place to roll out these safety huddles across all inpatient wards.

Pressure ulcers: quality improvements for 2016/17

We have plans in place to further increase awareness of pressure ulcer prevention in the community during 2016/17, particularly amongst GPs, district nurses and those involved in social care.

6. Dissemination of learning from Serious Incidents, near misses, inquests, complaints and claims

The following is a quarterly update regarding the ways in which the Trust is improving its ability to learn from safety incidents

6.1 Half day learning workshops for all staff

A series of eight half-day workshops aimed at all of our staff have been developed to help us improve patient safety and patient experience. Three workshops have already been held. Initial feedback from these has been overwhelmingly positive. These workshops are being held at both the hospital site and within the community to encourage both acute and community staff to attend.

All of the workshops are led by experienced clinicians and patient safety experts and are based on incidents or complaints that have occurred within the Trust.

The topics of the workshops include:
- Sepsis
- Maternity and paediatrics
- Adult safeguarding and team working
- Pressure ulcers
- Falls
- Challenging behaviour

6.2 Moodle

Since the last update to the Board, Whittington Health’s Education Team, led by Jana Kristienova and Professor Ian Bates, have introduced Moodle as an electronic platform for training and learning throughout the Trust. Any Trust staff member can acquire a user name and password to access Moodle, and there is an established mechanism for providing staff

members with permissions to create education content on this platform. Moodle is ideal for storing and sharing learning from patient safety incidents. As one example, all Trust Grand Rounds are now being uploaded to Moodle so that the safety learning from these weekly discussions is permanently retrievable and accessible to all staff. We are confident that Moodle will be used with increasing frequency in increasingly innovative ways, to disseminate learning and to record training that is relevant to patient safety.

6.3 Schwartz Rounds

Schwartz Rounds are structured one-hour meetings open to all of the staff with the purpose of reflecting on the experience of working in healthcare and non-clinical aspects of care. Schwartz Rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work (Reference 4 and 5).

There have been two Islington Integrated Schwartz Rounds held in 2015/16, which were open to all staff working in Islington across health and social care. Whittington Health has identified and trained its own Schwartz Round facilitators and will be resuming regular (bi-monthly) Whittington-specific Schwartz Rounds from September 2016. All staff, including executive and non-executive directors, will be encouraged to attend.

6.4 Junior Doctor Leads for Patient Safety

The recently appointed Associate Medical Director for Patient Safety, Dr Julie Andrews, has used the now established Junior Doctor Safety Forum to recruit seven named Junior Doctor Patient Safety Leads. It is anticipated that these Junior Doctor Leads will be instrumental in identifying and driving safety improvements, and new Leads will be appointed on a rolling basis as Junior Doctors rotate to other Trusts to continue their training.

6.5 Department of Health funded severe harm study

This was described in the last quality update to the Board (Reference 1). A consultant clinical lead has now been appointed for this study and is now currently working with the Department of Health to examine case notes of patients who have been discharged following a hospital admission to look for any evidence of avoidable harm and to identify the relevant learning (Reference 3).

6.6 Mortality review process

Since the last quarterly safety and quality report to the Board, the Trust's mortality review process has now commenced (Reference 2). The aim is that all inpatient deaths from 1st April 2016 will be reviewed, and the output of this review, with the accompanying learning, will be collated in the way described in the previous Board paper.

6.7Learning shared by a bereaved relative from elsewhere in England

In May 2016 the Medical Director of Whittington Health received a letter from the mother of an 18 year old steroid-dependant young man, who she explained had tragically died in June 2014 after not receiving steroid medication when he was admitted as an emergency in another acute Trust in England. His mother has taken the action of writing to the Medical Directors of all Acute Trusts in the country to highlight the risk of death if steroid-dependant patients do not receive the steroid medication that they need in periods of acute illness. The letter highlighted the very specific and practical learning point that the risk of such deaths

occurring could be significantly mitigated by added alerts to Acute Trust electronic prescribing systems.

In 2014 a Serious Incident was investigated at the Whittington (StEIS 2014.26694) in which steroid medication had been inadvertently omitted from a patient who was steroid-dependant. The Trust took a number of risk mitigating actions at that time, including the creation of electronic patient record alerts for patients known to be steroid-dependant. The electronic prescribing system, however, had not been fully rolled out at that time and so the action suggested in the letter we have just received is now being actively explored by the pharmacy department in collaboration with the IT department.

7 References

1. Whittington Health Board paper, *Quarterly Safety and Quality Board Report* (February 2016)
2. Whittington Health Board paper, *Identifying and learning from avoidable mortality - mortality review process for the Whittington* (February 2016)
3. London School of Hygiene and Tropical Medicine, *Developing methods for assessing avoidable severe harm attributable to problems in hospital care* (2015)
4. The Point of Care Foundation, *About Schwartz Rounds* available from https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/
5. Joanna Goodrich, The King's Fund, *Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals?*(2002)

Whittington Health NHS

Trust Board – 1 June 2016

Title:	Quality Account Review 2015/16 and Quality Account 2016/17		
Agenda item:	**16/086**	**Paper**	**06**
Executive Summary:	This is the final draft of the Trust's Quality Account Review 2015/16 (look back) and Quality Account (look forward) for 2016/17. It assesses our performance over the past year and sets out our vision and approach for the next year. It has been developed in line with the NHS Quality Accounts Regulations 2010. It has been derived from the work of the Trust with key stakeholders and staff throughout the year; including the Associate Director of Patient Safety, Dr Julie Andrews. The Quality Account gives an overview of performance on Quality for 2015/16 which demonstrates the Trust commitment to keep quality and safety as top priorities. The Account aligns to our Sign Up to Safety Plan. This document will be formatted for publication on the Trust's website and on the NHS Choices website by 30 June 2016.		
Recommendations:	Approval		
Fit with WH strategy:	Compliant with statutory duties		
Reference to related / other documents:	Clinical Strategy		
Reference corporate risks and/or BAF	Relevant corporate risk register		
Date paper completed:	31 May 2016		

Author name and title:		**Hannah Finney Strategy and Planning Manager**		**Director name and title:**		**Richard Jennings Medical Director**	
Date paper seen by EC	**May 16**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Whittington Health NHS

Quality Account Review 2015/16 & Quality Account 2016/17

Contents

Welcome to Whittington Health NHS Trust's Quality Account for 2015/16. Our Quality Account is a summary of our performance in delivering high quality, safe, effective care to our patients against our own priorities and national requirements.

The purpose of a Quality Account

The Quality Account provides a comprehensive description of the quality of care that we deliver to our patients, highlights the areas requiring improvement and describes the work we are doing to achieve this improvement.

What is included in a Quality Account?

Throughout the year we continually review and evaluate the quality of our services against three key criteria:

- Providing safe services
- Providing clinically effective services
- Providing the best experiences of our services to patients.

Our Quality Account considers how we have performed against these priorities, where we can improve, as well as our quality priorities for the coming year.

How to get involved

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing our report for 2016/17.

If you would like to receive a printed copy of our Quality Account, please contact us by email **communications.whitthealth@nhs.net** or call **020 7288 3131**.

Statement on quality from the Chief Executive

Quality remains our top priority. Our Quality Account describes some of our achievements in the past year and how we aim to continue providing high quality and safe services to help local people live healthier, longer lives.

During this year we opened our newly refurbished antenatal maternity ward at the Whittington Hospital and the £650,000 refurbishment features better facilities and a redesigned space that has enhanced privacy and dignity for women and their partners in a high quality and safe clinical area. We have expanded Simmons House which manages a successful and highly regarded community based in-patient psychiatric unit for young people. Following a £500,000 investment, the unit now features additional beds, allowing our expert teams to support and safeguard more vulnerable young people.

In December 2015 we were pleased to welcome the Care Quality Commission who carried out an extensive announced inspection of our community and hospital sites and services. We expect the official report to be published in summer 2016 and meanwhile we continue to implement changes to areas that we have identified as requiring improvement.

Like many other NHS trusts, we had a challenging winter. The particular pressure for us has been around emergency medical care; especially for frail and elderly patients. We have experienced a 6.4 percent increase in attendances in our Emergency Department with 96,787 attendances over the last 12 months. These pressures impacted on our ability to meet the 95 percent target for patients to be treated within four hours. We reported 91.1 percent performance for the year and we have already begun to implement an action plan which includes recruiting more consultants, reducing patient length of stay, improving discharge planning and fully utilising our award winning ambulatory care centre. We are committed to providing and sustaining our local emergency department for our patients.

During the year we continued to make the quality improvements that we pledged to make in our 'Sign up to Safety' commitment. These continue to focus on improving the care of people with sepsis and acute kidney injury, reducing pressure ulcers both in the hospital and in the community, reducing harm from inpatient falls and improving the care we give to people with learning disability. In the course of this year we have made significant measurable improvements in many of these areas. The Trust has had many successful achievements this year thanks to the hard work of our dedicated and talented staff.

Various services within the Trust have received local or national awards this year, including:

- Our specialist cancer nurses commended at the Quality in Care Oncology awards
- Jane Laking, bereavement midwife, was nominated as a 'healthcare hero' at the Tommy's Awards
- Paediatric doctor Dr Hannah Jacob and her research supervisor paediatric consultant Dr Caroline Fertleman won a prestigious regional award for innovation in healthcare education training
- Michael Clift, practice development nurse at Whittington Health was nominated for the Nursing Times Leaders 2015 list for his work to make sure our patients are given the very best care and are treated with compassion at all times
- Whittington Health was a Good Practice Award Winner at the London Senate Helping Smokers Quit Conference
- Our Director of Nursing and Patient Experience, Philippa Davies, received an MBE for services to Nursing

We have also continued to recognise the successes of staff internally through our excellence awards
I confirm that this Quality Account has been discussed at, and endorsed by the Trust Board, and I declare that to the best of my knowledge the information contained in this Quality Account is accurate.

Simon Pleydell, Chief Executive

Whittington Health an integrated care organisation, committed to helping local people to live longer, healthier lives.

Whittington Health provides hospital and community services to around 500,000 people living in Islington and Haringey, as well as other London boroughs including Barnet, Enfield and Camden. In 2011, the Whittington Hospital combined with community health services in Islington and Haringey, and we now have over 4,000 staff delivering care from more than 30 locations across Islington and Haringey.

With both hospital and community services, we are an Integrate Care Organisation (ICO) which means we can improve our patients' experience by bringing services closer to home and ensuring that the way patients receive healthcare is as joined up as possible between their GP, health facilities in the community and, when appropriate, the hospital. The Trust's vision is to continue to give people the most advanced care with quicker recovery times and where possible, enable our patients to receive their care at home and in the community. This is now considered the best way to provide healthcare to maintain health and wellbeing. We will 'help local people live longer healthier lives'.

We also have a highly regarded educational role, teaching undergraduate medical students, nurses and therapists each year, and providing a range of educational packages for postgraduate doctors and other healthcare professionals.

The trust's clinical strategy was developed in 2015, in consultation with our staff and our local community. Quality is a key theme throughout this strategy. The trusts mission is to help 'local people live longer, healthier lives' and the vision is: 'to provide safe, personal, co-ordinated care for the community we serve'.

In 2015/16 the trust appointed a permanent executive team, including the key roles of Director of Nursing and Patient Experience, Medical Director, Director of Finance and Director of Workforce.

Our services and our approach are driven by our mission and vision

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are committed to improving services to deliver the best care for our patients.

Our mission

Helping local people live longer, healthier lives.

Our vision

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

Our clinical strategy

During the past year we continued to implement our clinical strategy, engaging with staff and stakeholders to help us collectively meet the challenges our community and local health and social economy face over the next five years.

Our services

Our priority is to deliver the right care, at the right time, and in the right place for our patients. We provide an extensive range of services from our main hospital site and also run services from over 30 community locations in Islington and Haringey. Over the past year we have established seven Integrated Clinical Service Units which have reviewed their services and developed business plans to ensure continuous quality service improvements for our patients whilst meeting our financial commitments.

As an integrated care organisation we bring safe and high quality services closer to home and improve

communication between community and hospital services, improving our patients' experience. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

Our strategic goals

Providing the best possible healthcare services to patients will be achieved by delivering our clinical strategy. We have six strategic goals that guide us in delivering safe and high quality care for all.

- To secure the best possible health and wellbeing for all our community
- To integrate and coordinate care in person-centred teams
- To deliver consistent, high quality, safe services
- To support our patients and users in being active partners in their care
- To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

Listening to our staff

At the heart of delivering high quality and safe care is our staff, both those who work directly with patients and those who provide the support they need to keep our services running.

Our new workforce strategy, which was developed with our staff and introduced this year, outlines our ambition to develop a dynamic and flexible workforce with the right skills, expertise and equipment.

NHS staff survey 2015

In common with many parts of the NHS there has been an increase in the demand for our services and as we rise to meet this growing challenge, our teams are committed to providing the best care possible. Our latest staff survey demonstrates the continuing commitment of our staff;

- 53% of staff feel satisfied with the opportunities for flexible working
- 83% of staff would recommend Whittington Health to friends and family if they needed treatment
- 70% of staff would recommend Whittington Health to friends and family as a good place to work.

Staff Engagement Indicator

The Care Quality Commission (CQC) staff survey report provides an overall indicator of staff engagement for Whittington Health and how it compares with other acute Trusts. The possible scores range from 1 to 5 (with 1 indicating poor engagement and 5 high engagement). The Trust's score of 3.79 is in line with the national average and is an improvement from 3.74 in 2014.

Top Ranking Scores

Whittington Health compares favourably with other acute trusts in England in the following areas:

	Indicator	Trust	National
1	Staff experiencing violence from patients	9%	14%
2	Staff satisfied with opportunities for flexible working patters	53%	51%
3	Quality of appraisals	3.13	3.04
4	Effective team working	3.80	3.77
5	Staff reporting good communication between senior management and staff	31%	30%

Bottom Ranking Scores

Where we compare less favourably with other acute trusts is set out below;

	Indicator	Trust	National
1	Staff working extra hours	79%	72%
2	Staff Suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	29%	24%
4	Staff reporting errors, near misses or incidents witnessed in last month	87%	90%
5	Staff reporting most recent experience of violence	48%	52%

Whilst our staff survey highlights many areas we can be proud of, there are some areas we must improve.

Over the next year we will take active steps to address issues around bullying, harassment and discrimination, improving communications from senior management, as well as increasing the number of staff participating in the national survey.

Staff Friends and Family Test

The Trust continues to achieve a higher response rate than the London and national average. In Quarter four we received 611 responses which equates to a 15% return

The results for Quarter four, together with the London and national comparison data for Quarter two 2015 are illustrated below: (note; the national staff survey is undertaken in Quarter three)

Quarter 4 2015/16 Staff Friends and Family Test (FFT) responses compared with Quarter 2 2015/16 Staff FFT response

Organisation	Total Responses	HSCIC Workforce Headcount	Response Rate	% Recommend Care	% Not Recommend Care	% Recommend to Work	% Not Recommend to Work
Whittington Health Q4 15/16	611	4162	15%	82%	6%	70%	17%
England Q2 15/16	132068	1155635	11%	79%	7%	62%	19%
London Area Team Q2 15/16	18219	183356	10%	76%	8%	62%	20%
Whittington Health Q2 15/16	735	4162	18%	73%	12%	50%	33%

As can be seen from the results above, 82% of staff who responded to the survey would recommend our organisation to their friends and family as a good place to receive care. This is a 4% improvement on this time last year.

The comments and feedback received in the comments box suggest that this is due to our patient focus, professionalism and the excellent levels of patient care, by all teams across the Trust. The main area to focus on to improve this score is around better management of our resources, in particular staff shortages.

As a place to work, many staff would recommend the Trust due to its friendly, supportive environment with good training and professional colleagues. Many staff like the smaller size of our organisation and that it is closely aligned to the needs of the local population. Since this time last year we have seen an improvement of 8%. Of staff saying that they would recommend Whittington Health as a place to work. Equally we have seen an 8% improvement in those saying they would not recommend our organisation as a good place to work.

Priorities for improvement and statements of assurance from the Board

Our quality priorities for 2015/16

Review of our quality priorities 2015/16

During 2015/16 we reaffirmed our commitment to aim to deliver high quality and safe services for our patients in both the community and hospital settings. We agreed our clinical strategy which sets out six strategic goals and our ambition to continue to be patient focused, clinically led and high achieving. The strategy was developed and informed by working with and listening to our staff, clinical teams and stakeholders.

The Board is assured of the quality of our care, and is involved in setting priorities for improvement through the following governance mechanisms;

- Board discussions around quality, set out in the Board Annual Work Plan
- Quality Committee (subcommittee of the Board) discussions set out in the Quality Committee Annual Work Plan
- Executive Team discussions as set out in their Business Plans and Objectives of the Executive Directors
- Trust Management Group (TMG) (executives, directors and clinical directors) discussions as set out in the TMG Work Plan
- The seven Integrated Clinical Service Units discussions through their initial Planning Forums, their Quarterly Performance Reviews and their 2016/17 Business Plans
- The Cost improvement Programme, Quality Impact Assessment (QIA) meetings, chaired by the Medical director and Director of Nursing
- The Sign up to Safety Plan, Patient Safety Week which held a series of masterclasses, workshops and listening events to engage our workforce and stakeholders who provided their views on our existing and future plans

Our quality priorities set out in the Quality Account for 2015-16 were:

Trust Strategic Goals	Quality Priorities
To secure the best possible health and wellbeing for all our community	**Learning Disabilities** In quarter four 90 percent of inpatients with learning disabilities (LD) will meet the LD specialist nurse during their admission, be clearly identified on the electronic patient record, and have a personalised care plan (Purple Folder). In the Emergency Department (ED) 75 percent of all staff will have had specific training in the care of people with LD.
To integrate/co-ordinate care in person-centred teams	**Falls** We will reduce the number of inpatient falls that result in serious harm by 50 percent.

To deliver consistent high quality, safe services	**Sepsis and Acute Kidney Injury (AKI)** We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis. In addition we will effectively record our performance in delivering the sepsis six care bundle for all patients. We will improve our performance by 50 percent in the course of the year. We will achieve all our outcome measures associated with our AKI CQUIN in 2015/16.
To support our patients/users in being active partners in their care	**Pressure Ulcers** We will have no avoidable grade four pressure ulcers. We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 50 percent. We will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent.
To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research.	**Research and Education** We will increase by at least 20 percent the number of National Institute of Health Research (NIHR) programmes in which we participate. We will increase participation in inter- professional learning events within Whittington Health by 30 percent.
To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	**Patient Experience** We will improve the response rate of Family and Friends Test responses. We will reduce the no. of people who would not recommend Whittington Health, and increase the number who would. We will improve the capture of data that demonstrates the impact of service delivery on outcomes in our diabetic service and frail elderly service.

Our quality priorities for 2016/17 are:

Our quality priorities for 2016/17 are aligned to our Sign up to Safety pledges. The Sign up to Safety initiative aims to progressively improve quality in the chosen areas over a period of three years, and so many of the areas that were chosen for quality improvement in 2015/16 have been retained for the forthcoming year.

Trust Strategic Goals	Quality Priorities
To secure the best possible health and wellbeing for all our community	**Learning Disabilities** We will develop and implement 'Always Events' for people with Learning Disabilities in a relevant clinical setting. We will aim for 75 percent of inpatients with learning disabilities to meet the Learning Disability specialist nurse during their admission. We will aim for 75 percent of relevant staff who work in our Emergency Department to have specific training in the care of people with Learning Disabilities.
To integrate/co-ordinate care in person-centred teams	**Falls** We will reduce the number of inpatient falls that result in severe/moderate harm by 25 percent.
To deliver consistent high quality, safe services	**Sepsis and Acute Kidney Injury (AKI)** We will achieve the targets of the new and expanded national sepsis CQUIN in 2016/17
To support our patients/users in being active partners in their care	**Pressure Ulcers** We will implement our 'React to Red' pressure ulcer prevention campaign We will have no avoidable grade four pressure ulcers. We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25 percent. We will reduce the number of avoidable grade three pressure ulcers in the community by 25 percent.
To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research.	**Research and Education** We will increase by 10 percent the number of National Institute of Health Research (NIHR) programmes in which we participate We will launch and publish a newsletter to promote our research and education activities and engagement programmes. We will publish this at least four times a year.

To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	**Patient Experience** We will improve the response rate of Family and Friends Test responses by 20 percent in the year. We will document and report our actions from patients' and carers' feedback within our Quarterly Patient Safety Report to the Trust Board. We will revise our Communication and Engagement Strategy. We will establish a Community Forum which reflects the diverse community we serve. We will host a minimum of four engagement events and report to the our Board on how we have improved opportunities for our patients, carers, public and stakeholders to engage and inform our strategic plans to help local people live longer healthier lives.

Progress report on our 2015-16 priorities

Priority one: Learning Disabilities (LD)

Improving care for people with a learning disability is one of our 4 key Sign up to Safety pledges; a three year campaign which will focus on providing individualised person-centred care. For 2015/16, we agreed two priorities as part of this three year project.

1. In quarter four, 90 percent of inpatients with learning disabilities will
    - be clearly identified on the electronic patient record
    - meet the Learning Disabilities Specialist Nurse during their admission
    - have a personalised care plan (Purple Folder)
2. In the Emergency Department (ED) 75 percent of all staff will have had specific training in the care of people with learning disabilities

Target one: In Q4, 90 percent of inpatients with learning disabilities will be clearly identified on the electronic patient record, meet the Learning Disabilities Specialist Nurse during their admission and have a personalised care plan ('my purple folder')

In Quarter four of 2015/16, every inpatient known to have a learning disability was clearly identified on the electronic patient record system (Medway) and for all of these patients an electronic flag was added to the system, to alert staff from the beginning of the patient's admission that the patient has a learning disability.

The Learning Disability Specialist Nurse is automatically alerted via Medway, when a patient with a learning disability is admitted as an inpatient. In cases where the patient's learning disability was not previously recorded on Medway, a referral should be made by the clinical staff to the Specialist Nurse. We have not yet met the target of 90 percent of patients with the learning disability meet the Specialist Nurse during their admission. The improvement plan for 2016/17 (listed below) should enable us to meet this target in 2016/17.

We have not jet met the target that 90 percent of patients with a learning disability should have a personalised care plan, but again, the improvement plan for 2016/17 (listed below) should enable us to meet this target in 2016/17.

Target two: In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with learning disabilities

The Emergency Department adopted a two-pronged approach to learning disability awareness training in 2015/16. In addition to the comprehensive training provided by the Learning Disability Specialist Nurse, learning disability awareness briefing sessions are run at team meetings. This ensures that all staff receives regular awareness training on how to support patients with learning disabilities in the Emergency Department.

In Quarter four 2015/16 a trust wide electronic education platform, 'Moodle', was introduced to support the delivery and recording of learning and training throughout the trust. This is now being used to gather reliable data on learning disability training in the Emergency Department, and will enable us to demonstrate in 2016/17 that we have met our target of training at least 75 percent of relevant staff in the Emergency Department.

Learning disabilities: Quality Improvement priorities for 2016/17

Proposed plans for 2016/17 include:

- simplifying the existing paper-based tools for risk assessments, care plans and discharge planning for inclusion on Medway and Anglia ICE
- developing an electronic referral system for Anglia ICE to replace the existing paper-based system

Priority two: Falls

Every year, over 240,000 falls are reported in acute hospitals and mental health trusts in England and Wales. A fall in hospital can cause patients and their families to feel anxious and distressed. For frail patients even minor injuries caused by a fall can cause serious injury, permanent disability, or death.

Aside from the obvious impact on patient safety and patient experience, falls in hospital can also have an impact on the length of time a patient needs to stay in hospital and may require surgical or other major interventions, and potentially additional care after discharge from hospital.

Target: We will reduce the number of inpatient falls that result in moderate or severe harm by 50 percent.

In 2015/16 there were six falls resulting in moderate/severe harm. In 2014/15 there were 11 falls resulting in moderate/severe harm. The total numbers are low but do show a reduction of almost 50 percent.

We did achieve good results when benchmarked against other trusts in the most recent National Audit of Inpatient Falls undertaken by the Royal College of Physicians. We had a low level of 3.23 falls per thousand occupied beds days (OBD's), which was the second best figure among the participating trusts in the London region.

Falls: Quality Improvement priorities for 2016/17

In 2016/17 we will introduce the new role of Specialist Nurse in falls and dementia care and re-vitalise some of the education and training around this topic. A high proportion of inpatient falls occur in elderly patients with dementia and/or delirium, and the introduction of this new specialist role will strengthen the training an learning for our staff in caring for this vulnerable group of patients. We anticipate this will enable us to reduce the number of falls resulting in serious harm in 2016/17.

Priority three: Sepsis and Acute Kidney Injury (AKI)

Sepsis and acute kidney injury are recognised nationally as leading causes of harm and death. Early recognition of patients with sepsis/AKI and rapid initiation of treatment plans will lead to improvements in both morbidity and mortality rates.

We are committed to improving our care of people with sepsis in line with emerging national best practice. There is a trust-wide multi-professional sepsis team that leads on developing and disseminating pathways for patients and ensuring widespread education and training for all relevant staff. We have recently appointed to the new post of Lead Sepsis Nurse Specialist which will be instrumental in delivering further improvements.

Target one: We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis (90 percent).

Despite clear improvements in the number of patients being given antibiotics within the first hour, we are disappointed to have not met this target. Of the 46 patients with severe sepsis seen between January and

March 2016, 36 received antibiotics within an hour of arrival to hospital, which equates to 78.2 percent (which is up from 67.4 percent between October and December 2015).

One of the key ways to ensure more patients with severe sepsis receive antimicrobials within an hour of arrival to hospital is by ensuring patients with sepsis arrive with a pre-hospital alert for sepsis and this has increased from 8% of patients (April 2015-June 2015) to 40% of patients (January 2016-March 2016).

Target two: We will effectively record our performance in delivering the sepsis six care bundle for all patients with sepsis. We will improve our performance by 50 percent in the course of the year.

We are pleased to have made clear progress in our ability to deliver all 6 aspects of the sepsis care bundle that includes interventions such as rapid intravenous fluids and antibiotics. In 2014 an audit demonstrated that we delivered sepsis 6 bundle to 42% of patients. The latest audit in January -March 2016 80% of patients with sepsis received all 6 aspects of the care bundle.

Target three: In more than 90% of patients with Acute kidney injury (stage 3) we will ensure correct documentation and assessment has occurred in line with the national AKI CQUIN.

CQUIN AKI Audit Results

Quarter 1 – 15%	April 2015 – 7%	May 2015 – 15%	June 2015 – 23%
Quarter 2 – 14%	July 2015 – 11%	August 2015 – 19%	September 2015 – 11%
Quarter 3 – 39%	October 2015 – 29%	November 2015 – 38%	December 2015 – 49%
Quarter 4 – 60%	January 2016 – 56%	February 2016 – 56%	March 2016 – 68%

Whilst we have taken some key steps forward to improving the outcomes of patients with AKI, we have not met out target for 2015/16 of 90 percent although there has been steady improvement in the monthly figures.

Sepsis/AKI: Quality Improvement priorities 2016/17

Our sepsis CQUIN target for 2016/17 has been confirmed and now covers all emergency admissions with sepsis as well as patients who develop sepsis on the wards. We are committed to achieving this new target and will continue to focus our efforts, particularly on obstetric sepsis. We will also continue to strengthen our relationships with local GPs and other community teams to increase awareness of sepsis amongst health professionals before patients come to hospital.

The national AKI CQUIN has been dropped for 2016/17 but we will continue to work towards improving outcomes for patients with AKI in 2016/17, and have already introduced a number of important measures to help improve care, including:

- Increasing training and education for staff – particularly in amongst pharmacy and junior doctor teams
- Reviewing and refreshing the way clinical notes are managed for patients with AKI

- Including a specific AKI section in a patient discharge letter to ensure they receive the right care when back in the community.

Priority four: Pressure ulcers

We have a zero tolerance to our patients developing 'avoidable' pressure ulcers and are working closely with teams across the hospital and community to tackle this important issue.

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Target one: We will have no avoidable grade four pressure ulcers

Target two: We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 50 percent and we will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent

	Community (avoidable pressure ulcers)		Acute (avoidable pressure ulcers)		Total (avoidable pressure ulcers)	
	Grade 3	**Grade 4**	**Grade 3**	**Grade 4**	**Grade 3**	**Grade 4**
2014/15	58	10	4	2	62	12
2015/16	25	3	13	0	38	3
% change	- 59%	- 70%	+ 78%	- 100%	- 53%	- 75%

Overall, there has been a 75 percent reduction in the number of grade four pressure ulcers across Whittington Health. However, we have not met our target of no avoidable grade four pressure ulcers because we had three avoidable grade four pressure ulcers within the community in 2015/16.

We exceeded our target to reduce the number of avoidable grade three pressure ulcers in the community, but did not managed to reduce the number of avoidable grade three pressure ulcers acquired in the acute setting.

Key actions taken to reduce the number of avoidable pressure ulcers

We have undertaken a number of initiatives to help further reduce the number of avoidable pressure ulcers:

- We launched our 'React to Red' campaign, to increase awareness across our hospital and community sites.
- We developed a combined safe care and skin care bundle document which is in use across our inpatient wards. The care bundle has also been implemented in the Emergency Department for patients who are identified as being at high risk of skin damage.
- The 'React to Red' campaign was introduced during daily 'safety huddles'. It is currently being trialled in selected wards and plans are in place to roll out these safety huddles across all inpatient wards.

Pressure ulcers: quality improvements for 2016/17

We have plans in place to further increase awareness of pressure ulcer prevention in the community during 2016/17, particularly amongst GPs, district nurses and those involved in social care.

Priority five: Research and education

Learning and development are a key part in helping us to deliver excellent, high quality care to patients and we are keen to increase the opportunities our teams have to increase their clinical and specialist knowledge.

Target one: We will increase by at least 20 percent the number of National Institute of Health Research (NIHR) programmes in which we participate

We are pleased to have exceeded our target to increase the number of NIHR programmes in which we participate. In 2015/16 there were 41 NIHR portfolio studies in progress compared to 31 studies in 2014/15 and 21 in 2013/14.

Target two: We will increase participation in inter-professional learning events within Whittington Health by 30 percent

We have increased participation in inter-professional learning events. Throughout the year, we have delivered a number of inter-professional workshops that focussed on a range of areas including; ethics forums, care certificate training, advanced care planning and self-management. These events were well attended and teams found sharing knowledge with colleagues from other disciplines particularly helpful in being able to deliver the integrated care patients need.

Priority six: Patient experience

One of the key indicators of the quality of our services is what our patients think about them. In order to understand what our patients and think, we want to increase their participation in the NHS Friends and Family Test (FFT).

Target one: We will improve participation in the Family and Friends Test (FFT)

In 2015/16 we increased the number of responses in relation to the patient Friends and Family Test from 10,000 to 37,244 (To be confirmed)

Target two: We will reduce the number of people who would not recommend Whittington Health, and increase the number who would.

The trust consistently meets the 90% ‘recommend’ target for FFT and we have increased the number of ‘recommend’ ratings and decreased the number of ‘would not recommend’ ratings. Further information relating to FFT ratings is detailed in a later section of this account.

Target three: We will improve the capture of data that demonstrates the impact of service delivery on outcomes in our diabetic service and frail elderly service.

However, to improve outcomes for patients with diabetes we have introduced a new telephone clinic, and we were pleased to be rated first of all NHS trusts in England and Wales in the National Diabetes Audit for delivering the eight main care processes for those living with the condition. Over 95 percent of our patients were treated with all eight standards compared to the national standard of 59 percent.

Commissioning for Quality and Innovation (CQUINs) agreed with our commissioners for 2016/17

A proportion of our income in 2016/17 is conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local CCGs. Under the CQUIN payment framework, these goals were agreed as representing areas where improvements will result in significant benefits to patient safety, experience and health outcomes. These CQUINs have been agreed, subject to changes in detail with local commissioners:

- Discharge planning and delivery
- Obesity
- Domestic violence
- Nutrition and Hydration
- Acute Kidney Injury
- NHS staff health and wellbeing
- Sepsis
- Antimicrobial resistance

CQUINs 2015/16

In 2015/16 2.5 percent of our income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. These goals were agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

There is a full CQUIN team responsible for the achievement of CQUINs with an Operational lead and a Clinical lead. There is also a clinical lead and operational lead for each individual CQUIN.

Performance against CQUINS

CQUIN scheme	Rationale / Objectives	Estimated Compliance
Acute Kidney Injury	To make sure that the discharge information communicated to General Practitioners contains the relevant information for patients with Acute Kidney Injury.	Partially Compliant
Sepsis	To make sure that the appropriate patients who attend the trust in an emergency are screened for sepsis, and receive the necessary antibiotics if necessary.	Partially Compliant

Dementia screening in >75 years for emergency admissions	To make sure we screen patients who are admitted as an emergency for dementia.	Compliant
Urgent Care: Diagnosis recording in A&E	To make sure we record A&E diagnoses and submit this information to the 'Secondary Users Service' national data repository	Compliant
Safe and Timely Discharge	To make sure we discharge patients early in the day, where possible, and that information in the discharge summaries sent to general practitioners is complete and timely.	Compliant
Prevention - Smoking Cessation	Smoking cessation: Up to one in five deaths in London is due to smoking yet there are cost effective interventions that can be used in hospitals to reduce that mortality, improve health and prevent admissions.	Compliant
Prevention - Alcohol misuse	To make sure that patients with alcohol problems are identified and provided with brief advice and signposting to support services.	Compliant
Prevention - Domestic violence	To ensure that staff are trained in approaching patients about domestic violence and abuse, and are able to provide specialist advice, advocacy and support.	Compliant
Value based commissioning: Data recording and sharing	To ensure inpatient coding for Diabetes Co-morbidities, and Psychosis is complete, and to share data on incidence of pressure ulcers and hip fractures	Compliant
Child Health Information System (CHIS)	To promote the secure and timely transfer of clinical records between providers and the tracking of all HepB, BCG and LAC. This promotes best clinical care for the most vulnerable children.	Compliant
Neonatal Community Nursing	To ensure timely discharge of babies in the Neonatal Community Nursing caseload	Compliant
CAMHS	To ensure we improve involvement of MH carers, that unplanned admissions are appropriate and that we improve physical healthcare	Compliant
Support for Hep C Network	To ensure that we help support the development of a Hepatitis C partnership network	Compliant

Oncology Dx	To help improve uptake of oncology Dx test, to assist patients deciding on a potential chemotherapy pathway	Compliant
Oral Chemotherapy	To ensure that we minimise the amount of Oral Chemotherapy that is prescribed, yet not taken by patients - by reviewing length of prescription courses	Compliant

Statements of assurance from the Trust Board

All providers of NHS services are required to produce an Annual Quality Review (look back) and Quality Account (look forward) and certain elements are mandatory. This section contains mandatory information along with an explanation of our quality governance arrangements. The quality governance arrangements within Whittington Health ensure that key quality indicators and reports are regularly reviewed by clinical teams and by Committees and Working Groups, up to and including the Board of Directors.

There are a number of Committees and Working Groups with specific responsibilities for aspects of the quality agenda, which report to Whittington Health's Trust Board Quality Committee. The Executive and Trust Management Group reviews quality performance monthly. In addition, the Quarterly Performance Review meetings, consisting of Executive Directors and Clinical Directors, monitors in detail performance against Whittington Health quality and safety priorities.

Our Trust Board Audit and Risk Committee whose membership comprise of Non-Executive Directors, selects areas across Whittington Health reporting sub-optimal performance and requests in-depth reviews with the results reported to the Audit and Risk Committee by the accountable Executive Director.

The Audit and Risk Committee is responsible on behalf of our Trust Board for independently reviewing the systems of governance, control, risk management and assurance. Our Board of Directors receive monthly corporate performance reports that are available on our website as part of our published Trust Board papers. These include a range of quality indicators across the three domains of patient safety, experience and clinical effectiveness (outcomes).

Our Trust Board receives a new Quarterly Safety Report by the Medical Director and this includes updates on mortality, HSMR, SHMI and other measures of patient safety.

Our Board is further assured by reviews undertaken by internal audit (TIAA) and during this year the annual audit plan included the key quality areas of end of life care, dementia, mortality and pressure ulcers. Board members, including the Chairman and Chief Executive, Medical Directors, Director of Nursing and Patient Experience and Non-Executive Directors, regularly undertake 'safety huddles' which are back to the floor walkabouts around the community and hospital care settings to talk face to face with staff and patients. They focus discussions on the CQC essential standards that services should be safe, effective, caring, responsive and well led. These visits and the subsequent lessons implemented from the feedback provide additional assurance on the safety and quality of Whittington Health services.

The Trust appointed an Associate Medical Director for Patient Safety during 2015/16 and this new role will help Whittington Health continue to strengthen our patient safety culture.

Review of services

During 2015/16, Whittington Health provided 198 NHS services delivered through the seven Integrated Care Service Units (ICSUs), and did not sub-contract any services. The Trust has reviewed all data available on the quality of care of those services.

Our Board receives, reviews and acts on quality of data on a regular basis, as key quality indicators are included in the our Performance Dashboard. It also receives regular comprehensive patient feedback reports including information on complaints, our Patient Advice and Liaison Service (PALS), litigation and local patient survey findings.

The clinical income generated by the NHS Services reviewed in 2015/16 for the compilation of the Quality Account represents 90.6 percent of the total clinical income of Whittington Health.

Participation in Clinical Audits 2015/16

** Whittington Health used to refer to the ICO (legal name: The Whittington Hospital NHS Trust)*

During 2015/2016 there were **36** national audits and **6** national confidential enquiries covered NHS services that Whittington Health provides.

