Whittington Health NHS

TRUST BOARD

14.00 – 16.30
Wednesday 7 September 2016

Whittington Education Centre Room 7

Whittington Health NHS

Meeting	**Trust Board – Public**
Date & time	**7 September 2016 at 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
16/113	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
16/114	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1420hrs
16/115	**Draft Minutes, Action Log and Matters Arising 6 July** *Steve Hitchins, Chair*	1	*Approve* 1425hrs
16/116	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1430hrs
16/117	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1440hrs
Patient Safety & Quality			
16/117a	**Care Quality Commission Report** *Philippa Davies, Director of Nursing & Patient Experience*	2a	*Approve* 1450hrs
16/118	**Serious Incident Report Mth 4** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1500hrs

16/119	**Safer Staffing Report Mth 4** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1510hrs
16/120	**Quarterly Safety Board Paper** *Richard Jennings, Medical Director*	5	*Approve* 1520hrs
Performance			
16/121	**Financial Performance Month 4** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1535hrs
16/122	**Performance Dashboard Month 4** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1550hrs
Strategy			
16/123	**Nursing and Midwifery Strategy** *Philippa Davies, Director of Nursing & Patient Experience*	8	*Approve* 1600hrs
16/124	**Whittington Health Community Forum** *Siobhan Harrington, Director of Strategy/Deputy CEO*	9	*Approve* 1605hrs
Governance			
16/125	**Staff Survey 2016/17 Action Plan Update** *Norma French, Director of Workforce*	10	*Approve* 1615hrs
16/126	**Quality Committee Draft Minutes 13 July** *Anu Singh, Non Executive Director*	11	*Approve* 1625hrs
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meeting			
	5 October at 1400hrs to 16.30hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF		

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: 16/115

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 6th July 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
	Graham Hart	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
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Natasha Manning, Manager of Victoria Ward read a patient feedback letter to the Board. The letter explained the patient's stay on the ward following her admittance through ED, and she described the care she had received as both professional and kind. A nurse manager herself, she highlighted the importance of the smaller things and the attention to detail. Examples of these included her observation of patients being assisted at mealtimes and the patience and compassion shown by staff on night duty towards mental health patients. There was, she had written, an 'amazing culture' both on the ward and at Whittington Health.

Steve Hitchins had recently visited the ward and echoed the sentiments expressed in the letter. Philippa Davies added that the Quality Committee would be conducting a 'deep dive' into Victoria Ward the following week; the ward had not been without its problems, but the letter illustrated the commitment and dedication of the staff. In answer to a question from Greg Battle on how the high quality of the service might be maintained, Natasha explained there was a high level of vacancies, and existing staff were covering additional shifts. She and her colleague Sylvie (nurse in charge) said that planning was difficult since beds were frequently opened and closed so staffing needs were hard to predict. Norma French asked about recruitment plans, and they confirmed they expected nurses and health care assistants (HCAs) recently recruited from Greece to join them in September.

Richard Jennings enquired to what extent the ward endeavoured to create a 'family team' ethos, and Natasha replied that a summer picnic was planned and there was a planned event that day to celebrate the letter that had led to the Board presentation. Steve Hitchins would be writing to Vivien to thank her for the letter. Simon Pleydell congratulated the team, and wholeheartedly endorsed their principle of promoting gradual change.

16/96 Declaration of Conflicts of Interest

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

16/97 Apologies and welcome

97.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Tony Rice, Yua Haw Yoe and Janet Burgess.

16/98 Minutes, Action Log and Matters Arising

98.01 Three amendments were requested to the minutes of the Trust Board meeting held on 1st June as follows:

Patient Story – it was noted that Kerry Wykes was a matron rather than a practice development manager
85.02 – in the second line, the word 'extremely' should be omitted, and
85.05 – it was clarified that the death referred to had not occurred locally but in another part of the country.

Actions

98.02 105.08 IT Reviews: This was on the agenda for discussion.

160.09 Performance Dashboard: This remained scheduled for discussion at September's Board Seminar.

160.11 Speak Up Champion: Work continued on this. It was noted that there is more than one possible model for implementation, and organisations have been urged not to 'reinvent the wheel'. Robert Francis had informed Trusts that a regular forum would be held in order to share good practice and case studies. Siobhan commended the work carried out to date by Philippa and Doug Charlton.

53.04 The staff survey action plan was scheduled for discussion at the September Board.

86.01 The extraordinary public Board meeting had been held on 8th June, this item could therefore be closed.

90.02 An update on the clinical collaboration work with UCL was provided within the Chief Executive's Report.

93.02 Actions associated with the ED Business Case had all been logged, this item could be closed.

98.03 There were no matters arising other than those already scheduled on the agenda for discussion.

16/99 Draft Minutes of Extraordinary Board Meeting held on 8th June

99.01 The Board reviewed and agreed the minutes of the extraordinary Board meeting held on 8th June to discuss the Quality Account.

99.02 Steve Hitchins asked Lynne to check the list of those who had been present at that meeting to ensure the attendance recorded was accurate.

16/100 Chairman's Report

100.01 Steve Hitchins began his report by informing the Board that on Friday Grafton School was putting on a performance regarding the history of the Whittington; he would be attending. He expressed his thanks to colleagues in the Communications and Estates Departments for all the help they had given the school.

100.02 The following Tuesday there was to be a memorial service for the late Rev'd Canon Emile Jones, former chaplain of the hospital. All were welcome to attend.

100.03 On Saturday, a number of staff including Simon Pleydell, Tony Rice, Graham Hart and Norma French were participating in the 10K charity run. Over £20,000 had already been raised for the Whittington Health charitable funds.

100.04 Steve had attended the 'art of emergency care' live theatre performance by ED, where he had seen some good examples of the very real challenges faced by that team. The performance was a form of staff training with scenarios and audience participation, and is conducted annually – Steve felt it to be a particularly effective initiative. He had attended a screening of the video 'Footprints of Birth', which detailed mothers' experiences of giving birth, and about which NHS England had been complimentary.

100.05 The second community forum was to take place later that week, and Steve felt that positive progress was being made. The annual paediatric picnic was scheduled for the following Tuesday, all were invited to attend.

100.06 Greg Battle extended his thanks to the Islington Adult Learning Disabilities Partnership, who had put on an impressive performance the previous Wednesday, focusing on both need and experience.

16/101 Chief Executive's Report

101.01 Simon Pleydell said that to date the Trust's performance on MRSA was good; however figures for C. Difficile were of more concern, with four cases having been reported by the end of June against a target of not exceeding 17 for the year.

101.02 Cancer waiting times and RTT were broadly in line with targets. MSK waits were at 39.5% against a target of 95%; this was due to a combination of open access and self-referral. There was an urgent need to hold further discussions with commissioners regarding the volume and capacity issues with the service and the need to create a sustainable model. Carol Gillen informed the Board that a panel of GPs was to carry out a review of the self-referral pathway.

101.03 The CQC Report was due to be issued this month, and Simon, Philippa and Siobhan would be holding a series of briefing meetings for staff as well as issuing a letter thanking all staff for their contribution. Steve Hitchins extended his thanks to the Executive Team for the immense amount of work they had put in to the inspection and especially to Philippa Davies who led the work.

101.04 The first meeting of the clinical collaboration board with UCLH had been held, and Siobhan Harrington was drawing up an action plan. Simon confirmed this was an important step forward for stronger clinical collaboration to build on existing partnership working.

101.05 The North Central London Sustainability and Transformation Plan (STP) had been submitted on 30 June with a second iteration to be completed for the end of September. A report was attached to the CEO board report to explain the progress and governance arrangements.

101.06 ED remained under pressure with steady improvement over the month. In answer to a question from Deborah Harris-Ugbomah about the degree to which ED performance was under the Trust's control, Simon Pleydell confirmed demand was an issue but the operational and clinical teams were implementing changes to the patient pathway to enable 95% compliance with the 4hr target by the year end. Some of the initiatives to support the improvements included pre-11am discharge from all wards, nurse-led criteria discharge and working more closely with specialties.

101.07 Looking to priorities for the year ahead, Simon highlighted the focus would be on quality, safety, ED patient pathways and finance.

101.08 Phil Ient had recently retired after 15 years as Director of Estates & Facilities, and a new appointment had been made to that post – Adrian Cooper, currently Deputy Director at the Royal Free.

16/102 Serious Incident Report

102.01 Philippa Davies informed the Board that six serious incidents (SIs) had been declared in May, and all were under investigation. It was noted that there had been three unrelated Information Governance breaches and learning from these will be shared with staff.

16/103 Safe Staffing Report

103.01 Philippa Davies said there were no items of significance to report that month other than the fact that the report now included care hours per day. Future reports will aim to show comparison with other organisations. Allocate implementation was proceeding well and the employee on line model was being rolled out with the next phase planned for district nursing teams. At present a consultation exercise was being carried out on the e-roster policy.

103.02 Siobhan Harrington asked the Board to note the high incidence of mental health patients attending the hospital, its resultant impact on the use of agency staff, and consequently on the Trust's financial position.

103.03 In answer to a question from Deborah Harris-Ugbomah about a recent article in the Evening Standard, Philippa Davies confirmed that a Prevention of Future Deaths (PDF) notice had been issued by the Coroner; Richard Jennings said this had been because the Coroner had not been confident that the learning arising from an incident had been shared with all relevant staff in the most appropriate manner. Since then, Richard stressed, practice had changed considerably, and he was confident there were far more robust processes in place than had previously been the case. Lynne Spencer added that there was no automatic right of a reply to this particular case, as the article was reporting facts highlighted at a conference. The communications team always submit a considerable number of positive stories to the media to support balanced reporting and the team had developed good relationships with local journalists who regularly visited the Trust for face to face briefings with Simon Pleydell to support a transparent and open approach.

16/104 Financial Report

104.01 Stephen Bloomer confirmed that the Trust had reported a £0.4m deficit at the end of Month 2, some £0.3m better than the planned position, and due to receipt of one-off income. There continued to be a high level of spend on temporary staffing, particularly agency, and this was the subject of regulatory attention.

104.02 The other main area of focus was on the CIP plans, and Stephen felt there were good plans in place and the work was being supported by the Programme Management Office. Despite this, the Trust was not yet delivering the required savings, and this needed to be turned round without delay. Work will continue with the operational and clinical teams to enable the Trust delivery of the financial plan.

104.03 Moving on to cash balance, Stephen said that the Trust had ended Month 2 with a balance of £2m, and had therefore been able to make some long-standing creditor payments.

104.04 In answer to a question from Deborah Harris-Ugbomah about what message had come out of that morning's Finance & Business Development Committee, Graham Hart replied that Tony Rice as Chair of that Committee had written to all its members summarising that morning's discussion and the current challenging position. Siobhan Harrington echoed this, adding that John Watson (Director of Service Improvement) was clear on the imperative of working at pace on the schemes agreed for cost savings. Plans were in place for 2017/18 CIPs.

16/105 Performance Dashboard

105.01 Carol Gillen informed Board colleagues that theatre utilisation was a high priority for the Surgery & Cancer ICSU's CIP plan, and a theatre utilisation dashboard will be implemented to support improvements. Cancer waiting times had been achieved, and MSK services will be back at 65% performance by the end of September by implementing changes being agreed with commissioners. Agency staff were supporting improvements to the waiting lists for patients and recently recruited physiotherapy staff were due to start by September. GP communication with patients is part of the work that Carol and Beverleigh Senior will be working on as part of the MSK plan for improvement.

105.02 Within ED and Urgent Care, Carol said that the Trust had achieved 95% on some days the previous week but the pathway remained challenging. There had been a focus on pre-11am discharge, and each week staff are reviewing patients who have been in hospital over seven days. The intra-professional response times to ED is another area that the operational and clinical teams will focus on in the forthcoming months. The Business Case for additional staff had been approved and work was underway with social services and mental health colleagues to support improvements with patient flows.

105.03 In answer to a question from Deborah Harris-Ugbomah about why figures for Ambulatory Care were relatively low, Carol replied it was of how patients were screened at the front door of the service. Simon Pleydell added that there was a need to look at the entire front of house system, and Rachel Landau had initiated a piece of work on this area.

16/106 Capital Plan 2016/17

106.01 The Plan had been agreed by the Trust Management Group and it set out the capital resource available for the year and showed how capital requests were prioritised (areas of highest risk). There is a split between the first tranche (for which resource are already committed) and the second, which would be reviewed in September. All capital development schemes now flow through the PMO.

106.02 Simon Pleydell was confident that would enable the Trust to monitor areas of serious risk more closely and the team will need to anticipate risks more strategically. Steve Hitchins said that Phil Ient had produced a thorough report on estates and he had reported that a number of issues previously rated amber could become red so these will require close monitoring.

16/107 Community Engagement

107.01 Siobhan Harrington introduced her paper, which set out the Trust's approach to developing its community engagement strategy. The new community forum had met for the second time the previous week – around 40 people had attended to discuss estates, the STP and key priorities. The Board was asked:

- to support to the development of the forum
- to receive a progress report in the autumn
- to support the proposed approach to the development of the engagement strategy

Siobhan would be briefing the Overview & Scrutiny Panel the following week.

107.02 This was work in progress, and Siobhan said it was receiving considerable support from the voluntary sector, including contributions from Healthwatch. Anu Singh highlighted empowerment versus engagement and she agreed to discuss outside the meeting. Simon Pleydell suggested that it would be helpful to source some pump-priming funding for this work to enable appropriate resource.

16/108 Heatwave Plan 2016/17

108.01 Carol Gillen introduced this annual update for the Board, which had been prepared in line with guidance from both Public Health England and the Met. Office. The plan defines heat levels, what action should be taken in the event of a heatwave, and what messages are relayed. If a heatwave continues for longer than three days business continuity plans are triggered. Carol mentioned the expertise of the District Nursing Teams in dealing with vulnerable patients who might become affected by such events.

108.02 Carol said, there had been little change from the previous plan, except the system for debriefs had improved because of the new full-time Emergency Planning Officer.

16/109 Annual Medical Appraisal and Revalidation Report 2015/16

109.01 Richard Jennings reported that each year the Board receives a report setting out the Medical Appraisal and Revalidation and the position was good as the majority of doctors were engaged and over fifty doctors were now trained as appraisers.

109.02 In summary, feedback was positive; Richard acknowledged there were some areas where he would like to see improvement, and Rob Sherwin's appointment as Associate Medical Director for Revalidation would assist.

109.03 Norma French enquired how this information was relayed to the ICSUs, and how it related to job planning. Richard Jennings replied that the ICSU Clinical Directors all kept themselves well informed both about the overall picture within their ICSU and individual doctors; job planning was a separate process and one which he was currently reviewing with colleagues. Richard explained the difference between appraisal (a local process) and revalidation (the formal GMC process), adding that Rob Sherwin would be contacting all those who had not engaged with the latter. Non-engagement could lead to the Trust's invoking a formal process with the GMC. It was noted that this year doctors were to receive a certificate confirming their revalidation, which was a motivational incentive; also to be revalidated doctors had to be fully compliant with all mandatory training modules.

16/110 IM&T Improvement Plan and Deloitte Review

110.01 Steve Hitchins introduced Julian Hunt and Torrin Gatier from Deloitte's to present a review of two serious IM&T incidents that had occurred in July 2015. Torrin said that the first incident, which had involved a failing of air conditioning units and repair work not being carried out in a timely fashion had been preventable; the second, where a fault had occurred within data replication software, had not been foreseeable, although its impact could have been lessened had staff been better trained and equipped to cope with the incident. It was noted that the pharmacy department's business continuity had worked well.

110.02 Management actions had been agreed – these included the aspiration to become paper free at the point of care with financial investment in systems. Progress was to be reported through the Trust Management Group. Whilst the aspiration to become paper free was in

line with national policy, it was noted that the more dependant an organisation became on IT systems, the more costly any failure would become.

110.03 Glenn Winteringham would be reviewing and updating the IT Strategy, and in doing so would be taking into account changes and development in all systems across North Central London. The Strategy will be received by the Board in October.

110.04 The following points were highlighted for the I&MT Improvement Plan 2016/17

- specific alignment with the Operational Plan
- implementation of the health roster, which now provided data on patient care measured against nursing hours
- development of new dashboards
- going live, that day, of the North Central London resilience system
- capital programme investment agreed to mitigate the existing red risks

110.05 Commenting on how positive the paper appeared, David Holt suggested there was a need, when next looking at the Risk Register, for the Board to spend some time considering horizon scanning. Stephen Bloomer highlighted the age of some equipment in the community and noted that a financial calculation will support risk management decision making. Richard Jennings enquired whether the incident register had been maintained as agreed following the most recent incident; Glenn confirmed this was in place. Deborah Harris asked whether any common themes had emerged out of the review, and Julian replied that there were themes around capacity, leadership and investment.

16/111 Minutes of Finance & Business Development Committee held on 25th May and Minutes of Charitable Funds Committee held on 14th June

111.01 Both sets of draft minutes were noted by the Board.

16/112 Any other business and questions/comments from the public

112.01 Tricia, who had attended the recent community forum meeting, thanked the Board for running a hospital she felt safe in; Steve Hitchins thanked her.

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Action Notes Summary

160.09	Performance Dashboard: This will be discussed at a Board Seminar.	September TB Seminar **Closed**	CG
160.11	Speak up Champion: Trusts expected to be able to demonstrate processes for appointment by September. Confirm appointment to the Board.	September Board CEO report **Closed**	SP
53.04	A report on progress achieved on the staff survey action plan to come back to the Board in six months' time	September Board Agenda **Closed**	NF
99	The Board reviewed and agreed the minutes of the extraordinary Board meeting held on 8th June to discuss the Quality Account. Steve Hitchins asked Lynne to check the list of those who had been present at that meeting to ensure accuracy.	September Completed **Closed**	LS
110.03	The I&MT Strategy will be received by the Board in October	October	SB

Whittington Health Trust Board

7 September 2016

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/117**	**Paper**	**02**
Action requested:	For discussion and information.		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust.		
Summary of recommendations:	To note the report.		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent.		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework.		
Date paper completed:	31 August 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 continue to report 0 MRSA breaches and this retains our year to date performance of 0 breaches.

Clostridium Difficile

We have reported 5 cases of Clostridium Difficile up to the end of August. The target is for no more than 17 cases in each year. 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 exceeded all our national cancer targets except the 62 days from referral to treatment. *Reported 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 83% against a target of 85% (3 breaches)
- 14 days cancer to be first seen 96.4% against a target of 93%
- 14 days to be first seen for breast symptomatic 99.2% against a target of 93%

Community Access Targets

We are aware that the MSK targets are not achievable with our current service and workforce model.

We value our staff continuing work extremely hard against a difficult transition period. We will continue to liaise with our commissioners to support staff in changing the way we will operate in future so that we can match the demand of the service with the resources required to meet the current targets which reported as below for July.

- MSK waiting time – non consultant led patients seen 46.0% - target 95%
- MSK waiting time – consultant led patients seen 64.5% - target 95%
- IAPT – patients moving to recovery – 49.1% - target 50%
- IAPT – patients waiting for treatment <6 weeks – 95.4% - target 75%

Never Event

We regret that the Trust has reported a never event for a retained swab in a patient from our maternity unit. A full and thorough investigation is underway in line with our policies and procedures and the outcome will be reported to the Board as part of our monthly serious incident report. This will highlight the lessons learned and actions taken to

prevent further events occurring. I would like to sincerely apologise to the mother and her family and I am pleased that she has been discharged and has recovered.

Care Quality Commission (CQC)

Our CQC inspection report has been published and we were pleased to have been rated overall as Good – with caring being rated as Outstanding. For the five key measures, the CQC rated our services as

- 'Outstanding' for 'caring'
- 'Good' for 'effective'
- 'Good' for 'responsive'
- 'Good' for 'well-led'
- 'Requires improvement' for being 'safe'

Part of the process included a CQC quality summit which included stakeholders such as our commissioners in Islington and Haringey, NHSE and Healthwatch. We presented our safety and quality improvement action plan which sets out how we are working to improve areas identified from the inspection.

The safety and quality improvement action plan is being monitored each month by the Trust Management Group and the Trust Board Quality Committee.

Of the NHS Trusts in London who have been inspected, we are in the top quartile to be given the 'Good' rating and it stands as a testament to our staff for their tremendous hard work and commitment to delivering the best possible safe and high quality care for our patients**.**

2. STRATEGIC

Sustainability and Transformation Plan (STP)

We are working with our partners across North Central London (NCL) by attending a series of meetings to discuss our sustainability and transformation planning arrangements. This work has resulted in the submission of an outline plan to NHSI and NHS England for how NCL will work together more closely in future 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.

There are strict requirements to meet targets each quarter to secure STP funding. We missed quarter one targets which included our 4hr ED performance, meeting our agreed financial control targets and reducing agency spend. We are confident that our new corporate Project Management Office and establishment of strong clinical leadership in our seven Integrated Clinical Service Units will get us back on track to meet our targets by year end 2016/17 to secure the agreed £6.5m STP funding for the year.

Clinical Collaboration Board

We are now part of a Clinical Collaboration Board with our colleagues from University College London Hospitals NHS Foundation Trust (UCLH). One of the key drivers for the work has been to continue the joint work within Haringey and Islington on developing the Haringey and Islington Partnership and supporting the work on Care of the elderly, CHD and Diabetes, Learning Disabilities and MSK.

The group identified that Women's Services is an area that would benefit from collaboration. The Clinical Directors have agreed that there are three areas that will be prioritised; the home birth service; perinatal mental health and foetal medicine.

There has also been progress in terms of progressing our work on the joint MDT in Lung cancer which has now started and is already showing benefits for patients. We have developed a joint MDT in our LUTs service and are aiming to provide a more integrated service over time.

Both Trusts are exploring how working together can strengthen and improve our surgical services. This work is looking to identify ways of working which will improve outcomes for patients whilst being more efficient and ensuring services are sustainable into the future.

Maternity and Neonatal

Our full business case is being resubmitted to NHSI on 19 September to be considered at the October NHSI Resource Committee. The clinical safety case regarding the issue of requiring 2 co-located theatres has been emphasised. A letter of support from the emergent Sustainability and Transformation Plan process has been obtained and the financial strategy reviewed. The financial case has been updated in the light of latest activity figures, revised tariff assumptions and cost improvement plans. The changes to the original Full Business Case will be set out in a Full Business Case addendum document. The case will be discussed at the Finance and Business Development Committee on 21 September.

Community Dental Contract

We have been successful in being identified as the provider of community dental services from April 2017 for services, not only in our current footprint of Haringey, Islington, Camden and Enfield, but also Barnet, Hillingdon, Hounslow, Ealing, Brent and Harrow.

This extends our service from a £5.3m service to a £9.4m service.

Our community dental service achieved an outstanding rating from the CQC and this business success is an accolade to Dr Andrew Read and his team.

3. OPERATIONAL

Emergency Department (ED)

Pressures within the emergency care pathway continue and our 4hr performance for July was 87.5% against a target of 95%, with August performance continuing to improve at 92.73%.

The clinical and operational teams will continue to improve our performance by implementing our improvement plan and this includes new initiatives such as:

- pre 11am discharge
- reducing patient length of stay
- improving discharge planning
- implementing nurse led discharge (TICKED)
- fully utilising our ambulatory care centre
- fully utilising our community services.

We have increased resources in the operational management of the emergency department with new members of staff focused on supporting the busy teams to streamline the patient pathway and flows. We have also started a process for recruiting additional consultants to strengthen the existing team in the emergency department.

The Perfect Week

We want to make sure our hospital is functioning as efficiently as possible, and to help us achieve this we are launching a new Perfect Week initiative. This programme has worked well in other hospitals and it aims to change the way patients are seen, treated and discharged to improve safety, patient experience, and performance.

Lower Urinary Tract Services (LUTS) Clinic

Professor Malone Lee is retiring in September. The Trust is awaiting the Royal College of Physicians invited service review and this is expected later in the month. Plans are in place to continue the service following Professor's retirement with work over the summer focused on strengthening the governance and succession plan for the service. Service users are concerned about potential changes to the service. The Trust has met service users on three occasions to engage them in the plans. A joint MDT has been developed with UCLH and work continues through our clinical collaboration to finalise a detailed succession plan. Transitional arrangements are in place.

Speak Up Champion

In line with national policy we have started a process to appoint a Speak-Up Champion who will act as an independent advisor for staff who want to raise a serious concern. This role will promote the safety of our patients, visitors, staff and volunteers and help us to promote a culture of transparency.

Junior Doctors

The planned September industrial action has been cancelled.

We will monitor potential withdrawal of labour by junior doctors which may impact from October. We intend to manage services in line with our contingency arrangements if disruption to services over the Autumn and Winter occurs.

4. FINANCE

Month 4 (April 2016 to July 2016)

We are facing an extremely difficult financial position with significant challenges over the coming months.

We reported a £1.3m deficit for the month of July which takes the year to date 2016/17 deficit to £5.5m; £3m worse than our planned position.

Failure to deliver the planned position means we have not been able to collect our Sustainable and Transformation Plan funding of £2.3m for Quarter one of 2016/17. The main driver for the overspend is the continued high level of agency spend.

The Trust agreed a control total target with NHSI and we have to get back to that level which will allow us to collect the STF funding. We have limited time to achieve this and therefore need to

- reduce our agency spend and achieve our planned level of staffing expenditure
- deliver our agreed cost improvement programme of £10m; the majority of which is due to be delivered in the second half of the financial year October to March 2016/17
- deliver our agreed income targets

A key measure of financial sustainability is the underlying financial position. This is the position once the large non-recurrent transactions are removed and it shows how the organisation is performing routinely. Our underlying position has deteriorated to £17.9m from £12m at the end of April and it is only by delivering the above three actions that we will improve that position and demonstrate on-going financial viability.

5. AWARDS

Congratulations to Jonathan Barnes, Senior Information Analyst, who received our June staff excellence award for his work with the emergency department to support our improvement plan to meet 95% performance. Congratulations also to the Haematology Team, who received our July staff excellence award, for their integrated paediatric and adult red cell service. They are a committed team of health professionals and patients have been highly complementary of the service and have fed back how they value the integrated work between the hospital and the community. The team includes Dr Bernard Davies, Dr Ali Rismani, Emma Prescott, Dr Farrukh Shah, Dr Andrew Robbins, Dr Sarah Hamilton, Louise Collins, Matty Asante, Edith Aimiuwu, Sarah Cullen, Rachel Moll, Annabelle MacMillan and Zahra's Al Kafaji.

Congratulations also to Adrian O'Gorman and Sudhanshu Chitale, recognised at the UCL Partners Excellence in Medical Education Awards. Adrian, a consultant in our trauma and orthopaedics team was recognised for setting up an evening on-call rota for medical students to help them develop skills to support patients admitted to A&E and for setting up new staff training guides. Sudhanshu, a consultant urological surgeon developed special educational tutorials and a hands-on approach to teach and inspire students.

Simon Pleydell
Chief Executive Office

Whittington Health Trust Board

7th September 2016

Title:	CQC Report		
Agenda item:	**16/117a**	**Paper**	**02a**
Action requested:	For discussion and information.		
Executive Summary:	In July 2016, Whittington Health was rated 'good' by the CQC, with an 'outstanding' rating for caring. The summary report highlighted many areas of good practice across the ICO, including; • Inspectors found staff to be highly committed to Whittington Health and delivering high-quality patient care • Our patients were positive about the care they received and felt staff treated them with dignity and respect • Learning from incidents was shared across the ICO to improve patient safety • Community end of life care and community dental services were rated as outstanding • The multi-disciplinary model of the ambulatory care service was commended • Within ED there was "outstanding work" to protect people from abuse However the CQC also identified areas for improvement across the ICO and the Trust has developed an action plan for improvement based on the 'must do' and 'should do' recommendations from the report. This action plan was shared with the CQC and commissioners at the Quality Summit and the Trust will provide updates on progress. The action plan is monitored through the ICSU governance structure and reported by exception to the Trust Management Group. The Quality Committee is responsible for providing assurance to the Trust Board that actions are on target.		

	<table><tr><td>Total # of recommendations</td><td>40</td></tr><tr><td>Complete</td><td>15</td></tr><tr><td>On target</td><td>23</td></tr><tr><td>Overdue</td><td>2</td></tr></table> Overdue actions relate to cleaning schedules and processes in community centres where Whittington Health provides children's services but do not own the building. Work is in progress to liaise with the landlords to ensure cleaning schedules are kept up to date.
Summary of recommendations:	To note the report.
Fit with WH strategy:	Whittington Health Clinical Strategy
Reference to related / other documents:	CQC Summary Report (Appendix A) CQC Improvement Plan (Appendix B) For more detailed findings from the inspections, please see the individual reports for the hospital and community services http://www.cqc.org.uk/provider/RKE
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:	2nd September 2016

Author name and title:		Gillian Lewis, QI and Compliance Manager		**Director name and title:**		Philippa Davies, Director of Nursing and Patient Experience	
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**

The Whittington Hospital NHS Trust

Quality Report

Magdala Avenue
London N19 5NF
020 7272 3070
http://www.whittington.nhs.uk

Date of inspection visit: 8 - 11 December 2015
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

We carried out an announced inspection between 8 and 11 December 2015. We also undertook unannounced visits on 14, 15 and 17 December 2015.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust CAMHS services, Whittington Health community services for adults, children and young people and families, and patients receiving end of life care.

This was the first inspection of Whittington Health NHS Trust under the new methodology. We have rated the trust as good overall, with some individual core services as requires improvement.

In relation to core services most were rated good with critical care and outpatients and diagnostics rated as requires improvement. Community end of life care and community dental services were rated as outstanding.

Our key findings were as follows:

- During our inspection we found staff to be highly committed to the trust and delivering high quality patient care.
- We saw staff provided compassionate and patients were positive about the care they received and felt staff treated them with dignity and respect.
- The trust had vacancies across all staff groups, but was recruiting staff and staffing levels were maintained in services through the use of bank and agency staff.
- Staff were aware of how to recognise if a child or adult was being abused and received good support and training from the trust's safeguarding team.
- The trust had an incident reporting process and staff were reporting incidents and receiving feedback. Learning was shared across ICSU's which encompassed acute and community service.
- The Trust had promoted duty of candour and this was seen to be cascaded through the organisation.
- We observed effective infection prevention and control practices in the majority of areas we inspected.
- Patient care was informed by national guidance and best practice guidelines and staff had access to polices and procedures.
- Patients had their nutritional needs met and received support with eating and drinking.
- There was good team and multidisciplinary working across all staff groups and with clinical commissioning groups, voluntary organisations and social services to deliver effective patient care.
- We found evidence of good compliance with the World Health Organisation (WHO) surgical safety checklist, with good completion of the three compulsory elements: sign in, time out and sign out.
- There were processes in place to ensure staff attended training on the Mental Capacity Act 2005 and the majority of staff demonstrated a good practical understanding of this, with variability in some services,

Summary of findings

- Staff understood and responded to the needs of the different population groups the trust served and worked hard to meet the needs of individual patients.
- Patients were largely treated in timely manner with the trust meeting national access targets and performing higher than the England average, with the exception of the cancer two week wait standard, although it was noted that improvements were being made against that standard.
- The emergency department (ED) performed better than the average ED in England in the speed of initial assessment, the timeliness of ambulance handover, and the percentage of people staying for more four hours in the department. However, there were times when there were no in-patient beds available and patients remained in ED for a long time.
- The trust had introduced the ambulatory care unit, which engaged stakeholders across the health and social care economy to avoid unnecessary hospital admissions and transfer their ongoing care needs to the most appropriate provider.
- Patient flow out of theatres and critical care, impacted on patient movement and service capacity.
- Executive and non executive members of the trust were visible in most areas, in both acute and community settings.
- The trust had a clear vision and strategy , the development of this into local strategies were in place in some areas, but were still being developed in some cases.
- Staff were positive about how their local and senior managers engaged with them.

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within he Ambulatory Care Centre we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses' for patients who had been on cancer pathways to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington Health community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.

Summary of findings

- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at a specialist network level.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments the hospital must improve storage of records and ensure patient's personally identifiable information is kept confidential.
- Within the acute outpatient setting, departments improve disposal of confidential waste bags were left in reception areas overnight.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care the trust must review capacity and outflow of patients. We observed significant issues with the flow of patients out of critical care and found data suggesting 20% of patient bed days were attributed to patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care the service must review governance processes and use of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services the department must ensure the information captured for the safety thermometer tool is visible and shared with both patients and staff in accessible way.
- Within maternity the service must ensure the safety of women undergoing elective procedures in the second obstetric theatre and agree formal cover arrangements.
- Within palliative care the service did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to The Whittington Hospital NHS Trust

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

The health of people in Haringey is varied compared with the England average. Deprivation is higher than average and about 26.8% (14,200) children live in poverty. Life expectancy for both men and women is higher than the England average.

The health of people in Islington is varied compared with the England average. Deprivation is higher than average and about 34.4% (11,500) children live in poverty. Life expectancy for men is lower than the England average.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust acute hospital, Child and Adolescent Mental Health Services (CAHMS) and community services for adults, children and young people and families, and patients receiving end of life care.

Our inspection team

Our inspection team was led by

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Team Leader: Nicola Wise Head of Hospital Inspection Care Quality Commission

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, paediatrics, cardiology and palliative care medicine and junior doctors. The team also included midwives, as well as nurses with backgrounds in surgery, medicine, paediatrics, neonatal, critical care and palliative care, community services experience and board-level experience, student nurse and two experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection

Summary of findings

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

The trust also provides community services and we inspected

- Community services for adults
- Community services for children, young people and

their families

- Community services for people receiving end of life care
- Community services for inpatients

The trust also provides mental health services and we inspected

- Mental health services for adults

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

As part of this inspection, we visited a number of health centres and community team bases at: St Anne's Hospital, Crouch End Health Centre, Hornsey Central Neighbourhood Health Centre, City Road Health Centre, Holloway Community Health Centre, Hornsey Rise Health Centre, Islington Outlook and the Partnership Primary Care Centre.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals and community services, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

What people who use the trust's services say

Public Event

To capture the views of local people who use the trust we arranged market-style feedback stands. We received many positive comments about most of the services. Staff were described as caring and supportive.

Friends and Family Test

The percentage of patients who indicated they would recommend the trust met the England average in August 2015, however was consistently below the average between July 2014 and July 2015.

Patient led assessments of the care environment (PLACE)

The trust was above the England average in all measures (food, cleanliness, privacy, dignity and well-being) in 2013, 2014 and 2015.

Healthwatch

Healthwatch Haringey provided feedback from patients and relatives about a range of services including the emergency department, hospital outpatients, and pharmacy. There was a mix of positive and less positive experiences ranging from Reception staff attitude, appointment systems, interpreter services for hearing impaired patients and access to the PALS and complaints service.

Following the PLACE assessment feedback was assessors were impressed by the patient care, cleanliness and hygiene in the hospital. Comments and feedback made last year had been taken on board and there was a great improvement.

Clinical Commissioning Groups (CCGs)

Summary of findings

Islington and Haringey are the two main local commissioners. They were generally positive about services provided by the trust and believed quality and outcomes were good.

They commented on how the trust worked collaboratively to improve health care across the local health economy and had changed its' organisational structure since the formation of the ICO.

Areas of concern were highlighted as issues with the response time for urgent 2 hour assessment, access times for two week wait cancer assessments, six week diagnostic waiting times. Response rates to for Friends and Family indicators. Appraisals were highlighted as an issue for staff through the staff survey. Benchmarked against other London providers the Trust is in the bottom 50% for staff recommending the Trust as a place to work and also in receiving care.

Overall they described the trust as having "good relationships with commissioners and partners " that actively engaged in discussions about how to improve services.

Royal College of Nursing (RCN)

The RCN described past issues around waiting times in Accident and Emergency and failure to meet targets on patient flow and management. Some members had raised concerns about staffing levels and skill mix in the department as well as some issues around team dynamics, however these had since been resolved.

The RCN highlighted some concerns about the high level of sickness and work-related stress and highlighted the sickness absence policy as an area of concern.

The handling of disciplinary situations and investigations was also raised, feedback stating that a culture of learning and openness would be beneficial.

Overall the RCN described a good working relationship with the trust.

