Whittington Health NHS

TRUST BOARD

14.00 – 16.30
Wednesday 5 October 2016

Whittington Education Centre Room 7

Whittington Health NHS

Meeting	**Trust Board – Public**
Date & time	**5 October 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
16/127	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
16/128	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1420hrs
16/129	**Draft Minutes, Action Log & Matters Arising 7 September** *Steve Hitchins, Chair*	1	*Approve* 1425hrs
16/130	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1430hrs
16/131	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1440hrs
Patient Safety & Quality			
16/132	**Appointment of Deputy Responsible Officer** *Richard Jennings, Medical Director*	*Verbal*	*Approve* 1500hrs

16/133	**Serious Incident Report Mth 5** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1510hrs
16/134	**Safer Staffing Report Mth 5** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1520hrs
Performance			
16/135	**Financial Performance Month 5** *Stephen Bloomer, Chief Finance Officer*	5	*Approve* 1530hrs
16/136	**Performance Dashboard Month 5** *Carol Gillen, Chief Operating Officer*	6	*Approve* 1540hrs
Governance			
16/137	**Board Assurance Framework** *Siobhan Harrington, Deputy CEO & Director of Strategy*	7	*Approve* 1550hrs
16/138	**Workforce Assurance Committee Draft Minutes 31 August –** *Steve Hitchins, Chair*	8	*Approve* 1600hrsh
16/139	**Quality Committee Draft Minutes 14 September** *Anu Singh, Non Executive Director*	9	*Approve* 1610hrs
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meeting			
	02 November 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: 16/129
Doc: 01

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 7th September 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
	Yua Haw Hoe	Non-Executive
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Tony Rice	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
	Rai Gallo	Leadership Coach (for item 16/126)

Patient Story

Philippa Davies introduced Peter Usborne, who had been a patient on Thorogood Ward following a hip operation. Mr Usborne had begun to feel pain in his left hip back in January, and had been admitted to hospital in May. Prior to his admission he had been invited to attend hospital for a briefing session, which he felt to be an enlightened idea. Following his successful procedure he had come across a film clip of the same operation on U-tube, and suggested that some patients might find it helpful to view such films prior to their admission to hospital. Mr Usborne commented on the fact that staff were keen to encourage mobility as soon as possible after the operation. All went well although he had had to remain in hospital for four nights rather than the planned three because he was, as he put it, “a bit tottery”.

Mr Usborne had no complaints whatsoever about his treatment and nothing but praise for the staff, describing them as professional, kindly and intelligent. He was particularly pleased with the way he had been kept informed about his treatment throughout his stay in hospital, and his only small regret was that he had not been warned he might suffer from a clicking noise for a while when walking. He was keen to maintain links with Whittington Health, had already generously donated a number of books to the hospital, and would consider giving more to the hospital school for sick children. In addition he asked Board members to consider how he might contribute to any local initiatives around childhood obesity.

16/113 Declaration of Conflicts of Interest

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

16/114 Apologies and welcome

114.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Anu Singh.

16/115 Minutes, Action Log and Matters Arising

115.01 The minutes of the Trust Board held on 6th July were approved. There were no matters arising other than those already scheduled for discussion.

Actions

115.02 160.09 Performance Dashboard: This had been placed on the agenda for discussion at the September Board Seminar and could therefore be removed from the action log.

160.11 Speak Up Champion: An update on the process for appointing the Speak Up Champion was contained within the Chief Executive's report to the Board; this item could therefore be closed.

53.04 The staff survey action plan was on the agenda for discussion later in the meeting; this item could therefore be closed.

110.03 IM&T Strategy: Stephen Bloomer would let the secretariat know when this should be scheduled for discussion.

16/116 Chairman's Report

116.01 Steve Hitchins began his report by informing Board colleagues that the Metropolitan Police Borough Commander from Islington had recently visited the hospital. He himself had accompanied nurse consultant Colette Datt to a meeting of the Islington Youth Council, and reported that the Trust would be launching a Children & Young People's Board at a high profile location on 9th November. Other visitors to Whittington Health had included Jeremy Hunt's heath advisor James Friend, and Jeremy Corbyn, who had attended a retirement party for a nurse who had worked in the NHS for 41 years.

116.02 The Care Quality Commission (CQC) Report had been published shortly after the previous Board, and Steve said that this was an achievement everyone should take pride in. He had received a congratulatory e-mail from Mike Richards, and in turn he passed on his congratulations to the executive team, acknowledging the huge amount of work that had gone into preparing for the CQC inspection.

116.03 Deborah Harris reported on "Inspiring Tomorrow", a volunteering project in which she had been involved in partnership with HR lead, Charlotte Johnson, Head of Education, Learning & Development. The project activity includes creating informal introductions for BME students/undergraduates/ young adults to business leaders in a range of public and private sector organisations. Charlotte, Clive Blackwood, Siobhan and also Steven Hitchins held informal and lively discussions with over 12 young people who attended Whittington main site on 4 August. Feedback from the day from the students was that this was a life changing and inspiring session, helping them to have even more focus on their career and life goals.

16/117 Chief Executive's Report

117.01 Simon Pleydell informed the Board that sadly a never event had recently taken place at the Trust, details of which had been discussed at the private Board meeting earlier. He stressed the importance of being able to speak about such things openly, and was confident the learning from this event would be rapidly shared.

117.02 The Trust had still not declared any cases of MRSA in 2016/17, and there had been 5 cases of C. Difficile against the target of 17. Cancer targets had been met with the exception of the 62 day target; this was due to a shared breach with UCLH which

affected Whittington Health figures. Within the community, MSK performance remained a challenge, and Simon was clear that the existing target of 95% was both unrealistic and demoralising for the staff – he felt a target in the 60s would be more appropriate and hoped this could be renegotiated with commissioners.

117.03 The CQC rating boded well for the North Central London STP work, particularly as ratings of 'good' had also been achieved by both the Royal Free and UCLH (Whittington health had been the only Trust rated 'outstanding' for its care). STP consultations were due to begin in September and carry on in October, though as yet there were no definitive proposals. The Clinical Collaboration work with UCLH was also moving forward, with discussions being held about some parts of maternity, surgery and the future of the LUTS clinic. Work was also proceeding on the Islington & Haringey Health & Wellbeing Partnership.

117.04 The Trust had been successful in gaining the contract for an expanded community dental service, and Simon paid tribute to the work of both the clinical team and the contracts staff in achieving this. ED targets were not being achieved at present though there had been some improvement during August; the test would be to see whether the improved performance could be sustained as the holiday season ended. The Trust was out to advertisement for additional ED consultants, and hoped to gain at least two in the first phase of recruitment. The 'Speak up Champion' position has been advertised.

117.05 The junior doctors' industrial action scheduled for the following week had been cancelled, although further weeks of action remained scheduled for later in the autumn. Because of this, it has been decided to re-instate the 'perfect week' starting from 12th September; this provides an opportunity to free up time away from meetings and other commitments and work on patient flow throughout the hospital. Ward liaison officers are being trained, and the executive team will be walking the floor, as will staff from estates and facilities.

117.06 Simon Pleydell updated Board colleagues on future plans for the LUTS clinic. Professor Malone-Lee would be retiring in September, and discussions are ongoing with him, his clinical colleagues and patient representatives about transition plans for the clinic and how best to sustain the service moving forward; these plans will involve Professor Malone-Lee post retirement.

117.07 Over the next few months finance will be critical, especially trying to meet CIP targets and reducing agency spend. If the position is allowed to drift and there is no discernible improvement there is likely to be intervention from the centre.

117.08 Simon's report contained details of a number of awards which he encouraged Board colleagues to read about. In particular, he drew attention to the UCL Medical Education Awards, saying that this achievement was a real endorsement of Whittington Health's commitment to teaching and education. Richard Jennings had written to congratulate those involved.

117.09 Janet Burgess spoke in support of the Trust's participation in the Islington & Haringey Health & Wellbeing Partnership initiative, which now involved the two local authorities, two clinical commissioning groups, GP federations, Whittington Health and two mental health trusts. All appeared very enthusiastic about the planned agenda, and work was in hand to look at how best to align this with the STP developments.

16/118 <u>Care Quality Commission Report</u>

118.01 The Care Quality Commission (CQC) Report of the inspection carried out in December had been published after the July Board meeting, and the action plan circulated with the

Board papers had been produced in response. The plan was detailed, and would be monitored through the ICSU structure and the Trust Management Group (TMG). Philippa Davies also informed the Board that she had organised a series of briefing meetings for staff following the report's publication.

118.02 In answer to a question from David Holt about how the impressively high standards achieved for the CQC inspection were to be maintained, Philippa Davies stressed that such standards should be seen as the Trust's normal business, and there would be no reduction in quality, with the emphasis remaining on patient safety and the provision of the highest possible standards of care. It was noted that CQC inspections were themselves likely to change in the future as the degree of manpower and costs involved were becoming unsustainable in the long term.

16/119 Serious Incident Report

119.01 Philippa Davies informed the Board that three serious incidents (SIs) had been declared in June and three in July, making a total of 16 SIs recorded at the Trust since 1st April. The six declared comprised:

- an unexpected admission to NICU following an emergency caesarean section
- an information governance breach
- a safeguarding allegation related to an inpatient
- the unexpected death of a patient who developed a pulmonary embolism
- an unwitnessed patient fall resulting in two fractures
- a young person with mental health problems being delayed in ED because of a lack of Tier 4 beds.

119.02 Philippa had noted that there had been an increase in the number of incidents recorded since the implementation of the new Datix system, and this was echoed by Richard Jennings, who said that it had been widely acknowledged that the new system was less cumbersome to operate. Steve Hitchins had noticed that IG breaches had been by staff who had received the appropriate mandatory training, and Richard replied that the action plan did address this point. In particular, there had been opportunity on this occasion for witnesses to raise concerns but this had not happened. Conversely, however, there had been instances of those responsible for breaches voluntarily coming forward to declare them.

16/120 Safe Staffing Report

120.01 Philippa Davies said the Allocate e-roster system was now being used routinely to generate reports, and Appendix 1 showed that the average fill rate had in fact decreased since the last Board report. The new system had made it possible to plan staffing based on the acuity and dependency of patients on the wards, and thus contribute to decreasing agency spend.

120.02 Philippa went on to introduce Sandra Harding-Brown, the manager responsible for the implementation of the new system. Sandra delivered a presentation to the Board, demonstrating how the number of nurses required per shift was calculated (using a safer care tool), skill mix, and proportion of temporary staff. Key performance indicators (KPIs) had been set to measure acceptable levels, and requirements were calculated at daily bed meetings.

120.03 The e-roster system had now been implemented throughout all inpatient areas, ED, theatres and district nursing. There had been significant investment in education and training, and it was anticipated the Board would be able to measure the impact through

more robust and detailed reporting systems. In answer to a question from Tony Rice about whether it would also be possible to calculate the financial impact, Stephen Bloomer replied that work was already in hand to measure this.

16/121 Quarterly Safety Board Paper

121.01 Richard Jennings introduced Dr Julie Andrews, Consultant Microbiologist and Associate Medical Director for Patient Safety, who had written the Board report and who was also responsible for the establishment of a highly-regarded patient safety forum. Julie began by talking about sepsis, saying that Whittington Health had the lowest mortality rate for sepsis deaths in the country, had an average length of stay of two days less than elsewhere, and was also very successful at starting patients on antibiotics very quickly on their arrival in hospital. The Trust was however continuing to struggle with documentation, and problem areas were receiving daily checks in an attempt to improve compliance in this area.

121.02 Work was now in hand to combine work in this area with acute kidney injury, and challenging targets were being set in order to achieve the aspirations set out in the Trust's Sign up to Safety commitment. Further work included the launch of an interactive platform, an education programme, a patient safety newsletter and strengthened Grand Rounds with a six-weekly focus on patient safety. The introduction of the new Datix system was also seen as contributing to safety.

121.03 Richard Jennings paid tribute to the work of Julie and her team, in particular the establishment of patient safety forums which now involved nurses and AHPs in addition to doctors. The Trust was fortunate in having a dedicated workforce committed to high safety standards and maintaining continuous improvement in this area. Tony Rice enquired whether the Trust had communicated its success externally, and Julie replied that results had been published in clinical journals, and that invitations to speak at national conferences and to NHS England had been issued. Steve Hitchins added his congratulations, saying that he had personally attended two of the events organised.

16/122 Financial Report

122.01 Stephen Bloomer opened his report by informing the Board that the Trust had reported a £1.3m deficit in July, £3m worse than the planned position. This was mainly due to an overspend on pay, much of which related to spend on agency staff, where the current position continues to worsen. This in turn has an effect on the CIP target, as a high proportion of this is based on reducing agency spend, therefore if the organisation fails to address this now there is a risk that control totals will not be met at the end of the year. Discussions are to be held with the ICSUs with a view to escalating those areas of particular concern.

122.02 In answer to a question about whether more detailed information was required by the Board, Stephen said that there was to be a deep dive on spend at the Finance & Business Development Committee. It was also noted that from 1st September a new procedure had been introduced for medical agency spend whereby all requests were to be signed off by Richard Jennings as Medical Director, and a similar new process was to be introduced for booking AHP agency staff within the next few weeks.

16/123 Performance Dashboard

123.01 Introducing this item, Carol Gillen informed the Board that theatre utilisation had now risen to an average 80%, with an increase in productivity for breast but no discernible improvement within urology. Turning to cancellation, she reported that the Trust had

achieved its target for first appointment and was just above target for follow up appointments. The DNA rate remained just above target.

123.02 Good progress was being made within District Nursing, and there was some improvement on the 6 week waiting times for MSK, where the team was making every possible effort to turn round the position, and ongoing discussions were being held with the commissioners; the quality of the service had never been brought into question.

123.03 Within emergency and urgent care, performance continued to be challenging, although good progress had been made with the improvement plan. The North Middlesex diversion had had a particular impact on services in July which had meant that the hospital had started August in a poor position but significant progress on patient flow had been made since, with pre-11am discharges working increasingly effectively. An interim Director of Operations has now been appointed.

123.04 Carol informed the Board that she hoped to bring the first of the new performance dashboards to the October meeting.

16/124 Nursing & Midwifery Strategy

124.01 Philippa Davies informed the Board that this new strategy had been discussed at the Workforce Assurance Committee the previous week. Its development had been led by Doug Charlton, who had facilitated a number of engagement events, and it was shaped around the five CQC domains of safe, caring, effective, well-led and responsive to peoples' needs. The strategy also shows details of how it is intended to achieve these ambitions, including the development of milestones by which progress could be measured.

124.02 The Board discussed nursing qualifications, with some expressing concern that some of the Trust's more experienced nursing staff feeling disadvantaged by their not holding a master's degree and therefore being afraid they were likely to be viewed less favourably in any restructuring process. Deborah Harris suggested these staff might be able to gain recognition through an accreditation system. It was also agreed that there needs to be additional emphasis on the health and wellbeing of all staff, and Norma was pleased to be able to report on the adoption of the Health & Wellbeing Strategy at the Workforce Assurance Committee the previous week. She also informed the Board that the Occupational Health & Wellbeing Team had been nominated for a Mayor of London achievement award.

124.03 The strategy was formally approved by the Board, and Philippa would feed back all comments made to Doug and the team.

16/125 Whittington Health Community Forum

125.01 Steve Hitchins updated the Board on the development of the Community Forum, saying that the original intention had been to build a database of 100,000 people and indeed a good deal of progress was being made towards this target. The draft terms of reference were included, and the Board was asked to agree these. Steve was also pleased to inform Board colleagues of the support he had received from both local authority chief executives.

125.02 Deborah Harris praised the quality of the terms of reference. The Board held a brief discussion around the nature of community involvement, and it was duly agreed that it would be more appropriate to use the word 'engaged' rather than 'involved'. Other than this the terms of reference were approved. It was noted that a charitable funds grant of £4k had been approved to fund some of the IT costs.

16/126 Staff Survey Action Plan Update

126.01 Rai Gallo introduced this item, reminding Board members that the staff survey action plan had last been brought to the June meeting, since when considerable progress had been made, with 23 of the 31 actions having already been completed. ICSU Directors had all worked on the individual plans for their own areas with support from the HR Business Partners, two had not yet been completed due to the third HR Business Partner not starting work at the Trust until that week; in the meantime Norma French was personally monitoring progress via the ICSU performance review meetings. Carol Gillen assured the Board that the ICSUs not included within the paper were doing a great deal of work in this area.

126.02 There were three staff pledges, and two themes arising from them, the first being equality and diversity, the second errors and incidents. Rai spoke of some of the initiatives taken to date, including working with the IAPT team and the appointment of the anti-bullying and harassment advisers. He informed the Board that three members of staff had already requested appointments with the advisers, and the Learning & Development Team, who were responsible for administration, were matching them with appropriate advisers.

126.03 Rai had also organised four 'unconscious bias' masterclasses which had been very well received by those who had attended them, and a further four were to take place over the coming months.

126.04 Looking at the second theme, that of errors and incidents, Rai spoke about the installation of the new Datix system, which was both more user friendly, and also more conducive to learning since there was a need to complete the 'lessons learnt' section before it was possible to move on. The Board briefly discussed measures of success, and it was hoped that the feedback from this year's survey might reflect awareness of some of the measures that had been put in place.

16/127 Minutes of the Quality Committee held on 14th July

127.01 Philippa Davies highlighted two of the main agenda items, these were the receipt of the CQC Report, and a presentation given by staff from Victoria ward which demonstrated the improvements that had taken place there.

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Action Notes Summary

110.03	IM&T Strategy: Stephen Bloomer would let the secretariat know when this should be scheduled for discussion.	tbc	SB
123.04	Carol informed the Board that she hoped to bring the first of the new performance dashboards to the October meeting	October – closed new report on Agenda	CG
124.03	The strategy was formally approved by the Board, and Philippa would feed back all comments made to Doug and the team.	Actioned and Closed	PD

Whittington Health Trust Board

5 October 2016

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/131**	**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:	30 September 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.

PAULA MATTIN

We were very saddened by the news that Paula Mattin, who worked with us for over ten years, sadly died in September following a short illness. Paula was a much loved and incredibly valued part of our Trust. We are planning a special memorial service at the hospital, so that friends and colleagues can join together to share their memories.

1. QUALITY AND PATIENT SAFETY

Flu Campaign September to December 2016

We know it is important to protect ourselves, our families and our patients against the flu virus. Last year uptake was 62.06% of staff vaccinated against a target 75%. We want to do even better this year. There are some reservations about the efficacy of the vaccine because in 2014 it had been reported as having low efficacy. In 2015 the vaccine had a higher efficacy and we reported 32 inpatients that caught influenza from unvaccinated staff and/or visitors in this year and 2 of these patients subsequently died. The predictions are 2016 flu jab will have even higher efficacy. This means that the vaccine will work to save lives and protect the vulnerable, including children and the elderly.

Spotlight on Safety

We launched a newsletter 'Spotlight on Safety' in September that celebrates our achievements in delivering outstanding care, as well as providing a roundup of the latest patient safety alerts and issues. Highlights included Victoria Ward improvements (reduction in falls and pressure ulcers) and that we have the lowest mortality rate for sepsis deaths in London, with an average length of stay of 2 days less than elsewhere.

National Reporting and Learning System (NRLS)

We continue to make excellence progress with our open reporting culture. This month we were reported by the NRLS as being in the top highest 25% of reporters across NHS organisations. According to NRLS organisations that report more incidents have a better and more effective safety culture.

MRSA Bacteraemia

We continue to report 0 hospital acquired MRSA bacteraemia cases this year.

Clostridium Difficile

We reported 5 cases of Clostridium Difficile up to the end of September. The target is for no more than 17 cases this year.

Cancer Waiting Time Targets

We exceeded our national cancer targets except 62 days from referral to treatment for July**.** *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 83.3% against a target of 85%
- 14 days cancer to be first seen 97.7% against a target of 93%
- 14 days to be first seen for breast symptomatic 100% against a target of 93%

Community Access Targets

MSK targets are not achievable with our current service and workforce model. We have made improvements during July and August and we value our staff continuing to work extremely hard against a difficult transition period. We are liaising with Commissioners to change the targets to enable realistic achievements. We reported up to end of August:

- MSK waiting time – non consultant led patients seen 60.2% - target 95%
- MSK waiting time – consultant led patients seen 90.5% - target 95%
- IAPT – patients moving to recovery – 50% - target 50%
- IAPT – patients waiting for treatment <6 weeks – 95.1% - target 75%

2. STRATEGIC

Sustainability and Transformation Plan (STP)

The health and care system across North Central London (NCL) - clinical commissioning groups, local authorities and NHS providers are working together to develop an NCL wide STP. This will set out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the Five Year Forward View vision. For the NHS to meet the needs of future patients in a sustainable way, we need to close the gaps in health, finance and quality of care between where we are now and where we need to be in 2020/21.