During 2015/2016 Whittington Health participated in **100%** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in

The national clinical audits and national confidential enquiries that Whittington Health participated in and for which data collection was completed during 2015/2016 are included below, listed alongside are the number of cases submitted to each audit or enquiry or the percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Management Body	Participation during 2015/2016	If data collection completed, cases submitted (as total or % if requirement set)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research	Yes	90 cases
Bowel cancer (NBOCAP)	Royal College of Surgeons of England	Yes	61 cases
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	695 / 695 cases (100% case ascertainment)

Child Health Clinical Outcome Review Programme: • Young People's Mental Health (Eating disorders, self-harm, anxiety and depression) • Chronic Neurodisability (Cerebral palsies 11 – 25 years of age)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	In progress
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Yes	89 cases
Elective surgery (National PROMs Programme)	Health and Social Care Information Centre	Yes	Hip 104 knee 120 Groin Hernia 127 Varicose Vein 4 **Total 355**

Emergency Use of Oxygen	British Thoracic Society	Yes	17 / 17 cases (100% case ascertainment)
Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient Falls	Royal College of Physicians (London)	Yes	30 cases
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Royal College of Physicians (London)	Yes	112 cases (100% case ascertainment)
Inflammatory Bowel Disease (IBD) programme	Royal College of Physicians (London)	Yes	10 cases
Major Trauma: The Trauma Audit & Research Network (TARN)	Trauma Audit & Research Network	Yes	23 cases
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit	Yes	19 /19 cases (100% case ascertainment)

Medical and Surgical Clinical Outcome Review Programme	NCEPOD	Yes	100% compliance See section Below
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	Yes	Ongoing
National Audit of Intermediate Care	NHS Benchmarking Network	Yes	227 / 326 cases (70% case ascertainment)
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	30 cases Commenced June 2015
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Pulmonary Rehabilitation)	Royal College of Physicians (London)	Yes	63 cases
National Comparative Audit of Blood Transfusion programme: Audit of Patient Blood Management in Scheduled Surgery	NHS Blood and Transplant	Yes	6 cases
National Comparative Audit of Blood Transfusion programme: 2015 Audit of the use of blood in Lower GI bleeding	NHS Blood and Transplant	Yes	17 cases
National Comparative Audit of Blood Transfusion programme: 2016 Audit of Red Cells & Platelet Transfusion in Adult Haematology Patients	NHS Blood and Transplant	Yes	7 / 7 cases (100% case ascertainment)
National Complicated Diverticulitis Audit (CAD)	Yorkshire Surgical Research Collaborative	Yes	20 / 15 cases (134% case ascertainment)
National Diabetes Audit (Adults): Foot care	Health and Social Care Information Centre	Yes	38 cases
National Diabetes Audit (Adults): Inpatient	Health and Social Care Information Centre	Yes	58 cases
National Diabetes Audit (Adults): National Pregnancy	Health and Social Care	Yes	10 cases

in Diabetes Audit	Information Centre		
National Diabetes Audit (Adults)	Health and Social Care Information Centre	Yes	1997 cases
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	103 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	Yes	Ongoing
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Yes	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	71 cases
National Prostate Cancer Audit	Clinical Effectiveness Unit, The Royal College of Surgeons of England	Yes	55 / 85 cases (65% case ascertainment)
Neonatal Intensive and Special Care (NNAP)	The Royal College of Paediatrics and Child Health	Yes	440 cases
Oesophago-gastric cancer (NAOGC)	Royal College of Surgeons of England	Yes	28 cases
Paediatric Asthma	British Thoracic Society	Yes	27 cases
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Yes	50 cases
Rheumatoid and Early Inflammatory Arthritis	British Society of Rheumatology	Yes	3 cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Yes	Ongoing 18 cases Commenced Sept 2015
UK Parkinson's Audit (Elderly Care & Neurology – other streams not applicable)	Parkinson's UK	Yes	40 cases

Vital signs in children (care in emergency departments)	Royal College of Emergency Medicine	Yes	100 cases
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Yes	51 cases

There were four audits that were eligible for Whittington Health to participate, however Healthcare Quality Improvement Partnership confirmed that there was no data collection during 2015/2016:

- Adult Asthma
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (Secondary Care)
- Non-Invasive Ventilation – Adults
- Paediatric Pneumonia

Additional National Audits	**Management Body**	**Participated in 2015/16**	**Audit Status**
BTS Adult Community Acquired Pneumonia Audit	British Thoracic Society	Yes	Reported in 2014/15 and completed in 2015/16
2015 National End of Life Care Audit	Royal College of Physicians	Yes	Completed
Minimum Data Sets for Palliative Care	National Council for Palliative Care	Yes	Completed
Cardiac Rehabilitation	Health & Social Care Information Centre, British Heart Foundation	Yes	Ongoing data collection
Systematic anti-cancer therapy - chemotherapy dataset	National Cancer Intelligence Network	Yes	Ongoing data collection
National study of HIV in Pregnancy and Childhood	NSHPC	Yes	Ongoing data collection
Perinatal Institute Baseline IUGR Audit	Perinatal Institute	Yes	Completed
BASHH 2015 National re-audit of the management of under 16s (13 - 15 year olds) attending sexual health services.	BASHH	Yes	Completed
Society of Acute Medicine	Society of Acute	Yes	Completed

Benchmarking Audit	Medicine		
RCR National audit of the accuracy of interpretation of emergency abdominal CT in adult patients who present with non-traumatic abdominal pain	Royal College of Radiologists Audit	Yes	Completed
7 Day Services Self-Assessment Tool	NHS England, TDA	Yes	Completed
NPDA - PREM audit	Royal College of Paediatrics and Child Health	Yes	Ongoing data collection
London Ambulance Service out of hospital cardiac arrest	London Ambulance Service	Yes	Ongoing data collection
Care of Older People in Acute Settings	British Geriatrics Society	Yes	Completed
Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	Yes	Ongoing data collection
Standardising EEG investigation for Non-Epileptic Attack Disorder	Joint ANS/BSCN National Audit Projects	Yes	Completed

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Whittington Health eligibility and participation:

Title	Participation 2015/2016	Percentage of cases submitted
Mental Health in General Hospitals	Yes	100%
Acute Pancreatitis	Yes	100%
Sepsis	Yes	100%
Gastrointestinal Haemorrhage	Yes	100%

The reports of **14** national clinical audits and **three** national confidential enquiries were reviewed by the provider in 2015/16 and Whittington Health intends to take the following actions to improve the quality of healthcare provided.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2016/2017 by ensuring:

- Each of the seven Integrated Clinical Service Units (ICSU) have an agreed annual clinical audit (quality improvement) programme which will align with our overall audit strategy and priorities. National audit and national confidential enquiries will continue to be a key component of these programmes.
- Performance in national clinical audit will continue to be acknowledged through the dissemination of participation certificates and outcome presentations at senior ICSU and Corporate level meetings including speciality half day audit meetings.
- National audit compliance will continue to be monitored on an ongoing basis with reporting via the ICSU Quality Committee or Board meetings.

The following are examples of the results and actions being taken for national audits:

National Diabetes Audit (NDA) Report 2013/15

The National Diabetes Audit report assessed data for care processes and treatment targets from the 2013/14 and 2014/15 audit years. The NDA integrates data from both general practices and secondary care sources. Participating in national clinical audits, such as the NDA, is regarded as a mark of excellence by the NHS. The results of the audit showed that we were ranked first out of all trusts in England and Wales for undertaking the eight national care processes patients should receive.

NCEPOD: Sepsis (A review of the process of care received by patients with sepsis)

Sepsis is a major cause of avoidable mortality and morbidity. This study, whilst considering the plethora of other work in this important area, set out to identify in greater detail, remediable factors which if addressed would improve the quality of care of patients with sepsis.
Whittington Health contributed 100% of requisite cases to this study and reviewed all the recommendations, subsequent to the report publication in November 2015.

Areas of good practice identified include:

- A pathway for the early identification and immediate management of patients with sepsis has been developed and is available to all staff via the Whittington Health intranet and electronic patient systems. Additionally, hard copies of the pathway are kept in the Emergency Department, Triage and Resuscitation areas. Training is ongoing and the pathway is audited quarterly by our Sepsis Team.

- Training in the recognition and management of sepsis including simulation training is up and running, both in acute and community settings. This training is delivered by our Lead Sepsis Nurse.

- Whittington Health has a Joint Clinical Lead to champion best practice and take responsibility for the clinical governance of patients with sepsis.

- All antimicrobial policies are reviewed and up to date and available to all staff via the Whittington Health intranet. The MicroGuide ‘Antimicrobial Stewardship’ application is available to download on mobile devices.

- There is a 24 hour/7 days per week microbiology on-call service available for input into the management of all patients identified with sepsis. This input is sought early in the aforementioned care pathway.

- A follow up service is offered to all patients following an inpatient stay in Critical Care. This includes support and rehabilitation services, as recommended in NICE Clinical Guideline 83 and the Faculty of Intensive Care Medicine and Intensive Care Society Guidelines for the Provision of Intensive Care Services.

Vital Signs in children (Care in Emergency Departments)

This national audit was overseen by the Royal College of Emergency Medicine.

Vital signs are recorded in all children presenting to the Emergency Department with medical or surgical complaints. If abnormal, they can be helpful with triage/prioritisation and indicative of a disease process with the potential to cause increased morbidity and mortality. Detecting abnormal vital signs at the earliest opportunity allows a time appropriate response to avoid deterioration in the patient's health.

The purpose of the audit was to provide a baseline for future comparison; contribute to nationwide data collection of paediatric ED performance in this area and allow local benchmarking and to identify areas in need of improvement.

Significant result:

- Heart rate, respiratory rate, oxygen saturation and temperature are routinely recorded for most patients (>90 percent)

Identified actions for improvement include:

- Where abnormal vital signs are documented, the responsible clinician should document what action is taken to address these or why no action is needed;
- To re-audit at another time of the year (spring/summer) in order to make the results more reliable and representative

The reports of **95** local clinical audits were reviewed by the provider in 2015/2016 and Whittington Health intends to take the following actions to improve the quality of healthcare provided.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2016/2017 by ensuring:

- All clinical audits are now mapped against the Care Quality Commission five areas under Key Lines of Enquiry of Safe, Effective, Caring, Responsive and Well-led.
- Following previous external auditor recommendations, each local clinical audit will additionally identify the source of the audit and the quality driver.
- Capacity is channelled where appropriate away from small ad-hoc audits to major, national audits vital to safety without losing flexibility or suppressing good local ideas.
- The audit registration form has been updated to reflect the requirements of registering both clinical audit and service evaluation projects.

- A programme of clinical audit awareness sessions, half-day clinical audit teaching workshops and ad hoc information dates by the Clinical Governance Department will continue throughout the coming year.
- Clinical audit actions will continue to be assigned to a senior clinician and managerial representative if appropriate, with specific time scales for completion.
- Local clinical audit performance will continue to be monitored on an ongoing basis with regular reporting via the ICSU Quality Committee or Board meetings.

Examples of results and actions being taken for local audit:

Monitoring of Physical Health and Metabolic Parameters of Young Patients on Antipsychotic Treatments at Simmons House

(Simmons House: Child and Adolescent Mental Health Services (CAMHS) inpatient service)

This audit is to compare the clinical practice at Simmons House to the gold standard practice recommended by the *NICE Guideline CG155, "Psychosis and Schizophrenia in Children and Young People: recognition and management*". The aim is to ascertain if all patients on antipsychotic medication received the optimum monitoring of their physical health and metabolic parameters regardless of their diagnosis and duration of treatment. This data was recorded on an Antipsychotic Monitoring Form (AMF).

The audit of the AMF was undertaken prospectively between March – September 2015. During this time, there were 6 patients who were prescribed antipsychotic medication. The results of the audit found that Simmons House Adolescent Unit monitors patients on antipsychotic medication regularly with a compliance of above 95 percent.

For the Unit to improve care, they are undertaking the following:

- To include the Antipsychotic Monitoring Form as one of the plans in the Care Programme Approach so that it follows the patient post discharge.
- To encourage patient's compliance by the key worker and case managers encouraging young people to be more concordant with data collection through discussion and psycho-education.

Snapshot safety audit on the Neonatal Unit

This audit was undertaken in order to assess adherence to 12 safety and infection control standards on the neonatal unit. Data collection has been undertaken twice in the past (2009 and 2014) looking at the same or similar standards.

The aim of the audit was to assess the extent to which the team adhere to the patient safety and infection control standards. The long term aim is to achieve 100% adherence to all standards, in order to maximise patient safety and promote infection control.

The audit results demonstrated good compliance with adherence to infection control measures on the Unit. Areas for improvement included documentation of patient details on both sides of clinical notes and babies having two name bands on at all times.

Recommendations:

- Audit results to be presented during a staff meeting with specific communication on the areas which require improvement.
- Re-audit to take place within the next twelve months.

Oncology Outpatients Nutrition Screening Tool

Malnutrition is a common problem in cancer patient populations as the effect of cancer and anticancer treatments can severely impact on a patient's nutritional status. Therefore, preventing and correcting nutritional depletion are important objectives in the care of the cancer patient. The patient's nutrition can be measured by the completion of the Oncology Outpatients Nutrition Screening Tool which is based on the Patient Generated Subjective Global Assessment and consists of 6 sections. The first 3 sections are to be completed by the patient and the remainder by the healthcare professional. Patients who have a nutritional score ≥4 are to be referred to the dietician. However, all patients should be reassessed at next contact regardless of nutritional score.

This was an initial audit and reviewed 18 patients in November 2015. The standard for this audit was for 100% of oncology patients and haematology patients receiving chemotherapy to be screened at least once a month.
Of those patients audited it was identified that there was approximately a third of patients who had a screening tool filed in the outpatient section of the medical notes.

Before a re-audit is to take place, the following actions were identified:

- To validate the screening tool that is currently in use.
- To develop a set of standards for completing the screening tool which will assist the frequency of the screening tool being completed.
- Keep the screening tool separate from medical notes and use a 'nutrition' folder to store the tools and record if the patient is already known to the dieticians.
- To include a patient signature on the tool to monitor if the tool is being completed by the patient.

A Paediatric Approach to Smoking Cessation

This audit was to assess the current prevalence of smoking in paediatric patients/ parents/carers and the provision of smoking cessation interventions. Within Adult Services at Whittington Health, a Smoking Commissioning for Quality and Innovation (CQUIN) Working Group has done a considerable amount of work leading to consistently high rates of smoking assessment and smoking cessation interventions with a CQUIN target of 90% of patients. Although paediatric patients are not included within the CQUIN, the aim is to have equivalent levels of assessment and intervention.

This audit reviewed children who were admitted to the paediatric ward between April and June 2015.

Although none of the target standards were met, there were good rates of smoking assessment status: 82 percent of patients aged 13 and over, and 71 percent of parents and carers.

With a respiratory admission, there were higher rates of assessment in parents and carers (90 percent compared to 63 percent for a non-respiratory admission). This is likely to reflect the 'wheeze' pro-forma which has a smoking tick box and also perhaps an increased awareness of smoking amongst healthcare professionals when a child is admitted with a respiratory problem.

To support the improvement of paediatric smoking cessation, the following actions are to be taken:

- To introduce stop smoking flowcharts;
- To include a smoking tick box on patient list and;
- To introduce ‘Quit at the Whitt boxes’ on the paediatric ward.

Participation in clinical research

In 2015/16, 720 patients that received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio. This compares to 284 patients in 2013/14 and 701 in 2014/15.

There are currently 41 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 31 studies in 2014/15 and 21 in 2013/14. In addition to the 41 NIHR portfolio studies that are on-going, an additional eight non-portfolio studies were commenced in 2015/16, a reduction of four on the previous year, this is due to applying the HRA categorisation of studies more strictly than in previous years. These studies are undertaken by nurses, allied health professional and trainee doctors. The results and impact of these studies are published in peer reviewed publications and at conference presentations.

This year has seen the ratification of a Whittington Health Research Strategy that underpins the clinical strategy and reflects the aim of enabling local people to ‘live longer healthier lives’. A key strategic goal is to become a leader of medical, multi-professional education and population based research. We believe we are uniquely placed to take a life course approach to population based research and be at the forefront of the synergy between clinical service, education and clinical research.

Participation in clinical research demonstrates Whittington Health’s commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the number of studies in which patients can participate, and the specialities that are research active as research active hospitals deliver high quality care. The Trust's research portfolio continues to evolve to reflect the ambitions of our ICO and also reflect the health concerns of our local population, including cancer, haemoglobinopathies, critical care, infection, women’s health, continence science and speech and language therapy.

Care Quality Commission (CQC) and Whittington Health 2015/16

Whittington Health is required to register with the CQC and its current registration status is registered with no conditions. The CQC has not taken any enforcement action against Whittington Health in 2015/16.

In December 2015 the CQC carried out an extensive planned inspection of both our community and hospital services. We undertook a full mock inspection based on Safe, Caring, Responsive, Effective, Well-led methodology in October 2015 prior to our announced CQC inspection, the results of which contributed to our self-assessment against these five fundamental standards. The Trust acknowledges that we are on a journey of continuous improvement and while some areas we would rank as outstanding, there are others that we acknowledge require improvements.

We are awaiting delivery of a draft inspection report which is expected in summer 2016. The CQC has issued no warning notices or made any requests for immediate improvement and has taken no enforcement action against the Trust since its inception.

Quality of Data

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and enable healthcare improvements. Whittington Health submitted records during 2015/16 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

Overall validity of data submitted by Whittington Health to the NHS Secondary Uses Service for the year 2015/2016 (to Month 12) was 98 percent. This is an aggregate score across all acute data types. There is no equivalent system in place yet for community data although the implementation of the Children's and Young Person's mandatory reporting dataset will provide that opportunity. The timescale for this development is unknown.

Of the 36 Trusts in London in the benchmark, the Whittington was ranked at 13, with the best close to 100 percent and the least good down at 76 percent. We are performing better than the national and London averages.

The percentage of records relating to admitted patient care, outpatient care and emergency care which included the patient's valid NHS number; and General Medical Practice Code (April 2015 – March 2016)

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	99	100
Outpatient care	98.9	100
Emergency care	94	99.9

Whittington Health's Integrated Clinical Service Units (ICSUs) have responsibility for data quality within their ICSU. The Trust has a Data Quality Group which includes representation from both the community and acute services and each of the ICSUs. This group is chaired by the Trust's Chief Operating Officer. This group is responsible for implementing an annual data improvement and assurance plan and measures the Trust's performance against a number of internal and external data sources. A Senior Data Quality Lead is in place to ensure the agenda is part of everyone's business.

The Data Quality Group has agreed a procedure for the spot checking of the quality of data items and monitoring compliance as part of the continual audit programme for 2015/16. Data Quality issues can be reported directly to the Data Quality Team via a dedicated email address, which is monitored by the Data Quality Team.

Information Governance (IG) Statement – 2015/16

In 2015/16 Whittington Health continued to work to deliver IG Level 2 compliance with the DoH IG Toolkit (IGT). Whittington Health achieved 65 percent, narrowly missing the 66 percent required to be Level 2 compliant. This is an improvement on previous years' scores. We aim to meet the target in 2016/17.

Although Whittington Health has delivered high standards of governance for the management, protection and quality of patient and staff information, there remain areas for improvement, especially with regards to

corporate records and IG training compliance. The work to achieve these remaining standards is monitored by the IG Committee (IGC) and the Audit and Risk Committee.

The work in 2015/16 to improve data quality standards has had a significant impact in improving our IGT compliance. The other factor which contributed to improved IGT compliance was our commissioning of a clinical coding audit by the HSCIC Clinical Classifications Service.

Mitigation of Risk

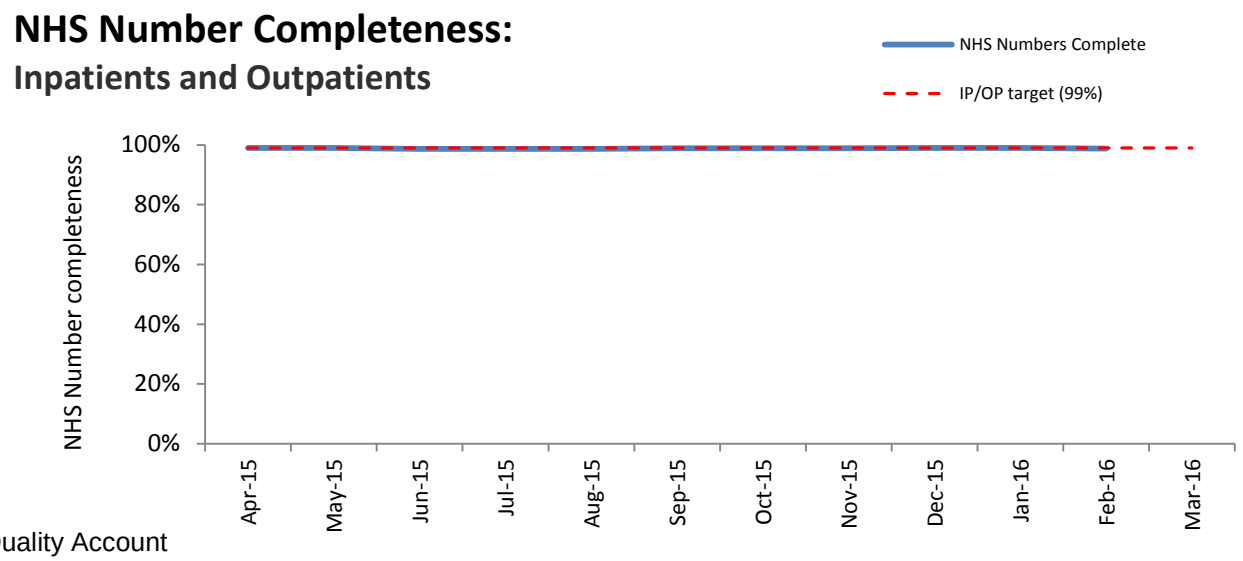
Actions are in place to mitigate against identified risk and to improve our performance against IG Toolkit requirements for 2016/17, including the following:

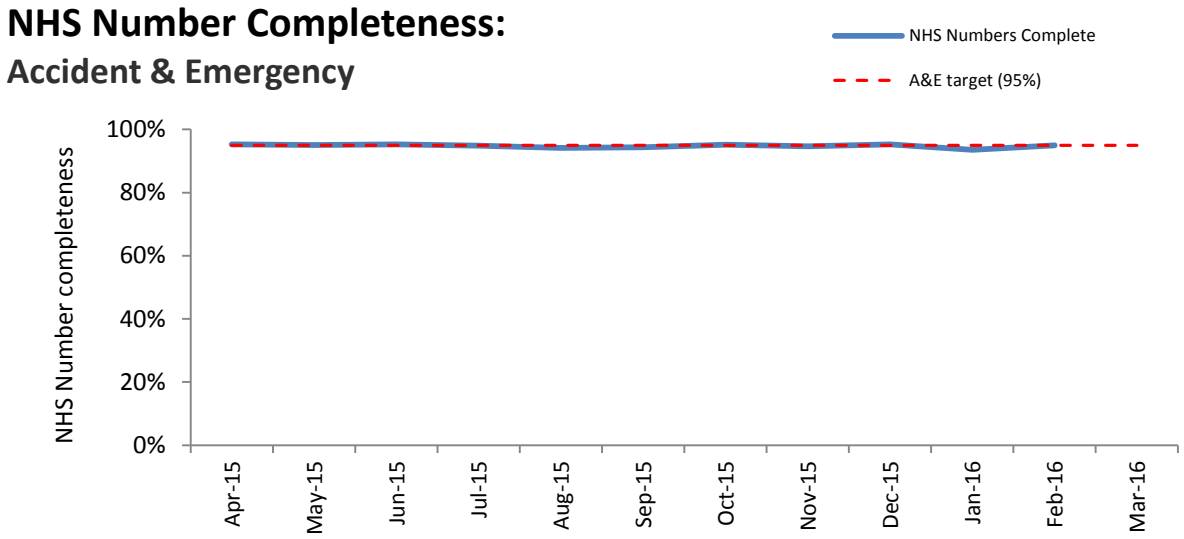
- The IGC will continue to monitor IG training compliance and distribute regular staff reminders (targeted emails and communications bulletin).
- The IG department aims to improve standards through the implementation of the 2016/17 IG Improvement Plan, information flow work-plan, and IG action plans (e.g. data sharing, communications, serious incidents, information security, and IG training).

The area that continues to present a challenge to us is the achievement of the 95 percent target for all staff to have completed IG training annually. The compliance rates will continue to be regularly monitored by the IGC, including methods of increasing compliance. The IG department will continue to target staff with individual emails, Whittington bulletin messages and classroom-based Induction sessions.

NHS Number Completeness

Month and Year	Inpatient and Outpatient Dataset		A&E Dataset	
	Completeness	Target	Completeness	Target
Apr-15	99.0%	99%	95.3%	95%
May-15	99.0%	99%	95.1%	95%
Jun-15	98.7%	99%	95.3%	95%
Jul-15	98.7%	99%	94.9%	95%
Aug-15	98.7%	99%	94.2%	95%
Sep-15	98.9%	99%	94.4%	95%
Oct-15	98.9%	99%	95.2%	95%
Nov-15	98.9%	99%	94.7%	95%
Dec-15	99.0%	99%	95.3%	95%
Jan-16	99.0%	99%	93.5%	95%
Feb-16	98.8%	99%	95.0%	95%
Mar-16	TBC	99%	TBC	95%





Whittington Health has an NHS number action plan in place and continues to work hard to achieve the targets in this area.

Clinical coding audit

Our last 'Payment by Results' audit was commissioned by the Audit Commission in 2012. As a result of that audit we were not one of the NHS Trusts that were designated to have another one.

In November 2015, an external clinical coding audit was completed. This audit reviewed 200 patient episodes across five specialties. Overall, the audit provided us with the assurance that our quality of clinical coding is good. The audit provided us with four recommendations:

- Provide in-house training for the whole Clinical Coding Team focussing on comorbidity coding, external cause codes and national standards for pain procedure diagnosis coding.
- Agree a Local Coding Policy for osteotomy eponyms with Orthopaedic Consultants.
- Engage with Urology Consultants and Doctors to improve annotation of all urology day case attendances.
- Update Policy and Procedure Document to reflect current classifications and standards.

These four recommendations were accepted and have now been implemented.

Review of quality performance

As well as monitoring our quality priorities, the Trust Board receives a monthly report on all national performance indicators. This report is part of the Trust's Board papers and is published on the Trust's website.

National performance indicators

Goal	Standard/benchmark	Whittington performance in 2015/16
4 hour ED wait	95% to be seen within 4 hours	91.11%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	92.41%
Outpatient follow up ratio	London upper quartile performance	1.49
Hospital Cancellations on the Day	Target = 0 Cancellations on the day (Trust monitors all cancellations and specifically those for Urgent procedures)	70 Total Cancellations on the day (13 of which were urgent procedures)
Waits for diagnostic tests	99% waiting less than 6 weeks	97.74%
Day surgery rate	NHS Better care, Better Value Indicators (using The British Association of Day Surgery aspirational day surgery rates guidelines)	84.88% (Reported quarterly. Most recent data available: 15/16 Q2)
DNA rate (hospital)	10%	Firsts: 12.7% Follow Ups: 13.4%
DNA rate (community services)	10%	6.73%
Average length of stay for all acute specialities	1 day reduction	6.48
Staff sickness absence rate	Local target: <3%	2.88%
Ward cleanliness score	95%	98.6%
Elimination of mixed sex accommodation	0 mixed sex breaches	0
New Birth Visits (Islington)	95% seen within 14 days	92.6%

New Birth Visits (Haringey)	95% seen within 14 days	86.3%
Sexual Health services	98% offered an appointment within 2 days	97.52%
Cancer waits		
Urgent referral to first visit	93% seen within 14 days	93.1%
Diagnosis to first treatment	96% treated within 31 days	99.5%
Urgent referral to first treatment	85% treated within 62 days	88.8%
Maternity		
Bookings by 12 weeks, 6 days of pregnancy	90%	81.73%
Smoking in pregnancy at delivery	<6%	4.81%
Rate of breast feeding at birth	>90%	90.18%
Complaints		
New complaints	no benchmark for ICO.	350

Summary Hospital Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

Nationally:

15 Trusts were graded as having a lower than expected number of mortalities
18 Trusts were graded as having a higher than expected number of mortalities
103 remaining trusts were graded as showing a number of mortalities in line with expectations

Whittington Health has the lowest SHMI score in the country. The data is obtained from Hospital Episodes Statistics (HES) data and sourced via the HSCIC Indicator portal. Performance is reviewed monthly in our performance report to the Board.

The most recent data available (released in March 2016) covers the period October 2014 to September 2015:

Whittington Health SHMI score	0.6516
National standard	100
Lowest national score	0.6516 (Whittington Health)
Highest national score	1.198

The combined percentage of deaths with either type of palliative care coding is 0.18% for the period October 2014-September 2015, which is the latest available data.

Whittington Health is taking the following actions to further improve this score, and so the quality of its services, by:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;
- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

Patient Reported Outcome Measures (PROMs)

We did not collect PROMs data in 2014/15. Our renewed improved process is now in place. Whittington Health participated in the PROMs project during 2015/16, although there was not a sufficient response rate to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required). We consider this data is as described because it is a nationally run and collated data set. Performance is reviewed monthly in our performance report to the Board.

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	312	190	60.90%	145	76.30%
Groin Hernia	155	69	44.50%	46	66.70%
Hip Replacement	90	62	68.90%	55	88.70%
Knee Replacement	60	59	98.30%	44	74.60%
Varicose Vein	7	*	*	*	*

Table 2: Post-operative issue and return					
	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	190	63	33.20%	21	33.30%
Groin Hernia	69	37	53.60%	15	40.50%
Hip Replacement	62	12	19.40%	6	50.00%
Knee Replacement	59	14	23.70%	0	0.00%
Varicose Vein	*	*	*	0	*

Within England there were a number of trusts with a lower participation rate, for example the Chelsea and Westminster NHS Foundation Trust has a published participation rate of 6.9% and a response rate of 35.7%. However, there were trusts with a high participation and response rate, for example the Chesterfield Royal Hospital NHS Foundation Trust has a published participation rate of 90.6% and a response rate of 65.4%. The Whittington intends to improve our PROMS outcomes by increasing the number of pre-operative and post-operative questionnaires that are returned.

Pre-operative participation and linkage (England)
April – December 2015 (latest available data)

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	198,020	146,489	74.0%	111,401	76.0%
Groin Hernia	52,297	29,575	56.6%	21,335	72.1%
Hip Replacement	57,878	49,133	84.9%	39,871	81.1%
Knee Replacement	62,974	59,726	94.8%	43,385	72.6%
Varicose Vein	24,871	8,055	32.4%	6,810	84.5%

Post-operative issue and return (England)
April – December 2015 (latest available data)

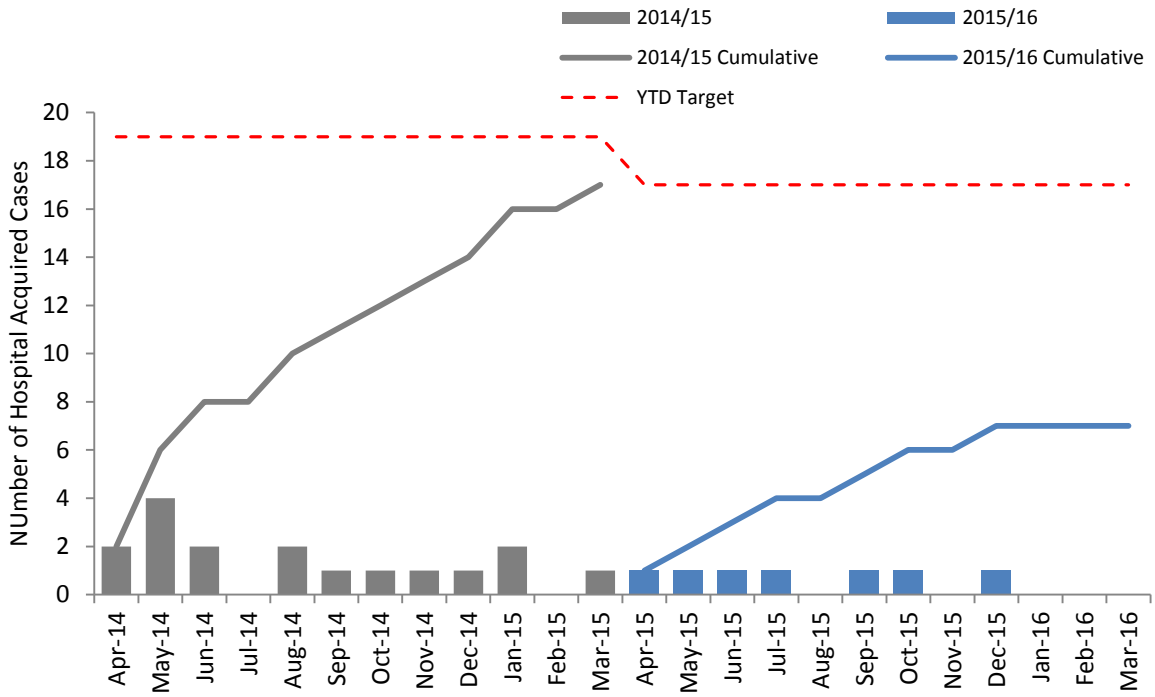
	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	146,489	87,619	59.8%	52,052	59.4%
Groin Hernia	29,575	24,555	83.0%	14,503	59.1%
Hip Replacement	49,133	26,272	53.5%	16,513	62.9%
Knee Replacement	59,726	30,005	50.2%	17,753	59.2%
Varicose Vein	8,055	6,787	84.3%	3,283	48.4%

Clostridium difficile-associated diarrhoea

Clostridium difficile (C.diff) rates per 100,000 bed-days

Month & Year		Monthly Cases	YTD Cumulative	YTD Target
Apr-14		2	2	19
May-14		4	6	19
Jun-14		2	8	19
Jul-14		0	8	19
Aug-14		2	10	19
Sep-14		1	11	19
Oct-14		1	12	19
Nov-14		1	13	19
Dec-14		1	14	19
Jan-15		2	16	19
Feb-15		0	16	19
Mar-15		1	17	19
Apr-15		1	1	17
May-15		1	2	17
Jun-15		1	3	17
Jul-15		1	4	17
Aug-15		0	4	17
Sep-15		1	5	17
Oct-15		1	6	17
Nov-15		0	6	17
Dec-15		1	7	17
Jan-16		0	7	17
Feb-16		0	7	17
Mar-16		0	7	17

Clostridium difficile Rates



Whittington Health considers that this data is as described for the following reasons; the data used for these calculations is sourced from national submissions of *Clostridium difficile* incidents. Locally reported performance is reviewed monthly in the Trust performance report to the Trust Board. The latest data published by Public Health England in March 2016 indicates that for October – December 2015 that there was a national Trust apportioned Clostridium difficile-associate diarrhoea reporting rate of 14.9 reports per 100,000 bed-days.

What we are doing to improve Clostridium difficile rates

During 2015/16 we had seven *Clostridium difficile* cases attributable to Whittington Health. Consultant led post infection reviews (PIR) were held on all cases and the reports disseminated to relevant parties both internally and externally. Our agreed ceiling trajectory for 2015/2016 was set at 17 cases and we came in well under trajectory.

Each patient case of attributable *Clostridium difficile* was thoroughly investigated with a full Consultant-led post-infection review focusing on all aspects of the patient pathway from admission to diagnosis.

Infection Prevention and Control alerts are already placed on our Medway electronic patient records system for patients diagnosed with healthcare associated infections but it is apparent that these are not always reviewed prior to bed placement. A further alert has been introduced to the JAC electronic prescribing system to improve staff awareness and aid the correct bed placement of the patient in order to reduce the risk of cross contamination

Education sessions specifically on *Clostridium difficile* continue on our acute wards.

Venous thromboembolism

Venous thromboembolism (VTE) is a condition in which a thrombus – a blood clot – forms in a vein. Usually, this occurs in the deep vein of the legs and pelvis and is known as deep vein thrombosis (DVT). The thrombus or its parts can break off, travel in the blood system and eventually block an artery in the

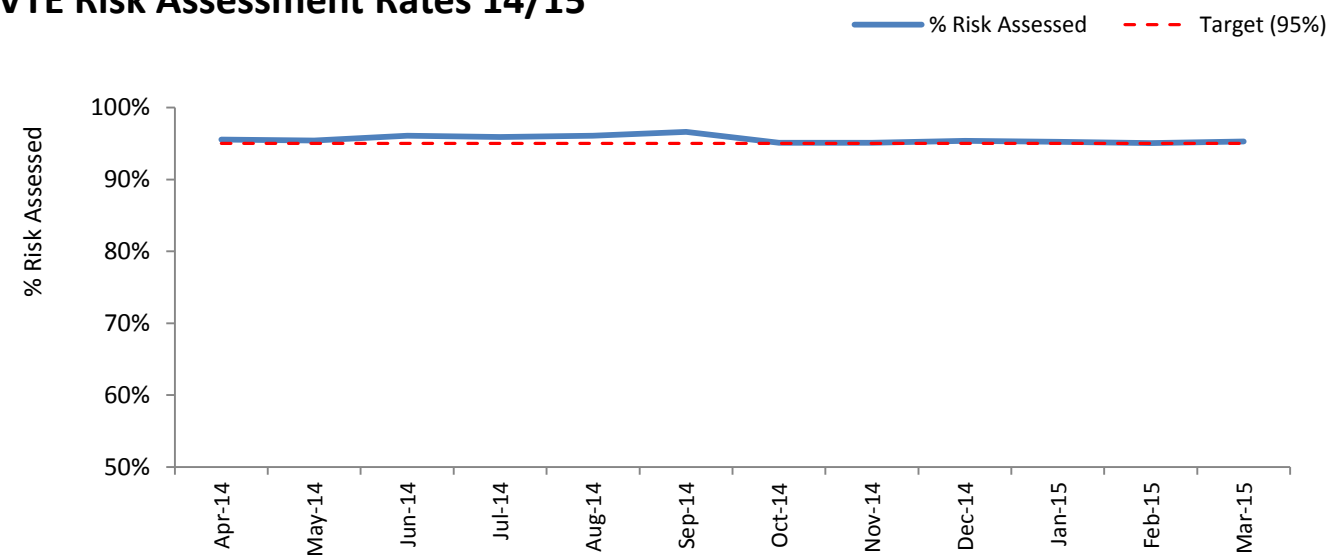
lung. This is known as a pulmonary embolism (PE). VTE is a collective term for both DVT and PE. VTE is a major cause of mortality and disability in England with thousands of deaths directly attributed to it each year. Over the years, hospital acquired venous thromboembolism has been referred to as the, “silent killer”. The majority of people still associate blood clots with long-haul air flights but the truth is a person is 1000 times more likely to suffer a VTE by simply being admitted to hospital. On the back of this the government has therefore set hospitals a target requiring 95 percent of all admitted patients to be assessed in relation to their risk of VTE and appropriate treatment administered.