Trust Governors

The trust governors described Whittington Health as an Innovative Trust with an engaged top management team. The governors felt listened to and there was a degree of innovation across the Trust. The Trust did not handle Patient Experience in an integrated and proactive way. The Trust collected only quantitative data about Patient Experience, but there was a need for more in-depth, qualitative study.

Top level management were described as thoughtful and engaged. Issues were raised with interpreting services and the way in which the trust cancels appointments.

Facts and data about this trust

Whittington Health NHS Trust is a general district hospital and integrated community provider with approximately 23 wards and providers community care services to 500,000 people living in Islington and Haringey as well as other London boroughs. It receives 86 % of referrals for acute services from Haringey and Islington GPs.

The organisation is a teaching institution for undergraduate medical students (as part of University College London Medical School) and nurses and therapists (linked to Middlesex University School of Health and Social Sciences).

Whittington Health NHS trust had a recorded annual income of £295 million (2014/15) and employs in excess of 4,400 staff. The trust recorded a financial deficit of £7.3 million in 2014/2015 and as per many organisations is proposing cuts to its budget, in order to break even over the next 2 to 3 years.

The hospital houses in the region of 320 beds, flexing up to 360 beds during the winter periods and is registered across three site locations with the Care Quality Commission: (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

Whittington Health reports having a slightly less Consultant grade Doctors (36%), compared to the England average of 39%, and less middle grade Doctors (5%) compared to an England average of 9%. Conversely

Summary of findings

the organisation houses a greater proportion of Registrars (42%) compared tp the England average of 38% and greater junior Doctors (17%) compared to an England average of 15%.

Safe?

- Number of delayed handovers in winter 2014/15 below the median of all Trusts
- The organisation reported one never event reported for misplaced naso or oro-gastric tubes during 2015.
- The ratio of all midwifery staff to births is better than the England average
- There have been no cases of MRSA since February 2015 and cases of Colostrum Difficile has varied over time compared to the England average.

Effective?

- In the Vital Signs in Majors audit 2010/11 the Whittington Hospital scored mostly in the upper England quartile
- Whittington Health scored above the England average for all but two of the indicators in the Heart Failure Audit.
- Performed better than the England average for two out of three nSTEMI indicators in the last two MINAP audits, the trust's performance has improved over time.
- Whittington Health performed well in the Hip fracture audit as 5 indicators were higher than the England average.
- In the bowel cancer audit the trust scored better than the England average and good for case ascertainment and data completeness.
- The lung cancer audit shows the trust as scoring higher than the England average for the two indicators
- The emergency re-admission rates within 2 days of discharge is lower than the England average for non elective admissions. There were no emergency re-admissions for elective admissions
- Unplanned re-attendance rate to A&E within 7 days was worse than the standard for 19 out of the 24 months.
- The trust's performance was also higher compared to the England average for those 19 months. Whittington Health scored similar to other trusts in the A&E survey for questions relating to effectiveness
- Whittington Health performed about the worse than other trusts for six out of the eight standards in the Mental health in the ED CEM audit 2014/15.
- In the national emergency laparotomy audit the trust's self-reported data indicated that the provision of facilities required to perform emergency laparotomy was unavailable for 11 out of the 28 measures reported on.

Caring?

- A&E Friends and Family Test (% recommend) is consistently above the England average.
- The response rate for the friends and family test are higher than the England average.
- In the friends and family test the postnatal ward is the only area to score consistently below the England average

Responsive?

- The percentage of emergency admissions waiting 4-12 hours from the decision to admit to admission below the England average for 49 of the 65 weeks.
- Only one patient who had their operation cancelled was not treated within 28 days, Q1 13/14 to Q1 15/16
- The average length of stay for elective and non elective is lower than the England average
- Since Nov'14 the referral to treatment (RTT) percentage within 18 weeks non-admitted and incomplete pathways (IP) is better than the standard and better than/similar to the England average.
- The percentage of patients (all cancers) waiting less than 31 days and 62 days from urgent GP to first definitive treatment is higher than the England average
- Percentage of patients leaving the A&E department before being seen is regularly higher than the England average. Average total time in A&E is higher than the England average for 25 out of 30 months.

Summary of findings

- The trust was meeting the 90% standard for percentage of admitted patients treated within 18 weeks of referral (RTT) however it has fallen below the standard after Jun'15. Particular areas of non-compliance are urology and general surgery.
- The percentage of patients (all cancers) seen by a specialist within 2 weeks from urgent GP referral to first definitive treatment is lower than the England average but has shown improvement since Q3 14/15.
- This trust had a high proportion of people waiting 6+ weeks for diagnostic appointments, from May'15 to Aug'15, when compared to the England average.

Well Led?

- Data analysis indicated that the organisation flagged against the Intelligent Monitoring risk for staff turn-over (leavers) rates within nursing and midwifery.
- The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.
- The trust performed lower than the national average in some areas of the NHS staff survey including: percentage of staff working extra hours, the percentage of staff appraised within the last 12 months and the percentage of staff suffering work related stress in the last 12 months.
- The NHS staff survey indicated there was a higher proportion of staff reporting the experience of harassment, bullying or abuse in the last 12 months, compared to the national average. With a lower proportion of staff believing the trust provided equal opportunities for career progression or promotion, compared to the national average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust is rated as requires improvement for safety. We found examples of safe care in many of the services we inspected but urgent and emergency services, medical care, maternity and gynaecology, end of life care, outpatients and diagnostics and community adults services were rated as requires improvement. For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services. Incidents We found systems for reporting and learning from incidents across services. Staff were aware of how to report patient safety incidents and knew about the trust-wide electronic system for incident reporting. Staff stated they were encouraged to report incidents. Staff told us they received feedback on the incidents they had reported. The trust reported a lower number of incidents per 100 admissions compared to the England average. We were concerned that the incident reporting culture on the critical care unit was not proactive as we expected more than 69 reported incidents in a twelve month period (other similar sized units reported approximately 25-45 incidents each month). Duty of Candour The trust had promoted duty of candour and this was seen to be cascaded through the organisation. Staff were aware of the requirements of the duty of candour, including apologising and sharing the details and findings of any investigation. Senior nurses and managers told us that a duty of candour presentation and email was sent to all senior managers describing their responsibilities in this area. Infection prevention and control The environment in the majority ofareas we inspected was clean and complied with infection prevention and control guidance. The exception to this was where we observed some areas where there were insufficient checks and audits on cleanliness and infection control practices. Where infection control audits demonstrated areas to be lower than the trust standard of 99%, we saw evidence of actions to address this.	**Requires improvement** 

Summary of findings

Environment and Equipment

We found evidence within adult community services that staff did not always carry items deemed as essential. We noted of an audit of essential items to be carried by District Nurses (DNs) in November 2015, only three of 14 items that were classed as essential were being carried by all DNs audited. We were informed that some agency staff did not have some basic equipment.

Within the Child and Adolescent Mental Health Services (CAHMS) inpatient unit we observed some blind spots, and ligature points which had not been identified via local risk assessments.

We found evidence of equipment being checked on a daily basis across the organisation, with the exception of maternity services where this was variable.

Records

We observed a mixture of paper and electronic records in use across the organisation. Concerns around the use of temporary records were evident across some services including the Emergency Department (ED) and outpatients.

We reviewed a sample of patient records and found that they were mostly completed in a comprehensive, legible way.

Within outpatients we found inconsistencies in the storage of records. Patients' personally identifiable information was not always kept confidential.

Safeguarding

In line with statutory guidance the trust had named nurses, named doctors and safeguarding teams for child protection and safeguarding vulnerable adults. The Trust had policies and procedures in place in relation to safeguarding adults and children. Safeguarding was embedded as part of mandatory training and induction. Staff were confident in reporting concerns to the relevant teams. Staff were able to explain what constituted a safeguarding concern and the steps required for reporting on these concerns.

Use of the ‘five steps to safer surgery’ procedure

The trust had not fully implemented the five steps of the World Health Organisation (WHO) Surgical Safety Checklist. We found evidence of good compliance with the three compulsory elements: sign in, time out and sign out. We followed the patient pathway through a number of different surgical procedures in main theatres and the Day Surgery Unit. Most of the procedures we witnessed completed the checklist comprehensively.

Summary of findings

The surgery service audited WHO checklist compliance in September 2015 over a period of 6-8 weeks. The audit found good general compliance with completing the checklist across the service

Staffing

The trust had vacancies across all staff groups, but staffing levels in most clinical areas were maintained at a safe level with the use of bank, agency and locum staff. Where agency staff were used there was an induction programme to help them become familiar with the environment.

Nursing and midwifery staffing levels were reviewed and assessed using the National Safer Nursing Care Tool which conducted every six months. Staff felt that senior managers would listen to their concerns about staffing levels. Safe staffing levels were updated on a constant basis using a safe care e-system.

Areas where we found some specific staffing issues were adult community, children's community, the paediatric Emergency Department (ED) and theatre recovery. We saw evidence of the trust attempting strategies to attract difficult to recruit staff cohorts, for example though the use of pay increases for Health Visitors and rotating staff through challenged areas.

We observed the number of consultants within the ED did not meet the Royal College of Emergency Medicine standards or the London commissioning standards to provide 16 hours consultant cover daily in the ED. Junior doctors in training told us they had concerns about the cover overnight, when consultants were not immediately available.

Assessing and responding to patient risk

The number of ambulance handovers delayed by over 30 minutes during the winter period of November 2013 to March 2014 was one of the lowest in the country, and better than the expected standard.

Within the community setting, services maintained a local database detailing 'patients of concern', these patients were reviewed more regularly by DNs and reviewed by a service manager monthly. Where risks were higher and cases more complex, other services could be called upon.

We observed careful consideration and planning for new patients coming into Simmons House CAHMS service. The unit accepted patients detained under the Mental Health Act. The team considered whether they could safely manage a patient within the unit or whether there was a more appropriate service for them.

Summary of findings

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre.

Mandatory Training

The trust's corporate induction for a new staff was part of mandatory training. It included infection prevention and control, adult safeguarding, adult life support and resuscitation, fire safety, health and safety, duty of candour, mental capacity awareness and equality and diversity. This included two days of lectures and three days of shadowing in their assigned clinical area.

There were some areas of the trust where mandatory training was below the trust's benchmark of 90% compliance across a number of subject areas, with midwifery being an identified area below the target level.

Training in Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) was variable with some services demonstrating compliance, whist others such as adult end of life care and midwifery having proportions of staff not trained.

Safety thermometer

The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs).

We observed safety thermometer data displayed across the core services within the organisation, along with good performance for the months preceding our inspection. Maternity services were the exception where we found the service did collect this information but did but did not use the safety thermometer tool and the information was not visible on ward areas.

Medicines

Medicines including controlled drugs (CDs) were stored and managed appropriately in the majority of areas, however there were some areas where medicines management was poor, for example on Victoria Ward. Due the nature of this ward and the low levels of experience of many of the nursing staff, we found that practices and procedures were not always adhered to.

Within community children's services we observed that although checks showed medicines were stored at the correct temperature, the gauges used appeared to be incorrectly labelled. We were therefore not assured vaccines were always kept at an appropriate temperature.

Summary of findings

Restraint

Within CAHMS inpatient services staff used the PROACT-SCIP model of restraint. It aimed to support staff to identify patient triggers and recognise early behavioural indicators that could lead to challenging behaviour.

Are services at this trust effective?

Good

Overall we rated the effectiveness of the majority of services at the trust as good. Care was evidence-based and the majority of services participated in national and local audits. With the exception of community end of life care, which we rated as outstanding because we found the service provided outstanding, effective services to children, young people and their families.

Feedback from patients and families were positive about the care and resources available to across many of the services.

Within end of life care Lifeforce worked closely with UK charities to take into account the 'Together for Short Lives' eight priorities of care for children with life threatening and life limiting conditions.

Within community end of life services we observed excellent care in the home which provided the family and patients with comfort and reassurance. The team were able to review the patients needs to ensure they could continue with meeting their own particular wishes in the face of great difficulty.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Evidence based care and treatment

The trust's policies and treatment protocols were based on organisational guidelines from professional organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Staff were able to access guidelines on the intranet.

A central trust team was responsible for arranging an appropriate clinician to review new guidelines and for disseminating them when they were approved.

The ED had performed among the worst 25% of trusts in six of the eight standards in the RCEM Mental Health audit 2014-2015. The department introduced a revised mental health risk assessment form for doctors and nurses, which had improved documentation, but further progress was needed.

Patient outcomes

Summary of findings

The trust showed no evidence of risk against mortality rates, according to the Intelligent monitoring system.

The trust has mixed results in the national fractured neck of femur audit 2012 -2013. A multi-disciplinary group of staff from orthopaedics and ED worked to improve the outcome for these patients.

The number of day surgery cases was lower than the England average. Approximately 53% of surgery patients were day case. The trust was aware of this and was investigating ways to increase it.

Competent staff

DN compliance with clinical supervision was low. Documentation demonstrated that 10 of 65 were completed for the year. The DN professional development and quality lead indicated that clinical supervision was a 'work in progress.'

Appraisal rates across the organisation were variable, with some areas demonstrating highly trained and appraised staff, with other areas falling significantly below the internal target of 90% of staff having received an appraisals.

Multi-disciplinary working and coordinated care pathways

Multidisciplinary (MDT) working was embedded and effective across the trust. Staff spoke positively about MDT working and we found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.

In the ambulatory care unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly, physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.

Community teams told us they felt very integrated with the trust hospital services, GPs and nurses and we saw examples of services which had implemented shared assessments.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Mental capacity and DoLS training was completed alongside the training for adult safeguarding level two, and was captured as part of mandatory training. The majority of nursing and medical staff we spoke with demonstrated a good understanding of mental capacity and knew about the importance of assessments of people with mental health needs or learning disability.

We found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for

Summary of findings

surgery was in some cases being taken on the day of the procedure in the pre-operative admissions unit. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. This approach is suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.

Access to information

Staff in the ED and ambulatory care had access to electronic patient information. There was also access to the trust community health records.

Ward staff were able to access patient notes from a locked notes trolley to read and add relevant information. Staff with access to computer workstations were able to access test results electronically.

Within the adult community service staff had to navigate their way around a number of information systems belonging to different care providers, in order to integrate patient care.

Access to information was inconsistent between teams depending on whether staff had tablets, laptops, or paper records.

Are services at this trust caring?

Outstanding ☆

The trust is rated as outstanding overall for caring. Many of the services we inspected were rated as good, but community end of life care and community dental services were rated as outstanding.

Throughout the inspection and across the trust it was evident that care was patient-centred and staff treated patients with dignity and compassion. Patients we spoke with were positive about their experience and staff caring for them. The trust used a range of mechanisms to obtain feedback from patients including national surveys and the Family and Friends Test (FFT).

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Compassionate care

We found compassionate and respectful care was present in interactions we observed across both acute and community settings. The trust met the England average in the Friends and Family Test for Aug'15, however was consistently below the average before.

Summary of findings

Within children's community services people we spoke with praised the service they received. Some commented that the care was "life changing" either for them or their children.

In some hospital outpatients clinics we did not find that there was adequate provision to protect a patient's privacy and dignity. For example; not all outpatients departments had suitable rooms for private consultations. In the anti-coagulant clinic patients were seen in a room that was the administration and clinical staff office.

Understanding and involvement of patients and those close to them

Across the organisation staff demonstrated compassion, kindness and respect for the patients and families they worked with.

Patients and relatives told us that doctors and nurses in ED and ambulatory care explained what they were doing and consulted them about treatment. One patient told us she chose to come to Whittington hospital because medical and nursing staff listened to what she said and answered her questions.

In critical care staff took time to get to know the patients and their relatives and made sure patients were comfortable on the unit. Patients and their relatives were involved in decision-making and had opportunities to ask questions about care plans and prognosis. Relatives were encouraged to fill in patient diaries.

Emotional support

We observed an understanding of the emotional impact to the patient of their condition. Patients in the surgery service had access to clinical nurse specialists for cancer support and guidance. Nurses on wards and service leaders told us that the cancer nursing service had transformed the support provided for patients with cancer. The trust had received sponsorship from a local football team to deliver a wellbeing course for patients to participate in after their treatment. The trust also provided 'Hope courses' for patients to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.

There was a trust wide chaplaincy and spiritual support service available. There was no bereavement officer, their duties were performed by the mortuary clerical staff member. They were supported by the mortuary staff.

Are services at this trust responsive?

Overall we rated responsiveness of services at this trust as Good. Many of the services were rated as good with the exception of community health for children's, surgery, critical care, and outpatients. Community end of life care was rated as outstanding.

Good

Summary of findings

Patient flow through surgery and critical care was a significant issue. We heard that some patients remained in recovery area for long periods while waiting for an appropriate bed to become available, some staying in recovery overnight. We saw little evidence of local leadership in recognising and improving these issues.

Surgery wards were used as overflow wards for medical patients and there were considerable numbers of medical patients on surgical wards. This was a regular occurrence despite reorganisation of wards to allocate bigger wards to medical patients.

Within critical care the departmental risk register was sparse and did not reflect all risks we identified during our inspection. We were concerned there was a culture of underreporting incidents and near misses however senior staff did not recognise this.

We found that the trust did not monitor effectively discharge times and obstacles to patients' discharge to ensure prompt response and that patients died in their preferred location. Staff were not always aware of patient's wishes in regards to their 'preferred place of death' and did not always record this information. There was no formal rapid discharge pathway to ensure speedy discharge of patients who wished to die at home or another location.

We rated community end of life care as outstanding because patients and families were able to access 24 hour 7 day per week help and advice for end of life care. There was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the network MDT meetings. The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient needs. The team responded to families' needs with their ongoing bereavement work, Memory Day and annual party. The team demonstrated a flexibility of service provision and an attitude of going above and beyond to ensure the patients and families received the best service possible.

Planning and delivering services which meet people's needs

The trust's integrated care approach was designed to meet the wide-ranging needs of patients by providing a variety of services within the acute and community settings to meet the needs of different patient groups. The trust also stated that as an integrated care organisation they aimed to work closely with commissioners on integrated pathways.

Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, was a trust-wide

initiative providing person-centred hospital level treatment without the need for admission. Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or, if they do, making sure that their medical and social care needs are quickly assessed.

The nurses and doctors in children's services were highly complimentary about the hospital at home service developed by the trust.

We observed long waiting times in outpatient clinics, which resulted in patients complaining during the time of our inspection.

Meeting people's individual needs

We saw a strong focus on the patients' needs and preferences, and we saw many examples of person-centred care and treatment during our inspection. We found good use of interpreter services within medicine, however this was not as apparent in other areas such as CCU and outpatients.

In CCU staff we met were not aware of support processes for patients with a hearing impairment, learning disability, psychiatric needs or those living with dementia.

Meeting the needs of people in vulnerable circumstances

We observed services to be supportive of older patients they visited and understood the needs of working with this patient group.

Community dental services provided home visits for people who were unable to attend clinic. This included elderly patients with limited mobility and patients who had a physical disability that made it difficult for them to attend the clinic.

We observed that when looked after children moved out of area but were still within easy travelling distance, the Whittington NHS Trust kept them on their caseload instead of transferring care. This helped to ensure continuity of care for vulnerable children.

Access and flow

Healthwatch Haringey informed us of a long-standing concern about the functioning of the hospital's outpatient's appointment system. Patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult, with no facility to leave messages.

We observed that the surgical floor was well managed, at the front end of the patient experience, from admissions through theatres and into recovery. However, post-procedure flow from the recovery

area onto surgical wards was impacted by the limited availability of beds in surgical ward. The surgery service was focused on reducing length of stay for surgery patients by using enhanced recovery pathways.

The 'bed management and transfer policy' identified patients should be admitted to the critical care unit within one hour of the decision to admit being made and the hospital target was to admit 95% of critical care patients within this time frame. Hospital audit data from October 2015 demonstrated 97% of patients were admitted within one hour of the decision to admit to critical care being made and the remaining 3% were admitted within 2 hours.

However, when examining critical care documentation we found ten patients were discharged directly home between 7 October 2015 and 7 December 2015. Staff told us some patients waited for a ward bed for so long that they were ready to go home directly from critical care.

The percentage of patients admitted, transferred or discharged from ED within the national target of four hours was regularly above 95%, and was 94.4% in the six months to September 2015. This was better than the England average and indicated that there was an effective initial assessment.

In information the trust provided prior to our visit, they stated they had responded to an increased demand in a number of ways. In relation to emergency activity, there were a number of initiatives in place to reduce demand. They told us there was an ambulatory care unit in place that worked to prevent emergency admissions and redirected patients away from A&E, as well as other community-based initiatives to help keep people out of hospital.

Learning from complaints and concerns

Information shared with us from external stakeholders indicated concerns in relation to access to the PALS and complaints service, particularly for hearing impaired patients.

The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.

We found local leadership on complaints responses, whilst the trust complaints staff reviewed comments on NHS choices website and if there was dissatisfaction with the service they responded to the comment by giving details of how to contact PALS.

Summary of findings

Are services at this trust well-led?

Good

The trust is rated overall as Good for well led. Critical care and outpatients and diagnostics were rated as requires improvement, whilst community end of life care was rated as outstanding.

Within surgery we found clinical governance structures beyond incident reporting were not robust. Staff were not able to articulate a clear structure for the escalation of risks, clinical governance or performance information. A number of identified risks remained on corporate risk registers for a long time and were not addressed adequately or in a timely way.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Service vision and strategy

In 2015 the trust reorganised from three large divisions to seven smaller Integrated Clinical Service Units (ICSUs), led by a clinical director reporting directly to the Chief Executive. Staff of all grades and professions told us they welcomed this change because it had given clinical staff more control over developments in their service. The new ICSU enabled a focus on patient care, working across community services, ambulatory care, acute assessment and ED.

The trust's vision and values around providing integrated patient centred care were reflected by most of the staff that we spoke with and the trust values were included as part of the appraisal process.

We observed examples of strong local leadership, and services were able to articulate individual service strategies and plans, however not all services were able to produce business plans within each ICSU.

Governance, risk management and quality measurement

We found evidence of clear governance and risk management structures in place in the majority of areas, with regular patient safety meetings, monthly senior managers meetings and meetings of the risk board across both acute and community services. Local dashboards provided information on risks, targets, incidents, complaints and infection control. The general managers worked with the trust information team to check the reliability of data about performance. We noted that the Key Performance Indicators were more focused on acute services.

Risk registers were regularly updated and discussed during governance meetings. With the exception of surgery and critical care.

Leadership of this service

Summary of findings

Staff said they felt well supported in terms of training and development. Staff reported varied levels of visibility of the executive team across the community services.

The trust reorganisation had resulted in some uncertainty, but staff reported that the new ICSU had made the necessary change to systems without disruption to services.

Staff told us that they regularly saw divisional managers and clinical leads on the wards. The Director of Nursing, COO and Chief Executive were visible to staff on the wards.

Culture within the service

Senior managers told us they had been a clinically led integrated care organisation since 2011, which had a philosophy of 'local care for local people'. The culture of the trust was all about integrated care, with learning shared across the integrated ICSUs.

Staff felt informed by their local teams and the executive team about changes within the trust. They received newsletters and emails about any changes.

Many staff commented on the friendliness of the trust and the fact that everyone knew everyone else.

Ward nurses told us that Whittington Hospital was generally a very good place to work. There was recognition that ward staff worked hard, but understood their areas for improvement.

Innovation, improvement and sustainability

The trust set up the Ambulatory Care Centre after piloting a small service and engaging stakeholders internally and externally in planning its development. The service was well known nationally for its innovative approach to providing hospital level care without the need for patients staying overnight.

The Michael Palin Centre was able to rely on a high amount of research from Australia. The Centre for the study of such children is located at the Faculty of Health Sciences at the University of Sydney.

Whittington Health worked well to avoid patients needing to attend. As part of the drive to keep patients out of hospital, the integrated pathways respiratory team has developed a new model across acute, community and primary care. The CORE team is led by two integrated consultants working with respiratory nurse specialists, physiotherapists, clinical psychologies, stop smoking advisors and an integrated specialist registrar.

Overview of ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within this unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust-wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses', for patients who had undergone cancer treatment, to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.
- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the Great Ormond Street MDT.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve
We saw areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments improve storage of records and ensure patients' personally identifiable information is kept confidential.
- Within acute outpatient departments improve disposal of confidential waste bags left in reception areas overnight.
- Within surgery review local strategy for consent for surgery processes to follow best practice, to allow patients to have a 'cooling off' period in advance of their surgery, should they wish to reconsider their procedure.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care there were significant issues with the flow of patients out of critical care which meant 20% of patient bed days were attributed to level 1 and level 0 patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care review governance processes and local ownership of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areas, for both patients and staff.
- Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There was routinely insufficient staff presence when cases were conducted, and failure to formally agree for adequate cover by recovery nurses from main theatres meant pregnant women and their families were left without visible staff presence.
- Within palliative care the trust did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks

RAG key:
Green = Complete
Amber = In progress (on target)
Red = Overdue

CQC Action Plan July 2016 (Inspection December 2015)
Actions developed from the Final CQC Inspection reports of 'must dos', 'should dos' and 'could dos'

Ref	CQC Recommendation	ICSU	Must Do*	Trust Actions	Sources of Assurance / Monitoring group	Responsible Lead(s)	Expected Completion Date	Status (RAG)	Progress / Comments	Evidence	Closed Date
1	Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are approriately placed within the correct specialsim and enhance hospital flow.	Trustwide	Y*	Launch TICKED programme to improve discharge planning [T- TTAs and Transport; I - Inform NOK; C - Confirm Care package and Section 5; K - keys; E - Equipment; D - Dressed, Discharge letter and District Nurses]	Evidence of TICKED posters on wards, discussions at team meetings Ongoing monitoring - Reduction in number of delayed discharges and Length of Stay /TMG	Heads of Nursing	01/04/16	Complete	11/7/16: Relaunch of TICKED as part of pre-11 discharge campaign. TICKED campaign launched. Ongoing work to reduce delayed discharges and improve bed capacity	Communications on TICKED campagin Ongoing monitoring via performance reports	04/04/2016
		Trustwide	Y*	Launch Pre-11 discharge campaign trustwide	Evidence of pre-11 discharge communication trustwide Ongoing monitoring -Reduction in number of delayed discharges and length of stay/ Monitoring number of discharges pre-11, Performance targets set / TMG and Performance meetings	Chief Operating Officer/ Heads of Nursing	01/06/16	Complete	Pre-11 discharge campaign launched. Trustwide communications and monitored via TMG.	Communications on pre-discharge campaign Performance targets set for ongoing monitoring	30/06/2016
		Trustwide	Y*	Develop and Implement Acute Admitted and Emergency Pathway Improvement Plan (see detailed improvement plan)	Completion of action plan Reduction in Length of Stay / Monitored via weekly Length of Stay reduction meeting chaired by Chief Operating Officer.	Chief Operating Officer/ Heads of Nursing	01/10/16		11/8/16: Weekly reviews of improvement plan ongoing - see plan for details. 12/7/16: Improvement Plan in place, monitored weekly		
2	Within the ED there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum doctors, which poses a risk to delivery of care and training staff	EUC	Y*	Develop business case for ED consultant cover	Final business case	Clinical Director, EUC	01/05/16	Complete	Business case agreed at TMG in May 2016. Approved at Trust Board 1st June 2016. Implementation plan in place, recruitment underway.	Final business case approved at TMG and Trust Board 1st June 2016	01/06/2016
		EUC	Y*	Recruit to vacant ED consultant posts	Job Descriptions agreed, Jobs advertised, Consultants in post / TMG	Clinical Director, EUC	01/07/18		12/8/16: Job advertisement to go out 15/8/16, first round of interviews planned for end-September. Full recruitment process expected to take 18mths - 2 years		
3	Within acute outpatient departments improve storage of records and ensure pateints' personally identifiable information is kept confidential	Outpatients	Y*	Develop and implement Trustwide Health Records Improvement Plan (see detailed improvement plan)	Completion of implementation plan / Health Records Assurance Group	Ops Director, PPP	31/12/16		12/8/16: Improvement Plan revised at Health Records Quality Assurance Group in July.		
		Outpatients	Y*	Purchase lockable trolleys for patient notes in all outpatient clinics (4C and 4D and 1B)	Confirmation of lockable trolleys delivered (Spot check in outpatients to confirm in use)	Ops Director, PPP	30/09/16		8/8/16: Lockable trolleys delivered to 1B. Ordered for Paeds and Maternity. Expected delivery date end Sept, Once delivered, close. (Expected completion date revised to end Sept) 11/7/16: Lockable trolleys delivered to all outpatient clinics except 4C, 4D and 1B. Locakable trolleys ordered for 4C (currently stored at manned reception desk)	Spot check audit in February showed good knowledge of IG issues and patient confidentiality.	
4	Within acute outpatient departments improve disposal of confidential waste bags left in reception areas overnight.	Outpatients	Y*	Review process for storing confidential waste bags in outpatient clinics: At night confidential waste bags to be locked in a secure room.	Evidence of change in practice (spot check reports) / monitor via Health Records Group	Ops Director, PPP	01/05/16	Complete	Spot-check audit completed in February, positive results.	Spot-check audit in February - all staff aware of process for locking away notes at night and not leaving unattended at desk	30/05/2016
5	Within surgery review local strategy for consent for surgery processes to follow best practice, to allow patients to have a 'cooling off' period in advance of their surgery, should they wish to reconsider their procedure	S&C	Y*	Review surgery consent processes to ensure best practice; audit to monitor compliance.	Audit of consent practice/ ICSU S&C	Clinical Director, S&C	30/10/16 (For Detailed Improvement Plan)		22/8/16: Discussed at TMG, Clinical Director agreed to support with process. 1/8/16: Clinical Director meeting with surgical leads and Director of Ops to review current procedures and agree changes to allow a 'cooling off' period for patients. Full review and action plan to be developed by end September.		
6	Within surgery and theratres review bed capacity to ensure patients are not staying in recovery beds overnight	S&C	Y*	As above - Trustwide actions around bed capacity and patient flow (pre-11 discharge and TICKED)	as above	Chief Operating Officer/ Heads of Nursing	01/10/16				
7	Within critical care there were significant issues with the flow of patients out of critical care which meant 20% of patient bed days were attributed to level 1 and level 0	S&C	Y*	As above - Trustwide actions around bed capacity and patient flow (pre-11 discharge and TICKED)	as above	Chief Operating Officer/ Heads of Nursing	01/10/16				

	patients who should have been cared for in a general ward environment. This led to mixed sex accomodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit	S&C	Y*	All L1 patients on Critical Care are deemed as mixed sex breaches as there is only one unisex patient bathroom. Report all L1 patients as incidents on DATIX and investigate to ensure correct procedure followed. Report on all breaches to be presented to TMG monthly and CQRG.	Monthly reports / TMG	CCU Matron	31/12/16		13/7/16: CCU reporting on DATIX any patients with delayed discharge and mixed sex breach		
		S&C	Y*	Review CCU Step Down policy (part of Bed Management Policy)	CCU step-down policy review/ TMG	Chief Operating Officer/ Heads of Nursing	30/09/16		8/8/16: Bed management policy currently under review.		
		S&C	Y*	Undertake investigations for all patients with delayed discharge in CCU to understand reason for delay and areas to improve practice. Review numbers of incidents reported and findings of investigations in Q3.	Investigation reports and completed action plans. Review of incidents and reports for Q3 / CCU governance group	Head of Nursing S&C	31/12/16		13/7/16: CCU reporting on DATIX any patients with delayed discharge and mixed sex breach		
8	Within critical care review governance processes and local ownership of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting to be promoted	S&C	Y*	Revise DATIX incident reporting and risk management system to improve reporting and learning	New DATIX in operation Ongoing monitoring of staff feedback on DATIX and # in incidents reported	Head of Integrated Risk	01/06/16	Complete	DATIX go-live 6th June 2016	New DATIX in place	01/06/2016
		S&C	Y*	Further training for all CCU staff on incident reporting	Staff attendance Increase in incidents reported / S&C ICSU Board	Head of Integrated Risk	12/09/16	Complete	1/8/16: Evidence of increase in incidents reported. Review numbers of incidents reported in Aug, if increase maintained, close. 26/7/16: Training provided for staff on 26/7 and 28/7 on risk register and incident reporting. 12/7/16: All delayed discharges over 4 hours now reported on DATIX	Attendance sheet for training Email to staff showing increase in incidents reported.	25/08/2016
		S&C	Y*	Further training for senior CCU staff on managing risk registers and carrying out risk assessments	Staff attendance evidence of CCU risk assessments and discussion at team meetings / S&C ICSU Board	Head of Integrated Risk	12/09/16	Complete	26/7/16: Training provided for staff on 26/7 and 28/7 on risk register and incident reporting.	Attendance sheet for training. August Highlights email focused on Risk Assessment. Minutes of ICSU governance meetings discussing risk	25/08/2016
9	Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately	S&C	Y*	Review security measures on CCU and remind staff of importance of challenging visitors	Staff meeting minutes, email reminders to staff Spot check findings / ICSU S&C	Head of Nursing S&C	15/07/16	Complete	18/7/16: Posters added to door 'You are now entering a clinical area, please report to the nurse in charge', doorbell, handset and camera fixed. Complete. 12/7/16: CCU door now locked 24/7, reminders to all staff. Work in progress to repair camera, upgrade doorbells and replace the handset at the nurses station (to be completed by 15/7/16)	Monthly checklist	18/07/2016
10	Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areass, for both patients and staff	WFS	Y*	Add posters with safety thermometer information to all maternity wards (update monthly)	Posters in place / Women's services ICSU	Head of Midwifery	15/08/16	Complete	21/7/16: Maternity Safety Thermometer started from March 2016. Data to be displayed from August.	Maternity Safety Thermometer information displayed	18/08/2016
11	Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There was routinely insufficient staff presence when cases were conducted, and failure to formally agree for adequate cover by recovery nurses from main theatres meant pregnant women and their families were left without visible staff presence	WFS	Y*	Review staffing model: Recruit additional nurses for theatre area and promote Enhanced Recovery Programme for women undergoing elective procedures	Recruitment of theatre nurses / Women's services ICSU	Clinical Director, WS	31/10/16		1/9/16: Maternity recruitment day planned for 16th September 2016 26/7/16: Maternity scrub nurse recruitment in progress. No successful applicants in first round of recruitment. Position re-advertised, date revised until end Oct for recruitment.		
12	Within palliative care the trust did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultants working at the hospital	IM	Y*	Develop business case for long term Palliative Care provision to meet national standards	Final business case / TMG	Clinical Director IM	01/06/16	Complete	Business case agreed at TMG on 21 June 2016. Implementation plan to be developed.	Final business case approved at TMG	30/06/2016
		IM	Y*	Develop and complete implementation plan for business case	Evidence of implementation plan completed (palliative care requirements met) / TMG	Clinical Director IM	01/12/16		10/8/16: Update from AK, discussion with UCLH to progress clinical collaborative working and they are working up a proposal for us. They anticipate being able to cover 7 day on call by November when Anna Korouska retires.		
13	Within palliative care services staff were not always aware of patient's wishes in regard to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of death'.	IM	Y*	Carry out audit of patient notes to identify areas for improvement in recording. Develop action plan to address non-compliance.	Completed action plan and positive re-audit results / IM ICSU	Head of Nursing Inpatient	30/10/16		1/9/16: Process for recording and updating information on 'preferred place of death' currently under review by Lead Nurse for palliative care.		
14	At Simmons House: Improve ligature risk assessments and the identification of associated risks	CYP : Simmons House	Y*	Revise ligature risk policy	Ligature risk policy disseminated to Simmons House staff / CYP ICSU	Health and Safety Manager	30/09/16		8/8/16: Policy discussed with Carol Gillen, revised date for completion end Sept. 8/7/16: Draft ligature risk policy under consultation.		