In order to create a better future for the NHS, we must make changes to how local people live, access care, and how this care is delivered. This doesn't mean doing less for patients or reducing the quality of care provided. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently. Our vision is to

- improve health and wellbeing outcomes for the people of North Central London and ensure sustainable health and social care services, built around the needs of local people.
- develop new models of care to achieve better outcomes for all; focused on prevention and out of hospital care.
- work in partnership to commission, contract and deliver services efficiently and safely.

The STP is an opportunity to continue to work together over the North Central London area (known as a 'footprint') and look at how we can do this better. This is a challenging piece of work, but the opportunities to improve care and the quality of health and care services are considerable. We are currently developing our plan on an iterative basis. We made a submission to NHS England in June setting out our initial thinking which we are continuing to refine and develop. We will be submitting further thinking in the future and would anticipate being in a position to discuss potential long term solutions from early 2017.

All of this work has been based on the case for change reported to our Board in June and developed by the STP's Clinical Cabinet, who is advising us on the plan to ensure it reflects the best clinical expertise from a range of health and care professionals. We are also starting an on-going programme of engagement and discussion with local people which we expect to continue over the coming months.

The following organisations are working together on the NCL STP: Clinical Commissioning Groups: Barnet, Camden, Enfield, Haringey and Islington , Local Authorities: Barnet, Camden, Enfield, Haringey and Islington and Providers: Barnet, Enfield and Haringey Mental Health NHS Trust; Camden and Islington NHS Foundation Trust; Central and North West London NHS Foundation Trust; Central London Community Health Care NHS Trust; Great Ormond Street Hospital; Moorfields Eye Hospital; North Middlesex University Hospital NHS Trust; Royal Free London NHS Foundation Trust; Royal National Orthopaedic Hospital; Tavistock and Portman NHS Foundation Trust; University College London; Whittington Health.

Strategic Estates Partner (SEP)

We are progressing a procurement process to identify a Strategic Estates Partner to support the delivery of our estates strategy. This will take the form initially of a contractual SEP arrangement.

3. OPERATIONAL

Director of Environment

Our new Director of Environment, Adrien Cooper, started work on 3 October. Adrien was Deputy Director of Estates at Royal Free and brings a wealth of knowledge to our Trust.

Emergency Department (ED)

Pressures within the emergency care pathway continue and our 4hr performance for September was 93.3% against a target of 95%. We are making steady progress with meeting our target and this new approach included the roll out of a 'Perfect Week in September. The aim of the week was to understand the issues that impeded flow which directly links to ED performance and to look at the interface between ward and support services. It was about resolving issues that prevent staff from carrying out this job on a day to day basis.

The Perfect Week showed us that bed occupancy runs at over 90%, that pre 11am discharge varies from 4 to 15 patients per day and that pre 11am senior clinical reviews varied over the week from 42% to 78%. We discovered a number of external delays waiting for ongoing non acute care (St Pancras) and mental health beds and the invaluable role of the ward clerk.

There are a number of key areas that we will focus on over the next few months which will include improving pre noon senior clinical reviews and rolling out a minimum data set for all White Boards. We did not achieve the 4 hour waiting target during the Perfect Week but we gained a good insight into some of the things that can impede flow. This will enable robust planning for the winter to ensure we continue to work towards compliance of the 95% performance target for 2015/16.

Annual NHS Staff Survey

The 2016 staff survey has been launched and sent to a random selection of staff via paper copy and email. The survey is confidential and managed independently by the Picker Institute Europe. We will use the feedback to tackle the highest areas of concern as part of our work to continuously improve working environments. Following last year's survey we trained 15 bullying and harassments advisors to support staff.

TB Expands Service

Our joint bid between North Central London South Hub Whittington Hospital and UCLH to be a specialist commissioned MDR and XDR-TB treatment centre has been successful. This means we will continue to expand our vital services for more patients who suffer from TB.

WORKFORCE

Recruitment

TMP Worldwide advertising agency has developed a recruitment microsite for us based on research feedback from staff. The focus of our first campaign is to attract Band 5 nurses to our vacant community and acute positions. We are promoting our new microsite via our social media sites http://www.whittingtonnurses.co.uk/.

Lower Urinary Tract Services (LUTS) Clinic

Professor Malone-Lee retired from UCL on 22 September and he has returned from retirement to support the future development of the service. We have received the Royal College of Physicians external service review and this will be published later this month.

4. FINANCE – APRIL TO AUGUST MONTH 5

We are facing an extremely difficult financial position with significant challenges over the coming months. We reported a £1.3m deficit in August and a year to date deficit of £6.8m. This was £3.9m worse than the planned year to date performance. The year to date deficit up to the end of August exceeds the planned deficit for the financial year by £0.4m.

The main driver for the overspend is pay, with a £1m overspend, £0.8m of which relates to agency on actual spend over and above the £11.1m plan. We will target reduction on agency spend for the last 2 financial quarters of the year to ensure we meet our target.

August's pay bill was £18.4m, a reduction of £40,000 on month 4, and £86,000 lower than the average for this financial year. It still exceeded the planned expenditure by £0.2m and took the Trust's accumulated pay overspend to £1m. The workforce has grown each month to June 2016 when total WTEs employed were 4,435 WTEs but reductions in successive months since June has brought it down to 4,392 WTEs in August. Filling vacancies and managing the vacancy pipeline is a key target. The fall in employed workforce has seen agency expenditure as a percentage of total pay expenditure increased from 6.6% in July to 7.0% in August.

The Trust's year to date income is £3.2m adverse against plan. This is mainly due to failure to achieve £2.7m STP funding. Although the income is only £0.5m behind plan in

total, there are material adverse variances in day case activity, elective activity which are offset by prior year income and a richer case mix in year.

The cash position is in line with plan, however, the increase in debtors is offset by a similar increase in creditors and we are focusing on reducing both. Capital expenditure is on track and is being closely monitored to maintain the cash position. Our key focus remains 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 continues to deteriorate and is in excess of £18m. We must achieve the above three actions that we will improve that position and demonstrate on-going financial viability.

5. AWARDS

Congratulations to our library team who won the August monthly excellence award for their outstanding services supporting staff with their study and research programmes.

The team comprise of Richard Peacock, Harriet Croxton, Heather McGuigan, Adam Tocock, Catherine Wardle and Nick Khan who recently left the Trust.

This valuable service enables our clinicians and support staff to improve patient experience, promote safety, equality and diversity.

Simon Pleydell
Chief Executive Office

Whittington Health NHS

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

Whittington Health

5 October 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**016/133**	**Paper**	**03**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of August 2016. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	27/09/2016		

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

Serious Incidents Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of 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 August bringing the total of reportable serious incidents to 19 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.
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.
Safe Guarding Incident Ref: 21646	Aug 16	Safeguarding allegation in relation to an inpatient.
Information Governance Breach Ref: 21713	Aug 16	Confidential information contained on a clinic handover sheet was recovered by a member of Trust staff .
Never Event.- Retained foreign object post-procedure Ref: 22867	Aug 16	Retention of a foreign object (swab) following forceps delivery and tear repair.

3.3. **The table below details serious incidents by category reported to the NEL CSU. The Trust reported 3 serious incidents during August 2016.**

STEIS 2016-17 Category	Apr	May	June	July	Aug	Total
Safeguarding	0	1	1	0	1	3
Confidential information leak/loss/Information governance breach	1	2	1	0	1	5
Diagnostic Incident including delay	2	1	0	0	0	3
Failure to source a tier 4 bed for a child	0	0	0	1	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	3
Maternity/Obstetric incident mother only	0	0	0	0	1	1
Slip/Trips/Falls	0	0	0	1	0	1
Unexpected death	0	1	0	1	0	2
Total	4	6	3	3	3	**19**

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 during August 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 1 report to NELCSU during August 2016.**

The table below provides a brief summary of lessons learnt and actions put in place relating to the serious incident investigation report submitted in August 2016.

Summary	Actions taken as result of lessons learnt
• **Ref:12428**	**Unexpected Admission to NICU- Baby** Admission of term baby to the neonatal unit following a category 2 emergency caesarean section. • The SBAR handover process was re-enforced. • Education and training via PROMPT Mandatory Maternity Training • SBAR handover structure included in Handover Whiteboards and electronic handover sheet. • A compliance audit of records to be carried out in September 2016.

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. 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.

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Whittington Health Trust Board

September 2016

Title:	Safe Staffing - Nursing and Midwifery – August data		
Agenda item:	16/134	**Paper**	4
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in August 2016. Key issues to note include: 1. New style report with greater data and analysis 2. A reduced fill rate for Registered Nurses displayed in the UNIFY report 3. High level of special shifts required because of high numbers of vulnerable patients 4. Red Shifts reported in August 5. CHPPD measure during the month 6. Continued use of agency and bank staff to support safe staffing		
Summary of recommendations:	Trust Board members are asked to note the August 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:	September 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?**	

Ward Staffing Levels – Nursing and Midwifery

1.0 Purpose

1.1 To provide the Trust Board with assurance with regard to the management of safe nursing and midwifery staffing levels for the month of August 2016.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of August 2016.

1.3 To provide assurance of the constant review of nursing/midwifery resource using the newly implemented Health roster.

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.

2.2 Staffing levels are viewed alongside reported outcome measures, patient acuity, '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.

2.3 The electronic Health Roster (Allocate) with its 'safer care' module is utilised across all inpatient wards. The data extracted, provides information relating to the dependency and acuity of patients. This, in addition to professional judgement is used to manage ward staffing levels on a number of occasions on a daily basis.

2.4 The recent requirement to capture Care Hours per Patient Day (CHPPD) is an additional parameter to manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (for August data by ward please see Appendix 1).

2.3 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st August 2016 for Whittington Hospital was 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 able to see how hospitals are performing on this indicator on the NHS Choices website.

2.4 Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	Day - 91.7% Night - 93.3%
	Care hours per Patient Day - CHPPD	Overall CHPPD was 9.01 for August this is comparable to the previous two months data
Staff are supported in their decision making by effective reporting.	% of Red triggered shifts	0.7% of shifts triggered red in August 2016 this was a very small increase from that of July 2015 (0.65%)
	% of shifts that remained partially mitigated (Amber shifts)	197 shift's i.e. 14.1% of all shifts in month. This is an increase on July's figure. These consisted of shifts mainly during the day distributed between early and late.

3.0 Fill rate indicator return

3.1 The 'actual' number of staffing hours planned is taken directly from our nurse roster system (Allocate). On occasions when there was a deficit in 'planned' hours versus 'actual' hours, and additional staff were required, staff were reallocated to ensure safe staffing levels across our organisation. Staff are also reallocated to ensure wards/areas are staffed to a safe ratio of permanent to temporary staff.

3.2 Appendix 1 details a summary of fill rates 'actual' versus 'planned'. The average fill rate was 91.7 % for registered staff and 116.0% for care staff during the day and 93.3% for registered staff and 123.2 % for care staff during the night.

3.3 Nine wards reported below 95% fill rates for qualified nurses. These shifts were managed safely by reallocating appropriate staff from other wards. Above 100% fill rate for qualified nurses occurred on one ward area.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
91.7%	116.0%	93.3%	123.2%

4.0 Additional Staff (Specials 1:1)

4.1 When comparing August's total requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease in the number of shifts required (Appendix 2). August saw 201 requests for 1:1 specials compared to 273 requests in July. 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 RMN 'specials' used to care for patients with a mental health condition was lower in August (28) compared to July (37). All requests for registered mental health nurses are validated by the Heads of Nursing and a clinical assessment made as to the therapeutic need. These requests may then be downgraded to provide an HCA rather than an RMN.

4.2 There continues to be a high level of need for specialling patients with mental health conditions and for managing patients who require constant supervision to prevent falls.

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

5.1 Safe staffing levels are reviewed and managed three times daily. 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 all areas are made safe. Matrons and Heads of Nursing review staffing levels again at 13.00 and 17.00 to ensure levels remain 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 and are managed in conjunction with patient dependency and acuity. The matron will be alerted, and take appropriate action. 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.

5.3 Red Shifts

During August 10 shifts triggering red from of a total of 1395. When compared to July, this was an increase of one. Staff were reallocated by Senior Nurses to ensure safe ward cover.

Month	% shifts triggering red in month	Actual number of red shifts
August 16	0.7	10
July 16	0.65	9
June 16	0	0
May 16	0.3	4
April 16	0.1	1

5.4 Wards triggering red shifts

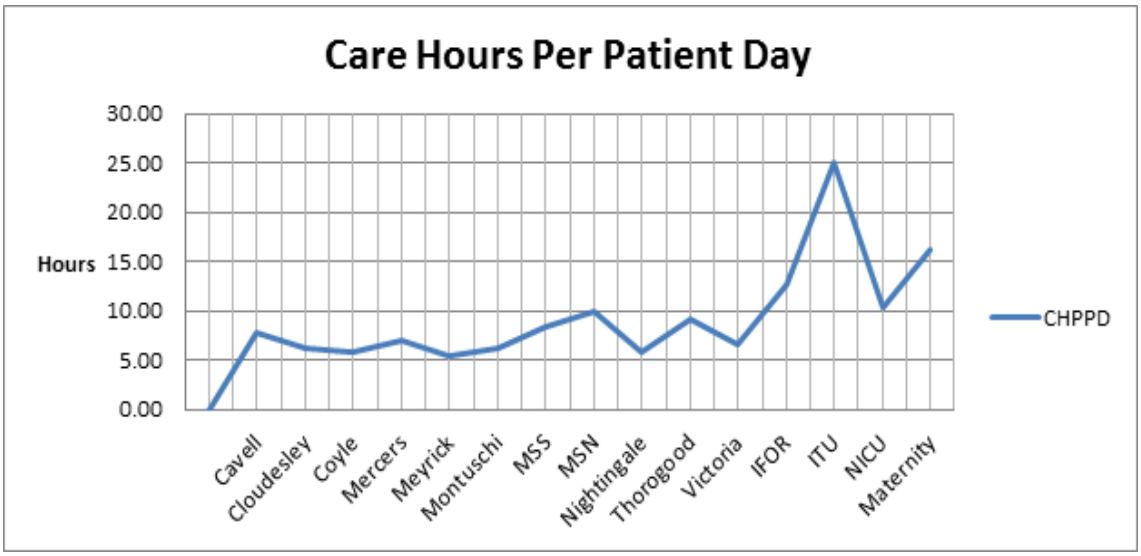
	Initial Red Shifts				
Wards	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a red rating**
Cloudesley	2	1	0	3	**3.2**
Nightingale	0	0	1	1	**1.0**
Mercers	0	0	2	2	**2.1**
Coyle	2	2	0	4	**4.3**

5.5 Summary of factors affecting red triggering shifts

a. Temporary staffing fill
b. Vacancy rate – Nurse Vacancy rate at ward level remains high and continues to impact on temporary staffing requirement.
c. 'Specialing' requirement
d. Additional beds opened to increase bed base capacity

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 calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. ITU have the most care hours (25.81) and Meyrick ward have the least (5.0).



6.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.66 hours and 2.35 hours for care staff. This provides an overall average of 9.01 hours of care per patient day.

	CHPPD
Registered Nurse	6.66
Care Staff	2.35
Overall hours	9.01

6.3 The total care hours per patient day is one of the metrics used on a daily basis by the Senior Nursing Team to monitor the level of nursing man hours required to delivery care on our inpatient wards.

6.4 The new SaferCare module of the Health roster system provides an estimate of the total time required to provide the necessary care using the acuity and dependency of patients and calculates the available nursing time.

6.5 The early data from CHPPD indicates the total amount of care hours delivered to patients over the last four months has remained similar. Each ward maintained a high level of care delivery when comparing the total registered nurses hours available.

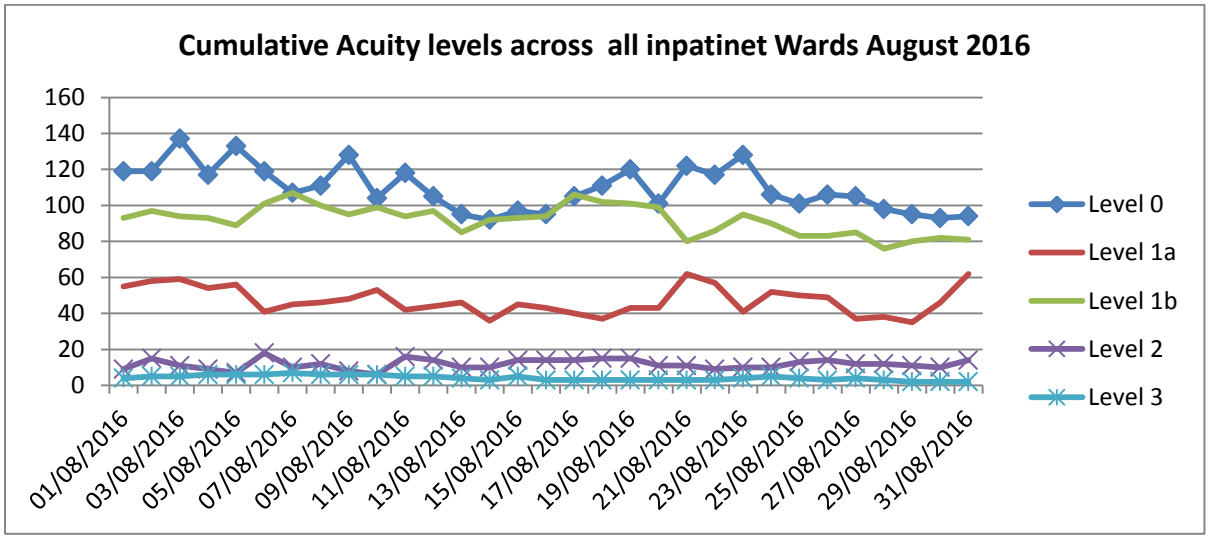
6.6 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight increase in hours of care delivered in August.

Ward Name	Aug	July	June	May
Bridges	-	-	8.39	6.78
Cavell	7.74	7.78	6.48	8.10
Cloudesley	6.14	5.85	5.51	5.37
Coyle	5.88	6.46	7.43	7.01
Mercers	6.98	7.55	7.77	7.57
Meyrick	5.46	5.55	5.97	5.99
Montuschi	6.23	6.52	6.42	6.74
MSS	8.34	7.90	8.72	8.00
MSN	10.04	9.91	9.75	8.39
Nightingale	5.81	5.50	5.96	5.71
Thorogood	9.08	9.38	7.57	8.83
Victoria	6.56	6.14	6.41	6.27
IFOR	12.76	10.02	12.87	10.55
ITU	24.95	25.15	25.81	23.79
NICU	10.33	10.69	11.35	11.93
Maternity	16.19	11.73	13.73	13.47
Total	9.01	8.52	8.97	8.68

7.0 Patient Acuity

7.1 The acuity of patients is dependent on their care requirements. Those patients requiring a low level of care are assigned level 0 and those requiring intensive care are assigned level 3. The trust is experiencing a high number of patients with levels of acuity at level 1b. This level indicates that a patient is requiring nursing support for their activities of daily living which would include washing, toileting and feeding. These patients require two staff to care for their daily needs.

7.2 The graph below demonstrates the level of acuity across inpatient wards in August. As expected, there are a low number of level 3 patients and a high number of level 0 patients. The number of level 1b patients is also high. This increased number of dependant patients requires a greater input of nursing care.



8.0 Temporary Staff Utilisation

8.1 Temporary staff utilisation (nursing and midwifery) is monitored daily by the Deputy Director of Nursing. All requests for temporary staff (agency) are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Director of Nursing.

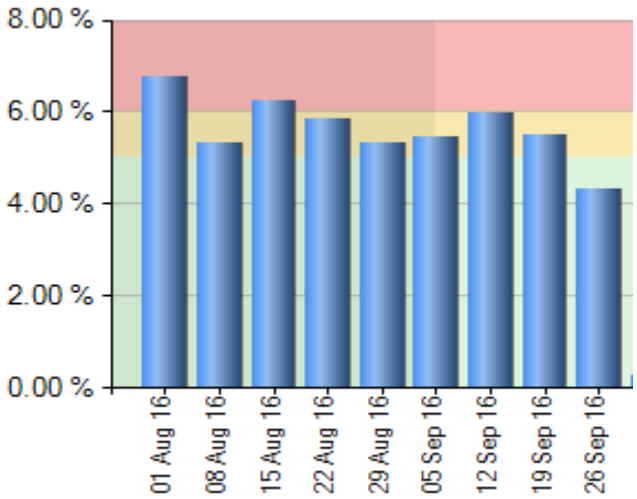
8.2 Monitoring the request for temporary staff in this way serves two purposes:

a) The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

9.0 Agency Usage Inpatient Wards (August to date)

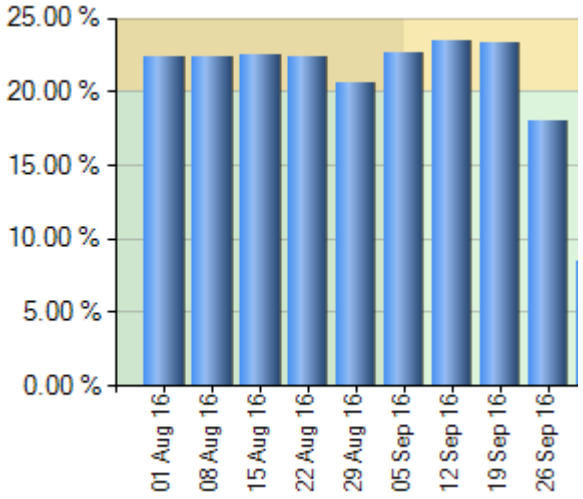
9.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards August to date (this is cumulative data captured from roster performance reports).