Whittington Health met or performed better than the 95 percent target for the year 2014/15. We cannot provide national comparison information as year-end information has not been published at the time of writing. Whittington Health considers that this data is as described because all information is recorded and stored electronically and we participate in regular internal and external audits that have not raised concerns with our recorded data.

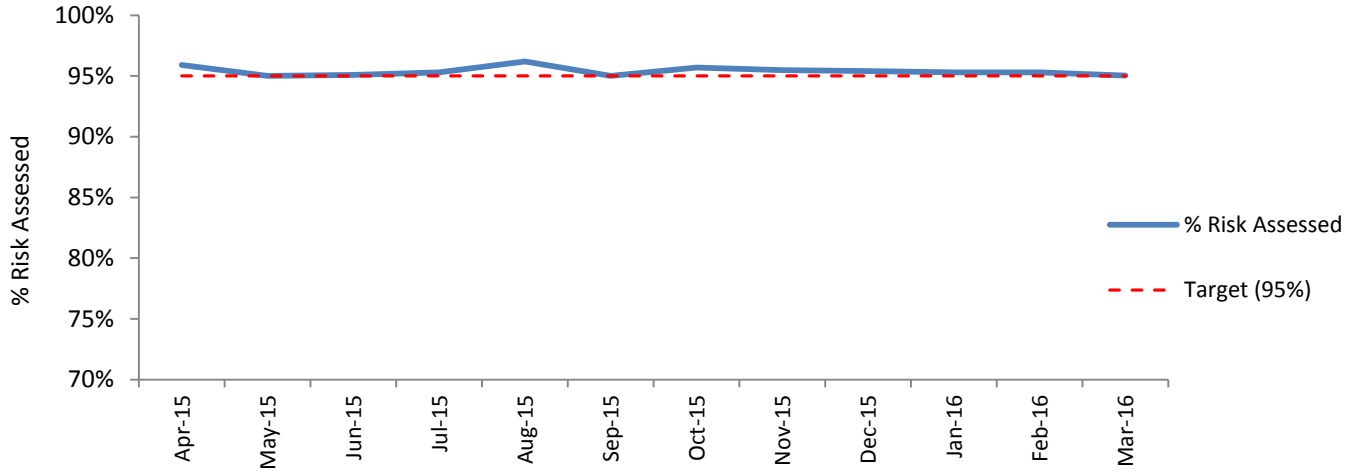
2014/15		
Month & Year	**% Risk Assessed**	**Target**
Apr-14	95.54%	95%
May-14	95.40%	95%
Jun-14	96.10%	95%
Jul-14	95.90%	95%
Aug-14	96.08%	95%
Sep-14	96.62%	95%
Oct-14	95.10%	95%
Nov-14	95.09%	95%
Dec-14	95.38%	95%
Jan-15	95.22%	95%
Feb-15	95.04%	95%
Mar-15	95.30%	95%

VTE Risk Assessment Rates 2015/16		
Month & Year	**% Risk Assessed**	**Target**
Apr-15	95.90%	95%
May-15	95.00%	95%
Jun-15	95.10%	95%
Jul-15	95.30%	95%
Aug-15	96.20%	95%
Sep-15	95.00%	95%
Oct-15	95.70%	95%
Nov-15	95.50%	95%
Dec-15	95.40%	95%
Jan-16	95.30%	95%
Feb-16	95.30%	95%
Mar-16	95.05%	95%

VTE Risk Assessment Rates 14/15



VTE Risk Assessment Rates 15/16



VTE improvement

Every year, thousands of people in the UK develop a blood clot in the vein. It is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. Here at Whittington Health, we continue to strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. There are however, patients who cannot receive pharmacological thromboprophylaxis due to a bleeding risk.

Whittington Health has taken the following actions to improve our VTE risk assessment rate, and so the quality of its service by:

- Introducing a new prompt list for identifying these patients which is generated twice weekly. The list is reviewed by the VTE clinical team, an e-mail is then sent to the patient's treating team to

undertake a review of the patient's clinical condition and repeat the VTE risk assessment. The purpose of this is to establish whether the bleeding risk continues to be a clinical concern, or has been resolved, in which case the patient can then be commenced on pharmacological thromboprophylaxis if required.

VTE risk assessment

The average for England was 95.6% of patients risk assessed for VTE in Quarter 3 of 2015/16 (latest data available). This data shows that Hull and East Yorkshire Hospitals NHS Trust had the lowest published percentage of patients risk assessed for VTE in England (78.5%). Four Trusts in England have published figures of 100% of patients receiving a risk assessment for VTE:

- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Bridgewater Community Healthcare NHS Trust
- Royal National Orthopaedic Hospital NHS Trust
- South Essex Partnership University NHS Foundation Trust

Patient safety incidents resulting in severe harm or death

The data in this report is derived from information uploaded to the National Reporting and Learning System (NRLS). The CQC obtains routine data about the patient Safety performance of Trusts from reports uploaded by Whittington Health to the NRLS.

Quality Accounts consider incidents that resulted in severe harm or death. It is important to recognise that not all incidents in which severe harm or death has occurred are incidents in which the harm or death was considered avoidable. In some cases the harm or death may be directly attributable to problems in the care or service delivery to the patient, but in other cases it may not. The Trust reports separately to NHS England, via the Mortality Analysis Toolkit Report, on avoidable and potentially avoidable deaths.

The most recent NRLS Organisation Patient Safety Incident Report (which covers the period April 2015 – September 2015, i.e. overlapping with but not identical to the period covered by this Quality Account) shows that 0.8 percent of the incidents reported to the NRLS by Whittington Health resulted in severe harm, compared with a national average of 0.3 percent of incidents. The percentage of incidents associated with death was 0.1 percent, which is the same as the national average. The NRLS in their report reminds Trusts to be concerned about possible underreporting if the reporting of such incidents to the NRLS is lower than expected. Whittington Health has done a lot to promote a positive reporting culture for incidents that may have caused harm.

In 2015/16 the Trust has reported 4058 incidents to the NRLS that related to incidents occurring between April 1 2015 and March 31 2016.

The 33 severe harm incidents in 2015/16 represented a decrease on previous years.

The nine deaths included seven which were investigated as Serious Incidents by Whittington Health and a further death is being investigated as a Serious Incident by a neighbouring NHS trust and Whittington Health have asked to contribute to this report.

The table below details five years of data relating to severe harm and death since the inception of Whittington Health as an ICO.

Year	Incidents associated with Severe Harm	As a % of all incidents reported to the NRLS	Incidents associated with Death	As a % of all incidents reported to the NRLS %
2011-12	76	2.22%	23	0.67%
2012-13	52	1.96%	14	0.53%
2013-14	56	1.55%	16	0.44%
2014-15	48	1.36%	13	0.37%
2015-16	33	0.81%	9	0.22%

Duty of Candour Process at Whittington Health

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, the clinician in charge initiates a "being open discussion" with the patient and family or relatives acting on behalf of the patient.

Whittington Health clinicians actively encourage service users and relatives to ask questions and contribute to the Terms of Reference of serious incident investigations.

Duty of Candour meetings take place whilst the patient is an in-patient, i.e. at the "bedside" or when a patient is back at home following discharge or via community based care.

If an incident results in moderate harm or above, a Duty of Candour Lead is identified and appointed by the service, unit or department. The Duty of Candour Lead sends an written apology which clearly states:

- Whittington Health is sorry for the suffering and distress resulting from the incident;
- Whittington Health consider the safety of patients to be a top priority and compliance with the Duty of candour is customary practice;
- A detailed inquiry into what happened and why which will include investigation of the patient's concerns will be carried out;
- The patient or next of kin is contacted once again when the investigation has been completed and offered the opportunity to discuss the findings and receive a copy of the inquiry outcome.

Patients are encouraged to provide feedback about how Whittington Health is embracing candour and what improvements could be made to the duty of candour approach.

Our Board is responsible for ensuring that a culture of openness, trust, service improvement and sharing of learning is present within the organisation. It has overall responsibility for ensuring that the Trust's duties with regard to the management of serious incidents are appropriately discharged, including ensuring compliance with the Duty of Candour. The Board receives assurance of compliance through the Quality Committee.

Duty of Candour Key Performance Indicators are reported quarterly and monitored by the Clinical Quality Review Group in order to provide assurance to partner Clinical Commissioning Groups on Whittington Health compliance with the statutory Duty of Candour.

TDA openness and transparency report

A league table identifying levels of openness and transparency within NHS trusts and foundation trusts was produced by Monitor and the Trust Development Authority (TDA) and published 9 March 2016. The league table has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust.

The data for 2015/16 – which is drawn from the 2015 NHS staff survey and from the National Reporting and Learning System – shows that:

- 18 providers were outstanding
- 102 were good
- 78 gave cause for significant concern
- 32 had a poor reporting culture
-

Whittington Health has been awarded a ranking of **'good'** indicating good levels of openness and transparency. Whittington Health is ranked 78 out of 230 NHS trusts.

Safety Alerts

The Trust receives Safety Alerts via the Central Alerting System (CAS) from external bodies, such as NHS England (statutory patient safety functions transferred to NHS Improvement from 1 April 2016), Medicines and Healthcare Products Regulatory Agency (MHRA), Department of Health and Public Health England. These alerts contain information about safety issues that could potentially harm patients or staff and usually contain a number of actions the organisation is required to carry out to minimise the risk of occurrence.

Alerts are received centrally in the first instance by the CAS Liaison Officer and are managed on the Datix Risk Management system. The Trust Safety Alerts Group is responsible for monitoring compliance with CAS alerts and reports regularly to the Patient Safety Committee.

During 2015/16 the alerts received included, 10 Patient Safety Alerts; 31 Medical Device Alerts and 44 Estates Alerts.

Medicines Management

There have been significant improvements and achievements in medicines management at the Trust over the past year.

The trust has pharmacists who work as part of the Integrated Community Ageing Team (ICAT) within care homes in the community to support the optimisation of medicines for patients. We also have pharmacists working as part of the locality teams in Haringey working in GP practices to review medications for patients.

MaPPs

The trust is now using the software Medicines: A Patient Profile Summary (MaPPs), which has advice for patients about how to take their medications and the potential side-effects of their medications that is written in plain English.

For a number of years the trust has been using an electronic system to record chemotherapy drugs for adult patients, but this has now been introduced for paediatric patients.

This year, we have also introduced e-prescribing on outpatients and we will be auditing the impact this has had on patient safety over the next six months.

Never Events

Never Events are key indicators that there have been failures to put in place the required systemic barriers to error and their occurrence can tell something fundamental about the quality, care and safety processes in an organisation.

The rationale behind a type of serious incident being included on the Never Events list is that there are barriers to prevent it from occurring and guidance is in place to ensure it should never happen.

Whittington Health reported one never event in September 2015 relating to a misplaced naso-gastric tube. The error was identified in a timely manner and the patient made a good recovery.

Key performance information

Emergency Readmissions within 30 days

Emergency readmissions are monitored and we review emergency readmissions as well as frequent attenders on an ongoing basis.

The latest data from the Hospital Episode Statistics in relation to emergency readmissions which covers the period 2002/03-2011/12 shows that nationally 11.45% of patients aged 16 or over were readmitted to hospital as an emergency within 28 days of having been discharged. Within this same published data the Whittington has published figure of 12.42% of patients aged 16 or over were readmitted to hospital as an emergency within 28 days of having been discharged.

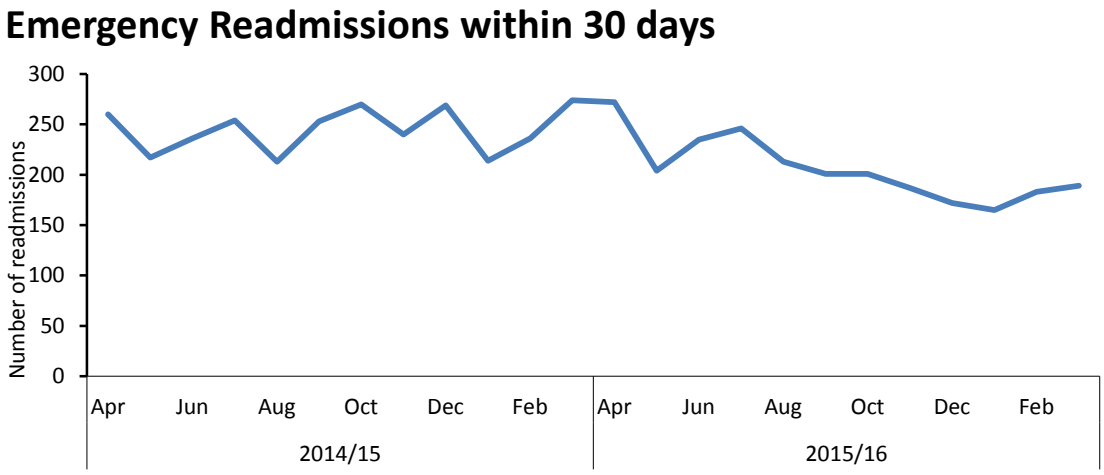
There is no national figure for the emergency readmission of patients aged 0-15 years old, but the latest published data from the Hospital Episode Statistics in relation to emergency readmissions covering the financial years 2002/03-2011/12 shows that within London 10.34% of patients aged 0-15 years old were readmitted to hospital as an emergency within 28 days of having been discharged. Within this same published data the Whittington has published figure that shows that 6.95% of patients aged 0-15 years old were readmitted to hospital as an emergency within 28 days of having been discharged.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust have the lowest published readmission rate for NHS trusts for 0-15 year old at 3.75%. The Royal Wolverhampton Hospitals NHS Trust has the highest published readmission rate for NHS Trusts for 0-15 year olds at 14.97%.

The Lancashire Care NHS Foundation Trust has the lowest published readmission rate for NHS Trusts for patients aged 16 years old and over at 4.88%. The Sheffield Childrens NHS Foundation Trust has the highest published readmission rate for NHS Trusts for patients aged 16 years old and over at 17.15%.

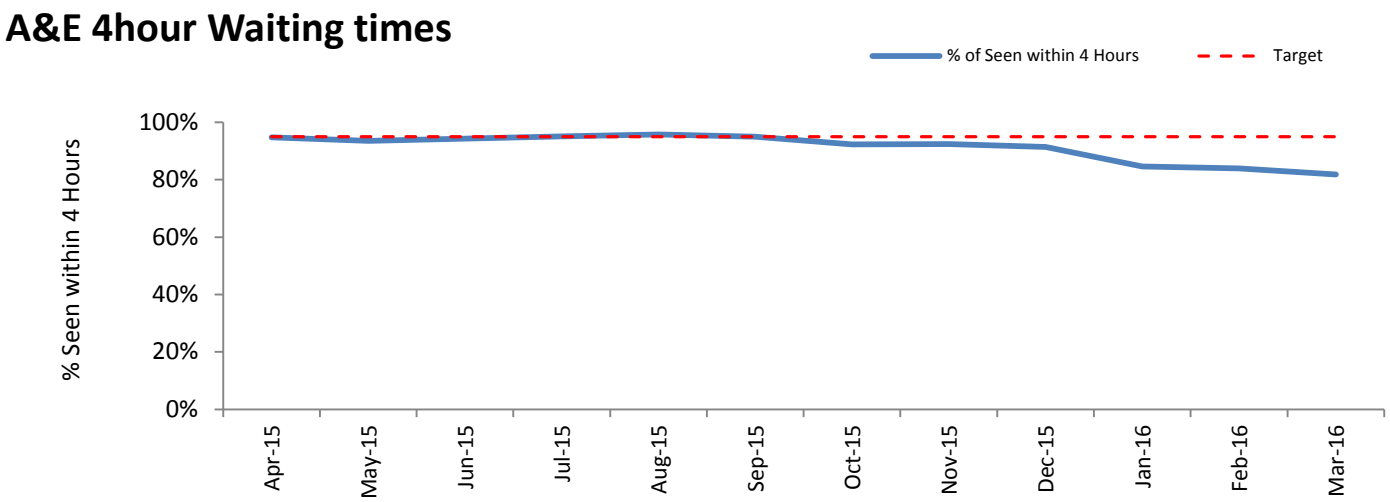
We consider this data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal. The Trust aims to improve its emergency readmission rate by focussing on a number of initiatives, which include implementing the discharge bundle, which sets out all the steps and safeguards that should be in place before a patient is discharged

Year and Month		Number of Readmissions
2014/15	Apr	260
	May	217
	Jun	236
	Jul	254
	Aug	213
	Sep	253
	Oct	270
	Nov	240
	Dec	269
	Jan	214
	Feb	236
	Mar	274
2015/16	Apr	272
	May	204
	Jun	235
	Jul	246
	Aug	213
	Sep	201
	Oct	201
	Nov	187
	Dec	172
	Jan	165
	Feb	183
	Mar	189



Accident & Emergency (A&E) Department - 4 hour wait performance

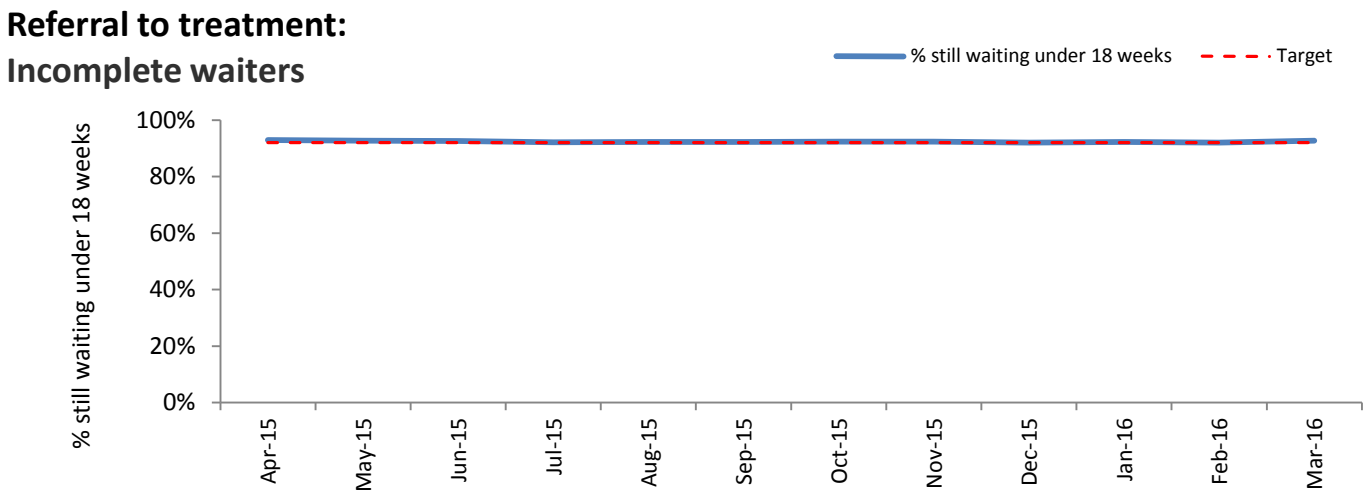
Month & Year	% Seen within 4 Hours	Target
Apr-15	94.8%	95%
May-15	93.6%	95%
Jun-15	94.4%	95%
Jul-15	95.1%	95%
Aug-15	95.8%	95%
Sep-15	95.0%	95%
Oct-15	92.3%	95%
Nov-15	92.5%	95%
Dec-15	91.5%	95%
Jan-16	84.6%	95%
Feb-16	84.0%	95%
Mar-16	81.8%	95%
Year Total	**91.1%**	**95%**



2015/16 was a very challenging year as we continued to experience high numbers of A&E attendances. However, the challenges we experienced were not unique to Whittington Health as other providers have also experienced increasing attendances. Whittington Health continues to have strong relationships with external agencies and we are currently working with Islington CCG to reflect on the challenging year and review our resilience plans for Winter 2016/17.

Referral to Treatment (RTT) Waiting Times

Month & Year	Incomplete Waiters	
	% still waiting under 18 weeks	Target
Apr-15	93.0%	92%
May-15	92.8%	92%
Jun-15	92.6%	92%
Jul-15	92.2%	92%
Aug-15	92.2%	92%
Sep-15	92.2%	92%
Oct-15	92.4%	92%
Nov-15	92.3%	92%
Dec-15	92.1%	92%
Jan-16	92.3%	92%
Feb-16	92.1%	92%
Mar-16	92.7%	92%



Average Length of Stay (LoS)

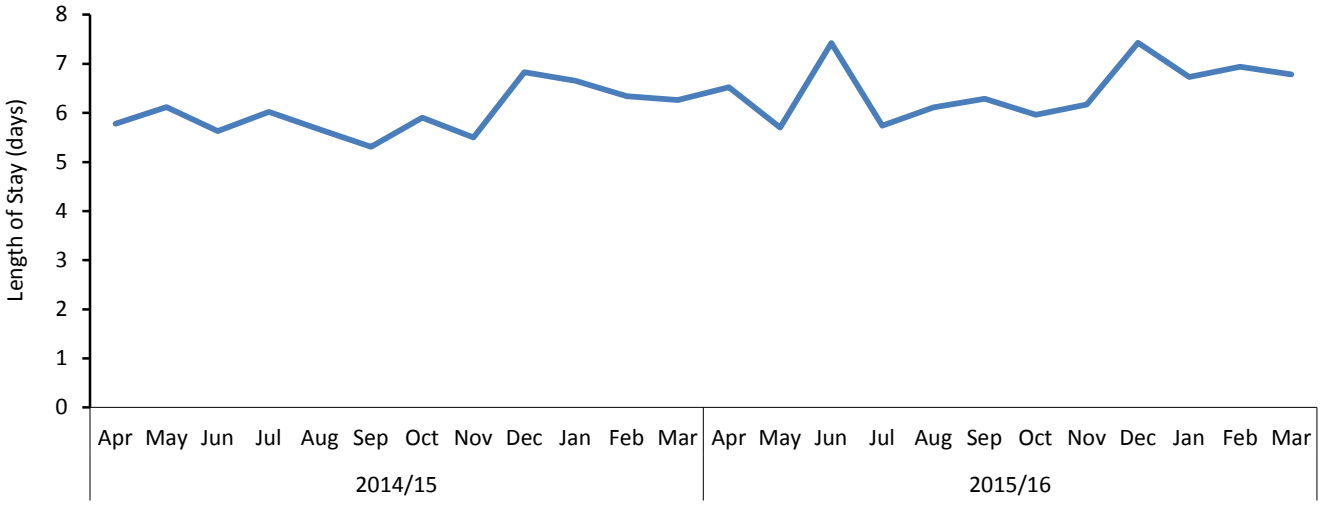
Year and Month		Average LoS
2014/15	Apr	5.78
	May	6.12
	Jun	5.63
	Jul	6.02
	Aug	5.66
	Sep	5.31
	Oct	5.90
	Nov	5.50
	Dec	6.83
	Jan	6.65
	Feb	6.34
	Mar	6.26
2015/16	Apr	6.52
	May	5.70
	Jun	7.42
	Jul	5.74
	Aug	6.11
	Sep	6.29
	Oct	5.96
	Nov	6.17
	Dec	7.43
	Jan	6.73
	Feb	6.94
	Mar	6.78

Our average Length of Stay in 2015/16 was 6.48 days, compared to an average of 6.00 days in 2014/15.

Analysis of Length of Stay is completed each week. This has shown an increase in acuity and age of patients needing admission into acute beds. The development of our ambulatory care unit has also shown a reduction in people who have a short stay admission to Whittington Health

We have strong working relationships to identify and progress integration of each individual patient's needs. This includes mental health, social care, and other providers. Length of stay will continue to be monitored and analysed throughout 2015/16.

Average Length of Stay per month



Patient Experience

Friends and Family Test (FFT)

FFT is a feedback tool which supports patients to feedback about their experiences. FFT was introduced in 2013 and has been made available across Whittington Health as follows:

- all inpatients that stay more than 24 hours (implemented April 2013)
- all those who attend ED and are discharged from there (implemented April 2013)
- all women at four stages of the maternity pathway: antenatal (36 weeks specifically); birth (labour ward/birthing unit/homebirth); postnatal ward and postnatal community (implemented October 2013)
- all those attending the day treatment centre (implemented September 2014)
- all those attending outpatients (implemented October 2014)
- all those accessing community services (implemented January 2014)

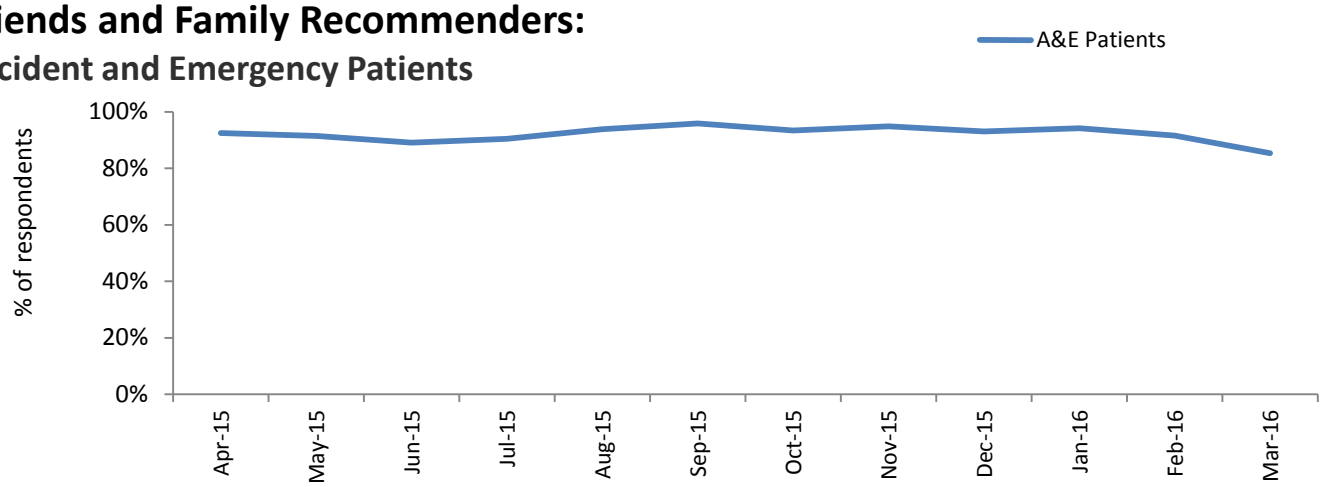
Whittington Health is using a variety of methods to collate patient feedback. This includes postcards, handheld devices and kiosks. Whilst the postcards only include the FFT questions the surveys available via kiosks and handheld devices also include additional questions regarding patient experience.

Feedback is being circulated every two weeks to clinical and operational leads for action. Monthly reports of the overall response rates and scores are submitted to our Board once the data is validated and approved.

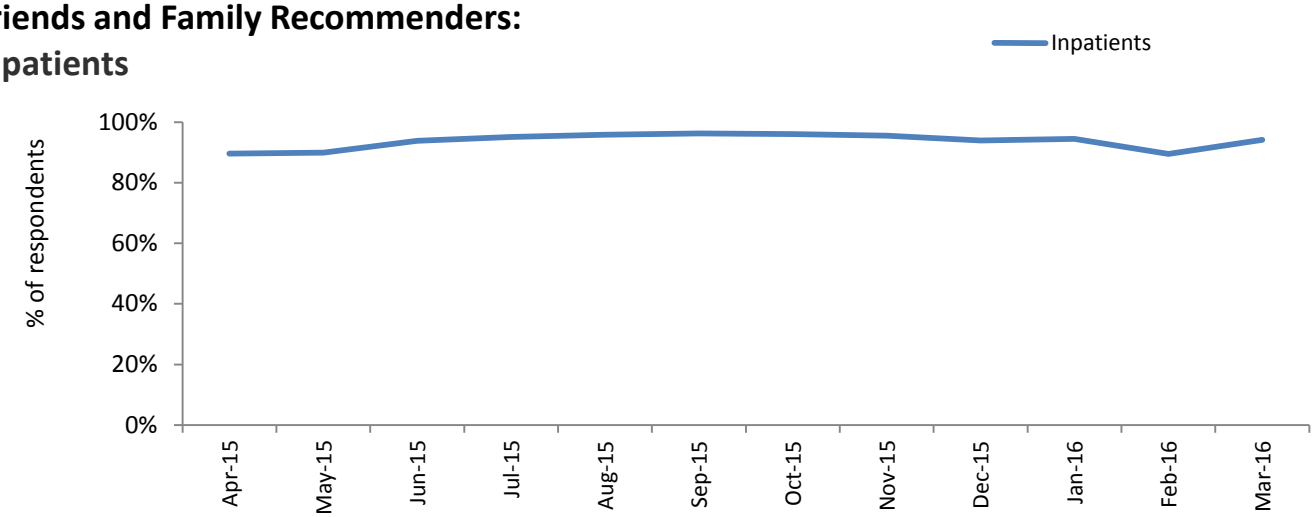
Whittington Health is currently required to meet a target response rate of 20 percent for our emergency department, 40 percent for inpatients and 15 percent for maternity. Whittington Health is currently achieving the target response rates in all areas and the scores have remained consistent overall. The responses rates, scores and actions taken are discussed regularly at the Patient Experience Committee.

Month & Year	A&E Patients	Inpatients	Maternity	Community	Outpatients
Apr-15	92.5%	89.6%	92.2%	89.2%	87.4%
May-15	91.5%	89.9%	89.1%	95.1%	86.7%
Jun-15	89.1%	93.8%	80.8%	96.3%	95.1%
Jul-15	90.5%	95.1%	92.5%	94.3%	96.5%
Aug-15	93.9%	95.9%	93.2%	95.6%	87.2%
Sep-15	95.9%	96.3%	91.1%	98.2%	90.9%
Oct-15	93.4%	96.1%	95.9%	97.5%	89.9%
Nov-15	94.9%	95.5%	94.6%	98.1%	91.2%
Dec-15	93.1%	93.9%	93.6%	97.0%	93.0%
Jan-16	94.2%	94.5%	95.3%	98.0%	94.3%
Feb-16	91.6%	89.5%	87.7%	96.3%	82.2%
Mar-16	85.4%	94.2%	87.9%	98.5%	84.7%

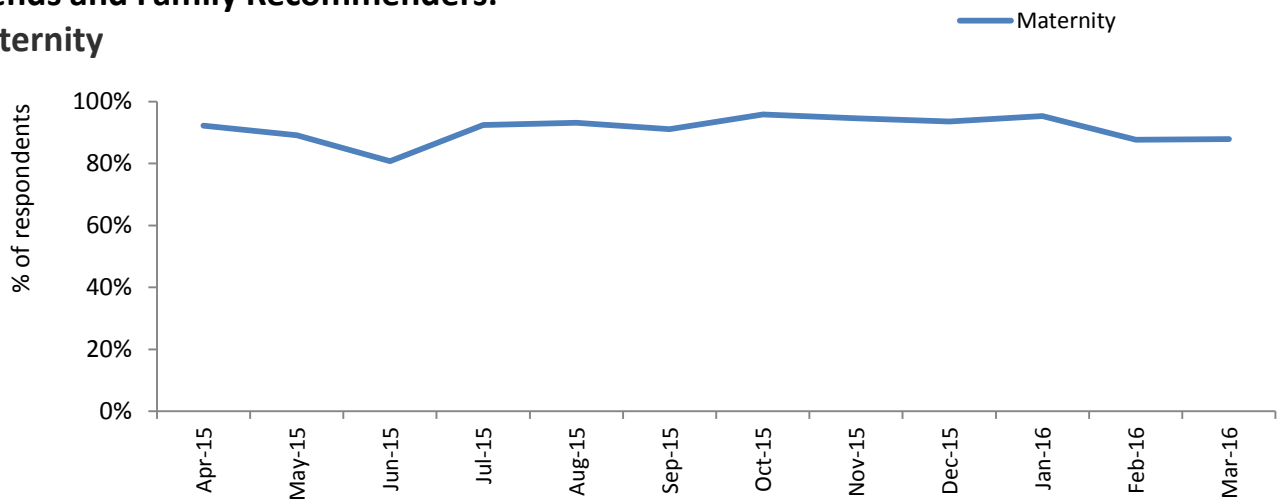
Friends and Family Recommenders:
Accident and Emergency Patients



Friends and Family Recommenders:
Inpatients



Friends and Family Recommenders:
Maternity



Responsiveness

The 2014 National NHS inpatient survey programme looked at the experiences of over 59,000 people who were admitted to an NHS hospital in 2014.

Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients at each Trust in England. Responses were received from 235 patients at the Whittington. We consider that this data is as described because it is taken from the CQC public website. This is the latest inpatient survey and the data was published in May 2015.

Our overall score for the 2014 National NHS inpatient survey programme:

Patient Survey	**Patient response**	**Compared with other trusts**
Overall experience	7.8 out of 10	About the same

Patient Advice Liaison Service (PALS) and Complaints

Feedback from concerns and complaints is also used to help us focus on areas where we need to improve. During 2015/16 we have continue to embed improvements with regards to how we manage our complaints. This has included our processes for handling complaints; engagement with complainants whilst investigations are underway; our response times; the timeliness and regularity of reporting on themes and trends and ensuring that action plans are developed and monitored for upheld complaints.

In the year 2015/16 the PALS and Complaints Team received a total of 400 formal complaints. During the first quarter, the 83 complaints received were allocated across the then three operational divisions as follows: Integrate Care and Medicine (ICAM) (34), Surgery and Cancer (S&C) (30), Women's, Children and Families (WCF) (16) and Estates and Facilities (E&F) (3). During quarter two, following our restructure, the remaining 312 complaints received were allocated as follows: Children and Young Persons Services (C&YPS) (13), Clinical Support Services (CSS) (17), E&F (13), Emergency and Urgent Care (E&UC) (58), Medicine, Frailty and Networked Services (MF&NS) (49), Outpatients, Prevention and Long Term Conditions (OP&LTC) (27), S&C (106), and Womens' Health Services (WHS) (26).

In terms of themes, 31 percent of complaints received during this period related to medical care and nursing care (124), 35 percent related to attitude and communication (140) and 12 percent were regarding policy and commercial decisions (47) and 7 percent regarding appointments (38).

Of the 400 formal complaints received, 81 (20 percent) required an allocation of 40 working days for response as they were deemed complex and 10 (2 percent) complaints remain opened as at 12 May.

Of the 390 closed complaints, 75 percent were responded to within 25 working days.

During 2015/16, we received 2417 PALS queries the majority of which related to issues around communication (35 percent), appointments (24 percent), delay (10 percent) and attitude (6 percent).

Many of concerns highlighted via the PALS and Complaints Service led to specific learning and improvements in care.

As well as patients, we also seek views from the public, particularly our Governors and Healthwatch. They provide us with a user perspective from our local population, and actively participate in a number of key forums including the Trust Board, the Quality Committee and the Patient Experience Committee.

Partnership working

We have continued to work collaboratively with colleagues in other hospitals. For example, we work in partnership with University College London Hospitals NHS Foundation Trust on our TB service, Hospital at Home, and bowel screening service.

We are a member of UCL Partners (UCLP), an Academic Health Science Network (AHSN), which is dedicated to achieving better health for our population. Its aim is to harness the best of academic medicine, high class education and clinical practice to deliver significant health improvement. Examples of work undertaken are: developing a new approach to providing an integrated, improved quality cancer service; providing patients with long term conditions with more information, choice and control, so that they have a better experience and reduced hospital visits; and developing a set of outcome measures to ensure patient pathways focus on what matters to patients.

We work closely with our partners in local authority social services. Joint work is essential in adult and children's safeguarding. Islington Social Services have a base at our hospital, enabling easy and fast access to advice and support. We also work with social services for the relevant borough to arrange patient discharges, particularly in complex cases, where support packages in the community are required.

Whittington Health is an active partner of the Islington and Haringey Wellbeing Programme.

As one of the largest employers in NCL, Whittington Health is a key partner in the Community Education Provider Network (CEPN), particularly for the boroughs of Islington and Haringey and as such is aligned with the local priorities set out for 2016/17. The key local priorities are; workforce planning and development, community nursing development and customer care which align with the Trust's priorities and workforce strategy.

Over the past twelve months strong working relationships have been developed to facilitate a more integrated approach to education and training opportunities across health and social care. Focussed local initiatives and development programmes have been designed and implemented to encourage better access to training and development opportunities for the local residents, communities and existing employees.

Our success in rolling out some of these initiatives especially in undergraduate nurse training and the care certificate has led to Whittington Health being designated the Training Super Hub

Topics such as anticipatory care, behaviour change skills, medical ethics, and population determined needs are included in the current joint education and training provision; and are available to all including the voluntary sector.

Our work with Kissing it Better

We work with the charity, *Kissing it Better*, who bring talented people from the local community into the hospital to help brighten the days of our inpatients. This initiative has shown that it quickly improves morale and motivation and, therefore, the energy within the hospital. Working with *Kissing it Better* provides the

trust with an exciting opportunity to work with our local community, particularly local schools and colleges, to help improve our patient experience. In 2015/16 *Kissing it Better* volunteers gave 5650 hours of their time to provide activities for our patients, including beauty therapy on wards and in our care homes, drama projects with local schools, music and reminiscence and singers on our wards, in our outpatients department and within the community.

