Whittington Health NHS

TRUST BOARD

14.00 – 16.30
Wednesday 6 July 2016

Whittington Education Centre Room 7

Whittington Health NHS

Meeting	**Trust Board – Public**
Date & time	**6 July 2016 1400hrs – 1630hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – 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 Yua haw Yoe, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director 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*	*Verbal*	*Declare* *1420hrs*
16/079	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
16/080	**Draft Minutes, Action Log and Matters Arising 4 May** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
16/081	**Draft Minutes Extraordinary Board Meeting 8 June** *Steve Hitchins, Chair*	2	*Approve* 1440hrs
16/082	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1450hrs
16/083	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	3	*Approve* 1500hrs
Patient Safety & Quality			
16/084	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1510hrs
16/085	**Safer Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	5	*Approve* 1520hrs

Performance			
16/086	**Financial Performance Month 02** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1530hrs
16/087	**Performance Dashboard Month 02** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1540hrs
Strategy			
16/088	**Capital Plan 2016/17** *Steve Bloomer, Chief Finance Officer*	8	*Approve* 1550hrs
16/089	**Community Engagement** Siobnhan Harrington, Director of Strategy/Deputy Chief Executive	9	*Approve* 1600hrs
Governance			
16/090	**I&MT Improvement Plan & Deloitte Review** *Steve Bloomer, Chief Finance Officer*	10	*Approve* 1610hrs
16/091	**Heatwave Plan 2016/17** *Carol Gillen, Chief Operating Officer*	11	*Approve* 1620hrs
16/092	**Annual Medical appraisal and revalidation annual report 2015/16** *Dr Richard Jennings, Medical Director*	12	*Approve* 1625hrs
16/093	**F&B Committee Draft Minutes 25 May** Tony Rice, Non-Executive Director Chair **Charitable Funds Committee Draft Minutes 14 June** Tony Rice, Non Executive Director Chair	13	*Note 1630hrs*
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meetings & 2015/16 AGM			
	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: 01
Doc: 16/080

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 1st June 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
	Siobhan Harrington	Director of Strategy/Deputy CEO
	Deborah Harris-Ugbomah	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Anu Singh	Non-Executive Director
In attendance:	Cllr. Janet Burgess	London Borough of Islington
	Greg Battle	Medical Director, Integrated Care
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs
	Norma French	Director of Workforce
	Duncan Carmichael	Emergency Care Consultant (for item 93.01)

Patient Story

Philippa Davies introduced Jane, wife of a patient who had been admitted to the Trust's Emergency Department (ED), and Kerry Wykes, practice development nurse from the ED. Jane began her story by thanking the Board for inviting her, she felt privileged to be present and her primary message to the Board was one of thanks for the treatment her husband Alan had received. Her husband had been extremely ill the previous year, and had been in the ED when he had suffered a cardiac arrest. Jane's feedback highlighted communication issues between hospital staff and herself regarding information sharing about her husband.

Kerry confirmed that learning from this complaint had resulted in staff training being rolled out on appropriate information sharing with relatives and it had been included at one of ED's regular 'ten minutes at 10.00' learning slots. It was noted that despite the ongoing pressures on ED Alan had been able to benefit from good continuity of care. Jane added that she had received an excellent response to her complaint, with all her questions being fully answered but she reported she had to deal with four different members of staff in the PALS office and therefore repeat her story. She felt a huge debt of gratitude to all who had been involved in Alan's care, and conveyed his personal best wishes and thanks to the Board.

Maria Elawar Duarte and Dominic Walsh

The Chairman conveyed the Board's condolences to the families of the late Maria Elawar Duarte and Dominic Walsh. The Chairman led the Board in a brief period of silence as a mark of respect for both Maria who was a member of staff when she sadly passed away recently and Dominic who also sadly passed away recently and was a well-known former member of staff and very well respected and active member of the Union.

16/78 Declaration of Conflicts of Interest

78.01 No member of the Board declared any conflicts of interest in the business scheduled for discussion at that afternoon's Board meeting.

16/79 Apologies and welcome

79.01 Steve Hitchins welcomed everyone to the meeting, especially Cllr. Janet Burgess, representing the London Borough of Islington and newly-appointed London Borough of

Haringey representative Cllr. Jason Arthur who had sent apologies for the meeting. Apologies were also received from Graham Hart, Tony Rice and Yua Haw Yoe.

16/80 Minutes, Action Log and Matters Arising

80.01 The draft minutes of the Trust Board meeting held on 4th May were approved.

Actions

80.02 105.08 IT Review: Stephen Bloomer confirmed the report and recommendations had been shared at the June Board Seminar and would come to the July public Board meeting.

160.09 Dashboard: The dashboard will be presented to the September Board Seminar.

67.01 It was agreed that an extraordinary public Board meeting will be convened the following week to agree the 2015/16 Quality Account. A formal notice will be advertised on the website in line with the Standing Orders.

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

80.04 There were no matters arising other than those already scheduled on that day's agenda for discussion.

16/81 Chairman's Report

81.01 Steve Hitchins began his report by commending Philippa Davies and all others who had been involved in arranging the Trust's nursing awards and annual conference held on International Nurses' Day 12th May. He had also been present at a celebratory reunion at the hospital for twelve retired nurses who had trained and worked at the Whittington fifty years ago.

81.02 Various events had been arranged as part of a week dedicated to the care of the dying. There had been a visit from the Vice-President of the Court of Protection, who had given a talk to staff on the deprivation of liberty; Steve was pleased to note that this had been attended by representatives of both Haringey and Islington local authorities and CCGs.

81.03 The first 'soft launch' of a new community and patient forum had taken place. This had been attended by 20 members of the community, and Steve was confident it would develop into a strong representative forum in the future.

81.04 On July 8th school children and teachers from Grafton School will be attending the hospital to learn about the history of the Trust and the children will host a theatrical performance in the atrium. Steve reported that this is the start of increasing engagement activities with children and schools. Janet Burgess confirmed the Grafton school children had visited the council and that she and Jeremy Corbyn had been interviewed as part of their history project. Janet confirmed the value and importance of connecting with young people to support learning opportunities and engagement events.

81.05 Steve had been pleased to attend a Buckingham Palace Garden Party on behalf of the Trust.

16/82 Chief Executive's Report

82.01 Simon Pleydell highlight that two cases of C. Difficile had been declared in April and the amendment to the CEO report was noted. The Trust was making good progress on its cancer targets, however MSK waiting times remained problematic, with the main cause continuing to be self-referrals. The IAPT service continued to out-perform other services in London.

82.02 Updating colleagues on the status of the CQC inspection report, Simon anticipated this would be published within the next few weeks. He confirmed that the 95% compliance target for the 4 hour ED performance was off-trajectory and he had convened a recent meeting for senior operational and clinical managers to discuss how to improve patient flows and increase the number of patients discharged before 11.00am.

82.03 Simon informed the Board that at Month 1 the Trust was reporting a deficit of £1m. He confirmed that the senior management team were focused on meeting the 2016/17 financial plan targets to meet the financial control total set for the year and to support the recovery to financial sustainability within the next two years.

82.04 He highlighted that the NHS Improvement Agency required all Trusts to achieve their agreed financial targets in year and that the emerging Sustainability and Transformation Plans will support the Trust to deliver its savings whilst creating benefits for the health economy. He reported that the Trust's trajectory to meet the cap on agency staff usage was off plan and acknowledged the challenges for the need to use additional staff to ensure the safety and quality of services. Steve Hitchins added that Board members were well aware of the challenges and suggested the executive team to request the help of the non-executive directors if required.

82.05 The Trust's record on patient safety remained amongst the best in the country and last month Whittington Health had been named as one of the top 40 best performing Trusts in the UK by CHKS against a range of clinical, safety and quality indicators. Simon was pleased to report that he had attended the annual Nursing and Midwifery conference to thank staff for their dedication and commitment in delivering high quality patient care.

82.06 Simon reported that the Trust had carried out significant work with Boston Consulting Group and had also reviewed the Carter review recommendations to inform future cost improvement plans and areas of focus. Simon confirmed that this provided a strong platform for success and that a central programme management office had been established to take forward the Boston work. He confirmed that meeting the ED and financial plan targets will ensure the future sustainability of the Trust. Deborah Harris commented on the Finance & Business Development Committee's positive discussion of CIP plans and the way that the ICSU leads were taking control and accountability.

16/83 Serious Incident Report

83.01 Philippa Davies informed the Board that four serious incidents (SIs) had been declared in April. All were currently the subject of investigations. Philippa confirmed the Board that four ongoing investigations were taking longer to complete due to their complexity and extensions to deadlines had been agreed with the commissioners.

83.02 In answer to a question from Stephen Bloomer about whether there were any links between the incidents involving delayed diagnoses, Richard Jennings replied that one had some aspects in common with a previous incident and this would be addressed as part of the ongoing investigation.

16/84 Safe Staffing Report

84.01 Philippa Davies drew the Board's attention to the requirements for RMNs during April – 160 during the month compared to 63 in March. Carol Gillen said that a meeting had been convened for June 6th to explore the underlying issues and identify how best to address them. Richard Jennings had written to Camden & Islington Mental Health Trust to highlight this issue.

16/85 Quarterly Safety & Quality Report and Sign up to Safety Plan

85.01 Richard Jennings informed the Board that one section of this report mirrored a section in the Quality Account; this was a review of how the Trust had performed against the Sign Up

to Safety Plan 2015/18. This was a three year plan, and Richard was pleased to report that the Trust had demonstrated improvement in most areas. He cited the example of the work that had been done on sepsis, and paid tribute to the junior doctors who had contributed to this success. He acknowledged that the Trust had not achieved all it had hoped to do, but a clear trajectory of improvement could be seen.

85.02 Richard said that the Royal College of Physicians benchmarking exercise for falls showed Whittington Health as having an extremely low number when compared to the London average. Additional training sessions had been arranged for staff on learning disabilities, and pressure ulcers had reduced.

85.03 In answer to a question from David Holt about the needs of out-patients with learning disabilities, Richard replied that there were areas that could be improved, however on this occasion it had been agreed to focus on in-patient services as these were the areas which posed the maximum risk. Janet Burgess reminded the Board of the Islington Learning Disabilities Partnership, where Whittington Health specialist nurse Hellen Odiembo had made a valuable contribution, and she supported Hellen continuing to attend meetings. Richard and Philippa were pleased to hear this but pointed out that resources were limited as there was only one specialist nurse in this position. Steve Hitchins had attended an event on diabetes with Maria Barnard, and said that some interesting issues for patients with learning disabilities had been identified.

85.04 The concluding section of the report focused on how learning was being shared, and Richard informed the Board that a series of half-day learning workshops had begun, the first of which had focused on safeguarding issues and the second on sepsis. Colleagues in Education had also developed a platform for learning. The Trust was participating in community Schwartz Rounds, with the hospital Schwartz Rounds commencing in August. All Board members were encouraged to attend these sessions in future.

85.05 There were now seven junior doctor leads for patient safety, which Richard highlighted was a positive development. In addition, he had recently re-launched the mortality review process, which would look at every death which had occurred since the start of the financial year. Richard informed the Board that all Medical Directors had received a letter about steroids and the death of a young man. An appropriate alert will be placed on the electronic prescribing system.

16/86 <u>Quality Account 2015/16 and Draft Quality Account 2016/17</u>

86.01 It was agreed that an extraordinary public Board meeting will be convened to discuss this item, and this would be scheduled as part of the Board away day 8th June.

16/87 <u>Financial Report</u>

87.01 Stephen Bloomer explained that the financial report was abbreviated for Month 1. He reported that the Trust was declaring £1m deficit at the end of Month 1, this was £228k worse than the planned position. The main drivers were pay, and particularly agency which was showing an upward trend. This was disappointing given the success in recruiting to vacant posts and no additional beds had been opened. He had spoken to the ICSUs about the financial position and would continue weekly discussions through the PMO.

87.02 Simon Pleydell highlighted the need for this to be addressed as a matter of urgency, all Board members needed to understand the underlying issues which included issues with the capacity within the mental health service that were impacting on the Trust's staffing position.

16/88 Performance Dashboard

88.01 Carol Gillen reported on the Friends & Family Test (FTT) – response rates were slow, and consideration was being given to employing an external company to support a rapid improvement.

88.02 Carol drew the Board's attention to an extensive piece of work being carried out on theatre utilisation; this was a key feature of the Surgery & Cancer ICSU's CIP plan. The junior doctors' strike had had some impact on services, but the position was recoverable.

88.03 Within community services, the rate of appointments with no outcome had risen slightly during the month, but the provision of laptops to district nurses would make a significant difference to improved data and reporting. A meeting with the Trust's commissioners had taken place earlier in the week to discuss self-referral, with a view to changing current practice. IAPT rates were reported as encouraging, with the Haringey service continuing to compare favourably with other London sites.

88.04 Carol informed Board members that there had been one medication incident which had resulted in harm to a patient; this had been caused by an incorrectly prepared blister pack. Philippa Davies expressed her congratulations to staff on the improved complaints response times noted in the report, rates had risen to 92% for April.

16/89 Strategic Estates Partnership

89.01 Steve Hitchins began by paying tribute to the work carried out by Phil Ient in this area, noting that this would be Phil's last Board meeting prior to his retirement next month. Phil had joined the Trust in 2001, and had made a huge contribution to the quality of patient care through his work, especially on the community estates, and Janet Burgess echoed this, saying what a great help he had been to her during her time as a ward counsellor.

89.02 Simon Pleydell introduced the item, saying that the next logical step for the Trust to take was to explore the options for how best to take the estates strategy forward, given that there were issues not just of backlog maintenance but also of buildings which were not fit for purpose. The team had looked at a number of options, and was recommending that the Trust would form a strategic estates partnership. This had been discussed with both NHS Improvement and NHS England, and should the proposal gain Board approval, the team would look to begin the process of seeking a partner.

89.03 David Holt expressed his support for the recommendation but was disappointed in the proposed timetable, adding that it would be necessary to work in congruence with the STP processes, and Greg Battle stressed the importance of absolute clarity over partnership arrangements. Simon Pleydell replied that the important point to emphasise was that the intention was to develop a joint venture, and the Trust was in no way bound to accept any proposals which did not meet its needs or fit with its clinical priorities. There would need to be a robust communications plan developed to build on the existing engagement work with key stakeholders such as the JHOSCs who had received the full and summary estate strategy and an update report for the 10 June meeting. This approach will ensure that patients, staff and all the Trust's other stakeholders understood the rationale behind all of the decisions taken and were kept fully informed throughout the process.

16/90 Clinical Collaboration

90.01 Simon Pleydell reported that although Whittington Health provided community services to the populations of Islington and Haringey, it did not provide hospital services to one hundred per cent of the residents of either borough. Within Islington around fifty per cent of hospital services (mainly to residents in the south of the borough) are provided by UCLH. Simon confirmed that he and Steve Hitchins had been holding discussions with Robert Naylor, CEO and Richard Murley, Chair of the UCLH, to discuss forming a clinical collaboration between the two Trusts.

90.02 The objectives of the UCLH Foundation Trust and Whittington Health formal clinical collaboration board will be:

To work with the Health and Wellbeing Partnership in Islington and Haringey to deliver service improvements in:

- 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 and to work with partner organisations in the Wellbeing Partnership to explore potential organisational forms for the future

Simon explained that both Boards of each of the organisations were being asked to agree this approach this month. It was agreed to establish the clinical collaboration board with an agreed terms of reference and action plan by the end of June 2016.

Simon confirmed there would be a need for a similar arrangement with the North Middlesex, to cover residents in East Haringey.

16/91 <u>Sustainability and Transformation Plan</u>

91.01 Simon introduced this item and reported that the paper set out progress on the Sustainability & Transformation Plan (STP) that 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

Work was in hand which would help the Trust achieve supporting the five year forward plan, and a more detailed paper would be brought to the Trust Board which would set out the priorities for the STP in the longer term. There are currently five priority workstreams: primary care, urgent and emergency care, mental health, estates and workforce with representatives from each of the partner organisations.

91.02 Simon highlighted that workforce was a key factor in the development process, and said that that the workforce workstream (Norma French was a member) would be addressing issues such as bank rates etc. Although all participants were now fully engaged, Steve Hitchins held some concern about the first draft of the plan being submitted by the target date of 30 June prior to its being seen by this Board; he was also concerned that the planned stakeholder consultation had been scheduled to take place during August (although there was a possibility this might be changed). The Board approved the approach and engagement of Whittington Health with the NCL STP, noted the Medical Director, Richard Jennings, is the acting NCL STP Clinical Lead and that the Clinical Cabinet will sign off the case for change.

16/92 <u>Report of the Audit Committee – Annual Accounts, Governance Statement and Report</u>

92.01 David Holt as Chair of the Audit & Risk Committee reported that that Committee had met earlier that day, and that papers from the meeting were available in dropbox. In highlighting some of the key areas covered, he reminded Board colleagues that the

annual accounts and report had been prepared in the context of NHSI & DH guidance, and said that the auditors had given a clean opinion.

92.02 He highlighted to the Board that the Trust had received a qualified rating for VFM, which triggered an automatic alert to the Department of Health (DH). The overall position however was broadly positive, and the finance team had been commended for their work. The Audit & Risk Committee had recommended that the Trust Board approve the annual report, governance statement and accounts for 2015/16. The Quality Account will be agreed at an extraordinary public Board meeting on 8 June and the Board noted the element of risk in collecting stakeholder views prior to deadline of 30 June, but SRO Richard Jennings reported that this was achievable. The Board formally approved the annual accounts, governance statement and report for 2015/16.

16/93 Emergency Department Business Case

93.01 Referring to the earlier discussion and risks about the meeting the performance of ED, Siobhan Harrington introduced the proposal as set out in the business case to increase the ED consultant workforce from 6.5 to 12 wte posts. In order to meet required performance standards there should be consultant cover 16 hours per day, and this would help to reduce reliance on expensive locum cover. Siobhan acknowledged that there were some issues to resolve around the phasing of the finance for the investment, but it was of critical importance for quality and safety. Richard Jennings spoke in support of the business case, and clinical lead Duncan Carmichael confirmed the benefits that these posts will bring from releasing consultants from less back office tasks and increased time with patients.

93.02 Norma French was engaged in testing the market, and it was noted that achieving the increased level of staffing could potentially take 18 months to 2 years to achieve. There would need to be an implementation plan with robust monitoring in order to be able to gauge benefits, as well as building this into the ICSU performance review process. The Board approved the business case, subject to the production of the implementation plan and monitoring at TMG.

16/94 Draft Minutes of the May Quality Committee

94.01 Anu Singh introduced the draft minutes of the Quality Committee held on 11th May 2016. She was pleased to inform the Board that the Committee was now receiving data on quality indicators for children's services, also an aggregated report of complaints, claims and incidents with associated trends.

94.02 An area of high concern had included Victoria ward, and there had been some discussion at Committee about the multiple elements of the risk, spanning different areas of the Trust, and where the oversight of mitigating actions was taking place. Lynne Spencer confirmed that the risk will be considered by the Executive and Clinical Directors as part of their overview of top risks in the Quarterly Performance meetings and within the TMG. The risk will be escalated to the corporate risk register if ICSU and Executive Directors escalate the risk to significant scoring >15 in line with the Trust risk management strategy.

16/95 Bribery Act 2010 and Board Declaration

95.01 The anti-bribery statement drafted by Lynne Spencer was agreed by the Board and will be promoted on the Trust website to demonstrate the Board's commitment to promoting anti-bribery and commitment to the Nolan principles.

"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."

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Action Notes Summary

105.08	IT External Deloitte Review: Stephen Bloomer confirmed this report would be brought to Board meeting.	July Board Closed	SB
160.09	Performance Dashboard: This will be discussed at a Board Seminar	September On forward plan	CG
160.11	Speak up Champion: Trusts expected to be able to demonstrate processes for appointment and report to the Board	September On forward pan	PD
53.04	A report on progress achieved on the staff survey action plan to to the Board in six months' time	October On forward plan	NF
86.01	Extraordinary public Board meeting to be called in order to approve the Quality Account and meeting to be advertised in line with the Trust Standing Orders	8 June 2016 Complete	LS
90.02	It was agreed to establish the clinical collaboration board with an agreed terms of reference and action plan by the end of June 2016 Simon confirmed there would be a need for a similar arrangement with the North Middlesex, to cover residents in East Haringey	July Board Update included in CEO report	SP
93.02	There would need to be an implementation plan with robust monitoring in order to be able to gauge benefits, as well as building this into the ICSU performance review process. The Board approved the business case, subject to the production of the implementation plan and monitoring at TMG.	On ICSU workplan Complete On TMG forward plan	RL/ CG LS

Whittington Health NHS

ITEM: 02
Doc: 16/081

The draft minutes of the meeting of the Trust Extraordinary Board of Whittington Health held in public at 1400hrs on Wednesday 8 June 2016 at Simmonds House

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Carol Gillen	Acting Chief Operating Officer
	Siobhan Harrington	Director of Strategy/Deputy CEO
	Deborah Harris-Ugbomah	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Anu Singh	Non-Executive Director
In attendance:	Greg Battle	Medical Director, Integrated Care
	Lynne Spencer	Director of Communications & Corporate Affairs
Apologies:	Norma French	Director of Workforce

1. Declaration of Conflicts of Interest

No member of the Board declared any conflicts of interest in the business scheduled for discussion at the Extraordinary Board meeting.

2. Apologies and welcome

Steve Hitchins welcomed everyone to the meeting and recorded apologies from the Director of Workforce, Norma French.

Steve confirmed that the Board had convened the meeting to ensure members were provided with sufficient time to review the Account and that stakeholder views could be included.

3. Quality Account Review 2015/16 and Quality Account 2016/17

Dr Richard Jennings highlighted that the Quality Account was developed for a three year period in 2015 and that the priorities aligned to the Trust Sign up to Safety Plan agreed by the Trust Board in 2015.

Stakeholder views had been included in the draft Account with some outstanding commentary due to be received later that week which will be added to the Account before submission to the DH on 30 June.

The Auditors had reviewed the Account and reported to the Audit and Risk Committee on 1 June in line with statutory requirements and confirmed that once all the stakeholder views had all been included they will issue a clean opinion.

Richard reported that the Quality Account included a review of performance against the previous year's priority and reiterated that the document was written for a three year timeline. The Account included a statement on quality from the Chief Executive and set out the priorities for Whittington Health which had been agreed with commissioners and these included our CQUINs.

The Account documented the Trust participation in clinical audits and research and provided an update on Information Governance and the Care Quality Commission requirements and compliance.

Graham Hart highlighted a factual error and it was agreed to clarify the correct target number for improvements in research studies outside of the meeting and amend the Account.

The Trust Board approved the Quality Account 2016/17 subject to the amendments listed above.

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Action Notes Summary

03	All stakeholder views to be added to the Quality Account before submission to the DH 30 June	Completed	PD
03	Graham Hart highlighted a factual error and it was agreed to clarify the correct target number for improvements in research studies outside of the meeting and amend the Account.	Completed	RJ

Whittington Health Trust Board

6 July 2016

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/083**	**Paper**	**03**
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:	30 June 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

We have a robust zero tolerance approach to MRSA bacteremia breaches and will continue to keep this as our top patient safety and quality priority. We reported zero MRSA breaches throughout May and this retains our year to date performance of zero breaches.

Clostridium Difficile

In May we reported zero cases of Clostridium Difficile. The target is for no more than 17 cases in each year and year to date we have reported 2 cases; both in April. We will continue to 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

We are pleased to have exceeded all our 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 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 96%
- 31 days to subsequent treatment (drugs)100% against a target of 98%
- 62 days from referral to treatment 88.1% against a target of 85%
- 14 days cancer to be first seen 97.6% against a target of 93%
- 14 days to be first seen for breast symptomatic 98.1% 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 reported:

- MSK waiting time – non consultant led patients seen in May – 39.5% against the target 95% - year to date 40.5%
- MSK waits – consultant led patients seen in April – 59.6%% against the target 95%
- IAPT – patients moving to recovery – reported 47.4% in April against the target 50%

Care Quality Commission (CQC)

Following the Trust's formal visit by the CQC in December 2015, publication of the report with recommendations is expected to be received during this month.

2. STRATEGIC

Clinical Collaboration Board

Last month our Board agreed to establish a clinical collaboration board with our valued colleagues from UCLH. The objectives include working with the wellbeing partnership in Islington and Haringey to deliver improvements for older people, musculo-skeletal, cardiovascular and diabetes services. Both trusts will explore and identify other areas of potential collaboration at speciality level ensuring a sustainable and viable future.

Sustainability and Transformation Plan

We are working with our partners across North Central London (NCL) by attending a series of meetings to:

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

This important partnership work is described further in the report attached to this briefing.

3. OPERATIONAL

Emergency Department (ED)

Pressures within the emergency care pathway continue and our 4 hour performance for May was 85.9% against a target of 95%.

The clinical and operational teams are implementing a comprehensive improvement plan that will see numerous changes in how we manage our emergency pathway differently in 2016/17 to make sure we regain compliance with our performance target for 2016/17. The work which our teams are focusing on is pre 11am discharge from every ward, 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.

New Adolescent Bay

We are pleased to have opened an adolescent bay in the hospital which was designed with the help of young patients. This means adolescent patients (12 to 17 years) have their own area, away from younger children, where they can relax in a chill out space which has books, music and games. The redevelopment was funded from a £5,000 hospital charitable donation and books, toys and games were donated from St Aloysius College in Highgate. We would like to thank our supporters for their fantastic generosity which is making a big difference for our young patients.

4. FINANCE

Month 2

We reported a £0.4m deficit at the end of May which takes the year to date deficit to £1.4m; £0.3m better than the planned position.

The total pay expenditure for May was £18.5m; an increase compared to the last quarter of 2015/16 (£18m) and the monthly average during 2015/16 (£17.8m). Agency costs were £1.3m which is a 3% increase compared to last year. The largest increases were in Emergency and Urgent Care up 69% and Medicine, Frailty and Networked Services up 21%. The majority of spend relates to specials, sickness and vacancy cover. All other areas reported a reduction in agency costs.

Reducing agency spend to our cap of £9.6m is a high priority and we are introducing rigorous controls led by our senior clinical and operational teams with the support of the PMO and executive teams. Non-pay expenditure of £6.7m was consistent with 2015/16.

CIP delivery was disappointing at £63,000 against our plan of £502,000. The year to date performance is £126,000 against our plan of £911,000. We remain focused to achieve a £10m CIP for the year and both clinical and operational teams will be working with our central PMO to get back on track over the summer months.

Our cash balance of £2m was £1.3m off plan due to late payment of debt relating to the 2015/16 financial year. The finance team will be rigorously managing our cash on a daily basis until we return to financial balance.

5. AWARDS

We are delighted that our specialist cancer team have been shortlisted for a prestigious 'Cancer Care Patient Safety Award' for their work in improving the experience and care of people living with the condition. These awards recognise teams that are striving to improve patient safety

Congratulations to our clinical coding team who won the May staff excellence award. The team achieved 100% coding of 62,072 'admitted care finished consultant episodes' within 10 working days of each month. The coding work is extremely important for the Trust to get right in order that we maximise our income and submit high quality and accurate data for our commissioners.

Simon Pleydell
Chief Executive Office

North Central London
Sustainability and
Transformation Plan

North Central London
Sustainability and Transformation plan

Summary of progress to date
June 2016

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

Barnet
Camden
Enfield Council
Haringey
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
Moorfields Eye Hospital 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

Content

North Central London Sustainability and Transformation Plan

1 The background of Sustainability and Transformation Plans

North Central London Sustainability and Transformation Plan

1. The NHS Five Year Forward View team set out a challenging vision for the NHS. Its aim is to bring local health and care partners together to set out clear plans to pursue the Forward View's **'triple aim'** to improve:

- the health and wellbeing of the population
- the quality of care that is provided
- NHS finance and efficiency of services

The NHS England 2016/17 **planning guidance** outlines a new approach to help ensure that health and care service are planned by **place** rather than around individual organisations.

There are 44 **Sustainability and Transformation Plans (STPs)** being developed in local geographical areas or **'footprints'** across the country that are being submitted to NHS England for approval. North Central London (NCL) is one of the five London footprints.

3. The most **compelling and credible** STPs will secure **funding from April 2017 onwards**. 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.

1 North Central London has a complex health and social care landscape

North Central London Sustainability and Transformation Plan

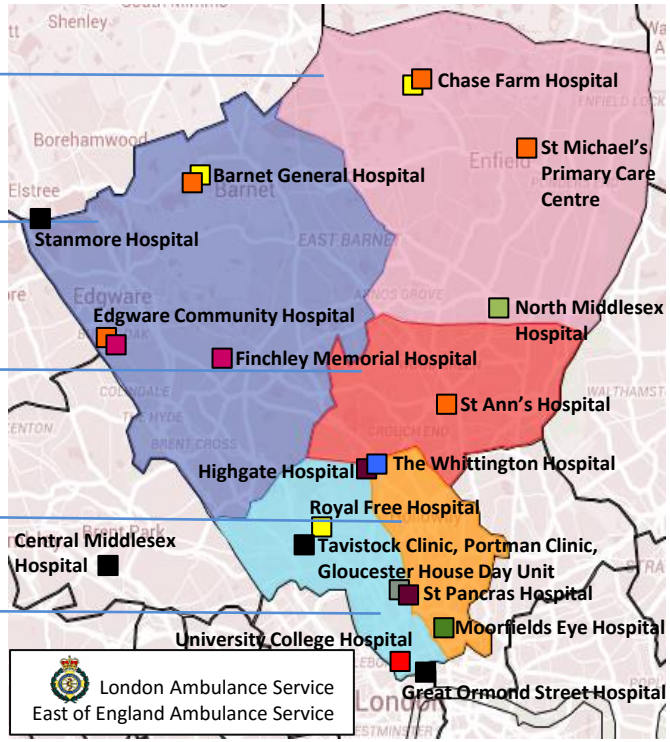
Enfield CCG / Enfield Council
~320k GP registered pop, ~324k resident pop
48 GP practices
CCG Allocation: £362m (-£14.9m 15/16 OT)
LA ASC, CSC, PH spend: £184m

Barnet CCG / Barnet Council
~396k GP registered pop, ~375k resident pop
62 GP practices
CCG Allocation: £444m (£2.0m 15/16 OT)
LA ASC, CSC, PH spend: £158m

Haringey CCG / Haringey Council
~296k GP registered pop, , ~267k resident pop
45 GP practices
CCG Allocation: £341m (-£2.8m 15/16 OT)
LA ASC, CSC, PH spend: £163m

Islington CCG / Islington Council
~233k GP registered pop, , ~221k resident pop
34 GP practices
CCG Allocation: £339m (£2.7m 15/16 OT)
LA ASC, CSC, PH spend: £138m

Camden CCG / Camden Council
~260k GP registered pop, , ~235k resident pop
35 GP practices
CCG Allocation: £372m (£7.2m 15/16 OT)
LA ASC, CSC, PH spend: £191m



Vanguards in scope
- Royal Free multi-provider hospital model
- Accountable clinical network for cancer (UCLH)

NCL CCGs activity stats

A&E	522,838
Elective	134,513
Non-elective	163,487
Critical Care	25,718
Maternity	45,528
Outpatients	1,803,202

Total GP registered population 1.5m

Our population
- Our population is **diverse and growing**.
- Like many areas in London, we experience **significant churn** in terms of people using our health and care services as people come in and out of the city.
- There is a **wide spread of deprivation** across NCL – we have a younger, more deprived population in the east and south and an older, more affluent population in the west and north.
- There are high numbers of households in **temporary accommodation** across the patch and around a quarter of the population in NCL **do not have English as their main language**.
- Lots of people come to settle in NCL from abroad. The largest **migrant communities** arriving during 2014/15 settling in Barnet, Enfield and Haringey were from Romania, Bulgaria and Poland. In Camden and Islington in 2014/15 the largest migrant communities were from Italy, France and Spain.

Total health spend £2.5b

Total care spend c.£0.8b

NHS England
- Primary care spend ~£180m
- Spec. comm. spend ~£730m

15/16 OT		
£185m	-£12.4m	BEH Mental Health NHS Trust (main sites, incl Enfield community)
£136m	£0.7m	Camden and Islington NHS FT (and main sites)
£249m	-£8.3m	North Middlesex University Hospital NHS Trust
£951m	-£51m	The Royal Free London NHS FT
£940m	-£31m	University College London Hospitals NHS FT
£293m	-£14.8m	Whittington Health NHS Trust (incl Islington and Haringey Community)
£202m	£2m	Moorfields Eye Hospital NHS FT
N/A – not in scope for NCL STP finance base case		Central and North West London NHS FT (Camden Community)
		Central London Community Healthcare NHS Trust (Barnet Community)

The specialist providers are out of scope: GOSH and RNOH
Tavistock and Portman NHS FT is out of scope financially but within scope for mental health

Note: all OT figures are normalised positions

1 We have agreed 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

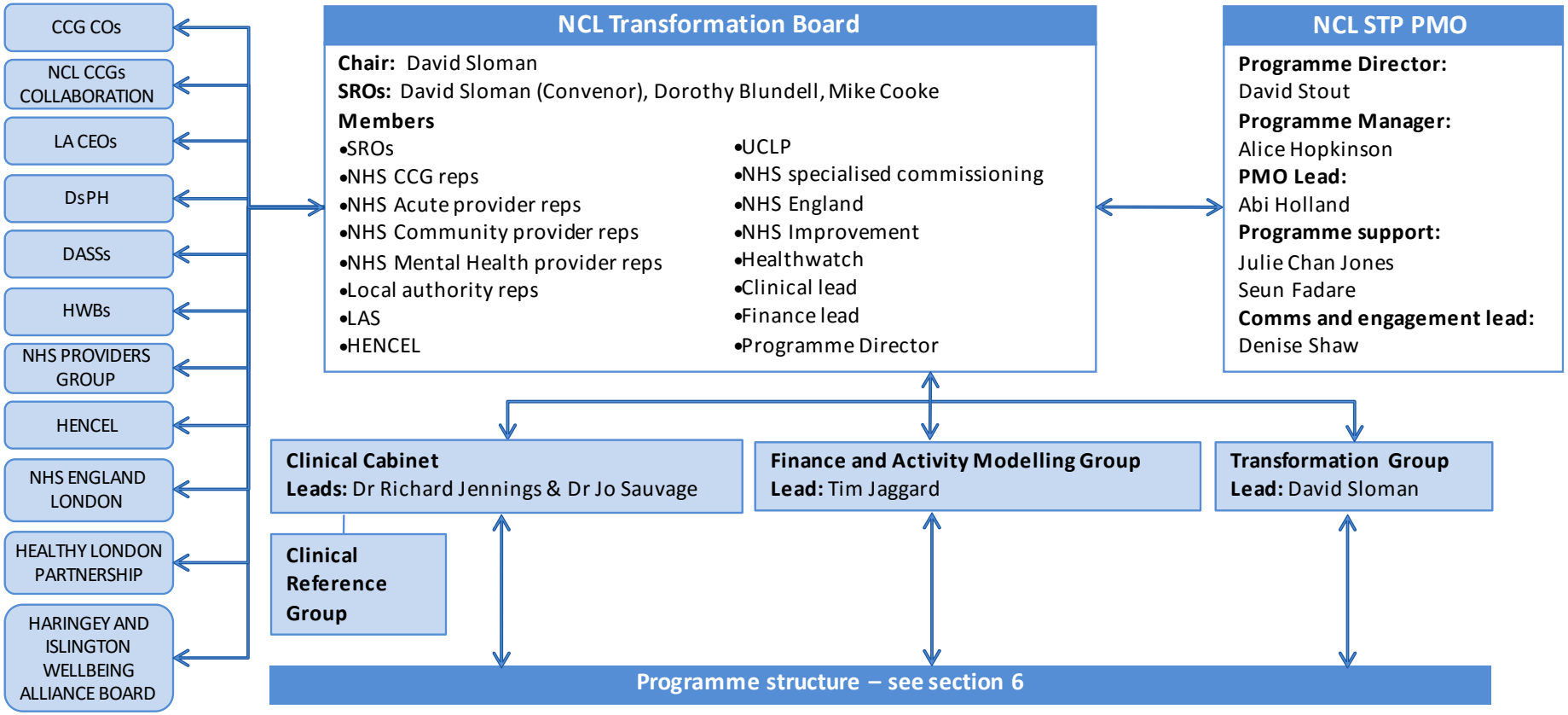
The **process** to developing our STP needs to:

- 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

2 We have developed a robust governance structure that enables collaborative input and steer from across the STP partners

North Central London Sustainability and Transformation Plan

The NCL STP **Transformation Board** meets monthly to oversee the development of the programme and includes representation from all programme partners. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. There are three subgroups supporting the Transformation Board. The **Clinical Cabinet** provides clinical and professional steer and input with CCG Chair, Medical Director, nursing, public health and adult social services and children's services membership. The **Finance and Activity Modelling Group** is attended by Finance Directors from all partner organisations. The **Transformation Group** is a smaller steering group made up of a cross section of representatives from organisations and roles specifically facilitating discussion on programme direction for presentation at the Transformation Board. Every workstream has a senior level named SRO to steer the work and ensure system leadership filters down across the programme. The **Clinical Reference Group** will be mobilised over the summer of 2016 and will provide a forum for input, review and co-design with a broader pool of clinicians and practitioners.



* Programme Governance Structure to be reviewed as programme moves into implementation

3 Case for Change

North Central London Sustainability and Transformation Plan

Clinical cabinet	• The NCL STP Clinical Cabinet is responsible for the Case for Change. Their role is to is lead the further development of STP work • The Clinical Cabinet will sign off the Case for Change with ultimate responsibility falling to the NCL STP clinical lead
Development and engagement process to date	• The Clinical Cabinet has met five times, since its inception, to develop a robust and accurate Case for Change for North Central London's health and social care • On 13 June, the Clinical Cabinet agreed the draft Case for Change, pending some outstanding issues; this was then endorsed by the Transformation Board on 22 June • Draft Case for Change was part of the submission sent to NHS England on 30 June; their feedback is expected in July • From now until the end of September, the Clinical Cabinet will move the Case for Change from draft to a comprehensive, final document which will be published in late Summer.

Initial messages from the Case for Change	• Some high level messages from analysis relating to our population's health and wellbeing are:
	  • People are living longer but in poor health
	  • Our different ethnic groups have different health needs
	  • There is widespread deprivation and health inequalities
	  • High levels of homelessness and households in temporary housing
	  • Lifestyle choices put people at risk of poor health and early death
	  • There are poor indicators of health for children
	  • High rates of mental illness among both adults and children
	• When analysing our care and quality metrics, we identify the following:
	  • There is not enough focus on prevention across the whole NCL system
	  • Disease could be detected and managed much earlier
	  • There are challenges in provision of primary care
	  • There is a lack of integrated care and support for those with a LTC
	  • Many people are in hospital beds who could be cared for at home
	  • There are differences in the way planned care is delivered
	  • There are challenges in mental health provision and in the provision of cancer care
	  • Some buildings are not fit for purpose
	  • Information technology needs to better support integrated care.
	• Initial financial analysis show we face a significant financial challenge. If we continue on our current spending path, the deficit will rise substantially over the next five years

4 In response to the case for change, we have collectively developed an overarching vision for NCL which will be delivered through the STP

North Central London Sustainability and Transformation Plan

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind. It will be supported by a world class, integrated health and social care system designed around our residents.