9.2 A key performance indicator (KPI) of less than 6% agency usage was set to coincide with the NHS England agency cap. August data demonstrates a positive position in the second and subsequent weeks of August/September.

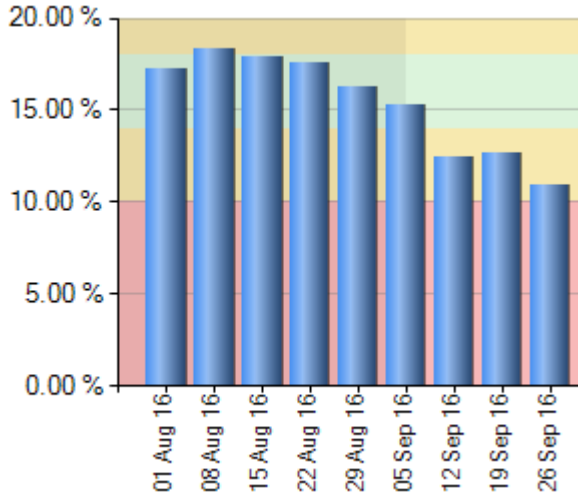
9.3 Temporary staff usage across the inpatient wards fluctuates depending on nurse vacancies and or the need to provide additional support for 1:1 care.

9.4 Temporary staffing usage (bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%.

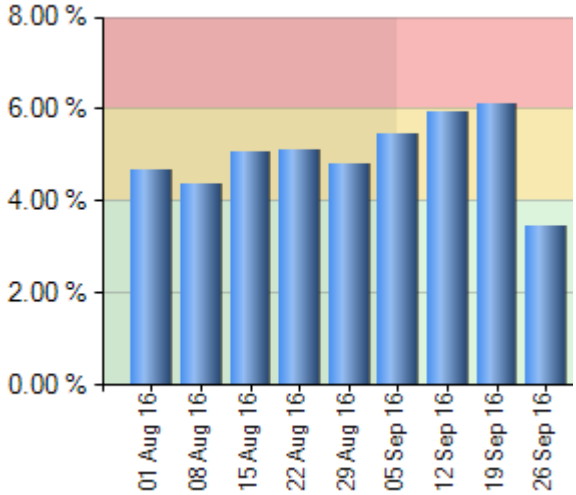


10.0 Managing Staff Resource

10.1 Annual leave taken August to date is within the set tolerance of between 15 -17%. This tolerance level ensures all staff are allocated leave appropriately and ensures sufficient staff are available throughout the year.



10.2 Sick leave reported in August was above the set parameter of less than 4%. Heads of Nursing have been reminded to ensure that all individuals reporting back from sick leave undergo a sickness review. The data for sickness includes all staff seen by Occupational Health, who are on a 'phased return' programme following a period of sickness.



11.0 Conclusion

11.1 Trust Board members are asked to note the work currently being undertaken to proactively manage the nursing/midwifery resource across the ICO and the August UNIFY return position.

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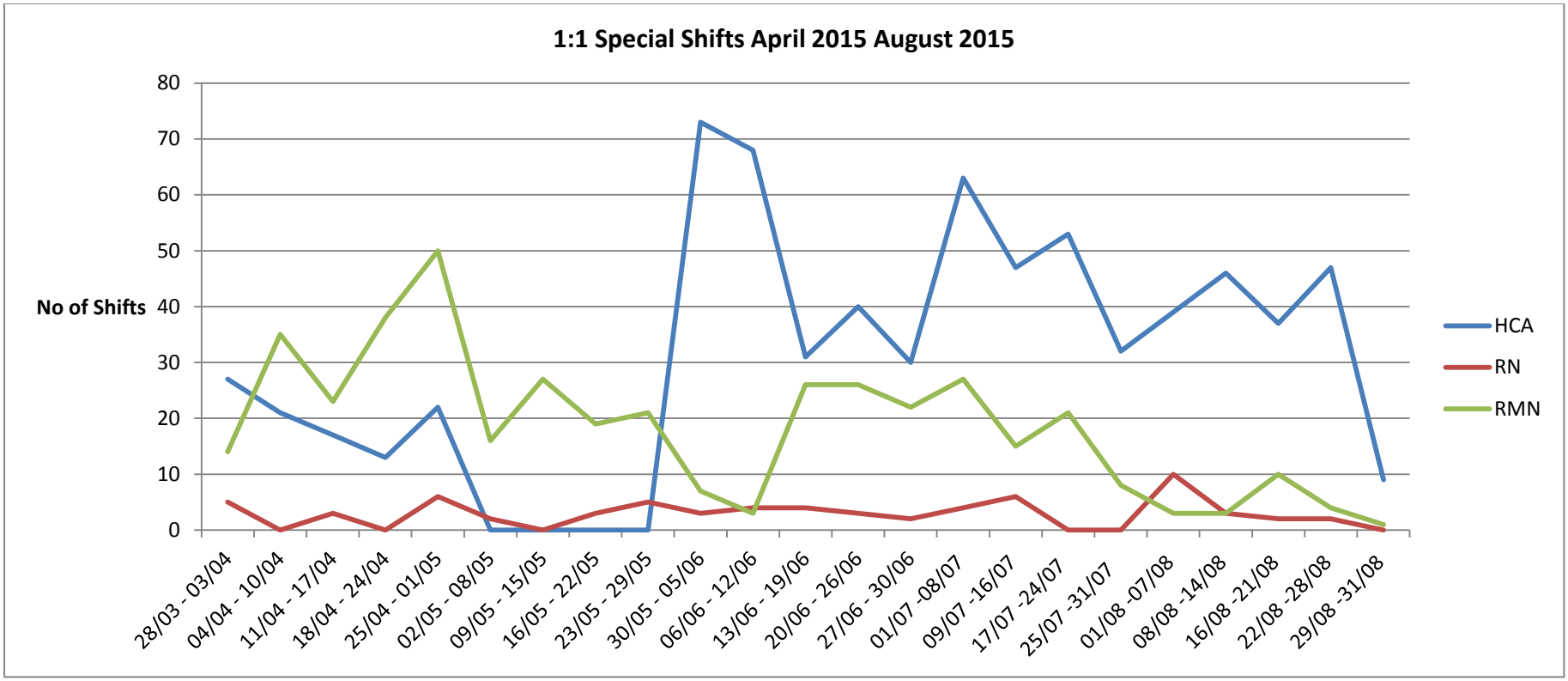
Fill rate data - summary
August 2016

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 (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)				
33118	30353	9434	10942	27414	25569	7123	8774	91.7%	116.0%	93.3%	123.2%

Care Hours per Patient Day
August 2016

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8394	6.66	2.35	9.01

August 2016


1:1 Special Shifts April 2015 August 2015
No of Shifts
80
70
60
50
40
30
20
10
0
28/03 - 03/04
04/04 - 10/04
11/04 - 17/04
18/04 - 24/04
25/04 - 01/05
02/05 - 08/05
09/05 - 15/05
16/05 - 22/05
23/05 - 29/05
30/05 - 05/06
06/06 - 12/06
13/06 - 19/06
20/06 - 26/06
27/06 - 30/06
01/07 -08/07
09/07 -16/07
17/07 -24/07
25/07 -31/07
01/08 -07/08
08/08 -14/08
16/08 -21/08
22/08 -28/08
29/08 -31/08
HCA
RN
RMN

Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Average fill rate RN & RM	**Average fill rate Care Staff**	**Average fill rate RN & RM**	**Average fill rate Care Staff**
Ward Name	%	%	%	%
Cavell	99.8%	86.0%	99.2%	98.3%
Cloudesley	90.8%	128.8%	97.3%	156.7%
Coyle	82.9%	108.0%	92.9%	104.9%
Mercers	81.9%	98.0%	97.8%	99.3%
Meyrick	92.9%	102.4%	98.7%	96.8%
Montuschi	81.9%	204.1%	94.6%	NA
MSS	87.2%	162.1%	98.4%	144.2%
MSN	88.2%	116.0%	105.0%	217.5%
Nightingale	79.9%	166.9%	74.8%	195.2%
Thorogood	99.9%	71.2%	90.7%	116.7%
Victoria	98.0%	125.6%	94.9%	141.2%
IFOR	83.8%	60.7%	79.1%	64.5%
ITU	100.0%	100.0%	100.0%	100.0%
NICU	90.1%	100.0%	89.2%	NA
Maternity	98.4%	109.4%	92.8%	95.9%
Average	91.7%	116.0%	93.3%	123.2%

Whittington Health NHS

The Whittington Hospital
NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

5 October 2016

Title:	August (month 5) 2016/17 – Financial Performance		
Agenda item:	**16/135**	**Paper**	**5**
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 August and a year to date deficit of £6.8m. This was £3.9m worse than planned YTD performance. The key variance driving the financial position is pay with a £1m overspend, circa £0.8m of which relates to agency premium on actual spend over and above the £11.1m plan.		
Summary of recommendations:	To note the financial results relating to performance during August 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). Finance Report to Finance & Business Development Committee.		
Date paper completed:	28 September 2016		

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

Financial Sustainability Risk Rating

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

Executive Summary

The Trust reported a £1.3m deficit in August and a year to date (YTD) deficit of £6.8m which is £3.9m worse than the planned YTD position.

The key variance which is driving the YTD financial position is pay with a £1m overspend, £0.8m of which relates to agency premium 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.

August's pay bill was £18.4m, a fall of £40,000 on month 4, and £86,000 lower than the average for this financial year. However, it still exceeded the planned expenditure by £0.2m and took the Trust's accumulated pay overspend to £1m. The workforce employed grew in the first quarter but successive reductions in July and August has increased the vacancy levels and the agency spend. Filling vacancies and managing the vacancy pipeline is a key executive target. The fall in employed workforce has seen agency expenditure as a percentage of total pay expenditure increased from 6.6% in July to 7.0% in August.

The Trust's year to date income is £3.2m adverse against plan. This is mainly due to failure to achieve £2.7m STP funding. Although the income is only £0.5m behind plan in total, there are material adverse variances in day case activity, elective activity which are offset by prior year income and a richer case mix in year.

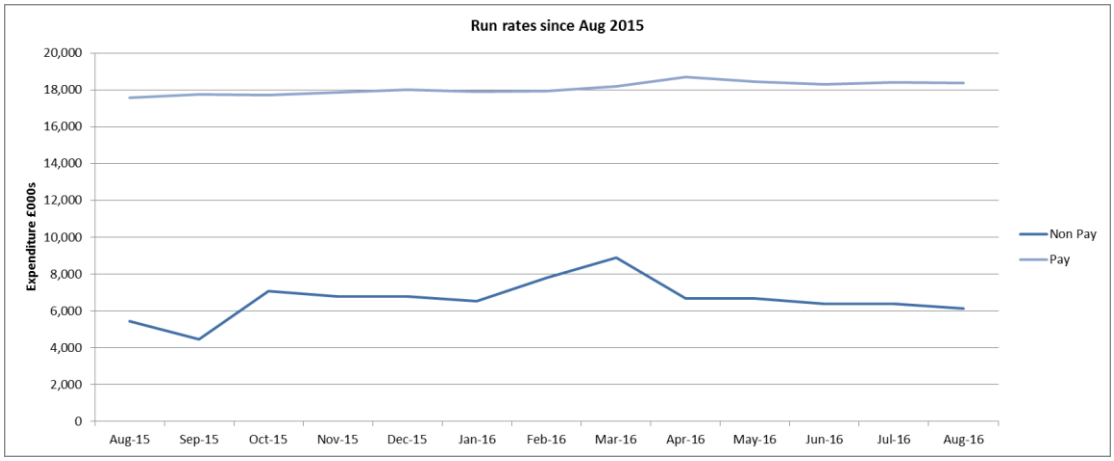
The cash position is broadly in line with plan, however, the increase in debtors is offset by a similar increase in creditors and the trust is focussing on reducing both. Capital expenditure is on track and is being closely monitored to maintain the cash position.

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	21,585	20,161	(1,424)	107,782	104,317	(3,465)	257,906
Non-Nhs Clinical Income	1,899	2,755	856	9,494	9,990	496	22,784
Other Non-Patient Income	2,028	1,737	(291)	10,270	10,049	(221)	26,484
Total Income	**25,512**	**24,653**	**(859)**	**127,546**	**124,356**	**(3,190)**	**307,174**
Non-Pay	(6,536)	(6,378)	158	(32,682)	(32,490)	192	(79,494)
Pay	(18,126)	(18,363)	(237)	(91,325)	(92,292)	(967)	(217,441)
Total Operating Expenditure	**(24,662)**	**(24,741)**	**(79)**	**(124,007)**	**(124,782)**	**(775)**	**(296,935)**
EBITDA	**850**	**(88)**	**(938)**	**3,539**	**(426)**	**(3,965)**	**10,239**
Depreciation	(690)	(669)	21	(3,450)	(3,426)	24	(8,280)
Dividends Payable	(353)	(331)	22	(1,767)	(1,768)	(1)	(4,243)
Interest Payable	(266)	(259)	7	(1,311)	(1,275)	36	(3,238)
Interest Receivable	3	2	(1)	15	13	(2)	36
Total	**(1,306)**	**(1,257)**	**49**	**(6,513)**	**(6,456)**	**57**	**(15,725)**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(456)**	**(1,345)**	**(889)**	**(2,974)**	**(6,882)**	**(3,908)**	**(5,486)**
Add back impairments and adjust for IFRS & Donate	7	5	(2)	21	24	3	(914)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(449)**	**(1,340)**	**(891)**	**(2,953)**	**(6,858)**	**(3,905)**	**(6,400)**

In month performance was driven by the closure of theatres which decreased elective and day case income against plan. Despite reducing activity the Trust continued to overspend on pay and agency cover, non-pay however reduced.

Given the in-month position the underlying deficit position continues to worsen and to improve the position the Trust is agreeing weekly activity targets with ICSUs in underperforming areas, focussing on the delivery of CIP schemes and has increased the controls on agency.



Cost Improvement Programme

In month 5 savings of £0.5m (54%) were delivered against the NHS Improvement operating plan of £0.95m. Year to date, £2m (70%) has been achieved. The Trust CIP profile requires a material increase in the rate of cost improvement in October through to March 2017.

The actual delivery of CIP is shown below by ICSU and when analysed by accounting classification delivery is £0.7m of its planned £1.4m pay CIP schemes, £0.6m of income through improved counting and coding in surgery and women's ICSUs, and £0.8m of non-pay through vacating premises at St Ann's and Goswell Road,

The Trust CIP plan forecasts that £10m of savings will be delivered in the financial year to support achievement of the income and expenditure plan. In order to meet the planned deficit, the Trust must:

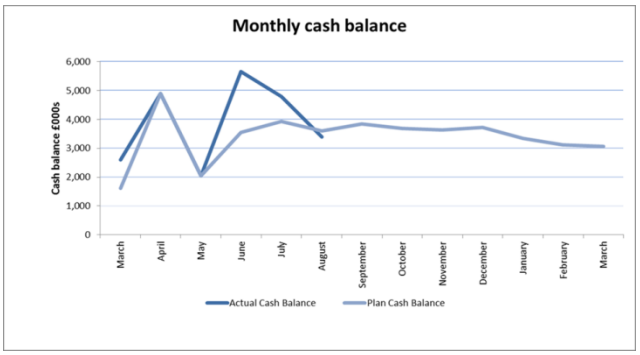
- continue delivering existing saving schemes and to close the gap reported by the PMO;
- minimise additional budgetary overspends; and
- control influenceable spend for areas such as temporary staff usage.

Integrated Clinical Service Units	Annual Plan £'000	August, month 5				YTD			
		Plan £'000	Actual £'000	% achieved	Variance £'000	Plan £'000	Actual £'000	% achieved	Variance £'000
Children's services	602	33	14	41.1%	-20	93	137	147.8%	44
Clinical Support Services	1,019	85	26	30.7%	-59	259	266	102.9%	7
Emergency & Urgent Care	786	38	92	239.2%	53	102	304	297.7%	202
Medicine, Frailty & Network Services	1,673	112	63	56.3%	-49	307	115	37.5%	-192
Outpatients Prevention & LTC	526	43	10	24.5%	-32	123	10	8.5%	-113
Surgery	2,613	241	133	55.2%	-108	652	277	42.5%	-375
Women's Services	1,189	83	35	42.1%	-48	254	299	117.5%	45
Corporate	2,307	313	139	44.4%	-174	1,129	665	58.9%	-464
Performance against operating plan	**10,715**	**948**	**512**	**54.0%**	**-436**	**2,919**	**2,073**	**71.0%**	**-846**

The PMO and Boston Consulting met with ICSUs to discuss the original schemes and ideas that were not full schemes at the start of the financial year to ensure that plans remained challenging and valid, those meetings will inform the forecasting for full year CIP. ICSU's confirmed they are working to the planned two years of schemes and are working on increasing delivery in year with support.

Statement of Financial Position

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 31 August 2016 £000	As at 31 August 2016 £000	Variance YTD 31 August 2016 £000
			Year to Date	Year to Date	
Property, plant and equipment	194,785	203,023	193,325	192,374	952
Intangible assets	4,583	2,831	3,867	4,342	(475)
Trade and other receivables	693	851	816	651	165
Total Non Current Assets	**200,061**	**206,705**	**198,009**	**197,367**	**642**
Inventories	1,403	1,500	1,500	1,807	(307)
Trade and other receivables	23,535	25,393	20,888	27,104	(6,216)
Cash and cash equivalents	2,598	3,060	3,599	3,385	214
Total Current Assets	**27,536**	**29,953**	**25,987**	**32,296**	**(6,309)**
Total Assets	**227,597**	**236,658**	**223,996**	**229,663**	**(5,667)**
Trade and other payables	39,112	43,391	34,922	43,210	(8,288)
Borrowings	376	2,455	6,274	6,633	(359)
Provisions	795	756	780	753	27
Total Current Liabilities	**40,283**	**46,602**	**41,976**	**50,596**	**(8,620)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(15,989)**	**(18,300)**	**2,311**
Total Assets less Current Liabilities	**187,314**	**190,056**	**182,020**	**179,067**	**2,953**
Borrowings	52,934	61,419	50,762	51,340	(578)
Provisions	1,773	1,513	1,667	1,773	(106)
Total Non Current Liabilities	**54,707**	**62,932**	**52,429**	**53,113**	**(684)**
Total Assets Employed	**132,607**	**127,124**	**129,591**	**125,954**	**3,637**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(10,889)	(14,378)	3,489
Revaluation reserve	78,076	78,076	78,075	77,928	148
Total Taxpayers' Equity	**132,607**	**127,124**	**129,591**	**125,954**	**3,637**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**



Property, Plant & Equipment (incl. Intangible Assets): The underspend remains as a result of on-going negotiations with the managed equipment services.

Cash: The annual cash plan assumes that the Trust would receive £8.9m cash support. The trust drew down £4.7m as at month 05. The cash position at the close of month 5 was £3.4m. The Trust is managing cash closely to plan and controlling payments.

Trade Receivables: The adverse variance of £6.2m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. Discussions are on-going with local providers which represent mainly NHS Islington £4.2m, London Borough of Haringey £2.5m, Royal Free Hospital £1.9m, NHS England £1.4m, London Borough of Islington £0.8m, and Camden Islington Foundation Trust £1.0m and UCLH £0.6m.

Payables: The Trust is negotiating with local providers to clear old invoices and reduce the balances. Payments have been slowed to manage the cash position and as debt collection increase the payments will increase reducing payables.