Medical revalidation

Medical revalidation improves the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical system. The Trust reports on a quarterly basis to NHS England, in addition to performing our own internal monitoring. The Responsible Officer has made 123 recommendations to the General Medical Council (GMC) in 2015/16, in line with the GMC's schedule of revalidation dates. We have assessed our processes and have submitted the third annual Medical Appraisal Annual Board Report to NHS England which is designed to provide the Board with oversight and assurance of its local medical appraisal and revalidation process.

Associate Medical Director for Revalidation

This year saw the creation of the role of Associate Medical Director for Revalidation. This role will help Whittington Health to promote and improve our medical revalidation and appraisal processes.

Nursing and Midwifery revalidation

In 2015/16 we started to prepare for the introduction of nursing revalidation. Revalidation is the process by which registered nurses will demonstrate to the Nursing and Midwifery Council (NMC) that they continue to be fit to practice. Revalidation will take place every three years and has replaced the post registration education and practice (PREP) standards. The aim of the new revalidation process is to improve upon the PREP system by setting new requirements for registered nurses. Revalidation has been developed to further increase patient safety, increase public confidence in nurses and help those on the NMC register to meet the standards required of them.

The new revalidation process requires registered nurses to declare they have:

- Met the requirements for practice hours (practice of at least 450 hours during the previous three years or 900 hours if holder of two professional qualifications)
- Met the requirements for continuing professional development (undertaken at least 35 hours of continuing professional development relevant to the registrants scope of practice as a nurse with a minimum of 20 hours being participatory learning)
- Reflected on their practice based on the requirements of the NMC Code (2015), using feedback from service users, patients relatives colleagues and others.
- Provided a health and character declaration and declare any conviction for criminal offence or the issuing of a formal caution
- Professional indemnity arrangements –confirmation of having or will have when practicing, appropriate cover under an indemnity scheme
- Received confirmation from a third party (referred to as a confirmer) that their declaration is reliable in accordance with the NMC Code (2015)

From April 2016, all nurses due to re-register commenced revalidation. By April 2019 everyone on the NMC register will be expected to have undergone revalidation.

Dealing with inequalities

Learning disabilities

The integration of health and social care services for people with learning disabilities has been policy of successive governments and local partners, and remains a key driver for future improvements in the delivery of health and social care services, nationally and locally. A section 75 partnership agreement sets out the contractual arrangements for an integrated provision of learning disabilities services.

Whittington Health is committed to providing the best possible care to ensure good health outcomes for people who have learning disabilities and their families. We recognise that all our patients are unique, with individual needs.

Safeguarding children

Whittington Health is committed to safeguarding children and young people by ensuring that safeguarding and promoting the welfare of children is embedded across all services.

Section 11 of the Children Act (2004) places a duty on every NHS Trust to have arrangements in place to ensure that the organisation and all staff working within it have regard to the need to safeguard and promote the welfare of children. In compliance with this responsibility the following arrangements for safeguarding children are in place:

- Whittington Health meets statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All relevant staff complete a DBS check prior to employment and staff working with children are required to complete an enhanced level of assessment.
- Legacy guidelines and policies have been combined and updated to form one Whittington Health Safeguarding Children Policy, 2015. The aim of the policy is to detail the operational and strategic management processes and procedures involved in regards to safeguarding children. All safeguarding children policies and systems are reviewed regularly as part of Whittington Health's quality assurance process.
- Whittington Health has a policy in place for working with women who have experienced, or girls who are at risk of experiencing Female Genital Mutilation. The policy in written in line with the Female Genital Mutilation Multi-Agency Practice Guidelines 2016, Working Together to Safeguard Children 2013.
- Whittington Health has an audit programme to assure the Trust Board that safeguarding children systems and processes are working.
- Safeguarding Children supervision is mandatory for all professionals who work with children and families and is available for all other staff. Supervision is provided by appropriately trained and experienced lead professionals and is monitored by the safeguarding children committee.
    - A Safeguarding Training Policy (2015) is in place to ensure that all staff are trained to the appropriate level. An active programme of safeguarding training exists in-house with a continued ethos of increasing staff awareness and responsibility is in place.

- Whittington Health has fully participated in review processes associated with safeguarding and has an action plan and work plan to embed learning from local and national Serious Case Reviews and incidents.
- The Director of Nursing is the Executive Director Lead for Safeguarding and Chairs the Whittington Health Safeguarding Children Committee. The Trust Board receives updates and an annual Safeguarding Children report.

Whittington Health is represented on Local Safeguarding Children Boards in Islington, Hackney and Haringey and actively participates in all LSCB sub groups and training events.

Safeguarding adults

This year has seen us appoint a substantive Safeguarding Adults Lead, who has ensured that the trust is working in line with the pan-London policy and procedures for safeguarding that were published in February 2016.

July 2015 saw the introduction of Prevent, which is part of the government counter-terrorism strategy. It is designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming involved in terrorism themselves. As part of this strategy all NHS staff who have contact with patients must be trained using the Workshop to Raise Awareness of Prevent (WRAP) 3 model.

Our plans for the year ahead include:

- Roll out of "Prevent WRAP 3" training across the organisation
- Embedding a culture of identifying patients who should be subject to Deprivation of Liberty Safeguards
- Improving awareness of use of the Mental Capacity Act and embedding this across the organisation
- Developing with Islington Safeguarding Adult Board guidance for staff around self-neglect and working with patients who refuse services even though they need them and lack the capacity to make decision

Equality, Diversity and Human Rights

As an organisation committed to continuous learning and improvement Whittington Health is keen to improve the lives of employees, patients and services users, eliminate discrimination and to foster positive relationships which will benefit health and wellbeing overall.

At our Board Seminar in 2015 directors discussed the issue of equality and planned further development sessions to tackle multi-faceted aspects of equality, inclusion..

Our core values ICARE (Innovation, Compassion, Accountability, Respect and Excellence) have been reviewed and strengthened to support the work in embedding a more inclusive culture, in particular the value 'Respect' which fundamentally deal with dignity, human rights and equality.

We published our first Workforce Race Equality Standard (WRES) in December 2015 [1] with a comprehensive improvement plan in recognition that there are multiple areas for improvement in order to achieve the Trust's clinical goals and vision by 2020.

Whittington Health, as one of the largest employers in the local borough of Islington and neighbouring boroughs of Haringey, Hackney, Enfield, Camden and Barnet, is part of the Community Education Partnership Network (CEPN). Whittington Health has been playing a significant role in exploring and

[1] Workforce Race Equality Standard – April 2014 to March 2015 (available from https://www.whittington.nhs.uk/document.ashx?id=6006)

creating opportunities for apprenticeships, and wider-participation for local residents in long term unemployment, school leavers, and individuals with disabilities.

Each ISCU and directorate has been preparing action plans to address areas of underperformance in line with the results of the National Staff Surveys for 2014 and 2015 in relation to equality and inclusion.

Our Board has supported the establishment of Anti-Bullying and Harassment Advisors. The Anti-Bullying and Harassment scheme will provide support to alleged victims and perpetrators and is available to all staff. The purpose of the scheme is to give all staff, new and existing, the confidence that there is zero-tolerance to bullying and harassment throughout the whole organisation.

Who has been involved in developing the Quality Account?

We have worked with many internal and external stakeholders in the development of this year's Quality Account.

Internally, clinical and operational teams have been at the forefront of developing the Account, from frontline staff to management level. Clinical and operational leads were crucial in ensuring the Quality Account is detailed and provides accurate information. Clinical and corporate divisions worked together to produce the Quality Account. The Information, Clinical Governance and Risk Management teams have all had significant input into developing the Account.

Externally, our Quality Account has been seen by our local CCGs, local Health Watch, and our designated external auditors.

Statements from external stakeholders

Commissioners' Statement

Healthwatch Islington Statement

Healthwatch Haringey Statement

Others

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

- **By writing to:** The Communications Department, Whittington Health, Magdala Avenue, London. N19 5NF
- **By telephone:** 020 7288 5983
- **By email**: communications.whitthealth@nhs.net

Appendix 1: Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, In particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes;
- papers relating to the Quality Account reported to the Board;
- feedback from Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009,;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment;
- feedback from Commissioners;
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality stands and prescribed definitions, and is subject to appropriate scrutiny and review; and

The Quality Account has been prepared in accordance with the Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Simon Pleydell
Chief Executive

Appendix 2: Independent auditors' Limited Assurance report to the directors of the Whittington Hospital NHS Trust on the Annual Quality Account

Glossary

Abbreviation	Definition
BTS	British Thoracic Society
C Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CEPN	Community Education and Provider Network
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUINS	Commissioning for Quality and Innovation
DATIX	Name of incident reporting system
DBS	Disclosure and Barring Service
DNA	Did not attend
DoLS	Deprivation of Liberty Safeguards
DTC	Day Treatment Centre
DVT	Deep Vein Thrombosis
ED	Emergency Department
FFT	Friends and Family Test
GMC	General Medical Council
HCAI	Healthcare Associated Infections
ICAM	Integrated Care and Acute Medicine
ICAT	Integrated Community Ageing Team
ICO	Integrated Care Organisation
IG	Information Governance
LoS	Length of Stay
MCA	Mental Capacity Act
MSK	Musculo-Skeletal
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
PALS	Patient Advice Liaison Service
PE	Pulmonary Embolism
PROMs	Patient Reported Outcome Measures
RTT	Referral to Treatment
SCD	Surgery, Cancer and Diagnostics
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
TDA	Trust Development Authority
UCLH	University College London Hospitals
UCLP	University College London Partners
VTE	Venous Thromboembolism
WCF	Women's Children & Families
YTD	Year to date

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board – Finance Report

01 June 2016

Title:	Month 1 2016/17 - Financial Performance		
Agenda item:	16/087	**Paper**	07
Action requested:	This report updates the Board of Directors on the financial performance of the Trust for April 2016 (month 1), following the meeting of the Finance and Business Development Committee (F&BD) on 25 May 2016. The report will provide an overview of the key finance information for the period, as well as highlight areas for management focus.		
Executive Summary:	The paper analyses the financial performance of the Trust covering income and expenditure, cash, CIPs and capital		
Summary of recommendations:	To note the financial results relating to performance during April 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. Board Assurance Framework (Section 3).		
Date paper completed:	26 May 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 | Statement of comprehensive income

The Trust reported a £1 million deficit at the end of April (month 1); this was £228k worse than the planned position. Total Trust income was marginally better than plan (£108k) and there was a modest over-spend on non-pay expenditure (£112k); pay costs were £264k greater than plan.

The table below is a statement of comprehensive income for month 1:

in £000	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Total Income	**25,516**	**25,624**	**108**	**25,516**	**25,624**	**108**	**306,176**
Non-Pay	(6,558)	(6,670)	(112)	(6,558)	(6,670)	(112)	(79,471)
Pay	(18,440)	(18,704)	(264)	(18,440)	(18,704)	(264)	(217,341)
Total Operating Expenditure	**(24,998)**	**(25,374)**	**(376)**	**(24,998)**	**(25,374)**	**(376)**	**(296,812)**
EBITDA	**518**	**250**	**(268)**	**518**	**250**	**(268)**	**9,364**
Depreciation	(690)	(645)	45	(690)	(645)	45	(8,280)
Dividends Payable	(350)	(359)	(9)	(350)	(359)	(9)	(4,310)
Interest Payable	(265)	(255)	10	(265)	(255)	10	(3,334)
Interest Receivable	3	2	(1)	3	2	(1)	36
Total	**(1,302)**	**(1,257)**	**45**	**(1,302)**	**(1,257)**	**45**	**(15,888)**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(784)**	**(1,008)**	**(224)**	**(784)**	**(1,008)**	**(224)**	**(6,524)**
Add back impairments and adjust for IFRS & Donate	10	6	(4)	10	6	(4)	121
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(774)**	**(1,002)**	**(228)**	**(774)**	**(1,002)**	**(228)**	**(6,403)**

Total pay expenditure for April was £18.7m, this is a large increase compared to both the average spend during quarter 4 2015/16 (£18m) and the monthly average during 2015/16 (£17.8m). Graph 1 and Table 1 in the Appendix illustrate the pay expenditure trend for the past 12 month period and summary April position by category. An element of known pay cost increases is factored into the pay plan for 2016/17, these relate to additional national insurance costs plus the impact of the national pay award.

Within total pay expenditure agency staff related costs were £1.46m for the month, this is a 17% increase compared to the average monthly cost of agency staff during 2015/16. The largest relative increases were seen in Emergency and Urgent Care (↑ 53%), Surgery (↑68%) and Women's and Family Services (↑ 43%); Clinical Support Services and Corporate areas reported a reduction in agency costs compared to 2015/16 rolling monthly averages.

Reducing the cost of agency staff borne by the organisation is a priority for 2016/17, the Trust has been allocated an agency expenditure ceiling by NHS Improvement and the Trust financial plan assume a material reduction in expenditure compared to 2015/16. All ICSU and corporate management teams are in the process of agreeing improvement trajectories and progress in the area will be reported frequently to the Trust F&BD Committee.

April non-pay expenditure of £6.6m was consistent with the monthly trend from 2015/16 (see Appendix Graph 2).

Within the overall income reported of £25.6m the following breakdown applied;

	£
NHS Clinical Income	21,733,675
Non-NHS Clinical Income	1,799,014
Non-Patient Income	2,090,880

The Trust over performed in quantum on income by £108,000. The positive variance was driven by an over-performance against NHS clinical income (£466,000) and in particular adult critical care days. It should be noted however that elective care was down by 5% as were outpatient attendances; whilst this may be the effect of the continuing winter pressures and recent industrial action by Junior Doctors, the activity will need to be delivered to ensure the annual plan is met. NHS non-clinical income and other operating revenues were both behind plan.

Appendix

Graph 1 – Pay expenditure trend

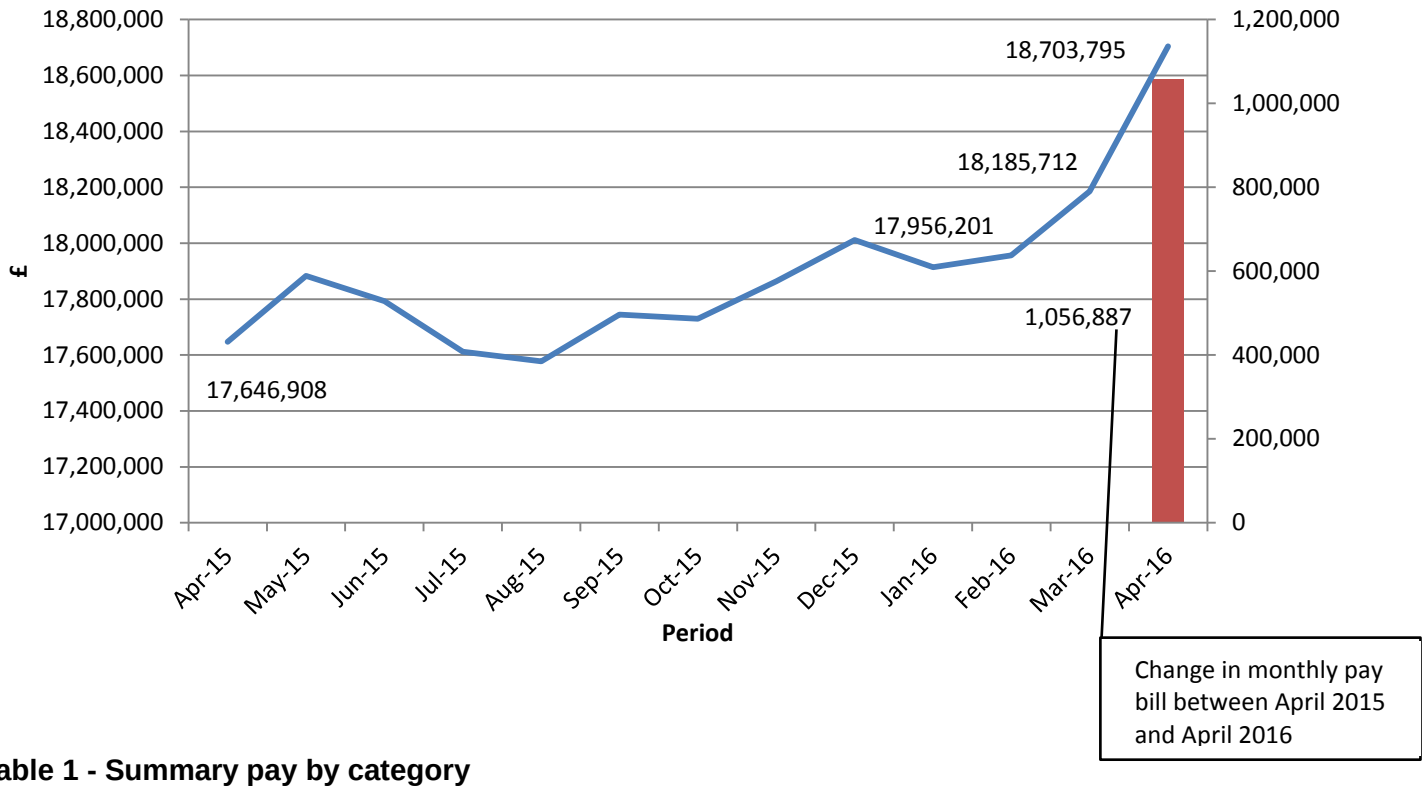
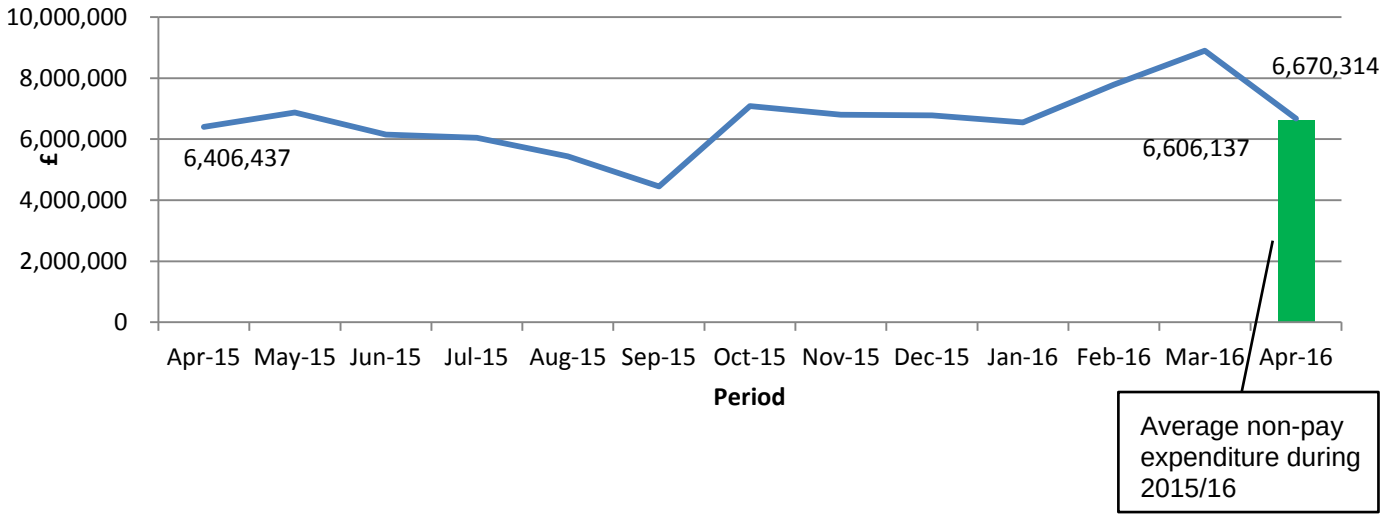


Table 1 - Summary pay by category

Pay Area	April 2016	Arithmetic Average 2015/16	% Change	
Agency	1,464,997	1,257,482	17%	↑
Bank	1,375,852	1,415,838	3%	↓
Locum	182,526	145,369	26%	↑
Permanent	15,680,420	15,007,785	4%	↑
Grand Total	**18,703,795**			

Graph 2 – Non-pay expenditure trend



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

Whittington Health Trust Board
1st June 2016

Title:	Trust Board Report May 2016 (April 16 data)		
Agenda item:	**16/088**	**Paper**	**08**
Action requested:	For discussion and decision making		
Executive Summary:	The following is the Performance and Quality report for April 2016 with a number of highlights and areas for focus identified. <u>Summary of report:</u> **PATIENT SAFETY AND EXPERIENCE** The Trust reported 3 **Serious Incidents** including two delays in diagnoses and one Information governance breach. The response to **complaints** within 25 days remains above the threshold at 88% for this month, despite the high number of complaints received for this period (48). There were **no new bacteraemia** identified within Whittington Health this month. **Friend and Family Test** now include the Community and Out Patient Services data. Increasingly more Children's Services data is going to be included from May 2016. **ACCESS** Whittington Health has **achieved** the target for **Incomplete Referral to Treatment.** **Theatre Utilisation** decreased further during April 16 to 75%. Extensive plans are in place to improve planned utilisation as part of Surgery & Cancer ICSU improvement plan. A theatre utilisation dashboard is developed and will be available to the ICSU in June 2016. It will be incorporated in the overall trust dashboard as part of the cross organisational dashboard refresh. **Hospital Cancellation for first** appointments remained low again this month despite the doctor's strikes at 6.2%. The strike did have an adverse effect again on follow up appointments (9%) and the **DNA rate** for first (12.7%) and follow up (12.5%) appointments which are above the 10% threshold. **The cancer** targets were all achieved.		

Community Cancellations and DNAs continue to achieve their target.

Appointments with no outcomes in the community have increased disappointingly to 2.5% (0.5% threshold). Service with a high number of un outcomed appointments, including Health Visiting, Speech and Language Therapy, District Nursing and the Islington Care Co-ordination Service. These are high volume appointment services. Services are reminded all appointments should be outcomed on the 3rd working day of the following month. All appointments are outcomed retrospectively before submission to SUS. Further work in undertaken to make sure all appointments are recorded on the EPRs.

District Nursing

The **2 hour target** in Haringey has improved. The 2 hours target in Islington has gone down considerably, but the number of 2 hours target referrals was very small this month. **Both 48 hour targets** in Islington and Haringey have reduced slightly. The quality impact for patients seen late has been scrutinised and there has been no identified patient harm. **Number of DN team reviewing POC and timely discharge** were not achieved. Due to a combination of senior vacancies and annual leave the team meetings for Timely Discharge and Patients of concern were late and were completed in early May. Extra support is recruited until new staff have started.

In **MSK service** the number of patients being seen within 6 weeks has decreased again for April 2016. Following performance notice issued to MSK Out-Patient Physiotherapy and CATS in March 16 the Trust met with the commissioners in April 16 to discuss demand and capacity issues and to formulate a Remedial Action Plan (RAP). This RAP was submitted by the trust on 6th May. Follow-up meeting with Commissioners has been scheduled for 30th May 16.
RAP Included following papers:

1. Proposed Self-referral criteria to potentially reduce number of referrals (demand) into the service.
2. Proposed Chronic Pain Services Model.
3. Paper outlining importance of role of (GP with Special Interest) GPwSI in the CATS service and how the loss of this 0.4WTE posts has negatively impacted on the capacity and quality of the CATS service.
4. Paper on DNA including actions the service is taking to reduce DNAs, which have reduced from 19.3% (12/13) to 11.6% (15/16).
5. Paper benchmarking the demand, capacity and funding of the service against the Homerton NHS Trust.
6. MSK Routine Physiotherapy and CATS service demand and capacity report.
7. Paper outlining Routine Physiotherapy and CATS services and pathways.

	MSK Physiotherapy waiting times dropped in April as there were an increased number of vacancies which removed capacity from the service resulting in increased waiting list. Recruitment process can take 3 months and is underway but slow. Recruitment of junior physiotherapists has been difficult due poor calibre of applicants and time of year. Advert is out and final year graduates have been encouraged to apply. Some of the vacancies are now being covered by agency staff to bring the numbers of patients waiting down. Improvement in wait times should start to show from mid/ end -May. MSK Waiting times – Non consultant led patients seen in month – 41.5% against the target of 95% MSK Waiting times – Consultant led patients seen in month – 82.2% against a target of 95% **IAPT** data for April is - recovery rate 46.6 % (target 50), reliable improvement rate 63.68% (target 55%), wait time – 96.8% seen within 6 weeks (target 75%), and patient satisfaction satisfied and very satisfied - 99%. The recovery rate being below 50 together with a higher improvement rate indicates that patients enter treatment with high levels of severity. Work in service on keeping recovery rate at 50% and above continues as detailed in the service improvement plans. Additional work being started to help this, is a full and detailed review of the themes emerging from the examination of all discharged cases that did not recover according to the data. Islington **Intermediate Care Services** continuing improvement without additional resource. Ongoing recruitment to vacant posts, all staff should be in place by end of July 16. Met with commissioners to review other access improvements, screening processes and demand & capacity information for each discipline, with input from NHS Elect. The referral pathway will be moved to central booking team in August16. The number of referrals **the Podiatry Service** has been able to see within 6 weeks has decreased again this month. Plans are still on track in recruiting new staff, but in addition to this 2 locums have been employed recently to support the backlog of referrals. **EMERGENCY AND URGENT CARE** All targets improved slightly for ED, although they are all still below target. The patient diverting from ED to Ambulatory Care has remained between 2 and 3.5% for the past 18 months. **MATERNITY** **12+6** remains under target and an extensive plan, including changes in admin processes and booking of pregnant women has been developed. There has been a delay in employing administrative staff to support the service in completing the plan. A list of late booked women is now pulled from the IT system and extra sessions are scheduled to book and see them on time. Improvement in the target should be expected in 3 to 4 months' time, August/ September 2016.

	NEW BIRTH VISITS Islington NBV just below the national target of 95% and Haringey improved slightly this month but below target currently at 85%. Reasons for late new birth visits captured monthly. **HUMAN RESOURSES** An extra tab has been added at the end of the dashboard containing high level workforce data. It is the intention that this will be further developed over the coming months in line with the development of the Performance dashboard.
Summary of recommendations:	That the board approves 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 May 2016

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**May 16**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

April 2016 Trust Board Report (March data)

Whittington Health NHS

Quality	Threshold	Feb-16	Mar-16	Apr-16
Number of Inpatient Deaths	-	31	36	32
NHS number completion in SUS (OP & IP)	99%	98.8%	98.5%	arrears
NHS number completion in A&E data set	95%	95.0%	95.8%	arrears

Quality (Mortality index)	Threshold	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
SHMI	-	0.67	0.66	0.65

Quality (Mortality index)	Threshold	Nov-15	Dec-15	Jan-16
Hospital Standardised Mortality Ratio (HSMR)	<100	94	70	102
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	119.3	85.9	78.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	80.1	65.0	110.1

Patient Safety	Threshold	Feb-16	Mar-16	Apr-16
Harm Free Care	95%	93.7%	93.6%	92.2%
VTE Risk assessment	95%	95.3%	95.1%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	1
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	42.6%	38.8%	48.1%
Serious Incident reports	-	8	2	3

Access Standards

Referral to Treatment (in arrears)	Threshold	Jan-16	Feb-16	Mar-16
Diagnostic Waits	99%	99.1%	98.8%	99.4%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Feb-16	Mar-16	Apr-16
Service Cancellations - Community	8%	6.5%	6.5%	7.0%
DNA Rates - Community	10%	5.9%	5.6%	6.0%
Community Face to Face Contacts	-	58,307	58,490	58,718
Community Appts with no outcome	0.5%	0.9%	0.4%	2.5%

Community Access Standards	Threshold	Feb-16	Mar-16	Apr-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	67.2%	49.2%	41.5%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	98.7%	82.2%	arrears
IAPT - patients moving to recovery	50%	47.1%	46.6%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	94.8%	96.8%	arrears
GUM - Appointment within 2 days	98%	98.9%	98.9%	98.7%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Feb-16	Mar-16	Apr-16
First:Follow-up ratio - acute	2.31	1.44	1.51	1.46
Theatre Utilisation	95%	78.9%	76.2%	75.0%
Hospital Cancellations - acute - First Appointments	8%	5.7%	5.3%	6.2%
Hospital Cancellations - acute - Follow-up Appointments	8%	7.0%	8.1%	9.0%
DNA rates - acute - First appointments	10%	9.8%	12.2%	12.7%
DNA rates - acute - Follow-up appts	10%	11.1%	12.8%	12.5%
Hospital Cancelled Operations	0	3	3	19
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	0	5

Meeting threshold

Failed threshold

April 2016 Trust Board Report (March data)

Whittington Health NHS

Patient Experience	Threshold	Feb-16	Mar-16	Apr-16
Patient Satisfaction - Inpatient FFT (% recommendation)	-	94%	96%	96%
Patient Satisfaction - ED FFT (% recommendation)	-	92%	85%	90%
Patient Satisfaction - Maternity FFT (% recommendation)	-	88%	88%	95%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	32	48	23
Complaints responded to within 25 working day	80%	90%	88%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Emergency and Urgent Care	Threshold	Feb-16	Mar-16	Apr-16
Emergency Department waits (4 hrs wait)	95%	84.0%	81.8%	84.1%
ED Indicator - median wait for treatment (minutes)	<60	94	103	88
30 day Emergency readmissions	-	183	189	arrears
12 hour trolley waits in A&E	0	1	0	0
Ambulatory Care (% diverted)	>5%	3.5%	3.4%	2.9%
Ambulance Handover (within 30 minutes)	0	3	21	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Feb-16	Mar-16	Apr-16
Hospital acquired MRSA infection	0	0	0	0
Hospital acquired *C difficile* Infections	17 (FY)	0	0	2
Hospital acquired *E. coli* Infections	-	1	1	0
Hospital acquired MSSA Infections	-	0	0	0
Ward Cleanliness	-	99%	-	97%

Cancer Access Standards (in arrears)	Threshold	Jan-16	Feb-16	Mar-16
Cancer - 14 days to first seen	93%	93.2%	99.5%	98.8%
Cancer - 14 days to first seen - breast symptomatic	93%	92.7%	98.3%	99.4%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	97.7%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	-
Cancer - 31 days to subsequent treatment - drugs	98%	-	100.0%	100.0%
Cancer - 62 days from referral to treatment	85%	93.5%	81.6%	88.5%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Feb-16	Mar-16	Apr-16
Referral to Treatment 18 weeks - Admitted	90%	77.4%	76.6%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	91.4%	90.8%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	92.1%	92.7%	arrears

Maternity	Threshold	Feb-16	Mar-16	Apr-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	82.1%	81.3%	80.1%
New Birth Visits - Haringey	95%	83.8%	85.7%	arrears
New Birth Visits - Islington	95%	92.8%	94.7%	arrears
Elective Caesarean Section rate	14.8%	13.1%	8.8%	12.0%
Breastfeeding initiated	90%	91.5%	93.0%	90.9%
Smoking at Delivery	<6%	7.4%	4.1%	4.4%

Meeting threshold

Failed threshold

	Threshold	Trust Actual		
		Feb-16	Mar-16	Apr-16
Number of Inpatient Deaths	-	31	36	32
Completion of a valid NHS number in SUS (OP & IP)	99%	98.8%	98.5%	arrears
Completion of a valid NHS number in A&E data sets	95%	95.0%	95.8%	arrears

	Standardised National Average	Trust		
		Nov-15	Dec-15	Jan-16
Hospital Standardised Mortality Ratio	<100	94.1	70.2	102.1
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	119.3	85.9	78.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	80.1	65.0	110.1

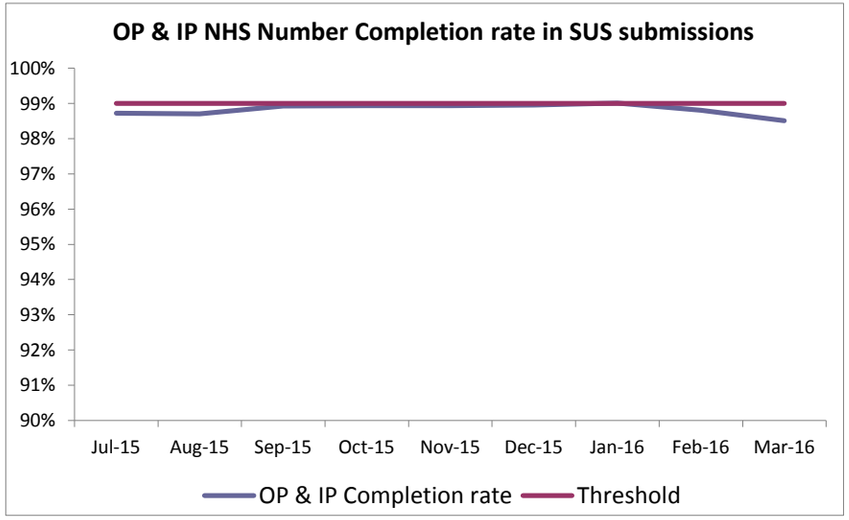
		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Oct 2014 - Sep 2015	0.89	1.12	0.65
	Jul 2014 - Jun 2015	0.89	1.12	0.66
	Apr 2015 - Mar 2015	0.89	1.12	0.67
	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54
	Apr 2013 - Mar 2014	0.87	1.15	0.54

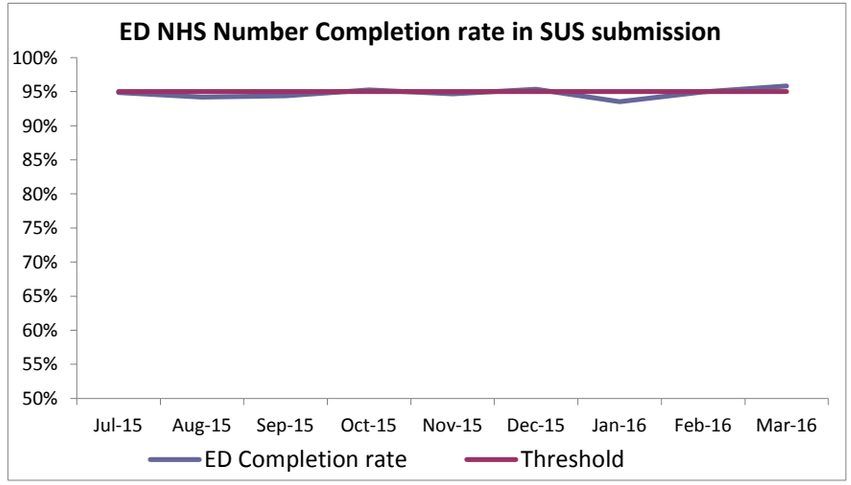
Commentary

Completion of NHS number in SUS
Issue: Below target and also not achieved for freeze date for February 16 data set.
Action: To adopt the approach taken in ED, to achieve compliance, including individualised reports, send out weekly, managed by Service Managers.
Timeframe: Within target for June 2016

Completion of NHS number in A&E data set
Target achieved and expected to be above target next month.

SHMI and HMSR
The Hospital Standardised Mortality has increased from 70.2 to 102. This is in the middle of the confidence interval (73.6 to 138) as set by Dr Fosters. Although the figure is shown as red on this dashboard, it means that Whittington Health's score is as expected by Dr Fosters compared to similar hospitals, as result is not conclusive in suggesting we had a higher than expected mortality rate.

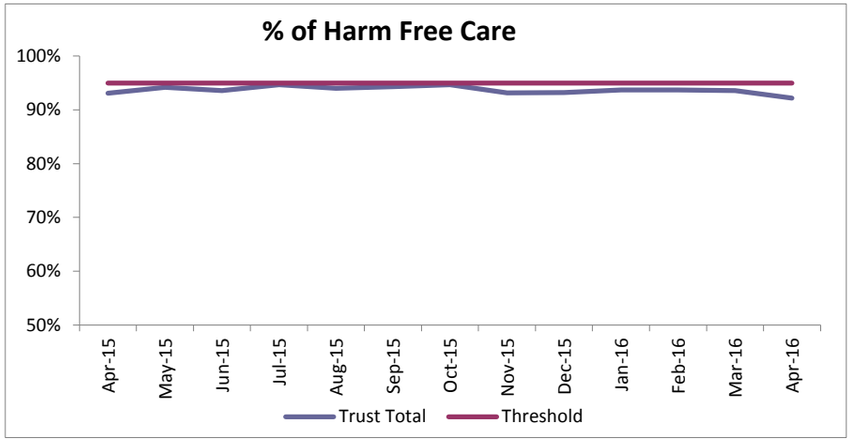


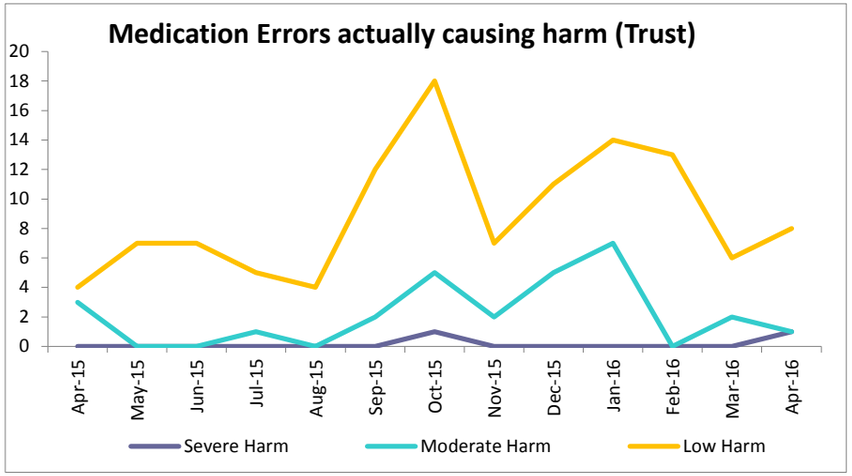


Patient Safety

Whittington Health NHS

	Threshold	Trust Actual Jan-16	Feb-16	Mar-16	Apr-16	Trend
Harm Free Care	95%	93.7%	93.7%	93.6%	92.2%	
Pressure Ulcers (prevalence)	-	5.64%	5.33%	5.59%	7.19%	
Falls (audit)	-	0.18%	0.49%	0.46%	0.35%	
VTE Risk assessment	95%	95.3%	95.3%	95.1%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	1	
Medication Errors actually causing **Moderate** Harm	-	7	0	2	1	
Medication Errors actually causing **Low** Harm	-	14	13	6	8	
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	-	46.7%	42.6%	38.8%	48.1%	
Serious Incidents (Trust Total)	-	4	8	2	3	





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 under 93%.