This means we will:

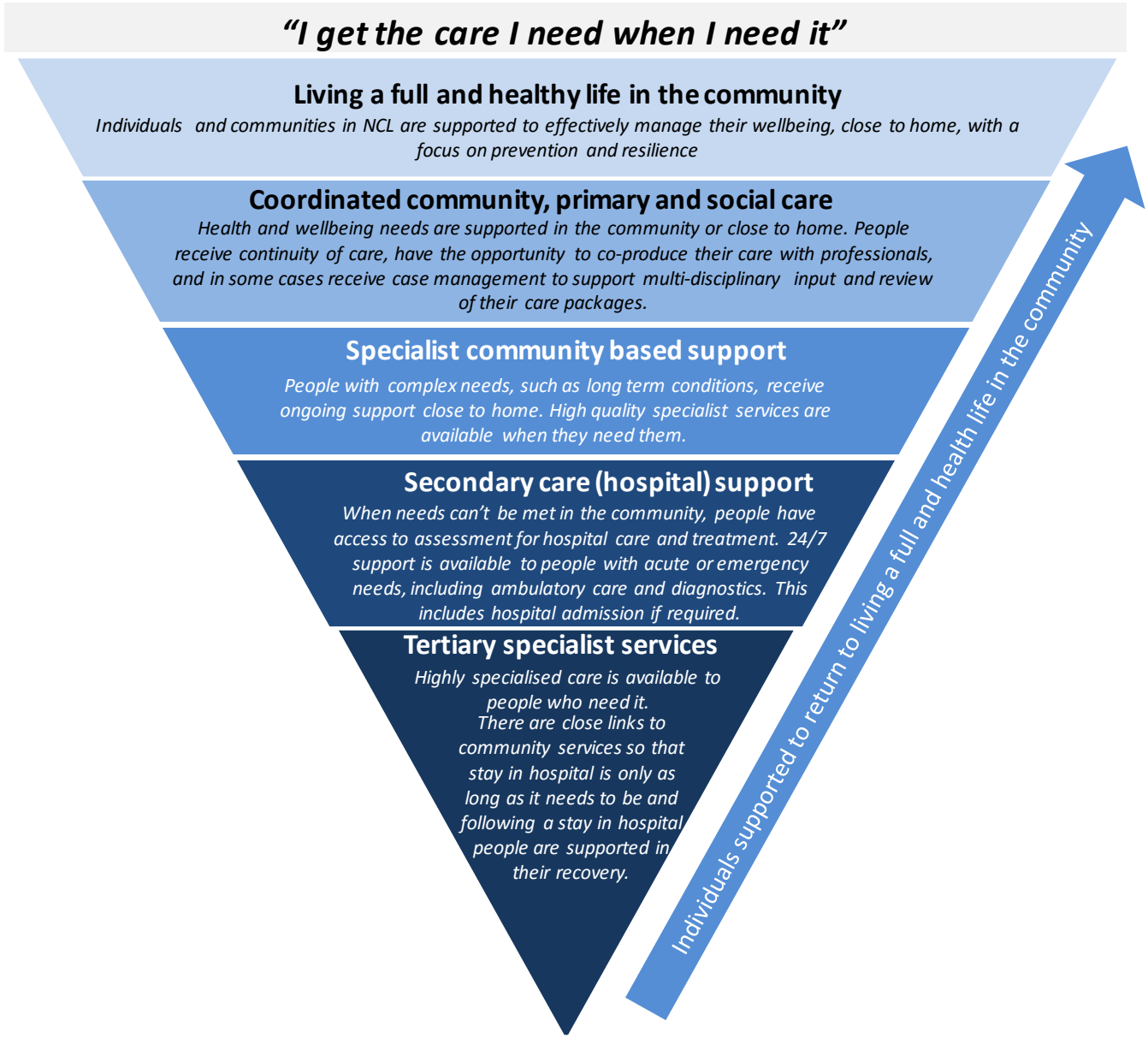
- help people who are well, to stay healthy
- work with people to make healthier choices
- use all our combined influence and powers to prevent poor health and wellbeing
- help people to live as independently as possible in resilient communities
- deliver better health and social care outcomes, maximising the effectiveness of the health and social care system
- improve people's experiences of health and social care, ensuring it is delivered close to home wherever possible
- reduce the costs of the health and social care system, eliminating waste and duplication so that it is affordable for the years to come
- at the same time we will ensure services remain safe and of good quality
- enable North Londoners to do more to look after themselves
- have a strong digital focus, maximising the benefits of digital health developments.

Our core principles are:

- residents and patients will be at the heart of what we do and how we transform NCL. They will participate in the design of the future arrangements.
- we will work together across organisational boundaries and take a whole system view
- we will be radical in our approach and not be constrained by the current system
- we will harness the world class assets available to us across the North Central London communities and organisations
- we will be guided by the expertise of clinicians and front line staff who are close to residents and patients
- we will build on the good practice that already exists in North Central London and work to implement it at scale, where appropriate
- we will respect the fact that the five boroughs in NCL have many similarities, there are significant differences which will require different responses in different localities.

4 The vision will be delivered through a consistent model of care

North Central London Sustainability and Transformation Plan



5 We are in the process of designing a cohesive programme that is large scale and transformational in order to meet the challenge

North Central London Sustainability and Transformation Plan

	A Health and wellbeing	B Care and quality	C Productivity	D Enablers
High level impact	• Improves population health outcomes • Reduces demand	• Increases independence and improves quality • Reduces length of stay	• Reduces non value-adding cost	• Facilitates the delivery of key workstreams
Initiatives	1. Population health including prevention *(David Stout, STP PD)* 2. Primary care transformation *(Alison Blair, ICCG CO)* 3. Mental health *(Paul Jenkins, TPFT CEO)*	4. Urgent and emergency care *(Alison Blair, ICCG CO)* 5. Optimising the elective pathway *(Richard Jennings, Whittington MD)* 6. Consolidation of specialties *(Richard Jennings, Whittington MD)*	7. Organisational-level productivity including: a) Commissioner b) Provider *(FDs)* 8. System productivity including: a) Consolidation of corporate services b) Reducing transactional costs and costs of duplicate interventions *(Tim Jaggard, UCLH FD)*	9. Health and care workforce *(Maria Kane, BEHMHT CE)* 10. Health and care estates *(Cathy Gritzner, BCCG CO and Dawn Wakeling, Barnet Council DASS)* 11. Digital / information *(Neil Griffiths, UCLH DCEO)* 12. New care models & new delivery models *(David Stout, STP PD)* 13. Commissioning models *(Dorothy Blundell, CCCG CO)*

6 What we aim to achieve from each of our workstreams

North Central London Sustainability and Transformation Plan

A Health and wellbeing	Population health	Focus on preventative care to achieve better health and care at a lower, cost, with a reduction in health inequalities
	Primary care transformation	Reduce demand by upgrading out of hospital care and support, for individuals with different types of needs
	Mental health	Joining up of mental and physical health, analysis of social determinants and supporting population to live well
B Care and quality	Urgent and emergency care	Improve care through integrated approach across health and social care
	Optimising the elective pathway	Understand the variation in delivery between acute providers to improve patient safety, quality and outcomes
	Consolidation of specialities	Identifying clinical areas which might benefit form consolidation
C Productivity	Organisational-level productivity	Efficiencies gained through better alignment of health and care services
	System productivity	Improved delivery opportunities in areas such as: workforce management, pharmacy, medical, surgical and food procurement and distribution, pooled digital information and corporate functions
D Enablers	Health and care workforce	Develop new workforce model, focused on prevention and self-care, including review of existing roles and requirements
	Health and care estates	Management of One Public Estate to maximize the asset and improve facilities for delivering care
	Digital/ information	Develop the digital vision: inc. digitally activated population, enhanced care delivery models, integrated digital record access and management
	New care models & new delivery models	Work with Kings Fund to develop our delivery model for population health for NCL
	Commissioning models	Develop strong commissioning through partnership working to develop whole population models of care, improve patients outcomes and financial and quality gaps

7 Current position

North Central London Sustainability and Transformation Plan

Establishing effective partnership working

- NCL-wide collaborative working is a relatively new endeavour and we continue to **build relationships** across the programme partners to ensure that health and care commissioners and providers are aligned in our ambition to transform care
- We have established a governance framework that supports **effective partnership working** and will provide the **foundation** for the planning and implementation of our strategic programme going forward
- 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

Understanding the size of the challenge

- We have undertaken **analysis to identify the gaps** in health and wellbeing, and care and quality in NCL in order to prioritise the areas we need to address
- Our draft Case for Change provides a narrative in support of **working in a new way** and provides the platform for **strategic change** through identifying key areas of focus
- Finance directors from all organisations have been working to identify the **projected NCL health and care position** in 20/21 should we do nothing

Delivering impact in year one

- There is already **work in train** that will ensure delivery of impact before next April, in particular, CCG plans to build capacity and capability in primary care and deliver on the 17 specifications in the **London Strategic Commissioning Framework** (SCF).
- However, **further work** must be done to broaden our **out of hospital strategy** and address issues with regard to the short-term sustainability and viability of general practice
- The **implementation of our Local Digital Roadmap** will support the delivery of the mental health, primary care and estates work, and our two Vanguards are continuing to progress with their plans.

8 We will ensure all our stakeholders and wider programme partners are appropriately involved in the development of the programme

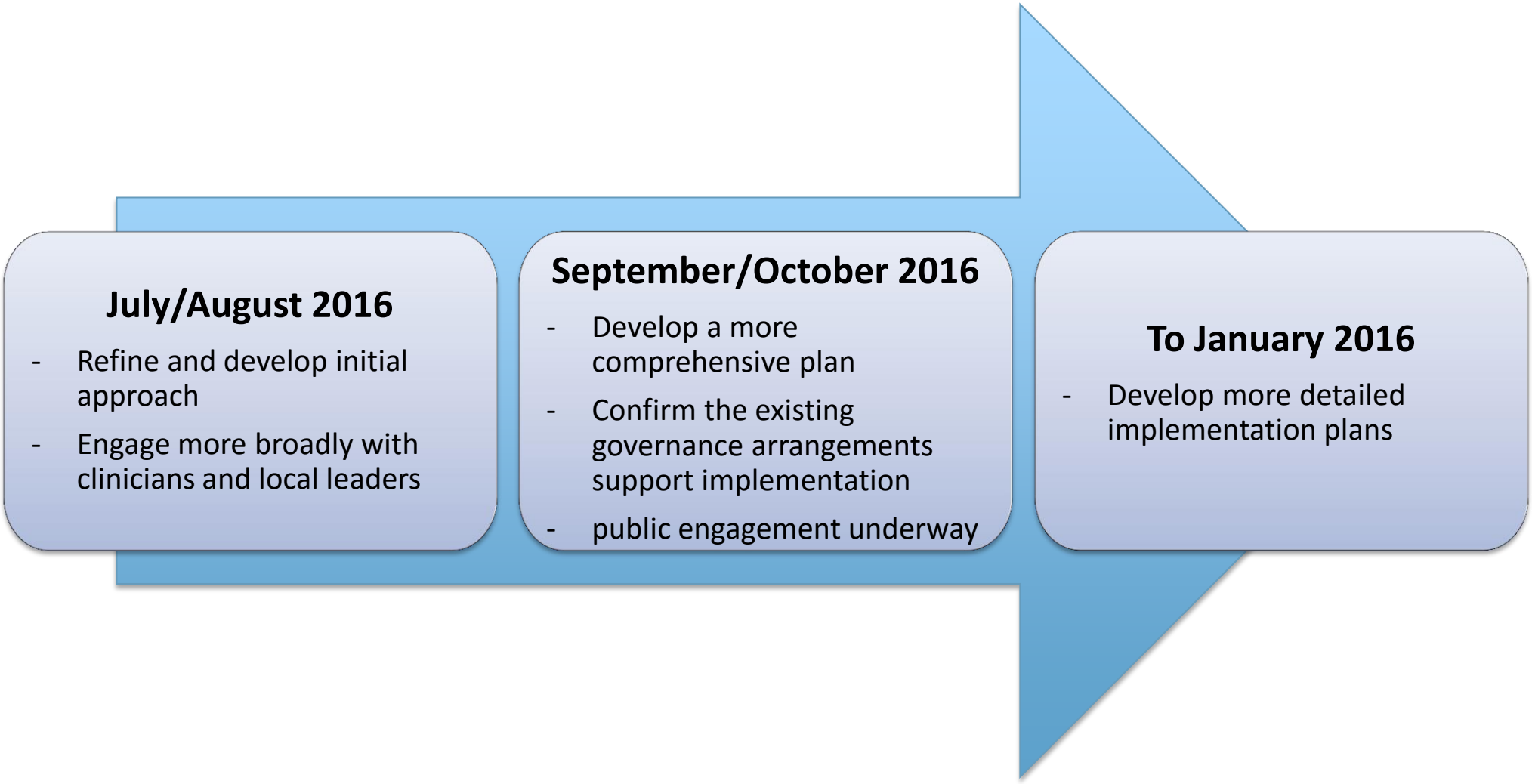
North Central London Sustainability and Transformation Plan

Engagement to date	Communications & engagement objectives	Delivering the objectives

Workstreams have been engaging with relevant stakeholders to develop their plans.
• The general practice transformation workstream has worked collaboratively with the London CCGs (and local groups of GPs) to develop pan-London five year plan
• Mental health workstream was initiated at stakeholder workshop in January 2016 and a further workshop in May. Further service user and carer engagement is done via programme updates and specification for a citizens panel is being developed
• Significant engagement was undertaken through reprocurement of 111 process in urgent and emergency care workstream
• The estates workstream has been developed through a working group, with representatives from all organisations in scope including Moorfields, the Office of the London CCGs, Community Health Partnerships, Healthy Urban Development Unit (HUDU) and GLA
• NCL Digital Roadmap Group meets to define, shape and contribute to the interoperability programme with representation from all key organisations
• Early engagement with Health & Wellbeing Boards and the Joint Overview & Scrutiny Committee
	• To support the engagement and involvement of STP partners across all organisations at all levels
	• To ensure a strong degree of organisational consensus on the STP content and on the approach to further developing the strategic plan and implementation approach, in particular political involvement and support
	• To support and co-ordinate STP partners in engaging with their stakeholders to raise awareness and understanding of:
	  • the challenges and opportunities for health and care in NCL
	  • how the STP – specifically the emerging priorities and initiatives - seeks to address the challenges and opportunities so that we can develop the best possible health and care offer for our population
	  • what the NCL strategic plan will mean in practice and how they can influence its further development and implementation
	• To encourage and gather feedback from stakeholders – NHS, local government, local and national politicians, patients and the wider community – that can:
	  • influence our emerging plans and next steps
	  • help build support for the STP approach
	• To ensure equalities duties are fulfilled, including undertaking equalities impact assessments
		• Forward planning underway to join up all partners and stakeholders in NCL footprint
		• Dedicated communications lead now in place to undertake this
		• Stakeholder mapping underway for external and internal bodies through integrated work approaches with CCG communications and engagement leads to include partners such as local authorities, NHS providers, GP practices and others to be determined
		• In addition to partners and stakeholders already consulted, we will identify opportunities for more STP partners clinicians/staff to have input into specific work streams asap, particularly local political engagement which will be key for community leadership of change
		• Plan to engage more formally with boards and partners after the July conversations
		• Effective communications channels will be established for all stakeholders and partners for transparent contributions to ongoing plans and discussions, including staff, clinicians, patients, politicians etc.
		• A core narrative is being created to cover our health and care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – in person-centred, accessible language
		• Review requirements for consultation before March 2017

9 Next steps for development of the STP

North Central London Sustainability and Transformation Plan



Nursing and Patient Experience
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

6 July 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**16/084**	**Paper**	**4**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of May 2016. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	13/06/2016		

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

Serious Incidents Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of May 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/Associate 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 declared 6 serious incidents during May 2016 bringing the total to 10 since 1st April 2016.

In addition, 3 current investigations have extended deadlines agreed;

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

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

c). Catastrophic subdural haematoma after a patient fell on an escalator (Deceased) – a second extension has been requested due to the fact that the Trust had difficulties in appointing an independent external Trauma Centre Neurosurgical Consultant.

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 colo-rectal cancer
Medication Incident Ref; 33733	Oct 15	Patient sustained long term harm from prolonged treatment with oral antimicrobials
Slip/Trips Falls Ref 604	Dec 15	Patient suffered a subdural haematoma following a fall on an escalator.

Unexpected Admission to NICU- Baby Ref 757	Feb16	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 abnormal results not followed-up and later found to be abnormal.
Information Governance Breach Ref:9747	Apr 16	Two reports were inadvertently placed in incorrectly labelled envelopes.
Intrauterine Death Ref:11789	Apr 16	Intrauterine death diagnosed by ultrasound scan.
Unexpected Death Ref:11950	May 16	Potentially avoidable death due to delayed diagnosis of leaking abdominal aortic aneurysm.
Information Governance Breach Ref:12430	May 16	Two discharge letters inadvertently placed in one envelope
Delayed Diagnosis Ref:12421	May 16	Delay in diagnosis resulting in delayed intervention.
Unexpected Admission to NICU- Baby Ref:12428	May 16	Admission of term baby to the neonatal unit following a category 2 emergency caesarean section.
Information Governance Breach Ref:12432	May 16	Incorrect discharge summary sent to patient.
Safeguarding Incident Ref:13782	May 16	Safeguarding incident in relation to a patient on a currant case load

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported 6 serious incidents in May 2016

STEIS 2016-17 Category	Apr	May	Total
Safeguarding	0	1	1
Confidential information leak/loss/Information governance breach	1	2	3
Diagnostic Incident including delay	2	1	3
Maternity/Obstetric incident mother and baby (includes foetus/neonate/infant)	1	1	2
Unexpected death	0	1	1
Total	4	6	**10**

4. Submission of SI reports

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

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

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, actions taken to improve services and learn from mistakes. A 'being open' meeting is offered in line with duty of candour recommendations.

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

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

4.1 The Trust ubmitted 9 reports to NELCSU in May 2016.

4.2. The table below provides a brief summary of lessons learnt and actions put in place relating to serious incident investigation reports submitted in May.**Summary**	**Actions taken as result of lessons learnt**
• **Ref 835**	**Maternity/Obstetric incident** Unexpected maternal death following delivery of probable cardio myopathy related to an existing health condition. • Following the recommendation from the SI panel, ITU now have a dedicated phone line to contact ralatives to allow easy identification of the caller (or missed call). • The guideline detailing management of pregnant patients who attend the Emergency Department has been reviewed and relaunched.
• **Ref:4117**	**Sub-optimal care of the deteriorating patient meeting SI criteria.** • Training for ward staff to ensure appropriate escalation of abnormal observations. • Monthly audit of patient 'observation' findings in addition to teaching programme on all in-patient wards. • The Trust has carried out a review of its current bed management and transfer policy. Revised policy developed.
• **Ref: 4100**	**Slip/Trips Falls** Patient sustained a fractured neck of femur following an unwitnessed fall. • Review of the pathway of patients admitted with delirium

4.2. The table below provides a brief summary of lessons learnt and actions put in place relating to serious incident investigation reports submitted in May.**Summary**	**Actions taken as result of lessons learnt**
	• Business case developed for a Falls and Delerioum Clinical Nurse Specialist post • 'STOP falls' project launched 16/06/16
• **Ref:5552**	**Unexpected Admission to NICU- Baby** Baby born in poor condition, requiring resuscitation: • All staff involved to attend a reflective session with their supervisor of midwives or educational supervisor and participate in a documentation audit.
• **Ref: 5535**	**Slips/trips/falls meeting SI criteria** Patient sustained a fractured neck of femur following an unwitnessed fall. • The Trust Bed Management Policy and process has been reviewed and includes advice on considering location of patients at high risk of falls and who require close observation. • A falls bundle is being developed to incorporate a multifactorial falls risk assessment. • Falls and dementia training is now included in the induction for all new ward staff and regular updates for existing staff.
• **Ref:5557**	**Maternity Birth Centre Closure** Maternity Birth Centre forced to close due to insufficent beds. • The Maternity Escalation Plan Policy has been updated and has been shared with all staff groups involved in the decision making process so that they are clear on the correct procedures to follow. • A review of the bed servicing contract is currently being undertaken to ensure that a robust system will be in place for timely repairs or replacement of beds. • Medical Devices Committee will review the investigation report, subsequent action plan and current Service Level Agreement. • Medical Devices Committee will monitor regular audits and contractor's performance.
• **Ref: 5989**	**Delayed Diagnosis** Sub optimal care relating to sepsis pathway and the implementation of care plans. • A new sepsis pathway has been introduced in ED and sepsis reminder cards have been issued.

4.2. The table below provides a brief summary of lessons learnt and actions put in place relating to serious incident investigation reports submitted in May.**Summary**	**Actions taken as result of lessons learnt**
	• The Trust has reinforced early identification of sepsis and following Sepsis 6 pathway in ED and throughout the Trust through education programmes. • A review of equipment used within the Trust ED (Manual blood pressure machine and Ultrasound machine) is being undertaken. • Full occupancy protocol and Standard Operating Procedure required for ED - A review of the Trusts current escalation plans, triggers and actions has been undertaken and a revised escalation plan has been approved and implemented.

5.0 Sharing Learning

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

6.0 Summary

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

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

Trust Board

6 July 2016

Title:	Safe Staffing - Nursing and Midwifery – May data		
Agenda item:	**16/085**	**Paper**	**5**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in May 2016. Key issues to note include: • All areas reported greater than 90 per cent 'actual' versus 'planned' staffing levels with the exception of Mary Seacole South. • Eight ward areas reported Registered Nurse 'actual' hours worked above those 'planned'. These were attributed in the main to an increase in patients requiring 1:1 'specialling' • The number of shifts required for 'specialling' purposes decreased slightly in May (93) compared to April (100) • 4 shifts initially triggered 'Red' in May with subsequent remedial action immediately taken		
Summary of recommendations:	Trust Board members are asked to note the May UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care, Francis Report recommendations, Cummings recommendations and NICE recommendations.		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	June 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		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Safe Nurse Staffing Levels

1.0 Purpose

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

2.0 Background

2.1 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.

2.2 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st May 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

3.1 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.

3.2 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.

3.3 Appendix 1 details a summary of fill rates 'actual' versus 'planned' in May 2016. The average fill rate was 99.3 % for registered staff and 115.9 % for care staff during the day and 101.3% for registered staff and 112 % for care staff during the night.

3.4 Eight wards reported below 95% fill rates for qualified nurses but were managed safely by moving staff from other green RAG rated areas and with support from matrons and practice development nurses. Above 100% fill rates occurred in eight areas where nurses were required to care for patients who required 1:1 care due to high dependency, acuity or mental health needs.

4.0 Additional Staff (Specials 1:1)

4.1 When comparing May's requirement for 1:1 'specials' with previous month, the figures demonstrate a high level of need (Appendix 2). May saw 93 requests for 1:1 specials compared to 100 requests in April. 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 lower in May (83) compared to April (160).The reason behind the continued use of temporary RMN specials is the high level of patients with mental health disorders requiring therapeutic interventions across the Emergency Department, Mary Seacoles North and South and Victoria ward.

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

5.1 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.

5.2 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.

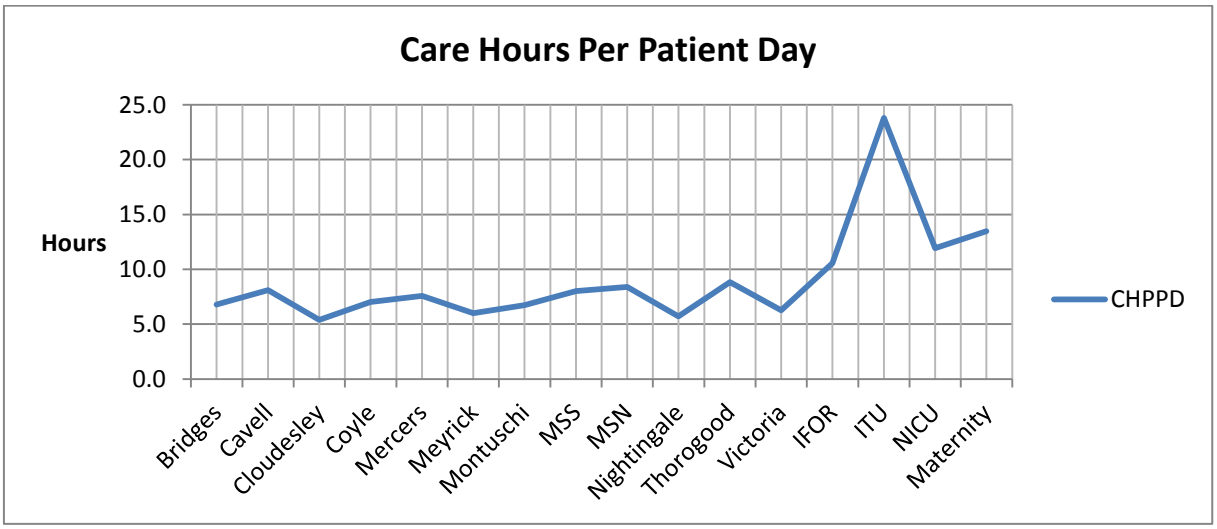
- Red shifts are determined to be at an unsafe level. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability. In 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.

5.3 In summary, in May a total of 4/1395 (0.3%) shifts triggered 'red' which was higher than the one shift in the previous month. All red shifts this month occurred in one ward (Meyrick) in the Medicine and Frailty ISCU 4/558 = 0.7%

6.0 New Requirements: Care Hours per Patient Day (CHPPD)

6.1 New reporting requirements have been requested by 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

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



6.3 The graph above shows the average individual care hours per patient for each clinical area. Intensive Therapy Unit have the most care hours (23.8) and Cloudesley ward have the least (5.4).

6.4 The overall average number of hours of Registered Nurse time spent with patients is calculated at 6.53 hours and 2.15 hours for care staff. This gives an overall average of 8.68 hours of care per patient day

	CHPPD
Registered Nurse	6.53
Care Staff	2.15
Overall hours	8.68

6.5 The collection of this measure was introduced in May 2016 and further guidance will be issued nationally in due course.

7.0 Conclusion

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

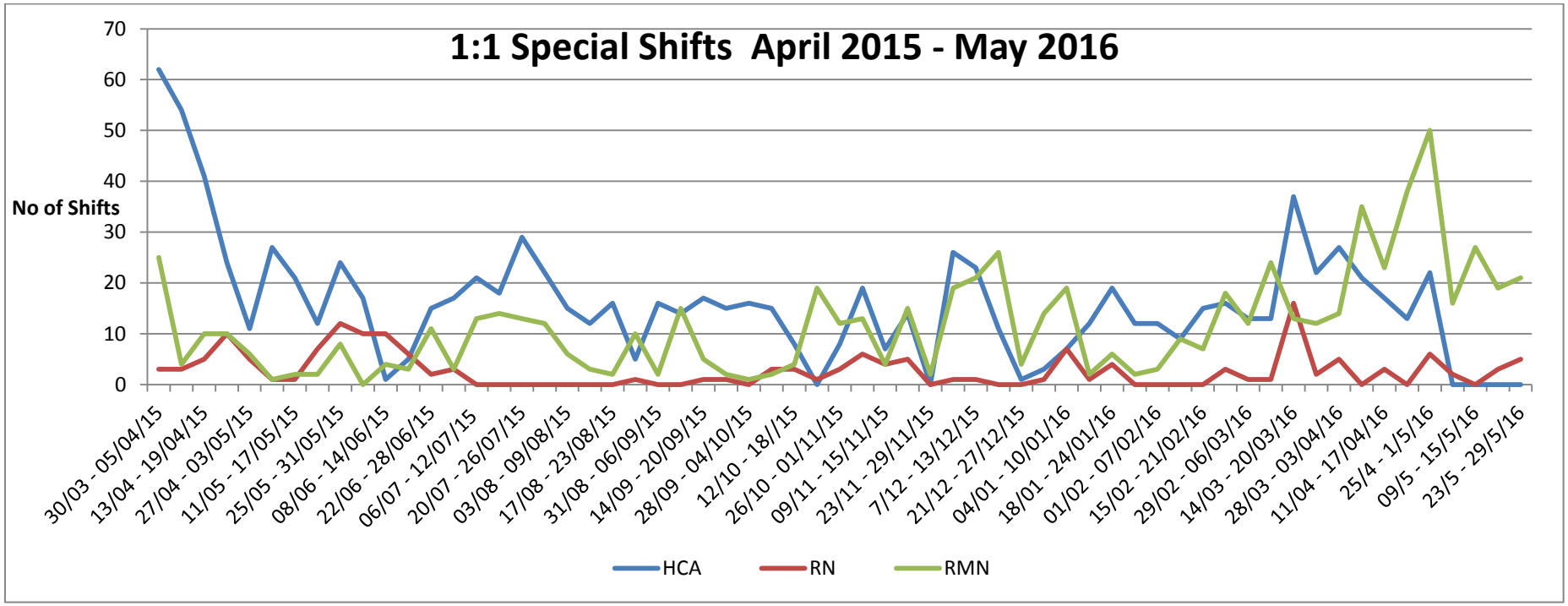
Fill rate data - summary
May 2016

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				
33970 Hours	33732 Hours	9757 Hours	11310 Hours	27433 Hours	27777 Hours	7931 Hours	8883 Hours	99.3%	115.9%	101.3%	112.0%

Care Hours per Patient Day

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
9413	6.53	2.15	8.68

May 2016


1:1 Special Shifts April 2015 - May 2016
No of Shifts
70
60
50
40
30
20
10
0
30/03 - 05/04/15
13/04 - 19/04/15
27/04 - 03/05/15
11/05 - 17/05/15
25/05 - 31/05/15
08/06 - 14/06/15
22/06 - 28/06/15
06/07 - 12/07/15
20/07 - 26/07/15
03/08 - 09/08/15
17/08 - 23/08/15
31/08 - 06/09/15
14/09 - 20/09/15
28/09 - 04/10/15
12/10 - 18//15
26/10 - 01/11/15
09/11 - 15/11/15
23/11 - 29/11/15
7/12 - 13/12/15
21/12 - 27/12/15
04/01 - 10/01/16
18/01 - 24/01/16
01/02 - 07/02/16
15/02 - 21/02/16
29/02 - 06/03/16
14/03 - 20/03/16
28/03 - 03/04/16
11/04 - 17/04/16
25/4 - 1/5/16
09/5 - 15/5/16
23/5 - 29/5/16
HCA
RN
RMN

Whittington Health NHS
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Trust Board – Finance Report

06 July 2016

Title:	May (month 2) 2016/17 - Financial Performance		
Agenda item:	16/086	**Paper**	6
Action requested:	This report updates the Board of Directors on the financial performance of the Trust for May 2016 (month 2), following the meeting of the Finance and Business Development Committee (F&BD) on 06 July 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 May 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:	22 June 2016		

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

Finance overview | Financial Sustainability Risk Rating

The Trust achieved its planned Financial Sustainability Risk rating of 2.

Financial Sustainability Risk Ratings	YTD Plan	YTD Actual	YTD Variance
Liquidity Ratio (days)	1	1	0
Capital Servicing Capacity (times)	1	1	0
I&E Margin Rating	1	1	0
I&E Margin Variance from Plan	4	4	0
Overall Financial Sustainability Risk Rating	**2**	**2**	**0**

Finance overview | Statement of comprehensive income

The Trust reported a £0.4m deficit at the end of May (month 2), which takes the ytd deficit to £1.4m. This was £0.3m better than the planned position.

in £000	In Month Budget	In Month Actual	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Nhs Clinical Income	21,382	22,145	763	42,768	43,879	1,110	255,973
Non-Nhs Clinical Income	1,900	1,951	51	3,799	3,750	-49	22,794
Other Non-Patient Income	2,101	2,019	-82	4,203	4,110	-93	25,860
Total Income	**25,383**	**26,114**	**732**	**50,770**	**51,738**	**968**	**-304,627**
Non-Pay	6,556	6,689	-133	13,114	13,360	-245	79,470
Pay	18,340	18,470	-131	36,779	37,174	-395	217,341
Savings	0	0	0	0	0	0	0
Contingency	0	0	0	0	0	0	0
Total Operating Expenditure	**24,896**	**25,159**	**-264**	**49,894**	**50,534**	**-640**	**296,811**
EBITDA	**487**	**955**	**468**	**876**	**1,204**	**328**	**7,816**
Depreciation	690	731	-41	1,380	1,377	3	8,280
Dividends Payable	350	359	-9	700	718	-18	4,310
Interest Payable	269	250	18	534	505	28	3,334
Interest Receivable	3	3	0	6	4	-2	36
Other Finance Costs	0	0	0	0	0	0	0
P/L On Disposal Of Assets	0	2	-2	0	2	-2	0
Total	**1,306**	**1,341**	**-35**	**2,608**	**2,598**	**10**	**15,888**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-819**	**-386**	**433**	**-1,732**	**-1,394**	**338**	**-8,072**
Add back impairments and adjust for IFRS & Donate	5	7	2	10	13	3	60
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-814**	**-380**	**434**	**-1,722**	**-1,384**	**338**	**-8,012**

The key area of management focus from this report is the total pay expenditure which for May was £18.5m. 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 May position by category.

Within total pay expenditure agency staff related costs were £1.3m for the month, this is a 3% increase compared to the average monthly cost of agency staff during 2015/16. The largest relative increases were seen in Emergency and Urgent Care (↑ 69%), and Medicine, Frailty and Networked Services (↑21%). The majority of this agency spend relates to specials, followed by sickness and vacancy cover.

All other areas reported a reduction in agency costs compared to 2015/16 rolling monthly averages.

Reducing agency staff 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.

May non-pay expenditure of £6.7m was largely consistent with the monthly trend in 2015/16 (see Appendix Graph 2).

The positive income variance was driven by a number non-recurrent items including revenue for system resilience beds which remain open in Q1, income relating to 2014/15 written off bad debt but has been paid following extensive discussions and discharged long stay patients in critical care.

Finance overview | Cost improvement programme

CIP delivery in month was £63,000 against a plan of £502,000. The year-to-date performance stands at £126,000 against a plan of £911,000.

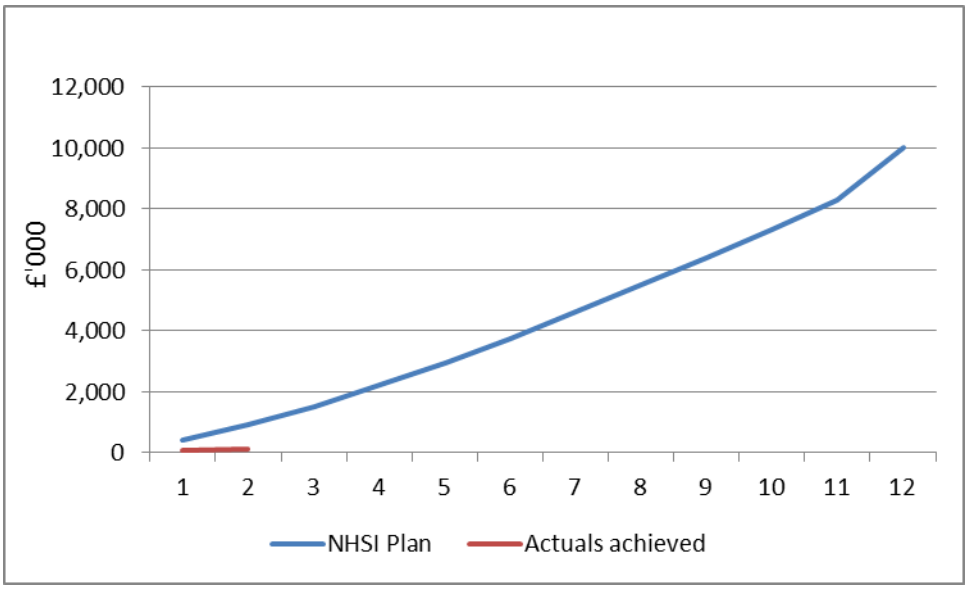
The Trust has a planning to achieve no less than £10m CIP in 2016/17.

The PMO is working with ICSUs and corporate teams to achieve £10.5m of new cash releasing efficiency schemes as part of the overall two year target of £25m.

The calculation of ICSU targets excluded prior-year non-recurrent CIP and missed CIP so a decision was taken not to include carry-forward CIP. There will be some carry-forward in procurement and on prior year property which will be included in corporate reporting. This is expected to be £600,000. In addition to this there are a specific reserve based schemes which have a target of £1m. This means that the schemes represent in excess of 120% of the annual plan target.

ICSU	In Month			YTD		
	Plan (£)	Actual (£)	Variance (£)	Plan (£)	Actual (£)	Variance (£)
Children'S Services	64	0	-64	122	0	-122
Clinical Support Services	52	0	-52	93	0	-93
Corporate Services	34	8	-26	54	17	-37
Emergency & Urgent Care	40	6	-34	72	12	-59
Med, Frailty & Networked Serv	85	3	-82	151	5	-146
Op, Prevention & Lt Conditions	27	0	-27	48	0	-48
Surgery	147	12	-135	264	24	-240
Women & Family Services	61	2	-59	108	2	-107
Sub Total	**509**	**30**	**-479**	**911**	**60**	**-851**
Prior Year savings	0	33	33	0	66	66
Total	**509**	**63**	**-446**	**911**	**126**	**-785**

Delivery year to date is low but the PMO roadmaps show significant improvement in month 4 onwards so the value of CIP is forecast to increase. The PMO is working with ICSUs and corporate areas to close the gap on schemes with high and medium confidence levels and the £10.5m target.



Finance overview | Statement of financial position

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

Property, Plant & Equipment (incl. Intangible Assets): The Trust's capital programme is currently on target. It is worth noting that the programme includes £10m relating to the Maternity development which is awaiting approval from NHSI and DH.

The current variance of £2.2m for property, plant and equipment is due to planning drift following the close of the 2015/16 accounting period. This will be corrected when the Trust resubmits its plan in June

Trade Receivables: The variance is due to the delayed settlement of outstanding activity invoices for 2015/16. These were received in early June.

Payables: The increase in creditors is mainly due to cash shortage and delays in agreeing leases with CHP and NHS Property Services. Payments will be increased in June following the payment of CCG debts.

Borrowings: The Trust will borrow, as planned an additional £8.9m this year to support its financial position.