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

Whittington Health Trust Board
5th October 2016

Title:	Trust Board Report September 2016 (August 16 data)		
Agenda item:	**16/136**	**Paper**	**6**
Action requested:	For discussion and decision making		
Executive Summary:	The following is the Performance report for August 2016. **Patient Safety** **Never Event** One Never event was reported in August 2016. A swap was retained after a forceps delivery. All early learning has been identified and shared with staff. **Theatre Utilisation** Overall August was a less well utilised month which is a seasonal variation, but again T&O, General Surgery & Breast were all over 80% while Gynaecology just under at 79% and Urology being 60% Theatre utilisation remains on average 80% and the Trust is aiming to meet 85%. Daily challenges in place to increased productivity across less productive surgical specialities. **Hospital Cancellation** Achieved target for first appointment and just above target for follow up appointments. **DNA rate** has gone up slightly for first appointments during the holiday season and remained the same for follow up appointments at just above the expected target of 10%. **Community Cancellations and DNAs** continue to achieve their target. **Appointments with no outcomes in the community** remain above the target of 0.5% at 0.9%. All appointments however are outcomed by the time the SUS submission is due (2 months arrears). The **MSK service** 6 weeks waiting times target is steadily improving and for August 2016 at 60%. There are ongoing meetings with commissioners looking at specific areas in the recovery action plan for further improvements. The **Podiatry service** has been given an improvement notice and although the number of patients being seen within 6 weeks is reduced again this month, the service is now fully staffed and targeting the backlog. Expected improvement in the next 2 months.		

	Islington Intermediate Care REACH number of patients being seen within 6 weeks has fallen this month after having made good progress in the last months. The service will be fully staffed in November and is on target to be compliant in December 2016. **The cancer 62-days from referral to treatment was** non-compliant for the month of July with 1 Breast and 3 Urology (shared care) patients. **Emergency and Urgent Care** Performance is improving and at 92% in August 16. It is forecast to improve during September. The improvement plan continues to make the intended impact. There has been a further reduction in the number of bed management breaches, due to the improved admitted pathway. The percentage of patients left without being seen is now below the target of 5%. The median time to treatment has reached its target for August (60mins) and there were no 12 hour trolley breaches.
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:	28th September 2016

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

September 2016 Trust Board Report (Aug 16 data)

Whittington Health NHS

Quality	Threshold	Jun-16	Jul-16	Aug-16
Number of Inpatient Deaths	-	31	28	26
NHS number completion in SUS (OP & IP)	99%	99.0%	98.9%	arrears
NHS number completion in A&E data set	95%	TBC	TBC	arrears

Quality (Mortality index)	Threshold	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr15 - Mar16
SHMI	-	0.65	0.67	0.68

Quality (Mortality index)	Threshold	Mar-16	Apr-16	May-16
Hospital Standardised Mortality Ratio (HSMR)	<100	86	71	71
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	50.8	39.7	101.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	97.3	80.0	58.2

Patient Safety	Threshold	Jun-16	Jul-16	Aug-16
Harm Free Care	95%	93.6%	93.8%	91.9%
VTE Risk assessment	95%	96.3%	98.0%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	1
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	20.7%	22.5%	21.6%
Serious Incident reports	-	3	3	3

Access Standards

Referral to Treatment (in arrears)	Threshold	May-16	Jun-16	Jul-16
Diagnostic Waits	99%	99.4%	99.9%	99.3%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Jun-16	Jul-16	Aug-16
Service Cancellations - Community	8%	5.6%	5.7%	5.8%
DNA Rates - Community	10%	5.7%	5.8%	5.7%
Community Face to Face Contacts	-	60,875	58,740	55,192
Community Appts with no outcome	0.5%	1.0%	0.9%	0.9%

Community Access Standards	Threshold	Jun-16	Jul-16	Aug-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	43.4%	46.0%	60.2%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	62.2%	90.5%	arrears
IAPT - patients moving to recovery	50%	48.1%	50.0%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	90.5%	95.1%	arrears
GUM - Appointment within 2 days	98%	95.6%	95.6%	97.8%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Jun-16	Jul-16	Aug-16
First:Follow-up ratio - acute	2.31	1.44	1.44	1.60
Theatre Utilisation	95%	80.6%	78.7%	77.6%
Hospital Cancellations - acute - First Appointments	8%	5.0%	5.9%	6.6%
Hospital Cancellations - acute - Follow-up Appointments	8%	8.2%	8.6%	9.3%
DNA rates - acute - First appointments	10%	11.4%	11.9%	12.7%
DNA rates - acute - Follow-up appts	10%	11.6%	11.5%	11.5%
Hospital Cancelled Operations	0	7	1	6
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	2	1	2

Meeting threshold

Failed threshold

September 2016 Trust Board Report (Aug 16 data)

Whittington Health NHS

Patient Experience	Threshold	Jun-16	Jul-16	Aug-16
Patient Satisfaction - Inpatient FFT (% recommendation)	-	95%	96%	96%
Patient Satisfaction - ED FFT (% recommendation)	-	88%	89%	92%
Patient Satisfaction - Maternity FFT (% recommendation)	-	95%	92%	93%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	31	26	38
Complaints responded to within 25 working days*	80%	82%	95%	85%
Patient admission to adult facilities for under 16 years of age	-	0	0	0

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

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Jun-16	Jul-16	Aug-16
Referral to Treatment 18 weeks - Admitted	90%	79.3%	75.5%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	90.0%	93.5%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	94.2%	93.9%	arrears

Meeting threshold

Failed threshold

Emergency and Urgent Care	Threshold	Jun-16	Jul-16	Aug-16
Emergency Department waits (4 hrs wait)	95%	87.7%	87.9%	92.7%
ED Indicator - median wait for treatment (minutes)	<60	85	87	60
30 day Emergency readmissions	-	246	226	arrears
12 hour trolley waits in A&E	0	1	1	0
Ambulatory Care (% diverted)	>5%	3.0%	3.6%	3.1%
Ambulance Handover (within 30 minutes)	0	28	33	arrears
Ambulance Handover (within 60 minutes)	0	9	0	arrears

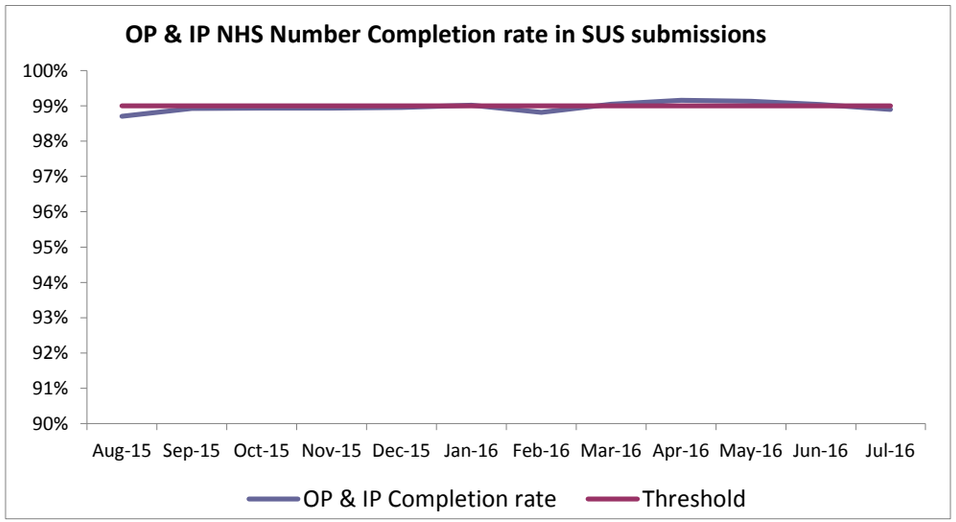
Cancer Access Standards (in arrears)	Threshold	May-16	Jun-16	Jul-16
Cancer - 14 days to first seen	93%	96.4%	96.4%	97.7%
Cancer - 14 days to first seen - breast symptomatic	93%	95.4%	99.2%	100.0%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	-	-
Cancer - 62 days from referral to treatment	85%	82.5%	94.9%	83.3%

Maternity	Threshold	Jun-16	Jul-16	Aug-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	84.1%	84.2%	85.3%
New Birth Visits - Haringey	95%	87.9%	93.2%	arrears
New Birth Visits - Islington	95%	94.4%	94.9%	arrears
Elective Caesarean Section rate	14.8%	14.8%	11.5%	12.0%
Breastfeeding initiated	90%	86.9%	93.7%	91.2%
Smoking at Delivery	<6%	5.9%	3.9%	4.4%

	Threshold	Trust Actual		
		Jun-16	Jul-16	Aug-16
Number of Inpatient Deaths	-	31	28	26
Completion of a valid NHS number in SUS (OP & IP)	99%	99.0%	98.9%	arrears
Completion of a valid NHS number in A&E data sets	95%	TBC	TBC	arrears

	Standardised National Average	Trust		
		Mar-16	Apr-16	May-16
Hospital Standardised Mortality Ratio	<100	85.6	71.3	71.1
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	50.8	39.7	101.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	97.3	80.0	58.2

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Apr 2015 - Mar 2016	0.89	1.13	0.68
	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



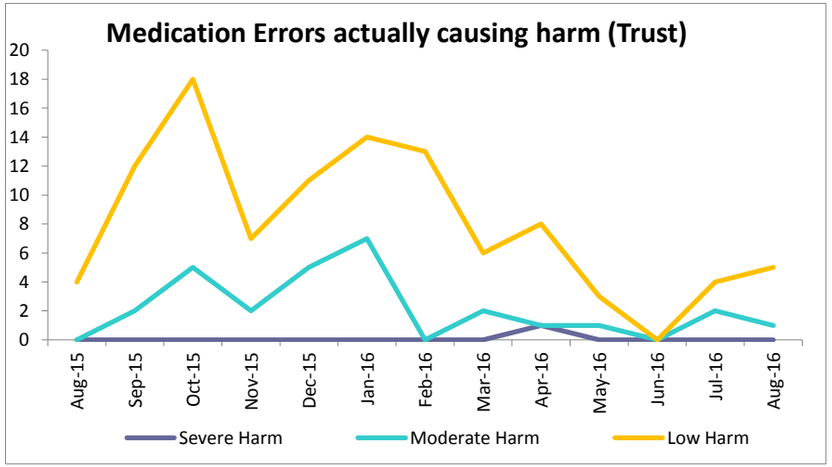
Commentary

Completion of NHS number in SUS
Just below target for Out patients and In patients. Improvements are being seen retrospectively and June 16 data is now within target.
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. Internal reporting is restored and shows over 95% compliance .However, the SUS portal also produces a suite of data quality metrics (including this metric) which seems to be producing slightly different values. To avoid confusion, the trust will not report this measure until it is clear why this discrepancy occurs.
Timescale: Ongoing for the foreseeing months.

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.

	Threshold	Trust Actual May-16	Jun-16	Jul-16	Aug-16	Trend
Harm Free Care	95%	92.7%	93.6%	93.8%	91.9%	
Pressure Ulcers (prevalence)	-	6.35%	5.85%	5.54%	6.72%	
Falls (audit)	-	0.45%	0.29%	0.38%	1.13%	
VTE Risk assessment	95%	96.0%	96.3%	98.0%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	1	0	2	1	
Medication Errors actually causing **Low** Harm	-	3	0	4	5	
Never Events	0	0	0	0	1	
Open CAS Alerts (Central Alerting System)	-	0	0	0	0	
Proportion of reported patient safety incidents that are harmful	-	26.3%	20.7%	22.5%	21.6%	
Serious Incidents (Trust Total)	-	6	3	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. which are not attributable to whittington Health. It remains above 90%.

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 has been agreed in principle at the Investment Group and TMG in August 2016, however funding from within the IM ICSU budget is being explored. Funding options will be presented at TMG again in one month's time.

Medication errors causing harm in August 16
There were 36 medication incidents reported on Datix in August 2016 (monthly average for 2016 is 51). This is the lowest number of incidents reported in a month in 2016.
Nineteen (67%) of medication incidents were reported by E&UC of which 11 (31% of the total) occurred in patients' homes. The largest reporting group were hospital nurses (36%), followed by district nurses (31%): 22% were reported by medical staff. One incident caused moderate harm: this concerned a patient seen in the ACU whose IV antibiotics were delayed – leading to an additional antibiotic being required and the patient being admitted as an in-patient. This

Medication errors cont.

The e-prescribing team have been informed and are following up.
The four incidents causing low harm in E&UC were all reported by District Nurses: two involved missed visits, one where a syringe driver had been incorrectly set up and the fourth missing CDs.
The low harm incident in MF&NS concerned a pre-procedure dose of gentamicin given at the incorrect time.

Proportion of reported patient safety incidents that are harmful
This report has now been restored and uses the new configuration of Datix into ICSUs. Data has been calculated back to May 2016, although for that month only, the figures are still affected by the old configuration. On previous reports the proportion of harm was reported to be higher and the Trust feels that this lower figure reported now reflects the true situation.

Serious Incidents
Whittington Health declared 1 Never Event in August 2016 and 3 SIs.
Never Event
Retained Swab after a forceps delivery.
SIs
1.Information Governance breach, lost RiO sheet, 2. Intrauterine Death at 32 weeks and 3. Intrauterine Death at 38+1.

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

Patient Experience

Whittington Health NHS

	Threshold	Trust Actual May-16	Jun-16	Jul-16	Aug-16	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	95%	95%	96%	96%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	92%	88%	89%	92%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	92%	95%	92%	93%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	23	31	26	38	
Complaints responded to within 25 working day	80%	90.5%	82.1%	95.5%	85.3%	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	

Complaints

ICSU	Jun-16	Jul-16	Aug-16
Integrated Medicine	67%	100%	57%
Emergency & UC	80%	100%	100%
Surgery & Cancer	83%	100%	83%
Clinical Support Services	100%	100%	100%
Patient Access, Prevention, etc	100%	100%	100%
Children's Services	75%	50%	100%
Women's Health Services	**100%**	**100%**	**100%**
Estates & Facilities	100%	100%	100%
Nursing & PE	100%	100%	N/A
IM&T	N/A	N/A	N/A
Finance	N/A	N/A	N/A
Trust	**83%**	**95%**	**88%**

Maternity FFT

2016/17

Month	Response Rate	% Recommend	% Not Recommend
Apr-16	19.3%	94.6%	0.8%
May-16	16.1%	92.1%	1.0%
Jun-16	18.3%	94.6%	2.2%
Jul-16	10.5%	91.6%	2.8%
Aug-16	18.9%	93.2%	0.0%

Commentary

Patient Satisfaction (Local standard 90%)
Please see breakdown of FFT to the left.

ED: Positive response rate above 90%. Response rate below 10%

Inpatients: Positive response rate above 90%. Response rate below 20% target

Outpatients: Positive response rate above 90%. Number of responses >200

Community: Positive responses over 90%. Number of responses <750

Maternity
Positive response rate target met; Response rate target met

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%
August 2016	**433**	**96%**	**2**	**0%**	**451**	**2924**	**15%**

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%
August 2016	**194**	**92%**	**9**	**4%**	**210**	**6184**	**3%**

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
August 2016	**208**	**91%**	**12**	**5%**	**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
August 2016	**594**	**98%**	**5**	**1%**	**609**

Infection Prevention

Whittington Health NHS

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

	Threshold	May 16	Jun 16	Jul 16	Aug 16	2016/17 Trust YTD
C difficile Infections	17 (Year)	1	1	1	0	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%	

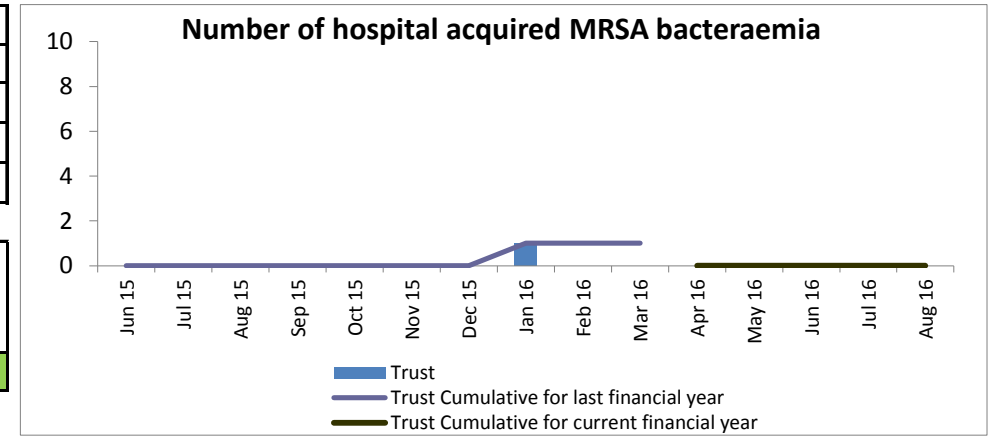
Commentary

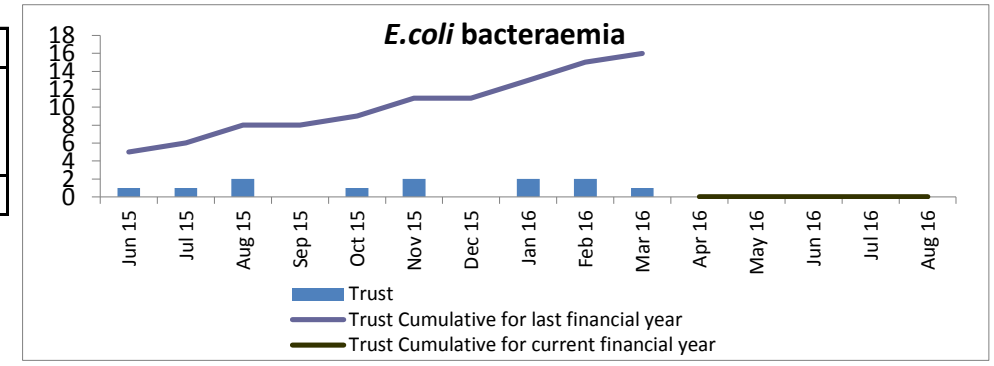
MSRA and E.coli
No new bacteraemia

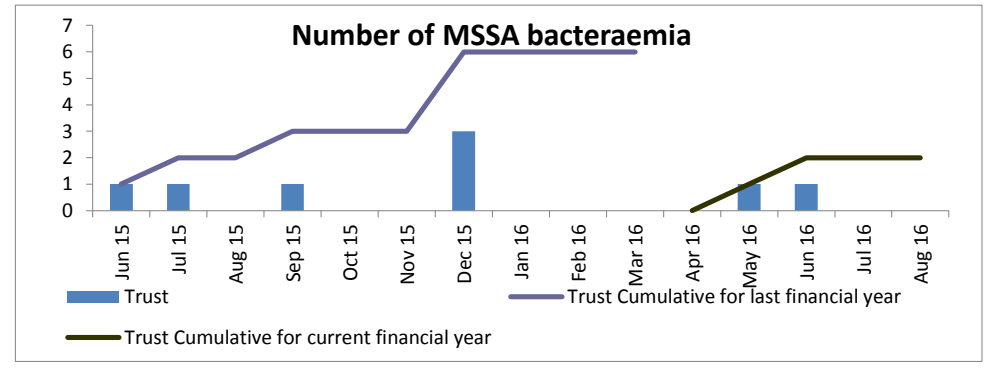
MSSA
No new bacteraemia

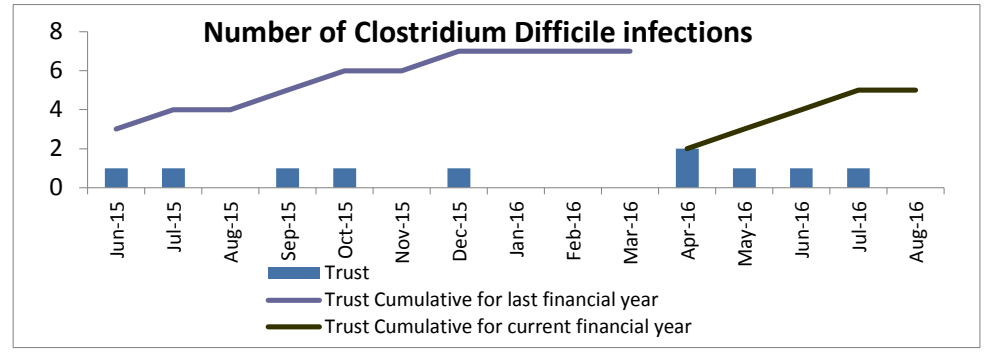
C difficile
No new bacteraemia

Ward Cleanliness
Issue: No new update. 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 by Estates and matrons to ensure standards are maintained.
Timescale: In place.