Falls (audit)

Issue: Falls audit shows less falls on audit day than last month. The overall numbers of falls recorded in the Nursing Indicators dashboard remain around 20 per month.

Action: Falls awareness and prevention training session continue to be included in new ward training programme (2pm daily). Business case for care of older persons nurse specialist and increased awareness and recognition of delirium through screening project is in draft format. To be presented at the Investment Group and TMG in June 2016

Timescale: Feedback in July 2016

Medication errors causing harm in April 16

There were 42 medication incidents reported on Datix in April 2016. This is a reduction compared with the previous month (55). This could be explained by only 4 incidents reported by the DNS, compared with 13 in March. **There was one incident causing high harm**: A 90 year patient was admitted after having taken medicines from the incorrect blister pack (dispensed by a community pharmacist) leading to an ICU admission for treatment of beta blocker overdose. Action - being followed up with the community pharmacist and providers of care package. **The incident causing moderate harm:** Post-operatively patient deteriorated due to duplicate analgesia prescribed. **Incidents causing low harm** concerned 3 CDs, either missed doses or incorrectly prescribed and 3 further incidents included non CD omitted doses and short dated medication to be kept at home.

Serious Incidents

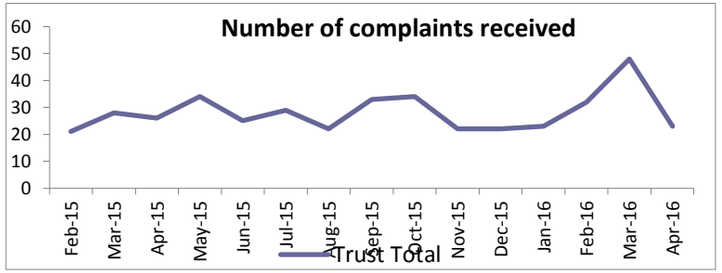
Whittington Health declared 3 SIs in April 2016 including a delay in diagnosis of ischaemic bowel, an Intrauterine death, Delayed Diagnosis - Cancer and an IG Breach of Confidentiality- Health Assessment reports sent to incorrect address.

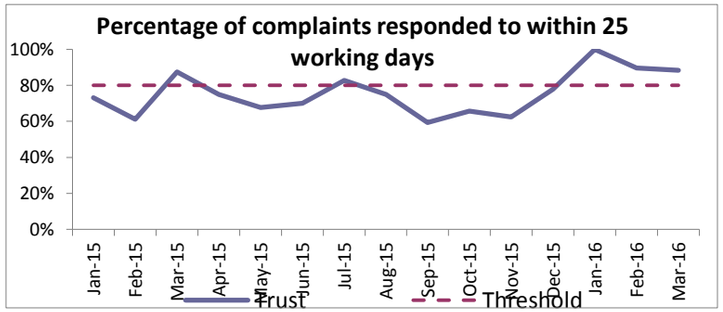
All identified learning form these incidents has been shared with the Services.

Patient Experience

Whittington Health NHS

	Threshold	Trust Actual Jan-16	Feb-16	Mar-16	Apr-16	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	96%	94%	96%	96%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	94%	92%	85%	90%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	95%	88%	88%	95%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	23	32	48	23	
Complaints responded to within 25 working day	80%	100%	90%	88%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	





***** Complaints responded to within 25 working days are previous months figures (reported in arrears)

Commentary

Patient Satisfaction (Local standard 90%)
Please see breakdown of FFT to the left.
ED: Positive % back up to 90%
Inpatients: Increased response rate on many wards and particularly in day cases
Outpatients: Increase in positive responses.
Community: Similar to last month

Mixed Sex Accommodation
Achieved

Complaints
Target achieved for March 2016

Emergency Department Friends and Family Test

Summary

2015/16	Responses						
Month	Positive	% Positive	Negative	% Negative	Total	Discharges	Response Rate
January 2016	245	94%	14	5%	260	6681	4%
February 2016	361	92%	23	6%	394	6480	6%
March 2016	245	85%	29	10%	287	7158	4%

2016/17	Responses						
Month	Positive	% Positive	Negative	% Negative	Total	Discharges	Rate
April 2016	259	90%	19	7%	288	6261	5%

Outpatient Friends and Family Test

Summary

2015/16	Responses				
Month	Positive	% Positive	Negative	% Negative	Total
January 2016	133	94%	4	3%	141
February 2016	60	82%	6	8%	73
March 2016	122	85%	8	6%	144

2016/17	Responses				
Month	Positive	% Positive	Negative	% Negative	Total
April 2016	120	90%	7	5%	133

Inpatient Friends and Family Test

Summary

2015/16	Responses						
Month	Positive	% Positive	Negative	% Negative	Total	Discharges	Response Rate
January 2016	346	95%	8	2%	366	3065	12%
February 2016	357	89%	25	6%	399	3168	13%
March 2016	405	94%	12	3%	430	3061	14%

2016/17	Responses						
Month	Positive	% Positive	Negative	% Negative	Total	Discharges	Rate
April 2016	567	97%	6	1%	587	3033	19%

Community Services Friends and Family Test

Summary

2015/16	Responses				
Month	Positive	% Positive	Negative	% Negative	Total
January 2016	796	98%	8	1%	812
February 2016	947	96%	10	1%	983
March 2016	742	99%	4	1%	753

2016/17	Responses				
Month	Positive	% Positive	Negative	% Negative	Total
April 2016	757	97%	3	0%	778

Infection Prevention

Whittington Health NHS

	Threshold	Trust Actual Jan-16	Feb-16	Mar-16	Apr-16	Trend
MRSA	0	1	0	0	0	
E. coli Infections*	-	2	1	1	0	
MSSA Infections	-	0	0	0	0	

	Threshold	Jan 16	Feb 16	Mar 16	Apr 16	2015/16 Trust YTD
C difficile Infections	17 (Year)	0	0	0	2	2

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

Ward Cleanliness

Audit period	Trust 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	16/03/16 to 06/05/16	Trend
Trust %	97.9%	97.7%	97.8%	98.6%	96.9%	

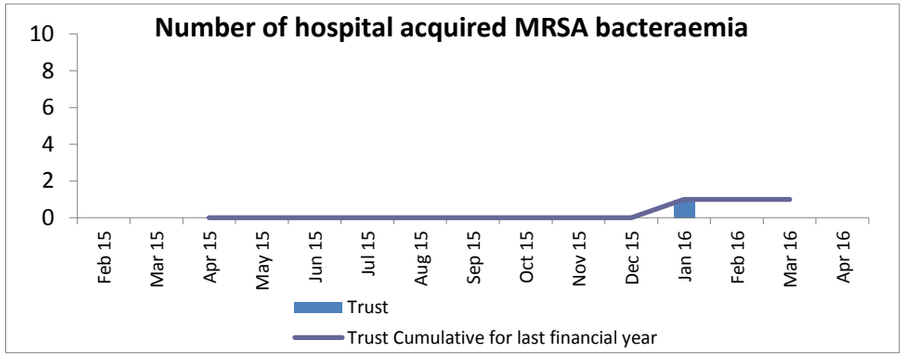
Commentary

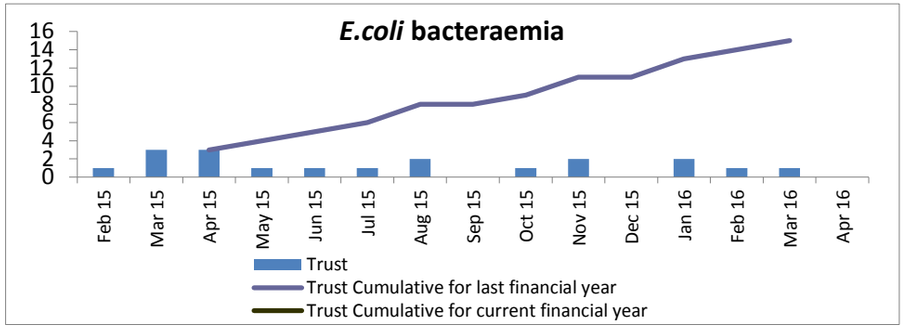
MSRA and E.coli
No new bacteraemia

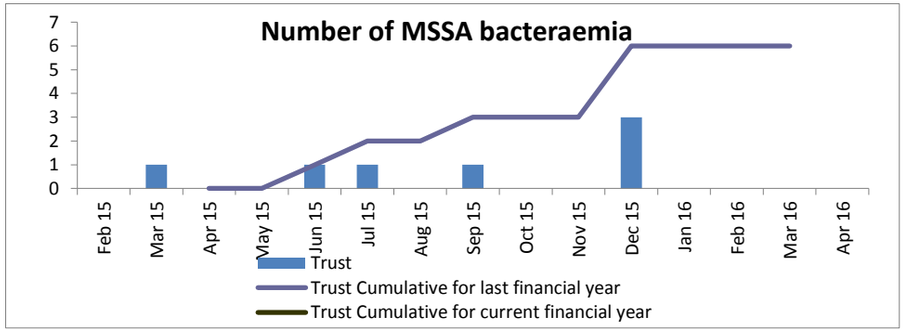
MSSA
No new bacteraemia

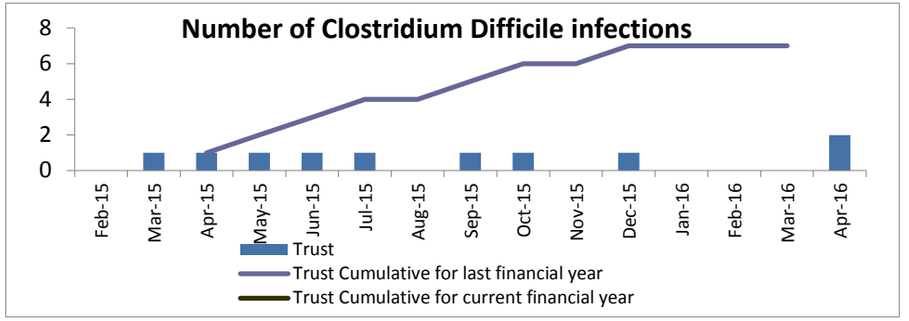
C difficile
Two new bacteraemia and all protocols implemented.

Ward Cleanliness
Issue: Ward Cleanliness figures between March and May 2016 have dropped to 96.9%.
Action: A detailed action plan is in place for infection prevention, cleaning standards and audits are being carried out by Estates and matrons to ensure standards are maintained.
Timescale: In place.





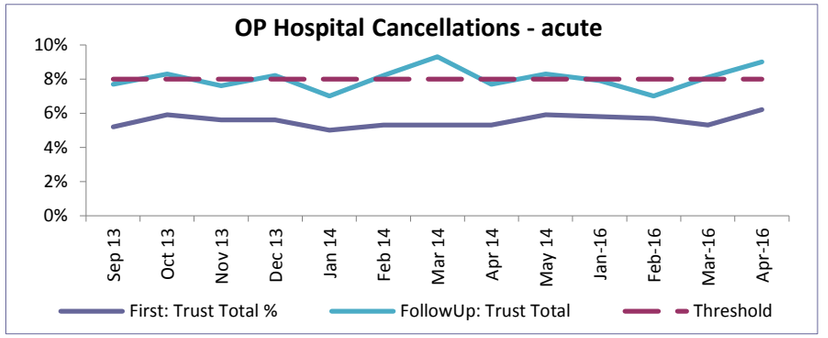


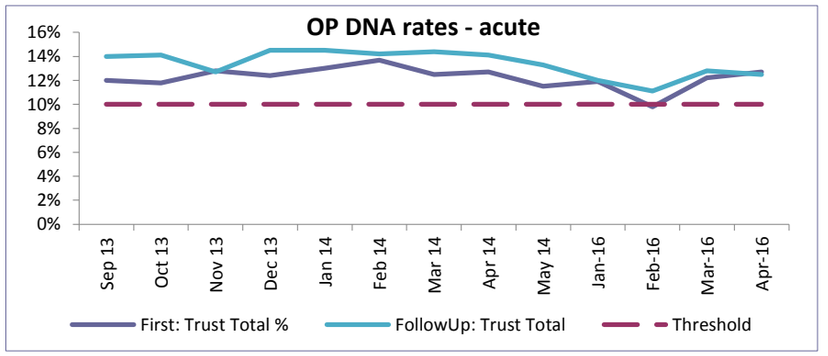


Efficiency and productivity - acute

Whittington Health NHS

	Trust						
	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Trend
First:Follow-up ratio - acute	2.31	1.44	1.56	1.44	1.51	1.46	
Theatre Utilisation	95%	77.3%	79.8%	78.9%	76.2%	75.0%	
Hospital Cancellations - acute - First Appointments	<8%	5.9%	5.8%	5.7%	5.3%	6.2%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	8.3%	7.9%	7.0%	8.1%	9.0%	
DNA rates - acute - First appointments	10%	11.5%	11.9%	9.8%	12.2%	12.7%	
DNA rates - acute - Follow-up appointments	10%	13.3%	12.0%	11.1%	12.8%	12.5%	
Hospital Cancelled Operations	0	1	16	3	3	19	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	1	0	0	0	5	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	





Commentary
Theatre Utilisation
Issue :
Current target is 95% on the scorecard for utilisation, we know from Benchmarking meetings we have attended that very few if any organisations deliver this number and if they do their calculation is different from how ours is derived. Whittington Health calculates theatre utilisation as recommended by National Theatre Benchmarking. This has been validated and checked by an external company Four Eyes.
Over the past few months we have had utilisation below the normal run rate due to Junior doctor strikes and extremely difficult flow within the organisation. This has affected start and finish times of lists and on occasion unplanned cancellation of patients, which again is contrary to the normal run rate. The performance per speciality in April 2016 by speciality is described below

Speciality	% Utilisation 3/4/16	% Utilisation 10/4/16	% Utilisation 17/4/16	% Utilisation 24/4/16	Average
General Surgery	97	82	72	91	85.50%
Gynaecology	83	73	82	85	80.75%
Urology	80	54	69	53	64%
T&O	72	98	83	76	82.25%
Breast Surgery	33	54	90	46	55.75%
Anaesthetics /pain	-	94	-	-	-

Action:
One breast theatre session is to be removed per week. Two urology theatre sessions are to be removed per week. All surgical specialities have been asked to undertake capacity and demand work for theatres to establish what they need as opposed to what is currently on the theatre schedule. Once this is known further theatre sessions may be removed or reallocated to ensure that both activity plans and RTT standards are met. This will happen from the 1st July 2016. Information is also collected for start and finish times, activity undertaken, turnaround time between patients. A more comprehensive dashboard is being developed for theatres. This should be ready within Surgery ICSU by end of June and is planned for Trust dashboard for September as part of the cross organisational dashboard refresh.

Commentary continued

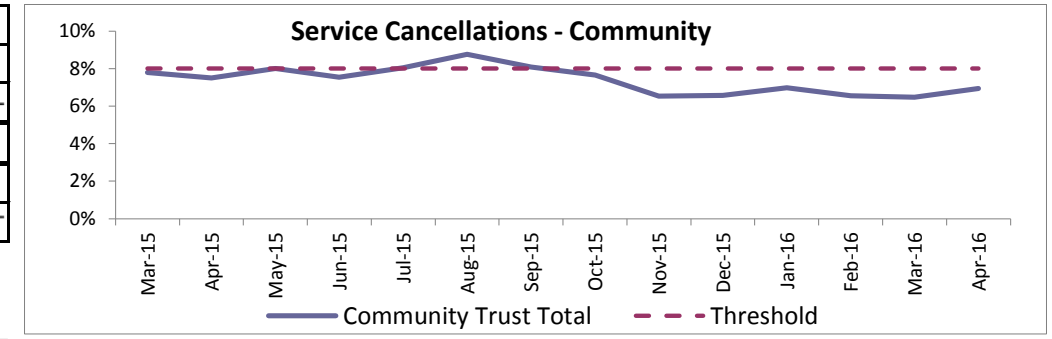
Hospital Cancellations and Did not attend
Hospital cancellations achieved for first appointments. Just under target for follow up appointments. DNA rate just under target for both.
Issue: The junior doctors' strike has impacted on the cancellation and DNA rate.
Action: Improvement to be expected from next month, using NetCall and continuing drive to update the EPR systems with patient details when attending appointments.
Timescale expected compliance in June 2016

Hospital Cancelled Operations
Issue: There were 19 reportable cancelled operation of which 5 were urgent procedures. Most were cancelled by the urology service due to the Junior Doctor strike. All operation were rescheduled within 28 days.
Action: The Surgical board continues pt monitor cancellations.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Jan-16	Feb-16	Mar-16	Apr-16	Trend
Service Cancellations - Community	8%	7.0%	6.5%	6.5%	7.0%	
DNA Rates - Community	10%	6.3%	5.9%	5.6%	6.0%	
Community Face to Face Contacts	-	58,882	58,307	58,490	58,718	
Community Appointment with no outcome	0.5%	1.9%	0.9%	0.4%	2.5%	



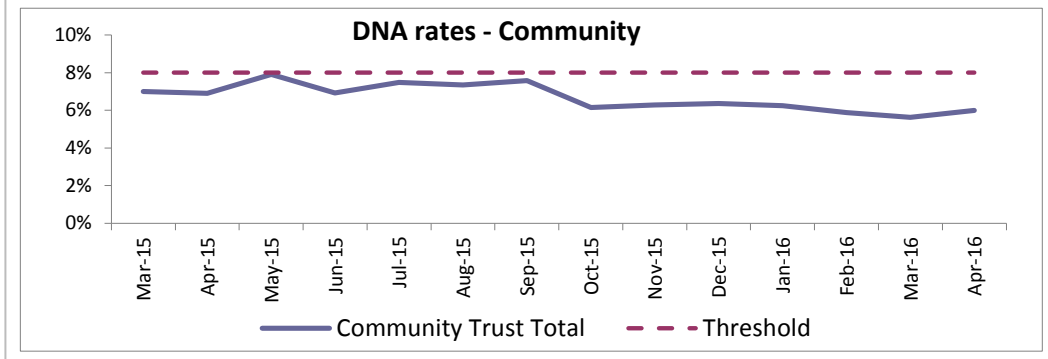
Commentary

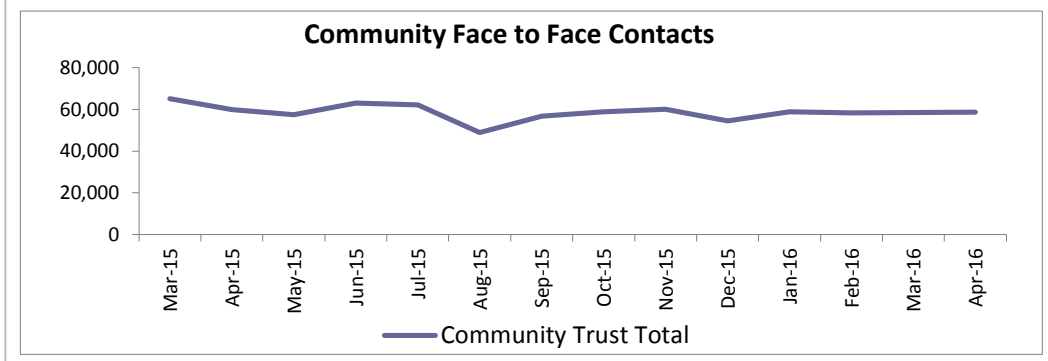
Service Cancellations - Community
Achieved

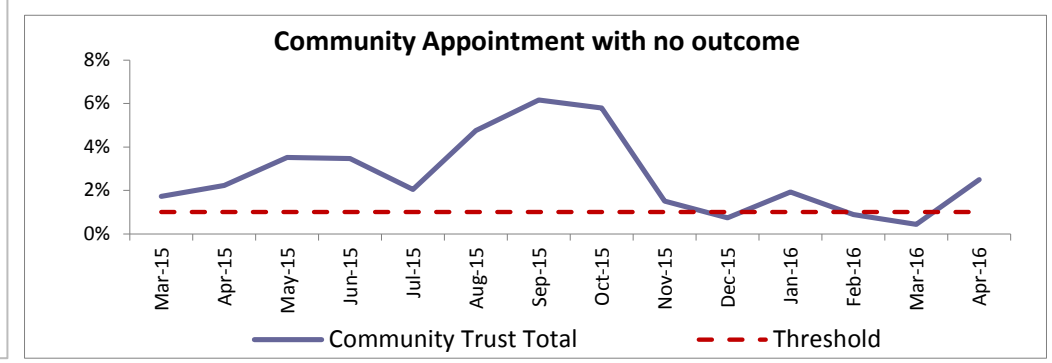
DNA Rates - Community
Achieved.

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

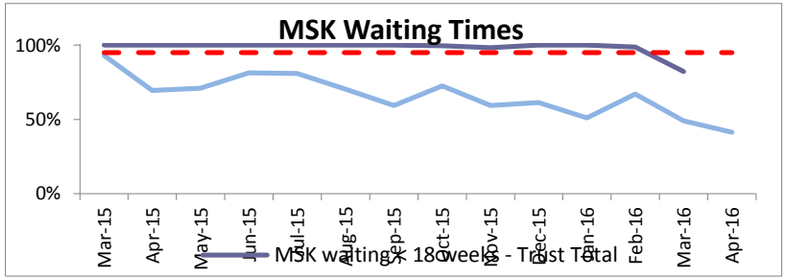
Community Appointment with no outcome
Not achieved.
Issue: Appointments are not outcomed on the electronic systems for services with high volume appointments, including Health Visiting, Speech and Language Therapy, District Nursing and the Islington Care Co-ordination Service.
Action: Electronic reports are in place for Services to monitor their unoutcomed appointments. All appointments are outcomed retrospectively before submission to SUS. Further work is completed on making sure all appointments are recorded on the EPRs RiO and Medway. A first meeting is scheduled at the beginning of June 2016
Timescale: in place







	Threshold	Trust Actual Feb-16	Trust Actual Mar-16	Trust Actual Apr-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	100.0%	83.3%	66.7%	66.7%
District Nursing Wait Time - 2hrs assess (Haringey)	-	88.2%	90.9%	94.1%	94.1%
District Nursing Wait Time - 48hrs for visit (Islington)	-	88.4%	100.0%	95.3%	95.3%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	97.8%	97.7%	96.3%	96.3%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	67.2%	49.2%	41.5%	41.5%
MSK Waiting Times - Consultant led (<18 weeks)	95%	98.7%	82.2%	arrears	-
IAPT - patients moving to recovery	50%	47.1%	46.6%	arrears	-
GUM - Appointment within 2 days	98%	99.4%	98.9%	98.7%	98.7%
Haringey Adults Community Rehabilitation (<6weeks)	85%	89.3%	88.2%	89.3%	89.3%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	60.4%	52.4%	50.2%	50.2%
Islington Community Rehabilitation (<12 weeks)	-	80.4%	93.2%	88.8%	88.8%
Islington Intermediate Care (<6 weeks)	85%	66.5%	72.5%	74.3%	74.3%
Islington Podiatry (Foot Health) (<6 weeks)	-	62.4%	54.6%	36.0%	36.0%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	94.8%	96.8%	arrears	-
Death in place of choice	90%	76.0%	75.0%	95.0%	
Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams)	8	8	8	4	
Number of DN teams completing a monthly caseload review of timely discharge (eight teams)	8	8	8	3	



District Nursing
The 2 hour target in Haringey has improved. The 2 hours target in Islington has gone down considerably, but the number of 2 hours target referrals was very small this month. Both 48 hour targets in Islington and Haringey have reduced slightly. The quality impact for patients seen late has been scrutinised and there has been no identified patient harm.
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: Missed appointments for 2 hours target to be put on Datix. Thresholds for 2 and 48 hours targets to be agreed with commissioners in the coming weeks.
Timescale: Improvements expected next month.

Number of DN team reviewing POC and timely discharge
Issue: Not achieved. Due to a combination of senior vacancies and annual leave the team meetings for Timely Discharge and Patients of concern were late and were completed in early May.
Action: The Director of Operations and Head of Nursing will insure that additional support is recruited until newly appointed staff have started.
Timescale: June 2016

Islington Intermediate Care
Issue: not achieved
Action: Continuing improvement without additional resource. Ongoing recruitment to vacant posts, all staff should be in place by end of July 16.
Met with commissioners to review other access improvements, screening processes and demand & capacity information for each discipline, with input from NHS Elect. The referral pathway will be moved to central booking team in August16.

IAPT
Issue: Dropped further to 46.6% as expected. The reliable Improvement rate for March is 68%. These two figures seen together suggest that the drop in recovery rate in March is due to a slight increase in the severity of cases at beginning of treatment. There is no indication to suggest this will be a continuous change. Haringey IAPT recovery rate continues to compare favourably with other London IAPT sites.
Action: all staff now receive their own recovery rates each quarter and have in place individual action plans when these are below 50%.

MSK:
Actions from March 16:
Performance notice meeting held on 28th April. Remedial action plan papers completed and submitted 6th May 16
Recruitment rounds in March complete. This continues throughout April.
April 16:
Issue: Increase in waiting times: Increased numbers of vacancies in April have removed capacity from the service. Therefore a queue of patients which built up quickly, resulting in increased waiting list. Little resilience in the service due to capacity and demand issues, coupled with staff turnover.
Action: Some of the vacancies are now being covered by agency staff to bring the numbers of patients waiting down. This is starting to show in the recent data from mid-May. Vacancy finances are being reviewed week on week with view to using more locums, within budget, to manage waiting list whilst we recruit into permanent posts.
Recruitment and retention plan in place and ongoing but process can take up to 3 months. Junior staff are being successfully developed in-house for senior physiotherapy posts. However recruitment of junior physios has been difficult due poor calibre of applicants and time of year. Advert is out and final year graduates have been encouraged to apply.
Timescale: Improvement in wait time should be apparent after Mid-May.

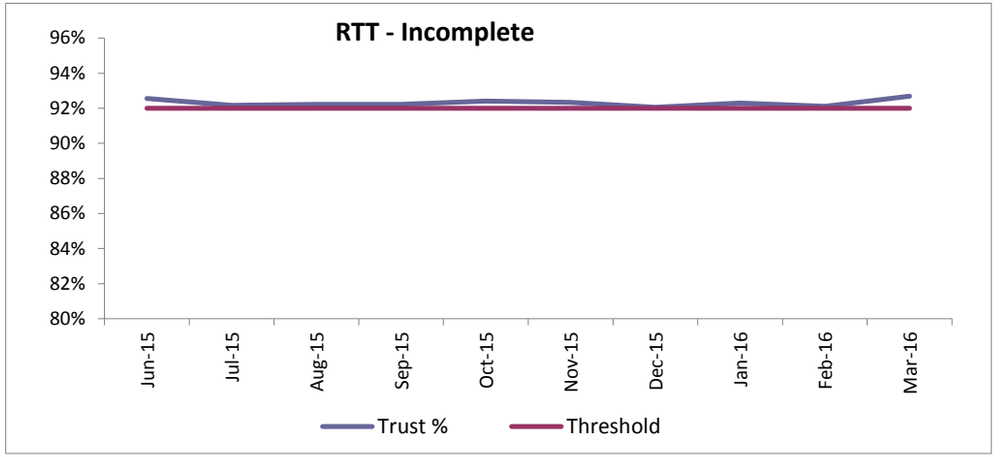
Podiatry reword
Issue: Vacant posts resulting in increase in waiting times for new patient as well as routine reviews.
Action: Recruitment continuing with 2 agreed start dates in July 16. One locum has started mid-May and one is starting at the end of May until the new staff is in post.
Timescales: There should be an improvement in waiting times from June 2016.

Death in place of choice
Target achieved this month.

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

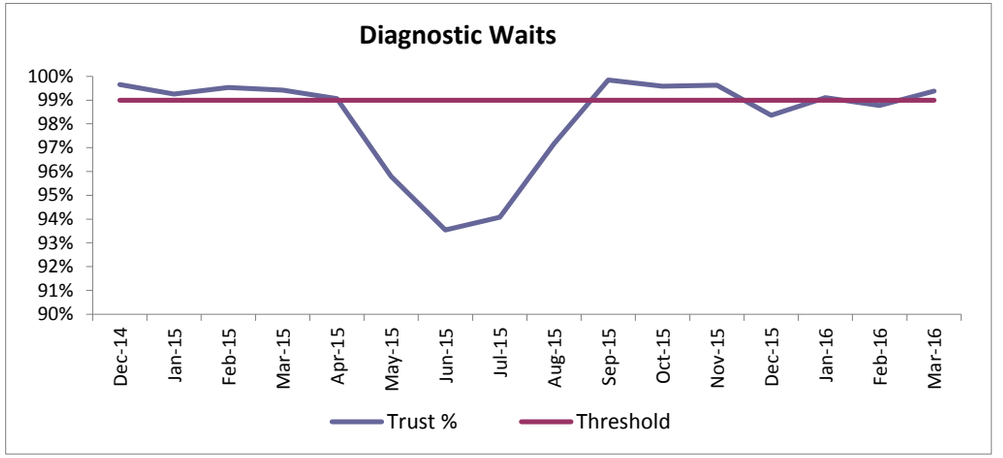
	Trust				
	Threshold	Jan-16	Feb-16	Mar-16	Trend
Referral to Treatment 18 weeks - Admitted	90%	73.5%	77.4%	76.6%	
Referral to Treatment 18 weeks - Non-admitted	95%	90.1%	91.4%	90.8%	
Referral to Treatment 18 weeks - Incomplete	92%	92.3%	92.1%	92.7%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	99.1%	98.8%	99.4%	



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.

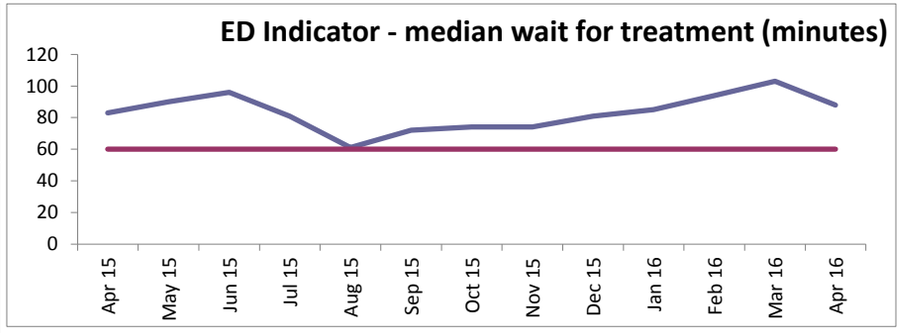
Diagnostic Waits
Target achieved as expected.

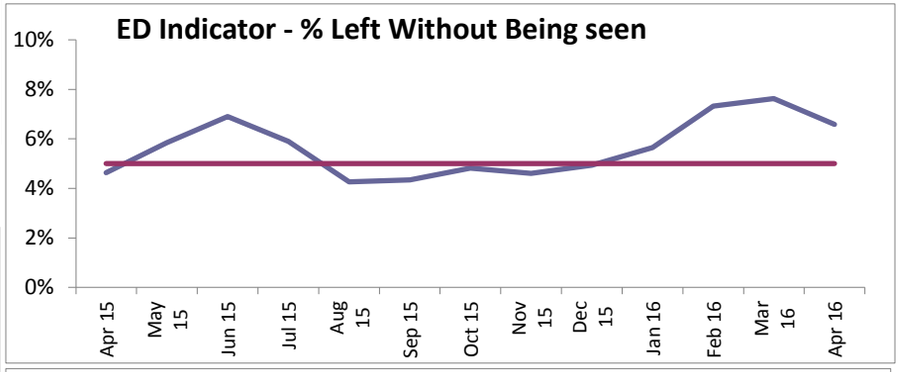


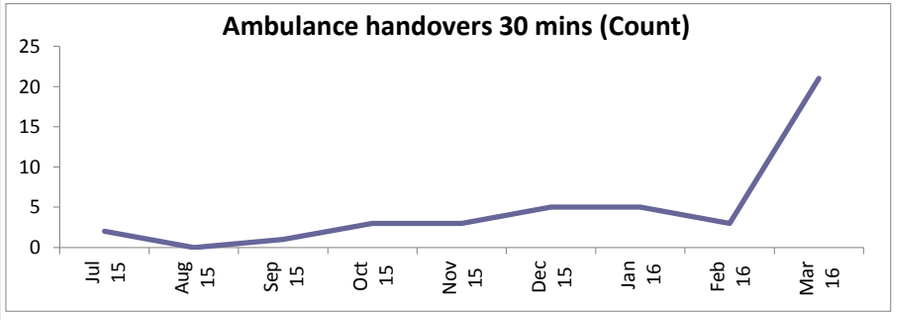
Emergency Care

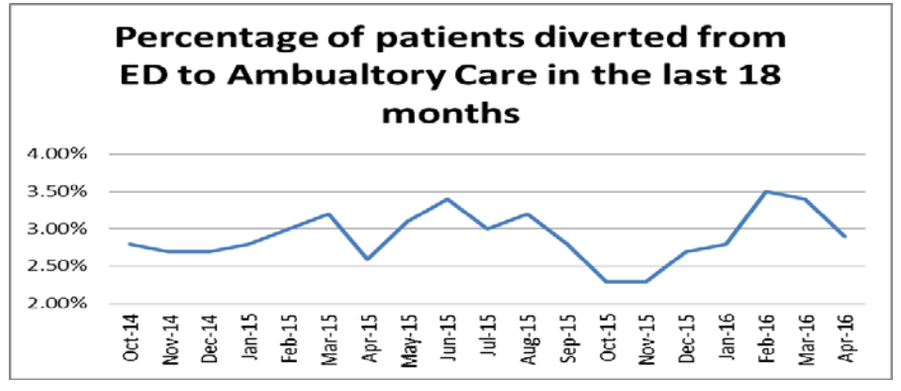
Whittington Health NHS

	Threshold	Trust Actual Mar-16	Trust Actual Apr-16	2016/17 Trust YTD
Emergency Department waits (4 hrs wait)	95%	81.8%	84.1%	84.1%
Emergency Department waits (4 hrs wait) Paeds only	95%	92.4%	93.3%	93.3%
Wait for assessment (minutes - 95th percentile)	<=15	19	19	19
ED Indicator - median wait for treatment (minutes)	60	103	88	88
Total Time in ED (minutes - 95th percentile)	<=240	537	504	504
ED Indicator - % Left Without Being seen	<=5%	7.6%	6.6%	6.6%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	21	arrears	-
Ambulance handovers exceeding 60 minutes	0	0	arrears	-
Ambulatory Care (% diverted)	>5%	3.4%	2.9%	









Commentary

Although all but one indicators have improved for April 16, all indicators remain below the threshold.

ED four hour wait continues to remain a significant challenge across the sector. Lack of available bed are an issue. On 12th May the CEO and COO hosted a workshop with Clinical Leads and managers to agree how we can improve LoS and flow. As a result of this an action plan will be tabled at TMG in June 2016.

Left without being seen remains above the 5% threshold. It should be noted the patients are taken off our EPR system, but any concerns are followed up by clinical staff contacting the patient's GP.

Ambulance handovers 30 minutes have increased significantly this month, due to congestion in ED. It is expect to reduce back to normal levels next month.

The number of patients **diverted to Ambulatory Care** has remained between 2 and 3.5% for the last 18 months. See graph to the right. A weekly monitoring plan is in place.

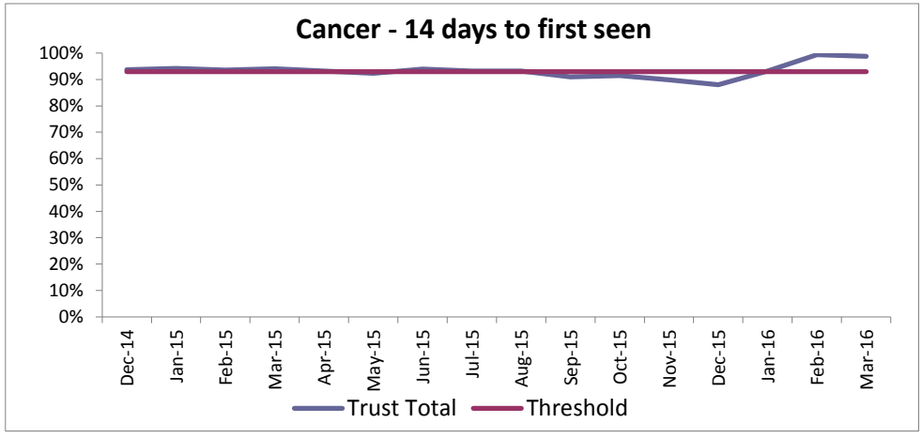
Cancer

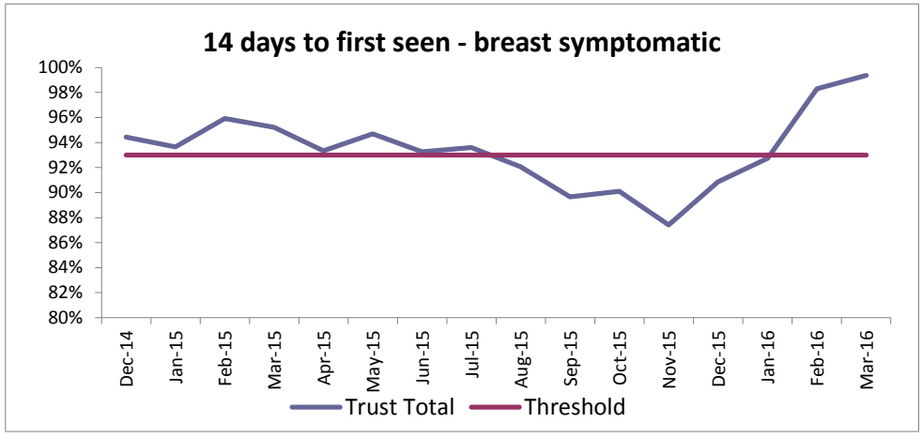
Whittington Health NHS

	Trust				2015/16 Trust				
	Threshold	Jan-16	Feb-16	Mar-16	Trend	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	93.2%	99.5%	98.8%		93.2%	92.5%	89.7%	97.4%	93.1%
Cancer - 14 days to first seen - breast symptomatic	93%	92.7%	98.3%	99.4%		93.6%	91.7%	89.4%	97.2%	93.1%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	97.7%		100.0%	100.0%	99.0%	99.1%	99.5%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	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%	93.5%	81.6%	88.5%		93.2%	85.5%	87.8%	87.8%	88.8%
Cancer - 62 days from consultant upgrade	-	50%	50%	50%		92.9%	83.3%	60.0%	50.0%	79.6%

Commentary

All targets achieved as expected for March 2016.