			Year to Date		Year to Date
	As at 1 April 2016 £000	Plan 1 April 2016 £000	Plan YTD 31 May 2016 £000	As at 31 May 2016 £000	Variance YTD 31 May 2016 £000
Property, plant and equipment	194,782	199,788	192,098	193,761	(1,663)
Intangible assets	4,586	2,646	3,699	4,285	(586)
Trade and other receivables	693	956	871	801	70
Total Non Current Assets	**200,061**	**203,390**	**196,668**	**198,847**	**(2,179)**
Inventories	1,404	1,456	1,456	1,570	(114)
Trade and other receivables	23,535	16,003	16,003	31,921	(15,918)
Cash and cash equivalents	2,597	3,060	3,323	2,038	1,285
Total Current Assets	**27,536**	**20,519**	**20,782**	**35,529**	**(14,747)**
Total Assets	**227,597**	**223,909**	**217,450**	**234,376**	**(16,926)**
Trade and other payables	39,112	34,937	33,838	44,734	(10,896)
Borrowings	377	2,156	6,056	2,946	3,110
Provisions	795	756	766	777	(11)
Total Current Liabilities	**40,284**	**37,849**	**40,660**	**48,457**	**(7,797)**
Net Current Assets (Liabilities)	**(12,748)**	**(17,330)**	**(19,878)**	**(12,928)**	**(6,950)**
Total Assets less Current Liabilities	**187,313**	**186,060**	**176,790**	**185,919**	**(9,129)**
Borrowings	52,933	64,613	50,607	52,933	(2,326)
Provisions	1,772	1,514	1,200	1,773	(573)
Total Non Current Liabilities	**54,705**	**66,127**	**51,807**	**54,706**	**(2,899)**
Total Assets Employed	**132,608**	**119,933**	**124,983**	**131,213**	**(6,230)**
Public dividend capital	62,404	62,651	62,651	62,404	247
Retained earnings	(7,872)	(16,984)	(11,934)	(9,274)	(2,660)
Revaluation reserve	78,076	74,266	74,266	78,083	(3,817)
Total Taxpayers' Equity	**132,608**	**119,933**	**124,983**	**131,213**	**(6,230)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**

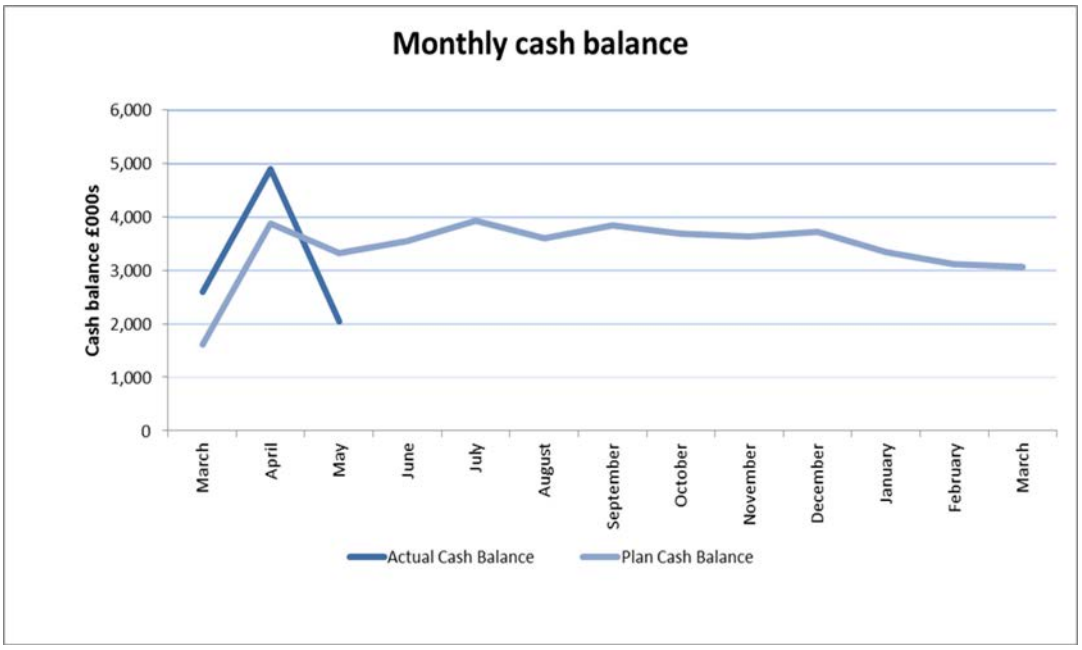
Finance overview | Cash position

The Trust ended the month with a cash balance of £2m which was £1.3m worse than plan. This was due to late payment of debt relating to the 2015/16 financial year. The outstanding invoices were settled in month 3 enabling the Trust in turn to reduce its creditor balances.

In anticipation of delays to CCG payments on over performance outside of NCL and up to the agreed settlement the Trust called down £2.9m of its agreed cash support (£8.9m) in April to fund cash requirements. Discussions are on-going with NHSI in terms of the previously agreed cash support value. It is anticipated that further drawdowns may be required in August.

As a result of the debt collection work being undertaken in month 2 the Trust received £10m on June 1st from local CCGs settling their main 2016/17 activity invoices. This enabled the Trust to make payment to a number of long-standing property creditors.

Cash management as shown as high risk on the risk register to reflect the priority attached to maintaining suitable liquidity during deficit operations. This is likely to remain a high risk for the organisation until such a date as the Trust returns to financial balance.



Financial Tables

Graph 1 – Pay Expenditure Trend

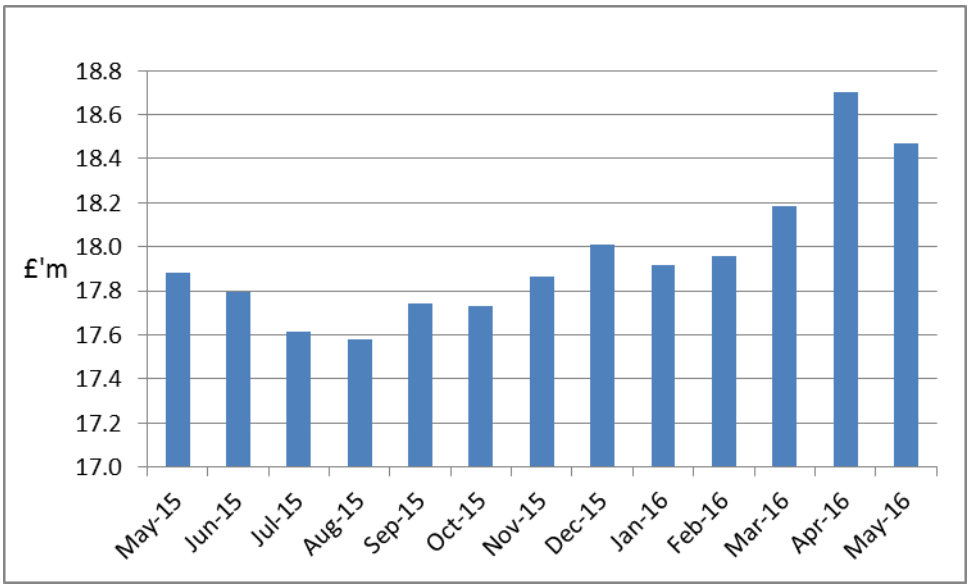
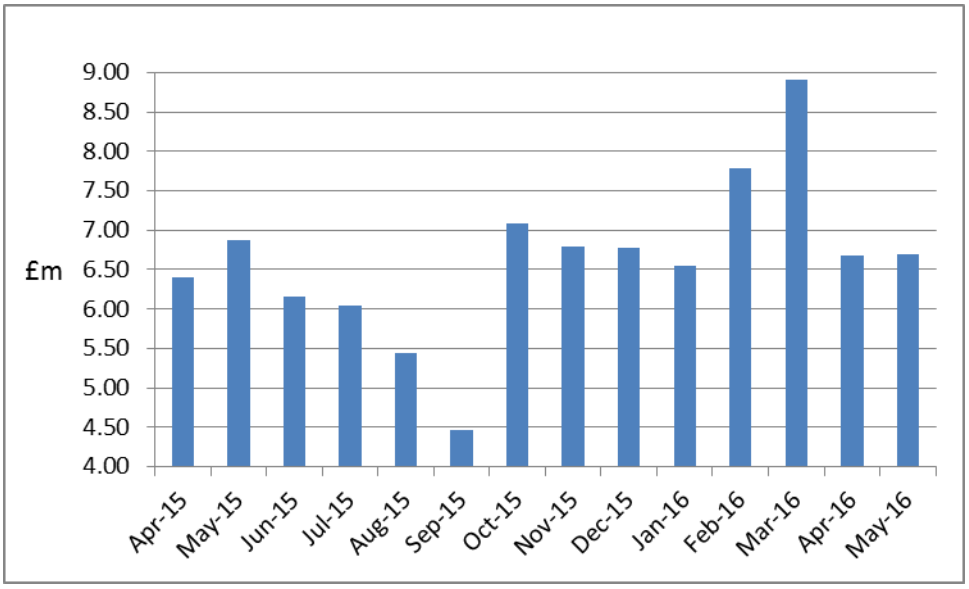


Table 1 - Summary Pay by Category

Pay Area	**May 2016**	**Arithmetic Average 2015/16**	%Change	
Agency	1,298,252	1,257,482	3%	↑
Bank	1,377,738	1,415,838	3%	↓
Locum	157,312	145,369	8%	↑
Permanent	15,636,951	15,007,785	4%	↑
Grand Total	**18,470,253**			

Graph 2 – Non-Pay Expenditure Trend



Whittington Health NHS

Trust Board

07 July 2016

Title:	Revised Financial Plan Submission		
Agenda item:		**Paper**	
Action requested:	To note the paper		
Executive Summary:	This paper updates the Trust Board on the formal revision of the control total for Whittington Health and the resubmission of the financial plan.		
Summary of recommendations:	The Board are asked to note the revised control total and key issues of challenge being cash funding and the agency cap.		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Operational Plan papers.		
Date paper completed:	28 June 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**

Report to the Trust Board
6th July 2016

This paper updates the Trust Board on the formal revision of the control total for Whittington Health and the resubmission of the financial plan.

1 Background

The Trust submitted a plan in May with £6.8m deficit

1.1 The Trust submitted a financial plan in May with a deficit of £6.4m which was lower than the control total of a £12.5m deficit. The plan set out the working capital assumptions and cash support requirement along with the capital spend assumptions.

A formal control total revision was requested

1.2 Following that submission NHSI wrote to the Trust to request the formal change in the control total to the submitted deficit.

2 Detail

The formal control total is now a £6.8m deficit

2.1 The Trust was asked to accept a formal revision of the control total in line with its original plan submission. This means that it will be monitored against this value and match or better it.

2.2 The Trust accepted the revision and noted to NHSI that we look forward to working with you on capital cases in the manner discussed with the London team.

Agency expenditure in the submitted plan exceeds the agency cap and this is likely to be challenged in the assurance process

2.3 The Trust plan included agency expenditure in excess of the £9.6m cap which was challenged. The plan was not changed for the following reasons:

a) we are unlikely to reach the cap based on current spend;

b) had advised NHSI formally we not hit the cap during the original planning round; and

c) had the £11.1m figure signed off by the Board

Cash is likely to be restricted to the deficit total which means a

2.4 The Trust included cash support of £8.9m in the plan which was in line with that previously advised by the Cash Support team. We are now advised that Trusts are not expected to ask for more cash

lower cash support

support than the planned deficit.

The Trust has kept the higher cash support total in the plan but this will be subject to challenge.

2.5 The Trust kept the cash support value at the higher value in total splitting between cash deficit and other support for the following reasons:

a) we require PFI support;

b) there are historic cash flow difficulties; and

c) the Trust will require revenue to capital support for the maternity development as previously discussed with the London team.

2.6 The revised plan was submitted on 29th June

3 Recommendations

The Committee is asked to note revised control total

3.1 The Board are asked to note the revised control total and key issues of challenge being cash funding and the agency cap.

Operations Directorate
Direct Line: 020 7288 5440
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The Whittington Hospital NHS Trust
Magdala Avenue, London N19 5NF

Whittington Health Trust Board
6 July 2016

Title:	Trust Board Report June 2016 (May 16 data) – Month 2		
Agenda item:	**16/087**	**Paper**	**7**
Action requested:	For discussion and decision making		
Executive Summary:	**Theatre Utilisation** Improvement from last month to 81.1% during May 2016 and the number of episodes of care has increased due to successful recruitment of replacement surgeon. Three theatre lists with low utilisation cease from week beginning 4th July 2016 to improve performance in July 2016. A theatre utilisation dashboard is being developed with the I&MT team and will include a range of metrics to comply with theatre benchmarking guidelines. This will form part of the performance dashboard reporting from September. **Cancer** targets all achieved **Hospital Cancellation** target achieved **DNA rates** reduced **Community Cancellations and DNAs** target achieved. **Appointments with no outcomes in the community** have increased in the District Nursing services. The service is reviewing the process on the community database Rio. **District Nursing** Urgent referrals data continues to be an area which requires improvement to move from manual to electronic systems. **The MSK service** continues to face challenges and the number of patients seen within 6 weeks has decreased throughout May. A series of improvement meetings have been held and will continue throughout the summer. These are supplemented by capacity and demand work to ensure the service improves performance to a minimum of 65% compliance by mid-September. **Emergency and urgent care** targets are improving and action plans are in place and monitored each month.		
Summary of recommendations:	That the board approves the performance report		
Fit with WH strategy:	Aligns to clinical strategy		

Reference to related / other documents:	Complies with national and local performance requirements
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on relevant risk register
Date paper completed:	23rd June 2016

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**5/7**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

June 2016 Trust Board Report (May data)

Whittington Health NHS

Quality	Threshold	Mar-16	Apr-16	May-16
Number of Inpatient Deaths	-	36	32	23
NHS number completion in SUS (OP & IP)	99%	98.5%	99.0%	arrears
NHS number completion in A&E data set	95%	96.1%	95.2%	arrears

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

Quality (Mortality index)	Threshold	Dec-15	Jan-16	Feb-16
Hospital Standardised Mortality Ratio (HSMR)	<100	70	101	73
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	85.9	79.3	81.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	65.0	107.6	62.6

Patient Safety	Threshold	Mar-16	Apr-16	May-16
Harm Free Care	95%	93.6%	92.2%	92.7%
VTE Risk assessment	95%	95.1%	95.0%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	1	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	TBC	TBC	TBC
Serious Incident reports	-	2	3	6

Access Standards

Referral to Treatment (in arrears)	Threshold	Feb-16	Mar-16	Apr-16
Diagnostic Waits	99%	98.8%	99.4%	99.6%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Mar-16	Apr-16	May-16
Service Cancellations - Community	8%	6.5%	7.0%	5.7%
DNA Rates - Community	10%	5.6%	6.0%	5.8%
Community Face to Face Contacts	-	58,490	58,718	58,331
Community Appts with no outcome	0.5%	0.4%	2.5%	5.9%

Community Access Standards	Threshold	Mar-16	Apr-16	May-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	49.2%	41.5%	39.5%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	82.2%	59.6%	arrears
IAPT - patients moving to recovery	50%	46.6%	47.4%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	96.8%	95.7%	arrears
GUM - Appointment within 2 days	98%	98.7%	98.7%	98.5%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Mar-16	Apr-16	May-16
First:Follow-up ratio - acute	2.31	1.51	1.46	1.37
Theatre Utilisation	95%	78.3%	78.2%	81.1%
Hospital Cancellations - acute - First Appointments	8%	5.3%	6.2%	4.6%
Hospital Cancellations - acute - Follow-up Appointments	8%	8.1%	9.0%	7.2%
DNA rates - acute - First appointments	10%	12.2%	12.7%	12.3%
DNA rates - acute - Follow-up appts	10%	12.8%	12.5%	11.5%
Hospital Cancelled Operations	0	3	19	4
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	0	5	4

Meeting threshold

Failed threshold

June 2016 Trust Board Report (May data)

Whittington Health NHS

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

Emergency and Urgent Care	Threshold	Mar-16	Apr-16	May-16
Emergency Department waits (4 hrs wait)	95%	81.8%	84.1%	85.9%
ED Indicator - median wait for treatment (minutes)	<60	103	88	88
30 day Emergency readmissions	-	189	159	arrears
12 hour trolley waits in A&E	0	0	0	2
Ambulatory Care (% diverted)	>5%	3.4%	2.9%	2.8%
Ambulance Handover (within 30 minutes)	0	21	23	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

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

Cancer Access Standards (in arrears)	Threshold	Feb-16	Mar-16	Apr-16
Cancer - 14 days to first seen	93%	99.5%	98.8%	97.6%
Cancer - 14 days to first seen - breast symptomatic	93%	98.3%	99.4%	98.1%
Cancer - 31 days to first treatment	96%	100.0%	97.7%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	-
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%
Cancer - 62 days from referral to treatment	85%	81.6%	88.5%	88.1%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Mar-16	Apr-16	May-16
Referral to Treatment 18 weeks - Admitted	90%	76.6%	77.3%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	90.8%	89.2%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	92.7%	93.9%	arrears

Maternity	Threshold	Mar-16	Apr-16	May-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	81.3%	80.1%	80.9%
New Birth Visits - Haringey	95%	85.7%	88.6%	arrears
New Birth Visits - Islington	95%	94.7%	95.1%	arrears
Elective Caesarean Section rate	14.8%	8.8%	10.5%	12.0%
Breastfeeding initiated	90%	93.0%	90.9%	92.1%
Smoking at Delivery	<6%	4.1%	4.4%	6.6%

Meeting threshold

Failed threshold

	Threshold	Trust Actual		
		Mar-16	Apr-16	May-16
Number of Inpatient Deaths	-	36	32	23
Completion of a valid NHS number in SUS (OP & IP)	99%	98.5%	99.0%	arrears
Completion of a valid NHS number in A&E data sets	95%	96.1%	95.2%	arrears

	Standardised National Average	Trust		
		Dec-15	Jan-16	Feb-16
Hospital Standardised Mortality Ratio	<100	70.2	100.7	73.4
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	85.9	79.3	81.0
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	65.0	107.6	62.6

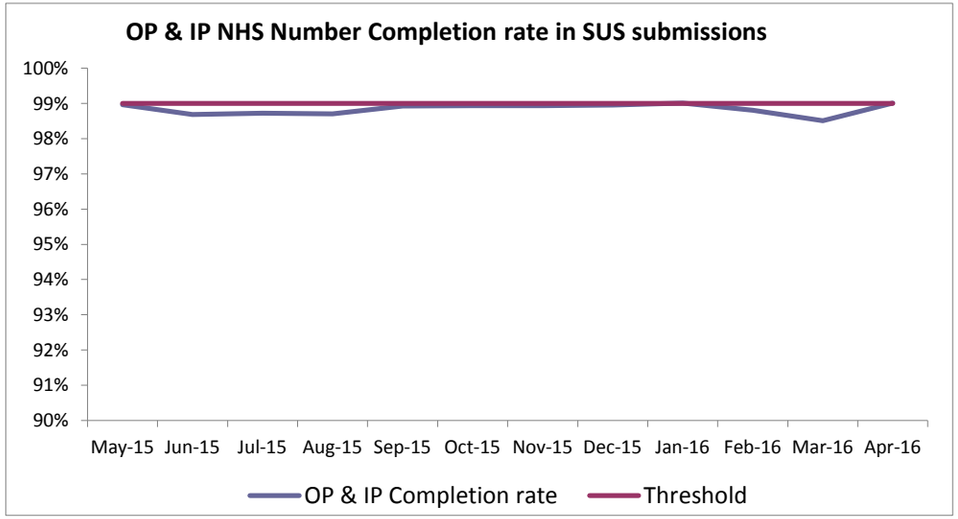
		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Jan 2015 - Dec 2015	0.89	1.13	0.67
	Oct 2014 - Sep 2015	0.89	1.12	0.65
	Jul 2014 - Jun 2015	0.89	1.12	0.66
	Apr 2015 - Mar 2015	0.89	1.12	0.67
	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54

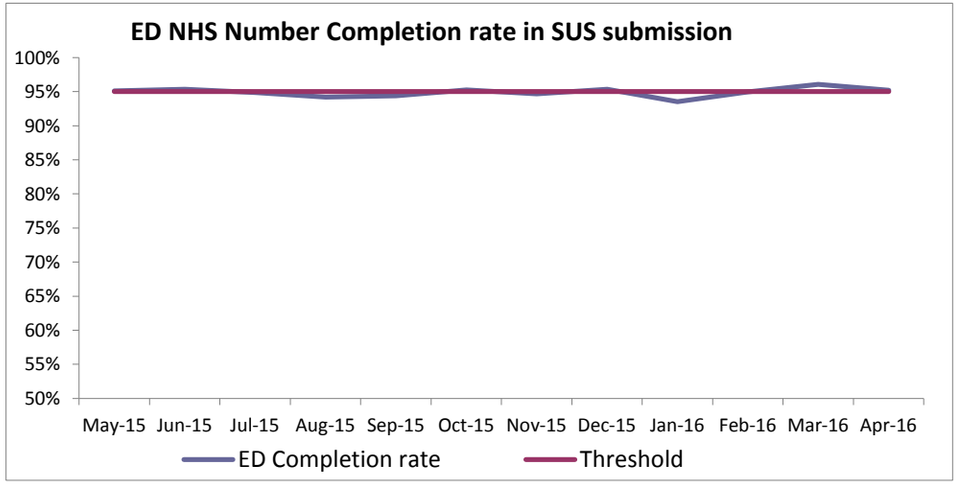
Commentary

Completion of NHS number in SUS
Within target as expected for June 2016

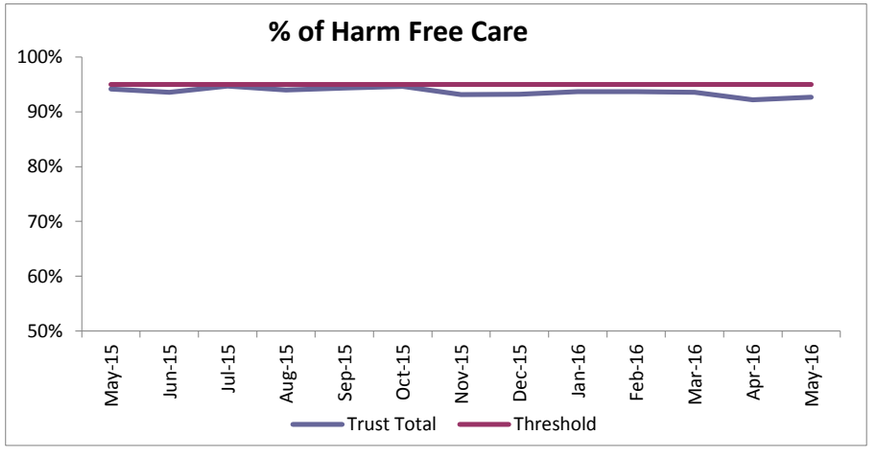
Completion of NHS number in A&E data set
Within target as expected for June 2016

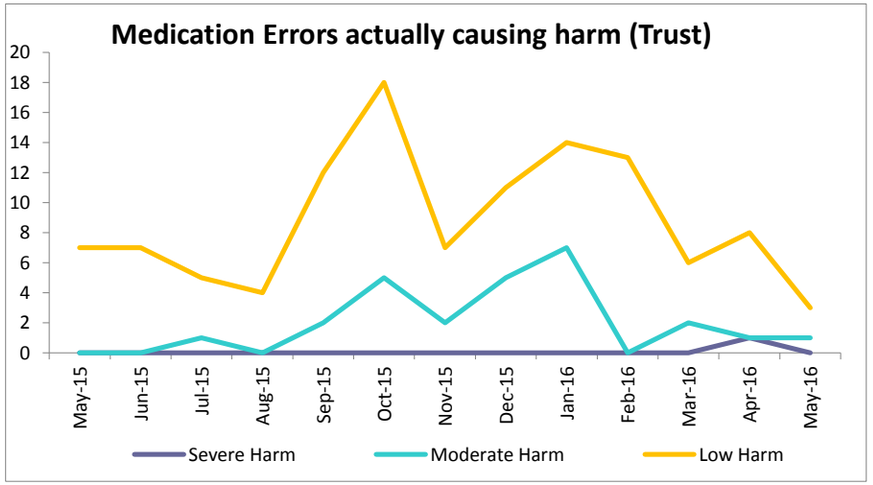
SHMI and HMSR
The above metrics are a ration of observed to expected death.
Whittington Health mortality is, again, below the level that is expected for the hospital.
The two different metric employ slightly different methodologies, so result in different values.
Weekend vs weekend mortality rate show extreme variability, because on a monthly basis the numbers are low. No inference can be made from this data.





	Threshold	Trust Actual Feb-16	Mar-16	Apr-16	May-16	Trend
Harm Free Care	95%	93.7%	93.6%	92.2%	92.7%	
Pressure Ulcers (prevalence)	-	5.33%	5.59%	7.19%	6.35%	
Falls (audit)	-	0.49%	0.46%	0.35%	0.45%	
VTE Risk assessment	95%	95.3%	95.1%	95.0%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	1	0	
Medication Errors actually causing **Moderate** Harm	-	0	2	1	1	
Medication Errors actually causing **Low** Harm	-	13	6	8	3	
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	-	TBC	TBC	TBC	TBC	
Serious Incidents (Trust Total)	-	8	2	3	6	





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: The overall numbers of falls recorded in the Nursing Indicators dashboard remain around 20 per month. IT is below the target of 5 falls per 1000 bed days at 2.73 falls.

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 July 2016

Timescale: Feedback in July 2016

Medication errors causing harm in April 16

There were 60 medication incidents reported on Datix in May 2016. This is the second highest monthly total reported in the last 12 months (61 incidents were reported in December 2015)

Twenty nine (48%) of medication incidents were reported by E&UC of which 15 (25% of the total) occurred in patients' homes. The largest reporting group were district nurses (25%), followed by pharmacists (23%), hospital nurses (22%) and medical staff (12%) The incident causing moderate harm concerned a patient discharged without the correct analgesia. The community care team visited and organised an emergency supply of fentanyl patches. This was followed up with the prescriber and ward pharmacy team. All three incidents causing low harm were reported by E&UC: a patient had been given the incorrect dose of oral morphine and two patients had drug doses omitted.

Proportion of reported patient safety incidents that are harmful

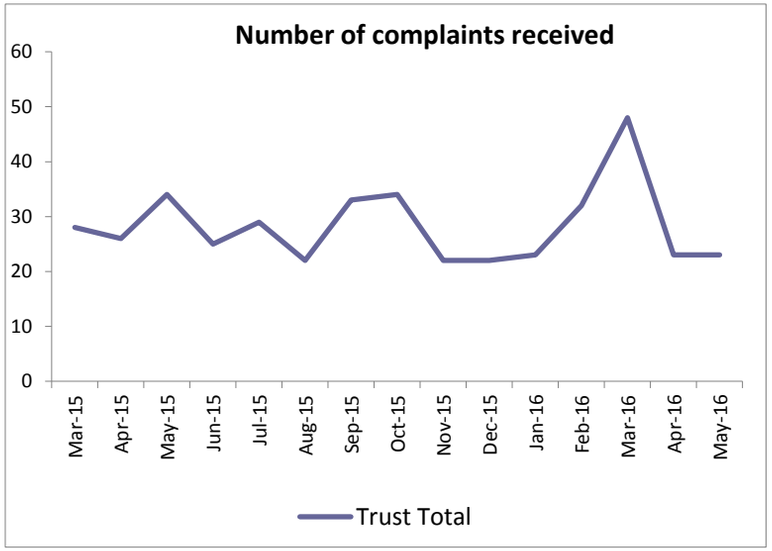
This report is under review due to the review of the Datix system.

Serious Incidents

Whittington Health declared 6 SIs in May 2016 including possible delayed diagnosis of leaking abdominal aortic aneurysm, delayed diagnosis of 2 week wait dermatology, 2 Information Governance breaches, one safeguarding children's and an unexpected admission to NICU.

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

	Threshold	Trust Actual Feb-16	Mar-16	Apr-16	May-16	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	94%	96%	96%	95%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	92%	85%	90%	92%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	88%	88%	95%	92%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	32	48	23	23	
Complaints responded to within 25 working day	80%	-	-	-	90.5%	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	



*'Complaints responded to within 25 working days' now refers to those responses made during reporting month. This is no longer in arrears, but trend data is not available prior to May16

Commentary

Patient Satisfaction (Local standard 90%)
Please see breakdown of FFT to the left.
ED: Similar to last month
Inpatients: Lower response rate than last month. Note Coyle ward in high number of negative responses.
Outpatients: More responses than in previous months. Positive response rate below 90%. Note high number of negative responses in ophthalmology.
Community: Similar to last month. Note Cavell high negative response rate but only 1 negative response.
Mixed Sex Accommodation
Achieved

Complaints
Target achieved for May 2016. Complaints responded to within 25 working days' now refers to those responses made during reporting month. This is no longer in arrears, but trend data is not

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%
May 2016	298	92%	22	7%	324	6742	5%

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	Response Rate
April 2016	567	97%	6	1%	587	3033	19%
May 2016	451	94%	16	3%	482	3111	15%

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
May 2016	150	88%	9	5%	171

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
May 2016	733	97%	5	1%	752

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

	Threshold	Feb 16	Mar 16	Apr 16	May 16	2016/17 Trust YTD
C difficile Infections	17 (Year)	0	0	2	0	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%	

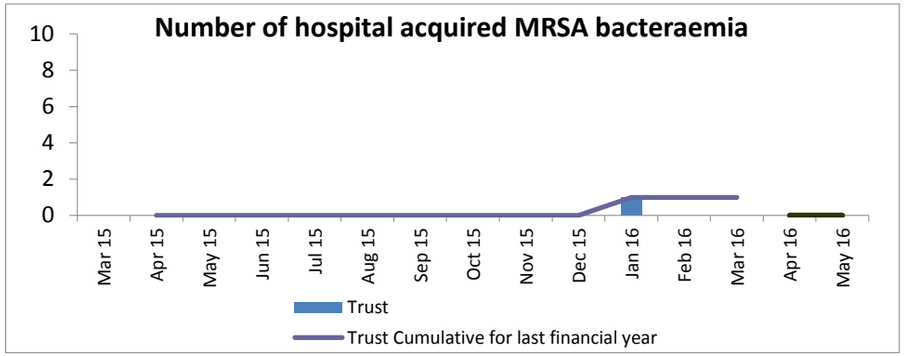
Commentary

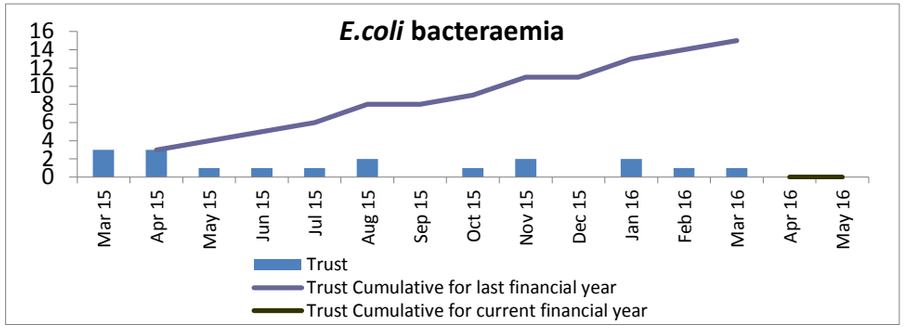
MSRA and E.coli
No new bacteraemia

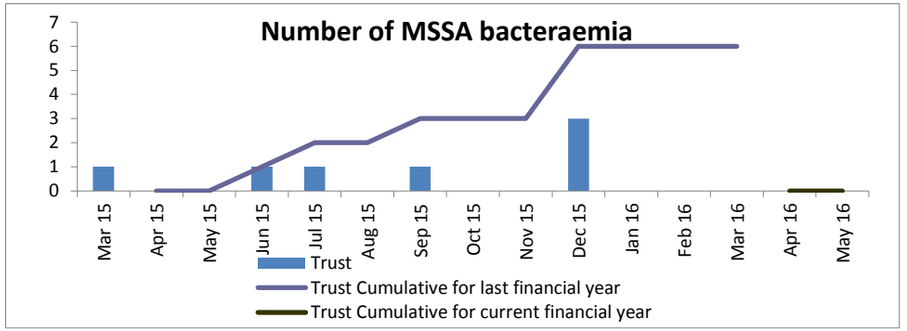
MSSA
No new bacteraemia

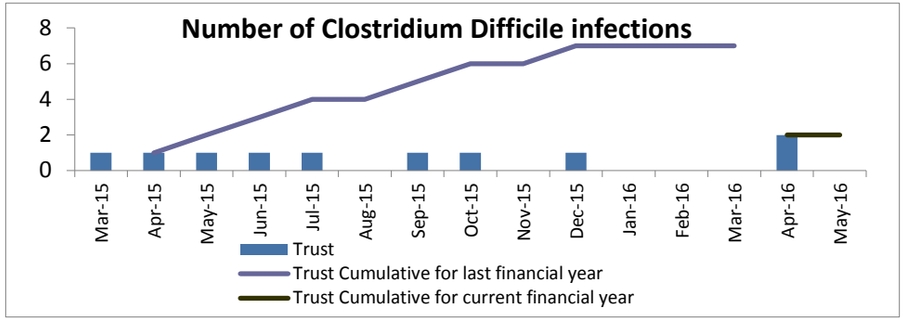
C difficile
Two new bacteraemia and all protocols implemented.

Ward Cleanliness
Issue: Ward Cleanliness figures between March and May 2016 have dropped to 96.9%. The area scoring under 95% are Ante Natal, ED, Clinic 3A, 4A and B and Victoria ward. All other areas score above 95%.
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.





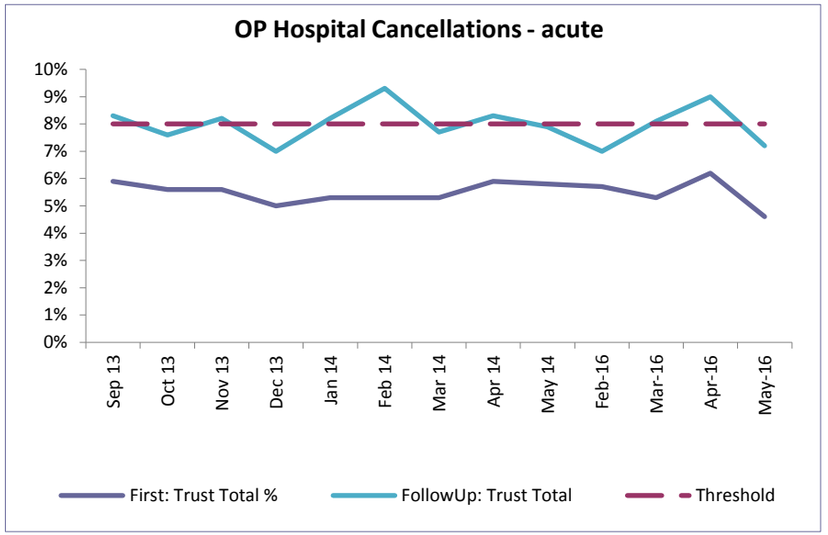


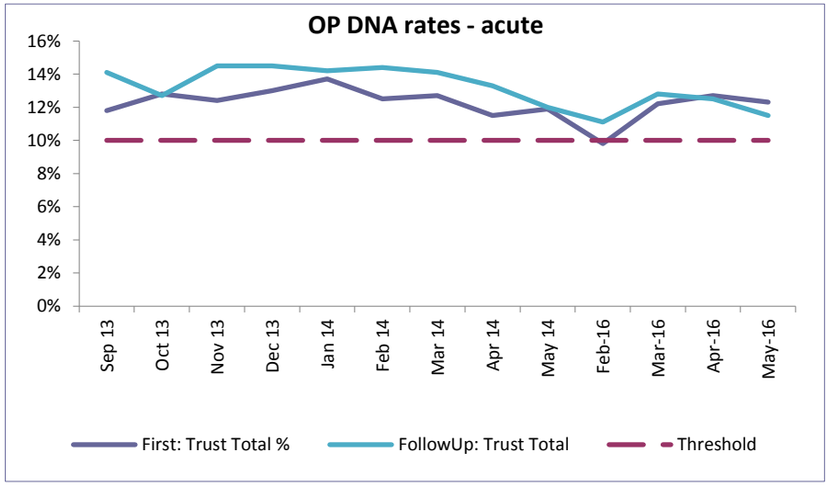


Efficiency and productivity - acute

Whittington Health NHS

	Trust						
	Threshold	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Trend
First:Follow-up ratio - acute	2.31	1.56	1.44	1.51	1.46	1.37	
Theatre Utilisation	95%	81.9%	81.1%	78.3%	78.2%	81.1%	
Hospital Cancellations - acute - First Appointments	<8%	5.8%	5.7%	5.3%	6.2%	4.6%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	7.9%	7.0%	8.1%	9.0%	7.2%	
DNA rates - acute - First appointments	10%	11.9%	9.8%	12.2%	12.7%	12.3%	
DNA rates - acute - Follow-up appointments	10%	12.0%	11.1%	12.8%	12.5%	11.5%	
Hospital Cancelled Operations	0	16	3	3	19	4	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	0	0	0	5	4	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	





Commentary

Theatre Utilisation
Improvement from last month to 81.1% during May 2016, in addition the number of cases being undertaken in theatres has increased due to replacement of vacant surgeons post. Three theatre lists which are not productive and have a low utilisation are stopping from week beginning 4th July 2016. This should improve performance in July 2016. A theatre utilisation dashboard is to be developed with IT to include a range of metrics in line with the Theatre Benchmarking guidelines. This will then be incorporated in the overall Trust dashboard when it is refreshed in the Autumn.

Hospital Cancellations
Within target as expected.

DNA
Just under target for both first and follow up appointments, but improving as expected.
Action: Further improvement to be expected month on month, using NetCall and continuing drive to update the EPR systems with patient details when attending appointments.
Timescale expected improve over the next months.

Hospital Cancelled Operations
Issue: There were 4 reportable cancelled operation of which all were urgent procedures. All were cancelled by the urology service due to no SHO available on the day which was unexpected . All operation were rescheduled within 28 days.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Feb-16	Mar-16	Apr-16	May-16	Trend
Service Cancellations - Community	8%	6.5%	6.5%	7.0%	5.7%	
DNA Rates - Community	10%	5.9%	5.6%	6.0%	5.8%	
Community Face to Face Contacts	-	58,307	58,490	58,718	58,331	
Community Appointment with no outcome	0.5%	0.9%	0.4%	2.5%	5.9%	

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

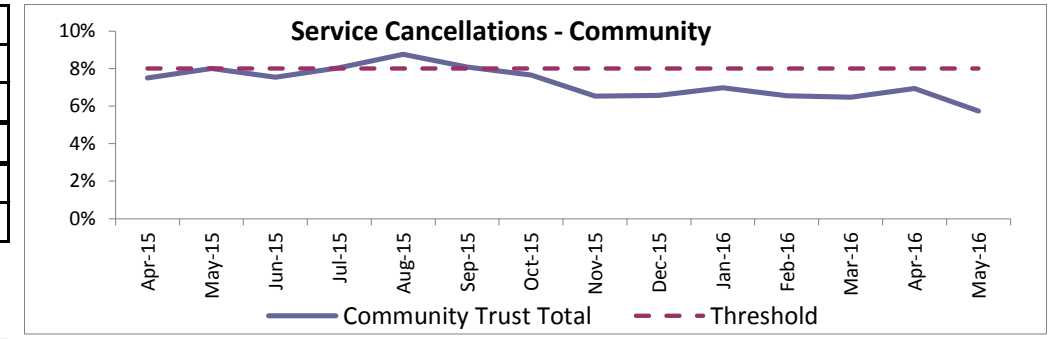
Commentary

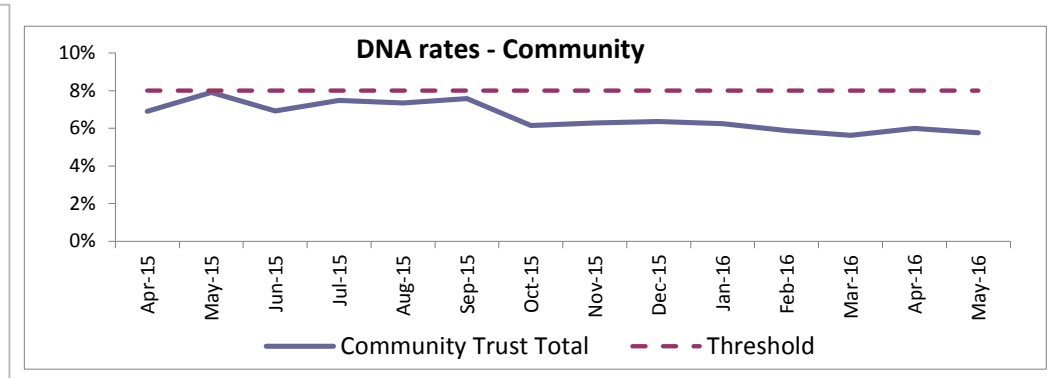
Service Cancellations - Community
Achieved

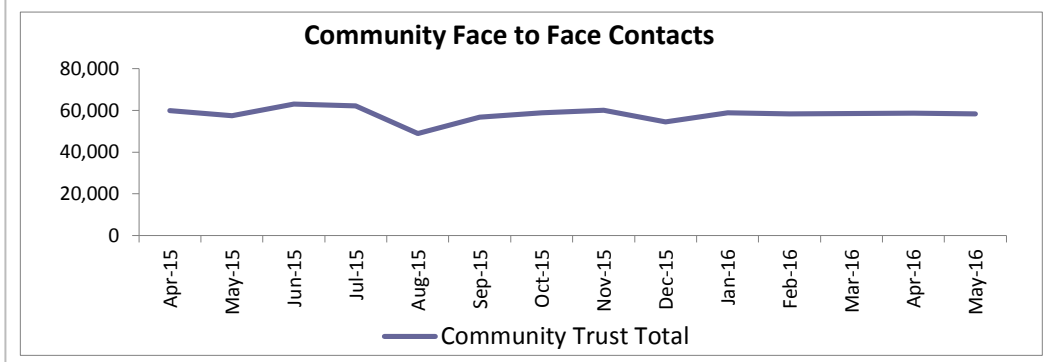
DNA Rates - Community
Achieved.