		CYP : Simmons House	Y*	Ensure all actions identified from October ligature risk assessment audit of Simmons House have been completed.	Completed action plans	Clinical Lead Simmons House	30/09/16		3/8/16: Revised date from end July to end Sept, due to annual leave and unexpected time off (broken ankle). Action plans in progress, awaiting evidence of completion then close. 11/7/16: SH noted that a sample of ligature risk assessment audit reports were sent to CQC pre-inspection, as well as summary report outlining Simmons House observation policy. However not all action plans had been completed. Health and Safety to review and confirm all actions completed in line with October assessment on 15/7/16		
		CYP : Simmons House	Y*	Complete ligature risk assessments of any areas missed in October audit in Simmons House and complete any required actions.	Re-audit of risk assessments following completion of actions / CYP ICSU	Health and Safety Manager	30/09/16		10/8/16: Sheelagh Holmes on sick leave, deadline extended to end Sept. 15/7/16: James Ward attended Simmons House for ligature risk assessment. (see email) actions to be completed as above. Health and Safety to attend Simmons House on 15/7/16		
15	**Requirement Notice *:** At Simmons House: Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and devices must be kept in full working order. They should be available when needed and within a reasonable time without posing a risk.	CYP : Simmons House	Y*	Specific issues raised by CQC: 1) Problems identified with emergency bag. a)Weekly emegency equipment check not robust. The records of checks lacked detail and did not state what items had been checked. Action: Review weekly check process with Resus team to ensure safety. B) No label on emergency bag. Action: Ensure emergency bag is clearly labelled. c) Emergency bag only contained one single patient adult sized manual resuscitator, no paediatric size available. Action: keep paediatric size resus mask in emergency bag d) Only one set of pads for use with defribrillator, spare pads should be available in case of equipment failure. Action: keep spare pads in emergency bag.	Confirmation from Resus team of safe equipment review process for emergency bag, and correct equipment in place.	Clinical Lead Simmons House	15/07/16	Complete	11/7/16: Whittington Health Resuscitation team reviewed weekly checklist process and confirmed safe practice. Emergency bag now clearly labelled. Paediatric mask ordered, (however, 13 year olds use adult masks, paediatric mask only required for 13 year old with unusually small skull). Extra defribillator pads ordered.	Spot check observations at Simmons House	11/07/2016
		CYP : Simmons House	Y*	2) Blood pressure machines only had adult sized cuffs. Action: Ensure child size cuffs available for use with BP machines	Evidence of child size cuffs available	Clinical Lead Simmons House		Complete	11/7/16Child size cuffs now in use. ordered after inspection.	Child size cuffs available	11/07/2016
		CYP : Simmons House	Y*	3) Two pulse oximeters, used to measure the amount oxygen in the patient's blood, were available but the calibration dates were missing on one of them. Action: Both oximters to have valid callibration dates	Evidence of callibration	Clinical Lead Simmons House	15/07/16	Complete	10/8/16: Simmons House confirmed oximeter ready for collection from Medical Devices on 11/8/16. Close. 11/7/16: Only the oximter with valid callibration date is currently in use. Second oximeter to be sent to medical physics for callibration on 15/7/16	Equipment callibrated, in date	10/08/2016
		CYP : Simmons House	Y*	4) The calibration sticker was absent on the alcohol measuring meter. Action: Ensure valid callibration sticker on alcohol measuring meter.	Evidence of callibration	Clinical Lead Simmons House	15/07/16	Complete	11/7/16: Alcohol measuring meter now callibrated.	Equipment callibrated, in date	11/07/2016
		CYP : Simmons House	Y*	5) There was incorrect calibration of the blood glucose monitoring machine. The wrong code had been inputted into the machine. Action: Ensure correct callibration used on blood glucose monitoring machine.	Evidence of callibration	Clinical Lead Simmons House	n/a	Complete	11/7/16: blood glucose machine was highlighted on the day of the inspection and problem rectified immediately.	Correct callibration	31/12/2015
16	**Requirement Notice *:** At Simmons House: Oxygen cylinders were stored on top of a tall cupboard in the clinic room. There was no footstool available. As a result there was a risk to peole because lifesaving equipment was not easily accessible in an emergency situation.	CYP : Simmons House	Y*	Review of oxygen cyclinder storage at Simmons House to ensure easily accessible to all staff in an emergency.	Oxygen stored in correct place	Clinical Lead Simmons House	n/a	Complete	Simmons House confirmed that two oxygen cylinders on site - one on a low shelf and one hanging on the back of the door. This is where the oxygen was when CQC visited. Decommissioned oxygen cyclinder had been stored on top of shelf. This was highlighted on the day and the decommissioned oxygen cyclinder removed.	confirmation of correct storage of oxygen cylinders	31/12/2015
17	**Requirement Notice *:** We found examples where HCAs were authorised to administer insulin following competency sign off which was not patient specific and not delegated appropriately by a nurse, or the prescriber with specific instructions about which patients the HCAs can administer insulin to. Specific staff are required to be authorised to administer to specific patients only.	Community Adult	Y*	Trust policy states that HCA competency for insulin administration is patient specific. Audit to be completed of District Nursing service to confirm which patients HCAs have been competency assessed to visit, identify any gaps, and provide competency assessments as needed.	Audit findings and action plan, copy of SOP/ DN Forum	Lead District Nurse	15/08/16	Complete, awaiting evidence then close.	2/8/16: Audit completed. Very few instances of HCA administering to patients not assessed to see, these have now been addressed. All HCAs now have insulin competencies reassessed every six months according to SOP. 11/7/16: Communication sent to all DNs and HCAs regarding policy on HCA insulin administraiton		

18	A process should be put in place to ensure cylinders for inhalation sedation are not past the expiry date, as we found one cylinder of nitrous oxide at Holloway Community Health Centre that was out of date	Community Dental		Add a check of the gas cylinders (re expiry date and labelling) to the clinic monthly checklist	monthly checklist / Dental Team meetings	Clinical Lead Community Dental	01/04/16	Complete	See Dental CQC Action Plan	Monthly checklist	01/04/2016
		Community Dental		Pre - Sedation checklist on EPR (Custom Screen) will specify expiry date check of gases to be used at each appointment	EPR screen, KPI or audit of screen checklist completion / Dental Team meetings	Clinical Lead Community Dental	26/07/16	Complete	See Dental CQC Action Plan	Screen shot	26/07/2016
		Community Dental		Email all staff regarding actions	Email to staff	Clinical Lead Community Dental	27/07/16	Complete	See Dental CQC Action Plan	Email to staff	08/08/2016
19	The provider should ensure that patient risk assessments and management plans are reviewed and updated following risk incidents. (CAMHS and Simmons House)	CYP: Community		Review processes for updating risk assessments and risk management plans across CAMHS servivces to ensure best practice. 1. Case note audit of CAMHS to ensure risk management plans updated in line with policy 2. Arms length review of Simmons House using CQNIC standards. (Full CQUIN Assessment of Simmons House in Feb 2017)	Audit/ Review reports and completion of any actions/ CYP ICSU	Head of Nursing CYP	15/10/16		12/8/16: Case note audit in progress across CAMHS including risk documentation		
20	At Simmons House: The provider should ensure that there are thorough weekly checks of emergency equipment and what is checked is clearly documented.	CYP : Simmons House		See Requirement Notice Action Action: Review weekly check process with Resus team to ensure safety.	See Requirement Notice Action	Clinical Lead Simmons House	15/07/16	Complete	See Requirement Notice Action	See Requirement Notice Action	11/07/2016
21	At Simmons House: The provider should ensure emergency equipment is calibrated properly to make sure it is fit for purpose.	CYP : Simmons House		See Requirement Notice Action Action: Ensure all emergency equipment is calibrated and fit for purpose	See Requirement Notice Action	Clinical Lead Simmons House	15/07/16	Complete	See Requirement Notice Action	See Requirement Notice Action	11/07/2016
22	The trust **could** provide administrative staff at the locations that did not have any, as dentists and nurses had to undertake administrative tasks and sometimes this caused problems.	Community Dental		To undertake survey of staff in clinics regarding key administrative tasks requiring support	Survey/ Dental team meetings	Clinical Lead Community Dental	12/08/2016 - Survey collection 15/9/16 - Survey report	Survey in progress	9/8/16: Andrew Read update- survey in progress, report on findings expected early September		
		Community Dental		Incorporate findings in refining admin responsibilities between clinics / central office / community reception for period 1/10/16 – 30/3/17	Mobilisation plan/ Dental team meetings	Clinical Lead Community Dental	15/09/16				
		Community Dental		Incorporate findings into mobilisation plan for new CDS contract from 1/4/17	Mobilisation plan/ Dental team meetings	Clinical Lead Community Dental	01/04/17				
23	The trust **could** seek to address patient transport issues, as patients were sometimes late for appointments or had to wait a long time to be collected after their appointment.	Community Dental		Dental Service to agree standards around patient transport to improve service for patients and monitor performance	Standards agreed/ Dental team meetings	Clinical Lead Community Dental	15/09/16		9/8/16: Andrew Read update - Meeting arranged with Tim Howitt, but unable to attend, meeting to be rescheduled. However staff feedback indicates improvements with transport issues recently. Date revised from August to September due to annual leave.		
24	Ensure that at the Holloway physiotherapist team base, there is a medicines management standard operating procedure and a control and audit trail of medicines	Community Adult		Update all PGDs	Signed copies of PGDs available to Holloway Centre staff/ Drugs and Therapeutic Committee	Clinical Director, CSS	15/07/16	Complete	11/7/16: Physiotheraphy PGDs updated and signed off by Drugs and Therapeutic Committee and available on intranet under MSK CATS		11/07/2016
		Community Adult		Establish drug log at each delivery site to monitor audit trail of medicines	Drug logs / MSK team meetings	Clinical Director, CSS	n/a	Complete	Clinical Assessment and Treatment Service (CATS) set up the drugs log from 1 April 2016.	Copies of Drug logs	01/04/2016
		Community Adult		Develop Medicines Management SOP for MSK	SOP approved/ Drugs and Therapeutics Committee	Clinical Director, CSS	31/08/16	Complete	12/8/16: SOP for Ordering Stock Medication for Holloway MSK service, Medication Stock List and Stock Medication Delivery Time-table SOP for Room Temperature Monitoring (where medication is kept), Temperature Log Sheet Audit of ordering arangements, correct storage and record keeping will be done periodically to ensure medication is continued to be ordered and stored in an appropriate way. 12/7/16: Draft Injection policy out for consultation. Meds Management SOP to be	Copies of SOPs and policy	25/08/2016
25	Ensure that agency nurses have the basic equipment such as glucometers and sticks and the basic equipment to carry out tasks such as take blood pressure readings. (District Nursing)	Community Adult		Full review of DN equipment requirements and resources to be completed to ensure adequate supplies	DN equipment checklist, audit or spot checks of equipment bags / DN Forum	Lead District Nurse			10/8/16: Discuss with Greg Battle, consider using GP Bulletin to highlight message to GPs on need to order sticks for patients. 11/7/16: a) glucometers sourced and in stock - complete. B) GPs asked to order sticks for patients to keep in homes, process needs to be reviewed.		
26	Ensure that district nurses are aware of the trust's dress code policy.	Community Adult		Review and update Dress Code policy	Approved policy on intranet / Partnership Group	Deputy Director of Workforce	15/09/16		25/8/16: Dress code policy not approved at TMG, recommendation to review existing infection control and smoking policies to ensure key aspects of dress code policy are incorporated. Revised date from end August to September. 12/8/16: To be ratified at TMG on 23/8/16. 20/7/16: Approved at Partnership Group on 14/7/16		

		Community Adult		Re-audit compliance with guidance on dress code and work directly with individuals who are non-compliant to improve practice	Findings of re-audit and completed action plan / DN Forum	Lead District Nurse	31/07/16	Complete but awaiting evidence to close	11/7/16: Reaudit completed, audit format amended to enable results to be broken down by individual. Findings to be disseminated via DN Forum and action taken to address areas of non-compliance.		
27	Ensure that infection control issues raised by the use of computer tablets by staff are subject to infection prevention and control procedure or direction. (DN team not decontaminating between patients; Respiratory team patients signed tablet leading to heightend infection control risk)	Community Adult		Infection Control Team to review current practice and advise on best practice. Advice to be circulated to staff and guidance developed, if appropriate.	Guidance for DN staff on cleaning of tablets (Email, minutes of meeting, infection control policies) Availability of detergent wipes.	DIPC (Designated Infection Prevention and Control)	31/10/16		31/8/16: IPCC team confirmed detergent wipes now included in daily DN back packs for cleaning tablets. Basic cleaning and decontamination policy applies, no requirement to change policy. DN service to provide evidence this guidance has been disseminated to staff, then close. 11/8/16: Infection control discussed at IPCC meeting on 26/7/16, detailed action plan to be agreed on 22/9/16 27/7/16: Advice on iPads from Patricia Folan provided to DN service 'The IPADs should be cleaned with a detergent wipe between patients if they have had contact with the pad. If no contact just regular cleaning. '		
28	Ensure that infection control issues raised by a dog that regularly visited a health centre is subject to infection prevention and control procedure or direction. (CRT team base)	Community Adult		Infection Control Team to review current practice and advise on best practice; no dogs to be permitted on community site.	Infection Control response circulated to staff - no dogs permitted on site, except assistance dogs / IPC Committee	DIPC (Designated Infection Prevention and Control)	31/10/16		31/8/16: Dog no longer permitted on site. Staff to keep manager informed if individual (non-Whittington staff) attempts to bring dog on site. No further issues reported. DN service to provide evidence this guidance has been disseminated to staff, then close. 11/8/16: Infection control discussed at IPCC meeting on 26/7/16, detailed action plan to be agreed on 22/9/16		
29	Ensure that the reported lack of training and competency around PICC lines and midlines for intravenous drug administration, are considered in the district nurses training needs analysis.	Community Adult		IV study day includes an introduction to PICC/Midline. Staff who administer intravenous medication must have attended the study or demonstrate competency if coming from another organisation. All Intravenous drugs in the community are administered via PICC or Midlines and database reveals that there is a good spread of competency across all teams. In addition to existing training the service will get all IV competent staff to attend the 1.5hrs PICC line specific in-house training. Action: Review database to ensure a suitable number of nurses have PICC training across service and add line to Training Needs Analysis	PICC training database/ DN Forum	Lead District Nurse	20/07/16	Complete	20/7/16: Database illustrates suffiicent number of nurses trained. Line added to TNA.	See email and copy of database	20/07/2016
30	Ensure that compliance with clinical supervision is improved, specifically in district nursing and sexual health services.	Community Adult / WFS		Improvement plan for clinical supervision to be developed and implemented. DN service - Poor supervision compliance linked to vacancy rates and the demands of patient care; expect the situation to improve as more team leaders move into post between July and September	Compliance with clinical supervision policy/ DN Forum and WFS ICSU Board	Clinical Director PPP and WS	15/09/16		1/8/16: Clinical supervision linked to vacancy rates in DN service. Improvement plan in development.		
31	Trust and trust nursing leadership should be more visible in the community in order to better understand the pressures and challenges of the community staff	Community Adult		Trust Nursing Leadership and Executives to attend staff meetings and Patient Safety Huddles in the community. Review attendance of nursing leadership and Execs at community meetings in Q2.	Trust leadership attendance at staff meetings and Patient Safety Huddles.	Clinical Director PPP	31/10/16		10/8/16: DON attended huddle with Simmons House 3/8/16: DON attended Crouch End for CQC briefing; CEO attended Hornsey Street (Islington DN Twilight Team) for CQC briefing; Deputy CEO attended River Place (SE and SW Islington DN team) for CQC briefing 26/7/16: CEOe attended Patient Safety Huddle with DN Team.	Summary of PSH with DN and Simmons House	

32	Paper notes must be reconciled with electronic records to ensure that all staff are enabled to see all pertinent and important information about a child or family	CYP: Community	Y	Implement OpenRiO Store and Forward (IM&T Improvement Plan and CIP) which will provide remote access to view and update patient records in the community Implement Health Visiting Worforce Plan (workstream on mobile working)	Introduction of OpenRiO Store and Forward	Director of IM&T	31/12/16		11/8/16: GW update - software issues identified following last weekend's upgrade. Patch-testing weekend of 13/14 August, Plan for roll out to being in Sept, full roll-out by Dec16. 11/7/16: IM&T Improvement Plan presented to TMG on 21/6/16 outlining plans to introduce Store and Forward Haringey Health Visiting team provided with 4G laptops rather than ipads to improve access to records.		
33	The management of vaccine storage during transit must be improved to ensure optimum temperature control (School Nursing)	CYP: Community	Y	Provide training and guidance for staff on cold-chain and transporting of vaccines to schools. Audit to monitor compliance.	training presentation and attendance, spot check reports/ ICSU CYP	Children's Services Lead	11/8//2016	Complete	11/8/16: Additional training provided, spot checks an dunannounced visits carried out to ensure compliance. Audit to be carried out in october.	Checklists, powerpoint presentation, staff attendance sheet (Further assurance from October audit)	11/08/2016
34	Enhanced procedures for checking expiry dates of drugs must be implemented as some vaccines were found to be past their expiry date	CYP: Community	Y	Immediate audit undertaken of all HV fridges to check expiry dates.	Positive audit report / ICSU CYP	Children's Services Lead	31/12/15	Complete	Audit completed at time of inspection	Audit of all fridges undertaken 11/12 – compliant	31/12/2015
		CYP: Community	Y	Review fridge monitoring process across Trust to ensure vaccines expiry dates are routinely checked 1. Fridge monitoring checklist revised to include section on expired drugs 2. Re-circulate guidelines to staff	Ongoing monitoring / ICSU CYP	Children's Services Lead	29/02/16	Complete	Action plan following fridge audit set up ongoing monitoring and audit process. 'expiry date for drugs' to fridge temperature added to monitoring sheet, clear guidelines on process circulated to staff.	Action plan and guidelines	27/01/2016
35	Out of date policies must be updated to ensure that best evidence is applied to care in all cases.	CYP: Community	Y	Review all outdated policies trustwide. Add standing agenda item to PAG for monthly status update.	Evidence of policies in date. Monthly review of database. Minutes of PAG.	Compliance Manager	31/07/16	Complete	Policies and SOPs monitored centrally.	Status report presented to Quality Committee 13/7/16	13/07/2016
36	The locations we visited did not have separate cleaning equipment for different areas and this should be addressed. (e.g. Areas did not use different coloured mops and buckets for cleaning toilets and clinical areas to minimise cross infection)	CYP: Community		Health Centre managers to ensure colour coded cleaning in operation and carry out spot checks to ensure compliance with standards (Areas visited by CQC - St Ann's Hospital, Bounds Green Health Centre, Northern Health Centre. Highbury Grange Health Centre, Hunter Street Health Centre and Kentish Town Health Centre)	Guidance for staff on colour coding and Spot checks by Health Centre Managers (confirmation via email)	Health Centre Managers CYP	31/08/16		16/8/16: Guidance available for staff on colour coding of cleaning equipment. Email confirmation that Health Centre managers have checked colour coding being followed in practice - Bounds Green, Stuart Crescent, Edwards Drive	Poster on colour coding guidance Confirmation emails (spot checks from Health Centre Managers)	
37	Haringey immunisations records were not synchronised with the community health service computer system and this should be addressed	CYP: Community		This is a Child Health Information Service issue which has been escalated to NHS England and Servelec, IT system provider. Actions to address this form part of Exit Strategy Action Plan for the new CHIS provider, managed by NHS England.	Completion of Exit Strategy Action Plan / NHS England	External - NHS England Internal - Children's Services Lead	External target from NHS England				
38	The care environment and facilities in various parts of the service should be improved, as they did not always meet the needs of children, with many pieces of equipment being worn and tired.	CYP: Community		*NB: No specific locations were mentioned in CQC report (Areas visited included St Anne's Hospital, Bounds Green Health Centre, Northern Health Centre, Highbury Grange Health Centre, Hunter Street Health Centre and Kentish Town Health Centre)* Estates and Facilities to undertake review of environment and equipment at the above sites and identify any improvement actions required	Estates Strategy / Health and Safety Committee, TMG	Interim Lead for Estates and Facilities and Director of Strategy	30/09/16		NB: Once review completed, update to reflect any improvement actions required		
39	The service should look to improve waiting times for children with autistic spectrum disorder and attention deficit hyperactivity disorder referrals.	CYP: Community		Waiting times relate to BEH Mental Health Trust, however Trust to develop and implement Autism Pathway Improvement Plan	completion of improvement plan / ICSU CSS	Clinical Lead, CSS	01/04/17		1/9/16: Improvement Plan in place, monitored by Clinical Director (waiting times relate to BEH so not under control of Trust)		
40	The service should implement routine cleaning checks (most locations did not have cleaning checks in place, with exception of Northern Health Centre)	CYP: Community		Implement regular cleaning checks and undertake quality audits at children's community centres (Areas visited by CQC - St Anne's Hospital, Bounds Green Health Centre, Highbury Grange Health Centre, Hunter Street Health Centre and Kentish Town Health Centre)	Evidence of cleaning schedule and quality audits / Health Centre Managers (ICSU PPP)	Head of Nursing, CYP	31/08/16		16/8/16: Evidence of cleaning checks received from Cordant contract areas - Bounds Green, Stuart Crescent, Edwards Drive, Crouch End, Lansdowne.		

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September 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**16/118**	**Paper**	**03**
Action requested:	For Information		
Executive Summary:	This paper is a combined report covering June and July as the Trust Board did not meet in August 2016. This combined report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) from 1st June to 31st July 2016. This includes SI reports completed during this timescale in addition to examples of 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:	30/08/2016		

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) between 1st June and 31st July 2016. This is a combined report for June and July as the Trust Board did not meet in August 2016.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also examples of 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, high risk incidents are reviewed by the panel 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 3 serious incidents during June and 3 during July 2016 bringing the total of reportable serious incidents to 16 since 1st April 2016.

The Trust has no overdue SI investigations.

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
Safeguarding Incident Ref:13782	May 16	Safeguarding incident in relation to a patient on a current caseload.
Unexpected Admission to NICU-Baby Ref: 17074	June 16	Admission of term baby to the neonatal unit following a category 1 emergency caesarean section.
Information Governance Breach Ref: 17076	June 16	Confidential information inappropriately sent out in group email list.
Safe Guarding Incident Ref: 17313	June 16	Safeguarding allegation in relation to an inpatient.
Unexpected Death Ref: 17767	July 16	Patient with Venous Thromboembolism (VTE) subsequently developed a Pulmonary Embolism (PE).
Slip/Trips/ Fall Ref: 19498	July 16	Unwitnessed patient falls resulting in 2 fractures.
Delay in sourcing a Tier 4 bed for child. Ref: 19479	July 16	A Young person with mental health needs had a prolonged stay in ED due to a lack of available Tier 4 beds across the system.

3.3. **The table below details serious incidents by category reported to the NEL CSU. The Trust reported 6 serious incidents from 1st June to 31st July 2016.**

STEIS 2016-17 Category	Apr	May	June	July	Total
Safeguarding	0	1	1	0	2
Confidential information leak/loss/Information governance breach	1	2	1	0	4
Diagnostic Incident including delay	2	1	0	0	3
Failure to source a tier 4 bed for a child	0	0	0	1	1
Maternity/Obstetric incident mother and baby (includes foetus/neonate/infant)	1	1	1	0	3
Slip/Trips/Falls	0	0	0	1	1
Unexpected death	0	1	0	1	2
Total	4	6	3	**3**	**16**

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. The panel discuss lessons learnt and appropriate action, both immediate if applicable, and planned, to prevent future harm occurances.

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, what has been learnt and what steps are being put in place . 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 investigations completed and submitted between 1st June and 31st July 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, Obstetrics and other departments. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 **The Trust submitted 12 reports to NELCSU between 1st June and 31st July 2016.**

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation reports submitted between 1st June and 31st July 2016.

Summary	Actions taken as result of lessons learnt
• **Ref:9747**	**Information Governance Breach** Two reports were inadvertently placed in incorrectly labelled envelopes. • Systems reviewed and redesigned to reduce the recurrence of an error occurring in the administrative process when sending out reports.
• **Ref: 12430**	**Information Governance Breach** Two discharge letters inadvertently placed in one envelope. • The importance of information governance is being highlighted in all services. All managers are and will promote extra vigilance when handling any patient identifiable records. This will be communicated through a message of the week system.
• **Ref: 12432**	**Information Governance Breach** Incorrect discharge summary sent to patient. • Persons assisting with duties involving any confidential patient information are required to complete the Trust Information Governance training prior to undertaking such duties.

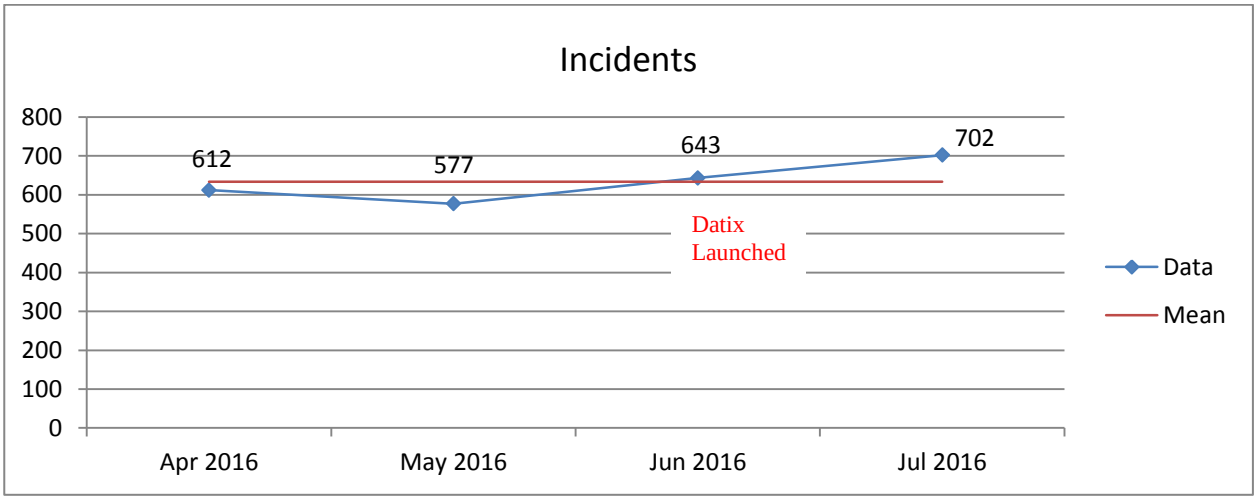
Summary	Actions taken as result of lessons learnt
• **Ref: 10345**	**Delayed Diagnosis** Delay in diagnosis resulting in delayed intervention A standard operating policy designed and implemented.
• **Ref: 11071**	**Delayed Diagnosis** Chest X-ray abnormal results not followed-up**.** • Options being explored to ensure all x-rays and other imaging tests are reported formally in a timely manner.
• **Ref: 11789**	**Intrauterine Death** Intrauterine death diagnosed by ultrasound scan. • The scan referral pathway in the antenatal clinic is being reviewed and systems put in place to prevent reoccurrence of such incidents including implementing a 'paper light' proocess.

5. 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. Incident Reporting

The chart below indicates a gradual increase in the number of all incidents including SIs reported since the new Datix system has been launched across the Trust on 1st June 2016.



7. 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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Whittington Health NHS

The Whittington Hospital NHS Trust

Whittington Health Trust Board

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September 2016

Title:	Safe Staffing - Nursing and Midwifery – July data		
Agenda item:	**16/119**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in July 2016. Key issues to note include: • All areas reported greater than 90 per cent 'actual' versus 'planned' staffing levels. • Three 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 from June (304) to July (273) • Nine shifts initially triggered 'Red' in July compared to none in June.		
Summary of recommendations:	Trust Board members are asked to note the July 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:	August 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 July 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 – 30th July 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 July 2016. The average fill rate was 91.7% % for registered staff and 98.0% for care staff during the day and 90.7% for registered staff and 116.8 % for care staff during the night.

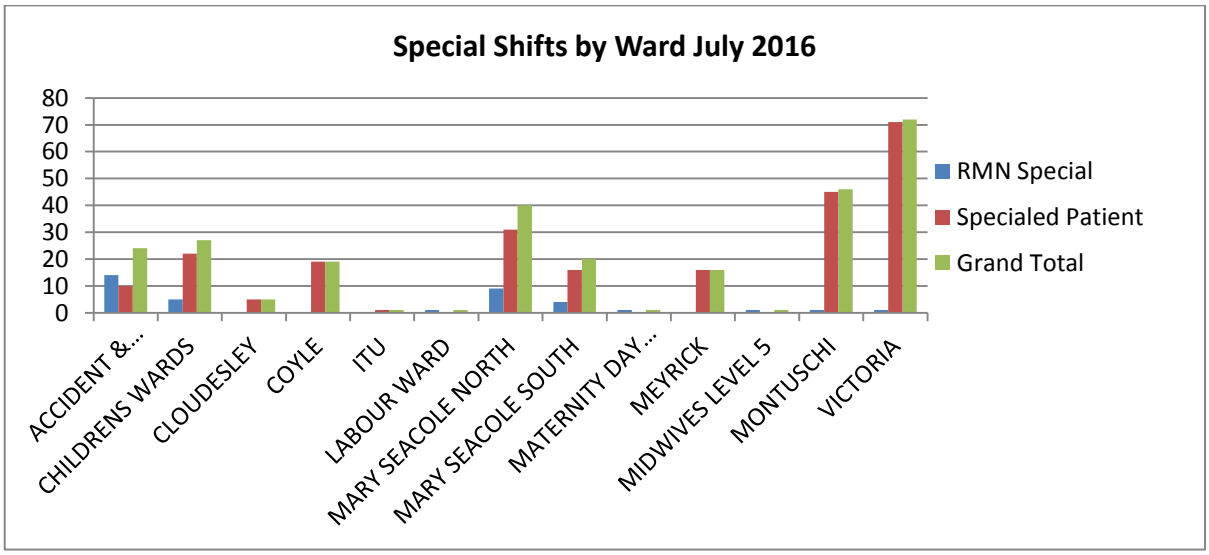
3.4 Eight wards reported below 95% fill rates for qualified nurses but were managed safely by moving staff from other green RAG rated areas and with support from matrons and practice development nurses. Above 100% fill rates occurred in three areas where nurses were required to care for patients who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

4.0 Additional Staff (Specials 1:1)

4.1 When comparing July's total requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease in the number of shifts used (Appendix 2). July saw 273 requests for 1:1 specials compared to 304 requests in June. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients.

4.2 The number of Registered Mental Health Nurse (RMN) 'specials' booked to care for patients with a mental health condition was lower in July (37) compared to June (84). All requests for RMNs are validated by the relevant Head of Nursing and a clinical assessment made as to the therapeutic need. Following review, it is on occasion appropriate to downgrade the request to HCA rather than RMN.

4.2 There continues to be a high level of need for specialing patients. A breakdown of the shifts worked clearly identifies of the 273 shifts used, 154 were booked using Bank Staff. The 119 shifts which could not be filled using Bank staff were filled by agency staff.



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.

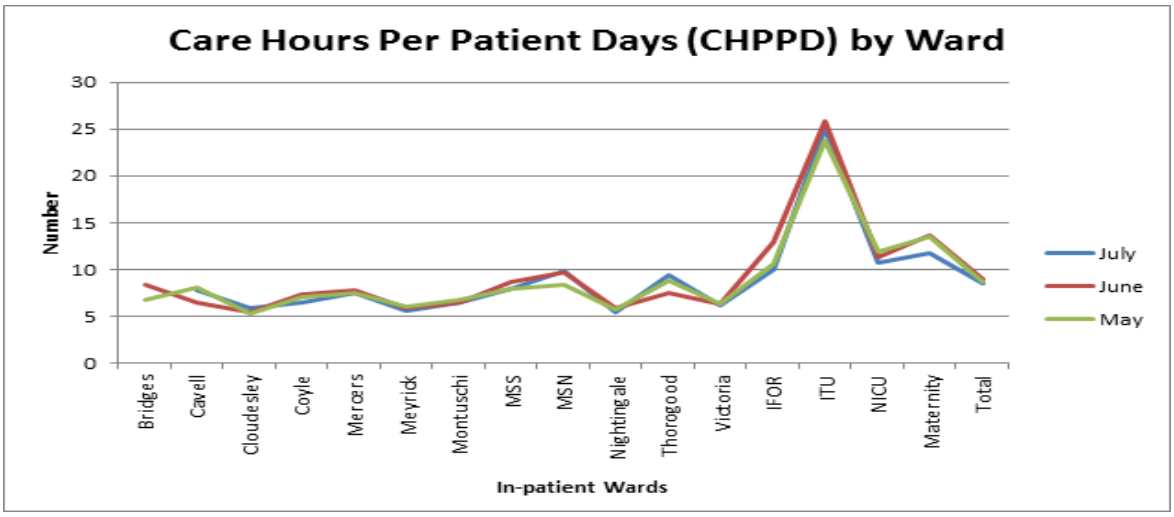
5.3 Red Shifts

In July, the number of shifts initially triggering 'red' was 9 from of a total of 1395 shifts compared to June where no shifts triggered red.

Month	% shifts triggering red in month	Actual number of red shifts
July 16	0.65	9
June 16	0	0
May 16	0.3	4
April 16	0.1	1
March 16	1.2	18
February 16	2.1	29
January 16	0.8	12

6.0 Care Hours per Patient Day (CHPPD)

6.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is automatically calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight.



6.2 The graph above shows the average individual care hours per patient for each clinical area. ITU have the most care hours (25.81) and Cloudesley ward have the least (5.51).

6.3 The overall average number of hours of Registered Nurse time spent with patients is calculated at 6.38 hours and 2.14 hours for care staff. This gives an overall average of 8.52 hours of care hours per patient day

	CHPPD
Registered Nurse	6.38
Care Staff	2.14
Overall hours	8.52

7.0 Conclusion

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

Fill rate data - summary
July 2016

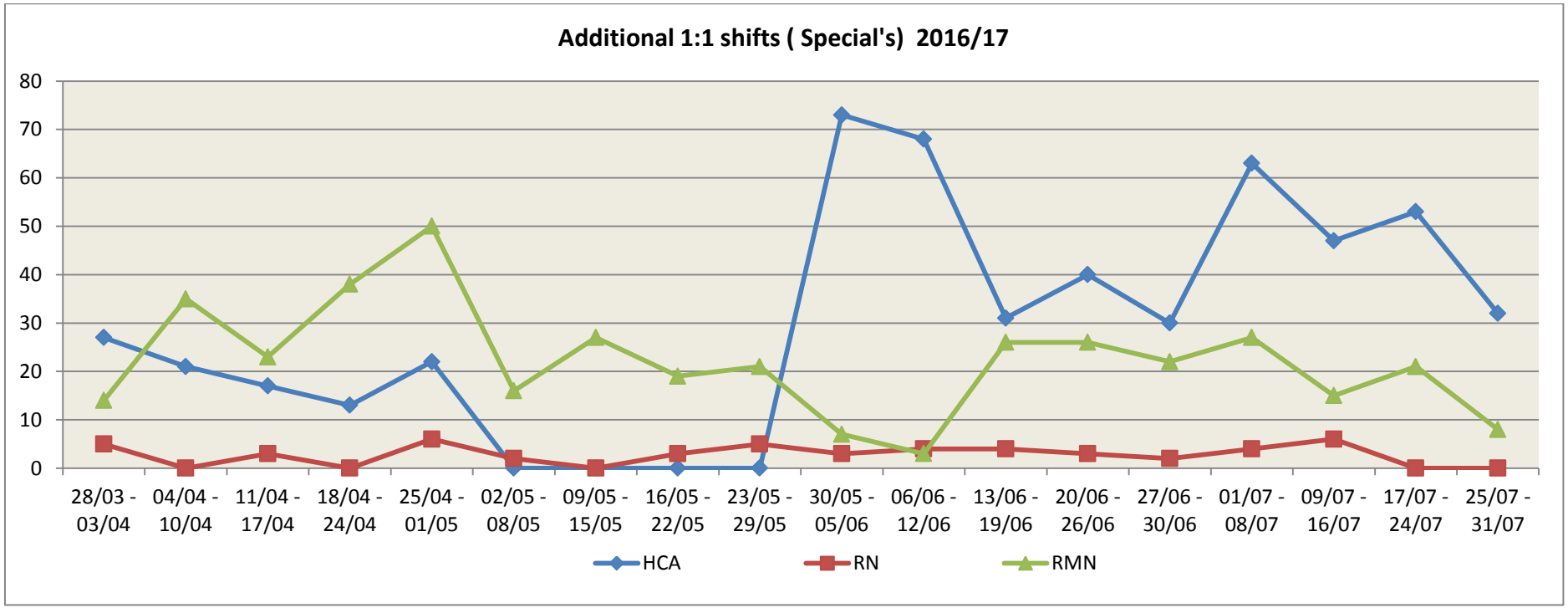
Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual				
34402 Hours	31558 Hours	10388 Hours	10185 Hours	28453 Hours	25808 Hours	7722 Hours	9021 Hours	91.7%	98.0%	90.7%	116.8%

Care Hours per Patient Day

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8989	6.38	2.14	8.52

Appendix 2

July 2016



Whittington Health

Trust Board

7th September 2016

Title:	**Quarterly Safety and Quality Board Report**		
Agenda item:	**16/120**		**05**
Action requested:	For the Board to note, discuss and make any additional recommendations		
Executive Summary:	This is the regular quarterly paper for the Trust Board giving an overview of safety and quality in the organisation.		
Summary of recommendations:	It is recommended that the contents are noted and discussed		
Fit with WH strategy:	To deliver consistent high quality, safe services.		
Reference to related / other documents:	Quality Account 2015-16 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards		
Date paper completed:	1st September 2016		

Author name and title:		**Richard Jennings, Executive Medical Director** **Dr Julie Andrews, Associate Medical Director (**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

1) Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.