Maternity

Whittington Health NHS

	Threshold	Trust Actual Feb-16	Trust Actual Mar-16	Trust Actual Apr-16	2016/17 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	82.1%	81.3%	80.1%	80.1%
New Birth Visits - Haringey	95%	83.8%	85.7%	Arrears	-
New Birth Visits - Islington	95%	92.8%	94.7%	Arrears	-
Elective Caesarean Section rate	14.8%	13.1%	8.8%	10.5%	10.5%
Emergency Caesarean Section rate	-	17.5%	18.4%	14.2%	14.2%
Breastfeeding initiated	90%	91.5%	93.0%	90.9%	90.9%
Smoking at Delivery	<6%	7.4%	4.1%	4.4%	4.4%

Commentary

12+6

Issue: Remaining just below target. Service practises reviewed and planned changes to be put in place over the next months, including changes to triage, personalised letters and administrative processes, calling women to offer appointment dates and asking for the reason when DNA.

Action: A member of our bank staff has been requested to support the work, but has not yet started. Resulting in a further delay of expecting improvement. However, a weekly list from the IT system is pulled to identify late booked women and extra sessions are scheduled so the women can be booked within time.

Timescale: 3 to 4 months to implementation from May 16, expected to see improvement in August/September 2016

New birth visits

Issue:

Islington: improvement to 94.7% just shy of 95% target. 9 NBVs later than 14 days:

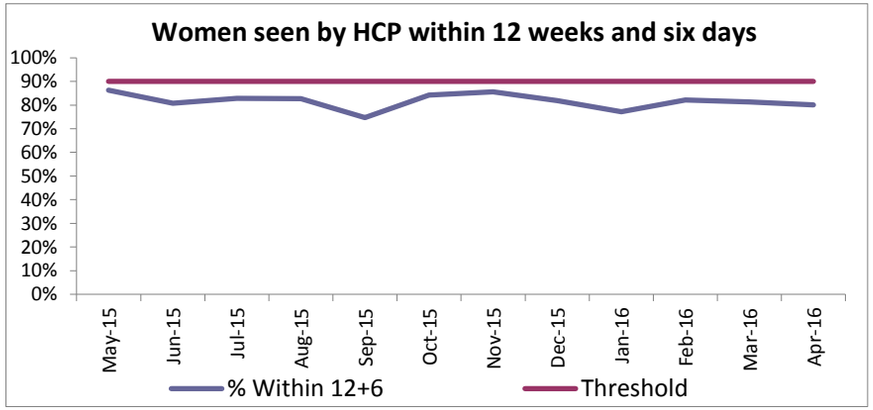
- 6 babies in hospital
- of the remaining 3 - 1x moved out; 1x a Hackney child and 1x late notification

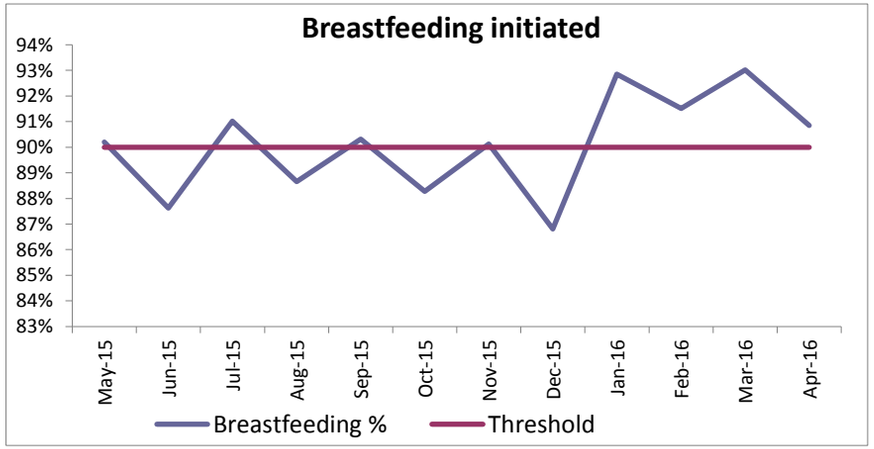
Haringey: improvement on previous month but still lower performance than expected at 85%. 46 late NBVs:

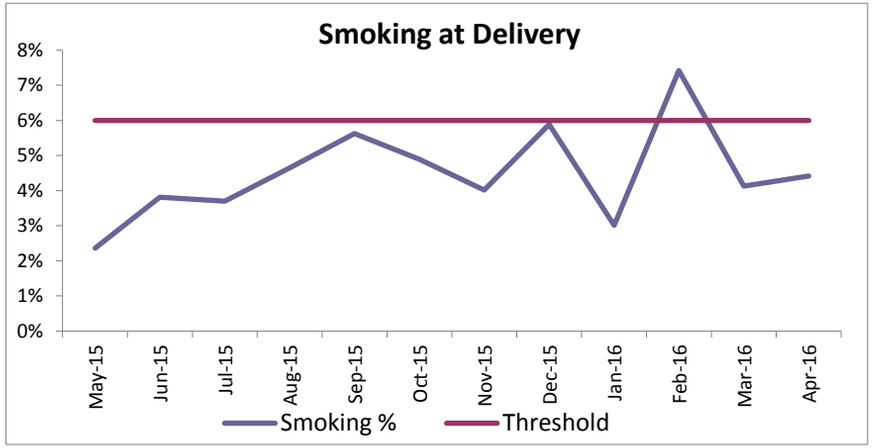
- 5 in hospital
- 9x parental request to change appointment / declined initial contact
- 6x late notifications / not on Monthly Team Planner in time
- 2x family staying with relatives elsewhere
- 7x HV capacity - sickness
- 1x interpreter not available
- remainder 16 no clear reason

Action: Continued workforce plan in place to mitigate. New staff in the process of starting.

Timescale: Ongoing







High Level Workforce Data

Whittington Health NHS

Q4 2015-2016

Metric	Target or Benchmark	Source	Apr-16	Notes and Definitions
Staff Headcount	Trust Annual Plan	ESR	**4,212**	No. of staff employed at the end of the quarter
Staff in Post (FTE)	Trust Annual Plan	ESR	**3,837.16**	No. of staff employed at the end of the quarter
Establishment (FTE)	Trust Annual Plan	Finance Ledger	**4,401.71**	
Bank and Agency Use(hours)		Bank Staff System	**8252.47**	This equates to around 220 fte
Vacancy Rate %	10%	Calculation	**9.5%**	The vacancy factor in qualified nursing has reduced from 21% to 13%. There is much focus on substantive recruitment to current HCA vacancies
Annual Turnover %	>13% - red 10-12% - amber <10% - green	ESR	**14.9%**	All areas in the trust are below the 13% threshold with the exception of: Nursing and Patient Experience, EUC 21, OPLTC , Finance 1 and CSS
Sickness %	> 3.5% - red 2.5-3.5% - amber <2.5% - green	ESR	**2.9%**	All areas are below 2.5% with the exception of : Facilities 5.26%, 4.48% Finance, OPLTC 4.27% WCF 3.42.
Appraisal Completion %	90%	ESR/OLM	**71%**	
Mandatory Training %	90%	ESR/OLM	**81%**	Percentage of staff compliant for mandatory training. Requirements vary by staff group and roles.

Estates and Facilities
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

1 June 2016

Title:	Estate Strategy Delivery Vehicle Option Appraisal		
Agenda item:	**16/089**	**Paper**	**09**
Action requested:	For approval		
Executive Summary:	This paper sets out the option appraisal that has been undertaken to select a preferred vehicle to support and enable the delivery of the Whittington Health Estates Strategy. Our Estates Strategy, our work with local commissioners and stakeholders, and the developing North Central London Service Transformation Plan has identified a number of Whittington Health estate investment requirements and possible opportunities to support us to deliver our mission to 'help local people live longer, healthier lives'. A number of key objectives for the delivery vehicle have been identified: ▪ To secure a delivery vehicle to drive the delivery of the estate strategy at pace. ▪ To create a long term, holistic, strategic estate master plan, and accompanying incentive based commercial master plan. ▪ To enable the Trust to access investment funding. ▪ To enable the rationalisation of the estate, in line with the clinical strategy, to drive value. ▪ To access commercial skills and expertise. ▪ To drive Estate based efficiencies. ▪ To create the capacity to support wider local health and social care integration objectives. Four delivery options have been considered: i) Traditional approach ii) Joint venture for single site/development opportunities iii) Joint venture for estate wide/development opportunities – Strategic Estates Partnership iv) Developer role Consideration of the delivery vehicle options has taken place within a number of Trust forums, including at Trust Board seminar and at Executive Team. In addition, a soft market sounding exercise has been undertaken to better understand the Strategic Estates Partnership Vehicle.		

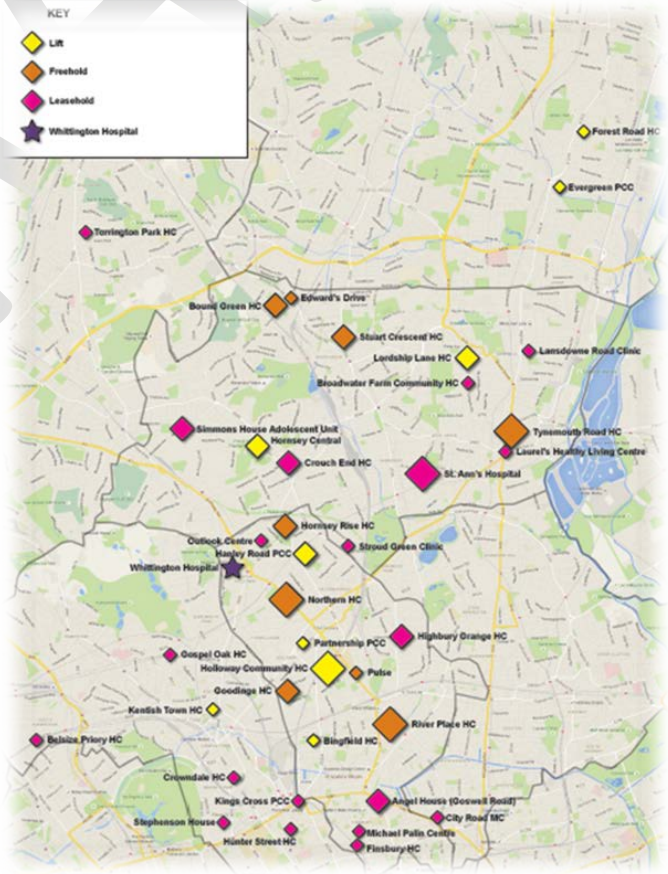
	The advantages and disadvantages of each option have been considered and a ranking exercise undertaken against the key objectives and a number of economic factors. The option appraisal recommends that the preferred delivery vehicle approach that the Trust should select to support and enable the delivery of the Whittington Health Estates Strategy is a Strategic Estates Partnership (SEP)
Summary of recommendations:	The Trust Board is asked to approve the recommendation to select a Strategic Estates Partnership delivery vehicle to support and enable the delivery of the Whittington Health Estates Strategy.
Fit with WH strategy:	Aligns to the Trust's Estate Strategy and Clinical Strategy
Reference to related / other documents:	NHS Planning Guidance 2016/17-20/21 Carter Review of Operational Productivity in NHS Providers June 2015 Five Year Forward View, NHS England
Reference to areas of risk and corporate risks on the Board assurance Framework	Captured on Corporate Risk Register
Date paper completed:	26th May 2016

Author name and title:		**Sophie Harrison Assistant Director of Estates**		**Director name and title:**		**Siobhan Harrington Deputy Chief Executive/Director of Strategy**	
Date paper seen by EC	**May**	**Equality Impact Assessment complete?**	**Y**	**Risk assessment undertaken?**	**Y**	**Legal advice received?**	**Y**

V.2

Whittington Health

Estates Strategy Delivery Vehicle - Option Appraisal



Section 1: Introduction and Background

1.1 Introduction

This paper sets out the option appraisal that has been undertaken to select a preferred vehicle to support and enable the delivery of the Whittington Health Estates Strategy.

Our Estates Strategy, our work with local commissioners and stakeholders, and the developing North Central London Service Transformation Plan has identified a number of Whittington Health estate investment requirements and possible opportunities to support us to deliver our mission to 'help local people live longer, healthier lives'. These requirements and opportunities include:

- Targeted investment in the hospital site is required to ensure the estate supports the delivery of high quality clinical services.
- Investment in, and rationalisation of, the community estate portfolio is required to support the development of integrated networks/hubs; provision of high quality clinical and patient care environments; and more efficient service delivery.
- Investment is required to maintain and develop high quality training and education facilities.
- Investment is required to deliver high quality staff residences.
- Investment and a change in working practices is required to enable non-clinical support and corporate services accommodation across the Trust estate to be rationalised and used more efficiently.

To meet these investment requirements, realise opportunities and deliver the extent and pace of change required, an option appraisal has been undertaken to select a preferred Estates Strategy delivery vehicle.

1.2 The Whittington Health Estate Strategy

The Whittington Health Estates Strategy was approved by the Trust Board on 3rd February 2016. The strategy provides a framework for future decision making on the future development and management of the Trust's estate for the period 2016 to 2021.

The strategy includes a review of the Trust's current estate, analysis of how our estate needs to develop to support the delivery of our five year clinical strategy, and sets out what is required and how this could be delivered.

- Estates Strategy Principles

The Estates Strategy outlines our commitment to providing high quality patient focussed environments, whilst balancing service delivery, affordability and risk. The key principles underpinning the strategy are described below:

Figure 1.1: Estate strategy principles

Estate Strategy Principles
Patient centred Improve the estate to be patient and client centred with ease of access to care, both physical access and transportation access; supporting the co-location of services to enable integrated care through the development of integrated networks/hubs.
Quality Improve the quality of the estate to meet patient and staff expectations**.**
Effective use of assets Maximise the effective use of the estate to support clinical service delivery.
Design Ensure that our estate has flexible and modern space in all our buildings.
Capacity Ensure that the Trust's estate has the capacity to meet demand for healthcare in the right places.
Statutory and non-statutory compliance Continue to manages estates risks and meet all necessary standards.
Future sustainability Ensure that the delivery of the estate strategy supports the future sustainability of the organisation in terms of quality, financially, effective working and environmental sustainability.
Partnerships and engagement Maximise the opportunity of partnerships and engagement with our local community and ensure Trust plans align with wider health economy plans.

1.3 The Whittington Health Estate

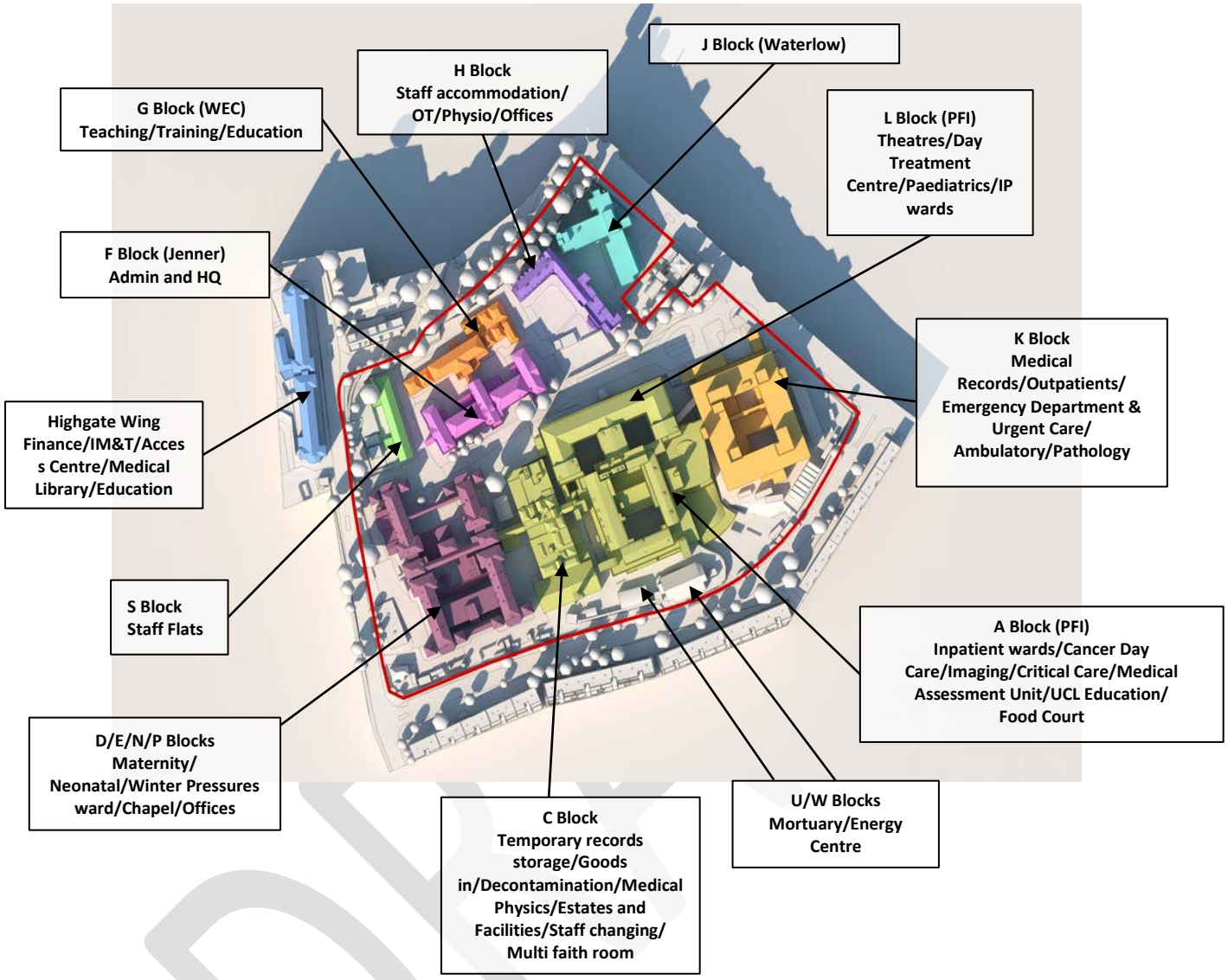
- **Hospital site**

The Whittington hospital site is located in the Archway/Highgate area of north London, within the London Borough of Islington, close to Archway Underground Station. The overall site area is approximately 4.6 hectares. The map at Fig 1.2 shows the main buildings at the hospital site, which provide floor space of over 70,000sqm. Buildings within the red line are owned by Whittington Health with the exception of Blocks A and L. Blocks A and L are operated under a 28 year arrangement with a special purpose vehicle formed to develop and maintain facilities on the site under a Private Finance Initiative (PFI) contract. This agreement ends in October 2034.

In addition to the hospital site, we offer staff accommodation under a partnership agreement with London Strategic Housing at a site nearby at Sussex Way, N19, and accommodate some corporate services in Highgate Wing, which is owned by a private landlord.

The site is bisected by a middle access road. Most clinical and patient activities take place south of this road. Buildings on the north of the site provide HQ, education, meeting or residence functions; and outpatient Physiotherapy and Occupational Therapy services. The Net Book Value of the hospital site buildings is £99.9m and £31.1m for the land.

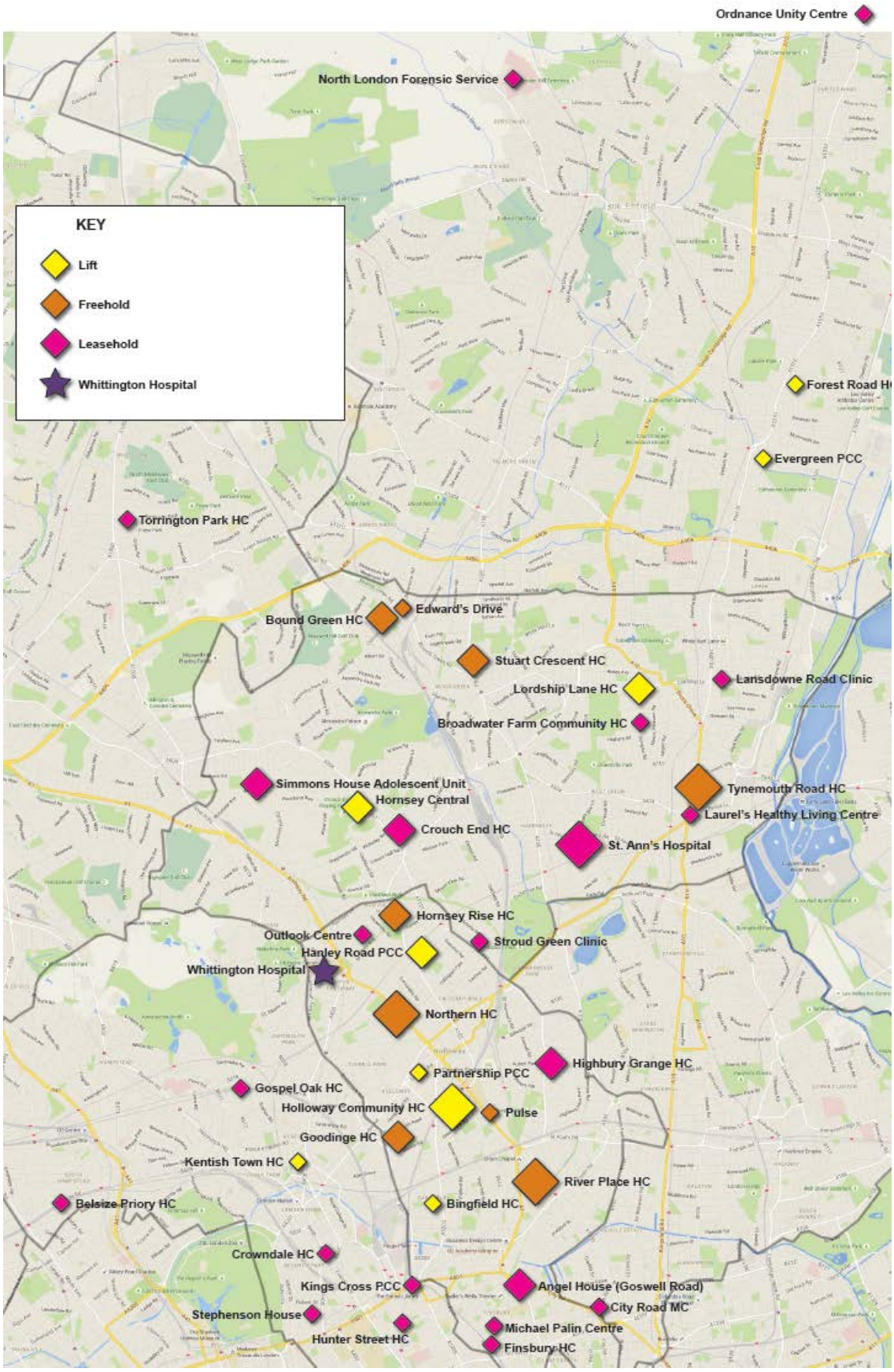
Figure1.2: Whittington hospital site – key buildings



- The community estate

Whittington Health occupies space in more than 39 properties located primarily in the London boroughs of Islington and Haringey, with smaller satellite sites for specific services located in the London boroughs of Camden, Barnet and Enfield. Figure 1.3 shows the location of the community premises by tenure and the borough boundaries of Islington and Haringey. Outside the main Whittington hospital site we have nine freehold premises and occupy space in eight Local Improvement Finance Trust (LIFT) premises, as well as space in other rented properties. The Net Book Value of the freehold community premises is £8.5m for land and £21m for buildings.

Figure 1.3: The community estate



Key findings about the estate are described below:

- Our current estates portfolio consists of a mixed position, with many buildings requiring significant improvement or redevelopment to address substantial functional suitability deficiencies. Our estate has developed in a reactive way as a result of historical artefact rather than as a response to delivering a clinical strategy.
- Overall total backlog costs for our estate (including uplift for works costs) are c. £23m.
- The majority of backlog maintenance costs relate to the hospital site in Blocks C, D, E, F, H and K.
- There are significant backlog maintenance and quality costs associated with the following community premises: The Northern; Hornsey Rise Health Centre; Highbury Grange Health Centre; Crouch End; and Lansdowne Road. And Finsbury Health Centre.
- Around a third of the hospital site was built pre 1948, with 18% built after 2005.
- We occupy space in more than 39 community premises, 9 of which are freehold and 8 are Local Improvement Finance Trust (LIFT) premises.
- LIFT premises provide higher quality environments, but are significantly higher cost per square metre than our other estate.
- We have a number of tenants in freehold properties who often provide complementary services.
- Nationally collected estates performance and cost data suggests we generally perform well – we are close to median values across a number of measures, with the main areas of lower performance relate to space per patient and single bedrooms.
- The 2014 Patient-Led Assessments of the Care Environment (PLACE) assessment shows that the main areas for improvement, in relation to the average, are privacy and dignity, and general building maintenance.
- Sustainability has been a priority for us and there has been some effective work done to minimise waste, promote efficiency, and contribute to the local community. We are also pursuing individual projects that improve environmental performance, such as RE:FIT.

1.4 External drivers for change

- **National**

The NHS is undergoing one of the most radical transformations in its history. In developing a strategy, it is important to be aware of the direction of national policy and the key national drivers of change. Transformation will have an impact on the estate of the Trust in terms of location, amount and style of facilities.

Although there is increasing demand for healthcare fuelled by a rising population and long-term and complex health conditions, alongside an increasing focus on quality and standards, there is no real growth in funding. Transformation programmes are expected to change "how and where" NHS Trusts deliver their services. This is coupled with significant financial and performance challenges posed by existing needs to produce efficiency savings.

Figure 1.4: National drivers for change

A number of factors are driving an increasing focus on quality and efficiency	
Overall	• Rising demand for healthcare faster than population growth Increasing focus on quality and driving quality through standards • Continuation of central designation process for specialist services • Increasing competition in healthcare provision
Emergency	• Rising emergency admissions across the UK with various policies in place to mitigate this Increased focus on standards especially senior presence and co-dependencies • Keogh work likely to lead to 'designation' of major emergency centres[1]
Elective	• Separation of emergency and elective activity to get better outcomes and efficiency • Significant growth in outpatients[2] • Increased tendering of services to external providers • Consolidation and specialisation to make most effective use of staff and equipment
Women and Children	• Birth rate increases minimal across the UK (increases locally will be high) • Increased consolidation and networking of maternity services to meet standards • Increased consolidation and networking of inpatient paediatric services to meet workforce requirements
Integrated Care	• Further pooling of money between health and social care (Better Care Fund[3]) • Movement towards capitation payments for cohorts of patients and provider partnerships to provide care for these cohorts • Increased GP responsibility for co-ordination of integrated care (e.g. named GP)
Cancer	• Cancer Centres to deliver specialised cancer care to populations of over 1,000,000 • Cancer Units to treat common cancers only with surgical sub-specialisation with sufficient volumes of activity • Close integration of primary and secondary care

- **Local Stakeholders**

We recognise and understand the importance of both working with our stakeholders and keeping them informed. We talked to many of our stakeholders during the development of our estates strategy in order to inform the shape our future direction.

Engagement took many forms, from informal drop-in sessions for staff, visitors and patients in the Whittington hospital reception area, to more formal meetings with MPs, the media and the Defend the Whittington Group. We are also an active member of the Haringey and Islington Estates Group which brings together representatives from the CCGs, local authorities and local provider trusts to develop an integrated approach to the future development of the overall estate.

The findings from these engagement opportunities demonstrated a wide spectrum of views on the future of our estate. However, there was recognition of the need and support for investment and change, supported by innovative and creative thinking.

[1] Transforming Emergency and Urgent Care Services in England, NHS England (2013)
[2] HES Hospital Outpatient Summary Report (2012-13)
[3] Health, wellbeing and adult social care, Local Government Association (2014)

- **Haringey and Islington CCGs, London Boroughs and local Providers**

In June 2015, the Department of Health and NHS England asked Clinical Commissioning Groups to develop Local Strategic Estate Plans. Subsequently, NHS Planning Guidance 16/17-20/21 outlines a NHS England priority to ensure CCG's local estates strategies support the overall goal of utilising opportunities reinvestment.

The Local Strategic Estate Plan is intended to support the health economy to create a fit for purpose estate at less cost, specifically addressing:

- changes in demography and population demand;
- changes in the way that health care services are provided – specifically reflecting plans for integrated health and social care, greater levels of care within communities and new commissioning models;
- challenges in funding and affordability.

Representatives from CCGS, local authorities and local provider trusts have been meeting as the Haringey and Islington Estates Group to develop a joint Haringey and Islington strategic estates plan.

- **North Central London devolution pilot**

North Central London (NCL) Clinical Commissioning Groups and Councils, in discussion with local Providers, have been successful in bidding to establish a NCL devolution pilot for estates. The pilot aims to develop the estate needed for new models of care, by optimising assets to reinvest in health and care and support wider benefits for local communities

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Section 2: Option Appraisal

2.1 Delivery Vehicle Objectives

The Trust has identified a number of key objectives for the Estates Delivery vehicle that is selected:

- To secure a delivery vehicle to drive the delivery of the estate strategy at pace.
- To create a long term, holistic, strategic estate master plan, and accompanying incentive based commercial master plan.
- To enable the Trust to access investment funding.
- To enable the rationalisation of the estate, in line with the clinical strategy, to drive value.
- To access commercial skills and expertise.
- To drive Estate based efficiencies.
- To create the capacity to support wider local health and social care integration objectives.

In addition, there are a number of economic factors to be considered:

- Cost of funding for strategic estates services
- Availability of funding for strategic estates services
- Cost of funding for projects
- Availability of funding for projects
- Up front set up costs

2.2 Delivery Vehicle Options

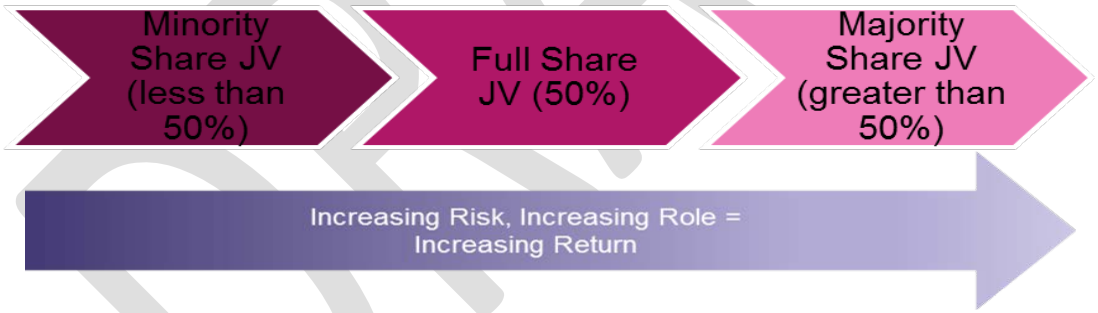
The Trust has identified a number of delivery vehicle approaches that could be adopted to deliver the Estates Strategy, as follows:

i) Traditional approach

- In-house team to develop plans and lead delivery of estates solutions (aligning estate to clinical strategy and management of projects/procurement of supply chain for delivery).
- Procure professional advisors to support in-house team
- Use surplus revenue - if available
- Secure capital through the NHS and/or disposing of surplus land and property

ii) Joint venture for single site/development opportunities

Various forms of JV exist (contractual or corporate) for the delivery of single site development opportunities. This type of JV arrangement is beyond a service based contractual partnership arrangement (for which there are also a number of examples of short-long term partnership arrangements, for the delivery of estate solutions that seek to drive efficiencies from the estate and deliver an estate strategy) which would involve the Trust taking a degree of risk alongside a partner for individual land/site development opportunities. Individual JV arrangements for a single site/asset development opportunity offer the opportunity for the Trust to share in risk and reward. There are a range of JV options available for a single solution development opportunity



Note: A single site solution JV will still be possible for the delivery of projects/development opportunities through options (i) (ii) and (iv).

iii) Joint venture for estate wide/development opportunities

- Estate wide Local Asset Backed Vehicle ("LABV")
  - Limited liability special purpose vehicle owned 50:50, with the specific purpose of carrying out development of a portfolio of assets.
  - The public sector invests property assets into the vehicle which are then “value matched”, by cash/resource by the JV partner.
  - The partnership may then use these assets as security to raise finance to bring forward further development.

- The partners are equal equity holders and share profits equally, according to their original equity contribution.
- The JV partner procured will have an exclusive arrangement with the public sector to deliver all development opportunities for the duration of the partnership.

This option is rejected at this stage due to (a) the limited pipeline of development opportunities envisaged by the Trust and the expectation for development by the JV partner; and (b) the expectation that land/assets would transfer into the LABV for each development opportunity.

- Strategic Estate Partnership (SEP)
  - Non-exclusive, 50:50 JV arrangement between the Trust and a JV partner.
  - Strategic, holistic approach to drive efficiency and optimise value across the whole estate (from an operational estate perspective, delivery of the estate strategy and new development opportunities).
  - "Integrator" role of the JV partner in relation to any works/supply chain/investment partner required to implement a 'new project' (new facility/development).
  - Flexible, bespoke funding and contractual solutions for delivery for individual projects (which may or may not include the transfer of land into the JV/subsidiary).
  - JV partner investment, working capital and resource.
  - Secondary EU compliant procurement required for the provision of construction and FM work packages for the delivery of any new capital development.

iv) Developer role

- Highest risk option that has the potential to deliver the highest return.
- Trust would develop new facility/assume developer role on an individual development/site basis.
- Reliance on design and development team already assembled (and procured by Trust).
- High risk but some risks can be mitigated (e.g. through agency advice, development management, cost management expertise).

2.3 Consideration of options

Consideration of the delivery vehicle options has taken place within a number of Trust forums, including at Trust Board seminar and at Executive Team. In addition, a soft market sounding exercise has been undertaken to better understand the Strategic Estates Partnership vehicle.

The advantages and disadvantages of each option have been considered and are documented at section 2.4.

2.4 Options – advantages and disadvantages

- Traditional

Advantages	Disadvantages
Trust knows best what it wants/Trust in control. Processes are known and understood - no need for complex/unfamiliar JV arrangements. Any income/receipt generated is retained by Trust (subject to approvals). Does not expose the Trust to commercial risk.	Reliant on existing Trust capacity and capability, or reliant on procuring/briefing managing multiple external advisors Likely to be one scheme at a time approach. Loss of potential benefit through cross subsidisation sequencing and prioritisation of schemes to maximise value. Limited opportunity for development of a master plan for wider estate and holistic longer term perspective. Multiple procurements required for individual schemes. Co-ordination/direction of external advisors required. No built in incentive for pace and efficiencies. Reliant on NHS capital, existing revenue, income from disposals. Fragmentary - lost opportunity costs. No share of financial return. No gain from potential JV partner efficiencies and commercial opportunities.

- JV single site development solution

Advantages	Disadvantages
Brings additional capacity and capability. Trust can focus on core business. Provides access to JV partner finance and management expertise - partners could bring external funding sources. Degree of risk share dependent on level of return Trust requires. Contractual Structure in place with agreed KPIs. Profit share with partner depending on risk and reward.	Likely to be one scheme at a time approach. Limited opportunity for development of a master plan for wider estate and holistic longer term perspective - Trust would need to develop its own master plan. Loss of potential benefit through cross subsidisation, sequencing and prioritisation of schemes to maximise value. Limited incentive for partners to consider longer term delivery. Limited built in incentive for pace and efficiencies. Time consuming to manage – contract management or Board structure. Multiple procurements needed for individual schemes. JV arrangements more complex than traditional delivery vehicles. Will be sharing of any returns – depending on nature of arrangement and how much risk the Trust is prepared to take. Still fragmentary – likely to be lost opportunity costs.

- JV – Whole Estate SEP

Advantages	Disadvantages
Brings additional capacity and capability. Trust can focus on core business. Opportunity for holistic view of Trust needs and development of solutions - Master plan would be the initial output . Potential benefit through cross subsidisation, sequencing and prioritisation of schemes to maximise value. Opportunity for partner to develop familiarity with Trust and partners and their needs. Long term arrangement – production line of schemes more likely. Partner only gets rewards if schemes are implemented – incentive for delivery. Non-exclusive arrangement. Provides access to JV partner investment working capital and expertise. Degree of risk dependent on level of return Trust requires – opportunity for considerable risk to be transferred away from the Trust if desired.	JV will require effective control through JV structure. JV arrangements more complex than traditional delivery vehicles. Dependent on Trust and partner agreeing on schemes to be implemented. Delivery vehicles for each scheme will still need bespoke arrangements and may require multiple procurements. Corporate JV needs initial TDA approval – once partnership in place light touch for subsequent approvals for individual schemes. JV arrangements more complex than traditional delivery vehicles. Will be sharing of any returns – depending on nature of arrangement and how much risk the Trust is prepared to take.