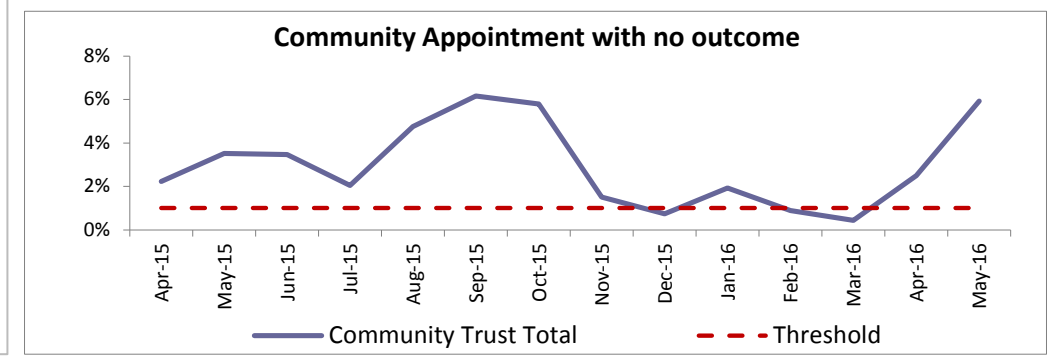
Community Face to Face Contacts
All services are monitored against activity targets.

Community Appointment with no outcome
Not achieved.
Issue: Appointments are not outcomed on the electronic systems for services with high volume appointments. This month DN had more unoutcomed appointments as usual, but all unoutcomed appointments shave now been completed.
Action: Electronic reports are in place for Services to monitor their unoutcomed appointments. All appointments are outcomed retrospectively before submission to SUS.
Timescale: in place

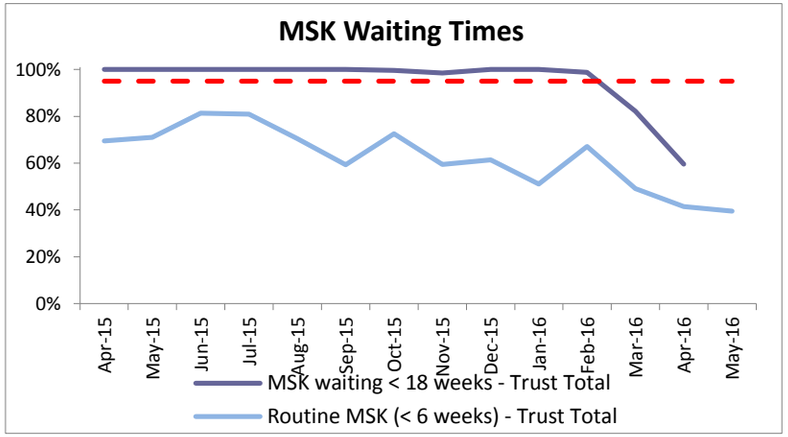








	Threshold	Trust Actual Mar-16	Trust Actual Apr-16	Trust Actual May-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	83.3%	66.7%	60.0%	66.7%
District Nursing Wait Time - 2hrs assess (Haringey)	-	90.9%	94.1%	97.1%	94.1%
District Nursing Wait Time - 48hrs for visit (Islington)	-	100.0%	95.3%	95.0%	95.3%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	97.7%	96.3%	99.1%	96.3%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	49.2%	41.5%	39.5%	40.5%
MSK Waiting Times - Consultant led (<18 weeks)	95%	82.2%	59.6%	arrears	59.6%
IAPT - patients moving to recovery	50%	46.6%	47.4%	arrears	47.4%
GUM - Appointment within 2 days	98%	98.9%	98.7%	98.5%	98.6%
Haringey Adults Community Rehabilitation (<6weeks)	85%	88.2%	89.3%	86.5%	88.0%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	52.4%	50.2%	51.3%	50.8%
Islington Community Rehabilitation (<12 weeks)	-	93.2%	88.8%	86.1%	87.5%
Islington Intermediate Care (<6 weeks)	85%	72.5%	74.3%	73.5%	73.9%
Islington Podiatry (Foot Health) (<6 weeks)	-	54.6%	36.0%	41.9%	38.7%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	96.8%	95.7%	arrears	95.7%
Death in place of choice	90%	75.0%	95.0%	100.0%	
Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams)	8	8	4	8	
Number of DN teams completing a monthly caseload review of timely discharge (eight teams)	8	8	3	8	



District Nursing
Urgent referrals are still called through and recording of these referrals is manual and retrospective. This means that the quality of the data mentioned above is still affected. Failure to respond within the call out time is recorded on Datix as a missed visit incident. There has not been an increase in missed visits. There has also not been a rise in complaints related to urgent wait times. It can be conclude that the quality of care has not been impacted on.
Issue: Amending data capture/recording to also reflect urgent requests and visit times .
Action: The service's imminent E-community platform will accurately capture when unplanned visits are added to the workload, the urgency, and when they are actioned by a healthcare professional
Timescale: Pilot launch scheduled for September 2016.

Number of DN team reviewing POC and timely discharge
Issue: No issues, targets met
Action: Teams will work to maintain the standard achieved
Timescale: June 2016

Death in Place of choice:
The district nursing teams and their palliative link nurses have worked hard to sensitively address with service users the preferred place of care. For the first time 100% of service users had end of life care in the environment they had chosen which is a remarkable achievement.
Issue: No issues, targets met
Action: Work with teams to consolidate and encourage good practice.

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IAPT
Issue: 'Recovery rate showing steady improvement in line with clinical improvement plan. May data submitted to Department of Health now showing recovery rate of 51.64% (target 50%) with reliable improvement - 66.03%
Action: all staff now receive their own recovery rates each quarter and have in place individual action plans when these are below 50%.

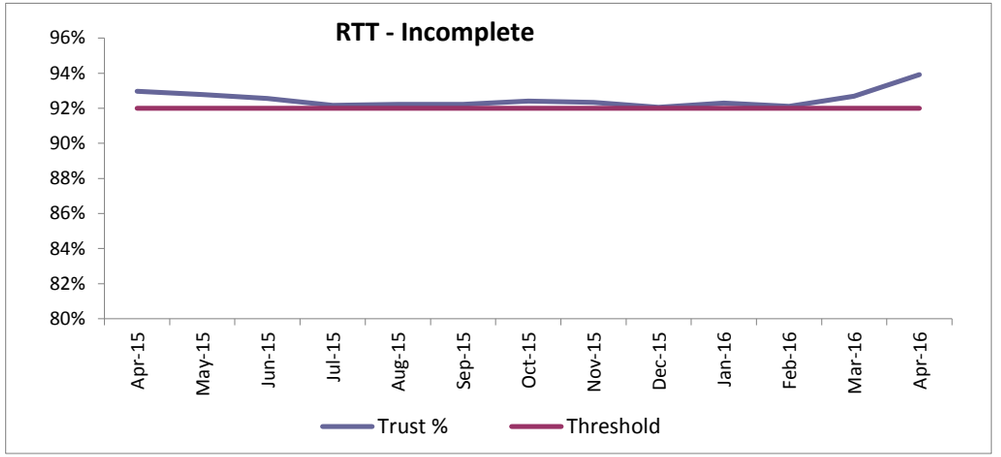
MSK:
Actions from April 16:
Continued working with CCG on improving access times. Second Performance Improvement notice meeting held on 31st May. Remedial action plan follow-up papers completed and submitted 10th June 15. This included Self-referral criteria and establishing a group of GPs to review this. Further capacity and demand figures were also provided. Now awaiting CCG response and new meeting date in July 2016.
Recruitment rounds in April complete. Recruitment continues throughout May and June.
Issue: Further reduction in both 6 week and 18 weeks waiting times. Focus on clearing backlog impact on increase in waiting times figures. Two locums have now started and the impact on the June figures will be minimal, but improvement to be seen in August, September Trust Dashboard. Average wait remains 6 weeks, which is up from 5 weeks last year in the same period.
Action: Further capacity work to be done in the last week of June 2016.
Timescale: Next meeting with the CCG in July 2016

Podiatry
Issue: Vacant posts have resulted in increase in waiting times for new patient as well as routine reviews. Slight improvement seen in waiting times in May 2016.
Action: Two locums full time currently in place (started late May '16) to help clear the wait times – and there has been an improvement in wait times since April in Podiatry. Recruited staff are now started to come into post.
Timescales: Improvement in waiting times from June 2016, but more noticeable from July 2016 onwards.

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

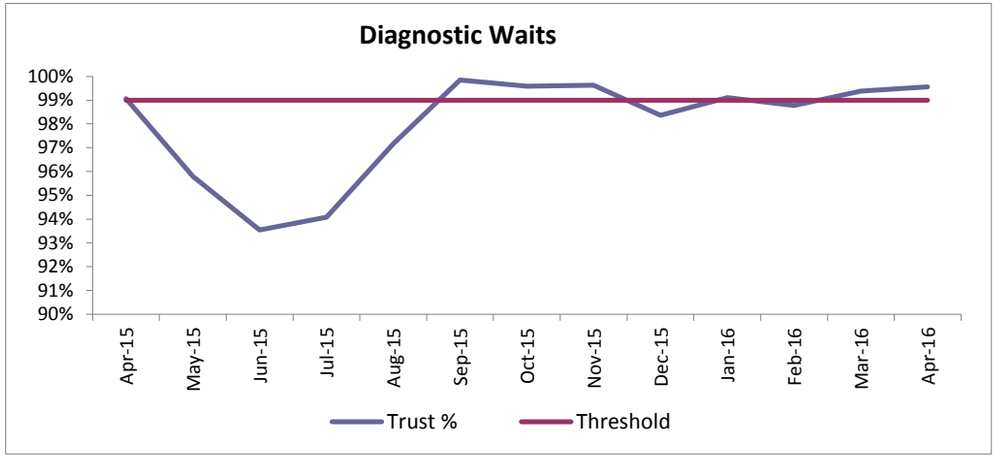
	Trust				
	Threshold	Feb-16	Mar-16	Apr-16	Trend
Referral to Treatment 18 weeks - Admitted	90%	77.4%	76.6%	77.3%	
Referral to Treatment 18 weeks - Non-admitted	95%	91.4%	90.8%	89.2%	
Referral to Treatment 18 weeks - Incomplete	92%	92.1%	92.7%	93.9%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	98.8%	99.4%	99.6%	



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.

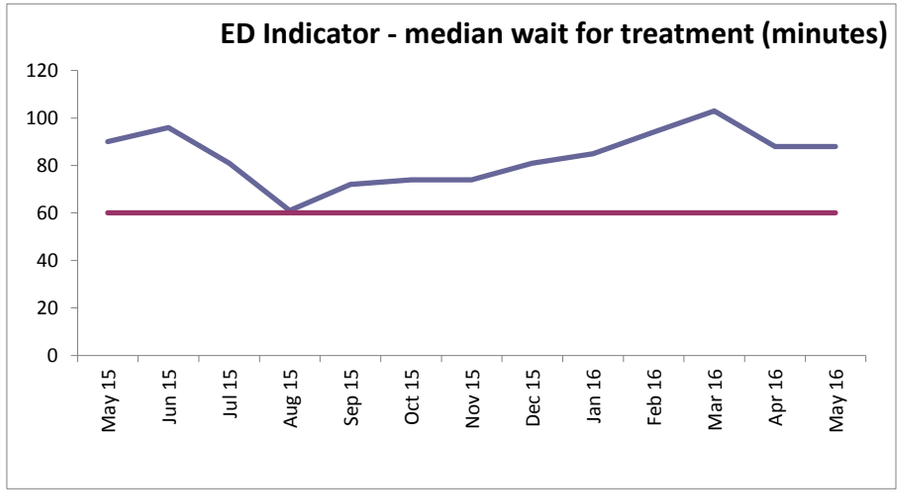
Diagnostic Waits
Target achieved as expected.

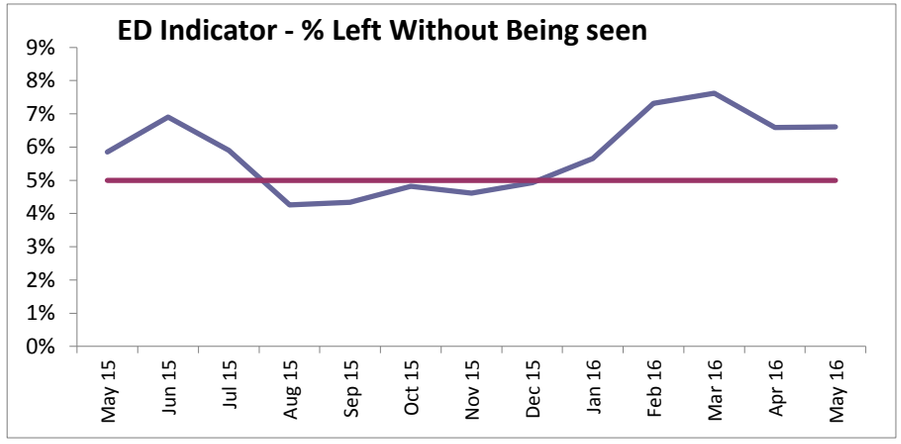


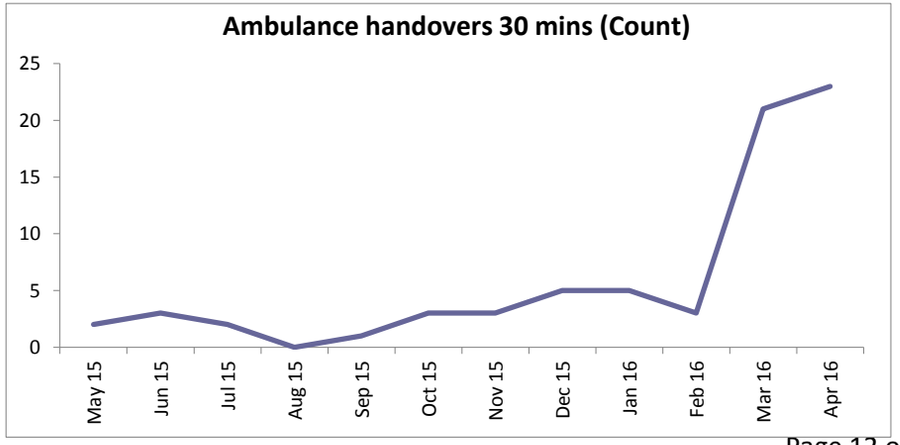
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Apr-16	Trust Actual May-16	2016/17 Trust YTD
Emergency Department waits (4 hrs wait)	95%	84.1%	85.9%	85.0%
Emergency Department waits (4 hrs wait) Paeds only	95%	93.3%	95.4%	94.4%
Wait for assessment (minutes - 95th percentile)	<=15	19	18	18
ED Indicator - median wait for treatment (minutes)	60	88	88	88
Total Time in ED (minutes - 95th percentile)	<=240	504	462	484
ED Indicator - % Left Without Being seen	<=5%	6.6%	6.6%	6.6%
12 hour trolley waits in A&E	0	0	2	2
Ambulance handovers 30 minutes	0	23	arrears	23
Ambulance handovers exceeding 60 minutes	0	0	arrears	0
Ambulatory Care (% diverted)	>5%	2.9%	2.8%	







Commentary

There has been further improvements seen in May 16, but all but one indicator remain below the threshold. Paediatric 4 hours wait achieved target.

ED four hour wait continues to remain a significant challenge across the sector. Lack of available bed are an issue. Following the workshop on the 12th May an in-depth improvement plan has been put in place with the focus on 5 main areas: pre 11 am discharge / criteria led discharge/ reducing LOS over 7 days/ improving speciality response to ED/ bench marking top 10 HRG LOS
the business case for additional consultants was approved at TOB 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.

12 hour trolley wait - two informal mental health patients waited in excess of 12 hours for a mental health bed due to non availability of mental health beds.

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. A weekly monitoring plan is in place.

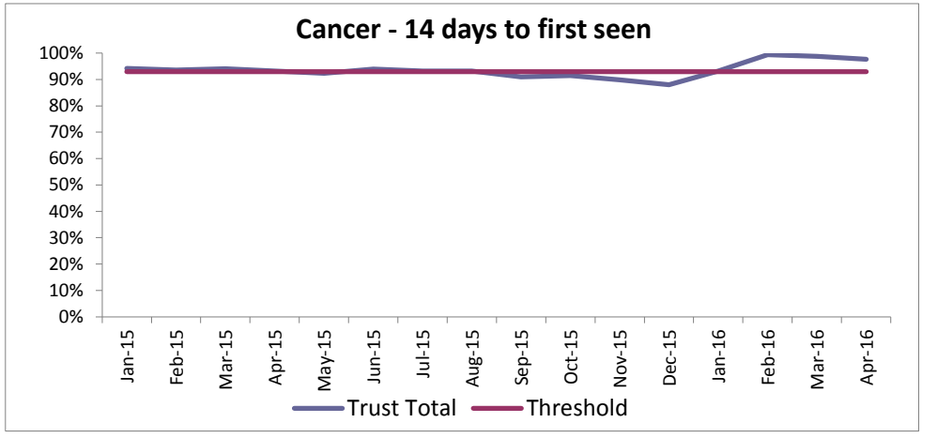
Cancer

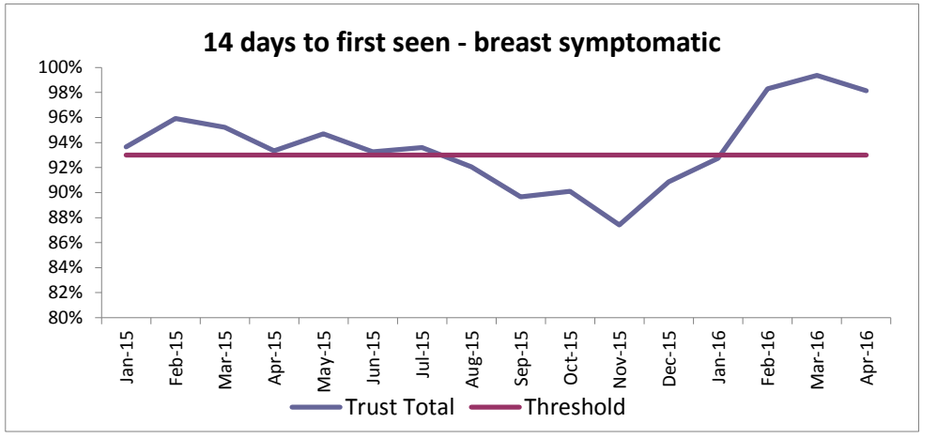
Whittington Health NHS

	Trust				2016/17 Trust				
	Threshold	Feb-16	Mar-16	Apr-16	Trend	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	99.5%	98.8%	97.6%		97.6%	-	-	-	97.6%
Cancer - 14 days to first seen - breast symptomatic	93%	98.3%	99.4%	98.1%		98.1%	-	-	-	98.1%
Cancer - 31 days to first treatment	96%	100.0%	97.7%	100.0%		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	-	-		-	-	-	-	-
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	81.6%	88.5%	88.1%		88.1%	-	-	-	88.1%
Cancer - 62 days from consultant upgrade	-	50%	50%	-		-	-	-	-	-

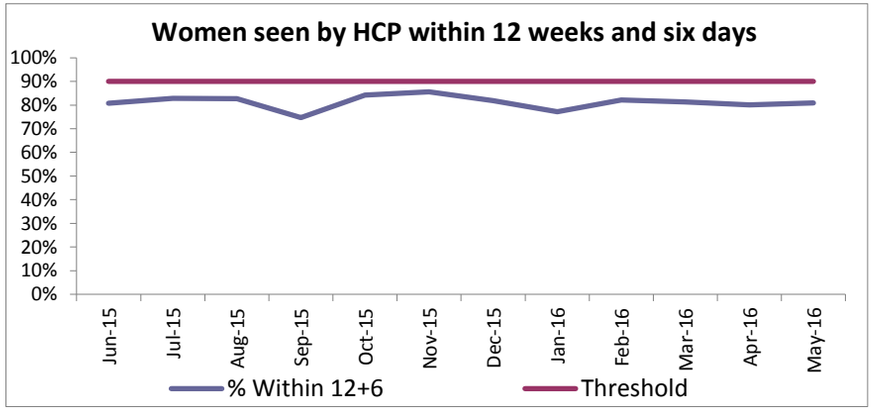
Commentary

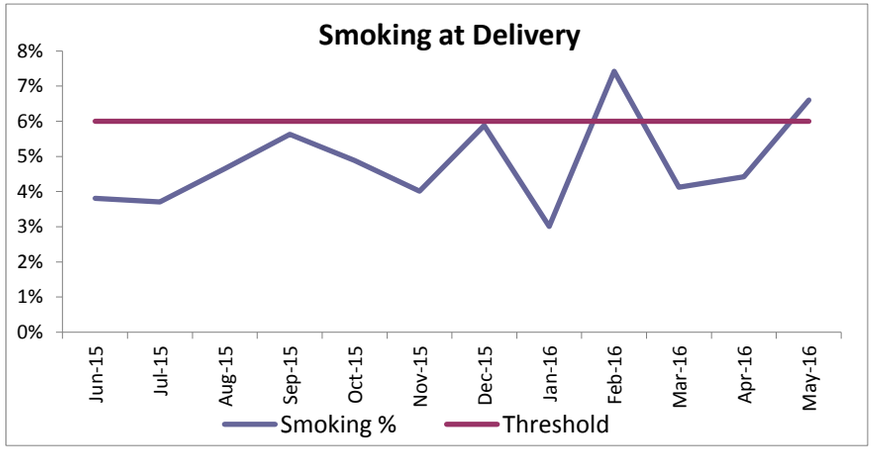
All targets achieved as expected for April 2016.





	Threshold	Trust Actual Mar-16	Trust Actual Apr-16	Trust Actual May-16	2016/17 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	81.3%	80.1%	80.9%	80.5%
New Birth Visits - Haringey	95%	85.7%	88.6%	Arrears	88.6%
New Birth Visits - Islington	95%	94.7%	95.1%	Arrears	95.1%
Elective Caesarean Section rate	14.8%	8.8%	10.5%	12.0%	11.3%
Emergency Caesarean Section rate	-	18.4%	14.2%	19.1%	16.7%
Breastfeeding initiated	90%	93.0%	90.9%	92.1%	91.5%
Smoking at Delivery	<6%	4.1%	4.4%	6.6%	5.5%





Commentary

12+6

Issue: Remaining just below target. Issue is with DNA's.
In May 422 bookings were completed , higher than the previous month. 56 referrals were received outside of 12+6 weeks. 37 patients booked outside of 12+6 due to patient choice. 86 DNA.
Action: member of bank staff now in place to focus on DNA's. Improvement to be seen in two months.
Timescale: August/September 2016

New birth visits

Issue: Islington within target and Haringey just below target, correlating with HV workforce.
Reasons for late visits
Islington - 95.1%
Eleven visits were late this month. Five babies were still in hospital when the New Birth visit was due, 5 parents moved their appointment (Patient Choice) and one birth notification cam in late.

Haringey - 88.6%
32 visits were late this month. 12 babies were still in hospital when the New Birth visit was due, 2 parents required Interpreter resulting in a delay in the New birth visit. 13 visits could not be scheduled in time due to parents requesting different times or the Health Visiting Service was not able to contact them in time. One visit was cancelled due to Health & Safety (dangerous dog) and two visits were late due to the family newly moving into the area. Two further visits were late due to re-allocation within the service and administrative complication.
Action: Continued workforce plan in place to mitigate. New staff in the process of starting.
Timescale: Ongoing

Smoking at Delivery

Issue: CO screening pilot completed in February and since the pilot was completed the number of patients accessing the cessation services has decreased, the ICSU are doing work around this. The evaluation for the CO screening pilot will be out soon.
Action: When we implement CO monitoring for all women in late June or early July, we hope to see a further fall in the number of smokers in pregnancy and at delivery.
Timescale: within target next month.

High Level Workforce Data

Whittington Health NHS

Metric	Target or Benchmark	Source	Apr-16	May-16	Notes and Definitions
Staff Headcount	Trust Annual Plan	ESR	**4,212**	**4,238**	No. of staff employed at the end of the quarter
Staff in Post (FTE)	Trust Annual Plan	ESR	**3,837.16**	**3,857.06**	No. of staff employed at the end of the quarter
Establishment (FTE)	Trust Annual Plan	Finance Ledger	**4,401.71**	**4,403.13**	
Bank and Agency Use(hours)		Bank Staff System	**8252.47**		This equates to around 220 fte
Vacancy Rate %	10%	Calculation	**12.9%**	**12.4%**	The vacancy factor in qualified nursing has reduced from 21% to 14%. There is much focus on substantive and bank recruitment to HCA roles. The vacancy rate for HCAs has fallen from 21% to 17.6%.
Annual Turnover %	>13% - red 10-12% - amber <10% - green	ESR	**14.9%**	**14.9%**	Children's Services and Women's Services remain below 13%. All other ICSU's are above the threshold for turnover - ranging from 15%(Surgery) to 22.1%(OP&LTC). In Corporate areas Finance had the highest turnover with 25.9%
Sickness %	> 3.5% - red 2.5-3.5% - amber <2.5% - green	ESR	**2.9%**	**3.3%**	All areas are below 3.5% with the exception of : Finance 6.7%, Facilities 6.2% and Emergency and Urgent Care 6.7%
Appraisal Completion %	90%	ESR/OLM	**71%**	**69%**	
Mandatory Training %	90%	ESR/OLM	**81%**	**81%**	Percentage of staff compliant for mandatory training. Requirements vary by staff group and roles.

Whittington Health NHS

The Whittington Hospital NHS Trust

Magdala Avenue

London N19 5NF

Trust Board
6th July 2016

Title:	2016/17 Capital Programme		
Agenda item:		**Paper**	8
Action requested:	The Trust Board are asked to: 1. Note allocation criteria 2. Note the two tranches to manage working capital 3. Approve the Capital Programme		
Executive Summary:	The Trust has a £8m capital programme which funds red risks and PMO capital only available in tranches subject to cash availability.		
Summary of recommendations:	To approve the capital programme for 2016/17		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meeting statutory duties.		
Reference to related / other documents:	2016/17 Annual Plan		
Date paper completed:	22nd June 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**

Trust Board

6th July 2016

2016/17 Capital Programme

1 Background

Capital is based on the affordable cash position

1.1 The capital allocation is based on the affordable cash position after accounting for PFI and capital financing liabilities. The allocation is stated in the Trust's Long Term Financial Model.

As a deficit Trust in receipt of Government support funding is limited

1.2 As a Trust in deficit Whittington Health requires funding to support its deficit to enable the release of non-cash expenditure to support its capital ambitions. The current cash constraints within the health system mean that there is a strong challenge to only fund those items of high risk in the coming financial year.

1.3 The Trust has a Capital Management Group that oversees allocation of capital funding to the identified high risk areas and strategic priorities. The Group recommends a capital programme to the Trust Management Group.

The expectation from NHSI is that only essential risks will funded in 2016/17

1.4 In order to ensure that the capital programme addresses appropriate risk the key areas of capital spend being medical equipment, Information Technology and Estates are engaged in an exercise to evaluate the risks held within the Corporate Risk Register, Local Risk Registers and Board Assurance Framework. This has been completed and the output shown in the paper.

2 Capital Programme 2016/17

Funding for capital is primarily planned depreciation

2.1 The capital allocation is calculated as shown below:

	£'m
Planned Depreciation	9,840
Less PFI payment	1,643
Less capital loan repayment	164
Net capital funding available	**8,033**

2.2 This calculation assumes that the Trust is successful in receiving funding for the whole of its planned deficit and historic working capital issues. Discussions with NHSI are in progress.

To manage the cash risk of failure to achieve the targeted deficit the programme is split into tranches

2.3 The above summary will only commit the organisation to £6.6 million of capital expenditure within the overall £8 million available funding. The balance of capital expenditure will be phased during quarter 3 and 4 of 2016/17 once an assessment has been made of the available cash funding after taking into consideration the financial operating performance of the Trust compared to the planned position. Therefore the proposed phasing of capital expenditure is as outlined in appendix 1.

The programme is linked to risk to ensure the highest risk items are funded as priority. Developments will be funded through the PMO allocation

2.4 The capital need within the organisation is higher than the funding available so therefore the following criteria have been applied. The criteria are risk based and look to fund those risks where mitigations are not available and the current risk is unsustainable.

1. Highest priority group comprises of:

   - Honouring historical and contractual commitments
   - All risk register entries of 20 and above, including:
     i. Patient Safety and Quality of Care;
     ii. Strategic Board Priorities (e.g. Maternity);
     iii. CQC Requirements; and
     iv. Operating Delivery.
   - Commitments made via the financial turnaround and PMO to facilitate scheme delivery

2. Risk register entries with a risk rating of between 16 and 20.

3. Risk register entries with a risk rating of less than 16

4. Business Cases Developments

Having applied the above criteria the schemes within the programme are shown in Appendix 1.

There were no capital related red risks

2.5 There are no red risk themes on the Board Assurance Framework or Corporate Risk Register as at the point of writing that are capital related and not addressed by this programme.

remaining

2.6 The Quality Committee Risk Register holds three capital related risks which are addressed by this programme being:

1. Failure to effectively manage the maintenance of medical devices will lead to patient safety and quality risks materialising which scores 16. The programme funds all risks scored above 16 across the two tranches which should reduce the risk score to amber;

2. Lack of resilience for bronchoscopy procedures could affect patient safety and inability to meet waiting time targets. The replacement of the two high risk obsolete equipment items is funded in the first tranche of this programme; and

3. Lack of provision to fund a new endoscopy and decontamination unit (current equipment at the end of life cycle) which will reduce the ability to service bowel screening and endoscopy procedures. The washer replacement is funded over two financial years being 2016/17 and 2017/18 in this programme.

2.7 There are no red IMT risks that are not funded by the first tranche of this programme and amber risks would be looked at in tranche 2. It is worth noting that no IMT developments are funded and funding would need to be obtained through the PMO funding where efficiency programmes are being funded.

2.8 There are no red risks outstanding on capital backlog maintenance from the initial tranche of monies with a number of amber schemes without mitigation funded. Further amber schemes would be looked at as part of tranche 2.

Finance and Business Committee approved the programme in May

2.9 The programme was approved by the Finance and Business Committee on May 25th 2016 and it has been discussed at TMG.

3 Recommendations

The Board is asked to approve the programme

3.1 The Trust Board are asked to

1. Note allocation criteria
2. Note the two tranches to manage working capital
3. Approve the Capital Programme

APPENDIX 1

Phasing of Capital Programme

	Q1	Q2	Q3	Q4	Total
First Tranche Programme	1,650	1,650	1,650	1,650	6,600
Contingent on I&E Performance			717	717	1,433
Total Planned Capital Spend	**1,650**	**1650**	**2,367**	**2,367**	**8,033**

CAPITAL PROGRAMME 2016/17 **Appendix 2**

	Scheme	Risk Register Reference	Score	Value £'000
IMT	Storage Area Network additional disc space		20	250
	St Anne's telephony service		20	100
	Back-up legacy tape library		20	70
	Upgrade Electronic Prescribing (JAC)		20	25
	Upgrade ORMIS theatre system		20	25
	Update Bronchoscopy / Endoscopy software version		20	5
	Update and back-up main switchboard		20	25
Estates	Increase cooling resilience to the main IT hub	521 & 637	20	100
	Backlog Maintenance	637, 646, 357	16-20	300
	Emergency Power Resilience	637	20	50
	Switchboard electrical infrastructure strategy	637	20	150
Medical Equipment	Theatre tables	661	20	220
	Electromyography Neurology Equipment	661	20	47
	Bronchoscopes	661	20	70
	Endoscopy equipment	661	20	110
	Theatre camera stacks	661	20	200
	Ultrasound machines	661	20	200
	Theatre Equipment	661	20	151
Other	Maternity Development			2,000
	Schemes undertaken by WH staff			500
	PMO enabling schemes including IMT developments, estates moves and building development			1,000
	Endoscopy business case	661 & 637	20	1,000

	GRAND TOTAL			**6,600**

Whittington Health NHS

Trust Board 1 June 2016

Title:	Community Engagement Model		
Agenda item:	**16/089**	**Paper**	**09**
Executive Summary:	The Trust Board has agreed a number of corporate objectives for this year and one of the most important for our future is to develop our community engagement model. This paper proposes our approach to creating an innovative model for Whittington Health over the coming year, resulting in a Community Engagement Strategy coming to the Trust Board for approval in December 2016. The shadow governor arrangement ceased in April and the new Whittington Health Forum has been meeting monthly since this time. The key objectives of the forum are to engage fully in the work of the Trust and support the development of our community engagement strategy. Membership of the Forum is to be inclusive and to date has initially invited former shadow governors, volunteers, Healthwatch colleagues, community representatives and voluntary sector groups. The invites have been extended to previous members on the members database and a flyer has been published in the local paper. Our next steps • Meeting with both Islington and Haringey Healthwatch to benefit from their experience of working within the community and engaging with our local communities. • Increasing the range and breadth of the community invited to join the forum. • Web page and email address (whh-r.WhittingtonForum@nhs.net) have been set up. • Co-creating the principles on which the new Forum will operate. The Trust values will be reflected in the manner in which the Forum is both organised and run. These include inclusiveness, openness and transparency. • Approaches to both the Council and to Trust staff will be considered as part of the plan to expand substantially the database of contacts. • During the inaugural meetings of the Forum we will establish a smaller working group to consider the programme of events, the structure, terms of reference and an action plan to sustain and expand the Forum. • Continuing to work through issues such as data protection as we aim to extend and expand the Forum and our use of digital media. • Discussing on a monthly basis at the Forum issues such as		

	strategic developments across our local area; updating on current issues such as the implementation of the estates strategy and ongoing developments in integrating care. The Deputy Chief Executive is leading this project supported by the Chairman of the Trust and some support from the Communications team. A volunteer has been recruited two days per week to handle some of the database administration. Resources will need reviewing in line with the success of the work of the Forum and a business case will be developed.
Summary of recommendations:	The Trust Board are asked to consider the following recommendations • The Board actively support the development of the Forum • The Board should receive a progress report on the work of the Forum in the Autumn • The Board support the proposed approach to developing our Community Engagement strategy
Fit with WH strategy:	Aligns with Clinical Strategy, Communication and Engagement Strategy
Reference to related / other documents:	Whittington Health PPI Toolkit
Reference to areas of risk / BAF:	Captured on relevant Risk Register
Date paper written:	30 June 2016

Author name and title:		**Siobhan Harrington, Deputy CEO/Director of Strategy**		**Director name and title:**		**Siobhan Harrington, Deputy CEO/Director of Strategy**	
Date paper seen by TMG	**5 /7**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Whittington Health
Community Engagement Model
Update to the Trust Board

1. Introduction.

The Trust Board has agreed a number of corporate objectives for this year and one of the most important for our future is to develop our community engagement model. This paper proposes our approach to creating an innovative model for Whittington Health over the coming year, resulting in a Community Engagement Strategy coming to the Trust Board for approval in December 2016.

Recent reports about NHS care, in particular the Francis Inquiry (2013), have made a call for real patient and public involvement in all that we do and a cultural change across the NHS to ensure greater openness, transparency and a duty of candour to patients.

There are many examples of how we have successfully and at times not so successfully engaged and involved patients and the public in our work. We know that there is more that we can do to ensure the voices of patients, carers and public stakeholders are central to how we work as a Trust.

The duty to involve patients in the development of services and in their individual care and treatment is also central to the NHS Constitution.

The Five Year Forward View (2014) 'sets out how the health services needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill health.' It proposes 'a new relationship with patients and communities'. This paper proposes how we aim to take forward that new relationship with our local communities.

The Trust Clinical Strategy (2015) reaffirms the importance of our relationship with our community and local partners.

This approach will result in a strategy which will build on the previous Stakeholder Engagement Strategy 2014 and the Patient and Public Involvement action plan and toolkit approved at the Board in February this year.

2. Background

Our Patient and Public involvement action plan identified a number of objectives in February that are pertinent to this agenda:

Patients, Families and carers' engagement

- Build a culture that puts our patients and people who use our services at the heart of everything we do
- Ensure patients and their carers are involved at all levels across the organization
- Listen, learn and act on patient feedback to drive continuous improvement
- Enable confidence in our service through an effective and responsive complaints process

Community and other stakeholder engagement

- Engage more effectively with our community through ongoing dialogue with our local population and key stakeholders to ensure their views are listened to and reflected in improved services, their development, future plans and redesign
- Have an ongoing relationship with our stakeholders so they feel involved, considered and can make a difference

In April 2016 the Trust conducted a review of governance arrangements including Board Standing Orders, Board Committees and Terms of Reference.

Alongside this as the Trust Development Authority came together with Monitor to become NHS Improvement, the drive for all Trusts to aspire to Foundation Trust status was slowed with a change in emphasis to 'earned autonomy'.

The Trust had in the past recruited members and contact details have been held on a database. Communication with members has been minimal in recent years. Our shadow governors were largely elected eight years ago for a three year term and had kindly stayed engaged whilst the detail of our journey to Foundation Trust status was not clear. The Trust originally had a number of staff and representative governors who had moved on.

These parallel events, alongside the national policy changes, have led Whittington Health to consider not only the position of our shadow governors and members but also the much broader issues of community and patient engagement. The Director of Nursing and Patient Experience is currently reviewing our approach to patient engagement and improving patient experience.

3. Towards a Community Engagement strategy

Following discussion with the shadow governors, it was agreed at the Board to review our community engagement model. This resulted in a commitment to build on the work of the shadow governors to develop an ambitious and effective engagement with both patients and our community. The shadow governor arrangement ceased in April and the new Whittington Health Forum has been meeting monthly since this time.

The key objectives of the forum are to engage fully in the work of the Trust and support the development of our community engagement strategy.

Membership of the Forum is to be inclusive and to date has initially invited former shadow governors, volunteers, Healthwatch colleagues, community representatives and voluntary sector groups. The invites have recently been extended to all previous members on the members database and a flyer has been published in the local paper.

Our next steps include:-

- Meeting with both Islington and Haringey Healthwatch to benefit from their experience of working within the community and engaging with our local communities.
- Increasing the range and breadth of the community invited to join the forum.
- A web page and an email address (whh-tr.WhittingtonForum@nhs.net) have been set up.
- Cocreating the principles on which the new Forum will operate. The Trust values will be reflected in the manner in which the Forum is both organised and run. These include inclusiveness, openness and transparency.
- Approaches to both the Council and to Trust staff will be considered as part of the plan to expand substantially the database of contacts.
- During the inaugural meetings of the Forum we will establish a smaller working group to consider the programme of events, the structure, terms of reference and an action plan to sustain and expand the Forum.
- Continuing to work through issues such as data protection as we aim to extend and expand the Forum and our use of digital media.
- Discussing on a monthly basis at the Forum issues such as strategic developments across our local area; updating on current issues such as the implementation of the estates strategy and ongoing developments in integrating care.

The Deputy Chief Executive is leading this project supported by the Chairman of the Trust and some support from the Communications team.

A volunteer has been recruited two days per week to handle some of the database administration. Resources will need reviewing in line with the success of the work of the Forum and a business case will be developed.