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

2) Contents

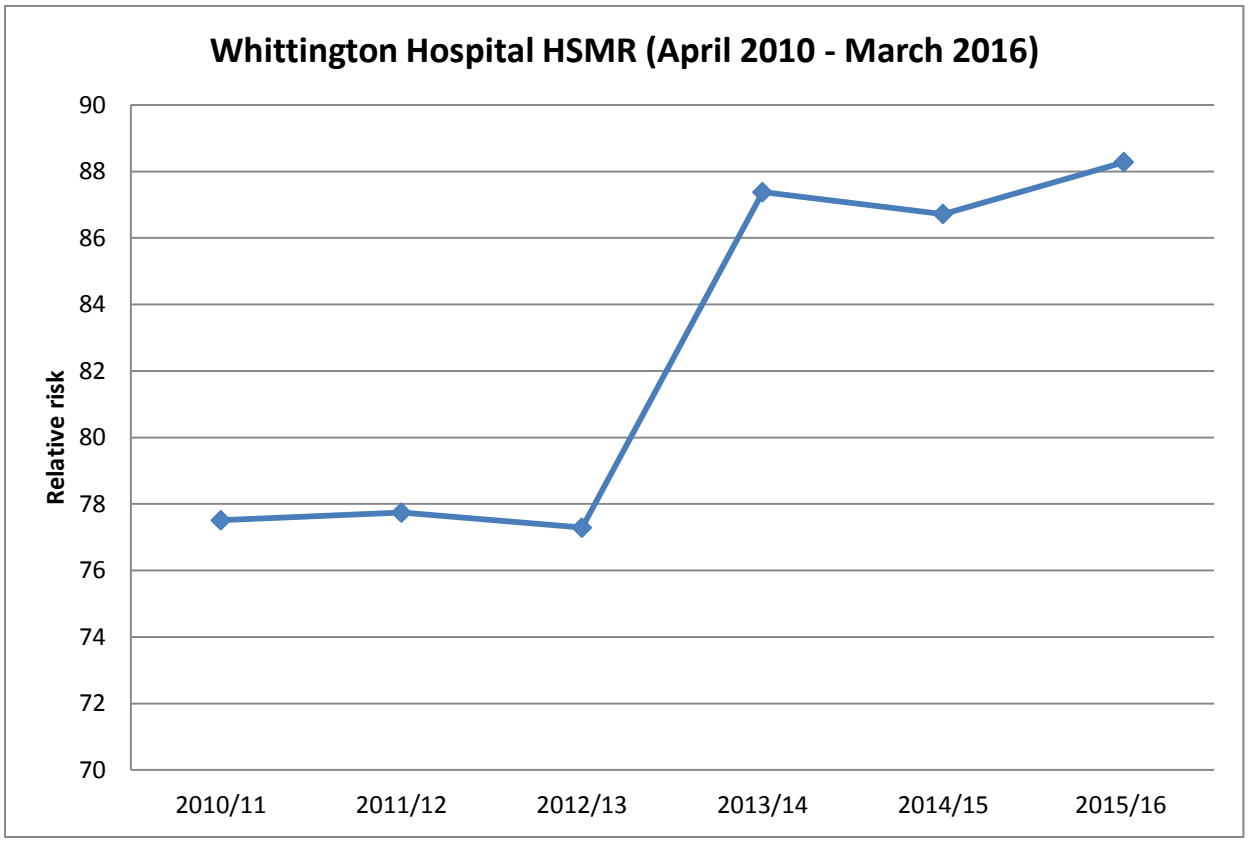
3. Mortality

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

3.1 Hospital Standardised Mortality Ratio (HSMR)

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

Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2010 – March 2016)



3.2 Summary Hospital-level Mortality Indicator (SHMI)

Summary Hospital Mortality Indicator (SHMI)

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

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

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

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

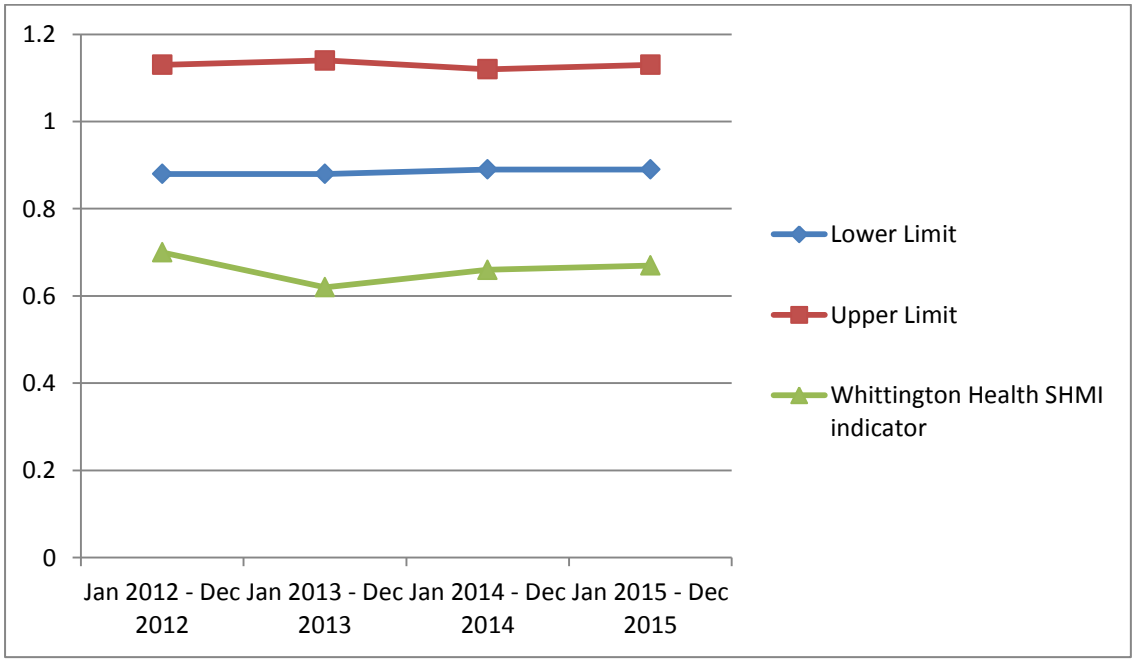
The most recent data available (released in June 2016) covers the period January 2015 to December 2015:

Whittington Health SHMI score	**0.688**
National standard	**1.00**
Lowest national score	**0.6688 (Whittington Health)**
Highest national score	**1.1731**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (April 2010 – December 2015)

Data Period	Lower Limit	Upper Limit	Whittington Health SHMI indicator
Jan 2012 - Dec 2012	0.88	1.13	0.7
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.6
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) by calendar year (January 2012 – December 2015)



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

4. Infection control report

4.1 MRSA Bacteraemia

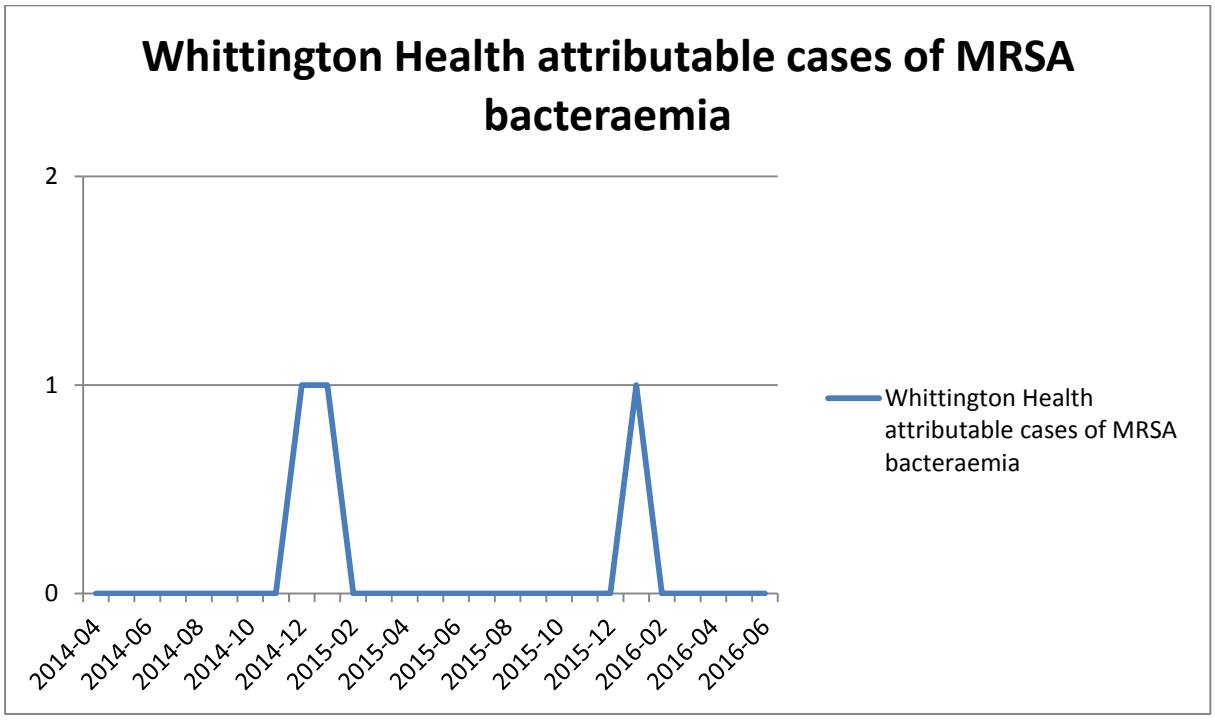
From the 1st April 2016 to the 26th August 2016 there were no incidences of Trust-attributable MRSA bacteraemia. There was one unavoidable MRSA bacteraemia, which was identified from a community sample and subsequently investigated by Islington CCG and the post infection review was shared with the Trust Infection Prevention and Control Team (IPCT).

The IPCT continue to monitor, investigate and feedback on MRSA colonisation transmission events on our care of older people (COOP) wards, Orthopaedic ward and Augmented Care Areas (Critical Care and Neonatal Unit). The following table documents MRSA colonisation acquisition events:

Table 2: Whittington Health MRSA acquisition April 2016- June 2016 (no Trust-attributable cases)

Number of patients with MRSA acquisition April 2016 to March 2017				
	April	May	June	**Total**
ITU	0	1	0	**1**
NICU	0	0	0	**0**
SCBU	0	0	0	**0**
Meyrick	0	0	1	**1**
Cloudesley	1	2	0	**3**
Cavell	0	0	0	**0**
Coyle #NOF	0	0	0	**0**

Chart 3: Whittington Health attributable cases of MRSA bacteraemia by month (April 2014 – June 2016)



4.2 *Clostridium difficile*–associated diarrhoea

From 1st April 2016 to the 26th August 2016 there were five **T**rust-attributable *Clostridium difficile*-associated diarrhoea cases. Consultant-led post infection reviews were held for all of these cases and the reports disseminated to relevant parties, both internally and externally. No lapses in care were identified, but these have identified delays in isolating patients to individual rooms. Our agreed objective for 2016/2017 is not to exceed a threshold of 17 cases of *Clostridium difficile*-associated diarrhoea.

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

Date	No. of Cases	Ward
April 2016	2	Montuschi and Victoria
May 2016	1	Coyle
June 2016	1	Cloudesley
July 2016	1	Victoria

Improvement work

Single use/easy to decontaminate monitoring equipment has now been introduced to side rooms on designated wards to reduce the risk of cross-contamination. Ten isolation trolleys have also been delivered and initial feedback from staff on Meyrick Ward has been positive. Three respirator hoods have also been delivered and fit testing of masks and the hoods was undertaken on the 21st April 2016.

Education sessions, specifically on *Clostridium difficile* continue on all wards. In conjunction with the Visible Leadership Team, objective structured clinical examination (OSCEs) will be reintroduced to all ward.

An enhanced *Clostridium difficile* test request form has been finalised on the Trust's Sunquest ICE system to reduce the chances of staff incorrectly requesting tests.

A more detailed review of *Clostridium difficile* cases is presented twice a year to the Infection Prevention & Control Committee.

4.3 Meticillin Sensitive Staphylococcus Aureus (MSSA)/ *E.coli* Bacteraemia Episodes

Between 1st April 2016 to 26th August 2016 there were two **T**rust-attributable MSSA bacteraemia episodes and three Trust-attributable *E.coli* bacteraemia episodes. There are no set Trust thresholds for these organisms.

Each episode is investigated to see if any interventions (such as urinary catheterisation or peripheral line cannulation) have occurred and, if so, whether all the correct procedures were followed.

4.4 Other Relevant Healthcare Associated Infection (HCAI) Issues - Carbapenamase producing Enterobacteriaceae (CPE)

Public Health England (PHE) issued guidance on the identification and control of CPE (highly resistant Gram negative bacteria). As a result of this the Trust devised an action plan, which is monitored by the Infection Prevention &Control Committee. All actions have been completed.

The Trust has processes in place to deal with a single case of CPE and a completed policy, which is available on the Trust's intranet.

Infection prevention and control talks have been updated to include information on CPE.

Since the 1st April 2016 there have been two new confirmed CPE cases found in the Whittington Health laboratory, one in May and one in June. Both of these cases were identified from community samples.

Between April and June 2016 the Infection Prevention and Control Team performed an audit of CPE screening by reviewing all patients admitted with a fractured neck of femur between October and December 2015 to ensure there is a record that they have been reviewed using the CPE questions and, if found to be a suspected case, screened appropriately. 32 patients were admitted and underwent repair of a fractured neck of femur. Of these, 87% (28) were asked the CPE questions. Only one required screening but unfortunately was not screened.

This audit is going to be repeated and results will be available by the end of September 2016. This audit will be presented to the Infection Prevention & Control Committee.

5. Sign up to Safety

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

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

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

Table 4: Whittington Health 'Sign up to safety' priorities and quality improvement priorities

Sign up to safety priority	Quality improvement priorities (as agreed in the Trust's Quality Account for 2015/16)
Priority one: Learning Disabilities (LD) • Target one: In Q4, 90 percent of inpatients with learning disabilities will be clearly identified on the electronic patient record, meet the Learning Disabilities Specialist Nurse during their admission and have a personalised care plan ('my purple folder') • Target two: In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with learning disabilities	**Learning disabilities: Quality Improvement priorities for 2016/17** • We will develop and implement 'Always Events' for patients with Learning Disabilities in a relevant clinical setting. We will aim for 75 percent of inpatients with learning disabilities to meet the Learning Disability specialist nurse during their admission. • We will aim for 75 percent of relevant staff who work in our Emergency Department to have specific training in the care of patients with Learning Disabilities.
Priority two: Falls • Target: We will reduce the number of inpatient falls that result in moderate or severe harm by 50 percent	**Falls: Quality Improvement priorities for 2016/17** • We will reduce the number of inpatient falls that result in severe/moderate harm by 25 percent.
Priority three: Sepsis and Acute Kidney Injury (AKI) • Target one: We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis (90 percent). • Target two: We will effectively record our performance in delivering the sepsis six care bundles for all patients with sepsis. We will improve our performance by 50 percent in the course of the year. • Target three: In more than 90% of patients with Acute kidney injury (stage 3) we will ensure correct documentation and assessment has occurred in line with the national AKI CQUIN.	**Sepsis and Acute Kidney Injury (AKI): Quality Improvement priorities for 2016/17** • We will achieve the targets of the new and expanded national sepsis CQUIN in 2016/17
Priority four: Pressure ulcers • Target one: We will have no avoidable grade four pressure ulcers • Target two: We will reduce the number of	**Pressure ulcers: Quality Improvement priorities for 2016/17** • We will implement our 'React to Red' pressure ulcer prevention campaign

avoidable grade three pressure ulcers in the acute setting by 50 percent and we will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent	• We will have no avoidable grade four pressure ulcers. • We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25 percent. • We will reduce the number of avoidable grade three pressure ulcers in the community by 25 percent.

Quarterly Sign up to Safety focussed report; sepsis

Introduction

Sepsis is diagnosed in approximately 100,000 patients in NHS England each year and is responsible for an estimated 37,000 deaths annually, including 1,000 paediatric deaths. Recognising sepsis early and commencing "sepsis 6" interventions rapidly, as well as escalating treatment plans for those with severe sepsis, is paramount in attempting to reduce these mortality figures.

Early recognition and rapid management of sepsis is a key patient safety objective for Whittington Health and monitored through our local Trust 'Sign up to Safety' priorities and the Trust's quality priorities for 2016/17. In addition, it is also a national CQUIN.

Sepsis Group (Team Sepsis)

Whittington Health has had an active multi-disciplinary sepsis group for the past 2 years, co-led by Dr Julie Andrews (Consultant Microbiologist) and Dr Sarah Gillis (Consultant in Critical Care Medicine). The objective of the group is to monitor and amend practice using Plan-Do-Study-Act (PDSA) methodology with the aim of improving outcomes for patients with sepsis. The focus of the group is on continued audit and feedback, delivering relevant short educational sessions and ensuring equipment and resources are reviewed and available for all relevant staff. A key priority of this group has been to improve recognition of sepsis by our community staff, GP's and London Ambulance Service staff.

The Trust supported the employment of a 0.5 WTE lead sepsis nurse in February 2016 and this role has been fundamental to sustaining the improvements demonstrated below. In August 2015 six junior doctor "sepsis leads" joined the Team Sepsis in a novel quality improvement project; their support has also been invaluable.

Sepsis CQUIN and the 'Sign up to Safety' performance data

Around 50 patients a month at the Trust are diagnosed with sepsis /severe sepsis, with 80% being diagnosed on admission and another 20% being diagnosed during their admission. The majority are adults with one to two paediatric sepsis cases diagnosed per month. Patients are all entered onto a bespoke local Whittington sepsis database, which has been created by reviewing sepsis pathway audit data, sepsis coding, critical care outreach referrals, and blood culture data. The gold standard is that each patient with observations compatible with a diagnosis of sepsis has a "sepsis pathway" completed and entered into

their notes. This sepsis pathway outlines the correct management steps required each and every time for all patients with sepsis, the so called “sepsis 6” care bundle consisting of fluids, antibiotics, lactate, urine output measurement, oxygen and blood cultures, all to be done within the first hour of presentation.

With severe sepsis a delay of an hour in giving antimicrobials is estimated to increase mortality by 7%, so this intervention is specifically measured by the national CQUIN. This CQUIN was further extended in 2016/17 to include the diagnosis and management of sepsis amongst inpatients and a 72 hour review of antimicrobials for all patients. The summary of this data is shown in the tables and graphs below.

Table 5: Whittington Health performance against the sepsis national CQUIN

	Percentage of patients finally diagnosed with sepsis with completed sepsis pathways in notes	**Percentage of patients with sepsis 6 care bundle completed within the hour from diagnosis**	**Percentage of patients with severe sepsis receiving antimicrobials within 60 minutes of arrival to hospital (and have a 72 hour antimicrobials review from 2016/17)**	**Percentage of patients with severe sepsis diagnosed within hospital receiving antimicrobials within 90 minutes of diagnosis**
CQUIN objective	>90%	n/a	>90%	>90%
Sign up for safety objective	n/a	n/a	>90%	>90%
Quality account objective	>90%	n/a	>90%	>90%
Internal objective	>90%	>90%	>90%	>90%
Q2 2013/14	n/a	37%	28%	n/a
Q2 2014/15	n/a	42%	41%	n/a
Q1 2015/16	46.0%	66%	55%	n/a
Q2 2015/16	46.9%	68%	59.4%	n/a
Q3 2015/16	45.6%	72%	67.4%	n/a
Q4 2015/16	63%	80%	78.2%	n/a
Q1 2016/17	66%	82%	82.2%	83%

As table 5 shows, there has been a steady and sustained improvement since the Sepsis Group was formed. However, there are still significant improvements required to ensure the correct use of the sepsis pathway. This will be achieved by continued weekly feedback to clinical staff, particularly in the emergency department, and by on-going internal education.

Sepsis Benchmarking

Table 5: Benchmark data for the percentage of patients with severe sepsis receiving antimicrobials within 60 minutes (January – March 2016)

Benchmark area	Percentage of patients with severe sepsis receiving antimicrobials within 60 minutes (Quarter 4 2015/16)
NHS England	68%
London	74%
Whittington Health	78.2%

Whittington Health had the lowest sepsis mortality SHMI value (0.339) in England for period January 2015-31st December 2015. Other trusts in the top 5 included UCLH, Guy's and St Thomas', East Cheshire and Basildon NHS Trust.

Local sepsis improvements

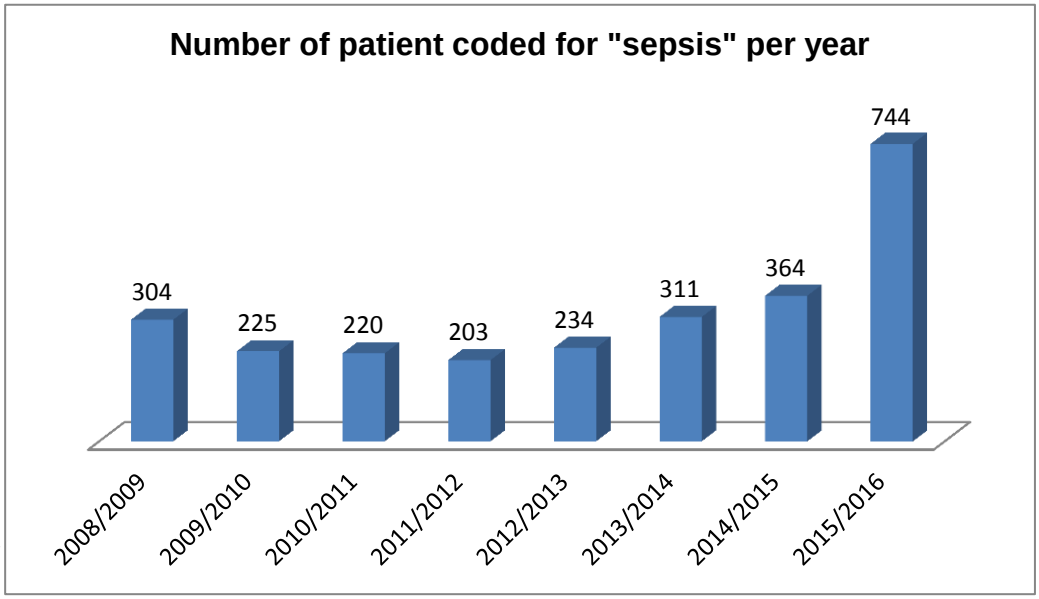
The Trust's average length of stay has reduced for patients with severe sepsis from **11.3** days average length of stay in Quarter 2 of 2015/16 to **9.4** days in Quarter 1 of 2016/17.

The number of patients being diagnosed with sepsis before arrival at hospital (by our community teams, GP's, London Ambulance Service or our triage teams) has increased from 8% in Quarter 1 of 2015/16 to 50% in Quarter 1 of 2016/17.

There were three Serious Incidents (SIs) relating to the delayed recognition/escalation of sepsis in 2015/16. There has been no reported SIs relating to the delayed recognition/escalation of sepsis between April and August 2016.

There have also been improvements the number of patients with sepsis who are now being coded for sepsis, as chart 7 shows.

Chart 4: Number of Whittington Health patients coded for sepsis (April 2008 – March 2016)



Sharing of improvements

Team Sepsis is part of the UCLP sepsis quality improvement project and has benefitted from the support provided by this network.

The team has been asked to present at the NHS England Sepsis Improvement Meeting, an acute medicine conference in September 2016 and a national sepsis conference in October 2016.

The team has given three Trust Grand Round presentations this year, numerous additional medical and nursing teaching sessions and developed one of our patient SI investigations into an interactive “moodle” education package and a community learning event.

Other governance issues regarding sepsis

There has been a recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, a National Institute for Health and Care Excellence (NICE) publication and a central patient safety alert on sepsis recognition and management. Our current management of sepsis is compliant with all the aspects outlined in these apart from two aspects. One aspect is patient information and we will have an approved sepsis patient information leaflet by end of October 2016. The Trust is currently not recording all specialty team attendances and are therefore not able to evidence that we meet the requirement for attendance by a consultant (either from Acute Medicine, ITU or the Emergency Department) within an hour for any patient with a diagnosis of sepsis who fails to improve within an hour of therapy commencing.

Requirements for continued and sustained improvements

- On-going weekly feedback to our Emergency Department and other key areas to improve use of sepsis pathways and interventions with continued short education sessions including simulation.
- On-going Trust financial support for the lead sepsis nurse position; this was approved as a one year fixed-term trial post in February 2016 and will need to be reviewed before February 2017.
- Additional Trust support for 0.2 WTE administrator for Team Sepsis. This support is required to ensure access medical notes and to add relevant data to the sepsis database.
- On-going project support from the CQUIN team. This has been limited in 2015/16 but we are having meetings to secure 0.1WTE/week project support.
- On-going commitment from new junior doctor leads in sepsis; six new junior doctor lead starters have signed up for 2016/17. Nursing and AHP sepsis champions have also been secured for 2016/17**.** Support from learning/education teams and the Director of Postgraduate Medical Education (Dr Maria Barnard) have been established.
- Formal recognition through job planning of the work of the two sepsis co-leads, estimated 1 programmed activity (PA) of work (4 hours) per week.
- Continued involvement in national and local networking groups to provide team with support and advice.

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

Moodle

Whittington Moodle is our new Clinical Learning website. This is currently being used in the Emergency Department for a variety of learning purposes. There are several areas on the site with different courses to which trainee doctors can upload their own anonymised case s such as interesting x-rays or ECG's either to serve as a log book of their own or to show their colleagues so everyone can benefit. We also have added quizzes about clinical cases that are interesting or were mismanaged in the first instance in order to share knowledge and learn from mistakes. The ITU team have created a fantastic teaching presentation for us, using the Trust's new Camtasia software, around sepsis based on a recent case involving a serious incident. Moodle will be used to generate an enhance online platform for learning points, for example Dr Giles Armstrong, Consultant paediatrician, has created a teaching presentation based on missed paediatric fractures. Moodle has mainly been used by ED so far but it is available to the whole Trust both in the hospital and in the community. It is an incredibly flexible and easy to use learning tool.

Grand Rounds

Grand Rounds being refreshed under the leadership of Professor Yudkin and Dr Michael Kelsey and the changes are designed to greatly enhance the reach of Grand Rounds to all clinical disciplines and all ICSUs (rather than focussing on physicians as they have done hitherto), with a clear structure to support dissemination of learning from patient safety and related issues. Formal links will be established between the Serious Incident Executive Advisory Group (SIEAG) and the Grand Round, so that every 6 weeks the safety learning points from SIEAG will be presented and discussed by this wider audience under the supervision of Professor Ian Bates and Jana Kristienova.

Nurse revalidation

All nurses and midwife must now participate in a tri-annual revalidation process that requires each of them to provide evidence they have met the required standard set by the Nursing & Midwifery Council.

As part of the revalidation process all nurses and midwives must now undertake a reflective discussion with another NMC registrant, usually their line manager. The discussion will cover five written reflective accounts.

These accounts may surround learning from their professional development and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code of Professional practice.

This provides for the first time, an opportunity for each nurse and midwife to reflect on a clinical or professional aspect of learning with another registrant which will improve their professional practice. Many nurses and midwives have commented on how this is the most rewarding part of their revalidation process.

Medicine Matters

Since January 2012 a regular publication 'Medicine Matters' has been published and circulated. This publications contains information about medicines from Pharmacy and the Medicines Safety Group

7. References

1. NHS Digital Indicator Portal (NHS Digital) available from https://indicators.hscic.gov.uk/webview/
2. National Confidential Enquiry into Patient Outcome and Death, *Just Say Sepsis*! (2015) available from http://www.ncepod.org.uk/2015sepsis.html
3. National Institute for Health and Care Excellence (NICE), *Sepsis: recognition, diagnosis and early management guidelines (NG51)* (July 2016) available from https://www.nice.org.uk/guidance/ng51

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

07 September 2016

Title:	July (month 4) 2016/17 - Financial Performance		
Agenda item:	16/121	**Paper**	6
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust reported a £1.3m deficit in July and a year to date deficit of £5.5m. This was £3m worse than the planned YTD performance. The key variance driving the financial position is pay with a £0.7m overspend, circa £0.6m of which relates to agency premia on actual spend over and above the £11.1m plan.		
Summary of recommendations:	To note the financial results relating to performance during July 2016		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	26 August 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 1. This is lower than plan due to lower capital servicing capacity and, more importantly, the I&E variance to plan.

Financial Sustainability Risk Ratings	YTD Plan	YTD Actual	YTD Variance
Liquidity Ratio days (metric)	1	1	0
Capital Servicing Capacity (times)	1	0	-1
I&E Margin Rating	1	1	0
I&E Margin Variance from Plan	4	1	-3
Overall Financial Sustainability Risk Rating	**2**	**1**	**-1**

Finance Overview | Executive Summary

The Trust reported a £1.3m deficit in July and a year to date deficit of £5.5m. This was £3m worse than the planned YTD performance.

The key variance driving the financial positon is pay with a £0.7m overspend, circa £0.6m of which relates to agency premia on actual spend over and above the £11.1m plan. As a significant value of the Trust's CIP target is based on reducing agency spend, the Trust will fail to meet its CIP target if agency spend is not reduced further. This is being targeted in the final two quarters.

The workforce has grown each month to June 2016 when total whole time employed (WTEs) were 4,435 but in July this fell to 4,413 WTEs. Despite the fall in employed numbers July's pay bill was £18.4m, an increase of £0.14m on month 3, exceeding planned expenditure by £0.2m and took the Trust's accumulated pay overspend to £0.7m.

Expenditure incurred on agency staffing year to date is £5.4m which accounts for 56% of the £9.5m cap set by NHSI. July saw agency expenditure decrease by 9.5% (£0.1m) from June, with reductions in nursing offset by increases to medical and allied health professional staff groups. Agency expenditure as a percentage of total pay expenditure decreased from 7.4% in June to 6.6% in July.

The Trust's year to date income is £2.3m adverse against plan. This is mainly due to failure to achieve £2.2m STP funding.

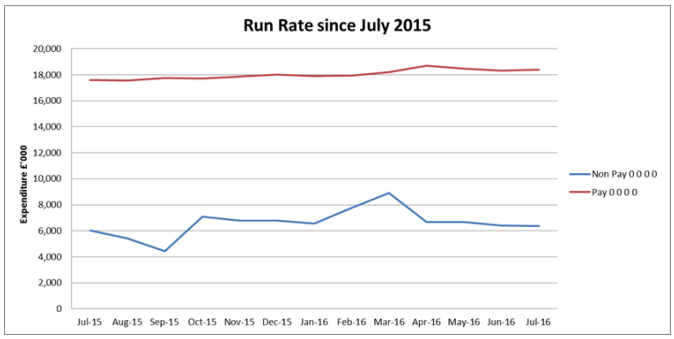
Although the headline activity is only £0.1m behind planned levels, there is a non recurrent benefit of £1m from 2015/16. Planned activity is behind plan, most notably day case activity is down by £0.4m and elective activity by £0.4m (primarily endoscopy and bariatric surgery respectively). There is further material adverse activity variances against Neonatology transitional care (£0.2m) and Paediatric HDU (£0.1m).

The cash position is broadly in line with plan, however the increase in debtors is matched by an increase in creditors and the trust is focussing on reducing both. Capital expenditure is on track and is being closely monitored to maintain the cash position.

Finance Overview | Statement of Comprehensive Income

in £000	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Nhs Clinical Income	21,445	20,814	-631	85,884	84,155	-1,729	255,981
Non-Nhs Clinical Income	1,899	1,684	-215	7,595	7,235	-360	22,784
Other Non-Patient Income	2,028	2,292	264	8,241	8,312	71	26,484
Income Cips	138	0	-138	312	0	-312	1,925
Total Income	**25,510**	**24,790**	**-720**	**102,032**	**99,702**	**-2,330**	**307,174**
Non-Pay	-6,510	-6,343	167	-26,146	-26,112	34	-79,493
Pay	-18,217	-18,449	-232	-73,199	-73,930	-731	-217,442
Total Operating Expenditure	**-24,727**	**-24,792**	**-65**	**-99,345**	**-100,042**	**-697**	**-296,935**
EBITDA	**783**	**-2**	**-785**	**2,687**	**-340**	**-3,027**	**10,239**
Depreciation	-690	-692	-2	-2,760	-2,757	3	-8,280
Dividends Payable	-353	-359	-6	-1,414	-1,437	-23	-4,243
Interest Payable	-264	-276	-12	-1,045	-1,016	29	-3,238
Interest Receivable	3	4	1	12	10	-2	36
Other Finance Costs	0	0	0	0	0	0	0
P/L On Disposal Of Assets	0	0	0	0	-2	-2	0
Total	**-1,304**	**-1,323**	**-19**	**-5,207**	**-5,202**	**5**	**-15,725**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-521**	**-1,325**	**-804**	**-2,520**	**-5,542**	**-3,022**	**-5,486**
Add back impairments and adjust for IFRS & Donations	7	5	-2	21	24	3	-914
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-514**	**-1,320**	**-806**	**-2,499**	**-5,518**	**-3,019**	**-6,400**

The underlying deficit position has deteriorated during the financial period from £12m at the end of March to £17.9m at the end of July. The worsening position is due to the increasing cost base primarily staffing, the failure to achieve recurring cost improvement at the level required in the tariff and a reduction in recurrent activity levels with income levels being achieved by non-recurrent means.



It can be seen from the run rate charts that there is no improvement in expenditure and the Trust will continue in deficit unless cost reduction schemes recurrently reduce expenditure.