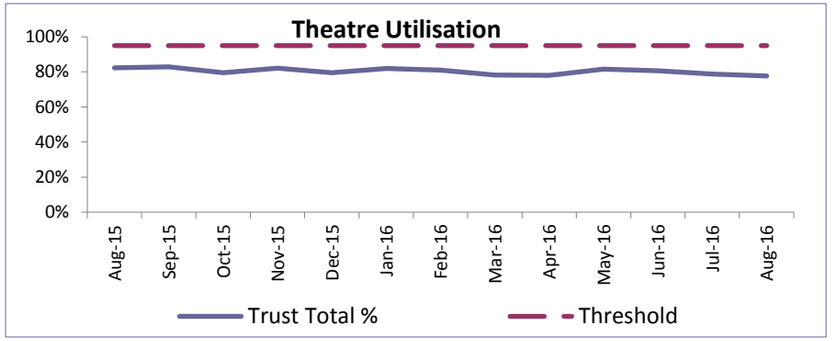


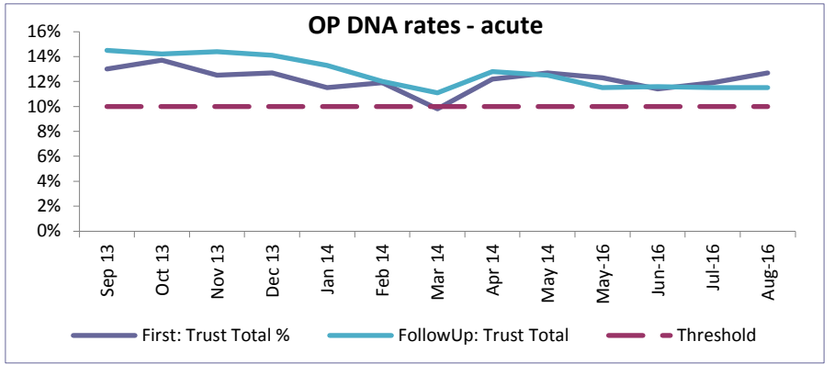


Efficiency and productivity - acute

Whittington Health NHS

	Trust						
	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Trend
First:Follow-up ratio - acute	2.31	1.46	1.37	1.44	1.44	1.60	
Theatre Utilisation	95%	78.1%	81.5%	80.6%	78.7%	77.6%	
Hospital Cancellations - acute - First Appointments	<8%	6.2%	4.6%	5.0%	5.9%	6.6%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	9.0%	7.2%	8.2%	8.6%	9.3%	
DNA rates - acute - First appointments	10%	12.7%	12.3%	11.4%	11.9%	12.7%	
DNA rates - acute - Follow-up appointments	10%	12.5%	11.5%	11.6%	11.5%	11.5%	
Hospital Cancelled Operations	0	19	4	7	1	6	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	5	4	2	1	2	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	





Commentary

Theatre utilisation

Issue: Theatre utilisation is still sitting on average around 80%. An average of 85% is what is expected.
Overall August was a less well utilised month which is a seasonal variation, but again T&O, General Surgery & Breast were all over 80% while Gynaecology just under at 79% and Urology being 60%

Actions:

1.TCI list meetings are having some impact. Partially filled lists and lists to be covered by a registrar are being closed as often these perform poorly. This should impact in mid October due to booking 6 weeks in advance.
2. Daily theatre utilisation report used to challenge each clinician. Triggers red is under 80% utilisation.
3. Increased theatre utilisation in Urology team discussed and implementation started.
4. Pre-operative assessment workshop with Bookings team and Pre-operative assessment team to ensure no patient gets an appointment for surgery unless has been assessed as fit.
5. Matron is in the process of assigning permanent nursing staff to Urology theatre team to develop capacity and productivity.
6. Theatres have recruited more staff to bring them closer to establishment, this will help to ensure that lunches are covered so that theatres can work through with no delays. This will have an impact in Q3.
7. Theatre matron to monitor start times for Urology theatre**.**
8. Two lists from Gynae will be removed as soon as possible impacting significantly on the overall percentage.
9. theatre utilisation dashboard now implemented.

Timescale: It is anticipated that from late October/early November there will be an impact on utilisation figures to achieve 85% more regularly.

Hospital Cancellations

Within target for first appointments, but above target for follow up appointments

Continued

DNA

Increased for both first and follow up appointments during August 2016, minor variations would be expected during the holidays.
Action: Further improvement to be expected month on month, using NetCall and continuing drive to update the EPR
systems with patient details when attending appointments.
Timescale: expected improve over the next months.

Hospital Cancelled Operations

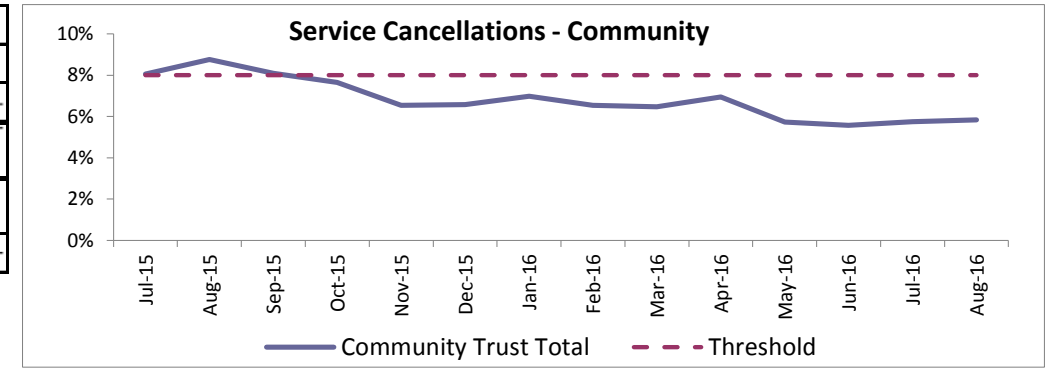
Issue: There were 6 reportable cancelled operation of which 2 were urgent procedures, which were cancelled due to no notes available in one case and the other was cancelled by the surgeon. The four non-urgent cancellations included 2 where the patient was incorrectly booked in (General Surgery), one for which the notes were not available (General surgery) and one the surgeon cancelled (Orthopaedics)

All operation were rescheduled within 28 days.

Efficiency and productivity - Community

Whittington Health NHS

	Trust					
	Threshold	May-16	Jun-16	Jul-16	Aug-16	Trend
Service Cancellations - Community	8%	5.7%	5.6%	5.7%	5.8%	
DNA Rates - Community	10%	5.8%	5.7%	5.8%	5.7%	
Community Face to Face Contacts*	-	58,331	60,875	58,740	55,192	
Community Appointment with no outcome	0.5%	5.9%	1.0%	0.9%	0.9%	



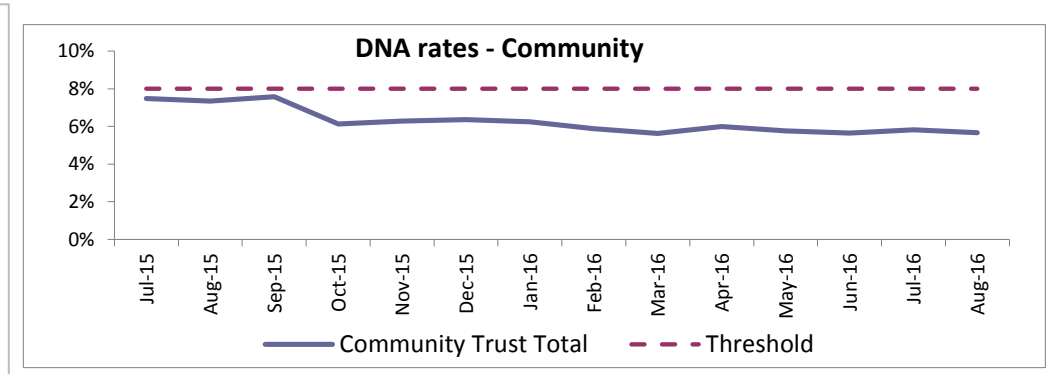
Commentary

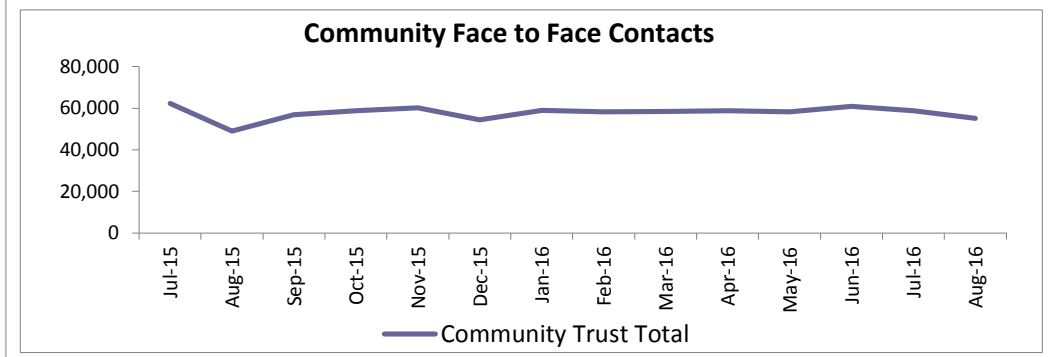
Service Cancellations - Community
Achieved

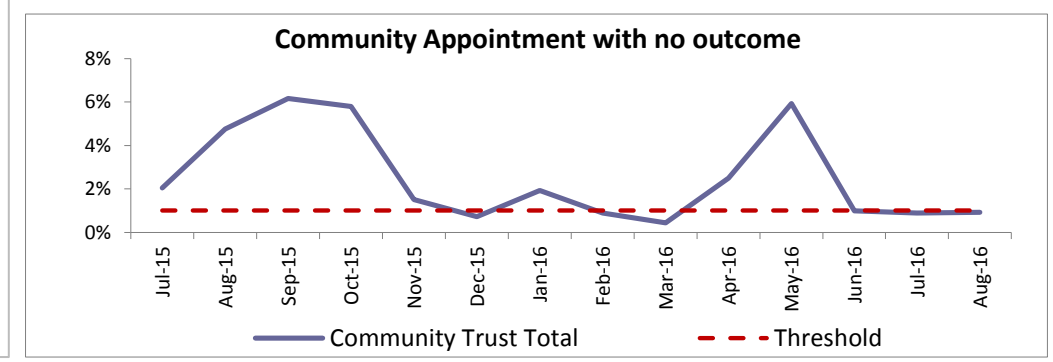
DNA Rates - Community
Achieved.

Community Face to Face Contacts
All services are monitored against activity targets.
Community Dental was not able to submit their number of appointments this month due to annual leave. The continuing Business plan will be amended to reflect continues monthly reporting.

Community Appointment with no outcome
Above the target of 0.5%, but remaining at 0.9% this month (519 appointments).
Issue: Appointments are not outcomed in time for services with high volume appointments.
Action: Electronic reports are in place for Services to monitor their unoutcomed appointments, e.g. District Nursing 289 were not outcomed by the 3rd working day of the following month. All appointments are outcomed retrospectively before submission to SUS 2 month in arrears.
Timescale: in place







	Threshold	Trust Actual Jun-16	Trust Actual Jul-16	Trust Actual Aug-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	-	-	-	-
District Nursing Wait Time - 2hrs assess (Haringey)	-	-	-	-	-
District Nursing Wait Time - 48hrs for visit (Islington)	-	-	-	-	-
District Nursing Wait Time - 48hrs for visit (Haringey)	-	-	-	-	-
MSK Waiting Times - Routine MSK (<6 weeks)	95%	43.4%	46.0%	60.2%	46.0%
MSK Waiting Times - Consultant led (<18 weeks)	95%	62.2%	90.5%	arrears	71.2%
IAPT - patients moving to recovery	50%	48.1%	50.0%	arrears	49.3%
GUM - Appointment within 2 days	98%	99.7%	95.6%	97.8%	98.1%
Haringey Adults Community Rehabilitation (<6weeks)	85%	87.5%	84.2%	82.4%	86.1%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	51.7%	44.8%	40.7%	48.0%
Islington Community Rehabilitation (<12 weeks)	-	71.8%	69.9%	78.6%	78.5%
Islington Intermediate Care REACH(<6 weeks)	85%	67.8%	71.3%	65.8%	70.6%
Islington Podiatry (Foot Health) (<6 weeks)	-	37.6%	26.6%	24.3%	32.6%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	90.5%	95.1%	arrears	95.3%
Death in place of choice	90%	96.0%	84.4%	85.7%	
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: There are no figures for 2 and 48 hrs waiting times for the last 3 months. It is not possible to produce these figures electronically.
Action: 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 will implement a new piece of software which is called E-community platform & store &forward (RiO). This will accurately capture unplanned visits that 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. From this data, when inputted correctly, it will be possible to capture the 2 and 48hrs waiting times.
Timescale: E community Pilot to launched in November 2016 . Store & Forward (October 2016)

Death in Place of choice:
The number of patients this indicator applies to in 28. The district nursing teams and their palliative link nurses have worked hard to sensitively address with service users the preferred place of care.
Issue: Four patients did not die in their place of choice this month.
Action: Work with teams to consolidate and encourage good practice.

GUM Issue: In August, the service missed the target by one patient, the correct escalation processes were not followed, this has been addressed locally.

IAPT

Continued

MSK:
Actions from Aug 16:
Commissioners review meeting took place in August. Timelines added to RAP and signed off. Discontinue IQP (rapid access service) In Islington as per CCG instructions. To Review other specialist services to see how much they impact on waiting times.
Issue: Waiting times < 6 weeks improved to 60% , although still below the threshold of 95%. This is due to the focus on clearing backlog to improve waiting times into service. Demand and Capacity is still the main issue in keeping wait times improving month on month. Percentage of patients waiting under 18 Weeks (CATS) has improved to 90%. This is the impact from Additional ad-hoc clinics were scheduled in CATS service to manage backlog of waits.
Action: Increase capacity in routine MSK since May 15 now all vacant post are filled with substantive staff. This is showing as increase in percentage of patient waiting less than 6 weeks month on month. 18-Weeks: Improvement in percentage of patients seen within 18 weeks for past 2 months. 1WTE FTT Extended Scope Practitioner (ESP) recruited to work on waiting list management using GPwSI funds. Start date 10th October 16 and impact thereafter. 1WTE ESP out to advert to add capacity into the service.

Podiatry
Issue: August 6 weeks data has fallen further.
Action: New service structure in Podiatry in place from Monday 22nd August. Focus on clearing the backlog is impacting negatively on waiting times figures. New patient blitz clinics have been running through September 2016 which has increased number of new patient appointment slots. Improvement notice has been issued and a remedial action plan is bring drawn up outlining actions to take to help clear back log of long waiters and improve 6 week target data.
Work is also being done in tightening the acceptance criteria to reduce number of inappropriate referrals to the service. All vacant posts are now in post.
Timescales: Demand V Capacity exercise will be carried out shortly to get a definite understanding on the timescales needed to clear the backlog. Improvement to be seen in the next 2 months.

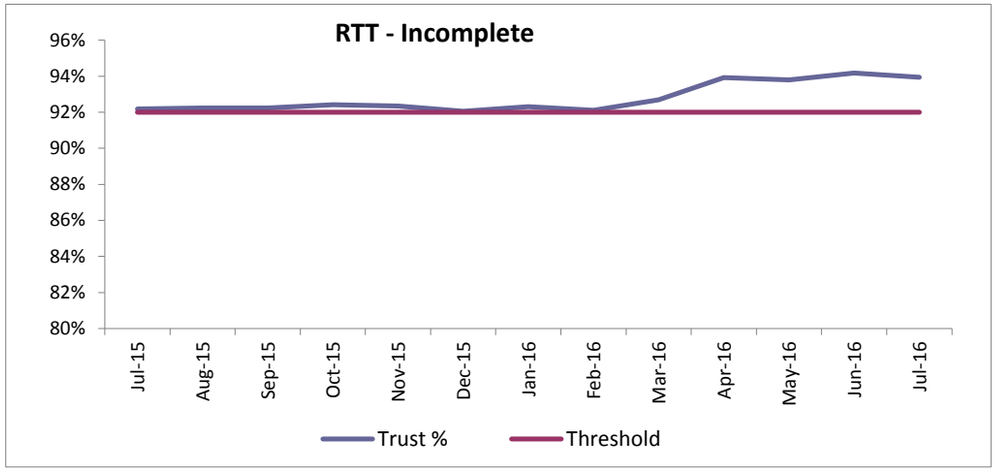
Islington Intermediate Care REACH
Issue: The performance of the REACH home based team has seen a steady improvement over the last 12 months. At the beginning of the calendar the service was at 50% compliance against the 6 weeks target. Additional locum staff, funded via the CCG for a 3 month period, were appointed in January 2016. The overall performance since March 2016 has on average maintained delivery of 70%. The recent dip in August has been as a result of staffing vacancies and the challenges of covering maternity leave.
Action: Newly appointed staff will join the team on a permanent basis; the service will be fully staffed by the end of November 2016.
Timescale: The aim of service to be compliant by December 2016.

Haringey Adults Community Rehabilitation
The Haringey Community Rehabilitation KPI is based on the performance of all the streams which are the general rehab and the neuro and stroke.
Issue: ICTT has consistently achieved the 85% target , a slight reduction during the months of July and August due to reduced capacity during August.
Action: Recruitment is ongoing and improvement will be seen when posts are filled.
Timescale: Expected to be back to achieving target in September 2016

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

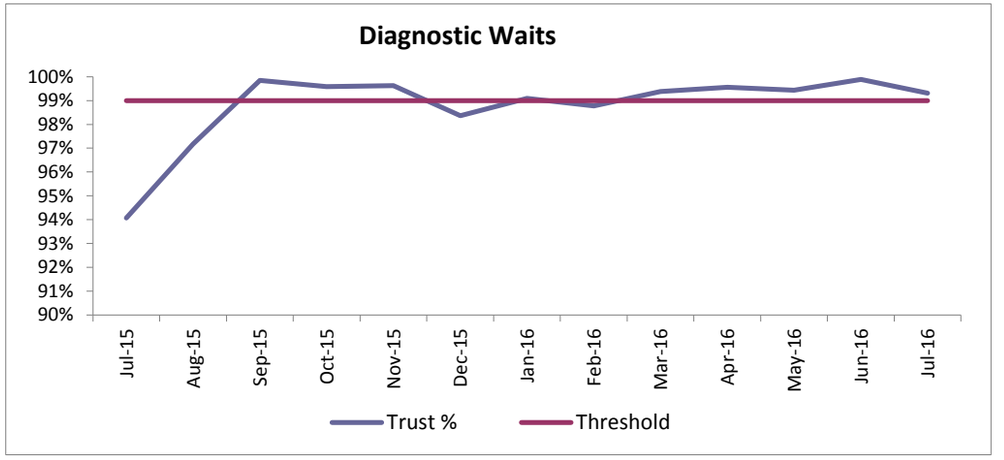
	Trust				
	Threshold	May-16	Jun-16	Jul-16	Trend
Referral to Treatment 18 weeks - Admitted	90%	81.1%	79.3%	75.5%	
Referral to Treatment 18 weeks - Non-admitted	95%	90.9%	90.0%	93.5%	
Referral to Treatment 18 weeks - Incomplete	92%	93.8%	94.2%	93.9%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	99.4%	99.9%	99.3%	



Commentary

RTT
National KPI for 18 weeks incomplete achieved.
Issues: 18 weeks admitted and non-admitted data reported above is un-validated.
These targets are not part of the national reportable standards.

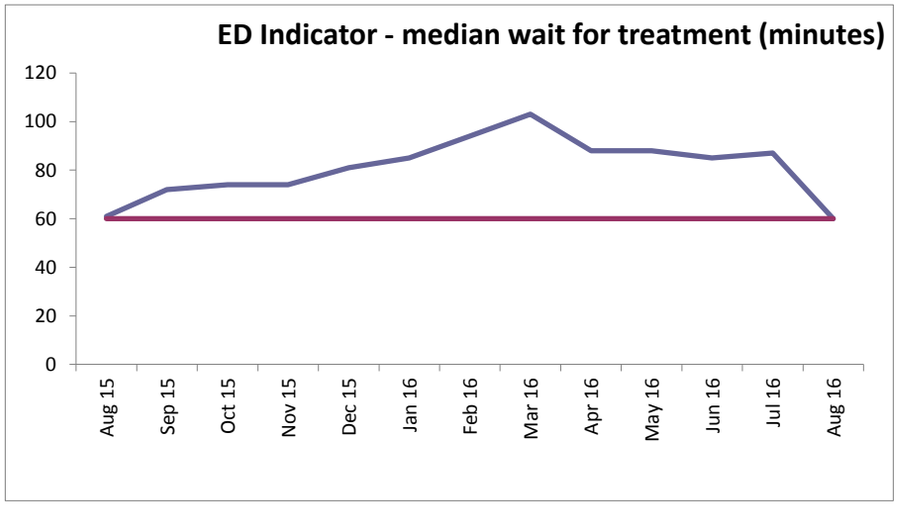
Diagnostic Waits
Target achieved as expected.