4. What will success look like?

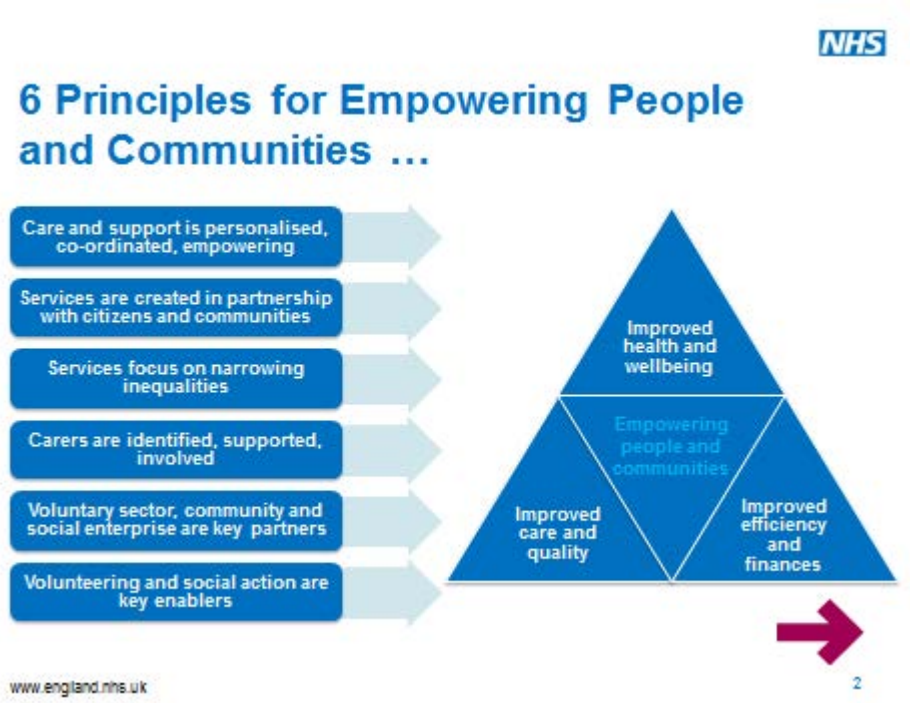
The plan is to engage a substantial number of people in this process who are from our local catchment area.

Trust activities and events will be both developed with and supported by members of our community and Forum members.

A Community Engagement Strategy will be in place. The key elements of the strategy could cover involvement in strategy development and transformation ; assurance; fund raising and open days. We would aim to utilise this engagement in supporting the culture change in cocreating and coproduction which will help us deliver our key strategic goals in relation to prevention and self-management.

We want our strategy to build on those things we do now as well as developing new ways of working too: from involving patients, carers and the public in recruitment, education and training of our workforce, to the design of services.

There are many models of Community engagement and through the development of the strategy there will be more consideration of the models. Patient Voices (2013) promoted by NHS England has published principles of empowering people and communities and we would consider incorporating these into our work.



Digital communication will be the ‘default’ method of communicating with our community although we will engage with people as required to maximise the breadth of engagement across all the community.

5. Conclusion

There is a widespread view that Whittington Health has a very strong relationship with its local community. The time is right to confirm this, to build on it and to sustain it.

As an innovative organisation we want to be at the forefront of new models of community involvement and engagement.

The Trust Board are asked to consider the following recommendations:-

1) The Board actively support the development of the Forum.
2) The Board should receive a progress report on the work of the Forum in the Autumn.
3) The Board support the proposed approach to developing our Community Engagement strategy.

June 2016.

Whittington Health NHS

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Director of IT
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

6th July 2016

Title:	IM&T Improvement Plan 2016-17		
Agenda item:	**16/090**	**Paper**	**10**
Action requested:	For Information		
	The IM&T Improvement Plan 2016-17 below was approved at TMG on 21/06/16 and is presented against the four key themes in the Trust Operational Plan 2016-17 to ensure it aligns to the clinical and business priorities of the Trust. The IM&T priorities can be summarised as :- 1. EPR and clinical system developments to improve patient care, safety, outcomes and experience 2. Clinical System, Information and Procurement developments to support financial sustainability through the delivery of ICSU CIP roadmaps and maximise contract income 3. Engagement with multiple external organisations and governance structures to develop external partnerships 4. IM&T developments to support our people and teams The IM&T Improvement Plan 2016-17 is one element of a wider development of Trust IM&T services e.g. Deloitte's IT Disaster Recovery capability review ; develop a new Trust IM&T Strategy ; appointment of a Chief Clinical Information Officer (CCIO) to lead on the adoption of digital working ; input and alignment to the Local Digital Roadmap (LDR) to deliver the Sustainability and Transformation Plan (STP).		
Summary of recommendations:			
Fit with WH strategy:	Align to Trust Operational Pan 2016-17 and various Trust Strategies e.g. Clinical, Estates, Workforce		
Reference to related / other documents:	See above		
Date paper completed:	26/05/16		

Author name and title:		**Glenn Winteringham Director of IM&T**		**Director name and title:**		**Glenn Winteringham Director of IM&T**	
Date paper seen by EC **By TMG**	**30/05/16** **21/06/16**	**Equality Impact Assessment complete?**	**N\A**	**Quality Impact Assessment complete?**	**N\A**	**Financial Impact Assessment complete?**	**N\A**

1. Introduction

The IM&T Improvement Plan 2016-17 sets out the key priorities for IM&T to improve patient care, safety, experience and outcomes and support financial sustainability by increasing productivity and efficiency. The plan excludes the business as usual operational delivery of the current IM&T services, which accounts for the majority of IM&T workload.

2. Context

The IM&T Improvement Plan 2016-17 has been developed in the context of a wide ranging number of national, local health economy and Trust requirements to ensure it aligns to and supports the delivery of the priorities shown below :-

Level	Policy Driver	Requirement
National	Five Year Forward View	- operate paperless at point of care by 2020
	Personalised Health & Care	- real time, digital, interoperable records by 2020
	NHS Operational Plan	- support delivery of mandated performance targets
	Carter Review	- support delivery of Carter Review priorities
	Care Quality Commission	- compliance as part of licence to operate by 2020
Local Health Economy	Sustainability & Transformation Plan (STP)	- transformation of clinical services across NCL to deliver £524m CIP by 2020
	Local Digital Roadmap (LDR)	- support delivery of STP
	Health & Wellbeing Board	- develop clinical services across Haringey & Islington
	Commissioning	- maximise PbR income for acute services - support community disaggregation
	Islington CCG Pioneer	- support delivery of shared health and social care portal for clinicians and patients (IDCR/PHR project)
	Clinical Networks	- support delivery of clinical networks across NCL e.g. Cancer, Child Health, GP federation hubs
	UCLP	- support innovation, education and research
	Procurement Shared Service	- deliver best vfm for IT services and commodities
WHICO	Clinical, Estates, Workforce and Finance strategies	- align to and support implementation of Trust strategies
	Trust IM&T Strategy	- develop a new IM&T Strategy 2016-2020 to enable access to real time, digital interoperable records
	Cost Improvement Programme	- support delivery of Boston transformation programme via PMO
	Trust operational plan	- support delivery of Trust objectives
	Board Assurance Framework and Risk Register	- mitigate identified risks e.g. Deloitte IT Disaster Recovery review, Digital Maturity Index
	Digital Maturity Index	- improve organisational readiness, capability and infrastructure to operate paperless at point of care
	Deloitte review of IT Disaster Recovery (DR)	- improve disaster recovery capability to operate paper free at point of care

3. IM&T Improvement Plan 2016-17

The IM&T Improvement Plan 2016-17 below has been aligned to the four key themes in the Trust Operational Plan 2016-17 :-

Operational Plan	Enabling IM&T Project	Key Benefit(s)	Milestone
Deliver high quality, safe care and improved patient experience	Shared Care Record Portal (Graphnet Carecentric)	Access to real time, interoperable data for acute, community, primary and social care to improve diagnosis and treatment ; reduce admissions and delays ; improve discharge process and reduce LOS	09/16
	HealthRoster SafeCare module	Improve patient care by matching nursing resources/skills to patient acuity	07/16
	Upgrade Medway EPR (PAS, ED, Maternity and Business Intelligence) to version 4.6	3 fixes to improve ED workflow, quick logon, quick triage and improved discharge letter workflow ; interoperability with other clinical systems e.g. EDMS, PACS ; improved Outpatient usability	08/16
	Upgrade OpenRIO to version 7.5	Operate paperless at the point of care to improve patient care and safety	07/16
	New IM&T Strategy		09/16
	Standardise on Dictate.IT v2 for Outpatient letters		09/16
	File and Action diagnostic test results on ICE and stop printing		09/16
	Digital Clinical Noting in ED		11/16
	EDMS viewer for clinical documents e.g. OP letters		12/16
Develop our business to ensure we are clinically and financially sustainable	HealthRoster	Reduce use of agency through improved rostering of permanent and bank staff to deliver £1m CIP identified in ICSU roadmaps	09/16
	OpenRIO Store & Forward	Improve productivity and efficiency through offline access to OpenRIO to deliver £1m CIP identified in ICSU roadmaps. Dependant on upgrading OpenRIO to v7.5 and implementing wi-fi access across Islington sites	08/16
	Implement E-community solution	Improve productivity and efficiency through smart visit allocation to deliver £310K CIP. Procurement in progress	09/16
	Maximise contract income	Deliver 100% high quality clinical coding within 10 working days	03/17
	Community disaggregation	Improve data capture and quality to maximise contract income	03/17
	Implement Qlikview dashboards for SLAM, Ledger & Community	Access to real time, self-service information to manage contract activity, maximise income and control revenue spend	09/16
	Cost Improvement Programme	Deliver 10% IM&T CIP target = £600K during 2016-18	03/17
	Carter Review and Procurement	Reduce spend and deliver improved value for money in collaboration with Procurement e.g. hybrid mail, PC refresh, pan London frameworks, UCLH ITO	03/17

Further develop and expand our partnerships and engagement	Haringey and Islington Wellbeing Programme	Transform service delivery to improve patient care and be financially sustainable. Enable emerging IM&T priorities :- - provide GPs and Social Care with access to WHICO Shared Care Record Portal - deliver LDR universal capabilities - improve digital maturity index - support future STP/LDR IT investment bids - collaborate on ICCG IDCR and PHR - collaborate on NCL urgent care system resilience - collaborate on Cancer Vanguard - collaborate on Child Health Information System - engage with emerging pan London IT solutions e.g. Healthy London Partnership Shared Care Record, Co-ordinate My Care	03/17
	NCL Sustainability and Transformation Plan (STP)		
	Local Digital Roadmap (LDR)		
	ICCG Integrated Digital Care Record (IDCR) and Person Held Record (PHR)		
	UCLH and UCLP		
	London CIO Council		
	Engagement Forum for local community	Improve engagement with local community via digital platforms e.g. e-mail, newsletters, listening events, surveys	09/17
Develop and support our people and teams	Moodle	Digital education and training tools e.g. ED training videos	03/17
	IM&T Self Service Portal	Enable users to log and track own calls to improve service	06/16
	Migration to NHSMail 2	Increased storage, Skype for business, instant messaging, presence management	07/16
	Upgrade Intranet	Improve access to on-line resources to support operational delivery	09/16
	Appraisal & Mandatory Training	Achieve 100% compliance to enable delivery of IM&T Improvement Plan	03/17

4. IM&T Capital Allocation

The proposed IM&T capital allocation for 2016-17 is £0.5m to address the red rated IT infrastructure risks, including the high priority items identified in the recent review of IT Disaster Recovery capability by Deloitte's:-

IM&T Red Rated Risk	Solution	Key Benefit(s)	Allocation
Running out of disk space to store data	Procure additional disk storage	No loss of data ; clinicians can view all digital images from a single vendor neutral archive (VNA) repository	£250K
Obsolete back-up tape library	Procure new tape library	Provides long term off-line store for back ups	£75K
Access to Trust IT services from St Ann's via BEH MHT IT infrastructure	Install own data and telephony IT infrastructure	£55K annual revenue saving and reduced risk of intermittent loss of access to IT services	£75K
Unsupported version of Pharmacy E-Prescribing & Medicines Administration	Upgrade to supported version	Support in the event of outage, improved functionality e.g. IV prescribing, and enables upgrade to new web version	£25K
Unsupported version of Theatres	Upgrade to supported version	Support in the event of outage	£25K

Unsupported version of Endoscopy	Upgrade to supported version	Support in the event of outage	£5K
Unsupported version of Switchboard	Upgrade to supported version	Support in the event of outage	£45K
Total			**£500K**

The allocation above does not address the:-

- Backlog of PCs and laptops. 65% of the Trust's IT devices are >6 years old with an estimated backlog of £1m and an annual rolling replacement of £500K to refresh every 4 years. Work with procurement is underway to review operating lease options

- 4 amber rated IT infrastructure risks totalling £165K capita. They will be reviewed regularly to ensure the mitigating actions are still appropriate or not and manage accordingly

- Investment for new applications or IT infrastructure to support the delivery of ICSU CIP via the PMO. These requirements are identified below and it is anticipated the bids will be funded from the PMO capital allocation of £1m subject to business case approval :-

CIP Requirement	Solution	Key Benefit(s)	Capital
Access OpenRIO Store and Forward	Install wi-fi across Islington	Improve productivity and efficiency through offline access to OpenRIO to deliver £1m CIP identified in ICSU roadmaps	£200K
Match demand with capacity for District Nursing	Implement E-community	Improve productivity and efficiency through smart visit allocation to deliver £310K CIP identified in ICSU roadmaps	£85K
Increase NHS number capture from 96% to 99%+	Medway EPR PDS module	Maximise contract income through improved data quality and minimise risk of challenges and fines	£120K
Total			**£405K**

- Investment for new applications to address known clinical safety or efficiency improvements. Their cost/benefits need to further developed to under their relative priorities :-

IT System Requirement	Key Benefit(s)	Est Capital
iFIT Medical Records	Reduce storage, improve tracking and therefore availability of casenotes, reduce duplicates	£290K
ITU	Digital vital sign charting in ITU, currently all observations manually transcribed onto paper charts	£150K
Clinical Observations	Complete, timely, legible observations generate early warning scores to reduce mortality and LOS	£100K
Blood Tracking	End to end digital workflow to dispense blood products safely	£100K
Foetal Imaging	Integrate Foetal Imaging system into Medway	£100K
Job Planning	Expand HealthRoster modules to include medical job planning and rostering	£75K

E-triage workflow	All C&B and paper referrals are printed then manually triaged and booked, create digital workflow	£60K
OPAT	Manage, track and audit for outpatient parenteral antimicrobial therapy	tbc

5. Digital Maturity Index (DMI) Assessments

The first national Digital Maturity Index (DMI) self-assessment baseline for the Trust was:-

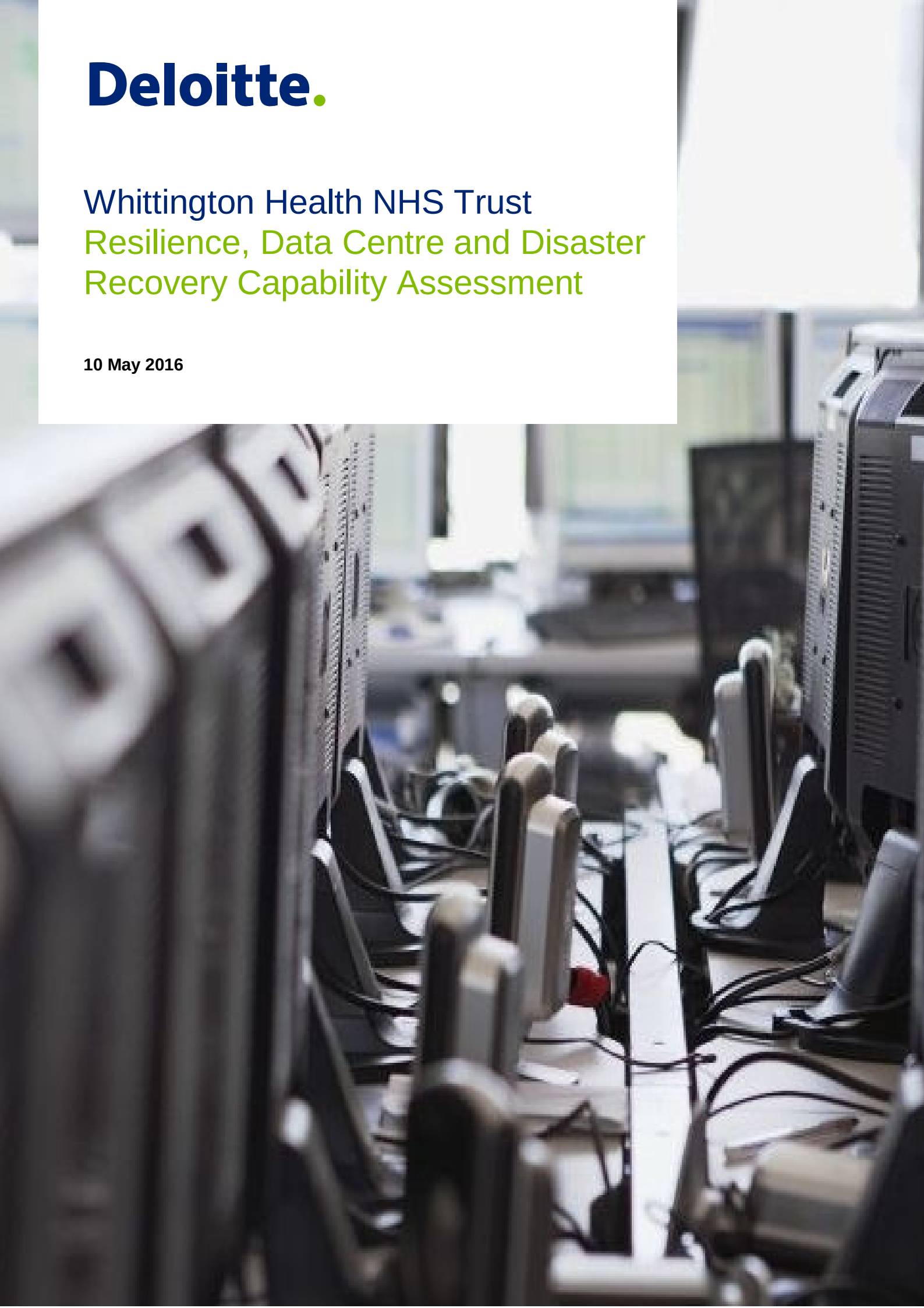
Theme	Score	Ranking	Improvement Required
Organisational Readiness	52/100	219/239	Appoint CCIO ; New IM&T Strategy owned and reviewed by Board ;
Functional Capability	47/100	62/239	Implement digital clinical observations and Early Warning Scores, Clinical Noting
IT Infrastructure	64/100	149/239	Implement Deloitte recommendations e.g. wi-fi access in Islington, rolling re-fresh of PCs

Improvements to the DMI will be addressed as part of the wider programme of IM&T service review and development i.e. Deloitte IT Disaster Recovery Review action plan, development of a new Trust IM&T Strategy, development of the Local Digital Roadmap to enable delivery of the NCL Sustainability and Transformation Plan.

Deloitte.

Whittington Health NHS Trust
Resilience, Data Centre and Disaster Recovery Capability Assessment

10 May 2016



Contents

1 Introduction

Background

Whittington Health NHS Trust experienced two significant outages of information technology (IT) at the Trust in July 2015, impacting the availability of clinical IT systems, including the Electronic Patient Record (EPR), which enable the delivery of care to patients. The initial event resulted in the outage of the EPR for approximately 15 hours, and the second event resulted in users being unable to access a number of clinical systems intermittently. Although the EPR was not impacted during the second incident, access to the ePrescribing application was impacted for eight days. Analysis has been performed by the Trust to consider the causes of the outages, and an external assessment was sought to consider the resilience, data centre and disaster recovery capabilities of the Trust.

The latest Information Management and Technology (IM&T) strategy for Whittington Health NHS Trust covers the period 2013 – 2015, and sought to support the creation of a digital integrated care organisation (ICO) that provides secure online access to the right information, to the right person, and to the right place. The delivery of the IM&T strategy is underpinned by enabling IT infrastructure, which is managed by the Trust's IM&T team, supporting approximately 4,400 users across Acute and Community settings. Progress has been made to integrate separate IT infrastructure environments following the creation of the ICO in 2011, including the integration of a third party commercial supplier, *2e2*, which previously supported NHS Islington and NHS Haringey infrastructure.

Investment in core IM&T components, including desktop PCs, has been inconsistent since FY 09/10, and capital investment in supporting IT infrastructure has been declining since FY12/13. Meanwhile, staff numbers have approximately doubled to 4,400 since the creation of the Whittington ICO on 1 April 2011.

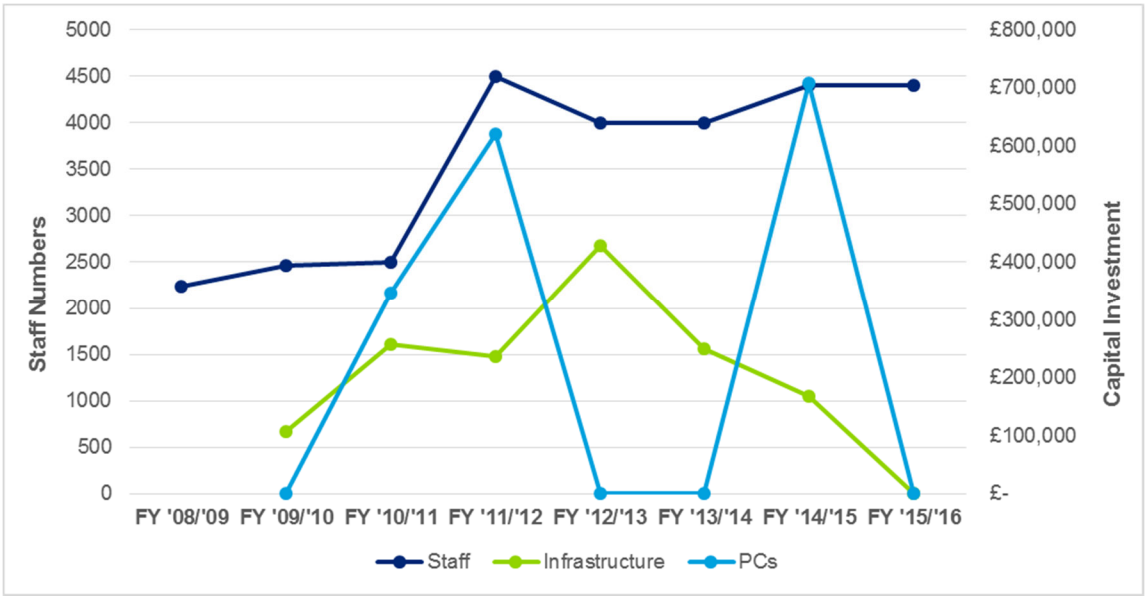


Figure 1: Capital investment in IT infrastructure and PCs

Acknowledgment

We would like to thank all Whittington Health staff for their co-operation during this assessment. A list of the staff involved during the assessment is included at Appendix B.

How to read this report

Detailed observations and recommendations have been categorised by scope area and are ordered in a logical sequence. To aid the reader, recommendations have been grouped into four categories: quick win, high, medium or low priority. Our priority ratings are indicative of our view on the relative importance of the recommendations to strengthening the Trust's Resilience, Data Centre and IT Disaster Recovery capabilities.

Table 1: Recommendation categories

Category	Description	Symbol
Quick win	The recommendation is important, and can be implemented relatively easily and quickly	
High	The recommendation is a critical priority and should be implemented promptly	
Medium	The recommendation is important but not as urgent in respect of timelines	
Low	The recommendation is relatively less important, and should be implemented when time and resources are available	

2 Conclusions

NHS and global context

The journey to operate 'paper-free at the point of care'[1] requires NHS Trusts to achieve and sustain a robust, resilient and secure IT infrastructure that supports key aspects of care delivery. Such IT infrastructure capability is critically important for providing confidence to clinicians to sustain the adoption of clinical technology in the delivery of care. For many Trusts this will require a 'step change' in their current IT infrastructure capability.

The digitisation of healthcare is globally recognised as one of the hardest public services in which to drive and sustain digitisation, being noticeably harder than for other transactional services in government or other industries, such as banking or travel. Collective experience indicates that significant improvements in patient safety, quality and efficiency can be made where healthcare services are effectively digitalised.

Conclusions

The capabilities of the Whittington Health NHS Trust's IT infrastructure and its associated IT management processes are currently insufficient to meet this key policy objective. Despite the positive use of clinical technology in certain aspects of clinical care delivery, including order, results and medicines management, many areas of the Trust's IT infrastructure are below the comparable capability levels for other Acute and Mental Health Trusts in England, as outlined in self-assessment responses to the NHS England Digital Maturity Index, published in April 2016.

The current level of IT infrastructure capability and associated IT management process maturity is insufficient to enable the Trust to be confident that the IT incidents that occurred in 2015 (subject to analysis within this report) are preventable or should similar events recur, would be resolved in a shorter period of time.

Given the Trust's use of clinical technology in key aspects of clinical care delivery, as described above, the risks associated with its current IT infrastructure capability and associated IT management process maturity presents heightened clinical risk.

In considering the IT incidents that occurred in July 2015, we have concluded the following:

- The EPR outage incident (1st July – 2nd July 2015) could have been prevented. While risks were known to the Trust, effective risk management was not demonstrated, and the air conditioning units in the data rooms are not included within the scope of the air-conditioning maintenance contract agreed in 2013. Consequently, remedial work to address known risks was not conducted for a significant period of time, contributing to the overheating of technology systems and their ultimate failure.

- The Storage Area Network (SAN) failure (23rd July – 31st July 2015) was not foreseeable by the Trust's IM&T team, as the outage was caused by an issues with the EMC RecoverPoint functionality. However the impact may have been lessened if full and tested recovery plans (including Recovery Time Objectives) had been in place to align recovery requirement and expectations, and IM&T staff had been better trained in the technologies at the heart of the problem.

However, multiple connected factors contributed to the occurrence of both 2015 IT incidents impacting the availability of clinical technology, including:

[1] Ambition outlined by the National Information Board (NIB), endorsed by the Department of Health, NHS England Local Government Association and the Health and Social Care Information Centre (HSCIC), to support in achieving the Government's Five Year Forward View for the NHS.

- The Board, Executive and Clinical Leadership did not define the expected recovery times (or lack of availability) from IT infrastructure or clinical application failure.

- The inability of the Trust to effectively identify, communicate and manage key IT risks (both identified and managed at an operational level and visible to the Board), including to determine their potential impact upon Trust clinical service delivery and to ensure appropriate mitigation actions were taken;

- Our analysis of the Trust's IT Effectiveness Maturity, demonstrated largely '**Basic**' or '**Standard**' maturity levels (levels two and three from a five point maturity scale). In our experience, while the current position of IM&T is not uncommon at NHS Trusts, it highlights the challenge of enabling continuous improvement in IM&T services alongside the effective management of existing technology to minimise the impact of aging hardware and software; and

- Finally, multiple, complex and connected failures in IT infrastructure, IT management processes, including relating to governance, suppliers, and the management of technology outside of the central IM&T team.

The Trust response to the two 2015 IT incidents did demonstrate the capability and determination of IM&T, operational and clinical teams to work tirelessly to resolve the issues and no serious patient safely issues were reported. Given Trust IT infrastructure capability and IT management process maturity, the recovery times realised are to be expected.

Nevertheless, it is clear that confidence in IT infrastructure capability and IM&T more widely, has been negatively impacted.

The Trust must understand the multiple findings and recommendations within this report to enable it to adapt and appropriately change to ensure that it will be effective in delivering 'paper free care at the point of care' and wider digitalised health services. Importantly change will be required in multiple areas:

- Consistent Board, Executive and clinical leadership - providing greater emphasis and engagement with the digitisation agenda (via the IM&T Strategy) to determine priorities and sustain and improve clinical quality as this agenda is implemented;

- Improvements in IT infrastructure capability and supporting IT management process maturity – providing a platform of improved availability and performance of IT infrastructure and clinical technology;

- Enhanced Trust wide change capability – ensuring the adoption of new and existing clinical technology requires clinical processes to permanently adopt the features and function of clinical technology to sustain improvements to patient quality and achieve the benefits of cost avoidance, capacity release and cash releasing savings. It can only be achieved with strong, sustained senior, clinical leadership and organisational culture change to ensure the adoption of technology.; and

- Financial investment step change– providing funding to improve and sustain IT infrastructure capability and clinical technology improvements.

3 Executive Summary

We observed that the Trust has set out a credible, incremental strategy to achieve digitisation (Whittington ICO IM&T Strategy 2013-15), however the documented strategy has not recently been refreshed, and it did not adequately articulate the infrastructure requirements needed to deliver resilient clinical applications. A number of IT incidents, including the incidents considered as part of this assessment, have impacted the confidence of clinicians in the reliability of key clinical information systems, contributing to a clinical reluctance to adopt digital methods for undertaking core clinical processes.

The Trust must outline the functional requirements and operational expectations for IT infrastructure that supports clinical systems, including EPR, to ensure alignment with sector priorities to become 'paper free at the point of care', and support in managing strategic risks. Board and Executive level leadership alongside clinical and operational input must be obtained to support the development of a complementary IM&T strategy, aligned with Trust ambitions and sector priorities.

It is essential that the strategic direction of IM&T addresses both existing Trust concerns, and ensures the establishment of a credible and robust foundation on which to build. If future adoption of clinical technology is encouraged while the supporting infrastructure is unable to provide a reliable foundation, there is a risk that the adoption of clinical technology will be limited, impacting benefits realisation. The ability to effectively implement the process and culture changes necessary to realise the benefits of the use of technology in delivering clinical care will be limited.

In addition, the Trust's current IT infrastructure capability and associated IT management process limitations expose patients and staff to the increasing risk of enacting business continuity plans (BCPs), which have not been aligned with existing IT disaster recovery (ITDR) capabilities. Enacting BCPs creates inherent transcription and fatigue risks for patients and staff, as well as further undermining confidence in IM&T to support the delivery of care digitally.

Senior clinical leaders recognise that confidence in the availability and resilience of clinical applications is essential to encourage their future adoption and is therefore vital to delivering the IM&T strategy and Trust strategy. The following must be considered to support in mitigating risks associated with the availability and resilience of key clinical applications, and to address the risks associated with the adoption of clinical technology:

1. The IM&T Strategy to achieve a digitally-enabled operating model should include the requirements for both applications and IT infrastructure to deliver an effective end to end technology strategy. Engagement with operational and clinical leads will be essential to support in the development of the IM&T strategy and the adoption of clinical technology;

2. Options analysis should be performed to determine the options available to address the application and IT infrastructure requirements necessary to support the Trust's clinical and operational strategy, including consideration of the extensive use of third parties to provide a 24/7 robust and resilient IT infrastructure.

   These options should explicitly consider the extent to which Trust culture and clinical process change will be necessary to adopt clinical technology, and the extent to which the use of existing clinical technology can be optimised to support the Trust's clinical and operational strategy;

3. IM&T risks should be managed effectively, including the risk of increased digital care in the absence of a resilient infrastructure. Analysis of risks should consider whether the Trust's approach to digitisation is revised in order to reduce the identified clinical risk; and

4. The Board and Executive should have an increased and collective role in enabling the Trust to transform to ‘paper free care at the point of care’, enabled through the delivery of an updated IM&T strategy. A critical component of this transformation is the role of clinical IT leadership, such as a Chief Clinical Information Officer (CCIO). A CCIO should be identified to support IM&T engagement, and the ongoing alignment of the IM&T function with clinical requirements.

Further areas for improvement have been highlighted based on our understanding of the IT incidents, completion of an IT Effectiveness Maturity Assessment, and broader consideration of the scope areas outlined in Appendix A. The summary below outlines our observations and associated recommendations which we believe are necessary to support Trust Management address identified weaknesses in the current resilience and ITDR capabilities at the Trust.

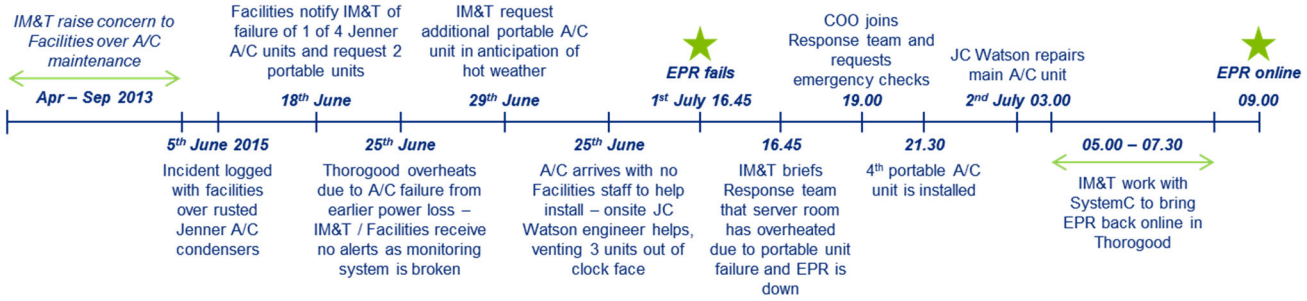
In addressing the recommendations raised, the Trust has the opportunity to enable a process of re-engagement with IM&T, to ensure the alignment of clinical, operational and IM&T strategies, and to re-establish expectations and requirements for IM&T going forwards. Such engagement will be critical in effectively progressing towards the Trust’s strategic goals including ‘paper free care at the point of care’.

3.1 Incident Diagnostics

In performing our assessment, we considered each of the outages in 2015, understanding timeframes, root cause, and the management of the incidents. We have summarised the events below, highlighting key areas for consideration.

EPR Outage, 1st July – 2nd July 2015

As a result of the failure of the air conditioning units and monitoring systems in the primary computer room (Jenner), the room overheated and caused an outage of the EPR application and subsequent controlled shutdown. A timeline of key events has been documented below:



Poorly maintained air conditioning condensers, ineffective risk management over a period of time, the failure of one of four main air conditioning units, and incorrectly installed portable air conditioning units during a very hot period culminated in a sequence of events that resulted in the outage of the Trust's EPR in July 2015. Additionally, the computer room monitoring system (Trend) had been broken for two weeks prior to the event, which had not been resolved prior to the incident occurring. While the circumstance was known to the Trust, sufficient pre-emptive action was not taken prior to the outage. In considering the contributing causal factors, it is likely that the incident could have been prevented.

The ability to complete a pre-emptive failover may have been prevented by an existing fault on the EPR hardware in the secondary computer room (Thorogood), which had not been resolved. As a result of this hardware fault, coupled with the fact the EPR data is configured to replicate every 15 minutes, the supplier did not recommend a failover of the EPR application to the secondary computer room. Owing to limited assurance over the failover hardware and the inability to gauge the quantity of EPR data that was lost, the EPR was offline for a period of over 12 hours. We note that the main air conditioning unit was repaired and the EPR subsequently re-instated.

Action taken to address the incident demonstrated the effective creation of a multi-departmental incident team to support decision making processes, although it still places significant reliance upon the 'best endeavours' of Trust colleagues and suppliers to resolve the incident. In addition, external contractors were engaged to support in repairing the air-conditioning fault, which was necessary to re-enable the effective operation of infrastructure.

However, the incident clearly highlights the necessity for effective risk management activities to enable escalation and decision making for significant issues to be made at an executive level, and to ensure the visibility of significant operational issues that may impact clinical departments. Additionally, the incident demonstrated the requirement for the process to be assured through periodic testing activity, and for metrics to have been agreed in support of the recovery process. A Recovery Time Objective[2] (RTO) would have provided both the Executive and IM&T Teams a schedule within which to work, while Recovery Point Objectives[3] (RPOs) would ensure acceptable EPR data loss is defined, with effective workarounds in place, neither of which have been defined and agreed.

The following key observations and recommendations in respect of resilience and ITDR, highlighted by the incident, have been detailed in Section 3:

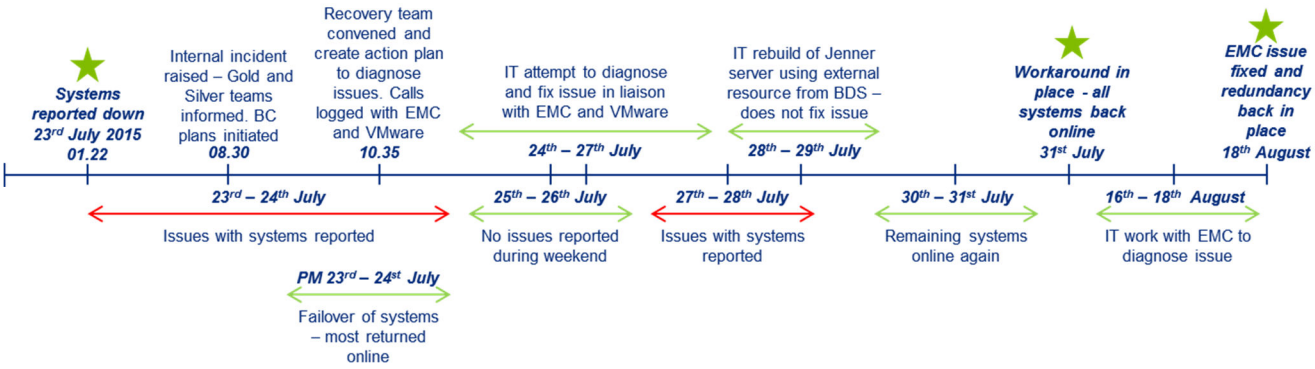
- No IM&T risk register is in place (High Priority)
- RTOs and RPOs are not defined for any systems (High Priority)
- A ITDR failover testing programme in not in place (High Priority)

[2] The target duration of a service's unavailability following a disruptive event.
[3] The maximum allowable age of data to be recovered following disruption.

- Ad-hoc maintenance and limited contractual support for computer room environmental controls (Medium Priority)

Storage Area Network (SAN) failure, 23rd July – 31st July 2015

Users were denied access to a number of applications for intermittent periods over eight days due to a fault in the data replication software, RecoverPoint, between the EMC Storage Area Network (SAN) units hosted in each computer room. A timeline of key events has been documented below:



The issue with EMC RecoverPoint functionality led to failures in writing data as required, which created a denial of service scenario. IM&T logged calls with both EMC and VMWare in order to support diagnosis and resolution of the problem. Resolution of the problem was prolonged owing to slow diagnosis from EMC's external support team, and the requirement for specialist EMC resource to be onsite in support of resolving the problem. The incident highlights the risk associated with limited in-house expertise, with only one member of the IM&T trained to use the EMC RecoverPoint solution.

While it is understood the problem is a 'known issue' to EMC, the problem could not be resolved by the EMC Team in the UK, which was not familiar with the issue, further impacting the timeframes for resolution. EMC resource from the Netherlands was ultimately required to diagnose and resolve the problem, taking almost one month to address.

However, prior to the root cause being determined, action was taken to recover impacted clinical applications (which did not include EPR) in the short-term and minimise the impact of the incident. IT infrastructure enabled a failover of systems from the primary computer room (Jenner) to the secondary computer room (Thorogood) to be actioned. The failover provided a workaround solution.

The incident highlights some key observations in respect of resilience and ITDR, which have been detailed in the following detailed observations in section 4 below:

- RTOs and RPOs are not defined for any systems (High Priority)
- Single point of failure risk, and limited training budget (High Priority)
- A ITDR failover testing programme in not in place (High Priority)

3.2 IT Effectiveness Maturity Self-Assessment

Working closely with the Director of IM&T, we used our IT Effectiveness Process Maturity Assessment Tool in support of a High Level IT Health Check, to enable a rapid self-assessment[4] of the current state process capability at the Trust. Our self-assessment Tool considers the capability to plan, build, transition and run ICT services. Through this process, we have gained insight into aspects of your current IT capability compared to similar organisations and we have used the following industry standard scale to make an initial assessment of your current maturity:

1. **Uncontrolled:** Processes are missing and if present are not widely used, tools or equipment are in multiple versions, missing or not integrated.

2. **Basic:** Some processes are in place and sometimes are documented and/or used, tools or equipment are mostly aligned with some integration points missing.