	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s	Oct-15 £000s	Nov-15 £000s	Dec-15 £000s	Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s
Establishment	287	325	249	196	270	269	310	338	378	249	351	346	331
Ext Cont Staffing & Cons	75	124	85	422	332	485	367	492	250	364	260	42	136
Healthcare From Non Nhs	41	58	42	66	(105)	(12)	49	(39)	(15)	41	0	(41)	0
Miscellaneous	1,113	641	1,589	1,372	1,454	1,313	1,307	1,658	2,324	1,416	1,420	1,261	1,190
Premises & Fixed Plant	1,535	1,545	(459)	1,622	1,581	1,465	1,836	1,517	2,163	1,560	1,538	1,411	1,733
Supplies & Servs - Clin	2,844	2,586	2,789	3,245	3,040	3,032	2,504	3,567	3,547	2,845	2,938	3,184	2,823
Supplies & Servs - Gen	148	160	162	164	226	226	173	256	254	195	182	201	166
Non Pay	**6,042**	**5,439**	**4,456**	**7,087**	**6,798**	**6,779**	**6,547**	**7,788**	**8,901**	**6,670**	**6,689**	**6,404**	**6,380**
A/C	2,740	2,874	2,680	2,680	2,599	2,656	2,616	2,617	2,688	2,669	2,672	2,603	2,648
Chairman & Non-Executives	4	4	8	5	5	5	5	5	5	4	6	5	5
Dental	199	194	199	197	196	202	207	206	197	212	208	181	197
Executive Board & Sen Mgmt	614	632	602	629	659	633	662	612	653	670	688	743	777
Maintenance & Works	40	41	38	40	42	43	36	37	45	33	34	26	26
Medical	3,579	3,613	3,724	3,758	3,728	3,631	3,625	3,664	3,648	4,003	3,730	3,778	3,822
Nurses & Midwives	6,448	6,339	6,535	6,490	6,698	6,847	6,815	6,840	6,973	7,151	7,121	7,118	6,895
Other Support Workers	477	529	509	501	510	508	508	502	538	520	522	519	484
Pay Reserve	0	0	0	21	40	173	0	15	11	0	0	0	0
Scientific, Ther & Tech	3,511	3,351	3,450	3,408	3,387	3,314	3,440	3,458	3,428	3,442	3,490	3,335	3,551
Pay	**17,612**	**17,577**	**17,744**	**17,730**	**17,863**	**18,011**	**17,914**	**17,956**	**18,186**	**18,704**	**18,470**	**18,307**	**18,403**
Grand Total	**23,654**	**23,016**	**22,200**	**24,817**	**24,662**	**24,790**	**24,461**	**25,744**	**27,087**	**25,374**	**25,159**	**24,711**	**24,783**

Finance Overview | Cost Improvement Programme

In month 4 savings amounting to £0.3m (47%) were delivered against the NHS TDA operating plan of £0.7m. Year to date, £1.6m (71%) has been achieved.

The CIP target for the Trust for 2016/17 was £10.7m, and the original breakdown of schemes was split into £2.1m income, £6.0m pay (including agency reduction) and £2.6m non pay. As schemes are found not to be achievable they are replaced by ICSUs and road-mapped in the PMO. At the end of M4 there was a gap of £2.0m in schemes with an increased reliance on income schemes. The PMO is tasked with closing the gap and increasing cost saving schemes to a minimum of £8.5m in year.

Whilst progress is being reported against schemes, and the majority are on target, to report progress in CIP the business as usual position must be in line with plans and cost and budget must be reduced. As there is a material overspend in staffing overall and in a number of ICSUs the improvements made through the PMO will not be CIP but cost management and the CIP target and overall financial position missed. Therefore the Trust must:

- continue delivering existing saving schemes;
- develop, roadmap and implement further CIP schemes;
- minimise additional budgetary overspends; and
- control influenceable spend for areas such as temporary staff usage.

Integrated Clinical Service Units	Annual Plan £'000	July, month 4				YTD			
		Plan £'000	Actual £'000	% achieved	Variance £'000	Plan £'000	Actual £'000	% achieved	Variance £'000
Children's services	602	19	0	0.0%	-19	73	123	168.9%	50
Clinical Support Services	1,019	60	240	400.6%	180	197	240	122.1%	43
Emergency & Urgent Care	786	19	0	0.0%	-19	77	212	275.8%	135
Medicine, Frailty & Network Services	1,673	71	0	0.0%	-71	247	52	21.1%	-195
Outpatients Prevention & LTC	526	30	0	0.0%	-30	81	0	0.0%	-81
Surgery	2,613	177	84	47.5%	-93	471	144	30.6%	-327
Women's Services	1,189	54	0	0.0%	-54	192	264	137.3%	72
Corporate	2,307	256	0	0.0%	-256	869	526	60.6%	-343
Performance against operating plan	**10,715**	**686**	**324**	**47.2%**	**-362**	**2,206**	**1,561**	**70.8%**	**-645**

The Trust has planned to reduce temporary staffing spend as a key CIP scheme and therefore the current overspend means that it is highly unlikely that this will be achieved.

Agency Expenditure	Mar-16	Apr-16	May-16	Jun-16	Jul-16
A/C	178,661	184,415	142,580	128,394	148,982
Dental	149	6,953	1,479	2,638	1,728
Medical	131,861	314,104	279,333	355,654	358,486
Nurses & Midwives	632,365	796,501	732,615	685,843	532,305
Other Support Workers	17,381	16,668	15,524	14,751	-22,337
Scientific, Ther & Tech	198,246	146,356	126,722	171,259	209,159
Agency	**1,158,663**	**1,464,997**	**1,298,253**	**1,358,539**	**1,228,323**

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.

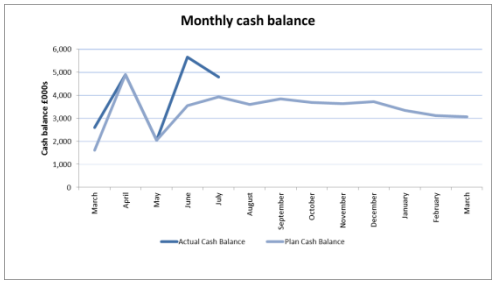
			Year to Date	Year to Date	
	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 31 July 2016 £000	As at 31 July 2016 £000	Variance YTD 31 July 2016 £000
Property, plant and equipment	194,785	203,023	193,615	192,613	1,002
Intangible assets	4,583	2,831	4,016	4,371	(355)
Trade and other receivables	693	851	811	651	160
Total Non Current Assets	**200,061**	**206,705**	**198,442**	**197,635**	**807**
Inventories	1,403	1,500	1,500	1,570	(70)
Trade and other receivables	23,535	25,393	21,131	25,463	(4,332)
Cash and cash equivalents	2,598	3,060	3,927	4,780	(853)
Total Current Assets	**27,536**	**29,953**	**26,558**	**31,813**	**(5,255)**
Total Assets	**227,597**	**236,658**	**225,000**	**229,448**	**(4,448)**
Trade and other payables	39,112	43,391	35,210	41,897	(6,687)
Borrowings	376	2,455	6,456	6,551	(95)
Provisions	795	756	783	729	54
Total Current Liabilities	**40,283**	**46,602**	**42,449**	**49,177**	**(6,728)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(15,891)**	**(17,364)**	**1,473**
Total Assets less Current Liabilities	**187,314**	**190,056**	**182,551**	**180,271**	**2,280**
Borrowings	52,934	61,419	50,775	51,432	(657)
Provisions	1,773	1,513	1,688	1,773	(85)
Total Non Current Liabilities	**54,707**	**62,932**	**52,463**	**53,205**	**(742)**
Total Assets Employed	**132,607**	**127,124**	**130,088**	**127,066**	**3,022**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(10,392)	(13,295)	2,903
Revaluation reserve	78,076	78,076	78,076	77,957	119
Total Taxpayers' Equity	**132,607**	**127,124**	**130,088**	**127,066**	**3,022**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**

Property, Plant & Equipment (inc Intangible Assets): As has been reported in previous board reports the year to date underspend against plan is a result of ongoing negotiations with a managed equipment service provider. The plan is likely to be agreed in Q3.

Trade Receivables: The adverse variance of £4.3m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. The situation is expected to reverse as discussions are underway with major debtors.

Payables: The Trust is in the process of approving and paying significant creditor balances and furthermore the Trust is in discussions with local providers.

Cash: The annual cash plan assumes the Trust will receive £8.9m cash support and by the end of month 4 the Trust has drawn down £4.7m. The cash position at the close of the month was £4.8m.



Operations Directorate
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The Whittington Hospital NHS Trust
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Whittington Health Trust Board
7 September 2016

Title:	Performance Dashboard Report August 2016 (July 16 data)		
Agenda item:	**16/122**	**Paper**	**07**
Action requested:	For discussion and decision making		
Executive Summary:	The following is the Performance report for July 2016. **Theatre Utilisation** Theatre utilisation is on average 80% and the Trust is aiming to meet 85%. Three theatre lists have been removed from the weekly programme to drive increased productivity across less productive surgical specialities i.e. urology and breast. Breast has improved where the average utilisation in July was 85%, but no impact in Urology with an average of 61.8%. Performance in Trauma and Orthopaedics 85%, General Surgery 80% and gynaecology 79.2%. **Hospital Cancellation** Achieved target for first appointment and just above target for follow up appointments. **DNA rate** remained the same at just above the expected target of 10%. **The cancer** targets were all achieved. **Community Cancellations and DNAs** continue to achieve their target. **Appointments with no outcomes in the community** are above target but reducing. District Nursing achieved zero unoutcomed appointments demonstrating the positive impact of new processes put in place. The **MSK service** 6 weeks waiting times target is steadily improving. There are ongoing meetings with commissioners looking at specific areas in the recovery action plan for further improvements. **Emergency and Urgent Care** Performance continues challenging but with good progress with the improvement plan and there has been a reduction in the number of bed related breaches. Increase blue light referrals over July.		

Summary of recommendations:	That the Board notes the performance.
Fit with WH strategy:	All five strategic aims
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	16th August 2016

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**6 Sep**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

August 2016 Trust Board Report (Jul data)

Whittington Health NHS

Quality	Threshold	May-16	Jun-16	Jul-16
Number of Inpatient Deaths	-	23	31	28
NHS number completion in SUS (OP & IP)	99%	98.8%	98.9%	arrears
NHS number completion in A&E data set	95%	95.2%	NA	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	Jan-16	Feb-16	Mar-16
Hospital Standardised Mortality Ratio (HSMR)	<100	104	76	84
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	81.3	63.3	49.8
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	110.7	82.2	94.7

Patient Safety	Threshold	May-16	Jun-16	Jul-16
Harm Free Care	95%	92.7%	93.6%	93.8%
VTE Risk assessment	95%	96.0%	96.3%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	TBC	TBC	TBC
Serious Incident reports	-	6	3	3

Access Standards

Referral to Treatment (in arrears)	Threshold	Apr-16	May-16	Jun-16
Diagnostic Waits	99%	99.6%	99.4%	99.9%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Meeting threshold

Patient Experience	Threshold	May-16	Jun-16	Jul-16

Efficiency and productivity - Community	Threshold	May-16	Jun-16	Jul-16
Service Cancellations - Community	8%	5.7%	5.6%	5.7%
DNA Rates - Community	10%	5.8%	5.7%	5.8%
Community Face to Face Contacts*	-	58,331	60,875	56,918
Community Appts with no outcome	0.5%	5.9%	1.0%	0.9%

* Community Dental figures delayed for Jul (reduced community activity by approx 1800)

Community Access Standards	Threshold	May-16	Jun-16	Jul-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	39.5%	43.4%	46.0%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	71.0%	62.2%	arrears
IAPT - patients moving to recovery	50%	51.6%	48.1%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	95.0%	90.5%	arrears
GUM - Appointment within 2 days	98%	99.7%	99.7%	95.6%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	May-16	Jun-16	Jul-16
First:Follow-up ratio - acute	2.31	1.37	1.44	1.44
Theatre Utilisation	95%	81.5%	80.6%	78.2%
Hospital Cancellations - acute - First Appointments	8%	4.6%	5.0%	5.9%
Hospital Cancellations - acute - Follow-up Appointments	8%	7.2%	8.2%	8.6%
DNA rates - acute - First appointments	10%	12.3%	11.4%	11.9%
DNA rates - acute - Follow-up appts	10%	11.5%	11.6%	11.5%
Hospital Cancelled Operations	0	4	7	1
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	4	2	1

Failed threshold

Emergency and Urgent Care	Threshold	May-16	Jun-16	Jul-16

August 2016 Trust Board Report (Jul data)

Whittington Health NHS

Patient Satisfaction - Inpatient FFT (% recommendation)	-	95%	95%	96%
Patient Satisfaction - ED FFT (% recommendation)	-	92%	88%	89%
Patient Satisfaction - Maternity FFT (% recommendation)	-	92%	95%	92%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	23	31	26
Complaints responded to within 25 working days*	80%	90%	82%	95%
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Emergency Department waits (4 hrs wait)	95%	85.9%	87.7%	87.9%
ED Indicator - median wait for treatment (minutes)	<60	88	85	87
30 day Emergency readmissions	-	191	246	arrears
12 hour trolley waits in A&E	0	2	1	TBC
Ambulatory Care (% diverted)	>5%	2.8%	3.0%	3.6%
Ambulance Handover (within 30 minutes)	0	20	26	arrears
Ambulance Handover (within 60 minutes)	0	2	9	arrears

Infection Prevention	Threshold	May-16	Jun-16	Jul-16
Hospital acquired MRSA infection	0	0	0	0
Hospital acquired *C difficile* Infections	17 (FY)	1	1	1
Hospital acquired *E. coli* Infections	-	0	0	0
Hospital acquired MSSA Infections	-	1	1	0
Ward Cleanliness	-	-	-	98%

Cancer Access Standards (in arrears)	Threshold	Apr-16	May-16	Jun-16
Cancer - 14 days to first seen	93%	97.4%	96.4%	96.4%
Cancer - 14 days to first seen - breast symptomatic	93%	98.1%	95.4%	99.2%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	-	100.0%	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	-
Cancer - 62 days from referral to treatment	85%	87.2%	82.5%	94.9%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	May-16	Jun-16	Jul-16
Referral to Treatment 18 weeks - Admitted	90%	81.1%	79.3%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	90.9%	90.0%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	93.8%	94.2%	arrears

Maternity	Threshold	May-16	Jun-16	Jul-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	80.9%	84.1%	84.2%
New Birth Visits - Haringey	95%	89.8%	87.9%	arrears
New Birth Visits - Islington	95%	96.1%	94.4%	arrears
Elective Caesarean Section rate	14.8%	12.0%	14.8%	12.0%
Breastfeeding initiated	90%	92.1%	86.9%	93.7%
Smoking at Delivery	<6%	6.6%	5.9%	3.9%

Meeting threshold

Failed threshold

	Threshold	Trust Actual		
		May-16	Jun-16	Jul-16
Number of Inpatient Deaths	-	23	31	28
Completion of a valid NHS number in SUS (OP & IP)	99%	98.8%	98.9%	arrears
Completion of a valid NHS number in A&E data sets	95%	95.2%	NA	arrears

	Standardised National Average	Trust		
		Jan-16	Feb-16	Mar-16
Hospital Standardised Mortality Ratio	<100	103.5	76.1	84.1
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	81.3	63.3	49.8
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	110.7	82.2	94.7

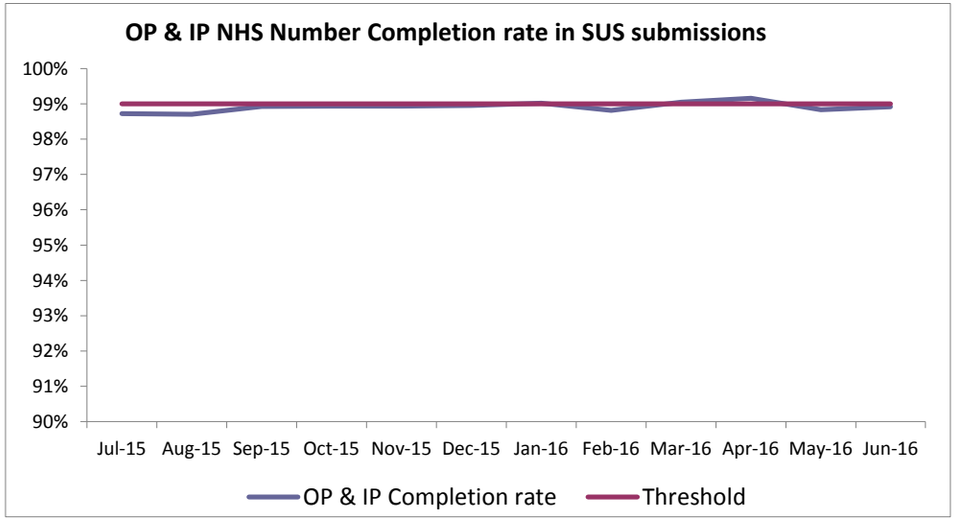
		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Jan 2015 - Dec 2015	0.89	1.13	0.67
	Oct 2014 - Sep 2015	0.89	1.12	0.65
	Jul 2014 - Jun 2015	0.89	1.12	0.66
	Apr 2015 - Mar 2015	0.89	1.12	0.67
	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54

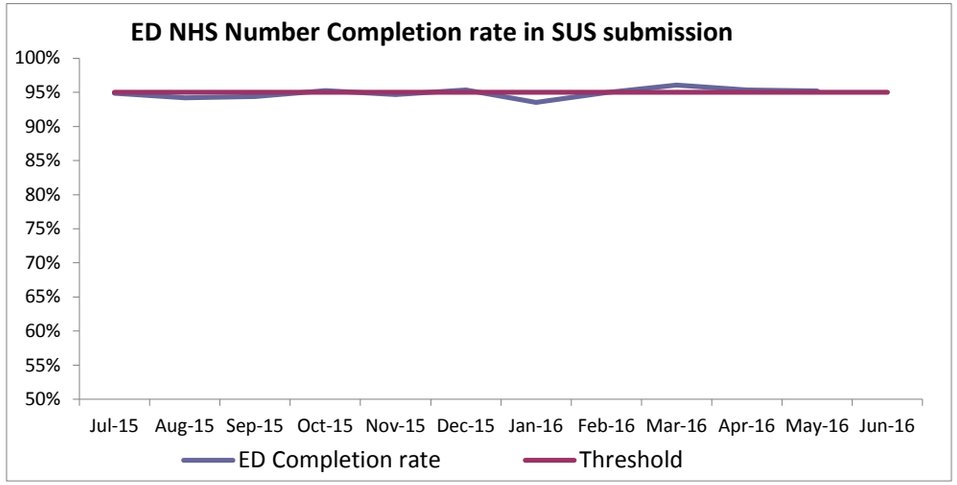
Commentary

Completion of NHS number in SUS
Just below target for Out patients and In patients
Issue: Missing patient demographics (i.e. NHS numbers and GP unknowns) validated, overseas visitors and un-registered GP patients are not filtered from above data.
Action: All un-registered patients are sent information on 'How to registered with a GP' and asked to confirm this information once they are registered and EPR is updated accordingly.
Timescale: ongoing

Completion of NHS number in A&E data set
An error in the reporting was discovered and is being investigated.
Timescale: The reported is expected to report correctly next month.

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.

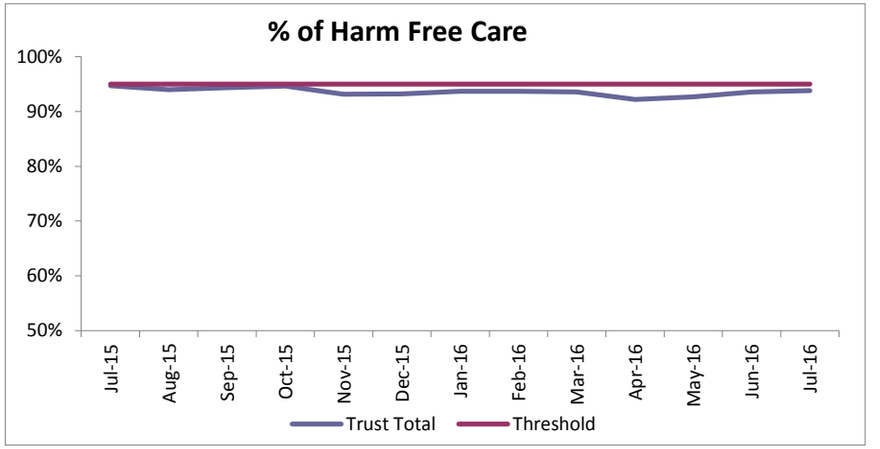


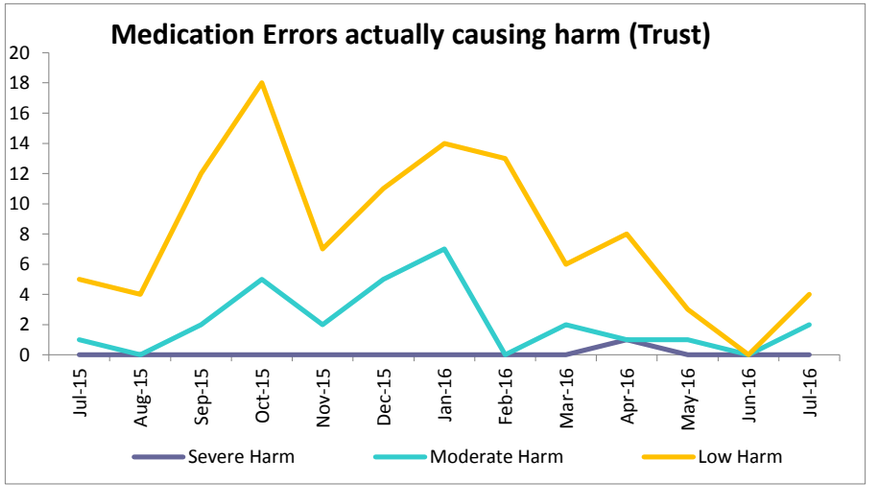


Patient Safety

Whittington Health NHS

	Threshold	Trust Actual Apr-16	May-16	Jun-16	Jul-16	Trend
Harm Free Care	95%	92.2%	92.7%	93.6%	93.8%	
Pressure Ulcers (prevalence)	-	7.19%	6.35%	5.85%	5.54%	
Falls (audit)	-	0.35%	0.45%	0.29%	0.38%	
VTE Risk assessment	95%	95.0%	96.0%	96.3%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	1	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	1	1	0	2	
Medication Errors actually causing **Low** Harm	-	8	3	0	4	
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)	-	3	6	3	3	





Commentary

Harm Free Care and Pressure Ulcer prevalence
Harm Free Care and the figure for prevalence of pressure ulcers include non-avoidable pressure ulcers. It remains above 93%.

Falls (audit)
Issue: The overall numbers of falls recorded in the Nursing Indicators dashboard remain around 20 per month. It is below the national 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 presented at the Investment Group and TMG in august 2016.

Medication errors causing harm in April 16
There were 62 medication incidents reported on Datix in July 2016, increased from 44 in June 16 (monthly average for 2016 is 51)
There were two incidents of moderate harm , 1 within WHS ICSU where IV Magnesium was administered at a faster rate that recommended (Infusion was stopped and patient monitored , no side effects exhibited) and one was CYP where an extra dose of Vancomycin was administered to a child at home (Level was checked and was high. Next dose omitted and no harm to patient observed).
There were 4 incidents relating to CD's but they were easily resolved and of low harm to the patient.

Proportion of reported patient safety incidents that are harmful
This report is under review due to the review of the Datix system.
Timescale: It is expected to be reporting again from next month.

Serious Incidents
Whittington Health declared 3 SIs in July 2016 including 1.an unexpected death possibly due to a missed Pulmonary Emboli, 2. patient fall resulting in fractured left and right shoulder and3. delay in assessing MH patient in ED and a delay in acquiring a Tier 4 Mental Health Bed.

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

Patient Experience

Whittington Health NHS

	Threshold	Trust Actual Apr-16	May-16	Jun-16	Jul-16
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	96%	95%	95%	96%
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	90%	92%	88%	89%
Patient Satisfaction - Maternity FFT (% recommendation) **	-	95%	92%	95%	92%
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0
Complaints (**incl Corporate**)	-	23	23	31	26
Complaints responded to within 25 working day	80%	-	90.5%	82.1%	95.5%
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0

Complaints by ICSU	May-16	Jun-16	Jul-16
Integrated Medicine	100%	67%	100%
Emergency & UC	71%	80%	100%
Surgery & Cancer	100%	83%	100%
Clinical Support Services	N/A	100%	100%
Patient Access, Prevention, etc	N/A	100%	100%
Children's Services	100%	75%	50%
Women's Health Services	100%	100%	100%
Estates & Facilities	N/A	100%	100%
Nursing & PE	N/A	100%	100%
IM&T	N/A	N/A	N/A
Finance	N/A	N/A	N/A
Trust	**90%**	**83%**	**95%**

Maternity FFT

2016/17

Month	Response Rate	% Recommend	% Not Recommend
Apr-15	19.3%	94.6%	0.8%
May-15	16.1%	92.1%	1.0%
Jun-15	18.3%	94.6%	2.2%
Jul-15	10.5%	91.6%	2.8%

*'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

** FFT calculation has now changed nationally from Nov 2014

Commentary

Patient Satisfaction (Local standard 90%)
Please see breakdown of FFT to the left.
ED: Positive response rate below 90%. Response rate below 10%
Inpatients: Response rate below 20%
Outpatients: Positive response rate below 90%. Number of responses for July required below 200.
Community: Fewer responses than last month. Number of responses for July required below 750.
Maternity
Note: Response rate below 15%, percentage recommending KPI met. But percentage recommended above the target of 90%.

Complaints
Achieved

Inpatient Friends and Family Test

Summary

2015/16

Month	Responses 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

Month	Responses 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%
June 2016	491	96%	7	1%	513	3315	15%
July 2016	**608**	**97%**	**9**	**1%**	**629**	**3253**	**19%**

Emergency Department Friends and Family Test

Summary

2015/16

Month	Responses 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

Month	Responses 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%
June 2016	279	88%	23	7%	318	6244	5%
July 2016	**261**	**89%**	**22**	**8%**	**292**	**6502**	**4%**

Outpatient Friends and Family Test

Summary

2015/16

Month	Responses 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

Month	Responses Positive	% Positive	Negative	% Negative	Total
April 2016	120	90%	7	5%	133
May 2016	150	88%	9	5%	171
June 2016	144	87%	8	5%	166
July 2016	**204**	**89%**	**15**	**7%**	**229**

Community Services Friends and Family Test

Summary

2015/16

Month	Responses 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

Month	Responses Positive	% Positive	Negative	% Negative	Total
April 2016	757	97%	3	0%	778
May 2016	733	97%	5	1%	752
June 2016	612	97%	6	1%	628
July 2016	**551**	**98%**	**6**	**1%**	**563**

Infection Prevention

Whittington Health NHS

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

	Threshold	Apr 16	May 16	Jun 16	Jul 16	2016/17 Trust YTD
C difficile Infections	17 (Year)	2	1	1	1	5

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

Ward Cleanliness

Audit period	Trust 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	08/07/16 to 05/08/16	Trend
Trust %	97.7%	97.8%	98.6%	96.9%	97.6%	

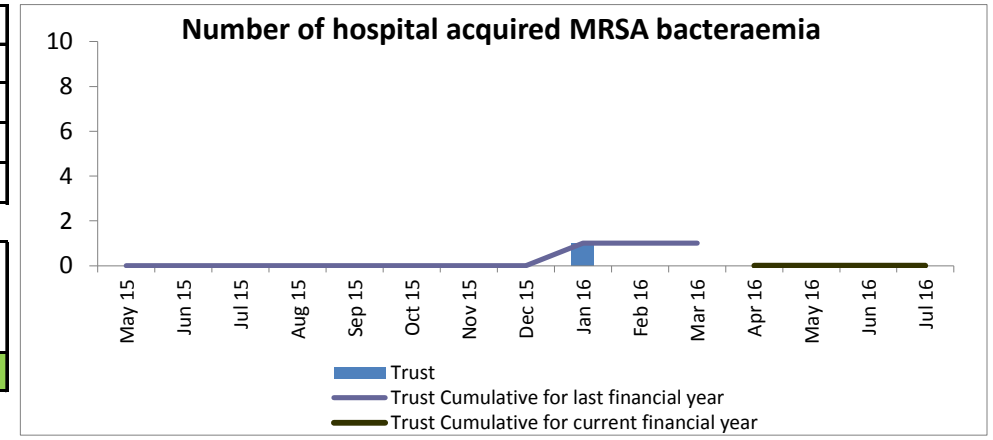
Commentary

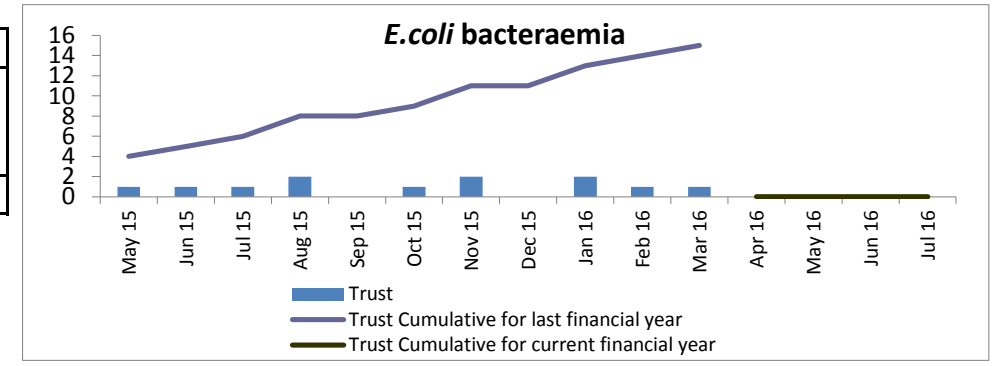
MSRA and E.coli
No new bacteraemia

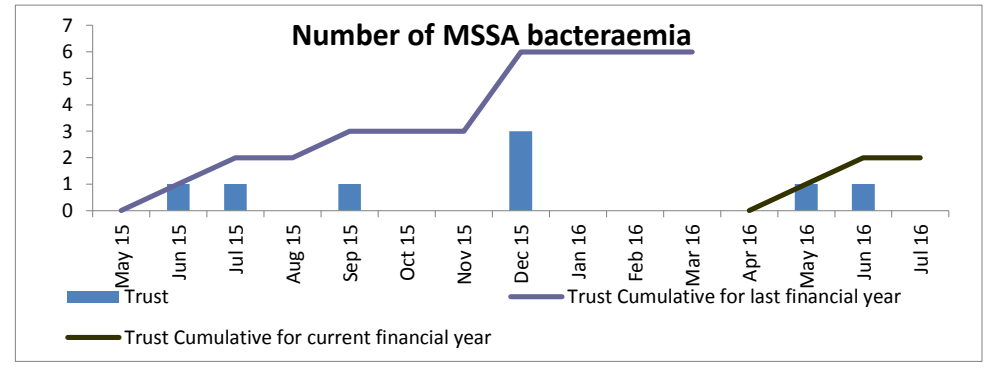
MSSA
No new bacteraemia

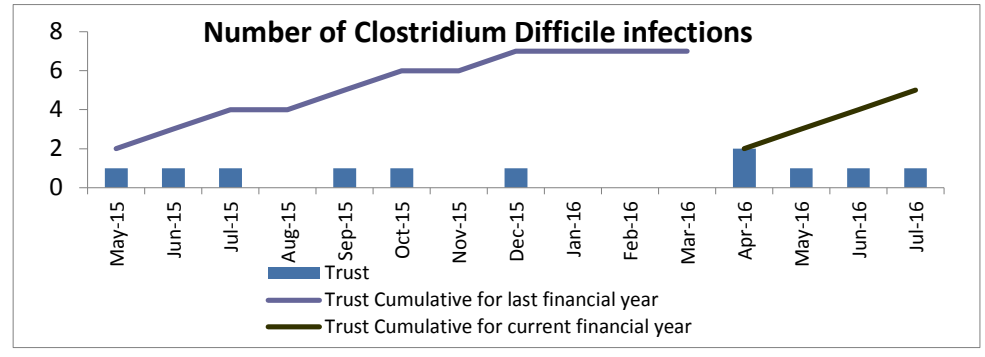
C difficile
One new bacteraemia and all protocols implemented.

Ward Cleanliness
Issue: Ward Cleanliness improved slightly for the period July to August 16.
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.





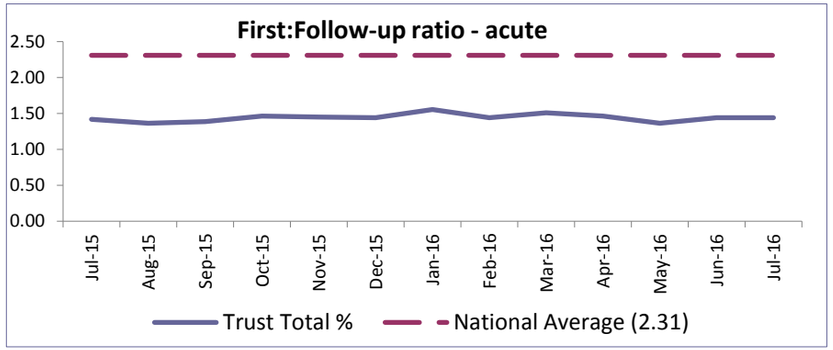


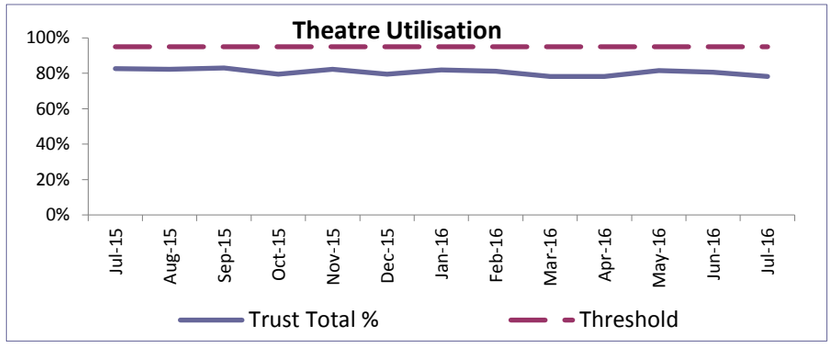


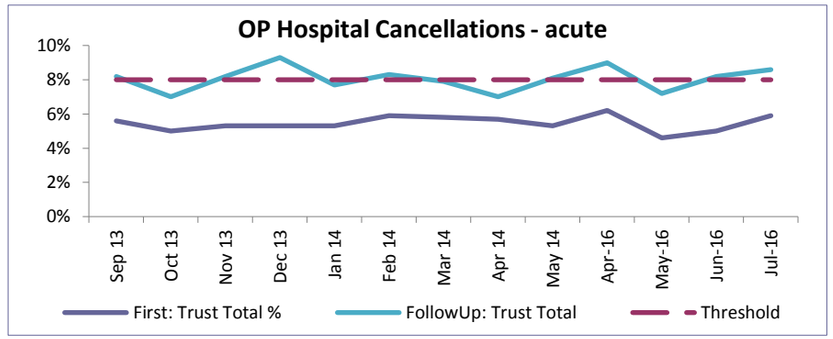
Efficiency and productivity - acute

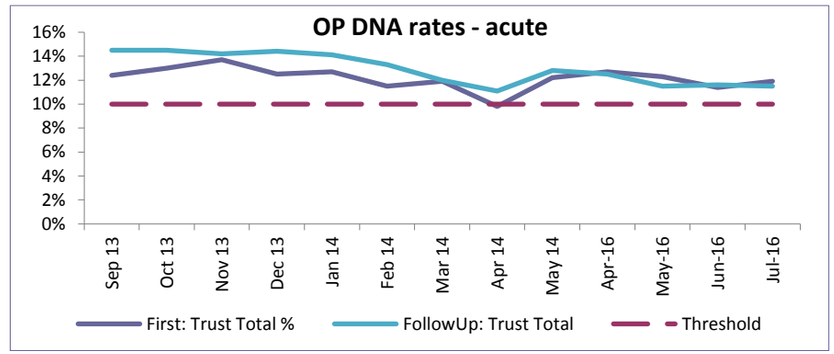
Whittington Health NHS

	Trust						
	Threshold	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Trend
First:Follow-up ratio - acute	2.31	1.51	1.46	1.37	1.44	1.44	
Theatre Utilisation	95%	78.2%	78.1%	81.5%	80.6%	78.2%	
Hospital Cancellations - acute - First Appointments	<8%	5.3%	6.2%	4.6%	5.0%	5.9%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	8.1%	9.0%	7.2%	8.2%	8.6%	
DNA rates - acute - First appointments	10%	12.2%	12.7%	12.3%	11.4%	11.9%	
DNA rates - acute - Follow-up appointments	10%	12.8%	12.5%	11.5%	11.6%	11.5%	
Hospital Cancelled Operations	0	3	19	4	7	1	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	0	5	4	2	1	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	









Commentary

Theatre utilisation

Theatre utilisation is still sitting on average around 80%. An average of 85% is what is expected.

Three theatre lists have been removed from the weekly programme to try to drive increased productivity across some less productive surgical specialities i.e. urology and breast. Breast has improved where the average utilisation in July was 85%, but no impact in Urology with an average of 61.8%.