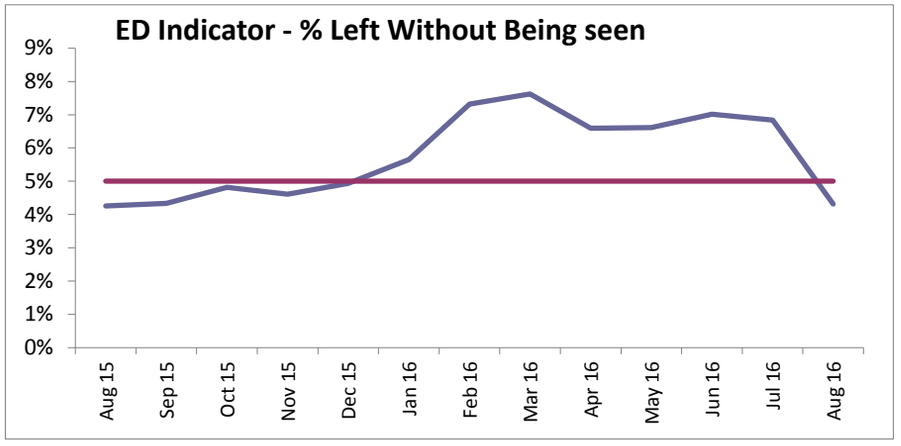


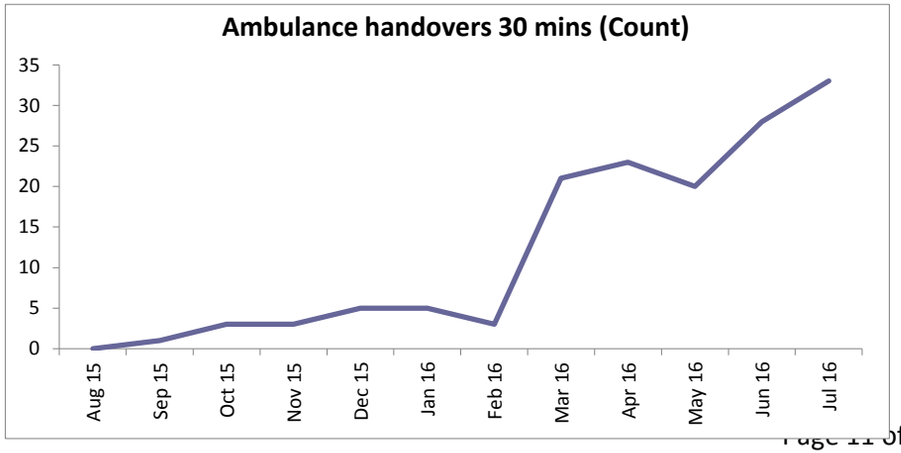
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Jul-16	Trust Actual Aug-16	2016/17 Trust YTD
Emergency Department waits (4 hrs wait)	95%	87.9%	92.7%	87.6%
Emergency Department waits (4 hrs wait) Paeds only	95%	96.3%	98.4%	95.9%
Wait for assessment (minutes - 95th percentile)	<=15	20	16	18
ED Indicator - median wait for treatment (minutes)	60	87	60	81
Total Time in ED (minutes - 95th percentile)	<=240	443	360	448
ED Indicator - % Left Without Being seen	<=5%	6.8%	4.3%	6.3%
12 hour trolley waits in A&E	0	1	0	4
Ambulance handovers 30 minutes	0	33	arrears	104
Ambulance handovers exceeding 60 minutes	0	0	arrears	11
Ambulatory Care (% diverted)	>5%	3.6%	3.1%	







Commentary

Encouraging steady progress has been made in particular in the admitted pathway as the improvement plan continues to make the intended impact.

ED four hour wait showed significant improvement for August and it is forcast to improve during September 2016. The Improvement plan is embedded and is focusing on admitted pathway and the Emergency department work stream. The time to treatment also reduced significantly achieving the threshold of 60 minutes. There were also significant reductions in bed management breaches and equally in delays in assessment / treatment time. This reflects early signs of the improvement work around the admitted pathway.

Median wait for treatment (minutes) Target achieved for August 16.

12 hour trolley waits in A&E there were no 12 hour trolley breaches in August 16.

The '**Perfect week** ' (breaking the cycle) planned from week commencing the 12th September will position the organisation in re-focussing on key areas to continue to improve flow ahead of winter.

Ambulance conveyances : Blue light activity diverts from North Middlesex Hospital continue to cause spikes in activity.
There are occasions when we see notably more ambulance arriving from the North Middlesex Hospital postcodes, on some occasions in August there has been up to a 5 fold increase compared to last year's mean.

Left without being seen we achieved below the 5% threshold in August which is positive but the number of patients **diverted to Ambulatory Care** decreased to 3.1 %.

		Trust				2016/17 Trust				
	Threshold	May-16	Jun-16	Jul-16	Trend	Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	96.4%	96.4%	97.7%		96.7%	97.7%	-	-	97.0%
Cancer - 14 days to first seen - breast symptomatic	93%	95.4%	99.2%	100.0%		97.5%	100.0%	-	-	97.9%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	-	-		100.0%	-	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	82.5%	94.9%	83.3%		87.4%	83.3%	-	-	86.5%
Cancer - 62 days from consultant upgrade	-	100%	100%	0%		100.0%	0.0%	-	-	60.0%

Commentary

62 Day Target

Non-compliant for the month of July with 1 Breast and 3 Urology (shared care) patients.

Issue:

July 2016 62 day standard non compliant 83% against a standard of 85%

There were four breaches:

1 full breach: Breast patient also unfortunately had a possible lung cancer so pathway was delayed – complex clinical breach

2 x 0.5 breach: Urology both patients utilised patient choice and so breached the standard

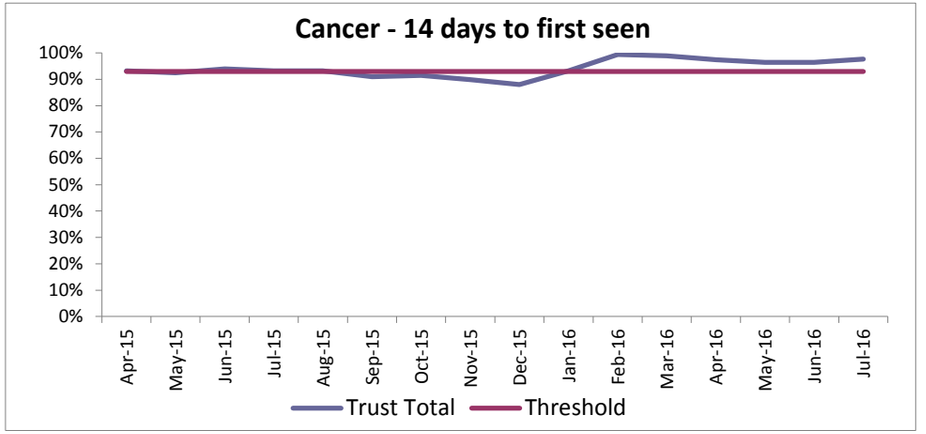
1 x 0.5 breach: Urology patient pathway was not fully adhered to so patient breached the standard

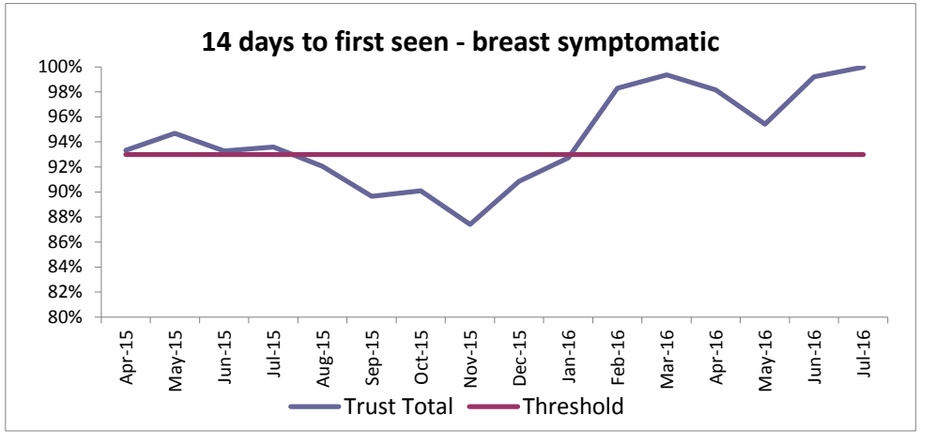
Action:

The Urology pathway is being reviewed by the Urology Team to ensure optimised and also is simpler to adhere to.

Timescale:

To implement the new pathway by mid October 2016.





	Threshold	Trust Actual Jun-16	Trust Actual Jul-16	Trust Actual Aug-16	2016/17 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	84.1%	84.2%	85.3%	82.9%
New Birth Visits - Haringey	95%	87.9%	93.2%	Arrears	89.9%
New Birth Visits - Islington	95%	94.4%	94.9%	Arrears	95.1%
Elective Caesarean Section rate	14.8%	14.8%	11.5%	11.4%	12.0%
Emergency Caesarean Section rate	-	17.7%	17.1%	17.7%	17.2%
Breastfeeding initiated	90%	86.9%	93.7%	91.2%	91.0%
Smoking at Delivery	<6%	5.9%	3.9%	4.4%	5.0%

Commentary

12+6

Issue: In August the service had a total of 339 bookings, only 278 referrals were made before the patient's 12+6 date. 13 patients booked outside of 12+6, 76 patient's DNA.

In August 10+0 compliance was 69.09% slightly lower than the previous month. (74.47% in July,63.7% in June, 43.8% in May).

Action: Improvement to be seen over the next months.

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

New Birth Visits July 2016

A big improvement seen in Haringey due to close monitoring at team level and increase in Health Visitor full time posts in place.

Islington maintaining performance close to target.

Islington: 13/253 late (2x late in North locality only - both in hospital)

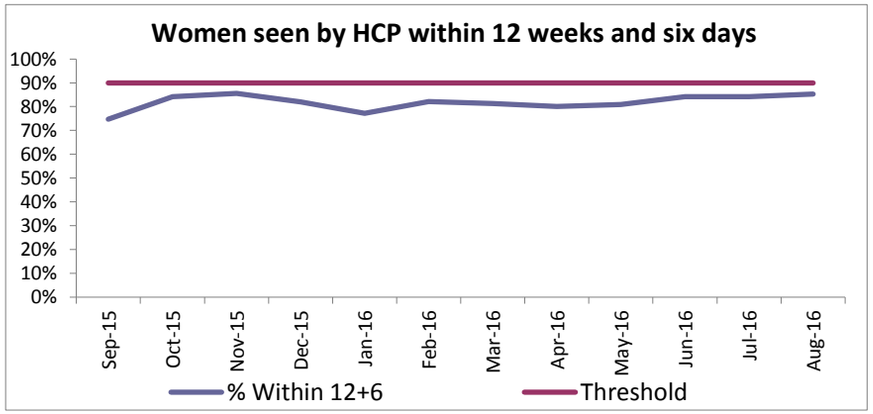
7x in hospital; 3x moved out of area; 1x not at notified address; 2x parental choice to change date

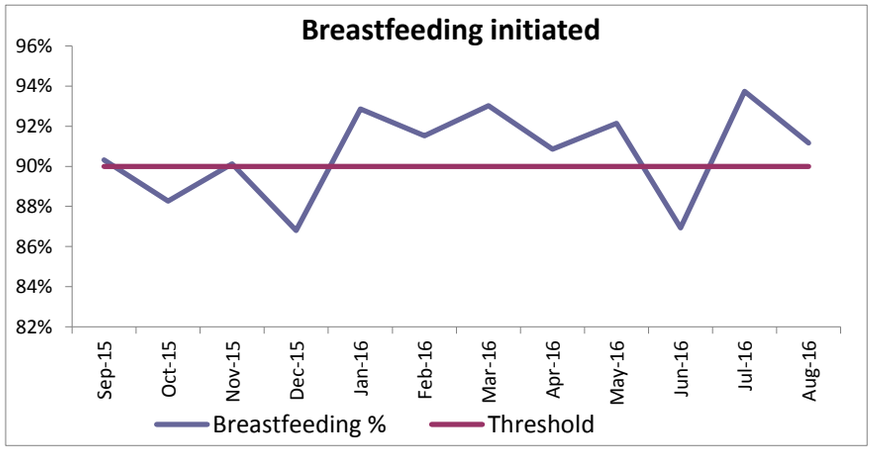
Haringey: 24/354 late (Tynemouth Road highest performer - only 3x late)

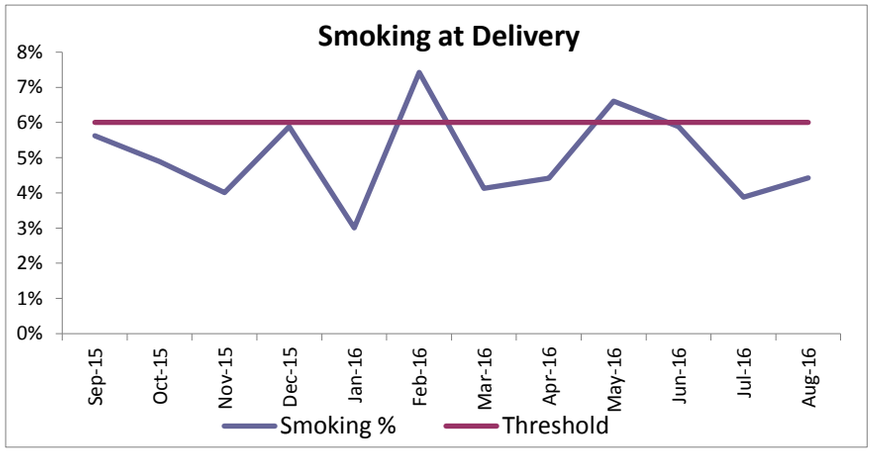
15x in hospital; 4x late notifications; 2x families moved into area; 2x interpreter required; 1x unable to contact

Smoking at Delivery and Breast feeding initiated

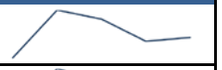
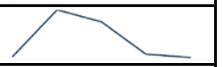
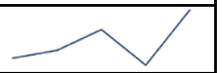
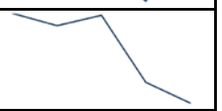
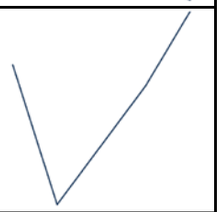
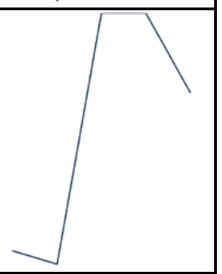
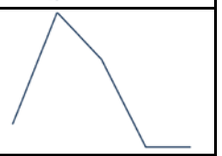
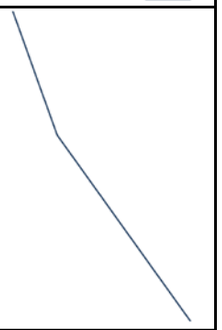
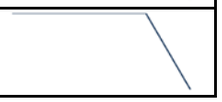
Targets achieved







High Level Workforce Data

Metric	Target or Benchmark	Source	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Notes and Definitions	Trend
Staff Headcount	Trust Annual Plan	ESR	4,212	4,238	4,233	4,221	4,223	No. of staff employed at the end of the month	
Staff in Post (FTE)	Trust Annual Plan	ESR	3,837.16	3,857.06	3,852.00	3,838.04	3,836.70	No. of staff FTE employed at the end of the month	
Establishment (FTE)	Trust Annual Plan	Finance Ledger	4,401.71	4,403.13	4,406.87	4,400.44	4,410.47	Budgeted FTE figures as at the end of the month	
Bank and Agency Use(WTE)		Bank Staff System	657.87	649.27	656.61	609.30	594.81		
Vacancy Rate %	10%	Calculation	12.9%	12.4%	12.6%	12.8%	13.1%	Qualified nursing vacancy rate increased from 14.9% in July to 16.2% in August. B5 community nurses had the highest turnover in August, which is linked to the vacancy rise in August. HCA vacancy rate also increased by 1% between July and August, from 17.4% to 18.4%.	
Annual Turnover %	>13% - red 10-12% - amber <10% - green	ESR	14.9%	14.9%	15.8%	15.8%	15.5%	Overall turnover has slightly decreased from previous month. PPP ICSU continues to have the highest turnover (22%) with AHP group having the highest levels within all staff groups, in particular B6 Dietitian and B5 Physio roles. The ICSUs with the lowest levels are Women's Health and CYP. Finance has the highest rate (33%).	
Sickness %	> 3.5% - red 2.5-3.5% - amber <2.5% - green	ESR	2.9%	3.3%	3.1%	2.8%	2.8%	There is no change from previous month. Facilities has the highest rate (6.4%), and on the ICSUs, PPP has the highest with 3.6%. Sickness rate within the remaining ICSUs is below target.	
Appraisal Completion %	90%	ESR/OLM	71%	69%	68%	67%	66%	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%	81%	80%	Percentage of staff compliant for mandatory training. Requirements vary by staff group and roles.	

	Nur&Mid		HCAs	
	Jul-16	Aug-16	Jul-16	Aug-16
Budgeted FTE	1414.86	1422.1	384.5	392.33
Staff in post FTE	1203.58	1191.2	317.5	320.3
Vacancy FTE	211.28	230.93	67.06	72.03
Vacancy%	14.9	16.2	17.4	18.4

Trust Board Seminar

5 October 2016

Title:	Board Assurance Framework, BAF		
	16/137	**Paper**	**7**
Recommendations:	Trust Board is asked to: • Approve the BAF		
Executive Summary:	The BAF provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important (principal) annual objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls. Potential risks to the achievement of the Trust's objectives are identified in two ways: • the 'top down' proactive identification of risks that directly affect the Trust's achievement of its principal objectives, by the Trust Board, Executive Team and Trust Management Group, and • the 'bottom up' assessment through the Trust's Risk Register. High-level risks in the Corporate Trust Risk Register of over 15 are reported regularly to Trust Board for consideration on the BAF. In this way, high level risks from the Risk Register filter up for inclusion in the BAF and specific risks from the BAF filter down for inclusion in the risk register. The format for the BAF is based on Northumbria NHS Trust (rated Outstanding by CQC) and the Good Governance Institute 'Building a Framework for Board Assurance'. It has been reviewed by the Executive Team and a smaller corporate governance sub-group. The risks are grouped by corporate objective; they are not presented in order of priority or level of risk. Definitions: • A gap in control is deemed to exist where adequate controls are not in place, or where collectively there are not sufficiently effective. • A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective.		

	The top risks currently on the BAF are BAF 5 Failure to deliver CIPs and transformation savings for 2016/17 •Failure to deliver CIPs and savings to £10m •Non identification of credible CIP schemes •Non achievement of agreed CIP schemes BAF 6 Failure to maintain liquidity and a sufficient level of working capital due to delayed CCG payment and/or Insufficient working capital facility due to failure to receive £6.5m STF BAF 7 Failure to access capital funding for the Maternity and Neonatal Full Business Case (FBC)
Fit with WH strategy:	Aligns to Clinical Strategy
Reference to related / other documents:	Risk Matrix Sub-Committee Risk Registers
Reference to areas of risk and corporate risks on the Board Assurance Framework:	n/a
Date paper completed:	26/8/16
Paper previously presented at:	n/a

Author name and title:	**Gillian Lewis, Compliance Manager**	**Director name and title:**		**Siobhan Harrington, Director of Strategy**	
Equality Impact Assessment complete?		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Summary of BAF:

The BAF provides a structure and process that enables the orgnaisation to focus on those risks that might compromise achieving its most important (principal) annual objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls.

Potential risks to the achievement of the Trust's objectives are identified in two ways:

- the 'top down' proactive identification of risks that directly affect the Trust's achievement of its principal objectives, by the Trust Board, and
- the 'bottom up' assessment through the Trust's Risk Register.

High-level risks in the Trust Risk Register of over 15 are reported regularly to Trust Board for consideration on BAF. In this way, high level risks from the Risk Register filter up for inclusion in the BAF and specific risks from the BAF filter down for inclusion in the risk register.

A **gap in control** is deemed to exist where adequate controls are not in place, or where collectively there are not sufficiently effective.
A **gap in assurance** is deemed to exist where there is a failure to gain evidence that the controls are effective.

The format for the BAF is based on Northumbria NHS Trust (rated Outstanding by CQC) and the Good Governance Institute 'Buiilding a Framework for Board Assurance'

The National Patient Safety Agency produced a set of guidelines for determining risk consequence and risk liklihood scores. This should be used as reference when determining risk scores for the BAF.