3. **Standard:** Most processes are in place, documented and are used, tools and equipment are standardised with clear integration points and interfaces with some automation.

4. **Rationalised:** All processes are in place, well documented and used, tools and equipment is standardised with virtualisation and automation as standard.

5. **Optimised:** The organisation is highly rationalised, using leading edge technologies using high levels of virtualisation and automation. Processes are well documented, highly accessible and used.

The self-assessment presents an IM&T function, demonstrating largely '**Basic**' and '**Standard**' maturity levels. In our experience, while the current position of IM&T is not uncommon at NHS Trusts. It highlights areas for improvement for the IM&T function, including the necessity to enhance IT infrastructure and associated IT management process maturity.

We perceive that the IM&T function is failing to meet its potential. This is due in part to limitations in investment and consequently the ability to enable the continuous improvement in IM&T services alongside the effective management of existing technology to minimise the impact of aging hardware and software.

The IT Effectiveness Maturity Assessment supported key observations in respect of resilience and ITDR, which have been captured in the following detailed observations in section 4 below:

- IM&T Strategic risks are not addressed (High Priority)
- No IM&T risk register is in place (High Priority)
- Laptop and PC hardware and software is aged (Medium Priority)

The outcomes of the IT Effectiveness Process Maturity Assessment are presented graphically on the following page.

[4] Our scope of work was limited to those areas outlined in Appendix A. The graphic represents a self-assessment of the Trust's position, completed on the basis of discussions with the Director of IM&T.

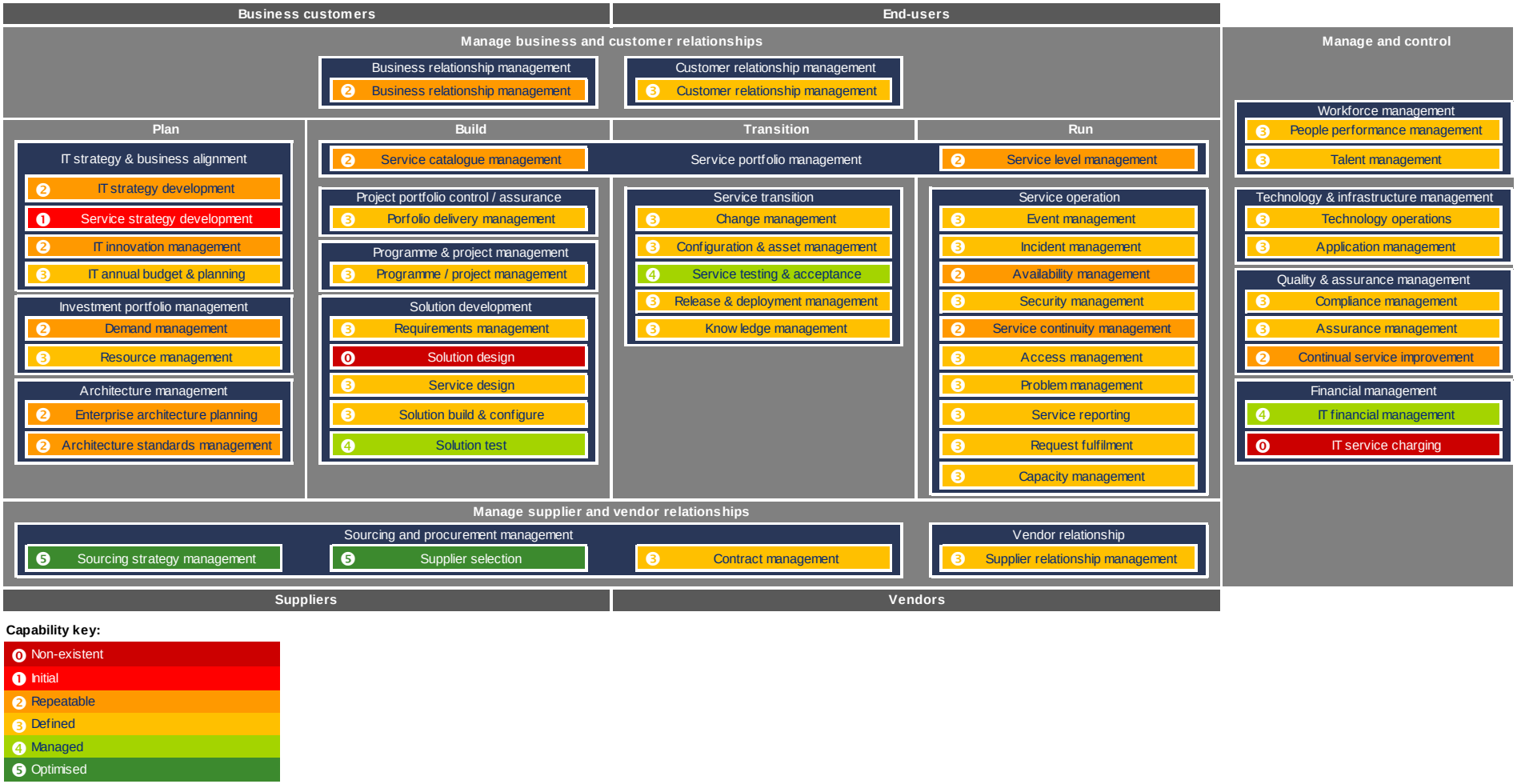


Figure 2: IT Effectiveness Process Maturity Assessment

3.3 Summary Findings

ITDR Governance Mechanisms

The IM&T Team are responsible for the management and oversight of ITDR at the Trust, and processes to support the management of ITDR have been defined. The ITDR plan, dated September 2011, outlines the requirements for the Executive to determine whether a disruptive event should be categorised as a major incident, upon escalation from the IM&T Team, who are responsible for the initial assessment of incidents.

However, while roles and responsibilities are defined, there is no mechanism to review and update policy documentation on a periodic basis, including the roles and responsibilities of individuals across the Trust, or of critical third parties who support Trust infrastructure. Additionally, the management of IM&T risks is not formalised, including risks associated with the resilience of Trust infrastructure. While an IT infrastructure risk has been recorded on the Board Assurance Framework (BAF) since July 2015, there is no IM&T risk register in place to record, categorise, mitigate, and escalate risks as required, to ensure adequate visibility at the appropriate level of Trust management.

ITDR Operational Resource and Skillset

'Control Centre' and 'Recovery' Teams' operational roles in the event of an incident are documented within the DR plan. It is understood there has been limited turnover in the IM&T Team, and key individuals remain in post. The IM&T Team is cross-skilled, and efforts have been made to standardise hardware in use to reduce the requirement for specialist skillsets. However, there is no programme to provide training for members of the IM&T team in respect of ITDR, and only one member of the team is formally trained on the 'RecoverPoint' solution, used to failover Trust systems. To support in addressing identified gaps, guidance documentation has been produced by IM&T.

ITDR Change Management

There is currently no process for periodically reviewing and updating ITDR policy and process documentation. The ITDR plan has not been reviewed or updated since 2011. It is understood that the plan will be incorporated into Information Governance (IG) Toolkit processes to ensure an annual review is performed, however this had not been performed at the time of the assessment.

Processes are in place to record changes and the impact they may have on IT infrastructure and ITDR at the Trust. Change Control Notice forms are mandated for all changes to IT, which include the requirement for roll back to be considered, and for the impact to ITDR to be captured prior to changes being implemented.

ITDR Technical Planning and Design

The Electronic Patient Record (EPR) is run on dedicated hardware as a managed solution by SystemC, who are able to remotely monitor and remotely failover the system if required. Other applications are hosted on a virtual server environment and Storage Area Network (SAN), located across two onsite computer rooms, Jenner and Thorogood. The computer rooms are configured with live production environments in each, with a 'warm' standby of applications also hosted in each location. The current configuration enables manual failover of systems between computer rooms to be performed in either direction. EMC 'RecoverPoint' software is used to provide the capability to restore systems, through the failover of pre-determined data stores.

The current configuration replicates data at defined intervals, and does not enable automatic failover of systems, for which manual intervention is required. We are informed that functionality to enable automatic failover of systems is cost-prohibitive. However, the extent to which current recovery capabilities are acceptable to operational and clinical departments has not been determined. While a prioritised application list has been produced by IM&T, RTOs and RPOs have not been defined or agreed with the Trust, and availability of support for the large majority of systems is limited to week day office hours.

Failover tests were performed in April and May 2015, following which recovery process documentation for 'RecoverPoint' was produced. However, issues and lessons learned resulting from the tests were not documented. Additionally, there is no programme to perform tests of ITDR capability on a periodic basis.

ITDR Supplier Management

IM&T are supported by third parties, primarily for on-call specialist system support. While the ITDR plan documents key third parties, these are not currently up-to-date as a result of the plan not being reviewed and

updated since 2011. However, Service Level Agreements were found to be in place with key third parties, including:

- SystemC, who provide support for the EPR;
- EMC, who provide Trust storage and DR support;
- Dell, who provide Trust servers; and
- Datrix who provide support for network hardware components.

Physical IT Environment

Trust systems are hosted across two on-site Computer rooms, which include uninterruptable power suppliers and generator backup, air conditioning and fire suppression units. A Computer Administration room, used for backup storage, is not equipped with fire suppression. Environmental controls are subject to maintenance on an ad-hoc basis, managed by the Trust Facilities Team, however computer room air conditioning units are not included within the remit of Trust-wide air conditioning maintenance contracts, although we understand contracts are being renewed and updated in 2016/17. Consequently, maintenance has not been performed on a routine basis, as indicated in the failure of air conditioning units in July 2015.

Access to the computer rooms is restricted to IM&T and Facilities staff with access to the key, and with knowledge of the key code. However, server cages are not locked within computer rooms as a mix of new hardware in older cages has led to cable management issues that have necessitated the removal of the back panel of server cages leaving them physically exposed. The ability to further expand in the current computer room locations is limited.

High Level IT Health Check

We used the IT Effectiveness Maturity Tool to support discussion of current IM&T maturity. The results, outlined in Figure 2 above, present a relatively immature IM&T function, demonstrating 'Basic' and 'Standard' maturity levels. This is due to limitations on investment and consequently the ability to continuously improve services and manage technical debt. The current position is not uncommon, in our experience, in NHS Trusts.

Annual IM&T plans, approved by the Trust Executive, have been produced historically to address priority areas for the Trust, and support the delivery of strategy. The annual plans identify priorities for IT service development and the associated capital investment requirements to deliver. Achievements, priorities and challenges associated with IM&T were reported to non-executive directors in April 2015 by IM&T. However, the IM&T Strategy has not been refreshed since 2013, and an annual plan was not produced for the current financial year. Capital programmes to address priorities and captured within the IM&T budget for the current year have not been progressed as a result of capital investment limitations.

In considering the Trust network, we identified that resilience has been designed in the network, with dual network cores and firewalls across Trust computer rooms. Network components have been configured to support automatic failover in the event of a network outage in one computer room, and escalation processes are defined for telecoms disruption at the Trust. Over 450 wireless access points are in place across the trust, with wireless controllers installed in each computer room.

3.4 Summary of Recommendations

We have highlighted a number of recommendations in our assessment of resilience, data centre and DR capabilities. Recommendations should be addressed by the Trust as a matter of importance.

Recommendations are summarised below, with further detailed observations captured in section 3. In line with our recommendations for action to address the key findings raised, the following management actions have been agreed:

Priority	Recommendation	Management Action	Timeframe	Responsibility
	IM&T should ensure that critical ITDR documents are reviewed on a periodic basis, at least annually, but also to reflect significant changes in personnel, suppliers and technologies. To support the process, the ITDR should be incorporated into the IG Toolkit process.	The ITDR plan will be reviewed and updated. The ITDR plan will be reviewed and updated at least annually as part of the IG toolkit submission each March. It is now scheduled into the IG toolkit policy review cycle.	July 2016 March 2017	Steve Illingworth
	ITDR documents should be version controlled, and outline the requirement for periodic review, including capturing the details of each review.	The revised ITDR will include version control and capture the details changed.	July 2016	Steve Illingworth
	A revised IM&T strategy should be developed, ensuring alignment with the clinical and operational strategies. It is recognised that some implications of this strategy will involve difficult choices including the consideration for outsourcing to ensure IM&T capacity and capability within the current organisation meets requirements of the Trust.	A new IM&T Strategy will be developed to align with local priorities and national requirements e.g. operate paper free at point of care by 2020. To facilitate this IM&T will tender for a Strategy partner (May 2016) and commence engagement across the Trust to capture requirements and agree priorities (July 2016). The IM&T Strategy will be drafted for approval by August 2016.	September 2016	Glenn Winteringham
	Analysis should be performed to determine the IM&T options available to address IM&T requirements necessary to support the Trust's clinical and operational strategy.	Alongside development of the IM&T Strategy, the options available to deliver Trust requirements and priorities will be considered. The annual IM&T work plan will be used to monitor progress against the delivery of the IM&T Strategy and reflect any new national or local priorities to ensure alignment to the clinical and operational needs of the Trust.	September 2016 May 2016	Glenn Winteringham

Priority	Recommendation	Management Action	Timeframe	Responsibility
↑	The Board and Executive should have an increased and collective role in enabling the Trust to transform to 'paper free care at the point of care', enabled through the delivery of an update IM&T strategy. A critical component of this transformation is the role of clinical IT leadership, such as a Chief Clinical Information Officer (CCIO). A CCIO should be identified to support IM&T engagement, and the ongoing alignment of the IM&T function with clinical requirements.	An annual IM&T work plan will be developed to agree IM&T priorities and capital investments. Progress will be monitored on a 6 monthly basis. A CCIO will be appointed. A multi-disciplinary clinical advisory group will be established to advocate the adoption of digital working.	May 2016 July 2016 July 2016	Glenn Winteringham Richard Jennings Richard Jennings
↑	IM&T risks should be recorded within a departmental risk register that is actively maintained and reviewed on a periodic basis. Risks should be categorised to determine priority, with defined risk and action owners recorded within the register.	An IM&T Risk Register will be developed and maintained on Datix. The IM&T Risk Register will be reviewed monthly as a standing item on the IT Senior Manager meeting.	June 2016	Glenn Winteringham
↑	A process for escalating IM&T risks into existing mechanisms, including the Corporate Risk Register, Datix and Board Assurance Framework (BAF), should be defined and documented, to ensure the appropriate escalation of risks to Trust IM&T.	All red rated IT risks will be escalated from the IM&T risk register to the Trust risk register where they will be monitored via TMG.	July 2016	Glenn Winteringham
↑	Operational and clinical leads should work with IM&T to define requirements for RTOs and RPOs for all applications. These should be incorporated into the prioritised applications list and inform the ITDR recovery strategy.	Business Continuity Plan leads in each service to define their RTOs and RPOs to enable alignment to the ITDR plan capability. Where they do not align, capture as a risk to manage clinical or business impact.	July 2016	Carol Gillen & Richard Jennings
↑	RTOs and RPOs should be reviewed on an annual basis or whenever a change in operations takes place in order to re-consider their accuracy.	RTO and RPOs will be reviewed on an annual basis by the Business Continuity Plan leads to ensure they still align to the ITDR plan.	March 2017	Carol Gillen
↑	Newly created RTOs and RPOs should be used a as a metric for assessing ITDR capability during annual failover tests.	RTO and RPOs will be reviewed on an annual basis as part of the ITDR plan review process.	March 2017	Steve Illingworth
↑	An IM&T skills matrix should be developed and maintained to identify and monitor skills gaps and single-points-of-failure within the team. The risk associated with identified gaps should be assessed and addressed through appropriate budget in the IM&T annual plan.	An IM&T skills matrix will be developed and reviewed to identify any gaps and risks captured on the IT risk register.	June 2016	Glenn Winteringham
↑	Where risks are determined to be in excess of acceptable levels, action should be taken to address skills gaps through formal training. In particular, training for RecoverPoint and CommVault should be provided to support ITDR and resilience capabilities of the team.	Any identified gaps will be managed via the appraisal and personal development plan process to ensure staff have the requisite skills to undertake their duties, subject to available funding for training. Other options will also be reviewed as part of this process e.g. outsource to a specialist third party supplier, partnership with local Trusts.	June 2016	Glenn Winteringham
↑	IM&T should schedule periodic (at least annually) testing activities that include testing the failover of critical systems. The team should consider expanding the scope of the test towards a full failover as the testing programme matures.	An ITDR testing plan will be developed in partnership with an expert 3rd party supplier. The ITDR plan will set out an on-going programme to test failover of critical systems on an annual basis. Subject to available resource and funding, all other IT systems will be subject to annual failover tests.	June 2016	Steve Illingworth

Priority	Recommendation	Management Action	Timeframe	Responsibility
	Post-test reports should be documented to capture details of the outcome of testing, a timeline of events, and any capability gaps identified. Action plans should be created and monitored, with defined action owners, to address identified gaps.	Post-test reports will be written up to audit outcomes. Actions identified will be assigned owners, and will be tracked to completion.	July 2016	Steve Illingworth
	Analysis should be performed to determine the impact of hardware issues for end users, and the associated cost of lost time, as a result of aged hardware. A programme of investment, aligned with analysis performed, should be considered to enable a consistent refresh programme for PC and laptops in use across the Trust.	The IT capital programme for 16/17 is under development to address the red rated risk (score >= 20) infrastructure. There will be an option appraisal to review CAPEX vs OPEX for rolling replacement of devices.	July 2016	Steve Illingworth
	The programme to migrate from Windows XP should be continued and completed at the earliest possible opportunity.	The remaining 45 PCs will be upgraded to Windows 7 in Medical Physics, Pathology, and Finance	June 2016	Steve Illingworth
	The renewed contract for Trust-wide maintenance should include environmental controls situated in the Trust computer rooms to ensure they are subject to routine maintenance checks.	The scope for the revised J.C Watson contract will be confirmed with Facilities. The SLA for on-going maintenance and support in and out of hours will also be confirmed.	May 2016	Phil Ient
	Defined roles and responsibilities should include consideration for monitoring capacity and for changes to the IT estate that are likely to impact Trust requirements.	IT will inform Estates of changes to the IT infrastructure in the two data centres and Estates will assess and monitor the impact to ensure the environmental controls meet the requirements including resilience capacity in the event of an enviromental control failure.	May 2016	Steve Illingworth
	The tape backup machine should be repaired or replaced at the earliest possible opportunity, to ensure backup to tape is completed in line with requirements.	IM&T Risk Register will be developed and maintained on Datix, and will be updated to include risks associated with the current backup process.	June 2016	Glenn Winteringham
	Risks associated with the backup process should be recorded within the IM&T risk register to enable formal consideration for the risks, including determining appropriate follow-up actions and periodic review.	IM&T Risk Register will be developed and maintained on Datix, and will be updated to include risks associated with the current backup process.	June 2016	Glenn Winteringham
	The Trust should record identified Physical Security risks within the IM&T risk register, determine appropriate actions to resolve issues, or formally accept the associated risks.	IM&T Risk Register will be developed and maintained on Datix, and will be updated to include physical security risks to the Trust's computer rooms.	June 2016	Glenn Winteringham

4 Detailed Observations and Recommendations

Observation	Priority	Recommendation	Scope Area
1. ITDR documents are not subject to periodic review An ITDR plan is in place, which was developed with the support of external resources, outlining the approach to ITDR and supporting processes. Roles and responsibilities are defined, and a contact list is included for those in 'control centre' and 'recovery' teams. However, the ITDR Plan was documented in September 2011, and has not been formally reviewed or updated since then. Critical suppliers to the Trust are not all captured in documentation, including EMC, who provide hardware support, and were required to address issues identified in the incident in July 2015. The current ITDR plan is not version controlled, and there is no embedded process to periodically review and update ITDR documentation despite the incremental evolution of the IM&T environment. We understand from management that it is the intention to include critical ITDR documents as part of the annual policy reviews monitored as part of the IG Toolkit return, however this has yet to be actioned. The effectiveness of ITDR planning is at risk, where supporting information is not up-to-date and reflective of current roles, responsibilities, processes, technologies, and suppliers necessary for effective ITDR.		• IM&T should ensure that critical ITDR documents are reviewed on a periodic basis, at least annually, but also to reflect significant changes in personnel, suppliers and technologies. To support the process, the ITDR should be incorporated into the IG Toolkit process. • ITDR documents should be version controlled, and outline the requirement for periodic review, including capturing the details of each review.	**ITDR governance mechanisms**
2. IM&T strategic risks are not addressed An IM&T strategy was developed to cover the period 2013-2015. In addition, annual plans have been completed by the IM&T to outline priorities for each year, which are reviewed and approved by the Trust Management Group. However, while priorities were documented by the IM&T Team for 2015-2016, a formal annual plan was not documented and approved, nor was the IM&T strategy updated beyond 2015. A revised IM&T strategy has not		• A revised IM&T strategy should be developed, ensuring alignment with the clinical and operational strategies. It is recognised that some implications of this strategy will involve difficult choices including the consideration for outsourcing to ensure IM&T capacity and capability within the current organisation meets requirements of the Trust.	**IT health check**

Observation	Priority	Recommendation	Scope Area
been developed to outline the direction and priorities for Trust IM&T beyond the existing strategy document, including how IM&T will support the Trust in achieving 'paper free at the point of care'. The ability for IM&T to provide a resilient and secure underlying infrastructure, to enable the development of clinical systems and processes, is critical in developing towards a digital hospital and achieving the Personalised Health and Care 2020 (PHC2020) vision. Where a defined and Board-approved strategy for IM&T is not in place, there is a risk that organisational expectations are not understood by the IM&T Team, and that priorities are not aligned with defined organisational requirements. Additionally, the ability to determine necessary strategic investments, to ensure underlying infrastructure is sufficiently resilient and aligned with requirements, is reduced. Consequently, there is a risk that the technical debt increases, impacting the delivery of care as the ability of infrastructure and systems to meet clinical requirements reduces. This is particularly concerning where progress to further digitisation is continuing while infrastructure remains unreliable.		• Analysis should be performed to determine the IM&T options available to address IM&T requirements necessary to support the Trust's clinical and operational strategy. • The Board and Executive should have an increased and collective role in enabling the Trust to transform to 'paper free care at the point of care', enabled through the delivery of an update IM&T strategy. A critical component of this transformation is the role of clinical IT leadership, such as a Chief Clinical Information Officer (CCIO). A CCIO should be identified to support IM&T engagement, and the ongoing alignment of the IM&T function with clinical requirements.	
3. An IM&T risk register is not in place The Corporate Risk Register and Datix risk management system are currently used to capture Trust risks. In addition, an IT infrastructure risk has been recorded on the Board Assurance Framework (BAF) since July 2015. It is noted that the number of risks associated with IT infrastructure recorded in the BAF increased from one to two in October 2015, with additional information added, taking into account the incidents that occurred in July 2015. However, a risk register is not maintained by IM&T to capture operational risks associated with IM&T at the Trust. As such, there is no formal mechanism for identified risks to be assessed, managed, and escalated beyond IM&T as appropriate. Concerns associated with computer room air conditioning were identified by IM&T in 2013, however the risks were not recorded to enable escalation and action to be taken. There is a risk that IM&T risks are not sufficiently managed and escalated as required to ensure the appropriate level of visibility across the Trust. As such, action may not be taken to address risks that are deemed to be unacceptable to the Trust, including those related to ICT infrastructure. Additionally, where risks cannot be effectively demonstrated, funding may not be available to support in addressing identified risks.		• IM&T risks should be recorded within a departmental risk register that is actively maintained and reviewed on a periodic basis. Risks should be categorised to determine priority, with defined risk and action owners recorded within the register. • A process for escalating IM&T risks into existing mechanisms, including the Corporate Risk Register, Datix and BAF, should be defined and documented, to ensure the appropriate escalation of risks to Trust IM&T.	**ITDR governance mechanisms**

Observation	Priority	Recommendation	Scope Area
4. RTOs and RPOs are not defined for any systems Recovery Time Objectives (RTOs) define the target duration of a service's unavailability following a disruptive event and Recovery Point Objectives (RPOs) define the maximum allowable age of data to be recovered following disruption. RTOs and RPOs have not been defined, agreed and communicated with clinical and operational leads across the Trust to confirm ITDR capabilities align with requirements, and acceptable levels of risk. We are informed that business continuity plans to support offline working have been strengthened, however there has been limited clinical and operational engagement to address concerns related to recoverability, and ensure ITDR capabilities meet requirements. The ability to determine gaps in ITDR capability and assess the necessary investment requirements to achieve RTOs and RPOs defined by the Trust is not possible, further impacting the current disconnect between expectations and capabilities. It is essential that risks associated with application outages are adequately addressed by ITDR capabilities. Where RTOs and RPOs are not defined and agreed, there is a risk for that expectations of capabilities do not align with the actual capabilities and technology available to the Trust. In the event of an incident, there is an increased risk of application outages that exceed the limits required by operational and clinical leads.		• Operational and clinical leads should work with IM&T to define requirements for RTOs and RPOs for all applications. These should be incorporated into the prioritised applications list and inform the ITDR recovery strategy. • RTOs and RPOs should be reviewed on an annual basis or whenever a change in operations takes place in order to re-consider their accuracy. • Newly created RTOs and RPOs should be used a as a metric for assessing ITDR capability during annual failover tests.	**ITDR Technical planning and design**
5. Single point of failure risk, and limited training budget It is understood that members of the IM&T Team are cross-skilled, and informal coaching has been provided for the use of backup and recovery tools. However only one member of the IM&T team has received formal training in the use of CommVault and RecoverPoint, the primary tools used for backup and recovery processes. The IM&T team rely on informal skills transfer, and the historic knowledge of Team members who have been with the Trust for a long period of time. Where possible, training is incorporated into the budget when procuring new systems, most recently demonstrated by the Trust when implementing the Rhapsody Integration Engine in 2015. However there is currently no dedicated budget allocated for IM&T training		• An IM&T skills matrix should be developed and maintained to identify and monitor skills gaps and single-points-of-failure within the team. The risk associated with identified gaps should be assessed and addressed through appropriate budget in the IM&T annual plan. • Where risks are determined to be in excess of acceptable levels, action should be taken to address skills gaps through formal training. In particular, training for RecoverPoint and CommVault should be provided to support ITDR and resilience capabilities of the team.	**ITDR operational resource and skillset**

Observation	Priority	Recommendation	Scope Area
in the current year, and no programme to support ongoing learning requirements. In addition, there is a single point of failure risk in the ability to provide effective support in the event of an incident impacting backup and recovery tools. The ability for the IM&T team to complete a timely failover of impacted clinical and non-clinical applications, in line with Trust expectations, is reduced. Limited opportunity for formal training of new IM&T team members, or the completion of refresher training for existing staff, limits the pool of resource that are familiar with systems essential to the ITDR process. There is a risk that Trust is subject to prolonged or sustained outage and systems may not be fully functional when brought online, as a result of incorrect failover procedures being performed by untrained members of the team.			
6. An ITDR failover testing programme in not in place A 'Proof of concept' ITDR failover test took place between April and May 2015, following which a step-by-step guide to support the ITDR process was produced. However, findings and lessons learned were not documented. The test was successful in demonstrating the failover process to IM&T staff, however a programme to perform similar tests on a periodic basis has not been developed and agreed. No further formal testing of resilience and ITDR capabilities takes place to support in identifying gaps in capability. Without a formal testing programme in place IM&T cannot provide assurance that a consistent ITDR capability is in place at the Trust, potentially leaving the Trust exposed to a prolonged outage if this capability is lacking. Additionally, the team will miss out on key opportunities to identify gaps in technology, skills or the team's knowledge of the ITDR plan.		• IM&T should schedule periodic (at least annually) testing activities that include testing the failover of critical systems. The team should consider expanding the scope of the test towards a full failover as the testing programme matures. • Post-test reports should be documented to capture details of the outcome of testing, a timeline of events, and any capability gaps identified. Action plans should be created and monitored, with defined action owners, to address identified gaps. • The requirement for periodic testing should be outlined within the updated ITDR policy (observation 2 above).	**ITDR operational resource and skillset**
7. Laptop and PC hardware and software is aged A programme is ongoing to migrate all laptops and PCs in use across the Trust to Windows 7. However, a number of devices remain on Windows XP, which is not supported by Microsoft, and not subject to periodic security updates. Additionally, a significant proportion of the Trust's PCs		• Analysis should be performed to determine the impact of hardware issues for end users, and the associated cost of lost time, as a result of aged hardware. A programme of investment, aligned with analysis performed, should be	**High level IT Health Check**

Observation	Priority	Recommendation	Scope Area
and laptops are in excess of 5 years old. In addition, capital investment in PCs has not been consistent, but rather reactive to availability of funding, with the latest investment being provided in FY14/15. Capital funding limitations in the current year have meant there has been no investment in IT hardware. Corresponding analysis has been captured in Figure 1 above. However, as identified in observation 2 above, the risk associated with aged hardware is not recorded within a risk register for formal management and escalation. The use of unsupported operating systems increases the risk of exposure to security threats. Where hardware becomes aged, there is an increased risk of hardware failures, and corresponding burden on the IM&T Service Management Team. In addition, the use of aged hardware may increase login and processing times when using applications, both operational and clinical, resulting in lost time when accessing technology.		considered to enable a consistent refresh programme for PC and laptops in use across the Trust. • The programme to migrate from Windows XP should be continued and completed at the earliest possible opportunity.	
8. Ad-hoc maintenance and limited contractual support for computer room environmental controls The Facilities team at the Trust are responsible for managing air conditioning and fire suppression units. Third parties have been engaged to check the status of air conditioning and fire suppression units on an ad-hoc basis. However, air-conditioning within the Trust computer rooms was not included within the scope of the maintenance contract agreed in 2013. As such, maintenance has been performed on an ad-hoc basis. Consequently, maintenance has not been performed on a routine basis, as indicated in the failure of air conditioning units in July 2015. Appropriately provisioned and maintained air conditioning and fire suppression units are essential to the running of computer rooms and the associated systems that IM&T manage within them. While we understand from management that Trust-wide maintenance contracts are due for renewal in April 2016, the current scenario presents a risk where the Trust may be further exposed to outages resulting from poor maintenance or inadequate air conditioning and fire suppression units.		• The renewed contract for Trust-wide maintenance should include environmental controls situated in the Trust computer rooms to ensure they are subject to routine maintenance checks. • Defined roles and responsibilities should include consideration for monitoring capacity and for changes to the IT estate that are likely to impact Trust requirements.	**ITDR** **Supplier Management**
9. Backup to tape is not currently fit for purpose The data backup process is managed by the IM&T Team for all Trust		• The tape backup machine should be repaired or replaced at the earliest possible opportunity, to ensure backup to	**Physical IT**

Observation	Priority	Recommendation	Scope Area
systems hosted within Trust computer rooms. Data is backed up on a daily basis using the 'CommVault' solution, and stored to disk for two months (except for EPR which has dedicated backup hardware and a more intensive tape backup schedule). Data backups are written to tape on a monthly basis, and maintained for five years. However, the following was identified in relation to the current backup processes operated by the Trust: • The Trust tape backup machine is currently broken and awaiting repair by a third party supplier (an alternative temporary machine has been sourced, however, backup times are greater than expected). Note, data backups to disk are not affected; • Fire suppression equipment is not installed in in the Computer Administration Room, where backups take place; and • There is limited space for long term tape storage. The most recent three months are retained in a fire proof safe, with the remaining tape stored in the Computer Administration Room. There is a risk to the effectiveness and integrity of Trust backup processes are not in line with expectations. Additionally, a prolonged period without backup tapes increases the risk that critical systems data is lost in the event of an incident in which production data is found to be corrupted.		tape is completed in line with requirements. • Risks associated with the backup process should be recorded within the IM&T risk register to enable formal consideration for the risks, including determining appropriate follow-up actions and periodic review.	**Environment**
10. Physical security in both server rooms is not fully optimised Trust computer rooms are secured through the use of key codes and/or lock and key, with access limited to IM&T and Facilities staff. However, further physical security mechanisms were found to not be operating effectively. While CCTV is installed, it was not functioning at the time of assessment, and server cages are not locked within the server rooms. Additionally the mix of new hardware in older cages has led to cable management issues that have necessitated the removal of the back panel of server cages leaving them physically exposed. With no security provided from CCTV or server cages the sole piece of physical security in each server room comes from the locked main door. This single-point-of-failure further exposes Trust systems to potential disruption should a malicious agent gain entry into the room.		• The Trust should record identified Physical Security risks within the IM&T risk register, determine appropriate actions to resolve issues, or formally accept the associated risks.	**Physical IT Environment**

Appendix A – Scope and Approach

ITDR Governance Mechanisms

We will understand and comment on the governance mechanisms supporting the ITDR programme at the Trust, including specific consideration for:

- the definition of roles and responsibilities for the oversight and management of ITDR at the Trust, including that of governance bodies and senior management;
- assessing the ITDR policies in place, and the processes for aligning ITDR documentation with Trust Business Continuity requirements; and
- processes for the management of risks associated with ITDR, including periodic risk assessments, definition of risk ownership, determining mitigating actions, and criteria for the escalation of risks.

ITDR Operational Resource and Skillset

We will understand and comment upon the existing ITDR resources within the Trust, with specific consideration for the following:

- the definition of roles and responsibilities to support the operational delivery of ITDR;
- training made available to trust resources in respect of ITDR, and programmes for periodic refresher training; and
- Trust processes for assessing skills requirements and identifying gaps in skillsets required to effectively support ITDR requirements.

ITDR Change Management

We will understand and comment on the management of changes associated with ITDR to ensure ITDR capacity and capability remains aligned with organisational change, including:

- the processes to periodically review and update ITDR documentation;
- the processes to assess the impact of IT changes on ITDR, including identification of changes required to ITDR policies and procedures, technical solutions and capacity; and
- considering a sample of IT projects, obtain evidence to demonstrate consideration for the impact to ITDR and the associated changes made.

ITDR Technical Planning and Design

We will understand and comment on the design of infrastructure across the primary and secondary Trust data centres, including:

- the ability of the infrastructure design to enable key clinical and operational applications to ‘failover’ in the event of an outage at either data centre;
- the plans in place to outline the requirements for ITDR and the processes defined to enable invocation of ITDR across Trust data centres;
- the technical solutions supporting the ITDR plan for key Trust clinical and operational systems;
- how the Trust has determined ITDR capacity requirements, including the extent to which ITDR capability has been informed and prioritised by clinical and operational requirements, including determining recovery timeframes to support business continuity processes; and
- processes to identify gaps in existing ITDR capacity and capability, including periodic testing of ITDR plans, and subsequent programme plans in place to address identified gaps.

ITDR Supplier Management

We will understand and comment upon the use of third parties, and technical solutions employed to support ITDR processes, including:

- the definition of third party responsibilities for supporting Trust ITDR capabilities, and the extent to which third party responsibilities are reflected within ITDR documentation, including policies and plans;
- definition of Service Level Agreements (SLAs) with third parties responsible for supporting Trust resilience capabilities; and
- the processes for monitoring compliance with SLAs for third parties supporting Trust ITDR.

Physical IT Environment

We will understand and comment upon the physical security and environmental controls in place at the Trust's two data centres, including specific consideration for the following:

- how environmental controls, including uninterruptable power supply (UPS), air conditioning, and fire suppression are monitored and configured, including alerting, and the definition of responsibilities for actioning adverse events;
- whether contracts are in place for the maintenance and support of equipment supporting environmental controls;
- physical locations and layouts of the Trust Data Centres; and
- how access to the Trust data centres is secured, restricted and monitored.

High Level IT Health Check

We will understand and comment upon the operational capacity, asset life, resilience and standardisation of the following areas of IT at the Trust:

- Community Wide Area Network (WAN)
- Hospital Local Area Network (LAN)
- Community and hospital Wi-Fi; and
- IT Devices, including PCs and iPads.

To inform our understanding, we will:

- Understand the design of Trust networks, and consider the extent to which resilience has been built into existing network designs;
- Discuss 'pain points' in respect of those IT areas outlined above with Trust Stakeholders within IM&T, clinical and operational departments, and community services;
- Understand IT helpdesk calls to inform our understanding of the 'pain points' discussed with stakeholders, and consider actions taken to address identified issues;
- Consider the PC operating system(s) in use across the Trust, including consideration for vendor support; and
- Understand the IM&T programme portfolio, and the extent to which programmes (planned or in-flight) are in place to address 'pain points' or improve existing It services outlined above, including rolling programmes for the replacement of ICT hardware.

Risks identified in performing our assessment will be discussed with management and captured within our report, supported by prioritised recommendations for improvement.

Appendix B – Interviews and Documentation

Interviews

In performing our assessment we met with the following individuals:

- Biplab Sen, Senior IT Engineer
- Brett Tomes, Devices Manager
- Carol Gillen, Acting Chief Operating Officer
- Glenn Winteringham, Director of IM&T
- Helen Taylor, Clinical Director (Clinical Support Services)
- Kelechi Maduta, IT Service Desk Manager
- Philip Ient, Estates Manager
- Steve Illingworth, Assistant Director of IM&T, IT Technical Services and Infrastructure
- Stuart Leighio, Estates Manager
- Tino Goncalves, Network Manager

Documentation

In performing our assessment, the following documentation was observed:

Document	Comments
Whittington IT Strategy 2013 – 2015	January 2013
72 hour incident report	Version 1, June 2015
Whittington IT Downtime Investigation report	December 2015
TIAA IT Disaster Recovery Internal Audit Report	Final Report, dated March 2014
Key WHICO IT Systems	Internal IM&T document, not dated
Escalation flow diagram – IT systems or telecoms failure	Operational process document, not dated
Tech Services Workplan	December 2014
Whittington ITDR Plan	September 2011
Rhapsody training proposal	June 2015
Sample Change Request Forms	Multiple changes sampled to determine ITDR impact
EMC RecoverPoint failover	Process support document, not dated
SystemC Performance Management contract schedule	Version 1.0, May 2012
Softcat Hardware and Software quotation	February 2013
EMC Premium Support features	November 2015
Reciprocal service brief	Issue 1, not dated
Dell Pro Support quote	January 2013
Dell Pro Support fact sheet	December 2011
Microsoft support contract, variation schedule	July 2015
Stone Computer Statement of work – network management and support	March 2015
Virgin Business Maintenance Quote	December 2015
Comtec Power UPS Maintenance	April 2014
Cetronic Power Solutions UPS Maintenance	November 2015
Windows 7 project rollout	Internal IM&T document, February 2016
IM&T Development Workplan 2014-15	June 2014
M12 Financial Reports	Year-end financial position
IM&T Update – NED Away Day	April 2015
Support Works 2015 Activity	Service Desk extract

Statement of Responsibility

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of assessment work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Auditors, in conducting their work, are required to have regards to the possibility of fraud or irregularities. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our audit work and to ensure the authenticity of these documents. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Deloitte LLP
London

May 2016

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

6th July 2016

Title:	Heatwave Plan 2016		
Agenda item:	**16/091**	**Paper**	**11**
Action requested:	For agreement		
Executive Summary:	To inform the Executive of changes to the Whittington Health Heat Wave Plan 2016. The Heat Wave plan provided by the Department of Health, NHS England and the Local Government Association. **Re: Heatwave plan for England** As we approach summer, this summary is intended to draw your attention to the Heatwave plan for England. No changes have been made to the plan this year which will remain in place until further notice. Three new resources have been developed: 'Beat the Heat' poster; 'Beat the Heat' supporting leaflet; 'Beat the Heat: keep cool at home – checklist'. These documents are available alongside the Heatwave Plan for England and other supporting material at www.gov.uk/government/publications/heatwave-plan-for-engla		
Summary of recommendations:	Distribution plan and resources to the Whittington Health key stakeholder. Establishment of the additional resources on the Whittington Intranet and internet.		
Fit with WH strategy:	This information in in accord with "helping local people live healthier lives" and The Civil Contingencies Act 2004: Category 1 responder's duties.		
Reference to related / other documents:	www.gov.uk/government/publications/heatwave-plan-for-england		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	North Central London Local Resilience Forum: Risk Rating: Medium High http://www.london-fire.gov.uk/Documents/NC_CRR_Apr_2011.pdf		
Date paper completed:	24/06/2016		

Author name and title:		**Lee Smith Emergency Planning Officer**		**Director name and title:**		**Carol Gillen Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**	**Yes**	**Legal advice received?**	

Whittington Health NHS

Heatwave Plan

Version and Date	5.4 June 2016
Valid Until	1 June 2017
Status	Live Document (1 June -15 September)
Document Purpose	This plan has been developed to ensure that the Acute and Community Services of the Trust is capable of responding to Heatwave.
Related Document	Major Incident Plan Business Continuity Plan, Flu Pandemic Plan, Risk Management Policy, Fire Safety Policy.
Accountable Director	Carol Gillen Chief Operating Officer – Accountable Emergency Officer
Author	Lee Smith Emergency Planning Officer

Contents Page

Distribution List

In order to comply with the requirements of being a category 1 responder under the terms of the Civil Contingencies Act 2004 the Trust has a responsibility to share its plans with partner agencies.