Performance in T&O was also over 85% in July, with General Surgery 80% & gynaecology 79.2%.

Actions in place:

1.'To come In' TCI meetings re-launched to be checked by Matron and Director of Operations to ensure all lists full and countersigned by Clinical Director. Urology a priority.

2.Ensure that no patient is given a date to come in unless has passed pre operative assessment. (as per policy)

3.Theater Matron to monitor start time for urology theatres .

Hospital Cancellations

Within target as expected.

DNA

Just under target for both first and follow up appointments.

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

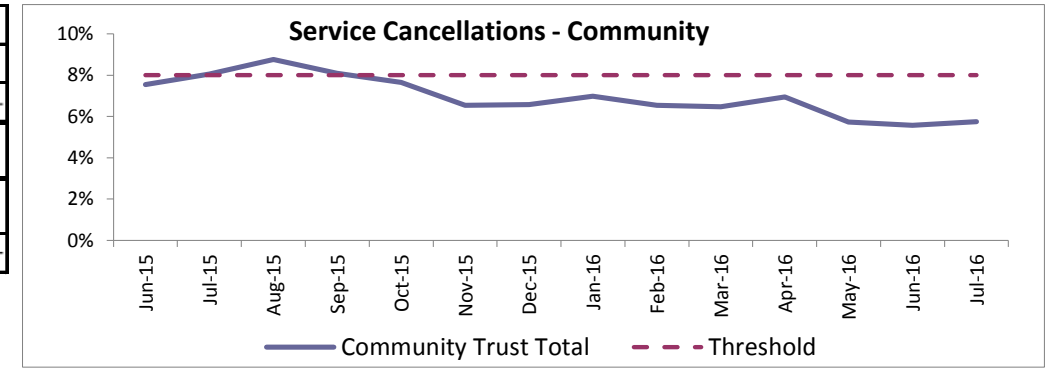
Issue: There was 1 reportable cancelled operation which was an urgent procedure. It was cancelled by Gynaecology due to lack of available equipment. All operation were rescheduled within 28 days.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	Apr-16	May-16	Jun-16	Jul-16	Trend
Service Cancellations - Community	8%	7.0%	5.7%	5.6%	5.7%	
DNA Rates - Community	10%	6.0%	5.8%	5.7%	5.8%	
Community Face to Face Contacts*	-	58,718	58,331	60,875	56,918	
Community Appointment with no outcome	0.5%	2.5%	5.9%	1.0%	0.9%	

* Community Dental figures delayed for Jul (reduced community activity by approx 1800)

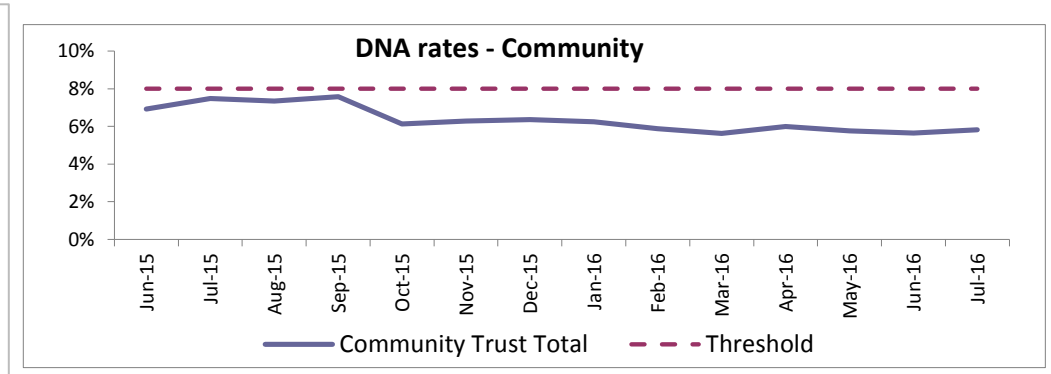


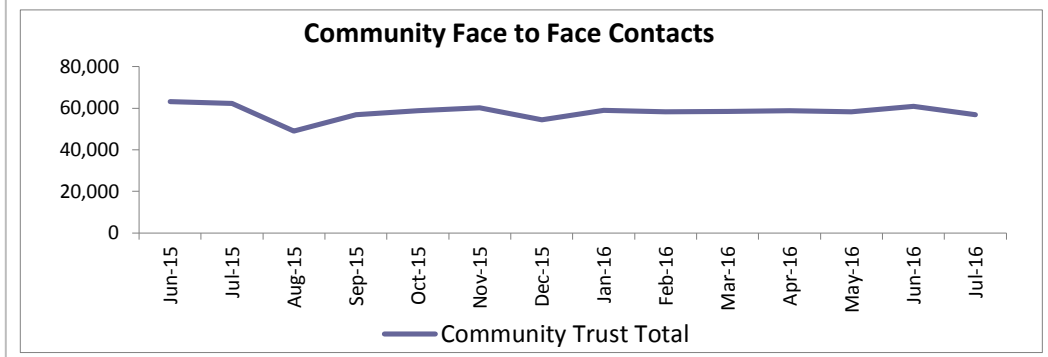
Commentary

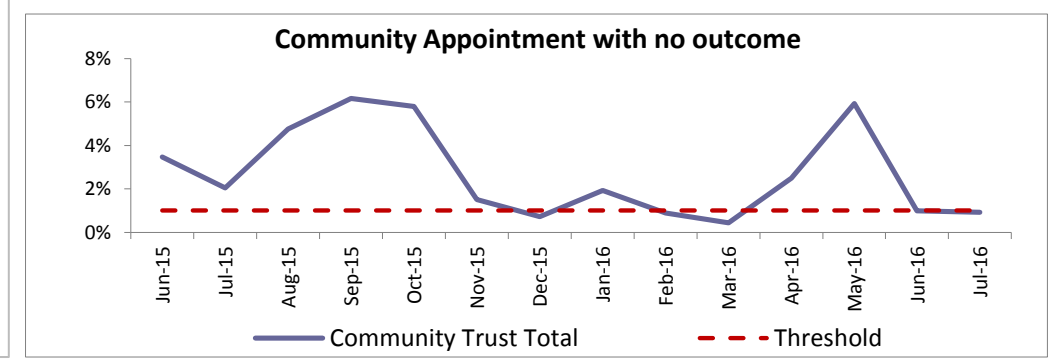
Service Cancellations - Community
Achieved

DNA Rates - Community
Achieved.

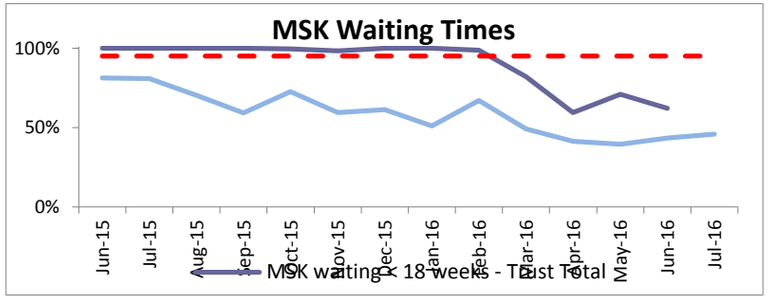
Community Appointment with no outcome
Not achieved.
Issue: Appointments are not outcomed on the electronic systems for services with high volume appointments. DN has made a significant improvement with now all appointments outcomed.
Action: Electronic reports are in place for Services to monitor their unoutcomed appointments. All appointments are outcomed retrospectively before submission to SUS.
Timescale: in place







	Threshold	Trust Actual May-16	Trust Actual Jun-16	Trust Actual Jul-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	60.0%	-	-	63.6%
District Nursing Wait Time - 2hrs assess (Haringey)	-	97.1%	-	-	96.2%
District Nursing Wait Time - 48hrs for visit (Islington)	-	95.0%	-	-	95.1%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	99.1%	-	-	97.7%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	39.5%	43.4%	46.0%	42.7%
MSK Waiting Times - Consultant led (<18 weeks)	95%	71.0%	62.2%	arrears	64.5%
IAPT - patients moving to recovery	50%	51.6%	48.1%	arrears	49.1%
GUM - Appointment within 2 days	98%	98.5%	99.7%	95.6%	98.2%
Haringey Adults Community Rehabilitation (<6weeks)	85%	86.5%	87.5%	84.2%	86.9%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	51.3%	51.7%	44.8%	49.4%
Islington Community Rehabilitation (<12 weeks)	-	86.1%	71.8%	69.9%	78.5%
Islington Intermediate Care (<6 weeks)	85%	73.5%	67.8%	71.3%	71.7%
Islington Podiatry (Foot Health) (<6 weeks)	-	41.9%	37.6%	26.6%	34.9%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	95.0%	90.5%	arrears	95.4%
Death in place of choice	90%	100.0%	96.0%	84.4%	
Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams)	8	8	8	8	
Number of DN teams completing a monthly caseload review of timely discharge (eight teams)	8	8	8	8	



District Nursing

Issue: Currently there is no electronic way to collect the data for 2 and 48 hrs targets. The data recording does not reflect urgent requests and visit times are entered to RiO retrospectively. Manually reviewing the data is currently not possible, due to vacancies and long term sickness in the DN admin.

Action: Urgent (2hrs) referrals are still called through and recording of these referrals is manual and retrospective and non-urgent (48hrs) are also manually reviewed. A report will need to be developed to capture this data electronically. Previous attempts to develop the report have only been partly successful. To mitigate the absence of electronic automated reporting the daily allocations teleconference coordinates the deployment of all nursing capacity to manage the patient demand. The discussion involves a lead district nurse or above reviewing any missed or late visits the previous 24 hours. All exceptions reported are recorded in Datix. 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. The service's imminent E-community platform & store &forward (rio) will accurately capture when unplanned visits are added to the workload, the urgency, and when they are actioned by a healthcare professional, recording the time and length of the visit appropriately.

Timescale: E community Pilot to launced in November 2016 . Store & Forward (October 2016)

D**eath 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.

Issue: A small number of patients did not die in their place of choice this month.

Action: Work with teams to consolidate and encourage good practice.

GUM

Issue: In July there were issues around availability of appointments, and there were also escalation issues. The team did not escalate in time to open up additional capacity.

Continued

IAPT

Issue: Of the 298 people who completed treatment in June, 48% showed that they had recovered against a target of 50%. Of these 298 people, 75% showed reliable improvement – dropping 6 points or more in their depression and anxiety scores.

This would suggest that the 48% recovery rate is due to an increase in severity of needs of people starting treatment in this cohort. Work continues to aim for month by month recovery rate of 50%, as well as reliable improvement rates continuing in the high 60 and 70% range.

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 July 16:

Teleconference regarding proposed changes to Self-referral criteria took place in July 16. Await conclusion of this meeting from CCG.

Ongoing improvement meetings with commissioners. Further work needs to be done around promoting self-management with patients prior to referral as well as updating the self-referral form with links to self-help/self-management information.

Issue: Waiting times < 6 weeks is below threshold. Although Percentage under < 6 weeks is below threshold, it is improving month on month since May 16. Percentage under 18 Weeks (CATS) has decreased. This is the impact from losing 0.2WTE GP with Special Interest (GPwSI)) capacity in service, as well as year on year increase in demand.

Action: Increase capacity in routine MSK from use of locums funded until September 16. Locum capacity used to clear backlog. From September service should have a full compliment of staff. Advert out to recruit Fix Term Contract Extended Scope PT Practitioner temporarily cover 0.20 wte GPwSI post.

Timescale: Extended Scope Practitioner Expected to start October 16 and impact thereafter. Waiting times for 6 weeks target currently at 65% for (part month) August 16 figures.

Podiatry

Issue: July 6 weeks data has fallen further.

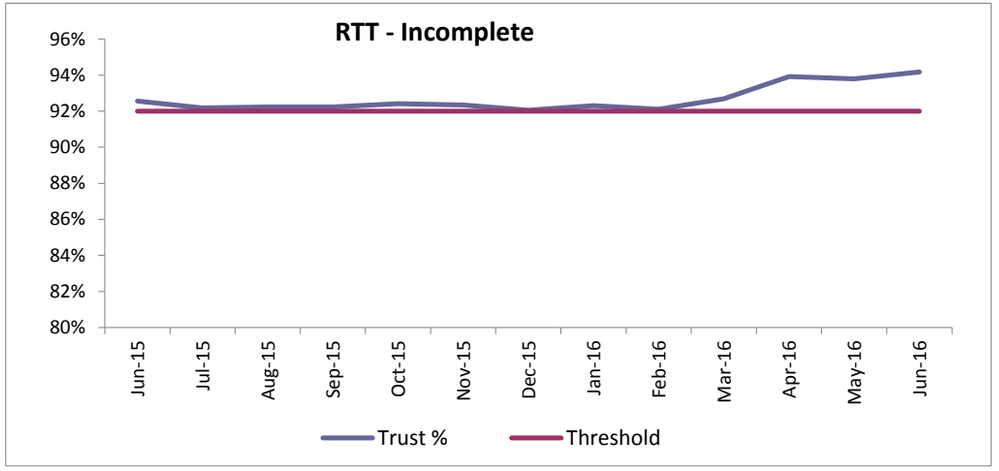
Action: New service structure in Podiatry in place from Monday 22nd August 2016. All vacant posts have been recruited to with some staff already in post and further dates agreed throughout Aug - Sept. Locum cover is in place until the end of August.

Timescales: Improvement in waiting times from October 2016.

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

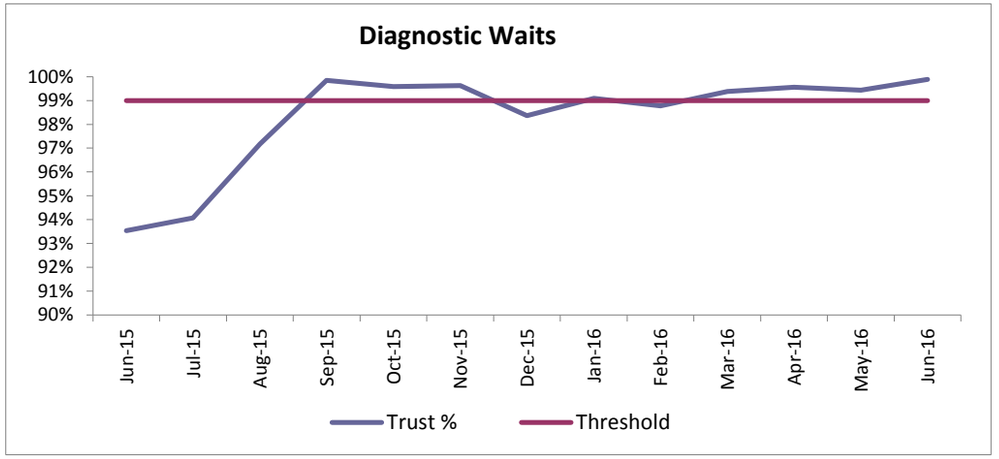
	Trust				
	Threshold	Apr-16	May-16	Jun-16	Trend
Referral to Treatment 18 weeks - Admitted	90%	77.3%	81.1%	79.3%	
Referral to Treatment 18 weeks - Non-admitted	95%	89.2%	90.9%	90.0%	
Referral to Treatment 18 weeks - Incomplete	92%	93.9%	93.8%	94.2%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	99.6%	99.4%	99.9%	



Commentary

RTT
National KPI for 18 weeks incomplete standard achieved.

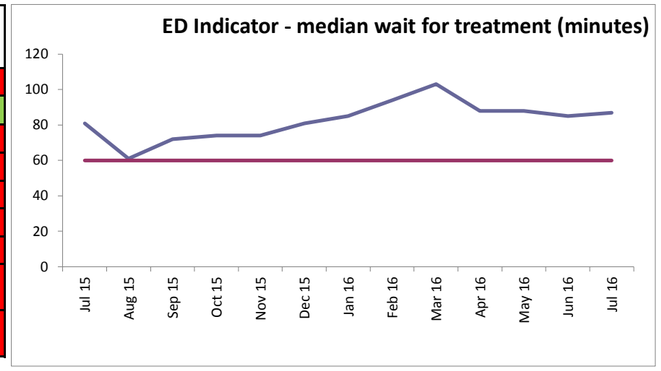
Diagnostic Waits
Target achieved as expected.

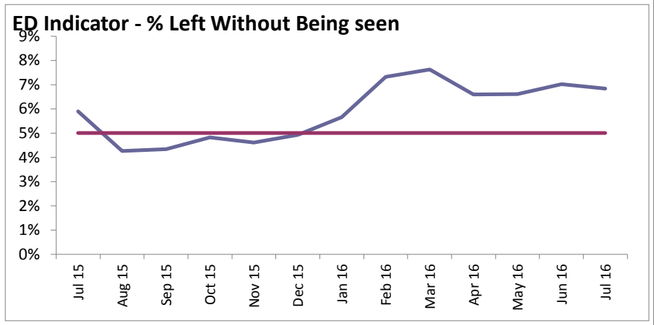


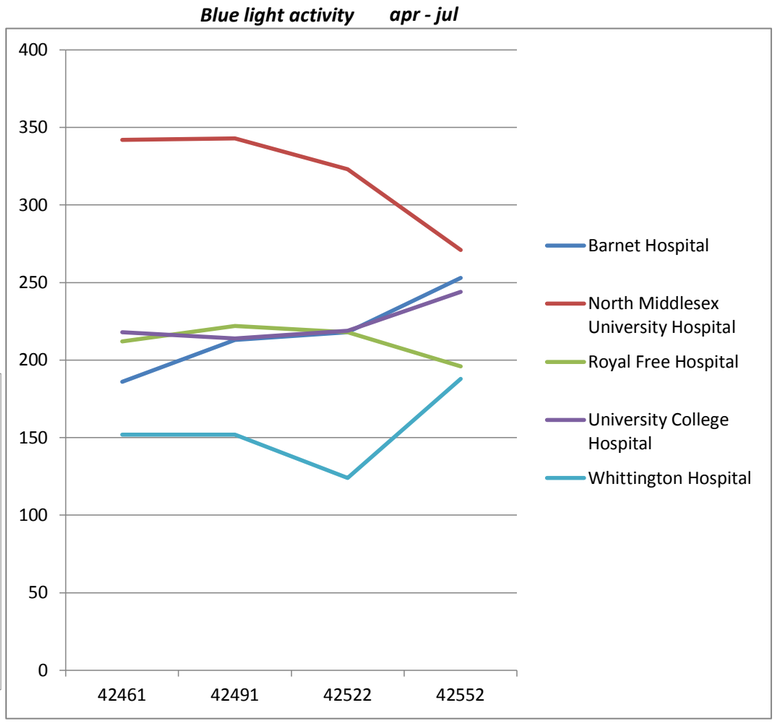
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Jun-16	Trust Actual Jul-16	2016/17 Trust YTD
Emergency Department waits (4 hrs wait)	95%	87.7%	87.9%	86.4%
Emergency Department waits (4 hrs wait) Paeds only	95%	96.7%	96.3%	95.4%
Wait for assessment (minutes - 95th percentile)	<=15	19	20	19
ED Indicator - median wait for treatment (minutes)	60	85	87	87
Total Time in ED (minutes - 95th percentile)	<=240	438	443	462
ED Indicator - % Left Without Being seen	<=5%	7.0%	6.8%	6.8%
12 hour trolley waits in A&E	0	1	TBC	TBC
Ambulance handovers 30 minutes	0	26	arrears	69
Ambulance handovers exceeding 60 minutes	0	9	arrears	11
Ambulatory Care (% diverted)	>5%	3.0%	3.6%	







Commentary

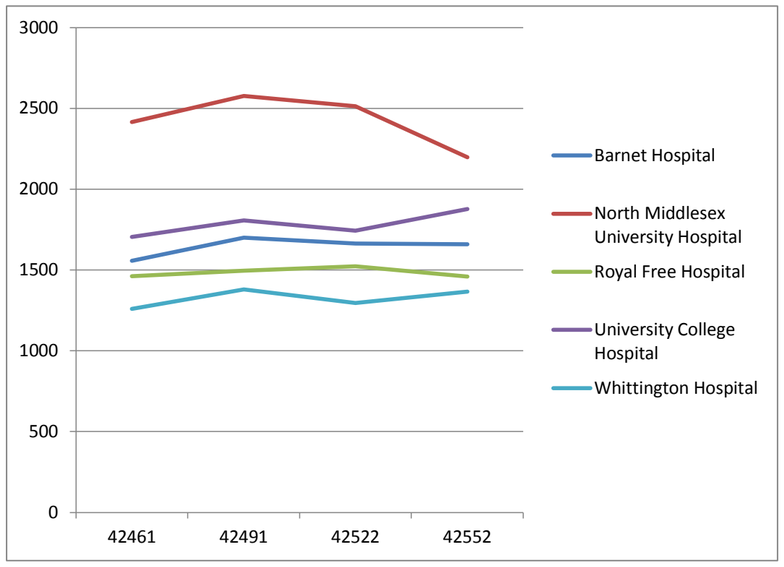
ED four hour wait continues to remain a significant challenge for July .
Robust Improvement plan in progress focusing on admitted pathway and Emergency department.
Bed breaches at 20% for July with some improvement made in admitted pathway (flow) as improvement schemes are implemented.
Weekly monitoring of key metrics including - pre 11 am discharges, speciality response , critiera led discharge , lenght of stay and time to treatment .

The **'Perfect week '** (breaking the cycle) planned from week commencing the 12th September.

Ambulance conveyances : Blue light activity diverts from North Mid has seen a significant increase in July which has had a n impact on the department , in particular out of hours .
Daily monitoring in place .

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.

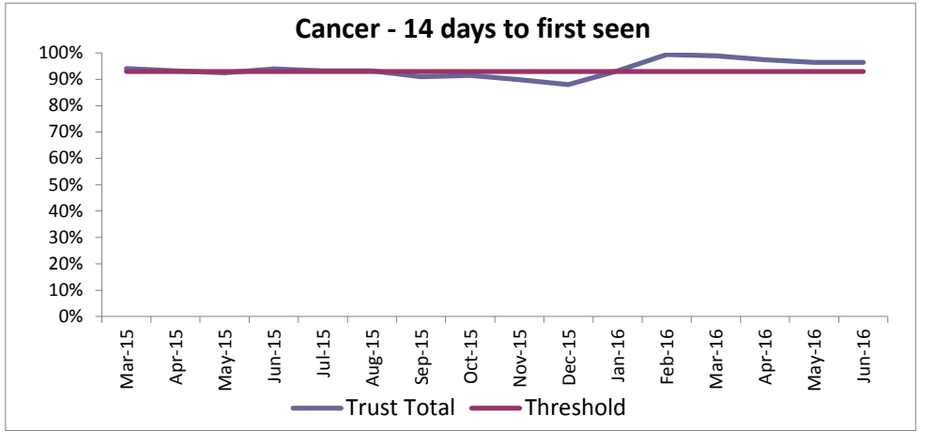
The number of patients **diverted to Ambulatory Care** has increased to 3.6 % with ongoing work to ensure that pathway y is full y optimised.

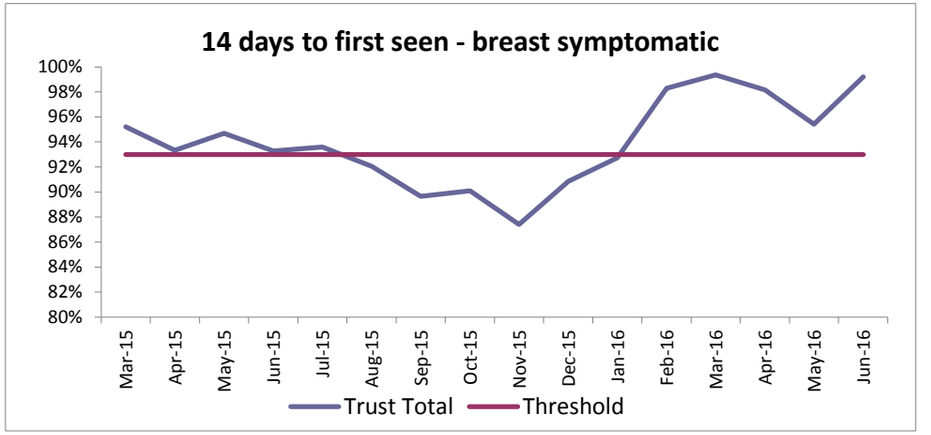


		Trust				2016/17 Trust				
	Threshold	Apr-16	May-16	Jun-16	Trend	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	97.4%	96.4%	96.4%		96.7%	-	-	-	96.7%
Cancer - 14 days to first seen - breast symptomatic	93%	98.1%	95.4%	99.2%		97.5%	-	-	-	97.5%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	-	100.0%	100.0%		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	-		100.0%	-	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	87.2%	82.5%	94.9%		87.4%	-	-	-	87.4%
Cancer - 62 days from consultant upgrade	-	-	100%	100%		100.0%	-	-	-	100.0%

Commentary

All targets achieved as expected for June 2016.





Maternity

Whittington Health NHS

	Threshold	Trust Actual May-16	Trust Actual Jun-16	Trust Actual Jul-16	2016/17 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	80.9%	84.1%	84.2%	82.4%
New Birth Visits - Haringey	95%	89.8%	87.9%	Arrears	88.8%
New Birth Visits - Islington	95%	96.1%	94.4%	Arrears	95.2%
Elective Caesarean Section rate	14.8%	12.0%	14.8%	11.5%	12.2%
Emergency Caesarean Section rate	-	19.1%	17.7%	17.1%	17.0%
Breastfeeding initiated	90%	92.1%	86.9%	93.7%	91.0%
Smoking at Delivery	<6%	6.6%	5.9%	3.9%	5.2%

Commentary

12+6

Issue: In July the service had a total of 400 bookings, only 333 referrals were made before the patient's 12+6 date. 15 patients booked outside of 12+6, 115 patient's DNA. In July 10+0 compliance was 74.47% (63.7% in June, 43.8% in May).

Action: Improvement to be seen in two months.

Timescale: August/September 2016. Staff continue to focus on the 10+0 target.

New birth visits June 2016:

Issue: slight fall in both boroughs this month. Fluctuations are expected at this level of performance; however, both boroughs should be achieving 95% each month as HV resource has improved across the services.

Islington: 14/250 late - 11/14 (78.6%) late NBVs in South locality

5 babies were in hospital; 3x staying elsewhere temporarily following delivery; 5x parental choice; 1x moved out of area

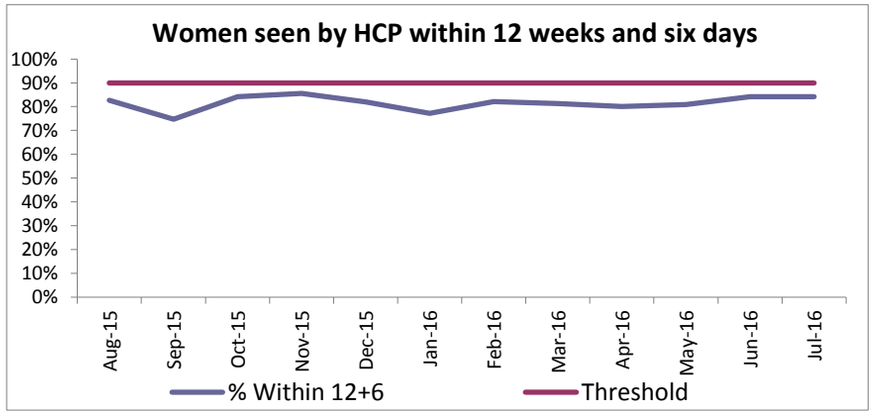
Haringey: 33/272 late - 18/33 (54.5%) late NBVs in Stuart Crescent team

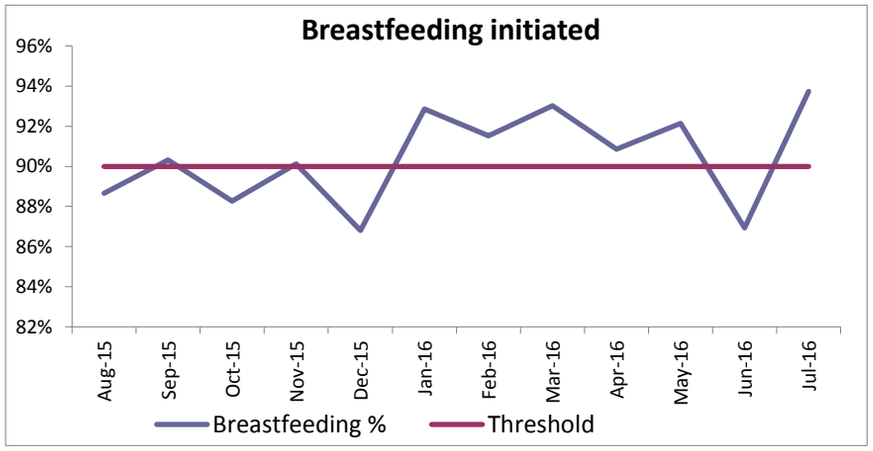
5 babies in hospital; 1x late notification; 5x staying elsewhere temporarily following delivery; 2x transfers into borough; 1x interpreter required; 14 due to parental choice; remainder no reason given

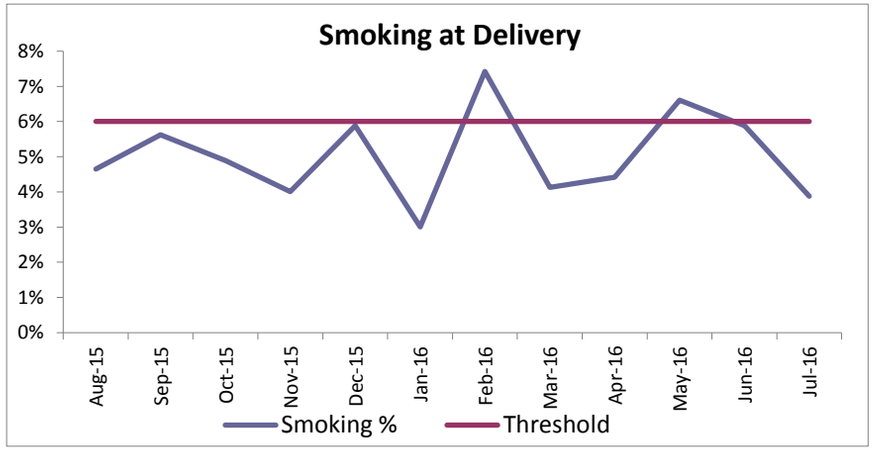
NB: **parental choice** to check how late an appointment was offered as suspect sometimes parents not given enough time to change date before 14 days

Smoking at Delivery

Target achieved







High Level Workforce Data

Table 1

Metric	Target or Benchmark	Source	Apr-16	May-16	Jun-16	Notes and Definitions
Staff Headcount	Trust Annual Plan	ESR	**4,212**	**4,238**	**4,233**	No. of staff employed at the end of the quarter
Staff in Post (FTE)	Trust Annual Plan	ESR	**3,837.16**	**3,857.06**	**3,852.00**	No. of staff employed at the end of the quarter
Establishment (FTE)	Trust Annual Plan	Finance Ledger	**4,401.71**	**4,403.13**	**4,406.87**	
Bank and Agency Use(WTE)		Bank Staff System	**717.24**	**699.71**	**704.62**	This month I have been given a report from Finance showing b&a use in wte (see table 2). It contains the wte for Apr,May and June 16
Vacancy Rate %	13%	Calculation	**12.9%**	**12.4%**	**12.6%**	The vacancy factor in qualified nursing has reduced further to 13.3%. The vacancy rate for HCAs has again fallen fro 17.6% to 11.7%.
Annual Turnover %	>13% - red 10-12% - amber <10% - green	ESR	**14.9%**	**14.9%**	**15.8%**	All ICSUs, with the exception of Women's Health Services, are above the 13% threshold. Patient Access, Prevention and Planned Care ICSU had the highest (23.3%) and Women's Health Services the lowest (9.3%)
Sickness %	> 3.5% - red 2.5-3.5% - amber <2.5% - green	ESR	**2.9%**	**3.3%**	**3.1%**	All areas are below 3.5% with the exception of Patient Access, Prevention and Planned Care (3.8%)
Appraisal Completion %	90%	ESR/OLM	**71%**	**69%**	**68%**	Concern about the drop in appraisal rate has been raised as a matter of urgency with ICSUs and Directorates. Each Director has been asked to prepare an action plan to rectify. In addition the new Trust Pay Progression Policy will be implemented from September 2016 whereby there will no longer be automatic increment progression and a satisfactory appraisal will be required before progressing. This should assist with overall compliance
Mandatory Training %	90%	ESR/OLM	**81%**	**81%**	**81%**	Percentage of staff compliant for mandatory training. Requirements vary by staff group and roles.

Table 2

Row Labels	Sum of 2016/17-Month 1
AGENCY	192.36
BANK	520.20
LOCUM	16.12

Whittington Health NHS

The Whittington
Hospital NHS Trust
Magdala Avenue
London N19 5NF
www.whittington.nhs.uk

Trust Board
7th September 2016

Title:	Nursing & Midwifery Strategy
Agenda item:	**16/123** **Paper 8**
Action requested:	For agreement
Executive Summary:	1. The three year Nursing & Midwifery strategy was developed with input from the Trust Nurses and Midwives following a number of engagement events held earlier this year 2. The strategy was formulated around the five key lines of enquiry used by the Care Quality Commission and sets out the strategic ambitions. 3. The strategy has clear improvement measures with clearly identified outputs over the three year period
Summary of recommendations:	Trust Management Group is asked to accept and support the Nursing & Midwifery Strategy.
Fit with WH strategy:	SG1- Deliver consistent high quality, safe service SG3- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population SG5 – Support patient to be active partners in their care
Reference to related / other documents:	Clinical Strategy and Workforce Strategy
Date paper completed:	8th August 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	Aug 16	**Equality Impact Assessment complete?**	n/a	**Risk assessment undertaken?**	n/a	**Legal advice received?**	n/a


Whittington Health
NHS
NURSING & MIDWIFERY
STRATEGY
2016 - 2019

Foreword

I feel extremely privileged to be leading the Nursing and Midwifery workforce who play a pivotal role in delivering high quality care to our patients and who represent a large proportion of the Trust's total employees.

This strategy has been developed by nurses and midwives following a series of 'listening events'. It articulates our intentions in a framework that supports the Trust mission to deliver high quality care.

The purpose of this Strategy is to define a series of ambitions which will be delivered by nurses and midwives over the next three years.

In developing this strategy we have considered feedback from our patients, their families and carers in terms of what safe, high quality care looks and feels like. It incorporates many of the 10 commitments of the 'Leading Change, Adding Value – a framework for nursing, midwifery and care staff' and supports the ambitions within Whittington Health's Clinical and Workforce Strategies.

Providing care for an ageing population remains a real challenge in the 21st Century. The time and skills needed to deliver kind, compassionate care for a person with complex needs, such as dementia, are significant and the healthcare professional's contribution to this is fundamental.

Our five ambitions represent stretching challenges for our nursing and midwifery staff, however they are based on solid foundations and I am confident that that they will be achieved.

Philippa Davies
Executive Director of Nursing & Patient Experience

Our nurses and midwives are the heartbeat of our Trust. They are directly involved in delivering almost every service for our Trust and have contact with all our patients. As a profession their contribution to high quality care has been recognised when Whittington Health was awarded an outstanding rating for care by the Care Quality Commission in July 2016, a remarkable achievement of which we are all immensely proud.

This strategy is their work and is a manifestation of the way we involve all who work here. It is a tribute to the strong and able leadership and the talented team that supports them.

I am privileged to contribute this foreword. It is a fine document of aspiration and ambition.

Whittington Health's mission is 'Helping local people live longer healthier lives'. This strategy shows how nursing and midwifery are delivering our mission.