- Trust as Full Developer

Advantages	Disadvantages
Trust knows best what it wants/Trust in control. No need for complex/unfamiliar JV arrangements. Any income/receipt generated is retained by Trust (subject to approvals). High potential returns.	Reliant on existing Trust capacity and capability or on procuring/briefing managing multiple external advisors as requires commercial skills which are not core to the Trust. Co-ordination/direction of external advisors required. Likely to be one scheme at a time approach. Limited opportunity for development of a master plan. Multiple procurements required for individual schemes. No built in incentive for pace. May require more NHS capital, existing revenue, income from disposals upfront to fund development costs. Business cases would require extensive scrutiny. Trust bears risk 100%.

2.5 Option appraisal

An option appraisal, using a ranking system, has been undertaken using the delivery vehicle objectives and considering a number of economic factors. The appraisal has built on the discussion and consideration of options undertaken by the Trust Board and Executive Team. See Table 2.1 for the results of the appraisal.

2.6 Recommendation

Following the delivery vehicle option appraisal the Trust Broad is recommended to select a Strategic Estates Partnership as the preferred delivery vehicle approach to support and enable the delivery of the Whittington Health Estates Strategy.

Table 2.1: Option Appraisal

	Criteria		Traditional	JV single development solution	JV – Whole Estate SEP	Trust as Full Developer
Benefits						
1	To secure a delivery vehicle to drive the delivery of the estate strategy at pace.		2=	2=	1	4
2	To create a long term, holistic, strategic estate master plan, and accompanying incentive based commercial master plan.		2=	3	1	2=
3	To enable the Trust to access investment funding.		4	2=	1	2=
4	To enable the rationalisation of the estate, in line with the clinical strategy, to drive value.		2	4	1	3
5	To access commercial skills and expertise.		2=	2=	1	2=
6	To drive Estate based efficiencies.		2	3=	1	3=
7	To create the capacity to support wider local health and social care integration objectives.		2	4=	1	4=
Economic factors						
1	Cost of funding for strategic estates services		2=	2=	1	2=
2	Availability of funding for strategic estates services		2=	2=	1	2=
3	Cost of funding for projects		1	3	2	1
4	Availability of funding for projects		4=	2	1	4=
5	Up front set up costs		1	3=	2	3=
	Overall ranking		**2**	**4**	**1**	**3**

Section 3: Scope and Structure of a SEP

A Strategic Estates Partnership (SEP) would work alongside the Trust in providing an intelligent estates strategy function that supports the Trust's clinical strategy (and wider local commissioning plans) to enable service change, improve the quality of care for residents and drive value and efficiency from the Trust's estate through: estates rationalisation; capital programme planning; strategic master-planning; delivery of the Trust's estate strategy and key priority capital projects, identification of wider commercial (and income generation) opportunities, raising finance and investment; strategic service transformation planning and also the provision of procurement support to the Trust and project/contract management of a range of services in relation to the delivery of new capital projects.

A SEP would be procured by the Trust with the key outcomes that the Trust will require the SEP to deliver set out in detail in the Invitation to Participate in Competitive Dialogue (ITPD), issued to those partner organisations with whom the Trust will enter into dialogue with following evaluation of responses to a Pre-Qualification Questionnaire.

It is proposed that the partnership would be for a term of 10 years with a Trust option to extend by a further 5 years. However, the partnering activities may give rise to new capital projects ("New Projects") or other estate solutions that last beyond the term of the 10 - 15 year partnership, delivered through separate commercial and funding arrangements (and project documentation).

It is proposed that the SEP will be set up as a corporate joint venture with the Partner and Trust incorporating a 50:50 joint venture limited liability partnership ("JV LLP"). The commercial structure will be subject to Trust Board and Trust Development Authority ("TDA")/NHS Improvement ("NHSI") approval.

It is envisaged that the Partner and Trust will enter into a Partnering Agreement and an LLP Agreement developed during the competitive dialogue procurement with the Bidders.

As part of the competitive dialogue procurement Bidders will be required to submit an Initial Partnership Plan. The Initial Partnership Plan shall become the overarching plan adopted by the partnership setting out the proposals for transforming the estate over the short medium and long term, identifying the delivery of the key priority projects and wider estate solutions to optimise efficiencies and value from the Trust estate. At the time the Trust enters into the SEP, it is expected that the Initial Partnership Plan will be a fully worked up business plan for the SEP, identifying resources, working capital requirements for the SEP and priorities for delivery within the first year to allow the Trust to deliver at pace its requirements. The Initial Partnership Plan will be appended to the LLP Agreement.

Section 4: Next Steps

Following receipt of approval to proceed with the procurement from NHS Improvement, the Trust would wish to proceed at pace to procure and establish a Strategic Estates Partnership.

The table at Table 4.1 gives an indication of the key milestones and an indicative timetable for completion of the SEP procurement.

Table 4.1: Key Milestones and indicative timetable

Milestone	**Date**
Procurement documentation prepared	June 2016
OBC approval by TDA	End June/July 2016
OJEU placed	July 2016
PQQ responses returned	August 2016
Trust approval of bidder shortlist and ITPD issues	End August 2016
Dialogue phase 1	September to early October 2016
Dialogue phase 2	Mid October to mid November 2016
Issues of "Invitation to Submit Final Tenders" (ISFT)	Mid November 2016
Evaluation of ISFT and preferred Bidder recommendation	End November to Mid December 2016
Preferred Bidder appointed	Mid December 2016
Confirming Commitments with Preferred Bidder and Contract Documents finalised	Mid December – Mid January 2017
Contract Close	End January 2017
JV operationalised	February 2017

Trust Board 1 June 2016

Title:	Clinical Collaboration						
Agenda item:	**16/090**		**Paper**		**10**		
Action requested:	To approve						
Executive Summary:	It is proposed that UCLH Foundation Trust and the Whittington Health establish a formal clinical collaboration board with the following objectives: • To work with the wellbeing partnership in Islington and Haringey to deliver the service improvements in the priority areas of: ➢ Services for older people ➢ Musculo-skeletal services ➢ Cardiovascular and diabetes services • To explore and identify other areas of potential collaboration at specialty level ensuring • a sustainable and viable future • To explore other areas of partnership with regard to the provision of corporate services; including for example workforce development, teaching and research • To work with partner organisations in the wellbeing partnership to explore potential organisational forms for the future						
Summary of recommendations:	The Boards of both organisations to agree this approach in order to establish the clinical collaboration board with agreed terms of reference and action plan to be agreed by the end of June 2016						
Fit with WH strategy:	Aligns with population health approach and Clinical Strategy						
Reference to related / other documents:	Complies with national policy and Trust duty to provide VFM, high quality and safe services						
Reference to areas of risk / BAF:	Captured on relevant Risk Register						
Date paper written:	25 May 2016						
Author name and title:	**Simon Pleydell, Chief Executive**		**Director name and title:**		**Simon Pleydell, Chief Executive**		
Date paper seen by TMG	**May 16**	**Equality Impact Assessment complete?**	**N/A**	**Quality Impact Assessment complete?**	**Y**	**Financial Impact Assessment complete?**	**Y**

PROPOSAL FOR ESTABLISHING A FORMAL COLLABORATION BETWEEN UNIVERSITY COLLEGE HOSPITAL FOUNDATION TRUST AND WHITTINGTON HEALTH NHS TRUST

1.0 BACKGROUND

A number of important factors have emerged in recent months to provide a real impetus for the two organisations to explore the benefits of working more closely together:

- The sustainability and transformation planning process across North Central London.
- The development of the Wellbeing partnership for the population of Islington and Haringey (see attached Annex A).
- The current national exploration of new forms of health and social care organisations, especially for the development of population Health based organisations.

Both organisations provide local hospital services to the people of Islington. This is based on approximately a 50% share each of local district acute services, split on a geographical north/south basis, with Whittington Health providing the community services for the whole population. There is a compelling logic for appropriate local acute services to work to deliver services against common standards, pathways and levels of integration with community and primary care. In addition, whilst endorsing the commitment for both organisations to maintain the delivery of services in a local setting, there is a need to explore what other benefits can be achieved through closer collaboration at an individual specialty level.

2.0 PRINCIPLES OF COLLABORATION

In order to instil collective confidence in the collaborative process between the organisations a number of key principles must be agreed and adhered to.

These are as follows:

- Work should be led by clinicians from participating specialties.
- To work to common standards and service pathways across the population served.
- To draw on the skills and experience of both Trusts to develop the quality of services.
- To be mindful of the critical relationships between specialties and support functions that ensures the future viability of services on any particular site.
- To protect access and the availability of services for people locally.
- To generate plans and solutions that deliver sustainable and viable services in overall terms against agreed national and local standards.

3.0 PROPOSAL

It is therefore proposed that UCLH Foundation Trust and the Whittington Health establish a formal clinical collaboration board with the following objectives:

- To work with the wellbeing partnership in Islington and Haringey to deliver the service improvements in the priority areas of:

    - Services for older people
    - Musculo-skeletal services
    - Cardiovascular and diabetes services

- To explore and identify other areas of potential collaboration at specialty level ensuring
  a sustainable and viable future.

- To explore other areas of partnership with regard to the provision of corporate services; including for example workforce development, teaching and research.

- To work with partner organisations in the wellbeing partnership to explore potential organisational forms for the future.

4.0 RECOMMENDATION

The Boards of both organisations to agree this approach as soon as possible in order to establish the clinical collaboration board with agreed terms of reference and action plan to be agreed by the end of June 2016.

Whittington Health Trust Board

4 May 2016

Title:	**APPENDIX A** - The Wellbeing Partnership - Working side by side in Haringey and Islington		
Agenda item:	**16/090**	**Paper**	**10**
Executive Summary:	The 'Wellbeing Partnership' is the coming together of NHS organisations and local authorities in Haringey and Islington. It is driven by a shared recognition that major changes are needed to ensure that health and care services are of the right quality and capable of meeting the future needs of our local communities. We know that our health and care system cannot be sustained in its current form. For Islington and Haringey that means helping our populations to live healthier lives and retain their independence for longer. It means using technology to make sure that people have the information that they need, in the way that they want it, so that they are more in control. It means taking a shared responsibility across health, housing, education, welfare and social care rather than passing people between agencies. It means recognising the links between mental and physical health. It means never passing up an opportunity to grow and learn from great practice within and outside our Boroughs. We do not want to create a system we cannot sustain and neither do we want to cut care down to the core. That means changes for people: across public services, voluntary organisations and, most importantly, for the people living in Haringey and Islington. This reports sets out the latest partnership working and is being provided to Haringey & Islington Trust Boards in May.		
Summary of recommendations:	The Board are asked to support the development and delivery of the Haringey & Islington health & care 'Wellbeing Partnership'. And to agree the recommendation for the next phase of work as described in section 7 of the report summarised below: **7.1 Population based and health & care pathways:** • A model of care that supports independence in older people with health and social care needs. • A re-designed musculoskeletal care pathway • An integrated model of care for people with learning disabilities • A model of care that improves the prevention, identification and management of diabetes and cardiovascular disease. The cross cutting themes across all these four areas will include: sustaining good mental health, prevention, action on the wider determinants of health including housing and environment, early identification and diagnosis of illness, maintaining independence. **7.2 Forms of Health & Care** In addition, an important area of work will focus on future care models; identifying the range of options which might be most appropriate for		

	providing health & care and commissioning health & care. We propose to undertake detailed financial modelling of savings and investments required across the whole system and look at additional key enablers: workforce, IT, estates.
Fit with WH strategy:	This report aligns with partnership working across NCL
Reference to related / other documents:	National policy and WH strategy
Reference to areas of risk and corporate risks on BAF	Risks captured in risk registers and/or Board Assurance Framework.
Date paper completed:	27 April 2016

Author name and title:		Anni Hartley-Walder Programme Director		**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**

1 Purpose of the report

The Board are asked to support the development and delivery of the Haringey & Islington health & care 'Wellbeing Partnership'. And to agree the recommendation for the next phase of work as described in section 7.

2 Background

The 'Wellbeing Partnership' is the coming together of NHS organisations and local authorities in Haringey and Islington. It is driven by a shared recognition that major changes are needed to ensure that health and care services are of the right quality and capable of meeting the future needs of our local communities.

We know that our health & care system cannot be sustained in its current form. For Islington and Haringey that means helping our populations to live healthier lives and retain their independence for longer. It means using technology to make sure that people have the information that they need, in the way that they want it, so that they are more in control. It means taking a shared responsibility across health, housing, education, welfare and social care rather than passing people between agencies. It means recognising the links between mental and physical health. It means never passing up an opportunity to grow and learn from great practice within and outside our Boroughs.

We do not want to create a system we cannot sustain and neither do we want to cut care down to the core. That means changes for people: across public services, voluntary organisations and, most importantly, for the people living in Haringey and Islington.

3 Why have Haringey and Islington organisations chosen to work together?

3.1 Haringey and Islington have a similar population:

- Combined population c. 500,000 with expected growth of 14% in the next 15 years.
- Ageing population – highest growth in those aged 65+ (48%) although this age group remains the smallest in absolute numbers.
- Deprived and affluent neighbourhoods side by side
- High population churn

3.2 Our populations have similar health and care needs:

- Overall life expectancy is increasing in both boroughs however people live (on average) the last 20 years of their life in poor health.
- Similar prevalence of lifestyle risk factors
- Similar prevalence of long term conditions (LTC) (20% of overall population living with LTC). This means more long term, complex illness and disability - increasing demand for health and social care. There is also inequality, with deprived communities experiencing more illness and shorter lives than those in more affluent areas.
- High prevalence of severe mental ill health and high rates of co-morbidities in people with mental ill health

3.3 We have shared ambitions

- We are committed to change: to fitting our organisations and care around people's needs. We need to focus now on people whose needs are complex and who need coordination, quick help and support to remain as independent as possible. Too often people experience form filling and multiple referrals. Currently we make people fit in and around our own organisations.
- We want to provide world class care when people need it.

To do this we need enable those who are well to stay healthy and to support those whose lifestyle puts them at risk to make healthier choices. Our local plans for housing, for schools, for employment, for business as well as for health services all need to support this. But agencies alone do not drive change. People, technology, communities will drive innovation and we will respond.

- Within and across different public sector organisations we are willing to work together. To listen carefully to our diverse populations; to challenge ourselves, to innovate and to learn from our staff and our residents who hold the answers to how health and care could be improved.

3.4 We have a shared 'vision'

Our commitment is to support our population to live healthier, happier and longer lives. We will improve health and care so people get more joined up, better quality services. There will be a focus on preventing poor health, as well as better outcomes when people need care and treatment.

At the same time given the financial pressures on us all, we need to make sure services are of value, affordable and fit for the future.

We will work together linking our residents and patients, hospitals, voluntary and community organisations, mental health services, social care and primary care services, in a system with one shared commitment to achieve our vision.

4. How will the Wellbeing Partnership work together?

The current Wellbeing partner organisations are:
Haringey Council, Islington Council, Whittington Health, Camden & Islington NHS Foundation Trust, Islington Clinical Commissioning Group, Haringey Clinical Commissioning Group. Other health providers have been involved during the preparation work and will further join in with the partnership as the work plan is developed. We are building an extensive stakeholder group to be engaged in the workplan, including the voluntary and third sector, our workforce, Healthwatch and other community, public, patient and service user representative groups.

We have established some agreed principles which are summarised here:

- Partner organisations will work together for the benefit of local people
- We will involve local people in our design, planning and decision-making
- Partner organisations will find innovative ways to cede current powers and controls to explore new ways of working together
- We will be open, transparent and enabling in sharing data, information and intelligence in all areas including finance, workforce and estates
- Partner organisations have agreed to find ways to 'risk share' during transformational change.
- We will find ways to share joint incentives and rewards.
- Partner organisations will make improvements by striving to be the best, together.
- We will be rigorous in ensuring value for money and financial sustainability.

5. How does the Wellbeing Partnership fit with the North Central London Sustainability & Transformation Plans (STPs)?

NHS England has mandated all areas of the country to be part of a predetermined local footprint that will prepare health and social care sustainability and transformation plans for 2016-2021. Haringey & Islington are part of the North Central London (NCL) footprint.

The Chief Officers of the Wellbeing Programme are all actively engaged and in some instances, leading, key areas of work in the NCL STP. We are well represented on the NCL Transformation Board and other key workstreams. There will be some areas of transformation and change

where there will be clear benefits from working collaboratively across the wider NCL footprint. In time it will provide access to central funding for transformation activity.

The critical question posed by the Wellbeing Partnership will always be: how will the proposed NCL plans benefit the residents of Haringey & Islington. There may well be local Wellbeing Partnership initiatives that may be more appropriate to local needs. And where the Wellbeing Partnership makes proposals for change, we will not suggest unnecessary delay because of the NCL STP, where there is no perceived material benefit to local people either in terms of financial sustainability or in terms of quality of service delivery.

6. Wellbeing Partnership preparation work

We started working together to establish the Wellbeing Partnership late in 2015. We held a major stakeholder event in the autumn and a clinical & care practitioners' event early in 2016.
We took all the information and learning found in each organisation from what our workforce and local people told us in the past about their experience of health and care.
Using all available information to inform future plans, we grew our understanding of the health needs of the local population and the evidence of what is working well locally. We have identified some priority area in population segments and clinical & care pathways.
We have looked at local 'good practice and innovation': to see where we might scale up across the partnership as a 'quick win' for positive change.
We have undertaken an outline financial analysis, identifying the precise scale of the financial challenge and are working out what the potential is for efficiencies and what requires bigger changes across the whole system.
We have set up a programme structure to take forward an agreed workplan which recognises current governance and decision making within the health and care systems.

7. The Wellbeing Partnership: what next – recommended priority work programme.

Using all the information and data described above, the Wellbeing Partnership has identified the following key priorities areas for the next phase of work. It is proposed to engage in co-production with key stakeholders, develop detailed scoping work and business cases for each of the pathways to identify the opportunities for working together in a different way.

7.1 Population based and health & care pathways:

- A model of care that supports independence in older people with health and social care needs.
- A re-designed musculoskeletal care pathway
- An integrated model of care for people with learning disabilities
- A model of care that improves the prevention, identification and management of diabetes and cardiovascular disease.

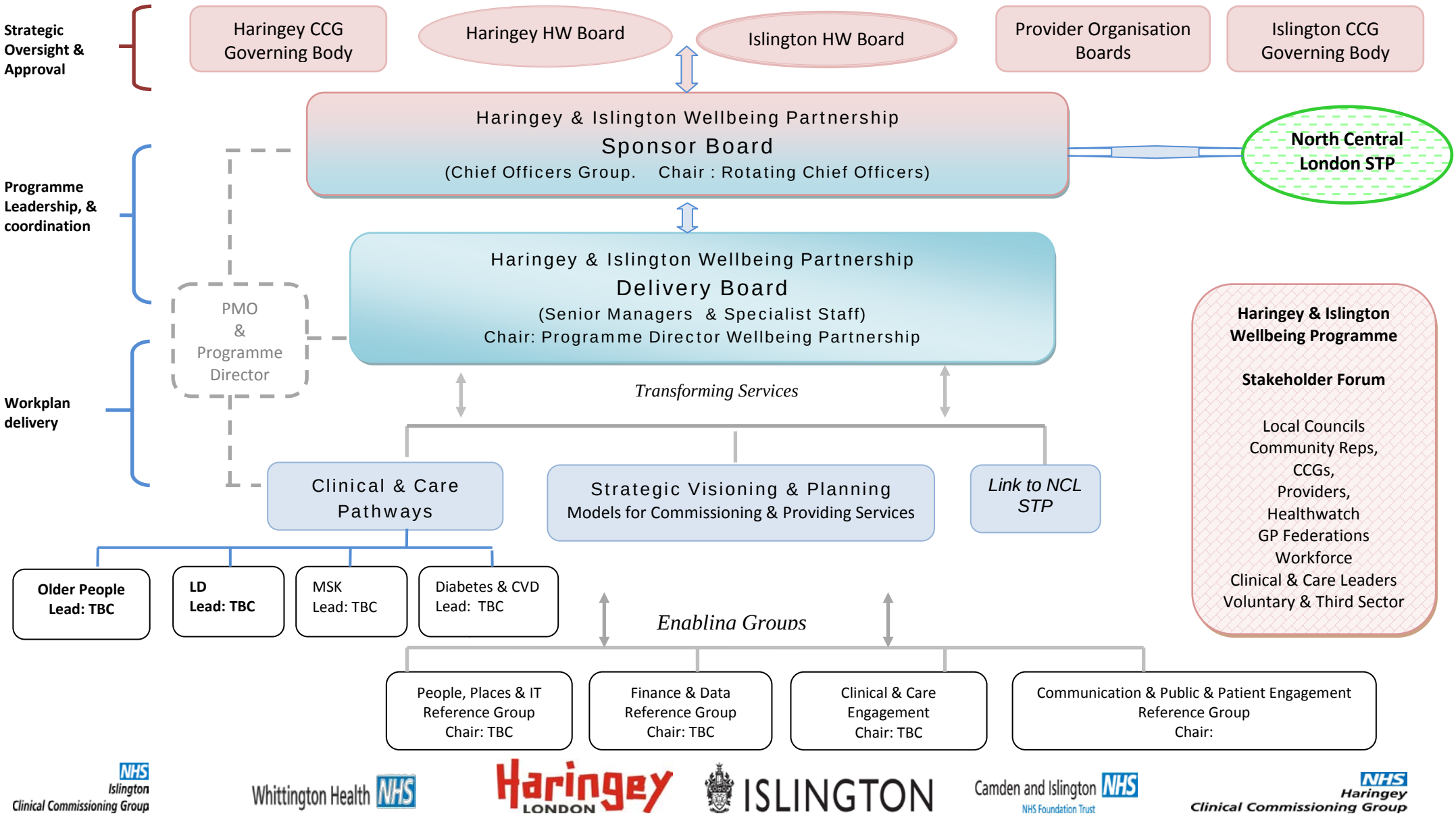
The cross cutting themes across all these four areas will include: sustaining good mental health, prevention, action on the wider determinants of health including housing and environment, early identification and diagnosis of illness, maintaining independence.

7.2 Forms of Health & Care

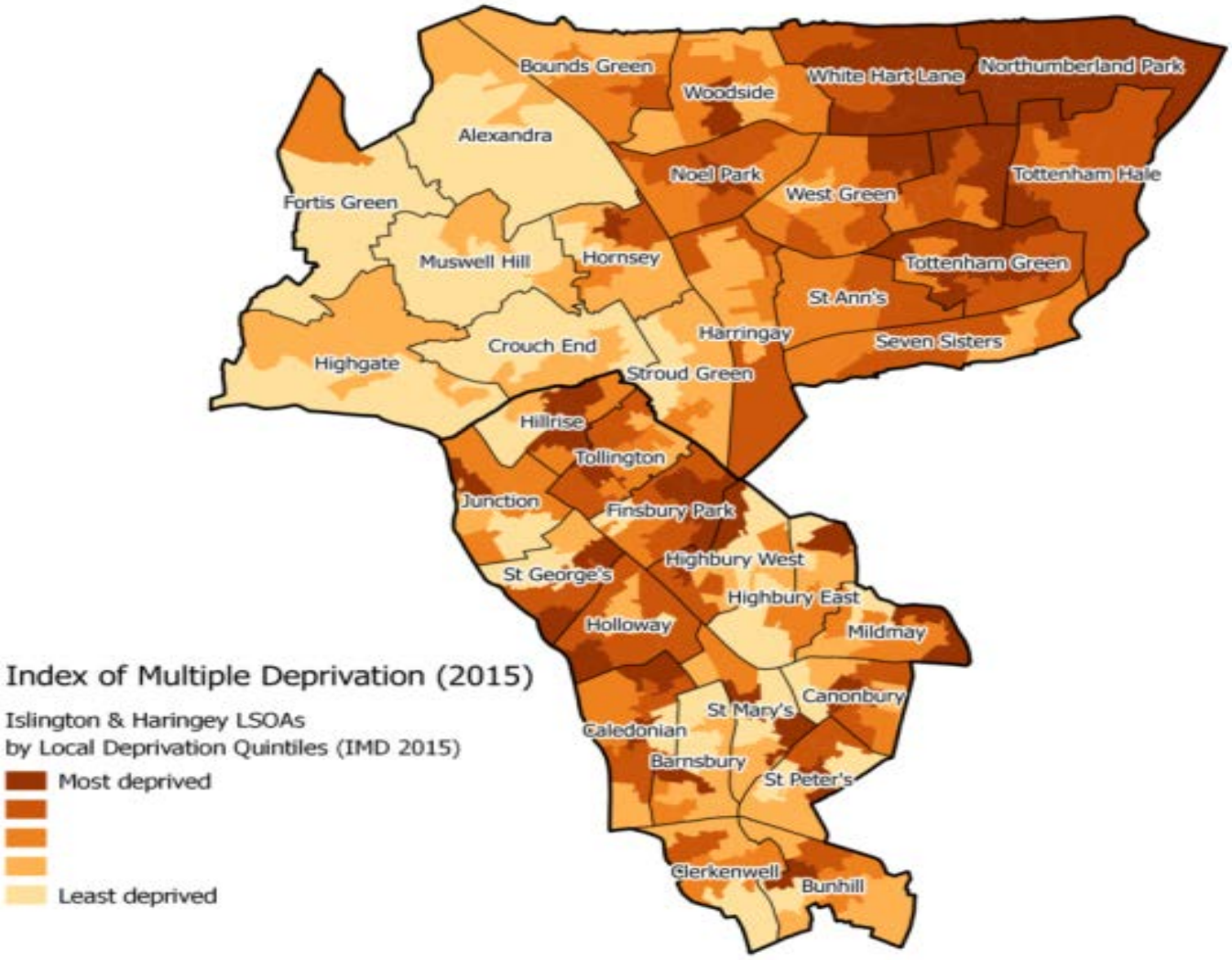
In addition, an important area of work will focus on future care models; identifying the range of options which might be most appropriate for providing health & care and commissioning health & care.

We propose to undertake detailed financial modelling of savings and investments required across the whole system and look at additional key enablers: workforce, IT, estates.

The Wellbeing Partnership
Working side by side in Haringey and Islington



Haringey & Islington

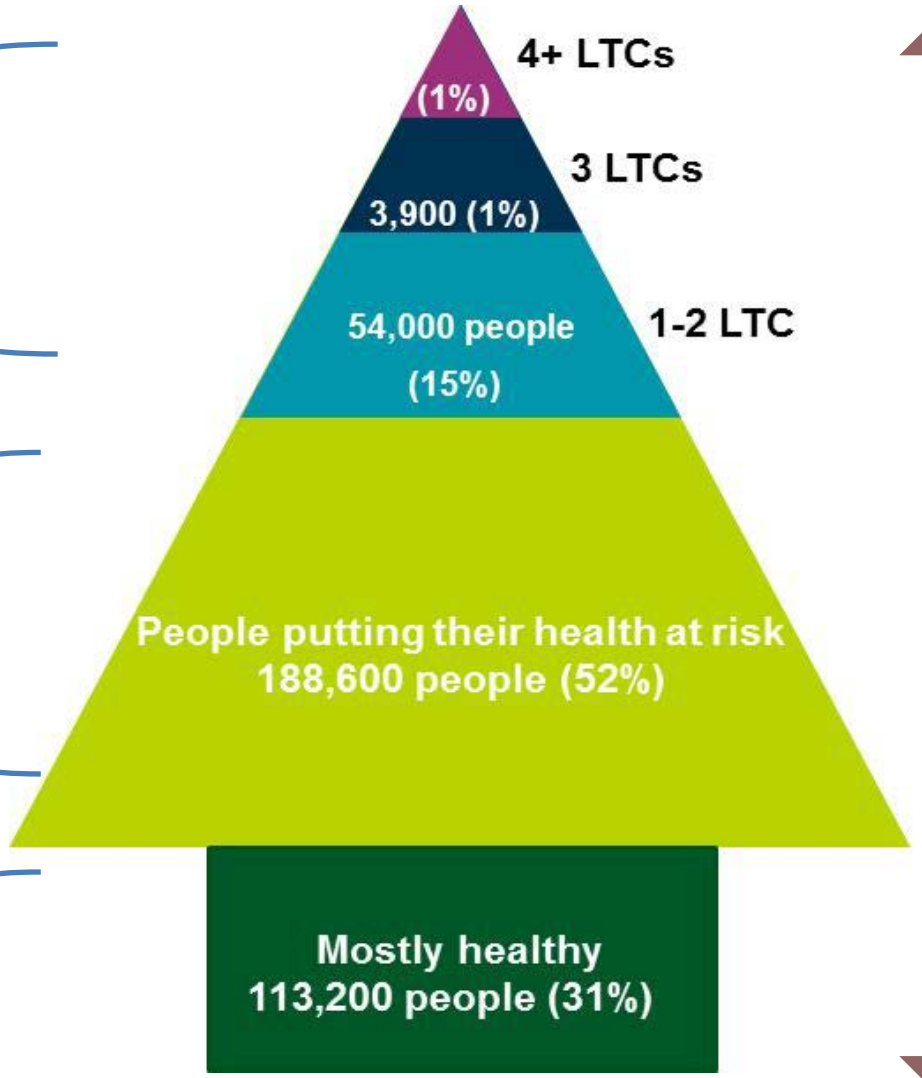


Haringey & Islington Population Health & Care Profile

Focusing on:
- Scaling up the coverage of integrated services
- Delivering measurable outcomes
- Releasing costs
- Secondary prevention

Focusing on:
- Prevention
- Providing information and access
- Reaching out into local communities
- Early intervention and diagnosis

Focusing on:
- Maintaining health and wellbeing
- Children and young people
- Single episodes of ill health



Diabetes and Cardiovascular Disease

Musculoskeletal care

An integrated model of care for Learning Disability

Supporting independence in Older People

* LTC: Long Term Conditions

Whittington Health NHS

Trust Board 1 June 2016

Title:	North Central London Sustainability and Transformation Plan		
Agenda item:	**16/091**	**Paper**	**11**
Executive Summary:	The development of the STP involves five key aspects • Local leaders coming together as a team • Developing shared vison with the local community which also involves local government • Programming a coherent set of activities to make it happen • Implementation against plan • Learning and adapting This paper sets out the progress of Whittington Health's engagement and partnership working with the NCL Sustainability and Transformation Plan.		
Summary of recommendations:	• Approve the approach and engagement of Whittington Health with the NCL STP • Note the Medical Director, Richard Jennings, is the NCL STP Clinical Lead • Note the Clinical Cabinet will sign off the case for change with ultimate responsibility falling to the NCL STP Clinical Lead.		
Fit with WH strategy:	Aligns with Clinical Strategy and WH population health approach		
Reference to related / other documents:	Complies with national policy and Trust duty to provide VFM, high quality and safe services		
Reference to areas of risk / BAF:	Captured on relevant Risk Register		
Date paper written:	25 May 2016		

Author name and title:		**Simon Pleydell, Chief Executive**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by TMG	**May 16**	**Equality Impact Assessment complete?**	**N/A**	**Quality Impact Assessment complete?**	**Y**	**Financial Impact Assessment complete?**	**Y**

North Central London Sustainability and Transformation Plan (STP)

Background

The development of the STP involves five key aspects

- Local leaders coming together as a team
- Developing shared vison with the local community which also involves local government
- Programming a coherent set of activities to make it happen
- Implementation against plan
- Learning and adapting

Access to future transformation funding

The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards

This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

The most compelling and credible STPs will secure funding from April 2017 onwards and NHS England will consider

- Quality of plans and the scale of ambition and track record of progress already made
- Reach and quality of the local process, including community, voluntary sector and local authority engagement
- Strength and unity of local system leadership and partnerships, with clear governance structures to deliver them
- Clarity of implementation plans

The goals of the STP

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities

Progress

There are currently five priority workstreams which have been established with representatives from each of the partner organisations.

- Primary Care
- Urgent and Emergency Care
- Mental Health
- Estates
- Workforce

Priorities

We have established four priority areas that will enable us to deliver the changes needed to create a viable and sustainable system, including

- **Population health**: understanding our population, segmenting into different groups, understanding what different interventions are required for each, and shifting the balance of care from reactive to proactive, starting with prevention and self-care.
- **Productivity:** leveraging productivity opportunities both within organisations, but also through exploring opportunities for efficiency and savings through collaboration
- **Consolidation and specialisation:** to deliver improved safety, better outcomes and value for money
- **Stopping things**: stopping services or initiatives that aren't working

Next Steps

- Mobilise a clinical cabinet
- Develop the structure of the 30th June submission and refine the roadmap
- Agree the shape of the full programme architecture
- Clarify scope, plans and quantify the potential impact for each workstream
- Progress population based approach to health
- Identify pan-NCL productivity opportunities
- Map out existing local and collaborative work and ensure alignment with STP plans
- Agree programme budget and funding beyond June
- Develop communications and engagement strategy and roll out across NCL

Recommendations

- Approve the approach and engagement of Whittington Health with the NCL STP
- Note the Medical Director, Richard Jennings, is the NCL STP Clinical Lead
- Note the Clinical Cabinet will sign off the case for change with ultimate responsibility falling to the NCL STP Clinical Lead

North Central London Sustainability and Transformation Plan

North Central London
Sustainability and Transformation plan

May 2016

NHS England
Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

BARNET LONDON BOROUGH
Camden
ENFIELD Council
Haringey LONDON
ISLINGTON

Barnet, Enfield and Haringey Mental Health NHS Trust
A University Teaching Trust
Camden and Islington NHS Foundation Trust
Central London Community Healthcare NHS Trust
Your healthcare closer to home
Central and North West London NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Whittington Health NHS

The background to the STP

North Central London Sustainability and Transformation Plan

1. The development of the STP involves five key aspects:
   - **Local leaders** coming together as a **team**
   - Developing **shared vison** with the local community **which also involves local government**
   - **Programming a coherent set of activities** to make it happen
   - **Execution** against plan
   - Learning and adapting

2. Access to future transformation funding
   - The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards
   - This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

3. The most **compelling and credible** STPs will secure **funding from April 2017 onwards**. The process will be iterative. NHS England will consider:
   - the **quality of plans**, particularly the **scale of ambition** and **track record of progress already made**. The best plans will have a **clear and powerful vision**. They will create **coherence across different elements**, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically **borrow good practice from other geographies**, and adopt **national frameworks**;
   - the **reach and quality of the local process**, including community, voluntary sector and local authority engagement;
   - the **strength and unity of local system leadership and partnerships**, with **clear governance structures** to deliver them; and
   - how **confident are NHS England that a clear sequence of implementation actions will follow as intended**, through defined governance and demonstrable capabilities.

There are a number of objectives for the NCL STP

North Central London Sustainability and Transformation Plan

Goals

The **goals** of our STP are:

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities

Outputs

The STP needs to deliver several **key outputs:**

- A compelling clinical case for change that provides the foundation for the programme and is embedded across the work, and supports the identification of priorities to be addressed through the STP
- A single version of the truth financial 'do nothing' base case with quantified opportunity impacts based on the priorities identified
- A robust and credible plan for implementation and delivery over five years
- A governance framework that supports partnership working across the STP and collective decision making
- The resource in place to deliver transformation at scale and pace in the key areas identified

Process

The **process** to developing our STP needs to:

- Be collaborative, and owned by all programme partners in NCL
- Be structured and rigorous
- Move at pace, ensuring quick wins are implemented and transformation is prioritised
- Involve all areas of CCG, local authority and NHS England commissioned activity, including specialised services, primary care and reflecting local HWB strategies

Where we are now: current status

North Central London Sustainability and Transformation Plan

Building relationships across NCL

- We are continuing to **build relationships** across the programme partners to ensure that health and care commissioners and providers are aligned in our ambition to transform care
- Our governance framework supports **effective partnership working**
- The SROs are working to bring CCGs, providers and local authorities together across the 5 boroughs together **recognising the history and context** that underlies working together in a new way

Developing the case for change

- We have undertaken analysis to **identify the gaps in health and wellbeing, and care and quality in NCL** in order to prioritise areas we need to address
- We now need to focus on **ensuring there is local buy-in and ownership** of the case for change which we will achieve through a programme of widespread engagement from now until June
- The **clinical cabinet** which will meet for the first time on 5th May will lead this work

Understanding our financial position

- Finance directors from all organisations have been **working well together** to identify the NCL position in 20/21 should we keep going as we are
- This includes some **assumptions around QIPP and CIP**, which we need to develop in further detail to remove the **risk of double counting** when we come to quantify opportunities, particularly around productivity

Mobilising the programme

- We have developed a **high level roadmap** to the end of June, based around the mobilisation of opportunity workstreams in each of our key themes: population health, productivity, consolidation and specialisation and enablers
- We are in the process of **recruiting a programme director and clinical lead** based on a shared understanding of what we need to drive this work forwards
- A key risk is how we **manage the impact of specialised services** in our patch which we will look to address through working closely with NHS England to identify what might be best considered at a pan-London level

Current overarching governance framework

North Central London Sustainability and Transformation Plan

- CCG COs
- NCL CCGs
- LA CEOs
- DsPH
- DASSs
- HWBs
- NHS PROVIDERS
- HENCEL
- NHS ENGLAND LONDON
- HEALTHY LONDON PARTNERSHIP
- HARINGEY AND ISLINGTON WELLBEING ALLIANCE BOARD

NCL Transformation Board

Chair: David Sloman
SROs: David Sloman (Convenor), Dorothy Blundell, Mike Cooke
Members

- SROs
- NHS CCG reps
- NHS Acute Providers reps
- NHS Community Providers reps
- NHS Mental Health Providers reps
- Local authority reps
- LAS
- HENCEL
- UCLP
- NHS specialised commissioning
- NHS England
- NHS Improvement
- Healthwatch
- Clinical lead
- Finance lead
- Programme Director

NCL STP PMO

Programme Director: Alice Hopkinson
PMO Lead: Abi Holland
Programme support: Julie Chan Jones
Comms and engagement lead: TBC

Clinical Cabinet
Lead: TBC

Clinical Reference Group
Lead: TBC

Finance and Activity Modelling Group
Lead: Tim Jaggard

Transformation Group
Lead: David Sloman

Sustainability and transformation plan priorities

Clinical work-streams	**Urgent and emergency care** **SRO:** Deborah McBeal	**Mental Health** **SRO:** Dorothy Blundell	**Primary Care** **SRO:** Alison Blair	**Cancer** **SRO:** Cathy Gritzner	Further opportunity areas to be confirmed
System enablers	**Estates** **SRO:** Cathy Gritzner Dawn Wakeling	**Workforce** **SRO:** Maria Kane Cathy Gritzner	Further opportunity areas to be confirmed		

Developing the NCL case for change

North Central London Sustainability and Transformation Plan

Development and engagement process	• The case for change is undergoing an iterative development process with feedback being provided from all health and social care organisations that are in scope of the NCL STP programme. • The fourth in a series of workshops was held on 20th April with clinicians and social care practitioners from across NCL, particularly those in the outer boroughs. The workshop focused on analysing the data, agreeing the emerging hypotheses and identifying gaps to address in the case for change so far. • Key themes discussed included a focus on primary, secondary and tertiary prevention, self management of minor illnesses, early diagnosis, LTCs, investment in primary care, and workforce. • Between now and June, energy will be focused on addressing the gaps and broadening the engagement such that widespread collective ownership of the case for change is achieved.
Clinical cabinet	• The NCL STP Clinical Cabinet, responsible for the case for change, will lead the further development of this work through to the STP submission in June. • The clinical cabinet will sign off the case for change with ultimate responsibility falling to the NCL STP clinical lead.
Final submission	• The STP submission in June will include the final version of the NCL case for change.