Internal Distribution List

Department /Role	Format
Major Incident Control Room Cupboard	Hard copy
Whittington Health Intranet Policies folder	Electronic copy
Silver and Gold dropbox	Electronic
Silver & Gold handbook (shared 'I'drive)	Electronic

External Distribution List

Organisation	Format
London Ambulance Service	Electronic Copy
NHS England (London Region)	Electronic Copy
London Borough of Islington	Electronic Copy
London Borough of Haringey	Electronic Copy

Amendment Record

No unauthorised amendments permitted.

This plan is a living document and is under constant review. A record of amendments follows any comments or suggestions for future versions are appreciated and should be directed to the Emergency Planning and Business Continuity Officer.

Change History			
version	**Date**	**Author/Editor**	**Details of Change**
22/10/08	1.0		Document created
22/03/09	2.0		Refreshed document for summer 2009 to take into account updated guidance
22/04/10	3.0		Updated to include revised national guidance from DoH Heatwave Plan
22/01/11	4.0	Mathew Boazman	Annual refresh and approval
1/10/11	5.0	Mathew Boazman	Integrated plan for ICO finalised following NHS Assurance process feedback
18/06/13	5.1	Rebecca Blake	Annual update reference to Heatwave Plan for England 2013
20/05/14	5.2	Rebecca Allsopp	Annual update reference to Heatwave Plan for England 2014
03/07/15	5.3	Lee Smith	Annual update reference to Heatwave Plan for England 2015
24/06/16	5.4	Lee Smith	Annual update reference to Heatwave Plan for England

1. INTRODUCTION

The Heatwave Plan for England is published by Public health England and sets out the responses required of health services and local authorities in the event of a heatwave. This plan acknowledged that climate change is becoming a serious threat to the population's health and that heatwaves are likely to become more common in England.

2. PURPOSE

The Heatwave Plan for Whittington health outlines how we will work with local partners to ensure health and social care services raise awareness of the risks relating to severe hot weather and prepare organisations and individuals (especially vulnerable groups) to help reduce those risks.

Whittington Health recognise that proper preparedness is essential as in contrast to deaths associated with cold weather, the rise in mortality during a heatwave occurs very quickly – within one or two days of the temperature rising. This means that by the time a heatwave starts the window of opportunity for effective action is very short, and proper preparedness is therefore essential.

The **Department of Health (DH)** is responsible for strategic leadership of both health and social care systems, but no longer has direct management of most NHS systems. **NHS England** provides national leadership for improving health care outcomes, directly commissions general practice services, some specialist services, and oversees **Clinical Commissioning Groups (CCGs)**. CCGs now commission planned hospital care, rehabilitative care, urgent and emergency care, most community health services and mental health and learning disability services. **Directors of Public Health** in Local Authorities are responsible for population health outcomes, supported by **Public Health England (PHE),** which provides national leadership and expert services to support public health.

PHE will make advice available to the public and health and social care professionals in affected regions, in preparation for an imminent heatwave, via NHS Choices, and the websites of the Met Office, PHE and the DH.

NHS Choices (www.nhs.uk) continues to provide reliable advice and guidance throughout the year on how to keep fit and well. It includes information on how to stay well in hot weather (www.nhs.uk/ summerhealth).

3. SUPPORTING DOCUMENTATION

As in previous years, the Heatwave Plan for England is also supported by a series of Information Guides published online which aim to provide an authoritative source of additional information about the effects of severe hot weather on health for:

- Looking After Yourself And Others During Hot Weather (for Individuals, families and carers);
- Supporting Vulnerable People before and during a Heatwave: Advice for Health and Social Care Professionals;
- Supporting Vulnerable People Before and During a Heatwave: Advice for Care Home Managers and Staff.
- 'Beat the Heat' poster: an infographic for the public with key advice for staying safe in hot weather

- ‘Beat the Heat’ poster: detailed information for the public about how to stay safe in hot weather
- ‘Beat the heat’: keep cool at home-checklist’: a checklist to help people identify situations where overheating in the home may cause harm to health, the actions to take, and how to access further help and support. This resource is aimed at members of the public as well as frontline workers (for example, health and social care staff)

These supporting documents have also been updated to reflect the changing responsibilities as a result of the Health and Social Care Act (2012).

These can be found at: https://www.gov.uk/government/publications/heatwave-plan-for-england

4. BACKGROUND

The evidence about the risks to health from heatwave is extensive and consistent from around the world. Excessive exposure to high temperatures can kill. During the summer heatwave in Northern France in August 2003, unprecedentedly high day- and night-time temperatures for a period of three weeks resulted in 15,000 excess deaths. The vast majority of these were among older people.

In England that year, there were over 2,000 excess deaths over the 10 day heatwave period which lasted from 4 – 13 August 2003, compared to the previous five years over the same period.

The first Heatwave Plan for England was published in 2004 in response to this event. Since that time we have had a significant heatwave in 2006 (when it was estimated that there were about 680 excess deaths compared to similar periods in previous years). In 2009 there were approximately 300 excess summer deaths during a heatwave compared to similar periods in previous years.

Climate change means that heatwaves are likely to become more common in England. By the 2080s, it is predicted that an event similar to that experienced in England in 2003 will happen every year.

In Northern France in August 2003, unprecedentedly high day and night time temperatures for a period of three weeks resulted in 15,000 excess deaths. The vast majority of these were among older people.

Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that these summer deaths are indeed ‘extra’ and are the result of heat related conditions.

Cities and urban areas tend to be hotter than rural areas, creating urban heat island effects. This is due to increased absorption and reflection of the sun on concrete compared with green or brown spaces; reduced cooling from breezes due to buildings and increased energy production from houses, industry, businesses and vehicles.

5. HEAT- HEALTH ALERT LEVEL SYSTEM

The Heat-Health Watch system operates in England from 1 June to 15 September each year. During this period, the Met Office may forecast heatwaves, as defined by forecasts of day and night time temperatures and their duration.

These vary from region to region but for **London** the threshold temperatures are **32 ºC (day time)** and **18 ºC (night time)** for a period of 3 or more continuous days.

The Heat-Health Watch system comprises of five main levels (Levels 0-4), which are outlined in Figure 1 below;

Figure 1: Heatwave Alert Levels

Level 0	**Long – term planning** *All year* Includes year round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heat waves. This involves urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient.
Level 1	**Heatwave and Summer Preparedness Programme** *1 June – 15 September* The heat wave plan will remain at level 1 unless a higher alter is triggered. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the heatwave plan.
Level 2	**Heatwave is forecast – Alert and readiness** *60% risk of heatwave in the next 2-3 days* This is triggered as soon as the Met Office forecasts that there is a 60 per cent chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2–3 days before the event is expected. As death rates rise soon after temperature increases, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave.
Level 3	**Heatwave Action** *Temperature reached in one o more Met Office National Severe Weather Warning Service Regions* This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one region or more. This stage requires specific actions targeted at high risk groups.
Level 4	**Major Incident – Emergency Response** *Central Government will declare a level 4 alert n the event of severe or prolonged heatwave affecting sectors other than health* This is reached when a heatwave is so severe and/or prolonged that its effects extend outside health and social care, such as power or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, illness and death may occur among the fit and healthy, and not just in high risk groups and will require a multi-sector response at national and regional levels.

6. HIGH RISK FACTORS

There are certain factors that increase an individual's risk during a heatwave. These include:

- Older age: especially women over 75 years old, or those living on their own who are socially isolated, or in a care home.

- Chronic and severe illness: including heart conditions, diabetes, respiratory or renal insufficiency, Parkinson's disease or severe mental illness. Medications that potentially affect renal function, the body's ability to sweat, thermoregulation or electrolyte balance can make this group more vulnerable to the effects of heat.
- Inability to adapt behaviour to keep cool: having Alzheimer's, a disability, being bed bound too much alcohol, babies and the very young.
- Environmental factors and overexposure: living in urban areas and south facing top floor flats, being homeless, activities or jobs that are in hot places or outdoors and include high levels of physical exertion.

7. MET OFFICE HEATWAVE WARNINGS

Figure 2 below summarises the Met Office service and notifications during a heatwave period for the summer of 2014.

Figure 2: Met Office service and notifications

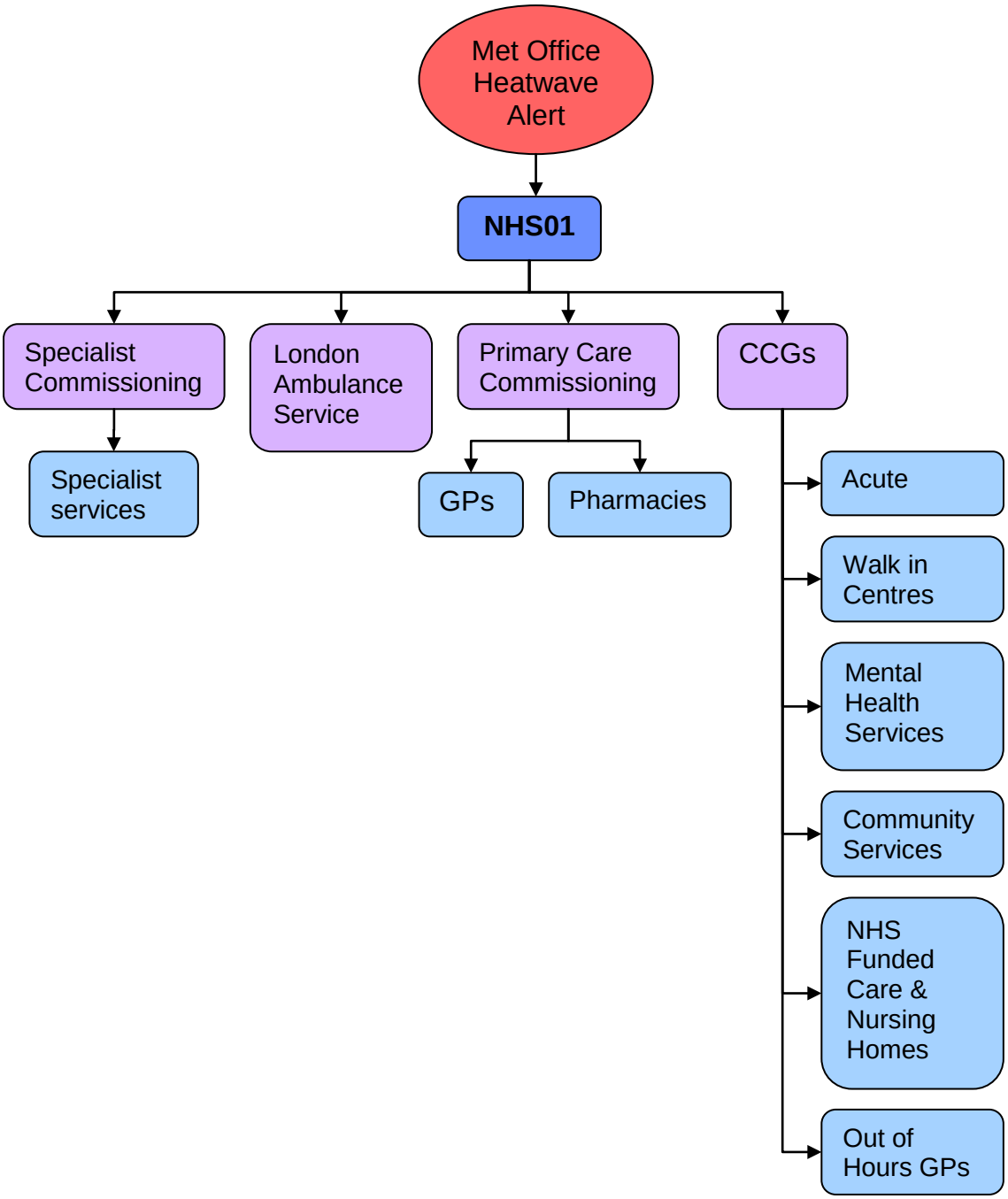
Service	Purpose	Distribution	Timing
Heatwave Warning	To provide early warning of high temperatures. The alert levels have been set with thresholds known to cause ill health from severe hot weather. They are to help ensure that healthcare staff and resources are fully prepared for hot weather periods that might impact and to raise awareness for those individuals whoa re more vulnerable to hot weather conditions	Email	Alert issued as soon as agreed threshold has been reached and when there is a change in alert level. Issued between 1 June and 15 September.
Heatwave Planning Advice	To probed advice through the summer period relating to high temperatures	Email	Twice a week (9am each Monday and Friday from 1 June to 15 September)
National Severe Weather Warning Service (NSWWS)	To provide warnings of sever or hazardous weather that has the potential to cause danger to life or widespread disruption. These warnings are issues to: • The public – to promote consideration of actions they may need to take • Emergency responders – to trigger their plans to protect the public from impacts in advance of an event, and to help them recover from any impacts after the event.	Email, web, SMS. TV, radio	When required
General Weather Forecasts	To enable the public to make informed decisions about their day to day activities	Web, TV, radio	Every day

8. ALERTING CASCADE

The response to a heatwave will be governed by the actions needed at each of the four alert actions. The Met Office will cascade a Heatwave alert to all Heat-Health Watch organisations.

The alerting cascade for London is shown in figure 3 and internally within Whittington Health seen in 8.1.

Figure 3: London Alerting Cascade



The alert levels will act as triggers for initiating internal organisational response arrangements. NHS England will request assurance from organisations as to the impact and mitigation in place during periods of sustained heatwave response at any alerting level.

In the event of a Level 4 heat-health alert being issued:

- A pager message will be cascaded to all NHS organisations directors on call via the paging system.

The pager message will read as follows:

RED from NHS01: Level 4 Heatwave – National; Emergency Declared. Confirm email address to receive further instructions to england.london-incident@nhs.net

NHS England will initiate command and control arrangements across London, and establish a reporting rhythm for situational reporting on the impacts of the incident on health organisations.

8.1 Whittington Health Alerting Cascade

Whittington Health NHS Trust receives heatwave alerts through the Emergency Planning Officer, who upon receipt of a will cascade it to all on call personnel.

Who will upon receipt of a heatwave alert will ensure the information is cascaded within their directorate/ department and in the absence of the Emergency Planning Officer, heatwave alerts will be cascaded by the Clinical Site Team.

Out of Hours this will be cascaded by the Clinical Site Team.

9. WHITTINGTON HEALTH ACTIONS

This section details the Trust responsibilities for responding at each of the levels of the Heat - Health Watch Alert System.

LEVEL 0 **LONG-TERM PLANNING**		
Includes year round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heat waves. This involves urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient.		
	Action	**Responsibility**
1	Develop systems to identify and improve resilience of high-risk individuals	
	Request an HHSRS assessment from EH for clients at particular risk.	District Nurses / health visitors
2	Encourage cycling / walking where possible to reduce heat levels and poor air quality in urban areas.	
3	Work with commissioners to develop longer term plans to prepare for heatwaves	
4	Make environmental improvements to provide a safe environment for clients in the event of a heatwave	
5	Prepare business continuity plans to cover the vent of a heatwave (e.g. storage of medicines, computer resilience, etc)	All
6	Work with partners and staff to raise awareness of the impacts of sever heat and on risk reduction awareness	EPLO
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

LEVEL 1 HEATWAVE AND SUMMER PREPAREDNESS PROGRAMME		
The heat wave plan will remain at level 1 unless a higher alter is triggered. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the heatwave plan.		
	Action	**Responsibility**
1	Ensure public is aware of actions to take to minimise risk during periods of hot weather and likely high risk groups	All
2	Ensure other partners are aware of the Heatwave Plan for England 2014, actions required and public information available	All
3	Distribution of heatwave plan	Emergency Planning Officer
4	Ensure business continuity plans are in place and implement as required.	All
5	Ensure appropriate contact details are provided to Local Authorities /NHS emergency planning officers to facilitate transfer of emergency information.	Emergency Planning Officer
6	Identify individuals who are particular risk from extreme heat, especially those aged over 75 and review their medication and care plans	Community health District Nurses, /Health Visitor/ Midwives/ General Practices and Social Care to identify individuals at risk
7	Working with families and informal carers to highlight dangers of heat and promote ways to keep cool	Community health – District Nurses
8	Where individuals households are identified as being at particular risk from hot weather, request environmental health to do an assessment using the Housing Health and safety Rating System (HHSRS)	Community health in liaison with Social Care
9	Review surge capacity and the need for, and availability of staff support in the event of a heatwave especially if it lasts more than a few days.	Clinical Site Manager, Emergency Department
10	Distribution of Public Health England advice to managers of residential and nursing care homes	Community health in liaison with Social Care
11	Cool rooms or cool areas should be created. Distribution of fans within Whittington Health clinic areas should be managed via the bed management team, Labour Ward and community management leads.	Clinical leads /estate managers
12	Estates to confirm operation of air conditioning units for use during a heatwave, and temperature recording instruments	Estates Managers
13	On receipt of Met office alerts and planning guidance for London region cascade to on call personnel.	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness;		

urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*

LEVEL 2 HEATWAVE IS FORECAST - ALERT AND READINESS		
This is triggered as soon as the Met Office forecasts that there is a 60 per cent chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2–3 days before the event is expected. As death rates rise soon after temperature increases, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave		
	Action	**Responsibility**
1	Cascade Met Office Alert and planning advice to on call personnel	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
2	Distribution of advice to all those defined as at high risk living at home (key public messages in section 10)	Community Health District Nurses/ Health Visitors / Midwives
3	Call a meeting of Trust colleagues who will become the 'heatwave emergency planning team' to agree key messages and cascade alert briefing through internal and external communications channels - Implement business continuity	Emergency Planning Officer
4	Work with Trust teams and Communications to ensure that independent contractors have guidance leaflet available	Facilitates
5	Initiation of home visits as planned, where appropriate	Community Health District Nurses, /Health Visitor/ Midwives / General Practices to coordinate visiting /phones call to vulnerable patients, where appropriate
6	Prioritise current list of patients at risk	Community Health District Nurses, /Health Visitors / Midwives
7	Determine what non essential activities could cease	District Nurses / Health Visitors / Midwives
8	Make provision for surge capacity	Emergency Department, Clinical Site Managers
9	Ensure cool rooms are ready and consistently at 26°C or below	Estates/Clinical Lead / Matron/ Senior Nurse in Charge/Labour Ward
10	Check that indoor thermometers are in place and recording sheets printed to measure temperature four times a day	Estates/ Clinical Lead / Matron / Senior Nurse in Charge /Labour Ward
11	Identify particularly vulnerable individuals (those with chronic/severe illness, on multiple medications, or who are bed bound) who may be prioritised for time in a cool room	Clinical Lead / Matron / Senior Nurse in Charge
11	Consider weighing clients regularly to identify dehydration and rescheduling physio to cooler hours	Clinical Lead / Matron / Senior Nurse in Charge
13	Monitor staff welfare	Clinical Lead / Matron / Senior Nurse in Charge/ Labour Ward
14	Monitor service level to ensure staffing levels will be sufficient to cover the anticipate heatwave	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers

	period	/ Midwives
15	Obtain supplies of ice / cool water	Housekeeping/ Clinical Lead / Matron / Senior Nurse in Charge
16	Re-enforce messages on risk and protective measures to staff	Clinical Lead / Matron / Senior Nurse in Charge / Midwives
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A *decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat*		

LEVEL 3 HEATWAVE ACTION		
This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one region or more. This stage requires specific actions targeted at high risk groups.		
	Action	**Responsibility**
1	Cascade of Met Office Alert and planning advice to on call personnel	**IN HOURS (Monday to Friday 0900-1700:** Emergency Planning Officer **Weekends and Bank Holiday:** Clinical Site Team
2	Continue to distribute advice to all those defined as at high risk living at home (key public messages section 10)	Community Health District Nurses/ Health Visitors /Midwives
3	Activate plans to maintain business continuity – including a possible surge in demand	
4	Call a meeting of Trust colleagues to agree key messages and actions and cascade alert briefing through internal and external communications channels	Emergency planning officer with Emergency Management Team
5	Consider use of media to get advice out to the general public	Communications lead
6	Stop non essential activities, commence daily contact with clients at risk	District Nurse / Health Visitors / Midwives
7	Consider where appropriate, daily visits /phone calls for high risk individuals living on their own who have no regular daily contacts. This may involve informal carers, volunteers and care workers and will be targeted at defined risk groups	Community Health District Nurse / Heath Visitors General practices to coordinate visiting /phone call to vulnerable patients, where appropriate
8	Use all available resources to maximise frontline district nurse / health visitor capacity	Community Health
9	District nurses /health visitors /Midwives to make daily contact with clients at risk and provide a situation report to locality manager	Community Health District Nurse / Health Visitors
10	Upon request produce situation reports and forward summary to Emergency Planning Officer for onward report to NHS England / CSU	Locality Managers
11	Discharge planning should reflect local and individuals circumstances so that people at risk are not discharged to unsuitable accommodation or reduced care	
12	Initiation of home visits as planned, where appropriate	Community Health District Nurses, /Health Visitor/ General Practices to coordinate visiting /phones call to vulnerable patients, where appropriate
13	Prioritise current list of patients at risk	Community Health District Nurses, /Health Visitors/Midwives
14	Make provision for surge capacity	Emergency Department, Clinical Site Managers
15	Ensure cool rooms are ready and consistently at 26°C or below	Estates/ Clinical Lead / Matron / Senior Nurse in Charge /Labour Ward

16	Ensure that indoor thermometers are in place and recording sheets printed to measure temperature four times a day for all areas with patients in	Clinical Lead / Matron / Senior Nurse in Charge / Labour Ward
17	Monitor and minimise temperatures in all patient areas and take action if the temperature is a significant risk to patient safety, as high risk patients may suffer undue health effects including worsening cardiovascular or respiratory symptoms at temperatures exceeding 26ºC	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
18	Continually review vulnerable individuals for prioritisation in cool rooms	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
19	Continue to monitor staff welfare	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
20	Continue to monitor service level to ensure staffing levels will be sufficient to cover the anticipated heatwave period	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
21	Implement appropriate protective factors, including a regular supply of cold drinks	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
22	Re-enforce messages on risk and protective measures to staff	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
23	Consider moving visit hours to mornings and evenings to reduce afternoon heat from increased numbers of people	Clinical Lead / Matron / Senior Nurse in Charge /Midwives
24	Reduce internal temperatures by turning off unnecessary lights and electrical equipment	Clinical Lead / Matron / Senior Nurse in Charge/ locality Managers /Midwives
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
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LEVEL 4 MAJOR INCIDENT - EMERGENCY RESPONSE		
This is reached when a heatwave is so severe and/or prolonged that its effects extend outside health and social care, such as power or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, illness and death may occur among the fit and healthy, and not just in high risk Groups and will require a multi-sector response at national and regional levels.		
	Action	**Responsibility**
1	If a major incident is declared implement Major Incident Plan	Chief Executive / Director on Call
2	Coordinate response with NHS Health Partners	All
3	All level 3 heatwave actions to continue	All
High Risk Groups **Community:** over 75, female, living on own and isolated, sever physical or mental illness; urban area, south facing top flat; alcohol and /or drug dependency, homelessness, babies and young children, multiple medications and over exertion **Care home or hospital:** over 75, female, frail, severe physical or mental illness; multiple medications, babies and young children (hospitals)		
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RECOVERY		
	Action	**Responsibility**
1	Hold a debrief and discuss any learning outcomes produce a report and action plan	EPLO / Emergency planning officer/ key staff
2	Amend the Trust Heat wave plan as necessary	Emergency Planning Officer

10. KEY PUBLIC HEALTH MESSAGES

Stay out of the heat:

- Keep out of the sun between 11.00am and 3.00pm.
- If you have to go out in the heat, walk in the shade, apply sunscreen and wear a hat and light scarf.
- Avoid extreme physical exertion.
- Wear light, loose-fitting cotton clothes.

Cool yourself down:

- Have plenty of cold drinks, and avoid excess alcohol, caffeine and hot drinks.
- Eat cold foods, particularly salads and fruit with high water content.
- Take a cool shower, bath or body wash.
- Sprinkle water over the skin or clothing, or keep a damp cloth on the back of your neck.

Keep your environment cool:

- Keeping your living space cool is especially important for infants, the elderly or those with chronic health conditions or who can't look after themselves
- Place a thermometer in your main living room and bedroom to keep a check on the temperature.
- Keep windows that are exposed to the sun closed during the day, and open windows at night when the temperature has dropped.
- Close curtains that receive morning or afternoon sun. However, care should be taken with metal blinds and dark curtains, as these can absorb heat – consider replacing or putting reflective material in-between them and the window space.
- Turn off non-essential lights and electrical equipment – they generate heat.
- Keep indoor plants and bowls of water in the house as evaporation helps cool the air.
- If possible, move into a cooler room, especially for sleeping.
- Electric fans may provide some relief, if temperatures are below 35°C.

(Longer term)

- Consider putting up external shading outside windows.
- Use pale, reflective external paints.
- Have your loft and cavity walls insulated – this keeps the heat in when it is cold and out when it is hot.
- Grow trees and leafy plants near windows to act as natural air-conditioners (see 'Making the Case')

Look out for others:

- Keep an eye on isolated, elderly, ill or very young people and make sure they are able to keep cool.
- Ensure that babies, children or elderly people are not left alone in stationary cars.
- Check on elderly or sick neighbours, family or friends every day during a heatwave.
- Be alert and call a doctor or social services if someone is unwell or further help is needed.

If you have a health problem:

- Keep medicines below 25 °C or in the refrigerator (read the storage instructions on the packaging).
- Seek medical advice if you are suffering from a chronic medical condition or taking multiple medications.

If you or others feel unwell:

- Try to get help if you feel dizzy, weak, anxious or have intense thirst and headache; move to a cool place as soon as possible and measure your body temperature.
- Drink some water or fruit juice to rehydrate.
- Rest immediately in a cool place if you have painful muscular spasms (particularly in the legs, arms or abdomen, in many cases after sustained exercise during very hot weather), and drink oral rehydration solutions containing electrolytes.
- Medical attention is needed if heat cramps last more than one hour.
- Consult your doctor if you feel unusual symptoms or if symptoms persist

11. FURTHER READING

The Heatwave Plan for England 2015:
https://www.gov.uk/government/publications/heatwave-plan-for-england

WHO Europe public health advice on preventing health effects of heat:
http://www.euro.who.int/__data/assets/pdf_file/0007/147265/Heat_information_sheet.pdf

Cochrane Review:
http://www.cochrane.org/sites/default/files/uploads/Evidence_aid/Electric%20fans%20for%20reducing%20adverse%20health%20impactsin%20heatwaves.pdf

Beat the heat: staying safe in hot weather (leaflet) 2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525358/Beattheheatstayingsafeinhotweather.pdf

Beat the heat (poster) 2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525360/Beattheheatposter2016.pdf

Beat the heat: keep cool at home (checklist) 2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525361/Beattheheatkeepcoolathomechecklist.pdf

Whittington Health NHS

The Whittington Hospital NHS Trust

Magdala Avenue

Dr Richard Jennings

Direct Line: 020 7288 5906

Whittington Health

Trust Board

6th July 2016

Title:	Medical Appraisal and Revalidation: Annual Board Report		
Agenda:	**16/092**	**Item**	**12**
Action requested:	To approve		
Executive Summary:	This is the annual Medical Appraisal Board Report in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation. Medical revalidation was introduced in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical system. This report reviews appraisals completed and revalidation recommendations submitted in the financial year 2015-16.		
Summary of recommendations:	The Board is asked to approve this report.		
Fit with WH strategy:	This report is a requirement under NHS England Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). It is designed to provide the Board with oversight and assurance of its local medical appraisal and revalidation processes.		
Reference to related / other documents:	Medical Appraisal and Medical Revalidation Policy Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff Maintaining High Professional Standards in the Modern NHS Responsible Officer Regulations		
Date paper completed:	29th June 2016		

Author name and title:		**Ashleigh Soan Medical Director Portfolio Manager**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC	**5/7**	**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

Medical Appraisal and Revalidation: Annual Board Report

June 2016

1. Executive Summary and Background

This is the fourth of the Trust's Medical Appraisal Annual Board Reports in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation.

Medical revalidation was live in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical profession.

All provider organisations known as Designated Bodies have a statutory obligation to support their Responsible Officer in fulfilling his or her duties under the Responsible Officer Regulations[1]. For this reason, this report has been designed to ensure that the Board has oversight of the following areas:

- monitoring the frequency and quality of medical appraisals within the Trust;
- checking there are effective systems in place for monitoring the conduct and performance of the Trust's doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for the Trust's doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work that they perform.

Dr Richard Jennings, the Trust's Executive Medical Director, was appointed to the role of Responsible Officer and has been in post since June 2014.

2. Terminology

'Revalidation': the process whereby the General Medical Council (GMC) renews a doctor's license to practise every five years, based on a recommendation from the doctor's Responsible Officer.

'Designated body': an organisation recognised by the GMC as responsible for submitting revalidation recommendations. Every designated body must have a Responsible Officer.

'Responsible Officer' (RO): a senior doctor, usually the Medical Director, who is responsible for medical appraisal and revalidation within the organisation and who makes recommendations to the GMC about doctors' fitness to practise. The revalidation recommendations submitted by the RO are considered by the GMC when they make the final decision with regards to a doctor's revalidation. The RO's responsibilities are laid out in the Responsible Officer Regulations, and in additional documents provided by the GMC such as the Responsible Officer Framework.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practise and Revalidation) Regulations Order of Council 2012'

'Prescribed Connection': the term used to indicate the link with a doctor and their designated body. The prescribed connection is determined by law in the Responsible Officer Regulations and cannot be chosen, though it can be altered in exceptional circumstances. For doctors in a formal training programme, their prescribed connection is with the Local Education Training Board (LETB) that administrates their course. All GPs on performers' lists have a prescribed connection to their Area Team for NHS England. Doctors who only work privately have a prescribed connection to the private organisation for which they do most work, and doctors employed only by an agency will usually have a prescribed connection to that agency. For all other doctors, including those with honorary contracts or on the bank, their prescribed connection is to the organisation for which they do most work, or, in the case of doctors who do an equal amount of work at two different NHS Trusts, to the organisation which is closest to their GMC registered address.

'Medical Appraisal': the evidence to inform revalidation recommendations is based on annual medical appraisals. Medical appraisals are performed by trained appraisers, and include a process whereby the doctor must provide a portfolio of evidence regarding their practice, including six kinds of information which are considered mandatory by the GMC. These should relate to:

1. Continuing Professional Development
2. Quality improvement activity
3. Significant events (including but not limited to Serious Incidents)
4. Colleague feedback (Completed through a formal 360)
5. Patient feedback (Completed through a formal 360)
6. Review of complaints and compliments

Revalidation recommendations

Responsible Officers are only able to submit one of three revalidation recommendations about a doctor to the GMC:

1. ***'Positive recommendation':*** a recommendation from the Responsible Officer to the GMC that in his/her opinion a doctor is up-to-date, fit to practise, and without unaddressed concerns.

2. ***'Deferral request':*** a request from the Responsible Officer to the GMC to delay a doctor's revalidation submission date to allow for additional information to be considered (for example, if the doctor has not completed a 360 Multi-Source Feedback exercise, or if they are in a local HR process that has not yet come to a conclusion). Deferral of revalidation is neutral and has no impact on a doctor's practice; however, more than one request for deferral of revalidation date for an individual will lead to the GMC requesting further information as to the reasons for the deferral.

3. ***'Recommendation of non-engagement'***: a recommendation of non-engagement is made by the Responsible Officer to the GMC where a doctor is failing to engage with the processes that support revalidation (for example, where a doctor has repeatedly failed to complete an appraisal). A recommendation of non-engagement can be made at any point in the revalidation cycle.[2]

[2] Revalidation Statements, accessible at http://www.gmc-uk.org/doctors/revalidation/12394.asp

3. Prescribed connection and appraisal completion rate

It should be noted that due to the nature of the prescribed connection, which includes doctors on honorary contracts, as well as doctors on short term contracts and doctors employed via the Trust Bank if they have no other NHS employment, these figures fluctuate. For this reason it is expected that the appraisal completion rate will fall short of 100%. At 31st March 2016, there were 267 doctors with a prescribed connection to Whittington Health.

Between 1st April 2015 and 31st March 2016 183 medical appraisals were completed, between 1st April 2016 and 31st May 2016 a further 26 doctors have completed a late 2015-16 medical appraisal. 40 doctors had an agreed postponement of appraisal with the RO. 18 doctors are now significantly past their appraisal due dates and the Associate Medical Director for Revalidation is writing to these 18 doctors in July and these doctors will be supported as appropriate to meet their appraisal obligations.

4. Governance Arrangements and Responsibilities

The Responsible Officer is supported by the Associate Medical Director for Revalidation, Medical Director Portfolio Manager and the Project Support Officer. The responsibilities of the Medical Director Portfolio Manager and Project Support Officer include:

- Maintaining the Trust's prescribed connection list on GMC Connect;
- Monitoring revalidation submission dates;
- Responding to revalidation information requests from other organisations on behalf of the Responsible Officer;
- Storing information relating to revalidation recommendations;
- Maintaining and monitoring the annual appraisal list, including providing reminders to doctors that their appraisals are due and escalating missed appraisals appropriately to Clinical Directors and the Responsible Officer;
- Supporting the Divisional Directors in allocating appraisers to the Trust's doctors, and keeping records of appraisal pairings in order to ensure that these are in line with the policy;
- Monitoring the Trust's online Revalidation Management System and liaising with the provider (Equiniti360Clinical) on improvements and development;
- Providing training for doctors with regard to using the online system, as well as more generally about the requirements of appraisal and revalidation;
- Providing refresher training to appraisers;
- Ensuring that Trust-held data on complaints, incidents and registered audit is entered onto the Revalidation Management System;
- Assisting the Directors of Medical Education with the completion of the Trainee Revalidation Portal;
- Monitoring new advice from the GMC and NHS England and providing advice on process to individual doctors and to the Responsible Officer as necessary;
- Reviewing and updating the Medical Appraisal Policy in line with new guidance as necessary;
- Managing appraisal reporting, including locally to the Responsible Officer, and the completion of quarterly reports to NHS England;
- Completing the Annual Organisational Audit;

- Completing first stage quality assurance audit of annual appraisals.

This year saw the creation of the role of Associate Medical Director for Revalidation. Dr Robert Sherwin, Consultant in Obstetrics and Gynaecology, was successfully appointed to the role on 1st February 2016 following a competitive recruitment process. This role will help Whittington Health to promote and improve our medical revalidation and appraisal processes.

The responsibilities of the Associated Medical Director for Revalidation include:

- Oversee the medical appraisal process to help ensure that all non-training grade doctors employed by the trust have an annual appraisal.
- With the day to day support of the Medical Director Portfolio Manager and Project Support Officer, agree a strategy to ensure improvements in the medical appraisal and medical revalidation processes.
- Develop reviews of medical appraisal outputs to ensure the inclusion of all required documentation and to use regular reviews to set a standard for medical appraisals in the trust.
- To offer bespoke advice and support to colleagues who have complex issues around evidencing performance and quality.
- To support the Responsible Officer in ensuring the evidencing of recommendations made to the GMC about the fitness to practise of doctors employed by the trust.
- To oversee the continuous quality review and improvement of training and guidance for trust medical appraisers.
- To assist the Medical Director in overseeing the trust's process for responding to correspondence from the GMC.
- Refer concerns about a doctor to the Responsible Officer (Medical Director) for further investigation and support the Responsible Officer in ensuring that appropriate timely action is taken, in accordance with trust procedures, when a concern is raised about a doctor's performance or conduct.
- Oversee existing processes to ensure that the trust complies with the external reporting related to medical revalidation and medical appraisals.
- Subject to agreement between the post holder and the Medical Director, the post-holder may deputise for the Medical Director.
- Chair appropriate meetings relating to the role.

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports and updates provided by the recruitment team. However, this requires further work in order to ensure that trust grade doctors can be distinguished from junior doctors in training programmes.

5. Medical Appraisal

a) Policy and Guidance

The Trust's Medical Appraisal and Revalidation Policy has been updated this year, in discussion with our Local Negotiating Committee (LNC), to reflect the new requirements in the Framework of Quality Assurance, the change in the trust's organisational structure and revalidation arrangements.

b) Appraisal and Revalidation Performance Data

As at 31st March 2015 183 appraisals had been completed and a further 26 appraisals were completed between 1st April 2016 – 31st May 2016. The audit of missed or incomplete appraisals (Appendix A) provides detail on the reasons for those appraisals not completed in the window within which they were due.

Completion of medical appraisals in 2015-16 by grade of doctor:

201 consultants

- 155 with an appraisals in line with policy
- 19 with late but acceptable appraisals (appraisals completed between 1st April 2016 – 31st May 2016)
- 16 with previously agreed and acceptable reasons for not completing
- 11 with no previously agreed or acceptable reasons for not completing

22 specialty doctors/associate specialists

- 17 with appraisals in line with policy
- 3 with late but acceptable appraisals (appraisals completed between 1st April 2016 – 31st May 2016)
- 1 with a previously agreed and acceptable reason for not completing
- 1 with no previously agreed or acceptable reason for not completing

44 trust grade doctors (non-training grade junior doctors)

- 11 with appraisals in line with policy
- 4 with late but acceptable appraisals (appraisals completed between 1st April 2016 – 31st May 2016)
- 23 with previously agreed and acceptable reasons for not completing
- 6 with no previously agreed or acceptable reason for not completing

c) Appraisers

The Trust had 58 active appraisers for the 2015-16 appraisal period (an active appraiser is defined as having performed at least one appraisal in the year). This represents approximately one quarter of the total number of doctors with a prescribed connection. All appraisers received revalidation-ready training from approved external providers.

Additional refresher training for the 2016-17 appraisal period will be provided by an specialist external training company. Refresher training is important and is recommended at least every 3 years to ensure our medical appraisers are up to date with the latest developments in appraisal and revalidation. This training will be developed using the audit of a sample of medical appraisals completed in 2015-16 (Appendix B) and the feedback we have received from doctors. This will include:

- **Setting the scene**: Describing the full scope of a doctor's practice and providing objective statements about the quality of the evidence provided.
- **Reflection and effective learning**: Documenting evidence of challenge or sharing learning with colleagues.

- **PDP and developmental progress:** Specific Measurable Achievable Realistic and Time-bound (SMART) PDPs that are linked to the summary of discussion.
- **Revalidation Readiness:** Documentation or reference to the stage of revalidation and progress towards revalidation.

Appraiser feedback 2015-16

Following each completed appraisal doctors are invited to complete a short survey to give feedback to their appraiser. The below table represents the feedback received for appraisals completed between 1st July 2015 – 1st June 2016.