Steve Hitchins
Chair, Whittington Health

Nursing & Midwifery Strategy 2016-2019

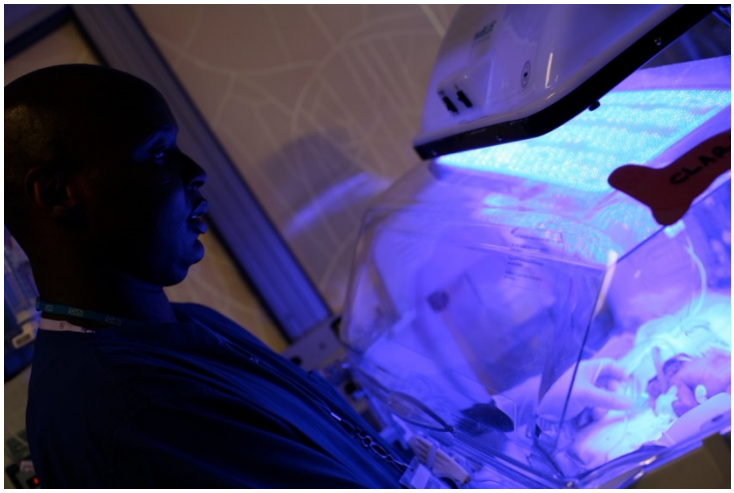
Safe

Ensuring our patients are safe is important to us. We need to ensure that we are doing the right thing, for the right patient, at the right time, in the right place, every time.

Ambition 1

Working together we will reduce harm and provide the best possible care for our patients

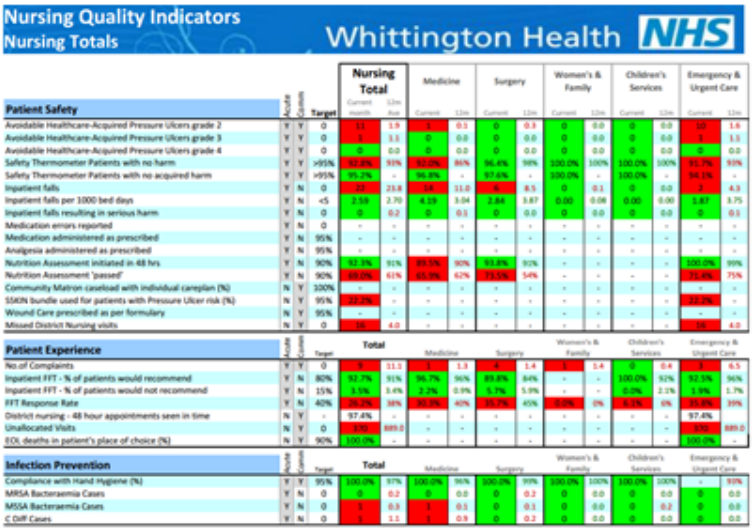
To achieve this, we will:



- Increase the number of nurses and midwives trained in the recognition and management of critical illness including the management of sepsis.
- Empower staff to generate an open, receptive culture
- Increase compliance with observations and recording of both National and Midwifery Early Warning Scores and further improve effective communication using SBAR
- Implement a medicines management work program.
- Reduce avoidable harm i.e. falls and pressure ulcers.
- Have correct nursing establishments with skill mix and rosters that reflect the requirement of the ward or service.
- Maintain high standards of infection prevention and challenge poor practice
- Have robust mentorship in place and embed clinical supervision
- Deliver high quality, safe, effective and compassionate care
- Advance practice and care by participating in clinical research and audits with a particular emphasis on improving clinical outcomes
- Continue to drive improvements in safety and quality of care through continuous learning from incidents, errors and complaints
- Speak out when we believe something is wrong and has the potential to compromise patient safety
- Embrace the delivery of effective and efficient services through enhancing skills and knowledge and the use of technology to ensure we have a competent workforce
- Continue to safeguard children, young people and vulnerable adults underpinned by education and training
- Ensure that we further develop a safeguarding culture which provides children, young people and adults with the protection they require
- Put processes in place to collectively learn and share lessons from complaints and incidents

To measure improvement we will:

- ✓ Use the monthly Safety Thermometer to show a decline in the number of hospital acquired falls, pressure ulcers, catheter associated urinary tract infections and VTE's
- ✓ Use Nursing & Midwifery Quality Indicators and the maternity dashboard to demonstrate continuous improvement
- ✓ Use incident reporting to demonstrate an overall reduction of incidents associated with harm
- ✓ Monitor complaints, concerns and PALS queries, identifying the themes and trends and learn from these to improve patient experience


Nursing Quality Indicators
Nursing Totals
Whittington Health NHS

Patient Safety	Acute	Comm	Target	Nursing Total Current month	Nursing Total 12m Ave	Medicine Current	Medicine 12m	Surgery Current	Surgery 12m	Women's & Family Current	Women's & Family 12m	Children's Services Current	Children's Services 12m	Emergency & Urgent Care Current	Emergency & Urgent Care 12m
Avoidable Healthcare-Acquired Pressure Ulcers grade 2	Y	Y	0	11	1.9	1	0.1	0	0.3	0	0.0	0	0.0	10	1.6
Avoidable Healthcare-Acquired Pressure Ulcers grade 3	Y	Y	0	1	1.1	0	0.0	0	0.0	0	0.0	0	0.0	1	1.1
Avoidable Healthcare-Acquired Pressure Ulcers grade 4	Y	Y	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Safety Thermometer Patients with no harm	Y	Y	>95%	92.3%	93%	92.0%	86%	96.4%	98%	100.0%	100%	100.0%	100%	91.7%	93%
Safety Thermometer Patients with no acquired harm	Y	Y	>95%	95.2%	-	96.8%	-	97.6%	-	100.0%	-	100.0%	-	94.1%	-
Inpatient falls	Y	N	0	23	23.8	14	11.0	4	8.5	0	0.1	0	0.0	7	4.3
Inpatient falls per 1000 bed days	Y	N	<5	2.59	2.70	4.19	3.04	2.84	3.87	0.00	0.08	0.00	0.00	5.87	3.75
Inpatient falls resulting in serious harm	Y	N	0	0	0.2	0	0.1	0	0.0	0	0.0	0	0.0	0	0.1
Medication errors reported	Y	N	0	-	-	-	-	-	-	-	-	-	-	-	-
Medication administered as prescribed	Y	N	95%	-	-	-	-	-	-	-	-	-	-	-	-
Analgesia administered as prescribed	Y	N	95%	-	-	-	-	-	-	-	-	-	-	-	-
Nutrition Assessment initiated in 48 hrs	Y	N	90%	92.3%	91%	89.5%	90%	93.8%	91%	-	-	-	-	100.0%	90%
Nutrition Assessment 'passed'	Y	N	90%	69.0%	61%	65.9%	62%	71.5%	54%	-	-	-	-	72.4%	75%
Community Matron caseload with individual careplan (%)	N	Y	100%	-	-	-	-	-	-	-	-	-	-	-	-
SSKIN bundle used for patients with Pressure Ulcer risk (%)	N	Y	95%	22.2%	-	-	-	-	-	-	-	-	-	33.3%	-
Wound Care prescribed as per formulary	N	Y	95%	-	-	-	-	-	-	-	-	-	-	-	-
Missed District Nursing visits	N	Y	0	16	4.0	-	-	-	-	-	-	-	-	16	4.0

Patient Experience	Acute	Comm	Target	Total		Medicine		Surgery		Women's & Family		Children's Services		Emergency & Urgent Care	
No.of Complaints	Y	Y	0	9	11.1	1	1.3	4	1.4	1	1.4	0	0.4	3	6.5
Inpatient FFT - % of patients would recommend	Y	N	80%	92.7%	91%	96.7%	96%	89.8%	84%	-	-	100.0%	92%	92.5%	96%
Inpatient FFT - % of patients would not recommend	Y	N	15%	3.5%	3.4%	2.2%	0.9%	5.7%	5.9%	-	-	0.0%	2.1%	1.9%	1.7%
FFT Response Rate	Y	N	40%	26.2%	38%	30.9%	40%	35.7%	45%	0.0%	0%	6.1%	6%	35.8%	39%
District nursing - 48 hour appointments seen in time	N	Y	-	97.4%	-	-	-	-	-	-	-	-	-	97.4%	-
Unallocated Visits	N	Y	0	1750	889.0	-	-	-	-	-	-	-	-	1750	889.0
EOL deaths in patient's place of choice (%)	N	Y	90%	100.0%	-	-	-	-	-	-	-	-	-	100.0%	-

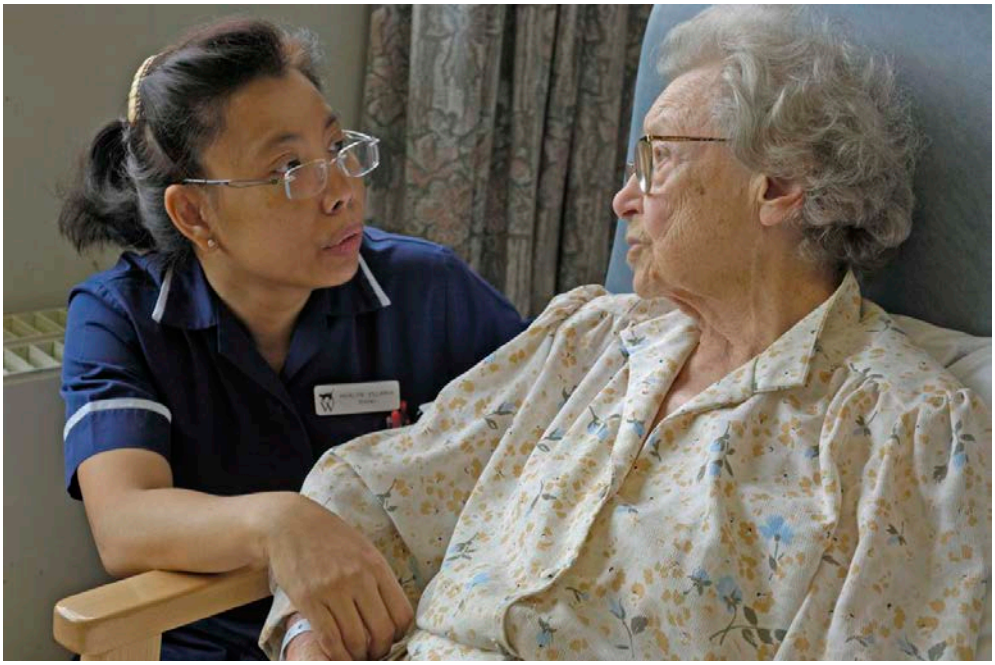
Infection Prevention	Acute	Comm	Target	Total		Medicine		Surgery		Women's & Family		Children's Services		Emergency & Urgent Care	
Compliance with Hand Hygiene (%)	Y	Y	95%	100.0%	97%	100.0%	96%	100.0%	99%	100.0%	100%	100.0%	100%	-	99%
MRSA Bacteraemia Cases	Y	N	0	0	0.2	0	0.0	0	0.2	0	0.0	0	0.0	0	0.0
MSSA Bacteraemia Cases	Y	N	0	1	0.3	1	0.1	0	0.1	0	0.0	0	0.2	0	0.0
C Diff Cases	Y	N	0	1	1.1	1	0.9	0	0.2	0	0.0	0	0.0	0	0.0

Caring

Caring is fundamental to the work we do every day. Patients have a right to be treated by appropriately qualified and experienced staff who are compassionate, kind and caring.

Ambition 2

We will respond with humanity and kindness to each person's pain, distress, anxiety or need. We will demonstrate this with a smile, a laugh, a hand held when needed, a shoulder to cry on or an arm to steady; we will listen to people's needs and respect the decisions they make.



To achieve this, we commit to:

- Being courteous to one another and give thanks where due
- Continue to promote the values and behavioural standards set out in our 'I.C.A.R.E values
- Involve patients, carers and expectant mothers in planning the care they receive
- Ensure that patients have adequate food, fluids and support with feeding
- Ensure all staff have sufficient knowledge and experience to enable effective decision making on behalf of adults who may lack capacity to make decisions on their own
- Use patient stories and feedback to drive improvement in care we deliver
- Make time to care.
- Review the recruitment process in the Trust to ensure we recruit staff with the right ethos and attitudes
- Work with our local universities to ensure we recruit the right students for our clinical professions

- Continuously review and feedback to universities when students require academic support
- Support and mentor our new nurses and midwives
- Set out clear expectations to all new Nurses and Midwives
- Use performance dashboards to report and drive improvements in care delivered

To measure Improvement we will:

✓ Monitor the number of complaints, concerns and PALS queries, identifying the themes and trends

✓ Use the results from national and local patient experience surveys to demonstrate improvement in specific areas.

✓ Use Ward to Board reporting of patient experience survey results to identify themes and trends

✓ Use Nursing and Midwifery Quality Indicators and maternity dashboard to demonstrate continuous improvement

Effective

Ambition 3

We will strive to deliver clinical and therapeutic care that is research based and benchmarked with best practice. We will put measures in place to identify themes, trends and strive for continuous improvement

To achieve this, we commit to:

- Support and engage in a peer service review process that encourages and supports improvement.
- Act on staff and patient feedback.
- Contribute to a robust process of answering complaints and completing investigations and disseminating lessons learnt in agreed time frames.
- Understand, contribute and action key performance indicator findings.
- Have a clear professional career progression from health care assistants to advanced practitioners.
- Have an effective appraisal process that encourages growth and development.
- Develop research projects and innovative practice that can be shared locally, regionally, nationally and internationally.
- All clinical nurses and midwives will deliver an improved patient experience which results in less patient time spent in the acute care setting
- Nurses and midwives will recognise their personal accountability in driving quality while reducing overall cost.
- Reviewing opportunities to encompass new ways of working
- Continually support staff to further their professional education and development
- Continue to support the revalidation of nurses and midwives
- Promote productivity and innovation
- Promote and deliver nurse-led discharge
- Respond to national guidance to support the future development of our non-registered nursing work force.
- Ensure that our shift handover is productive, safe and effective
- Empower nurses and midwives to improve the patient and carer experience and be a strong patient advocate.
- Recognise good clinical practices and share widely
- Learn from others and celebrate local improvements in care
- Promote innovations and support suggestions
- Encourage staff to publish and present their work with a wider audience

To measure improvement we will:

- ✓ Monitor the number of complaints, concerns and PALS queries, identifying the themes and trends
- ✓ Monitor internal promotions and career development of staff
- ✓ Implement career coaching to retain staff
- ✓ Monitor research activity monthly and increase the number of participants enrolled in to research studies
- ✓ Record the number of learned/academic publications produced by our nursing and midwifery staff

Well led – Leadership

Ambition 4

To create and promote a culture and centre of excellence we require leaders who possess certain behavioural qualities; these include vision, commitment and the ability to motivate and lead others.

To achieve this, we commit to empower all our staff to:

- Act always in accordance with standards set within the Professional Code at all times
- Set standards of care that are clear and professional.
- Act as role models.
- Promote and develop Whittington Health to be the best and to be a 'centre of excellence' for Nurses and Midwives to work.
- Have effective, inclusive leadership walkabouts and promote visibility of clinical leaders
- Support an environment where clinical excellence can flourish.

- Identify talent and develop succession planning.
- Develop a training programme for senior staff/ward sisters, team leaders, midwives and their deputies that incorporate and utilise new and recognised leadership methodologies.
- Encourage all staff to complete the NHS staff survey.
- Set out our leadership vision and ensure our staff are equipped to lead by using the Trust's leadership training programme
- Use recognised change methodologies to empower staff to improve care.
- Ensure robust governance.
- Contribute to the development of a service user and carer experience strategy.
- Value each other and understand each other's roles.
- Recruit talented individuals who share our vision and values and demonstrate our required behaviours
- Increase our retention rate
- Reduce our reliance on temporary staff
- Reduce our sickness absence rates
- Deliver services within agreed budgets
- Use our specialist nursing and midwifery roles to improve practice, pioneer new, innovative ways of working and continually promote excellence in practice

In addition, Ward / Department/ Area Sisters, Charge Nurse and Team Leaders will:

- Increase the time spent in clinical leadership activity to at least 75% of their time.
- Ensure they are known to all patients in the ward or department or have systems in place to maximise clinical leadership visibility in community teams.
- Be educated to Masters level

To measure improvement we will:

- ✓ Measure compliance against individual appraisal rates by ISCU
- ✓ Monitor the participation in and results of the staff satisfaction survey
- ✓ Measure compliance with the uptake of mandatory and professional training
- ✓ Monitor uptake of post graduate professional training through continuing professional development
- ✓ Monitor and act on feedback from educational audits completed by pre-registration students
- ✓ Monitor the number of walkabouts and analyse themes for improvement
- ✓ Monitor promotions and internal development of existing staff
- ✓ Monitor the sickness rates by ICSU
- ✓ Monitor completion of E-Rostering rosters across all areas
- ✓ Monitor the Nursing and Midwifery Quality Indicators and ensure continued improvement
- ✓ Monitor and facilitate the participation in leadership training courses for all grades of staff
- ✓ Develop and implement a ward accreditation scheme

Responsive to People's needs

Ambition 5

Patients tell us their experience of care is as important to them as clinical effectiveness and safety. They want to feel informed, supported and listened to. They want to be treated as a person, not a number and they value efficient processes.

To achieve this, we commit to:

- Encourage and promote the NHS Friends and Family test.
- Communicate in a professional way.
- Work with other organisations and providers to enable clear discharge planning.
- Treat people as individuals and treat them as you would want to be treated.
- Embed clinical supervision.
- Learn and plan from patient experience initiative
- Develop a clear portfolio of educational opportunities, recognizing the importance of work related learning, theoretical knowledge and research
- Provide the opportunity to increase the number of nurses and midwives with Bachelor and Masters degrees
- Develop grade specific competencies and appropriate education programmes to support individuals within each banding
- Support our students as the Whittington Health workforce of tomorrow, talent spotting and encouraging their future employment with us
- Develop our preceptorship programme so we retain our newly qualified nurses and midwives
- Develop mentors who support and grow our students
- Give **all** new nursing and midwifery starters a positive induction and outline expectations clearly
- Support our staff in their development and equip aspiring leaders to become leaders of tomorrow
- Develop and implement our Back to the Floor 'work with' initiative

To measure improvement we will:

- ✓ Use the qualitative statements from patient FFT satisfaction survey to monitor improvements in patient satisfaction
- ✓ Monitor agreed KPI's to ensure compliance with rostering best practice
- ✓ Monitor agreed workforce KPI's through monthly Nursing and Midwifery Quality Indicators reported by ward ICSU and Trust level
- ✓ Facilitate an increase in both participation and response scores of the Friends and Family Test results (staff and patient)
- ✓ Actively engage all staff to maintain continued professional development through the appropriate use of the Training Needs Analysis
- ✓ Provide and support preceptorship programmes for all newly qualified and return to practice professionals
- ✓ Establish a 'back to the floor – work with' programme for all professionals in managerial/leadership positions.

Ambition 1

Working together we will reduce harm and provide the best possible care for our patients.

SAFE		
2016/17	**2017/18**	**2018/19**
Reduce the number of inpatient falls by 25%	Reduce the number of inpatient falls by a further 25%	Reduce the number of inpatient falls by a further 5%
Reduce the number of inpatient fractures from falls by 25%	Reduce the number of inpatient fractures from falls by 25%	Continued good practice to ensure sustained improvements
Eliminate all avoidable acquired pressure ulcers by December 2016	Maintain zero acquired avoidable pressure ulcers	Maintain zero acquired avoidable pressure ulcers
85% of patients to have malnutrition universal screening tool assessment (MUST)	95% of patients to have a malnutrition universal screening tool assessment (MUST)	100% of patient to have a malnutrition universal screening tool assessment (MUST)
85% of patients to have their hydration needs assessed and met	90% of relevant patient to have their hydration needs assessed and met	95% of relevant patient to have their hydration needs assessed and met
Nursing indicators to be included in Ward to Board reports	Excellent performance to be maintained and action plans in place to address areas of underachievement	Excellent performance to be maintained and action plans in place to address areas of underachievement
Establish new Children's Dashboard with appropriate indicators	Excellent performance to be established and maintained	Excellent performance to be maintained and action plans in place to address areas of underachievement
Increase the number of spontaneous vaginal births to 60%	Increase the number of spontaneous vaginal births to 65%	Increase the number of spontaneous births to 70%
Increase the overall reporting of incidents using Datix from 15/16 baseline	Increase the overall reporting of incidents using Datix from 16/17 baseline	Increase the overall reporting of incidents using Datix from 17/18 baseline
Using the Safety Thermometer monitor the continued improvement of safe care targeting specific areas of underperformance	Using the Safety Thermometer monitor the continued improvement of safe care targeting specific areas of underperformance	Using the Safety Thermometer monitor the continued improvement of safe care targeting specific areas of underperformance
Increase the number of planned deaths in place of patient choice	Increase the number of planned deaths in place of patient choice by 10%	Increase the number of planned deaths in place of patient choice by 10%

Ambition 2

We will respond with humanity and kindness to each person's pain, distress anxiety or need. We will demonstrate this in a smile, a laugh, a hand held when needed, a shoulder to cry on or an arm to steady; we will listen to people's needs and respect the decisions they make.

CARING		
2016/17	**2017/18**	**2018/19**
90% of wards and departments to be delivering target minimum Friends and Family (FFT) response rate and capturing patient feedback using Meridian trackers	95% of wards and departments to be delivering target minimum FFT response rate and capturing patient feedback using Meridian trackers	95% of wards and departments to be delivering target minimum FFT response rate and capturing patient feedback using Meridian trackers
Deal with complaints 'in the moment' and aim to reduce written complaints by 5%	Continue to deal with complaints 'in the moment' and aim to reduce written complaints by a further 5%	Continue to deal with complaints 'in the moment' and aim to reduce written complaints by a further 5%
All relevant patients to be assessed using Mental Capacity Act assessment tools	All relevant patients to be assessed using Mental Capacity Act assessment tools	All relevant patients to be assessed using Mental Capacity Act the assessment tools

Ambition 3

We will strive to deliver clinical and therapeutic care that is research based and benchmark with best practice. We will put measures in place to identify themes, trends and strive for continuous improvement.

EFFECTIVE		
2016/17	**2017/18**	**2018/19**
Training needs of all staff to be identified yearly at appraisals and communicated to the Learning & Development department	Training needs of all staff to be identified yearly at appraisals and communicated to the Learning & Development department	Training needs of all staff to be identified yearly at appraisals and communicated to the Learning & Development department
Opportunities to participate in local and national research studies to be sought	Evidence of nursing and midwifery staff participating in local and national research studies	Evidence of publication and presentation from research studies and/or service design
Develop a nursing & midwifery research strategy	Provide a series of research seminars to increase staff capability and capacity for research	Achieve a minimum of 5 staff to attend MRes Masters' degree programme
Develop a Nursing & Midwifery Conference of innovation and excellence	Develop a Nursing & Midwifery Conference of innovation and excellence	Develop a Nursing & Midwifery Conference of innovation and excellence
Demonstrate action of staff feedback	Demonstrate action of staff feedback	Demonstrate action of staff feedback
85% of all Nurse & Midwives staff to have received an appraisal	90% of all Nurse & Midwife staff to have received an appraisal	95% of all Nurse & Midwife staff to have received an appraisal

Ambition 4

To create a 'centre of excellence' we require leaders who possess certain behavioural qualities; these include vision, commitment and the ability to motivate and lead others.

WELL LED – LEADERSHIP

2016/17	2017/18	2018/19
Demonstrate action of staff feedback	Demonstrate action of staff feedback	Demonstrate action of staff feedback
Increase the participation of the staff survey by 15%	Increase the participation of the staff survey by 20%	Increase the participation of the staff survey by 10%
Networking and shadowing opportunities provided for Senior Staff	Networking and shadowing opportunities provided for Junior Staff	Networking and shadowing opportunities provided for all staff Nurses & Midwives
100% of interviews and appraisals to test the understanding and application of the Trust's core values	Interviews and appraisals to continue to test the understanding and application of the Trust's core values	Interviews and appraisals to continue to test the understanding and application of the Trust's core values.
100% of relevant staff will have had a meaningful appraisal	100% of relevant staff will have had a meaningful appraisal	100% of relevant staff will have had a meaningful appraisal
100% of relevant staff will be up-to-date with statutory and mandatory training	100% of relevant staff will be up-to-date with statutory and mandatory training	100% of relevant staff will be up-to-date with statutory and mandatory training
Retention rate improved by 10%	Retention rate improved by further 5%	Retention rate improved by further 5%
Skill mix reviewed and reduction in reliance of temporary staff	Skill mix reviewed and reduction in reliance of temporary staff	Skill mix reviewed and reduction in reliance of temporary staff
10% Reduction in sickness absence rates	Further 5% Reduction in sickness absence rates	Further 5% Reduction in sickness absence rates
Services delivered within agreed budgets	Services delivered within agreed budgets	Services delivered within agreed budgets
Expectations of professional behaviour to be reminded and challenged where appropriate and showcased by Nurse/Midwife leaders	Expectations of professional behaviour to be reminded and challenged where appropriate and showcased by Nurse/Midwife leaders	Expectations of professional behaviour to be reminded and challenged where appropriate and showcased by Nurse/Midwife leaders
All staff to be supported through their Professional Revalidation	All staff to be supported through their Professional Revalidation	All staff to be supported through their Professional Revalidation
Introduce leadership walkabouts with direct staff engagement	Increase the number of leadership walkabouts by 10%	Increase the number of leadership walkabouts by 15%

Ambition 5

Patients tell us their experience of care is as an important as clinical effectiveness and safety. They want to feel informed, supported and listened to. They want to be treated as a person, not a number and they value efficient processes.

RESPONSIVE TO PEOPLES NEEDS		
2016/17	**2017/18**	**2018/19**
Good news stories to be shared and celebrated on a regular basis	Good news stories to be shared and celebrated on a regular basis	Good news stories to be shared and celebrated on a regular basis
80% of nursing rosters to be managed and published four weeks before they begin	80% of nursing rosters to be managed and published four weeks before they begin	80% of nursing rosters to be managed and published four weeks before they begin
Nursing and Midwifery staff participating in the internal staff survey and actions to be put in place to improve satisfaction	A 5% increase of satisfaction demonstrated through the internal staff	A 25% increase of satisfaction demonstrated through the internal staff survey
Programme of talent mapping and succession planning in place		

Acknowledgements

We would like to thank everyone who attended the engagement whose ideas informed our ambitions and led to the development of this strategy.


care
clinical
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Develop
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Increase
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leaders
experience
AHP's
ensure
commit
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education
development
deliver
complaints
improvement
Encourage
Reduce
safety
adults
Continue
Midwives
ways
universities
Learn
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efficient
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Set
Midwifery
performance
compassionate
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Empower
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Patients
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AHP
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methodologies
management
place
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continuous
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planning
enable
innovative
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process
every
Contribute
Whittington
harm
working
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improvements
time
future
excellence
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drive
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ward
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productive
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Whittington Health NHS

Whittington Health Trust Board

7 September 2016

Title:	Community Forum		
Agenda item:	**16/124**	**Paper**	**09**
Action requested:	To note the report and approve the Terms of Reference		
Executive Summary:	This paper updates the Board on the development of the Trust Community Forum. The Board agreed to support the development of the Forum and to receive a progress report in the Autumn. The progress has been significant over the summer as can be seen from this report and the draft terms of reference are included for Trust Board approval. The original objective was to build a database of 100, 000 residents, patients and supporters across Islington and Haringey who will engage interactively and mostly digitally with the Trust. This will support the Trust's ability to engage robustly and regularly and reflect the community's ambitions for healthcare in our two boroughs.		
Summary of recommendations:	To approve the Terms of Reference		
Fit with WH strategy:	Aligns with Clinical Strategy and Communication and Engagement Strategy		
Reference to related / other documents:	Fits with Whittington Health regulatory framework		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on BAF and Risk Registers		
Date paper completed:	August 2016		

Author name and title:		**Siobhan Harrington, Deputy CEO and Director of Strategy**		**Director name and title:**		**Siobhan Harrington, Deputy CEO and Director of Strategy**	
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**

Whittington Health Community Forum

Trust Board Update

September 2016

This paper updates the Board on the development of the Trust Community Forum. The Board agreed to support the development of the Forum and to receive a progress report in the Autumn. The progress has been significant over the summer as can be seen from this report and the draft terms of reference are included for Trust Board approval.

The original objective was to build a database of 100, 000 residents, patients and supporters across Islington and Haringey who will engage interactively and mostly digitally with the Trust. This will support the Trust's ability to engage robustly and regularly and reflect the community's ambitions for healthcare in our two boroughs.

There will be a separate forum for under-17s which we have yet to develop.

1. Progress to date

1.1 Building the database

The database for the Forum has a significant starting point of 3000 contacts with email addresses from former members, complainants, volunteers and former shadow governors.

Both councils, both lead voluntary sector umbrella groups and a number of larger voluntary sector organisations have welcomed the Forum and agreed to forward an email message from the Trust. A link has been created on our website where people will be asked to sign in and offered to participate with the Forum.

The aspiration is to reach at least 60,000 people this September.

The Trust's free wi-fi now has an opt-out box releasing those who don't want "to hear more about Whittington Health" which has produced c6000 contacts each month.

Local voluntary sector organisations are supporting the work. It will take time to develop and they will distribute paper copies of our planned e-letter.

The Chairman has attended Youth Council and Voluntary and community sector events in August and September; these are continuing into the Autumn. The voluntary sector will be particularly critical in achieving a diverse and representative forum.

The forum is also promoted through our use of existing social media channels of Twitter and Facebook.

1.2 Activities

We have held a small number of meetings which were promoted to the Forum members which resulted in around 40 people attending. These meetings have been held during the day on a week day. From this group a core group met to discuss Terms of Reference which were then shared and agreed more widely. The intention is to engage with people more broadly than those who can attend meetings so it is not envisaged that there will be regular meetings.

The forum has been discussed at local Scrutiny Committees and with Healthwatch and the CCGs.

An E newsletter has been developed and circulated to all contacts in the Forum.

2. Next steps

2.1 Extending the Forum

Community groups will be contacted through the Autumn. We are also exploring the opportunities through engaging with a local platform network "Nextdoor" which is launching in September and will enable us to contact all their members across Islington & Haringey.

The method for staff engagement in the forum will be considered with staff.

2.2 Future activities

Future activities have been suggested by Forum members which include seminars on health related topics and the work of Trust staff (eg Sickle Cell, Obesity, Dementia, Day in the life of a district nurse); an Open Day at the Trust; occasional open meetings; fund-raising activities; celebratory events (Christmas Lights switch-on) and possibly future public health campaigns. Members have been very positive about being engaged in Trust policy development before the Board make decisions.

We will ensure that the planning of these activities fits within the communications strategy and plan for the Trust.

3. Resources

A volunteer has been engaged to work on the database.

It is proposed to identify a budget of £5000 to support the development and work of the Forum and funding sources are being sought.

The Board are asked to note this progress report and agree the terms of reference for the Trust Community Forum.

Appendix 1

DRAFT TERMS OF REFERENCE

THE FORUM

The forum will be called Whittington Health Community Forum.

PURPOSE

Whittington Health Community Forum exists to facilitate two-way empowerment and engagement with communities that Whittington Health serves.

The Forum shall be representative of all our communities.

The Trust commits that the forum will be involved with all significant decisions whenever possible to enable the Board to be informed of the forum's views before decisions are taken by the Board.

These views will be reported to the Board when decisions are taken.
The forum cannot discuss or become involved in any matter relating to an individual or group of patients.

PARTICIPANTS

The Whittington Health Community Forum is not a membership organisation but is open to:

- patients and former patients;
- their carers or former carers;
- staff colleagues and former staff colleagues;
- anyone who has an interest in either Whittington Health or health services delivered in our area;
- anyone who lives or works in Islington or Haringey
- anyone who attends voluntary or community groups in Haringey or Islington.

Participants at the Forum are expected to adhere to the Nolan principles of public life.

COMMUNICATION

The Whittington Health Community Forum will communicate digitally in the main and a variety of digital platforms may be utilised.

Communication will be two-way and interactive.

Assistance from any participant in the forum to relay information and messages to those with/without access to digital technology through their independent networks is welcomed and encouraged.

Every communication will offer participants the opportunity to both unsubscribe from the forum's participation list and also to enlist more new names to add to our list of participants.

ACTIVITY

The Chair of the Whittington Health Trust Board will convene the Whittington Health Community Forum.

The forum will have a flat and low-cost structure.

All participants will receive regular communications which will be limited in quantity and frequency.

Occasionally the forum will establish ‘task and finish’ smaller groups to consider specific matters. These groups will operate for a limited period only. All those whose email address is registered will be invited to every event held.

EVENTS may include:

- Seminars on health related topics and the work of Trust staff
- Open Day at the Trust
- Engagement over Trust Policy before Board decisions
- Occasional open meetings
- Fund-raising activities
- Celebratory events
- Health campaigns
- Involvement in specific projects

All events will be organised with appropriate notice to the Forum.
Events may be organised to coincide with nationally planned events.

The Whittington Health Board meetings and Annual General Meeting are held in public and all are welcome to attend.

REPORTING

There will be a short report on Whittington Health Community Forum's activities to the Trust's Annual General Meeting.

The Chair will report on the forum’s activities and views to the Trust Board.
These Terms of Reference will be reviewed by the Forum annually.