5 key priority workstreams have been identified and mobilised

North Central London Sustainability and Transformation Plan

	Description
Primary care (SRO – Alison Blair)	Currently has a medium term focus on delivering a plan which sets out the vision of the CCGs to transform Primary Care in NCL. The focus is on driving up the quality of primary care, recognising there are differences and opportunities to tackle variation in the quality and outcomes delivered to our patients
Urgent and emergency care (SRO – Deborah McBeal)	Programme to support people to access urgent and emergency care appropriately, in the right place at the right time. The aim is to provide consistently high quality care to patients, significantly reducing variation across NCL providers as well as across the days and times of the week
Mental Health (SRO – Dorothy Blundell)	Develop a MoC and support to enable our population to live well in the least restrictive setting; by breaking down barriers between mental and physical health, delivering consistent and better outcomes that matter to service users and carers, and reducing inappropriate use of acute inpatient beds. This 5 year, all age approach programme has a focus on early intervention
Estates (SRO – Cathy Gritzner, Dawn Wakeling)	The estates workstream is an enabler. It aims, at the NCL level, to support the development of remodelled estate for transformed health and care services, secure efficiencies and release capital, release land for housing. The workstream is also a devolution pilot project as part of the London programme .
Workforce (SRO – Cathy Gritzner, Maria Kane)	Define the workforce requirements required to deliver the STP across NCL and determine how we will train, recruit, retain, develop and support the health and care workforce of the future in NCL

Next steps

For all 5 workstreams to:

- Clarify the scope
- Determine SMART objectives
- Identify timeline and key milestones
- Define the immediate priorities for delivery
- Articulate the quantifiable impact anticipated at the end of year 1 and at the end of year 5
- Specify the support and/or resource requirements
- Identify any asks to put forward to the national leaders

Our identified priority workstreams maximise leverage of existing work but we know we need to do more

North Central London Sustainability and Transformation Plan

Further opportunities need to be identified and analysed to close the key gaps identified in the clinical case and the finance base case. Together, we have agreed a number of principles for selecting additional priorities in order to fully address the gaps:

- We should be **radical in our approach** and **not constrict ourselves** to opportunities available within the constraints of the current system
- We should be considering **more effective vehicles for taking change forwards** including taking advantage of opportunities to **share resources**
- We should be able to **articulate the opportunities to all audiences**, including patients, health commissioners and providers, local authorities and NHS England
- We should be looking to **reduce demand** through new opportunities
- New opportunities should be focused around **eliminating variation** and **adding value**

We have established four key themes that will enable us to deliver the changes needed to create viable and sustainable system, including:

- **Population health**: understanding our population, segmenting into different groups, understanding what different interventions are required for each, and shifting the balance of care from reactive to proactive, starting with prevention and self care. This lens is important because it will enable us to do something radical and ensure we are non-institutional in our approach.
- **Productivity:** leveraging productivity opportunities both within organisations, but also through exploring opportunities for efficiency and savings through collaboration across organisations
- **Consolidation and specialisation:** in order to deliver improved safety, better outcomes and value for money
- **Stopping things**: stopping services or initiatives that aren't working

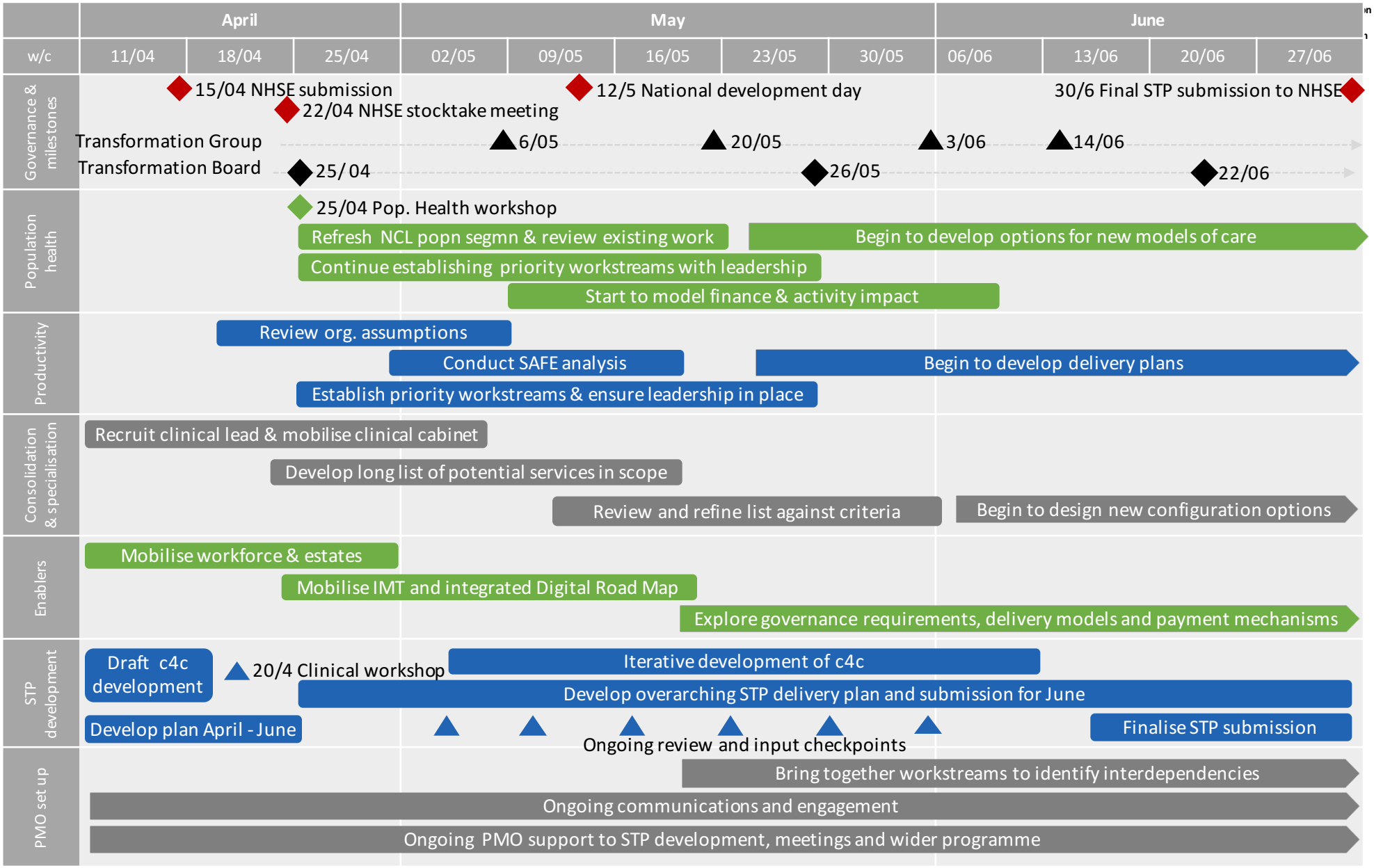
We recognise that a set of **key enablers** will be vital for transformation, including:

- information
- estates
- workforce
- new payment models
- governance and organisational models

Our Transformation Group will review the additional opportunities and recommend and prioritise where further effort can be made

Work in progress

High level roadmap to STP submission in June in development



Next steps: priority actions prior to STP submission in June

North Central London Sustainability and Transformation Plan

- ❑ Mobilise clinical cabinet
- ❑ Develop structure of the 30th June submission and refine the roadmap
- ❑ Agree the shape of the full programme architecture
- ❑ Clarify scope, plans and quantify the potential impact for each workstream
- ❑ Progress population based approach to health
- ❑ Identify pan-NCL productivity opportunities
- ❑ Map out existing local and collaborative work and ensure alignment with STP plans
- ❑ Agree programme budget and funding beyond June
- ❑ Develop communications and engagement strategy and roll out across NCL

Trust Board 1 June 2016

Title:	Emergency Department Business Case		
Agenda item:	**16/093**	**Paper**	**12**
Action requested:	To approve		
Executive Summary:	The Trust Management Group discussed the Business Case on 17 May and agreed that the Trust Board to be advised to approve the case to invest in the Consultant workforce in the Emergency Department. The case is strong from a strategic, quality, safety, operational and financial perspective. It supports the delivery of the ICSU roadmap. The Clinical Director and team are currently detailing the implementation plan and this will be monitored closely for delivery to agreed timescales. The TMG discussed the issue of 10 or 12 WTE posts and agreed that the direction of travel was to aspire to 12 and to review for benefits realisation after recruitment to 10 WTE posts.		
Summary of recommendations:	To increase the Emergency Department Consultant workforce from 6.5WTE to 12 WTE.		
Fit with WH strategy:	The proposal supports our strategic objectives within our clinical strategy:- 1. To secure the best possible health and wellbeing for all our community 3. To deliver consistent high quality safe services 6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population		
Reference to related / other documents:	Clinical Strategy		
Reference to areas of risk and corporate risks on the BAF:	On both the Trust Risk Register and Board Assurance Framework		
Date paper written:	12 May 2016		

Author name and title:		**Paula Mattin, Dir. Operation Emergency/ Urgent Care**		**Director name and title:**		**Dr Rachel landau Clinical Dir. Emergency & Urgent Care**	
Date paper seen by TMG	**17 May 2016**	**Equality Impact Assessment complete?**	**N/A**	**Quality Impact Assessment complete?**	**Y**	**Financial Impact Assessment complete?**	**Y**

Emergency Department Consultant
Business Case

Project Title	Emergency Department Consultant Workforce Expansion	
ICSU	Emergency and Urgent Care	**Clinical Director** Dr Rachel Landau **Project Lead** Paula Mattin
Date TMG	12th May 2016	
SECTION	**DETAIL**	
Background	**Introduction and local context** The Whittington Health Emergency Department (ED)had 96,787 annual attendances during 15/16 up from 90,965 in 13/14. This is an increase of 6.5%. In 2012 the department took part in a benchmarking exercise in association with The Royal College of Emergency Medicine comparing the Whittington with 130 other Emergency Departments in the UK. The results of this comparison demonstrated that the Whittington had fewer consultant posts compared to other departments of a similar size. Emergency Departments with 80,000-99,999 attendances had an average of 8.6 WTE(10PAs) consultants in post during the time that the Whittington ED had 5.5 WTEs (12PAs) Since then another consultant has been appointed but this still places the department significantly behind comparable departments and the 12 WTE Consultants that the College of Emergency Medicine (CEM) and the British Medical Association (BMA) would recommend for a department of this size. The department is supported by a Consultant in Paediatric Emergency Medicine but the post is not part of the main rota or group job plan. There are no current vacancies. The North Central London Sustainability & Transformation Plan includes a review of North Central London Urgent & Emergency Care provision. The draft template for the Urgent & Emergency Care programme clearly specifies that all hospitals in NCL will need to fully meet the London Quality Standards specifically having senior doctors for at least 16 hours a day, 7-days a week in order to become a designated 'Emergency Centre'. Not achieving 'Emergency Centre' designation will have significant implications for Whittington Health as designation as an 'Urgent Treatment Centre' may will affect our ability to deliver a full range of acute services without 24/7 Emergency Care. The department (along with others across the country) has struggled to recruit to middle grade posts and relies heavily on the use of locum medical staff. A review of the rota suggests that some (3.0wte) of this resource could be converted to Consultant posts. It should be noted that each vacant middle grade post has an	

associated cost pressure of £66k temporary staff costs above established cost. The Emergency department currently has 7.0wte middle grade vacancies. These savings form part of the ICSU temporary staffing CIP.

Meeting Commissioning Standards

London Health Programmes has published a set of commissioning standards for Emergency Departments in London. Standard 2 specifically relates to the Consultant cover across the 24 hour period:

'A Consultant in Emergency Medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week.'

This standard is supported by the Royal College of Emergency Medicine. Currently the 6.5 WTE Consultants in Emergency Medicine provide 12 hours cover on weekdays and 8 hours cover at the weekends. The BMA and the Royal College of Emergency Medicine recommend that the current level of cover should be provided by at least 8WTE consultants (10PAs). The current work pattern is challenging given current consultant numbers. Increasing shop-floor cover to 16 hours a day, seven days a week would require between 10-12 consultants. Investing in the consultant workforce in this manner would allow the Trust to meet the commissioning standards for consultant presence and ensure a rota that was robust and sustainable with a uniform level of cover.

Quality, Clinical Excellence and Patient Safety

Emergency Medicine by its very nature involves uncertainty, high stakes and critical decision making, and the environment of the Emergency Department (ED) can be particularly challenging to work in as a doctor. The need for strong clinical leadership is further underlined by the high concentration of foundation doctors and junior trainees providing clinical care in the ED.

Evidence shows that involvement of a consultant leads to better quality care for patients, improved outcomes, and more appropriate use of resources by providing

- rapid and appropriate senior decision making
- a more focused differential diagnosis
- appropriate use of investigations
- fewer hospital admissions
- shorter lengths of stay
- a greater throughput and stronger leadership of the department as a whole

- a better patient experience

Increasing consultant numbers in the ED can also improve patient safety by providing :

- consultant-led care
- increased supervision of more junior members of the ED medical team
- reduced numbers of serious untoward incidents
- fewer unplanned returns
- fewer abnormalities missed x-rays

Performance and Quality Indicators

The need to expand consultant numbers in the ED in order to meet national quality indicators has been evident during the last year at the Whittington. During 2015/16 the Trust performed poorly (91.1%) against the 'Total Time' quality indicator or 4 hour standard, which mandates that 95% of patients must be seen and discharged or admitted within 4 hours. Performance against the 'Time to Treatment' quality indicator, (which mandates that patients should be seen within a median of 60 mins) was also compromised and averaged 80 mins during 2015/6. The current level of Consultant cover means the department has been unable to allocate a dedicated Consultant to the rapid assessment and treatment area (nationally seen as best practice) which means the department has not realised the full benefits of the Rapid Assessment and Treatment area.

The reliance on temporary staff meant that the Trust was not getting the value for money from this investment in staffing, as a significant premium was being paid to employ senior doctors at bank and agency rates. During 15/16 £681,060 (against an established budget of £1,401,334) was spent on locum middle grade doctors. The benefits of having a larger consultant team to share the other work within the department would improve their availability on the shop floor.

Away from the shop floor, many of the activities that consultants are involved in are also processes that have targets that the trust is held to account for. Our response to complaints, follow up of x-ray reports, investigation of serious incidents, and quality improvement projects such as the Alcohol CQUIN all require consultant time and are areas in which we could improve performance.

Moving forward the Trust may be subject to contract performance penalties. During January 2016 the penalties would have been £99,600 for the month as a result of our performance against the four hour standard.

Training

The ED relies on a workforce of junior medical staff at various stages in their training. These junior doctors must have both formal and informal training and supervision in order to meet their needs and to maintain the reputation of the Emergency Department as a training site. The 2014 GMC Trainees' Survey has highlighted concerns from our foundation doctors, identifying periods of time in which they felt there was a lack of clinical supervision. It is important that our department remains a site for training.

As specialist trainee allocations are made based on the number of WTE consultants working on a site, as well as providing better provision for training, increasing consultant numbers would also increase the number of trainees allocated to the Trust. Our current lower than average consultant numbers are exacerbating the operational and financial problems that we face with regards to middle grade staffing. Currently there are only four trainees in post, with seven vacancies on the middle grade rota, with a resulting significant locum spend.

As well as reducing vacancies, an increase in consultant numbers would help to provide extra senior shop floor cover during the busiest parts of the day and go some way to reducing reliance on expansion of the middle grade tier.

The Emergency Department Consultants support undergraduate training in Emergency Medicine and generated £106k income during the last financial year. An increased establishment will offer additional opportunities to increase this income.

New ways of working

Increased emphasis on early assessment and senior clinical decision making in the Emergency Department as the key to improving Emergency Department performance across the time based quality indicators has led the department to pilot a number of new ways of working. The "time to treatment" quality indicator requires the department to start clinical assessment in a median of 60 minutes, a standard that the department struggles to achieve but has aimed to improve by front loading senior decision making. Senior decision making early on improves quality of care by ensuring the patient is on the correct pathway from the outset, and that investigations, treatments, and referrals are initiated as early as possible. Evidence shows that it also improves efficiency and cost by reducing unnecessary investigations.

In this hospital, rapid assessment would enable more patients to be identified as suitable for ambulatory care at an earlier stage, thus maximising the use of this area and reducing duplication.

Increasing consultant numbers would allow these new ways of working to be fully

	adopted by providing a dedicated shift covering hours during each weekday, matched to peak attendance. Opportunities for sub speciality working will also be considered such as Ambulatory Emergency Care and Care of Older people. **Recommendation** This business case recommends an increase in consultant numbers to a minimum of 10 WTEs and also illustrates an option of 12 WTEs. With12 WTE Consultants there would no longer be any need for short term additional spending on bank or agency consultants. The department would be able to have two Consultants on the floor for 12 hours each weekday which could be matched to peak attendances and protect rapid assessment area. Trainee allocations to the Whittington would be maximised. This business case makes a conservative estimate that this would increase trainee numbers by 2 WTEs. Additionally 12 Consultants would further reduce reliance on middle grade agency staff of varying quality.
Objective of Proposal and financial analysis	To increase the establishment of Consultants to 10-12 WTE to ensure Whittington Health: 1. Meets commissioning standards 2. Is placed to become an Emergency Centre in NCL following Urgent Care review 3. Minimises current clinical risks and improves patient safety 4. Would allow more time for essential non shop floor activity (complaints, investigations, timely x ray checking) 5. Improve performance across all ED quality indicators 6. Reduce unnecessary admissions 7. Reduce unnecessary investigations 8. Is able to attract additional trainees 9. Delivery of temporary staffing CIP 10. Increase innovation and deliver clinical excellence

	To have an establishment of 10 WTE: £139,066 x 10 = £1,390,660 We have 6.5 (12PAs) already funded = £903,929 Leaves shortfall of **£486,731** Convert 3.0 WTE vacant middle grade posts into the Consultant budget – 3 x **£**88,644 = £265,932 **£486,731 -** £265,932 = **£220,799** (amount required) **To have an establishment of 12WTE:** £139,066 x 12 = £1,668,792 We have 6.5 already funded = £903,929 Leaves shortfall of **£764,863** Convert 3.0 WTE vacant middle grade posts into the Consultant budget – 3 x **£**88,644 = £265,932 **£764,863 -** £265,932 = **£498,931** Further reduction in middle grade by 40 hours per week saving £156k **£342,863 (amount required)**

Whittington Health NHS

Whittington Health Trust Board
1 June 2016

Title:	Quality Committee Meeting 11 May 2016 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**16/094**		**Paper**		**13**		
Action requested:	For the Board to note the business of the 11 May Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft 11 May 2016 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 Quality Committee, a sub-committee of the Trust Board, considers business relating to quality and safety of services						
Reference to related / other documents:	Duty of Candour, Being Open, SO's. SFI's and Scheme of Delegation, Duty of the Trust Board for quality and safety of patient care, Annual Governance Statement						
Date paper completed:	24 May 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	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

DRAFT Minutes cleared by Chair
Quality Committee, Whittington Health

Date & time: Wednesday 11th May 2016 2:00pm –4.30pm

Venue: Room 6 Whittington Education Centre, Whittington Hospital

Chair: Anu Singh (AS) Non-Executive Director

Members Present:
Yua Haw Yoe, Non-Executive Director
Philippa Davies, Director of Nursing and Patient Experience
Carol Gillen, Chief Operating Officer
Lynne Spencer (LS), Director of Communications & Corporate Affairs
Doug Charlton (DC), Deputy Director of nursing & Patient Experience
Paula Mattin, Director of Operations EUC
Fiona Issacson, Director of Operations S&C
Helen Taylor (HT), Clinical Director CSS
Clarissa Murdoch (SM), Clinical Director MFNS
Neeta Patel, Clinical Director CYP
Sarah Hayes, Clinical Director OPLT / Head of Nursing

In attendance
Daniela Petre (DP), Head of Risk
Dr Adi Cooper, Chair Haringey Safeguarding Adults Board
Deborah Clatworthy, Head of Nursing, Surgery and Cancer
Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes)
Rachel Landau, Clinical Director EUC
Manjit Roseghini (MR), Head of Midwifery
Vivian Bacani, ITU Sister (observing Quality Committee)
Louisa Mitchell, Legal Services Manager (for item # only)

Apologies:
Deborah Harris-Ugbomah, Non-Executive Director
Richard Jennings, Medical Director
Beverleigh Senior (BS), Director of Operations, OPLTC
Russell Nightingale (RN), Director of Operations, CYN
Gurjit Mahil, Director of Operations, WFS
Mark Madams, Head of Nursing, Children's Services

Agenda items

1.	**Welcome & Apologies**	AS
	AS welcomed Yua Haw Yoe to the Quality Committee in her role as Non-Executive Director. Apologies were noted (see above).	

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

2.	**Minutes of the previous meeting (9th March 2016)**	AS
	The minutes of the last meeting were approved with no changes.	

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

3.	**Action Log**	AS
	The Action Log was approved and updates recorded. The Quality Committee discussed the Risk Register. • DP explained that the DATIX revisions would go live on 1/6/16. • AS asked for assurance that risks were being discussed at ICSU Board level. LS explained that 'ICSU risks' is a standing agenda item at TMG, and 'Top 3 Risks' are also reviewed at Quarterly Quality and Performance review meetings chaired by the Chief Executive. • FI and NP outlined the individual processes at ICSU level, whereby only risks approved by the Clinical Director/ICSU team are added to the Risk Register. PD asked how progress against SI action plans was monitored and proposed a statement report at Quality Committee. AS agreed that for quality assurance a status update position on SI action plans should be presented to future Quality Committee meetings.	

Actions	**Deadline**	**Owner**
See action log SI Action Plan to be brought to future Quality Committee meetings for assurance.	On Log July 2016	On Log DP

4.	CQC Inspection - Update	
	PD provided an update on the expected timeframe for the CQC report; a draft is expected by the end of May, at which point a two week factual accuracy will take place before publication and a risk summit.	

Actions	Deadline	Owner
Await report to trigger process to enable publication	Await CQC	PD

5.	Haringey Safeguarding Adult Board Strategic Plan	AC
	Dr Adi Cooper, Chair of the Haringey Safeguarding Adults Board, introduced the Strategic Plan for Haringey Safeguarding Adult Board. AC noted that next year the Annual Report would be presented; this report outlines the strategic plan for 2016/17. AS asked what affect the legal change in the definition of DoLs was having on DOLS assessments and capacity in Haringey. AC noted that it was very challenging to meet the demand for DoLs assessment as the volume has increased significantly. The Law Commission is currently reviewing DoLs definitions and processes, however in the meantime, the Haringey Safeguarding Adults Board receives regular monitoring reports. DC added that the Trust Safeguarding report referenced the recent problems with Haringey Local Authority not attending on time to complete DoLs assessments. AC responded that the key to managing demand is in risk management. CM agreed that there needed to be a joint approach to risk prioritisation between the Trust and the Local Authority. An audit of DoLs has been completed at Whittington, and the Trust is now proposing a basic risk assessment tool, which will be agreed externally with the Local Authority.	

Actions	Deadline	Owner
Annual Report to be added to the annual cycle.	July 16	LS/ GL
Progress on the DOLs risk assessment prioritisation process to be included in the next Safeguarding report	July 16	DC

6	Quality Performance Reports Children and Young People's Services Emergency and Urgent Care Surgery and Cancer	ICSU Leads
6.1	The CYP Quality Report was approved by the Quality Committee. Key points were highlighted as follows: • A CYP Safety Thermometer was developed, which was welcomed by service as a good change and more relevant to the service	

	• Work is ongoing to develop specific children and young people's services quality indicators. AS congratulated the ICSU on this work. • FFT community services have good response rates and good feedback but they currently use a different system and so are not reflected in the Meridian report. These figures will be integrated by the next report in November 2016. • Appraisals were highlighted in the staff survey as not being very useful; this will be an area for improvement in CYP for 2016. • DC noted that nursing appraisals were now linked to revalidation, and so an increase in nursing appraisal completion figures was expected in 2016. • NP noted that work was ongoing to make Adult Outpatient areas more child-friendly.
6.2	**The EUC Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • PM noted record attendances at ED which put extreme pressure on the service to continue to deliver safe, high quality care. These pressures have been regularly discussed in detail at TMG and Patient Safety Committee. • There was a drop in pressure ulcers reported • CG noted that a workshop was arranged for 12/5/16 to review bed management and patient flows across the Trust
6.3	**The S&C Quality Report** was approved by the Quality Committee. (Ward indicators with exception report was included as an appendix.) Key points were highlighted as follows: • No healthcare associated infections for 2015/16 • Improvement in complaint responses, which has been sustained over last four months • Compliant with two week wait cancer targets • Challenge identified in stepping down patients from ITU due to bed capacity issues • AS congratulated S&C on their patient experience feedback work, and suggested the Trust use this as an example of good practice in other areas • FS noted that maternity colleagues had shared experience in good practice around sharing learning; a 'message of the week' was introduced in S&C with work ongoing to improve mechanisms for learning • AS asked what the culture of safety and openness was in S&C. DCl noted the strong working relationships between the risk manager, clinicians and operational leads.

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

8.	**Director of Nursing Patient Experience Report**	**DC**
	The Patient Experience Report was approved by the Quality Committee. Key issues were highlighted as follows; • An action planning workshop was held to discuss the findings of the National Inpatient Survey. The workshop was well attended though DCl noted that the	

	attendance was primarily nurses and midwifes, resulting in a nursing-focused action plan. DCl advised that action plans may need to be tweaked within ICSUs to make it more MDT focused. • The National adult inpatient survey will take place between September 2016 and January 2017 • FFT response rates remain low. MJ noted that ipad usage has increased uptake in maternity, but this requires ongoing work. MJ emphasised the importance of ensuring focus on FFT did not drop while Phillipa Marszall was on maternity leave. • PD highlighted the need to be proactive in improving performance in the national inpatient survey 2016/17. For example, including mats on patient trays highlighting improvement projects at the Trust during the patient survey period. • PD noted there will be a separate children's inpatient survey this year.

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

9.	**Quarterly Patient Safety Report, Medical Director**	PM
	Deferred	

Actions	**Deadline**	**Owner**
Add item to July Agenda	July Mtg	RJ

9.	**Safeguarding Report**	PM
	The Safeguarding Report was approved by the Quality Committee. DC noted this was a new, separate, safeguarding report which is a work in progress. Key issues were highlighted as follows; • Safeguarding adults training remains good • DC noted that the number of alerts appears low for an organisation this size • The Domestic Violence post will finish at the end of June as funding was not received from the CCG. The work will be divided between existing posts. • Work is ongoing to improve uptake of safeguarding children training, actions include the development of e-learning packages and improving processes to allow training in other NHS trusts to be recognised. CG noted that with the revised version of ESR it should be easier to recognise staff training between NHS organisations • DC highlighted that the Goddard Inquiry, a national independent enquiry into child sexual exploitation was in progress. A national directive was set not to destroy any records relating to children. • With respect to the Myles Bradbury report, Whittington Health is undertaking a gap analysis to ensure we are compliant with recommendations • Dr Adi Cooper noted it was helpful to see the Trust's internal reporting processes	

	for safeguarding	
Actions	**Deadline**	**Owner**
None		

11	**Quality and Safety Risk Register**	**LS/ DP**
	LS provided a summary of the strengthened risk management process at the Trust. Due to the DATIX transition to reflect moving to seven ICSUs from three Divisions, the next full Risk Register will be presented in July 2016. AS noted the positive improvements in the governance of risk management, but emphasised the importance going forward, of looking at what actions are being taken to mitigate individual risks within a timely manner.	
Actions	**Deadline**	**Owner**
Risk Register to July Quality Committee	July Mtg	DP/LS

12.	**Integrated claims, inquests, complaints and SI report 2015/16 (Legal Services Report)**	**DP**
	The annual aggregated report was approved by the Quality Committee. Key issues were highlighted as follows; • Quarter 4 increase in clinical claims • No Prevention of Future Deaths in Q4, three in total for year. However all learning from coroners inquests is being monitored (not just when PFD received) • No change noted in areas reporting high number of incidents or types of incidents reported • The majority of 'Implementation of care' incidents refer to pressure ulcers acquired outside Whittington Health; there is a national requirement to capture and report this information. • There have been eight serious incidents relating to 'slips, trips and falls' in total in 2015/16, including one death. A trustwide action plan is in place to address areas for improvement. However DP noted that in comparison with other acute trusts, the number of serious incidents relating to falls is relatively low. The Quality Committee thanked DP for the comprehensive report and proposed that the paper be shared with all ICSU Boards. AS added that the next challenge is to identify themes and actions to mitigate risk and drive improvement. FI asked if it was possible to add more benchmarking data on NRLS and LS asked for more detailed information from NHSLA extranet that benchmarks Trusts across the UK. DP noted that many Trusts are not happy to disclose the number of SIs and this information is not currently in the public domain. LS proposed inviting NHSLA safety leads to present on the high level trends as they are leading on a new initiative to share collective data to support learning from patients' experience. This links to the national Sign up to Safety initiative led by the Secretary of State.	

Actions	Deadline	Owner
Annual aggregated report to be presented at all ICSU Boards	July 16	ICSU
Next aggregated report to include benchmarking NRLS data and NHSLA data (liaise with NHSLA safety leads)	July 16	DP

12.	Infection Control Q4 2015-16	
	The Infection Control Q4 report was approved by the Quality Committee. Key issues were highlighted as follows; • 7 CDIF cases last year, with a target of 17. • 1 MRSA case last year • New Infection Control Nurse (Band 5) appointed • PF discussed the improvements with regard to single-use equipment identified in infection control reports. The Trust purchased 22 new dyno mats, which can be screwed to walls in side-rooms to prevent movement of dyno mats between infected patients. Work is in progress to prioritise placement of the 22 mats. In addition, 10 equipment trolleys have been ordered to use as isolation carts (to be placed on medical wards and one surgical ward) and 3 respirators purchased for staff who cannot wear masks.	

Actions	Deadline	Owner
None		

12.	Nursing Quality Indicators	DC
	The Nursing Quality Indicators report was approved by the Quality Committee. Key issues were highlighted as follows; • DC thanked Alison Kett for her support in developing the nursing indicators • Total response rate for March was 7.4% , which reiterates issues raised in the patient experience report • The Committee discussed the parameters and indicators possible for unallocated slots in District Nursing. Further work is required to identify a suitable target. • DCl noted that the indicators on nutrition in May have been revised to focus on safety and quality. AS commented on the usefulness of the nursing indicators. DC noted that targets were high as the Trust aspires to excellence.	

Actions	Deadline	Owner
Review how District Nursing quality indicator target is represented for next report.	July 16	DC
Review the accuracy of the medication safety incidents causing harm figures for next report.	July 16	DC

13	**Quality Account**	
	Report deferred	

Actions	**Deadline**	**Owner**
Add to July Agenda	July Mtg	RJ

10	**Accessible Information Standard**	DP
	LS provided an overview of the approach taken to ensure trust compliance with the Accessible Information Standard. A detailed gap analysis was in progress, coordinated by GL, and would be discussed at the next TMG. PD noted that the Trust would not be fully compliant by July 2016 but would have an implementation plan in place.	

Actions	**Deadline**	**Owner**
Add to Cycle of Business to report on implementation progress	September Mtg	LS

14.	**Six monthly review of ward nursing establishments**	**DC**
	DC noted that a full establishment review was carried out in October 2015; this paper represents the findings of a second update on ward nursing establishments carried out in March 16. Key issues were highlighted as follows; • Problems identified with respect to the retention of staff at Whittington Health. DC noted some work was in progress interviewing existing staff to ask 'why do you stay' in addition to traditional exit interviews. • AS noted that the Workforce Committee should provide assurance to the Quality Committee on the recruitment and retention strategy. • CG noted that following the last big recruitment drive, regular follow-ups were helpful in retaining staff. • Review showed that, in general, establishments are correct so no recommendations to change. • The Committee discussed the new Allocate acuity tool which was currently in operation on three wards. From September, the Trust expects to be able to pull figures for all wards via Allocate system. • The Committee requested a live demonstration of the system at the next meeting.	

Actions	**Deadline**	**Owner**
Live demonstration of Allocate software to be presented at July Quality Committee	July 2016	DC

15.	Trust Policies Update	DP
	The list of Trust policies approved since the last meeting received and noted. PD asked about the policy management process for ensuring policies and SOPs were kept up to date, and requested an update on the number of policies overdue at the next Quality Committee meeting.	
Actions		**Deadline** / **Owner**
Next policy report to include number of overdue policies		July 2016 / GL/ DP

10	Serious Incident Report	DP
	The Serious Incident report was approved by the Quality Committee. • No further comments, SI report reviewed previously at Trust Board in public.	
Actions		**Deadline** / **Owner**
None		

16	Terms of Reference and annual work plan	AS
	For information only; the Quality Committee noted the revised TOR which reflected Ned substitution rights for Trust Board Committees and the updated annual work plan.	
Actions		**Deadline** / **Owner**
None		

18.	AOB	Lead
	CG described the bed base plan, which aimed to change bed usuage by the first week in June. The plan is being monitored weekly. CD noted that progress will be linked to ongoing bed pressures and agency costs and was on track to deliver. DP provided an update on the DATIX system revision. All work in terms of design was completed, with the system now mapped to seven ICSUs and a more streamlined reporting and investigation process. The upgrade is in the final stage of roll out with an expected go live date of 1/6/16. DP added that two sessions on RCA Training had been held for staff. YHH asked for assurance on the process for monitoring medication safety incidents across the Trust which HT and CM described.	

	AS outlined changes to the Quality Committee membership. Shadow governors are no longer Committee members and the Trust Chairman and Director of Communications and Corporate Affairs are currently reviewing the best mechanism for ensuring a diverse community forum is established to enable patients/carers voices to feedback and work with the Trust.

Actions	**Deadline**	**Owner**
Establish appropriate patient and carer engagement for the Trust	September 16	LS & SH

Next meeting: Wednesday 13th July, 2:00pm, Room 6, Whittington Education Centre

Whittington Health NHS

Trust Board Meeting in Public 1 June 2016

Title:	Anti-Bribery Statement – Our Commitment		
Agenda item:	**16/095**	**Paper**	**14**
Action requested:	For the Board of Directors to demonstrate their commitment and champion Whittington Health Anti-Bribery Statement		
Executive Summary:	We value our reputation for delivering high quality and safe care, financial probity and conduct our business in an ethical and transparent manner. The Bribery Act 2010, effective from 1 July 2011 was introduced to make it easier to tackle the issue of bribery which is a damaging practice. Bribery can be defined as 'giving someone a financial or other advantage to encourage them to perform their function or activity improperly or reward them for having done so'. In order to limit our exposure to bribery we have in place a clear Code of Conduct and Conflict of Declarations of Interest Policy, a Whistleblowing (Raising Concerns) Policy, a Counter Fraud Policy, and a Local Counter Fraud Specialist. These are promoted on our intranet and internet sites for staff and members of the public to access 24/7. We encourage staff to report any suspicion of bribery and rigorously investigate any allegations. In addition we hold a Register of Declaration of Interests for the Trust Board Executive and Non-Executive Directors (Board of Directors), senior staff, and others in positions of influence and power. We hold a Trust Register of Gifts and Hospitality and ask staff not to accept gifts or hospitality that will compromise them or the Trust. The Board of Directors carries out its business in an open and transparent way and we meet every month in public; except August. We are discussing more and more business in our public meetings to enable members of the public and staff to understand the way we make decisions to help local people live longer healthier lives. We are committed to the prevention of bribery as well as to combating fraud and expect those organisations we work with to do the same. Doing business in this way enables us to reassure our patients, staff, and stakeholders that public funds are properly safeguarded.		
Summary of recommendations:	For the Board of Directors to approve the Trust Anti-Bribery Statement which will be promoted on the Trust website		
Fit with WH strategy:	Compliant with the Nolan Principles and Board Code of Conduct		
Reference	Duty of Candour, Being Open, SO's. SFI's and Scheme of Delegation		
Date paper completed:	24 May 2016		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC	**May 16**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**Govern-ance review**	**Legal advice received?**	**N/A**