Combined appraiser feedback for all our 58 active appraisers in 2015/16. This is based on the responses of 205 doctors who were surveyed straight after their appraisal	Unable to Comment	Poor	Borderline	Satisfactory	Good	Very Good
Establishing rapport	0%	0%	0%	2%	19%	79%
Demonstrating thorough preparation for your appraisal	0%	0%	1%	2%	23%	74%
Listening to you and giving you time to talk	0%	0%	0%	20%	18%	80%
Giving constructive and helpful feedback	0%	1%	0%	3%	22%	74%
Supporting you	0%	0%	2%	3%	21%	74%
Challenging you	0%	1%	0%	4%	31%	64%
Helping you to review your practice	0%	1%	0%	3%	28%	68%
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	1%	1%	0%	4%	30%	64%
Helping you to review your progress against your Personal Development Plan (PDP)	0%	0%	1%	3%	28%	68%
Helping you to produce a new PDP that reflects your development needs	0%	1%	0%	2%	26%	71%

Examples of written feedback received for medical appraisers:

- “This was a very useful exercise and has given me food for thought on how to maintain and expand my knowledge and bring new energy into the different areas in which I work.”
- “Thank-you - made me feel that the work we do in the Trust, for and with patients, as a team is valued”
- “This appraisal meeting has been an extremely useful one for me. We had the chance to go in detail through my progress since last year and by getting positive feedback for my achievements I feel very encouraged to keep on working hard and with enthusiasm. It is also very important that we set useful and realistic targets for the next months and we highlighted areas where further improvement is needed. I

had also the opportunity to discuss my career aspirations and get useful advice regarding my future career move."

d) Quality Assurance

Quality assurance of appraisals

Individual appraisal portfolios and output documents are reviewed at two stages. An audit is conducted by the RO's team on 10% of completed appraisals following the completion of the appraisal cycle. For the most recent cycle, the audit was conducted using the NHS England Appraisal Summary and PDP Audit Tool Template (ASPAT). The results of this audit are included in Appendix B.

An individual doctor's appraisal output documents and some key pieces of evidence from the appraisal portfolio are then reviewed again by the Responsible Officer and a member of his team prior to a revalidation recommendation being made.

Quality assurance for appraisers

All Trust appraisers have undertaken revalidation-ready training in order to provide a level of assurance that they have the skills and knowledge appropriate for the role. In addition, the Trust collects anonymous feedback on individual appraisers via the online Revalidation Management System; this feedback is collated by the RO's team and provided to individual appraisers so that they can reflect on it at their own appraisal. In cases where an appraiser consistently scores very low in a number of areas, where multiple doctors have requested not to be appraised by one individual, or where audits have identified substandard appraisals conducted by one appraiser, the RO's team will escalate this to the Responsible Officer and this appraiser may be asked to undertake further training. The Trust also keeps records of appraiser attendance at refresher training events which can be used in the appraiser's portfolio as evidence of ongoing professional development.

e) Access, security and confidentiality

In line with GMC requirements that all medical appraisals be performed electronically, the Trust uses the Revalidation Management System (RMS) provided by software company Equiniti. The system is part of the G-cloud programme, which provides a very high level of data security and assurance. A doctor's appraiser only has access to the appraiser's portfolio once it has been submitted to them, and loses access once the appraisal is signed off. The Responsible Officer has access to a doctor's information in order to be able to make revalidation recommendations, and the RO's team have administrative access in order to be able to provide IT and technical support, as well as conducting audits.

f) Clinical Governance Data

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and PALS;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

Complaints, PALS, claims, incidents and audit data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

6. Revalidation Recommendations

The audit of revalidation recommendations (Appendix C) details recommendations made for the year 1st April 2015 to 31st March 2016. Since revalidation went live in November 2012, the Trust has made 286 recommendations for doctors with a prescribed connection to the Whittington, of which 189 were positive recommendations, and 97 were requests for deferrals. So far there have not been any recommendations of non-engagement. Between the 1st April 2015 and 31st March 2016 the Trust has made 123 revalidation recommendations for doctors with a prescribed connection to the Whittington, of which 78 were positive recommendations, and 45 were requests for deferral. In this time period 6 recommendations were submitted later than the requested submission dates, these were due to administrative error, and the longest delay was 8 days. To prevent late submissions revalidations are now reviewed up to four months in advance by the Revalidation Group.

7. Recruitment and engagement background checks

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- CRB checking and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK where this is necessary
- Verification of license to practise and other relevant qualifications
- Filing of references and CVs

Honorary contract holders have previously had their pre-employment checks performed by the RO's team but this is now performed by and administrator with the recruitment team. Where a doctor applies for an honorary contract with the Whittington, but also holds a substantive role at another organisation, the recruitment team seek confirmation of their employment checks from that organisation's HR department.

With regard to doctors working at the Trust via an agency, the Trust only uses agencies where reassurance is provided that all pre-employment checks have been performed.

8. Responding to Concerns and Remediation

The Trust has a local policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS'[3] and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

[3] Department of Health, *Maintaining High Professional Standards in the Modern NHS,* accessible at http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

9. Risk and Issues

There is a risk that the percentage of recommendations that are for deferral is higher that it needs to be. This is being addressed through the newly set-up Revalidation Group, which anticipates possible short-falls in relevant appraisal evidence for individual doctors, and then works with those doctors to prospectively address these.

There is a risk that through administrative error, revalidation recommendations will be made late. This is also being addressed through the strengthened processes associated with the newly formed Revalidation Group.

There is a risk that doctors whose prescribed connection is with this Trust, but whose primary employer is the University will not have comprehensive clinical and academic appraisals in line with the Follett Principles[4]. This risk is being addressed through the Revalidation Group by assembling a list of all such doctors and making joint appraisal arrangements in advance with UCL.

There is a risk that the Trust will have insufficient numbers of senior staff trained in MHPS case investigation and case management such that all Trust case investigations comply with our 'Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff'. This risk is being addressed by identifying suitable staff members to be formally trained, and by recruiting external case investigators under exceptional circumstances when this is necessary.

10. Action Planning and Next Steps

The actions for 2015-16 were:

Action	Progress
Appointment of an Associate Medical Director for Patient Safety and Revalidation	Completed.
Reintroduction of the Revalidation Working Group	The Revalidation Group was introduced in April 2016. This is chaired by the Associate Medical Director for Revalidation.
Update of the Medical Appraisal Policy, to include: • Quality assurance details in line with the Framework of Quality Assurance • Clear escalation framework with timescales for missed appraisals • Further details on educational appraisal and the link between revalidation and educational supervisor accreditation • Stronger language on not	Completed.

[4] Professor Sir Brian Follett and Michael Paulson-Ellis, *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties* (September 2001)

uploading patient identifiable data to the appraisal portfolio	
Responsible Officer to have individual discussion with doctors who have outstanding appraisals	This will completed by the newly appointed Associate Medical Director, who has been meeting with doctors individually regarding appraisal and revalidation issues.
Working with the recruitment team to ensure that all necessary pre-employment checks are completed	On-going.
Clarify the actions to be taken if an employed doctor's previous RO does not respond to the request from this Trust to confirm that there are no outstanding concerns	On-going.
Additional training for doctors on writing reflective notes in their appraisal portfolios	Completed.

For 2016-17 we will focus on:

- Reducing the number of potentially avoidable revalidation deferral recommendations
- Reducing the number of late revalidation submissions to the GMC
- Facilitating Follett Principle appraisals for all clinical academics
- Increasing the number of suitably trained senior members of staff to conduct MHPS case investigations

11. Recommendations

The Board is asked to accept the report, which will be shared (along with the Annual Organisational Audit or AOA) with the higher level Responsible Officer for NHS England, London Region.

The CEO is asked to approve the 'statement of compliance' (Appendix E) confirming that the organisation, as a designated body, is in compliance with the regulations.

Medical Appraisal Annual Board Report Appendix A

Audit of all missed or incomplete appraisals audit
Please note that this relates only to doctors due for an appraisal within the year 1st April 2015 – 31st March 2016

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	5
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	0
Exclusion during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date (within 6 months)	32
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by doctor within 28 days	0
Doctor cited insufficient time and capacity*	13
Lack of engagement of doctor	0
Other doctor factors: Insufficient engagement of doctor not yet warranting recommendation of non-engagement	1
Carers' leave	0
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe): Appraisal meeting occurred but documentation inadequate and then not revised	0
Organisational factors	
Administration or management factors – Requirement to change appraiser	3
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe) – Requirement to resource external appraiser	1

***Please note that of these doctors there have been no instances where it has been agreed formally that a doctor would not have to complete an appraisal. Where doctors cite this reason we work with individual doctors to ensure that they understand what is required for the medical appraisal and revalidation processes.**

Quality assurance audit of appraisal inputs and outputs
Please note that this relates only to doctors due for an appraisal within the year 1st April 2015 – 31st March 2016

Audit appraisal reference	Setting the scene (out of a possible 18 marks)	Reflection (out of a possible 6 marks)	PDP (out of a possible 16 marks)	Revalidation Ready (out of a possible 10 marks)	Total (out of a possible 50 marks)
1	11	2	10	6	29
2	5	2	10	6	23
3	8	3	9	6	26
4	5	0	10	6	21
5	7	0	11	6	24
6	8	1	12	6	27
7	4	0	7	4	15
8	9	0	9	6	24
9	10	4	11	6	31
10	11	4	11	6	32
11	18	6	12	9	45
12	4	0	8	8	20
13	15	6	16	8	45
14	17	6	14	7	44
15	17	6	16	9	48
16	16	6	15	7	44
17	18	6	15	6	45
18	16	6	14	7	43
19	14	6	14	6	40
20	17	6	15	7	45
21	17	6	13	6	42
22	13	4	11	7	35
23	13	6	12	9	40
24	14	0	13	9	36
25	4	1	3	7	15
Average	**11.64 / 18**	**3.48 / 6**	**11.64 / 16**	**6.8 / 10**	**33.56 / 50**

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2015 to 31 March 2016	
Recommendations completed on time (within the GMC recommendation window)	117
Late recommendations (completed, but after the GMC recommendation window closed)	6
Missed recommendations (not completed)	0
TOTAL	**123**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	4
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	2
Describe other	Discussions around deferral period
TOTAL [sum of (late) + (missed)]	**6**

Employment relation cases concerning the Trust's medical & dental staff for the period 1st April 2015 – 31st March 2016

The purpose of this paper is to provide a numerical breakdown of the employment relations casework relating to the Trust's Medical & Dental staff. This is in accordance with the requirement under the NHS England Annual Organisational Audit and the Trust Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff, to provide this information to the Trust Board. Please note this information is based on all cases notified and managed by Medical HR.

1. Number of formal cases by grade

Grade	Numbers
Consultant	10 cases (involving 7 consultants)
SASG*	1
GPs	0
Dentists	0
Trainee Doctors	1
Total	9

2. Number of informal cases by grade

Grade	Numbers
Consultant	3
SASG*	0
GPs	0
Dentists	1
Trainee Doctors	0
Total	4

3. Number of medical & dental staff excluded by grade

Grade	Numbers
Consultant	0

SASG*	0
GPs	0
Dentists	0
Trainee Doctors	1
Total	1

4. **Number of medical & dental staff restricted from clinical practice or with restrictions on their clinical practice but not excluded from work.**

Grade	Numbers
Consultant	1
SASG*	0
GPs	0
Dentists	0
Trainee Doctors	0
Total	1

5. **Type of concerns by grade (informal and formal).**

Type of Concern	Consultant	SASG	GP	Dentists	Trainees
Conduct	3	0	0	0	0
Capability	2	0	0	1	0
Grievance	6	1	0	0	0
Bullying & Harassment	2	0	0	0	0
Health	0	0	0	0	1
Total	13	1	0	1	1

*SASG: Includes all doctors in the following grades: Associate Specialist, Specialty Doctor, Staff Grade & Trust Grade

Designated Body Statement of Compliance

The board/executive management team –[delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: New RO appointed in June 2014; booked for training in September sessions (earliest available)

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[5] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible

[5] Doctors with a prescribed connection to the designated body on the date of reporting.

officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners[6] have qualifications and experience appropriate to the work performed; and

Comments: These checks are performed but work is required to ensure that the checks are recorded centrally so that the data can be collected in real time

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: Signed: _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date:

[6] Doctors with a prescribed connection to the designated body on the date of reporting.

Appraisal Summary and PDP Audit Tool Template

Appraiser identifier	Click here to enter text.
Doctor identifier	Click here to enter text.
Date of appraisal	Click here to enter a date.
Organisation	Click here to enter text.
Auditor (usually the senior appraiser)	Click here to enter text.

Scale:
0 Unsatisfactory
1 Needs improvement
2 Good

Score each item out of two

1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	Choose an item.
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	Choose an item.
c) There is documentation of whether the supporting information covers the whole scope of work	Choose an item.
d) Specific evidence is summarised with a description of what it demonstrates	Choose an item.
e) Objective statements about the quality of the evidence are documented	Choose an item.
f) All statements made by the appraiser are supported by evidence	Choose an item.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance *Good medical practice framework for appraisal and revalidation*	Choose an item.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	Choose an item.
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Comments: Click here to enter text.

1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the doctor should document their reflection	Choose an item.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	Choose an item.
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	Choose an item.
Comments: Click here to enter text.	

1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	Choose an item.
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	Choose an item.
c) The completion (or not) of last year's PDP is recorded	Choose an item.
d) Reasons why any PDP learning needs that were not followed through are stated *(if the PDP was completed then score 2)*	Choose an item.
e) There are clear links between the summary of discussion and the agreed PDP	Choose an item.
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	Choose an item.
g) The PDP covers the doctor's whole scope of work and personal learning needs and goals	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

h) The PDP contains between 3-6 items	Choose an item.
Comments: Click here to enter text.	

1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	Choose an item.
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	Choose an item.
c) The stage of the revalidation cycle is commented on	Choose an item.
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	Choose an item.
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given *(if signed off score 2)*	Choose an item.
Comments: Click here to enter text.	

TOTAL SCORE (OUT OF 50)	Click here to enter text.

General comments from the senior appraiser:

Click here to enter text.

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Medical Revalidation Group

Terms of Reference

Version 0.1 05/02/2016

1. Authority and Scope

1.1 The Medical Revalidation Group has been established by the executive authority of the Executive Medical Director.
1.2 The Medical Revalidation Group shall meet no fewer than 10 times per year.
1.3 The Group is authorised by the Executive Medical Director to act within its terms of reference and to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation by the General Medical Council (GMC).
1.4 The revalidation recommendation is made by the Trust's Responsible Officer and the Responsible Officer is not obliged to take the advice of the Medical Revalidation Group.
1.5 The Group is authorised by the Executive Medical Director to obtain such internal information as is necessary to exercise its functions and discharge its duties.

2. Membership

2.1 The Group will be chaired by the trust's Associate Medical Director for Revalidation and administered by the Medical Director Portfolio Manager or appropriate nominated officer.
2.2 The Group will comprise of the Medical Staffing Manager, Head of Integrated Risk Management, Responsible Officer, Executive Medical Director, and Medical Director Project Officer.
2.3 If the Medical Staffing Manager and Head of Integrated Risk Management are not able to attend meetings then a summary document detailing the relevant information for each individual doctor may be sent to the Chair in advance of the meeting.
2.4 The Responsible Officer, Executive Medical Director, and Medical Director Project Officer are members of the Group, but attendance by these members or their nominated officers is not required for the Group to be quorate.

3. Purpose and role

3.1 The purpose of the Group is to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation to the GMC.
3.2 The Group will provide scrutiny of the medical appraisal documentation and information from Trust governance and risk systems to inform the recommendations made to the Responsible Officer.
3.3 The Group will make one of three recommendations to the Responsible Officer for each individual doctor linked to the Trust for the purposes of revalidation. The three recommendations the Group can make are: revalidate, defer, or non-engagement.
3.4 A recommendation by the Group that a doctor should be positively recommended for revalidation will act to provide the Responsible Officer with assurance that all information required by the GMC has been appropriately considered and is deemed

by the Group to be sufficient for a positive revalidation recommendation to be made by the Responsible Officer.

4. Duties

4.1 Ahead of the meeting a list of all medical doctors to be considered will be circulated to members. Members of the Group are required to review and interrogate all relevant information in their area of expertise for all doctors to be considered at the meeting. Members are required to bring summary information for each doctor to the meetings.

4.2 The Head of Integrated Risk Management is required to review information from the Trust's risk management systems and information highlighted to them through patient safety.

4.3 The Medical Staffing Manager is required to review information all employee relation and human resourcing matters.

4.4 The Associate Medical Director for Revalidation is required to review appraisal output documentation, colleague and patient feedback and external information received or sent by the trust relating to the doctor (e.g. correspondence with other employers, correspondence from the GMC).

4.5 The Group will decide on the recommendation to make to the Responsible Officer for each doctor considered by the Group. If a consensus between members cannot be reached then the Chair will decide on the recommendation.

4.6 The Group will ensure a completed summary form (Appendix A) is made available to the Responsible Officer in good time to ensure that revalidation recommendations can be submitted to the GMC.

5. Review

5.1 The terms of reference of the Group will be reviewed annually by the Trust's Executive Medical Director.

Whittington Health NHS

Finance & Business Development Committee
Draft Minutes & Action Log
Wednesday 25th May 2016

Paper No	Draft Minute	Action	Progress	Lead
01	**Apologies, Minutes of the previous meeting and Action Notes**			
1.1	Apologies were received Simon Pleydell, and Mark Inman. Carol Gillen introduced John Watson who will be joining the Trust in June as the Director of Service Improvement. The minutes of the 24th March April 2016 were agreed as an accurate record			
1.2	Action Note update: Education of Junior Doctors and professionalism with regard to Coding: Discussion with Coding Manager & some clinicians It was agreed to return with an update for the third Quarter.			**GW**
1.3	TR spoke of his visit to Wolverhampton and their use of pre-formatted forms. SB explained the issue is overseen by the Income Steering Group. Progress made on processes/training and the planned improvements would feature in the presentation agreed at a future meeting. DHU felt this should be a tick box procedure and for surgical procedures this should include the notes. [Note: Trust uses ORMIS that forces tick box procedure unless hand written] JW asked what feedback is given to Consultants on their notes and SB informed the Committee that this is limited currently. The ICSUs receive Income and activity reports but not broken down to individual Consultant level. Discussions have taken place with a number of clinical areas including Orthopaedics and Maternity where the Trust demonstrated improvement in depth of coding and income. TR agreed cultural and DHU potential for change in clinical leadership.	Presentation by income steering group on consultant engagement & junior Doctor training.		**MI**
1.4	DHU asked if a league table of coding performance would improve engagement and clinical notation. CG responded that each ICSU has a target around their coding. Medicine have a run chart and are sharing that with clinical leads. All agreed that clinical targets should go back into the ICSUs.			
02	**2016/17 Contracting Update**			
2.1	SB reported this had been finalised with a contract form using national PbR tariff and rules format He added that this is important culturally to the Trust, as it balances risks and rewards within the contract structure more appropriately with local commissioners being responsible for demand management in to the Trust through their QIPP schemes and the Trust accepting responsibility for			

	productivity through QIPP and CIP. SMH felt that, at Chief Officer level, while the process had been difficult there remains a commitment to work collaboratively in future. SB highlighted the total figure of £216m and explained the bridge to commissioner contracts. He outlined the items within the long-stop date relating to productivity metrics and QIPP schemes which need to be concluded by June 30th.			
03	**PMO/CIP**			
3.1	Carol Gillen reported that the Boston Consulting Group have been in regular weekly meetings with the Clinical Leads and have worked with the ICSUs in stage 1 and Stage 2. However, the implementation phase is in-house with a PMO being created. BCG provided a light touch over the last few months working with the PMO			
3.2	CG outlined the new structure with John Watson as Director of Service Improvement, Paula Meale as Clinical Improvement lead supporting Medicine, & Children for example & Eleanor Clarke as Operational Improvement Lead. David Emmerson will undertake the high level analytics and James Ross has moved into the team for detailed analytics.			
3.3	CG emphasised the Trust is keen to maintain a mechanism for monitoring and governance including roadmap calls each week where red items are tracked to be able to achieve the cost improvements at the end of the year. The Weekly PMO meetings look at key issues effecting more than one ICSU, gaps in financial forecasts and enabling workstreams. The Quality impact review process is in place.. The Trust has reviews and an ongoing process with ICSU quarterly reviews against the CIP plan. Finally, there is the Finance & Business Development quarterly review.			
3.4	TR asked how the Trust accesses the capability of information flow. TW confirmed it had invested in new tools with testing for income monitoring, which will be a live environment for the teams to use. In addition there is trend analysis and improving the finance offer, which has moved on, but there is more still that can be done. CG confirmed the Trust has a visual roadmap plan to get reds converted into ambers. Closing the gap is discussed and each of the PMO service leads have closing the gaps plan. The roadmaps have been running since February. DHU queried if there are any common themes that can be spread to others or that continue. CG said the common themes are that staff haven't updated their roadmaps and the Trust was instilling that discipline; because the calls are quick and sharp updates can then be taken forward into the PMO and the weekly calls are proving very useful.			
3.5	With regard to Projected Savings by quarter, the ICSU Directors risk assess their schemes and those rated as high risk are replaced by additional schemes, but kept live. There is a named lead for the Procurement work-stream. CG confirmed every scheme must have a roadmap and CG spoke of the detail schemes.			
3.6	SB stated that the Trust will work the new Kings model on overseas visitors. TW stated the King's			

	proactive system was a very fast reactive system that drilled through the PAS system to see what was likely to be an overseas visitor and provide an invoice on the ward to the patient and then hand immediately to the debt collection agency. Finance is working to see if it can use that model at the Whittington.			
3.7	CG reported a round of ICSU deep dives had just been completed and there was a challenge around cost reduction at present rather than income generation. Additional schemes to close the gap came from the ICSUs themselves. Slide 7 onwards provided a breakdown of all the schemes with confidence ratings which were signed off by the Clinical Directors.			
3.8	TR asked CG if there is anything CG needed to deliver and CG felt involving the clinical leadership is key but she knew that SB had met already met with one junior doctor. TR suggested coaching of leadership at meetings to help with this and CG confirmed the Trust is using Rai Gallo, HR Leadership Coach. JW said he expected to do part of this work, and as culture improves it will feed into itself.			
3.9	NF stated the Temporary Staffing CIP is discussed in the roadmap meetings and the first Temporary Task and Finish group was taking place that day. The Executives had also looked at additional payments to doctors and recommendations have been made to standardise payments. There was focus to ensure agency staff are not booked to cover annual leave.			
3.10	TR asked about two CIP schemes with low confidence, CAMHS and Theatre. TR felt there was a lot of scope for theatre improvement if linked to paperless working.			
3.11	DHU asked about staff attitudes to CIP and CG but the PMO promotes service improvement to achieve improved financial performance, which has been received positively e.g. of medicine reducing costs in beds in winter. This was a step change from a year ago and key is the clinical leadership in the ICSUs which wasn't present previously.			
3.12	DHU said she was impressed that what needs to be measured is being measured and she was looking forward to seeing future developments. JW believed there is a lot of granularity and in the short term the Trust will have schemes to manage but to keep coming up with schemes to get rid of waste will be more difficult so there is a need to do both with the cultural change. CG emphasised they have to be seen as ICSU plans culturally. TR felt there is an increase in Ward Managers being clear on what they need to do.			
04	**Financial Position Month 1**			
4.1	The position was noted.			
	2016/17 Improving the underlying Deficit Run-Rate (Presentation) **16/020**			
4.2	SB presented the underlying position emphasising that for a financial turn-around the Trust must recurrently improve. The end of year was disappointing as the position recurrently worsened despite achieving headline targets. TW felt there is a need to be very clear on communicating the			

	plan and he had worked with the senior finance managers on the message to go out to the Trust.			
4.3	SB said the Trust had planned for a recurrent deficit of £10m in 2015/16 and outturned at £13.2m This was primarily due to a high amount of non-recurrent CIP; 35% of CIPs were non-recurrent. DHU asked if there is a system in place this year to identify focus on recurrent CIPs and SB stated all of the schemes CG described are recurrent. TW emphasised 78% of CIP was achieved last year. DHU asked if this a realistic projection and SB stated £10m on a recurrent basis and the challenge is to push forward Temporary staffing.			
4.4	2016/17 I&E plan assumptions and key risks: SB outlined the key risks and assumptions. The main risk being short-term staffing as last year £15-16m was spent on agency and this year there is an agency cap of £9.5m against the plan of £11.1m			
4.5	The Trust is working on a number of initiatives to reduce agency spend. There is a daily telephone challenge ensuring staff are being flexible by moving staff across the wards and working smarter i.e. hiring on fixed term basis and never having agency staff to cover annual leave.			
4.6	SB said month 1 results tell us agency spending will need to improve in Q2/Q3 to allow for the increase in Q4 relating to winter pressures to achieve the cap. TW said it is important that the winter bidding process is completed in sufficient time to allow the Trust to use alternative models other than agency otherwise the cap will be breached.			
4.7	SB outlined risks in relation to fines and challenges following the move to full PbR contracting.			
4.8	Opportunities to improve the underlying run-rate: The Plan is looked on as stretching and realistic TW stated the NHSI assurance checks the plan and while it has not formally rated, it has rated the Whittington in the top quartile of Trusts in London rated green i.e. credibility and confidence of delivery the plan. SB said the Trust has been honest in the way in which it described the story that we will finish the year in better shape than started as some CIPs have a full year effect and are recurrent and will improve LOS and improve the flow or will produce a saving that can be taken out next year.			
4.9	SB said to reduce the cost of the estate and administration functions was a key Carter initiative and this will be pursued in the second part of the year. The Trust will have to be able to show that nursing and procurement around administration in Carter is on track.			
05	**Annual PFI report**			
5.1	PI summarised the activity over the year to assure the Committee that there is a grip on the day to day activity and the Trust are using all the metrics to monitor and control the PFI partners' performance both for planned maintenance and defect maintenance. PI outlined legacy issues for the two new NEDs to the Committee. He reported the serious incident process and referred to an incident that took place in December. Full analysis will go to via the Health & Safety report to the Audit and Risk Committee in October. All maintenance records of PFI were up to date and the H&S			

	Executive were satisfied.			
5.2	Every 2-3 years the Trust undertakes due diligence under Clause 28.12 of the Project Agreement. This permits the trust to commission an independent audit into the Hard Service provision, to ensure that the facilities are being maintained in accordance with WFL's obligations. The report is due this year.			
06	**2016/17 Capital Programme**			
6.1	SB stated the paper sets out how the Trust had gone about allocating the £6.6m of capital expenditure based on only undertaking high risks items. This meant risk entries of effectively 16 and above. This was reviewed in the Capital Group and the Executive Group. Control is linked to the long-term sustainability of the Trust and the rigorous PMO approach. SB asked the Committee to recommend to the Trust Board for a public paper.			
6.2	DHU asked about risk mitigation for unfunded amber risks. SB explained each risk has a mitigation plan in place and will be assessed regularly.			
6.3	DHU asked about maternity and SB said it is an anchor service for the Trust and strategically important. DHU asked if IT funding is sufficient to improve the service and SB explained the allocation will maintain business as usual. Improvement work for IT will come through the PMO schemes			

07	**F&BD Committee Risk Register**			
7.1	The Committee discussed the risk register and felt that there should be an IMT risk relating to Capital Spend and the inability to progress new developments.			
	Actions from previous Committees			
	Commercial Strategy to the March Committee	March		
	Run rate for 16/17 to Non-Execs		completed	

MEMBERS
Tony Rice, Chair
Graham Hart, Non-Executive Director
Deborah Harris-Ugbomah, Non-Executive Director
Simon Pleydell, Chief Executive Officer
Steve Bloomer, Chief Finance Officer
Siobhan Harrington, Director of Strategy and Deputy Chief Executive

In attendance:
Carol Gillen, Chief Operating Officer
Mark Inman Director of Contracts & Business Development
Vivien Bucke (minute taker)
John Watson, Director of Service Improvement

Whittington Health NHS

Draft minutes of
The Whittington Health Charitable Trust Committee
held on 14 June 2016

Present:	Tony Rice	TR	Non-Executive Director
	Steve Hitchins	SH	Chairman
	Simon Pleydell	SP	Chief Executive Officer
	Stephen Bloomer	SB	Chief Finance Officer
	Carol Gillen	CG	Chief Operating Officer
	Graham Brogden	GB	Head of Fundraising
	Keith Miller	KM	Head of Financial Services
	Esmine Passley	EP	Finance Assistant
	Vivien Bucke	VB	Business Support Manager, Finance

Item	Discussion

16/009 **Welcome and Apologies for Absence**

9.1 Apologies were received from Lynne Spencer.

16/010 **Declarations of Interest**

10.1 None were received.

16/011 **Minutes of the Charitable Funds Committee 3rd February 2016**

11.1 The minutes were approved as an accurate record.

16/012 **Approval of the Terms of Reference**

12.1 TR said the aim in the updated Terms of Reference was to ensure a more efficient process and to have medical and non medical members on the board and that fund managers have certain discretion to spend.

12.2 SB stated the TOR now had three non executives of which two will be Tony Rice (Chair) and Steve Hitchins and the CFO, CEO and one more Executive Director and introduced medical and non-medical clinical staff representatives. The key change in the document is the inclusion of delegated powers. Fund holders can authorise up to £2,000 with CFO countersignature,, £2,001-£5,000 to be signed off by the Fund holder CFO and another Executive Director and £5,000 and above to the Committee.

12.3 The Committee discussed the delegated power and SB reported that Finance had looked at the bids for a period of six months and only four were over £5,000. The majority of bids will move very quickly through the checks. The Committee will still have sight of expenditure.

12.4 SH asked if there was to be a sub-group of the Committee and TR stated there will be a Fundraising group and fundraising ambassadors and that will be broader to include clinical colleagues but not a sub-group with delegated powers.

12.5 GB said there was work still to be done on fund signatories and SB said that an email had been sent to the relevant colleagues to update/confirm who is responsible for which fund and why funds have not been spent but the response had been poor and this work is continuing.

12.6 GB & Finance staff is currently reviewing the handbook which states how to set up a fund, access those funds and the responsibilities of fund holders. Training will then follow the launch of the book which will incorporate how to raise funds. CG asked how this will be communicated to ICSUs and SB confirmed that once the handbook is agreed it will be sent out and then additional communication will be via training.

12.7 GB and SB agreed that if funds appear to be dormant and are without spending plans it is possible for the committee to consolidate them within the general funds. He emphasised this is not an unusual thing to do as the responsibility of the Committee is to spend the funds within a reasonable time period and in line with the wishes of the donor. GB said he had expectation that as he continued to meet staff the amount of funds not spent will change. TR suggested that the Committee schedule to meet six times a year rather than the four annual meetings proposed or alternatively some authorisation mechanics outside of meetings might need to be put in place to avoid undue delay in decision making and implementation.

12.8 SP asked if £5,000 was a normal figure to have to gain agreement from the Charity Committee as this is lower than he is used to in previous organisations. SB said that if the Fund does get swamped with requests for the general funds more than £5k this can be reviewed.

12.9 TR concluded the updated guidance notes will be issued with the process of fund establishment, process of fund management etc. updated.

12.10 Action: TR agreed to provide specific comments, for circulation to the Committee members who were asked to respond within the next few days and then circulated to member so that they can go to the next Trust Board.

16/013 Fundraising Update

13.1 GB reported 18 expressions of interest for the Marathon next year and the Trust has seven gold bonds for next year with 2 carried over from last year. There is a big turnout for the upcoming 10k. There is a keenness for the maternity fundraising and Fredericke Eben has already raised £5k in sponsorship for the 10k. Frederick Eben is willing to take the lead on this but only when the plans are finalised.

13.2 Tottenham FC are interested in working with the Charity on a bid for bowel screening and a scanner. The scanner needs to have a lead lined room and Tottenham are confident that together with the Trust they can put a joint bid to the Football association.

13.3 The Rotary club did a presentation and singing for lungs choir members are fired up to get involved with fund raising and will provide positive case studies to help fund raising.

13.4 The stall at the Highgate Fair raised £450, but more importantly this gave GB the opportunity to talk to locals who gave positive feedback on the Trust. GB has 10 names to speak to create positive case studies from.

13.5 TR felt it would still be good to have a dedicated event and GB said he is still trying for an abseil on site but he is waiting to establish where the previous abseil took place and thought it wasn't very visible but would address the dedicated event. TR concluded that getting the fundraising sub-committee in place is critical.

16/014 Financial Report Month 12 2015/16

14.1 The Committee heard from KM who stated the fund is in a good position as some large legacies had been received. The Layton legacy has been confirmed as unrestricted.

14.2 TR reported to the Committee that he and SB had met with Hugh Montgomery, the clinician lead in securing the legacy and Hugh will be coming back within the next 2-3 weeks with thoughts on how the money could be spent. This has to be spent within the Kanitz unit.

14.3 KM stated this is the draft position for the Accounts and the next Charitable Committee will receive the final audited accounts once the audit is complete.

14.4 The report shows an increase in funding through legacies however merchandising has decreased. TR hoped this recovers and said he felt the staff are doing a good job and help awareness of the Charity.

14.5 KM stated an email was received with regard to Edith Layton legacy and within the next month the Fund will be in the position to look for a purchaser of the Economist shares. There is a need to find a buyer as they are not traded shares. SB confirmed the Trust is one of seven benefactors and they are not ordinary shares. At the end of the month the timing for the other benefactors to purchase will have expired. TR asked about the sum expected and we have no information on this other than the total bequest is to be split evenly between seven charities of which we are one. TR noted that the sum to be received could be significant given the value of the Economist business and asked KM to further investigate with the solicitor administering the estate to establish the approximate value of this bequest.

14.6 TR felt the fund is in a reasonably healthy position and he asked if it was in a position to begin maternity fundraising and would do so as soon as position re NHS funding of the new core Maternity Unit was clarified. GB stated that he and SB will meet with the Deputy CEO to discuss maternity in a few weeks and SB said that in terms of timing there is a fair amount of work to do on maternity as the scheme goes to the TDA and to the London team.

14.7 The Committee approved the paper.

16/015 Analysis of Fund Balances and their usage

15.1 The Committee approved the paper.

16/016 Applications for Funding

16.1
- Sonsonite X-porte Ultrasound Machine**:**
  RL presented the case on the ultra sound which would reach a broader patient group through emergency and forms part of doctor training. This machine has enhanced technology for training, superior image quality, larger screen, and it is bed side so is above NHS standard. It saves delays in getting to X-ray, and tying up imaging and it is a one-stop piece of kit to deal with patients. RL reported the desire to do more MSK diagnostics. This also includes an MSK probe to move beyond the usual to manipulate fractures with ultrasound guidance and increase in cardiology techniques to look at the function of heart. It can improve learning and patient outcomes and can identify early pneumonias. The machine is entirely touch screen and good for infection control. It will enhance the teaching training of junior doctors in Emergency Medicine and will help train nurses for use on fractures. It will enhance skills of a workforce and therefore is good for retention of staff where difficult to retain

In answer to TR query on the MSK probe, RL stated there are 4 probes and the fourth is MSK, so there is increased functionality. TR asked why the Charity should pay and SB stated the machine has capabilities above the normally funded kit particularly in relation to education. Therefore, if the Committee agrees this should be paid for by Charitable funds. SH asked if there was any issue on choosing which manufacturer in terms any restrictions and SB stated once agreed there will be a check by Medical Physics that there is no restriction with other contracts. SH asked about maintenance and SB said initially Sonsonite will maintain. The bid was approved in principle subject with monies not to be paid before the 5th August and with the need to decide which fund monies will come from.

- Electric Cars in the DN Service: Agreed from the Community General Fund with revenue funding from the ICSU
- Upgrade to Radiology seminar and WEC Room 10: TR questioned whether this is old technology and other methods e.g. skype should be promoted. CG felt skype would be a challenge and may not be appropriate or safe for medical use. SB confirmed that this type of capital request won't be funded from the Capital Programme as only red risks are being funded this year. CG said clinicians are travelling off site so there is a productivity gain as well as a patient benefit. Agreed funding from surgery funds
- Support for the Darzi Fellowship for one year: Agreed from Pharmacy
- 14 x Toronto Manually Reclining Mobile Chairs: Agreed and Finance to confirm funding source.
- Bladder Scanner Biocon 700 and trolley for Coyle Ward: Agreed from Coyle ward
- Trust Annual Award Bid: TR asked if we have a list of what other Trusts do and SP confirmed most other Trusts work along the lines of this bid. SP said the issue is to be inclusive for all teams and NHS money cannot be spent on this so should be funded via the Charity. TR felt that he would like to discuss the minimum 5 year commitment with SP. SP said this was a way to give back to staff in a legitimate way and he wanted a proper process in place. SB said he would support the paper as over and above usual expenditure and therefore falls into Charity expenditure. SH said he would support but the only issue is whether sponsorship may be available also. He believed there is a need to delegate final detail to the Executives. The proposal was agreed in principle subject to further review by TR and the Executive of the practice in other Trusts and the question of such a multi year commitment of Charitable Funds to this cause.

16/017 Presentation on Transfer of Funds to a limited company (Mouse Project)

17.1 SB said the decision to be made is whether the Committee is happy to transfer the remaining funds to a limited company and whether the Committee can guarantee funds will be used correctly. From a governance perspective the Committee needs to be comfortable. There are three options:

1. Transfer funds with a legally binding contract so the Committee can go back to donors to say it has a guarantee
2. Say no and continue with funds within the Charity
3. Give the £47,000 back to the donors and they can transfer the funds to a limited company if they wish.

17.2 TB, Creative Director of Resilient, stated Simmons House is a development test and pilot site. If successful the hope is this will become a national project. Patients and staff had worked over the last three years on the project along with Pathway. UCLH, and Crisis has just joined the group. The Anna Freud Centre is providing evidence based practice and evaluation of the project. The Royal College of Psychiatrists and GOSH have endorsed the project and the Wellcome Trust, the Maudsley Charity and

the Department of Health (£48,350) have funded the project monies which are held by Pathway.

17.3 On the Board are the CEO of Pathway, the FD of Pathway, the Head of Research at Crisis and Simon Lewis and Theo Baines. Everything is overseen by the Board/Steering Group. TB said he was happy to email TR with a letter from Pathway and Pathway are happy to liaise with TR.

17.4 SL stated the Trust had been good at helping the fund to be set up but now it is at a point where money needs to be easily accessible; although he emphasised everything will be accountable and not for profit. SL said he was committed to work with TB as this project is about trying new things and being innovative. He felt that with the Anna Freud Centre on board this gave a sign of the projects importance. SL stated a lot of his colleagues are interested and now other CAMHS services are involved. TR queried Shelter involvement but SL said not as yet.

17.5 SB stated the decision for the Committee is whether to transfer funds out in a way suggested and to ensure that the administration and governance are correct. He felt that certainly the Trust might want a presence on the Steering Committee but the duty of care is the issue and making sure the Trust can demonstrate it has followed due process and had asked the right questions.

17.6 SL said there has to be clear governance and every single penny will be accounted for and he is happy to share this with the Committee. SP said that the Committee did not want to hold things up but asked how will the money be spent, will staff be employed, and there may be intellectual property issues arising from this project. He said the Committee had to know the detail on what is actually being undertaken but on the proviso there is this discussion he was happy. He also wanted to know what the company will have the ability to do in do in due course.

17.7 SL stated a video/dvd will all be free but SP reiterated if the project controlled the idea this would be worth something in monetary terms. TB said in due course the idea is to go national and to get more beneficiaries with future projects to come from this one.

17.8 SB said he agreed in principle with someone on the Project Steering Group or Company Board but he noted that there is no intellectual property and that will be reflected in a note to SL/TB (TB said he owns the copy write to the film) but SP reiterated that if there are DoH monies there is an issue of intellectual property.

17.9 *SL/TB left the meeting.* SP stated there is a cost to a limited company and KM confirmed it is a limited company with one shareholder of TB.
It was agreed in principle to transfer the funds to the limited company subject to:

1. membership on the Steering Project or Limited Company Board;
2. Detailed reports on expenditure going forward; and
3. a fuller understanding of the intellectual property rights.