July 2016

Whittington Health NHS

Workforce Directorate
Direct Line: 020 7288 3696
www.whittington.nhs.uk

TRUST BOARD

7th September 2016

Title:	2015 NHS Staff Survey Action Plan		
Agenda item:	16/125	Paper	10
Action requested:	Board members are asked to note the corporate staff survey actions agreed and progress made within the action plan. Whilst there are still a few actions to be completed, Board members are asked for their support in the completion of these actions, and in particular adding unconscious bias training to our recruitment process and as a requirement for recruitment panel members.		
Executive Summary:	• Good progress has been made in the development and execution of the staff survey corporate action plan. • We have high level of engagement in cascading the results through the ISCUs and more local service team meetings. With the Clinical Directors and HRBP there has been more staff engagement and involvement of staff in the improvement actions at a local level. • Quarterly ICSU performance reviews with the Director of Workforce ensures that actions are being delivered at a local level • 23 of the 31 corporate actions have been completed. Of the other 8, activities are happening and most are likely to be completed by the end of 2016. The unconscious bias training used as part of the recruitment process will not be completed until 2017. • At an ICSU level we have received 5 of the 7 plans. 2 are outstanding primarily due to a delay in the recruitment of the third HRBP who starts in September. In the meantime the Director of Workforce is monitoring progress via ICSU performance reviews. • Planning preparations have started for the 2016 staff survey, where we intend to run a mixed mode random sample survey for 1250 staff.		
Fit with WH strategy:	Staff engagement around the staff NHS survey is a key priority in the OD and Workforce Strategy for the Trust.		
Reference to related / other documents:			
Reference to corporate risks on the BAF	HR Risk register Item number 13		
Date paper completed:	2nd August 2016		
Author name and title:	**Raimondo Gallo Leadership Coach**	**Director name and title:**	**Norma French Director of Workforce**

CORPORATE STAFF SURVEY ACTION PLAN 2016

	Staff Pledge 1 – To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities. **Areas for Improvement following staff survey feedback:** • **Staff satisfaction with level of involvement and responsibility** • **Staff satisfaction with resourcing and support**				
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	The development of a staff communication and engagement plan, which keeps staff up to date and encourages involvement	• Staff survey results, TMG report and action plan communicated and placed on the intranet	Director of Communications	Improved staff survey scores in 2016	First point completed
2.	CEO Briefings – Ensure the right managers are attending and that team briefings are happening locally within their business areas	• Clear communications to relevant staff advising CEO briefing dates and follow-up briefing notes to cascade	Director of Communications	Quarterly staff FFT and staff survey results 2016	Action Completed
3.	Operational staff are involved in our Organisational / service transformation plans, CIP	• Meeting arranged with our COO to coincide with the establishing of a PMO office for our Service Improvement plans.	Chief Operating Officer Service Improvement	Signed-off SI paper at TMG	Oct 2016

	/ QIP	• Meeting held with Service Improvement director who is focused in the building of a service improvement culture. P{aper as to approach to be presented at TMG / Trust Board in September / October 2016	Director		
4.	Cascade of Level 2 / 3 staff survey results to ICSU's and service areas. HRBP / OD support offered where necessary in facilitating staff survey action planning workshops	• Distribute all L2/L3 staff surveys to Clinical / Operations Directors and appropriate heads of service • Offer analysis workshop support to ICSU's and corporate functions • HR Managers to ensure each ICSU develops a staff survey action plan for their areas with appropriate engagement from staff	Clinical Directors Leadership Coach HR managers	ICSU Completed staff survey action plans and corporate staff survey action plans developed. On-going progress monitored as part of the quarterly performance management meetings with the Director of Workforce	All staff surveys completed. Analysis and staff survey presentations provided where requested. Action Completed
5.	Organisational goals and objectives cascaded within service areas and individual objectives aligned so there is a clear line of sight between individual role and organisational objectives	• ICSU business plans completed • Business planning peer review meetings to be undertaken at which point ICSU business plans to be cascaded to all staff	Clinical Directors	Director of Workforce to hold CD to account as part of their quarterly performance reviews	Action completed

Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

Areas for Improvement following staff survey feedback:

- **Staff appraised in last 12 months**

	What do we need to do?	HOW WILL WE DO IT?	WHO IS RESPONSIBLE & WHEN?	HOW WILL WE MEASURE IT?	Action plan progress update
1	Continue with managers' appraisal training twice monthly	Twice monthly appraisal training for managers delivered by the leadership coach	Leadership Coach	Monthly appraisal compliance statistics 2016 NHS Staff Survey Results	Action on-going and completed
2	Continue with staff appraisee training once a quarter	Part of the L&D training budget is used to provide appraisee training bi-monthly	Head of L&D	Monthly appraisal compliance statistics 2016 NHS Staff Survey Results	12 half-day sessions between May 2016 to March 2017 commissioned and promoted for appraisees to access. Actions on-going and completed
3	Monthly appraisal performance reporting to TMG	Director of Workforce to hold CD's to account as part of their monthly performance meetings	Director of Workforce	Monthly appraisal compliance statistics2016 NHS Staff Survey Results	Actions on-going and completed

4	ICSU monthly performance reporting to Executive team	Director of Workforce to hold CD's to account as part of their monthly performance meetings	Director of Workforce	Monthly appraisal compliance statistics 2016 NHS Staff Survey Results	Actions on-going and completed
5	Quarterly reporting to Workforce Assurance Committee and Trust Board	The Workforce Assurance Committee meets quarterly basis and receives a comprehensive corporate workforce report	Director of Workforce		

Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety.
Areas for Improvement following staff survey feedback:

- Working extra hours
- Suffering work related stress
- Organisation and management interest in and action on health and wellbeing
- Experiencing physical violence from staff
- Reporting most recent experience of violence
- Experiencing harassment, bullying or abuse from patients or relatives
- Experiencing harassment or bullying from staff
- Reporting most recent experience of harassment, bullying or abuse

	What do we need to do?	HOW WILL WE DO IT?	WHO IS RESPONSIBLE & WHEN?	HOW WILL WE MEASURE IT?	Action plan progress update
1	Occupational Health (OH) to promote the use of the stress self-assessment questionnaire	Stress survey used as part of the monthly appraisal training for managers OH nurses advise managers to do stress risk assessments as per policy. District nurse – HSE questionnaire and subsequent stress work shop delivered by IAPT team. Stress questions covered in Health	Head of OH		On-going Action completed Ongoing Awaiting date Report expected Sept 16

		workplace survey – await report			
2	L&D to organise training for managers around work related stress	To be reviewed due to collaborate and align with OH provision.	Head of L&D	Take-up of attendance to mindfulness training.	On-line tool to be developed for roll-out alongside mindfulness training – November 2016
3	Promote the Employee Assistance Programme (EAP) through OH and other support available through OH	Met with comms 2 months ago - web link to our EAP and screen savers created. Posters circulated to community sites. Information displayed in OH and all staff aware of referral process. People at Work video sent to comms. EAP info distributed at induction	Head of OH		Completed Screen savers also sent to community PCs Video sent to Internal communications manager to host on intranet Info distributed
4	Promote bi-annual health and well-being month, promoting well-being for staff and what is on offer	We have set up a Wellbeing page on the intranet which is dedicated to listing bi monthly health theme and listing up and coming events Notice board used to promote health events for staff Tweeting lunchtime walks and other events	Head of OH		On-going Action completed Notice board now in situ in N19

		Staff health and wellbeing event planned for 5th July 2016 We have purchased a notice board for the staff canteen to promote up and coming staff events and health initiatives We will be recruiting for Wellbeing champs Applying for Excellence Charter award			Staff event held on 5th July – very positive feedback Notice board now in situ in N19 Preparation for Excellence presentation on 31/10/16
5	Introduce a half yearly health and safety bulletin communicated to all staff	This is on-going on a monthly basis on the web page	Head of OH		Action completed
6	Trained bullying and harassment advisors, available to both alleged victims and alleged perpetrators	2-day Anti-bullying and harassment training undertaken by 15+ staff to become Advisors. Scheme launched in June 2016.	Head of L&D	Excellent feedback. B&H advisors to be provided with on-going support from our E&D lead	Action completed
7	Develop our unconscious bias masterclass for all managers	4 x half day Unconscious Bias masterclass delivered during May and June 2016.	Head of L&D	Excellent feedback from participants who attended. Less than 50% attendance in terms of course capacity and 'no-	Action completed

				shows', therefore poor attendance overall.	
8	Re-enforce our organisational values and zero tolerance of bullying and harassment	Organisational values reinforced through the Anti-bullying and harassment training of advisors and the scheme. The scheme's logo will reflect the Trust's core values, in particular 'respect'. Appraisal training re-enforces the need to have conversations with staff about behaviours and our organisational values I·CARE Bullying Stops	Head of L&D	Quarterly staff FFT and 2016 staff survey	Action completed
9	Equality and Diversity training introduced as management induction training	Revised 'managing diversity' to be offered as part of induction for new staff and refresher for existing managers – every 3 years.	Head of L&D	Quarterly reporting via ESR from December 2016	On-going 01/04/17
10	Incorporate unconscious bias training as part of our recruitment and retention workshops	New Head of Recruitment and Deputy to attend next available Unconscious Bias training.	Head of L&D	Attendance achieved to an Unconscious Bias training event.	On-going 01/04/17

11	Review and promote our flexible working policy	Policy review completed and ratified. ER manager currently developing a policy communications protocol. Policy to be promoted in accordance with new policy communications protocol.	Employee Relations Manager		April 2016 completed Awaiting completion date from ER Manager

	Staff Pledge themes – Equality and Diversity Areas for Improvement following staff survey feedback: • Experiencing discrimination at work • Believing the organisation provides equal opportunity for career progression / promotion				
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Develop our unconscious bias masterclass for all managers	Design, promote and deliver unconscious bias training.	Head of L&D	Level of attendance and feedback/evaluation	Completed
2.	Refresh our E&D training as a formal programme	Review and launch updated E&D offerings as a formal programme.	Head of L&D	Monitor take-up via mandatory training and training activity monitoring via ESR.	To be implemented April 2017.
3.	Re-enforce our organisational values and zero tolerance of bullying and harassment	Organisational values reinforced through the Anti-bullying and harassment training of advisors and the scheme. The scheme's logo will reflect the Trust's core values, in particular 'respect'. Appraisal training re-enforces the need for managers to have conversations	Head of L&D	Quarterly staff FFT and 2016 staff survey	Action completed

		with our staff on organisational values and behaviours			
4.	Trained bullying and harassment advisors, available to both alleged victims and alleged perpetrators	2-day Anti-bullying and harassment training undertaken by 15+ staff to become Advisors. Scheme launched in June 2016.	Head of L&D		B&H advisor training completed. On-going support to be provided by the E&D lead Action completed
5.	Incorporate unconscious bias training as part of our recruitment and retention workshops	To be reviewed as part of the review of recruitment and retention training.	Head pf L&D		See staff pledge – above – item 10 01/04/17
6.	To introduce and monitor outcomes relating to workforce race equality standards	July 2016 as indicated by the revised Workforce Race Equality Standard (WRES) and proposed Disability standard.	Head of L&D	Via quarterly reports to Workforce Assurance Committee	On-going

	Staff Pledge themes – Errors and incidences Areas for Improvement following staff survey feedback: • Reporting errors, near misses or incidents witnessed in last month • Action Staff feeling confident and secure in reporting unsafe practice				
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Review mechanism for staff feedback who report an incident	The new Datix System was launched on June 1st 2016 to ensure a user friendly system which meets the organisation's reporting needs.. The new system will be aligned to the Trust organisational structure and new ICSU. All Datix users profiles will be reviewed and updated to ensure only active Datix users appears on Datix. All users no longer working in the Trust have now been locked out of the system and we are automatically alerted to new leavers now by IMT (We have closed about 160 accounts!) Profiles and access of existing users (over 650) are being checked	Head of Integrated Risk Management Director of Nursing	Datix audit trial	Rolling out new function on datix Complete

		individually and this is nearly complete The new Datix reporting form will take no longer than 5 minutes to complete.			
2.	Commitment to staff to acknowledge they reported an incident, and when they can expect feedback	As part of the upgrade a new Datix feature will be incorporated to ensure Datix feedback will be provided to each member of staff reporting an incident on Datix once the Datix handler is reviewing and concluding the incident. Note that automatic feedback is not yet switched on. We wanted to get people used to the new system and train Managers. It will be switched on by the end of July	Head of Integrated Risk Management	Datix audit trial, training sessions (Trust induction, datix, duty of candour, risk management, RCA)	Rolling out new function on datix Update to be provided in next progress update report
3.	Quarterly analysis / report feeding back learning and outcomes from reported incidences to all staff on a half-yearly basis		Head of Integrated Risk Management	Datix audit trial	Patient Safety Committee
4.	Raising awareness on how, what and where you can report a serious incident	Trust-wide learning events	Head of Integrated Risk Management Director of Nursing	Over 200 members of staff trained so far and an on-going plan to educate staff on using the new Datix system	On-going - Complete

Our ICSU staff survey action plans collated.

Childrens and Young Peoples Services ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Appraisals	Embed Trust's new appraisal system – linking objectives to organisational values Introduction of 360 appraisals for Band 8a and above – 1st step to roll out values based self-assessment tool Provision of training and development across ICSU - LET B funding.	All Managers - ongoing RN and JB – by July 2016 LR & LP – June 2016	Improved staff survey results – improved quality of appraisal Increased appraisal rates	Monthly appraisal data reported Identify Band 8a's across ICSU. Seek information on 360 tools available LR & LP to meet with Lisa Smith
2.	Feedback from patients/error reporting	Re-launch of Datix – feedback direct to individuals Introduce ICSU monthly newsletter – celebrate success's Ensure departments have structures in place to communicate patient feedback	AK – June 2016 NP – by July 2016 All managers - ongoing	Staff survey 16/17	

3.	Staff Health and Wellbeing	Ensure managers are trained in fair application of sickness absence policy Review of case load pressures Promotion of Trust wellbeing initiatives	All managers supported by HR – ongoing All managers - ongoing	Staff survey 2016/17	
4.	Equipment to do the job	Address levels of recruitment – recruitment drive to fill current vacancies Support mobile working through securing new lap-tops Hot-desk at hospital site for community based staff	All managers with support from HR – ongoing Heads of Service – ongoing	Staff Survey 2016/17	
5	Senior management	CD & Director of Ops to hold quarterly staff forums – regular area visits across the ICSU Ensure team briefings are happening Monthly newsletter – as above More meetings to be held on community sites	NP & RN – June 2016 onwards All managers - ongoing	Staff engagement survey	
6	Whistleblowing/bullying	Roll out of anti-bullying & harassment advisors– encourage applicants from	HR by July 2016	Number of B&H cases	

		CYP ICSU Promote Trust initiatives to address these issues – eg Guidance for staff, Employee assistance programme, Promoting zero tolerance messages in all settings Lunchtime session exploring bullying & harassment themes with paediatric consultants	All managers supported by HR – ongoing NP facilitated by Rai Gallo – June 2016	Exit survey themes Staff survey 2016/17	
In addition the ICSU will introduce a quarterly 'staff engagement' survey to 'temperature check' levels of overall engagement. This will also be used as a measure to help us know how our actions are working to improve staff's experience.					

INTEGRATED MEDICINE STAFF SURVEY ACTION PLAN 2016/17

	KEY RESULTS THEME	WHAT & HOW WILL WE DO IT?	WHO IS RESPONSIBLE & WHEN?	HOW WILL WE MEASURE IT?
1	• **Training**			
1.1	No mandatory training in the last 12 months	• Ensure staff have protected time for mandatory training. Service areas to produce timetable for releasing staff to complete mandatory training • Maximise use of mandatory training booklet	All line managers On-going – compliance monitored monthly	Mandatory training compliance
2	• **Management**			
2.1	Do not know who senior managers are	• Visible leadership in ISCU. Ensure senior managers walk the shop floor, introduce coffee morning sessions open to all staff to engage, meet and discuss issues with senior team Introduction of ICSU monthly newsletter	ISCU leadership team 31st July 2016 First issue – 31st July 2016	Staff survey results ISCU leadership team understanding shop floor issues
2.2	Immediate manager does not value my work	• Ensure staff are having regular 1:1's whereby managers can provide positive feedback • Implement Customer service training/ICARE values across ISCU	All managers – on-going Janet Edwards/Paul Attwal On-going 30th June 2016	Better understanding of core values across staff groups including managers Improved customer care

3	• **Bullying, Harassment and Whistleblowing**			
3.1	Last experience of harassment/bullying/abuse not reported	• Encourage staff to report any incidences via line manager, datix and newly established Bullying and Harassment Advisors	All line managers June 2016	Increase in reporting
3.2	(Physical violence) Harassment, bullying or abuse from patients/service users, their relatives or members of the public	• Raise awareness of zero tolerance of this type of these incidents • Newly established Bullying and Harassment Advisors to support staff when incidents occur • Visible leadership to challenge patients when they are abusive to staff	ASAP Anti-B&H Advisers dentified by June 2016 Senior Managers – on-going	Safer environment for staff Decreased number of incidents
4	• **Health, well being and safety**			
4.1	Disability: organisation not made adequate adjustment(s) to enable employee to carry out work	• Raise awareness of sickness and absence policy. Managers adhere to policy. • Ensure appropriate assessment for changes are carried out and making reasonable adjustments made in a timely manner	All managers supported by HR/Occ Health Ongoing	Improved staff survey resuls
5	• **Appraisal and your job**			
5.1	Not supported by manager to receive training, learning or development identified in appraisals	• Ensure all staff have protected time to complete mandatory training and identification of training needs for individual development in their role through good quality appraisals	All line managers Ongoing	Appraisal compliance Improved score at next survey

Woman's Health Services ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Focus on completion of appraisals.	Increase communication and awareness to all staff to ensure meaningful appraisals take place	Matrons / Band 7 monthly	Monthly appraisal reports	
2.	Focus on mandatory training in all areas.	Monitor and check for compliance on a regular basis Increase communication to all staff e.g. Weekly newsletter	Practice Development Nurses. Monthly	Monthly mandatory training reports	
3.	Improve and increase communication from management to all the staff teams.	Quarterly open meetings to all staff Weekly open house within clinical areas within maternity unit Senior staff accessible (weekly) and available to staff located off site: St Anne's Re-launch Huddles: listening, reflection exercises	Clinical / Operational Director Head of midwifery Operational Director Matrons		

4.	Effective and efficient team engagement with senior staff.	Weekly SMT meeting and clinical and operation director attend every month Visible Scorecards reporting quality & performance indicators Maintenance of noticeboards	Head of Midwifery Clinical Rick & Governance Lead Matron		
5	Tackle key issues such as bullying and harassment.	Named Trust Bully & Harassment Advisors includes senior managers Launch Women health Code of Conduct and workplace champions Sign up and commit to the RCN Care for you campaign	Senior Managers Senior managers All staff		
6	Leadership training for all managers to improve team building, and to enhance effective leadership.	Signpost staff and encourage training and development of all staff	Practice Development Nurses		
7	Becoming a more Inclusive Organisation – Unconscious Bias	All senior managers to attend Unconscious bias training	Head of Midwifery		

	Emergency and Urgent Care ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**Areas within ICSU**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Focus on completion of appraisals and completion of mandatory training in all areas.	clear objectives defined and department structure .	ED	Matrons	ED Shift leader competency checklist	Ongoing – scheduled to complete August 2016
		Agreed monthly 1;1 template for each band to be written	ED	Matron	All band 6 to have 1:1 completed and recorded	Completed
		Management 1:1's (catch ups) will take place with every staff member ever 6-8 weekly	ED	Matron/ Band 7	Spreadsheet tracker to record 1:1 meetings and regularly reviewed	Ongoing
		Regular monitor and communicate mandatory training requirements, professional development plans/competencies	ED	Practice Development Nurse	Database used to track and record development	Ongoing

2.	Effective and efficient team engagement	Daily 10;10 for teaching session and self-awareness : reflection skills	ED	Band 7		Ongoing
		Mission statement aligned to Trusts I Care values	ED	Senior Managers	Communicate to all staff, posters / team meetings inviting staff to agree there objectives and values that are aligned to the mission statement	Ongoing
		Reintroduction of Schwartz Round took place 16th June	ED	Matron	14 out of the 18 attended. Staff debriefed for staff to provide a response with action point	Ongoing
		Introduction of staff you said we did. Poster ' You said, we did'	ED	Matron/ Business manager		
		Team nights have been introduced and regular team days including supportive conversation		Matron		

3.	Adopting a formal clinical supervision structure (nursing)	Clinical monthly supervision groups	ED	Matron / Practice Development Nurse / Bullying Advisor	Database to be set up to record clinical supervision date	Ongoing
4	Tackle key issues such as bullying and harassment & Stress at work	Reflection exercise / self-awareness support at team meetings, 10;10	ED	TBC		
		Signpost (posters) the support available to staff experiencing Bullying & Harassment Named bullying and harassment advisors	ED	Department Bullying & Harassment Advisor		
		HR (onsite) Clinic - Support managers and staff with all HR queries and questions.	ED	HR BP Fortnight. Thursdays 7.45 to 8.45am	Staff engagement and staff feedback	Ongoing
5.	Stress management sessions for District Nurses	Stress management tool , self-referral to occupations health, signposting to support available online	DN	TBC		

		Communicate and engage with communicate staff to understand challenges and obstacles	DN	HR BP tbc		
6.	Leadership training for all managers to raise self-awareness and to enhance effective leadership	ED Band 7, 2 day development day	ED	HR BP/ Matron		
		Development opportunities for Band 6 – Frontline leadership course	ED	Matron		

Surgery and Cancer ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	tackle bullying and harassment	HR Theatre Clinics every Wednesdays	HR BP/ Band 7 – Weekly	Number of attendance recorded and staff engagement	Ongoing
		Support Trust Bullying & Harassment Advisors – Communicate departmental zero tolerance to Bullying & Harassment	Senior Managers	Staff Survey results and regular communication with staff	ongoing
		Walk around clinical wards/areas	Head of Nursing & Director of Operation		
2.	management of absence	Pilot Case Conference to discuss live sickness cases	Theatre Matron/Team leaders, Occupational Health & HR - Quarterly		
		Tackling work related stress thorough daily team meetings; reflection	Matron/ Band 7		

		exercises			
		Impact Sickness Absence posters	Matron/ Band7		
3.	firm but fair	Promote Surgery standards and values e.g. Hierarchy of needs/ I Care values	Senior Managers		
		Improve and increase communication and staff engagement: message of the week, Big 4. Daily team meetings and huddles	Senior Managers		
		Update Theatre notice Boards	Band 7		
4.	offer development and courses	Management & Leadership development for all staff clinical and non-clinical	Director of Operations/Clinical Directors and Head of nursing		
		Business Development Away Day Service managers and Operation Heads	Director of operations & HR BP		
		Focus on completion of appraisals and mandatory training in all areas	Service Managers/ Heads of Operations		

Outpatients, Prevention & LTC ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Bespoke training on how to conduct quality appraisals				
2.	Service lead to feedback outcomes taken following incidents				
3.	Service leads to agree clear structure for team meetings				
4.	E-bulletin to recognise good work				
5	ISCU team member of the month				

Clinical Support Services ICSU Staff Survey Action Planning 2016					
	What do we need to do?	**HOW WILL WE DO IT?**	**WHO IS RESPONSIBLE & WHEN?**	**HOW WILL WE MEASURE IT?**	**Action plan progress update**
1.	Run session on whistleblowing/ raising concerns				
2.	Run session on Datix				
3.	Ensure staff are aware how to and are supported to make Occupational Health self referrals				
4.	List of staff to support new appraisers				
5.	Review local induction programme				

Whittington Health NHS

Whittington Health Trust Board
7 September 2016

Title:	Quality Committee Meeting 13 July 2016 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**16/126**		**Paper**		**11**		
Action requested:	For the Board to note the business of the 13 July Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft 13 July 2016 Quality Committee Minutes						
Summary of recommendations:	The Trust Board is asked to take assurance that the Quality Committee is compliant with its terms of reference and delegated authority						
Fit with WH strategy:	The Quality Committee, a sub-committee of the Trust Board, considers business relating to quality and safety of services						
Reference to related / other documents:	Duty of Candour, Being Open, SO's. SFI's and Scheme of Delegation, Duty of the Trust Board for quality and safety of patient care, Annual Governance Statement						
Date paper completed:	August 2016						
Author name and title:	**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Anu Singh, Non-Executive Chair**		
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

DRAFT Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 13th July 2016 2:00pm – 4.30pm
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS) Non-Executive Director
Members Present:	Yua Haw Yoe, Non-Executive Director Philippa Davies, Director of Nursing and Patient Experience Deborah Harris-Ugbomah, Non-Executive Director
In attendance	Lynne Spencer (LS), Director of Communications & Corporate Affairs Fiona Isacsson (FI), Director of Operations S&C (deputising for Carol Gillen) Clarissa Murdoch (CM), Clinical Director MFNS Daniela Petre (DP), Head of Integrated Risk Deborah Clatworthy (DC), Head of Nursing, Surgery and Cancer Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes) Manjit Roseghini (MR), Head of Midwifery Mark Madams (MM), Head of Nursing, Children's Services Julie Andrews (JA), Associate Director for Patient Safety Dorian Cole (DC), Head of Quality PPP (deputising for Sarah Hayes) Alison Kett (AK), Head of Nursing Jane Laking (JL), Bereavement Midwife/ Supervisor of Student Midwives Sinead Farrell (SF), Supervisor of Midwives Sandra Harding Brown (SHB), (Item 4 only) Natasha Manning (NM), Victoria ward manager (Item 6 only) Consultant, Victoria Ward (Item 6 only) Angel Bellot (AB), PALS and Complaints Manager (Item 7 only) Lisa Smith (LSm), Assistant Director of Nursing Education (Item 15 only) Theresa Renwick (TR), Adult Safeguarding Lead (Item 14 only) Karen Miller (KM), Child Safeguarding Lead (Item 14 only)
Apologies:	Carol Gillen (CG), Chief Operating Officer Richard Jennings (RJ), Medical Director Beverleigh Senior (BS), Director of Operations, OPLTC Paula Mattin (PM), Director of Operations EUC Russell Nightingale(RN), Director of Operations, CYN Gurjit Mahil (GM), Director of Operations, WFS

Rachel Landau (RL), Clinical Director EUC
Sarah Hayes (SH), Clinical Director PPP
Doug Charlton (DC), Deputy Director of nursing & Patient Experience
Helen Taylor (HT), Clinical Director CSS

Agenda items

1.	**Welcome & Apologies**	**AS**
	AS welcomed Deborah Harris-Ugbomah to the Quality Committee in her role as Non-Executive Director. Apologies were noted (see above).	
Actions	**Deadline**	**Owner**
None		

2.	**Minutes of the previous meeting (2016)**	**AS**
	The minutes of the last meeting were approved with no changes.	
Actions	**Deadline**	**Owner**
None		

3.	Action Log	**AS**
	The Action Log was approved and updates recorded.	
Actions	**Deadline**	**Owner**
See action log	On Log	On Log

4.	**Allocate software e-rostering**	**PD**
	SHB provided a live demonstration of the e-rostering software system. PD asked if there had been any notable improvements since the system was introduced. SHB noted staff feedback and reports to date were positive. Activity can be monitored via the cost centre with targeted training in areas not using the system. DH asked about training available and push-notifications to match employees to staffing gaps (ie can the system automatically email or text staff requesting them to book onto shifts) SHB responded that push notifications are an additional cost; instead the Trust is looking at other ways to encourage staff to use the system. The tool has the functionality to deploy staff to areas most in need; ward managers monitor the system every few hours to measure acuity and ensure safe levels of staffing on each ward.	

	PD noted discussions at Trust Board about the benefits of effective rostering and the importance of setting KPI targets.

Actions	Deadline	Owner
None		

5.	CQC Inspection - Update	PD
	PD and AS praised all staff for their work across the Trust in gaining an overall 'Good' rating and 'Outstanding' for caring. PD noted that the Quality Summit would be held on Thursday 14th July with the CQC, commissioners and Healthwatch. This meeting will focus on the Trust's achievements as well as the areas for improvement.	

Actions	Deadline	Owner
None		

6	Quality Performance Reports	ICSU Leads
6.1	The IM Quality Report was approved by the Quality Committee. Key points were highlighted as follows: • Ongoing work with falls management and prevention • Pressure ulcers identified as an area for improvement across IM ICSU • Vacancy rate remains a problem across IM ICSU Victoria ward presentation from NM: • CM provided background to the changes in Victoria Ward and the new leadership • Pressure ulcer improvement work contributing to zero new pressure ulcers this month (daily teaching programme, TVN input and ongoing monitoring) • Number of falls on ward reducing (staff training on falls bundle, safe care round tool and ensuring correct equipment available) • Medication safety incident work ongoing (weekly CD audits, training, monitoring of incidents) • Stable leadership has made a difference to ward safety and staff morale • Complaints project being led by Band 6 nurse to de-escalate issues before they become formal complaints (no formal complaints in three months) • Staffing levels Band 7, Band 6 and HCA posts filled. Band 5 vacancy remains resulting in temporary staffing. Uptake in own staff joining bank to work on Victoria ward • Areas for further improvement outlined including introduction of 'Well Run Ward' programme, quality improvement initiatives and positive feedback to staff to boost morale AS asked if the initiatives on Victoria Ward could be rolled out to other wards. AK noted that the Band 6 Development Programme was trustwide, but initiated on Victoria Ward.	

	Ward managers and matrons meet weekly to discuss sharing learning. Committee congratulated the ward staff for their work in improving care on Victoria Ward.
6.2	**The Women's and Sexual Health Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • No complaints in May, however two complaints received in June. Response rate target met • Breastfeeding UNICEF audit carried out in June. Partially met standards. MJ reassured Committee that action plans in place to meet standards not met • Footprints project which is a teaching tool for staff based on real stories from women using our services SF and JL provided an update on the Action plan from the LSA audit. Key issues as follows; • A number of staff currently training to become Supervisors of Midwives • Survey completed on choice of birth, illustrated women are largely aware of the Birth Centre • Level of obstetrician involvement at correct level (consultant and ST7) • LSA Audit Action plan now complete • JA asked what the national benchmark for caesarean sections was. MG responded the figures had risen slightly from 25%. • FI raised questions regarding theatre utilisation • AS asked if the rise of 'smoking at delivery' figures was a concern. MG responded that the figures had most likely been under-reported previously; this data presents an accurate reflection of smoking at delivery. DC noted that increase in reporting links to smoking cessation CQUIN.

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

7.	**Patient Experience: Complaints and PALS Annual Report**	**DC**
	The Patient Experience Report was approved by the Quality Committee. AB presented the key issues from the report as follows: • Increase in number of complaints, largely attributed to LUTS clinic issues • Surgery commended for response rates to complaints (89%) • Trustwide response rate improved since 2014-15 • Number of complaints allocated 40 working days increased, these are not included in target • 298 complaints upheld, high percentage • Issues ongoing with complaint action plans not being completed, however AB noted surgery good at completing action plan templates • MM noted that CYP ICSU reviewing themes from PALS concerns as well as formal complaints • Main themes from complaints relate to staff attitude and communication • Communication work focusing on clearing phone message boxes and responding to phone messages	

	• LS noted that WH twitter platform was receiving an increase in patients using social media for both complaints and compliments. She confirmed all contacts were dealt with immediately as the account was monitored in/out of hours so all detailed were forwarded to the relevant ICSUs and/or PALs teams to feedback • AB noted that from 1st April 2016, there was a change in reporting. Previously reported in arrears but now reporting on complaints which have closed in the month. • FI asked the process for PALS reporting, and stressed importance of reviewing new and open PALS received in month, as FI concerned some PALS were left open • JA asked how the Trust learns from Ombudsman responses. AB noted this was an area for improvement, currently learning focused within ICSUs. Proposal to monitor these action plans at Quality Committee • DHU questioned the discrepancy between the main theme from complaints around staff attitude, and an 'outstanding' result on caring from CQC. PD noted that the number of complaints received was a small proportion of patients seen

Actions	**Deadline**	**Owner**
AB to review process for reporting new and open PALS per ICSU, in addition to formal complaints	Sept	AB
Action plans from complaints sent to Ombudsman to be monitored by Quality Committee	Sept	AB

8.	**Quarterly Patient Safety Report, Medical Director**	**PM**
	Previously presented at Trust Board. JA provided a brief summary of the key highlights; • Trust highest performing trust nationally around sepsis • No MRSA, within target for CDif (no more than 17 in calendar year) • Trust taking part in national prevalence study on hospital acquired infection in Sept/ Oct • JA clarified the Quality Account and Sign up to Safety target for falls was to have no more than four falls resulting in serious harm (defined as meeting criteria for serious incident) • AKI no longer a CQUIN but remains a Sign up to Safety target. This will require investment and business case in development • Mortality audits remain an issue across the Trust. Intention to carry out audits for all inpatient deaths however this is not happening in practice. JA noted the template takes around 45 minutes to complete, currently only reviewing about 15% • FI noted incident reporting on CCU which was raised by CQC. FI asked for benchmarking data or an estimate measure for CCU reporting	

Actions	**Deadline**	**Owner**
Mortality audits; Update on progress to be provided at next Quality Committee	Sept 2016	RJ
Benchmarking data on incidents; DP to assess what the data		

need is and what information is available and report back to Quality Committee	Sept 2016	DP

9.	**Quality Impact Assessment of Cost Improvement Plans**	**PD**
	The QIA of CIP was approved by the Quality Committee. PD noted no issues to be highlighted to the Quality Committee.	
Actions	**Deadline**	**Owner**
None		

10.	**Quality and Safety Risk Register**	**DP**
	DP noted all risks graded 16 and higher were being presented. Operational risks between 12 – 16 are being managed at ICSU level AS asked if the three new risks were completely new risks to Trust or newly escalated; • FI noted that the oncology risk has been high and on the ICSU risk register for a long time, and asked why it was only coming to Quality Committee. FI and DC noted this had been updated on DATIX but not reflected in the Risk Register. • MSK risk has been escalated following a performance notice. • MM noted expecting to see risk here that was escalated FI and DC raised concerns that the Risk Register is not reflective of risks at ICSU level LS confirmed that the ICSI CDs presented their top risks at Quarterly Performance Reviews to the Executives and the moderation of risks by the Head of Integrated Risk Management and the corporate affairs team was informed by this reporting process. DP to liaise with ICSU CDs and DOs to ensure feedback of risk escalation and moderation within their own team meetings to their staff. Tighten up the feedback loop for risk management and moderation/reporting. Timeliness of transferring patients from ITU – PD noted this was a trustwide issue, not an ITU issue. Update to be brought to next Quality Committee.	
Actions	**Deadline**	**Owner**
Risk escalation and moderation process to be tightened up so all staff were sighted on the movement of risks. DP to meet with ICSU CDs and DOs to strengthen the communication and process.	Sept 2016	DP/CDs & DOs
Update on timeliness of transferring patients from ITU at next meeting	Sept 2016	DP

11.	Nursing Quality Indicators	DC
	The Nursing Quality Indicators report was approved by the Quality Committee. FI commented that the ICSU Quality Indicators could be added to, with respect to theatres. MM asked if the Indicators could be presented under CQC five key questions	

Actions	Deadline	Owner
Nursing indicators to be revised to reflect CQC questions as headings	Sept 16	DC

12.	Quality Account (deferred from May 2016)	RJ
	Noted and approved at an extraordinary meeting of the Trust Board 8 June 2016	

Actions	Deadline	Owner

13.	Safety Guardian, Freedom to Speak Up	DC
	The approach was approved by the Quality Committee. • Agreed as 3 days per week (in line with national standards) and suitable for a clinician • JA noted importance of working with new role, as currently JA takes that role for Junior Doctors. It was noted that contact from staff can also be out of hours • Report back on recruitment process	

Actions	Deadline	Owner
Report back to Committee on progress of recruitment	Sept 16	DC

14.	Safeguarding Annual Reports (Children and Adults) 2015/16	KM / TR
	The Safeguarding Children's Annual report was approved by the Quality Committee. Key issues were highlighted as follows; • Training remains an ongoing issue. AS asked where the obstacles to training were; KM noted capacity within the team was an issue. Areas of non-compliance with training have been identified across the trust in order to provide focused training e.g. medical staff on wards • Multi-agency audits carried out by Local Authority. Haringey highlighted the Trust needed further improvement with regard to the Child's Voice • Training programmes relating to new policies • Number of Serious Case Reviews reduced since 2014/15 • Family Nurse Partnership acknowledged as well respected service across the community. Positive outcomes in terms of getting mothers back into education and fewer repeat pregnancies than the national average	

	• Committee acknowledged the huge achievement of safeguarding children in 2015/16 and the positive comments reflected in the CQC report The Safeguarding Adult's Annual report was approved by the Quality Committee. Key issues were highlighted as follows; • Sustained increase in safeguarding training • CQC report positive on safeguarding adults across trust, in particular weekly ED meetings • Increase in DoLs and improved processes in place to measure DoLs (new central database in operation) • Mental Capacity Act well used and understood across the trust • Learning events run to share learning from Safeguarding Adult Reviews • FI asked about delays in transferring patients waiting for assessment under the Mental Health Act. TR noted this was an ongoing issue for review by Camden and Islington MHT; assessment cannot be completed until an inpatient bed has been identified (usually a mental health bed). Committee proposed monitoring these measures at Patient Safety Committee Update on DoLs prioritisation: TR updated the Quality Committee on the delays nationally, but particularly with Haringey Council in carrying out DoLs assessments. New guidance significantly lowered the threshold for DoLs resulting in five-fold increase in DoLs applications. Islington are managing DoLs applications well, however Haringey are not meeting targets (14 days). Haringey have an action plan in place and aim to complete the backlog within six months.

Actions	**Deadline**	**Owner**
Delays in transferring patients waiting for Mental Health Act assessment to be monitored via Patient Safety Committee	Sept 2016	TR

15	**Nursing Midwifery and AHP Education Annual Report 2015-16**	**LSm**
	The Nursing Midwifery and AHP Education Annual Report 2015-16 was approved by the Quality Committee. • Good year for Education Training and Development • 10% increase in staff attending courses, despite reduction in funding. High proportion of funding went to train staff in Bands 1 -4. • Two staff members awarded MRES qualification • Presentations given at National Conferences • The Quality Committee congratulated LSm on the achievements in Education.	

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

16	**Serious Incident Report**	DP
	The Serious Incident report was approved by the Quality Committee. SI report reviewed previously at Trust Board. • JA noted the conflict with investigators being the same person involved in the report. This needs to be reviewed. • Issue around confidentiality and sharing reports – DC asked for clarity on what can be shared. JA noted all reports can be shared unless family specify otherwise.	

Actions	**Deadline**	**Owner**
Clarification to be circulated on what can be shared for learning, with regard to patient and staff confidentiality	Sept 2016	DP

17.	**Trust Policies**	**GL**
	The Trust Policies paper was approved.	

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

16	**Annual work plan**	**AS**
	For information only; the Quality Committee noted the updated annual work plan which informed the CQRC workplan and reporting cycle.	

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

18.	**AOB**	
	MM noted the CYP safety thermometer had been launched.	

Actions	**Deadline**	**Owner**

Next meeting: Wednesday 14th September, 2:00pm, Room 6, Whittington Education Centre