Sources for BAF

1. DATIX - Risk Registers >15
2. Finance and Business Development Risk Register and Workforce Assurance Committee Risk Register (NB. These risk registers are currently in a transition period due to DATIX re-design, intention to include on DATIX to standardise process and enable better reporting, however currently managed as separate Risk Registers)
3. Trust Board identified risks, which are then added to BAF and Risk Register, as appropriate

Whittington Health NHS

Board Assurance Framework (BAF) v2 June 2016 DRAFT

Key: Text highlighted blue indicates the changes that have been made to the BAF since it was last presented to the Trust Board

2016/17 Corporate Objectives

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

Strategic Goals2015-20

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

BAF Ref	Corporate Objective	Risk	Impact of Risk	Date added to BAF	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and Action plans to mitigate risk	Reporting/ Monitoring arrangements	Update on Action Plans	Current Risk Rating	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF1	CO1. Deliver quality, patient safety and patient experience.	Failure to maintain the quality of patient care	Impact on patient safety and experience Reputational risk	Jul-16	Medical Director	SERIOUS (4)	LIKELY (4)	16	Developing our Organisation –ICARE' Values and behaviours CQUIN & contract monitoring process Quality impact review process of all cost improvement programme ICSU Board governance meetings ISCU Deep Dive Performance meetings Quality Committee Appraisal / revalidation Pressure ulcer reduction plan Falls reduction Plan Mortality and morbidity meetings Review of Trust governance structures	Quality and safety report Report from Quality Committee Internal Audit Reports Bi-annual nursing skill mix review National patient and staff surveys National clinical audits Infection Prevention and Control report Serious incident report Patient stories Board walkabouts Safety Huddles CQRG Review meetings with commissioners	Quarterly Patient Safety reports to Board and Quality Committee (July, Sept)	Gaps in control: Embedding divisional performance reviews Fully embedded governance structure within the ICSUs	CQC registration CQC report CQC Action Plan	**August 2016:** Quality and Patient Safety report presented to Board Quality Committee annual reporting of CQC action plan and compliance	12		Nov-16	8	
BAF2	CO1. Deliver quality, patient safety and patient experience.	Failure to provide an ongoing service to LUTS patients	This risk has three distinct potential impacts: 1. Impacts on the experience and quality of service received by LUTS patients 2. This presents a risk to the reputation of the Trust. 3. Financial risk due to antimicrobial prescribing	Jul-16	Medical Director	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Medical Director and ISCU central leadership group managing action plan • Clinical and Medical experts in Trust advising leadership group on actions • NHSI Medical Director liaison • Reported as SI on STEIS in line with policy • National clinical guidance • RCP review • Patient User Group established	RCP review report and completed action plan SI report and completed action plan	Reports to TMG, Executive and Trust Board	**Gaps:** Succession plan not in place **Actions:** Identify extra resources to support with LUTS complaint responses Agree TOR for external review	**Trust Board, TMG**	**August 2016:** RJ to provide update at Board Seminar Nov 15: • PALS extra resource recruited • Clinic reinstated • MDT in place • TOR agreed with RCP and published on Trust website, March 2016 • Weekly meetings with CEO, medical director and team to ensure oversight of service • Liaison with NHSLA ongoing • Liaison with Trust Legal Team ongoing	16	From Nov 15	Nov-16	8	TBC - DATIX Ref QC
BAF3	CO1. Deliver quality, patient safety and patient experience CO3. Develop our business to ensure we are financially sustainable.	Failure to meet performance targets, in particular ED	• Long waiting times impact on patient experience and safety • Financial penalties for non compliance with ED targets • Continued failure to meet operational targets will damage the reputation of the Trust. • Non-compliance with NHSI/NHSE/CQC single oversight framework could result in trust being put in special measures.	Sep-15	Chief Operating Officer	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Performance management monitoring • Action plans developed to meet ED targets, monitored at operational meetings. • Daily teleconferences with system wide health economy to work collectively to support better patient flow. ☐ Management of ward bed capacity/opening of additional wards	Performance reports to Trust Board and Quarterly Performance Review meetings ED Action Plan	Monthly performance reports July - Sept 2015 - target met	**Gaps in assurance:** Target not met Oct15 - April 16 **Actions:** Action plan developed to achieve ED targets Continue to monitor targets regularly to ensure compliance.	**ICSU performance reviews, Trust Operational meetings, TMG**	**August 2016:** Detailed improvement plan in place including focus on admitted pathway, improving patient flow and reducing variation in ED Weekly reporting of of key metrics - pre 11 am discharge/criteria led discharge/timely speciality response/reducing LOS /improving time to treatment Dedicated Improvement support from PMO **November 2015:** • Ongoing negotiation with commissioners re winter funding • System Resilience Winter Plan ongoing • Ward reconfiguration; Eddington ward agreed as stand by in TMG	16	Ongoing in year	Nov-16	8	TBC - DATIX Ref QC
BAF4	CO2. Develop and support our people and teams.	Failure to recruit and retain quality staffing	• Failure to recruit and retain permanent nursing staff will lead to the inability to maintain high quality and safe services. This will also impact on the agency/bank spend.	Sep-15	Director of Workforce	SERIOUS (4)	LIKELY (4)	16	• Development of a Recruitment and Retention Strategy • ICSU governance structure allows better clinical leadership •Creation of Board-level Workforce Assurance Committee with responsibility for R&R •Stable team within HR	•Trust Board safety/quality/safe staffing reports • Quality Committee safety/quality reports • Workforce KPI reports • Progress reports on R&R Strategy	Recruitment and Retention Strategy 2016-19 approved	**Gaps in assurance:** High turnover of staff, ongoing vacancy rate **Actions:** Implement recruitment and retention strategy	WAC and TMG	**August 2016:** Regular recruitment pipeline reports to ICSUs Monthly AHP nursing and midwifery meetings, chaired by Director of Workforce Approval of Band 5 nurse recruitment and attraction campaign for launch in September 2016	16	Ongoing in year	Nov-16	12	WAC5
BAF5	CO3. Develop our business to ensure we are financially sustainable.	Failure to deliver CIPs and transformation savings for 2016/17 • Failure to deliver CIPs and savings to £10m • Non identification of credible CIP schemes • Non achievement of agreed CIP schemes	Will not deliver agreed control total with NHSI and will fail to collect the £6.5m STF	Sep-15	Chief Operating Officer	V SERIOUS (5)	LIKELY (4)	20	• PMO led by COO • CIP work programme and schemes developed by Boston Consultancy • CIP implementation monitored via CIP steering group and CIP PMO team who meet monthly • ICSU governance structure with financial controls • Quarterly Performance Reviews with ICSUs and Executive teams • NHSI performance meetings with Executives monthly	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Cmt Internal Audit reports and recommendations which are agreed with management actions monitored and reported as implemented	Deep dives to F&BD, deep dive with NHSI	Gaps in controls: Unindentified £2m, not currently captured in existing CIP plans with over relience on income schemes Gaps in assurance: CIP targets not met to date (end July) Actions: Downside scenario plans for each CIP scheme to show escalation routes to recover position and get back on plan to deliver savings in year	Trust Board TMG Finance and Business Development Committee	**August 2016:** Current position continues with gap and underperformance.	20		Nov-16	10	F&BD007
BAF6	CO3. Develop our business to ensure we are financially sustainable.	Failure to maintain liquidity and a sufficient level of working capital due to delayed CCG payment and/or Insufficient working capital facility due to failure to receive £6.5m STF	Financial impications and reputational risk	Jun-16	Chief Financial Officer	V SERIOUS (5)	LIKELY (4)	20	• Regular CFO/Deputy CEO and CCG meetings • Regular CFO/Deputy CEO and NHSI meetings • Weekly monitoring of cash and working capital by the Finance team • Increased monitoring and reporting to Finance and Business Development Committee (now meets more frequently since 2015) • Monitored and reported to TMG, F&BD & Board - Ability to use draw-down facility if agreed borrowing is exceeded	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Cmt	ITFF Paper and following annual plan approved by NHSI Annual Governance Statement Going Concern assurance report	**Actions:** • Deep dives with ICSU focus on corrective financial actions • Monitor and report cash & liquidity at NHSI monthly performance meetings • Cash managment discussed at F&BD and reported to Board • Capital spend trajectory to be reported within financial reports	Trust Board TMG Finance and Business Development Committee	**August 2016:** Ongoing monitoring via ICSU deep dives and monthly reporting to TMG	20		Nov-16	15	F&BD010
BAF7	CO3. Develop our business to ensure we are financially sustainable.	Failure to access capital funding for the Maternity and Neonatal Full Business Case (FBC)	• Failure to start the modernisation and development programme • Impact on patient expeirence and safety	Sep-15	Chief Financial Officer/ Deputy Chief Exec	SERIOUS (4)	ALMOST CERTAIN (5)	20	• Meetings with NHSI • Clinical Case for Change submitted to NHSI in June - iterative process • Financial plan submitted to NHSI in June - iterative process • Capital Plan agreed with 2016/17 and 2017/18 ringfenced capital contribution • Updates to Trust Board on progress	Final Full Business Case approved by the Trust Board Final Full Business Case approved by NHSI Investment Committee July 2016 ICSU Womens' Health Business Plan agreed by Trust Board	STP letter in support of plan received	**Actions:** 1. NHSI iterative process will mean continual reconcilation of the FBC, operational plan and LTFM and report to F&BD impact 2. Develop and implement a fundraising campaign when the FBC is finalised to enable a comprehensive marketing plan to be developed with adequate resources 3. Time limited risks to be monitored and reported for financial implications eg planning permission penalties 4. Procure a SEP / JV vehicle 5. Meet maternity targets to demonstrate market growth	Finance and Business Development Committee Maternity Steering Group and Transformation Board	**August 2016:** Clinical case submitted, Final documentation to be sent to NHSI on 19th Septebmer 2016	20	Ongoing in year	Nov-16	8	F&BD011

BAF Ref	Corporate Objective	Risk	Impact of Risk	Date added to BAF	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and Action plans to mitigate risk	Reporting/ Monitoring arrangements	Update on Action Plans	Current Risk Rating	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF8	CO3. Develop our business to ensure we are financially sustainable.	Failure to reduce reliance on agency staffing	There are two parallel implications for this risk with separate risk scores: 1. Failure to meet agency spending targets will impact on financial plan to become financially sustainable [Serious(4) x Likely(4)] **Risk score - 16** 2. Quality of care and patient experience may be affected by use of temporary staffing [Moderate(3) x Likely(4)] **Risk score - 12**	Jun-16	Director of Workforce/ Chief Financial Officer/ COO	SERIOUS (4)	LIKELY(4)	16	• Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • Monthly ICSU deep dives on agency usage • E-rostering and real time data	Reports to Trust Board Reports to TMG	Assurance on quality of care provided received through ICSU deep dives (monthly) and e-rostering live data	**Gaps in assurance:** Agency costs greater than planned. **Actions:** Implement R&R strategy Monitor WAC workplan to strengthen controls and compliance with agency cap. Continue to monitor KPIs	Workforce Assurance Committee Finance and Business Development Committee	**August 2016:** ICSU deep dives carried out, with particular attention on temporary staff spend. Review of process for securing temporary medical staff implemented Review of medical staff bank rates approved	16	Ongoing in year	Nov-16	8	F&BD022
BAF9	CO4. Further develop and expand our partnerships and engagement.	Failure to align Whittington Health's population health model to the final NCL STP	Risk that the new model would be acute-centric and prevent Whittington Health from achieving population health and integration in line with Clinical Strategy	Aug-16	Deputy Chief Executive/Director of Strategy	SERIOUS (4)	LIKELY(4)	16	• Engagement with NCL STP process • Whittington Health Medical Director as co-Clinical Lead for STP process • Haringey and Islington Wellbeing Partnership Governance	Final STP submission Open and transparent public engagement in place	STP stakeholder meetings with Executive and senior management	**Gaps in assurance:** STP work not complete Public engagement process not yet fully evolved	Trust Board	**August 2016:** Engagement in the STP process Haringey and Islington Partnership Board in place with governance arrangements and work plan and resource	16		Nov-16	8	

The following risks are for consideration for inclusion on BAF

BAF Ref		Risk	Impact of Risk	Date added to BAF	Accountable Director	Original Consequence Score	Original Likelihood Score	Original Risk Rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and Action plans to mitigate risk	Reporting/ Monitoring arrangements	Update on Action Plans	Current Risk Rating	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
	CO1. Deliver quality, patient safety and patient experience.	IMT infrastructure failure causing harm to patients by disrupting services	The downtime created by infrastructure failure would create patient harm as clinical colleagues can not access key clinical information	tbc	CFO / D of IT				The controls were detailed in the independent report taken ot Board	Deloitte report and action plan	Deloitte report and action plan	None	Downtime for all systems Is monitored and will be reported monthly	Action are in line with agred action plan and will be reported to F&BC in Q3					
	CO1. Deliver quality, patient safety and patient experience.	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience.	1. Patient experience would be affected if environment and estates not improved 2. Future financial stability	tbc	Deputy Chief Executive				Estates Strategy and delivery plan in place	Estates Strategy Estates Strategy Delivery Plan	Estates Strategy agreed at Trust Board, Feb 2016 Estates Strategy delivery vehicle agreed at Trust Board, June 2016	Gaps in control: Procurement process for delivery vehicle not yet started Gaps in assurance: Lack of ongoing stakeholder and community engagement							
	CO2. Develop and support our people and teams.	Failure to support staff engagement in regular supervision, appraisals and the development and achievement of personal development plans	This will affect staff ability to deliver excellent care and maintain professional standards.	tbc	Director of Workforce				KPIs on appraisals, mandatory training Workforce Assurance Committee ICSU deep dives	Workforce KPIs, including appraisals, revalidation, compliance with mandatory training, staff turnover and vacancies. • Regular reports to the Workforce Compliance Committee, which reports to the Quality and Safety Committee. • Staff Survey Results								

DRAFT

Whittington Health NHS

WORKFORCE ASSURANCE COMMITTEE

ITEM: 16/138
Doc: 08

Minutes of meeting held on Wednesday 31st August 2016

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing & Patient Experience
	Carol Gillen	Chief Operating Officer
	Cathy Ferguson	Manager, Occupation Health & Wellbeing
	Norma French	Director of Workforce
	Kate Green	PA to Director of Workforce (notes)
	Graham Hart	Non-Executive Director
	Steve Hitchins	Trust Chairman (in the Chair)
	Jana Kristienova	AD, Integrated Care Education

16/14 Welcome and Introductions

01.01 Chairman Steve Hitchins welcomed everyone to this second meeting of the Workforce Assurance Committee and all introduced themselves. Apologies for absence were received from Siobhan Harrington, Ian Bates and Helen Gordon.

16/15 Minutes of the meeting held on 7th April

16.01 The minutes of the Workforce Assurance Committee held on 7th April 2016 were approved.

16/16 Matters arising

16.01 (Minute 12.01) It was noted that HHS Providers had recently publicised some dates for NED training.

16.02 (Minute 03.03) It was intended to bring the first 'staff story' to the October Workforce Assurance Committee (WAC) meeting, and Norma was considering giving this a staff side focus. The intention was to discuss this with staff side members at their meeting with Board members following the Trust Board Seminar on 14th September.

16.03 (Minute 16.05) Work on the main objectives of the workforce strategy was ongoing, and Norma would continue to keep WAC members informed of progress.

16.04 (Minute 16.09) The new HR structure was now complete, and the third HR Business Partner was due to start work the following week. There was an ongoing piece of work which focused on staff bank rates. Norma had also recently commissioned a review of the Trust's Learning & Development Service, with a view to launching a formal consultation process before the end of the calendar year.

16.05 In answer to a question about whether this work was affected by the North Central London Sustainability & Transformation Plan, Norma replied that she was already engaged in very positive working with her opposite numbers at UCLH and the Royal Free, and was due to attend

a clinical collaboration meeting at UCLH the following evening. Options which might be usefully explored included a communal staff bank, portability of staff, and talent management. Generally, there were good opportunities for learning through such collaborative working.

16/17 Quarter 1 Workforce Report

17.01 Norma French introduced the Quarter 1 Workforce Report which had been circulated, and which contained data up until the end of June. She began by drawing attention to the sickness rate, which compared favourably to the national average. There had been a slight increase in turnover.

17.02 The dashboard section of the report replicated what was submitted monthly to the Trust Board as part of the Performance Dashboard, but for this meeting the information was presented by Integrated Clinical Service Unit (ICSU) key performance indicators (KPIs).

17.03 Spending on bank and agency staff had reduced in four ICSUs, but had either risen slightly or remained constant in the remainder. The position on this was monitored in detail at weekly road map meetings, quarterly ICSU performance review meetings, and 'deep dives'. Norma was pleased to report that within nursing there had been some real success in reducing agency spend, however spending on medical agency staff and AHPs remained of concern. The previous week's Trust Management Group (TMG) had agreed the implementation of a new process for signing off medical agency staff, and this was due to come into force from 1st September. The review of bank rates commissioned by Norma was also now complete, and new rates of pay for medical staff, benchmarked against other Trusts, had been agreed. It was more difficult to agree new rates for nursing and midwifery staff due to the range of differing rates throughout the Trust; further work was being carried out on these with a view to bringing a further paper back to TMG within a few weeks.

17.04 Referring to the far right column of the dashboard report, Steve Hitchins felt there was scope for increased clarity in this column, adding that it would be helpful to be able to see at a glance whether there had been improvement or deterioration from the previous quarter's position.

17.05 The recruitment section of the report gave information on the number of vacancies advertised by the Trust, how many had been shortlisted, then numbers in the pre-employment stage. In answer to a question from Steve Hitchins about whether recruitment was difficult at present, Norma replied that it was, and particularly so for medical nursing positions. Maternity services were also carrying a fairly high rate of vacancies. Over recent months the Trust had been working with a specialist company on branding, and a new microsite would become live in September, focusing particularly on Band 5 nursing staff. Overall, Whittington Health's position did not differ greatly from that of other Trusts, and for the first time the report showed benchmarking data across other London Trusts. There was however mileage to be gained from using the very positive CQC report in service descriptions. The vacancy rate was higher than that shown the previous quarter, and stood at 13% at the end of June. Sickness rates were highest in Facilities and Finance, but both employed a relatively small number of staff which affected percentage rates.

17.06 Mandatory training stood at 81% at the end of Quarter 1, and appraisal had fallen to 68%. Norma receives monthly reports, which she scrutinises and adds commentary to prior to distributing them via ICSUs and directorates. It had recently been agreed to implement a pay progression policy, which meant in practice that pay increments would no longer be automatically paid to those staff who had not completed both their mandatory training and annual appraisals.

17.07 Moving on to equality and inclusion date, Norma reminded the committee that there were nine key indicators, and Charlotte Johnson had described each in detail in her section of the report. Charlotte and Greg Battle were leading in this area, which included convening focus groups and mentoring. Norma also mentioned the Stepping Stones development programme, saying that she and Carol had both acted as mentors for participants on that programme. The results of the staff survey showed there was still a perception that there remained fewer opportunities for development for BME staff, and further consideration was being given to this.

17.08 There had been an increase in the number of exit interviews completed, although the proportion of leavers completing them remained relatively low. Overall, the quality of data had improved and it was possible to have far more confidence in the data. Norma had also heard anecdotally that the Trust's commissioners had also expressed the opinion that there had been an improvement in the quality of reports received, for example through the Clinical Quality Review Group.

16/18 Employee Relations Activity

18.01 Fifty-eight cases had been reported that quarter, the majority of which concerned disciplinary action; there were no cases of bullying/harassment. The cases reported were broken down by ICSU, and Philippa Davies enquired whether it might be possible for future reports to be broken down by staff group also.

18.02 Stephen Bloomer enquired whether Whittington Health's figures were broadly typical amongst equivalent Trusts, and Norma replied that in her view the figures were not unduly high and there was therefore no cause for concern. Graham Hart suggested the figures should also be broken down into BME categorization. The point was also made however that whilst the data shown here is robust, it only includes cases which are going through a formal process, and there are other cases which are resolved at a local level.

16/19 Staff Survey Action Plan

19.01 Norma French introduced the action plan which had been produced in response to the results of the 2015 staff survey. It was noted that each ICSU was producing its own plan, although two (Clinical Support Services and Patient Access, Prevention & Planned Care) were not yet complete. This year's survey was due to start towards the end of the 2016 Calendar year, and would be conducted via a random sample of around 1200 staff. Norma said that she would like to see a reduction in the amount of references to bullying and harassment this year; it was also noted however that morale was fairly low in the NHS generally.

16/20 Health & Wellbeing Strategy

20.01 Introducing this item, Cathy Ferguson, Head of Occupational Health & Wellbeing, said that this was the 5-year Health & Wellbeing Strategy and represented the Trust's commitment to the health and wellbeing of its staff. The draft strategy had already been to Partnership Group, and following this meeting of the WAC it would, if approved, be formally adopted and implemented. The strategy covers three main areas – primary, secondary and tertiary. Around three years ago a staff survey was conducted; this revealed a very high proportion of staff (78%) indicating stress in the workplace. As a result of this a number of initiatives were instigated including a new workplace counselling service and fast track physiotherapy appointments.

20.02 Considerable progress has been made since then, and the department has been nominated for the national healthy workplace awards, in competition with large companies such as Boots. This is timely as for the first time this year there are CQUINs based on health and wellbeing. There is also increased focus on sickness absence and stress, which Jana Kristienova said was an issue for GPs and community services as well as within acute services. There was a live action plan which was regularly updated to meet the changing needs and priorities of the Trust.

20.03 Cathy outlined some of the initiatives planned for later in the year; these included a cycle to work day in mid-September and a healthy living week from 22-30 September. She had been pleased with the support these initiatives were receiving from colleagues such as therapists and dietitians. Social media was increasingly being used to publicise events, and Cathy commended the communications team for the support they had provided. There was also a slot within the corporate induction day to introduce the work of the department.

20.04 Referring to Appendix 2, Stephen Bloomer suggested selecting one or two measurable initiatives which could be used as an indicator of success by, for example, seeing whether there was visible correlation between take-up and subsequent sickness absence figures. Steve Hitchins added that since there was now an increasing move towards population-based healthcare, identifying initiatives that could be proven to help staff might be a useful indicator of how services could be developed to help the local population.

20.05 Committee members congratulated Cathy and her team on their achievements, and noted that outcomes would continue to be monitored through the Health & Wellbeing Steering Group, chaired by Norma.

16/21 Nursing & Midwifery Strategy

21.01 Philippa Davies introduced the three year nursing and midwifery strategy, which she said had been developed using a number of focus group sessions held throughout the hospital and the community. Ambitions for the next three years had been built around the five CQC domains of safe, caring, effective, well-led and responsive to peoples' needs. The strategy also shows details of how it is intended to achieve these ambitions, including the development of milestones by which progress could be measured. The strategy would be taken to the Trust Board meeting the following week, and progress on its implementation would be reported to the Quality Committee. Philippa thanked Doug Charlton, who had led on the development of this strategy.

16/22 External Inspection – Care Quality Commission

22.01 Norma reported that the full CQC report was now available; Philippa Davies would be leading on the action plan that was to go the next week's Trust Board. Additionally, she intended in future to bring the results of the GMC survey of trainees to this meeting.

22.02 Board Assurance Framework

22.01 An extraordinary meeting of the Trust Management Group had taken place the previous day to discuss the Board Assurance Framework (BAF), which had changed considerably since its previous iteration. Further discussion of the BAF would be taking place at a Trust Board Seminar in the near future.

16/23 Any other business

23.01 Committee members were reminded that staff side representatives had been invited to attend the last half hour of the Trust Board Seminar on a quarterly basis, and it was hoped this would provide the opportunity to plan the first 'staff story' referred to in minute 16.02 above.

23.02 Committee members were asked to consider staff engagement and participation in the recently developed community forum. It was suggested this might provide a good vehicle for further consideration of the Health & Wellbeing Strategy.

23.03 Steve Hitchins informed the committee that a group of 'bright young things' a.k.a. the 'Ginger Group' was looking at ideas that would help with retention, and asked for any suggestions that committee members might have to be sent to him.

23.04 The 'flu vaccine would be arriving on 18th September, and Cathy informed the committee that the target was to have 75% of staff vaccinated by the end of December. Philippa Davies was to act as flu champion during this year's campaign, and consideration was being given to making a film. Moira Stern's 'Sing for your lungs' choir had also been invited to participate.

Whittington Health NHS

Whittington Health Trust Board
5 October 2016

Title:	Quality Committee Meeting 14 September 2016 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**16/139**		**Paper**		**09**		
Action requested:	For the Board to note the business of the 14 September Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft 14 September 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:	September 2016						
Author name and title:	**Gillian Lewis Corporate Governance Manager**		**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**

Whittington Health NHS

DRAFT Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 14th September 2016 2.30pm – 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 Richard Jennings, Medical Director
In attendance	Lynne Spencer (LS), Director of Communications & Corporate Affairs Fiona Isacsson, Director of Operations S&C (deputising for Carol Gillen) Sarah Hayes, Clinical Director PPP Daniela Petre (DP), Head of Risk Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes) Manjit Roseghini (MR), Head of Midwifery Mark Madams, Head of Nursing, Children's Services Julie Andrews, Associate Director for Patient Safety Helen Taylor (HT), Clinical Director CSS Lisa Smith, Assistant Director of Nursing Education (Item only 19) Doug Charlton (DC), Deputy Director of nursing & Patient Experience Charlotte Johnson, Head of Education, Learning and Development (Item 17 only) Karen Phillips, Lead Cancer Nurse (Item 10 only)
Apologies:	Deborah Clatworthy (DCl), Head of Nursing, Surgery and Cancer Clarissa Murdoch (SM), Clinical Director MFNS Carol Gillen, Chief Operating Officer Beverleigh Senior (BS), Director of Operations, OPLTC Russell Nightingale (RN), Director of Operations, CYN Gurjit Mahil, Director of Operations, WFS Rachel Landau, Clinical Director EUC

Agenda items

1.	**Welcome & Apologies**	AS
	PD welcomed the Committee and acted as chair at the chairs request until AS arrived at 3.30pm.	

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

2.	**Minutes of the previous meeting (July 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 tracker		

4.	**Patient and Community Forum: Update**	
	LS provided an update on the progress of the Whittington Health Community Forum. This is a new community engagement model being led by the Chair, Steve Hitchins. Key issues included; • The September Trust Board received a report from the Deputy CEO of progress and a Terms of Reference has been agreed by the Board • The Forum has founding group of c. 25 people who have attended face to face meetings to set up the Forum. • Digital communications will be the main mechanism for communications in line with the Trust strategy to increase the use of these platforms. This aligns with NHS policy to operate paper free. • The Forum is about participation and events so there are not members and few meetings. LS noted that further resources may be required in future to manage the administration of the Forum, the database management and to respond to enquiries if the membership target of 100,000 is met and as engagement activities increase. Meanwhile there is a volunteer supporting the communication and patient experience teams who are working together to support growth of the Patient and Community Forum. MM asked if there was an opportunity to use an apprentice to cover the social media aspect of the role. LS agreed this could be looked at but confirmed that the role required knowledge of WH and experience in social media as it is a front-facing and high	

	profile role where the responsible officer would need to be able to respond to varied queries on behalf of the Trust. LS confirmed the teams were working together at present to support this initiative and that it was working well.	
Actions	**Deadline**	**Owner**
Continue publishing newsletter for Forum	Ongoing	S Hitchins

5.	**Nursing and Midwifery Strategy**	**PD**
	PD reported that this strategy was the result of focus groups attended by some of our nursing and midwifery staff which were held in community settings and in the hospital. This is a 3 year strategy, linked to the CQC domains of Safe, Caring, Responsive, Effective and Well led. It states ambitions and details annual milestones against which progress will be measured and reported to the Quality Committee. PD noted that the Strategy had been presented to the Workforce Assurance Committee and also to the Trust Board (due to meeting schedules) DCh reported that Allied Health Professions (AHPs) were originally going to be included in a combined strategy but following consultation, it was decided that a separate AHP strategy would be developed. DH asked what the plan was for AHP strategy. HT updated that she is leading on the development of separate strategy for AHPs which will dovetail with the nursing and midwifery strategy.	
Actions	**Deadline**	**Owner**
Progress against milestones to be reported to QC in 12 months	September 2017	PD

6	**Quality Performance Reports**	**ICSU Leads**
6.1	The **PPP Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • Appraisal rates good • Mandatory training ongoing – action plans developed per team • Outpatient CQC improvement work ongoing – storage of records and confidential waste improved, work on FFT and patient experience • Increased incident reporting in key areas. Themes identified around aggression from patients – plans in progress to support staff with de-escalation techniques • One SI relating to the management of a two week wait referral to dermatology. There does not appear to have been any significant harm to patient from delay, however incident being fully investigated for learning • One high risk incident in IAPT service under review • Risk Register high risks relate to MSK demand and capacity issues • Tea trolley implemented on Outpatients following CQC recommendations. Executives will be taking part in tea round, good patient feedback. Yua Haw	

	volunteered to take part to support the initiative. SHayes summarised the key findings from the King's Fund report into District Nursing. The findings of the report were not surprising and highlighted the increase in demand and fall in supply of district nurses nationally. The report has received national media coverage and government interest. SHayes noted that nurses were encouraged to join the 'Queen's Nurses' programme, which is designed for community nurses who want to develop their professional skills and promote the highest standards of patient care
6.2	**The CSS Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • Serious incident relating to missed diagnosis of lung cancer, investigation in progress and learning to be shared • In response to themes emerging from complaints, a change has been made to reduce delays in MRI reporting. If any patient waits longer than 4 weeks for an MRI report, the scan will now be outsourced for reporting. • Medication incident reporting is increasing but medication errors resulting in harm are decreasing. HT highlighted that staff perception of harm varied, and it was agreed at Patient Safety Committee to provide support to improve staff understanding. • Risk register: Risk identified in relation to capacity to deliver breast imaging which could impact on quality and safety. Service currently supported with locum doctors who can leave with short notice so resilience requires improvement. While private doctors can be hired to ensure patients continue to receive breast imaging service, there could be associated delays. Currently working with UCLH and Royal Free to find a solution and mitigate risk to patients. The risk will be discussed in detail at the next Trust Management Group meeting.

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

7.	**Patient Experience Report**	**DC**
	• Due to the scheduling of the Patient Experience Committee in October this paper was postponed until November 2016 QC	

Actions	**Deadline**	**Owner**
Present at next Quality Committee	November	DC

8.	**Quarterly Patient Safety Report, Medical Director**	PM
	This report was previously presented in detail at the September Trust Board, RJ provided a brief summary of the key findings to assure the Committee of the good progress with quality and safety initiatives.	

Actions	**Deadline**	**Owner**

Ongoing quarterly reports to TB and Quality Committee	Quarterly	RJ

9.	**Cancer Survey Report**	
	Karen Phillips provided a summary of the report which was largely positive but identified some areas of learning. Key issues were highlighted as follows; • Format of report to be reviewed to better present the 'You said, we did' aspect of the survey and highlight improvements made. Satisfaction survey to be revised to look at waiting time for results. Information on support groups and Health and Wellbeing groups is working well. • Areas for improvement were identified and actions had been put in place to address. For example, patients reported a lack of confidence in doctors and nurses, in response the trust has launched 'introduction to health coaching' for doctors and nurses. A CNS audit was completed to improve visits from cancer teams when cancer patients are admitted via ED; 81 -93% of AOS alerts receive follow-up phone call or ward visit from a CNS. Work is ongoing to improve pain control support across the service. • KP noted there had been a lack of engagement from consultants to date, with only one doctor signing up to the health coaching initiative. JA proposed advertising the course through Maria Barnard to attract more doctors. • YH asked if open access was encouraged post-discharge. KP confirmed open access was available and described the new electronic follow-up process for key cancer groups which enables patients to contact the service instantly in between routine follow-up appointments. • RJ noted that the London Cancer Network had cited the Trust as best practice for their services. • PD thanked KP for the report which was a very useful assurance document.	

Actions	**Deadline**	**Owner**
KP to feedback to next Committee on engagement from doctors for health coaching to ensure lessons are being embedded from patient feedback.	November	KP

10.	**Quality Assurance Report**	PD
	The Quality Committee approved the Quality Assurance Report. The CQC Action Plan had been presented to Trust Board on 7 September.	

Actions Re; CQC Action Plan, QC to receive progress against plan	**Deadline** **November**	**Owner** **PD**
None		

11.	**PLACE 2016 Findings**	SP
	The Quality Committee noted and approved the PLACE 2016 paper and invited SP to present the action plan to the November meeting.	

Actions	**Deadline**	**Owner**
Steven Packer to present an action plan from the PLACE 2016 findings to the November Quality Committee meeting	Nov 16	SPacker

12.	**Quality and Safety Risk Register**	DP
	DP informed the Committee that the updated DATIX system was now in use for all risks and the Quality and Safety Risk Register was derived from these risks. DP presented the revised risk register, with risks over 15. DP noted there had been 19 new risks since the last Risk Register presented to Quality Committee. Some risks were initially graded low but ICSU boards reviewed and escalated these risks to the Quality Committee. DP advised the Committee that ICSUs are responsible for the mitigating actions to ensure robust oversight of risk management. DP noted excellent practice at ICSU level in reviewing and updating risk registers. In terms of Trust Board Committee corporate risks, DP noted the process for reporting and reviewing continued to be developed. The Finance and Business Committee and Workforce Assurance Committee currently maintain separate Risk Registers which require uploading onto DATIX for consistency and to enable robust reporting. FI noted that last year a financial risk was on the ICSU risk register but the advice was to escalate this to the corporate financial register for monitoring at F&BD. The Quality Committee agreed that financial risks should be included at ICSU level for transparency and oversight. DP stressed that all risks over 15 are presented to Quality Committee for oversight. DP provided an update on the rationale for increasing the risk grading in relation to resuscitation compliance. JA noted that this would be discussed at the next Patient Safety Forum (now open to all healthcare professions).	

Actions	**Deadline**	**Owner**
JA to provide update to RJ and JA on resuscitation audit findings following the Patient Safety Forum.	November	JA
Risk Register process to be continually reviewed by DP to ensure it follows good governance.	Ongoing	DP

13.	**Safeguarding Reports (Children and Adults)**	
	The **Safeguarding Children's report** was approved by the Quality Committee. Key issues were highlighted as follows;	

	DC noted the Trust had not achieved 80% target for training. DHU asked if the completion of mandatory training was tied in to appraisals; DC advised that as of September the pay progression policy states that all mandatory training must be completed to qualify for incremental pay increase. DC advised that a more detailed review of ESR was required to identify if staff have been assigned the correct mandatory training and to provide targeted training to non-compliant individuals The **Safeguarding Adult's report** was approved by the Quality Committee. Key issues were highlighted as follows; • Slight increase in training compliance for level 2, and a slight reduction in level 1 compliance • In May 2016, Whittington Health was delighted to welcome Mr Justice Charles, the vice president of the Court of Protection to speak to staff and partners. The event was well attended and helped to increase awareness of DoLs across the organisation • Slight decrease in the number of adult safeguarding concerns raised; the rationale is being examined • Pressure ulcers are raised as safeguarding concerns where they are assessed as avoidable. The findings are captured in the Medical Directors Safety Report.

Actions	**Deadline**	**Owner**
Ongoing reports to the Committee	On annual cycle	DC

14.	**Nursing Quality Indicators**	**DC**
	The Nursing Quality Indicators report was approved by the Quality Committee. Key issues were highlighted as follows; • Improvement in indicators since last month • Good feedback from staff on the usefulness of the indicators which are used by ward managers with staff to identify areas for improvement • MM advised that children's data had been collected and would be presented next month • AS asked if the data collection was sustainable. FI confirmed this was one of the most useful tools available for nursing staff on the wards and congratulated the team for the excellent report.	

Actions	**Deadline**	**Owner**
Ongoing reports to the Committee	On annual cycle	DC

15.	**Aggregated SI, complaints and claims report (including Legal Services Q1 report)**	
	The Quality Committee approved the Aggregated SI, complaints and claims report. DP provided an update on the process for collating the data for the report. • The PALS team are still reviewing the process for updating DATIX and so there is only a partial summary provided in this report. • The NHSLA scorecard analysis, published in July 2016, was included for information. This will be a useful tool for aggregated learning going forward. Next step will be for NHSLA to provide benchmarking data. DP highlighted common trends emerging across SI, complaints and claims within service areas and in headline areas. AS asked what the process was for making improvements based on the trends identified. DP responded that this was a work in progress. AS suggested the themes should be discussed by the Executive Team with respect to strategic improvement planning. JA noted that one of the key areas for responding to themes will be in presenting the key learning in the new Safety Newsletter.	

Actions	**Deadline**	**Owner**
Executive Team to review themes from learning with regard to strategic improvement planning	November	PD

16.	**Infection Control Report Q1**	**DP**
	The Quality Committee approved the Infection Control Q1 report. JA provided a summary of the Infection Control Q1 report which covered 1 April to 26 August 2016 for all activity across the WH. Headlines from the report included: • **0** Trust attributable MRSA bacteraemia episodes. There was **one** MRSA bacteraemia identified from a community sample which has been investigated by Islington CCG. • **5** Trust attributable (post 48-hour) C.*diff* cases were diagnosed on Montuschi, Victoria x 2 (unconnected), Cloudesley and Coyle wards. PIR meetings have been held. The Trust objective for 2016/17 has again been set at 17 cases. • **2** further cases of CPE identified in community patients. There is no indication that these patients had contracted the organism at the Whittington. • Surgical site infection surveillance has been collated for quarter one, 1 April to 30 June 2016, with **0** hip implant infections (40 operations), **0** knee implant infection (49 operations) and **0** fracture neck of femur infections (28 operations). Collation of data for 1 January to 31 March 2016 was suspended due to staffing issues. • Collation of data for July to September quarter has commenced with 31 Total Hip Replacement (no infections so far); 16 Total Knee Replacement (no infections so far); and 22 fracture neck of femur operations (no infections so	

	far). • A total of 254 out of a possible 261 IPC audits (97%) were completed. 83% of IPC audits were fully compliant. • From figures obtained from ESR on 17 August 2016, **85%** of Whittington Health staff have now received infection prevention & control training. JA raised concerns about the denominator figure in terms of training compliance and noted that a full cleansing exercise was required on ESR staffing data as staff may be assigned incorrectly to clinical groups.

Actions	**Deadline**	**Owner**
Ongoing reports to the Committee	On cycle	DP
JA to liaise with HR team to clarify ESR recording and staff assignment	November	JA

17.	**Equality and Diversity Bi-Annual Report**	**CJ**
	The Quality Committee approved the Equality and Diversity bi-annual report. CJ provided a summary of the report; • Workforce Race Equality Standard on target for submission • AS reported that she was the national lead for the Workforce Race Equality Standard and provided an overview of the WRES for Committee members • DHU asked what actions were agreed at the Workforce Assurance Committee to reduce inequality. CJ responded she would feedback to the Committee on the actions agreed within a plan that had been part of the materials presented to the CQC. DHU stressed the importance of driving this forward and asked for a clear action plan to address inequality.	

Actions	**Deadline**	**Owner**
CJ to feedback on actions agreed at the Workforce Assurance Committee around equality and diversity.	November	CJ
Board seminar on equality and diversity improvement plan to be arranged.	October Seminar	CJ

18.	**Duty of Candour Report Q1**	**DP**
	Deferred to November Quality Committee due to data quality issues which need further clarification. DP provided assurance to Committee that duty of candour had been completed for all SIs.	

Actions	**Deadline**	**Owner**
November committee to receive Duty of Candour Report	November	DP

19	**Nursing Midwifery and AHP Education Q1 report**	
	The Nursing Midwifery and AHP Education Report Q1 2016/17 was approved by the Quality Committee. Key issues included; • Trust recognised as area of good practice in terms of dementia care and has been asked to be involved in research project. • New quality framework for education announced, against which all trusts will be measured and benchmarked. • Tariff for students will be reducing by 2% next year. Initial calculations suggest this will not have a huge impact but the finance team are reviewing projections.	
Actions		**Deadline**	**Owner**
None			

20.	**Trust Policies**	**GL**
	The Trust Policies paper was approved.	
Actions	**Deadline**	**Owner**
None		

21	**Serious Incident Report**	DP
	The Serious Incident report was approved by the Quality Committee. SI report reviewed previously at Trust Board. No trends identified from information governance SIs, as all a result of human error. Trustwide learning on information governance will be disseminated to all staff via the safety newsletter to ensure lessons learned are embedded across the trust.	
Actions	**Deadline**	**Owner**
Information governance learning to be included in next edition of the Safety Newsletter	November	GL

22.	**AOB**	**Lead**
	DH raised concerns relating to the length of the agenda and the volume of business for the meeting. LS noted that the Quality Assurance Committee had a large brief, although not as large as other trusts which could include information governance and Health and Safety. LS added that the Committee met bi-monthly as opposed to some trusts who met monthly. DHU felt it valuable to hear directly from ICSUs and asked what value the Quality	

	Committee brought to the Trust. AS responded that the Committee was a mandatory scrutiny Committee which provides assurance of quality and patient safety compliance to the Board and Commissioners, and escalates issues to trust working groups to action or to the executive team (TMG) or the Trust Board to provide strategic direction. DH asked for feedback from the last evaluation of the Committee's effectiveness and LS provided assurance that there was a Committee annual review of effectiveness in line with good practice principles and the lessons from 2014/15 had been reported to the Committee and implemented. This included a review of the business cycle, administration processes and distribution of papers in a timely manner, information flows and appropriate membership. LS highlighted the Terms of Reference for the Quality Committee which were in the Dropbox folder and had been part of the Trust Board SOs and SFIs report in June presented by the Chair. AS proposed discussion on the Trust culture and governance at Whittington at NEDs only meeting. LS reported that the Chair will be undertaking a review of governance which she will be supporting to ensure compliance with the NHS Code of Governance and Nolan principles.

Actions	**Deadline**	**Owner**
LS to forward the Terms of Reference to DHU	November	LS
AS to discuss with the Chairman the option to include the trust culture and governance as an agenda topic in a future NED meeting	November	AS/LS

Next meeting: Wednesday 9 November, Room 6, Whittington Education Centre